South London and Maudsley NHS Foundation Trust

Annual Report and Summary Accounts
2016/2017
Our Vision

Everything we do is to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all.

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Annual Report
This report was produced by the Communications and Media Department. Please contact us if you would like a copy in large print, audio, braille or translated into another language.

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Chapter 1

Overview of performance
Chapter 1

Joint message from the Chair and Chief Executive

This past year has been an important one for the Trust with significant steps forward in terms of improving the quality of care we provide for our patients, as well as significant operational, research and clinical developments. Having said that, 2016-2017 has also been a year of real challenge and although we have seen an increased level of support and understanding across the public arena for mental health issues, on the front line, NHS finances are stretched and the demand for services remains high.

One of the ways in which the NHS is addressing the financial challenges is to move towards a model of place based planning, expressed most clearly in the Sustainability and Transformation Plans (STPs), published earlier this year. The trust is part of two STPs – for south east and south west London - and we continue to be positively engaged in both, advocating for mental health services to be upheld as core to these developments, alongside acute physical health trusts.

It is in part the emergence of the STPs and the need to continue to find ways of providing quality care within a tighter financial envelope that has led to one of the most significant developments of the year, namely the formation of the South London Mental Health and Community Partnership (SLMHCP). With our neighbouring two trusts, Oxleas and South West London and St George’s, the partnership is focused on delivering better care and outcomes to the people we serve. In order to do this we are bringing together clinicians and managers to work together to drive quality and make optimal use of a significantly bigger, combined budget.

One key achievement of the partnership so far is the new model of care we have developed across our forensic mental health services. Authorised by NHS England, together we have now taken on the total budget for forensic services in South London, some £70m including £28m that formerly went out of area to private sector providers. Together we are working to develop improved pathways of care, to treat patients closer to home, and to draw resource into our sector and geography.

In addition to clinical changes the partnership is collaborating in other areas such as HR and workforce issues, estates, IT, pharmacy and procurement. For example, our Directors of Nursing successfully bid for £800k to train a new cohort of band two to four nurse practitioners to address gaps in our workforce, and our HR Directors are developing a new staff passport to allow staff to move easily between organisations.

At a Trust level there is also a great deal to be positive about.

We continue to receive good results in our Friends and Family Test (FFT) and the internal patient experience surveys for 2016-2017, with 83% of people who responded saying that they would recommend their friends and families to the Trust, and 96% saying they found staff to be kind and caring.

Financially speaking we have delivered 90% of our Cost Improvement Programmes and surpassed our control total, our financial target for the year.

We have invested significantly in our workforce in the past year and continue to focus on recruitment activity with a particular emphasis on nursing; and in spite of our challenges, we have very significantly reduced our spend on agency staff. We have implemented two key new systems – LEAP, our new learning management platform and TRAC, our new recruitment system - and our staff survey scores show that we are still ahead of national average but with, we believe, much more that we can do.

We continue to focus on staff development and in September we held our first awards ceremony as part of the Annual Members Meeting to recognise the dedication and expertise of our staff. For the first time we asked service users and carers to nominate individuals and teams that have gone the extra mile in their work. We also celebrated the hard work and support of our extraordinary team of governors.

Over the coming year we want to continue to improve the experience of our staff. In particular we will be especially focused on the support and opportunities for development that we provide for our staff who are from Black and Minority Ethnic (BME) backgrounds, who make up around 40% of our workforce. We are actively working to ensure that these
colleagues have the same working experience as non-BME staff and we have set out Trust objectives to ensure that staff are represented at senior pay grades that reflect the proportion of BME staff in our workforce.

The theme of this year’s Trust conference in March was quality improvement (QI). A year ago our contract with Institute for Healthcare Improvement and Intermountain Healthcare went live and since then we have Rolled out QI across the organisation, with 141 projects now in train from Trust-wide to team-led. Many staff have already been trained and the numbers are growing. One of the main Trust-wide programmes, four steps to safety, is already impacting significantly on the incidence of violence and use of restraints on wards. Teams are engaging positively with the programme and some teams are seeing a reduction in violent incidents of up to 80%. All members of the Senior Management Team are now undertaking monthly QI walkarounds to support staff on the ground with their quality improvement work.

We have appointed new Board members: a new Medical Director, Director of Nursing and Director of Corporate Affairs. As a Board we have been focusing on what really matters - the quality of outcomes and the lives that we can support through contact with our services.

Our staff at all levels continue to influence the development of NHS services. They are in leading roles in mental health transformation across London and nationally, including, amongst others, Early Intervention in Psychosis, the Royal College of Psychiatrists and the development of the London Mayor’s Thrive London initiative. We are particularly proud of our teams who have won national awards this year including from the BMJ Awards, the Royal College of Psychiatrists and the National Autistic Society.

Our research profile has been further strengthened this year by the news in September that the Department of Health awarded £66m funding over the next five years to our National Institute for Health Research (NIHR) Biomedical Research Centre at the Maudsley and Institute of Psychology, Psychiatry & Neuroscience at King’s College London. This award represents a substantial uplift in funding compared to the previous award and will allow the research unit to build on its current work and expand into new areas of research such as substance use, pain and mobile health technology.

The Trust is also leading in terms of digital and mobile health technology. In March we received the good news from NHS England that the Trust was to be London’s first mental health ‘Global Digital Exemplar’ with £5m matched funding allotted to exploit the potential of digital technology to ensure that care is more personalised and responsive to patient need. This funding will accelerate the work we are already doing to develop innovations that will provide patients with technology to support them to self-manage their conditions.

Operational improvements include the creation of three new Clinical Academic Groups (CAGs) including a CAG focused on improving our acute care pathway. As part of this new CAG we have opened a new, centralised Place of Safety to provide support to people in crisis across our four boroughs.

Looking forward to the year ahead, our aims are quadruple: to deliver outstanding services with outcomes that matter to our patients; to ensure that the experience of our patients and carers comes first; to secure the organisation’s sustainability in terms of finance and performance and, importantly, to improve the experience of our dedicated and passionate workforce.

To deliver these ambitions we will continue to listen to and work closely with our staff, commissioners and local and national partners, and to be guided by our Council of Governors and Membership. The Trust is fuelled by the passion of the people who work for it and we would like to take this opportunity to say a heartfelt thank you to everyone.

Roger Paffard, Chair
South London and Maudsley NHS Foundation Trust

Dr Matthew Patrick, Chief Executive
South London and Maudsley NHS Foundation Trust
Who we are

We provide NHS care and treatment for people with mental health problems. We also provide services for people who are addicted to drugs or alcohol. Our aim is to be a leader in improving health and wellbeing - locally, nationally and globally.

As well as serving the communities of south London, we provide over 50 specialist services for children and adults across the UK including a Mother and Baby Unit, Eating Disorders, National Psychosis Unit and National Autism Unit.

We provide:

- mental health services for people living in Croydon, Lambeth, Southwark, and Lewisham
- substance misuse services for residents of Lambeth, Bexley, Greenwich and Wandsworth
- specialist services for young people in Kent and Medway who require hospital admission for serious mental illness and outpatient treatment for adults with ADHD
- primary care, secondary care and inpatient mental health services in HMP Wandsworth and Increasing Access to Psychological Therapies (IAPT) services in HMP Brixton
- a range of mental health services internationally, in Europe and the Middle-East
- the largest mental health research and development portfolio in the country
- an extensive range of education, training and learning opportunities – including the Recovery College and Mental Health Simulation Centre. We host the most comprehensive mental health NHS library in London.

In partnership with the Institute of Psychiatry, Psychology and Neuroscience, King’s College London, we host the UK’s only specialist National Institute for Health Research (NIHR) Biomedical Research Centre for mental health and a Biomedical Research Unit for Dementia.

We are part of one of England’s six Academic Health Sciences Centres, King’s Health Partners, alongside King’s College London, Guy’s and St Thomas’ and King’s College Hospital NHS Foundation Trusts.

Our year 2016 - 2017

The Trust continued to face challenges on several fronts throughout 2016/17, with demand remaining high and pressurised NHS finances.

We are meeting these challenges by focusing on clinical outcomes that matter to patients and service users and making sure we prioritise the wellbeing of our staff. We are proud that our staff are continuing to embed and deliver high quality care, that is being recognised both locally and nationally.

In 2016/17 we have:

- Maintained positive ‘NHS ‘friends and families’ test results that showing that 83% of people asked would recommend their friends and families to the Trust. From our internal patient experience surveys, 96% said they found staff to be kind and caring.
- Delivered 90% of our Cost Improvement Programmes and hit our control total, financial target for the year.
- Acted on feedback from people who use our services, as well as their friends, families and carers by introducing “You said. We did” posters for all community teams and wards.
- Continued to work in partnership with service users to agree a set of outcome measures for their involvement at an individual, service, operational and strategic level.
- Significantly reduced our spend on agency staff and also training a new cohort of band 2-4 nurse practitioners to address gaps in our workforce.
- Rolled out quality improvement across the organisation, with 141 projects now in train from Trust-wide to team led. [insert project examples]
- Continued tackling mental health stigma by working with documentary makers and allowing them to film a critically acclaimed Channel 4 documentary, ‘Life on the Psych Ward’, about our work to ensure that offenders with mental health problems are assessed and treated effectively in a secure environment.
Enabled staff at all levels to take leading roles in mental health transformation across London and nationally, including Early Intervention in Psychosis, the Royal College of Psychiatrists and the development of the London Mayor’s Thrive London initiative.

- Won national awards including from the BMJ, the Royal College of Psychiatrists and the National Autistic Society.

- Raised the profile of mental ill health thanks to our contribution to a Wellcome Collection exhibition ‘Bedlam: the asylum and beyond’

- Been awarded £66m government funding for the next five years for our National Institute for Health Research (NIHR) Biomedical Research Centre at the Maudsley and Institute of Psychology, Psychiatry & Neuroscience, helping us to translate basic research discoveries into early stage experimental medicine in areas such as substance use, pain and mobile health technology.

- Become London’s first mental health ‘Global Digital Exemplar’ with £5m in matched funding, allowing us to accelerate our work using new platforms such as our e-observation programme, our mobile clinical app and our new online personal health record for patients and service users to self-manage their conditions.

- Created three new Clinical Academic Groups (CAGs) including a CAG focused on improving our acute care pathway, which included opening a new, centralised Place of Safety to provide support to people in crisis across our four boroughs.

- Been rated top mental health Trust in the country for recruiting patients to clinical studies, by the National Institute for Health Research (NIHR) Clinical Research Network.

- Have received prestigious seven Senior Investigator Awards from the National Institute for Health Research (NIHR).

- Pioneered a Consent for Contact (C4C) scheme that reached a milestone of recruiting 10,000 patients, interested in participating in research at the Maudsley and King’s College London’s Institute of Psychiatry, Psychology & Neuroscience.

- Four of our SLaM scientists and clinicians recognised in the Queen’s birthday honours, including Academic Director of our Addictions CAG, Professor Sir John Strang, who received a knighthood for services to medicine, addiction and public health.

- Formed the South London Mental Health and Community Partnership (SLMHCP), with Oxleas and South West London, focusing on delivering better care and outcomes for the people we serve by making optimal use of a significantly bigger £70m combined budget.
Who we are

Everything we do is to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all.

Who we are and what we do as an organisation is constantly changing and today we provide a much higher number of community services than we did in 1999 when the Trust was created. We’ve also expanded into some different areas and exciting partnerships.

NUMBER OF STAFF

4,673

PATIENT CONTACT VIA LOCAL CLINICAL COMMISSIONING GROUP (CCG)

Lambeth CCG
324,832

Croydon CCG
260,710

Lewisham CCG
257,956

Southwark CCG
250,449

Treat 45,000 patients in the community

Provide 5,300 people with inpatient care

BEDS ACROSS 8 INPATIENT SITES

(SEPTEMBER 2016)

760

Average numbers of employees (wte basis)

- Medical and dental: 413
- Ambulance staff: 0
- Administration and estates: 982
- Healthcare assistants and other support staff: 596
- Nursing, midwifery and health visiting staff: 1,246
- Nursing, midwifery and health visiting learners: 0
- Scientific, therapeutic and technical staff: 1,000
- Healthcare science staff: 0
- Social care staff: 69
- Agency and contract staff: 942
- Bank staff: 0
- Other: 0

Annual Report and Summary Accounts 2016/2017

South London and Maudsley NHS Foundation Trust
The number of partnerships with international organisations is increasing and we provide a number of clinical services and educational programmes in Europe, the Middle East and China.

In London we provide community and inpatient mental health services in Croydon, Lambeth, Lewisham and Southwark.

We provide drug and alcohol (addictions) services in Bexley, Greenwich, Lambeth and Wandsworth.

To address gaps in our workforce, our Directors of Nursing successfully bid for £800k, from Health Education England, to train a new cohort of band two to four nurse practitioners.

We employ around 5,248 permanent staff

942 staff are temporary

596 Healthcare assistants and other support staff

1,272 registered nurses (September 2017)

1,000 scientific, therapeutic and other technical staff

439 medical and dental

982 administration and estates staff

Proud of our diverse workforce - around 40% of our workforce are from a BME background

Over 75% of communications from our community teams to GPs includes a discussion about a service user's physical health

83% would recommend us to friends and family

96% say they found staff to be kind and caring

Proud of our diverse workforce - around 40% of our workforce are from a BME background

£387m turnover 2016/17

We also provide a series of partnership services working with other NHS organisations, local authorities, criminal justice services and the third sector. Across the UK we provide approximately 50 national and specialist services for children and adults. In Kent we provide specialist child and adolescent mental health services.
Brief history of the Trust

Our history dates back to the foundation of the Bethlem Royal Hospital in 1247, the oldest psychiatric institution in the world.

1247
The Priory of St Mary of Bethlehem, Bishopsgate, is founded on land given by Alderman Simon FitzMary. It later becomes a place of refuge for the sick and infirm. The names ‘Bethlem’ and ‘Bedlam’, by which it came to be known, are early variants of ‘Bethlehem’. It is first referred to as a hospital for ‘insane’ patients in 1403, after which it has a continuous history of caring for people experiencing mental distress.

1676
In its first move, the Bethlem is re-sited at Moorfields, the first purpose-built hospital for the ‘insane’ in the country.

1815
The Bethlem moves to St George’s Fields, Southwark. Following a parliamentary inquiry into the treatment of patients, blocks for the ‘criminally insane’ are built in 1815-1816.

1863
The newly-built Broadmoor Hospital in Berkshire admits Bethlem’s ‘criminal patients’.

1867
The Southern Districts Hospital (or Stockwell Fever Hospital as it became known) opens on the site which is today known as Lambeth Hospital.

1908
Henry Maudsley writes to the London County Council offering to contribute £30,000 towards the costs of establishing a “fitly equipped hospital for mental diseases.” The Maudsley initially opens as a military hospital in 1915 to treat cases of “shell shock” and becomes a psychiatric hospital for the people of London in 1923.

1948
With the introduction of the National Health Service (NHS) in 1948, the Bethlem Royal Hospital and Maudsley Hospital are merged to create a postgraduate psychiatric teaching hospital. The Maudsley’s medical school becomes the Institute of Psychiatry.

1954
Sister Lena Peat and Reginald Bowen become the first community psychiatric nurses, caring for patients at home who had been discharged from Warlingham Park Hospital in Croydon.

1997
The Ladywell Unit, at University Hospital Lewisham, is refurbished for use by adult inpatient mental health services. The development brings together inpatient services which had previously been spread across other hospital sites (Hither Green, Guy’s and Bexley).

1999
South London and Maudsley NHS Trust (SLaM) is formed - providing mental health and substance misuse services across Croydon, Lambeth, Lewisham and Southwark; substance misuse services in Bexley, Greenwich and Bromley; and national specialist services for people from across the UK.
2006
South London and Maudsley becomes the 50th NHS Foundation Trust in the UK under the Health and Social Care [Community Health and Standards] Act 2003

2007
South London and Maudsley and the Institute of Psychiatry, King’s College London establish a Biomedical Research Centre, funded by the National Institute for Health Research (NIHR), one of only 12 in the UK and the only one devoted to mental health

2009
South London and Maudsley becomes part of one of the five Academic Health Sciences Centres (AHSCs) in the UK to be accredited by the Department of Health. King’s Health Partners AHSC also involves King’s College London, Guy’s and St Thomas’ and King’s College Hospital NHS Foundation Trusts.

2010
SLaM introduces mental health Clinical Academic Groups (CAGs) in partnership with the Institute of Psychiatry, King’s College London. This is a new way of bringing clinical services, research and education together to improve patient care

2011
SLaM opens a new 24 bed, state-of-the-art centre for children and teenagers with mental health problems living in Kent and Medway

2012
Discussions underway about the idea of creating a new academic healthcare organisation, involving Guy’s and St Thomas’, King’s College Hospital, and South London and Maudsley NHS Foundation Trusts and our University partner King’s College London

2014
As part of King’s Health Partners, received formal accreditation for a further five years as one of just six Academic Health Science Centres in the country.

2015
Achieved an overall ‘Good’ and ‘Outstanding’ ratings from the CQC for our learning disability and autism services. The Department of Health awarded £4 million investment to our Clinical Research Facility and £66m to our NIHR Maudsley Biomedical Research Centre to continue our research into ground-breaking treatments and care for mental health and dementia and expand research into new areas.

2016
The Bethlem Museum was a finalist for the prestigious Art Fund’s Museum of the Year.
Strategic overview of the Trust

This section sets out a summary of the Trust's vision, strategic direction and priorities. More detailed information is available in our Operational Plan, submitted to NHS Improvement and available on our website slam.nhs.uk

Our vision

Everything we do is to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all.

Our five commitments

Our staff work in ways that build mutual, respectful relationships with each other, with people when they use our services, and their families, friends and carers, in accordance with our five commitments:

1. be caring, kind and polite
2. be prompt and value your time
3. take time to listen to you
4. be honest and direct with you
5. do what I say I am going to do

Our strategy

The Trust has been working with our stakeholders to develop a five-year strategy.

We have been doing so at a time of exceptional financial pressure and demand on the NHS, prompting unprecedented focus on delivering quality services whilst managing costs downwards. This has necessitated a drive to change the way care is delivered through new national imperatives (Mental Health 5-Year Forward View), new ways of delivering services (the New Models of Care Programme and thinking on group structures) and through joint planning across localities (Sustainability and Transformation Plans).

Our strategy and implementation plan is still being detailed but the broad strokes and goals we are seeking to achieve are becoming clearer. We believe we can best improve the lives of the people and communities we serve and promote mental health and wellbeing for all by focusing on the development and delivery of population-based mental health solutions. This means improving outcomes that matter to patients, enhancing patient and staff experiences and delivering better health prevention and promotion goals for every pound spent by health and care systems.

We will do this by using our unique combination of strengths in service innovation, quality improvement, partnership working, research and informatics to:

- Develop and deliver outstanding mental health services for the people and populations we serve
- Translate, with the Institute of Psychiatry, Psychology & Neuroscience at King's College London, internationally recognised academic excellence into practice
- Support truly integrated and preventative health and care by innovating in partnership with our staff, service users, carers and the organisations with whom we work most closely

We have set out key goals under these three foundations that we will continue to develop going forward.

Our key goals for the next five years

Outstanding mental health services

- Embed quality improvement (QI) fully within the organisation in a way that engages staff, service users and carers in pursuit of outcomes that matter to people
- Work with staff, carers and service users to improve service quality and safety with our QI approach, reflected in a Care Quality Commission rating of ‘outstanding’ across all pathways of care
- Become the employer of choice for staff wanting to work in the mental health field, where staff engagement is at the highest level and people feel valued, developed and empowered to deliver the best possible care

Innovating and delivering in partnerships

- Engage more effectively with our service users, carers and staff to ensure we listen to their needs and involve them fully and appropriately in service development and delivery
Work effectively with our key corporate partners to increase the impact of services by delivering new, local delivery models of care with our borough, Clinical Commissioning Groups (CCGs) and local care network partners

Build our regional scale to innovate and set the standard for mental health services in southern England with the South London Mental Health and Community Partnership, within our local Sustainability and Transformation Plan (STP) and within King’s Health Partners

Continue the strong, historic and organic relationship between the Trust’s research and development and the Institute of Psychiatry, Psychology & Neuroscience at King’s College London

Academic excellence into practice

Establish early detection and targeted prevention as an international focus for mental health fundraising, supporting the development of a new Institute for Child and Young People’s Mental Health

Develop the Centre for Translational Informatics, supporting both population health and optimised clinical service delivery

Future performance

We face a number of key challenges in the year(s) ahead. These include:

Alongside all public services, the NHS has been set challenging savings targets over the past few years. Although, at 2%, the annual NHS efficiency target in 2017/18 is unchanged from the previous year, the cumulative efficiency target over the last 6 years is just under 20%. Such levels of savings are an increasing challenge at a time when pressures on services continue to mount.

Our four main local CCGs that together provide approximately 60% of our total Trust income continue to require additional savings as part of their Quality Innovation, Productivity and Prevention (QIPP) programme. In 2017/18 these amount to £7.7m. It is vital that the plans agreed with commissioners will enable this funding to be released from services through the delivery of planned developments or service changes to avoid destabilising the delivery of local service care pathways.

Achieving the new NHS Improvement surplus Control Total of £2.3m (£0m before core Sustainable Transformation Fund) compared to the deficit Control Total of £4m (£6.3m before core SFT) in 2016/17 – an improvement required in 2017/18 of over £6m.

Funding an internal investment programme focused on increasing our investment in our value based, quality improvement, healthcare programme, and including continuing improvements in ICT, and a new catering/dominic contract funding new cost pressures arising from the introduction of the apprenticeship levy, increased clinical negligence premiums and new junior doctor contract.

The introduction of new innovative commissioning models, such as alliance contracting, which will support the principal objective of the Trust for increased partnership working with other local Trusts, primary care, other statutory services and the independent and voluntary sectors.

Doing this successfully will also mean:

Becoming the employment organisation of choice for NHS and care staff, with a special focus on people from Black and Minority Ethnic (BME) communities

Maintaining financial sustainability and pursuing selected commercial opportunities to help us invest in core infrastructure and areas that make the Trust distinct

Being leading advocates for the advancement of people with mental disorders everywhere

Over the coming year we will work with our partners, staff and the Board to develop our strategy and implementation plans.
Actual levels of activity in adult acute inpatient and complex/residential placement services exceeded contractually funded (block funded) levels of activity in 2016/17 causing in-year financial pressures. In 2017/18 the Trust has agreed reduced contract baselines based on a series of measures that are being introduced to help reduce future activity. However the risk remains of activity demand exceeding planning totals with subsequent use of unfunded beds. This position may become exacerbated by the impact of social care cost reductions.

Significant under-performance has been recorded on some cost improvement plans (CIPs) in 2016/17 that, in part, will cause a financial pressure in 2017/18. Within the current climate, however, effective identification, management and implementation of CIPs are key. A Programme Management Office, set up during 2015/16, is being restructured to help drive improvements in the planning and delivery of the CIP, QIPP and transformation programmes.

Work continues on implementing mental health tariff currencies. The Trust will continue to allocate patients to clusters and will undertake joint work with commissioners to help develop outcome based capitation models of commissioning. This may involve a potential rebasing between commissioners from 2018/19.

An additional 2.5% of the Trust’s contractual income is available to incentivise achieving quality and innovation targets under the contractual Commissioning for Quality and Innovation (CQUIN) scheme negotiated with commissioners. The Trust will continue to seek to maximise its performance in this area. However, as part of new planning guidance, 0.5% of CQUIN must now be held back as a risk reserve and will only be released for investment in the Trust if the STP overall delivers its in-year system control total.

The Trust continuing to maximise its performance in terms of meeting national and local commissioner and regulatory quality standards and information requirements.

The Trust working to deliver the new access targets for mental health in 2017/18.

The Trust ensuring that inpatient services have adequate staffing levels to provide safe and effective care through continuous advertising, new external advertising campaigns, workforce transformation initiatives and efficient use of e-rostering.

**Going concern disclosure**

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.
1.2 Performance analysis

How we monitor and measure performance

The new NHS Improvement single oversight and improvement framework replaced the Monitor risk assessment framework from 1 October 2016. The new framework sets out operational metrics for monitoring how performance is improved and sustained. A number of metrics were consistent with the previous framework and are set out below, showing the target and performance achieved for the full year.

<table>
<thead>
<tr>
<th>Operational performance metrics</th>
<th>Target</th>
<th>16/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards</td>
<td>95%</td>
<td>96.5%</td>
</tr>
<tr>
<td>2. People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral</td>
<td>50%</td>
<td>61.9%</td>
</tr>
<tr>
<td>3. Mental Health Services Data Set completeness, MH: identifier metrics</td>
<td>95%</td>
<td>98.9%</td>
</tr>
<tr>
<td>4. Improving access to psychological therapies (IAPT) Waiting Times 6 Weeks Standard</td>
<td>75%</td>
<td>89.7%</td>
</tr>
<tr>
<td>5. Improving access to psychological therapies (IAPT) Waiting Times 18 Weeks Standard</td>
<td>95%</td>
<td>99.3%</td>
</tr>
<tr>
<td>6. Cardio-metabolic assessment and treatment for people with psychosis: inpatient wards</td>
<td>90%</td>
<td>81%</td>
</tr>
<tr>
<td>7. Cardio-metabolic assessment and treatment for people with psychosis: early intervention in psychosis services</td>
<td>90%</td>
<td>62%</td>
</tr>
<tr>
<td>8. Cardio-metabolic assessment and treatment for people with psychosis: community mental health services (people on Care Programme Approach)</td>
<td>65%</td>
<td>42%</td>
</tr>
<tr>
<td>9. Mental Health Services Data Set completeness, MH: priority metrics</td>
<td>85%</td>
<td>82.0%</td>
</tr>
<tr>
<td>10. Improving access to psychological therapies (IAPT) Recovery Rate</td>
<td>50%</td>
<td>50.4%</td>
</tr>
</tbody>
</table>

A number of new operational metrics were introduced in October 2016 and there has been on-going development and implementation of action plans to improve our performance and quality of care. Additionally there is continued development of the way this data is captured and reported to ensure it accurately represents performance. Month 12 performance is shown in the table given the mid-year implementation or the metrics.
National standards performance 2016/17

The provision of physical health checks remains a priority and is a national CQUIN for 2017/19. We continue to make progress as we work towards achieving the target.

Earlier in the year we struggled in two areas, and in response to this recovery plans were developed for these standards:

- **Indicator 1 - Crisis Resolution / Home Treatment Team Gatekeeping:**
  
  The Home Treatment Gatekeeping indicator was not achieved in Quarter 2. Following the implementation of a new 24-hour central triage function, with embedded Home Treatment Teams, performance improved significantly and the full year performance exceeded the national target.

- **Indicator 2 - Early Intervention in First Episode Psychosis:**
  
  The access standard for Early Intervention in Psychosis treatment in Quarter 1 was not met. The Early Intervention performance in Quarter 2 exceeded our recovery trajectory and the full year performance exceeded the national target. Commissioners were briefed at the six month review meeting on the risk of increasing caseloads in some boroughs and the potential impact on NICE guidance concordance based on the projected growth of caseloads against existing investments.

Improving Access to Psychological Therapies (IAPT) waiting time performance (indicators 4 and 5) has been consistently above the 6 week and 18 week targets. Whilst the standard has been met, there is a continued risk in one borough, with potential implications to overall Trust performance, due to changes in service provision arising from an affordability challenge.

Achieving the new recovery rate target of 50% (indicator 10) in month 12 has been the result of considerable focused work. In two boroughs, locally agreed plans have successfully delivered sustained improvements in the recovery rate. Significant improvements have been made for the third borough and there is a shared recognition with the CCG of the complexity of a cohort of the patients and solutions are being considered, including for more specialised provision. There is a risk in one borough due to changes in service provision arising from an affordability challenge; the focus has been minimising the impact on access targets and the recovery rate has consequently been affected.

In January 2017 NHS Improvement modified the definition of the Mental Health Services Data Set completeness metric for priority metrics (indicator 9). The table above reflects our performance against the revised definition covering the remaining three elements of this measure – ethnicity, accommodation status and employment status.

Activity outturn in 2016/17

Adult acute inpatient services have experienced continuing pressure through the year and the planned reduction in Occupied Bed Days (OBD) for 2016/17 has not transpired. The key driver for this is that while rates of admission have been stable or reduced slightly the anticipated reductions in length of stay have not materialised as planned. The rise in OBDs was not consistent across all CCG populations and the work to understand the detailed root causes will continue to be a key area of focus in 2017/18. Where we do have detailed analytics, however, the rise in delayed transfers of care consequent on housing and social care issues has been the primary driver. The activity forecast for Adult Acute Care was in excess of the agreed indicative activity plan with commissioners and this resulted in higher levels of patients being placed in private overspill throughout the year.

In response to this, the acute and crisis pathways have been brought together to better support patient flow, reduce length of stay and improve patient experience. The full benefit of this approach is anticipated to impact fully in 2017/18. This has included the development of an Assessment and Referral Centre (ARC) providing a centralised triage function and a reconfiguration of Home Treatment Team provision.

Performance management framework

In addition to the NHS Improvement metrics, the Trust uses a Performance Management Framework to support the management and assurance of our overall performance. There are Key Performance Indicators across the following areas:

- Finance (including cost improvements and cost reductions)
- Operations (workforce, activity and quality indicators)
- Patient and commissioner measures
- Learning and growth

Performance indicators are reviewed at a service level and aggregated to produce overarching dashboards for performance and quality across the Trust – as detailed overleaf.
Trust performance and quality dashboards
Trust performance and quality dashboards
Trust performance and quality dashboards
Significant developments

To respond to increasing demands on our system, we have reviewed and changed our structure of Clinical Academic Groups (CAGs), looking at what was working well and what needed improvement - the need for more emphasis and focus on our local and borough communities and the importance of freeing up the recovery pathway to deliver the benefits of our Adult Mental Health plan. In relation to these factors we have made the following changes with the aim of establishing clear pathways that will support the highest quality of care and outcomes:

- The Psychological Medicine CAG has been brought together with the Mood, Anxiety and Personality CAG to focus on delivering our community facing services and our ‘mind and body’ provision (including specialist services).
- A new Acute Care CAG has been created to establish a single pathway structure across our entire adult care pathway. It includes place of safety; crisis line; psychiatric intensive care units; triage wards; acute ward; home treatment team; overspill and bed management teams.
- The Psychosis CAG now focuses on promoting recovery, early intervention and rehabilitation and complex care.

A significant development in 2016/17 has been the introduction of our new Acute Care CAG providing acute care across inpatients and home treatment teams, as well as providing urgent assessment, a centralised Place of Safety and a 24 hour mental health support line. This joined up approach supports working across the system in order to maintain flow in the system and thereby reduce lengths of stay. A new Acute Referral Centre became operational in October and this ensures patients requiring acute care receive a gatekeeping assessment and can therefore best determine the appropriate pathway to follow.

Centralised Place of Safety

A new centralised Place of Safety service opened on the Maudsley site and started receiving patients from across our four boroughs on 7 February 2017. The new service offers a dedicated 24-hour service to patients in crisis across Lambeth, Southwark, Lewisham and Croydon. The service opened following engagement with patients and the public, Healthwatch, voluntary sector groups and other local partners; and plans were approved by Overview and Scrutiny Committees. The separate 136 suites across the Trust have now closed.

The centralised Place of Safety is part of a pilot to test guidance published by NHS England on health based Place of Safety suites.

During 2016/17 the Trust’s review of social care provision in Southwark mental health services resulted in a change from the historic integrated arrangements for Southwark council mental health social workers within community teams. A new model has been developed moving the social workers to a central team, with a closer interface with primary care and local care networks; there is an ‘in-reach’ service into our secondary care services. The Trust continues to work in partnership with partners in Southwark to develop shared protocols in order to mitigate and minimise the associated risks.

We recognise the key issues we need to address. We are tackling this in a number of ways, including through:

- Our quality improvement programme, focusing on the management and redesign of the acute care pathway
- Addressing commissioning and capacity issues to help reduce the pressure on our inpatient areas
- Prioritising recruitment and safer staffing
- Resolving outstanding estates and facilities issues
- Establishment of the Programme Management Office, and Transformation Steering Group and Board to deliver transformative service delivery changes and cost improvements

In order to best position ourselves to manage our risks we are:

- Collaborating with our commissioners to ensure the services we provide meet the needs of their populations and the available investment in mental health services
- Working across the system with partners such as Our Healthier South East London and Sustainability and Transformation Plans
- Ensuring we work across the organisation including community, child and adolescent, older adults and specialist services.
Our performance

Trust financial position

This year we reported a net surplus of £3.8m. This was a £9.1m favourable position from the Trust’s deficit Control Total agreed at the start of the year with NHS Improvement (NHSI). This position was reached only after receipt of £7m of non-recurring incentive and bonus payments from NHSI. These were payable as a result of the Trust meeting both its Control Total and delivering a profit on disposal of assets. In addition to the incentive and bonus payments, the Trust also received £2.3m of Sustainability and Transformation (STF) funding for meeting its quarterly Control Totals.

In terms of the operating position (i.e. prior to the £7m incentive payment and £2.3m STF payment, the Trust made a deficit of £5.5m but did achieve the deficit Control Total.

This has been a challenging year for the Trust and was set against a background of:

- Cost pressures in a number of CAGs and corporate services where delays or gaps in cost improvement plans contributed to those services not being in financial balance. To mitigate against this, additional in year savings measures were implemented including ‘locking in’ underspends from those services that were in surplus.
- A requirement to invest in our ICT infrastructure to improve resilience and user experience and a clear Board commitment to ensure we could continue to invest into a number of quality initiatives including a new single place of safety, launching our quality improvement programme (QI), improving volunteer services and updating our training systems.
- A wide ranging programme of cost improvements required to meet Government efficiency targets (set at 2% in 2016/17) and re-investment into more efficient service delivery and other improvements.
- A further reduction in costs required to meet the budgetary targets of local CCGs. In 2016/17, contracts with Lambeth, Southwark, Lewisham and Croydon CCGs included £6.6m of additional saving initiatives.
- Our financial performance has been supported by a positive average cash balance in 2016/17 of approximately £49.7m (£62.4m 2015/16). Liquidity increased from 13 days to 19 days as a result of STF incentive and bonus payments.

During the year, the main drivers of the Trust’s performance have been:

- The impact of high levels of adult acute inpatient activity resulting in the use of beds outside the Trust (‘overspill’). The key driver for this is that while rates of admission were stable or reduced slightly, the anticipated reductions in length of stay did not materialise as planned. This has meant that the planned reduction in OBDs for 2016/17 has not transpired. Although the Trust had risk share arrangements in place with all four of its local CCGs, the scale of overspill (up to 54 external beds) meant that unfunded placements contributed £2.8m to the bottom line deficit (a 50% reduction from 2015/16). In response to this, the acute and crisis pathways were brought together in 2016 to better support patient flow, reduce length of stay and improve patient experience. The full benefit of this approach is anticipated to impact fully in 2017/18. This has included the development of an Assessment and Referral Centre (ARC) providing a centralised triage function, reconfiguration of Home Treatment and Bed Management Teams and reconfiguration of the wards and their alignment with local boroughs.
- Responsibility for purchasing (non-medium and low secure) external placements in Lambeth, Southwark and Lewisham lies with the Trust. Whilst Lambeth and Lewisham operated within plan, Southwark placements continued to be an outlier. Prior to the impact of any risk shares, placement activity in Southwark was £1.9m above funding available. Such placements remain a high cost, high risk area for the Trust with much focus on their management during the coming year to ensure activity can be met within the resources available.
- Ward nursing costs remained an issue and although the variance from plan was £0.8m lower than 2015/16, these costs still ended the year £1.9m above funding. In particular our four Psychiatric Intensive Care Units (PICUs) exceeded staffing establishments by £1.14m (60% of the total ward nurse overspend). Going into the new financial year the PICU budgets have been revised with the clear expectation that these wards will work within the new establishment set in future.
Use of agency staff at rates above funded pay budgets. In 2016/17 NHSI set a ceiling to spend no more than £17.4m on all agency staff. Based on this target the Trust spent £22.6m, missing the target by £5.2m (30%). The use of agencies to fill vacant posts meant the Trust incurred an additional expense of £3.8m above the cost of employing permanent staff (assuming a 20% agency premium). This will clearly be an area of continued focus in 2017/18 with new NHSI targets set which the Trust is expected to perform within and the drive to realise further savings in reduced agency premiums.

Cost Improvement Plans (CIPs) To achieve the planned deficit for the year of £6.5m, the Trust had planned to deliver savings of £29m. At year end, the Trust recorded savings against cost improvement schemes of £23.1m. The savings generated represent a substantial achievement being approximately 6% of total expenditure. The main shortfalls occurred on planned overspill reductions and slippage on infrastructure review initiatives. In-year recovery planning generated additional savings to mitigate against this risk including tight controls and close monitoring of budgets giving rise to in-year underspends, combined with non-recurrent utilisation of contingency reserves and the release of balance sheet provisions.
Details on our financial performance are shown below

<table>
<thead>
<tr>
<th>Income and Expenditure Position</th>
<th>FT</th>
<th>Group</th>
<th>£m</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>387.0</td>
<td>385.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>(380.6)</td>
<td>(383.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Finance Income</td>
<td>3.2</td>
<td>3.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fair Value Movements</td>
<td>0.1</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDC (Gov) Dividend</td>
<td>(6.0)</td>
<td>(6.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Deficit) Surplus</td>
<td>3.8</td>
<td>13.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash Position</th>
<th>FT</th>
<th>Group</th>
<th>£m</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening cash</td>
<td>56.7</td>
<td>57.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBITDA Operating Surplus</td>
<td>21.2</td>
<td>17.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restructuring</td>
<td>(1.5)</td>
<td>(1.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Grants</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Finance Income</td>
<td>0.0</td>
<td>3.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividend Paid</td>
<td>(5.0)</td>
<td>(5.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>(14.7)</td>
<td>(14.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net movement in financial assets</td>
<td>0.0</td>
<td>0.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in working capital</td>
<td>(6.5)</td>
<td>(5.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDC received</td>
<td>0.3</td>
<td>0.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closing cash</td>
<td>55.1</td>
<td>57.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Control Total</th>
<th>FT</th>
<th>Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus</td>
<td>3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less STF core funding</td>
<td>(2.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less STF funding incentive and bonus</td>
<td>(7.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deficit before STF funding</td>
<td>(5.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plus net impairments</td>
<td>4.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plus depreciation on donated assets</td>
<td>0.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less net gains on disposal of assets</td>
<td>(3.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relevant deficit against total control</td>
<td>(4.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control total set by NHSI before STF</td>
<td>(6.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus against total control</td>
<td>2.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Trust is assigned a Use of Resource rating by NHSI. The rating is based upon 5 financial metrics: liquidity (number of days of operating costs held in cash or cash-equivalents), capital service capacity (the degree to which income covers financial obligations), I&E margin (the degree to which the Trust is operating a surplus/deficit), distance from plan (the variance between our planned I&E deficit and our actual deficit) and agency spend (distance from our NHSI target). The ratings are averaged to calculate the overall rating and range from 1-4 where 1 represents the best. In 2016/17 we achieved a rating of 1 due to the incentive payments received from NHSI.
Trends in income, EBITDA and assets employed

The charts below show the trends in turnover, retained surplus/deficit and assets employed over the seventeen year period since the formation of the Trust.

