South London and Maudsley NHS Foundation Trust

# Annual Report and Accounts 2018/2019

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Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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# Chapter 1. Performance report

# 1.1 Overview of performance

### Joint foreword from the Interim Chair and Chief Executive

The major focus of our work over the past year has been to further improve the quality of the care we provide to our service users, the primary ambition set out in the Trust's strategy, Changing Lives.

Our Quality Improvement QI programme has supported staff to make improvements to a number of important areas. We have continued to redesign our organisation, aligning ourselves more closely to our local boroughs. We have improved our governance structures and our use of data. And we have reduced the prevalence of restraint across the organisation.

Our Multi-Agency Discharge Event (MADE) partnership events have helped to improve the flow of people through our care pathways and the number of occasions when no bed is available for people when they need it most.

The Care Quality Commission's (CQC) inspection in July 2018 highlighted the areas of concern that we were already aware needed considerable support and attention. Thanks to the hard work and commitment of our staff, the CQC found these areas much improved at their recent visit in April 2019 and the improvement notice previously in place was not renewed.

We are proud of the numerous areas in which the CQC identified not only good, but also outstanding, practice across the Trust. The organisation was rated 'good' overall and either 'good' or 'outstanding' for every single pathway in the 'caring' domain. Inspectors recognised our skilled and 'high calibre' board and noted the high-quality role of our Governors. We are hopeful for more good news once the CQC publish our refreshed ratings in summer 2019.

From a financial perspective, the Trust has performed well, meeting its control total. We are extremely grateful to our local Clinical Commissioning Groups (CCGs) for their support in the recent contracting round, recognising the parity between physical and mental health and the need for additional resources.

The 6.6 per cent uplift we received in our CCG contracts for the coming financial year will enable us to invest in improving services and work towards delivering the quality and performance standards set out in the 5 Year Forward View. We intend to make this new investment count by carefully manage our existing resources to ensure that we deliver real value – better outcomes for every pound we have to spend – for the people we serve.

We are committed to working with our partners to commission and deliver integrated health and social care at a neighbourhood and community level and we have progressed the development of our two alliance contracts, the Lambeth Living Well Network Alliance and Partnership Southwark.

As part of the Lambeth Alliance we are formal partners with Certitude, Lambeth Clinical Commissioning Group, Lambeth Council and Thames Reach. A key member of Partnership Southwark, we work alongside local GP federations and elements of Guy's and St Thomas' community services. We are continuing to work with partners to develop other population-scale contracts across both Lewisham and Croydon.

Our work as part of the South London Mental Health and Community Partnership goes from strength to strength, with two strong new models of care and many other developments, including those within our nursing workforce. A particular highlight was excellent news that the average distance from home for children using our Tier Four service is now seven miles, down from 73 miles when the work was started.

This will make a significant difference to the lives of the young people who use these services and their families.

We have played a strong and strategic role within two STPs, and our King's Health Partners' Mind and Body programme and Children and Young People's programme have both developed in strength and clarity.

We remain grateful for the contribution of the now independent Maudsley Charity, and our close partner the Institute of Psychology, Psychiatry and Neuroscience (IoPPN) for working with us to promote positive change in the world of mental health, develop research and service improvement, and raise public awareness and understanding.

Drawing on the wealth of expertise across the Trust and IoPPN, Maudsley Learning was launched in December. It aims to design and deliver high-quality education and courses to meet the training needs of healthcare professionals, as well as colleagues in social services, policing, schools and in the private sector.

Our NIHR Biomedical Research Centre (BRC) continues its important research into new tests, treatments and theories in mental health, neurology, and dementia. We were rated the top mental health trust in the country for the number of open studies with over 100 studies available for patients to participate in. This year also marked the tenth anniversary of the BRC's Clinical Research Interactive Search (CRIS) – it is now the most in-depth mental health resource in Europe, containing over 400,000 anonymised mental health records. Over 130 research papers have been published using data from the system

Alongside all of this work we continue to invest in the experiences of our BME workforce to ensure that our organisation a great place to work for everyone. This year, staff led and organised a number of events exploring experiences of our workforce in relation to diversity and inclusion. The Speaking Truth to Power event in December 2018 was a moving and impactful conference about the experiences of our BME staff. In January 2018 staff launched the Lived Experience Network – bringing together staff who have direct experience of mental health issues. Both events involved members of staff demonstrating considerable bravery by sharing their personal experiences.

The 70th birthday of the NHS was a chance for colleagues to come together and celebrate our remarkable workforce. The tea parties we held across the organisation served as a reminder of how proud we are to be part of such a remarkable organisation with fantastic staff who are so dedicated to the needs of our service users.

Another opportunity to recognise the tremendous contribution of our workforce was at the annual staff awards ceremony. The event, on 25 September 2018 was a celebration of the excellent work of our dedicated staff teams and individuals. We also continue to recognise the achievements of staff through our monthly 'SLaM STARS' awards.

Our staff continue to be award winning. We are very proud of the many individuals and teams who won external awards this year and to those recognised in the Queen's New Years Honours.

In January 2019, we launched our Changing Lives film at the Whirled Cinema. The film tells of how, every day, our staff support people to change their lives. The event was attended by the service users and their clinicians who star in the extraordinary and moving stories that are told in the film.

The theme of our annual Trust conference this year was 'Changing Lives – Building foundations for a brighter future'. Held on 28 March 2019, over 200 members of staff attended the event with service

users and key figures from our local communities. The day explored the importance of identifying and managing mental health issues at an early age to build resilience and give people the right tools to cope with the pressures of modern life.

The Council of Governors continues to support the organisation to meet the needs of patients and provides constructive challenge to the Board in line with its statutory duties.

Finally, there have been significant changes to our Trust Board membership. In January, Dr Matthew Patrick announced his intention to retire from his role as chief executive in July 2019. In his six-year tenure at the Trust, Matthew has made huge strides in system collaboration and partnership working in south London, delivering real improvements to the 1.3 million population we serve. David Bradley has been appointed as his successor. David has over 30 years' experience working within the NHS and is a highly experienced Chief Executive. We look forward to welcoming him soon.

We were also delighted to welcome Mary Foulkes OBE as our new Director of People and Organisational Development, a fantastic addition to our Board.

More recently, Roger Paffard announced that he would step down from his role as Chair on 30 April 2019, for health reasons. Roger joined the trust as Chair in January 2015. Under his guidance, the organisation has strengthened and deepened its partnership with local boroughs and communities. In all that he did, he championed our service users, their families and their carers and worked hard to improve the experience of our front-line staff.

We are confident that our strong executive leadership team, supported by non-executive Directors and governors will continue to deliver its vision to improve the lives of people living with mental illness and the experience of staff working in our organisation over the year-ahead.

**June Mulroy, Interim Chair**
South London and Maudsley NHS Foundation Trust

**Dr Matthew Patrick, Chief Executive Officer**
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

## 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 population 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.
We work with Oxleas NHS FT and St West London and St George's NHS Trust to collaborate to provide more sustainable healthcare in South London through the South London Mental Health and Community Partnership.

**Our year 2018-2019**

- Embedding our Nursing Development Programme and growing our community nursing workforce. Work this year includes developing a new BME Leadership Programme, an enhanced career pathway at Band 6 and above and more workplace opportunities at all levels for nursing staff across the three South London Mental Health and Community Partnership (SLP) trusts. Our work has been recognised by Nursing Times who gave the Programme an award for 'Best Workplace for Learning and Development'.
- Our Quality Improvement QI programme has supported staff to make improvements to a number of important areas such as reducing the prevalence of restraint, seclusion and fewer complaints across the organisation.
- Making a significant difference to the lives of families and young people who use our CAMHS Tier 4 services who previously, might have been placed outside south London. The average distance from home for children using our Tier Four service is now seven miles, down from 73 miles when the work was started.

- A successful flu vaccination campaign with almost 68% of our frontline staff getting a flu jab, protecting themselves, their patients and their families. This represents a 9 percent uptake and compares very favourably with other mental health trusts in London.
- Our staff continue to be award winning. We are very proud of the many individuals and teams who won external awards this year including, a BMJ award for 'Project of the Year' by Maudsley Simulation, Education Team; a Design in Mental Health Award for Eileen Skellern 1's sensory room. Director of the Psychological Interventions Clinic for Outpatients with Psychosis (PICuP) Dr Emmanuelle Peters, was awarded the British Psychological Society Award for Distinguished Contributions to Psychology in Practice. Community Development Services Manager for the Mental Health Promotion team, Juney Muhammad was shortlisted for a 'Lifetime Achiever', National Diversity Award.
- Our staff have also been recognised in the Queen's New Year's Honours – Lead Consultant Psychiatrist in specialist perinatal mental health services, Dr Trudi (Gertrude) Senevirante OBE and Consultant Psychiatrist in rehabilitation and Visiting Senior Clinical Lecturer at the King's College London's Institute of Psychiatry, Psychology and Neuroscience, Dr Sridevi Kalidindi CBE.
- A set of leaflets for children whose parents are admitted to a mental health ward have been developed thanks to staff from the Friends and Family Clinic at Nelson Ward, Lambeth Hospital, to support families. The leaflets are part of SLaM's Think Family initiative, which seeks to strengthen how we think about all our patients within their wider family networks, identifying a need to support those looking after the children of mothers admitted to the unit - often under traumatic circumstances for the child.
- Café Central, a project run together by service users and staff, was opened by SLaM Clinical Director and Professor of Forensic Mental Health, King's College London, Tom Fahy. The café project enables service users to get first-hand experience in a vocational setting, providing a commercially recognised environment for professional training and work experience.
- Young people who have been treated for OCD have featured in a film designed to raise awareness and provide hope for parents whose children have the debilitating condition. The film, called 'OCD is not me', was made in partnership with our Trust and OCD Action
- We were rated the top mental health trust in the country for the number of open studies with over 100 studies available for patients to participate in. This year also marked the tenth anniversary of the BRC's Clinical Research Interactive Search (CRIS) – it is now the most in-depth mental health resource in Europe, containing over 400,000 anonymised mental health records. Over 130 research papers have been published using data from the system
- From a financial perspective, the Trust has performed well, meeting its control total.
- We are investing in improving services and working towards delivering quality and performance standards set out in the Mental Health 5 Year Forward View, thanks to our work with commissioners in our four CCGs (clinical care groups). Commissioners in Croydon, Lambeth, Lewisham and Southwark have agreed a 6.6 per cent increase in the funding they give us to provide mental health services.
- Progress in improving Adult Forensic patient's experience and care outcomes
- We have progressed the development of our two alliance contracts, the Lambeth Living Well Network Alliance and Partnership Southwark.
- As part of the Lambeth Alliance we are formal partners with Certitude, Lambeth Clinical Commissioning Group, Lambeth Council and Thames Reach. A key member of

Partnership Southwark, we work alongside local GP federations and elements of Guy's and St Thomas' community services. We are continuing to work with partners to develop other population-scale contracts across both Lewisham and Croydon.

- Our Multi-Agency Discharge Event (MADE) partnership events have helped to improve the flow of people through our care pathways and the number of occasions when no bed is available for people when they need it most.
- Drawing on the wealth of expertise across the Trust and IoPPN, Maudsley Learning was launched in December 2018. It aims to design and deliver high-quality education and courses to meet the training needs of healthcare professionals, as well as colleagues in social services, policing, schools and in the private sector.

**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 Foundation 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.

South London and Maudsley NHS Foundation Trust, started joining together with South-West London and St George's NHS Trust and Oxleas NHS FT, to form the South London Mental Health and Community Partnership to spearhead a better mental health service across South London.

**2017**

The first out of seven mental health trusts in England to be awarded Global Digital Exemplar (GDE) status for the NHS in London, by NHS England, to help drive digital innovation for the rest of the NHS to learn from.

SLaM is using £5million funding to help ensure care is more personalised and responsive to patient needs and supporting the digital transformation of our services. For example, electronic observations, electronic prescribing, a Trust data Dashboard 'Deming' and an online Personal Health Record (PHR), Healthlocker.

**2018**

SLaM achieved an overall 'Good' rating from the Care Quality Commission (CQC) including for well-led and the Maudsley Charity became independent of the Trust.

**2019**

SLaM is celebrating its 20th birthday.

**Strategic overview of the Trust**

This section sets out a summary of the Trust's vision, strategic direction and priorities.

**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

**Changing Lives - Our strategy**

Our strategy is named *Changing Lives* because everything we do is to help people improve their lives. We know this is what matters to our service users, carers, families, local communities and our passionate staff.

Embedding our strategy is continuing during 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 the NHS long-term plan and 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).

To achieve this we are focusing on the quality of our services, but we are not doing this alone. We are working in partnership with people and communities, to make the trust a great place to work to attract and retain the very best people, maximise our ability to innovate, and deliver best value from all of our assets and resources.

As a large, diverse mental health trust providing local and national services, we aim to make a difference to lives by seeking excellence in <u>all</u> mental health and wellbeing: prevention, care, recovery, education and research.

Our *Changing Lives* strategy sets out five strategic aims to steer our work:

1. *Quality*: we will get the basics right in every contact and keep improving what matters to service users
2. *Partnership*: we will work together with service users, their support networks and whole populations to realise their potential
3. *A great place to work*: we will value, support and develop our managers and staff

4. *Innovation*: we will strive to be at the forefront of what is possible, exploiting our unique strengths in research and development, with everyone involved and learning
5. *Value*: we will make the best use of our assets, resources, relationships and reputation to support the best quality outcomes

**Changing Lives focus**

One fundamental shift that we have made is to change the relationship with service users, carers and families at all levels. We have already made strong progress but we need to support both professionals and service users to take different roles and approaches that will help people change their lives. Our well-established five commitments to build trusting, mutual relationships set us on good course for this.

The *Changing Lives* strategy builds on our direction of travel, evolving from our previous strategy, but with stronger emphasis on consistent quality, continuous improvement and partnership in its different forms. The strategy is aligned with a wide range of partners (Clinical Commissioning Groups, STPs, South London Partnership, Healthy London Partnership, the Maudsley Charity, King's College London's IoPPN) and will engage an increasingly wide range of partners such as schools, employers, voluntary sector, community and faith groups.

We will continue to evolve our strategy in light of views from stakeholders and as we review its delivery and impact.

**Future performance**

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

- NHS benchmarking data suggests that mental health community teams across the country have experienced around 20% cuts to their budgets as investment has been directed to support key improvement areas identified in the Mental Health 5 Year Forward View.

- In order to match the London Average community investment, SLaM requires a 17% increase in our total borough contract values. This 2019/20 contract settlement is a 6.6% (full year effect) with all CCG commissioners having met the Mental Health Investment Standard in line with the NHS Ten Year Plan. Even at this level of increased investment, however, it will still take us around 3 years to bridge the funding gap in community services.

- All four Borough leads are actively engaged with partners to improve community services, ranging from an active Alliance in Lambeth to early discussions in Croydon. A great deal of progress is expected in 2019/20 by the end of which it is anticipated that all four boroughs that SLaM works with, will be in some form of Alliance or local partnership to support a partnership approach to the development of community services

- 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 2019/20 is unchanged

from the previous year, the cumulative efficiency target over the last eight years is over 23%. Such levels of savings are an increasing challenge at a time when pressures on services continue to mount

- An additional 1.25% of the Trust's contractual income in 2019/20 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. The value of these payments for 2018/19, based on a higher value 2.5% CQUIN, was £4m.

- Our Addictions services will continue to operate in a competitive market, with Local Authority budgets under enormous pressure and services subject to regular review and tender processes.

- Linked to the NHS Ten Year Plan, the Trust is leading developments as part of the South London Partnership to put in place a delivery framework to meet objectives of the NHS Ten Year Plan. This includes a focus on delivery of ambitious IAPT, Dementia, Children and Young People (CYP) and Early intervention in Psychosis (EIP) targets across South London with standardised governance arrangements and common pathways based on learning from the SLaM Quality Centre.

- The Trust continues the focus on implementing its new Borough based structures within the context of Alliances and local partnerships. Clinical Academic Groups continue to focus on research, new care pathways and new models of care. This work has initially focussed on the acute care pathway and quality and patient flow improvements required to deliver the Trust ambition of 85% occupancy levels and a 32 day length of stay.

- A new Digital Strategy has been developed in 2018/19 for roll out in 2019/20. This will ensure that all staff from floor to Board will use data in a way that enables a review of performance trends to support improvements in both (1) the quality of services delivered to patients and their carers; and (2) the offer SLaM as an organisation makes to its employees to support recruitment and retention.

- 2018/19 and future years will see an increasing focus on the services accessed by children and young people to support delivery of the right care at the right time. Increased funding has been allocated to CAMHS services across the four boroughs SLaM leads on providing MH services in, and also via NHSE to support increased capacity levels for regional and national services the Trust delivers. With a SLaM Children's Centre development and the increased capacity this can bring, the Trust is well placed to deliver innovation and improved outcomes for all children and young people who need support.

**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 NHS Improvement Single Oversight Framework (SOF) sets out operational metrics for monitoring how performance is improved and sustained. 2018/19 performance is shown in the table below.

| | Operational performance metrics | Target | 18/19 |
|---|---|---|---|
| 1 | People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral | 50% | 76% |
| 2 | Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:<br>a) inpatient wards<br>b) early intervention in psychosis services<br>c) community mental health services (people on care programme approach) | 90% | 94.81% |
| 3 | Data Quality Maturity Index (DQMI) – MHSDS dataset score | 95% | 95.8% |
| 4 | Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery | 50% | 50.43% |
| 5 | Improving access to psychological therapies (IAPT): patients seen within 6 weeks of referral | 75% | 92.47% |
| 6 | Improving access to psychological therapies (IAPT): patients seen within 18 weeks of referral | 95% | 98.96% |
| 7 | Inappropriate out-of-area placements | Eliminate by 2021 | 17,998 |

**National standards performance 2018/19**

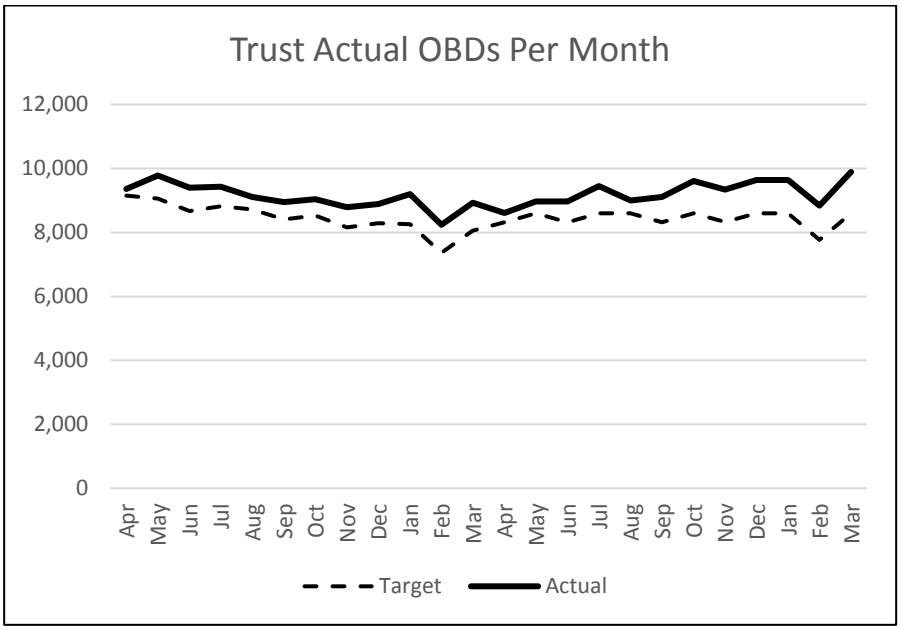
In Improving Access to Psychological Therapies (IAPT) waiting time performance (indicators 5 and 6), the Trust has consistently achieved all standards throughout 2018/19 across all four boroughs.

An area of concern last year has been the IAPT recovery rate (indicator 4) in one borough. In response to this, an action plan was drawn up in November 2017 and has been successful in meeting all standards this year.

The Trust has consistently exceeded the national standard in 2018/19 for Early Intervention in Psychosis (indicator 1). Caseloads across the teams have been increasing since the standard was introduced in April 2016 and the service continues to monitor the impact of this growth.

**Activity outturn in 2018/19**

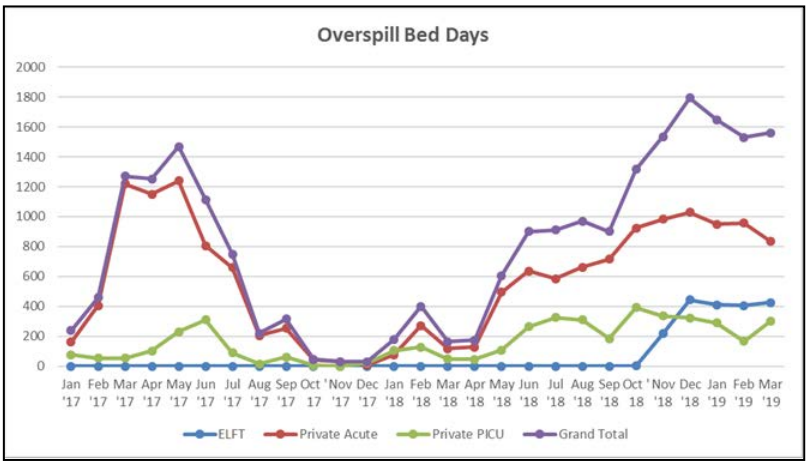
Activity for 2018/19 has been consistently above contracted bed usage throughout the financial year. As we are still above contracted levels, work is ongoing in all boroughs to reduce bed occupancy including focussed work on reviewing barriers to discharge, delayed transfers of care and length of stay.

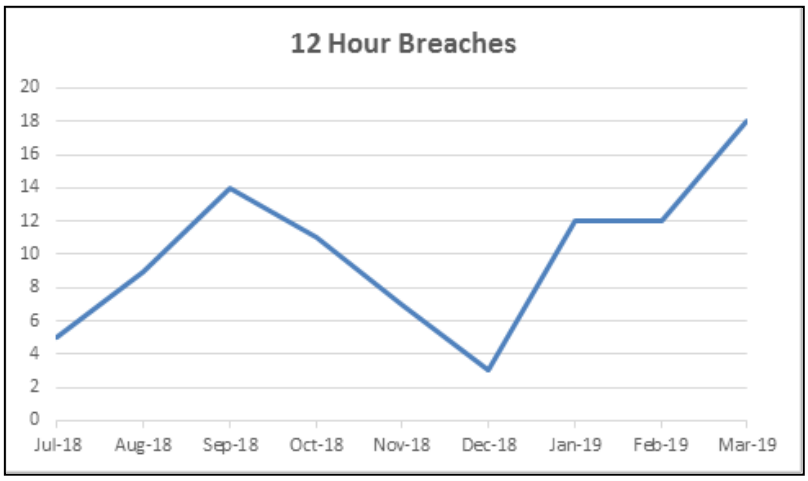


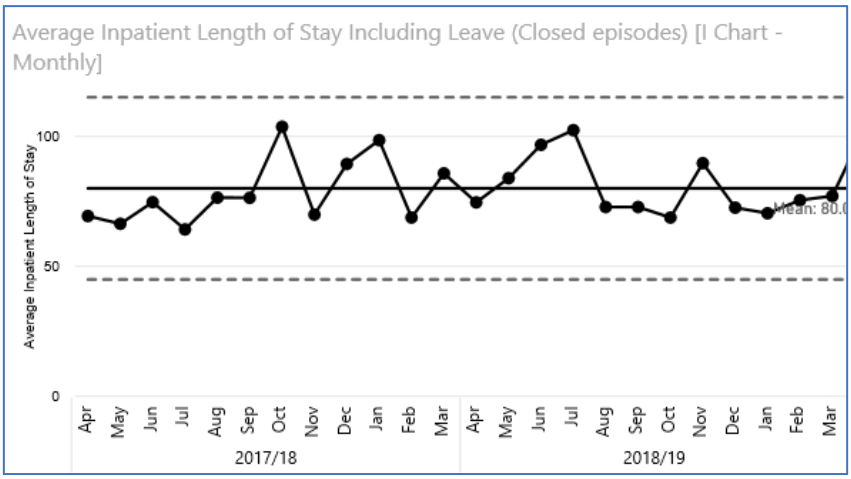

To deliver on OBD, length of stay targets and other key metrics for in-patient wards the Trust continues to implement its agreed Flow Plan. The end of 2018/19 saw an increase in mental health presentations in local ED departments with King's and Croydon University Hospital particularly challenged.

With Trust and private beds running at full capacity this additional demand has led to both a spike in 12 hour breaches and a continued heavy reliance on private bed capacity.

With the recent positive 2019/20 financial settlement, Community Transformation Plans are now being ramped up in each borough to deliver a reduction in demand for beds as more individuals are supported in a community setting. This aligns with Alliance and Partnership plans in each of our Boroughs. The link between an overall increase in ED presentations, including mental health presentations, and an increase in private overspill, 12 hour breaches and Place of Safety Breaches should be noted. Length of stay has remained static at a circa 50 day average reflecting that discharge patterns are also static (based on available services and alternative provision to discharge to).


Overspill Bed Days
2000
1800
1600
1400
1200
1000
800
600
400
200
0
Jan '17 Feb '17 Mar '17 Apr '17 May '17 Jun '17 Jul '17 Aug '17 Sep '17 Oct '17 Nov '17 Dec '17 Jan '18 Feb '18 Mar '18 Apr '18 May '18 Jun '18 Jul '18 Aug '18 Sep '18 Oct '18 Nov '18 Dec '18 Jan '19 Feb '19 Mar '19
ELFT
Private Acute
Private PICU
Grand Total


12 Hour Breaches
20
18
16
14
12
10
8
6
4
2
0
Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19


Average Inpatient Length of Stay Including Leave (Closed episodes) [I Chart - Monthly]
Average Inpatient Length of Stay
100
50
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2017/18
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2018/19

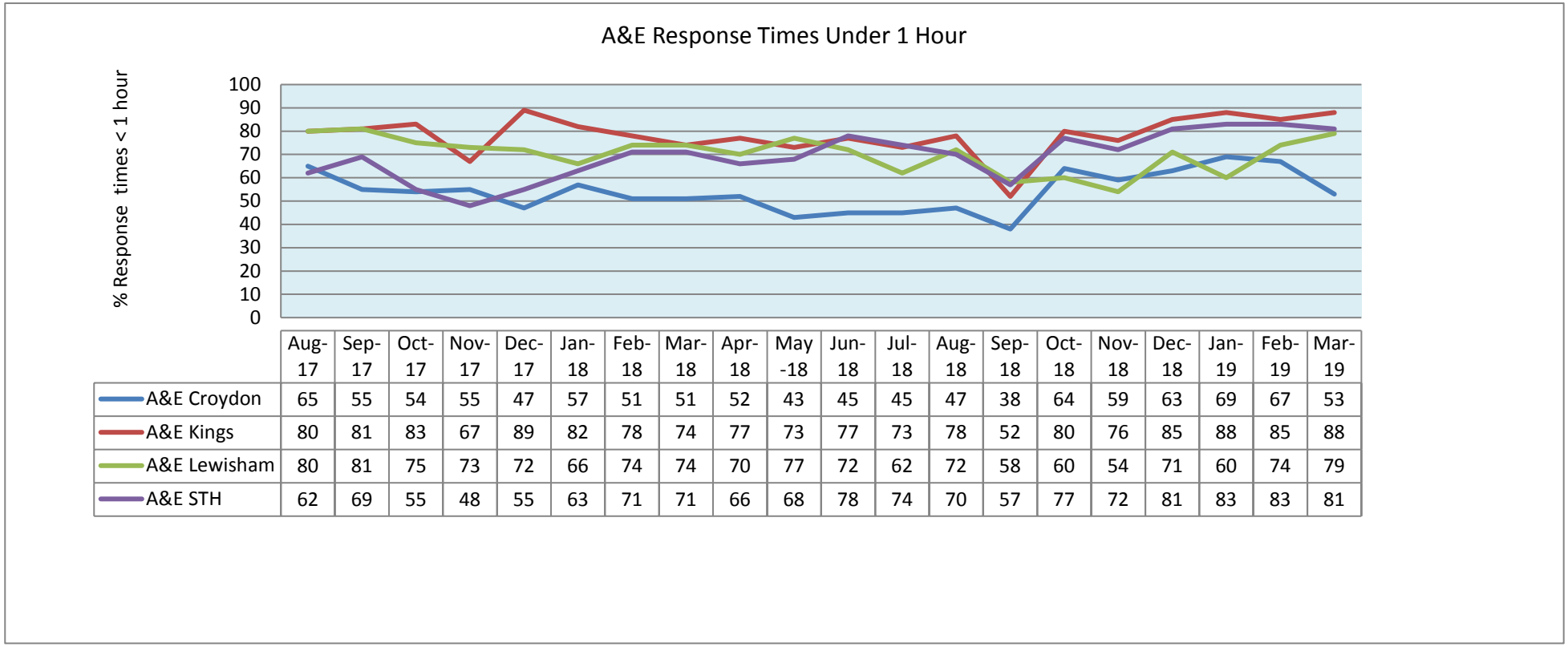
**Dementia Diagnosis**

Throughout 2018/19 the trust has consistently exceeded dementia diagnosis targets with an average of 73% diagnosed (Target = 67%).

| | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trajectory - diagnoses | 8580 | 8673 | 8689 | 8731 | 8742 | 8739 | 8769 | 8794 | 8821 | 8830 | 8852 | 8844 | 8840 |
| Actual number diagnosed | **6,169** | **6,186** | **6,235** | **6,248** | **6,325** | **6,234** | **6,271** | **6,320** | **6,287** | **6,454** | **6,471** | **6,409** | **6,409** |
| Trajectory % diagnosed | 67 | 67 | 67 | 67 | 67 | 67 | 67 | 67 | 67 | 67 | 67 | 68 | 68 |
| Actual % diagnosed | **73** | **72** | **73** | **73** | **73** | **72** | **72** | **73** | **72** | **74** | **74** | **73** | **73** |

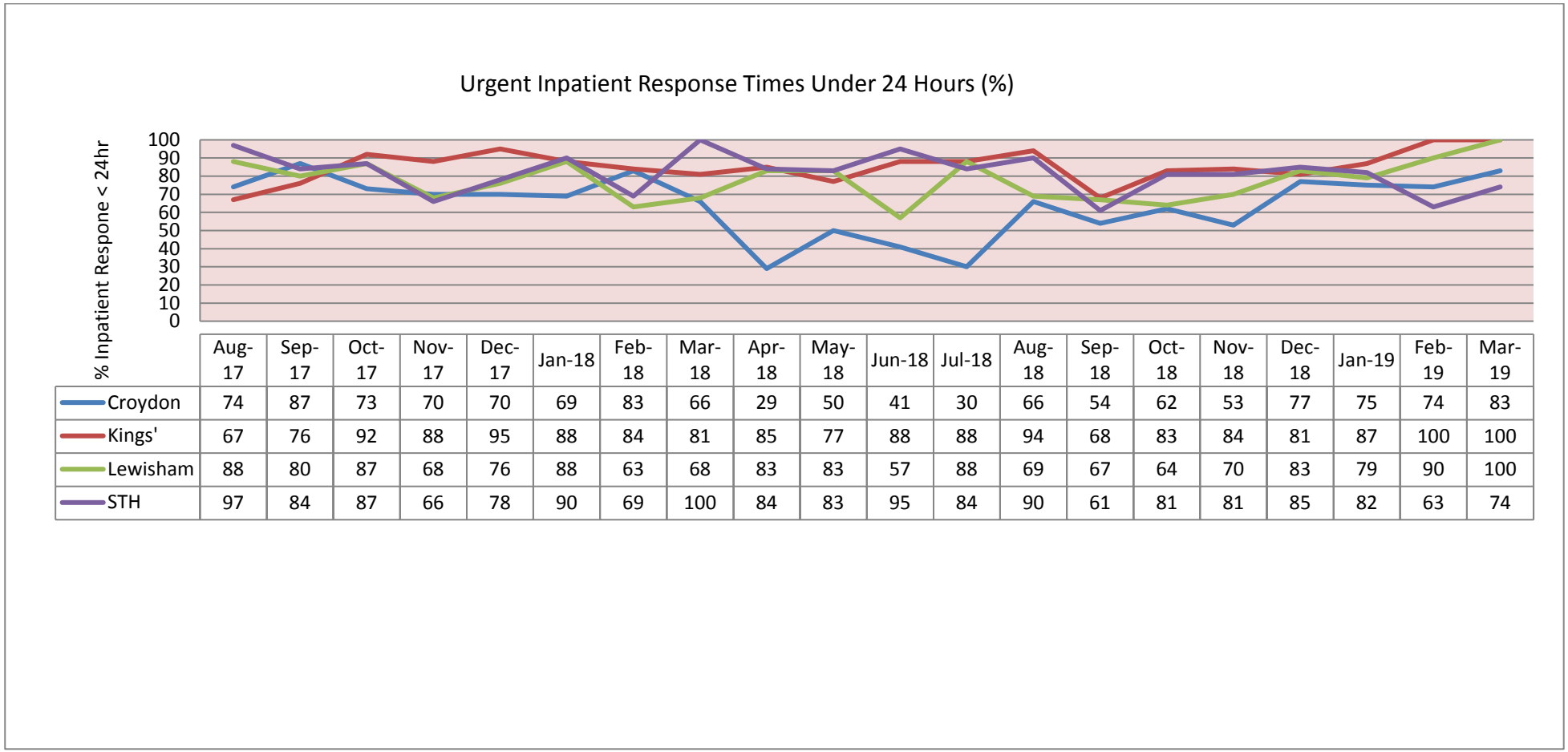
*March figures unavailable at time of report

**Core 24**




| | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E Croydon | 65 | 55 | 54 | 55 | 47 | 57 | 51 | 51 | 52 | 43 | 45 | 45 | 47 | 38 | 64 | 59 | 63 | 69 | 67 | 53 |
| A&E Kings | 80 | 81 | 83 | 67 | 89 | 82 | 78 | 74 | 77 | 73 | 77 | 73 | 78 | 52 | 80 | 76 | 85 | 88 | 85 | 88 |
| A&E Lewisham | 80 | 81 | 75 | 73 | 72 | 66 | 74 | 74 | 70 | 77 | 72 | 62 | 72 | 58 | 60 | 54 | 71 | 60 | 74 | 79 |
| A&E STH | 62 | 69 | 55 | 48 | 55 | 63 | 71 | 71 | 66 | 68 | 78 | 74 | 70 | 57 | 77 | 72 | 81 | 83 | 83 | 81 |

Response times remained similar for all teams except A&E Croydon in March. The largest differences being Croydon with a decrease of 6% from February.




| | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Croydon | 74 | 87 | 73 | 70 | 70 | 69 | 83 | 66 | 29 | 50 | 41 | 30 | 66 | 54 | 62 | 53 | 77 | 75 | 74 | 83 |
| Kings' | 67 | 76 | 92 | 88 | 95 | 88 | 84 | 81 | 85 | 77 | 88 | 88 | 94 | 68 | 83 | 84 | 81 | 87 | 100 | 100 |
| Lewisham | 88 | 80 | 87 | 68 | 76 | 88 | 63 | 68 | 83 | 83 | 57 | 88 | 69 | 67 | 64 | 70 | 83 | 79 | 90 | 100 |
| STH | 97 | 84 | 87 | 66 | 78 | 90 | 69 | 100 | 84 | 83 | 95 | 84 | 90 | 61 | 81 | 81 | 85 | 82 | 63 | 74 |

King’s and Lewisham have response rates for urgent inpatient referrals of 100%. Both Croydon and GSST increased by 9% and 11% Respectively

**Performance and Quality Reporting**

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 below.

**Significant developments**

The Trust, in partnership with Oxleas NHS Foundation Trust in South East London, has secured a 6.6% uplift across all mental health services and a commitment in the South East London Sustainability and Transformation Plan to transfer commissioning function to both organisations in 2019/20. This will enable the Trust to become an internal commissioner of services to deliver improvements and efficiencies as scale and pace.

All developments are now targeted at enabling the Trust to deliver against the aims and ambitions of the NHS 10 Year Plan:

**Patient Centred**

- By March 2020 – IAPT access at 22%
- 50% of people receiving IAPT treatment should recover
- 75% of those referred to IAPT should begin treatment within 6 weeks of referral (and 95% within 18 weeks)
- 66.7% of dementia patients should receive a formal diagnosis
- 56% of 14 to 65 year olds with first episode psychosis receiving treatment within 2 weeks
- At least 34% of CYP with diagnosable MH condition should have treatment from NHS funded community service
- By March 2021 – 95% of CYP with and Eating Disorder getting urgent referral seen in 1 week (routine within 4 weeks)
- Reduce OOA placements in line with local trajectories
- 60% of people with SMI should get annual health check
- 3000 MH therapists to be co located in in primary care by 20/21
- 4500 additional MH therapists to be recruited and trained by 20/21 \
- Reducing LD & Autism to 18.5 inpatients per million population by March 2020 (NHSE funded)
- 75% of people on LD register to get annual health check

**Supporting Our Workforce**

- Updated workforce plan in place that is detailed, phased and aligns with activity and financial plans
- Unnecessary agency spend is being eliminated
- Offer of full time employment to all nurses trained locally
- Retention and improving the Trust offer to staff is a focus of planning

**Our Improvement Plan**

Successful delivery of a Trustwide Improvement Plan targeted at the inpatient pathway and governance arrangements saw the implementation of standardised pathways and floor to Board reporting in 2018/19. This led to a CQC improvement notice lapsing and a renewed focus on making sure SLaM's performance and quality narrative is understood from floor to Board. This work has helped identify areas of risk and improved how the Trust reacts to putting in place mitigations that have the ultimate end goal of improving patient outcomes through having a standardised model of care that is articulated and understood across all four boroughs-based directorates.

**CAMHS**

CAMHS community services have continued to focus on transformation plans. Dedicated crisis teams have been introduced, offering outreach to young people who would otherwise have presented at an Emergency Department. Early Intervention Psychosis workers are embedded within the Psychosis pathway to ensure that young people presenting with first episode Psychosis are assessed and treated within two weeks. There is ongoing work taking place to further develop our crisis support offer within CAMHS.

CAMHS are also working as part of the South London Partnership (SLP) New Models of Care. This is a partnership between Oxleas, South West London & St. George's and SLaM, with a focus on ensuring that young people who require a hospital admission are being placed closer to home, and where possible, supporting people in the community rather than admitting them to hospital.

In response to a lack of adolescent PICU beds both locally and nationally, an eight bed inpatient unit has opened on the Bethlem site. Whilst the PICU is managed by CAMH services at SLaM, the team work closely with colleagues across the SLP to improve pathways across all areas and associated outcomes. The service offers quick access to young people who need to step up from a general adolescent unit as well as to young people requiring admission via A&E, preventing inappropriate admissions.

In addition, the SLP has been successful in securing funding for a Forensic CAMHS service which will be hosted within SLaM.

**Corporate Enablers and Local Partnerships**

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

- Our quality improvement programme, which continues to monitor the acute care pathway and implement improvements across all Trust services
- 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
- Through the Board, Programme Management Office, and Transformation Steering Group and we continue to deliver transformative service delivery changes and cost improvements

To best position ourselves to manage our risks we are:

- Leading on a mental health offer to local populations through the continued development of local Alliances and partnerships
- Collaborating with our commissioners to ensure the services we provide meet the needs of their populations and fulfil the mental health investment standard
- Working across the system with partners such as Our Healthier South East London, Sustainability and Transformation Partnerships and the South London Partnership
- Ensuring we work across the organisation including community, child and adolescent, older adults and specialist services

## 1.2 Performance analysis

### Financial performance

### Trust financial position

We ended the year in line with the Trust's original financial plan, resulting in us achieving our target NHSI control total of £0.7m deficit, on an operational basis (breakeven 2017/18). The Trust reported a technical net surplus of £4.2m. However, this includes £6.4m of additional incentive funding from NHS Improvement (£5.0m 2017/18) and less a £1.1m net cost adjustment related to the revaluation of Trust assets. None of the additional incentive funding counts against the Trust's financial control total from NHSI and could not be used for patient care related activities in 2018/19. However, the additional cash after funding the deficit (£5.7m) will be used in future years to support the Trust's longer-term capital planning strategy for the benefit of our service users.

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, a reduction in R&D funding, and a delay in transfer of our Kent CAMHS inpatient services. To mitigate against this, additional in year savings measures were implemented including 'locking in' underspends from those services that were in surplus.

- A need to ensure high quality and safe patient services responding to findings from the 2018/19 CQC inspection which were not in the original business plan. This included making additional investment in our estate as well as focusing SLaM management capacity on delivering the CQC's requirements.

- A need to manage ongoing systemic inpatient bed pressures. Demand for inpatient beds exceeded the original plan across all boroughs and was evident in the increasingly high demand for Mental Health beds from ED presentations. This resulted in significant additional cost in terms of the use of private beds and staffing our wards sufficiently with bank and agency medical and nursing staff. The annual spend on private beds was £10m based on an average over the year of 37 overspill beds per month.

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').** Although the Trust had risk share arrangements in place with all four of its local CCGs, the scale of overspill (up to 58 external beds) meant that unfunded placements contributed £6.2m to the bottom-line position (£6.2m was the cost net of risk share income). Going into 2019/20, there will be a continued focus on the flow plan and reducing our reliance on external beds, driving lengths of stay down so that we can realise our ambition to run the adult acute wards at 85% occupancy.

- **Responsibility for purchasing (non-medium and low secure) external placements in Lambeth, Southwark and Lewisham lies with the Trust.** Southwark placements is a high risk for the Trust where the funding is no longer being routed through the CCG contract

under a Section 75 agreement. Previously this provided the Trust with some certainty as the CCG effectively underwrote any issues that the CCG had with the Local Authority as regards recovery of funding. The Trust must now invoice the Local Authority direct in order to recover costs which last year overspent by £0.8m against a baseline budget of £3.1m. This year the LA element of placements has cost £2.4m with £1.7m costs classed as unallocated. The Council have indicated they are only willing to purchase activity up to a value of £2.4m leaving a potential gap of £1.7m. This situation is being taken up with the Council and CCG and whilst progress is being made, the funding gap still exists.

- **Ward nursing costs** were an issue during 2018/19 with an overspend of £2.6m. The main areas of concern were with Lambeth, Croydon and Lewisham adult wards which represented 82% of the total overspend. The Lambeth Challenging Behaviour Unit, AL 3 (Southwark), Johnson Unit PICU and Clare (Lewisham), Fitzmary 1 (Croydon) and Snowsfield (CAMHS) were all +15% above their funded nurse establishments.

- **Use of agency staff** at rates above funded pay budgets. In 2018/19 NHSI set a ceiling to spend no more than £15.1m (£17.4m 2017/18) on all agency staff. Based on this target the Trust spent £19.1m (£17.2m 2017/18) above the target set by £4.0m (26%). This meant that using agencies to fill vacant posts incurred an additional expense of c£3.2m above the cost of employing permanent staff (assuming a 20% agency premium). This will clearly be an area of continued focus in 2019/20 with the NHSI target again set at £15.1m which the Trust is expected to perform within as well as helping the drive to realise further cost reductions from reduced agency premiums.

- **Cost Improvement Plans** (CIPs) - the Trust had planned to deliver savings of £16.4m. At year end, the Trust recorded savings against cost improvement schemes of £14.1m. The main shortfall occurred on planned overspill reductions – the savings plan for this was not achieved due to increased demand on inpatient beds.

**Details on our financial performance are shown below**

## Income and expenditure position

| | FT £m |
|---|---|
| Income | 406.2 |
| Expenses | (404.3) |
| Net gains on disposal of assets | 7.9 |
| Net finance income | 0.4 |
| Fair value movements | 0.1 |
| PDC (Govt) Dividend | (6.1) |
| Surplus | 4.2 |

## Control Total

| | |
|---|---|
| Surplus | 4.2 |
| Less PSF core funding | (3.2) |
| Less PSF funding incentive and bonus | (1.3) |
| Less PSF funding general distribution | (1.5) |
| Surplus before STF funding | (1.8) |
| Plus net impairments releases | 1.1 |
| Plus depreciation on donated assets | 0.0 |
| Relevant deficit against Control Total | (0.7) |
| Control total set by NHSI before STF | (0.7) |
| Breakeven against Control Total | (0.0) |

## Cash position

| | FT £m |
|---|---|
| Opening cash | 70.2 |
| Operating surplus | 12.4 |
| Net finance income | 0.4 |
| Dividend paid | (6.4) |
| Capital expenditure | (11.3) |
| Capital receipts and gains | 19.8 |
| Increase in working capital | (2.2) |
| Loans repaid | (0.2) |
| PDC received | 1.3 |
| Closing cash | 84.0 |

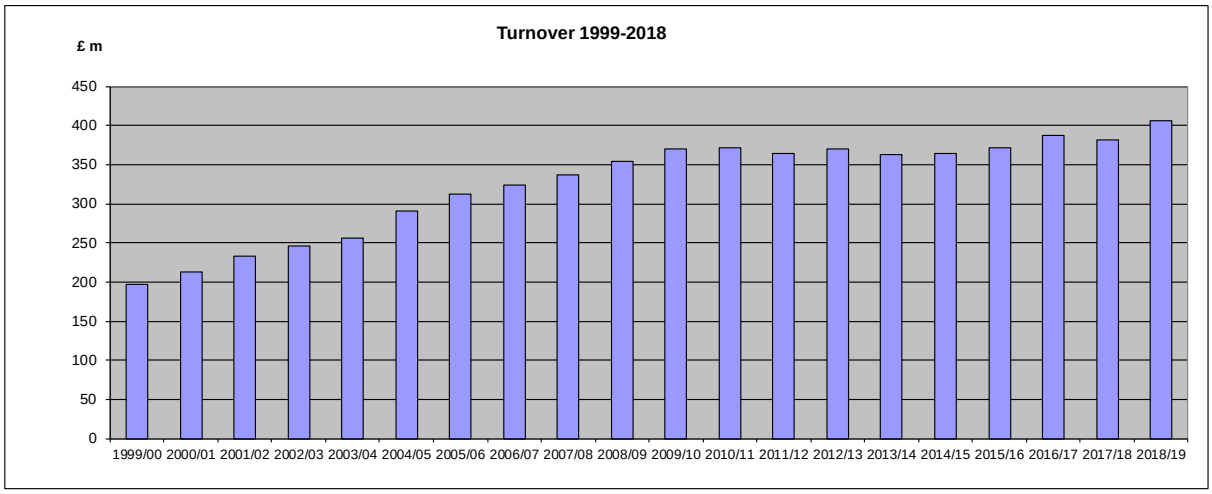
The Trust is assigned a Risk Rating by NHSI. The rating is based upon five financial metrics:

1. Liquidity (number of days of operating costs held in cash or cash-equivalents)
2. Capital service capacity (the degree to which income covers financial obligations)
3. I&E margin (the degree to which the Trust is operating a surplus/deficit)
4. Distance from plan (the variance between our planned I&E deficit, and our actual deficit)
5. 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 2018/19 we achieved a rating of 2 (2017/18 rating 1).

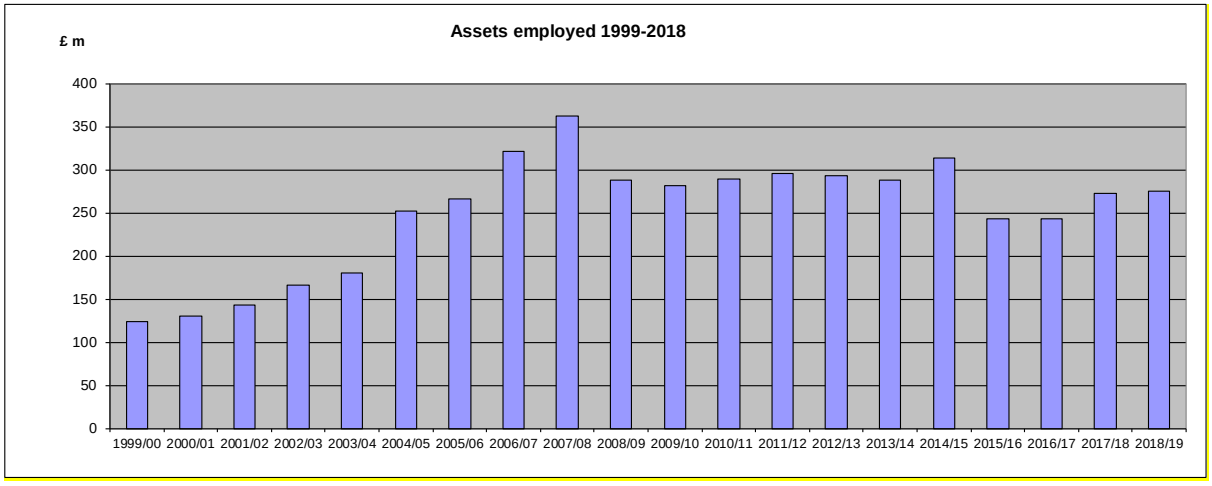
The charts below show the trends in turnover, retained surplus/deficit and assets employed over a twenty-year period since the formation of the Trust.

## Turnover




Turnover increased by 6.6% in 2018/19. 78% of income is received from NHS Clinical Commissioning Groups and NHS England and a further 14% from other NHS organisations.

## Assets employed




The net assets of the Trust include property of £236m.

We ended the year in line with the Trust's original financial plan, resulting in us achieving our target NHSI control total of £0.7m deficit, on an operational basis (breakeven 2017/18). The Trust reported a technical net surplus of £4.2m. However, this includes £6.4m of additional incentive funding from NHS Improvement (£5.0m 2017/18) and less a £1.1m net cost adjustment related to the revaluation of Trust assets. None of the additional incentive funding count against the Trust's financial control total from NHSI and could not be used for patient care related activities in 2018/19. However, the additional cash after funding the deficit (£5.7m) will be used in future years to support the Trust's longer-term capital planning strategy for the benefit of our service users.

- **Our financial performance** has been supported by a positive average cash balance in 2018/19 of approximately £80m (£58m 2017/18) to ensure the Trust continues as a going concern and is able to fund its estates transformation strategy.
- **Use of agency staff** at rates above funded pay budgets. In 2018/19 NHSI set a ceiling to spend no more than £15.1m (£17.4m 2017/18) on all agency staff. Based on this target the Trust spent £19.1m (£17.2m 2017/18) above the target set by £4.0m (26%).

**Events since year end affecting the Trust**

There are no events affecting the Trust since the year-end.

**Overseas operations**

This year the Trust saw further growth of Maudsley Health, its footprint in the United Arab Emirates (UAE) which is a collaboration between our organisation and the Macani Medical Centre.

An outpatient 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. The clinic grew in activity and staffing numbers over the year, and participated in initiatives such as the Strong Minds Programme at the Special Olympics MENA Region and the Mental Health Seminar at the New York University Abu Dhabi.

At the beginning of the year, Maudsley Health secured a contract with the UAE's Ministry of Health and Prevention to support the management of Al Amal Hospital in Dubai. Al Amal is a state-of-the-art 276-bed mental health hospital that opened in 2016. The Maudsley Health Team are tasked with developing the clinical strategy, introducing policies and protocols to enhance standards of care, increase safety measures, set education and training strategy and delivery plan and introduce research and development initiatives. Most recently Al Amal Hospital achieved the Gold Seal of Approval as a Joint Commission International-accredited Hospital with support from the Maudsley Health Team.

**Equality and diversity**

The Trust has a longstanding commitment to demonstrating accountability for its performance on promoting equality within its workforce and service provision. The Trust publishes a suite of annual equality information to demonstrate how it complies with its equality obligations. This includes the following:

- 2018 Workforce equality information: This provides equality data for staff with different protected characteristics on a range of workforce metrics.
- 2018 Trust-wide equality information: This provides information on the demographic profile of the Trust's service users and the experience of service users from all protected characteristics during the previous three years
- 2018 ethnicity reports for Croydon, Lambeth, Lewisham and Southwark: These provide ethnicity access and experience ethnicity data on key services in each borough. This year's report also includes outcome data for Improving
- Workforce Race Equality Standard (WRES) information
- Annual gender pay gap report.

The Trust's equality objectives are set out in our Integrated Equalities Action Plan 2018-21. It aligns the Trust's approach to promoting equality for its workforce and for service users, carers, families and communities and reflects the strategic priorities of the Trust's 'Changing Lives Strategy'. It captures existing commitments, legal requirements, prioritised areas for improvement and sets out measures of success over the next three years.

From this year the Board will receive an integrated annual report on action plan delivery, equality information and a refreshed Equality Delivery System (EDS 2) assessment in June. This alignment will provide the Board with an efficient and effective view of implementation and outcomes of all workstreams in the Integrated Equalities Action Plan. It will also enable the Trust to be more focussed and responsive to the equality information it publishes each year.

**Environmental matters**

The trust has a Sustainable Development Management Plan (SDMP), based on best practice guidance issued by the Sustainable Development Unit and NHSi. The plan details our sustainable vision:

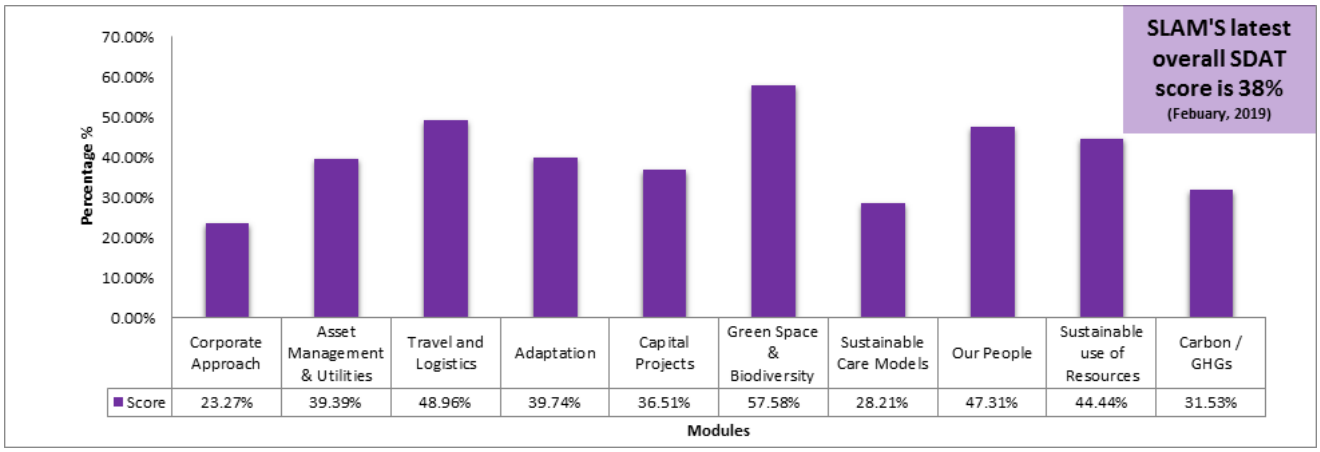
> ***"To lead in sustainability within the mental health sector and to reduce our carbon footprint and wider environmental impact, while providing exemplar care to the patients and the local community"***

CE&F is responsible for the coordination of the plan and is supported by Trust departmental leads and the board director for sustainability. Together they are responsible for SLAM's sustainable work within the Trust and the community.

The Trust continues to work with NGO's, NHS bodies and the local community to implement sustainable development activities. These include Sustainability Leads NHS National Performance Advisory Group; ACT/Travelwise (for the promotion of sustainable and active travel); The Environmental Agency; Workwell project (Slam led community employment project); Southwark Council (Grove Lane and Champion Hill cycle route project); and Bromley Beekeepers (locating beehives on Bethlem Royal Hospital site).

Alongside the SDMP we have completed the Sustainable Development Assessment Tool (SDAT), which has been comprised by the SDU to evaluate the benefits of sustainability actions and help to align strategies with the priorities and ambitions of the United Nations Sustainable Development Goals (SDGs). The Trust's overall score was 38%. and the SDMP future initiatives and plan has been aligned with this tool. It is envisaged in 12 months the initiatives will be evolved with ownership of the areas within the plan.

Table 1. Trust SDAT score 2019




The Estates and Facilities department continues 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 Trust successfully passed audit visits undertake by BSI in October 2018.

The EMS has continued to support the reduction of the Trusts use of gas, electricity and fuel and $CO_2$ emissions. 'The headline Trust figure for $CO_2$ emissions for **xxx** has provisionally been calculated at **xxx** tonnes, a from the emissions produced by the Trust in xxx [to be updated]

Diesel use has continued to fall with average consumption reducing by an average xxx per month, from xxx to xxx litres in the previous year.

While the Trust's environmental management system and related polices are principally driven by the Capital Estates and Facilities (CEF) Department there is an increasing amount of work being undertaken across the Trust to improve the Trusts sustainability performance and CSR work stream. Examples include the Work Well Project developed by the Career Management Service which includes a sustainability action plan and Green champion within the project delivery team.

Partnership working across the trust will be further expanded in 2019/20 with the establishment of the Trust's new Sustainability Forum which is a key action within the new Sustainable Development Management Plan.

The Trust's CEF Department has led on the waste tender for the Trust and South West London and St Georges. The contract has been awarded and it is anticipated the new contract will be mobilised in May. The tender specification was designed to drive Trust's ambition to be zero to landfill, improve waste transparency and to utilise waste technology. It is envisaged that contract will improve the Trust's recycling performance and data.

The Trust's Procurement team has switched to purchasing 100% recycled paper and adopt minimum environmental specifications such as government buying standards. Where applicable procurement request access to supplier's approaches to equality, diversity and environmental policies and that they comply with the modern slavery Act 2015. An environmental element is contained within the scoring of tenders, in the recent transport tender this amounted to 10%.

The following examples show the practical work the Trust has undertaken in 2018/19.

- The LV infrastructure has been upgraded on the Bethlem site to give the Estates team more control in distributing electricity across the site. In the future and under request from the UK Power Network (UKPN), the generators on the Bethlem site will be able to assist the national grid in alleviating high electrical demand.
- As part of the environmental management system the Trust has produced energy reports in 2018 for each of its three main sites: Lambeth Hospital, The Maudsley Hospital and Bethlem Royal Hospital.
- The Environmental Management System holds a Legal Register, containing details of all Environmental Legislation and associated regulations and their impact on the Trust. This is reviewed on a 6 monthly basis and has been independently audited by BSI during 2018/19 as part of the ISO:14001 & ISO:50001 auditing and re-accreditation process.
- The Trust has continued to work with the First Step Trust, contracting vehicle servicing and maintenance CEF fleet with their Smart Garages subsidiary. First Step Trust are a social

enterprise who 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.

- CEF took part in a Department for the Environment, Food and Rural Affairs (DEFRA ) workshop around the health risks associated risks with the Oak Processionary Moth (OPM) and how to best manage infestation. CE&F shared best practice with other landowners on their experiences and management of OPM's.
- The Environment Agency (EA) are still considering the Bethlem as a potential site to carry out minor modifications to help mitigate flooding in Elmer's End during periods of heavy rain. The scheme to mitigate flooding has not yet been approved yet by the EA but the Trust has approved their request to use fallen logs in the woods for natural flood bunding mechanisms.
- The Trust has engaged with a local Bee Keeper who has installed a beehive on the Bethlem grounds and the honey produced from the bee hive is sold locally.
- Car Park: the Trust has introduced a new car park management system using Automatic Number Plate Recognition (ANPR) technology backed by an intelligent information management system. This allows for the more effective management of permit user groups encouraging promoting sustainable travel. The new system also allows staff to pay daily on the days they actually park on site rather than a set yearly fee as previously used, promoting a more efficient use of the car park, saving staff money and promoting use of alternative methods of transport to the car.
- The Trust has installed four electric vehicle charge points at Bethlem Royal Hospital which can be used to charge staff vehicles staff members personal vehicles and those of members of the public. In addition the Trust purchased an Alke STX240E Electric vehicle for use by Facilities staff at the Bethlem Royal Hospital.
- The Maudsley Psycling Club, set up by staff in 2017, has continued operating with the aim of appealing to the wider Trust community. The group has organised led rides, developed contacts with local shops, supported cycle promotion events and has agreed to act as the Trust's bicycle user group (BUG).

**Signed**

**Dr Matthew Patrick**

Chief Executive
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

# Chapter 2. Accountability report

## 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. There are meetings between the Governors and the Non-Executive Directors before every public Board, to provide an additional opportunity for Governors to ask questions of the Non-Executive Directors.

**Compliance with fit and proper persons test**

The Trust regularly reviews the fitness of directors to ensure that they remain fit for their role. We require all persons in relevant roles to complete an annual self-declaration form confirming that they continue to be a fit and proper person. The Chief Executive is responsible for appraising the Executive Directors and ensuring that all other relevant roles are appraised. The Chair is responsible for appraising the Non-Executive Directors, and the Council of Governors receive an annual statement about compliance. The Chief Executive is appraised by the Chair. The Chair is appraised through processes agreed with the Nominations Committee, and includes feedback from Governors, Non-Executive Directors and Executive Directors.

Individuals are required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that this can be considered by the Trust. Any issues of non–compliance are to be notified to the Chair and he is responsible for making an informed decision regarding the course of action to be followed.

**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 12 Jan 2015 – Jan 2018, reappointed January 2018 – Jan 2021. Resigned 30 April 2019.

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 13 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 was Vice-Chair of Newark and Sherwood NHS Clinical Commissioning Group until end of 2016. He was Chair of the Charity Sue Ryder until July 2017.

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.

**Béatrice Butsana-Sita – Non-Executive Director**

Appointed 1 July 2018 – June 2021

Beatrice brings a wealth of experience in commercial strategy and leadership from a series of high-profile senior roles. She was currently Managing Director at Capita IT & until late 2018.

She began her career at KPMG in Belgium, then moved to New York to pursue her career in consultancy. Her roles have also included running her own software business and working as a managing director at British Telecom(BT).

Béatrice has previous experience as a Non-Executive Director in the NHS, at Newham Primary Care Trust in London. She represented BT at the World Economic Forum in Davos in 2014 and appeared on the list of the 100 women to watch published by Cranfield University.

**Alan Downey – Non-Executive Director**
Appointed 24 June 2014 – May 2017, re-appointed December 2016, stepped down June 2018

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.

Alan was appointed as Chair of South Tees Hospitals NHS FT and formally took up his role from March 2018. He has indicated his plan to step down from his South London and Maudsley NHS FT NED role later in 2018.

**Mike Franklin – Non-Executive Director**
Appointed 23 May 2019 – May 2022

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 12 May 2019 – May 2022

Duncan Hames is a Director of Policy at Transparency International UK, a charity which seeks to reduce corruption in the UK and around the world.

He was previously a Member of Parliament from 2010-2015, during which time he served as the parliamentary aide to the Deputy Prime Minister, 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.

He is a Chartered Management Accountant and has over 10 years of experience as a management consultant. For six years, he also served on the board of the South West of England Regional Development Agency, chairing its Audit Committee.

Duncan took up the role of Senior Independent Director from January 2018, following the departure of Julie Hollyman.

**June Mulroy MBE – Non-Executive Director**

Appointed 12 January 2015 – January 2018, reappointed January 2018 – January 2021. Appointed Interim Chair from 1 May 2019.

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 an MBE.

June took up the role of Deputy Chair from January 2018, following the departure of Julie Hollyman. She was appointed Interim Chair from May 1 2019.

**Anna Walker – Non-Executive Director**
Appointed 1 July 2016 – June 2019. Re-appointed June 2019-June 2022

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 was the Chair of Young Epilepsy.

She is a Non-Executive on the Board of Dŵr 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 Ian Everall – Non-Executive Director**

Appointed 1 September 2017 – July 2020

Professor Ian Everall was appointed Executive Dean of the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) in September 2017. He has been the forefront of research into cellular, molecular and genetic changes in the brain in major psychiatric disorders for more than 20 years.

Professor Everall trained in psychiatry at the Bethlem Royal and Maudsley Hospitals. Previously Cato Chair of Psychiatry and Head of the Department of Psychiatry at the University of Melbourne, he obtained his MBChB at Leicester University School of Medicine.
In 1989 he obtained Membership of the Royal College of Psychiatrists and a MRC Clinical Research Training Fellowship, followed in 1992 by an advanced MRC Clinician Scientist Fellowship in the Department of Neuropathology, Institute of Psychiatry.

Professor Everall gained his PhD in 1992 and in 1993 was appointed Senior Lecturer at the Institute of Psychiatry and Honorary Consultant Psychiatrist at The Maudsley Hospital. He was appointed Professor of Experimental Neuropathology at the Institute of Psychiatry in 1999 and in 2004 became Professor of Psychiatry at the University of California, San Diego.

**Dr Geraldine Strathdee – Non-Executive Director**

Appointed January 2018 – January 2021

Geraldine's roles have included NHS England's National Clinical Director for Mental Health and consultant psychiatrist at Oxleas NHS Foundation Trust from 2013-2016. For over 20 years Geraldine has held senior roles in mental health policy, regulation and clinical management, at national and London regional levels, and advises internationally on mental health service design and quality improvement, while working as a practising clinician.

Clinically, Geraldine has worked in a wide range of primary care, inpatient and community services, and latterly with people with complex and multiple needs, as a Consultant Psychiatrist for the Bromley Assertive Community Treatment team in Oxleas. Geraldine's research interests have included the fields of primary care mental health, evaluation of community services and dual diagnosis. Current research interests include the evaluation of competency based leadership programmes and clinical networks to drive transformational improvements, and high impact educational programmes.

**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.

**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.

**Beverley Murphy- Director of Nursing**
Beverley Murphy joined the trust as Director of Nursing in April 2017. She was previously director of nursing at West London Mental Health Trust and before that Chief Nurse at Leeds & York Partnership NHS Foundation Trust. Beverley has worked as a mental health nurse for 33 years and has held a range of senior nursing and quality governance roles across the NHS.

**Altaf Kara – Director of Strategy and Commercial**

Altaf Kara is Director of Strategy and Commercial – he joined South London and Maudsley NHS Foundation Trust in June 2016 and was appointed as an Executive Director on the Trust's board from November 2017.

Prior to joining the Trust, he was a partner in corporate finance at Deloitte where he specialised in hospital turnarounds, operational impact and health economy restructuring within the NHS.

With over 20 years' experience in professional services covering a range of issues in the public and private sector, including retail, consumer products, media and entertainment and healthcare, Altaf brings a depth of commercial and strategic experience and skills to the Trust both in the UK and overseas.

Apart from responsibility for commercial and strategic activities, he has Board responsibility for estates, and external partnerships.

*Attendance at boards and committees

| Board Member | Trust Board 12 meetings held in 2018/19 | Remuneration Committee xxx held in 2018/19 | Quality Committee 7 meetings held in 2018/19 | Business Development & Investment Committee (BDIC) 8 meetings held in 2018/19 | Finance and Performance (FPC) 6 meetings held in 2018/19 | Equalities and Workforce Committee 5 meetings held in 2018/19 | Mental Health Law Committee 5 meetings held in 2018/19 | Audit Committee 5 meetings held in 2018/19 |
|---|---|---|---|---|---|---|---|---|
| Roger Paffard Trust Chair | 12 | | 7 | 6 | 6 | 5 | | |
| Matthew Patrick | 12 | | | 6 | 4 | 5 | | |
| Kris Dominy | 10 | | 6 | 2 | 4 | | | |
| Gus Heafield | 11 | | 1 | 6 | 4 | | | |
| Michael Holland | 12 | | 5 | 3 | | | 3 | |
| Beverley Murphy | 11 | | 7 | | | | 3 | |
| Altaf Kara | 11 | | | 8 | 5 | | | |
| Dr Geraldine Strathdee Chair of Mental Health Law Committee | 11 | | 6 | | | | 5 | |
| Alan Downey - left June 18 | 1 | | | 2 | 2 | | | |
| Mike Franklin | 10 | | | | | 5 | | |
| Duncan Hames- Chair of Audit Committee | 12 | | | | | | | 5 |
| June Mulroy -Chair of BDIC & FPC | 10 | | | 9 | 6 | | | 4 |
| Anna Walker- Chair of Quality | 10 | | 7 | | | 3 | | 4 |
| Professor Ian Everall | 8 | | | 3 | | | | |
| Béatrice Butsana-Sita - Started July 18 | 8 | | | 4 | | | | |
| Sally Storey - until Nov 18 | | | 2 | | | | | |
| Mary Foulkes - from Jan 19 | 2 | | 2 | | | | | |

*Attendance refers only to core members

There is a register of Directors interests on the Trust website. This is also available by contacting the Trust Secretary, Rachel Evans, on telephone 0203 228 5376.

**Committee structures**

**Audit Committee**

The overall 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: (a) generally to 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) specifically to monitor, review and periodically report to the Board on the adequacy of the financial systems and procedures used within the Trust.

At its meetings for 2018/19, 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 Committee's Terms of Reference, an observer from the Council of Governors attends the Committee's meetings. The observer receives copes of the Committee's minutes and summaries of key issues reported by the Committee to the Board, 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 strategy, 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. An observer from the Council of Governors attends the meetings.

**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. An observer from the Council of Governors attends the meetings.

**Quality Committee**

The overall purpose of the Quality Committee is to monitor improvement and provide assurance to the Board on quality across the Trust. It monitors the delivery of the Trust's quality priorities, national mandatory requirements and professional regulators' standards. It examines service failures, ensuring that action plans are in place and lessons learned, whilst also having oversight of the Trust's mechanisms for involving service users and carers in all aspects of their care and at all levels of decision-making. An observer from the Council of Governors attends the meetings.

**Remuneration Committee**

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

**Equalities and Workforce Committee**

The Board established a new Board Committee in late 2017 to provide an increased focus on equalities and workforce issues. The Committee was established on a one-year basis in the first instance, but after review this was extended. An observer from the Council of Governors attends the meetings.

**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 2019 and up to the date of approval of the annual report and accounts.