**Turnover**

<table>
<thead>
<tr>
<th>Year</th>
<th>Value (£M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999/00</td>
<td>150</td>
</tr>
<tr>
<td>2000/01</td>
<td>150</td>
</tr>
<tr>
<td>2001/02</td>
<td>150</td>
</tr>
<tr>
<td>2002/03</td>
<td>150</td>
</tr>
<tr>
<td>2003/04</td>
<td>150</td>
</tr>
<tr>
<td>2004/05</td>
<td>150</td>
</tr>
<tr>
<td>2005/06</td>
<td>150</td>
</tr>
<tr>
<td>2006/07</td>
<td>150</td>
</tr>
<tr>
<td>2007/08</td>
<td>150</td>
</tr>
<tr>
<td>2008/09</td>
<td>150</td>
</tr>
<tr>
<td>2009/10</td>
<td>150</td>
</tr>
<tr>
<td>2010/11</td>
<td>150</td>
</tr>
<tr>
<td>2011/12</td>
<td>150</td>
</tr>
<tr>
<td>2012/13</td>
<td>150</td>
</tr>
<tr>
<td>2013/14</td>
<td>150</td>
</tr>
<tr>
<td>2014/15</td>
<td>150</td>
</tr>
<tr>
<td>2015/16</td>
<td>150</td>
</tr>
<tr>
<td>2016/17</td>
<td>400</td>
</tr>
</tbody>
</table>

Turnover increased by 4.4% in 2016/17, 1.9% before STF. 80% of income is received from NHS Clinical Commissioning Groups and NHS England and a further 12% from other NHS organisations.

**EBITDA 1999 - 2017**

<table>
<thead>
<tr>
<th>Year</th>
<th>Value (£M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999/00</td>
<td>10</td>
</tr>
<tr>
<td>2000/01</td>
<td>10</td>
</tr>
<tr>
<td>2001/02</td>
<td>10</td>
</tr>
<tr>
<td>2002/03</td>
<td>10</td>
</tr>
<tr>
<td>2003/04</td>
<td>10</td>
</tr>
<tr>
<td>2004/05</td>
<td>10</td>
</tr>
<tr>
<td>2005/06</td>
<td>10</td>
</tr>
<tr>
<td>2006/07</td>
<td>10</td>
</tr>
<tr>
<td>2007/08</td>
<td>30</td>
</tr>
<tr>
<td>2008/09</td>
<td>30</td>
</tr>
<tr>
<td>2009/10</td>
<td>30</td>
</tr>
<tr>
<td>2010/11</td>
<td>30</td>
</tr>
<tr>
<td>2011/12</td>
<td>30</td>
</tr>
<tr>
<td>2012/13</td>
<td>30</td>
</tr>
<tr>
<td>2013/14</td>
<td>30</td>
</tr>
<tr>
<td>2014/15</td>
<td>30</td>
</tr>
<tr>
<td>2015/16</td>
<td>30</td>
</tr>
<tr>
<td>2016/17</td>
<td>30</td>
</tr>
</tbody>
</table>

2016-17 EBITDA includes £9.3m STF
The net assets of the Trust include property of £230m.

Events since year end affecting the Trust

There have been no significant events after the year-end affecting the Trust.

Overseas operations

The Trust launched a new child and adolescent service in Abu Dhabi in autumn 2015. Maudsley Child and Adolescent International Abu Dhabi is a collaboration between our organisation and the Macani Medical Centre. The service is managed by the Trust, with a core team based in Abu Dhabi supplemented by visiting consultant staff from the Maudsley Hospital who provide specialist clinics such as Mood Disorders, OCD and Eating Disorders.

We do this by delivering effective, evidence-based interventions and comprehensive, high quality assessments, using the most appropriate tools. Our services are centred on young people and their families and are delivered with compassion, respect and a commitment to the developmental needs of children and young people.

Mental Health services for children and adolescents aged 2-18 years are provided including:

- Autism spectrum disorders, learning difficulties
- Attention deficit disorders, tic disorders
- Mood disorders: depression, mania and bipolar affective disorders
- Anxiety and stress related disorders: obsessive compulsive disorder, phobias, generalized anxiety, post traumatic stress disorders, reaction to severe stress and attachment disorders
- Eating disorders
- Conduct disorders, personality disorders
- Organic conditions, including psychosis
- Medical conditions with associated psychological difficulties

Dr Martin Baggaley, the Trust’s former Medical Director assumed the role of Chief Medical Officer of Maudsley Health in October 2016.

In 2017, mental health services for adults opened, operating a similar model to that of the Child and Adolescent Mental Health Service (CAMHS), experienced staff based in Abu Dhabi, again supplemented by senior clinicians from the Trust in London.
The team consists of a multi-disciplinary team of experienced professionals including clinical psychologists, nurses and psychiatrists, using the pathways, protocols and outcome measures from the Trust.

The local team has the necessary expertise and experience to treat the vast majority of patients presenting with a broad range of mental health disorders including depression, anxiety, relationship problems, bipolar disorder, alcohol and addiction problems, psychosis, autism and personality disorder.

Like CAMHS, the locally based team in Abu Dhabi is supported by world leading academics and clinicians based in London. There are regular visits from experts from the UK who see patients for second opinions and take part in training and education programs in Abu Dhabi and the UAE.

The local team supported by visiting specialists offer an extensive range of cutting edge, evidence based treatments, often developed and researched on at SLaM such as the New Maudsley model for eating disorders which is the most established and successful treatment regime for eating disorder.

**Equality and diversity**

The Trust continues to work hard to put its commitment to equality and diversity into everyday practice

**Examples of activity include:**

- Continued partnership working with Lambeth Black Health and Wellbeing Commission Independent Advisory Group to improve accountability, communication and action in partnership with representatives of black communities in Lambeth on shared priorities.
- To improve staff awareness and competency, updated guidance on working with interpreters for psychologists and psychotherapists and interpreters delivering psychological therapy.
- 21 Black History Month events were held across the Trust during October and November to celebrate cultural diversity and promote mental wellbeing for service users and staff.
- Working to improve communication with disabled service users by implementing the NHS Accessible Information Standard.
- Promoting the Trust’s guidance on supporting adult transgender service users.
- Promoting leaflets and posters on reporting homophobia, biphobia and transphobia.
- The Trust uses around 500 face-to-face interpreters per month (in around 90 different languages including British Sign Language) to ensure effective communication with service users whose first language is not English.
- The Trust helped challenge stigma and promote greater understanding about mental health at a national level by facilitating the development and production of a Channel 4 documentary ‘Life on the Psych Ward’ about our forensic services.

For detailed information about our work on equality and diversity, as well as social, community and human rights, please see the ‘Trust governance’ section of this annual report.

**Environmental matters**

The Estates and Facilities department continue to operate an Environmental Management System (EMS) which is accredited to the ISO:14001 and ISO:50001 standards, as monitored by the British Standards Institute (BSI). The department has set up a new Environmental Management group to oversee the EMS, overseeing the reaccreditation of the ISO:50001 (Energy) standard and the ongoing monitoring and auditing for the ISO:14001 standard. The auditors from BSI have raised no major nonconformities in external audits and the re-assessment results have been positive.

The EMS has continued to support the reduction of the Trust’s use of gas, electricity and fuel and carbon dioxide (CO2) emissions. The headline Trust figure for CO2 emissions for 2016/17 has provisionally been calculated at 9,967 tonnes, an 11% reduction from the emissions produced by the Trust in 2015/16. Diesel use has reduced by an average 176 litres per month, a reduction of 8% from the previous year principally as a result of the introduction of a fleet of 16 new vehicles with improved fuel efficiency. The waste contractor has made a conscious effort to increase recycling awareness across the Trust through roadshows, audits and training. The recycling rate across the Trust is 26% and there has been improvement in waste segregation on the main sites.
Within the EMS the Trust has established five steering groups covering different project areas within the environment and sustainability field. These cover: waste; water; energy management; transport; and biodiversity, and develop and manage the implementation of new initiatives and projects. As well as improving the Trust’s environmental performance, they also help to meet the objectives contained with the Trust’s Sustainable Development Plan.

The following examples show the practical work the Trust has undertaken in 2016/17:

- The Trust has commissioned a new online energy and carbon management system which will come into operation in 2017/18. This will link the Trust’s existing sub metering network with invoices from our energy suppliers to produce real time and historic energy use reporting, reporting at different levels, from the entire Trust’s Estate through to individual sites and individual buildings. In addition the system will include a dashboard, allowing all staff to access real time information on the energy performance of their building. The system will also record usage figures from other generators of carbon including transport and water and will feed into our carbon management plan and environmental reporting systems.

- As part of the environmental management system the Trust has produced Energy reports in 2016 for each of its three main sites: Lambeth Hospital, The Maudsley Hospital and Bethlem Royal Hospital.

- Also as part of the Environmental Management System the Trust holds a legal register, containing details of all Environmental Legislation and associated regulations and their impact on the Trust. This is reviewed on a six monthly basis and has been independently audited by BSI during 2016/17 as part of the ISO:14001 & ISO:50001 auditing and re-accreditation process.

- The Trust has agreed a servicing and maintenance contract for its Estates and Facilities fleet vehicles, with Smart Garages, a subsidiary of a social enterprise the First Step Trust. First Step Trust train and employ ex-mental health service users with the aim of providing them work experience and skills, in order to help them find long term employment in the community.

- The Energy Management steering group has developed a number of projects designed to reduce the use of fuel and carbon. The Boiler Replacement Project has created a list all gas boilers within the Trust and rated them for energy efficiency. The poorest performing boilers will then be replaced in addition to the ongoing replacement of broken boilers.

- Alongside purchasing 16 new vehicles for its Estates and Facilities fleet which replaced a number of older and less efficient owned and hired vehicles, all Estates and Facilities vehicles have been fitted with Telematic GPS devices which promote safer and more fuel efficient driving techniques.

Dr Matthew Patrick
Chief Executive
South London and Maudsley NHS Foundation Trust
30 May 2017
Chapter 2

Accountability report
Chapter 2

2.1 Directors’ report - How the Board operates

Board of Directors
The Board of Directors is collectively responsible for the Trust’s strategic direction, its day-to-day operations and performance. Their powers, duties, roles and responsibilities are set out in the Trust’s Constitution.

The role of the Board includes:
- Providing active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed.
- Setting the Trust’s strategic aims, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance.
- Ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies.
- Ensuring compliance by the Trust with its terms of authorisation, its Constitution, mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations.
- Ensuring that the Trust exercises its functions effectively, efficiently and economically and sets the Trust’s values and standards of conduct and ensures that its obligations to its members, services users, carers and other stakeholders are understood and met.

As a unitary Board, all Executive Directors and Non-Executive Directors have joint responsibility for every decision of the Board of Directors and share the same liability. This does not impact on the particular responsibilities of the Chief Executive as the Accounting Officer. Non-Executive Directors are responsible for determining appropriate levels of remuneration of Executive Directors and have a key role in appointing, and where necessary removing, Executive Directors and in succession planning.

The Board of Directors meets in public and actively encourages Governors, members and the public to attend. The Board also holds private sessions when these are required. There is also a regular programme of Board development and self-assessment.

Meet the Board
The descriptions below of the expertise and experience of the Trust’s Directors demonstrates their breadth of skills, knowledge and expertise.

The current Non-Executive and Executive Directors are as follows:

Roger Paffard Non-Executive Director (Chair)
Appointed Jan 2015 – Dec 2017
Roger Paffard was appointed Chair in January 2015. He has broad experience at Chair, Non-Executive and Chief Executive level across the business, public and voluntary sectors.

Roger’s career started in marketing with Lever Bros and Bristol-Myers and he subsequently held Chief Executive posts with Alberto Toiletries, Sharps Bedrooms (part of ADT), Staples Office Superstores and Thorntons Chocolates. In 2000 he switched to the public sector with chief executive roles at Remploy (a non-departmental public body helping to train and find employment for disabled people) and United Lincolnshire Hospitals NHS Trust. Over the last 12 years he has also held Trustee roles with three national charities (Marie Curie, Royal Voluntary Services and Sue Ryder) and some smaller educational or grant-making charities.

He has developed a special interest in end of life care, parity of esteem for mental health services, equality of opportunity for disabled people and integrated care.

He is currently Chair of the charity Sue Ryder and until 31 December 2016 was Vice-Chair of Newark and Sherwood NHS Clinical Commissioning Group.
Dr Julie Hollyman – Non-Executive Director
(Senior Independent Director and Deputy Chair)
Appointed January 2015 – Dec 2017
Dr Julie Hollyman trained and worked as a consultant psychiatrist in London. She then became the Chief Executive of the mental health service in which she worked.
Subsequently she was Chief Executive at Richmond, Twickenham and Roehampton Healthcare NHS Trust, Broadmoor Hospital Authority, and West London Mental Health NHS Trust.
She left the NHS 11 years ago and since then has worked as a Non-Executive in the not for profit and charitable sectors. Her roles have included being a member of the Refugee Council, and the Youth Justice Board, and chairing the Hyde Group (a housing association) and New College Worcester (a non-maintained special school for blind and visually impaired children).

Alan Downey – Non-Executive Director
Appointed June 2014 – May 2017, reappointed December 2016 – November 2019
Alan Downey began his career in 1981 as a fast-stream civil servant at the Department of the Environment, where he worked on a range of policies in areas such as urban regeneration, social housing, environmental protection and local government finance. He also spent two years as private secretary to successive Ministers of Local Government. In 1989 he joined KPMG, one of the Big Four accountancy and consulting firms, becoming a partner in 1997.
At KPMG, his clients included government departments, local authorities and NHS Trusts as well as companies in the transport, leisure and financial services sectors. Much of his consulting work focused on performance improvement and commercial strategy. In his final years at KPMG Alan led the firm’s public sector business in the UK and in Europe, Middle East and Africa. He retired from KPMG in June 2014 and has taken on a number of non-executive and charitable roles.

Mike Franklin – Non-Executive Director
Appointed May 2016 – May 2019
Mike Franklin is a former Commissioner with the Independent Police Complaints Commission. He was also HM Assistant Inspector of Constabulary and has acted as a Specialist Assistant Inspector, Race and Diversity across 43 policy orders in England and Wales. Mike was Chair of the Community Policy Consultative Group for Lambeth and also served on the TUC race relations Committee. Having grown up in Lambeth and Southwark, Mike is passionate about engaging with diverse local communities. He was also a Non-executive at Guy’s and St Thomas’ NHS Foundation Trust.

Duncan Hames – Non-Executive Director
Appointed May 2016 – May 2019
Duncan Hames was a Member of Parliament from 2010-2015, during which time he served as the parliamentary aide to the Deputy Prime Minister, Nick Clegg MP – attending the Government’s weekly Cabinet. He was also a board member of the Great Britain China Centre and a member of the Policy Advisory Board of the Social Market Foundation.
Duncan is a Chartered Management Accountant and has over 10 years of experience as a management consultant. Before entering Parliament, he also served on the board of the South West of England Regional Development Agency, chairing its Audit Committee. In August 2016, he was appointed as Director of Policy at Transparency International UK.

Duncan Hames was a Member of Parliament from 2010-2015, during which time he served as the parliamentary aide to the Deputy Prime Minister, Nick Clegg MP – attending the Government’s weekly Cabinet. He was also a board member of the Great Britain China Centre and a member of the Policy Advisory Board of the Social Market Foundation.

June Mulroy MBE – Non-Executive Director
Appointed January 2015 – Dec 2017
June is a chartered accountant with over 35 years’ experience including at main board level in both the private and public sectors in the UK and overseas. For over 15 years June has also served as a non-executive governor/director in higher and further education, and in restorative justice and has been audit chair for most of that time.
June’s working experience has been principally in financial services in UK, Switzerland, Ireland and France. There have also been substantial projects in the NHS and in UNESCO (Paris). Her 7 year appointment as an executive director in the Pensions Regulator where she was tasked with changing UK Pensions Policy and Regulation, resulted in her being awarded the MBE.
Anna Walker – Non-Executive Director  
**Appointed May 2016 – May 2019**  
Anna Walker brings extensive expertise in regulation and governance relevant to safety and quality. She was Chair of the Office of Rail Regulation until December 2015 and is currently Chair of Young Epilepsy.  
She is a Non-Executive on the Board of Cymru Welsh Water and a member of the Council of Trustees of Which? She was formerly Chief Executive of the Healthcare Commission, a Director General at the Department of Trade and Industry and the Department for Environment, Food and Rural Affairs and Deputy Director General of the Office of Telecommunications.

Professor Matthew Hotopf  
– Interim Non-Executive Director  
Matthew Hotopf is Director of the National Institute of Health Research Maudsley Biomedical Research Centre (BRC) and Professor of General Hospital Psychiatry at the Institute of Psychiatry, Psychology and Neuroscience, King’s College London. Matthew was trained in epidemiology at the London School of Hygiene and Tropical Medicine and in Psychiatry at the Maudsley and Bethlem Royal Hospitals. Matthew’s main interest is in the interaction between mental and physical health. He has worked extensively in areas where mental health relates to other walks of life – including occupational and military health, mental health law, and the wider community.

Dr Matthew Patrick – Chief Executive  
Dr Matthew Patrick took up the role of Chief Executive of the Trust in October 2013. Prior to this, he was Chief Executive of the Tavistock and Portman NHS Foundation Trust in north London, a specialist mental health trust of international standing. Originally trained as a psychiatrist at the Maudsley and Bethlem Royal Hospitals, for many years Dr Patrick combined clinical work and developmental research.

Gus Heafield – Chief Financial Officer  
Gus is a Chartered Accountant with over twenty years’ experience across both the private and public sectors. He has been the Director of Finance and Corporate Governance at the South London and Maudsley since 1999.

Kristin Dominy – Chief Operating Officer  
Appointed in 2015, Kris was previously Executive Director of Operations for Avon and Wiltshire Mental Health Partnership NHS Trust. Kris has previously worked for the Trust as a mental health nurse having first trained as a general nurse, the Healthcare Commission and the National Treatment Agency.

Dr Michael Holland – Medical Director  
Michael was appointed as Medical Director in 2016, having previously been the Trust’s Deputy Medical Director and Chief Clinical Information Officer. He has many years of clinical leadership experience having been appointed as a consultant psychiatrist in the Trust in 2003.

Dr Neil Brimblecombe – Director of Nursing  
Neil originally trained as a mental health nurse and has worked in a wide range of clinical services. He has degrees in nursing and medical anthropology and completed his PhD researching outcomes in mental health crisis services. He has experience in executive director roles in other NHS Trusts, both as Director of Nursing and Chief Operating Officer.

Robert Coomber – Non-Executive Director  
**Appointed May 2007 - June 2010.**  
**Re-appointed June 2010 – June 2013.**  
**Re-appointed June 2013 – June 2016.**  
Bob Coomber joined SLaM in 2007, having left Southwark Council in June 2006 after twelve years as their Chief Executive and a similar period as Director of Finance. At Southwark Bob was instrumental in driving much of the improvement and regeneration that has taken place in recent years which can be seen in Peckham and Bermondsey. Southwark was also one of the first authorities to attempt to integrate its social care function with that of the local PCT. In all Bob has spent more than thirty five years in London local government and has extensive experience of working with public service organisations to improve local public services like health, community safety, education and housing. Bob lives in the London borough of Lewisham.
Professor Shitij Kapur – Non-Executive Director
Professor Shitij Kapur, FRCPC, PhD, FMedSci was the Dean and Head of School at the Institute of Psychiatry, Psychology & Neuroscience, King’s College London, and Deputy Vice Principal for Health Sciences for King’s College London. He moved to this post after serving as Canada Research Chair and Professor of Psychiatry at the University of Toronto.

He graduated from the All India Institute of Medical Sciences, did his psychiatric training at the University of Pittsburgh and subsequently completed a PhD and Fellowship at the University of Toronto. His main research interest is in the use of brain imaging, animal models and clinical studies to understand the basis of psychosis, antipsychotics and how to improve them. His work has led to a better understanding of antipsychotic action and its relationship to D2 blockade, and to the development of the ‘salience’ framework of psychosis and has given rise to the ‘early onset’ hypothesis of antipsychotic action. He has published over two hundred peer-reviewed papers, made dozens of presentations worldwide, and serves in advisory capacity to public charities and pharmaceutical companies and has received national and international awards including the AE Bennett Award of the Society for Biological Psychiatry, Paul Janssen Award of the CINP and is a Distinguished Fellow of the American Psychiatric Association and Fellow of the Academy of Medical Sciences, UK.

Lesley Calladine – Non-Executive Director
Appointed June 2014 – May 2017, stepped down in June 2016
Lesley Calladine was appointed in June 2014 as Non-Executive Director, Quality and Safety for South London and Maudsley NHS Foundation Trust. Lesley has considerable experience in the HSSE (Health, Safety, Security and Environment), risk and investigation fields gained over the last 20 years working in various HSSE roles across transportation, construction and custodial environments. Lesley is Vice President, Health and Safety, BP Ltd and is a Chartered Fellow of the Institute of Occupational Health and Safety, a Chartered Fellow of the Institute of Directors and a member of the Institute of Environmental Management.
### Attendance at boards and committees

<table>
<thead>
<tr>
<th>Board meetings</th>
<th>Remuneration Committee</th>
<th>Audit Committee</th>
<th>Business Development and Investment Committee (BDIC)</th>
<th>Quality</th>
<th>Finance and Performance</th>
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<tbody>
<tr>
<td>11 held in 2016/17</td>
<td>5 held in 2016/17</td>
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<td>9 held in 2016/17</td>
<td>6 held in 2016/17</td>
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<tr>
<td>Roger Paffard (Trust Chair)</td>
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<tr>
<td>Matthew Patrick</td>
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<td>Kristin Dominy</td>
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<td>Gus Heafield</td>
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<td>Michael Holland</td>
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<td>Neil Brimblecombe</td>
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<td>Dr. Julie Hollyman (Chair of the Remuneration Committee)</td>
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<td>Alan Downey (Chair BDIC)</td>
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<td>Mike Franklin</td>
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<tr>
<td>Duncan Hames (Chair Audit from Sept 2016)</td>
<td>10</td>
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<tr>
<td>June Mulroy (Chair Audit until Sept 2016)</td>
<td>11</td>
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<tr>
<td>Anna Walker Chair Quality (from July 2016)</td>
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<td>Shitij Kapur</td>
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<td>Robert Coomber</td>
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<td>Lesley Calladine</td>
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*Attendance refers only to core members*
Committee structures

Audit Committee
The role of the Committee is to promote the efficient and effective management of risk and excellent financial management and governance within the Trust. It does this by putting in place arrangements to (a) review and periodically report to the Board on the adequacy of the Assurance Framework and the associated systems and procedures which support it; and (b) financial systems and procedures used within the Trust.

The Committee reviewed its Terms of Reference in June 2016 they were approved by the Board in July 2016. During 2016/17, the Committee held five meetings - 18 May 2016, 28 June 2016, 27 September 2016, 20 December 2016 and 28 March 2017.

At these meetings, the Committee considered reports that it had requested from Trust management, external audit, internal audit and counter-fraud specialists. These reports were requested in accordance with a work programme specified and regularly updated by the Committee.

In accordance with the Terms of Reference, an observer from the Council of Governors attends the Committee’s meetings. The observer receives copies of the minutes and reports back to the Council of Governors.

Business Development and Investment Committee
The Business Development and Investment Committee scrutinises the development and implementation of the Trust’s commercial strategic, approves major investment decisions including proposals for new business and scrutinises the strategy for the improvement of efficiency and productivity in order to enable delivery of the Trust’s strategic and operational objectives.

Finance and Performance Committee
The main role of the Finance and Performance Committee is to provide assurance to the Board about the delivery and sustainability of performance and delivery against operational and financial plans and the delivery of the Trust’s financial strategy.

Quality Committee
The main role of the Quality Committee is to provide assurance to the Board on the delivery of the Trust’s Quality Strategy. It has a role in examining where there have been failures in service or clinical quality and monitor progress against action plans to address them. The Committee meets monthly and is chaired by Anna Walker, Non-Executive Director.

Remuneration Committee
Information about the Remuneration Committee is provided in the Remuneration report.

Regard to NHSI Quality Governance Framework
The Trust has taken regard to NHSI’s quality governance framework in arriving at its overall evaluation of the organisation’s performance, internal control and board assurance framework. See the annual governance statement for our plans to improve the governance supporting the improvement of service quality.

Internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the South London and Maudsley NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the South London and Maudsley NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.
### Board assurance framework 2016/17

Below is a summary review of risk areas and our Trust’s system of internal controls

**Objective: Provide effective and efficient that meet the needs of our service users**

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Risk Area</th>
<th>Risk Description</th>
<th>Trust Lead(s)</th>
<th>Key Actions</th>
<th>Progress</th>
</tr>
</thead>
</table>
| 1.   | Quality - To continuously improve clinical quality and reduce inappropriate variation in care and treatment across the organisation | Failure to complete agreed action plans  
- Inability to provide evidence for completed actions  
- Failure to embed completed actions enhances risk of re-inspection  
- Inability to manage blockages in the system which prevent delivery of action plan  
- Failure to learn from complaints and Serious Incidents | CAG Service Directors, co-ordinated by Medical and Nursing Directors | a) Executive led committee supports delivery and reports to Quality Sub-Committee  
b) Action Plan in place to deliver against recommendations  
c) On-going preparation for CQC revisits in 2017  
d) Further work has been commissioned on the reporting of risks and assurance on service quality from CAGs to the Board | The risk is being mitigated but further work is required to reduce it to the target level. |

*Source of Assurance:*

- On-going preparation for CQC revisit in 2017  
- Evidence collected on Datix system  
- Internal Audit Report  
- Oversight by Quality Sub Committee
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<tr>
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<tbody>
<tr>
<td>2.</td>
<td>Right People to deliver right care - To develop and retain a skilled, diverse and caring workforce who are proud to work for SLaM</td>
<td>The Trust has been unable to recruit the numbers of qualified staff that it would wish it has been difficult to achieve full staffing on wards and in other areas. Structural changes have simultaneously increased the overall demand for staff. This has resulted in a reliance on bank staff. However, these issues present an increased risk of serious incidents, patient on patient/staff assaults and poorer patient experience.</td>
<td>Director of Human Resources</td>
<td>a) Review of medical workforce underway to develop a Consultant Bank (in process)  b) Development of cross London approach to contingency workforce (in process)  c) New South London Partnership includes agreement on Bank and agency rates and usage.  d) Increased Trust activity on Branding/Advertising and Recruitment to increase rates of good standard applications has been implemented.  e) A complete review of all agency contractors and ad hoc workers has been initiated  f) Further work is being done on a holistic approach to identifying the issues and mitigations arising from workforce and recruitment issues on services and its interrelationships with the principal risk</td>
<td>The risk rating score has reduced since 2016, due to actions by the Trust. But while the risk is being effectively managed issues remain and are a concern.</td>
</tr>
</tbody>
</table>

Quality Committee

Source of Assurance:
- Overall workforce plan to address the organisational design and transformation components that will ensure the Trust has the right people with the right skills in the right place.
- Workforce strategy includes placing limits on the use of agency staff, and centrally aligning its recruitment processes.
- Co-ordinated SMT approach to agency and contingency workforce being implemented.
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</table>
| 3.   | To ensure we have buildings and clinical environments that we can be proud of | • Lack of execution capacity in estates to deliver capital programme  
• Waste of ineffective capital developments  
• Risk of misalignment between clinical strategy and estates strategy  
• Inadequate realisation of value from surplus estate.  
• Ineffective partnering skills to deliver joint developments or commercial funding / development solutions  
• Inability to fund proposed capital developments | Director of Strategy and Commercial | a) Estates strategy plan with milestones and process to align clinical requirements  
b) Market testing of all disposal values  
c) Sustainable Organisation Board Review  
d) Finance and Performance scrutiny  
e) Oversight by Capital Programme Group  
f) Evidence of Good outcomes with disposal activity. | Risk of misalignment between clinical strategy and estates strategy reduced after the development of the Trust’s Estates Strategy  
Estates Strategy will come to Board in April 2017. Main risk to organisation will now be focussed on delivery of the strategy |
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<tr>
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</tr>
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</table>
| 4.   | Right Information | - To develop our information capability to provide accurate, timely, reliable information to support decision making, partnership working and transparency of performance | The Board | Chief Information Officer | a) Controls and assurance are focussed on risk avoidance.  
b) The IT department has a local PMO to support programme delivery.  
c) Business Intelligence is closely linked to the development of an improved EPJS system which promotes pathway standardisation and supports QI.  
d) The contract for the delivery of the improved EPJS system has been signed.  
e) Key controls would have been put in place by Digital Services/BI to assure all data (from multiple sources) into the data repository and cubes.  
f) A presentation on the capabilities of the new Business Intelligence platform was delivered to the Trust SMT on February 2017 | A recent reorganisation and implementation of a new business information platform will over time ensure improvements in this area. |

Source of Assurance:
- Reports are made to the COO  
- Portfolio Delivery Steering Group  
- Ad-hoc to Senior Management Team and  
- The Board
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| 5.   | Partnerships (Clinical Transformation) | Working in partnership to transform clinical services, develop community based models of care and deliver these through new population based models of commissioning | Trust Board | Chief Executive Officer | a) Regular STP Workstream meetings attended by members of the Board  
b) SLMHP Board new established  
c) Resources now in place  
d) Governance of the Lambeth Alliance has been agreed | The Trust continues to engage with several partners to develop new pathways of care. Governance for these developments is progressing |
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</table>
| 6.   | Right Value - Secure and manage the appropriate levels of resources to deliver high quality, safe and effective services | Remaining areas of risk of delivery in 2016/17 are adult acute overspill and agency expenditure. For 2017/18 the Trust still has unidentified CIP of £9m (approx 35%) There are risks of failing to deliver the cost improvement programme identified schemes; infrastructure programme. Management of adult bed capacity, placements and other over-performance that is not fully funded are risks to delivery; financial pressures from other parts of the system e.g. other Trusts or Local Authorities may have an indirect impact. | Chief Financial Officer            | a) Internal audit reviews of systems and processes;  
b) External audit review; review meetings with commissioners.  
c) Investment in MH has been escalated through the recent MHIS sign-off process and Trust challenged CCGs plans appropriately.  
d) Planning and Contracts for two-years finalised December 2016.  
e) Agency spend challenge has reduced expenditure in Q4 16/17 and FYE into 17/18 | The risk reduced consistently as the Trust approached 16/17 year end. Contracts have been signed for 20017/18-18/19. Risk while there is an unidentified savings gap for 17/18. |

**Source of Assurance:**
- Internal audit programme
- Audit Committee review with FPC Ratings reported to Monitor
- Reports are made to the Finance and Performance Committee and the Trust Board
The role of internal audit

Internal audit

Internal Audit has reviewed and reported on systems of internal control, governance and risk management processes based on an internal audit plan approved by the Audit Committee. Internal Audit’s work included identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management. Internal Audit reports to the Audit Committee on management’s progress in implementing agreed recommendations.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation’s risk management, control and governance processes. This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to certain inherent limitations. The purpose of the annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board’s own assessment of the effectiveness of the organisation’s system of internal control. This opinion will in turn assist the Board in the completion of its Annual Governance statement.

Reasonable assurance can be given by the Head of Internal Audit that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. These have been reported to the Trust Chief Executive and Audit Committee in order to inform the basis and conclusions within the Annual Governance Statement.

The Head of Internal Audit opinion highlighted the six reports (listed below) where he was only able to give limited assurance on the systems of internal control based on risk-based audits carried out during the course of the year.

These were:
- Board Assurance Framework
- Procurement
- Agency Staff Spend Arrangements
- Consultant Job Planning
- eRostering
- Mobile Devices

In each case the Trust has been addressing the issues and implementing the agreed recommendations as quickly as possible following the receipt of the audit report. Internal Audit will conduct a follow up review during 2017/18 and report back to the Audit Committee on progress.

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**Conclusion**

We have identified significant risks earlier in the statement. No significant internal control issues have been identified by our internal reviews or through the work of our internal auditors, external auditors or other external regulators. Overall, my assessment is that South London and Maudsley NHS Foundation Trust has a generally sound system of controls that supports the achievement of its objectives and that identified control issues have been or are being addressed.

**Significant issues**

The Audit Committee confirms that for 2016/17 no matters arose which needed to be escalated for the attention of the Board of Directors. However the Committee considered that the Board of Directors should be made aware of the Committee’s concerns about certain issues, and of the actions proposed to address them, and has reported these to the Board of Directors during the period.

**Key issues thus reported include:**

- internal audit’s reports on: the Trust’s Adult Mental Health (‘AMH’) prototype initiative; Procurement; and agency spend arrangements;
- Board review of committee reporting arrangements;
- issues around the business case for the proposed Forensic Services initiative; and
- CQC key issues and recommendations follow up.

The Committee considered significant issues in relation to the financial statement, particularly, at its meeting in December 2016, with input from external audit, the Committee considered issues around: recognition of NHS revenue and recoverability of debtors; property valuations (in particular those involving assessment of depreciated replacement cost and market based valuations); and the risk of management override of controls.

**Appointment of external auditors**

In September 2012 the Council of Governors appointed Deloitte to replace the Audit Commission as the Trust’s external auditor. The process by which Deloitte was appointed involved three meetings of a group of representatives from the Council of Governors, the Audit Committee Chair, the Chief Financial Officer, the Head of Procurement and the Audit Committee Secretary. The group met representatives from Deloitte on two occasions and made a recommendation to the Council of Governors that, using the result of a full-scale OJEU tendering exercise conducted by Guy’s and St Thomas’ NHS Foundation Trust and as permitted under the terms of that tendering exercise, Deloitte be appointed as the Trust’s external auditor for the period 29 September 2012 to 23 September 2015, with options to extend to 23 September 2016 and 23 September 2017. This is subject to Deloitte’s ongoing satisfactory performance in that role, which the Audit Committee confirmed for 2012/13, 2013/14, 2014/15 and 2015/16. The Board of Directors and the Council of Governors decided to extend Deloitte’s appointment to 23 September 2017 in line with the contract. The Trust is reviewing its approach for the appointment of external auditors for the period subsequent to 23 September 2017.

**External audit process**

The Audit Committee has reviewed the performance of the external auditors. That review took account of the reports from external audit, and other parties, considered at each Audit Committee meeting. Based on this, the Audit Committee considers that the performance of the Trust’s external auditors (including the quality and value of the work, the timeliness of reporting and the external audit fee) is and has been appropriate.

**Statement of disclosure to the auditors**

Each of the persons who is a director at the date of approval of this Annual Report confirms that: so far as the director is aware, there is no relevant audit information of which the NHS Foundation Trust’s auditor is unaware; and the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust’s auditor is aware of that information.
The Trust has taken regard to NHS Improvement’s quality governance framework in arriving at its overall evaluation of the organisation’s performance, internal control and board assurance framework.

See the annual governance statement for our plans to improve the governance supporting the improvement of service quality.

The Quality sub Committee (QSC) carries out an annual review of any major issue vital to the delivery of high quality services in the Trust, common to most or all services and presenting major risk if unmanaged.

The rationale of having the thematic review is to provide an in depth analysis of key quality issues, the QSC has agreed that a programme of annual reviews be established. These ‘Thematic reviews’ are presented and discussed at the QSC and then summarised for the Board to ensure that the Board itself is well informed and engaged with these issues.

The programme is reviewed and agreed annually. It currently covers: Safeguarding adults and children; service user involvement; prevention of violence and aggression; staff experience; reducing suicide; physical health care; service user and carer experience; Equality and diversity; medicines management.

For reports arising from Care Quality Commission reviews of the Trust and consequent action plans, including consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas please see Chapter 8 Quality Report.

Details of senior employees’ remuneration and expenses can be found in the remuneration report. The directors considered the Annual Report and Accounts taken as a whole are fair, balanced and understandable and provide the information necessary for stakeholders to assess the Trust’s performance, business model and strategy. The directors are responsible for the maintenance and integrity of the corporate and financial information included in the Trust website. Legislation in the United Kingdom governing the preparation and dissemination of financial information differs from legislation in other jurisdictions.

### Value of external audit services for 2016/17

The value of the external audit services was as follows. The Group comprises the Trust and the Maudsley Charity. The amounts in all cases include VAT.