**Board assurance framework 2018/19**

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

| Ref | Risk area / responsible Committee | Risk Description | Trust Lead(s) | Key Actions | Progress |
|---|---|---|---|---|---|
| BAF1 | Workforce<br><br>Equalities & Workforce Committee | If the trust cannot attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change the risk is that the quality of care may not be acceptable or consistent across services.<br><u>*Source of Assurance:*</u><br>• *Quarterly workforce & equalities action plan progress report*<br>• *Recruitment and retention KPIs*<br>• *Annual national staff survey*<br>• *Quarterly staff friends and family test*<br>• *Deep dive reports e.g. to CCG* | Director of Human Resources | a) Implementing retention and recruitment strategy actions including getting the basics right, improving recruitment processes, staff engagement and succession planning<br>b) Enhancing the development and training offer and redesigning roles<br>c) Talent management programme<br>d) Targeted recruitment campaigns<br>e) BME development and support network strategy<br>f) Working Race Equalities Scheme and Equalities and Workforce Action Plan<br>g) Improvements to e-appraisal.<br>h) Leadership engagement plan.<br>i) Participation in NHSI retention initiative | **The risk is being mitigated but the external recruitment and retention factors remains highly challenging.** |

| Ref | Risk area / responsible Committee | Risk Description | Trust Lead(s) | Key Actions | Progress |
|---|---|---|---|---|---|
| BAF2 | Operational delivery<br><br>Quality committee / Finance and Performance Committee | If the trust does not deliver services from an effective operational structure that provides good leadership and governance or have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.<br>*Source of Assurance:*<br>• Integrated monthly performance, quality and finance assurance reports<br>• New governance framework monitoring for all delivery units<br>• CQC inspection reports & action plan governance with CEO led Portfolio Board, Delivery Board, Oversight and Scrutiny Committee and bi monthly Quality Committees<br>• Qualitative audit programme of risk assessments<br>• Weekly key performance indicator reporting | Chief Operating Officer | a) Trust re structure to a borough model delivered<br>b) iCare QI programme designed to reduce variation in operational practices, improve patient outcomes and experience & enhance staff experience<br>c) weekly iCare meetings including senior leaders from across the Trust<br>d) restructure to a Borough based management model has been delivered.<br>e) Development of community QUESTT as a tool to enable performance monitoring and pre-emptive corrective action<br>f) Multi-Agency Discharge Events (MADE)<br>g) CQC Trust & Directorate level improvement action plan addressing; fundamental standards of care, leadership, governance and patient flow.<br>h) Quality Centre developed responsible for the development and monitoring of standardised best practice protocols<br>i) Integrated monthly performance, quality and finance assurance reports | **The risk has been mitigated. Principles of Community design agreed, performance and Quality reporting in place. Boroughs now established and entering alliance conversations with partners. Delivery Board, Oversight and Scrutiny Committee and Quality Committee will continue to monitor implementation. MADE events now being completed as BAU in all Boroughs.** |

| Ref | **Risk area / responsible Committee** | **Risk Description** | **Trust Lead(s)** | **Key Actions** | **Progress** |
|---|---|---|---|---|---|
| BAF3 | Informatics<br><br>Finance and Performance Committee | Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements.<br>Source of Assurance:<br>• A quarterly BI assurance report has been developed between the Head of Business Intelligence and the Head of Information Governance<br>• Global Digital Exemplar / QI Committee<br>• QC oversight of IT developments & impacts on quality data collection | Medical Director | a) Power BI continues to be developed as the single point of access for information across the Trust<br>b) Regular "Data Summits" of all system owners improved communication and agreement around priorities<br>c) Central record of systems, owners and inter-connections compiled<br>d) Weekly information development meetings led by the Deputy Medical Director for Informatics and Quality Improvement<br>e) Global Digital Exemplar / QI Programme Board<br>f) Digital Me programme to` ensure staff have access to the necessary hardware | The risk is being mitigated but further work is required to further develop BI assurance reporting and moves to secure cloud-based platforms. |

| Ref | Risk area / responsible Committee | Risk Description | Trust Lead(s) | Key Actions | Progress |
|---|---|---|---|---|---|
| BAF5 | Partnership working with service users<br><br>Quality committee | If the Trust fail to listen to the experience of people that use services and / or fail to implement the learning from all sources of adverse incidents there is a risk that services will not learn, not improve safety and present unacceptable risks for people that use services.<br><u>*Source of Assurance:*</u><br>• *Learning lessons report to QC and Board*<br>• *Practice changes (locally and trust wide) as a result of adverse incidents*<br>• *PPI strategy reports to Trust Wide Involvement Committee*<br>• Trust wide SI meeting and incident reports to QC<br>• *Medical and Nursing Director oversight of level 2 SI reports & closure of all SI reports by CCGs*<br>• *Director of nursing oversight of CEO level complaint responses*<br>• *Oversight of reported incidents by Service and Clinical Directors*<br>• Monthly Operational Directorate quality compliance committees<br>• External oversight via CRQG, deep dives by CCGs and NHSE oversight of delivery of homicide plans<br>• Delivery and monitoring of action plans in relation to PFDs (rule 28)<br>• Care plan and risk assessment audits | Director of Nursing | a) PPI strategy and outcome framework metrics<br>b) Involvement of service users in Service governance<br>c) Adherence to 'Being Open'<br>d) Quality of complaints and SI reports is overseen by senior CAG and Executive Directors<br>e) Risk management strategy and incident reporting structure in place<br>f) Action plans developed to implement learning from adverse incidents<br>g) Borough/local level SNAP audit system and My Team Dashboards introduced<br>h) Service users and carers Quality improvement methodology training.<br>i) QI team recruitment commencing of 2x people with lived experience | **Governance for these developments is progressing. Combination of oversight of PPI implementation plans at trust wide level; Operational services being held to account for delivery of improvement plans internally and by the CCG; clear escalation framework for all incidents reported and closure of complaints offers reasonable assurance.** |

| Ref | Risk area / responsible Committee | Risk Description | Trust Lead(s) | Key Actions | Progress |
|---|---|---|---|---|---|
| BAF7 | Quality & statutory compliance<br><br>Quality Committee | In the context of significant demand and change there is a potential risk that the trust will fail to deliver the necessary quality improvements identified by the CQC or meet our other statutory duties and therefore create a risk of breaching regulation.<br><u>*Source of Assurance:*</u><br>• *COO Quality report*<br>• *Learning lessons reports*<br>• *Compliance reports*<br>• *CQUINN reports*<br>• *progress reports of delivery of CQC inspection improvement actions*<br>• *QUEST scores*<br>• *Safer staffing reviews*<br>• *QI progress reports*<br>• *Monthly Directorate quality compliance committees and Quality matters governance meetings embedded*<br>• *CQC Improvement action plan governance with CEO led Portfolio Board, Delivery Board, Oversight and Scrutiny Committee and bi monthly Quality Committees* | Director of Nursing | a) Established, well led Board of Directors, experienced Service and Clinical Directors<br>b) Clear operational and professional structure<br>c) Quality governance structures in place<br>d) Operational performance management processes<br>e) Recruitment of sufficient high quality staff with good knowledge or regulatory standards<br>f) Development of relationships with commissioners, full engagement with alliance boards and engagement / leadership of transformation programmes (locally and nationally)<br>g) CQC improvement action plans at Trust and Directorate level<br>h) Bi monthly Quality Committee meetings and regular Board discussions<br>i) Monthly Operational Directorate Quality Governance Compliance meetings embedded<br>j) Risk management strategy and incident reporting structure in place<br>k) Established relationships with commissioners, full engagement with alliance boards, engagement / leadership of transformation programmes (locally and nationally). CQRG clinical quality review group chaired by CCG | **Trust wide improvement plan developed following July – August 2018 CQC inspection. Implementation governance structures developed to support implementation and evidence embedded delivery and outcomes Service Director led development of local implementation plans. The improvement plans closely considered by SMT and subject of a detailed review Delivery Board, Oversight and Scrutiny Committee and Quality/** |

| Ref | Risk area / responsible Committee | Risk Description | Trust Lead(s) | Key Actions | Progress |
|---|---|---|---|---|---|
| BAF 8 | Finance contracts<br><br>Finance and Performance Committee | If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high quality clinical care there is a risk that the trust will not be able to provide timely access to safe high quality services across all Boroughs and care pathways<br><u>*Source of Assurance:*</u><br>• *Contract settlements that align with STP and Trust based business planning requirements (Business Planning Reports and Contract Reviews)*<br>• *Scrutiny of key contract arrangements and changes (Business Planning Reports and Contract Reviews)*<br>• *Clear quality impact assessments detailing the implications and mitigations of any contract changes*<br>• *Internal Assurance on Value for Money (Internal audit reports, Benchmarking, Red Lines analysis, Business Cases).*<br>• *Commissioner Commitment to MHIS (CCG Contracts)*<br>• *Agreed Risk Shares and Additional Funding E.g. Winter funding (CCG Contracts, Contract Variations, SDIPs).*<br>• *No unmitigated QIPPs or QIPPs in inpatient budgets (CCG Contracts).*<br>• *Evidenced Improvements in SLP new models of care* | Chief Financial Officer | a) Dedicated and focused contracting and finance resource to assess financial sustainability implications and terms<br>b) Clear quality assurance procedures (e.g. QIAs) to assess and validate impact of any new contracts on patient care<br>c) Contracts to be sanctioned by FPC, SMT and the Board<br>d) Established QI process and PMO function to ensure a focus remains on delivering maximum value for patients to ensure limited funds are spent effectively and strengthening the Trust's bargaining position<br>e) "Red Lines" analysis to assess material projects including alliances<br>f) Contract challenges and funding shortfalls formally escalated monthly to NHSI through the Trust's financial returns and at the Performance Oversight Meeting (PoM)<br>g) Contract Alignment exercises carried out with the STP<br>h) Long Term financial model to project consequences of funding changes | **There are reasonable risk mitigation processes in place however the pace of change and breadth of scope of the new contracting and commissioning arrangements coupled with the uncertainty and complexity of new models will create capacity pressures across all the relevant assurance mechanisms in the Trust** |

| Ref | Risk area / responsible Committee | Risk Description | Trust Lead(s) | Key Actions | Progress |
|---|---|---|---|---|---|
| BAF9 | Estates<br><br>ELT & Finance and Performance Committee | The trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised. Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget.<br><u>*Source of Assurance:*</u><br>• *Quarterly Estates and Facilities performance reports to Finance and Performance Committee, Audit Committee and Trust Board*<br>• *Issues based updates to the Quality Committee on specific concerns relating to services or functions*<br>• *Topic based updates to the Audit Committee based on commissioned reports* | Director of Strategy & Commercial | a) Six facet surveys on maintenance needs.<br>b) Robust systems and processes (Planet; Datix)<br>c) Achievement of demanding targets for responsiveness - particularly for statutory and urgent needs<br>d) Follow through of escalation processes into corporate risk registers<br>e) Continuous health and safety workplace assessments, including where the service is occupying a building under third party ownership<br>f) Ligature anchor point assessment and associated work plan<br>g) Monthly contract management meeting with key cleaning and catering service provider<br>h) Enhanced capital project management process and capital works programme<br>i) Monthly Capital Review Group meetings | **The risk is being mitigated but further work is required** |

| Ref | Risk area / responsible Committee | Risk Description | Trust Lead(s) | Key Actions | Progress |
|---|---|---|---|---|---|
| BAF 11 | QI delivery<br><br>Quality committee | There is a risk that the significant time, resource and money that the trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that is anticipated.<br>*Source of Assurance:*<br>• *Weekly central QI meetings to review QI work plans and QI projects in directorates*<br>• *Weekly directorate huddles*<br>• *Weekly huddles with Trust Executive Leadership Team*<br>• *Weekly iCare governance*<br>• *Outcome monitoring by Quality Centre and reporting to Quality Committee*<br>• *Board committee updates*<br>• *Value for money assurances* | Medical Director | a) Central QI team established with increased skill level.<br>b) QI coaches in each directorate<br>c) Central QI team engagement with staff, service users and carers and external stakeholders, building QI methodology knowledge and skill<br>d) Large programmes of work such as ICare and individual team QI projects, sponsored through local leadership and coached through the QI team<br>e) Quality Centre developed and monitors progress of QI delivery<br>f) Internally developed registration system for individual QI projects | **The risk is being mitigated but further work is needed to ensure that all QI projects are registered and develop BI systems.** |

| Ref | Risk area / responsible Committee | Risk Description | Trust Lead(s) | Key Actions | Progress |
|---|---|---|---|---|---|
| BAF 12 | Finance (cost management)<br><br>Finance and Performance Committee | If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINs and if we do not manage the need for inpatient beds within the trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which prompt intervention by the Regulators<br><u>*Source of Assurance:*</u><br>• *Year to date reports to the Finance and Performance Committee and the Trust Board, including agency analysis*<br>• *Internal audit reviews of systems and processes*<br>• *External audit review (year end audit opinion)*<br>• *Review meetings with commissioners*<br>• *Monthly position analysis Mental Health Investment Standard has been agreed with commissioners for 2018/19 and beyond (Commissioner contracts and alliance agreements).*<br>• *Commissioner contracts and alliance agreements*<br>• *19/20 planning and contract negotiations commenced via contract meetings schedule* | Chief Financial Officer | a) Regular financial performance meetings with Operational Directorates and corporate areas with escalation to a Portfolio board chaired by the CEO<br>b) Financial performance (incl. CIP and QIPP) reported routinely to the FPC, Trust Board, NHSI and SMT<br>c) Quality Impact Assessments in place for all required CIPs to ensure patient care and safety assured<br>d) New Operational delivery units embedded providing better cost control<br>e) Fully staffed PMO<br>f) Balanced scorecards | **The risk mitigation measures are in place and kept under constant review** |

| Ref | Risk area / responsible Committee | Risk Description | Trust Lead(s) | Key Actions | Progress |
|---|---|---|---|---|---|
| BAF 14 | Patient flow<br><br>Quality committee | In the context of current capacity and increased demand, if there is a lack of integrated working by internal and external stake holders there is a risk of delays in patient discharge and optimum bed occupancy levels that may negatively affect patient outcomes and experience, staff morale and Trust finances.<br>*Source of Assurance:*<br>• Quality Committee oversight<br>• Multi Agency Discharge Events (MADE)<br>• Gold meetings.<br>• Daily dashboard<br>• CQC Improvement action plan governance with CEO led Portfolio Board, Delivery Board and oversight and scrutiny group<br>• Delivery Board monitoring delivery of Directorate pathway, flow and discharge management improvement action plans | Chief Operating Officer | a) MADE events<br>b) Work with SLP to develop specialist placement portfolios<br>c) R2G introduced in wards<br>d) Inpatient care process model especially around admission/discharge cycles<br>e) In-reach Home Treatment and Social Care Discharge teams<br>f) Enhanced assessment and liaison in ED<br>g) Additional purchased of 14+1 beds from NHS provider<br>h) Daily dashboard of key metrics<br>i) Twice daily internal escalation conference calls, daily surge calls & weekly Gold meeting chaired by CEO<br>j) Ring fenced Borough beds<br>k) Identified ED assessment beds by Borough<br>l) Block purchasing of male PICU beds to replace current spot purchased overspill<br>m) Trust level & individual directorate pathway, flow and discharge management improvement action plans | **The risk mitigation measures are in place and work continues to further enhance mitigation via improvement action plans** |

**The role of 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 Public Sector 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.

**Significant issues – to be updated after Audit Committee Monday 20 May 2019**

**Appointment of external auditors**

The Council of Governors appointed external auditors for the Trust in September 2017 – Grant Thornton. They were appointed as the Trust's external auditor for the period 23 September 2017 to September 2020.

**External audit process**

The Audit Committee reviews the performance of the external auditors. These reviews take 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 over the past year.

**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.

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 the Quality Report later in this 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 2018/19**

The value of external audit services was as follows and the amounts in all cases include VAT.

| | Statutory audit/£ | Other remuneration for 'non-audit' work/£ |
|---|---|---|
| Trust | £74k | £8k |

[Grant Thornton's audit plan, reviewed by the Audit Committee at its xxx meeting, reported the nature and value of non-audit services provided by Grant Thornton both before and after being appointed as the Trust's external auditor. Grant Thornton confirmed in the plan that there were no significant facts or matters that impacted on their independence as auditors that they were required or wished to draw to the Trust's attention. On the basis of the information reported in the plan 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 £45m including £84m 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**

Most 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

### Executive Leadership Team

The Executive Leadership Team (ELT) - until February 2019 referred to as the Senior Management Team - comprises the Executive Directors, together with the Director of Human Resources and the Director of Corporate Affairs. It is chaired by the Chief Executive. The ELT exists to promote the effective functioning of the organisation, to ensure that quality and clinical advice is properly considered, to make decisions on the allocation of resources within the Scheme of Delegation and to ensure that the ELT has an effective understanding of the operational functioning of the Trust. The Executive Leadership Team meet every week and discuss performance, quality, finance, strategy and delivery.

### Operations Directorates

We have reorganised our services over the last year, as a key part of our Changing Lives strategy. This is aimed at improving care to service user through a borough focussed organisation in a way that supports closer working and a better fit with our local partners.

The reorganisation was based on a matrix model which includes Operations Directorates responsible for delivery; a Quality Centre (including seven Clinical Academic Groups) responsible for the setting of best practice guidance and the monitoring of associated outcomes; and corporate services providing support. Previously, our organisational structure was built around CAGs which were formed to bring together clinical and academic expertise to develop and deliver care pathways across the whole spectrum of mental health conditions.

The new structure includes:

1. Six Operations Directorates each led by a service director to deliver the care required in each borough or Trust-wide for small, national and specialist services.
2. A Quality Centre including seven CAGs that will be led by academic and clinical directors and focus on quality improvement, education and training, evidence and research to enable the development of new clinical pathways.
3. Core services and corporate services to support both the operations directorates and the new CAGs.

In some instances, our services are provided for national patients or are specialist for specific groups of our local population, such as CAMHS. In these instances, we continue to manage these services on a trust-wide basis so that we can concentrate expertise around smaller numbers of patients.

**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.

**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 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 eNews, Maud (the Trust intranet) and Directorate team 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. Each member of the Executive Leadership Team is visiting teams across the breadth of the Trust as part of the Quality Improvement Leadership Walkarounds. Issues raised at these walkarounds are discussed on a monthly basis with the Executive Leadership Team.

We have been engaging staff, as well as service users and carers, in evolving our new strategy – 'Changing Lives'. We launched a Changing Lives film to communicate the strategy and we have had a range of screenings across the Directorates where staff have been able to feed in their views.

We obtain feedback from our staff through the appraisal process, team meetings, the annual staff survey, through the quarterly friends and family test and the Quality Improvement leadership walkarounds.

**Stakeholder relations**

The Trust continues to engage and work with our staff, service users, carers, partner organisations and local communities on a variety of topics and in a range of ways, from face to face to digital, through social media channels and printed format.

While our vision remains the same – to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all – during 2018-19 we have been further embedding our five-year strategy. The strategy is called Changing Lives which reflects our desire to make a positive difference to the lives of the people we work with. The strategy is an evolution of our previous strategy, refreshed through feedback via the Quality Priorities development process, and consultation with staff via focus groups and road shows and culminating in our annual staff conference. This year, there has been a programme of borough events to gather feedback on the strategy from service users and local communities, engagement with our service user and carer groups culminating in a Trustwide Service User and Carer event to be held at the end of April 2019.

We continue to be a key stakeholder in the Lambeth Living Well Network Alliance which brings together Lambeth CCG and Local Authority, Guy's and St Thomas NHS Foundation Trust, the voluntary sector, service users and carers, and Lambeth Healthwatch to improve access to support, including easier early access and a rapid crisis response, integrated and coordinated care and support for people who experience mental health problems, and managing demand and resources effectively.

We are also developing important partnerships and alliances in each the boroughs we serve. We are remodelling our community services, working in partnership with our local boroughs, and are ensuring that each supports a core, evidence-based model for community mental health teams

The Trust convenes a quarterly meeting with colleagues from the four Healthwatch organisations that work across Lambeth, Southwark, Lewisham and Croydon. These meetings enable all the organisations to share information and identify opportunities to work collaboratively, with a focus on:

- Service changes that are being planned

- Healthwatch reports that are being planned, to increase service user involvement and maximise feedback from a mental health perspective
- Share results and learning from relevant Healthwatch reports
- Update Healthwatch colleagues on the developing Trust strategy and direction of travel

The Trust is committed to improving the experience of black, asian and minority ethnic (BAME) service users and carers and recognises the importance of working in partnership with communities. Trust staff are members of the Croydon BME Partnership Group, which brings together statutory bodies and voluntary groups to improve the experience of BME service users and carers in Croydon, and Lambeth Black Thrive which has been set up as a partnership-based, cross-sector approach to deliver system change.

In addition, a partnership which was initiated in Lambeth a few years ago, where Trust staff work closely with Lambeth Independent Advisory Group (IAG) who connect back to BME communities, is now being replicated across the other boroughs. We are working with these Independent Advisory Groups to develop their work programmes to improve the experience of black service users and carers, reporting into a Trustwide Partnership Group. Each IAG is developing QI projects which bring the community and SLaM services together to work on improving care and experience of care locally in their boroughs.

The South London Mental Health Partnership (SLMHP), brings together our Trust with Oxleas NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, and enables us to bring together our expertise and resources to improve services across South London. The SLMHP collaboration work to date includes:

- Delivering forensic mental health services so that patients who had previously been treated outside the local area can be supported closer to home.
- Commissioning and delivering Tier 4 CAMHS services for young people with the most complex problems.
- A Nursing Development Programme to improve training and career opportunities for nurses across the Trusts.

**Social, community, equality and human rights**

Our Recovery College continues to deliver a patient and service user co-produced and co-delivered 'Ours to Own' course. This helps participants understand how they can use human rights in their daily lives as service users, carers or staff members.

The Trust published its annual equality information in January 2018 to comply with the public-sector equality duty. This includes 2019 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 12 of the Trust's services, IAPT recovery rates and the experience of service users of different ethnicities in each borough.

The Trust is also developing a Trust-wide integrated equalities action plan. Evidence from a range of sources suggests that the Trust's priority areas for equality improvement should be in relation to service users, carers and staff who are from BME backgrounds, disabled, lesbian, gay, bisexual or transgender (LGBT).

**Patient and public involvement**

During 2018 the Trust's improved governance structure has supported service user and carer involvement. Both the Family and Carers Committee and the Service User Involvement Committee are now co-chaired. We now have service user and carer representation at the Quality Sub-Committee of the Board.

An outcomes framework continues to provide a road map for the implementation of a patient and public involvement policy. Service users and carers have been involved in and consulted on the Quality Priorities for the Trust and are particularly interested in the development of the priorities for Carer Identification and Service User Care Plans.

The number of responses to the Friends and Family Test (FFT) and the internal patient experience surveys has remained consistent with the previous year. In 2018/19 the Trust received approximately 12,000 FFT responses. On average for 2018/19, 85% 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 continues to demonstrate that it is responsive to feedback from people who use services, their friends, families and carers by holding 'Changing Lives' engagement events in the four boroughs we serve.

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

The overall performance from the National Community Mental Health Survey for 2018 scored 'about the same' as most other Trusts that took part in the survey. The Trust scored 'better' than most other trusts in one question: changes in who people see – What impact has this had on the care you receive (7.3/10). The top five scoring questions five were: Organising Care - Do you know how to contact this person if you have concerns about your care? (9.4/10), Changes in who people see – What impact has this had on the care you receive (8.2/10), Organising Care – Have you been told who is in charge of organising your care and services? (7.8), Overall views of care and Services – Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services? (7.8/10), Treatments – Were these NHS therapies explained to you in a way you could understand (7.6/10).

There continues be a wide range of involvement activities across the Trust and within the Boroughs for people who use services, their friends, families and carers. As the Trust moves forward with its Quality Improvement programme, many projects will be co-produced and co-delivered in partnership with people who use services and their friends, families and carers. The Quality Improvement team have recruited a service user and a carer as Peer Project Workers to increase the involvement of service users and carers in QI projects.

Also see the Quality Report.

**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 provides 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 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 Director of Nursing is the Executive lead for health and safety. The Trust takes the health and safety of its staff, patients and visitors very seriously. The Trust has a Health & Safety Work Plan

which enables the Trust Board to be provided with assurances that there are satisfactory arrangements in place for managing health and safety risk across the Trust. The Trust has a Health, Safety & Fire Committee that monitors performance in this area through receiving reports and updates on a range of areas including: -

- Bi monthly reports on health and safety compliance audits.
- Bi-monthly reports on fire and health and safety inspections and risk assessments.
- Occupational reports on needle stick and sharps incidents.
- Staff related incidents e.g. violence and aggression.

The Trust has a dedicated health and safety team who work across corporate and clinical departments to establish a system which improve safety practices, procedures and provide assurances.

During period April 2018 – March 2019 there were a total of xxx reported RIDDOR incidents reported. 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.

The Trust's core health and safety policies have been updated to ensure that these comply with comply with health and safety legislation and NHS management standards.

There have been no HSE or Fire Enforcement Notices during the period of 2018

**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 89% of non-NHS invoices within this period (91% in terms of value) and 86% of NHS invoices within this period 92 % in terms of value.

**Countering fraud and corruption**

Since entering into a shared service arrangement with another NHS Foundation Trust last year, the Trust is embedding its dedicated counter fraud resource. The Trust complies with the requirements of the NHS Counter Fraud Authority in relation to proactive and reactive counter fraud work. The Local Counter Fraud Specialist attends each monthly induction session and provides information on fraud prevention and detection to all new starters and the Trust has recognised reporting lines for staff to raise concerns regarding fraud and corruption. Any allegations are assessed and investigated in accordance with professional standards with the outcome of all referrals reported through to the Trust's Audit Committee.

**Complaints**

The Trust received 533 formal complaints from 1 April 2018 to 31 March 2019. This is a decrease (3%) from the previous year 2017/18 during which the Trust received 551 complaints. Of the number of complaints investigated (and closed at the date of this report) 44% were either upheld or partially upheld.

Currently there have been two requests for Independent Review by the Parliamentary Health Service Ombudsman (PHSO) where the original complaint was made during the same period. This accounts for 0.38% 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 2019, 1 case (Croydon Directorate) is still under review by the Ombudsman's office, and 1 (Lambeth Directorate) is closed with no further action.

**Complaint themes**

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

| Primary subjects of formal Complaints 2017/18 | Number of Complaints |
|---|---|
| Administration | 15 |
| Admission/Transfer Arrangements | 27 |
| Assistance and Information | 1 |
| Attitude/Behaviour | 118 |
| Care and Treatment | 232 |
| Carers Issues | 1 |
| Catering | 2 |
| Communication | 32 |
| Complaints Handling | 1 |
| Detention under the Mental Health Act | 13 |
| Discharge | 25 |
| Environment | 6 |
| Hotel Services/Catering/Portering/Security etc. | 2 |

| | |
|---|---|
| Other | 26 |
| Patient privacy/dignity/confidentiality | 19 |
| Patients property | 7 |
| Policy/Corporate decisions | 5 |
| Wellbeing & Restraint | 1 |
| **Totals:** | **533** |

The highest number of complaints received were categorised under the Care and Treatment category including concerns relating to co-ordination of treatment, poor care planning, problems with medication, lack of therapies and behaviour issues.

Quarter 3 saw a marked increase in the number of Care and Treatment related formal complaints with the highest reporters being Assessment & Liaison Service (Southwark South), Assessment & Liaison Service (Lambeth South), A&E MH Liaison Service, KCH and Assessment & Liaison Service (Croydon East) which accounted for 15% of the total reported Care and Treatment related formal complaints reported for this period.

As part of on-going work to address in response to the increasing dissatisfaction, the service

- Planned an administration away day which included a patient speaker. As an interim measure the administrative team attended a well-received day of customer service training
- Formalised team meetings at which quality standards, patient concerns and complaints are reviewed. One team meeting a week focuses on reflective practice to improve learning and increase conversations about the impact of staff behaviour on patients
- Carried out on a communications survey to analyse and take forward different ways to improve communication, which would better accommodate the needs and preferences of patients
- Worked with PALS to provide reference information to ensure some more frequent enquiries could be addressed in a more timely manner
- Continues to work with the ePJS team to explore regarding electronic solutions to clinic processes
- Liaising with commissioners to review communication with patients and general practioners.

**Compliments**

The Trust formally recorded 310 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 have been summarised below.

| Directorate | Number |
|---|---|
| Addictions | 54 |
| BDP | 38 |
| CAMHS | 6 |
| Corporate | 11 |
| Croydon | 21 |
| Lambeth | 12 |
| Lewisham | 25 |
| PMOA | 99 |
| Southwark | 44 |
| **Totals:** | 310 |

| Ward | Description |
|---|---|
| Centre for Anxiety Disorders and Trauma, 99 Denmark Hill | "Thank you for the work that you did with me in CBT a couple of years ago. I have benefited a huge amount and I can really say that my life has improved greatly because of it. Thank you so much for being caring, thoughtful and attentive in our sessions. You have really changed my life." |
| Ruskin, AL2, Maudsley Hospital | Family thanked the Ruskin team for the care and treatment that was given to the patient. They feel that their sister is now on the road to recovery and brothers have reported that they are happy with all the patient's care at the Maudsley. |
| Mother & Baby Unit (Inpatient), BRH | "Thank you for the compassion, the hugs, words of wisdom, the laughs, the jokes, being taught how to twerk and for looking after us both with unconditional level of support." |

**Research and development**

R&D is at the core of SLaM's identity of quality and excellence. A key aim is that all of our service users are offered the opportunity to participate in research appropriate to their interests and to place them at the centre of our research endeavour. We actively encourage service user involvement in the

research process itself, through collaboration with researchers in the design, implementation and oversight of research, such as through membership of the Service User Research Enterprise (SURE) at IoPPN/SLaM and representation on the Trust R&D Committee.

SLaM 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 Maudsley Biomedical Research Centre (BRC), now under its third 5-year period of competitively awarded National Institute for Health (NIHR) funding. Our approach is to seek ways to promptly and effectively translate our research findings into clinical settings, enhancing the transfer of knowledge from research into practice and service development, not just within our own Trust, but nationally and globally. Reciprocally, we work with our partners to help answer new research questions prompted by clinical need. With our world-leading specialist research facilities and close interactions between the Trust and the university 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 ensure 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.

Our research has shown impact in many areas, for example:

- First episode rapid early intervention service for eating disorders - service model is now rolled out in several eating disorder services in England.
- Domestic violence and abuse and mental health – our intervention has been cited by NICE and WHO as a rationale for routine enquiry; our training materials are used by NHS, social care and domestic violence sectors.
- Our antenatal depression guided self-help intervention is being used by many of the IAPT services across England

We continue to build our collaborations and partnerships with industry through our Centre for CNS Therapeutics while our new Centre for Translational Informatics (CTI) introduces a fresh perspective on commercial research, focusing on digital innovations. Using our specialised Clinical Research

Facility, extensive databases, and consent-gathering procedures, we are well placed to lead trials of new treatments. Our close 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).

A key priority for the Trust is a campaign to bring about a societal change in mental health with the ambition for every child to enter adulthood with robust mental health. This will include a Centre for Children and Young People's Mental Health, bringing together scientists, clinicians and educators form SLaM and King's College London.

**Signed**

**Dr Matthew Patrick**
Chief Executive
South London and Maudsley NHS Foundation Trust
Date:23 May 2019

## 2.2 Remuneration report

**Annual Statement**

There have been no changes to the majority of the Trusts 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.

An opinion is sought from NHS Improvement where salaries for senior staff exceed £150,000. Salaries over £150,000 are benchmarked to the market. No appointment is confirmed until an opinion has been received.

**Mr Duncan Hames**

**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.

**Executive director remuneration:**

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

| Salary + Pension | = | Total Remuneration |
|---|---|---|
| Salary:<br>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:<br>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. Mr Duncan Hames is Chair of the Remuneration Committee.

The Chief Executive and the Director of HR, OD and Education and Development act as Advisors to the Committee.

**Remuneration Committee Attendance:**

| Name | Role | No. of attendances |
|---|---|---|
| Roger Paffard | Trust Chair (until April 30 2019) | 1 |
| Duncan Hames | Non-Executive Director and Remuneration Committee Chair | 1 |
| June Mulroy | Non-Executive Director | 1 |
| Anna Walker | Non-Executive Director | 1 |
| Mike Franklin | Non-Executive Director | 1 |
| Geraldine Strathdee | Non-Executive Director | 1 |
| Béatrice Butsana-Sita | Non-Executive Director | 1 |

During the reporting period, the Committee met once.

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, set those 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 Managers' remuneration is subject to the achievement of satisfactory performance.

Consideration is given to pay and conditions of all employees when setting senior managers remuneration policy.

**Senior managers service contracts**

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

| Name | Role | Start Date | Term of Office | Notice Period |
|---|---|---|---|---|
| Roger Paffard | Chair | 12 January 2015 | 3 years (renewed from January 2018). Stepped down April 2019 | N/A |
| Duncan Hames | Non-Executive Director | 12 May 2016 | 3 years (renewed from May 2019) | N/A |
| June Mulroy | Non-Executive Director | 12 January 2015 | 3 years (renewed from January 2018) | N/A |
| Geraldine Strathdee | Non-Executive Director | 1 January 2018 | 3 years (renewable) | N/A |
| Alan Downey | Non-Executive Director | 24 June 2014 | Stepped down 30 June 2018 | N/A |
| Professor Ian Everall | Non-Executive Director | 1 September 2017 | 3 years (renewable) | N/A |
| Mike Franklin | Non-Executive Director | 23 May 2016 | 3 years (renewed from May 2019) | N/A |
| Anna Walker | Non-Executive Director | 1 July 2016 | 3 years (renewed from July 2019) | N/A |
| Béatrice Butsana-Sita | Non-Executive Director | 14 December 2018 | 3 years (renewable) | N/A |
| Dr Matthew Patrick | Chief Executive | 7 August 2015 | 5 years fixed term; stepping | 6 months |

| | | | | |
|---|---|---|---|---|
| | | | down in July 2019 | |
| Dr Michael Holland | Medical Director | 6 September 2016 | Open ended | 12 weeks (medical terms and conditions) |
| Gus Heafield | Chief Financial Officer | 1 April 1996 | Open ended | 6 months |
| Beverley Murphy | Director of Nursing | 1 May 2017 | Open ended | 6 months |
| Kristin Dominy | Chief Operating Officer | 14 August 2015 | Open-ended | 6 months |
| Altaf Kara | Commercial and Strategy Director | 28 November 2017 | Open-ended | 6 months |

**Signed**

**Dr Matthew Patrick**
Chief Executive
South London and Maudsley NHS Foundation Trust
Date:23 May 2019

## Single total figure table – salary and pension entitlements of senior employees (Audited)

| Name and role | | Salary and fees (bands of £5k) | Pension related benefits (bands of 2.5k) | Total Pay (salary plus pension benefits) (bands of £5k | Real increase in pension at age 60 (bands of £2.5k) | Lump sum at age 60 related to accrued pension (bands of £2.5k) | Total accrued pension at age 60 (bands of £5k) | Lump sum at age 60 related to accrued pension (bands of £5k) | Cash Equivalent Transfer Value (CETV) | Real increase in Cash Equivalent Transfer Value (CETV) | Expenses |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| Roger Paffard:<br>Chair | **2019** | 55-60 | - | 55-60 | - | - | - | - | - | - | - |
| | *2018* | *55-60* | | *55-60* | | | | | | | |
| Duncan Hames: Non-Executive Director/Chairof Audit Committee | **2019** | 15-20 | - | 15-20 | - | - | - | - | - | - | - |
| | *2018* | *15-20* | | *15-20* | | | | | | | |
| June Mulroy:<br>Non-Executive Director | **2019** | 10-15 | - | 10-15 | - | - | - | - | - | - | - |
| | *2018* | *10-15* | | *10-15* | | | | | | | |
| Geraldine Strathdee:<br>Non-Executive Director | **2019** | 10-15 | - | 10-15 | - | - | - | - | - | - | - |
| | *2018* | *0-5* | | *0-5* | | | | | | | |
| Alan Downey:<br>Non-Executive Director (to 1 July 2018) | **2019** | 10-15 | - | 10-15 | - | - | - | - | - | - | - |
| | *2018* | *10-15* | | *10-15* | | | | | | | |
| Professor Ian Everall:<br>Non-Executive Director | **2019** | 0-5 | - | 0-5 | - | - | - | - | - | - | - |
| | *2018* | *0-5* | | *0-5* | | | | | | | |
| Mike Franklin:<br>Non-Executive Director | **2019** | 10-15 | - | 10-15 | - | - | - | - | - | - | - |
| | *2018* | *10-15* | | *10-15* | | | | | | | |
| Beatrice Butsana-Sita:<br>Non-Executive Director (from 18 December 2018) | **2019** | 10-15 | - | 10-15 | - | - | - | - | - | - | - |
| Anna Walker:<br>Non-Executive Director | **2019** | 10-15 | - | 10-15 | - | - | - | - | - | - | - |
| | *2018* | *10-15* | | *10-15* | | | | | | | |
| Dr Matthew Patrick:<br>Chief Executive | **2019** | 135-140 | - | 135-140 | - | - | - | - | - | - | - |
| | *2018* | *135-140* | | *135-140* | | | | | | | |
| Dr Michael Holland:<br>Medical Director | **2019** | 165-170 | 160-162.5 | 330-335 | 7.5-10 | 12.5-15 | 50-55 | 115-120 | 879 | 223 | - |
| | *2018* | *160-165* | *80-82.5* | *245-250* | *5-7.5* | *5-7.5* | *40-45* | *100-105* | *637* | *100* | |
| Gus Heafield:<br>Chief Financial Officer | **2019** | 145-150 | 0-2.5 | 150-155 | 0-2.5 | 5-7.5 | 40-45 | 130-135 | 989 | 130 | - |
| | *2018* | *145-150* | *10-12.5* | *155-160* | *0-2.5* | *2.5-5* | *40-45* | *125-130* | *850* | *74* | |
| Beverley Murphy:<br>Director of Nursing | **2019** | 135-140 | 105-107.5 | 245-250 | 5-7.5 | 20-22.5 | 65-70 | 200-205 | 1,364 | 274 | - |
| | *2018* | *125-130* | *140-142.5* | *270-275* | *5-7.5* | *20-22.5* | *60-65* | *180-185* | *1,079* | *130* | |
| Kristin Dominy:<br>Chief Operating Officer | **2019** | 140-145 | - | 140-145 | - | - | - | - | - | - | - |
| | *2018* | *140-145* | | *140-145* | | | *60-65* | *185-190* | *1,256* | *67* | |
| Altaf Kara:<br>Commercial and Strategy Director | **2019** | 155-160 | - | 155-160 | - | - | - | - | - | - | - |
| | *2018* | *50-55* | | *50-55* | | | | | | | |

**Median Pay Disclosures (Audited)**

| | 2018<br>000's | 2019<br>000's |
|---|---|---|
| Total Directors remuneration: | 873 | 895 |
| Total employer's contributions: | 68 | 58 |
| Number of Directors to whom benefits are accruing under defined benefit schemes | 4 | 3 |

| | 2018<br>000's | 2019<br>000's |
|---|---|---|
| Mid Point of Band of Highest Paid Director: M Holland. | £162.5 | £167.5 |
| Median Staff remuneration | £37,113 | £36,537 |
| Ratio of highest paid director to median staff remuneration | 4.5 | 4.6 |

There were no benefits-in-kind received by senior employees

There were no performance related bonuses and there are no long term performance related bonuses.

Individuals have been informed of the intention to disclose information about them, invited to review the information and given the opportunity to object under the General Data Protection Regulation (GDPR).

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 an arrangement to secure pension benefits in another pension scheme or arrangement when the members leaves the scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme not just their service in a senior capacity to which the disclosure applied. 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 pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV's 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.

The following are subject to audit:
The single total figure of remuneration for each director (table above) and CETV disclosures (table above). There were no payments made to past Directors. Payments for loss of office is outlined above and is in line with standard loss of office processes for all staff. Fair pay disclosures, exit packages and analysis of staff number and costs are also subject to audit.

**Signed**

**Dr Matthew Patrick**
Chief Executive
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

## 2.3 Staff report

### Workforce Strategies and staffing systems

The Trust aims to provide the best possible care to the people it serves and to continually review the workforce profile to maintain a skilled, adaptable and efficient workforce that is able to deliver efficient high-quality services and fulfil the Trust's contractual, regulatory and statutory obligations.

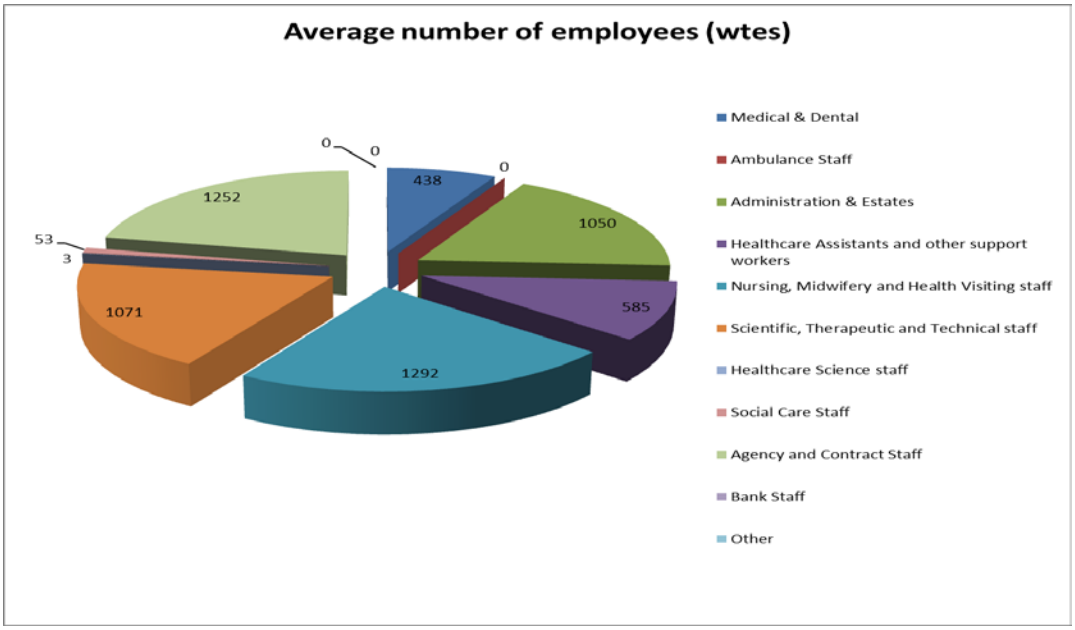
There is regular reporting through the Quality sub-Committee, the Audit Committee and the Equalities and Workforce Committee on workforce activities and initiatives which contribute to, and support the operational workforce plan. Each month the Performance Report presented to the Board includes information on safer staffing levels, Trust agency spend and mandatory training compliance.

Workforce Plans which concern the provision and delivery of services to patients are service-led and modelled around patient safety, quality and financial viability to ensure we provide effective, efficient and high quality care to our patients. All changes to services which have an impact on patients are consulted on with a view to achieving the best service possible. All plans are validated by local services responsible for delivery and the Trust's' Senior Management Team.

We have a committed and engaged workforce with our overall Staff Engagement scores from the Staff Survey 2017 being equal to the national average for Mental Health Trusts. However, we recognise there is still more to work on. There is acknowledgement that for some groups their experience at work can be different to that of others. We have developed our BME Network and Lived experience Network (LEN) to help ensure under-represented groups have the support they need to fulfil their roles to their greatest potential.

### Our workforce profiles

South London and Maudsley has more than 230 services including inpatient wards, outpatient and community services, and have over 4,800 substantive staff working for us across a range of different professional groups. 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.




The figures below are based on the average number (whole time equivalent) staff we have employed through the year.

| Average number of employees (WTE) | Total Number |
|---|---|
| Medical & Dental | 438 |
| Ambulance Staff | 0 |
| Administration & Estates | 1050 |
| Healthcare Assistants and other support workers | 585 |
| Nursing, Midwifery and Health Visiting staff | 1292 |
| Scientific, Therapeutic and Technical staff | 1071 |
| Healthcare Science staff | 3 |
| Social Care Staff | 53 |
| Agency and Contract Staff | 1100 |
| Bank Staff | 0 |
| Other | 0 |
| Total | 5593 |

**Staffing costs (Audited)**

| | 000,s |
|---|---|
| Salaries and wages | 195,740 |
| Social security costs | 19,011 |
| Apprenticeship levy | 911 |

| | |
|---|---|
| Pension cost – employers contribution to NHS Pension scheme | 29,935 |
| Pension cost - other | 0 |
| Other post-employment benefits | 0 |
| Termination benefits | 0 |
| Temporary staff – external NHSP bank | 27,238 |
| Temporary staff - agency/contract staff | 19,067 |
| **TOTAL GROSS STAFF COSTS** | **285,902** |

Registered nurses (Nursing, Midwifery and health visiting staff) form the largest part of the workforce at 29%. When combined with healthcare assistants (support to nursing) this makes up over 42% of the overall workforce. Our agency workers are mainly comprised of NHS Professional bank workers. The largest proportion of agency workers (which includes NHS Professionals) will also be registered nurses. Scientific, Therapeutic and Technical staff which includes Psychology, Psychotherapy and Allied Health Professions staff remain the second largest group followed by Administration & Estates. Over the course of the year £1,646k 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 were required and providing further training. The Trust's Occupational Health department provides advice where staff become disabled during their employment. We operate under "disability confident" status and offer any disabled applicant a guaranteed interview where they meet the minimum requirements and have Mindful Employer status. The latter of which has recently been renewed. We will report and publish our Workforce Disability Equality Standard (WDES) later in the year.

During the reporting period the Trust continued to deliver its equality objectives and published equality information (including data on the Workforce Race Equality Standard) as part of its Integrated Equalities Action Plan 2018-21 to comply with the public sector equality duty. The Trust published its Workforce Race Equality Standard (WRES) data in July 2018 and is continuing to implement Year 2 of our WRES Action Plan and build upon the work started in Year 1 to improve equality, diversity and access.

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 Executive Walkarounds and Changing Lives roadshows, 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 Equalities and Workforce Committee. Staff can have direct access to our Freedom to Speak Up Guardian and a number of advocates.

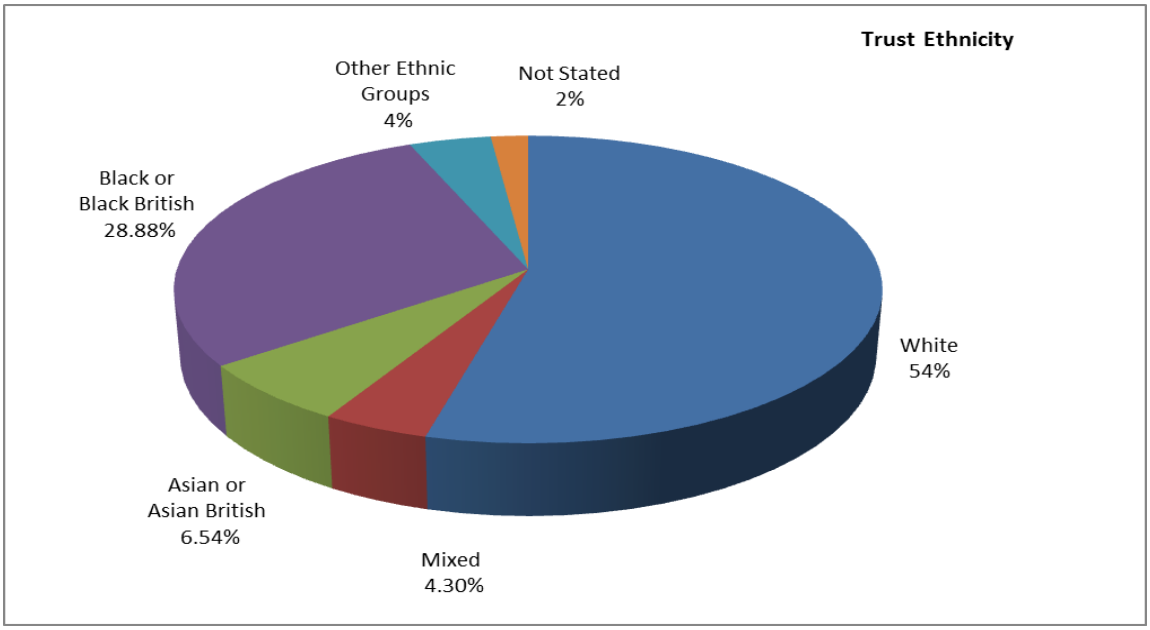
During the year we have continued with our extensive performance development (appraisal) programme where 90% of all non-medical staff had a performance development review to ensure the activities undertaken work towards the Trust's overall performance. All appraisals are recorded on our LEAP training and development platform. 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.

**Sickness absence and occupational health**

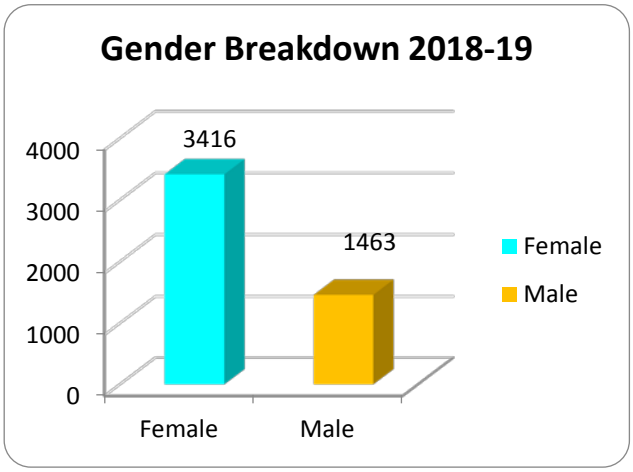
The sickness level for 2018/19 was 2.95% which has decreased from 3.06% in March 2018. The Trust moved to using a common denominator of 365 days in the last year. The Trust actively promotes health and wellbeing amongst employees. All staff members have access to the Trust's occupational health service, Employee Assistance programme, physiotherapy and the staff counselling and wellbeing service. Information on health, safety and occupational health is published on the Trust's new intranet – "Maud". The Trust has been awarded Achievement status under the London Healthy Workplace Charter. Staff are also actively encouraged to participate in Schwartz rounds and access support from the Critical Incident Support Service following a traumatic event at work plus Reflective Practice. Staff are signposted to a range of health and wellbeing information and support via the intranet and other useful sources of help and guidance.

**Trust ethnicity profile**




Staff from a White ethnic background remain the largest proportion in the workforce and has reduced by 2% on the previous year and now marginally lower 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 almost 2% and remains fairly consistent with the local populations across the boroughs. Asian or Asian British has remained the same compared to the last couple of years.

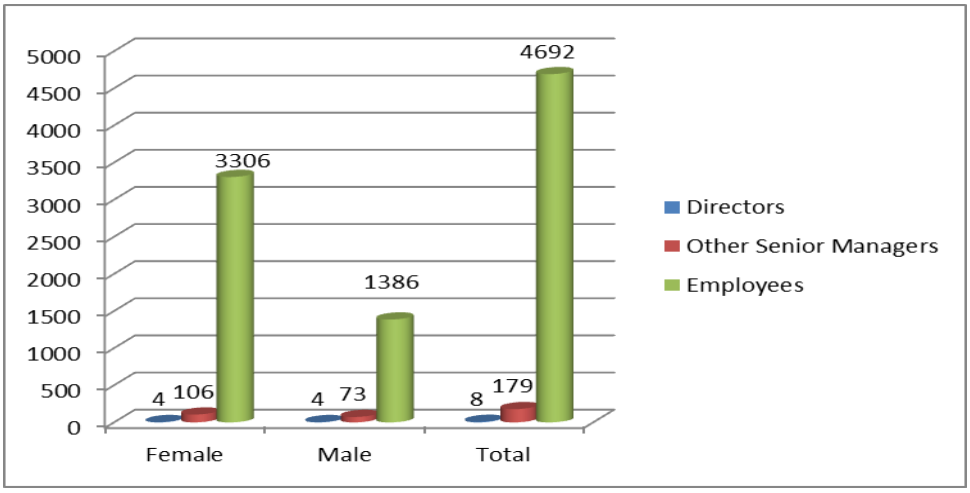
**Trust gender profile**




The Trust gender profile has changed marginally from the previous year with a slight increase in female staff and a contrasting slight decrease in male staff.

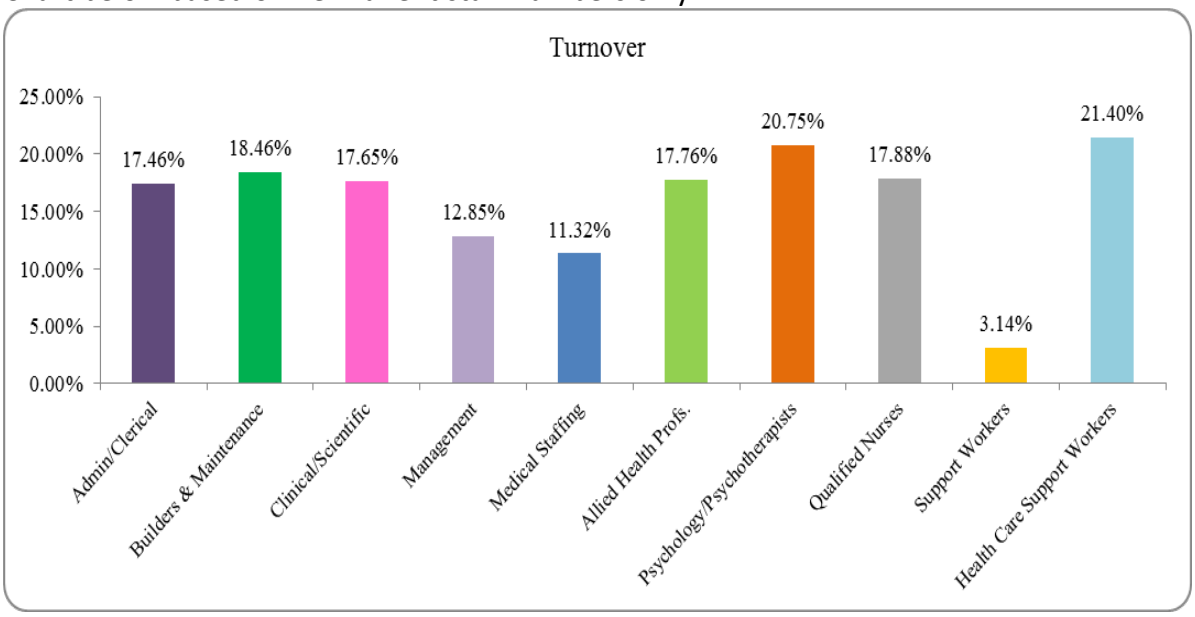
**Gender data**

| Gender Breakdown 2018-19 | Female | Male | Total |
|---|---|---|---|
| Directors | 4 | 4 | 8 |
| Other Senior Managers | 106 | 73 | 179 |
| Employees | 3306 | 1386 | 4692 |
| Total | 3416 | 1463 | 4879 |




**Staff turnover**

Chart below based on Permanent staff numbers only



Staff turnover has been highest in the healthcare support worker group with one fifth of staff leaving over the past year. The largest increase in turnover compared to the previous year has been in building and maintenance staff. Qualified nursing has also seen increased turnover from the previous year as has Allied Health Professions. Psychology/Psychotherapy plus Medical staff groups have seen reductions in turnover and Administrative and Clerical has remained relatively the same.

**Staff exit packages (Audited)**

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.

**Staff exit packages**

| Number of staff exit packages by cost band | £ 000's | Compulsory redundancy No. | Other No. | 2019 Total No. | 2018 Total No. |
|---|---|---|---|---|---|
| | 0-10 | 4 | - | 4 | 3 |
| | 10-25 | 1 | 1 | 2 | 4 |
| | 25-50 | 6 | - | 6 | 5 |
| | 50-100 | 3 | - | 3 | 6 |
| | 100-150 | 1 | - | 1 | 2 |
| | 150-200 | - | - | - | 2 |
| | 200-250 | - | - | - | - |
| | | 15 | 1 | 16 | 22 |
| Cost of staff exit packages | | £ 000's 601 | £ 000's 15 | £ 000's 616 | £ 000's 1,318 |

**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:

| | Number |
|---|---|
| Number of existing engagements as of 31 March 2017 | 19 |
| Of which, the number that have existed: | |
| for less than 1 year at the time of reporting | 2 |
| for between 1 and 2 years at the time of reporting | 4 |
| for between 2 and 3 years at the time of reporting | 2 |
| for between 3 and 4 years at the time of reporting | 6 |
| for 4 or more years at the time of reporting | 5 |
| 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. | yes |

**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

| | Number |
|---|---|
| Number of new engagements between 1 April 2016 and 31 March 2017 | 6 |
| Number of new engagements which include contractual clauses giving SLaM the right to request assurance in relation to income tax and NI obligations | 6 |
| Number for whom assurance has been requested | 6 |
| Of which: | |
| assurance has been received | 6 |
| assurance has not been received | 0 |
| engagements terminated as a result of assurance not being received, or ended before assurance received. | 0 |

**TABLE 3**

For off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2016and 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 |
| 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 |

**Off payroll arrangements**

In accordance with HM Treasury definitions the following tables outline the number of off-payroll payments for more than £245 per day, which have been in excess of six 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 Executive Leadership Team. This includes the use of agency staff within infrastructure and corporate services.

**TABLE 1**

For all off payroll engagements, as of 31 March 2019 for more than £245 per day and that last longer than six months:

| | Number |
|---|---|
| Number of existing engagements as of 31 March 2019 | 0 |
| Of which, the number that have existed: | |
| for less than 1 year at the time of reporting | 0 |
| for between 1 and 2 years at the time of reporting | 0 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 0 |
| for 4 or more years at the time of reporting | |
| 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. | Y |

**TABLE 2**

For all new off payroll engagements between 1 April 2018 and 31 March 2019, for more than

£245 per day and that last longer than 6 months

| |
|---|
| Number of new engagements between 1 April 2018 and 31 March 2019 |
| Number of new engagements which include contractual clauses giving SLaM the right to request assurance in relation to income tax and NI obligations |
| Number for whom assurance has been requested |
| Of which: |
| assurance has been received |
| assurance has not been received |
| engagements terminated as a result of assurance not being recieved, or ended before assurance received. |

**TABLE 3**

For off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2018 and 31 March 2019

| | Number |
|---|---|
| No. of off-payroll engagements of board members and/or senior officials with significant financial responsibility during the financial year | 0 |
| 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. | 6 |

**Pension Scheme**

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 .The Trust's contract with SBS for payroll services covers this

**Staff survey results**

This year 1939 employees of Trust's eligible workforce completed the survey. The response rate to the survey was 43% which is a slight decrease on the 2017 response rate of 44%.

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. 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 fourth 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.

| Response | | | | |
|---|---|---|---|---|
| | 2017 | 2018 | | Trust Improvement/deterioration |
| | Trust | Trust | Mental Health and LD average | |
| Response Rate | 44% | 43% | 54% | Reduction of 1% |

| | 2018/19 | | 2017/18 | | 2016/17 | |
|---|---|---|---|---|---|---|
| | Trust | Benchmarking Group | Trust | Benchmarking Group | Trust | Benchmarking Group |
| Equality, diversity and inclusion | 8.3 | 8.8 | 8.6 | 9.0 | 8.6 | 9.0 |
| Health and wellbeing | 5.7 | 6.1 | 6.0 | 6.2 | 6.0 | 6.2 |
| Immediate Managers | 7.1 | 7.2 | 7.1 | 7.2 | 7.0 | 7.1 |
| Morale | 5.9 | 6.2 | - | - | - | - |
| Quality of appraisals | 5.5 | 5.7 | 5.7 | 5.5 | 5.7 | 5.5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Quality of care | 7.3 | 7.3 | 7.3 | 7.3 | 7.4 | 7.4 |
| Safe environment – bullying and harassment | 7.7 | 7.9 | 7.8 | 8.0 | 7.8 | 8.0 |
| Safe environment - violence | 9.1 | 9.3 | 9.0 | 9.2 | 9.1 | 9.2 |
| Safety culture | 6.6 | 6.7 | 6.7 | 6.7 | 6.6 | 6.6 |
| Staff Engagement | 7.0 | 7.0 | 7.0 | 7.0 | 7.0 | 6.9 |

- No data available for this theme for previous years

The trust embarked on a series of actions over the past year to address the clear messages from the 2017 survey. These included:

- Programme of executive visits to every team
- Encouraging managers to allow more flexible working, with the Director of HR looking into every case that is appealed
- Pilots to re-introduce long days for nursing staff
- Four Steps to Safety to reduce violence that staff face on our wards
- Introduction of Diversity in Recruitment champions so that there is a BME panel member on every interview at band 7 and above, to ensure fairness
- Training 500 managers and supervisors in Inclusive Leadership
- Nurse Development programme offering a clear career path for all nurses from band 2 upwards
- Review and Reflect checklist to encourage informal resolution of problems and ensure our disciplinary processes are fair
- Mentoring programme for BME staff
- Supporting staff networks for BME, LGBTQ staff and staff with lived experience of mental health issues
- Promoting Freedom to Speak Up through our FTSU guardian and advocates so that everyone can feel able to speak out or raise concerns safely
- Working with staff focus groups on a plan to make SLaM a joyful place to work
- New intranet making it easier for staff to know what's going on
- Changing Lives roadshows to introduce our vision and plans for the future

We have been working hard to improve staff experience at SLaM following the 2017 results. This work has included improving our communication and engagement with staff with a programme of executive visits to every team. We launched a new intranet making it easier for staff to know what's

going on and ran Changing Lives roadshows to share our vision and plans for the future. Our re-organisation into borough-based clinical directorates has clearly had an impact though, with fewer staff saying they know their senior managers.

We have celebrated achievements and successes and it is pleasing that we have seen an improvement in staff feeling they get recognition for good work.

We have promoted Four Steps to Safety to reduce the violence that staff face on our wards, and fewer staff are reporting experiencing physical violence from colleagues than before.

Involving staff in service improvement through QI (Quality Improvement) has been high on our agenda, and we score well in the survey for staff feeling able to make improvements and for making good use of service user feedback.

Our staff are our eyes and ears, and we have been encouraging staff to speak up, and report errors incidents and near misses so we can learn from them. More staff this year are saying that we treat them fairly if they are involved in these events, but also more staff are saying that they have witnessed them.

We have focused on improving the experience of our BME staff, and introduced Diversity in Recruitment Champions so that there is a BME panel member on every interview for managerial posts at band 7 and above. We have trained 500 managers and supervisors in Inclusive Leadership and introduced a mentoring scheme. We introduced a Review and Reflect checklist to encourage informal resolution of problems and ensure our disciplinary processes are fair.

We have supported staff networks for BME, LGBTQ staff and launched a network for staff with lived experience of mental health issues.

Many of these actions need to be sustained over the long term to make a difference, and there is no indication in this latest survey that they are inappropriate. The Trust-wide action plan is largely therefore a reinforcement of actions that are already in train, though renewed energy is needed to ensure they start delivering tangible results.

**Top five scores**

Our top five scores were: ·

1. Staff getting regular feedback from service users – 68%
2. Effective use of service user feedback – 62%
3. Staff being appraised – 95%
4. Staff able to make improvements happen – 63%

5. Training and development needs identified – 75%

**Worst five scores**

Our bottom five scores were as follows:

1. Satisfaction with flexible working opportunities – 52%
2. Perceptions of equal opportunity in career progression or promotion – 72%
3. Staff working additional unpaid hours – 28%
4. Staff believing we take positive action on health and wellbeing – 21%
5. Staff thinking they will be looking to move away from the Trust within the next 12 months – 44%

**Staff Survey 2018 Trust-wide Action Plan**

| **Key Finding** | **Action in place or in progress** | **Further action proposed** |
|---|---|---|
| KF 6. Percentage of staff reporting good communication between senior management and staff | Executive visibility programme/QI walkabouts<br><br>Changing Lives roadshows<br><br>Staff fora | Leadership development<br><br>Setting expectations of all managers<br><br>Assessing managers against those expectations |
| KF 15. Percentage of staff satisfied with the opportunities for flexible working patterns | Flexible working policy<br><br>HRD review of flexible working appeals<br><br>E-rostering system<br><br>Pilots to re-introduce long days | Publish the results of the long days pilots and make decision<br><br>Promote the value of flexibility to managers<br><br>HRD to oversee all appeals |
| KF 16. Percentage of staff working extra unpaid hours | Recruitment campaigns targeting hot spots<br><br>Introduction of nurse associates<br><br>Guaranteed offer of employment to all new qualified nurses | Focused action on areas reporting high stress levels |

| | | |
|---|---|---|
| KF 19. Organisation and management interest in and action on health and wellbeing | Wellbeing action plan including Pause, eye tests, wellbeing events<br><br>OH and EA Programme<br><br>Staff Counselling Service and Crisis/Incident Support Service<br><br>Schwartz Rounds<br><br>Lived Experience Staff Network | Review of our health and well-being offer and the resources devoted to it.<br><br>Improved signposting and promotion through new intranet<br><br>Focused risk assessments and action on areas reporting high stress levels<br><br>Setting expectations of all managers |
| KF 20. Percentage of staff experiencing discrimination at work in the last 12 months | WRES/Snowy White Peaks action plan and aspirations<br><br>Inclusive Leadership programme – phases 1 and 2 (500 managers)<br><br>Reflect and Review checklist | WRES/SWP objectives for year 2<br><br>Inclusive Leadership Programme – phase 3 – remaining managers<br><br>WRES experts programme action plan |
| KF 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion | WRES/Snowy White Peaks action plan and aspirations<br><br>Diversity in Recruitment Champions<br><br>Transparency in acting up | WRES/SWP objectives for year 2<br><br>Inclusive Leadership Programme – phase 3 – remaining managers<br><br>WRES experts programme action plan<br><br>Publish data on profile of staff on leadership development programmes<br><br>Extend DiR Champions to all clinical roles at band 7 and above |

| | | |
|---|---|---|
| KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | Bullying & Harassment Policy<br><br>CEO open letter to all staff<br><br>Inclusive Leadership programme<br><br>Leadership development | Reinforce zero tolerance approach<br><br>Repeat CEO letter to staff |
| KF 27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse | Promotion of Freedom to Speak Up Guardian and champions<br><br>Inclusive Leadership programme | Reinforce zero tolerance approach<br><br>Repeat CEO letter to staff |
| KF 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month | QI Project Four Steps to Safety in inpatient areas<br><br>QI I-Care Project Improving Care and Outcomes for adult mental health (includes care process and patient flow)<br><br>QI Project on Community Safety<br><br>QI Project on improvements in Pharmacy | Continue Four Steps to Safety roll-out<br><br>Other directorate-based QI projects |

**Trade Union Facility Time**

Relevant Trade Union Officials:

| Number of employees who were relevant union officials during the relevant period | Full time equivalent employee number |
|---|---|
| 4 | 4.0 |

Percentage of time spent on facility time:

| Percentage of time | Number of employees |
|---|---|
| 0% | 0 |
| 1-50% | 4 |
| 51-99% | 0 |

| | |
|---|---|
| 100% | 0 |

Percentage of pay bill spent on facility time:

| First column | |
|---|---|
| Provide the total cost of facility time | £22,664 |
| Provide the total pay bill | £286,058,812 |
| Provide the percentage of total pay bill spent on facility time, calculated as:<br>(total cost of facility time ÷ total pay bill) x 100 | 0.008% |

Paid trade union activities:

| | |
|---|---|
| Time spent on trade union activities as a percentage of total paid facility time hours calculated as:<br><br>(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100 | 100% |

## 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**

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). Both were re-elected in December 2017 and January 2019. Susan Scarsbrook (Carer Governor) was elected to a newly created Deputy Lead Governor post in January 2019.

**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 regularly attend 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.

**Council of Governors meetings and attendance**

The following table sets out the details of our Governors, their attendance at Council of Governor meetings and their term of office.

| | | **CoG meeting** | | | | Period of service | |
|---|---|---|---|---|---|---|---|
| **Constituency** | **Name** | Jun | Sept | Dec | Mar | **Start** | **End** |
| **Chair** | **Roger Paffard** | Y | Y | Y | Y | Full year | |
| **Appointed Governor** | Bobby Abbott | A | Y | A | N | Full year | |
| **Staff Governor** | Ermias Alemu | Y | A | Y | Y | Full year | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Service User Governor** | Christine Andrews | A | N | A | - | | December 2018 |
| **Appointed Governor** | Jane Avis | Y | N | N | N | May 2018 | |
| **Service User Governor** | Ray Baker | - | - | Y | A | December 2018 | |
| **Service User Governor** | Mark Banham | N | A | - | - | | November 2018 |
| **Service User Governor** | Stephen Bawa | - | - | A | - | December 2018 | December 2018 |
| **Service User Governor** | Stella Branthonne-Foster | N | N | - | - | | November 2018 |
| **Public Governor** | James Canning | Y | Y | Y | A | Full year | |
| **Service User Governor** | Sean Casey | Y | A | A | A | Full year | |
| **Public Governor** | Handsen Chikowore | Y | Y | A | Y | Full year | |
| **Service User Governor** | David Clugston | - | - | Y | Y | December 2018 | |
| **Public Governor** | Jenny Cobley | Y | Y | Y | Y | Full year | |
| **Staff Governor** | Giles Constable | Y | A | Y | Y | Full year | |
| **Staff Governor** | Simon Darnley | Y | Y | Y | Y | Full year | |
| **Appointed Governor** | Ed Davie | A | Y | Y | A | May 2018 | |
| **Public Governor** | Janet Davies | A | A | A | A | Full year | |
| **Service User Governor** | Barbra Davison | N | - | - | - | | June 2018 |
| **Appointed Governor** | David Dawson | N | N | - | - | | September 2018 |
| **Appointed Governor** | Helen Dennis | - | - | Y | Y | July 2018 | |
| **Appointed Governor** | Jim Dickson | - | - | - | - | | May 2018 |
| **Carer Governor** | Angela Flood | A | Y | Y | Y | Full year | |
| **Appointed Governor** | Tom Flynn | - | - | - | - | | May 2018 |
| **Appointed Governor** | Heather Gilmour | - | - | Y | Y | November 2018 | |
| **Appointed Governor** | Dr Charles Gostling | Y | Y | A | Y | Full year | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Public Governor** | Ruth Govan | Y | N | A | Y | Full year | |
| **Service User Governor** | Kathryn Grant | Y | Y | A | Y | Full year | |
| **Appointed Governor** | Harpal Harrar | Y | N | N | N | Full year | |
| **Carer Governor** | Jeannie Hughes | Y | Y | Y | Y | Full year | |
| **Appointed Governor** | Bert Johnson | Y | Y | Y | Y | Full year | |
| **Public Governor** | Prof Michael Kopelman | - | - | Y | Y | December 2018 | |
| **Appointed Governor** | Nancy Kuchemann | Y | A | Y | Y | Full year | |
| **Public Governor** | Brian Lumsden | Y | Y | Y | Y | Full year | |
| **Service User Governor** | Clara Martins de Barros | Y | A | Y | A | Full year | |
| **Staff Governor** | Rosie Mundt- Leach | Y | Y | Y | Y | Full year | |
| **Appointed Governor** | Girda Niles | Y | N | A | N | Full year | |
| **Appointed Governor** | Prof Ian Norman | Y | Y | Y | Y | Full year | |
| **Service User Governor** | Phathiwe Ntini | N | N | - | - | | November 2018 |
| **Service User Governor** | Modupe Oluwapowale | - | - | - | Y | February 2019 | |
| **Service User Governor** | Zoe Rafah | Y | N | N | N | Full year | |
| **Carer Governor** | Susan Scarsbrook | Y | Y | Y | Y | Full year | |
| **Public Governor** | Gillian Sharpe | Y | Y | Y | Y | Full year | |
| **Appointed Governor** | Luke Sorba | Y | A | Y | Y | Full year | |
| **Service User Governor** | Tutiette Thomas | - | - | Y | Y | July 2018 | |
| **Public Governor** | Michael Tinarwo | N | N | N | - | | November 2018 |
| **Staff Governor** | Tom Werner | Y | - | - | - | | August 2018 |
| **Staff Governor** | Emma Williamson | Y | Y | Y | N | Full year | |
| **Appointed Governor** | Louisa Woodley | - | - | - | - | | May 2018 |

**Council of Governors' elections 2018-19**
One election was held in 2018, with results announced in November 2018.

| Constituency | Vacancies | Nominees | Number voted | % voted | Elected |
|---|---|---|---|---|---|
| Service user (local) | 3 | 6 | 42 | 6% | 3 |
| Public | 2 | 13 | 282 | 3% | 2 |
| Staff | 2 | 1 | N/A | N/A | 1 |

**Current vacancies**

- NHS England – 1 vacancy; appointed post has not been filled for some time.
- Service User (Local) – 1 vacancy; following a resignation there were insufficient candidates from the previous election to fill the role.
- Staff – 1 vacancy; there were insufficient candidates during the previous election process.

**Recruitment, training and development**
**Governor recruitment**
Ten new governors have joined the Council of Governors this year – four appointed, two stepped up to fill a vacant elected Governor position, and four elected. Two Governors were re-elected. Encouragingly, one of the newly elected Service User Governors was the subject of a Patient Story to the Board in summer 2018, and was encouraged to stand as a result of that experience.

The Council recently decided to introduce a second Deputy Lead Governor post for the benefit of succession planning for the role of Lead Governor.

**Governor training**
As well as offering Governwell courses (there has been take-up for the Accountability, Finance, Membership and Public Engagement courses), bespoke, in-house sessions have been arranged for Governors in response to their development needs and to help them in their roles. These have included a session on reading and understanding Finance reports with the Chief Financial Officer, and an introduction to commissioning led by the Director of Performance, Contracts and Operational Assurance at the Governors' Away Day. All new Governors are invited to SLaM-focused induction training.

**Engagement between governors, members and the public**
Two Members' Seminars (lunchtime seminars with expert speakers open to any members) have been held in 2018-19, with more planned for late Spring and Summer 2019. The Annual Members' Meeting took place in September 2018, with Governors on the steering committee and acting as "meeters and greeters" at the event and a stall for non-members to sign up.

Two of the Governors' Working Groups (Membership & Involvement and Planning & Strategy) have identified in their work plans for 2019-20 an aim to support the Trust in its dissemination of its *Changing Lives* strategy to staff and the wider population.

The annual data protection mailing will contain a free text space for members to feedback how they would like to engage with membership, this data will also be used to inform further ways in which governors can engage with members and the public membership.

**Membership strategy and efforts to engage a diverse range of members**

As well as holding Members' Seminars (as referenced above), the Governors (in conjunction with the Maudsley Charity) run a Bids Scheme, open to any members of the Trust. The scheme awards up to £750 to successful bidders so that they may run projects of benefit to at least three service users / carers.

Governors attend local events which are advertised via the Governors' weekly newsletter. This can lead to a rich source of information / contacts to reach a diverse range of members from across the constituency e.g. speakers.

The Membership & Involvement Working Group has identified an aim for its 2019-20 work plan to increase the number of staff (particularly more junior staff) standing for election to the Council of Governors, as well as raising awareness (and therefore hopefully increasing membership and candidates for election) from the BME population.

**Governor working groups and committees**

**Membership and Involvement Group:** 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 promotes 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 choosing one of the areas in the Quality report to be subject to audit by the Trust's Auditors.

**Planning and Strategy:** This group is concerned with the development of SLaM's key strategies and plans. This involves understanding and questioning why certain goals have been prioritised, how they will be monitored and achieved, how they will improve the quality of SLaM's services and the service

user and carer experience, and what organisational changes are required to support the implementation of the strategies.

**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. It works with the Maudsley Charity.

### 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

**Nominations Committee members and attendance**

| | | **23 May 2018** | **21 Nov 2018** |
|---|---|---|---|
| Roger Paffard | Nominations Committee Chair | **Y** | **Y** |
| Brian Lumsden | Staff Governor | **Y** | **Y** |
| Ian Norman | Appointed Governor | **Y** | **Y** |
| Susan Scarsbrook | Carer Governor | **Y** | **Y** |
| Gill Sharpe | Public Governor | **Y** | **Y** |
| Tom Werner (to July 2018) | Staff Governor | **y** | **N/A** |
| Simon Darnley (from October 2018) | Staff Governor | **N/A** | **Y** |

### 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 Trust 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. 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. The audience also includes our colleagues in King's Health Partners.

The Membership and Involvement Group, with support from the Non-Executive Directors, is actively looking at the composition of the Trust's membership and is developing plans for ensuring that they better represent the make-up of our local communities.

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.

**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.

Members elect the Governors who sit on the Council of Governors and help the Board to determine 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 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 stood at 16058 members on 31st March 2019.

| **Public constituency** | **At 31 March 2019** |
|---|---|
| At year start (1April 2018) | 9050 |
| New members | 1244 |
| Members leaving | 649 |
| At year end (31 March 2019) | 9645 |

| | |
|---|---|
| **Staff constituency** | |
| At year start (1 April 2018) | 4826 |
| New members | 1108 |
| Members leaving | 879 |
| At year end (31 March 2019) | 5055 |
| | |
| **Patient constituency (service user + carer)** | |
| At year start (1 April 2018) | 1337 |
| New members | 41 |
| Members leaving | 20 |
| At year end (31 March 2019) | 1358 |

Increased awareness of data security has been reflected in a slightly increased level of requests to be removed from membership.

**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:
Director of Corporate Affairs and Trust Secretary Rachel Evans,
Email: membership@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.

External evaluation of the Chair was undertaken by Qi consultants for the 2017 / 18 period and was undertaken in-house for the 2018 / 19 period. Qi consultants do not have other relevant connections to the Trust.

The statement of details of appointment to each Non-Executive Director set out the circumstances in which their appointment may be terminated, subject to the approval of the Council of Governors in general meeting. These circumstances include breach of obligations to the Trust, committing an act that brings the NED or the Trust into serious disrepute, committing an act of negligence or dishonesty, and more.

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 key messages are then presented to the full Council. 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.

The recruitment of new Non-Executive Directors has involved, with the agreement of the Nominations Committee, the use of external recruitment consultants and extensive advertising to ensure a robust and diverse field of applicants.

**Signed**

**Dr. Matthew Patrick**
Chief Executive
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

## 2.5 NHS Improvement's Single Oversight Framework

This segmentation information is the trust's position as at 31 March 2019**.** Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

| **Area** | **Metric** | **2018/19 Q3 score** | **2018/19 Q4 score** |
|---|---|---|---|
| Financial sustainability | Capital service capacity | 3 | 2 |
| | Liquidity | 1 | 1 |
| Financial efficiency | I&E margin | 2 | 1 |
| Financial controls | Distance from financial plan | 1 | 1 |
| | Agency spend | 3 | 3 |
| **Overall scoring** | | **2** | **2** |

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 South London and Maudsley 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 and Social Care 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 and Social Care 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

• ***confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the South London and Maudsley NHS Foundation Trust's performance, business model and strategy*** and

• 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 South London and Maudsley NHS Foundation Trust and to enable him 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 South London and Maudsley 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*.

**Signed**

**Dr Matthew Patrick**
Chief Executive
South London and Maudsley NHS Foundation Trust
Date:23 May 2019

## 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 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 South London and Maudsley NHS Foundation Trust for the year ended 31 March 2019 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 ways. The following sections define the organisational expectations of 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. The Director of Nursing also leads on Risk and Assurance strategy and has particular responsibility for Health and Safety.

**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.

**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.

**Operational Service Directors:** Operational Service Directors are accountable for ensuring that appropriate and effective risk management processes are in place within operational services, 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 they are captured on local risk registers, ensuring that risks are reviewed by an appropriate management group at least quarterly as part of performance monitoring, to consider and plan actions being taken.

They must ensure appropriate escalation of risks from team to pathway to directorate level within 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.

**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.

**Head of Risk and Assurance:** The Head of Risk and Assurance is the professional lead for the development and implementation of risk management strategy, oversight of risk management systems and risk registers and the co-ordination of the Board Assurance Framework

**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**

Like all NHS organisations, the Trust faces a wide range of risks as a provider of mental health care services – from patient-related treatment risks to organisational issues.

Risk management is a vital part of our governance and quality frameworks.

The Trust's Risk Management Strategy was approved by the Board in July 2016 and the annual action plan for 2018/19 approved in March 2018. 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. The strategy is being reviewed in 2019.