<table>
<thead>
<tr>
<th></th>
<th>Statutory audit/£</th>
<th>Other remuneration for ‘non-audit’ work/£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>£101,000</td>
<td>£15,000</td>
</tr>
<tr>
<td>Trust</td>
<td>£101,000</td>
<td>£15,000</td>
</tr>
</tbody>
</table>

The proposal to engage Deloitte to perform non-audit work audit was discussed by the audit committee, the external auditor and the Chief Financial Officer. The external auditor reported the nature and scale of the non-audit work and confirmed that appropriate arrangements were in place at Deloitte to safeguard the independence and objectivity of the external auditor. For instance, the external auditor advised that non-audit work would be performed by teams with no involvement in the external audit. On this basis the Audit Committee concurred that such non-audit work did not pose a significant risk to the independence and objectivity of the external auditor.

### Liquidity

At the year-end the Trust had net current assets of £19m including £55m cash. The Trust is not, therefore, exposed to significant liquidity risks

### Cost allocation

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

### Credit

The majority of our income comes from contracts with other public sector bodies, and we therefore have low exposure to credit risk.

### Price

The majority of our income is covered by contracts signed with CCGs at the start of the year and paid over 12 months in equal instalments. The contracts with CCGs are adjusted in line with the nationally agreed efficiency target and a generic inflation factor that covers pay and non-pay inflation and other specific national cost pressures such as new drugs and changes to employers national insurance.
Trust Governance

Senior Management Team
The Senior Management Team (SMT) reports to the Chief Executive and then Board of Directors. It exists to promote the effective functioning of the organisation, to ensure that clinical advice is properly presented and considered, to make decisions on the allocation of resources within the Scheme of Delegation and to ensure that the SMT has an effective understanding of the operational functioning of the Trust. The Senior Management Team meet every week and discuss performance, quality, finance, strategy and delivery.

Clinical Academic Groups (CAGs)
The services we provide to patients are organised into Clinical Academic Groups (CAGs). Clinical Academic Groups bring people together who are experts in their field in areas such as addictions, psychosis and child and adolescent mental health so that we can offer patients the very best care and treatment, based upon reliable research evidence that it works.

The following are appointed Clinical Academic Group (CAG) Directors

Addictions
Feizal Mohubally Service Director
Dr Emily Finch Clinical Director
Professor John Strang Academic Director

Acute Care Pathway
Jo Kent Service Director
Dr Hugh Jones Clinical Director
Claire Henderson Academic Director
Nick Sevdalis Academic Director

Behavioural and Developmental Psychiatry
Feizal Mohubally Service Director
Professor Tom Fahy Joint Clinical Director
Professor Declan Murphy Academic Director

Child and Adolescent Mental Health Services
Jo Fletcher Service Director
Dr Bruce Clark Clinical Director
Professor Emily Simonoff Academic Director

Mental Health Older Adults and Dementia
Vanessa Smith Service Director (acting from 01/02/16)
Dr Dan Harwood Clinical Director
Dr Rob Stewart Professor Rob Stewart

Mood Anxiety and Personality and Psychological Medicine
Neil Robertson Service Director
Dr Ranga Rao Clinical Director
Professor Matthew Hotopf Academic Director
Professor Allan Young Academic Director

Psychosis
Godfried Attafua Service Director
Professor Philippa Garety Clinical Director
Professor Philip McGuire Academic Director

Maudsley Charity
The Trust Board of Directors is the corporate Trustee for the Maudsley Charity.

The Charity commissioned an external review of its strategic direction and governance processes in 2015. Following this review, the Board made a decision to support the conversion of the Charity from a ‘corporate trustee’ model to that of an independent NHS charity to support its intention to grow in impact and in income. Rebecca Gray was appointed Chief Executive of the Charity and took up her post in January 2016.

Scheme of delegation
The Trust operates a Scheme of Delegation which provides examples of how powers may be reserved to the Board, generally for matters for which it is held legally accountable or through its terms of authorisation, whilst at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. That said, the Board remains accountable for all of its functions - including those delegated to the Chair, individual directors or officers - and therefore expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
Quality
The quality group helps the Trust to develop the quality strategy, priorities and accounts. It also provides a forum for discussions on specific quality issues and where governors can raise issues for resolution.

Disclosures in the public interest
Income disclosures required by section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

The Trust confirms that it has met the requirement under Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that:
- income from the provision of goods and services for the purpose of the Health Service in England is greater than its income from the provision of goods and services for any other purposes
- and that, there is no impact from other income received on its provision of goods and services for the purposes of the health service in England.

Staff consultation
We provide information to our staff through a number of different mechanisms including SLaM News, SLaM eNews, the Trust intranet and Clinical Academic Group management briefings. We have a joint staff committee which includes all representative staff organisations and trade unions where information about key strategic and operational matters is discussed including the Trust’s financial performance. In situations where they may be changes to services, all staff and key stakeholders are consulted with.

We obtain feedback from our staff through the appraisal process, team meetings, the annual staff survey and more recently through the quarterly friends and family test. Our Chair and Chief Executive have also held a series of staff fora across hospital and community based sites.

Patient care
There have been a number of patient experience successes over the last year, including the development of the new central service user ‘Engagement, Participation and Involvement Committee’ (EPIC). The aim of EPIC is to work collaboratively with stakeholders to support the Trust in the delivering of its five-year transformational change plan and by so doing ensuring that the sharing of good practice and involvement activities are brought together and reviewed.

There has been the full implementation throughout the Trust of the Friends and Family Test (FFT), which means that all SLaM service users have access to provide their FFT feedback.

The overall performance from the National Community Survey for 2016 was, comparatively very good. For the first time SLaM did not have a single red rating. When comparing the diversity of our demography against other more homogenous boroughs in England this is a remarkable result.

The range of involvement activities within all of the CAGs increased throughout 2014/15, highlighting strong collaborations between staff, service users and carers.
Stakeholder relations

We have continued to engage widely with staff and key stakeholders in the development of our vision, values and strategy. We will continue to work in this way, developing key messages for a variety of audiences both face to face and by using our digital, print and social media channels. We will also build on our established platform for engagement with staff, alongside other key stakeholders including patients, governors, members, carers and the public as we develop and implement service transformation plans set out in our strategy. In 2017/18, we will develop a new Communications Strategy which will build on our work to date and support our goal to achieve a CQC rating of “outstanding”.

Examples in 2016/17 of our engagement work include:

- A new Centralised Place of Safety service opened on the Maudsley site and started receiving patients from across our four boroughs on 7 February 2017.
- Quarterly meetings have been held with representatives of the HealthWatch in each local borough.
- Focused work on improving our engagement with the black community in Lambeth, via the Lambeth Independent Advisory Group (IAG) which has advised on SLaM strategic work in taking forward the recommendations of the Lambeth Black Mental Health Commission.
- Engagement with local partners on the development of new models of integrated care via Local Care Networks LCN) in Lambeth and Southwark, Neighbourhood Care Networks in Lewisham, including Senior Clinicians chairing LCN Boards and operational representatives involved in clinical model working groups.
- Working with the Council of Governors Planning and Strategy Working Group, and over the past three four years we have involved the wider membership through engagement events that have taken place in each borough, including Have Your Say Events described below.
- Internally, we have used our Trust conference in March 2017 and Annual Public Meeting in September 2016 to communicate the plan and engage our staff, patients and governors in its continued development and implementation.

Our updated strategy has placed partnership working at its heart as a key enabler, and we continued to align our vision and planning with those of our key stakeholders, on the basis of our belief that it is through partnership working that we will continue to improve the quality of outcomes and health for local people when the economics of health and care continue to be hard pressed.

For example, we have been a key stakeholder within the development of the Lambeth Alliance which seeks to move to an outcomes based, population approach to the organisation of mental health treatment and support across health, social care and the voluntary sector. In Lewisham we have worked closely with Lewisham Hospital, Adult Social Care and the CCG to help define the new neighbourhood model to improve the quality and accessibility of community support.

In addition, we have developed our strategic partnership with our fellow Mental Health Trusts across South London to form the South London Mental Health Partnership (SLMHP). This partnership successfully bid to set up the “Forensic Vanguard” which will ensure people within the forensic system previously in out of area placements are supported closer to home, their families and communities. Members of our Council of Governors have continued to seek the opinion of the Trust’s members and the public following a successful pilot event in late 2015 a series of events were held in spring 2016 using a new co-produced design between the Council of Governors and the Trust. The aim of these borough-based engagement events was to gain an insight into the needs, views and experiences of people who use our services, their friends, family and carers. Each ‘Have Your Say’ event was chaired by a Governor, with senior Trust staff participation, including, when possible the Chair or Chief Executive. At each event an undertaking was made that there would be a return event approximately six months later to report back on what had been heard and what action had been taken as a result. The return events were held during August and September 2016 to report on progress.
Social, community, equality and human rights

All Trust employment policies are assessed to identify any equality and human rights implications which may arise from implementation or application.

A human rights approach was taken when developing the engagement and observation policy. This includes information for service users and carers that acknowledged service users’ rights to privacy alongside the Trust’s duty of care. We commit to working with service users to help them to understand the reasons for any enhanced observations required after a risk assessment; to discuss alternatives where possible and how we can be as least intrusive as possible.

The Trust published its annual equality information in January 2016 to comply with the public sector equality duty. This includes 2016 Trust-wide equality information that provides information on the demographic profile of the Trust’s service users and the experience of service users with different protected characteristics.

We also continue to publish local ethnicity reports for Croydon, Lambeth, Lewisham and Southwark. These provide information on the ethnicity of service users accessing 11 of the Trust’s services and the experience of service users of different ethnicities in each borough.

The Trust has developed new CAG equality objectives for 2017-20 to comply with the public sector equality duty. A high-level summary of these is provided below:

- **Acute Care CAG**: To improve access and experiences for service users with learning disabilities in acute wards.
- **Addictions CAG**: To improve access to substance misuse services in Wandsworth for men who have sex with men.
- **Behavioural and Developmental Psychiatry CAG**: To improve the physical health of Black and Minority Ethnic service users in forensic inpatient services.
- **Child and Adolescent Mental Health CAG**: To improve access and experiences for Asian and Black girls in CAMHS community services.
- **Mental Health of Older Adults and Dementia CAG**: To achieve earlier access to memory services in Lambeth and Southwark for Black service users.
- **Psychological Medicine and Integrated Care CAG**: To improve access and outcomes for Black service users in Lewisham Improving Access to Talking Therapies [IAPT] service.
- **Psychosis CAG**: To ensure equitable access to early intervention services for people aged 35 and over.

Patient and public involvement

During 2016 the Trust has worked to develop a Public and Patient Involvement Policy that sets out the values and expectations for all the involvement work the Trust undertakes as well as setting out a governance and assurance framework.

In early 2016 benchmarking was undertaken to support the implementation of the Involvement Strategy and the Family and Carers Strategy. Going forward the Trust will be working in partnership with service users to agree a set of outcome measures for involvement at an individual, service, operational and strategic level and we will undertake a further benchmarking exercise against these outcomes. The Trust will also undertake the formal benchmarking exercise required to become a member of the Triangle of Care Scheme.

The number of responses to the Friends and Family Test (FFT) and the internal patient experience surveys has increased from the previous year. In 2016/17 the Trust received over 11,500 survey and FFT responses. On average for 2016/17, 83% said that they would recommend their friends and families to the Trust.
(FFT) and from the internal patient experience surveys 96% said they found staff kind and caring. The Trust has introduced new “You said. We did” posters for all community teams and wards so that it can demonstrate that it acts on the feedback from people who use services, their friends, families and carers.

The Trust is one of only a few number of NHS organisations to provide demographic breakdowns of the experience of people who use services, and this is published as part of the Trust's annual Human Rights and Equality Report.

The overall performance from the National Community Survey for 2016 was, comparatively, good and in line with previous years results. The three questions where the Trust had the greatest increase in performance in 2016 compared to 2015 are providing help or advice with finding support for finding or keeping work (+11.2%), knowing who to contact out of office hours if you have a crisis (+10.1%) and being involved as much as the service user wanted to be in discussing how their care is working (+4.6%).

There continues be a wide range of involvement activities across the Trust and within the CAGS for people who use services, their friends, families and carers. As the Trust moves forward with the Quality Improvement programme all projects will be co-produced and co-delivered in partnership with people who use services and their friends, families and carers.

Disability

The Trust has a range of policies and approaches which enable disabled people to gain employment with the Trust, and remain in employment where feasible, should they become disabled during their period of employment with the Trust.

The Trust’s Equal Opportunities Policy covers all aspects of employment, from recruitment and selection, training and development to conditions of service and reasons for the termination of employment. It also sets out the guiding principles that influence the way the Trust carries out its employment based activities and the expectations of all staff accordingly.

The Trust’s Recruitment Policy makes reference to eliminating all forms of discrimination in accordance with the Equality Act 2010 which also covers disability. The Trust operates the “Two Ticks” standard for recruitment whereby disabled applicants are guaranteed an interview if they meet the essential requirements of the person specification. When invited to interview, all applicants are asked if any special adjustments are required to enable them to attend.

Where a disabled candidate is appointed, the Trust is responsible for carrying out any reasonable adaptations to the workplace or supplying additional equipment to assist the new employee in their role. This usually follows assessment, advice and support from our Occupational Health Service. Additional help may also be sought through external agencies such as the Local Employment Services Office.

The Trust’s Sickness Policy and Disability Policy provide guidance on the support available and provided to employees where they may become disabled during their employment. The Sickness Policy is designed to support employees during periods of illness which may possibly lead to a disability. The Sickness Policy offers employees the option of a phased return/period of rehabilitation with no loss in pay. Occupational Health advice is sought through all stages of the sickness process in accordance with the policy.

Where an employee can no longer sustain their former role due to capability, the Trust seeks to medically redeploy them into a role which they may be able to suitably fulfil. This may include a period of re-training. Where an employee develops a disability the Trust’s Disability Policy is used as guidance for managers on the Trust’s expectations of how employment related processes are managed regarding employees with a disability. The policy is designed to enable a working environment in which having a disability does not act as a barrier to staff enjoying a positive and full working life in which they are able to reach their full potential.

A central feature of the Disability Policy is the need to make reasonable adjustments which will enable a disabled employee to remain in work.

The concept of ‘reasonable adjustment’ is the cornerstone of the Equality Act 2010. Since 1995 employers have had a legal duty to make such adjustments in order to accommodate employees who may find themselves unable to work under the arrangements they were initially employed due to disability. This can involve a number of different things including adjustments to premises, changing working hours, transferring to other locations, purchasing specialised equipment and re-training, to name a few.

All staff have equal access to an appraisal, training opportunities and career development throughout the year.
Health and safety

The Chief Operating Officer is the Executive lead for health and safety. A health and safety work plan has been developed. The plan enables the Trust Board to be provided with assurances that there are satisfactory arrangements in place for managing health and safety risks across the Trust. The plan was formally accepted by the Board in the summer of 2016.

A Ligature Reduction Policy together with a guidance document was developed in the Spring of 2017. The Policy is specifically concerned with guidance and clarity on the control and management of potential ligature risks. Ligature risk assessments continue to be completed on an annual basis and are monitored through the Trust Ligature Board.

A new Fire Safety Policy together with a Fire Safe Management System has been developed. All of the Trust fire safety documents and procedures are based on the framework HTM 05 “Managing Healthcare Fire Safety” as representing best practice.

Fire is monitored through the Trust Health, Safety & Fire Committee and reported up to the Trust Quality Safety Committee.

The Trust encourages open and honest reporting of risks, hazards and incidents. The period April 2016 to the end of March 2017 there has been a 5% decrease in reported health and safety incidents. In addition there has been a 28% decrease in the reporting of fire related incidents for the same period. There has been an escalation in the provision of Datix training across the Trust. This has raised the overall profile of incident and accident reporting which has led to a greater awareness and understanding over the overall reporting procedures. All reported incidents are scrutinised and follow up action taken which is proportionate to the incident.

There has been decrease of 1% in the number of incidents reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). Under the reporting criteria, the vast majority of these incidents were due to staff taking an over ‘7 day’ absence from work as a result of injuries sustained during the course of their duties.

There have been no HSE or Fire Enforcement Notices during period 2016.

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There has been an increase of 37% in the number of incidents reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). Under the reporting criteria, the vast majority of these incidents were due to staff taking an over ‘7 day’ absence from work as a result of injuries sustained during the course of their duties.

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Better payments practice code

Better Payments Practice Code is a target of paying 95% of bills within contract terms or 30 days where no terms have been agreed. The code requires the Trust to aim to pay undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. We paid 74% of non NHS invoices within this period (87% in terms of value) and 63% of NHS invoices within this period (91% in terms of value).

Countering fraud and corruption

Our Local Counter Fraud Specialist (LCFS) has been implementing a new Bribery and Corruption Policy and disseminating information as part of its proactive programme. The Trust LCFS has also worked with the training team to put into place an e-learning package, enabling the dissemination of information and training to be delivered more efficiently which went live during April 2016.

Complaints

The Trust received 511 formal complaints from 1 April 2016 to 31 March 2017. This is a decrease (9%) from the previous year 2015/16 during which the Trust received 555 complaints. Of the number of complaints investigated (and closed at the date of this report) 59% were either upheld or partially upheld.

Currently there have been seven requests for Independent Review by the Parliamentary Health Service Ombudsman (PHSO) where the original complaint was made during the same period. This accounts for 0.1% of the number of complaints received at the first stage going to the second stage of the Complaints procedure. As we write this report in April 2017, five cases (PMIC) are still under view by the Ombudsman’s office, with one case (Psychosis) closed with no further action and two cases (PMIC, Corporate department) referred back for further local resolution.

Complaint themes

A breakdown of the formal complaints received by category is detailed below:

<table>
<thead>
<tr>
<th>Categories of Formal Complaints 2016/17:</th>
<th>Number of Formal Complaints received:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and Treatment</td>
<td>195</td>
</tr>
<tr>
<td>Attitude/Behaviour</td>
<td>104</td>
</tr>
<tr>
<td>Communication</td>
<td>34</td>
</tr>
<tr>
<td>Admission/Transfer Arrangements</td>
<td>33</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
</tr>
<tr>
<td>Detention under the Mental Health Act</td>
<td>26</td>
</tr>
<tr>
<td>Administration</td>
<td>22</td>
</tr>
<tr>
<td>Patient’s property</td>
<td>19</td>
</tr>
<tr>
<td>Discharge</td>
<td>17</td>
</tr>
<tr>
<td>Patient privacy/dignity/confidentiality</td>
<td>9</td>
</tr>
<tr>
<td>Assistance and Information</td>
<td>6</td>
</tr>
<tr>
<td>Policy/Corporate decisions</td>
<td>4</td>
</tr>
<tr>
<td>Carers Issues</td>
<td>3</td>
</tr>
<tr>
<td>Environment</td>
<td>3</td>
</tr>
<tr>
<td>Wellbeing &amp; Restraint</td>
<td>3</td>
</tr>
<tr>
<td>Catering</td>
<td>1</td>
</tr>
<tr>
<td>Equipment</td>
<td>1</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
</tr>
<tr>
<td>Hotel Services/Catering/Portering/Security etc.</td>
<td>1</td>
</tr>
<tr>
<td>Transport</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>511</strong></td>
</tr>
</tbody>
</table>

Patient concerns about staff attitude (20%) continue to be a Trust priority, with the Trust’s five commitments incorporated into organisational appraisal and training.
Compliments

The Trust formally recorded 240 compliments this year covering a range of services within the Trust. Some summaries of, and verbatim extracts from, expressions of appreciation received by Trust staff and across services are set out below:

“I feel listened to and respected...I’m grateful and delighted’...I’ve been with services since 1970 and in the past could fill a book with complaints! …things have improved since the 2014 reshuffle”

“…Much as we are eternally grateful to the Maudsley for restoring X to his former self, we would like to extend our sincere gratitude to you as for your enduring patience, care and kindness towards X during his long and often challenging stay with you. You treated him with the dignity of his true person, not the agitated, delusional soul he presented.”

The member of staff was “amazing…she was so down to earth, so compassionate, her compassion was huge, she was so kind, she gave him the time... [her approach] led to my brother opening up about the reality of his illness.

“… has helped me build my life again. I cannot really find words to describe how much she has helped me mentally and emotionally. She was totally professional but not in such a way as to create a barrier. I trusted her completely and she has left me with tools to cope in future on my own, but with no false expectations. I now have recovered a valuable degree of self-confidence which enables me to be the best I can and live the life I choose, respecting others, but making my own decisions. However she has helped me to recognise that I cannot change my essential make-up and will continue throughout the remainder of my life to have ups and downs and I feel better able to cope with both.”

“This is a short note in appreciation of excellent work carried out by XX in relation to a client’s Safeguarding. She engaged this client really well and supported her throughout the Safeguarding process. Client as a result managed to muster courage to obtain, execute and report breach of the Non Molestation order and finally succeeded in evicting the perpetrator from her property. XX is now receiving additional support and advise through the Women’s space (Violence against Women) Safe space…felt this good practice deserved a mention.”

Research and development

SLaM is in a position of considerable strength as a research-focused organisation: as well as the extensive opportunities for engaging its service users in research at every level, the Trust benefits from its strong academic partnerships as well as access to state-of-the-art research facilities and a wide portfolio of R&D funding streams. These streams cover a mix of biomedical research and more applied, later-stage research through various programmes such as NIHR Programme Grants for Applied Research and NIHR Research for Patient Benefit. Being part of an Academic Health Science Centre - King’s Health Partners - brings us into a stronger and unique partnership where both mental health and physical care come under the same umbrella, allowing us to further expand our research perspectives.

Working in close partnership with Europe’s largest centre for research in this area, the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) at King’s College London, the Trust hosts the UK’s National Institute for Health (NIHR) Biomedical Research Centre (BRC) for mental health. The BRC’s focus is on translational research which is about bringing findings from basic research into early phase experimental medicine and clinical studies more efficiently and quickly. With our world-leading specialist research facilities and close interactions with the NHS we can conduct research from ‘bench to bedside’, including a large number of clinical trials which test new treatments or approaches to see whether they are effective.

We are building our collaborations and partnerships with industry through our new Centre for CNS Therapeutics while our new Centre for Translational Informatics (CTI) introduces a fresh perspective on commercial research, focusing not on traditional pharmacological trials but instead on digital innovations.

Using our specialised Clinical Research Facility, extensive databases, and consent-gathering procedures, we lead trials of new treatments. For example, we developed pimavanserin, a new treatment for psychosis symptoms in Parkinson’s disease which avoids side-effects other medications produce; we have also developed computer based cognitive therapies for schizophrenia, now available in 14 countries.

Our collaboration with the Collaboration for Leadership in Applied Health Research and Care (CLARHC South London) provides an implementation component to our translational work as well as sharing expertise in Patient & Public Involvement (PPI).
We work extensively with patients, industry and charities. We have developed new genetic and imaging technologies, new insights into the psychological basis of mental illness, new ways of working with electronic medical records, and effective ways to prevent unhealthy behaviour.

Many patients need to try several treatments before finding one which works. We will use genetic information and neuroimaging to guide treatment choice. For example, we have developed a neuroimaging test for autism to select patients more likely to respond to new treatments.

We require that all research in our organisation is undertaken to the highest scientific and ethical standards through effective research governance and management, led by the joint R&D Office of SLaM and IoPPN.
2.2 Remuneration report

Annual statement

There have been no changes to the majority of the Trust’s most senior managers’ remuneration packages since their appointment. The salaries of the most senior managers are based on a market comparison benchmark data at the time of the appointment. The Medical Director is employed under Medical and Dental terms and conditions which are agreed nationally.

Approval is sought from NHS Improvement where salaries for senior staff exceed £142,500. Salaries over £142,500 are benchmarked to the market. No appointment is confirmed until approval has been received.

Dr Julie Hollyman
Remuneration Committee Chair

Senior managers’ remuneration policy

The salaries of the most senior managers are based on a market comparison benchmark data at the time of the appointment. The Medical Director is employed under Medical and Dental terms and conditions which are agreed nationally.

All Executive Directors are substantive employees of the Trust with contracts of employment. All contracts are open-ended and subject to contractual notice periods by either party. Termination of employment and calculation of payment would be in accordance with contractual notice periods. The contracts contain clauses relating to the adherence of Trust policies. All senior manager positions are subject to the same employment policies as all other employees and consistent with the arrangements under Agenda for Change, including performance, disciplinary and redundancy arrangements. Details of the actual remuneration packages for each senior manager is outlined in the table below.

Pension benefits accrued under the NHS Pension Scheme are the only non-cash element of senior managers’ remuneration. This includes both a contribution from the employee and the employer made in accordance with statutory scheme regulations.

Senior managers have objectives set by the Chief Executive Officer, and the Board, in the case of the Chief Executive Officer in delivering the Trust’s long term aims and strategy. These are monitored and reviewed on a regular basis and form part of the Annual Appraisal process. All Senior Manager’s remuneration is subject to the achievement of satisfactory performance. The aggregate sum of expenses paid to governors during the reporting period is £10357.16

Consideration is given to pay and conditions of all employees when setting senior managers remuneration policy. This is achieved through analysis and benchmarking of organisational reporting relationships between different hierarchies and pay of staff.
Executive director remuneration

The total remuneration for each Executive Director consists of the following:

<table>
<thead>
<tr>
<th>Salary + Pension</th>
<th>=</th>
<th>Total Remuneration</th>
</tr>
</thead>
</table>

**Salary:**

To provide a reward for the role. This is set at an appropriate level in light of benchmarking and market conditions. The experience of an individual and the nature of the role contribute to determining the salary. The salary is linked to the delivery of the strategic objectives of the Trust and measurement of performance is determined through achievement of an individual’s objectives in meeting Trust objectives and strategic aims. The salary incorporates the High Cost Area Supplement and any increases are in line with cost of living increases for other NHS staff groups. Salary levels may be increased in light of additional responsibilities and in such circumstances will be approved by the Remuneration Committee. Salaries are spot rates and do not include an incremental pay increase on a periodic basis.

**Pension:**

All NHS staff are eligible to join the NHS Pension Scheme operated through NHS Business Services Authority, unless already in receipt of NHS pension. All new appointments from April 2015 will join the 2015 Pension Scheme. There are a range of benefits covered by the pension scheme and details of these can be seen on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Under pension scheme membership rules an employee can contribute up to a maximum of 14.5% of salary depending on salary level and the employer will contribute 14.3%. There are no performance standards or measures associated with the NHS Pension scheme.

Annual report on remuneration

The Remuneration Committee is appointed and authorised by the Trust to develop and implement reward management strategies and systems that attract, retain and motivate staff at all levels in the Trust.

This includes reward and recognition for Executive Directors, the Senior Management Team and those staff not covered by nationally agreed terms and conditions.

The Committee shall:

- Agree the remuneration, conditions of service and any compensation/termination payments to the Chief Executive and Executive Directors of the Trust.
- Take into account relevant nationally determined parameters on pay, pension and compensation payments and any guidance issued by the NHS.
- Be responsible for approving any significant variation to nationally agreed pay and compensation rates for other employees.

Remuneration committee

All Non-executive Directors of the Trust Board are members of the committee but there are three core Non-executive Directors which includes the Chair of the Trust. A quorum will be at least two members. Dr Julie Hollyman is Chair of the Remuneration Committee.

The Chief Executive Matthew Patrick and the Director of Human Resources, Organisational Development and Education and Development, Louise Hall, act as Advisors to the Committee.

The group will be chaired by the Chair of the Foundation Trust or a Non-Executive Director designated by the Chair. Membership includes the Trust Board Chair, 1 other Non-executive Director, the Chief Executive. The Director of HR attends as advisor.
Remuneration committee attendance

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>No. of attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Julie Hollyman</td>
<td>Remuneration Committee Chair</td>
<td>3 (+2)</td>
</tr>
<tr>
<td>Roger Pafford</td>
<td>Trust Chair</td>
<td>3 (+2)</td>
</tr>
<tr>
<td>June Mulroy</td>
<td>Non-executive Director</td>
<td>3 (+2)</td>
</tr>
</tbody>
</table>

During the reporting period the Committee met three times with two further extraordinary meetings during the year.

Senior manager’s service contracts

The following table includes details of the service contracts for Senior Managers who have served during the reporting period:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Start Date</th>
<th>Term of Office</th>
<th>Notice Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roger Paffard</td>
<td>Chair</td>
<td>12 January 2015</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Robert Coomber</td>
<td>Non-Executive Director</td>
<td>May 2007 (to May 2016)</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>June Mulroy</td>
<td>Non-Executive Director</td>
<td>12 January 2015</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Julie Hollyman</td>
<td>Non-Executive Director</td>
<td>12 January 2015</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Lesley Calladine</td>
<td>Non-Executive Director</td>
<td>24 June 2014 (to May 2016)</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Alan Downey</td>
<td>Non-Executive Director</td>
<td>24 June 2014</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Professor Shitij Kapur</td>
<td>Non-Executive Director</td>
<td>September 2010 (to September 2016)</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Mike Franklin</td>
<td>Non-Executive Director</td>
<td>23 May 2016</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Anna Walker</td>
<td>Non-Executive Director</td>
<td>1 July 2016</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Duncan Hames</td>
<td>Non-Executive Director</td>
<td>12 May 2016</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Professor Matthew Hotopf</td>
<td>Non-Executive Director</td>
<td>October 2016</td>
<td>3 years (renewable)</td>
<td>N/A</td>
</tr>
<tr>
<td>Dr Matthew Patrick</td>
<td>Chief Executive</td>
<td>7 August 2015</td>
<td>5 years fixed term</td>
<td>6 months</td>
</tr>
<tr>
<td>Dr Martin Baggaley</td>
<td>Medical Director</td>
<td>18 August 1997 (to September 2016)</td>
<td>Open ended</td>
<td>12 weeks N.B Employed under medical / dental contract</td>
</tr>
<tr>
<td>Dr Neil Brimblecombe*</td>
<td>Director of Nursing</td>
<td>16 December 2013 (to December 2016)</td>
<td>Open ended</td>
<td>6 months</td>
</tr>
<tr>
<td>Dr Michael Holland</td>
<td>Medical Director</td>
<td>6 September 2016</td>
<td>Open ended</td>
<td>12 weeks N.B Employed under medical / dental contract</td>
</tr>
<tr>
<td>Gus Heafield</td>
<td>Chief Financial Officer</td>
<td>1 April 1996</td>
<td>Open ended</td>
<td>6 months</td>
</tr>
<tr>
<td>Kristin Dominy</td>
<td>Chief Operating Officer</td>
<td>14 August 2015</td>
<td>Open-ended</td>
<td>6 months</td>
</tr>
</tbody>
</table>

All Non-Executive Director appointments are for a period of three years which can be renewed or terminated by the Council of Governors and Chair.

* Dr Neil Brimblecombe retired on 31st December 2016 and returned for an interim period of six months.
Single total figure table – salary and pension entitlements of senior employees

<table>
<thead>
<tr>
<th>Salary and pension entitlements of senior employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Roger Purfield</td>
</tr>
<tr>
<td>Robert Coomber</td>
</tr>
<tr>
<td>Gus Heafield</td>
</tr>
<tr>
<td>Robert Coomber</td>
</tr>
<tr>
<td>Alan Disney</td>
</tr>
<tr>
<td>Mike Franklin</td>
</tr>
<tr>
<td>Duncan Hames</td>
</tr>
<tr>
<td>Julie Holfman</td>
</tr>
<tr>
<td>Matthew Hoppit</td>
</tr>
<tr>
<td>Shrit Kapur</td>
</tr>
<tr>
<td>Tarek Mouly</td>
</tr>
<tr>
<td>Anna Walker</td>
</tr>
<tr>
<td>Matthew Patrick</td>
</tr>
<tr>
<td>Gus Heafield</td>
</tr>
<tr>
<td>Martin Baggsley</td>
</tr>
<tr>
<td>Nai Binnlumbarch</td>
</tr>
<tr>
<td>Kristin Domney</td>
</tr>
<tr>
<td>Michael Holland</td>
</tr>
</tbody>
</table>

*Expenses are not subject to audit

2017 2016
£ 000's  £ 000's

| Total directors remuneration | 872 | 833 |
| Total employers pension contributions | 60 | 69 |

Number of directors to whom benefits are accruing under defined benefit schemes

Gus Heafild is the highest paid director (2016 Martin Baggsley)

Remuneration rate as highest paid director

£146,450 £162,430

Median staff remuneration

£36,025 £36,884

Ratio of highest paid director to median staff remuneration

4.07 4.40

There were no benefits-in-kind received by senior employees. There were no performance related bonuses and there are no long-term performances related bonuses.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Five Governors of the Members Council claimed expenses during the year totalling £8,128 (2015 £6,983).

Gus Heafild is the highest paid director and his remuneration rate as Chief Financial Officer is 4.4 times that of the median staff remuneration of £36.9k. In 2016-17 there were 16 employees who received remuneration in excess of the highest-paid director. The remuneration for the P&L Chair and Non-executive Directors is determined and agreed by the Board of Governors taking into account guidance from the NHS Confederation, NHS Employers and independent benchmark survey data, as required.

Dr Matthew Patrick, Chief Executive

South London and Maudsley NHS Foundation Trust
30 May 2017
2.3 Staff report

Our workforce profile

SLaM has more than 230 services including inpatient wards, outpatient and community services, and have almost 4,700 substantive staff working for us. Locally we serve a population of 1.3 million people, and we treat more than 45,000 patients in the community across south London as well as providing inpatient care for approximately 5,300 people each year.

Note 4.2 Average number of employees (WTE basis) 2016/17

<table>
<thead>
<tr>
<th>Category</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental</td>
<td>413</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>0</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>982</td>
</tr>
<tr>
<td>Healthcare assistants and other support staff</td>
<td>596</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>1,246</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting learners</td>
<td>0</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>1,000</td>
</tr>
<tr>
<td>Healthcare science staff</td>
<td>0</td>
</tr>
<tr>
<td>Social care staff</td>
<td>69</td>
</tr>
<tr>
<td>Agency and contract staff</td>
<td>942</td>
</tr>
<tr>
<td>Bank staff</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total average numbers</strong></td>
<td><strong>5,248</strong></td>
</tr>
</tbody>
</table>

*During the course of the year, the Trust employed 4306 staff and engaged a temporary workforce of 942 on average.
Registered nurses form the largest part of the workforce at 25%. When combined with healthcare assistants (support to nursing) this makes up over 37% of the overall workforce. The largest proportion of agency workers (which includes NHS Professionals) will also be registered nurses. Scientific, Therapeutic and Technical staff (Psychology, Psychotherapy and Allied Health Professions) remain the second largest group followed by Administration & Estates. Over the course of the year £2,077k has been spent on consultancy.

All Trust employment policies are assessed to identify any equality and human rights implications which may arise from implementation or application. This includes staff who are or become disabled where we apply our Disability in Employment Policy which includes making reasonable adjustments where required and providing further training. The Trust’s Occupational Health department provides advice where staff become disabled during their employment. We operate the “two ticks” symbol and offer any disabled applicant a guaranteed interview where they meet the minimum requirements and have Mindful Employer status.

During the reporting period the Trust continued to deliver its equality objectives for 2013-16 and published equality information (including data on the Workforce Race Equality Standard) in January 2016 to comply with the public sector equality duty. The Trust published its Workforce Race Equality Standard (WRES) data in July 2016.

We regularly consult with staff and their representatives systematically on matters of concern, through our Joint Staff Committee. In areas where we have undertaken significant service changes or staff reductions, we undertake a full consultation exercise with potentially affected staff and other stakeholders. To continue improving Trust performance, we regularly ask for feedback from staff through regular staff forums with the Chair and Chief Executive, carrying out an Annual Staff Survey and Friends and Family Test, with the latter being conducted three times a year. The results from the staff survey are presented annually to the Board and an action plan developed in response to the feedback. This action plan is monitored through the Trust’s Quality sub-Committee.

During the year we have carried out an extensive performance development (appraisal) programme where 97% of all non-medical staff had a performance development review to ensure the activities undertaken work towards the Trust’s overall performance. Medical staff appraisals are undertaken as part of the training programme for doctors in training and as part of revalidation for non-training doctors.

Information on policies relating to counter fraud and corruption is published on the Trust’s Intranet and we work closely throughout the year with our local counter fraud service. We have just developed an e-learning package for staff which is currently being piloted.

**Sickness absence and occupational health**

The sickness level for 2016/17 was 5.04% which has increased from 4.96% in the previous year. However, the Trust calculates sickness by the actual number of working days lost. If the Trust used the common denominator of 365 days the sickness level for 2016/17 would be 3.08%. The Trust actively promotes health and wellbeing amongst employees. All staff members have access to the Trust’s occupational health service and the staff counselling and wellbeing service. Information on health, safety and occupational health is published on the Trust’s intranet. The Trust has been awarded Achievement status under the London Healthy Workplace Charter.
Staff from a White ethnic background are the largest proportion in the workforce and has reduced by 1% on the previous year but still remains marginally higher than the profiles across our four main boroughs which have an average population of 55% white. Staff from a Black or Black British ethnic background has increased by 1% and remains fairly consistent with the local populations across the boroughs. Asian or Asian British has also increased by 1% compared to the previous year.
Staff turnover
Staff turnover has been proportionally highest in the psychology/psychotherapy professional group. Medical staffing turnover remains high and is due to junior doctors in training rotating to new posts.

Staff exit packages
All staff exit packages are in accordance with contracts of employment. There have been no exit packages which did not comply with contractual notice periods under a contract. During the reporting period the Trust operated an approved Mutually Agreed Resignation Scheme (MARS).

<table>
<thead>
<tr>
<th>Number of staff exit packages by cost band</th>
<th>£ 000's</th>
<th>Compulsory Redundancy</th>
<th>Other</th>
<th>2017 Total</th>
<th>2018 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td>5</td>
<td>12</td>
<td>17</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>10-25</td>
<td>3</td>
<td>26</td>
<td>29</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>25-50</td>
<td>2</td>
<td>14</td>
<td>16</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>50-100</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>100-150</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>150-200</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>54</td>
<td>71</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£ 000's</td>
<td>£ 000's</td>
<td>£ 000's</td>
<td>£ 000's</td>
<td></td>
</tr>
<tr>
<td>Cost of staff exit packages</td>
<td>802</td>
<td>1,111</td>
<td>1,913</td>
<td>501</td>
<td></td>
</tr>
</tbody>
</table>
Off payroll arrangements

In accordance with HM Treasury definitions the following tables outline the number of off-payroll payments for more than £220 per day, which have been in excess of 6 months. These relate to contractors undertaking fixed term projects for the Trust, or where skills required are not available within the Trust. It is the usual practice to employ substantive employees through the payroll but there may be exceptions to this.

Off payroll payments are regularly reported on and monitored by members of the senior management team. This includes the use of agency staff within infrastructure and corporate services.

Table 1

For all off payroll engagements as of 31 March 2017 for more than £220 per day and that last longer than 6 months:

<table>
<thead>
<tr>
<th>Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of existing engagements as of 31 March 2017</td>
<td>19</td>
</tr>
<tr>
<td>Of which, the number that have existed:</td>
<td></td>
</tr>
<tr>
<td>for less than 1 year at the time of reporting</td>
<td>2</td>
</tr>
<tr>
<td>for between 1 and 2 years at the time of reporting</td>
<td>4</td>
</tr>
<tr>
<td>for between 2 and 3 years at the time of reporting</td>
<td>2</td>
</tr>
<tr>
<td>for between 3 and 4 years at the time of reporting</td>
<td>6</td>
</tr>
<tr>
<td>for 4 or more years at the time of reporting</td>
<td>5</td>
</tr>
<tr>
<td>Please confirm that all existing off-payroll engagements, outlined above have at some time been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary that assurance has been sought.</td>
<td>yes</td>
</tr>
</tbody>
</table>

Table 2

For all new off payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than 6 months:

<table>
<thead>
<tr>
<th>Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements between 1 April 2016 and 31 March 2017</td>
<td>6</td>
</tr>
<tr>
<td>Number of new engagements which include contractual clauses giving SLaM the right to request assurance in relation to income tax and NI obligations</td>
<td>6</td>
</tr>
<tr>
<td>Number for whom assurance has been requested</td>
<td>6</td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
</tr>
<tr>
<td>assurance has been received</td>
<td>6</td>
</tr>
<tr>
<td>assurance has not been received</td>
<td>0</td>
</tr>
<tr>
<td>engagements terminated as a result of assurance not being received, or ended before assurance received.</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 3
For off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2016 and 31 March 2017:

| Number | No. of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year |
|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
|        | 0                                                                                                                          |
| Number | No. of individuals that have been deemed ‘board members and/or senior officials with significant financial responsibility’ during the financial year. This figure should include both off-payroll and on-payroll engagements. |
|        | 17                                                               |

Staff survey results
This year 1832 employees of Trust’s eligible workforce completed the survey. The response rate to the survey was 40% which is an increase on the 2015 response rate of 38%.

The aim of the national staff survey is to gather information that help Trusts provide better care for patients and improve working lives of those who provide this care. It is also used to form the foundations and development of the Trust’s Engagement Strategy.

The survey results will also support our Equality Delivery System for the workforce and will provide the basis to identify how Trust policies are working in practice. This year the survey report includes a dedicated section for the Workforce Race Equality Standard (WRES). The staff survey complements the Friends and Family Test which is now in its third year.

The survey contains questions about the job staff perform, how they work with colleagues, about the Trust leadership, the supervision staff receive and staff views on their healthcare organisation.

<table>
<thead>
<tr>
<th>Response</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Trust Improvement/deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response Rate</td>
<td>38%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>Mental Health and LD average</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Top 5 ranking scores

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
<th>Trust Improvement/deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff appraised in the past 12 months.</td>
<td>96%</td>
<td>93%</td>
<td>89%</td>
</tr>
<tr>
<td>Effective use of patient/service user feedback</td>
<td>3.81</td>
<td>3.82</td>
<td>3.70</td>
</tr>
<tr>
<td>Percentage of staff/colleagues reporting most recent incident of violence</td>
<td>93%</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td>Percentage of staff able to contribute towards improvements at work</td>
<td>76%</td>
<td>76%</td>
<td>73%</td>
</tr>
<tr>
<td>Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves.</td>
<td>55%</td>
<td>53%</td>
<td>55%</td>
</tr>
</tbody>
</table>

### Bottom 5 ranking scores

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
<th>Trust Improvement/deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>54%</td>
<td>51%</td>
<td>59%</td>
</tr>
<tr>
<td>Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>20%</td>
<td>20%</td>
<td>14%</td>
</tr>
<tr>
<td>Percentage of staff/colleagues reporting most recent incident of violence</td>
<td>93%</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td>Organisation and management interest in and action on health and well-being</td>
<td>3.55</td>
<td>3.56</td>
<td>3.71</td>
</tr>
<tr>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression and promotion</td>
<td>77%</td>
<td>78%</td>
<td>87%</td>
</tr>
<tr>
<td>Percentage of staff reporting good communication between senior management and staff</td>
<td>30%</td>
<td>30%</td>
<td>35%</td>
</tr>
</tbody>
</table>
In addition, our Trust score for overall staff engagement has gone down to 3.80 (3.81 in 2015) compared to a score of 3.77 which was the national average for all mental health/learning disability Trusts. BME, non-disabled and male staff reported the most positively. The Addictions CAG reported the most positively and the Acute CAG the least positively.

### Overall Staff Engagement

(1 being poorly engaged, 5 being highly engaged)

<table>
<thead>
<tr>
<th>Scale summary score</th>
<th>Trust score 2016</th>
<th>3.80</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trust score 2015</td>
<td>3.81</td>
</tr>
<tr>
<td></td>
<td>National 2016 average for mental health</td>
<td>3.77</td>
</tr>
</tbody>
</table>

The table below shows how South London and Maudsley NHS Foundation Trust compares with other mental health/learning disability trusts on each of the sub-dimensions of staff engagement and whether there has been a change since the 2015 survey.

<table>
<thead>
<tr>
<th>OVERALL STAFF ENGAGEMENT</th>
<th>Change since 2015 survey</th>
<th>Ranking, compared with all mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF1. Staff recommendation of the Trust as a place to work or receive treatment</td>
<td>No change</td>
<td>Above (better than) average</td>
</tr>
<tr>
<td>(the extent to which staff think care of patients/service users is the trusts top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)</td>
<td>No change</td>
<td>Average</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>No change</td>
<td>Average</td>
</tr>
<tr>
<td>(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)</td>
<td>No change</td>
<td>Above (better than) average</td>
</tr>
<tr>
<td>KF7. Staff ability to contribute towards improvements at work</td>
<td>No change</td>
<td>Above (better than) average</td>
</tr>
<tr>
<td>(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)</td>
<td>No change</td>
<td>Average</td>
</tr>
</tbody>
</table>
Particular questions (12a-d and KF1) are used to support the key finding concerning staff recommendation of the Trust as a place to work or receive treatment. These questions also form the basis of the “Friends and Family Test (FFT).”

The table below highlights that there have been improvements in two but we are the same or better than the national average.

<table>
<thead>
<tr>
<th>Question</th>
<th>Your Trust in 2016</th>
<th>Average (median) for mental health</th>
<th>Your Trust in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q21a “Care of patients / service users is my organisation’s top priority”</td>
<td>72%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Q21b “My organisation acts on concerns raised by patients / service users”</td>
<td>74%</td>
<td>74%</td>
<td>72%</td>
</tr>
<tr>
<td>Q21c “I would recommend my organisation as a place to work”</td>
<td>58%</td>
<td>56%</td>
<td>59%</td>
</tr>
<tr>
<td>Q21d “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation”</td>
<td>61%</td>
<td>59%</td>
<td>60%</td>
</tr>
<tr>
<td>KF1 staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)</td>
<td>3.67</td>
<td>3.63</td>
<td>3.68</td>
</tr>
</tbody>
</table>

**Areas for action and next steps**

There were a number of themes identified by our Quality Sub Committee that have been addressed at Trust-wide level, Main areas are:

1. Career development, opportunities and increased visibility of these
2. Health and wellbeing for staff
3. Bullying and harassment and discrimination
4. Reduction in violence and aggression
5. The role of the manager and positive proactive leadership, including good communication and engagement
6. Reward and recognition

A number of activities are already underway. Some, such as increasing the number of leadership development courses or the reward strategy implementation may lead to a request for investment in these areas but as much as possible, activities will not lead to greater costs and where they do, these will be addressed by the senior management team investment planning process.

Over the past year following on from the previous Staff Survey we have been actively engaging with and supporting the development of the new BME network. This has included the development of a “Tackling Snowy White Peaks” Working group following on from a network event where Roger Kline presented his findings on his research into Snowy White Peaks in the NHS.

We have also started working up comprehensive proposals around the workforce reward proposition, to recognise the challenges faced by our staff living and working in London and to support employee engagement, recruitment and retention through our employer value proposition.

The group has been looking at particular issues and themes and has developed a “Reflect and Review” checklist to be used before any formal investigation is undertaken. This will enable managers to take a step back and look at whether there are better alternatives than formal action.
A review of disciplinary investigation outcomes has been conducted on those staff involved in a formal disciplinary process and from a Black African background as there were a greater proportion going through formal disciplinary processes. It is recognised that the Reflect and Review checklist may assist in ensuring that staff are only taken through a formal process where there is no alternative.

We are presently scoping the implementation of a programme of inclusive leadership which helps organisations think about the impact and implications of unconscious bias. It is intended that we may be in a position to conducting a trial or pilot later in the year.

In the previous Staff Survey report it was highlighted that the Trust was in the worst 20% in terms of the percentage of staff who experience physical violence from other staff. In September 2016 the Chief Executive wrote an open letter to all staff reminding them of the need to report any incidents of unacceptable behaviour from other staff and to use the mechanisms already available to escalate any matters. It is positive to see a reduction in these reported in the 2016 survey which is also identified as one of the most improved areas but there is still further work to do to make this zero.

At a local level, each CAG and Directorate will again be asked to develop an action plan in relation to the responses in the staff survey. This should be based on the requirements identified within the report for their specific areas as some CAGs may need to develop and improve approaches to particular themes. There will need to be regular updates on progress through the CAG HR Business Partners. It is important that local issues are identified and staff are given the opportunity to work towards their resolution and for the CAGs to reassure their staff that they have heard the feedback and are addressing it.

We need to ensure we maintain our areas where we have scored in the top 20% of mental health and learning disability Trusts.

We will need to continue to reinforce the importance of the new annual performance review (appraisal) process which commenced in 2015. We have updated the ratings guide and redesigned the recording form. The performance review process allows an open dialogue about what is good and what needs to improve.
2.4 NHS Foundation Trust Code of Governance Disclosures

South London and Maudsley NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust integrates governance principles and procedures within its operations and management arrangements. The Board of Directors has reviewed the Trust’s compliance with the NHS Foundation Trust Code of Governance, and considers that the Trust has complied in all material respects. This section has three parts:

(A) Council of Governors
(B) Membership
(C) Directors – additional disclosures

Council of Governors

Meet the Governors

Since February 2017, the Lead Governor for the Trust has been Jenny Cobley (Public Governor) and the Deputy Lead Governor has been Brian Lumsden (Public Governor).

This table sets out the 2016 / 17 Governors.

<table>
<thead>
<tr>
<th>Name</th>
<th>Constituency</th>
<th>Appointment duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris Anderson</td>
<td>Elected service user</td>
<td>To January 2017</td>
</tr>
<tr>
<td>Christine Andrews</td>
<td>Elected service user</td>
<td>From January 2017</td>
</tr>
<tr>
<td>Mark Banham</td>
<td>Elected service user</td>
<td>Full year</td>
</tr>
<tr>
<td>Adam Black</td>
<td>Elected service user</td>
<td>Full year</td>
</tr>
<tr>
<td>David Blazey</td>
<td>Elected staff</td>
<td>Full year</td>
</tr>
<tr>
<td>Stella Branthonne-Foster</td>
<td>Elected service user</td>
<td>Full year</td>
</tr>
<tr>
<td>Sean Casey</td>
<td>Elected service user</td>
<td>From March 2017</td>
</tr>
<tr>
<td>Handsen Chikowore</td>
<td>Elected public</td>
<td>Full year</td>
</tr>
<tr>
<td>Jenny Cobley</td>
<td>Elected public</td>
<td>Full year</td>
</tr>
<tr>
<td>Chris Collins</td>
<td>Elected service user</td>
<td>To August 2016</td>
</tr>
<tr>
<td>Ian Creagh</td>
<td>Appointed</td>
<td>To September 2016</td>
</tr>
<tr>
<td>Simon Darnley</td>
<td>Elected staff</td>
<td>Full year</td>
</tr>
<tr>
<td>Janet Davies</td>
<td>Elected public</td>
<td>From December 2016</td>
</tr>
<tr>
<td>Barbra Davison</td>
<td>Elected service user</td>
<td>From September 2016</td>
</tr>
<tr>
<td>David Dawson</td>
<td>Appointed</td>
<td>Full year</td>
</tr>
<tr>
<td>Jim Dickson</td>
<td>Appointed</td>
<td>Full year</td>
</tr>
<tr>
<td>Angela Flood</td>
<td>Elected carer</td>
<td>Full year</td>
</tr>
<tr>
<td>Tom Flynn</td>
<td>Appointed</td>
<td>Full year</td>
</tr>
<tr>
<td>Mark Ganderton</td>
<td>Elected public</td>
<td>To November 2016</td>
</tr>
<tr>
<td>Robert Gay</td>
<td>Elected service user</td>
<td>To July 2016</td>
</tr>
<tr>
<td>Name</td>
<td>Constituency</td>
<td>Appointment duration</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Marnie Hayward</td>
<td>Elected service user</td>
<td>Full year</td>
</tr>
<tr>
<td>Alan Hall</td>
<td>Elected public</td>
<td>Full year</td>
</tr>
<tr>
<td>Paul Heenan</td>
<td>Appointed</td>
<td>From August 2016</td>
</tr>
<tr>
<td>Jeannie Hughes</td>
<td>Elected carer</td>
<td>From September 2016</td>
</tr>
<tr>
<td>Bert Johnson</td>
<td>Appointed</td>
<td>Full year</td>
</tr>
<tr>
<td>Seb Kalwij</td>
<td>Appointed</td>
<td>Full year</td>
</tr>
<tr>
<td>Francis Keaney</td>
<td>Elected staff</td>
<td>Full year</td>
</tr>
<tr>
<td>Nancy Kuchemann</td>
<td>Appointed</td>
<td>From January 2016</td>
</tr>
<tr>
<td>Brian Lumsden</td>
<td>Elected public</td>
<td>Full year</td>
</tr>
<tr>
<td>Matthew McKenzie</td>
<td>Elected carer</td>
<td>To August 2016</td>
</tr>
<tr>
<td>Raj Mitra</td>
<td>Appointed</td>
<td>Full year</td>
</tr>
<tr>
<td>Nash Momori</td>
<td>Elected service user</td>
<td>To August 2016</td>
</tr>
<tr>
<td>John Muldoon</td>
<td>Elected public</td>
<td>Full year</td>
</tr>
<tr>
<td>Rosie Mundt-Leach</td>
<td>Elected staff</td>
<td>From December 2016</td>
</tr>
<tr>
<td>Siobhan Netherwood</td>
<td>Elected staff</td>
<td>From September 2016</td>
</tr>
<tr>
<td>Girda Niles</td>
<td>Appointed</td>
<td>Full year</td>
</tr>
<tr>
<td>Ian Norman</td>
<td>Appointed</td>
<td>From October 2016</td>
</tr>
<tr>
<td>Phathiwe Ntini</td>
<td>Elected service user</td>
<td>Full year</td>
</tr>
<tr>
<td>Dele Olajide</td>
<td>Elected staff</td>
<td>To November 2016</td>
</tr>
<tr>
<td>Roger Oliver</td>
<td>Elected carer</td>
<td>To November 2016</td>
</tr>
<tr>
<td>Crada Onuegbu</td>
<td>Appointed</td>
<td>To August 2016</td>
</tr>
<tr>
<td>Zoe Rafah</td>
<td>Elected service user</td>
<td>From September 2016</td>
</tr>
<tr>
<td>Iyoni Ranasinghe</td>
<td>Elected staff</td>
<td>To August 2016</td>
</tr>
<tr>
<td>Susan Scarsbrook</td>
<td>Elected carer</td>
<td>From December 2016</td>
</tr>
<tr>
<td>Gillian Sharpe</td>
<td>Elected public</td>
<td>Full year</td>
</tr>
<tr>
<td>Luke Sorba</td>
<td>Appointed</td>
<td>From September 2016</td>
</tr>
<tr>
<td>Paula Swann</td>
<td>Appointed</td>
<td>Full year</td>
</tr>
<tr>
<td>Michael Tinarwo</td>
<td>Elected public</td>
<td>Full year</td>
</tr>
<tr>
<td>Tom Werner</td>
<td>Elected staff</td>
<td>Full year</td>
</tr>
<tr>
<td>Louisa Woodley</td>
<td>Appointed</td>
<td>Full year</td>
</tr>
</tbody>
</table>

There were no Governors who left their posts due to ineligibility to continue to serve under paragraph 10C of Schedule 7 to the NHS Act 2006.
Roles and responsibilities of the Council of Governors

The responsibilities of Council of Governors are as set out in the NHS Act 2006 as amended and reflected in the Trust’s Constitution. They include:

- Supporting the Board in setting the longer-term vision for the Trust, to influence proposals to make changes to services and to act in a way that is consistent with NHS principles and values and the terms of the Trust’s authorisation;
- Engaging in dialogue with, and provide advice to, the Board regarding the Trust’s future vision and strategy, and to act as a source of ideas about how the Trust can provide its services in ways that meets the needs of the communities it serves;
- Reviewing annually the extent to which the Trust is meeting its objective of delivering high-quality services;
- Working with the Board of Directors on such other matters for the benefit of the Trust as may be agreed between them;
- Exercising other functions at the request of the Board of Directors;
- Responding as appropriate when consulted by the Board of Directors;
- Exercising such other powers and to discharge such other duties as may be conferred on the Council of Governors under the Constitution.

The legislation relating to NHS Foundation Trusts lists further responsibilities for the Council of Governors as follows:

- Appointing the Chair and their Non-Executive Directors of the NHS Foundation Trust at a general meeting;
- Removing, where it is deemed necessary by three-quarters of the Council of Governors, the Chair or Non-Executive Directors of the NHS Foundation Trust at a general meeting;
- Approving, by a majority, the appointment of the Chief Executive by the Non-Executive Directors;
- Appointing or removing the auditor at a general meeting of the Council; and
- Receiving a presentation of the Annual Report and Accounts at a general meeting.

The Board has a duty to consult and pay due regard to the views of the Council of Governors in relation to forward planning. The Council of Governors is not responsible for the day-to-day running of the Trust. Legislation provides that all powers of the NHS Foundation Trust are to be exercisable by its Directors. The Council of Governors cannot veto decisions made by the Board.

All Directors are invited to attend all meetings of the Council of Governors as a means of both gaining an understanding of the issues being considered and to respond directly to questions or issues raised during the meeting. There is a dedicated slot for Non-Executive Directors to provide a presentation at the Council meetings, followed by a question and answer session. A report on the Council of Governors activity is a standing item on the agenda for the monthly meeting of the Board. There is a formal procedure for Governors to log questions with the Non-Executives and there are regular slots scheduled between Governors and Non-Executive Directors for the former to ask questions in person. Governors attend as observers at Board Committee meetings.

The Council of Governors has the power to remove the Chair or any Non-Executive Director, but this should only be exercised after exhausting all means of engagement with the Board. In the first instance, the Council should raise any issues with the Chair and the Senior Independent Director.
As stated in the 2006 Constitution, the Trust has established appropriate Dispute Resolution Procedures where necessary, relating to matters such as eligibility, disqualification and termination of tenure.

### Attendance at Council of Governors’ meetings 2016/17

<table>
<thead>
<tr>
<th>Name</th>
<th>06/16</th>
<th>09/16</th>
<th>12/16</th>
<th>03/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roger Paffard</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Chris Anderson</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Christine Andrews</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Y</td>
</tr>
<tr>
<td>Mark Banham</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Adam Black</td>
<td>Y</td>
<td>Y</td>
<td>APOL</td>
<td>Y</td>
</tr>
<tr>
<td>David Blazey</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Stella Branthonne-Foster</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>APOL</td>
</tr>
<tr>
<td>Sean Casey</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Y</td>
</tr>
<tr>
<td>Handsen Chikowore</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Jenny Cobley</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Chris Collins</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Ian Creagh</td>
<td>APOL</td>
<td>Y</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Simon Darnley</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Janet Davies</td>
<td>N/A</td>
<td>N/A</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Barbra Davison</td>
<td>N/A</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>David Dawson</td>
<td>APOL</td>
<td>N</td>
<td>APOL</td>
<td>APOL</td>
</tr>
<tr>
<td>Jim Dickson</td>
<td>Y</td>
<td>APOL</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Angela Flood</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Tom Flynn</td>
<td>APOL</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mark Ganderton</td>
<td>Y</td>
<td>Y</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Robert Gay</td>
<td>APOL</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Alan Hall</td>
<td>APOL</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Marnie Hayward</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Paul Heenan</td>
<td>N/A</td>
<td>N</td>
<td>APOL</td>
<td>Y</td>
</tr>
<tr>
<td>Jeannie Hughes</td>
<td>N/A</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Bert Johnson</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Seb Kalwij</td>
<td>APOL</td>
<td>APOL</td>
<td>APOL</td>
<td>APOL</td>
</tr>
<tr>
<td>Francis Keaney</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Nancy Kuchemann</td>
<td>Y</td>
<td>APOL</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Brian Lumsden</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Matthew McKenzie</td>
<td>Y</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Raj Mitra</td>
<td>APOL</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Nash Momori</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*APOL* indicates an apology has been given for non-attendance.
<table>
<thead>
<tr>
<th>Name</th>
<th>06/16</th>
<th>09/16</th>
<th>12/16</th>
<th>03/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Muldoon</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>APOL</td>
</tr>
<tr>
<td>Rosie Mundt-Leach</td>
<td>N/A</td>
<td>N/A</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Siobhan Netherwood</td>
<td>N/A</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Girda Niles</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Ian Norman</td>
<td>N/A</td>
<td>N/A</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Phathiwe Ntini</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Dele Olajide</td>
<td>APOL</td>
<td>Y</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Roger Oliver</td>
<td>APOL</td>
<td>Y</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Crada Onuegbu</td>
<td>APOL</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Zoe Rafah</td>
<td>N/A</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Iyoni Ranasinghe</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Susan Scarsbrook</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Gillian Sharpe</td>
<td>APOL</td>
<td>Y</td>
<td>Y</td>
<td>APOL</td>
</tr>
<tr>
<td>Luke Sorba</td>
<td>N/A</td>
<td>N/A</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Paula Swann</td>
<td>Y</td>
<td>APOL</td>
<td>APOL</td>
<td>APOL</td>
</tr>
<tr>
<td>Michael Tinarwo</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Tom Werner</td>
<td>Y</td>
<td>Y</td>
<td>APOL</td>
<td>Y</td>
</tr>
<tr>
<td>Louisa Woodley</td>
<td>APOL</td>
<td>APOL</td>
<td>APOL</td>
<td>APOL</td>
</tr>
</tbody>
</table>

Y = attended the meeting; APOL= apologies sent, N = did not attend the meeting

**Council of Governors’ elections 2016/17**

<table>
<thead>
<tr>
<th>Constituency Type</th>
<th>Full Name of Constituency</th>
<th>No. of candidates</th>
<th>No. of Votes cast</th>
<th>Turnout</th>
<th>No. of Eligible voters</th>
<th>Date of election</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Service User</td>
<td>Carer</td>
<td>6</td>
<td>47</td>
<td>14.6%</td>
<td>321</td>
<td>15/8/2016</td>
</tr>
<tr>
<td>Public</td>
<td>Public</td>
<td>6</td>
<td>327</td>
<td>4.2%</td>
<td>7794</td>
<td>15/8/2016</td>
</tr>
<tr>
<td>Staff</td>
<td>Staff</td>
<td>4</td>
<td>513</td>
<td>10.8%</td>
<td>4748</td>
<td>15/8/2016</td>
</tr>
<tr>
<td>Patient/Service User</td>
<td>Service user residing in England (outside of the London Boroughs of Croydon, Lambeth, Lewisham and Southwark)</td>
<td>1 Elected unopposed</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A (March 2017)</td>
</tr>
</tbody>
</table>
Governor working groups and committees

Membership and Involvement Group: This Group combines two previous groups – Inclusion and Social Responsibility and Membership and Communications. This group looks at issues of membership, recruitment and communication with the Council of Governors and the membership. It identifies how members can become more actively involved and oversees and promoted involvement and social responsibility activities of the membership. The group is working on how to improve involvement of service users and carers and under-represented groups. It approves annual membership targets and election strategy.

Quality Working Group: This group aims to review and comment on quality-related information so that the various perspectives can be collated and made available to the Non-Executive Directors. The group uses the annual Quality Accounts, the Limited Assurance Report from the external auditors and quality-related information presented to the Board, as well as information from visits and inspections, to identify specific areas of interest or concern. It looks at, and feeds into the Quality Report, including nomination one of the areas in the Quality report to be subject to Audit by the Trust’s Auditors.

Planning and Strategy: This group works with the Director of Strategy, feeding in to the Trust’s annual Forward Plan. The role of the group is to assist the Governors to fulfil their responsibility for regularly feeding back information about the Trust’s strategic vision and goals to the membership constituencies and stakeholder organisations.

Bids Group: The Council of Governors has run an innovative scheme for a number of years which awards small funds (up to £750) for members who wish to develop schemes to improve patient experience or increase social inclusion. The Bids Group assesses the proposals submitted, authorises funds and evaluates the outcomes.

Governance: This group looks at issues of governance relating to the Council of Governors and has produced a number of policies including the Governors’ Handbook. It provides stakeholder input into the development and implementation of a strong governance structure within the Trust. The work of the Nominations Committee is addressed below.

Nominations committee

The Nominations Committee is appointed and authorised by the Council of Governors. The Committee is responsible for:

- the selection and re-appointment process for Non-Executives;
- receiving reports on behalf of the Council of Governors regarding the outcome for appraisals for the Chair and Chief Executive;
- providing advice to the Council of Governors on remuneration and low aces for the Chair and Non-Executives; and
- reviewing the skill mix on the Board of Directors

There were no appointments to the Non-Executive Board appointments in 2016-17. But when required the Trust use an external search consultancy to find candidates with the rights skills and aptitude for the Trust’s needs.
Members of the nominations committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Attendance: Meeting 23 November 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roger Paffard</td>
<td>Nominations Committee Chair</td>
<td>Y</td>
</tr>
<tr>
<td>Dr Dele Olajide</td>
<td>Staff Governor</td>
<td>Y</td>
</tr>
<tr>
<td>Marnie Hayward</td>
<td>Service User Governor</td>
<td>Y</td>
</tr>
<tr>
<td>John Muldoon</td>
<td>Public Governor</td>
<td>Y</td>
</tr>
<tr>
<td>Francis Keaney</td>
<td>Staff Governor</td>
<td>Y</td>
</tr>
<tr>
<td>Ian Creagh (until Sep 2016)</td>
<td>Appointed Governor</td>
<td>N/A</td>
</tr>
<tr>
<td>Ian Norman (since Nov 2016)</td>
<td>Appointed Governor</td>
<td>Y</td>
</tr>
<tr>
<td>Gill Sharpe (since Mar 2017)</td>
<td>Public Governor</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Governors’ interests

There is a register of Governors interests held by the Trust Secretary. This is available by contacting the Trust Secretary, Rachel Evans, on telephone 020 3228 5376.

Membership

The Trust is committed to continuing to develop an active and engaged membership community. The objectives are to:

- Value all members;
- Promote mental and physical wellbeing among members;
- Grow membership numbers in a meaningful way; and
- Provide practical and relevant information.

We aim to:

- Target specific membership audiences, not just membership as a whole;
- Regularly communicate our news, events and membership benefits;
- Seek feedback and listen to the views of our members;
- Organise events relevant to the needs and interests of our members; and
- Highlight the work of the Council of Governors and encourage members to put themselves forward for nomination.

Anyone in England can be a member of the Trust. Our key membership constituencies are made up of our patients and service users, our carers, our staff and the wider public – which includes groups such as our partners and stakeholders, community support groups and local networks. Our audience also includes our colleagues in King’s Health Partners.
We use the following channels to engage with our members:

- **Members’ Bulletin**: This is a monthly online bulletin featuring the latest Trust News and Events. It is sent to all non-staff members with email addresses.

- **“Get Involved”**: This is a designated part of the Trust’s website which includes the following sections:
  - **Membership** – basic information on what it means to be a member of the Trust, a link to the online registration form and detail on the benefits of membership.
  - **Events** – displays a range of events taking place around the Trust and in our local communities.
  - **Volunteering and other opportunities** – links to a range of volunteering, involvement and paid opportunities.
  - **Connect with us** – details on how to keep in touch with us as well as news from around the Trust and our local communities.

The Governors held a series of ‘What we did’ public meetings in our four core boroughs. These meetings followed an initial round of ‘Have Your Say’ meetings where attendees reported areas of service which they felt needed improvement, and other concerns. The follow-up meetings informed attendees of the actions and progress taken to address the concerns, and also allowed participants to make further comments.

**Looking to the future, our plans are to:**

- Relaunch our Members’ Seminars series to provide information on key issues of interest to our members;
- Increase the levels of electronic communication with our members, where appropriate, so that information can be provided quickly and in an engaging format; and
- Increasing the participation by Governors in Best Practice Visits, PLACE visits and other similar opportunities.

**Reasons to become a South London and Maudsley NHS Foundation Trust member**

There is always something happening at South London and Maudsley NHS Foundation Trust and becoming a member means that you can keep up to date with news and events at the Trust. Members receive a monthly member bulletin and a quarterly news magazine.

Members elect the Governors who sit on the Council of Governors and help the Board to determine our priorities for the future. As a member, you can stand for election yourself (if you are over 16) and make your voice heard.

Unique to SLaM, our Council of Governors runs a bids scheme to award up to £750 funding to members who have a good idea that will support the patient experience, social inclusion or mental wellbeing.

We also have a Members-only discount scheme in partnership with Healthcare Staff Benefits who have signed up a variety of businesses, local and otherwise who can offer you discounts on goods and services.

**Becoming a member of SLaM**

- Anyone who lives in England and Wales can join the Trust as a public member.
- Anyone who is employed by the Trust under a contract of employment may become or continue as a staff member provided that they are (1) employed by the Trust under a contract of employment who has no fixed term or has a fixed term of at least 12 months; (2) have been continuously employed by the Trust under a contract of employment for at least 12 months.
- Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.
- Anyone whose name is recorded as a patient on the Trust’s patient administration system or other record maintained for the purpose of identifying patients of the Trust and who has, within the last five years, attended the Trust as a patient can join as a member of the service user constituency.
- Anyone who has within the last five years attended the Trust as the carer of a patient, may become or continue as a member of the Trust in the carer constituency.
Membership recruitment

We continued to increase the membership base of the Foundation Trust which now stands at 14,519 members at the end of March 2017. The Council of Governors has set a long-term target of developing a membership base of 25,000.

The priority remains to increase the service user and carer constituency which is currently considered to be under-represented.

<table>
<thead>
<tr>
<th>Public constituency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>At year start (April 1 2016)</td>
<td>7638</td>
</tr>
<tr>
<td>New members</td>
<td>970</td>
</tr>
<tr>
<td>Members leaving</td>
<td>174</td>
</tr>
<tr>
<td>At year end (31 March 2017)</td>
<td>8434 at 22/3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff constituency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>At year start (April 1 2016)</td>
<td>4788</td>
</tr>
<tr>
<td>New members</td>
<td>900</td>
</tr>
<tr>
<td>Members leaving</td>
<td>918</td>
</tr>
<tr>
<td>At year end (31 March 2017)</td>
<td>4770 at 22/3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient constituency (service user + carer)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>At year start (April 1 2016)</td>
<td>1272</td>
</tr>
<tr>
<td>New members</td>
<td>60</td>
</tr>
<tr>
<td>Members leaving</td>
<td>17</td>
</tr>
<tr>
<td>At year end (31 March 2017)</td>
<td>1315 at 22/3</td>
</tr>
</tbody>
</table>

This excludes February 2017 starters and leavers as data had not been supplied at 24/3/17

Contact details for the Membership Office

The contact point within the organisation for members who wish to communicate with the Council of Governors or the Directors is:

Rachel Evans, Director of Corporate Affairs and Trust Secretary
Email: rachel.evans@slam.nhs.uk
Telephone: 0203 228 5376

Information about the membership of the Board and the roles of the Directors are set out in the Accountability Report.
Non-Executive Directors – independence and experience

The Board of Directors has continued to assess the independence of its Non-Executive Directors further to the requirements of the Code of Governance, and considers that each Non-Executive Director is independent in character and in judgment.

Declarations of interest are made, where relevant, at each meeting of the Board. The Board considers that the materiality and circumstances relating to these relationships are such that they do not affect, nor could appear to affect, the independence of the Directors concerned.

The Board of Directors has an appropriate balance of skills and experience between the Executive Director posts and the Non-Executive Director posts. This is kept under regular review.

Directors – assessing performance

Individual evaluation of the performance of Non-Executive Directors is carried out by the Chair. Evaluation of the performance of Executive Directors is carried out by the Chief Executive. Evaluation of the performance of the Chair is carried out by the Senior Independent Director, who engages an external consultant to gather 360 degree feedback to inform the evaluation.

The Nominations Committee receives reports on behalf of the Council of Governors on the process and outcome of the appraisal for the Chair and the other Non-Executive Directors. The Remuneration Committee receives a report from the Chief Executive on the performance of all Executive on the performance of all Executive Directors. The Chair reports to the Remuneration Committee on the performance of the Chief Executive.
2.5 NHS Improvement’s Single Oversight Framework

The new NHS Improvement Single Oversight and Improvement Framework replaced the Monitor risk assessment framework from 1 October 2016.

<table>
<thead>
<tr>
<th>Area</th>
<th>Metric</th>
<th>2016/17 Q3 score</th>
<th>2016/17 Q4 score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial sustainability</td>
<td>Capital service capacity</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Liquidity</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Financial efficiency</td>
<td>I&amp;E margin</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Financial controls</td>
<td>Distance from financial plan</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Agency spend</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Overall scoring</td>
<td></td>
<td><strong>3</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

The finance and use of resources area is based on the scoring of five measures from ‘1’ to ‘4’, where ‘1’ reflects the strongest performance. These scores are then weighted to give an overall score.
2.6 Statement of the Chief Executive’s responsibilities as the Accounting Officer of South London and Maudsley NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require South London and Maudsley NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of South London and Maudsley NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Dr Matthew Patrick  
Chief Executive  
South London and Maudsley NHS Foundation Trust  
30 May 2017
2.7 Annual governance statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust’s policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the South London and Maudsley NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the South London and Maudsley NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Risk Management is the responsibility of all staff. Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself on a day to day basis in many different ways.

The following sections define the organisational expectations of particular roles or groups:

Chief Executive: The Chief Executive is the responsible officer for the South London & Maudsley NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As Accountable Officer, the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the Annual Governance Statement. Operationally, the Chief Executive has delegated responsibility for implementation of risk management as outlined below.

Chief Finance Officer: The Chief Finance Officer has responsibility for financial governance and associated financial risk.

Medical Director: The Medical Director has joint responsibility for clinical governance and clinical risk management, including incident management, and has joint responsibility with the Director of Nursing for quality.

Director of Nursing: The Director of Nursing has responsibility for patient safety and patient experience, and has joint responsibility with the Medical Director of quality and clinical risk management.

Chief Operating Officer: The Chief Operating Officer (COO) has responsibility for ensuring that effective operational arrangements are in place throughout the Trust and across all sites, this includes performance management and the management of operational risks. The COO has particular responsibility for Health and Safety.

Trust Secretary: The Trust Secretary leads on the management of strategic risk within the organisation and the Board Assurance Framework.
Executive Directors: Executive Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates.

Executive Directors have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.

CAG Directors: CAG Directors are accountable for ensuring that appropriate and effective risk management processes are in place within the CAGs, and that all staff are aware of the risks within their work environment, together with their personal responsibilities.

They must ensure that risks are identified, assessed, and acted upon. They must ensure that where appropriate captured on local risk registers, ensuring that risks are reviewed by an appropriate divisional group at least quarterly as part of performance monitoring, to consider and plan actions being taken.

They must ensure appropriate escalation of risks from service or directorates to divisional level within the defined tolerances. Divisional Directors have further responsibility for ensuring compliance with standards and the overall risk management system as outlined in this strategy and related documentation.

The Divisional Directors are responsible for ensuring that staff receive the relevant elements of risk management training and then non-attendance is followed up.

Clinical Directors: Clinical Directors are responsible for ensuring that appropriate and effective risk management processes are in place in their designated area and scope of responsibility; implementing and monitoring any control measures identified; ensuring risks are captured on the relevant risk register; and ensuring that local groups review risk registers on a regular basis to consider and plan actions being taken.

Senior Managers: Senior managers that lead on risk management and set the example through visible leadership of their staff. Senior staff are expected to be aware of and adhere to the risk management best practice.

Health and Safety Risk Manager: The Health and Safety Risk Manager advises the Trust on Health and Safety, including statutory compliance requirements; responsible for ensuring that there are systems in place to ensure that safety alerts are disseminated, implemented and monitored.

All Staff: All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective they should be aware and encouraged to follow the Whistleblowing Policy incorporating guidance on raising concerns.

Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate, and providing advice in the event of a dispute to the validity of a risk assessment.

The Trust uses QI methodology to encourage staff to learn from good practice and stopping what does not work.

QI improvement activity enables the Trust to learn from good practice as local improvement outcome data is shared and visible to all teams so that they can learn from and scale up and spread what works well. The training methodology encourages people to attend learning events, network and share their experiences and data.