Our approach recognises the need to ensure that risks are openly discussed and reported within a culture of improvement and openness. We use a standard 5 x 5 matrix for risk scoring. All clinical and

corporate services, service line management and executive directors are expected to systematically review risks on their risk registers and to provide assurance that the risks are being managed through their local governance.

All significant risks are escalated to the Executive Risk Register and reviewed by the senior management team to consider whether further mitigation and moderation may take place. Where these risks could impact on the delivery of corporate objectives and business plan, they are mapped on to the board assurance framework, which is presented quarterly to both the Audit Committee and the Trust Board.

**Compliance with NHS Foundation Trust condition 4**

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 existing Board Committees are well-established, with a new Committee having been established in 2017 – the Equality and Workforce Committee. 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 performance and quality, 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.

**Work to assess services are well-led under NHS Improvement's well-led framework**

The Trust has given due regard to NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's governance, leadership, vision and capacity to deliver high-quality, sustainable services.

The Trust's five-year strategy, Changing Lives, was formally launched in Autumn 2018 and sets out five strategic aims to steer our work:

1. *Quality*: we will get the basics right in every contact and keep improving what matters to service users
2. *Partnership*: we will work together with service users, their support networks and whole populations to realise their potential
3. *A great place to work*: we will value, support and develop our managers and staff

4. *Innovation*: we will strive to be at the forefront of what is possible, exploiting our unique strengths in research and development, with everyone involved and learning
5. *Value*: we will make the best use of our assets, resources, relationships and reputation to support the best quality outcomes

The strategy has been developed in conjunction with staff, service users, carers and other stakeholders. More information about the strategy can be found elsewhere in this report.

See the Annual Governance Statement for more details of the Trust's systems of internal control, and how those structures monitor and support the improvement of service quality.

The Board Assurance Framework (BAF) is presented quarterly to the Audit Committee and the Board. In 2018-19, the Board also received "deep dives" into specific BAF risk at each meeting. Please see the section on the Board Assurance Framework in this Report for more information.

The overall purpose of the Trust's Quality Committee (QC) is to monitor improvement and provide assurance to the Board on quality across the Trust. It does this predominantly by:

- Ensuring there is a shared and communicated understanding of quality, monitoring the delivery of the Trust's quality priorities, the national mandatory requirements and professional regulators' standards and its annual national and local quality priorities, incentives and targets
- Focussing on the Trust's overarching system of quality, patient and staff safety and risk governance ensuring this covers the Trust as a whole, its organisational and clinical units, patient pathways and arrangements / partnerships / contractual arrangements with the local healthcare economy
- Having oversight of the Trust's mechanisms for involving service users and carers in all aspects of their care and at all levels of decision-making
- Examining service failures and ensuring action plans are in place and lessons learned
- Reviewing the information which underpins the monitoring of the Trust's quality strategy and approach and ensuring it is fit for purpose

The Quality Committee also receives Care Quality Commission reports following planned and responsive reviews of the Trust, monitoring and scrutinising action and sustainability plans arising from them. For more information, please see the Quality Accounts.

The Trust continues to identify opportunities for learning, including the introduction of Serious Incident (SI) discussions at the Board, as well as implementing a Trust-wide Serious Incident Review Group to increase the scrutiny and oversight of Duty of Candour for serious incident investigations.

Patient and Public Involvement (PPI) remains a priority for the Trust, with service user and carer involvement carried through from 2017-18 to 2018-19 as a Quality Priority. More information as to how the Trust engages patients, carers and other stakeholders can be found in the Quality Accounts.

**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 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.

**Business Development and Investment Committee**

The Committee is responsible for monitoring the business development, investment and commercial strategy and provides assurance to the Board in terms of investment decisions and scrutiny of the Trust's commercial activities.

**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 Committee is responsible for monitoring improvement and providing assurance to the Board on quality matters across the Trust, including the implementation of quality improvement. The Committee focuses on the Trust's overarching systems of quality, risk governance, and patient / staff

safety, ensuring these cover the Trust - its organisational and clinical units, patient pathways and arrangements / partnerships / contractual arrangements with the local healthcare economy as a whole. The Committee ensures that there is a shared and communicated understanding of quality, monitoring the delivery of the Trust's quality priorities, the national mandatory requirements, professional regulators' standards and the Trust's annual national and local quality priorities, incentives and targets. It examines service failures, ensuring that action plans are in place and lessons learned, whilst also having oversight of the Trust's mechanisms for involving service users and carers in all aspects of their care and at all levels of decision-making.

**Equalities and Workforce Committee**

This Committee provides assurance to the Board on the recruitment, retention, management and development of the Trust's workforce and the development of an equalities strategy.

**Executive Leadership Team**

The Executive Leadership Team - until February 2019 referred to as 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 Executive Risk Register and Board Assurance Framework, and for agreeing resourced treatment plans and ensuring their delivery.

**Operational and Corporate Directorate Risk Management Arrangements**

Operational and corporate areas will put the necessary arrangements in place within their areas for proper governance, safety, quality and risk management.

The Operational Directorate governance 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 Operational Directorate governance forums will develop, populate and review their risks, drawing on risk processes within the services, to ensure that Ward/team, Pathway and Operational Directorate 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 Operational Directorate 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.

**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.

**Register of interests for decision making staff**

SLaM has published its register of interests for decision making staff, within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance. It is on the website, here: https://slam.nhs.uk/about-us/policy-and-publications

**Equality**

The Trust continues to work hard to put its commitment to equality and diversity into everyday practice. Examples of the extensive activity on equality and inclusion have been set out earlier in the report.

**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**

In auditing the 2018/19 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 and savings plans for the next financial year. The plan is developed at Operations 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)
- Directorate 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 Operations and Borough 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 rust, 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 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 Data Security and Protection Toolkit is an updated annual online national self-assessment process overseen by NHS Digital, which enables the Trust to measure its compliance against the National Data Guardian's data security standards.

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.

| Summary of serious incidents requiring investigation involving personal data as reported to the Information Commissioner's Office in 2018-19 | | | | |
|---|---|---|---|---|
| Date of incident | Nature of incident | Nature of data involved | Number of individuals potentially affected | Notification steps |
| October 2018 | Inadvertent disclosure of personal email addresses | Service user email addresses | 60 | Escalated internally to senior responsible officers. Reported to the CCG and the ICO. Affected individuals were notified and supported. Fully investigated and actions completed. |
| December 2018 | Inadvertent disclosure of personal email addresses | Service user email addresses | 300 | |

**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 and quality reports are submitted to the Board every month. The same data sets are being considered at Directorate level, at Performance and Quality meetings, at Quality Committees and at the Board
- 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.
- Senior Managers visit teams across the Trust as part of a programme of Leadership Walkarounds – a key element of the Quality Improvement programme.
- Quality of services are monitored at the Quality Committee; a 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 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, the audit committee, and risk/ clinical governance/ quality committee, if appropriate, 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.

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 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.

The Head of Audit Opinion is as set out below:

> "I have considered all of the work conducted by internal audit staff during 2018/19. I have also considered work conducted by the Trust's Local Counter Fraud Specialist. This includes oversight of all internal audit reports, fraud investigations and personal conduct of specific projects during the year.
>
> "In my opinion, with the exception of those areas in which limited assurance reports have been issued as reported to the committee during the year, the controls in those areas reviewed are adequate and effective. Where weaknesses have been identified these are being addressed by management and actions have been confirmed through follow up work by internal audit.
>
> "I am satisfied that the Board Assurance Framework, as presented to the Audit Committee in 2018/19 over the course of the year is representative of the key risks faced by the organisation and that the processes are effective.
>
> "I confirm that I have monitored compliance with the Public Sector Internal Audit Standards. In my view, the department complies with those that are applicable to the public sector."

**Conclusion**

Our approach to identifying and managing significant risks is explained 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
Date: 23 May 2019

South London and Maudsley NHS Foundation Trust

# Quality Report 2018/2019

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# Part 1: Statement on quality from our Chief Executive

It is my pleasure to introduce the 2018/19 Quality Report. The report is an important way for the Trust to communicate our commitment to improving the services we deliver to our service-users, their families, their carers and our local communities, and to report on progress with our Quality Priorities

As a large, diverse mental health trust providing local and national services, we aim to make a difference to lives by seeking excellence in all areas of mental health and wellbeing: prevention, care, recovery, education and research. This year we refreshed the Changing Lives strategy with five strategic aims; Quality, partnership, a great place to work, Innovation and Value to help achieve this aim. Our staff, service users and Governors helped us to select our Quality Priorities.

Each year we work with our commissioners, the CCGs, to agree funding available to provide mental health services in the boroughs we serve. The CCGs have worked with us to ensure that across Lambeth, Lewisham, Southwark and Croydon we have an increase this year that will enable us to invest in improving services and continue to work towards the quality and performance standards set out in the 5 year forward view, and more recently the Long Term Plan. This year the Trust has received a 6.6% uplift across all CCG contracts for 2019/20.

Our priority now is to work with services to ensure investments are made in the right place to have most impact for the people that use our services and for our staff. Of course, to make this new investment count we must continue to carefully manage our existing resources and to ensure that we deliver real value – better outcomes for every pound we have to spend – for the people we serve.

South London and Maudsley NHS Foundation Trust (SLaM) continued its leadership role in joint working at system-level, covering 3.6 million people, through the South London Mental Health and Community Partnership (SLP), alongside Oxleas and South West London and St George's. Particularly significant progress was made in improving Adult Forensic patients' experience and care outcomes; providing care locally for CAMHS Tier 4 patients previously placed outside south London; and developing skills and improving retention rates across the south London NHS mental health nursing workforce. The SLP's work continued to deliver millions of pounds of savings for reinvestment in local services through improved commissioning, new services and clinical pathways, and has been recognised for innovation and best practice in national awards and by NHSI, NHSE and CQC.

It is becoming clearer and clearer that we have a shared challenge within our local communities linked to mental health and emotional vulnerability which is approaching critical public health proportions. At the same time, we are on the cusp of being able to transform our understanding, identification and treatment of mental health issues in children and young people. A new partnership between SLaM, the Institute of Psychiatry, Psychology and Neuroscience (IoPPN), Kings Health Partners (KHP) and the Maudsley Charity is seeking to radically transform our understanding, identification and treatment of mental health problems in children and young people.

The project's vision is for an ambitious programme of research, clinical innovation and education across three key themes – mother and baby, brain development, and contemporary childhood. The programme will connect clinicians and researchers working across SLaM and the IoPPN in a range of localities. It will also support the creation of a brand-new centre at Denmark Hill. It will be supported in part by the Trust's first major fundraising campaign, which will launch in September 2019.

We are committed to working with our partners to commission and deliver integrated health and social care at a neighbourhood and community level and we have progressed the development of our two alliance contracts, the Lambeth Living Well Network Alliance and Partnership Southwark.

As part of the Lambeth Alliance we are formal partners with Certitude, Lambeth Clinical Commissioning Group, Lambeth Council and Thames Reach. A key member of Partnership Southwark, we work alongside local GP

federations and elements of Guy's and St Thomas' community services. We are continuing to work with partners to develop other population-scale contracts across both Lewisham and Croydon.

In 2018 we set Quality Priorities that are aspirational. This report is given at the end of year one. During the first year we have built the foundation from which to make change and as we go into the second year, in some areas, we are confident we are beginning to see positive change.

Finally, our workforce is our most valuable asset and it is imperative that all staff feel valued, supported and engaged in order to provide the highest quality of service. Feedback from the Staff Survey and the BME Network indicates that the experiences by our BME staff are reported as less positive. Diversity and inclusion are core to the delivery of good high quality services by motivated and engaged staff and therefore the Trust Board has set the Organisation the challenge by Spring 2021 to improve the experience of our BME staff by setting some clear goals and objectives in this area, including improved representation of BME staff in senior positions and improved career opportunities. Although disappointed in the survey results, we see them as an invitation to redouble our efforts and lead positive change. We are confident in tour abilities in this regard.

In relation to the above, 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**

**Dr Matthew Patrick**

**Chief Executive Officer**
**South London and Maudsley NHS Foundation Trust**
Date: 23 May 2019

## Trust 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 - locally, nationally and internationally.

## Trust Strategy

During 2018 we refreshed our Trust Strategy which is named 'Changing Lives' because everything we do is to help people to improve their lives. The refreshed strategy was approved by the Board in September 2018 and launched in October 2018.

This strategy builds on the direction of travel set out in our previous strategy, with five strategic aims that include a strong focus on the quality of our services. These are:


Fig. 3: Trust strategic aims

## 2018/2019 quality priorities

The quality priorities set for 2018/2019 below incorporated the broader quality domains of patient safety, clinical effectiveness, and both patient and staff experience. Progress against these priorities are outlined later in this report. These areas continue to be priorities for 2019/2020.


Fig. 4: 2018/19 quality priorities

## Care Quality Commission (CQC)

Below highlights the current Trust CQC rating; the overall rating is Good.


Fig. 5: Current trust CQC rating

## Service user involvement

SLaM's Recovery College had 569 new students in the past year, with a total of 3,186 students participating since its launch with Maudsley Charity funding in 2014. Students consist of:

- People who use SLaM services
- Supporters (carers, family and friends) of SLaM's service users
- People who have been discharged from SLaM services within the last six months and their supporters
- Anyone working with SLaM as a volunteer or peer supporter or who is on the Involvement Register
- SLaM staff (not including students on clinical placement).


The workshops and courses aim to provide the tools for recovery through a learning approach that complements the existing services provided by the Trust. Every course and workshop are co-designed and co-run by trainers with lived experience working alongside trainers from the mental health profession.

The trust runs an Involvement Register as a way for the trust to advertise and allocate opportunities to people who want to use their experience of using our services to help us to develop and improve them in the future. The trust's Peer Support scheme provides additional support to people leaving services from people with a lived experience.

There are currently 350 active volunteers across the Trust, of which approximately 47% have had lived experience. Volunteers make a valued contribution to many areas and services across the trust, including inpatient wards, administration and reception areas, phlebotomy, community group befriending, football group volunteers, IT support for service users, peer support befriending, Bethlem Community Café, Bethlem Museum of the Mind and Gallery, and gardening.

# Part 2: Priorities for improvement and statements of assurances from the Board

## Statements of assurance from the Board

During 2018/19, SLaM provided or subcontracted 233 NHS 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 3,700 people each year and we treat more than 63,000 patients in the community in Lambeth, Southwark, Lewisham and Croydon, with a local population of 1.3 million with a rich diversity.

SLaM has reviewed all the data available to us on the quality of care in 233 of these NHS services.

- The income generated by the relevant health services reviewed in 2018/19represents 100 per cent of the total income generated from the provision of relevant health services by SLaM for 2018/19.

## Audits

### Participation in national quality improvement programmes

National quality accreditation schemes, and national clinical audit programmes are important for several 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.

During 2018/19, nine national clinical audits and one national confidential enquiry covered NHS services that SLaM provides.

During that period SLaM participated in 100% of the national clinical audits it was eligible to participate in and 100% of national confidential enquiries.

The national clinical audits and national confidential enquiries that SLaM was eligible to participate in and did participate in during 2018/19 are as follows: [insert list].

- Four national Prescribing Observatory for Mental Health (POMH-UK) audits:
  - Valproate prescribing in bipolar illness
  - Use of antipsychotic long-acting injections for relapse prevention
  - Use of Clozapine
  - Rapid tranquilisation
- Commissioning for Quality and Innovation (CQUIN) 2017/18 Indicator 3a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)
- National Audit of Care at the End of Life
- National Clinical Audit of Anxiety & Depression
- National Clinical Audit of Anxiety and Depression – Psychological Therapies Spotlight Audit
- National Clinical Audit of Psychosis
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The national clinical audits and national confidential enquires that SLaM participated in, and for which data collection was completed during 2018/19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- Commissioning for Quality and Innovation (CQUIN) 2017/18 Indicator 3a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) (n=150; 100%)
- National Audit of Care at the End of Life (N/A – site level responses required)
- National Clinical Audit of Anxiety & Depression (n=200; 100%)
- National Clinical Audit of Anxiety and Depression – Psychological Therapies Spotlight Audit (n=200; 100%)
- National Clinical Audit of Psychosis (n=200; 100%)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (N/A – Trust required to report every suicide and homicide incident; 100% compliance).

The reports of two national clinical audits were reviewed by the provider in 2018/19 and SLaM intends to take the following actions to improve the quality of healthcare provided.

| National Audit | Key actions |
|---|---|
| CQUIN Indicator 3a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) | Develop strategy to improve communication with GP mental health leads.<br>Physical Health Improvement and Implementation Leads to review and develop pathways to ensure appropriate physical health interventions are offered/received. |
| National Audit of Care at the End of Life | Report not yet available |
| National Clinical Audit of Anxiety & Depression | Report not yet available |
| National Clinical Audit of Anxiety and Depression – Psychological Therapies Spotlight Audit | Report not yet available |
| National Clinical Audit of Psychosis | Please see Fig. 24 below |

Fig. 23: Participation in national quality improvement programmes

**National Clinical Audit of Psychosis (NCAP) 2018**
In general performance was around the national average. Notable findings include:

- Monitoring of most physical health risk factors was above the national average.
- Prescribing practice was above average but provision of information to patients was below average in some respects.
- Availability of psychological therapies appeared to be above the national average.

Detailed recommendations are detailed in the table below, which Trust Leads will take forward.

| Recommendation topic | Detailed recommendation | NICE Guidance |
|---|---|---|
| Physical health monitoring | Have at least an annual assessment of cardiovascular risk (using the current version of Q-Risk) | NICE CG181, 1.1.8 |
| | Receive appropriate interventions informed by the results of the intervention | |
| | Have the results of this assessment and the details of the interventions offered recorded in their case record | |
| Psychological therapies and family interventions | Deploying sufficient numbers of trained staff who can deliver these interventions | NICE CG178, 1.4.4.1 |
| | Making sure that staff and clinical teams are aware of how and when to refer people for these treatments | |
| Provision of written information | Are given written or online information about the anti-psychotic medication they are prescribed | NICE CG178, 1.3.5.1 |
| | Are involved in the prescribing decision, including having a documented discussion about benefits and adverse effects of the medication. | |
| Employment and training opportunities | Ensure that all people with psychosis who are unable to attend mainstream education training or work are offered alternative educational activities according to their individual needs; and that interventions offered are documented in their care plan | NICE CG178, 1.5.8.1 |

| | | |
|---|---|---|
| Annual summary of care | An annual summary of care should be recorded for each patient in the digital care record. This should include information on medication history, therapies offered and PH monitoring/interventions; be updated annually; be shared with the patient and their primary care team. | N/A |
| Use of data in conjunction with NHS digital | NHS Digital, NWIS, Commissioners, Trusts and Health Boards should work together to put in place key indicators for which data can easily be collected, perhaps using an Annual summary of care (see rec 5). This work should be informed by the NCAP results and the experience of the NCAP team. | N/A |

Fig. 24: NCAP recommendations 2018

## 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 submitted data for the 2018-19 POMH-UK audits, as required. Below is a summary of the findings from those audits. SLAM is trust 022 and TNS is the total national sample.

**Use of antipsychotic long-acting injections for relapse prevention**

This survey assessed adherence with certain recommendations in the NICE guideline for the management of psychosis and schizophrenia in adults. SLAM submitted data for a random sample of community patients.

Overall, a higher proportion of patients in SLAM had evidence of the assessment of side effects of a depot, as shown below.

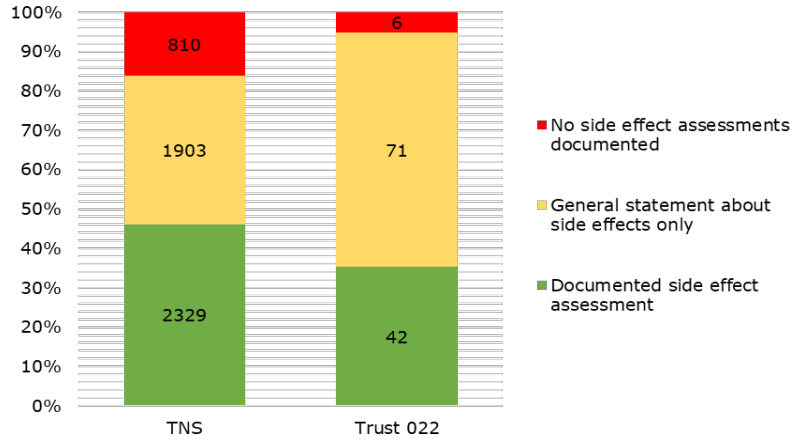



Fig. 25: POMH - Use of antipsychotic long-acting injections for relapse prevention

A similar proportion of patients in SLAM and the average national sample had received a medication review within the previous year and had a clinical plan documented in their notes for the management of non-adherence with a depot, as shown below.

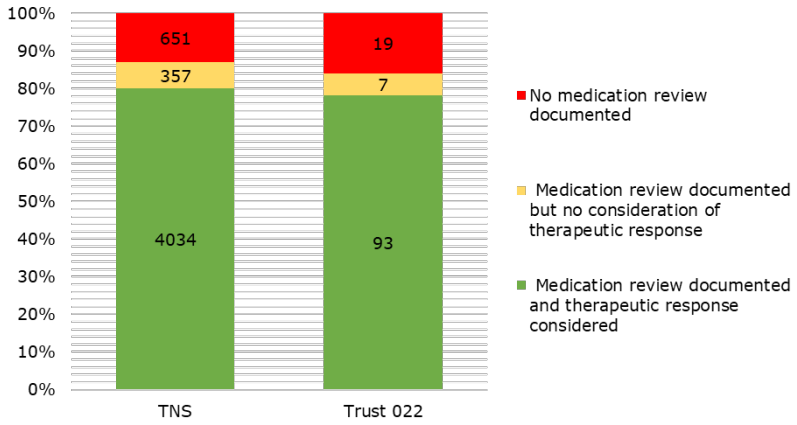



Fig. 26: POMH - Use of antipsychotic long-acting injections for relapse prevention

A similar proportion of patients in SLAM and the average national sample had a clinical plan documented in their notes for the management of non-adherence with a depot, as shown below.

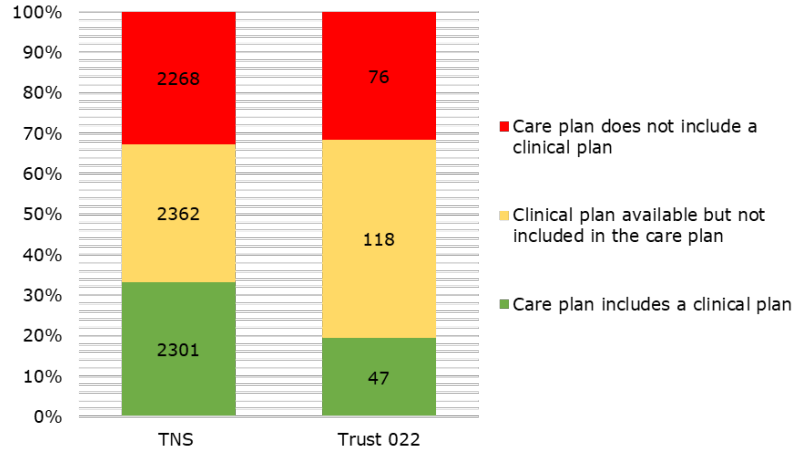



Fig. 27: POMH - Use of antipsychotic long-acting injections for relapse prevention

**Actions:** Clinicians have been informed of results and recommendations.

## POMH – valproate prescribing in bipolar illness

Valproate should not routinely be prescribed for women of childbearing age. All patients prescribed valproate should have an annual physical health check. In 2017 the trust participated in the re-audit of valproate use in bipolar disorder. Results were reported in 2018.

Overall, more patients had evidence of physical health monitoring in SLAM compared with the average national sample, as shown below.

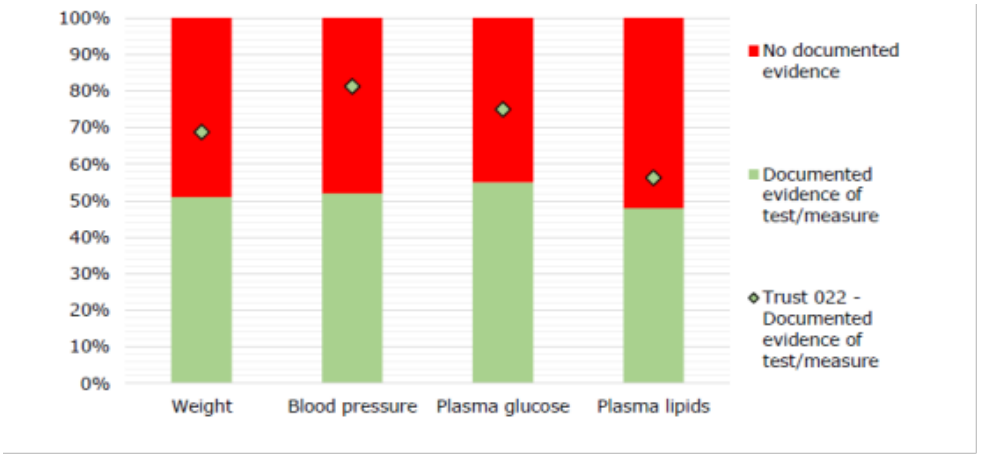



Fig. 28: POMH - valproate prescribing in bipolar illness

Fewer women of childbearing age were prescribed valproate in SLAM compared with the average national sample, as shown below.

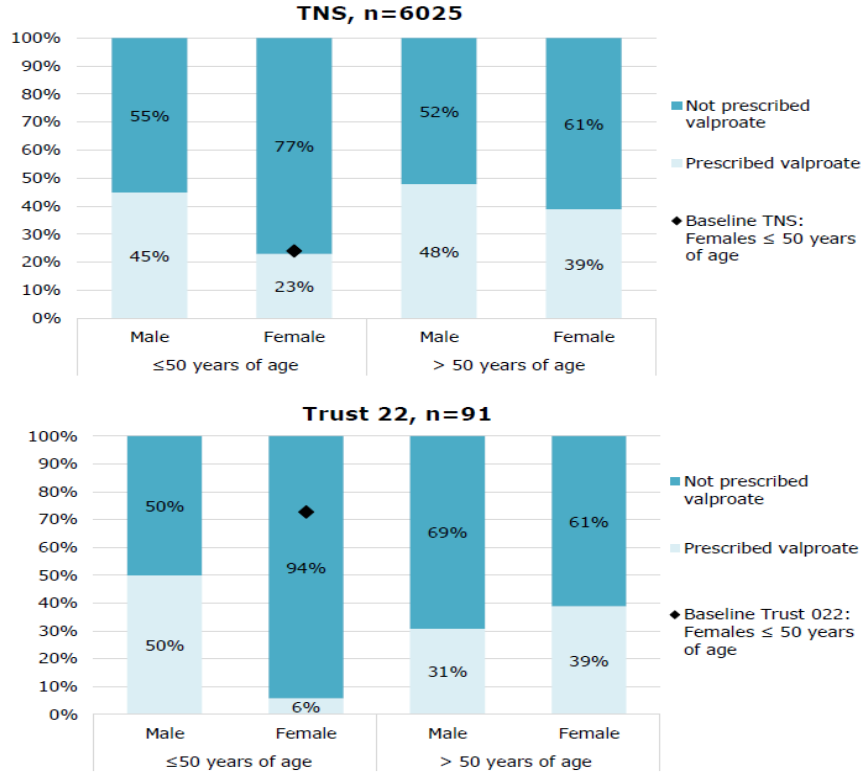



Fig. 29: POMH - valproate prescribing in bipolar illness

**Actions:** Clinicians have been informed of the results. In addition, clinicians have been informed of the MHRA requirements for valproate use in women of childbearing age. When supplying valproate to pharmacy checks that the women of childbearing age have been enrolled in the pregnancy prevention programme (PPP) and that they are given information about teratogenic potential of valproate. Prescribers are informed of any women who have not been enrolled in the PPP.

**POMH – Rapid tranquilisation (RT)**

Data were collected in March 2018.

Overall, no patients were administered IM haloperidol, which is in line with SLAM RT policy. Monitoring of physical and mental health after RT was evident for fewer patients in SLAM than in the average national sample (as shown below)

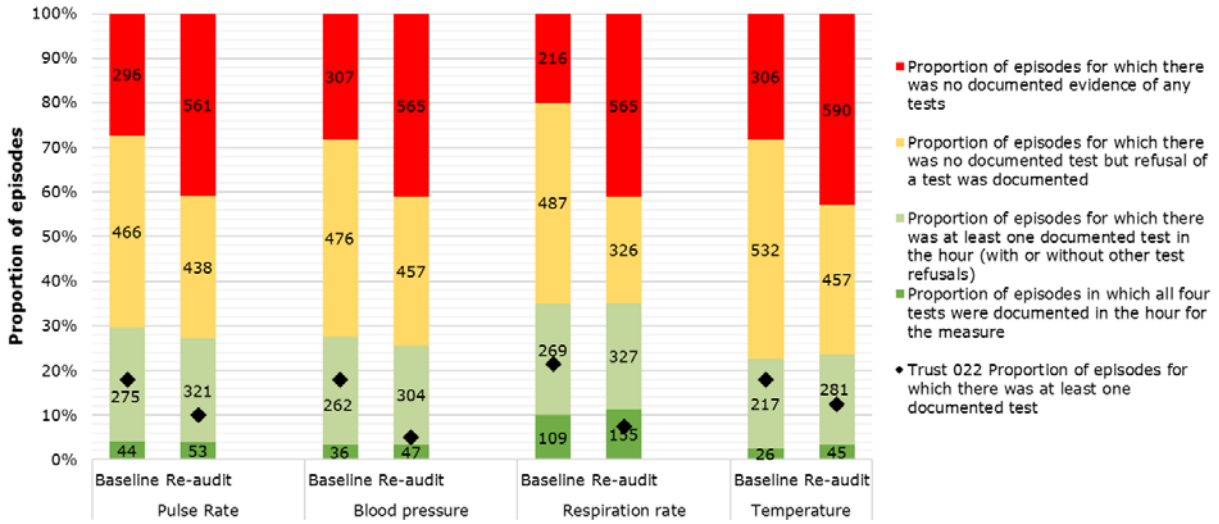


Fig. 30: POMH – Rapid Tranquilisation

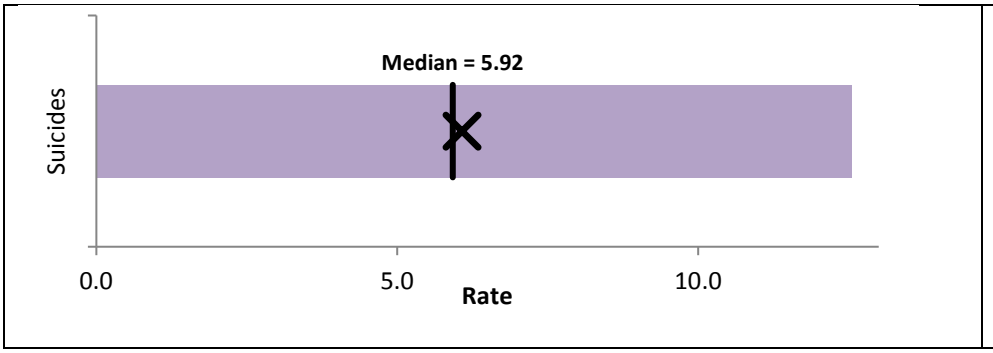
**Actions:** The RT policy has been updated to include the updated physical health monitoring requirements after RT. The trust has provided training on physical health monitoring after RT. Individual incidents of RT are identified each week from prescription charts by pharmacy and followed up by the nursing team to ensure physical health monitoring was completed.

**Use of clozapine**
Data have been submitted and the Trust is awaiting the report.

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

The Trust participated in the NCISH which reviews data relating to people who have died by suicide or were convicted of homicide based on the most recent available figures (2014-2016).

The figure below gives the range of results for mental health providers across England, based on the most recent available figures for suicides (2014-16). 'X' marks the position of the Trust. Rates have been rounded to the nearest 1 decimal place and percentages to whole percentage numbers.




**Suicide rate**

The suicide rate was 6.08 (per 10,000 people under mental health care) between 2014-16.

Fig. 31: Suicide Rate (2014-2016)

The Trust is implementing a new suicide project group in May 2019 which will look at the implementation of the zero suicide strategy which will report into the mortality review group.

### Trust Local Clinical Audit Programme

The reports of ten local clinical audits were reviewed by the provider in 2018/19 and SLaM intends to take the following actions to improve the quality of healthcare provided outlined in the table below.

| Audit | Status | Summary | Key outcomes | Key actions |
|---|---|---|---|---|
| Care Plan and Risk Assessment - Inpatient and Community Monthly | Complete | To monitor ongoing care plan and risk assessment documentation. | There is good documentation of issues being identified in care plans, as well as support and intervention plans to address identified needs. Most care plans are written in ways which will be understood by service users and carers. There is good documentation with regards to risk domains being identified accurately. | Care Plan and Risk Assessments are reviewed monthly at Performance and Quality meetings. Service Directors will be supported to deliver improvements. |
| QuESTT – Inpatient Monthly | Complete | The Quality, Effectiveness and Safety Trigger Tool (QuESTT) is completed by inpatient wards on a monthly basis. It is a safety trigger tool developed so individual wards can anticipate where standards may start to deteriorate and therefore act to prevent care failures occurring. | Action plans for wards scoring Red, Blue and Amber have been formulated in a timely manner to address concerns highlighted in the relevant month's QuESTT tool. Services continue to experience unusual demand and high acuity on some of the units which is being monitored. Vacancies and supervision compliance also being monitored. | QuESTT scores are reviewed monthly at Performance and Quality meetings. Where wards score Red, Blue or Amber, action plans are recorded onto Datix for review and implementation. Immediate action is taken at the time of the audit with concerns/increasing risk and escalated. |
| Policy | Complete | The audit was undertaken to assess policy documentation across the Trust and identify and determine whether policies adhered to the Trust Policy for the Development and Management of Trust wide Policies. The audit followed changes in the clinical policy process carried out by the Clinical Policy Working Group (CPWG). All policies (179) publicised on the Trust intranet, from 25th October 2017 to 28th February 2018, were included within the audit. | A summary was brought to the attention of the Operational SMT and Policy leads were made aware of any overdue policies. | An ongoing outcome is that the standard of policies is monitored and reviewed within the Clinical Policy Working Group according to the agreed checklist. |
| Duty of Candour | Complete | The audit was undertaken to assess ongoing compliance with the Being Open and Duty of Candour policy (2018) and to review the action plan from the 2017 audit. A sample of | The audit demonstrated high levels of compliance for SIRIs, but overall lower levels for C grade incidents which met the criteria for Duty of Candour. The recommendation from | The key action is that the comprehensive action plan derived following the 2017 audit will continue to be |

| | | | | |
|---|---|---|---|---|
| | | 80 serious incidents was randomly extracted from the Datix incident reporting system spread across a period of twenty months up to June 2018. The sample was split equally between Serious Incident Requiring Investigation (SIRI) and Serious Incidents (SIs). | this audit was to continue to implement the comprehensive action plan that was derived following the 2017 audit. | implemented and compliance monitored. |
| Engagement and Observation | Complete | The audit highlighted that while there was evidence of positive engagement with service users and observations were carried out correctly there still needed to be an improvement in documentation of these events. The audit involved four different approaches; incident analysis, service user questionnaire, daytime monitoring of interactions on the wards and night time monitoring too. | Compared to the 2015 audit, there is a significant improvement in observations of service users of the highest level of risk however overall compliance around record keeping for intermittent observations was generally low across most standards and require improvement. This includes documentation of decision making, risk assessments and care planning. | Audit results are informing the Engagement and Observations policy review currently underway. |
| Domestic Abuse | Complete | The audit aimed to assess awareness, knowledge and understanding of domestic violence among clinical staff. An electronic survey was emailed to all clinical staff and included questions regarding their attitudes and identification processes, and knowledge. A total of 167 responses were returned. | Staff reported that they feel confident in asking questions about domestic violence and documenting risks and history on EPJS. 20% increase in the number of staff reporting they knew who their borough MARAC representative is. Required improvements identified regarding staff awareness and in staff reporting they felt confident in conducting a safety assessment for children. A re-audit is planned for 2019. | Trust safeguarding Lead and safeguarding children advisors to look at the current training package to ensure that the current slides reflect domestic abuse and the impact on children. Trust Safeguarding adult lead will provide an update on guidance offered in the recent intercollegiate adult safeguarding document in relation to domestic abuse. |
| Safeguarding Children | Complete | The audit is designed to assess the current compliance with the Safeguarding Children Policy Principles and Procedures (2014). A random sample of 150 cases was selected where children were identified in the child risk screen in a minimum of 50 cases. The sample of 150 was distributed between 13 Safeguarding Children leads for data collection. Data was collected from 1st June 2018 to 20th July 2018. | Whilst compliance was generally high there were some standards which needed improving. Where dependent children were identified, not all sections of the child need risk screen were completed (35%). In a small number of cases (10%) current child need risk screens were not sufficient, and where no dependent children were identified the screens were inaccurate in 4% of cases. Where dependent children were identified, not all sections of the child need risk screen were completed (35%). | Recommendations in light of this audit include informing or reminding staff about timelines of completion and appropriate review of child need risk screens. |

| | | | | |
|---|---|---|---|---|
| Supervision | Complete | The Supervision Audit assessed the current compliance with the Supervision Policy V5 (2018) standards for the Quality of Supervision. The Supervision Audit is a Trust-wide review of the quality of supervision as it has been experienced by all staff groups, not limited to clinical staff. | There was an increase of 3% in staff receiving supervision compared with the 2013 audit. There was high compliance relating to supervision enabling staff to do their jobs better, feeling valued and able to raise concerns, although the former two questions did decrease on 2013 results. | The audit is informing work to improve staff engagement, and a re-audit in 12 months is recommended. |
| Section 132 - Inpatient and Community Treatment Order | Complete | The audit assessed whether patients detained under the Mental Health Act (MHA) or subject to a Community Treatment Order (S17A/CTO) are informed of their statutory rights via the S132/132A and whether rights are repeated as required by policy. | The standards audited indicated that policy is being adhered to, however there is room for improvement. | Recommendations in light of this audit include the reissuing of a Blue Light Bulletin to emphasise the importance of improved compliance with S132, the issue of a Purple Light Bulletin, updates of the weekly MHA monitoring tables, continuation of a QI project to improve compliance at ward level and a re-audit in 12 months to check compliance. |
| Central Alerting System | Complete | The audit assessed compliance with reporting, actioning and maintaining evidence logs. | For reportable alerts, 100% compliance was confirmed for reporting, actioning and maintaining evidence logs. However, a lack of a formal system for logging drug alerts and non-reportable alerts was identified. | Formal logging systems for drug alerts and non-reportable alerts have been implemented and governance arrangements formalised with compliance reporting and annual reports. The policy has been updated. |

Fig. 32: Trust clinical audit programme (2018/19)

## Patients participating in research

The number of patients receiving NHS services provided or sub-contracted by SLaM for the reporting period, 1 April 2018 – 31 March 2019, that were recruited during that period to participate in research approved by a research ethics committee was 3,578.