The risk and control framework

The Trust’s Risk Management Strategy was approved by the Board in July 2016. This sets out the structures and processes to systematically identify, assess analyse the Trust’s risks, whether clinical or non-clinical, and put in place robust plans for mitigation.

Risk appetite

The Trust uses the 5 x 5 matrix (likelihood and consequence) to identify risk ratings. The Trust’s risk appetite line is set at 12; any risks rated at or above this level are reported to the relevant Board Sub-Committee and the Board on a quarterly basis.

A risk score of 12 or above should therefore be treated as a trigger for a discussion as to whether the trust is willing to accept this level of risk. A residual risk rating should be set for all risks. This residual risk rating is a means of expressing a target for the lowest acceptable (tolerated) level for that risk. When setting residual risk ratings, risk leads should consider what level of tolerated risk they are willing to retain.
For some risks, the residual risk rating could be high, especially where the consequences are potentially severe and the overall score remains high even when the likelihood of occurrence is minimised or some elements of the risk lie outside the direct control of the Trust. All risks will have a risk appetite rating which will be derived from the Risk Appetite Matrix.

Risk management process

The process for managing risks in the Trust starts with ensuring clarity about the Trust’s strategic and local objectives and the outcomes that are being sought. Risks to those objectives or outcomes can then be identified by considering what could happen and what could go wrong, how and why this could happen, what is depended upon for continued success, what different perspectives could be provided on the risk in question.

Once the risk has been identified, it needs to be described as follows and then captured on the risk register.

(a) described so that others can understand it - this involves considering the cause, the effect and the impact;
(b) assigned an owner;
(c) allocated key controls, i.e. those actions being taken to reduce the likelihood of the risk happening or reduce the impact;
(d) for severe (red/orange risks), need to develop a contingency action plan;
(e) rate the likelihood of the risk materialising;
(f) rate the consequence of the risk happening.

Proactive risk assessment involves the regular review of risks in a given locality, service or operation. The Trust uses a variety of different risk assessment tools for different situations – including the Health & Safety risk assessment tools, clinical risk assessment tools, the Capital Programme risk assessment tool and infection control audit tools.

Other means of identifying risks include:
- Multi-disciplinary review of incidents, complaints and claims data
- Patient and staff feedback surveys
- Root cause analysis following serious adverse incidents
- Underlying root causes of incidents, complaints and claims
- Concerns raised by Trade Unions
- Whistleblowing
- Coroners reports
- Financial forecasting and reports Board Quality walkabouts
- Recommendation and reports from assessment/inspections from internal and external bodies
- Safety alerts e.g. Central Alerting System, NHS Protect
- Non-Clinical/Generic Risk Assessments completed by staff
- Incident Reports
- Serious Adverse Incident Reports
- Health and Safety Audits
- Regular Health and Safety Checks e.g. Window checks, Fire Inspections
- Complaints
- National Guidance/Reports
- Patient’s conditions (e.g. inherent risk of falls in people with dementia)
- Major incident (drill or live)
- Recommendations and reports from external agencies such as NHSLA, Health and Safety Executive, Patient-led Assessments of the Care Environment (PLACE) etc
- Actions taken to reduce risks which could not be or were not implemented for various reasons such as resource limitations
- Quality Impact assessments
- Best practice visits etc.
Board Assurance Framework and Corporate Risk Register submitted to Board and monitored through Board governance and assurance committees.

Risks scoring 15 or above impacting across the Trust escalated to corporate risk register with agreement by SMT and recommend risks to be incorporated into the BAF.

All risks 15 or above (corporate or CAG) and any risks regardless of score if unmanageable escalated by the CAGs to RAG.

Service / CAG risks reviewed at CAG Governance Forums / CAG Boards.

Risks identified populate the Risk Register.

Risk escalation

Board of Directors

Audit Committee

Assurance Committees
Board Assurance Framework

Senior Management Team
Board Assurance Framework

CAG/Corporate Areas (Operational SMT)
Review Delivery risk registers

CAG Business Meetings (Performance Review Meetings)
CAG Risk Registers

Risk Registers

Internal / External Audit
Complaints/ PALS/ incidents
Risk Assessment
Business Planning
Clinical Audit
Legislation
Litigation
External Review

Annual Report and Summary Accounts 2016/2017 South London and Maudsley NHS Foundation Trust
Risk analysis and prioritisation

Risk rating allows each risk to be prioritised relative to other risks. It uses the likelihood of the risk occurring and the consequence of the risk occurring to produce a risk rating between 1 (1 x 1) and 25 (5 x 5). The initial risk rating reflects the position if no controls were in place and the current risk rating takes the assured effectiveness of current controls into account. The target risk rating reflects the realistic level at which the risk is deemed to be acceptable and no further action is required to mitigate it.

Risk treatment

Key controls are the measures put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and the severity if it does.

The options available to manage risk include:

- Tolerate – the likelihood and consequence of a particular risk happening is accepted;
- Treat – work is carried out to reduce the likelihood or consequence of the risk;
- Transfer – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party;
- Terminate – an informed decision not to continue involvement in the risk situation; and
- Take the opportunity – actively taking the advantage, regarding the uncertainty as an opportunity to benefit.

When considering the best course of action, the cost associated with managing the risk is also to be considered, e.g. associated financial cost or the introduction of new associated risks.

Risk monitoring and review

Systemic and structured reporting, escalation and monitoring of risk assessments and action plans are required, consistent with the overall status of the risk. Information relating to each operational risk is held within Datix, the Trust’s Risk Management system. This can be reported in different formats to different fora as required.

Each Clinical Academic Group and Directorate has a nominated officer with responsibility for maintaining their risk and assurance register. All Clinical Academic Group and Directorate risk and assurance registers are held on the Datix Risk Management System, maintained on the intranet. Clinical Academic Groups and Directorates are required to monitor any Red risks within their registers on a monthly basis and review all risks quarterly. Closed risks are reviewed annually to confirm that they no longer exist or are still under control.

The Board Assurance Framework is reviewed quarterly at the Audit Committee, where Executive leads are invited to attend meetings to present the actions underway to mitigate the risk, progress to date and any issues identified. The Framework is reviewed quarterly by the Board.

Compliance with the NHS Foundation Trust condition 4 requires trusts to “apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate as a supplier of healthcare services”.

Compliance with the NHS Foundation Trust condition 4 requires trusts to “apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate as a supplier of healthcare services”.

The principal risk to non-compliance with this condition is for the trust to fail to have in place effective Board and Committee structures that have clear terms of reference and lines of accountability.

The Board Committees are well-established. Each Committee is chaired by a Non-Executive Director who is assisted by at least one other Non-Executive. This enables rigorous and constructive challenge to be given to the executive directors about the performance of the Trust and to provide strategic leadership. The Terms of Reference of each Committee are reviewed on an annual basis and improvements are regularly identified and implemented. The outcomes of the Committee discussions are reported to the Board every month, enabling key points to be escalated and risks and areas of assurance to be highlighted.

The Board receives and discusses a report every month on both the operational and financial performance of the Trust. This provides key information about compliance with NHSI indicators. The Board identifies any areas of concern and areas where further information is required or action needs to be taken.
The Audit Committee’s key objectives include monitoring, reviewing and reporting to the Board of Directors on whether the Trust’s processes regarding internal control and risk management are efficient and effective. The Audit Committee has reported to the Board of Directors and where scope for improvement was found, has noted these for the senior management team’s attention.

Handling future risks
The Board has overall responsibility for ensuring systems and controls are in place to address, manage and mitigate risk. Assurance is gained from a wide range of sources, but where ever possible it is systematic, supported by evidence, independently verified, and incorporated within a robust governance process.

At Board level this control is achieved, by having an annual review of the Board Assurance Framework ensuring that all strategic risks are maintained, amended or deleted as required. During the year, the BAF also regularly returns to the Board and is assessed through the work of its Assurance committees, such as Audit and other independent inspections and by the systematic collection and scrutiny of performance data, to evidence the achievement of the objectives and mitigations.

In June 2017, a Board Workshop has been planned to discuss and refine the articulation of the strategic risks faced by the Trust going forward.

The expectation of the Trust is that strategic risks going forward will encompass:

Maintaining and improving clinical quality and reducing inappropriate variation in care and treatment across the organisation. This will be addressed by evidence based reviews of progress toward completing actions and by the Quality Delivery Committee. This in turn will report to the Board’s Quality Committee.

Developing and retaining a skilled, diverse and caring workforce who are proud to work for Trust. The Trust had developed a workforce strategy and is planning increased activity in relation to recruitment and retention to ensure that we attract and retain high-quality staff. The Board will develop a resource to oversee and support workforce planning and mitigations against risk.

Ensuring the Trust has buildings and clinical environments that reflect the needs of 21st century healthcare. To achieve this, the Trust has developed an Estates strategy plan with milestones with a focus on the next five years. The next stage will be its implementation and in parallel there will be a focus on operational estates management to ensure the safety and wellbeing of staff. Assurance will be supplied by Finance and Performance Committee; scrutiny and oversight will be by the Capital Programme Group.

Developing the information capability of the Trust to provide: accurate, timely reliable information to support decision making, partnership working and transparency of performance. Over the last two years, the Trust has transformed its IT, delivering significant improvements including enhanced email systems and the complete transition to Office 365. The programme is progressing and meeting programme checkpoints and delivery milestones. Further progress will be monitored by the Board.

Working in partnership to transform clinical services, develop community based models of care and deliver these through new population based models of commissioning and delivery. Senior management have and will continue to be closely involved with both Sustainability and Transformation Plans for South East London and the South London Mental Health Partnership with regular reporting to the Trust Board and its committees.

Securing and managing the appropriate levels of resources to deliver high quality, safe and effective services. There are risks of failing to deliver the cost improvement programme and infrastructure programme. Management of adult bed capacity, placements and other over-performance issues that are not fully funded remain risks and there are potentially financial pressures from other parts of the system. Performance is reviewed monthly by the Portfolio Board and fortnightly by the Performance Delivery Steering Group.
Compliance with NHS Foundation Trust condition 4

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The Audit Committee’s key objectives include monitoring, reviewing and reporting to the Board of Directors on whether the Trust’s processes regarding internal control and risk management are efficient and effective. The Audit Committee has reported to the Board of Directors and where scope for improvement was found, has noted these for the senior management team’s attention.

Effectiveness of governance structures

Board of Directors

The Board is the accountable body for risk and is responsible for ensuring the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps to deliver the responsibility for implementing risk management systems throughout the Trust.

Specific responsibilities for the management of risk and assurance on its effectiveness are delegated as follows:

Audit Committee

The Audit Committee is responsible for providing assurance to the Trust Board on the process for the Trust’s system for internal control by means of independent and objective reviews of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:

- To maintain an oversight of the Trust’s general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.
- To review the Trust strategic risk register at each meeting or as the Board determines.
- To monitor the Board Assurance Framework, and ensure its presentation to the Trust Board at intervals that the Board determines.
- To assess the overall effectiveness of risk management and the system of internal control.
- To challenge on the effectiveness of controls, or approach to specific risks.

Finance and Performance Committee

The Finance and Performance Committee is responsible for providing information and making recommendations to the Trust Board on financial performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and Trust level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate.
Quality Committee
The Quality Sub-Committee (QSC) is responsible for providing the Trust Board with assurance on all aspects of quality of clinical care; governance systems including risks for clinical, corporate, workforce, information and research & development issues; and regulatory standards of quality and safety. The Committee will consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Trust Board as appropriate. Following a review by the Trust’s Director of Nursing and Senior Management team, the QSC receives a CQC compliance report at every meeting to ensure the Trust remains fully compliant with the registration requirements of the CQC. Please see ‘CQC inspection 2017 results and actions’ sections of the quality report for more information.

Senior Management Team
The Senior Management Team in its role as the Executive decision making committee of the Trust maintains oversight of the operational risk and is responsible for the operational management and monitoring of risk, through the Corporate Risk Register and Board Assurance Framework, and for agreeing resourced treatment plans and ensuring their delivery.

CAG and Corporate Directorate Risk Management Arrangements
CAGs and corporate areas will put the necessary arrangements in place within their areas for proper governance, safety, quality and risk management.

The CAG forums have the responsibility, through the Clinical Directors, for the risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks. The CAGs will develop, populate and review their risks, drawing on risk processes within the services, to ensure that Service, Directorate and CAG Risk Registers are kept up to date through regular review.

In doing this, due account will be taken of the Trust’s strategic and corporate objectives, particularly in terms of meeting regulatory standards and guidance, national performance standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular CAG and its services. Directorate meetings similarly will review the risk registers and contribute to the development of the Directorate and CAG Risk Registers and ensure risk registers are in place and operating within the defined tolerances and escalation processes.

Directorate and CAG management teams will be responsible for managing risks that fall within the defined tolerances, and escalating those risks above set tolerances for information, or further action.

Embedding risk management in the Trust’s activity
The Trust is committed to a risk management culture that underpins and supports the business of the Trust. This involves:

Awareness: All staff will have an awareness and understanding of the risks that affect patients, visitors, and staff.
- Risk identification – line managers will encourage staff to report incidents and identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.
- Accountability – staff will be identified to own the actions to tackle risks.
- Communication – there will be active and frequent communication between staff, stakeholders and partners.

Competence: Staff will be competent at managing risk -
- Training – staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally.
- Behaviour and culture – senior management will lead change by example, ensuring risks are identified, assessed and managed. Front line staff are encouraged to identify risks.

Management: Activities will be controlled using the risk management process and staff are empowered to tackle risks.
- Risk assessment and management – risks will be assessed and acted upon to prevent, control, or reduce them to an acceptable level. Staff will have the freedom and authority, within defined parameters, needed to take action to tackle risks, escalating them where necessary. Contingency plans will be put in place where required.
- Process – the process for managing risk will be reviewed to continually improve. This will be integrated with our processes for providing assurance, and the processes of our stakeholders and any relevant third parties.
• Measuring performance – exposure to risk will be measured with the aim of reducing this over time. The culture of risk management will also be measured and improved.

Involving public stakeholders in managing risks which impact on them

The trust believes that effective risk management is important not only to provide a safe environment and improved quality of care, but also to the business planning process and to public accountability in delivering health services.

There are a range of organisations and individuals which require information on adverse events or significant risks facing the Trust. These include service users, carers, governors, members, commissioners, regulators, local government and central government. The main local stakeholders are all represented at the Council of Governors where discussions take place to understand the key risks facing the Trust and the mitigating action being taken. Regular meetings are held with CCGs, Community groups, local authority Directors of Social Services and Police Borough Commanders, as well as monitoring our contracts.

Data assurance and security

There is a process of data quality assurance by Business Intelligence for performance and activity reporting which is then reviewed by the Clinical Academic Groups together with the performance team. It is the responsibility of the clinical services to improve their data quality and this is strengthened by Performance Reviews sessions held monthly with each Clinical Academic Group. Risks to data security are managed by the Information Security Committee and described in the section on Information Governance.

Equality

The trust is committed to promoting equality of opportunity for all its employees and the population it serves. The trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. No detriment is intended.

Care Quality Commission. The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. Please see the quality report for further detail

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and human rights legislation compliance

Control measures are in place to ensure that there is compliance with all the organisation’s obligations under equality, diversity and human rights legislation.

Climate change obligations

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources - Data still being verified

In auditing the 2016/7 financial statements, the external auditors are required to satisfy themselves that the Trust has appropriate arrangements to secure economy, effectiveness and efficiency. The conclusions of this work are presented to the Audit Committee and the Board. The external audit review did not identify any issues which would lead them to conclude that the Trust did not have proper arrangements in place.

The Trust uses financial models to help develop an annual plan setting out expenditure ad savings plans for the next financial year. The plan is developed at Clinical Academic Groups and Directorate level.

During the year, the financial plan is monitored on a regular basis with scrutiny of performance taking place at:

• Board, where a financial report is provided on a monthly basis
• Operational Performance Management meetings (monthly)
• Finance and Performance Committee (monthly)
• Audit Committee (quarterly)
• CAG Executive meetings (monthly)

The consistency of financial and other performance information, provided to the Board, NHSI and produced in the Annual Accounts, is supported by auditors. The information is also subject to review by the Commissioners.
All Clinical Academic Group and Corporate Directorates receive regular financial reports and workforce information to enable their management of allocated resources. They are also assigned a named, qualified accountant to ensure that an appropriate level of financial support and advice is provided.

The remit of the Trust’s internal auditors includes reviewing the processes and controls in place to ensure resources are used appropriately and economically. Their work is subject to scrutiny by the Audit Committee.

Information governance

The Trust Information Governance Operating Model, which is the Management and Assurance Framework that outlines key roles and committees which are responsible for managing and monitoring confidentiality, records management, information risk and security.

The Information Security Committee (chaired by the Senior Information Risk Owner) is responsible for protecting the Trust from data security threats and delivers improved data security through the review of incidents, policy development, education of users, highlighting risks and developing risk mitigation action plans.

The Caldicott Committee (chaired by the Caldicott Guardian) is responsible for overseeing the Trust’s compliance with confidentiality, information sharing and clinical records policies, developing awareness of Caldicott and confidentiality issues throughout the trust, implementing policies and strategies to improve service user experience in relation to fair, lawful and secure use of their personal confidential information, leading and overseeing the implementation of controls and receiving assurance to maintain service user confidentiality whilst enabling effective and lawful sharing of information.

The Freedom of Information Committee (chaired by the Director of Corporate Affairs and Trust Secretary) is responsible for the implementation of an effective records management strategy, improving awareness of and overseeing the Trust’s compliance with the Freedom of Information Act 2000 and implementation of an open culture to improve transparency.

The Information Governance Toolkit is an annual online national self-assessment process overseen by the Health and Social Care Information Centre, which enables the Trust to measure its compliance against Department of Health standards of information governance management, confidentiality and data protection, information security, clinical information, secondary uses and corporate information. The Trust provides evidence to demonstrate compliance with each of the standards in the toolkit, which is independently audited by Internal Audit. Following the independent audit and sign-off by the Trust Caldicott Guardian and the Senior Information Risk Owner, the Information Governance Toolkit assessment is submitted on 31 March each year.

The Trust scored Level 2 or above for all requirements of the Information Governance Toolkit v14 that form the Information Governance Statement of Compliance with an overall score of 91% satisfactory compliance. Internal Audit reviewed the key requirements of the Toolkit and gave reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently.
One serious confidentiality incident (SIRI at level 2) was reported in 2016-17. Details of the incident are provided below.

### Summary of serious incidents requiring investigation involving personal data as reported to the Information Commissioner’s Office in 2016-17

<table>
<thead>
<tr>
<th>Date of Incident (month)</th>
<th>Nature of Incident</th>
<th>Nature of Data Involved</th>
<th>Number of Data Subjects Potentially Affected</th>
<th>Notification Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2016</td>
<td>Lost paperwork</td>
<td>Loss of a confidential report in with sensitive information about a patient’s HIV status</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

The ICO, the DH and relevant CCG were notified. The ICO closed the matter with no fine levied on the Trust.

Further action on information risk:

1. Improved training and awareness resources on data security, secure transfer of confidential records and mobile working.
2. Additional guidance on reducing the need for manual transfers of personal data and good practice around effective de-identification.
3. Improved awareness of the duty of Candour.

Incidents classified at lower severity level (level 1) are summarised below.

### Summary of other personal data related incidents in 2016-17

<table>
<thead>
<tr>
<th>Category</th>
<th>Type</th>
<th>Total No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Corruption or inability to recover electronic data</td>
<td>-</td>
</tr>
<tr>
<td>B</td>
<td>Disclosed in error</td>
<td>4</td>
</tr>
<tr>
<td>C</td>
<td>Lost in transit</td>
<td>-</td>
</tr>
<tr>
<td>D</td>
<td>Lost or stolen hardware</td>
<td>-</td>
</tr>
<tr>
<td>E</td>
<td>Lost or stolen paperwork</td>
<td>-</td>
</tr>
<tr>
<td>F</td>
<td>Non-secure disposal - hardware</td>
<td>-</td>
</tr>
<tr>
<td>G</td>
<td>Non-secure disposal - paperwork</td>
<td>-</td>
</tr>
<tr>
<td>H</td>
<td>Uploaded to website in error</td>
<td>-</td>
</tr>
<tr>
<td>I</td>
<td>Technical security failing (including hacking)</td>
<td>1</td>
</tr>
<tr>
<td>J</td>
<td>Unauthorised access/disclosure</td>
<td>2</td>
</tr>
<tr>
<td>K</td>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>
Annual quality report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The viewpoints of all our stakeholders are sought during the consultation process in identifying our priorities for the upcoming year.

The approach the Trust Board takes to assuring the quality of our clinical services is to continuously strive for robust assurance. Assurance is provided by:

- Performance data and management reports. The Board receives a Performance dashboard each month, as well as a Quality dashboard. Performance and quality indicators are used at the monthly Operations meetings, and include performance and progress against the quality targets and priorities.
- External inspection, assessment and investigations reports including those from the CQC. The Trust has robust processes to follow through actions resulting from CQC inspections, including Mental Health Act reviews.
- The annual clinical audit programme is prioritised according to risk in three areas of patient safety, clinical effectiveness and patient experience. The Quality Effectiveness Safety Trigger Tool (QUESTT) is used to monitor the key indicators that may impact on quality.
- Board members go on site visits to clinical settings, talk directly to service users and listen to what staff and governors have to say about the services that they provide.
- Quality of services are monitored at the Quality Committee; a sub-committee of the Board which provides assurance to the Board of Directors on the delivery on the Trust’s Quality Strategy.
- The Board Assurance Framework identifies the key risks that might compromise the Trust achieving its most important strategic objectives. Quality is the first strategic objective within the Framework. The Framework is reviewed by the Senior Management Team, at sub-Committee level and at the Board.
- The system for receiving and responding to formal complaints and serious incidents.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Annual Governance Statement is discussed and approved by the Senior Management Team. The Board of Directors reviews the Annual Governance Statement as part of the draft annual report prior to submission to NHSI.

The Audit Committee’s key objectives include monitoring, reviewing and reporting to the Board of Directors on whether the Trust’s processes regarding internal control and risk management are efficient and effective. In fulfilling that objective, the Audit Committee has (a) regularly reviewed the financial risks within the Assurance Framework; (b) received reports from relevant members of senior management, including service management, and from the Trust’s internal auditors, external auditors and local counter fraud specialists; and (c) discussed those reports with the relevant parties. The Audit Committee has reported to the Board of Directors and where scope for improvement was found, has noted these for the senior management team’s attention.

All Committees report regularly to the Board and have a clear escalation route as required.

In October 2015, Deloitte provided a follow-up to their 2014 assessment against the Well Led Framework. This highlighted significant improvements since the previous year and identified scope for further improvements, including on governance of risk management, connectivity between the corporate level of the organisation and the Clinical Academic Groups and the Board Committee coverage of financial performance.
This led in November 2015, to the launch of a Well-Led action plan to take forward a detailed package of improvements. Progress against this plan was subject to a peer-review by the Trust Secretary of Guy’s and St Thomas’ Hospital in January 2017. Given the progress in all substantive areas, the action plan was formally closed by the Board in February 2017.

Clinical audit, along with internal audit, publish a series of audit reports throughout the year on audits against internal policy standards and national standards which include:

- CQC essential standards of safety and quality in health care
- NICE clinical guidelines
- NHSLA risk management standards

The annual audit programme is prioritised on the basis of risk. Audit reports are reviewed at Executive level and are incorporated into topical Board reports.

Internal audit

Internal Audit has reviewed and reported on systems of internal control, governance and risk management processes based on an internal audit plan approved by the Audit Committee. Internal Audit’s work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management. Internal Audit reports to the Audit Committee on management’s progress in implementing agreed recommendations.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation’s risk management, control and governance processes. This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to certain inherent limitations. The purpose of the annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board’s own assessment of the effectiveness of the organisation’s system of internal control. This opinion will in turn assist the Board in the completion of its Annual Governance statement.

Reasonable assurance can be given by the Head of Internal Audit that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. These have been reported to the Trust Chief Executive and Audit Committee in order to inform the basis and conclusions within the Annual Governance Statement.

Conclusion

We have identified significant risks earlier in the statement. No significant internal control issues have been identified by our internal reviews or through the work of our internal auditors, external auditors or other external regulators. Overall, my assessment is that South London and Maudsley NHS Foundation Trust has a generally sound system of controls that supports the achievement of its objectives and that identified control issues have been or are being addressed.

Signed on behalf of the Board

Dr Matthew Patrick
Chief Executive
South London and Maudsley NHS Foundation Trust
30 May 2017

Accountability Report

Signed on behalf of the Board

Dr Matthew Patrick
Chief Executive
South London and Maudsley NHS Foundation Trust
30 May 2017
Part 1

Statement on quality from the Chief Executive of the NHS Foundation Trust
Statement on quality from the Chief Executive of the NHS Foundation Trust

The annual quality account report is an important way for the Trust to report on quality and show improvements in the services we deliver to local communities and stakeholders.

The National Health Service (NHS) is facing unprecedented financial pressures; these pressures are experienced in our Trust and we have worked hard to ensure the quality of care has not been compromised.

This year has been an important year in improving the quality of the service we provide to both our patients and carers. We have made a really good start to our Quality Improvement (QI) work. Many staff have already attended training, and a raft of QI initiatives are now in train across the Trust. It is core to our strategy to deliver long term sustainability through our pursuit of quality and value. Most importantly we are continuing to deliver high quality care to all of the people who use our services. One way in which this is reflected is through external recognition – for example the individuals and teams who were winners in five categories at the recent Royal College of Psychiatrists awards.

Working in close partnership with the people who make use of our services, their friends, families, carers and local communities is key to our ability to support people in achieving the best possible health outcomes. For QI to work within our trust, it is also key that these partnerships run through our improvement projects at all levels of the organisation. It is with this in mind, we will be opening up our QI training to those who use our services along with their friends, families and carers.

We recognise that valuing staff is an important feature in providing high quality care and in 2016 we held our first Trustwide staff awards, which was a successful day in recognising the contributions staff make in delivering quality care. We are also proud that the national staff survey showed that the Trust scored above the national average for staff recommending the organisation as a place to work. It is recognised that engaged staff who feel supported and empowered at work provide the best quality care therefore building on our success in this area will remain a priority.

The Care Quality Commission (CQC) carried out week long focused inspections of both our Acute and Mental Health Older Adults (MHOA) pathways to ensure implementation of the actions plans following the 2015 inspection. At this point we have only received the formal written feedback to the Acute re-inspection, which I am pleased has resulted in the Trust no longer having any services that are rated ‘inadequate’ in any of the five domains and has highlighted positive improvements delivered by our staff since our 2015 inspection. We are awaiting the final report for our MHOA services but initial verbal feedback has again been positive in highlighting improvements made. We remain committed to keep improving the quality of services, our top priority in the year ahead.

The CQC’s publication of its rating and full report can be found at the following website:
http://www.cqc.org.uk/provider/RV5

To our best knowledge the information presented in this report is accurate and I hope you will find it informative and stimulating.

Signed on behalf of the Board

Dr Matthew Patrick
Chief Executive Officer
A summary of successes and developments in 2016/2017

<table>
<thead>
<tr>
<th>AREA</th>
<th>SUCCESS/DEVELOPMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Quality Commission (CQC)</td>
<td>▪ Sustained the overall Inspection rating of ‘Good’ given in 2015. Acute and MHOA compliance inspections demonstrated improvements as a result of action plans.</td>
</tr>
<tr>
<td>ICT/Technology</td>
<td>▪ SLaM’s Chief Information Officer (CIO) was ranked 55th in the UK top 100 Chief Information Officers</td>
</tr>
<tr>
<td>Research</td>
<td>▪ The Pioneering research registration scheme has had over 10,000 patients agree to be contacted to participate in research, following the “Consent for Contact” (C4C) programme.</td>
</tr>
<tr>
<td></td>
<td>▪ SLaM was rated the top mental health trust in the country for recruiting patients to clinical studies, in October 2016, by the National Institute for Health Research (NIHR) and Clinical Research Network (CRN).</td>
</tr>
<tr>
<td>Awards/Creditations</td>
<td>▪ In September 2016, the Director of the NIHR Maudsley Biomedical Research Centre won the prestigious “Katon Research Award” from the Academy of Psychosomatic Medicine.</td>
</tr>
<tr>
<td></td>
<td>▪ In October 2016, Forensic inpatient services won six awards in the Koestler Trust Awards. The awards were for art work done by service users from River House.</td>
</tr>
<tr>
<td></td>
<td>▪ The Psychological Interventions Clinic for Outpatients with Psychosis (PiCup) Clinic is shortlisted for the 2017 HSJ Value in Healthcare Awards. The awards are for NHS services that responded to the NHS’ drive to improve the cost effectiveness of its care. The service is nominated for two awards.</td>
</tr>
<tr>
<td></td>
<td>▪ Seven researchers received prestigious “Senior Investigator Awards“ from NIHR research wing of NHS.</td>
</tr>
<tr>
<td></td>
<td>▪ Organisers of the Schwartz Round won an award for the Best Academic Poster at Points of Care Foundation’s annual Schwartz Community Conference.</td>
</tr>
<tr>
<td></td>
<td>▪ In June 2016, the ward manager of Acorn Lodge Inpatient children’s unit was shortlisted for Nurse of the Year in the prestigious Nursing Times Awards.</td>
</tr>
<tr>
<td></td>
<td>▪ A SLaM pharmacist won UKCPA Patient Safety Award for their pilot scheme. It was for work in pharmaceutical care of patients on “psychotropic” medication in an acute hospital.</td>
</tr>
<tr>
<td></td>
<td>▪ Local Care Record won an award at eHealth Insider (EHI) Award held in September 2016. The category was “Best use of IT to support integrated health care services”. The service joins up patient records between GP practices in Lambeth and Southwark with Guy’s &amp; St Thomas’, Kings College Hospital (KCH) and SLaM.</td>
</tr>
<tr>
<td></td>
<td>▪ The National Adult Outpatient Neurodevelopmental Clinic won the “Outstanding Health Services” award at the Autism Professionals Awards held in March 2017 (National Autistic Society’s).</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>AREA</th>
<th>SUCCESS/DEVELOPMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Organisations</td>
<td>▪ Public Health England (PHE) are working to promote NHS being tobacco free and they have encouraged NHS to follow SLaM, as SLaM is one of the first mental health trusts to be smoke free</td>
</tr>
<tr>
<td>24 hour crisis Line</td>
<td>▪ The SLaM 24 hour crisis helpline was one of the top ten most read stories in the “Mental Health Today” (MHT). The MHT is a guide to understanding and achieving the best in mental healthcare.</td>
</tr>
<tr>
<td>Other</td>
<td>▪ The Bethlem Hospital's new Gallery and Museum space in the original hospital administration building was shortlisted down to the last 4 for the national museum of the year award.</td>
</tr>
</tbody>
</table>

Table one: A summary of successes and developments in 2016/2017

...and what we can do better.

▪ We need to improve in the areas that the CQC inspectors judged to require further improvement in their last two visits, whilst the Trust is awaiting the final version report the areas raised verbally included;
▪ Improve staff levels and vacancies, a reduction in prone restraint, individualised care planning.

All these have been translated into quality priorities for 2017/18.

Trust Activity

During 2016/2017 the Trust provided or subcontracted 255 services including inpatient wards, outpatient and community services. As well as serving the communities of south London, we provide 53 specialist services for children and adults across the UK including perinatal services, eating disorders, psychosis and autism. We provide inpatient care for approximately 3,900 people each year and we treat more than 67,000 patients in the community in Lambeth, Southwark, Lewisham and Croydon, with a local population of 1.3 million with a rich diversity.

South London and Maudsley NHS Foundation Trust (SLaM) has reviewed all the data available to us on the quality of care in these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by SLaM for 2016/17.
Part 2

Priorities for Improvement and statements of assurance from the Board
Priorities for Improvement and statements of assurance from the Board

Our priorities for improvement for 2017/2018

Over the last year we have listened to feedback from service users, their families, carers, staff, local Healthwatches, Council of Governors as well as commissioners and regulators. A Trust Quality priority setting event was held on the 22nd February 2017 with all our stakeholders. This feedback alongside feedback from CQC focused visits in January and March 2017 as well as Trust information from complaints, serious incidents and audits has helped us to identify our future priorities.

The Trust is committed to being a learning organisation and will continue the work underway to ensure outcomes from incidents, CQC Mental Health Act (MHA) inspections, complaints will all be used to improve the care we deliver.

Quality Improvement

Over the last year the Trust has seen a drive to improve the quality of care we provide and the implementation of the Trust Improvement strategy by using Quality Improvement methodology. The Trust has made a really good start to our Quality Improvement work with many staff now trained in QI methodology. It is this pursuit of quality and value that will deliver longer term sustainability.

Mission Statement

"Our long term vision is to create and sustain a culture of continuous quality improvement"

How we plan to do it

We aim to become an organisation with a culture of continuous improvement that is based on service users, carers, staff and key partners working together. We want to improve outcomes and experiences for all people who use our services, and improve the value of the care we provide.

This is a bottom up approach, not top down. The programme will support staff to learn and use quality improvement methods, involving and engaging everyone in thinking about how to improve services.
Trust Improvement Plan

The aim of the Trust improvement plan is to deliver the Right Care in the Right Place at the Right Time with the Right Value. This will be achieved through delivering a person centred approach, improving safety, experience, outcomes and delivering balanced budgets within agreed time frames. The strategy is outlined in the graph below.

Delivering a person-centred approach

Graph one: Trust Improvement plan

The quality indicators below align to both the Trust Improvement plan outlined above and the nationally set areas of patient safety, clinical effectiveness and patient experience.
**Quality Priorities 2017/2018**

The priorities for 2017/2018 have been arranged under three broad domains which, put together, provide the national definition of quality in NHS services: patient safety, clinical effectiveness and patient experience. Progress on achievement of these priorities will be reported on in next year’s Quality Accounts.

<table>
<thead>
<tr>
<th>1. Reducing Restrictive Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim</strong></td>
</tr>
<tr>
<td><strong>Quality Indicator</strong></td>
</tr>
<tr>
<td><strong>How progress will be monitored</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Violence &amp; Aggression Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim</strong></td>
</tr>
<tr>
<td><strong>Quality Indicator</strong></td>
</tr>
<tr>
<td><strong>How progress will be monitored</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim</strong></td>
</tr>
<tr>
<td><strong>Quality Indicator</strong></td>
</tr>
<tr>
<td><strong>How progress will be monitored</strong></td>
</tr>
</tbody>
</table>
### 4. Digital Health

<table>
<thead>
<tr>
<th>Aim</th>
<th>A reduction in mortality of people with severe mental health problems</th>
</tr>
</thead>
</table>
| Quality Indicator | Further develop electronic systems to improve delivery of care (eOBS) across all Trust service areas.  
>50% of all Adult inpatient wards  
**Baseline:** 2 wards |
| How progress will be monitored | QSC, Board, Performance monitoring reports, Quality Dashboard, Physical healthcare project Board |

### 5. Physical Health Awareness

<table>
<thead>
<tr>
<th>Aim</th>
<th>A reduction in mortality of people with severe mental health problems</th>
</tr>
</thead>
</table>
| Quality Indicator | Ensure clinical and non-clinical staff have received level 1 physical health awareness training across all Trust service areas.  
**Target:** 65%  
**Baseline:** 0% |
| How progress will be monitored | QSC, Board, Performance monitoring reports, Quality Dashboard, Physical healthcare Committee.  
LEAP Education and training |
### 6. Physical Health Screening and Intervention

<table>
<thead>
<tr>
<th>Aim</th>
<th>A reduction in mortality of people with severe mental health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Indicator</strong></td>
<td>Inpatients and early intervention patients will have 90% or greater rates for each metabolic screening parameter and where indicated, interventions. Patients with psychotic illnesses in longer term follow up (CPA) will have 65% or greater for screening/intervention rates. Inpatient and EI Target: 90% Community CPA Target: 65%</td>
</tr>
<tr>
<td><strong>Baselines</strong></td>
<td></td>
</tr>
</tbody>
</table>
  **Inpatients:**  
  77% metabolic screening,  
  60% intervention  
  **Early Intervention Services**  
  52% metabolic screening,  
  61% intervention  
  **Community CPA:**  
  41% metabolic screening,  
  51% intervention |
| **How progress will be monitored** | QSC, Board, Performance monitoring reports, Quality Dashboard, Physical healthcare Committee. LEAP Education and training |

### 7. Family and Carer Engagement

<table>
<thead>
<tr>
<th>Aim</th>
<th>Ensure Family and Carer Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Indicator</strong></td>
<td>75% of identified carers in all Trust service areas will have been offered a Carers Engagement and Support Plan. <strong>Baseline:</strong> 0 (new form)</td>
</tr>
<tr>
<td><strong>How progress will be monitored</strong></td>
<td>QSC, Board, Performance monitoring reports, Quality Dashboard, Carer and Family strategy meeting</td>
</tr>
</tbody>
</table>
8. Care Closer to Home - Inpatient Admissions

Aim | Reduction in overall admissions because patients are better managed in their illnesses at home as is appropriate

Quality Indicator | 10% reduction in admissions in Trust Inpatient Adult Services. Reduction in admissions from 8 to 7 per day

How progress will be monitored | QSC, Board, Performance monitoring reports, Quality Dashboard

9. Care closer to home - Length of Stay

Aim | Reduction in overall admissions because patients are better managed in their illnesses at home as is appropriate

Quality Indicator | 30% reduction in Length of stay (LOS) in Trust Inpatient Adult services. Reduction in LOS from 45 days to 30 days

How progress will be monitored | QSC, Board, Performance monitoring reports, Quality Dashboard

10. Staff Health and Well-Being

Aim | To improve structures and processes that facilitate positive staff experience.

Quality Indicator | Increase of 5% of staff reporting the organisation definitely takes positive action on health and well-being. (CQUIN)

Baseline: 25% in 2015 staff survey

How progress will be monitored | QSC, Board, Performance monitoring reports, Quality Dashboard (Friends and Family Test quarterly)

Staff survey
### 11. Management of Work Related Stress

<table>
<thead>
<tr>
<th><strong>Aim</strong></th>
<th>To improve structures and processes that facilitate positive staff experience.</th>
</tr>
</thead>
</table>
| **Quality Indicator** | Decrease of 5% of staff saying they have felt unwell in the last 12 months as a result of work related stress (CQUIN)  
**Baseline:** 43% 2015 staff survey |
| **How progress will be monitored** | QSC, Board, Performance monitoring reports, Quality Dashboard (Friends and Family Test quarterly)  
Staff survey |

### 12. Staff recommendation of the organisation as a place to work

<table>
<thead>
<tr>
<th><strong>Aim</strong></th>
<th>To improve structures and processes that facilitate positive staff experience.</th>
</tr>
</thead>
</table>
| **Quality Indicator** | Achieve >70% on average across the year of staff reporting they would recommend the organisation as a place to work.  
**Baseline:** 63% in 2016/17 |
| **How progress will be monitored** | QSC, Board, Performance monitoring reports, Quality Dashboard (Friends and Family Test quarterly)  
Staff survey |

*Table two: Quality Priorities 2017/2018*
Care Quality Commission (CQC); Inspection September 2017 Results and Actions

SLaM is required to be registered with the CQC and its current registration status is registered, without condition. In 2016/2017 SLaM has participated in special reviews or investigations by the Care Quality Commission relating to the following areas; MHOA and Acute pathway. SLaM is currently awaiting the final report and findings from MHOA which may result in a change in the grid below, which is the current overall and service specific ratings following the results of the comprehensive inspection of some of our services by the CQC in 2015 and Acute in 2017.

SLaM made the following progress by 31st March 2017 in taking such action outlined in table 4. The CQC has not taken enforcement action against SLaM during the period 2016/17.

Table three: Care Quality Commission Inspection Results
The table below outlines some of the quality improvement work currently being undertaken as a result of the CQC live action plans from both 2015 and 2017 inspections.

<table>
<thead>
<tr>
<th>Area of Improvement</th>
<th>Actions undertaken</th>
</tr>
</thead>
</table>
| Staffing                                 | - E-rostering redesign
- Assessment days reviewed and changed.
- Media and recruitment campaigns
- Development of Band 4 Assistant practitioner role job
- Staff retention initiatives implemented. |
| Food                                     | - New menu introduced
- Implemented interactive meal times
- New catering contract
- Forensic wards – Activity of daily living kitchen |
| Reducing Restraint                       | - The Trust has developed a reducing restrictive interventions three year strategy
- The strategy provides a framework for the reduction of restrictive interventions across all in-patient services in line with the DH Positive and Safe initiative (2014)
- Continued roll out of violence reduction programme called ‘Four Steps to Safety’ |
| Environment                              | Above national average in PLACE scores in:
- Cleanliness
- Condition, appearance and maintenance
- Privacy, dignity and wellbeing |
| Privacy and Dignity                      | - Vistamatic windows programme
- Variety of daily activities and individual goal setting. |
| Creating and sustaining a culture of continuous Improvement | Since the CQC inspection in 2015 we have appointed the Institute of Healthcare Improvement and an internal Quality Improvement Team to support us all in our drive to improve the quality of everything we do, with transformation projects now taking place at a local ward and team level. |
Managing Clinical Risk

Managing clinical risk is central to all the work that we do, to manage risk all clinical staff receive clinical risk management training commensurate with their grade and experience.

Audit

Participation in National Quality Improvement Programmes

National quality accreditation schemes, and national clinical audit programmes are important for a number of reasons. They provide a way of comparing our services and practice with other Trusts across the country, they provide assurances that our services are meeting the highest standards set by the professional bodies, and they also provide a framework for quality improvement for participating services.

The National Clinical Audits and National Confidential Inquiries that SLaM participated in, and for which data collection was completed during 2016/2017, are listed below. During that period SLaM participated in 100% of national clinical audits 6/6 and 100% of National Confidential Inquiries 1/1 which it was eligible to participate in.

The National Clinical Audits and National Confidential Inquiries that SLaM participated in, and was eligible to participate in during 2016/17 are listed below:

- The 5 national, Prescribing Observatory for Mental Health - POMH-UK audits:
  - Use of sodium valproate
  - Prescribing for substance misuse: alcohol detoxification
  - Prescribing antipsychotic medication for people with dementia
  - Monitoring of patients prescribed lithium
  - Rapid tranquilisation
- The Commissioning for Quality and Innovation (CQUIN) 2016/17 Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)
- The national confidential inquiry into suicide and homicide by people with mental illness

The reports of six national clinical audits were reviewed by the provider in 2016/2017 and SLaM intends to take the following actions to improve the quality of healthcare provided

POMH-UK audits

Participation in the five Prescribing Observatory Audits (POMH-UK) managed by the Royal College of Psychiatrist’s Centre for Quality Improvement

SLAM pharmacy has collected and submitted data for the 2016-17 POMH-UK audits, as required.

Below is a summary of the findings from those audits:

i) Use of sodium valproate

The National Institute for Health and Care Excellence (NICE) recommends that valproate should not routinely be prescribed for women of childbearing age. In addition to this, all patients prescribed valproate should have an annual physical health check. In 2015, the Trust participated in the national POMH-UK audit of valproate prescribing for bipolar disorder. Results of the audit were reported by POMH in March 2016.

Overall, the rate of prescription of valproate for women of childbearing age was found to be higher in SLaM than in the average national sample (33% vs 8%). Physical health monitoring was evident for more patients prescribed valproate in SLaM than the national average.

Actions: The Trust is following MHRA guidance for valproate prescribing in women of child bearing age: Women are assessed for the need for valproate and treatment is only initiated or continued where absolutely necessary. Women prescribed valproate are informed of its risks in pregnancy, advised to avoid becoming pregnant, offered a contraceptive and prescribed folic acid.
ii) Prescribing for substance misuse: alcohol detoxification

Results of this national audit showed that patients admitted to a SLaM in-patient unit for alcohol detoxification are more likely to have their physical health monitored compared with the national average. However, assessment for Wernicke's encephalopathy and prescription of parenteral thiamine was lower in SLaM than in the national sample.

**Actions:** The results have been discussed with the Addictions nurse consultant and the doctor leading the audit. An improvement programme has been implemented.

iii) Prescribing antipsychotic medication for people with dementia

NICE guidance recommends against the routine use of antipsychotics for patients with dementia. When considering an antipsychotic the risks must be discussed with the patient and their carers. In addition, antipsychotic use should be regularly reviewed and the indication documented in the patient's notes.

The Trust recently participated in a national audit of the prescribing of antipsychotics for patients with dementia. The results showed that the rate of antipsychotic prescription in dementia was comparable with the average national sample. The indication for antipsychotic prescription was documented for the majority of SLaM patients. Medication reviews were evident for a higher proportion of patients in SLaM than in the average national sample. However, discussions of the risks of antipsychotics use were not evident for many patients in SLaM.

**Actions:** The results have been discussed with the MHOA CAG. An improvement programme has been implemented.

iv) Monitoring of patients prescribed lithium

Patients prescribed lithium must have their renal and thyroid function tested before starting lithium and at least every six months whilst maintained on treatment. Lithium plasma levels should be monitored at least every six months.

Results of the 2016 National Audit showed that renal and thyroid function tests were completed before lithium initiation for more patients in SLaM than in the national average. However physical health and plasma level monitoring was evident for fewer SLaM patients during maintenance treatment than in the national sample.

**Actions:** Results have been shared with CAG leads and are being reported in the medicines bulletin.

v) Rapid Tranquilisation

Results of the 2015 audit showed that whilst prescribing for rapid tranquilisation was consistent with trust guidance physical health monitoring after administration of parenteral medication was not evident for all patients. The trust has submitted data for the 2016 national audit of rapid tranquilisation. Results are due to be reported by POMH later this year.

In the meantime, we have analysed data locally for a sample of patients who received medication for rapid tranquilisation. There appears to have been an improvement in physical health monitoring, when loosely defined as eyesight observations. However, physical health monitoring as recommended by NICE and the trust guidelines is still poor.

Data for this audit were collected from ePJS. It is possible that as previously suggested, physical parameters are recorded on MEWS chart, which are then not available on ePJS. The introduction of eOBS (electronic MEWS) will improve availability of information on ePJS.

**Actions:** The recommendations for physical health monitoring following RT (including documentation) have been re-issued to clinical staff. The physical health monitoring audit will be repeated on wards using eOBS.
Other trust-wide patient safety audits and quality improvement programmes

Dose omissions

All doses of medicines prescribed for an in-patient must be administered at the time specified, unless there is a valid reason for the dose being delayed or omitted. The administration box for each prescribed dose must be either signed by the person who administered the dose or annotated with a valid reason for the dose being missed.

The trust conducts an annual survey of the number of doses of regularly prescribed medicines for which the corresponding administration box is blank (neither signed as administered nor annotated with a reason for dose omission).

Results of the 2016 audit showed an improvement from previous years: 0.6% of administration boxes were left blank compared with 1% in previous years.

**Actions:** Results have been sent to the relevant CAG leads. In addition, ways of improving practice are being discussed by the medicines safety and trust nurse executive committees.

Allergy status documentation

The allergy status for each patient should be documented on the prescription and in the ‘alert’ section of ePJS. Results of the 2016 audit were similar to the previous year: 100% of patients had their allergy status documented on their prescription and in 74% of cases the prescription was consistent with the patient’s recorded allergy status in ePJS.

**Action:** A project aimed at improving the documentation in ePJS of patients’ medication and allergy status is currently underway. The project group has representation from trust medical, nursing, pharmacy and ePJS teams.

Antibiotic prescribing

Results of the 2016 antibiotic prescribing audit showed that 90% of patients prescribed an antibiotic had the indication for the prescription documented in ePJS. The choice of antibiotic was deemed appropriate for all patients, according to the trust antimicrobial guidelines. Results have been reported at the trust infection control committee and are included in the medicines bulletin.

vi) CQUIN Indicator 4a:

Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2016/17

The Trust participated in data collection and entry onto the NHSE online Webform Portal from December 2016 to February 2017. Confirmation was received from the Royal College of Psychiatrists. Results from the audit are pending.

Results received in 2015/16

**National CQUIN Indicator 4a:**

Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2015/16

During December 2015 and January 2016, the Trust collected and entered (onto the NHSE online Webform Portal) data for the National CQUIN audit. The Trust was assessed against the following parameters:

1. Smoking status
2. Lifestyle (including exercise, diet, alcohol and drugs)
3. Body Mass Index
4. Blood pressure
5. Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
6. Blood lipids
Performance against the CQUIN is presented as a single percentage figure for each provider, calculated on the basis of the following:

a) The denominator will be the total number of inpatients in the sample.

b) The numerator will be the total number of patients in the sample for whom there was documented evidence that:

- they were screened for all six measures listed in the CQUIN guidance during their inpatient stay; and
- where clinically indicated, they were directly provided with, or referred onwards to other services for interventions for each identified problem (with thresholds for intervention being as set out in NICE guidelines).

The data submitted to NHSE is outlined below:

<table>
<thead>
<tr>
<th>Standard/Indicator</th>
<th>CQUIN, SLAM I/P Q4 15/16 Target = 90% (n=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring of physical health risk</td>
<td></td>
</tr>
<tr>
<td>Monitoring of smoking</td>
<td>99%</td>
</tr>
<tr>
<td>Monitoring of BMI</td>
<td>95%</td>
</tr>
<tr>
<td>Monitoring of glucose control</td>
<td>93%</td>
</tr>
<tr>
<td>Monitoring of lipids</td>
<td>89%</td>
</tr>
<tr>
<td>Monitoring of blood pressure</td>
<td>99%</td>
</tr>
<tr>
<td>Monitoring of 5 risk factors in those with established cardiovascular disease</td>
<td>N/A</td>
</tr>
<tr>
<td>Assessment of physical activity</td>
<td>43%</td>
</tr>
<tr>
<td>Assessment of diet</td>
<td>96%</td>
</tr>
<tr>
<td>Assessment of substance misuse</td>
<td>97%</td>
</tr>
<tr>
<td>Monitoring of alcohol consumption</td>
<td>97%</td>
</tr>
</tbody>
</table>

**Intervention offered for identified physical health risks**

| Intervention for smoking                                 | 97%                                           |
| Intervention for BMI \(\geq 25\text{kg/m}^2\)            | 85%                                           |
| Intervention for abnormal glucose control                | 96%                                           |
| Intervention for elevated blood pressure                 | 88%                                           |
| Intervention for physical activity                       | 100%                                          |
| Intervention for diet                                    | 91%                                           |
| Intervention for substance misuse                        | 81%                                           |
| Intervention for alcohol misuse                         | 67%                                           |

Table five: CQUIN Indicator 4a results

vii) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The Trust participated in the NCISH. Data for the NCISH reviewed suicide data over a 10 year period (2004-2014). Following a themed review of suicides in SLaM which was completed in 2015/16, a number of recommendations have been implemented, including:

- The launch of a new Risk Assessment Tool on ePJS
- Audits on the management of self-harm have been completed (the findings are outlined below in the Trust Clinical Audit Programme)
- Audits on carers’ assessments and care plans have been completed.
Trust Clinical Audit Programme

The reports of 25 local Trust wide clinical audits have been completed in 2016/17 and where relevant, have been reviewed by the appropriate Trust committees for the development of actions to improve the quality of health care provided. A summary of some of the key audits are outlined below.

Management of Violence and Aggression: Physical Interventions

The audit provided insight into practices of physical restraint within inpatient services which the Trust is committed to addressing. Most physical restraints were carried out on men; service users from Black Minority Ethnic (BME) backgrounds; and service users being treated under the MHA.

Physical restraints were mostly prompted by service user to staff aggression. Much of the behaviour which led to the restraint did not have a ‘trigger’ as such and was thought to be related to the service user being unwell at the time of the incident. However, where triggers were identified these centered around the themes of: medication, other services, property/items and leave. These themes may be important areas for consideration in taking steps to reduce violence and aggression in inpatient settings.

The Trust has been developing a ‘Reducing Restrictive Interventions’ Strategy which will provide a sustainable framework for clinical services in the reduction of the use of restraint, prone restraint and seclusion.

The 4-Steps to Safety violence reduction programme continues to be rolled out across the in-patient services.

Missing persons’ policy for detained patients (AWOL) and informal patients

An audit was completed in 2016 to assess compliance with the Trust Missing and Absent Persons’ policy for detained patients (AWOL) and informal patients, 2015; and to identify any deficiencies in care and make recommendations to address these.

- Care provision was good in respect of reporting the incidents on DATIX, completing risk assessment, recording the AWOL Forms one and two, and reporting patients as missing to the police.
- There was room for improvement for informing the police of high risk informal patients who had gone missing.
- The audit found key focus for improvement needed to be given to the documenting of leave care plans on electronic patient journey system (ePJS) and fact finding reports being completed for C Grade incidents.

The report recommended that leave care plans should be documented and updated as and when necessary in line with Trust policy, as well as improved documentation of risk assessments. The documentation of risk assessments is expected to improve with the new Risk Assessment Tool which was launched on ePJS in January 2017.

The completion of fact finding reports for Grade C incidents is also expected to improve since the launch of the electronic fact finding report on DATIX in April 2016.

Seclusion of Service Users

This report focuses on examining the use of seclusion, compliance of staff to procedures and policy within the SLaM Seclusion Policy version 7(2015) and NICE Violence Guideline (2005). Authority to seclude a service user who is an inpatient has long been recognised as a necessary element in dealing with patients who pose a risk of significant harm to others and staff.

Overall, compliance with policy standards was lower than the performance from the previous Seclusion audit which was completed in 2012.

- There was high compliance around the authority to initiate seclusion, doctors attending reviews after seclusion was initiated, and medical reviews being completed within 30 minutes of seclusion being initiated.
- Most of the service users had a risk assessment completed within the current spell at the time of the incident, and documentation for care plans were adequately evidenced on ePJS.
- The characteristics of the seclusion rooms showed high compliance policy standards.
- More than half of the informal patients were assessed under the Mental Health Act shortly after being placed in seclusion.
The emergency team was contacted for half of the incidents leading to seclusion.

- Care plans were formulated or updated for just over half of the incidents after seclusion was terminated or following decisions to continue seclusion.
- Service users were rarely informed of the reason for being placed in seclusion.
- Patient observations were inconsistent for all service users.

The report puts forward a number of recommendations aimed to improve the use of seclusion in compliance with the Trust policy. These include regular refresher training for staff; and improved documentation around the duration of seclusion, service user activities and physical observations on ePJS and seclusion forms. Furthermore, evidence of communication with service users regarding the reasons for initiating seclusion also needs to improve.

**Self-Harm: Longer Term Management**

The NICE Clinical Guideline for Self-Harm: Longer Term Management details the management of single and recurrent episodes of self-harm and the longer term psychological treatment. The 2016 audit was undertaken to provide assurance that standards detailed in the NICE clinical guideline were being adhered to and where compliance was not met, recommendations were made to improve the care provided to service users.

- Care provision was good in respect of assessments of needs and risks, including for older adults and children.
- However, some room for improvement was identified with regards to documenting coping strategies, psychosocial and occupational functioning, and the need for dependent treatment.
- There were also gaps in identifying significant relationships that could affect the level of risk, and long term risks.
- There was high compliance with documentation around care plans and risk management plans.
- Psychological interventions for self-harm was offered for all patients and where appropriate pharmacological intervention alongside this.
- Gaps were highlighted in documentation regarding service user skills, strengths and assets, and employment.
- There were also gaps in documentation regarding occupational rehabilitation.

Following the report, there has been further promotion of the NICE guideline (2011) to psychiatric liaison nurses and doctors in training of recommendations and workshop / training sessions.

The report also recommends the consideration of service user and carer involvement in training to address assessment of coping strategies, protective factors and roles of carers. There should also be improved understanding between liaison teams and occupation therapists of how to assess and address occupational health needs in the liaison setting.

**Use of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) audit**

This audit assessed the current compliance with the Mental Capacity Act Policy (May 2015).

- Compared to the previous audit, the report found that fewer service users had a capacity assessment on admission.
- The most common reason for capacity assessments was for medication and treatment.
- There was little documented evidence of how service users were helped to make the decision as independently as possible.
- Best interest meeting documentation was variable, however there were high records of family/carer involvement.
- Staff awareness of the use of MCA and DoLS was high.

Further work in the Trust needs to be done to ensure capacity assessments are completed for all admissions. The report also recommends that service users should be encouraged to make decisions as independently as possible and this should be documented on ePJS.
Informal Patient Experience of Admission

The audit assessed compliance with the Leave for Informal Patient Policy (2016) and if the rights detailed in the ‘Being an Informal Patient’ leaflet (2016) were being upheld.

- In a majority of cases, patients were allowed to leave the ward when they wanted, and where they were not, reasonable explanations were given.
- Where treatment was refused, this decision was mostly respected.
- A low percentage of service users were aware of their leave care plans.
- The leave poster was displayed on all of the wards visited; however it was not always positioned for obvious sighting.
- It was also found there were variations in the versions of posters being used among the wards.

The report recommends that staff should ensure informal inpatient service users are aware of their leave care plans, and wherever possible be involved in the care planning.

Clinical Academic Group (CAG) leads have also been advised to check the correct Trust Informal Patient poster is clearly displayed on wards.

Food Satisfaction Survey

An audit was completed in 2016 to ascertain patient satisfaction with catering and food provision offered to patients in inpatient services. The audit found:

- The monthly menu display board on the Acute wards was not clear in both content or visually.
- While patients appeared overall to enjoy the food, they stated that the quality of the meal was not always consistent.
- Patients were satisfied with portion sizes.
- There was a poor response regarding access to menu choices except for Forensic services, where patients stated they had both access to a menu and always received what they ordered.
- Child and Adolescent Mental Health Service (CAMHS) patients were less satisfied than the rest of the organisation.

The outcome of the audit will be considered in future tendering processes.

Patients participating in research

The number of patients receiving NHS services provided or sub-contracted by SLaM for the reporting period, 1 April 2016 – 31 March 2017, that were recruited during that period to participate in research approved by a research ethics committee was 2337.

Commissioning for Quality and Innovation (CQUIN)

As last year, 2.5 % of SLaM income in 2016/2017 is conditional on achieving quality improvement and innovation goals agreed between SLaM and any person they entered into an agreement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The value of these payments for 2016/17 was £5.6m.

Further details of the agreed goals for 2016/2017 and for the following 12 month period are available electronically at http://intranet.slam.nhs.uk/cquins/default.aspx.
Hospital Episode Statistics Data – HES

SLaM submitted records during 2016/17 to the Secondary Uses services for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

<table>
<thead>
<tr>
<th></th>
<th>In-Patients – SUS data</th>
<th>Out-patients and Community – MHMDS Apr 2016/ Feb 2017 (provisional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS No</td>
<td>98.2%</td>
<td>99.3%</td>
</tr>
<tr>
<td>GP Practice code</td>
<td>99.8%</td>
<td>98.1%</td>
</tr>
</tbody>
</table>

Table six: The percentage of records relating to patient care which included the patient’s NHS No and GP practice code.

Information Governance

The Trust’s submission for the annual NHS Information Governance Toolkit for 2016-17 demonstrated 91% compliance with national health and social care information governance standards (all Level 2 or above), which is satisfactory compliance. SLaM annual submission was independently assessed by internal audit with a reasonable assurance outcome.

The Trust is undergoing a digital transformation programme and has implemented a revised Information Governance Operating Model and continued to implement improvements around information governance compliance with national standards and key legislation. All IT staff were trained according to the Control Objectives for Information and Related Technologies (CoBIT) governance framework.

The Trust closely followed the publication of the new Caldicott Review and the CQC data security review. The recommendations from these national reviews were incorporated in the overall IG action plan. The Local Care Record has been launched with trust’s partnership. The Local Care Record (LRC) provides timely and secure sharing of relevant patient information between care professionals to support direct provision of care within King’s Health Partners, and GP practices in Lambeth and Southwark.

The Trust joined the NHS Digital care CERTassure programme to develop and implement a robust cyber security programme. The information governance team developed new expertise around privacy, cyber security and risk management. The information risk assurance process was reviewed and updated. The IG team has implemented a dashboard for effective and timely monitoring of IG reviews, investigations and compliance reviews.

The Trust continues to provide clear, concise and up-to-date notification material to service users to ensure they are sufficiently information about the way their personal data is utilised with opportunities to opt-out of any scheme if they wish to do so.

Assurance around Information Governance is regularly presented to relevant IG Committees chaired by the Caldicott Guardian, the CCIO (Chief Clinical Information Officer) and the Chief Information Officer. The Board receives quarterly and annual updates on levels of assurance.

Payment by Results Clinical Coding

SLaM was not subject to payment by results clinical coding audit by the National Audit Office during the 2016/2017 financial year. Focus remains on improving the data completeness and accuracy of the Mental Health Clustering Tool which may become the payment by results currency in mental health. The Clinical Information System has built in alerts to remind clinicians that a mental health cluster has expired.
Improving Data Quality

SLaM will be taking the following actions to improve data quality:

- Clinical Academic Groups will be working collaboratively with the Business Intelligence and Performance Management teams to improve their data quality.
- Introduction of modern information reporting toolsets to improve access to information
- The Quality Improvement Initiative has raised awareness for the need ensure better data capture.
- Improved design of reports promotes the use of information for service improvement
- Data Quality of Mental Health Services Data Set (MHSDS) and other external submissions are routinely checked prior to the submissions.

National indicators 2015/2016

NHS Outcome Framework Indicators

SLaM is required to report performance against the following indicators:

1. Care Programme Approach (CPA) 7 day follow-up
2. Access to Crisis Resolution Home Treatment (Home Treatment Team Gatekeeping)
3. Re-admission to hospital within 28 days of discharge

Care Programme Approach (CPA) 7 Day follow-up

Follow up within seven days of discharge from hospital has been demonstrated to be an effective way of reducing the overall rate of death by suicide in the UK. Patients on the care programme approach (CPA) who are discharged from a spell of inpatient care should be seen within seven days.

<table>
<thead>
<tr>
<th>National Target</th>
<th>SLaM 2014/15</th>
<th>SLaM 2015/16</th>
<th>SLaM 2016/17</th>
<th>National Average 2016/17</th>
<th>Highest Trust % or Score 2016/17</th>
<th>Lowest Trust % or Score 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not specified (formerly 95%)</td>
<td>97.4%</td>
<td>96.99%</td>
<td>97.1%</td>
<td>96.2% (Q3)</td>
<td>100%</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

Table seven: Seven day follow-up

The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2016/17 published at the time of writing the quality account available at www.england.nhs.uk/statistics

SLaM considers that this data is as described for the following reasons: There continues to be a strong operational and performance focus on this indicator within the Trust.

The Trust performance continues to be comparable with previous years.

Access to Crisis Resolution Home Treatment (Home Treatment Team)

Home Treatment Teams provide intensive support for people in mental health crisis, in their own home. Home Treatment is designed to prevent hospital admissions and give support to families and carers.

The indicator here is the percentage of admissions to the Trust’s acute wards that were assessed by the crisis resolution home treatment teams prior to admission.
<table>
<thead>
<tr>
<th>National Target</th>
<th>SLaM 2014/15</th>
<th>SLaM 2015/16</th>
<th>SLaM 2016/17</th>
<th>National Average 2016/17</th>
<th>Highest Trust % or Score 2016/17</th>
<th>Lowest Trust % or Score 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of admissions to acute wards that were gate kept by the CRHT teams</td>
<td>95%</td>
<td>91.5%</td>
<td>95.9%</td>
<td>96.5%</td>
<td>98.7 (Q3)</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>76.0%</td>
</tr>
</tbody>
</table>

**Table eight: Access to crisis resolution**

The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2016/17 published at the time of writing the quality account available at www.england.nhs.uk/statistics

Note: that Psychiatric Liaison Nurse assessments of patients in Emergency Departments are included in the gatekeeping performance figures for previous years. Following the creation of the Assessment and Referral Centre (ARC) in 2016 with embedded Home Treatment the ARC now acts as the single point of access for the adult care pathway. PLNs now refer to ARC who do the HTT assessment as part of the admission/diversion process.

SLaM considers that this data is as described for the following reasons: SLaM failed to achieve the 95% standard in Quarters 1 and 2. In October the development of the Assessment and Referral Centre (ARC) and standardisation and development of the Home Treatment Teams has led to significant improvements and the thresholds have been met in Quarters 3 and 4.

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by further development and embedding of the acute care pathway reconfiguration that has occurred in the financial year. Also to ensure patients get timely access to all settings we must work with our partners which include our local acute hospitals where people may be assessed when distressed.

**Re-admissions**

The table below provides the emergency readmissions rate within 28 days for adult acute patients. The Health and Social Care Information Centre (HSCIC) has not published results for 2016/17 at the point of writing.

<table>
<thead>
<tr>
<th>Patients readmitted to hospital within 28 days of being discharged</th>
<th>SLaM 2014/15</th>
<th>SLaM 2015/16</th>
<th>SLaM 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.95%</td>
<td>2.7%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

**Table nine: Readmissions to hospital**

SLaM considers that this data is as described for the following reasons:

The routine monitoring indicator for readmissions for mental health contracts and Clinical Commissioning Groups (CCG) is readmissions within 30 days. The Benchmarking Network for Adult Mental Health report 2015/16 reports that, using a weighted population, the Trust had a 4.3% emergency readmission rate in comparison to a national mean of 8.4% for emergency readmissions within 30 days.

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by further development of the Adult mental health pathways.
Service Users Experience of Health and Social Care Staff

<table>
<thead>
<tr>
<th>SLaM 2015/2016</th>
<th>SLaM 2016/2017</th>
<th>Highest Trust % or Score 16/17</th>
<th>Lowest Trust % or Score 16/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service users experience of Health and Social Care Staff Scores out of 10</td>
<td>7.6</td>
<td>7.5</td>
<td>8.1</td>
</tr>
</tbody>
</table>

Table ten: Service Users Experience of Health and Social Care Staff

SLaM considers that this data is described for the following reasons:

The patient survey responses to the question of how users of services found the health and social care staff of the Trust show that in 2016, overall SLaM scores for this section were about the same as other mental health Trusts. The average Health and Social Care Worker section score for SLaM patients was 7.5 with other Trusts performing in a range of 6.9 to 8.1. Two out of three questions maintained the same score as 2015 (Q4 and Q6), whilst Q5 there was a slight decrease from 7.6 to 7.3.

Health and Social Care Workers

| S1 Section score | 7.5 | 6.9 | 8.1 |
| Q4 Did the person or people you saw listen carefully to you? | 7.9 | 7.3 | 8.6 | 198 | 7.9 |
| Q5 Were you given enough time to discuss your needs and treatment? | 7.3 | 6.8 | 8.2 | 199 | 7.6 |
| Q6 Did the person or people you saw understand how your mental health needs affect other areas of your life? | 7.1 | 6.2 | 7.8 | 190 | 7.1 |

Table eleven: Survey of people who use community mental health services 2016

Scores for this NHS trust

<table>
<thead>
<tr>
<th>Highest trust score achieved</th>
<th>Lowest trust score achieved</th>
<th>Number of responders</th>
<th>2014 score for this NHS trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1 Section score</td>
<td>7.5</td>
<td>6.9</td>
<td>8.1</td>
</tr>
<tr>
<td>Q4 Did the person or people you saw listen carefully to you?</td>
<td>7.9</td>
<td>7.3</td>
<td>8.6</td>
</tr>
<tr>
<td>Q5 Were you given enough time to discuss your needs and treatment?</td>
<td>7.3</td>
<td>6.8</td>
<td>8.2</td>
</tr>
<tr>
<td>Q6 Did the person or people you saw understand how your mental health needs affect other areas of your life?</td>
<td>7.1</td>
<td>6.2</td>
<td>7.8</td>
</tr>
</tbody>
</table>

‘Better/Worse’ Only displayed when this trust is better/worse than most other trusts

◆ This trust’s score (NB: Not shown where there are fewer than 30 respondents)
SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by ensuring service users are involved in the planning of their care and co-producing a consensus statement for involvement in own care and taking forward a programme plan to deliver on the Trust’s Patient and Public Involvement Strategy.

**Core Indicators**

NHS Improvement was formed in 2016 (replacing the previous Foundation Trust regulator Monitor). NHS Improvement published the Single Operating Framework with effect from October 2016. The framework replaced Monitor’s Risk Assessment Framework and introduced new measures whilst discontinuing others or changing thresholds. The Quality Account guidance advises that the indicators included in both of these frameworks should be reported here.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>SLaM 2016/17</th>
<th>National Target</th>
<th>National Target Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral</td>
<td>89.7%</td>
<td>75%</td>
<td>✓</td>
</tr>
<tr>
<td>2. Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral</td>
<td>99.3%</td>
<td>95%</td>
<td>✓</td>
</tr>
<tr>
<td>3. Care Programme Approach (CPA) 7 Day follow-up</td>
<td>97.1%</td>
<td>Not specified (formerly 95%)</td>
<td>✓</td>
</tr>
<tr>
<td>4. Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards</td>
<td>96.5%</td>
<td>95%</td>
<td>✓</td>
</tr>
<tr>
<td>5. People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral</td>
<td>61.9%</td>
<td>50%</td>
<td>✓</td>
</tr>
<tr>
<td>6. Data Completeness, Mental Health: identifiers – NHS Number, Date of Birth, Post Code, Gender, GP code, Commissioner code</td>
<td>98.9%</td>
<td>97%</td>
<td>✓</td>
</tr>
<tr>
<td>7. Data Completeness, Mental Health: outcomes (for patients on CPA) – accommodation and employment status</td>
<td>57.4%</td>
<td>50%</td>
<td>✓</td>
</tr>
</tbody>
</table>

Table twelve: Core Indicators

Indicators 1 and 2 are based on collated monthly internal Trust reporting, NHS Digital (formerly Health and Social Care Information Centre) will publish full year performance later in 2017/18.

Performance, following a failure to meet 50% in Quarter 1, has been in excess of the target and the Trust’s recovery trajectory. For the rest of the financial year.

The indicator percentage of CPA patients with a review in 12 months is not specified within the Single Oversight Framework. The Trust continues to monitor this internally through performance reviews.

The indicator for Meeting commitment to serve new psychosis episodes by early intervention teams indicator has been replaced by the Early Intervention in Psychosis standard.

**Delayed Transfers of Care**

The indicator ‘minimising delayed transfers of care’ for mental health trusts is not included in the Single Oversight Framework but the indicator was selected for quality report assurance so therefore is included in the Quality Account; 4.8% of bed days were lost in 2016/17 due to delayed transfers of care.
Patient safety incidents resulting in severe harm or death

The Trust records all reported incidents on a database, in order to support the management of, monitoring and learning from all types of untoward incident. In addition patient safety incidents are uploaded to the National Reporting and Learning Service (NRLS) for further monitoring and inter-Trust comparisons. The NRLS system enables patient safety incident reports to be submitted to a national database which is designed to promote understanding and learning.

The process of reporting Trust data to the NRLS and NRLS publication of national data is retrospective by nature. For the latest benchmarked data, SLaM reported:

<table>
<thead>
<tr>
<th>NRLS Data Q3-Q4 15/16</th>
<th>SLAM 15/16</th>
<th>Average for Mental Health Trusts</th>
<th>Highest Trust % or Score 15/16</th>
<th>Lowest Trust % or Score 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported incidents per 1000 bed days</td>
<td>23.18</td>
<td>42.02</td>
<td>85.06</td>
<td>14.01</td>
</tr>
<tr>
<td>Percentage of incidents resulting in severe harm</td>
<td>0.3%</td>
<td>0.4%</td>
<td>2.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Percentage of incidents reported as deaths</td>
<td>0.4%</td>
<td>1.0%</td>
<td>5.2%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NRLS Data Q1-Q2 16/17</th>
<th>SLAM 15/16</th>
<th>Average for Mental Health Trusts</th>
<th>Highest Trust % or Score 15/16</th>
<th>Lowest Trust % or Score 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported incidents per 1000 bed days</td>
<td>22.05</td>
<td>46.02</td>
<td>88.97</td>
<td>10.28</td>
</tr>
<tr>
<td>Percentage of incidents resulting in severe harm</td>
<td>0.3%</td>
<td>0.4%</td>
<td>2.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Percentage of incidents reported as deaths</td>
<td>0.4%</td>
<td>1.1%</td>
<td>10.0%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Table thirteen: NRLS (National Reporting and Learning Service) Data
Duty of Candour 2016/2017

Since April 2016, the following measures have been taken regarding duty of candour:

1. A Learning Lessons Half Day event took place at the Ortus on 19.04.17 with over 40 attendees.
2. The PALs service has produced a video aimed at staff which gives advice on how and when to use the duty of candour.
3. The Practical Guide to Structured Investigations training continues to provide education on how and when to use the duty of candour.
4. The Patient Safety intranet website provides practical advice and duty of candour document templates for staff.
5. The mandatory Datix (Trust Incident reporting system) fields for the recording of Duty of Candour were updated in March 2016 and continue to be used and monitored. The entries regarding duty of candour on Datix have been used to inform a re-audit.
6. A re-audit of the duty of candour was conducted and completed in April 2017. Initial findings indicate that since the previous audit in July 2014, the following is to be noted:

Positive points

- Verbal, face to face and written communication with service users and family improved by 37.5% from the previous audit to 82.5%.
- Apologies are being offered more often for both sympathy and admission of responsibility.
- Most cases do record asking the family if they had any questions for the investigation (80%).

Areas for improvement

- Minutes with the service user / family / carer were not recorded for the majority of pre-investigation meetings and required items were not recorded.
- 17.2% of SI cases recorded an offer to meet the service user / carer / family and feedback the investigation, which appears to have slightly decreased from the previous audit.

Governance and Assurance

The Trust has robust operational and quality governance systems and processes in place to monitor the quality of care provided.

The Trust Board receives assurance from the Quality Sub Committee (QSC) chaired by a Non-Executive Director. The purpose is to:

- Provide assurance to the Board of Directors on the delivery of the Trust’s Quality Strategy.
- Examine where there have been failures in service or clinical quality and monitor progress against action plans to address them.
- Ensure that there are processes in place to monitor quality effectively.
  - Identify risks related to service and clinical quality and provide assurance to the Board that the principal risks threatening quality are being managed appropriately at all levels within the Trust.
  - Consider issues escalated by the committees accountable to the Quality Sub-Committee.
Part 3

Review of quality performance 2016/2017
# Review of quality performance 2016/2017

## Review of progress made against last year’s priorities

Our 2016/2017 quality priorities were selected after consultations with stakeholders and staff from our services. The following summarises progress made against each priority over the year.

### Priority One – Patient Safety: Reduce the use of restrictive interventions applied to service users

| Target | Reduce any use of restraint that includes prone restraint by 20%.  
**Baseline:** 220 in Q4/2017 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Datix incidents in Q4/2016</td>
</tr>
</tbody>
</table>
| Headline | **This was not achieved.**  
Datix incidents in Q4/2017 showed 240 restraints which included prone restraint. Overall, the number of restraints in the Trust have decreased by 19.6%. However, the number of prone restraints have increased by 9.1% |

### Restrictive Interventions

![Bar chart showing restrictive interventions from 2015/16 Q4 to 2016/17 Q4.](chart.png)

- **Overall Restraints**
- **Prone Restraints**
In Quarter 4 2015/16, 31% of all reported restraints were prone. Although the overall number of restrictive interventions used has reduced, 42.1% of the reported restrained in Quarter 4 2016/17 are prone. Positively, the overall data may suggest that in general, the management of violence and aggression has improved as well as reporting of restraint as per recommendation by the CQC following the comprehensive inspection in 2015 and the quality improvement work carried out as a result.

The Trust internal audit on physical interventions in 2016 found that prone restraint was no longer the most common position used, compared to the findings of the audit completed in 2012.