SLaM research is having an impact in many areas including:

- **Developing novel treatments:** e.g. Trials of Cannabidiol (CBD) for psychosis.
- **Influencing health policy:** e.g. Enhancing treatment guidelines for depression
- **Improving services based on our research evidence:** e.g. First episode service for eating disorders (FREED)

More information can be found here: https://www.kcl.ac.uk/ioppn/research/agenda.aspx

## Payment by Results Clinical Coding

SLaM is not subject to a Payment by Results Clinical Coding audit as it has not provided acute hospital services during the 2018/2019 financial year. Mental health services have a different payment approach which includes mental health care clusters. Our clinical information system has built in alerts to remind clinicians that a mental health cluster has expired which promotes data capture.

We see high quality data as key to informing the provision of high-quality care, both at an individual patient level and in terms of commissioning services for our local populations.

Currently we recognise that, like many NHS organisations, we have challenges with both the consistency and accuracy of data across our systems, and ensuring this data is used in a meaningful way to drive improvements in our services.

Last year we started our data framework project to address these issues, specifically to develop an online automated Trust dashboard so that all staff can access data to make better data informed decisions. As part of this on-going project we have been addressing the issue of data quality through our weekly project meetings, looking at how, where and by whom data is entered, and how that data is integrated across our systems and subsequently presented back to staff in a way that is useful.

Our series of data summits 'Operation SOS: Solving our Systems' brought together our data system owners to collaboratively address these issues, and meanwhile work has continued to develop a new user interface for our electronic health record ePJS (launch April 2019) that will make accurate, timely and complete data entry easier for staff.

Over the course of the coming year we will continue to build on our data quality work, through development of our informatics strategy, system architecture and the establishment of the Trust's new Quality Centre, which will see intelligent, high quality data use as central to improvements across our system for the benefit of all our patients, carers and staff.

## Care Quality Commission (CQC); inspection July 2018 results and actions

The Trust is required to be registered with the CQC and its current registration status is registered, without condition. In 2018 SLaM participated in a Well Led review of the Trust as well as a CQC inspection of the following services outlined in the table below:

| **Pathway** |
|---|
| Acute wards for adults of working age and Psychiatric intensive care units |
| Community-based mental health services for older people |
| Forensic Inpatient/Secure wards |
| Mental health crisis services and health-based paces of safety |
| Specialist Services - Eating Disorders |
| Specialist Services - Lishman Unit |

Fig. 21: Services inspected by CQC in 2018.

Whilst the overall rating for the Trust remains the same at 'Good' the Trust received a regulation 29A (HSCA) Warning notice for the Acute and PICU pathway.

The Trust was asked to make improvements by the 1st April 2019 and ensured an appropriate action plan was brought in place which would build on the many actions that were already underway as a part of borough reorganisation. Following receipt of the Warning Improvement Notice the Trust Senior Management Team set about engaging with Trust Executives to develop a robust and achievable improvement plan.

These discussions resulted in the following priority areas for improvement:

(i) Fundamental standards of care
(ii) Governance
(iii) Leadership and culture
(iv) Clinical pathways including flow and discharge planning.

There was also a clear focus on ensuring that there is the right infrastructure in place (enablers) to support these improvements and a clear structure for engaging and communicating with staff (communication), service users and carers.

The CQC re-inspected the Trust in April 2019 and initial verbal feedback indicates there has been significant improvement. The warning notice has lapsed and the CQC has confirmed on the basis of improvement that there is no need for further regulatory action.

## Commissioning for Quality and Innovation (CQUIN)

As last year, 2.5% of SLaM income 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 2018/19 was £6.0m and at the time of writing the Trust is collating quarter four reports for submission to our commissioners.

Further details of the agreed goals for 2017-19 and for the following 12 month period (2019/20) are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/ and https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

## Hospital Episode Statistics Data – HES

SLaM submitted records during 2018/19 to the Secondary Uses services (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data was:

| | In-Patients – SUS data Apr -Dec 2018 | Out-patients and Community – Mental Health Monthly Data Set (MHMDS) Nov 2018 (Final) |
|---|---|---|
| NHS No | 98.1% | 99.1% |
| GP Practice code | 98.9% | 98.3% |

Fig. 33: Percentage of records relating to patient care which included the patient's NHS No and GP practice code.

## Information Governance

Our submission for the NHS Digital Information Governance (IG) Toolkit 2017-18 demonstrated 90% compliance, which is satisfactory compliance. The submission was independently assessed by internal audit with a substantial assurance outcome. The Trust Digital Services are continuing to lead the digital transformation programme. The IG Operating Model has been implemented to further improvements around IG compliance with national standards and key legislation whilst implementing the trust's Digital Strategy.

The Trust undertook the General Data Protection Regulations (GDPR) preparedness programme overseen by the Information Security Committee (ISC). The ISC is also overseeing the Cyber Security Programme with close engagement and independent reviews by NHS Digital's careCERT and careCERT Assure Programmes. The trust has undertaken an extensive review of all data assets and data flows undertaking data protection impact assessments. All trust policies have been updated in line with the Data Protection Act 2018 and an updated Privacy Notice to notify service users and the public published. The Trust appointed a Data Protection Officer to oversee compliance and has set up the SE London DPO Forum to enable knowledge exchange and regional compliance between the DPOs.

SLaM refreshed NHS Digital's SCCI1596 Secure Email Standard conformance and @slam.nhs.uk continues to be accredited as a secure email system since 30 September 2017.

The Trust has worked with regional partners to sign up to a single, consistent, clear and unified data sharing framework across SE London. This has led to further expansion of the shared care record with the successful implementation of the Virtual Care Record (VCR).

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

Assurance around IG is presented to relevant committees chaired by the Caldicott Guardian, the CCIO and the Chief Information Officer (the Senior Information Risk Officer). The Trust Senior Management and the Board receives regular updates on levels of data assurance.

## Patient safety incidents resulting in severe harm or death

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

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:

| NRLS Data Q1-Q2 17/18 | SLAM 17/18 | Average for Mental | Highest Trust % | Lowest Trust % or |
|---|---|---|---|---|

| | | Health Trusts | or Score 17/18 | Score 17/18 |
|---|---|---|---|---|
| Reported Incidents per 1000 bed days | = | 51.5% | 126.47 % | 16% |
| Number of incidents resulting in severe harm | 0.5% | 0.3% | 2.0% | 0.0% |
| Number of incidents reported as deaths | 0.2% | 1.0% | 3.8% | 0.0% |

| NRLS Data Q1-Q2 18/19 | SLAM 18/19 | Average for Mental Health Trusts | Highest Trust % or Score 18/19 | Lowest Trust % or Score 18/19 |
|---|---|---|---|---|
| Reported Incidents per 1000 bed days | - | 55.5 | 114.3 | 24.9 |
| Percentage of incidents resulting in severe harm | 0.2% | 0.3% | 2.1% | 0.0% |
| Percentage of incidents reported as deaths | 0.7% | 0.9% | 2.3% | 0.1% |

Fig. 39: NRLS (National Reporting and Learning Service) Data

SLaM will improve the route of reporting, by continuing to improve and develop our monthly Serious Incidents Review Group (SIRG) and continuing to drive an open culture focussed on learning and improving safety for patients and staff.

### Learning from Deaths

During 2018/19, 511 SLaM patients died. This is a reduction from 565 deaths in 2017/18. This comprised the following number of deaths which occurred in each quarter of that reporting period: 120 in the first quarter; 133 in the second quarter; 134 in the third quarter; 124 in the fourth quarter.

144 case record reviews and 62 investigations have been carried out in relation to the 511 deaths. In 23 cases, a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

| Number of deaths where case record review or investigation was carried out | Q1 2018/19 | Q2 2018/19 | Q3 2018/19 | Q4 2018/19 |
|---|---|---|---|---|
| | 29 | 36 | 47 | 94 |

Fig. 40: Number of deaths where case record review or investigation was carried out

| Number of deaths reported in 2018/19 where case record review or investigations were carried out | Total |
|---|---|
| | CRR 144<br>SIRI 62 |

Fig. 41: Number of deaths reported in 2018/19 where the case record review or investigation was carried out in 2018/19

Our mortality reviews used adapted versions of two frameworks: the Mazars framework, and an adapted version of the grading system for case reviewers from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). Reviewers assess and grade the care provided to a patient using the two systems to assess and identify learning or a requirement for further review.

We have identified a number of learning points from case record reviews and investigations conducted in relation to the deaths identified above:

- The quality of risk assessments and care plans in some cases has been variable.
- Where care plans and risk management plans were completed these were not always individualised or specific enough.
- In Psychological Medicine and Older Adults (PMOA) directorate there have been instances of referrals to the Memory Service that were either late, or the patient was too physically unwell.
- Mortality reviews have identified the need for improved physical health follow up in the community. This should include better links with primary care and better care planning.

A total of three cases in this reporting period were judged to be more than likely than not to have been due to problems in the care provided by the patient. This is 0.59% of all reported deaths.

| Q1 2018/19 | Q2 2018/19 | Q3 2018/19 | Q4 2018/19 |
|---|---|---|---|
| 0 (0%) | 0 (0%) | 2 (11.11%) | 1 (5.88%) |

These figures were estimated using an adapted version of the grading system for case reviewers from the NCEPOD. Reviewers assess and grade the care provided to a patient using the two systems to assess and identify learning or a requirement for further review. The deaths considered in this section are those assessed using the NCEPOD Classification as Several aspects of clinical and/or organisational care that were well below satisfactory requires reporting as Serious Incident or SI.

**Actions taken**

The Trust has taken the following actions during 2018/19:

- In PMOA there is work underway with GPs to redesign the referral process and referral form.
- Older Adult have worked with CRISS to develop a tool to monitor antipsychotic monitoring for patient with dementia.
- Quality improvement projects to improve the waiting times for patients with a diagnosis of dementia have been ongoing; including increasing memory service capacity in Croydon.
- Up to date Information on community Speech and Language Therapy (SALT) services has been circulated to community teams.
- The inpatient nutrition screening tool is being redeveloped and that will include feeding / swallowing issues.

The Trust continues to assess the impact of the actions highlighted in mortality reviews.

In 2019/20 we will be implementing the Royal College of Psychiatrists' standardised care review tool for mental health services. The new care review tool will replace the existing mortality review tool in Datix. All deaths will be subject to completion of Section 1 of the review tool. Comprehensive mortality reviews (Section 2) will be triggered by Red Flags identified, or by random allocation of cases to be reviewed. The Red Flags included are:

- Family, carers or staff have raised concerns about the care provided.

- Diagnosis of psychosis or eating disorders during the last episode of care.
- Psychiatric inpatient at time of death or discharged from inpatient care within the last month.
- Under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.
- Other locally determined criteria for review.

Directorates will be expected to randomly allocate 5% of all reported deaths for a mortality review. We are currently in the process of ratifying our mortality review policy and making changes to Datix. Directorates might decide on locally determined red flag criteria, and this will be presented and recorded in the Mortality Review Group meetings.

### Duty of Candour 2018/2019

A number of actions have been taken during this year, including:

- A Duty of Candour information poster was produced April 2018.
- The Policy was revised in June 2018 including guidance for staff, template letters and external website reference.
- The Maud intranet site was updated regarding Duty of Candour in August 2018.
- The Serious Incident Review Group has continued to increase the scrutiny and oversight of Duty of Candour for serious incident investigations.

Further work that will be taking place in 2019/2020, including:

- Datix fields will be updated to help to improve Datix reporting.
- A QI project will be undertaken during 2019 to improve Datix reporting

### 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 Committee (QC) 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.

## 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.

## National indicators 2018/2019

SLaM is required to report performance against the following indicators:

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

## National indicators 2019/2020

SLaM is required to report performance against the following indicators:

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

## Care Programme Approach (CPA) seven-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.

| National Target | SLaM 2015/16 | SLaM 2016/17 | SLaM 2017/18 | SLaM 2018/19 | National Average 2017/18 | Highest Trust % or Score 2017/18 | Lowest Trust % Score 2017/18 |
|---|---|---|---|---|---|---|---|
| Not specified (formerly 95%) | 96.99% | **97.1%** | **97.5%** | **96%** | 95.4% (Q3) | 100% | 69.2% |

Fig. 34: CPA, seven day follow up

***The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2017/18 published at the time of writing the Quality Report 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. SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by ongoing monitoring through the I-Care programme as part of the trust's quality improvement programme.

## 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.

| | National Target | SLaM 2015/16 | SLaM 2016/17 | SLaM 2017/18 | SLaM 2018/19 | National Average 2017/18 | Highest Trust % or Score 2017/18 | Lowest Trust % Score 2017/18 |
|---|---|---|---|---|---|---|---|---|
| Number of admissions to acute wards that were gate kept by the CRHT teams | 95% | 95.9% | **96.5%** | 99.9% | **96.1%** | 98.5 (Q3) | 100% | 84.3% |

Fig. 35: 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 Report 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. PLN's 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: The Acute Referral Centre (ARC) is fully operational and all patients are triaged through this system.

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by ongoing monitoring of the Adult mental health pathways, a redesign of our community provision and the implementation of QI initiatives.

## Readmissions to hospital within 30 days of discharge for patients 0 – 15 years and 16+ years

| Readmission within 30 days<br><br>Standard measure is 30 days | SLaM<br><br>2018/19 |
|---|---|
| Patients readmitted to hospital within 30 days of being discharged (0 – 15 years) | 10.9% |
| Patients readmitted to hospital within 30 days of being discharged (16 years or over) | 5.9% |

Fig. 35: Readmissions to hospital for within 30 days by age group

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 2016/17 reports that the Trust had a 4% emergency readmission rate in comparison to a national mean of 9% 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 ongoing monitoring of the Adult mental health pathways, a redesign of our community provision and the implementation of QI initiatives.

## Core indicators

The following indicators form part of appendices 1 and 3 of the Single Oversight Framework (SOF) published by NHS Improvement.

| Indicator | SLaM 2018/19 | National Target | National Target Met |
|---|---|---|---|
| 1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral | 76% | 50% | ✓ |
| 2. Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery | 50.1%* | 50% | ✓ |
| 3. Improving access to psychological therapies (IAPT): patients seen within 6 weeks of referral | 90.8% | 75% | ✓ |

| | | | |
|---|---|---|---|
| **4. Improving access to psychological therapies (IAPT): patients seen within 18 weeks of referral** | 99.3% | 95% | ✓ |
| **5. Care programme approach (CPA) follow-up: proportion of discharges from hospital followed up within seven days** | 96.1% | Not specified (formerly 95%) | ✓ |
| **6. Admissions to adult facilities of patients under 16 years old** | 0 | Not specified | ✓ |
| **7. Inappropriate out-of-area placements for adult mental health services**<br><br>***(This is a new requirement for 2017/2018 and reporting begins in Q4/18 which is broken monthly in the data presented.)*** | Apr-18 – Feb-19 13,439 OBDs | Not specified | ✓ |
| **8. Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:**<br>**a) inpatient wards**<br>**b) early intervention in psychosis services**<br>**c) community mental health services (people on care programme approach)** | 96% inpatient and 75% community | 90% inpatient and 75% community | ✓ |

Fig. 36: Core indicators

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

*The yearly average for indicator 2 for 2017/18 was 48 per cent although by the end of the financial year the Trust had achieved a recovery rate of 52 per cent

Indicators two, three and four are based on collated monthly internal Trust reporting, NHS Digital will publish full year performance later in 2019/20.

The indicator percentage of CPA patients with a review in 12 months is not specified within the Single Oversight Framework.

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services: these indicators will continue to be monitored via monthly performance and quality meetings.

## Service Users Experience of Health and Social Care Staff Service Users Experience of Health and Social Care Staff

| | SLaM 2017 | SLaM 2018 | Highest Trust Score 2018 | Lowest Trust Score 2018 |
|---|---|---|---|---|
| **Service users experience of Health and Social Care Staff** *Scores out of 10* | 7.5 | 7.2 | 7.7 | 5.9 |

Fig. 37: 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 2018, 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 7.2 with other Trusts performing in a range of 5.9 to 7.7. The score for Q4 decreased by 0.2 points and Q5 increased by 0.1 points, although these changes are not categorised as significant shifts (changes of 5 points).

| | | SLaM 2018 | Lowest trust score | Highest trust score | SLaM (n) | SLaM 2017 | SLaM 2016 | SLaM 2015 | SLaM 2014 |
|---|---|---|---|---|---|---|---|---|---|
| **Health and social care workers** | | | | | | | | | |
| S1 | Section score | 7.2 | 5.9 | 7.7 | | 7.6 | | | |
| Q4 | Were you given enough time to discuss your needs and treatment? | 7.3 | 6.2 | 8.0 | 176 | 7.5 | 7.3 | 7.6 | 8.0 |
| Q5 | Did the person or people you saw understand how your mental health needs affect other areas of your life? | 7.1 | 5.7 | 7.5 | 168 | 7.0 | 7.1 | 7.1 | 7.8 |

Fig. 38: National survey of people who use community mental health services 2018

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services: The trust continues to prioritise service user and carer involvement. Feedback regarding this is collected in a systematic way across the Trust, including through the local experience survey programme, PEDIC. This work is taken forward as part of the Patient and Public Involvement strategy and directorate improvement plans.

# Part 3: Other information

# Review of quality performance 2018/2019

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

Our 2018/2019 quality priorities were selected after consultations with stakeholders and staff from our services and are highlighted below:

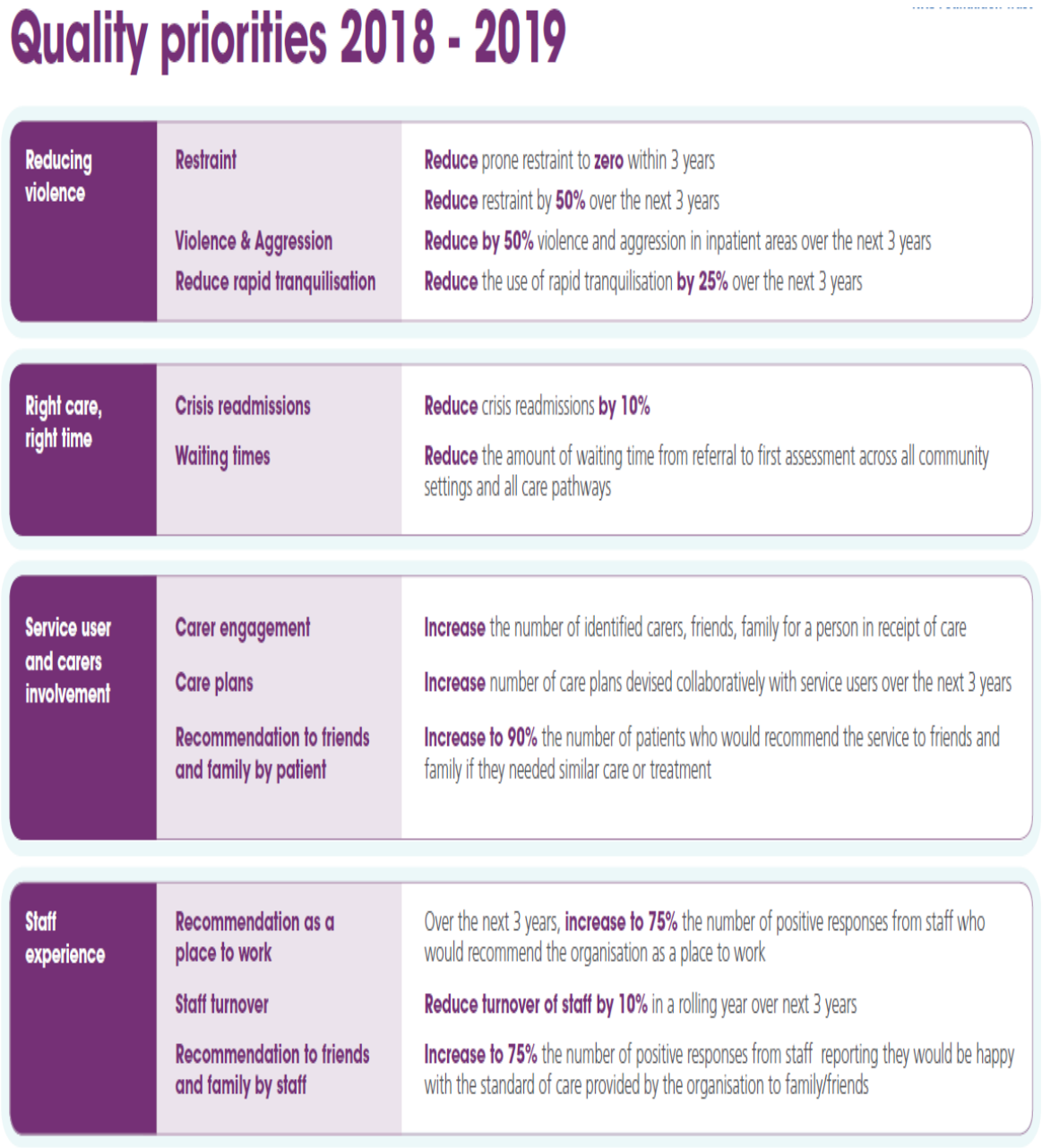



Fig. 6: Quality priorities 2018/19

The following summarises progress made against each priority over the year. The priorities set for 2018/19 were three-year targets to allow for systems to embed and afford real sustained improvement. Therefore, whilst targets have not been achieved fully in 2018/19, good systems have been embedded and progress has been made, such as around care plans. The wording of three indicators (two staffing and one carer) have been clarified. The metric indicators to measure performance in the key priorities are outlined below:

| | Trust wide | | CAMHS | Croydon & BDP | Lambeth | Lewisham | Southwark & Addictions | PMOA |
|---|---|---|---|---|---|---|---|---|
| | 17/18 | 18/19 | | | | | | |
| **Reducing violence by 50% over 3 years** | | | | | | | | |
| **Reducing violence by 50% over 3 years** | 4158 | 4372 | 659 | 1198 | 665 | 661 | 812 | 377 |
| **Reduction in restraint by 50% in over 3 years** | 1716 | 1789 | 357 | 386 | 257 | 275 | 396 | 118 |
| **Reduction in prone restraint – zero by 3 years** | 708 | 549 | 40 | 92 | 80 | 134 | 188 | 15 |
| **Reduction in the use of rapid tranquilisation by 25% in 3 years** | 840 | 772 | 25 | 143 | 140 | 173 | 224 | 47 |

## Patient safety

### How did we do?

The number of reported incidents of violence and aggression appears to be on an increasing trajectory. With a focus on restrictive practice and violence reduction it is expected that the quality of the data will improve and thus is likely to increase before reducing again. At present, Trust wide data do not show any overall indicators of change, however, there have been local areas of improvement, for example, an area of particularly good performance is the reduction in use of prone restraint in the Lambeth directorate. We are proud of this change driven by our clinical staff.

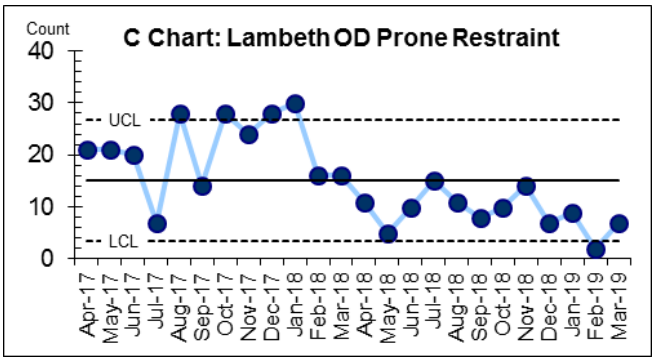



Fig. 8: Lambeth OD Prone Restraint

The main focus with the work around Rapid Tranquillisation has been to ensure that where it is being used in the Trust it is done so safely and with appropriate physical health monitoring. An area of good performance is in Lewisham directorate, which may be seeing a downward shift in the rates of rapid tranquillisation usage, including a seven-week period in the male PICU where no rapid tranquillisations were used at all.

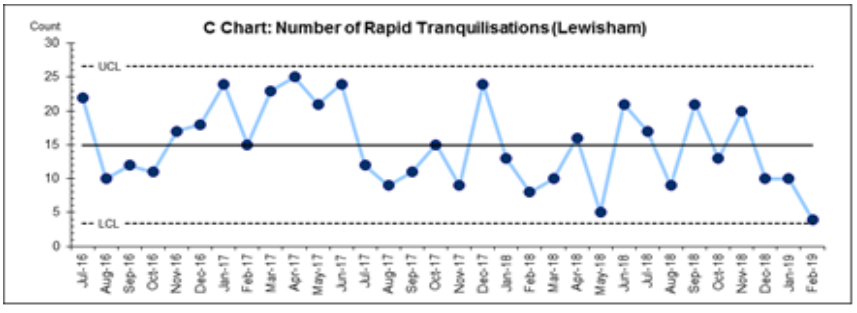
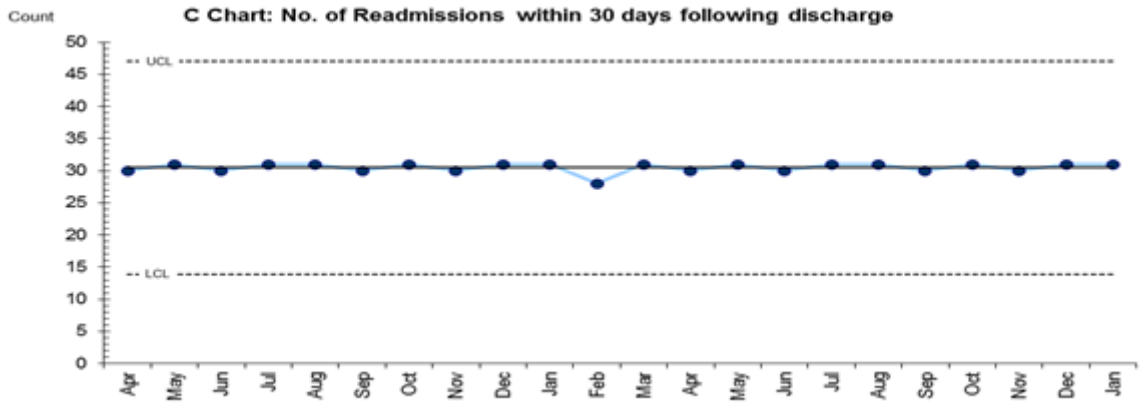



Fig. 10: Lewisham OD Rapid Tranquilisation

## Right care, Right time

| | Trust wide | | CAMHS | Croydon & BDP | Lambeth | Lewisham | Southwark & Addictions | PMOA |
|---|---|---|---|---|---|---|---|---|
| | 17/18 | 18/19 | | | | | | |
| **Right care, right time in appropriate setting** | | | | | | | | |
| **Reduction in the amount of time waiting from referral to first assessment. (Days)** | 45 | 47.8 | 88.62 | 71.72 | 20.78 | 21.90 | 16.78 | 64.56 |
| **Reduction in crisis readmissions by 10%** | 311 | 295 | 19 | 80 | 56 | 55 | 71 | 14 |

## How did we do?




ICare is a trust wide Quality Improvement (QI) programme within the general adult care pathway (inpatient and community). There are three work streams:

1. Patient safety
2. Standardised ways of working
3. Patient flow and capacity

## Inpatient operational care process model

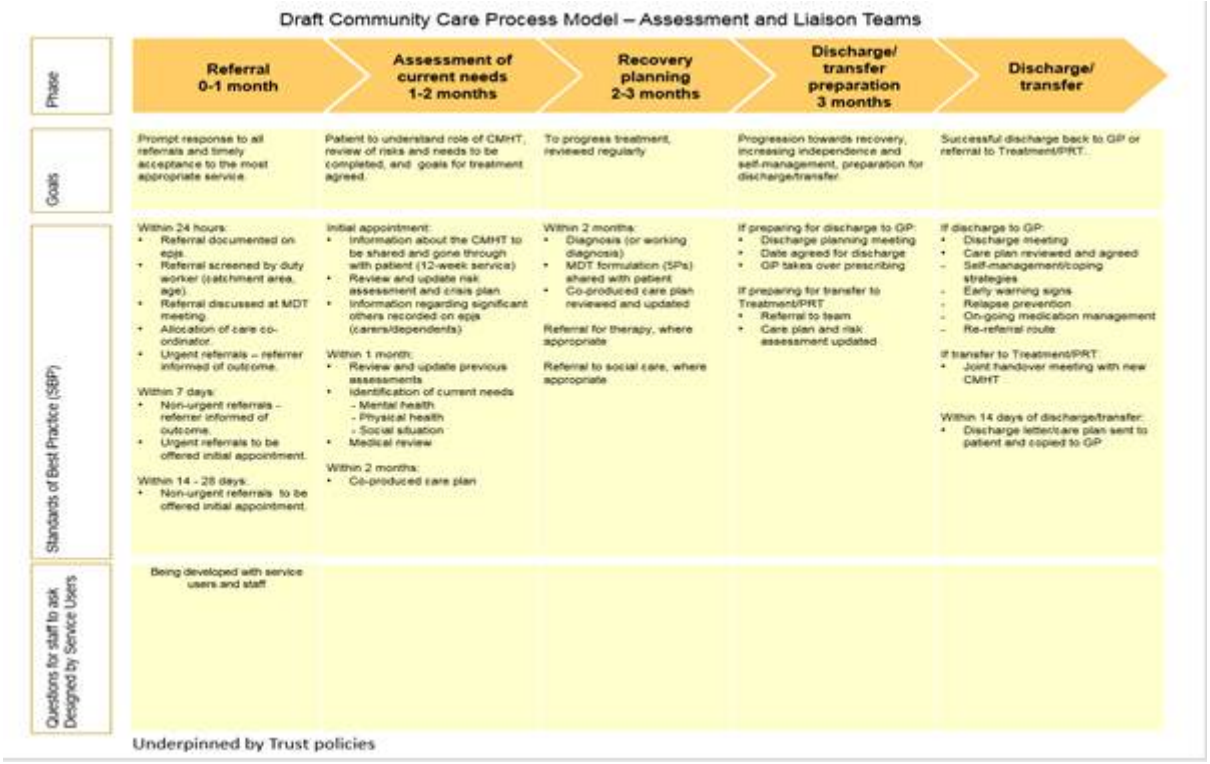
### Inpatient Care Process Model (CPM) and expectations of community in the adult acute inpatient care pathway

**Inpatient CPM**

The inpatient Care Process Model (CPM) has taken ten months to develop and is being tested in Lewisham, prior to being scaled up and spread across the Trust. The first phase is collecting baseline data with staff and service users and carers to identify which standards of best practice are being demonstrated and the focus for priorities for improvements. Initial tests will focus on the admission and discharge elements of the process in order to prioritise the improvement in flow.

**Community CPM (see visual below)**

Several very positive engagement events were held throughout 2018 with staff, service users and carers, and partner organisations to inform the development of the Community Care Process Model. Feedback from these events, along with data, have formed the basis of the community care process model (CPM) that is being drafted with clinicians, service users and carers from Southwark community teams, where the model will initially be tested.




**CPM Model- Draft Community Care Process Model- Treatment/Promoting Recovery Teams**

Fig. 7: Progress against quality priorities 2018/19

| | Trust wide | | CAMHS | Croydon & BDP | Lambeth | Lewisham | Southwark & Addictions | PMOA |
|---|---|---|---|---|---|---|---|---|
| | 17/18 | 19/20 | | | | | | |
| **Service User and carer involvement** | | | | | | | | |
| **Increase the proportion of service users under the care of SLAM services who have at least one carer, partner, relative or friend identified, with their contact details recorded on the Core Info section of EPJ.** | 50.3% | 51.1% | 64.3% | 42.5% | 63.6% | 65.5% | 58.2% | 51% |
| **Increase in the number of care plans over the next three years that have been co-produced with the service user and the contents shared with them. Target: 100%** | 54.3% | 78% | 85% | 77% | 58% | 60% | 75% | 64% |
| **Increase the number of positive responses to 90% over the next three years regarding patients recommending the service to friends and family if they needed similar care or treatment** | | 85.36% | 85.55% | 81.42% (Croydon)<br>82.13% (BDP) | 80.02% | 81.03% | 78.81% (Southwark)<br>93.93% (Addictions) | 92.65% |

## Service user and carer involvement

## How did we do?

### Carer Engagement- Increase in identified carers

This year work was completed with Business Intelligence to establish a reporting mechanism to broaden the terminology for identifying carers to include Carer, Family member, Children's Guardian, Nearest relative, Next of kin, Resident and Non-resident parent, and Friend, recognising that not everyone identifies with the word carer.

There has been communication with the Service Directors/Clinical directors and the Carers leads in each directorate in preparation for the Performance and Quality meetings to discuss ways to increase the number of identified carers.

Work streams to help with improvement in this area, included:

- Work with communications to raise awareness for "Think Carer" month
- Directorates to remind staff / do a drive for the month to complete field on EPJ re contact information – role and relationship (provided guidance/rationale).
- If directorates have carers leads/ champions on wards for example, consider doing a snapshot audit of completion of contact form completion for identified carer or family – identify gaps and complete as appropriate, feedback on ideas to improve.
- Work ongoing in the directorates to engage and work with families and carers and examples of this could be promoted.

## Co-produced Care plans

This year has seen a continued effort by clinical services to improve the numbers of care plans being co-produced with service users. Ongoing monitoring of this by monthly audits has seen an increase during the year and was identified as an improvement in the recent 2019 CQC inspection. The percentage of co-produced care plans has seen a very positive change. We will build on this further to ensure our patients' needs are accurately documented and understood.

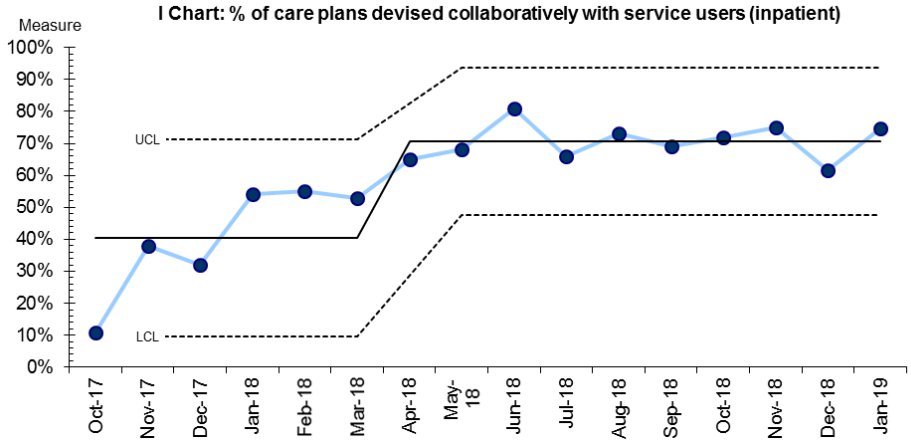
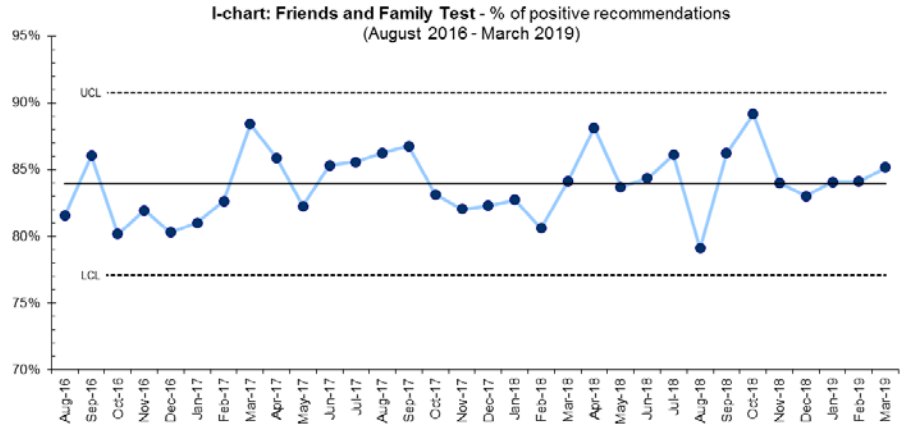



Fig. 11: Percentage of care plans co-produced with service users (Trust wide – inpatient)

## Friends and Family Test (FFT)

The trust collects approximately 12,000 Friends and Family Test (FFT) responses annually. It is available in several formats to aid collection of opinions from different patient groups, such as easy-read for Learning Disabilities and child- and adolescent-friendly formats. The trust's FFT score sees peaks twice a year when the Addictions directorate complete their bi-annual push for responses. The trough in August 2018 was due to a temporary issue with the freepost address which paper surveys are returned to. The FFT score has been maintaining or exceeding the median line for the past two quarters. The trust has several projects in development to improve FFT performance, which includes the co-production of a dementia-friendly survey, launching in the Place of Safety, development of a trust PEDIC dashboard in Power BI, and a project to validate some new core PEDIC questions. These new questions have been developed with staff, service users and the IoPPN to ensure the questions are consistently interpreted across patient groups, valid and reliable, which will make it easier for people to give us feedback. The trust has also been part of the national working group for the review of the FFT with NHS England.



## Safer staffing and staff experience

| | Trust wide | | CAMHS | Croydon & BDP | Lambeth | Lewisham | Southwark & Addictions | PMOA |
|---|---|---|---|---|---|---|---|---|
| | 17/18 | 18/19 | | | | | | |
| **Staff experience** | | | | | | | | |
| **Achieving buy-in across the organisation for the need for a large-scale programme of work to enable staff to experience improved satisfaction and joy at work, as measured by reducing turnover rate by 10% in a rolling year over the next three years using the current baseline of 19%. [Quality Priority]** | 18.6% | 18.9% | 26.76% | 19.69% | 17.8% | 13.17% | 14.06% | 17.99% |
| **Increase to 65% of staff who recommend SLaM as a place to work from its current level at 59% by Spring 2020. [Quality Priority]** | 60% | 58.9% | N/A | N/A | N/A | N/A | N/A | N/A |
| **Increase the number of positive responses to 75% over the next three years of the number of staff who, if a friend or relative needed treatment, would be happy with the standard of care provided by the organisation.** | 61% | 58.6% | N/A | N/A | N/A | N/A | N/A | N/A |

### How did we do?

The newly designed Operations Directorate leadership teams are recruited to and have gained traction. The teams clearly know their wards and teams well and are sighted on the quality issues of which staffing is a part. Recruitment activity continues in earnest and through the General Managers, the Matrons and the Heads of Nursing we are ensuring that ward teams have the support they need to recognise and deliver the expected standards of care.

Actions to improve staff experience are detailed in the Trust's Staff Survey Action Plan and include the following:

- Executive visibility walkabouts
- Changing Lives Roadshows
- Staff fora
- Flexible working policy and HR oversight of requests
- E-Rostering
- ICare
- Wellbeing strategy
- Schwartz rounds
- BME and Lived experience networks
- Transparency in acting up and secondments
- Four Steps to Safety
- Various local QI projects
- Reinforcing the bullying and harassment policy with a personal message from the CEO
- Promoting FTSU

In addition, we have added a local question to the Friends and Family Test (FFT) about perceptions of career progression and promotion based on ethnicity. This is one of the three key aspirations of the Workforce Race Equality Standard (WRES) action plan. It is recognised that this question is only asked once per year so in order to gain more regular feedback it has been included in the quarterly FFT survey.

## National patient survey of people who use community mental health services 2018

SLaM scored 'about the same' as most other trusts that took part in the 2018 National Community Mental Health Survey. One survey section scored 'better' than most other trusts, related to changes in who people see (7.3/10). A total of five questions increased on 2017 scores (two significant shifts; a shift of 5 or more), 20 decreased (ten significant shifts) and for three there was no change. One individual question scored 'better' than most other trusts in relation to changes in who people see having a positive impact upon care (8.2/10) and was also one of the two questions with a significant shift upwards. A total of two questions scored 'worse' than most other trusts in 2018 (care organisation and involvement in agreeing what care will be received; 7.4/10 and 6.6/10 respectively). The scores for the top two rankings on the overall experience question stayed the same as last year (16% 10/10 and 11% 9/10). When comparing SLaM scores against other London-region trusts only, SLaM scored within the highest 20% for two survey sections (health and social care workers and changes in who people see) and within the lowest 20% for six sections.

| Section | Significant shift upwards | Score 2017 | Score 2018 |
|---|---|---|---|
| Support and wellbeing | Have NHS mental health services involved a member of your family or someone else close to you as much as you would like? | 6.2/10 | 6.7/10 |
| Changes in who people see | What impact has this had on the care you receive? | 7.6/10 | 8.2/10 |

Fig. 12: National community mental health survey – questions with significant shift upwards

| Section | Top five performing questions | Score |
|---|---|---|
| Organising care | Do you know how to contact this person if you have a concern about your care? | 9.4/10 |
| Changes in who people see | What impact has this had on the care you receive? | 8.2/10 |
| Organising care | Have you been told who is in charge of organising your care and services? | 7.8/10 |
| Overall views of care and services | Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services? | 7.8/10 |
| Treatments | Were these NHS therapies explained to you in a way you could understand? | 7.6/10 |

Fig. 13: National community mental health survey – top five performing questions

| Section | Bottom five performing questions | Score |
|---|---|---|
| Support and wellbeing | In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs? | 5.3/10 |
| | In the last 12 months, has someone from NHS mental health services supported you in joining a group or taking part in an activity? | 4.7/10 |
| | In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits? | 4.1/10 |
| | In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work? | 3.7/10 |
| | Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you? | 3.6/10 |

Fig. 14: National community mental health survey – bottom five performing questions

The survey free-text comment themes largely reflect the trust's other experience feedback. The theme care and treatment received the most free-text comments (35.71%), of which the largest sub theme was that people had a general positive experience of their treatment (n=17) and excellent care (n=17). The largest number of negative comments related to wanting more support from staff (n=10) or more sessions (n=9). There were also many comments about staff, of which most were positive (n=28) with some negative comments regarding staff turnover and staffing levels (n=5). The theme with the largest number of negative comments was appointments and access, with 17 comments regarding long waiting times.

Overall, when comparing the national survey results with local trust feedback, including the trust-wide survey programme (PEDIC), it seems that respondents to the 2018 national survey generally reported a more negative experience. This apparent discrepancy could be due to several reasons such as small sample size and differences in sample population, methodology and timeframe. As such, services should consider these results in conjunction with other feedback mechanisms and in light of any actions that have taken place in the time following the data collection period. This will enable the findings to be incorporated into local improvement initiatives. To further improve experience of services, the Trust continues to implement the Patient and Public Involvement (PPI) strategy and report to the Service User Involvement and Family and Carers Committees, which in turn report to the Quality Committee.

## National Staff Survey 2018

In 2018, 1939 staff across the Trust took part in this survey. The response rate was 43% which is below the average for mental health/learning disability trusts in England (54%) and compares with a response rate of 44% last year.

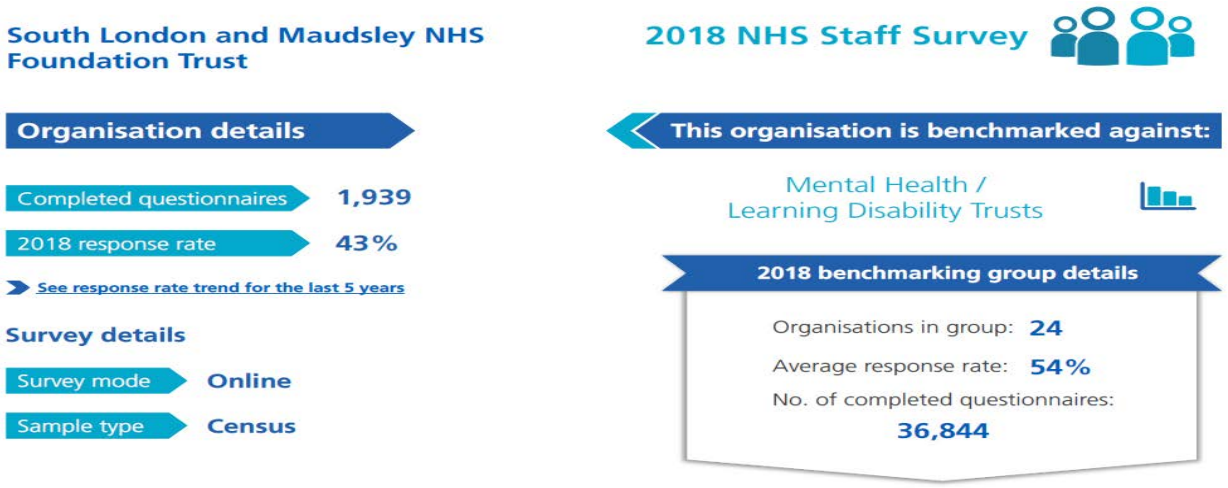



Fig. 15: 2018 NHS Staff survey details

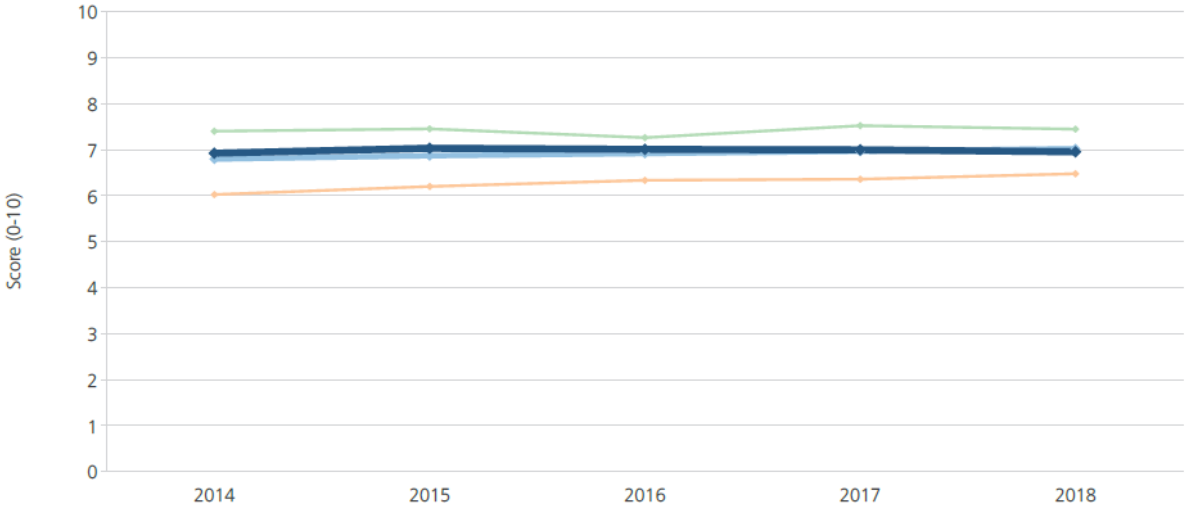
### Overall Staff engagement

The graph below highlights Trust performance with staff engagement overall. SLaM performed alongside the average score of 7.0 and the same as 2017.

Survey Coordination Centre

**2018 NHS Staff Survey Results > Theme results > Trends >** Staff engagement

NHS England



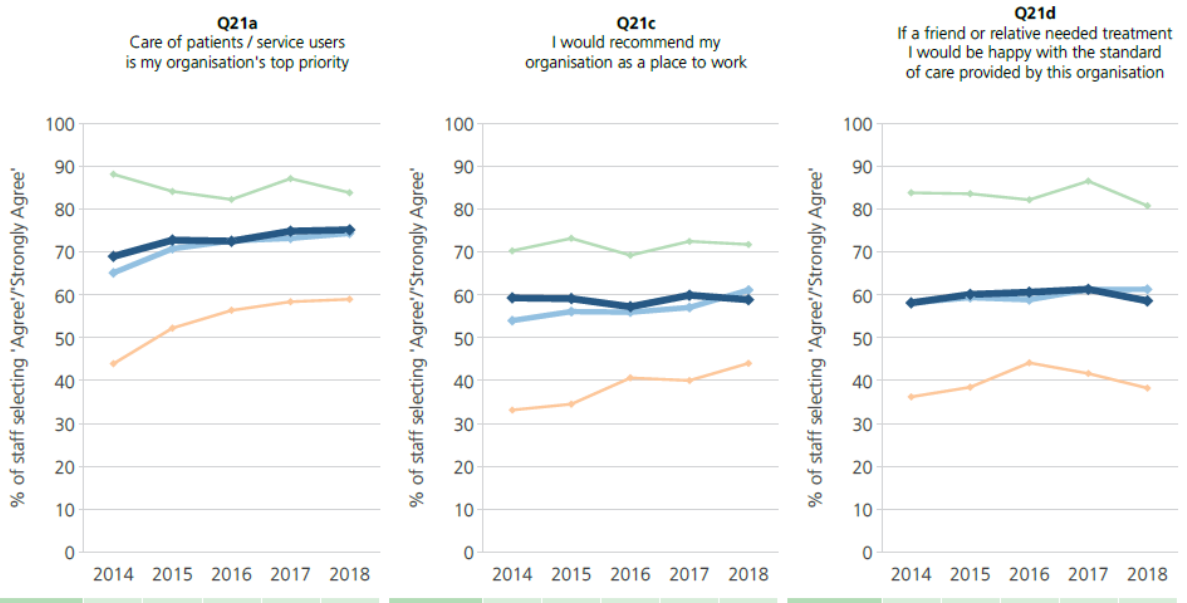

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| Best | 7.4 | 7.5 | 7.3 | 7.5 | 7.4 |
| Your org | 6.9 | 7.0 | 7.0 | 7.0 | 7.0 |
| Average | 6.8 | 6.9 | 6.9 | 7.0 | 7.0 |
| Worst | 6.0 | 6.2 | 6.3 | 6.4 | 6.5 |
| No. responses | 1,752 | 1,689 | 1,814 | 1,872 | 1,919 |

Fig. 16: 2018 NHS Staff survey results – staff engagement

Survey Coordination Centre

**2018 NHS Staff Survey Results > Theme results > Detailed information >** Staff engagement – Recommendation of the organisation as a place to work/receive treatment

NHS England




| Q21a | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| Best | 88.1% | 84.2% | 82.3% | 87.1% | 83.9% |
| Your org | 69.0% | 72.8% | 72.5% | 74.9% | 75.2% |
| Average | 65.1% | 70.8% | 72.6% | 73.2% | 74.3% |
| Worst | 43.9% | 52.2% | 56.4% | 58.4% | 59.0% |

| Q21c | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| Best | 70.3% | 73.2% | 69.2% | 72.5% | 71.8% |
| Your org | 59.3% | 59.1% | 57.2% | 59.9% | 58.9% |
| Average | 54.0% | 56.1% | 55.9% | 57.0% | 61.1% |
| Worst | 33.1% | 34.5% | 40.6% | 40.0% | 44.0% |

| Q21d | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| Best | 83.8% | 83.6% | 82.2% | 86.5% | 80.8% |
| Your org | 58.1% | 60.1% | 60.6% | 61.3% | 58.6% |
| Average | 58.1% | 59.4% | 58.9% | 61.2% | 61.3% |
| Worst | 36.2% | 38.4% | 44.1% | 41.6% | 38.2% |

Fig. 17: 2018 NHS Staff survey results – detailed staff engagement theme

**Key Findings – Overall Trust**

| Theme | 2017 score | 2017 respondents | 2018 score | 2018 respondents |
|---|---|---|---|---|
| Equality, diversity & inclusion | **8.6** | 1786 | **8.3** | 1853 |
| Health & wellbeing | **6.0** | 1825 | **5.7** | 1875 |
| Immediate managers | **7.1** | 1824 | **7.1** | 1886 |
| Morale | | 0 | **5.9** | 1843 |
| Quality of appraisals | **5.7** | 1653 | **5.5** | 1717 |
| Quality of care | **7.3** | 1603 | **7.3** | 1625 |
| Safe environment - Bullying & harassment | **7.8** | 1758 | **7.7** | 1831 |
| Safe environment - Violence | **9.0** | 1753 | **9.1** | 1818 |
| Safety culture | **6.7** | 1801 | **6.6** | 1862 |
| Staff engagement | **7.0** | 1872 | **7.0** | 1919 |

Fig. 18: 2018 NHS Staff survey results – key findings

There are some similarities between the Trust's overall results and the national picture. Nationally there are disappointing scores in relation to health and well-being, bullying and harassment, increases in the areas of stress and musculo-skeletal problems, and worsening perceptions of fairness of opportunity or career progression. Similarly, there are improvements nationally in the fairness of treatment of staff involved in incidents.

**Next steps**

Much of the work the Trust embarked upon over the past year to improve staff experience needs to be sustained over the long term to make a difference. The Trust-wide action plan is largely therefore a reinforcement of actions that are already in train, though renewed energy is needed to ensure they start delivering tangible results.

Now that the new borough-based clinical operational structure is well-established, the new directorates are being asked to develop and implement targeted local action plans to complement and reinforce this Trust-wide plan. We are confident that local leadership will make a difference to our staff.

## Workforce Race Equality Standard (WRES)

Below outlines the percentage of staff experiencing harassment, bullying or abuse from staff in 12 months.

| | | |
|---|---|---|
| White | Trust score 2017: 23% | Trust score 2018: 25% |
| BME | Trust Score 2017: 26% | Trust Score 2018: 31.6% |

Fig. 19: Percentage of staff experiencing harassment, bullying or abuse from staff in 12 months.

Our workforce is our most valuable asset and it is imperative that all staff feel valued, supported and engaged in order to provide the highest quality of service. Feedback from the Staff Survey and the BME Network indicates

that the experiences by our BME staff are reported as less positive. Diversity and inclusion are core to the delivery of good high-quality services by motivated and engaged staff.

The WRES Implementation Plan Year 1 and Year 2 are aimed at continuing to develop the foundations for change for equality and inclusion within the Trust, especially for BME staff where their reported experience is less favourable than white staff. This report identifies the difference in experience between white and BME staff and applicants through the 9 different WRES standards including Board composition and the proportional ethnicity of staff across the different pay scales and bandings. Four standards are taken from the Annual Staff Survey.

The first 9 months of Year 1 of the WRES Implementation Plan has provided useful learning with a range of degrees of progress. The Snowy White Peaks Group's reflection is that the components of the plan largely remain valid however there is a need in Year 2 to become much more focused in ensuring full implementation in all parts of the Trust and in obtaining detailed monitoring and more contemporaneous data that will enable Operational Directorates and Corporate Directorates to spot issues as they arise and adjust their plans and behaviours accordingly.

To remind ourselves, the Board's 3 Aspirations approved at its May 2017 meeting are that there will be proportionate numbers of BME staff:

• Across all senior grades

• Within disciplinary processes

• Accessing career development opportunities.

We are continuing to implement the Action Plan which will include a further phase of the inclusive leadership organisational intervention, the development and implementation of a mentoring programme, ongoing monitoring of recruitment success and referral to formal disciplinary process and additional training of Diversity in Recruitment Champions to participate in recruitment to senior roles within the Trust. We are beginning to see more BME staff represented at Band 7 and anove – it is too soon to report a sustained change.

## Freedom to Speak Up Guardian (FTSU)

2018/19 has been a busy year for Freedom to Speak Up (FTSU) in the Trust. As the statistics show in the Board reports, we have seen an increasing number of cases being raised and a growing recognition of the function across the Trust.

The National Guardian's Office (NGO) declared October 2018 to be a national Freedom to Speak Up month and the Trust fully participated. Many activities were carried out across the Trust to increase staff awareness of the function. This was reported in detail at a presentation to the Board at the end of October. As a result of the activity three new Advocates came forward to join the FTSU Network and cases jumped from nine in Q2 to 19 in Q3.

The CQC in August 2018 scrutinised the FTSU function as part of the Well Led Inspection. They identified tree "should do's" about the need to continue to promote the function so that every member of staff is aware of it; to ensure there is clear open recruitment to the role of Advocate; and to continue to train and develop the Advocates. A report to the Delivery Board in February 2019 has demonstrated satisfactory progress on all three fronts.

Preparation is underway for the Board to undertake a self-review against the Guidance for Boards on Freedom to Speak Up in NHS Foundation Trusts. The response to the Guidance was reported to the Board by the Chief Executive in October 2018 and the Self-Review exercise will take place in May 2019.

The second Annual Report of the Freedom to Speak Up Guardian (FTSUG) will be presented to the Board in April 2019 with quarterly reports to the Board from the FTSUG for the rest of the year. This report will analyse the cases for 2018/19, reported quarterly to the NGO, identifying themes and barriers to speaking up as well as learning and improvement opportunities.

## Equality information and objectives

The Trust has a longstanding commitment to demonstrating accountability for its performance on promoting equality within its workforce and service provision. The Trust publishes a suite of annual equality information to demonstrate how it complies with its equality obligations. This includes the following:

- 2018 Workforce equality information: This provides equality data for staff with different protected characteristics on a range of workforce metrics.
- 2018 Trust-wide equality information: This provides information on the demographic profile of the Trust's service users and the experience of service users from all protected characteristics during the previous three years
- 2018 ethnicity reports for Croydon, Lambeth, Lewisham and Southwark: These provide ethnicity access and experience ethnicity data on key services in each borough. This year's report also includes outcome data for Improving
- Workforce Race Equality Standard (WRES) information
- Annual gender pay gap report.

The Trust's equality objectives are set out in our Integrated Equalities Action Plan 2018-21. It aligns the Trust's approach to promoting equality for its workforce and for service users, carers, families and communities and reflects the strategic priorities of the Trust's 'Changing Lives Strategy'. It captures existing commitments, legal requirements, prioritised areas for improvement and sets out measures of success over the next three years.

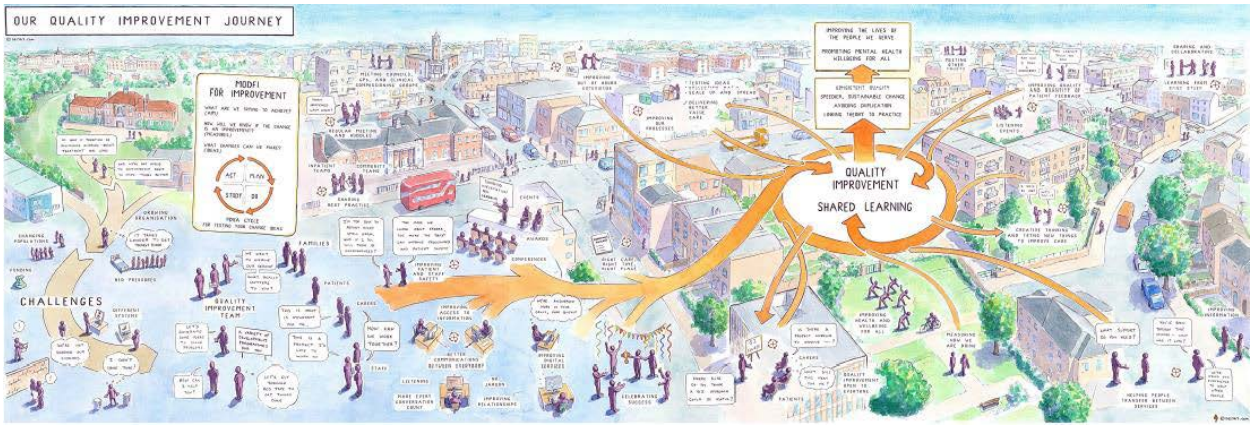
From this year the Board will receive an integrated annual report on action plan delivery, equality information and a refreshed Equality Delivery System (EDS 2) assessment in June. This alignment will provide the Board with an efficient and effective view of implementation and outcomes of all work streams in the Integrated Equalities Action Plan. It will also enable the Trust to be more focussed and responsive to the equality information it publishes each year.

## Our priorities for improvement for 2019/2020

The priorities for 2019/2020 have rolled over from 2018/2019 and remain arranged under the four areas outlined below which incorporate the broader domains of patient safety, clinical effectiveness, patient experience and staff experience. It was agreed to set the priorities over a three year stretch target to enable Quality Improvement (QI) programme and relevant work streams to embed and sustain real improvement. Wording for three indicators has been clarified for 2019/20. Achievement relating to these priorities will be reported in next year's Quality Report.


Fig. 20: Percentage of staff experiencing harassment, bullying or abuse from staff in 12 months.

### Quality Improvement (QI)




Instrumental in achieving the Trust Quality priorities is the QI methodology underpinning the many improvement work streams within the Trust. The main Trust-wide streams are outlined below:

**Improving Care and Outcomes (ICare) with general adult mental health inpatient and community services**

ICare is a trust wide Quality Improvement (QI) programme within the general adult care pathway (inpatient and community). It was set up in May 2017 with support from the Institute for Health Care Improvement (IHI), in response to problems that were highlighted with inconsistency in the quality of care and outcomes for people who use SLaM services. Whilst there were some areas of excellent practice, others required improvement. Too

many patients are admitted outside of their local borough, significant variation in hospital length of stay was highlighted, with significant delays in some areas, and teams were not always working at their best across boundaries with teams in other directorates and with primary and social care.

The IHI quality improvement collaborative methodology was adopted as an approach. This provides an opportunity for the four boroughs to work together to develop and improve a consistent approach to care (access, safety, experience) and outcomes.

Seven key principles, developed collaboratively underpin the approach, namely that ICare improvement work would:

1. Have clear sponsorship and leadership from senior clinicians and managers
2. Be co designed or co-produced with patients being at the centre and involve carers, staff and external stakeholders
3. Make systematic use of data to inform and test and change ideas for improvement
4. Ensure service users and staff feel physically and psychologically safe to use and work in services
5. Provide opportunities for people to develop their knowledge and skills in QI methodology to enable them to test changes, share learning and scale up and spread successes.
6. Be supported by the Quality improvement and SLaM Partners (QISP) team, who have expertise in QI methodology (methods, tools, measurement, value) and psychological approaches to organisational development
7. Governed through weekly Icare meetings

**Patient Safety**

There are a range of initiatives being tested to improve the safety of our inpatient units. ICare has focussed on Four Steps to Safety and latterly the testing of behaviour support plans.

**Four Steps to Safety**

Four Steps to Safety was initially launched in January 2016 and involved an extensive suite of interventions to reduce violence and aggression. This is a trust-wide initiative and for adult mental health this work has been incorporated into ICare. Between January – April 2018, the QI Team facilitated a review of the work across each directorate, identifying the challenges and what had worked well. The findings were presented at an Inpatient Safety Learning event in May 2018. As a result, the initiative was relaunched with fewer interventions:

- DASA: A risk assessment tool used to identify and communicate the likelihood of violence and aggression over a very short period of time, prompting staff to provide support earlier to prevent incidents from escalating.
- Report-out board: A visual tool used to update the team of specific tasks and who in the team is responsible for which task, to help ensure people's needs are being met.
- Proactive engagement: 'Checking-in' conversations with patients during each shift to identify and act on their needs promptly.
- Mutual agreement: A document coproduced with patients and staff around the values and shared expectations of how people will behave towards each other.
- SBARD (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, **D**ecision): A communication tool used for clinical handovers to ensure the concise communication of pertinent information.

**Successes and challenges**

The QI Team have worked alongside the Matrons in adult mental health to support the acute wards to implement the Four Steps to Safety. There are pockets of success where wards have fully implemented the interventions and are demonstrating improvements. Although we have not yet reached the target of a reduction by 50% there are a number of teams that have demonstrated positive and sustained change.

**Standardised ways of working**

We want to ensure that the people who access our services experience the same standards of care no matter which borough they live in or which service they are under. Both the inpatient and community operational care process models (CPM) are being developed with service users, carers and staff so that people know the fundamental standards of care, namely standards of best practice (SBP), they can expect to receive in every ward and community team. The theory is that SBPs will reduce variation in practice and have a positive impact on patients receiving timely assessments and treatment thereby reducing need for admission, improving experience and achieving outcomes that matter to them. The operational standards for the SBP in the models below have been developed in the context of Royal College of Psychiatrists' Standards and learning from other mental health Trusts, Trust policies for good practice and national guidance. Furthermore, it has been informed and developed using Trust data and the outputs of the detailed care process maps produced with clinicians, service users and carers.

The aim therefore is:

**For inpatient CPM that**:

*The patient experience and recovery journey is structured, purposeful, collaborative, safe and compassionate, taking into account complex needs and harm minimisation.*

**For the community CPM that:**

*Together with partners provide the community with easy access to the right mental health services, of the right quality, for the right length of time that meets their needs*

We will measure whether the inpatient and community CPMs contribute to making a difference to outcomes using the agreed set of outcome and process measures for ICare, including length of stay, number of admissions, readmissions with 30 days, adherence to SBP, patient experience and staff engagement and cost. Local and more specific ward/community improvement measures will be used in addition and will be determined based on the needs of local teams.

## Annex 1

## 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 Report 2018/19

The Clinical Commissioning Groups contracting with the South London and Maudsley NHS Foundation Trust have welcomed the opportunity to review your Quality Account for 2018–2019. We are able to confirm that it complies with the requirements as set out by NHS England. The Quality Account provides an open and transparent declaration of the status of the quality of the services the Trust provides which is well written and generally easy to navigate. It appears to be at a fairly final draft stage at the point of review.

We have been grateful to the Trust for the way that colleagues have worked openly with us – supporting our assurance processes – taking our concerns seriously and responding to questions helpfully and in a timely way. We are grateful and supportive of the move taken by the Trust during 2018/19 to listen to our concerns and suggestions for improvement in its internal serious incident processes in order to provide us with greater levels of information.

We also note the Trust's engagement and commitment to working in partnership and their open and honest approach to quality. There is widespread appreciation across the four commissioners of SLaM's senior commitment and regular attendance at CQRGs, enabling transparent productive discussions.
Commissioners recognise that the Trust is committed to providing the very best quality care to patients.
We support the Trust's quality priorities for 2019/20 and beyond, noting that that there are fewer priorities than in some previous years and that delivery of these priorities is planned over three years (2018-19 being the second of three years). This makes the achievement of the ambitious targets the Trust has set itself more likely, as a consequence of the clearer prioritisation and the ability to plan over longer timeframes this approach will afford.

We are disappointed that progress against the quality priorities has been slow but are looking forward to an increase in the pace of change. There is recognition amongst commissioners that the Trust has set challenging targets, and look forward to more tangible improvements in 2019/20. The enhanced Quality and Performance report now includes the quality priorities, giving them more profile and the ability to be tracked. This is welcomed by all four commissioners.

We wish to publicly acknowledge the significant amount of work undertaken and sheer focus and application across all grades of staff in response to the CQC inspection. This was demonstrated most clearly by the quick response to the issues raised by CQC in the 2018 core services inspection and the lifting of the improvement notice just into 2019/20. We see this as evidence that SLaM staff are able to make rapid and effective improvement when fully supported to do so.

We are pleased to see feedback about the work of the Freedom to Speak up Guardian and a clear plan for how the Trust intends to learn from this.

The CCGs are looking forward to continuing to work collaboratively with the Trust over the coming year in new partnerships and alliances as we implement wider system changes in support of quality improvement for the benefit of service users in Croydon, Lambeth, Lewisham and Southwark.

# Council of Governors' reply to South London and Maudsley NHS Foundation Trust (SLaM) Quality Report 2018/19

The SLaM Governors are drawn from a membership which covers the very wide area of south London served by the Trust. We have aimed over the past year to play a robust and meaningful part in the governance of the Trust, and the Governors value this opportunity to comment on the current year's Quality Accounts. The Governors' Quality Working Group meets four times a year and sends an observer to meetings of both the Quality Committee and the Trust-wide Mental Health Law Committee, who reports the proceedings back to the group.

We have followed closely the effect of the CQC warning notice following the 2018 inspection, and have been aware of the very real efforts made by the Board, the NEDs and the staff as a whole to bring about a more qualitatively even level of service across all pathways of care. We congratulate them on their success, whilst acknowledging the further improvement that can still be made.

We have followed the development of the QI programme at Board meetings and have seen some impressive ideas and outcomes, particularly on the management areas of the Trust's work. Whilst we recognise that this ultimately, of course, has a positive effect on patient experience, and are aware that the key QI initiatives are co-produced with service users, we are looking forward, in future, to hearing examples of service user initiation in QI initiatives.

Stakeholders were surveyed on their general awareness and understanding of the Trust's Quality Priorities and it made interested reading, showing that not all staff are as aware as they might be of them and how they might/should affect their work. However, this confirms, we feel, the good sense in the decision made to keep the same priorities for three years in order to give them a chance to embed as fully as possible throughout this very large organisation.

**Review of the Quality Performance for 2018/19**

**Patient safety**

We accept that the apparent increase in reported incidents of violence and aggression is a recognised effect of increased observation and recording of these events, and are pleased to note that, while no statistically important changes have been signalled in the Trust-wide data graphs, there are significant examples of reduction in prone restraint in Lambeth, and there has been decreased use of Rapid Tranquillisation in Lewisham. We will be eager to see if the data continues to show reduction as this important Quality Priority continues into another year.

**Patient experience**

We are pleased to see the increase in the number of care plans being co-produced, and the involvement of carers in this process, and hope that this performance will continue to increase in the year ahead.

We are pleased to see that the Trust scores highly in many areas in the *2018 National Community Mental Health Survey*. We note, with particular approval, the "significant shift upwards" in scores in answers to questions about support and wellbeing in relation to carer involvement.

We hope that the disappointing results of the bottom five questions are being noted, and while we understand that there is excellent work being done in some areas in the Trust, we hope that this good practice will extend throughout all the boroughs, so that all service users will eventually get the advice and help that they need, particularly on practicalities such as advice on benefits and job advice.

**Safer staffing and staff experience**

The wellbeing of staff is crucial for the success of the Trust's work, and is a major concern of the Governors. As the clinical operational structure of SLaM has changed to borough-based directorate, and more focus is placed on community services, we recognise that recruitment and retention of good staff is of prime importance if this change is to have the success that everyone is looking for. Equality and diversity issues have to be fully and successfully addressed. We know that the Board is fully aware of this issue, and that they are committed to finding ways of improving staff experience so that they feel valued, supported and engaged. Many new initiatives have been introduced, but sustained and sympathetic action is needed to ensure their success.

The Freedom to Speak Up Guardian plays a vital role in this work, and we are pleased to see this function making some significant progress.

**Priorities for improvement 2019/2020**

Staff at all levels of the Trust approached the CQC inspection in July 2018 with their usual energy and are to be congratulated on the overall 'good' rating. The warning notice given for the Acute and PICU pathway for, in the main, inconsistency in quality of care was tackled with similar energy and determination. A new method of reporting and monitoring activity at team level – involving reporting concerns and issues from 'floor' up to the Board – was implemented, huddles happened, changes were wrought and, as a result, the warning notice expired in April 2019. The Governors are fully aware of how much focused effort and hard work went into this undertaking, and know how deserved was the result. We have every hope that the changes will become firmly embedded – and improvements made permanent.

**Participation in national quality improvement programmes - Audit**

The Governors are interested to see that SLaM has taken part in national audit programmes, thus ensuring that our services are constantly being improved and kept up to the highest national standards.

The Trust has undergone an operational structure change from Clinical Academic Groups to borough-based directorates; we hope that community services – also the focus of a redesign process - will be subject to the same rigorous audits. We are encouraged, therefore, to see that the *National indicators for 2018/2019* and the *National indicators for 2019/2020* require SLaM to report performance against indicators in three areas of community care:

1) Care Programme Approach 7-day follow up;

2) Home Treatment Team Gatekeeping; and

3) Re-admission to hospital within 28 days of discharge.

As these are all significant indicators of the quality of community care (and in (1) contributing to reducing the suicide rate) we are hopeful that good oversight will be kept on these future developments throughout the Trust.

**Information Governance**

The Trust is to be congratulated on its work to improve its digital competence. In signing up to a unified data-sharing framework across South East London, it has further supported the expansion of the shared care record in this part of London – the Virtual Care Record.

We are aware that SLaM, like NHS organisations throughout the country, has challenges with the consistency and reliability of its digital systems. However, we are also cognisant of the work being done to improve data provision for all its staff, and therefore to contribute to the ultimate improvement in care for its service users. Governors welcome improvements to data quality, and anticipate effective and regular training to make the most of digital tools available to staff.

We might mention here the work being done to develop the Trust's informatics strategy, and to establish the Quality Centre which will provide the basis of Trust-wide data which will prove central to the provision of excellent care for all its service users and staff.

## Local Healthwatch organisations' reply to South London and Maudsley NHS Foundation Trust (SLaM) Quality Report 2018/19

No response received

# Annex 2

**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. NHS Improvement 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 2018/19 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2018 to 21 May 2019, including
  - Papers relating to Quality reported to the Board over the period April 2018 to 21 May 2019;
  - Feedback from commissioners dated May 2019
  - Feedback from Governors dated May 2019
  - Feedback from local Healthwatch organisations May 2019
  - 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 2018/2019
  - 2018 national patient survey results dated November 2018
  - 2018 national staff survey results dated November 2018
  - The Head of internal audit's annual audit opinion over the Trust's control environment dated 20 May 2018
  - 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 NHS Improvement'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

**Signed**

June Mulroy
Chair
**South London and Maudsley NHS Foundation Trust**
Date: 23 May 2019

**Signed**

**Dr Matthew Patrick**
Chief Executive
**South London and Maudsley NHS Foundation Trust**
Date: 23 May 2019

# Annex 3

## Glossary

| | |
|---|---|
| **Approved Mental Health Professionals (AMHP)** | AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating assessment and admission to hospitals. |
| **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. |
| **Chief Clinical Information Officer (CCIO)** | Deputy Medical Director for Information |
| **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. |
| **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 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. |
| **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)** | A 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 Health Minimum Data Set (MHMDS)** | Mental Health Minimum Data Set (MHMDS) is a regular return of data from providers of NHS funded adult secondary mental health services, produced during in the course of delivering services to patients. |
| **National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)** | 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). |
| **National Health Service England (NHSE)** | 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. |
| **National Reporting and Learning Service (NRLS)** | 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. |

| | |
|---|---|
| **Operations Directorates (OD)** | In 2018/19, the services SLaM provides were reorganised into Operations Directorates. These directorates are largely organised by borough. This means that the trust can work in close partnership with local organisations and health and social care agencies across all mental health conditions to provide care closer to home. In some instances, our services are provided for national patients or are specialist for specific groups of our local population. In these instances, the care is best managed on a trust-wide basis so that we can concentrate expertise around smaller numbers of patients. Therefore, the new management model brings together Operations Directorates and previous research-focussed Clinical Academic Groups (CAGs) to ensure we have the expertise to offer patients the very best care and treatment, based upon reliable research evidence.<br>The new Operations Directorates are:<br>• Child and Adolescent Mental Health Services<br>• Croydon and Forensics<br>• Lambeth<br>• Lewisham<br>• Psychological Medicine and Older Adults<br>• Southwark and Addictions. |
| **Prescribing Observatory for Mental Health -UK (POMH-UK Audits)** | 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. |

Fig. 40: Glossary

Fig. 28: POMH - valproate prescribing in bipolar illness

Fewer women of childbearing age were prescribed valproate in SLAM compared with the average national sample, as shown below.