A three year strategy to reduce restrictive interventions has been developed by the Trust and will be ratified in 2017. The strategy provides a framework for the reduction of restrictive interventions across all in-patient services in line with the DH Positive and Safe initiative (2014) and other relevant national guidance including NICE guideline NG10. The strategy delivery is monitored by the Trust Safe and Therapeutic Services Committee.

As part of this strategy the trust is in the process of implementing a violence reduction programme called ‘Four Steps to Safety’ which is being delivered collaboratively with Devon Partnership NHS Trust and is sponsored by the Health Foundation.

The Four Steps to Safety project is a system for safer care and uses a series of evidence based clinical interventions which are implemented using quality improvement methods. The project aims to reduce the levels of violence and aggression by 50% across all inpatient wards achieving better and safer care for the patients and better, safer working environment for the staff. An important part of the project is to enable clinical staff to embed a system of care which is proactive, rather than reactive. This work was designed and is delivered in partnership with people with lived experience of inpatient services. The programme is being delivered to 48 inpatients wards across the trust and is due to be completed by September 2017.
### Priority Two – Patient Safety: Safer staffing

| **Target** | To reduce the number of wards breaching agreed Trust minimum safe staffing levels by 30%.
| **Baseline:** 15 Wards |
| **Measure** | Safer staffing monthly returns – Safecare |
| **Headline** | **We did not achieve this target**
Between April 2016 and March 2017, the average number of wards with staff breaches per month was 20.

### Safer Staffing Breaches 2016 - 2017

![Safer Staffing Breaches 2016 - 2017](chart)

### Process and system improvements Recruitment and Retention

The difficulty in recruiting nurses in the capital multi factorial, some of the factors are difficulties beyond local control such as the cost of living in London. We invest time in making advertising campaigns imaginative in order to raise our profile and attract staff. However, this is not enough to make our wards safe. Therefore, SLaM in partnership with London South Bank University, are training Assistant Practitioners an additional workforce to support nurses.

Retaining our nurses requires a multifaceted approach, which includes listening to staff through staff surveys, enabling staff undertake professional development and making provisions for staff wellbeing.

The Trust has worked hard to increase its presence across London and the country. We have attended RCN recruitment Fairs and hosted successful open days at the Bethlem, Kent, Maudsley and Lewisham.

We have had a timetable of monthly assessment centres for Band 5 nurses where we have seen a month on month increase in attendance due to our advertising campaigns in the Metro/Evening Standard and local newspapers.
We have also had a Learning Disability conference to showcase and celebrate the Trusts Learning Disability nurses. It was a widely promoted event. We invited university students and many were expressed an interest to work for the Trust once they qualified.

Nationally, a scheme has been developed to create band 4 Nursing Associate roles, trained at Foundation degree level. Whilst the Trust watches this development with interest, as currently defined, these roles appear better suited for acute general Trusts than Mental Health organisations.

Therefore, in partnership with the other two mental health Trusts who comprise the South London Partnership – Oxleas and South West London and St Georges, an agreement has been reached to take a common approach to the development of band 4 Assistant Practitioners (AP) staff to work in inpatient care areas.

Assistant Practitioners will receive robust training with our partner University, London Southbank University (LSBU), including an initial two week course focusing on mental health practice and then complete a Foundation degree level course via day release for 18 months.

The first cohort of 12 students from SLaM embarked on this course; the first two ‘step up’ weeks have been completed.

The effect of changes in the workforce will be monitored by seeking service user and staff feedback, and monitoring indicators including complaints and compliments and incident data.

**Erostering**

Ward managers regularly attend e-roster efficiency meetings; here they discuss the best practice methods in order to plan staff shifts six weeks in advance. This reduces the level of agency staff. The process and systems within erostering requires continual improvement including building capacity within the team to roll out the SafeCare system across the trust.
### Priority Three – Patient Safety: Risk Assessments

<table>
<thead>
<tr>
<th><strong>Target</strong></th>
<th>85% of service users in in-patient services and community service users under CPA will have a full risk assessment completed for each in-patient admission or CPA review. <strong>Baseline:</strong> 78%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure</strong></td>
<td>This will be measured through clinical audit in Q4/2017.</td>
</tr>
</tbody>
</table>
| **Headline** | **We achieved this target**  
The audit sample taken from Q4 achieved 90.8%  
Inpatient services achieved 95.6%  
Community services achieved 85.7% |

#### Risk Assessment Scores

Graph four: Risk Assessment Scores 2015 – 2017

Since 2015, the completion of risk assessments has increased by 26%.

Over the summer of 2016 the trust undertook a comprehensive review and redesign of the ePJS which has helped to ensure the risk assessment process is streamlined, understood and standardised across all clinical services. Completion of risk assessments is audited on a monthly basis and escalated to CAG leadership on a quarterly basis as a governance monitoring structure.
In January 2017, the new Risk Assessment tool went live on ePIS, replacing the previous Brief Risk Screen, Full Risk Screen and Risk Plan. In-patient services were given a 4 week transition period ending in March 2017, and community services were given a 20 week transition period which will end in June 2017.

All clinical staff have to complete risk assessment training every three years as mandatory training and with the development of the new risk assessment template and a standardised audit tool, training is currently being roll out to all clinical staff in our inpatient settings to reflect this.

To ensure we are identifying and mitigating against risks associated with individual patients all patients have a full risk assessment within four hours of admission. Risk assessments are reviewed weekly at ward rounds and clinical review meetings, or as required in the case of an event during the patient’s stay on the ward. Collaborative risk assessment and management has also been integrated into the inpatient group treatment programme.

The 2017 internal audit found the new Risk Assessment Tool was already in use in 49.4% of the sample.
**Priority Four – Clinical Effectiveness: Physical healthcare screening**

| Target | 90% of both in-patients service users and early intervention service users. 50% of community service users on CPA audited will have had an assessment of each of the key cardio metabolic parameters; Smoking status; Lifestyle (including exercise, diet alcohol and drugs); Body Mass Index; Blood pressure; Glucose regulation and Blood lipids. They will be offered interventions based on need.  
**Baseline:** 85.4% Inpatients; Community Zero baseline (new scope) |
| Measure | Audit for CQUIN submission in Q4/2017  
**Baseline:** Inpatients 85.4%, Community (no baseline,- new priority) |
| Headline | We partially achieved this target.  
The audit sample taken from August/September Q2 patients achieved 79.3%  
Inpatients 93%, EIP 77% and Community 68% |

In 2016/17, the CQUIN target for physical healthcare excluded Early Intervention service users from the sample. An internal audit was completed to include Inpatient, Early Intervention and Community patients.

**Physical Healthcare Screening**

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>91%</td>
<td>93%</td>
</tr>
<tr>
<td>Early Intervention</td>
<td>67%</td>
<td>77%</td>
</tr>
<tr>
<td>Community</td>
<td>68%</td>
<td></td>
</tr>
</tbody>
</table>

**Graph five:** Physical Healthcare Screening

The internal audit showed improvements in the completion of screening since the previous year and interventions offered. Whilst this is an area of continued focus we are proud of our achievements so far.
Priority Five – Clinical Effectiveness; Care planning

<table>
<thead>
<tr>
<th>Target</th>
<th>&gt;89% of service users will state that they feel involved in their care.</th>
</tr>
</thead>
</table>
| Measure | This will be measured through the patients survey results in response to the question ‘Do you feel involved in your care?  
Baseline: 89% |
| Headline | We achieved this target.  
89% of service users state that they feel involved in their care (n=10,628) (89.08% to 2dp). |

The Trust will maintain and improve on this target by co-producing a consensus statement for involvement in own care and taking forward a programme plan to deliver on the Trust’s Patient and Public Involvement Strategy.

Priority Six – Clinical Effectiveness; Developing electronic systems to improve the delivery of care

| Target | 50% of inpatient teams to embed electronic observations in practice (eOBS); technology to enable paper free patient observations.  
Baseline: 0 Wards. |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>No. of wards using eOBS</td>
</tr>
</tbody>
</table>
| Headline | We did not achieve this target.  
2 wards are using eOBS (Johnson and ES2).  
AL1 has completed training and is ready to start using the new system.  
6 more wards are being trained and will be prepared to start implementation in May 2017. |

Technical Development

The developers are working towards fully replacing the physical health chart currently being used trust wide to record physical health observations, Modified Early Warning Score (MEWS), with a digital tool.

They have alongside this work, been making some improvements to some of the functionalities on the system being piloted on Eileen Skellern 2 (ES2) and Johnson Psychiatric Intensive Care Unit (PICU). The latest release in March, saw some useful additions to the system that both improve its user friendliness as well as the effectiveness in improving the process of recording and accessing meaningful data and alerts that contribute to timely clinical decision making. The full replacement of the paper chart has been delayed by the findings of the pilot and the need to address technical issues. earlier projection.
Wards implementing eOBS:
ES2 and Johnson PICU wards are no longer considered to be pilots wards as eOBS is now fully established into the ward routine and the system is used regularly to carry out physical health observations. Both wards played a significant role in influencing the changes and further developments in the system since the pilot started almost a year ago.

The data available supports the operators feedback that latest upgrade to the software has significantly improved the system usability, this data will continue to be monitored and acted upon. No adverse events or system failures have been reported since both wards started using the electronic system, and neither ward have had to resort to using paper records.

**Trends in the physical health completion - ES2**

**Number of obs**

Graph six and seven: Trends electronic physical health observations in pilot wards

**Trends in the physical health completion - Johnson PICU**

**Number of obs**
Integrating QI methodology with the roll-out of eOBS.

Aubrey Lewis 1 (AL1), older adults unit is the first ward to be trained to use QI methodology in its implementation of eOBS. The ward manager and a nominated champion had the three days QI training from the Institute of Healthcare Improvement (IHI) followed by training for the whole team on e-Observation and the new physical health tool, NEWS. The ward is also allocated additional support from the QI team to guide them through the process of setting up their PDSAs and measures to monitor improvement. AL1 is now ready to go live once IT support is in place. The learning from their implementation of eOBS using QI methodology will be useful for the roll-out to the rest of the trust.

Trust Roll-Out

The Ladywell site in Lewisham is half-way through the training and preparation for eOBS implementation. It is anticipated that up to 80% of staff in each ward will be trained by the 28th April before implementation can go ahead. Subject to the progress of the software development, implementation will start from the first week of May 2017.

Phase two of eOBS

The second phase of eOBS will be focused on developing the mental health observation tools and the enhancement of the task management functionalities on the system.

This is expected to start from June while the physical health aspect is being rolled out.
Priority Seven – Patient Experience; Reducing the number of Acute out of area treatments

| Target | A 40% reduction in the number of adult patients admitted to external providers (overspill).  
Baseline: Yearly average of 46.1 |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>This will be measured in monthly performance meetings and data extracted. Complaints data will also be monitored.</td>
</tr>
</tbody>
</table>
| Headline| We did not achieve this target.  
Average number of admissions/ transfers to private overspill beds:  
2015/16 – 46.1  
2016/17 – 40.7  
There has been an improvement in the last year, but only a 13.3% reduction. |

Whilst this target was not met, a significant amount of work was carried out to improve the patient experience in this area. The Acute CAG came into existence on 1 July 2016. The remit of the CAG is to provide 24/7 adult acute care across inpatients and home treatment teams.

In November 2016 the Acute care CAG published its two year plan. Over the last six months the acute and PICU wards across the four hospital sites have been looked at in terms of admission rates, length of stay, number of beds, nurse staffing ratios and multidisciplinary input, with a view to developing a two year plan to standardise our offer to people who use in patient services. A new Acute Referral Centre (ARC) has been formed to create a single administrative point for acute admissions. The service operates 24 hours a day, 7 days a week for 365 days per year. ARC staffing consists of a clinical service lead, a crisis line practitioner, home treatment clinicians and a patient flow co-ordinator. The purpose of the Acute Referral Centre is to ensure that referrals for patients requiring a crisis or acute response are directed swiftly and offered the most appropriate intervention without delay.

Ensuring the most appropriate treatment without delay for all will enhance quality and effectiveness. This is a key strategy to reduce reliance on out of area (overspill) beds.

<table>
<thead>
<tr>
<th>Average for the year (external plus McKenzie)</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

Table fourteen: Overspill averages 2015 to 2017

The Trust intends to reduce the average length of stay from 45 days to 40 days, which in turn will contribute to preventing external overspill.

Throughout 2017/18, through a series of quality improvement projects we aim to further reduce the average length of stay to 35 days.

Getting the average length of stay to 35 days and creating four acute wards for each borough (as well as the PICU provision and the early intervention ward) will allow the wards to run at 85%, with a target four hour wait time for admission.

In 2018/19 we plan to further decrease the length of stay to 30 days. Once this is achieved the CAG executive believe that this will be a good time to further review the skill mix of staff on the wards.
Priority Eight – Patient Experience; Carer’s assessments and associated care plan

| Target | >50% of identified carers will have been offered a carers’ assessment and a carer’s care plan.  
Baseline: 32% |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>This will be measured through internal audit.</td>
</tr>
</tbody>
</table>
| Headline| **We did not achieve this target.**  
The internal audit achieved 43.4%  
43.4% of identified carers were offered a carers’ assessment. |

**Carers Assessment Scores**

The previous audit undertaken in 2016 showed performance in offering carers’ assessments was 32% and an action plan was sought to address this poor performance and achieve a target of 50% by April 2017.

A key challenge of this work has been to design an assessment tool which was tailored for the needs of mental health carers but also complied with the Care Act and was able to be developed on the ePJS system. Following involvement from carers and staff, a ‘carers’ engagement and support plan’ was developed on ePJS and went live at the end of November 2016 and the old forms were removed. This tool enables staff to assess the presenting needs of the carer, offer advice, information and support and share the support plan with the carer. The tool has links to the four borough local authority forms and guidance on how to access a formal carers’ assessment under the Care Act if one is indicated. Staff feedback on the forms has also been encouraged and received and will be used to make further design improvements.

Graph eight: Carer Assessment Scores 2015-2017
In order to have local leadership and ownership of carers’ assessments, each CAG nominated a carers’ lead to help to develop the tool and to champion carers’ assessments in the CAGs to facilitate an improvement in performance. The initial launch of the forms was, in general, positively received by staff and since the end of November 2016, approximately 300 carers’ engagement and support plans have been completed.

However, the current Trust-wide position of patients on CPA with an identified carer offered a carers’ assessment is 42.5%. 6.3% of the assessments completed used the new form. Carers’ assessments and care planning will continue to be a quality priority in 2017/18, and further work will be completed to promote the use of the new Carers’ engagement and support form.

**Priority Nine – Patient Experience – Quality of environments and food within in-patient services**

| Target | Patient Led Assessments of Care Environments (PLACE) and Food audit scores will achieve overall > 89.95%.  
Baseline: 89.95% (food) |
| Measure | PLACE audit reports and hotel services Spot Light reports will be monitored and reviewed. |
| Headline | We achieved this target. 
The Trust scored 95% overall for the PLACE audits. 
The food audit score was lower than the previous year and equal to the national average (88.07%). However, all other audit scores were higher than the national average. |

<table>
<thead>
<tr>
<th>Cleanliness</th>
<th>Food</th>
<th>Condition, Appearance &amp; Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Score 2016</td>
<td>99.26%</td>
<td>88.07%</td>
</tr>
<tr>
<td>National Average 2016</td>
<td>98.06%</td>
<td>88.07%</td>
</tr>
<tr>
<td>% above National Average</td>
<td>1.20%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

**Table fifteen:** PLACE audit scores 2016

We involved our service users in assessing the quality of our care environment as part of the PLACE inspection between February and June 2016.

A team made up of service users, staff and an external assessor from another trust inspected 40 of our wards.

We have exceeded national averages in every PLACE assessment area except ‘food’, and are taking action to address this. Having changed menus, we currently maintain the national average for food. We are looking to improve this by refining our current catering and domestic food contracts and moving to fully cooked fresh food in Spring 2017.

The patient environment and the settings in which we deliver our clinical services is a clear factor in good healthcare delivery. Through PLACE assessments we demonstrate a clear commitment to delivering a well maintained, clean and safe environment for everyone who uses our services.
National patient survey of people who use community mental health services: SLaM report 2016

The National Patient Survey was returned by 206 SLaM patients giving a response rate of 26%; this is slightly lower than the national average response rate of 28% for all mental health trusts. SLaM performed ‘about the same’ as all other trusts nationally for every question in the 2016 survey of people who use community mental health services and therefore ‘about the same for each separate survey section.

SLaM’s highest three performing questions are as follows:

Section 2: Organising care

Q7 Have you been told who is in charge of organising your care and services?

Q9 Do you know how to contact this person if you have a concern about your care?

Section 7: Treatments

Q31 Were these treatments or therapies explained to you in a way you could understand?

Graph nine: SLaM’s patient survey highest three performing questions

The three questions where the Trust had the greatest increase in performance in 2016 compared to 2015 are providing help or advice with finding support for finding or keeping work (+11.2%), knowing who to contact out of office hours if you have a crisis (+10.1%) and being involved as much as the service user wanted to be in discussing how their care is working (+4.6%).

To build further on these improvements the Trust has reviewed the approach to Patient and Public Involvement (PPI). The PPI policy was endorsed by the board in December 2016. The policy sets out a governance structure for involvement by people who use services and their friends, families and carers at all levels of the organisation to ensure a consistent approach across all parts of the organisation.

A new Involvement Oversight Group with Non-Executive Directors, service user and carer governors as well as staff attending has been set up to ensure that the policy is implemented and adhered to thereby improving the quality of services we provide. This group reports to the Quality Sub Committee.

We are proud that we increased the number of respondents to FFT and other service user questionnaires by 50% since 2014/2015.
National Staff Survey 2016 – Results

1832 staff at South London and Maudsley NHS Foundation Trust took part in this survey. This is a response rate of 40% which is below average for mental health/learning disability trusts in England, and compares with a response rate of 38% in this trust in the 2015 survey.

Number of Staff recommending the Trust

In the 2016 survey, SLAM performed slightly lower to the year before on the question ‘would staff recommend the trust as a place to work or receive treatment?’. SLaM performed slightly above the national average on this question. The SLAM Trust score for this question was 3.67 compared to the national average score of 3.62 for other mental health trusts.

<table>
<thead>
<tr>
<th>Question</th>
<th>2016 Score</th>
<th>Average (median) for mental health</th>
<th>2015 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q21a “Care of patients / service users is my organisation's top priority”</td>
<td>72%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Q21b “My organisation acts on concerns raised by patients / service users”</td>
<td>74%</td>
<td>74%</td>
<td>72%</td>
</tr>
<tr>
<td>Q21c “I would recommend my organisation as a place to work”</td>
<td>58%</td>
<td>56%</td>
<td>59%</td>
</tr>
<tr>
<td>Q21d “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation”</td>
<td>61%</td>
<td>59%</td>
<td>60%</td>
</tr>
<tr>
<td>KF1 Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)</td>
<td>3.67</td>
<td>3.63</td>
<td>3.68</td>
</tr>
</tbody>
</table>

Table sixteen: National staff survey results

Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment

Scale summary score

<table>
<thead>
<tr>
<th>Category</th>
<th>2016 Score</th>
<th>2015 Score</th>
<th>2016 Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2016</td>
<td>3.67</td>
<td>3.68</td>
<td>3.68</td>
</tr>
<tr>
<td>Trust score 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National 2016 average for mental health</td>
<td></td>
<td></td>
<td>3.62</td>
</tr>
<tr>
<td>Best 2016 score for mental health</td>
<td></td>
<td></td>
<td>3.96</td>
</tr>
</tbody>
</table>

Graph ten: National staff survey results – key finding 1
Overall Staff Engagement

The Trust score for overall staff engagement has gone down marginally to 3.80 (3.81 in 2015). This is higher than the national average for all mental health/learning disability Trusts which was 3.77.

<table>
<thead>
<tr>
<th></th>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2016</td>
<td>3.80</td>
</tr>
<tr>
<td>Trust score 2015</td>
<td>3.81</td>
</tr>
<tr>
<td>National 2016 average for mental health</td>
<td>3.77</td>
</tr>
</tbody>
</table>

Poorest staff

Scale summary score

Highly engaged staff

Graph eleven: National staff survey results – overall staff engagement
Key Findings – overall Trust

The following are the top five ranking scores for the Trust compared to Mental Health Trusts in England:

Percentage of staff appraised in last 12 months.
Trust Score: 93%  National Average: 89%

Effective use of patient/ service user feedback (scale summary score).
Trust Score: 3.82  National Average: 3.70

Percentage of staff/ colleagues reporting most recent experience of violence
Trust Score: 95%  National Average: 93%

Percentage of staff able to contribute towards improvement at work
Trust Score: 76%  National Average: 73%

Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (the lower the score the better)
Trust Score: 53%  National Average: 55%

The following are the lowest five ranking scores for the Trust compared to Mental Trusts in England:

Percentage of staff satisfied with the opportunities for flexible working patterns
Trust Score: 51%  National Average: 59%

Percentage of staff experiencing discrimination at work in the last 12 months
Trust Score: 20%  National Average: 14%

Organisation and management interest in and action on health and wellbeing (Scale summary score)
Trust Score: 3.56  National Average: 3.71

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
Trust Score: 78%  National Average: 87%

Percentage of staff reporting good communication between senior management and staff
Trust Score: 30%  National Average: 35%

The following is the area where the experience of staff has improved on the previous annual survey:

Percentage of staff working extra hours (the lower the score the better)
Trust Score 2016: 76%  Trust Score 2014: 81%

Percentage of staff experience physical violence from staff in last 12 months (the lower the score the better)
Trust Score 2015: 3%  Trust Score 2014: 5%
The following is the area where the experience of staff has deteriorated most on the previous annual survey:

Percentage of staff appraised in last 12 months

<table>
<thead>
<tr>
<th></th>
<th>Trust Score 2016</th>
<th>Trust Score 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>93%</td>
<td>96%</td>
</tr>
</tbody>
</table>

Workforce Race Equality Standard

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

<table>
<thead>
<tr>
<th></th>
<th>Trust Score 2016</th>
<th>Trust Score 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>24%</td>
<td>23%</td>
</tr>
<tr>
<td>BME</td>
<td>27%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Over the past year following on from the previous Staff Survey we have been actively engaging with and supporting the development of the new BME network. This has included the development of a “Tackling Snowy White Peaks” Working group following on from a network event where Roger Kline presented his findings on his research into Snowy White Peaks in the NHS.

The group has been looking at particular issues and themes and have developed a “Reflect and Review” checklist to be used before any formal investigation is undertaken. This will enable managers to take a step back and look at whether there are better alternatives than formal action.

A review of disciplinary investigation outcomes has been conducted on those staff involved in a formal disciplinary process and from a Black African background as there were are a greater proportion going through formal disciplinary processes. It is recognised that the Reflect and Review checklist may assist in ensuring that staff are only taken through a formal process where there is no alternative.

We are presently scoping the implementation of a programme of inclusive leadership which helps organisations think about the impact and implications of unconscious bias. It is intended that we may be in a position to conducting a trial or pilot later in the year.

In the previous Staff Survey report it was highlighted that the Trust was in the worst 20% in terms of the percentage of staff who experience physical violence from other staff. In September 2016 the Chief Executive wrote an open letter to all staff reminding them of the need to report any incidents of unacceptable behaviour from other staff and to use the mechanisms already available to escalate any matters. It is positive to see a reduction in these reported in the 2016 survey which is also identified as one of the most improved areas but there is still further work to do to make this zero.

At a local level, each CAG and Directorate will again be asked to develop an Action Plan in relation to the responses in the staff survey. This should be based on the requirements identified within the report for their specific areas as some CAGs may need to develop and improve approaches to particular themes. There will need to be regular updates on progress through the CAG HR Business Partners. It is important that local issues are identified and staff are given the opportunity to work towards their resolution and for the CAGs to reassure their staff that they have heard the feedback and are addressing it.

We need to ensure we maintain our areas where we have scored in the top 20% of mental health and learning disability Trusts.

We will need to continue to reinforce the importance of the new annual performance review (appraisal) process which commenced in 2015. We have updated the ratings guide and redesigned the recording form. The performance review process allows an open dialogue about what is good and what needs to improve.

We have seen a reduction in the overall percentage appraisal scores which is a little disappointing and although the score is higher than the national average and a good achievement we need to strive to ensure this is better than the 96% in the previous year over the forthcoming year. We have introduced a new learning development system which will also provide the platform to record and report on appraisals over the forthcoming year.
Freedom to Speak up Guardian

The Trust has appointed a Freedom to Speak Up Guardian. A Steering Group has been established to oversee a body of work which includes a refreshed promotion and cultural change programme. This follows the visit of the National Guardian on 17th March 2017. There are a number of Ambassadors and Advocates and the aim is to increase the visibility and encourage everyone in the Trust to see ‘Speaking Up and Being Heard’ as business as usual.

Two reports have been made to the Board and the third is scheduled for June 2017.

SLaM Equality Information and Objectives

The Trust published its annual equality information in January 2016. This includes 2016 Trust-wide equality information that provides information on the demographic profile of the Trust’s service users and the experience of service users with different protected characteristics.

We also continue to publish local ethnicity reports for Croydon, Lambeth, Lewisham and Southwark. These provide information on the ethnicity of service users accessing 11 of the Trust’s services and the experience of service users of different ethnicities in each borough.

The Trust has developed new CAG equality objectives for 2017-20. A high-level summary of these is provided below:

**Acute Care CAG**
To improve access and experiences for service users with learning disabilities in acute wards.

**Addictions CAG**
To improve access to substance misuse services in Wandsworth for men who have sex with men.

**Behavioural and Developmental Psychiatry CAG**
To improve the physical health of Black and Minority Ethnic service users in forensic inpatient services.

**Child and Adolescent Mental Health CAG**
To improve access and experiences for Asian and Black girls in CAMHS community services.

**Mental Health of Older Adults and Dementia CAG**
To achieve earlier access to memory services in Lambeth and Southwark for Black service users.

**Psychological Medicine and Integrated Care CAG**
To improve access and outcomes for Black service users in Lewisham Improving Access to Talking Therapies [IAPT] service.

**Psychosis CAG**
To ensure equitable access to early intervention services for people aged 35 and over.
NHS Croydon CCG, NHS Lambeth CCG, NHS Lewisham CCG and NHS Southwark CCG Joint Statement on South London and Maudsley NHS Foundation Trust’s Quality Account 2016/17

May 2017

The Clinical Commissioning Groups contracting with the South London and Maudsley NHS Foundation Trust have reviewed the Trust’s Quality Account for 2016/17 and congratulate the Trust on its substantial achievements during the year. We share the Trust’s view that there are still many areas of its work that require improvement to ensure that service users experience the best possible care promptly and in the most appropriate setting.

The CCGs have supported the Trust to tackle some deep seated long standing issues such as reducing the number of occasions when a patient is restrained in the prone position and reducing the number of wards breaching agreed Trust minimum staffing levels. The Trust was unable to achieve its targets in either of these two areas in 2016/17, however CCGs are assured that the Trust has credible plans within its Violence Reduction and Reducing Restrictive Practices Strategy and Workforce Strategy to achieve improvement in 2017/18.

The Trust had greater success in achieving its improvement plans in relation to improving its use of risk assessments, physical health screening, involving service users in care planning and improving the quality of the environment and food within in-patient settings. These improvements were recognised and highlighted in the recent Care Quality Commission inspection.

The CCGs are looking forward to working collaboratively with the Trust over the coming year to support the on-going health quality improvement programmes for the benefit of service users in Croydon, Lambeth, Lewisham and Southwark.

Comments from Overview and Scrutiny Committee, London Borough of Lambeth

Lambeth Council’s Overview and Scrutiny Committee would like to thank South London and Maudsley NHS Foundation Trust for the invitation to submit a statement on the Trust’s draft Quality Account for 2016/17.

It has not been possible to formally consider the draft QA within the timeline requested. The Committee would however wish to record that a positive working relationship exists between Lambeth OSC and the Foundation Trust; the committee would also wish to be assured that the actions being taken by the Trust in response to the areas identified by the CQC as requiring improvement are sufficient to address these concerns. Committee members have also noted the findings from the audit on Management of Violence and Aggression: Physical Interventions that service users from BME background are a cohort who experience most use of physical restraint.

Whilst this matter has been separately raised with the Trust the committee seeks assurances around actions and interventions to minimise the use of restraint.
Governors’ reply to Quality Accounts 2016/17

Governors appreciate the opportunity to comment on the draft Quality Accounts. We address quality concerns at our Quality working group (QWG) and send an observer to the Board Quality subcommittee (QSC). Members of the QWG also have regular contact with the NED who chairs the QSC.

We recognise that it has been a challenging and busy year, with the CQC’s re-inspection of acute wards of adults and psychiatric intensive care units (PICU) to ascertain if improvements had been made since the Trust-wide inspection in September 2015. We acknowledge the actions taken by the Trust to improve services and recognise the hard work of staff in trying to achieve this. Whilst we appreciate the rating for ‘are services safe’ has improved from ‘inadequate’ to ‘requires improvement,’ we acknowledge that there is still a long way to go and are therefore pleased to see many of the concerns raised aim to be addressed in the coming year’s quality priorities. We will be monitoring the development and implementation of the Trust’s action plans and seek assurance that governance processes are robust enough to continue to identify where improvements are needed.

Governors welcome the Trust’s on-going commitment to developing a PPI strategy (which will be aligned with Quality Improvement initiatives) outlining principles for involving people who use services, their families, friends, carers and members of the public. To this end, the development and implementation of Trust-wide Involvement standards will be monitored by the establishment of an Involvement Oversight Group which will include service user and carer governors.

Governors welcome the commitment of the Trust to the ongoing development of their Quality Improvement (QI) strategy in order to deliver sustainable high quality care. We understand that a large number of staff have been trained to initiate, develop and support these initiatives. Whilst we have seen some engagement with other stakeholders, we look forward to further training to ensure true co-production.

We note the 24 hours crisis line is listed as a success/development however it would be helpful to see more data to support this.

We hope that there has been some improvement in Delayed transfers of Care. The data is not yet available to assure us of this.

Trust Clinical Audit Programme

We note the inclusion of data for seven out of the 25 clinical audits undertaken by the Trust and will seek further assurance that the recommendations from the audit findings are implemented, along with the additional 18.

We are concerned that the report on the Seclusion of Service Users revealed compliance with policy standards was lower than the previous audit, in particular that service users were rarely informed of the reason for being placed in seclusion.

Governors recognise the Trust’s on-going commitment to its digital transformation programme and improving data quality. We look forward to seeing how the Trust ensures that data captures processes effectively to support QI initiatives.

National Indicators 2015/6

We note the Trust’s actions taken following recognition of the failure to reach the 95% standard for Access to Crisis Resolution (Home Treatment Team) in Q1 and Q2 which led to significant improvements. We look forward to seeing further improvements with the embedding of the acute care pathway.

We note the inclusion of NRLS data relating to the reporting of serious incidents. However, it would have been helpful to include further explanation and an indication of how the Trust monitors, investigates and learns from serious incidents and we will seek further assurance on this.
Review of Quality Performance 2016/17

**Priority One - Reduce the use of physical interventions applied to service users.**

We are pleased to see the Trust’s continued commitment to the development and implementation of their Reducing Restrictive Interventions Strategy including the further roll out of the 4 Steps to Safety programme across patient services. However, governors remain concerned at the high number of prone restraints (also highlighted by the CQC) as well as the high proportion of physical restraints carried out on men; service users from BME backgrounds and those detained under the MHA.

We welcome the roll-over of this priority for the next year.

**Priority Two - Safer staffing**

Governors remain concerned about the Trust’s failure to reach safe staffing targets despite initiatives taken to address this. However, we recognise that this is a national problem with a shortage of appropriately skilled staff competent in delivering safe, high quality care. We also note this indicator does not appear to include staff delivering services in the community and would welcome further explanation on how the Trust determines safe staffing levels for community services and how it plans to adopt recommendations made in the National Quality Board’s (draft) improvement resource for Mental Health ‘Safe, Sustainable and Productive Staffing.’

We welcome the roll-over of this priority for the next year.

**Priority Three - Risk Assessments**

We are pleased to see this target has been met and welcome the redesign of the ePJS which has supported this. We note the disparity in compliance between inpatient and community services and in the absence of safe staffing indicators for community services it is difficult to ascertain the reason for this. For example, how far is this due to the transition of ePJS not being complete or are community staff being overburdened. We will work with the Trust to seek further assurance.

**Priority Four - Physical Healthcare Screening**

We acknowledge the Trust has worked hard to achieve this target in inpatient services. We note the low baseline for community services and will seek assurance that staff in the community and early intervention services are appropriately supported and therefore enabled to further improve compliance.

We welcome the roll-over and expansion of this priority for next year which will focus on reducing mortality for people with severe mental health problems

**Priority Five - Care Planning**

We recognise the Trust has worked hard to achieve this target and welcome the linking of this with the Trust’s Patient and Public Involvement Strategy in order to develop a consensus statement for involvement in own care. We welcome the continued inclusion of this priority for the next year.

**Priority Six - Developing electronic systems to improve the delivery of care**

Although this target has not been met, we understand the Trust has been piloting the eObs system which will digitally record physical health observations instead of the current MEWS paper record. We are pleased to see the roll out has been aligned with the Trust’s QI strategy and understand this may take time initially to ensure usability but should improve long term sustainability. We are pleased to see that a number of actions have been taken to improve data quality.
Priority Seven - Reducing the number of Acute out of area treatments

We are concerned this this target has not been met and the resultant impact on service users and their families and friends; however, we acknowledge the initiatives the Trust has taken to try and address this. We welcome the Trust’s aim to deliver sustainable change through quality improvement initiatives and will be monitoring this closely.

Priority Eight - Carers Assessments and associated care plan

Governors note this target has not been met; however, we acknowledge the steps the Trust has taken to develop a carers’ engagement and support plan on ePJS in conjunction with carers. We will seek further assurance that the measures being taken to identify named carers, and to promote the uptake of the carers’ engagement and support plans are successful. We welcome the roll-over of this priority for the next year.

Priority Nine - Quality of environments and food within in-patient services

We recognise the Trust’s PLACE score achievement of 95% and acknowledge the steps taken to improve ‘food’ assessment scores through the refinement of catering contracts and a move to fully fresh food by Spring 2017. We look forward to monitoring ‘food’ assessment scores for improvement.

New quality priorities for 2017-18

We are very pleased to see the inclusion of a new quality priority that focuses on improving the experience of staff. We look forward to hearing more about the initiatives the Trust will undertake to achieve this.

We welcome the introduction of a quality priority that will aim to reduce in-patient admissions and length of stay on the basis that patients may (be supported to) manage their illnesses better at home ‘as appropriate’; however it is unclear how the Trust will determine what ‘appropriate’ is. We will seek further assurance as to how this will be implemented and monitored.

We note that there is an aim to reduce the average length of stay to 30 days in order to make more beds available for new admissions. We would like to be reassured that this will not reduce the standard of care; that adequate support will be available after discharge and that the number of readmissions would not increase.

Staff survey

We note an increased percentage of staff feeling able to contribute to improvements at work and anticipate this improving further next year with the development of the Trust’s QI strategy.

We welcome the introduction of a new quality priority for next year which focuses on improving structures and processes which facilitate positive staff experience.

Workforce Race Equality Standard

We welcome the Trust’s engagement with the development of the BME network which has identified particular issues and themes and introduced a ‘Reflect and Review’ checklist to be used before a formal investigation is undertaken.

We are pleased to see the development of the new CAG equality objectives for 2017-2020 and welcome the Trust’s increased use of Equality Impact Assessments which demonstrate a commitment to further improvements.

In future, it would be helpful for assurance purposes to include information on the Central Place of Safety, the use of the Freedom to Speak Up Guardian and an assurance that improvements have been made following the development and implementation of the Family and Carers’ strategy.
Response from local Healthwatch

The Healthwatch teams of Lewisham, Lambeth and Southwark are glad of the opportunity to comment as ‘critical friends’ on SLaM’s quality report and priorities. We base our responses on feedback from the public and service users about their experiences, and aim to promote the voice of patients in order to improve care.

We appreciate the Trust’s focus on quality improvement as reflected in the Mission Statement, and are glad to see the introduction this year of the Quality Improvement team. We value the commitment to a ‘bottom up’ approach to improving services and the focus on person-centred care. We would like to point out that as well as experience, outcomes, staff experience and sustainability, ‘access’ is an important area for the Trust to consider when making improvements.

Layout and readability

To further improve the structure, the order and the clarity of headings could be better – we recognise that this is a draft version.

It could be clearer why each priority has been chosen, and the old and new priorities could be placed together. The Equalities targets (which we very much welcome) should also be presented alongside the main priorities rather than right at the end.

Healthwatch agree that the use of jargon and abbreviations needs to be addressed, as the report is difficult for a layperson to understand.

Comments on priorities carried over or adapted between 2016/17 and 2017/18

Reducing violence: reducing restrictive interventions: We welcome the 19.6% reduction in the use of restraint overall, but it is concerning that rather than decreasing (as per last year’s goal), the use of prone restraint has actually increased by 9.1%. We recognise this may be the result of changes in reporting – the Trust should be clear about what is meant by this.

Restraint is an issue that is often reported by service users to cause much distress, and was highlighted by the CQC. We are therefore glad that the reduction of restraint, by a suitably ambitious 50%, remains a priority, but we question the abandonment of the more specific goal of reducing prone restraint. We particularly look forward to the implementation of the Reducing Restrictive Interventions Strategy.

Safe staffing levels: reducing breaches: Healthwatch (along with the CQC) are very concerned about the increasing issues around staffing.

We have heard from staff who feel under massive strain due to capacity/absence issues, and from patients about the impact on care (including use of generic care plans and patients not being able to take advantage of leave or exercise). We therefore agree that this needs to be a key focus for the Trust. We look forward to seeing the effect of the new band 4 Assistant Practitioner posts. However, the phrasing of the new goal (‘more than 15 wards reducing average staffing breaches’) is difficult to understand and compare with last year’s goal.

Reducing mortality: developing electronic systems to improve the delivery of care: The report should state more clearly the baselines and how many wards would constitute 50% wards using the system – it is hard to place the achieved outcome of 2 wards in context.

We would like more explanation around this goal and why it is important in order to improve outcomes for service users.
Reducing mortality: increasing physical health screening: we are glad to see the improvements in this area especially for inpatient and community services. (It should be noted that the Q2 scores given on p.34 do not align with the baseline rates given on pp.8-9).

Given the inequality of life expectancy for people with serious mental illness, and the issues raised by various clinical audits listed in this report, we agree that this should remain a priority. We would also like to see further progress for patients on the Care Programme Approach (CPA) pathway to bring them up to par with inpatients.

Service user involvement and personalised care plans, increasing the number of users who feel involved in their care: We wonder why the baseline in this area has not risen.

Likewise, we wonder why the target is simply to maintain the baseline. We welcome the plans to improve via the consensus statement and the Patient and Public Involvement Strategy, but would like to see the Trust set a more ambitious goal in this important area.

Family and carer engagement, increasing the number of carers being offered Engagement & Support Plans: Healthwatch note the challenges encountered and more recent progress. However, we feel that the achievement of a rise from 32% to 43.4%, with a goal of 50%, should not be described as ‘almost achieved.’ We would also like to see a breakdown of this figure by Clinical Activity Group (CAG).

The involvement of carers is important for improving their and users’ experience and outcomes. Healthwatch have identified, for example, that experiences of discharge can be poorer when carers are not involved. We are glad to see this priority rolled over, and a new and ambitious goal to build on the recent progress.

Reduction in number of adults admitted to external providers, connected to new priority of reducing admissions (and length of stay) because patients are better managed in their illnesses at home: We recognise that reducing external admissions can be important to improving patient experience. While we are glad that there was improvement, we would like to see analysis of why the Trust missed the target of reducing external admissions by 40%, achieving only 13.3% reduction. (Note that the data provided specifies ‘private’ providers – the report should be consistent).

However, we have some concerns about potential risks to patients from the new, connected goal of reducing admissions and length of stay, (and wonder if this is most appropriately placed under ‘experience’). The plan to reduce the length of stay from 45 to 40, 35 and later 30 days, seems ambitious, as does the goal of 10% reduction in inpatient admissions. 96.5% of patients are already assessed by the Home Treatment Team (HTT) crisis team before admission. External pressures such as housing problems also play a role. It would be valuable to know what improvements actions have been made in relation to the community services provision to meet this target.

We welcome the plan to create 4 acute wards per borough in order to increase capacity.

Goals ended after 2016/17

Increasing the number of patients with risk assessments in inpatient wards and Care Programme Approach (CPA): The increase in risk assessments for inpatients has been excellent, and we are glad that the goal was met for CPA patients.

However, we would like to know why the rate is still lower for community patients at 85.7% and how this can and will be addressed now that this is not highlighted as a priority area. The quality of risk assessments is also important so we would like to see continued emphasis on use of the new tool (currently at 49.4%).

Improving the quality of environments and food: A PLACE score of 95%, with 99% for condition, appearance and cleanliness, is impressive and we commend the Trust. We are pleased that scores for food are now in line with the national average as this supports the recovery and dignity of patients.
New priorities in 2017/18

Reducing violence and aggression in inpatient areas by 50%: We are glad to see an ambitious target in this area, which is connected to goals around restraint already covered above. Healthwatch intelligence suggests that one of the more distressing concerns for patients is feeling unsafe on wards. As well as violence this can include loud environments and the presence of drugs.

Reducing mortality: increasing the number of staff with level 1 physical health awareness: Again, this goal is closely connected to topics already covered above, and we are happy to see an ambitious target.

We note that all of the Clinical Effectiveness goals appear to be around physical rather than mental health. While this is an important area of focus it should not exclude improvements in the treatment of mental illness itself.

Staff experience goals: While Healthwatch focus on patient experience, we are very aware of the impact of pressure on staff in turn, and are glad to see the inclusion of these goals. It is very concerning that 43% of staff have felt unwell in the last year due to work-related stress, and we are not sure that a 5% reduction target is enough.

Likewise, it is very worrying that 20% of staff felt they had faced discrimination and only 78% felt the Trust provided equal opportunities, so this should be an area for future work. We are glad to see the improvements brought about by the BME Network and ‘Tackling Snowy White Peaks’ Working Group, and the reduction of BME experiences of harassment, bullying and abuse from 32% to 27%.

Information on how the Trust chose its priorities: Audits and indicators

We are glad to see that the Trust participated in all clinical audits and confidential enquiries for which it was eligible.

We feel that the findings of audits concerning physical health and premature mortality and physical interventions for aggression are well reflected in the new priorities.

However, it is made less clear why findings of other audits are not included in the new priorities: those on prescribing, seclusion (connected to the issue of restraint), and the Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DOLS) - it is disappointing for example that capacity assessments on admission have declined.

In light of the audits we also question the discontinuation of the risk assessment goal, particularly in relation to potential improvements identified around self-harm, and the bedding-in of new measures to prevent suicide and homicide.

The information (including data still pending) presented on access, follow-up/review, and readmissions is key to understanding the quality of care. Healthwatch are happy to see the Trust’s achievement of 97% of patients being followed up within 7 days of discharge. While we note that there are still issues with IAPT access, we are encouraged that the rates are above average.

Likewise we are reassured that the number of Serious Incidents (SIs) is below average and decreasing.

Information on how the Trust chose its priorities: CQC findings

Given the scale of the CQC inspection, we feel that the emerging action plans merit more detail in this report, particularly for the area of safety in the working age intensive care units, which received an ‘Inadequate’ rating. The CQC also raised concerns around topics such as risk assessments/documentation, seclusion, crisis planning, physical health interventions, care planning, training in support for patients with dementia or autism, staff awareness of the Mental Health Act and Mental Capacity Act, access to children’s and adolescent services (CAMHS), access to therapeutic activities, and some governance issues.

However, the CQC’s highlighting of issues around staffing, reductions in restraint, and individual goal setting are well reflected in the chosen priorities. The report explains how issues around food and environment have already been adequately addressed.
Information on how the Trust chose its priorities: User feedback

We would like the report to include further information about the Quality Event held on 22nd February, including validation of the claim that it included all the Trust’s stakeholders, and outlines of the discussions that took place.

We would also like to see the report include a breakdown of complaints received by the Trust.

The Trust’s scores for users’ experience of staff (pp.25-6) is in line with other trusts despite a slight decrease – however, this covers only community services. Feedback overall on community services (p.41) does not highlight the lowest performing areas.

Overall we would like to see more comprehensive attention to the views of patients in the Trust’s priority setting, and more prominence in the report. It is good however to hear about users reporting large improvements around the provision of support for finding or keeping work, and knowing who to contact out of hours when in a crisis.

Areas raised by patients and the public with Healthwatch

As well as the areas noted above, Healthwatch engagement has raised the following issues which we feel merit future monitoring and attention by the Trust:

- Issues with user involvement and with the complaints system.
- Inconsistent practice around the use of the Mental Health Act, with not all staff aware of patients’ rights.
- Poor management of discharge, for example poor involvement of carers, discontinuity of care or lack of onward support, and people discharged before they felt ready.
- Issues with access and waiting times for talking therapies – including the right kinds of talking therapies. Some service users and GPs have told us that group therapy is not appropriate for everyone and can make it more difficult for people to engage.
- Issues with access and waiting times for Child and Adolescent services (CAMHS).
- Issues with access to mental health support for those with mild drug use, and need for more support around drug and alcohol use itself.
- Language barriers to accessing mental health support.
- Poor communication about the services that are available.
- Issues with supervision/staff feedback into SLaM: some staff do not feel there is any point to feeding back as they do not feel heard by senior staff members and feel no change occurs as a result.
- Transition from children’s into adult services can be difficult due to changes and large reductions in the support offered.
Statement of Directors’ Responsibilities In Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17;

- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2016 to May 2017, including
  - Papers relating to Quality reported to the Board over the period April 2016 to May 2017;
  - Feedback from commissioners dated 11/05/2017
  - Feedback from Overview and Scrutiny Committee 15/05/2017
  - Feedback from Governors 18/05/2017
  - Feedback from local Healthwatch organisations 12/05/2017
  - The Trusts complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, Quarters 1, 2, 3 and 4 2016/2017
  - 2016 national patient survey results
  - 2016 national staff survey results
  - The head of internal audit’s annual audit opinion over the Trust’s control environment dated?
  - CQC quality and risk profiles published throughout the year

- The Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered;

The performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and,

- The Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Roger Paffard, Chair
South London and Maudsley NHS Foundation Trust
30 May 2017

Dr Matthew Patrick, Chief Executive
South London and Maudsley NHS Foundation Trust
Independent auditor’s report to the council of governors of South London and Maudsley NHS Foundation Trust on the quality report

We have been engaged by the council of governors of South London and Maudsley NHS Foundation Trust to perform an independent assurance engagement in respect of South London and Maudsley NHS Foundation Trust’s quality report for the year ended 31 March 2016 (the ‘Quality Report’) and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of South London and Maudsley NHS Foundation Trust as a body, to assist the council of governors in reporting South London and Maudsley NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and South London and Maudsley NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Home Treatment Teams (Gateway); and
- Delayed Transfer of Care (DTOC)

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the ‘NHS foundation trust annual reporting manual’ issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’ and the six dimensions of data quality set out in the ‘Detailed guidance for external assurance on quality reports’.

We read the quality report and consider whether it addresses the content requirements of the ‘NHS foundation trust annual reporting manual, and consider the implications for our report if we become aware of any material omissions.
We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from the Commissioners dated May 2017;
- feedback from the governors dated May 2017;
- feedback from local Healthwatch organisations, dated May 2017;
- the trust’s complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, Quarters 1, 2, 3 and 4 2016/2017;
- The 2016 national patient survey;
- The 2016 national staff survey;
- The CQC quality and risk profiles published throughout the year; and
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated May 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’).

**Our limited assurance procedures included:**

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the ‘NHS foundation trust annual reporting manual’ to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the ‘NHS foundation trust annual reporting manual’.
The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’;
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’.

Deloitte LLP
Chartered Accountants
St. Albans
30 May 2017
# Glossary

| **Acute Out of Area Treatments (OATs)** | An Acute Out of Area admission is when a service user is admitted to an Acute inpatient ward which is located outside of the funding CCG’s (See Clinical Commissioning Group entry) area. |
| **Adult Mental Health Model (AMH)** | The Adult Mental Health Model (AMH) is the model used within SLaM to treat people with mental illness, the model focuses on preventing illness and taking a holistic approach to treatment i.e. physical, social and mental health care. |
| **Biomedical Research Centre (BRC)** | The Biomedical Research Centre (BRC) is a research centre formed by the National Institute for Health Research (NIHR) (see National Institute for Health Research entry). The Maudsley BRC is in partnership with SLaM, the Institute of Psychiatry, Psychology and Neuroscience at King’s College London. The BRC has a number of research themes including Bioinformatics and statistics. |
| **Care Programme Approach (CPA)** | The Care Programme Approach (CPA) is a type of support that a person might receive or be offered if they have mental health problems or complex needs. The Care Programme Approach is inclusive of: an assessment of needs, a care plan, regular review of your needs and the care plan and a Care Co-ordinator. |
| **Care Quality Commission (CQC)** | The Care Quality Commission (CQC) is a health and adult social care regulator in England. The CQC inspects services based on five Key Lines of Enquiry, these are: safety, effectiveness, caring, responsiveness and well-led. |
| **CareCERTassure** | Cyber security programme led by NHS Digital to improve cyber defences in line with Cyber Essentials Plus scheme. SLaM is an early adopter. |
| **Chief Clinical Information Officer (CCIO)** | Deputy Medical Director for Information |
| **Clinical Academic Group (CAG)** | SLaM is divided into “Clinical Academic Groups”. Services fall into particular CAGs depending on who they treat and what treatment they provide. **The Trust’s CAGs are as follows:**  
**Acute:** provides care to people who experience a mental health crisis and need to be home treated or on occasion admitted to hospital.  
**Addictions:** provides community services to adults with drug and alcohol disorders.  
**Behavioural and Developmental Psychiatry (BPAD):** Provides Forensic and neurodevelopmental services to adults.  
**Child and Adolescent Mental Health Services (CAMHS):** Provides a range of mental health services for children and young people.  
**Mental Health for Older Adults (MHOA):** Provides services to those either: over the age of 65 with dementia or severe and complex mental health needs or under the age of 65 who develop dementia  
**Psychological Medicine and Integrated Care (Psych Med):** Provides clinical care across mental and physical health through the General Hospital Liaison services with four acute hospitals. Psych Med also provides specialist services i.e. Mother and Baby, Eating Disorders Service, Chronic Fatigue, Neuropsychiatry, and Psychosexual Conditions.  
**Psychosis:** Provides early intervention services, acute inpatient services, community services promoting recovery, and a range of rehabilitation services as well as two national specialist services. |
**Clinical Commissioning Groups (CCG)/Commissioner**
A Clinical Commissioning Groups (CCG) (also known as Commissioners) “are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.” (About CCGs, NHS Clinical Commissioners). SLaM is commissioned by Croydon, Lambeth, Lewisham and Southwark CCG.

**Control Objectives for Information and Related Technologies (CoBIT)**
IT governance and management framework which covers risk management, assurance and audit, data security, governance and governance

**Commissioning for Quality and Innovation (CQUIN)**
Commissioning for Quality and Innovation (CQUIN) is a payment framework whereby quality improvement goals are linked to financial reward.

**Datix**
Datix is the incident reporting system which SLaM uses for the recording of incidents and complaints.

**Deprivation of Liberty Safeguards (DoLS)**
The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person’s best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.

**Electronic Observation Solution (eOBS)**
Electronic Observations Solution is the digitalisation of patient observations (vital signs) also known as early warning signs (MEWS) as opposed to the use of paper MEWS Charts.

**Electronic Patient Journey System (ePJS)**
ePJS is the electronic system that SLaM uses to document patient notes.

**Health and Social Care Information Centre (HSCIC)**
The Health and Social Care Information Centre (HSCIC) is a public body which produces national data for health and social care with the aim of improving care. The HSCIC is sponsored by the Department of Health.

**Health Service Journal (HSJ)**
The Health Service Journal (HSJ) is a website and serial publication which covers topics relating to the National Health Service and Healthcare.

**Healthcare Quality Improvement Partnership (HQIP)**
The Healthcare Quality Improvement Partnership (HQIP) is an independent organisation which aims to promote quality in healthcare and increase the impact of clinical audit (see Audit entry). HQIP is led by the Academy of Medical Royal Colleges (see Academy of Medical Royal Colleges entry), The Royal College of Nursing (see Royal College of Nursing entry) and National Voices (see National Voices entry).

**Hospital Episode Statistics (HES)**
Hospital Episode Statistics is a data repository held by the Health and Social Care Information Centre (see Health and Social Care Information Centre entry) which stores information on hospital episodes i.e. admissions for all NHS trusts in England.

**Local Care Record (LCR)**
An secure integrated portal between SLaM, GSTT, KCH and 90+ GP practices in Southwark and Lambeth electronic health records, which provides instant real-time access to health records to care professionals during direct care.

**Mental Capacity Act (MCA)**
The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

**Mental Health Services Data Set (MHSDS)**
The Mental Health Services Data Set (MHSDS) is a data set held by the Health and Social Care Information Centre (see Health and Social Care Information Centre entry) which contains care data relating to the people who use mental health services. It is mandatory for NHS Trusts to submit data to the MHSDS.
<table>
<thead>
<tr>
<th><strong>National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)</strong></th>
<th>NCISH is a National Confidential Inquiry into Suicide and Homicide by People with Mental Illness which collected suicide data in the UK from 2003-2013 (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester). It is commissioned by the Healthcare Quality Improvement Partnership (see Healthcare Quality Improvement Partnership entry).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Health Service England (NHSE)</strong></td>
<td>National Health Service England (NHSE) is a body of the Department of Health (see Department of Health entry) which leads and commissions NHS services in England.</td>
</tr>
<tr>
<td><strong>National Institute for Health Research (NIHR)</strong></td>
<td>The National Institute for Health Research (NIHR) is the body which oversees research in the NHS.</td>
</tr>
<tr>
<td><strong>National Reporting and Learning Service (NRLS)</strong></td>
<td>The National Reporting and Learning Service (NRLS) is a system which enables patient safety incident reports to be submitted to a national database which is designed to promote understanding and learning.</td>
</tr>
<tr>
<td><strong>Quality Sub Committee (QSC)</strong></td>
<td>The Quality Sub Committee is the Committee within SLaM which is responsible for the monitoring of serious incidents and complaints, clinical governance. Other Trust Committees such report to the Quality Sub Committee.</td>
</tr>
<tr>
<td><strong>Patient Led Assessment of Care Environment (PLACE)</strong></td>
<td>Patient Led Assessment of Care Environment (PLACE) assessments are annual assessments of hospital environments which evaluate: cleanliness, food and hydration, privacy, dignity and wellbeing, condition, appearance and maintenance and dementia.</td>
</tr>
<tr>
<td><strong>Prescribing Observatory for Mental Health-UK (POMH-UK Audits)</strong></td>
<td>The Prescribing Observatory for Mental Health UK audits are National Clinical Audits (see National Clinical Audit entry) which assess the practice of prescribing medications within mental health services in the United Kingdom.</td>
</tr>
<tr>
<td><strong>Safecare (HealthRoster) E-roster</strong></td>
<td>Safecare HealthRoster also known within SLaM as e-roster is the e-rostering system designed by Allocate Software (see Allocate Software entry) and used within SLaM to complete shift rostering and record sickness, absence and competencies for all staff.</td>
</tr>
</tbody>
</table>
Independent auditor’s report to the board of directors of South London and Maudsley NHS Foundation Trust

Opinion on financial statements of South London and Maudsley NHS Foundation Trust

In our opinion the financial statements:

- give a true and fair view of the state of the Group and Trust’s affairs as at 31 March 2017 and of the Group and Trust’s income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement - Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The financial statements that we have audited comprise:

- the Group and Trust Statements of Comprehensive Income;
- the Group and Trust Statements of Financial Position;
- the Group and Trust Statements of Cash Flows;
- the Group and Trust Statements of Changes in Equity; and
- the related notes 1 to 29.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement - Independent Regulator of NHS Foundation Trusts.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Summary of our audit approach

<table>
<thead>
<tr>
<th>Key Risks</th>
<th>The key risks that we identified in the current year were:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- NHS revenue and provisions; and</td>
</tr>
<tr>
<td></td>
<td>- Valuation of properties, including investment properties.</td>
</tr>
<tr>
<td></td>
<td>These risks are the same as those reported last year.</td>
</tr>
</tbody>
</table>

| Materiality        | The materiality that we used in the current year was £7.5m which was determined on the basis of 1.9% of revenue. |

| Scoping            | Our group audit was scoped by obtaining an understanding of the Group and its environment, including internal controls, and assessing the risks of material misstatement at the Group level. The focus of our audit work was on the Trust, with work performed at the Trust’s head offices directly by the audit engagement team, led by the audit partner. The Trust’s principal subsidiary, the Maudsley Charity, was also subject to a full audit. |

| Significant changes in approach | There were no significant changes in our approach. |
## Going concern

We have reviewed the Accounting Officer’s statement in the Performance Report that the Group is a going concern.

**We confirm that:**

- we have concluded that the Accounting Officer’s use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified any material uncertainties that may cast significant doubt on the Group’s ability to continue as a going concern.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Group’s ability to continue as a going concern.

## Independence

We are required to comply with the Code of Audit Practice and Financial Reporting Council’s Ethical Standards for Auditors, and confirm that we are independent of the group and we have fulfilled our other ethical responsibilities in accordance with those standards.

We confirm that we are independent of the group and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.
Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

### NHS revenue and provisions

<table>
<thead>
<tr>
<th>Risk description</th>
<th>How the scope of our audit responded to the risk</th>
<th>Key observations</th>
</tr>
</thead>
</table>
| As described in note 1Accounting Policies, there are significant judgements in recognition of revenue from care of NHS service users and in provisioning for disputes with commissioners due to:  
   - the judgements taken in evaluating NHS revenue that has been recognised in the year but that is yet to be settled by commissioners, including contract variations, risk share payments, Commissioning for Quality and Innovation (CQUIN) income and income which is activity based or otherwise based on outturn; and  
   - the judgemental nature of provisions for disputes on this income.  
Details of the Group's income, including £321m of income from healthcare activities, are shown in note 3.1 to the financial statements. NHS debtors are shown in note 16 to the financial statements.  
The majority of the Group's income comes from 4 key commissioners, increasing the significance of associated judgements.  
We evaluated the design and implementation of controls over recognition of activity based income, with IT specialists performing the testing of the systems controls.  
We tested the recognition of income through the year. We tested unsettled NHS debt at year-end and inspected evidence to support the validity and accuracy of the unsettled amounts. We assessed the assumptions ions made in respect of achievement of CQUIN targets and STF funding and evaluated the results of the agreement of balances exercise.  
We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.  
We did not identify any material misstatements through our procedures in respect of this risk, and we considered the estimates made by the Trust to be within an acceptable range. |                                                                                                                                                                                                                                                                                                                                                                                                   |
## Property valuations

<table>
<thead>
<tr>
<th>Risk description</th>
<th>The Group holds property assets within Property, Plant and Equipment at a valuation of £213m and Investment Properties at a value of £73m. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. The net valuation losses and impairment charges on the Group’s operational estate shown in note 11 is an impairment of £8.2m and net gain on investment properties shown in Note 12 is f0.5m.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How the scope of our audit responded to the risk</td>
<td>We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Group to the valuer. We used Deloitte internal valuation specialists to review the appropriateness of the key assumptions used in the valuation of the Group’s properties. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.</td>
</tr>
<tr>
<td>Key observations</td>
<td>We did not identify any material misstatements through our procedures in respect of this risk, and we considered the estimates made by the Trust to be within an acceptable range.</td>
</tr>
</tbody>
</table>

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

<table>
<thead>
<tr>
<th>Group Materiality</th>
<th>£7.5m (2016: £6.0m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basis for determining Materiality</td>
<td>1.9% of revenue (2016: 1.6% of revenue)</td>
</tr>
<tr>
<td>We reassessed the percentage used in the context of our cumulative knowledge and understanding the audit risks at the Trust and our assessment of those risks for this year.</td>
<td></td>
</tr>
<tr>
<td>Rationale for the benchmark applied</td>
<td>Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.</td>
</tr>
</tbody>
</table>

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £250,000 (2016: £250,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the Group and its environment, including internal controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust, with work performed at the Trust’s head offices directly by the audit engagement team, led by the audit partner.

The Trust’s principal subsidiary, the Maudsley Charity, was also subject to a full audit, where the extent of our testing was based on our assessment of the risks of material misstatement and the materiality of the Charity to the Group. This component was not audited by the group engagement team. We issued instructions to the component audit team, including detailed instructions relating to the performance of testing of the Charity’s investments and reviewed documentation of the planning and findings from their work and held discussions with the team. We used our property valuation specialist directly to assess the approach and key assumptions used in the valuation of investment properties held by the Charity.

The remaining two components, which are both subsidiaries of the Charity, represent less than 1% of the group’s net assets and revenue (year ended 31 March 2016- less than 1%) and are therefore not subject to audit or subject to audit of specified account balances. Our audit work at the Trust and the Maudsley Charity was executed at levels of materiality applicable to each individual entity which were lower than group materiality and were £6.4 million and £3.7 million respectively (year ended 31 March 2016- £5.1 million and £3.0 million, respectively).

At the Group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit or subject to audit of specified account balances.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors’ Remuneration Report and Staff Report to be audited has been properly prepared in accordance with the National Health Service Act 2006, and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.
## Matters on which we are required to report by exception

### Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

### Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

### Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors’ statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

We confirm that we have not identified any such inconsistencies or misleading statements.
Respective responsibilities of Accounting Officer and auditor

As explained more fully in the Accounting Officer’s Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

This report is made solely to the Board of Governors and Board of Directors (“the Boards”) of South London and Maudsley NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Board as a body, for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Group’s and the Trust’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Susan Barratt BA ACA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans, United Kingdom
30 May 2017
Annex 2

Summary financial statements for the year ended 31 March 2017
Summary financial accounts for the year ended
31 March 2017

Foreword to the accounts
These accounts, for the year ending 31 March 2017, have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Dr Matthew Patrick
Chief Executive
South London and Maudsley NHS Foundation Trust
30 May 2017
### Statement of comprehensive income
For the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating income</strong></td>
<td>385,672</td>
<td>369,572</td>
<td>386,996</td>
<td>370,694</td>
</tr>
<tr>
<td><strong>Operating expenses</strong></td>
<td>(383,163)</td>
<td>(399,621)</td>
<td>(380,631)</td>
<td>(395,205)</td>
</tr>
<tr>
<td><strong>Operating surplus (deficit)</strong></td>
<td>2,509</td>
<td>(30,049)</td>
<td>6,365</td>
<td>(24,511)</td>
</tr>
<tr>
<td><strong>Gain (loss) on disposal of assets</strong></td>
<td>3,209</td>
<td>(5)</td>
<td>3,209</td>
<td>(5)</td>
</tr>
<tr>
<td><strong>Finance costs</strong></td>
<td>(9)</td>
<td>(52)</td>
<td>(9)</td>
<td>(52)</td>
</tr>
<tr>
<td><strong>Finance income</strong></td>
<td>3,365</td>
<td>3,136</td>
<td>88</td>
<td>152</td>
</tr>
<tr>
<td><strong>Public Dividend Capital dividend</strong></td>
<td>(6,030)</td>
<td>(6,881)</td>
<td>(6,030)</td>
<td>(6,881)</td>
</tr>
<tr>
<td><strong>Movement in fair value of investments</strong></td>
<td>10,282</td>
<td>4,382</td>
<td>159</td>
<td>357</td>
</tr>
<tr>
<td><strong>Surplus (deficit) for the year</strong></td>
<td>13,326</td>
<td>(29,469)</td>
<td>3,782</td>
<td>(30,940)</td>
</tr>
</tbody>
</table>

**Other comprehensive income Will not be reclassified to income and expenditure:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revaluation loss on plant, property and equipment</strong></td>
<td>(10,717)</td>
<td>(39,023)</td>
<td>(10,717)</td>
<td>(39,023)</td>
</tr>
<tr>
<td><strong>Revaluation gains on plant, property and equipment</strong></td>
<td>6,510</td>
<td>-</td>
<td>6,510</td>
<td>-</td>
</tr>
<tr>
<td><strong>Other movements</strong></td>
<td>(215)</td>
<td>(141)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total comprehensive income (expense) for the financial year</strong></td>
<td>8,904</td>
<td>(68,633)</td>
<td>(425)</td>
<td>(69,963)</td>
</tr>
</tbody>
</table>
## Statement of financial position
For the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th>Group 31 Mar 17</th>
<th>Group 31 Mar 16</th>
<th>Trust 31 Mar 17</th>
<th>Trust 31 Mar 16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>280</td>
<td>276</td>
<td>280</td>
<td>276</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>226,026</td>
<td>231,965</td>
<td>224,401</td>
<td>230,164</td>
</tr>
<tr>
<td>Investments</td>
<td>140,710</td>
<td>131,081</td>
<td>5,497</td>
<td>5,338</td>
</tr>
<tr>
<td>Financial assets</td>
<td>100</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other assets</td>
<td>237</td>
<td>238</td>
<td>237</td>
<td>238</td>
</tr>
<tr>
<td></td>
<td>367,353</td>
<td>363,560</td>
<td>230,415</td>
<td>236,016</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>363</td>
<td>322</td>
<td>363</td>
<td>322</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>21,051</td>
<td>14,259</td>
<td>21,176</td>
<td>14,040</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>57,290</td>
<td>57,780</td>
<td>55,095</td>
<td>56,652</td>
</tr>
<tr>
<td></td>
<td>78,704</td>
<td>72,361</td>
<td>76,634</td>
<td>71,014</td>
</tr>
<tr>
<td>Asset classified as held for sale</td>
<td>-</td>
<td>400</td>
<td>-</td>
<td>400</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>446,057</td>
<td>436,321</td>
<td>307,049</td>
<td>307,430</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>50,337</td>
<td>50,443</td>
<td>48,761</td>
<td>49,361</td>
</tr>
<tr>
<td>Borrowings</td>
<td>147</td>
<td>-</td>
<td>147</td>
<td>-</td>
</tr>
<tr>
<td>Provisions</td>
<td>3,232</td>
<td>3,238</td>
<td>3,232</td>
<td>3,238</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>5,650</td>
<td>5,690</td>
<td>5,019</td>
<td>5,353</td>
</tr>
<tr>
<td></td>
<td>59,366</td>
<td>59,371</td>
<td>57,159</td>
<td>57,952</td>
</tr>
<tr>
<td><strong>Total Assets less Current Liabilities</strong></td>
<td>386,691</td>
<td>376,950</td>
<td>249,890</td>
<td>249,478</td>
</tr>
<tr>
<td><strong>Non-Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borrowings</td>
<td>147</td>
<td>-</td>
<td>147</td>
<td>-</td>
</tr>
<tr>
<td>Provisions</td>
<td>6,778</td>
<td>6,349</td>
<td>6,778</td>
<td>6,349</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>379,766</td>
<td>370,601</td>
<td>242,965</td>
<td>243,129</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>183,041</td>
<td>182,602</td>
<td>183,041</td>
<td>182,780</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>83,917</td>
<td>88,378</td>
<td>83,917</td>
<td>88,378</td>
</tr>
<tr>
<td>Retained (deficit) earnings</td>
<td>(23,993)</td>
<td>(28,029)</td>
<td>(23,993)</td>
<td>(28,029)</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity</strong></td>
<td>242,965</td>
<td>243,129</td>
<td>242,965</td>
<td>243,129</td>
</tr>
<tr>
<td>Charitable Funds</td>
<td>136,801</td>
<td>127,472</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity and charitable funds</strong></td>
<td>379,766</td>
<td>370,601</td>
<td>242,965</td>
<td>243,129</td>
</tr>
</tbody>
</table>
Statement of changes in taxpayers’ equity
For the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th>Public dividend capital £ 000’s</th>
<th>Revaluation reserve £ 000’s</th>
<th>Income and expenditure reserve £ 000’s</th>
<th>Charitable Funds £ 000’s</th>
<th>Total £ 000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group At 1 April 2015</strong></td>
<td>182,602</td>
<td>127,401</td>
<td>2,911</td>
<td>126,142</td>
<td>439,056</td>
</tr>
<tr>
<td>Total comprehensive income for the year;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Deficit) Surplus for the year</td>
<td>-</td>
<td>-</td>
<td>(30,940)</td>
<td>1,471</td>
<td>(29,469)</td>
</tr>
<tr>
<td>Deficit on other revaluations</td>
<td>-</td>
<td>(39,023)</td>
<td>-</td>
<td>-</td>
<td>(39,023)</td>
</tr>
<tr>
<td>Other movements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(141)</td>
<td>(141)</td>
</tr>
<tr>
<td>PDC received during year</td>
<td>178</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>178</td>
</tr>
<tr>
<td><strong>At 31 March 2015</strong></td>
<td>182,780</td>
<td>88,378</td>
<td>(28,029)</td>
<td>127,472</td>
<td>370,601</td>
</tr>
<tr>
<td><strong>Group At 1 April 2016</strong></td>
<td>182,780</td>
<td>88,378</td>
<td>(28,029)</td>
<td>127,472</td>
<td>370,601</td>
</tr>
<tr>
<td>Total comprehensive income for the year;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus for the year</td>
<td>-</td>
<td>-</td>
<td>3,782</td>
<td>9,544</td>
<td>13,326</td>
</tr>
<tr>
<td>Revaluation losses</td>
<td>-</td>
<td>(10,717)</td>
<td>-</td>
<td>-</td>
<td>(10,717)</td>
</tr>
<tr>
<td>Revaluation gains</td>
<td>-</td>
<td>6,510</td>
<td>-</td>
<td>-</td>
<td>6,510</td>
</tr>
<tr>
<td>Realised gains</td>
<td>-</td>
<td>(254)</td>
<td>254</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other movements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(215)</td>
<td>(215)</td>
</tr>
<tr>
<td>PDC received during year</td>
<td>261</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>261</td>
</tr>
<tr>
<td><strong>At 31 March 2017</strong></td>
<td>183,041</td>
<td>83,917</td>
<td>(23,993)</td>
<td>136,801</td>
<td>379,766</td>
</tr>
<tr>
<td><strong>Trust At 1 April 2015</strong></td>
<td>182,602</td>
<td>127,401</td>
<td>2,911</td>
<td>-</td>
<td>312,914</td>
</tr>
<tr>
<td>Total comprehensive income for the year;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Deficit) Surplus for the year</td>
<td>-</td>
<td>-</td>
<td>(30,940)</td>
<td>-</td>
<td>(30,940)</td>
</tr>
<tr>
<td>Deficit on other revaluations</td>
<td>-</td>
<td>(39,023)</td>
<td>-</td>
<td>-</td>
<td>(39,023)</td>
</tr>
<tr>
<td>PDC received during year</td>
<td>178</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>178</td>
</tr>
<tr>
<td><strong>At 31 March 2015</strong></td>
<td>182,780</td>
<td>88,378</td>
<td>(28,029)</td>
<td>-</td>
<td>243,129</td>
</tr>
<tr>
<td><strong>Trust At 1 April 2016</strong></td>
<td>182,780</td>
<td>88,378</td>
<td>(28,029)</td>
<td>-</td>
<td>243,129</td>
</tr>
<tr>
<td>Total comprehensive income for the year;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus for the year</td>
<td>-</td>
<td>-</td>
<td>3,782</td>
<td>-</td>
<td>3,782</td>
</tr>
<tr>
<td>Revaluation losses</td>
<td>-</td>
<td>(10,717)</td>
<td>-</td>
<td>-</td>
<td>(10,717)</td>
</tr>
<tr>
<td>Revaluation gains</td>
<td>-</td>
<td>6,510</td>
<td>-</td>
<td>-</td>
<td>6,510</td>
</tr>
<tr>
<td>Realised gains</td>
<td>-</td>
<td>(254)</td>
<td>254</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>PDC received during year</td>
<td>261</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>261</td>
</tr>
<tr>
<td><strong>At 31 March 2017</strong></td>
<td>183,041</td>
<td>83,917</td>
<td>(23,993)</td>
<td>-</td>
<td>242,965</td>
</tr>
</tbody>
</table>
### Consolidated statement of cash flows
For the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net cash generated from operating activities</strong></td>
<td>10,258</td>
<td>4,811</td>
<td>13,117</td>
<td>10,002</td>
</tr>
<tr>
<td><strong>Cash flows from investing activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>3,365</td>
<td>3,136</td>
<td>88</td>
<td>152</td>
</tr>
<tr>
<td>Purchases of intangible fixed assets</td>
<td>(111)</td>
<td>(79)</td>
<td>(111)</td>
<td>(79)</td>
</tr>
<tr>
<td>Purchases of property, plant and equipment</td>
<td>(14,745)</td>
<td>(15,458)</td>
<td>(14,741)</td>
<td>(15,456)</td>
</tr>
<tr>
<td>Proceeds from disposals of property, plant and equipment</td>
<td>4,564</td>
<td>(5)</td>
<td>4,564</td>
<td>(5)</td>
</tr>
<tr>
<td>Purchase of financial assets</td>
<td>(9,349)</td>
<td>(16,420)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sale of financial assets</td>
<td>10,002</td>
<td>18,450</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash (generated) used in investing activities</strong></td>
<td>(6,274)</td>
<td>(10,376)</td>
<td>(10,200)</td>
<td>(15,388)</td>
</tr>
<tr>
<td><strong>Cash flows from financing activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Dividend Capital received</td>
<td>261</td>
<td>178</td>
<td>261</td>
<td>178</td>
</tr>
<tr>
<td>Loans received</td>
<td>441</td>
<td>-</td>
<td>441</td>
<td>-</td>
</tr>
<tr>
<td>Loans repaid</td>
<td>(147)</td>
<td>-</td>
<td>(147)</td>
<td>-</td>
</tr>
<tr>
<td>Public Dividend Capital dividend paid</td>
<td>(5,029)</td>
<td>(7,732)</td>
<td>(5,029)</td>
<td>(7,732)</td>
</tr>
<tr>
<td><strong>Net cash used in financing activities</strong></td>
<td>(4,474)</td>
<td>(7,554)</td>
<td>(4,474)</td>
<td>(7,554)</td>
</tr>
<tr>
<td>(Decrease) Increase in cash and cash equivalents during the year</td>
<td>(490)</td>
<td>(13,119)</td>
<td>(1,557)</td>
<td>(12,940)</td>
</tr>
<tr>
<td>Cash and cash equivalents at 1 April</td>
<td>57,780</td>
<td>70,899</td>
<td>56,652</td>
<td>69,592</td>
</tr>
<tr>
<td>Cash and cash equivalents at 31 March</td>
<td>57,290</td>
<td>57,780</td>
<td>55,095</td>
<td>56,652</td>
</tr>
</tbody>
</table>

Signed on behalf of the Board

**Dr Matthew Patrick**  
Chief Executive  
South London and Maudsley NHS Foundation Trust  
30 May 2017
Registered address
Bethlem Royal Hospital, Monks Orchard Road, Beckenham BR3 3BX

Contact details
Switchboard: 020 3228 6000
Patient Advice and Liaison (PALS): 0800 731 2864
email: pals@slam.nhs.uk

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email: membership@slam.nhs.uk

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www.slam.nhs.uk

Twitter: @MaudsleyNHS
Facebook: www.facebook.com/slamnhs
YouTube: www.youtube.com/slamnhsft

King's Health Partners
Academic Health Sciences Centre: www.kingshealthpartners.org

Quality Report
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Please contact us if you would like a copy in large print, audio, braille or translated into another language.
Tel: 020 3228 2830
email: communications@slam.nhs.uk