**Actions taken**

The Trust has taken the following actions during 2018/19:

- In PMOA there is work underway with GPs to redesign the referral process and referral form.
- Older Adult have worked with CRISS to develop a tool to monitor antipsychotic monitoring for patient with dementia.
- Quality improvement projects to improve the waiting times for patients with a diagnosis of dementia have been ongoing; including increasing memory service capacity in Croydon.
- Up to date Information on community Speech and Language Therapy (SALT) services has been circulated to community teams.
- The inpatient nutrition screening tool is being redeveloped and that will include feeding / swallowing issues.

The Trust continues to assess the impact of the actions highlighted in mortality reviews.

In 2019/20 we will be implementing the Royal College of Psychiatrists' standardised care review tool for

**Independent Practitioners Limited Assurance 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 limited assurance engagement in respect of South London and Maudsley NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

**Scope and subject matter**

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- inappropriate out-of-area placements for adult mental health services

We refer to these national priority indicators collectively as "the indicators".

**Respective responsibilities of the directors and Practitioner**

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 2018/19' and supporting guidance issued by NHS Improvement.

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 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance 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 1 April 2018 to May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to May 2019;
- feedback from commissioners dated May 2019;
- feedback from governors dated May 2019;
- the Trust's internal complaints reports over the period April 2018 to January 2019

- the 2018 national patient survey;
- the 2018 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 20/05/2019; and
- the Care Quality Commission's inspection report dated 23rd October 2018;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.
The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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.

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 2019, 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.

**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;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 that 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 2018/19' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by South London and Maudsley NHS Foundation Trust.

Our audit work on the financial statements of South London and Maudsley NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as South London and Maudsley NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to South London and Maudsley NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to South London and Maudsley NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of South London and Maudsley NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than South London and Maudsley NHS Foundation Trust and South London and Maudsley NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

**Conclusion**
Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual

reporting manual 2018/19' and supporting guidance.

***Grant Thornton UK LLP***

Grant Thornton UK LLP
Chartered Accountants
110 Bishopsgate, London, EC2N 4AY

29 May 2019

# Financial statements for the year ended 31 March 2019

## Foreword to the accounts

These accounts, for the year ending 31 March 2019, 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.

**Signed**

**Dr. Matthew Patrick**
Chief Executive
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

**Independent auditor's report to the Council of Governors of South London and Maudsley NHS Foundation Trust**

# Report on the Audit of the Financial Statements

## Opinion

**Our opinion on the financial statements is unmodified**

We have audited the financial statements of South London and Maudsley NHS Foundation Trust (the 'Trust') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

## Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

## Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

**Overview of our audit approach**

**Financial statements audit**

- Overall materiality: £8,087,000, which represents 2% of the Trust's gross operating costs (consisting of operating expenses);
- Key audit matters were identified as:
  - Valuation of land and buildings
  - Occurrence and accuracy of non-block contract patient care income and other operating income and existence of associated receivable balances

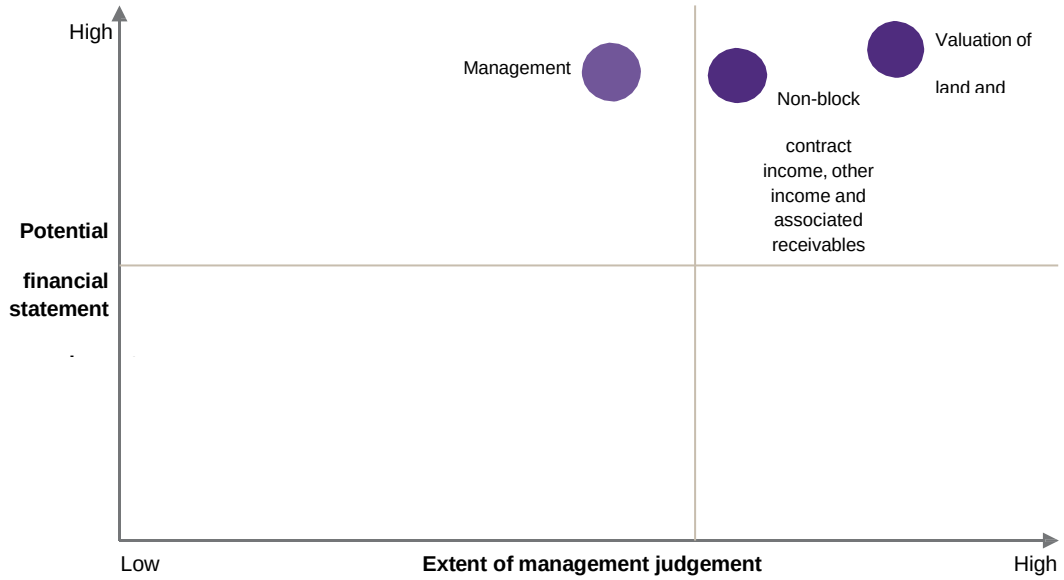
We have tested the Trust's material income and expenditure streams and assets and liabilities covering 100% of the Trust's income, 99.9% of the Trust's expenditure, 99.6% of the Trust's assets and 92.3% of the Trust's liabilities.

**Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources**

- We identified one significant risk in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources regarding the Trust's financial sustainability (see Report on other legal and regulatory requirements section).

## Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.




Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. 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.

| Key Audit Matter | How the matter was addressed in the audit |
| --- | --- |
| **Risk 1 – Valuation of land and buildings**<br>The Trust revalues its land and buildings on an annual basis to ensure that the carrying value is not materially different from the current value at the financial statements date. This valuation represents a significant estimate by management in the financial statements.<br><br>Management have engaged the services of a valuer to estimate the current value as at 31 March 2019.<br><br>The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. | Our audit work included, but was not restricted to:<br><br>• evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts and the scope of their work<br>• evaluating the competence, capabilities and objectivity of the valuation expert<br>• obtaining an understanding from the valuer of the basis on which the valuations were carried out<br>• challenging the information and assumptions used by the valuer to assess completeness and consistency |

| Key Audit Matter | How the matter was addressed in the audit |
| --- | --- |
| | **Key observations**<br>We have obtained sufficient audit assurance to conclude that:<br>• the basis of the valuation of land and buildings was appropriate, and the assumptions and processes used by management in determining the estimate were reasonable;<br>• the valuation of land and buildings disclosed in the audited financial statements is reasonable. |
| **Risk 2 – Occurrence and accuracy of non-block contract patient care income and other operating income and existence of associated receivable balances**<br>The Trust's significant income streams are operating income from patient care activities and other operating income.<br><br>The Trust recognises income from patient care activities during the year based on the completion of these activities. This includes the block contract, which is agreed in advance at a fixed price, and non-block contract income.<br><br>Patient care activities provided that are additional to those incorporated in the block contracts with NHS commissioners, are subject to verification and agreement of the completed activity by commissioners. As such, there is a risk that income is recognised in the financial statements for these additional services that is not subsequently agreed to by the commissioners.<br><br>Due to the nature of block contracts we have not identified a significant risk of material misstatement in relation to block contracts.<br><br>We therefore identified occurrence and accuracy of all income and other operating | Our audit work included, but was not restricted to:<br><br>• Evaluating the Trust's accounting policies for recognition of income for appropriateness and compliance with the Department of Health and Social Care (DHSC) group accounting manual 2018-19;<br>• Obtaining an understanding of the Trust's system for accounting for income and evaluating the design of the associated controls;<br><br>In respect of patient care income:<br>• using the DHSC mismatch report, we will investigate unmatched revenue and receivable balances over the NAO £0.3 million threshold, corroborating the unmatched balances used to your supporting evidence;<br>• agree, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from your commissioners<br>• evaluate your estimates and the judgments made by management in respect of significant contract variations with regard to corroborating evidence in order to arrive at the total income from |

## 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 in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

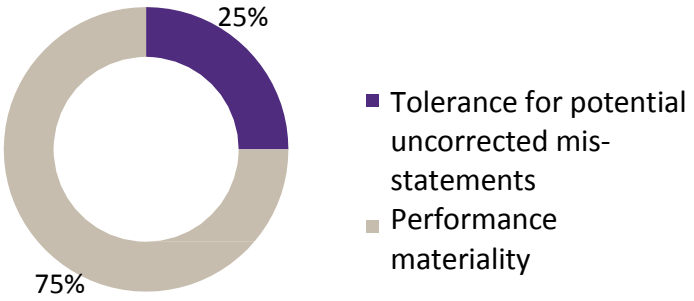
Materiality was determined as follows:

| Materiality Measure | Trust |
|---|---|
| Financial statements as a whole | £8,087,000 which is 2% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding.<br>Materiality for the current year is at the same percentage level of gross operating costs as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the Trust or the environment in which it operates. |

| Materiality Measure | Trust |
|---|---|
| Performance materiality used to drive the extent of our testing | 75% of financial statement materiality |
| Communication of misstatements to the Audit Committee | £300,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds. |

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

**Overall materiality – Trust**




## An overview of the scope of our audit

Our audit approach was based on a thorough understanding of the Trust's business, was risk based and included an evaluation of the Trust's internal controls environment including relevant IT systems and controls over key financial systems.

The scope of our audit included:

- obtaining supporting evidence, on a sample basis, for all of the Trust's material income streams covering 100% of the Trust's revenues;
- obtaining supporting evidence, on a sample basis, for 99.9% of the Trust's operating costs;
- obtaining supporting evidence, on a sample basis, for property plant and equipment and the Trust's other material assets and liabilities.
- There were no changes in the scope of the current year audit from the scope of the prior year

## Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report**,** other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable – set out on Page 56, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit Committee reporting set out on Page 117, in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

## Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider 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 this regard.

**Our opinion on other matters required by the Code of Audit Practice is unmodified**

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual 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

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator 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 which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency**.**

We have nothing to report in respect of the above matters.

## Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, set out on page(s) 109 and 110, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2018/19, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

### Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

## Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

### Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019**.**
We have nothing to report in respect of the above matter.

### Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

| Significant risks | How the matter was addressed in the audit |
|---|---|
| **The Trust's Financial Position**<br><br>In 2017-18, you delivered a retained surplus position of £2.4 million, along with delivering £25.4 million of Cost Improvement Plans (CIPs). The retained surplus position was in line with plan, however you delivered £1.6 million less of CIP than planned. For 2018-19, you have been set a Control Total of a £2.506 million surplus for 2018-19 (excluding PSF), along with the delivery of £16.4 million of Cost Improvement Plans (CIPs). At the end of January 2019, you are now forecasting a surplus of just £13k excluding PSF, along with an under delivery of CIPs by £3.3 million, which indicates that there may be a weakness in your arrangements for ensuring sustainable resource deployment across the Trust. | Our audit work included, but was not restricted to:<br><br>• This year we will update our understanding of your financial position and the underlying arrangements, including gaining an understanding for the movement in the planned financial position during the course of the year. We will also look to understand the financial plans for the year ahead and determine whether this has any impact on our overall Value for Money Conclusion.<br><br>**Key findings**<br>• You achieved a deficit of **£658k**, which subsequently unlocked the planned Provider Sustainability Funding of **£6.4 million** and thus the Trust ended up with its planned Surplus position. This position looked under threat during the course of the year, particularly at Month 9, but a strong performance in Q4 brought you back to the planned position.<br><br>• Linked to this, you delivered **£14.138 million** of CIPs, which was 86% of the planned level, which was **£16.401 million**. The main issue impacting the delivery of CIPs was the pressure on overspill beds with a financial impact of **£2.40 million** during the year.<br>• For 2019-20 you set a budget to achieve breakeven, which includes **£3.5 million** of Provider Sustainability Funding and **£11.1 million** from the new Financial Recovery Fund set up by NHS Improvement to support Trusts who are carrying underlying deficits within their Financial Position. To support this position you are planning to deliver £12.0 million of CIPs in 2019-20, which has been based on the outturn level of spend in 2018- 19 to provide some realism to the plans. |

### Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

### Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its Use of Resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

## Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of South London and Maudsley NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

### Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors 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 Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

***Sarah L Ironmonger***

**Sarah Ironmonger, Key Audit Partner**

For and on behalf of Grant Thornton UK LLP, Local Auditor

**London**

**29 May 2019**

# Foreword to the accounts

# South London and Maudsley NHS Foundation Trust

These accounts, for the year ending 31 March 2019, 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.

Signed
Matthew Patrick, Chief Executive

23rd May 2019

## Statement of Comprehensive income

For the year ended 31 March 2019

| | 2019<br>£ 000's | 2018<br>£ 000's |
|---|---|---|
| **Operating income** | **406,233** | 381,066 |
| **Operating expenses** | **(404,357)** | (368,612) |
| **Operating surplus** | **1,876** | 12,454 |
| Gain on disposal of assets | **7,937** | 3,936 |
| Finance costs | **(76)** | (3) |
| Finance income | **473** | 253 |
| Public Dividend Capital dividend | **(6,092)** | (6,248) |
| Movement in fair value of investments | **46** | 111 |
| **Surplus for the year** | **4,164** | 10,503 |
| **Other comprehensive income** | | |
| **Will not be reclassified to income and expenditure** | | |
| Revaluation loss on plant, property and equipment | **(3,251)** | (2,248) |
| Revaluation gains on plant, property and equipment | **709** | 18,544 |
| **Total comprehensive income for the financial year** | **1,622** | 26,799 |

## Statement of Financial Position

As at 31 March 2019

| | 31 Mar 2019 £ 000's | 31 Mar 2018 £ 000's |
|---|---|---|
| **Non-current assets** | | |
| Intangible assets | **601** | 181 |
| Property, plant and equipment | **233,372** | 234,426 |
| Investments | **2,293** | 2,247 |
| Other assets | **235** | 236 |
| | **236,501** | 237,090 |
| **Current Assets** | | |
| Inventories | **320** | 351 |
| Trade and other receivables | **24,949** | 18,513 |
| Cash and cash equivalents | **84,014** | 70,174 |
| | **109,283** | 89,038 |
| Asset classified as held for sale | **-** | 10,100 |
| **Total assets** | **345,784** | 336,228 |
| **Current Liabilities** | | |
| Trade and other payables | **55,173** | 46,565 |
| Borrowings | **-** | 207 |
| Provisions for liabilities and charges | **1,335** | 1,556 |
| Other liabilities | **7,781** | 9,069 |
| | **64,289** | 57,397 |
| **Total Assets less Current Liabilities** | **281,495** | 278,831 |
| **Non-Current Liabilities** | | |
| Provisions for liabilities and charges | **5,877** | 6,160 |
| **Total assets employed** | **275,618** | 272,671 |
| **Equity** | | |
| Public dividend capital | **187,273** | 185,948 |
| Revaluation reserve | **85,961** | 99,099 |
| Retained earnings (deficit) | **2,384** | (12,376) |
| **Total taxpayers' equity** | **275,618** | 272,671 |
| **Total taxpayers' equity** | **275,618** | 272,671 |

**Signed**

**Dr. Matthew Patrick**
Chief Executive
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

## Statement of Changes in Equity

For the year ended 31 March 2019

| | Public dividend capital | Revaluation reserve | Income & expenditure reserve | **Total** |
|---|---|---|---|---|
| | £ 000's | £ 000's | £ 000's | **£ 000's** |
| **At 1 April 2017** | 183,041 | 83,917 | (23,993) | 242,965 |
| Total comprehensive income for the year: | | | | |
| Surplus for the year | - | - | 10,503 | 10,503 |
| Revaluation losses | - | (2,248) | - | (2,248) |
| Revaluation gains | - | 18,544 | - | 18,544 |
| Realised gains | - | (1,114) | 1,114 | - |
| PDC received during year | 2,907 | - | - | 2,907 |
| **At 31 March 2018** | 185,948 | 99,099 | (12,376) | 272,671 |
| | | | | |
| **At 1 April 2018** | **185,948** | **99,099** | **(12,376)** | **272,671** |
| Total comprehensive income for the year: | | | | |
| Surplus for the year | **-** | **-** | **4,164** | **4,164** |
| Revaluation losses | **-** | **(3,251)** | **-** | **(3,251)** |
| Revaluation gains | **-** | **709** | **-** | **709** |
| Realised gains | **-** | **(10,596)** | **10,596** | **-** |
| PDC received during year | **1,325** | **-** | **-** | **1,325** |
| **At 31 March 2019** | **187,273** | **85,961** | **2,384** | **275,618** |

## Statement of Cash Flows

For the year ended 31 March 2019

| | 2019<br>£ 000's | 2018<br>£ 000's |
|---|---|---|
| **Net cash generated from operating activities** | **10,202** | 16,493 |
| **Cash flows from investing activities** | | |
| Interest received | **473** | 253 |
| Purchases of intangible fixed assets | **(532)** | - |
| Purchases of property, plant and equipment | **(10,774)** | (5,626) |
| Proceeds from disposals of property, plant and equipment | **19,775** | 6,879 |
| **Net cash generated from investing activities** | **8,942** | 1,506 |
| **Cash flows from financing activities** | | |
| Public Dividend Capital received | **1,325** | 2,907 |
| Loans repaid | **(207)** | (87) |
| Public Dividend Capital dividend paid | **(6,422)** | (5,740) |
| **Net cash used in financing activities** | **(5,304)** | (2,920) |
| **Increase in cash and cash equivalents** | **13,840** | 15,079 |
| **Cash and cash equivalents at 1 April** | **70,174** | 55,095 |
| **Cash and cash equivalents at 31 March** | **84,014** | 70,174 |

# South London and Maudsley NHS Foundation Trust

## Notes to the Accounts

### 1 Accounting policies

**Accounting policies and other information**

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

#### 1.1 Going concern

The directors, having made enquiries, have a reasonable expectation that the Trust has adequate resources to continue its operations for the foreseeable future. As a result the accounts continue to be prepared on a going concern basis.

#### 1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

#### 1.3 Consolidation

The Trust has no subsidiaries, associates, joint ventures or joint operations. The Maudsley Charity was a subsidiary in 2017/18 but is no longer consolidated following change in status and governance.

#### 1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Foundation Trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

#### 1.5 Critical judgements in applying accounting policies

There are no critical judgements apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

**Key sources of estimation uncertainty**

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period not already included in the note above, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

**Property valuations**

As described in Note 1.10, the Trust's properties are valued at either market value for existing use or depreciated replacement cost. Properties have been subject to a full independent valuation at 31 March 2019 by the District Valuer on the basis set out in Note 1.10.

The useful economic life of each category of fixed asset is assessed when acquired by the Trust and for property reassessed on revaluation by the District Valuer. A degree of estimation is used in assessing the useful economic lives of assets.

The Trust has considered provisions in the Modern Equivalent Asset (MEA) valuation approach for whether the existing buildings and sites are optimal in terms of number, size, configuration and location. Where appropriate a modern equivalent asset has been valued at a notional alternative location.

The Trust is required to review property, plant and equipment for impairment. In between formal valuations by qualified surveyors, management make judgments about the condition of assets and review their estimated lives.

**Investment property valuations**

Investment properties are stated at fair value at the balance sheet date. Properties were valued at 31 March 2019 by the District Valuer.

#### 1.6 Income

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

## 1.7 Expenditure on Employee Benefits

**Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs**

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

## 1.8 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

## 1.10 Property, Plant and Equipment

**Recognition**

Property, Plant and Equipment is capitalised where:

it is held for use in delivering services or for administrative purposes;

it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;

it is expected to be used for more than one financial year; and

the cost of the item can be measured reliably.

the item has a cost of at least £5,000; or

collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

items forming part of the initial equipping and set-up cost of a new building, or refurbishment, and have a combined cost of at least £5,000

**Valuation**

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

Land and non-specialised buildings – market value for existing use

Specialised buildings – depreciated replacement cost

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

Equipment, vehicles, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

**Subsequent expenditure**

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

**Depreciation**

Items of Property, Plant and Equipment are depreciated straight-line over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Equipment is depreciated over a useful economic life of 5 to 10 years. The remaining useful economic lives of freehold and long leasehold buildings are reassessed during revaluation and range from 2 to 45 years. Capitalised improvements to other leasehold and rental properties are depreciated over the shorter of the primary lease term, or the useful economic life.

Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

**Revaluation gains and losses**

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

**Impairments**

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

**De-recognition**

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

the sale must be highly probable i.e. ;

- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

**Donated and grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

## 1.11 Cash and cash equivalents

Cash is cash at bank and in hand and deposits repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. The Trust has no cash equivalents.

Cash and bank are recorded at current values. There were no overdrafts.

## 1.12 Revenue - government and other grants

Government grants are grants from Government bodies other NHS bodies for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure once all conditions have been met.

## 1.13 Financial assets and financial liabilities

**Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

**De-recognition**

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

**Classification and Measurement**

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income. Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

**Financial assets and financial liabilities at amortised cost**

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

**Financial assets measured at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

**Financial assets and financial liabilities at fair value through income and expenditure**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

**Impairment of financial assets**

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

## 1.14 Leases

**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

**Operating leases**

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease. Contingent rentals are recognised as an expense in the period in which they are incurred.

**Leases of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

## 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

**Post employment benefits**

Provisions for post employment benefits resulting from early retirements and injury benefits are discounted at the nominal rate of 2.9%

**Clinical negligence costs**

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 17.6 but is not recognised in the trust's accounts.

**Non-clinical risk pooling**

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

## 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 17 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 19, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

## 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.
A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the actual average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, average daily cash held with the Government Banking Services and National Loan Fund deposits, any PDC dividend balance receivable or payable and the receivable due for STF incentives and bonus.
In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

### 1.18 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### 1.19 Foreign exchange

The functional and presentational currencies of the Trust are sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.
Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

### 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However the losses and special payments note 22 is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

### 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

### 1.22 Accounting Standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FReM adoption.
IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019.

### 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

## Notes to the Accounts

### 2 Segmental analysis

The Foundation Trust does not consider that it has reportable segments as defined by IFRS 8 : Operating Segments.

| 3 Operating Income | 2019 £ 000's | 2018 £ 000's |
|---|---|---|
| **3.1 Income from healthcare activities** | | |
| Cost and Volume Contract income | **49,574** | 66,480 |
| Block Contract income | **243,779** | 217,147 |
| Clinical Partnerships (including S31 agreements) | **1,093** | 1,253 |
| Other clinical income | **47,752** | 33,911 |
| | **342,198** | 318,791 |
| **3.2 Non-mandatory clinical income** | | |
| Private patients | **108** | 217 |
| **Income from healthcare activities** | **342,306** | 319,008 |
| **3.3 Other operating income** | | |
| Research and development | **24,756** | 22,728 |
| Education and training | **19,302** | 19,463 |
| Charitable and other contributions to expenditure | **2,589** | 4,089 |
| Non-patient care services to other bodies | **911** | 796 |
| Provider Sustainability funding (Sustainability and Transformation funding) | **6,415** | 5,042 |
| Other income | **9,954** | 9,940 |
| | **63,927** | 62,058 |
| **Total income** | **406,233** | 381,066 |

From 1 April 2016, NHS Improvement (NHSI), an arms length body of DH, has awarded Provider Sustainability Fund income (PSF), previously Sustainability and Transformation Fund (STF), to Trusts which have:
- achieved their assigned financial targets ('control totals') and specified clinical performance trajectories ('core' PSF);
- exceeded their assigned 'control totals' through a £ for £ reward scheme ('incentive' PSF); and
- to the extent that funds are available to NHSI, additional PSF to Trusts meeting and/ or exceeding their assigned 'control totals' ('bonus' and 'general distribution' PSF).

The Trust was awarded the following PSF (STF):

| | | |
|---|---|---|
| Core | **3,181** | 2,262 |
| Incentive | **505** | 838 |
| Bonus | **1,275** | 1,523 |
| General distribution | **1,454** | - |
| Post Accounts reconciliation bonus | **-** | 419 |
| | **6,415** | 5,042 |
| **Revenue from contract liabilities at the previous year-end** | **7,781** | n/a |

## 4 Operating expenses

| Notes | | | 2019 £ 000's | 2018 £ 000's |
|---|---|---|---|---|
| | Operating expenses comprised: | | | |
| | Non-executive directors' costs | | **158** | 164 |
| | Supplies & contracts: | healthcare from NHS and non-NHS bodies | **29,288** | 22,416 |
| | | services from NHS bodies | **4,589** | 3,963 |
| | | drugs | **7,727** | 8,008 |
| | | other clinical | **1,925** | 2,047 |
| | | general | **12,841** | 12,541 |
| | | establishment | **3,375** | 3,212 |
| | | research and development | **17,290** | 15,078 |
| | | transport | **1,121** | 1,181 |
| | | premises | **21,156** | 18,782 |
| 5 | Staff costs: | employed staff and directors | **230,766** | 221,657 |
| | | NHS bank, agency, contract and seconded staff | **55,136** | 50,904 |
| 10 | Depreciation | | **9,358** | 8,676 |
| | Amortisation | | **110** | 100 |
| 10 | Fixed asset impairments: | | **1,274** | 4,105 |
| | Reversal of fixed asset impairments | | **(207)** | (9,942) |
| | Auditor's remuneration: | statutory audit | **74** | 74 |
| | | other remuneration | **8** | 8 |
| | Other | | **8,368** | 5,638 |
| | | | **404,357** | 368,612 |

| **Other audit remuneration** | 2019 £ 000's | 2018 £ 000's |
|---|---|---|
| Audit related assurance services - Quality Report | **8** | 8 |
| | **8** | 8 |

Auditor's remuneration includes irrecoverable VAT

| | £ 000's | £ 000's |
|---|---|---|
| **Limitations on auditor's liability** | **2,000** | 2,000 |

## 5 Employees costs and pensions

| | 2019 £ 000's | 2018 £ 000's |
|---|---|---|
| Emoluments of employees comprised: | | |
| Executive directors | **895** | 776 |
| Other salaries and wages | **186,014** | 178,473 |
| Social security costs | **19,922** | 19,279 |
| Employer contributions to NHS Pensions Agency | **23,935** | 23,129 |
| | **230,766** | 221,657 |
| Agency and contract staff | **19,067** | 17,196 |
| NHS Bank staff | **27,238** | 25,069 |
| Seconded-in staff | **8,831** | 8,639 |
| | **285,902** | 272,561 |

**Average staff numbers**

| | Directors | Permanent employees | Other | 2019 Total | 2018 Total |
|---|---|---|---|---|---|
| | No. | No. | No. | **No.** | No. |
| Medical staff | 1 | 433 | 36 | **470** | 452 |
| Nursing and health visiting staff | 1 | 1,325 | 339 | **1,665** | 1,623 |
| Healthcare assistants and other support and ancillary staff | - | 612 | 389 | **1,001** | 960 |
| Scientific, therapeutic and technical staff | - | 973 | 113 | **1,086** | 1,052 |
| Administration staff | 3 | 998 | 107 | **1,108** | 1,092 |
| Social care staff | - | - | 39 | **39** | 58 |
| | 5 | 4,341 | 1,023 | **5,369** | 5,237 |

**Ill-health retirement costs borne by the NHS Pension Scheme**

| | 2019 | 2018 |
|---|---|---|
| Number of cases | **-** | - |
| Estimate of additional pensions liabilities (£ 000's) | **-** | - |

**Staff exit packages**

| Number of staff exit packages by cost band | £ 000's | Compulsory redundancy | Other | 2019 Total | 2018 Total |
|---|---|---|---|---|---|
| | | No. | No. | **No.** | No. |
| | 0-10 | 4 | - | **4** | 3 |
| | 10-25 | 1 | 1 | **2** | 4 |
| | 25-50 | 6 | - | **6** | 5 |
| | 50-100 | 3 | - | **3** | 6 |
| | 100-150 | 1 | - | **1** | 2 |
| | 150-200 | - | - | **-** | 2 |
| | 200-250 | - | - | **-** | - |
| | | 15 | 1 | **16** | 22 |
| | | £ 000's | £ 000's | **£ 000's** | £ 000's |
| Cost of staff exit packages | | 601 | 15 | **616** | 1,318 |

## Notes to the Accounts

### 5.1 Employees costs and pensions

**Pensions**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

## Notes to the Accounts

| 6 Net finance income | | 2019 £ 000's | 2018 £ 000's |
|---|---|---|---|
| **Finance costs** | | | |
| Unwinding of discount on provisions for liabilities and charges | | **76** | 3 |
| Payments made under The Late Payment of Commercial Debts (Interest) Act 1998 | | **-** | - |
| | | **76** | 3 |
| **Finance income** | | | |
| Interest receivable: | Government Banking Service | **(398)** | (127) |
| | National Loans fund | **(43)** | (8) |
| | Bank deposits | **-** | - |
| | Other | **(32)** | (118) |
| | | **(473)** | (253) |
| **Net finance income** | | **(397)** | (250) |

| 7 Gains and losses on disposal of fixed assets | Property £000's | Equipment £000's | **2019 £ 000's** | 2018 £ 000's |
|---|---|---|---|---|
| Net book value of assets disposed | 11,838 | - | **11,838** | 2,943 |
| Net proceeds from sale | (19,775) | - | **(19,775)** | (6,879) |
| | (7,937) | - | **(7,937)** | (3,936) |
| Gains on disposal | 7,945 | - | **7,945** | 4,043 |
| Losses on disposal | (8) | - | **(8)** | (107) |
| | 7,937 | - | **7,937** | 3,936 |

## Notes to the Accounts

| 8 Public Dividend Capital dividend | 2019<br>£ 000's | 2018<br>£ 000's |
|---|---|---|
| Accrued dividend payable (receivable) at start of year | **266** | (242) |
| Dividend provided in year | **6,092** | 6,248 |
| Accrued dividend receivable (payable) at end of year | **64** | (266) |
| Dividend paid | **6,422** | 5,740 |

## Notes to the Accounts

| 9 Intangible assets | Software<br>£ 000's | **2019**<br>**£ 000's** | 2018<br>£ 000's |
|---|---|---|---|
| **Cost or valuation** | | | |
| **At 1st April** | 539 | **539** | 539 |
| Additions | 532 | **532** | - |
| Transfers | (3) | **(3)** | - |
| **At 31st March** | 1,068 | **1,068** | 539 |
| **Amortisation** | | | |
| **At 1st April** | (358) | **(358)** | (259) |
| Charged during the year | (109) | **(109)** | (99) |
| **At 31st March** | (467) | **(467)** | (358) |
| Net book value at 1st April | 181 | **181** | 280 |
| **Net book value at 31st March** | 601 | **601** | 181 |

| 10 Property, plant and equipment | Land | Buildings | Plant and equipment | Assets under construction | Total |
|---|---|---|---|---|---|
| | £ 000's | £ 000's | £ 000's | £ 000's | £ 000's |
| **Cost or valuation** | | | | | |
| **At 1st April 2017** | 23,635 | 189,034 | 19,838 | 4,836 | **237,343** |
| Revaluation | 1,244 | 24,939 | 55 | - | **26,238** |
| Additions | - | 2,949 | 2,503 | 798 | **6,250** |
| Reclassifications | (8,830) | (824) | - | | **(9,654)** |
| Transfers to assets in the course of construction | 1,417 | 3,567 | 147 | (5,131) | **-** |
| Impairments | (14) | (4,091) | - | - | **(4,105)** |
| Cumulative depreciation transferred after revaluation | - | (6,407) | - | - | **(6,407)** |
| Disposals | - | - | (214) | - | **(214)** |
| **At 31st March 2018** | **17,452** | **209,167** | **22,329** | **503** | **249,451** |
| **Revaluation** | 11 | (2,346) | - | - | **(2,335)** |
| **Additions** | 125 | 7,306 | 3,405 | 2,812 | **13,648** |
| **Reclassifications** | (578) | (1,160) | 3 | | **(1,735)** |
| **Transfers to assets in the course of construction** | - | - | - | - | **-** |
| **Impairments** | - | (1,274) | - | - | **(1,274)** |
| **Cumulative depreciation transferred after revaluation** | - | (7,074) | - | - | **(7,074)** |
| **Disposals** | - | - | - | - | **-** |
| **At 31st March 2019** | **17,010** | **204,619** | **25,737** | **3,315** | **250,681** |
| **Depreciation** | | | | | |
| Depreciation for the period | - | (6,407) | (2,269) | - | **(8,676)** |
| Disposals | - | - | 186 | - | **186** |
| Netted off cost/value following revaluation | - | 6,407 | - | - | **6,407** |
| **At 31st March 2018** | **-** | **-** | **(15,025)** | **-** | **(15,025)** |
| **Depreciation for the period** | - | (7,074) | (2,284) | - | **(9,358)** |
| **Disposals** | - | - | - | - | **-** |
| **Netted off cost/value following revaluation** | - | 7,074 | - | - | **7,074** |
| **At 31st March 2019** | **-** | **-** | **(17,309)** | **-** | **(17,309)** |
| Net book value at 31st March 2018 | 17,452 | 209,167 | 7,304 | 503 | 234,426 |
| **Net book value at 31st March 2019** | **17,010** | **204,619** | **8,428** | **3,315** | **233,372** |

**Valuations**

Property assets with a net book value of £216m were revalued as at March 2019 by the District Valuer using modern equivalent asset (MEA) depreciation replacement cost for specialised buildings and existing use market value for land and non-specialised buildings. Improvements to leasehold buildings are held at depreciated cost and not revalued.

**Asset lives**

Building asset lives are reassessed by the District Valuer during revaluation. Leasehold improvements valued at cost are written down over the shorter of the useful life of the improvement and the remaining leasehold term Equipment assets are depreciated at between 5 and 10 years. Heritage assets are included within Equipment assets and are not depreciated.

| | Land and buildings | Plant and equipment | Assets under construction | Total |
|---|---|---|---|---|
| **Donated assets** | £ 000's | £ 000's | £ 000's | £ 000's |
| Net book value of donated assets at 1st April 2018 | 16,555 | 1,012 | - | 17,567 |
| **Net book value of donated assets at 1st April 2019** | **16,068** | **1,012** | **-** | **17,080** |

| **Land and buildings** | Existing use Modern equivalent asset vale | Existing use Existing use value | Existing use Existing use Cost | Alternate use Open market value | Total |
|---|---|---|---|---|---|
| Analysis of net book value at 1st April 2018 | £ 000's | £ 000's | £ 000's | £ 000's | £ 000's |
| Freehold | 101,500 | 26,185 | - | - | **127,685** |
| Long leasehold | 89,668 | 4,421 | - | - | **94,089** |
| Short leasehold | - | - | 4,845 | - | **4,845** |
| | 191,168 | 30,606 | 4,845 | - | **226,619** |
| **Analysis of net book value at 1st April 2019** | £ 000's | £ 000's | £ 000's | £ 000's | £ 000's |
| Freehold | 100,119 | 24,601 | 208 | - | **124,928** |
| Long leasehold | 87,505 | 2,867 | 3,156 | - | **93,528** |
| Short leasehold | - | - | 6,488 | - | **6,488** |
| | 187,624 | 27,468 | 9,852 | - | **224,944** |

| **Capital commitments** | £ 000's |
|---|---|
| Contracted for but not provided in the accounts 31 March 2018 | 866 |
| **Contracted for but not provided in the accounts 31 March 2019** | **1,599** |

## 11 Investments

| | 31 Mar 2019 | 31 Mar 2018 |
|---|---|---|
| | £ 000's | £ 000's |
| **Investment property** | | |
| Investment property at 1 April | **2,247** | 5,497 |
| Revaluation gains | **71** | 111 |
| Revaluation losses | **(25)** | - |
| Reclassified | **-** | (3,361) |
| Investment property at 31 March | **2,293** | 2,247 |

The fair value of the Trust's investment property at 31 March 2019 has been arrived at on the basis of valuations carried out at that date by the District Valuer Service.

The valuations accord with the requirements of International Financial Reporting Standards (IFRS) and the RICS Valuation – Professional Standards (incorporating the International Valuation Standards) ("the RICS Red Book").

The DVS valuations have been prepared using the market approach, which is described at paras B5 to B7 of IFRS 13; it uses prices and other relevant information generated by market transactions involving identical or comparable (i.e. similar) assets.

The inputs to this technique constitute Level 2 inputs in each instance. Level 2 inputs are inputs that are observable for the asset, either directly or indirectly. The inputs used took the form of analysed and weighted market evidence such as sales, rentals and yields in respect of comparable properties in the same or similar locations at or around the valuation date.

## Notes to the Accounts

| 12 Inventories | 31 Mar 2019 | 31 Mar 2018 |
|---|---|---|
| | £ 000's | £ 000's |
| Drugs | 320 | 351 |
| | 320 | 351 |

## 13 Trade and other receivables

| | 31 Mar 2019 | 31 Mar 2018 |
|---|---|---|
| Amounts receivable within one year: | £ 000's | £ 000's |
| Contract receivables - NHS (NHS receivables) | **11,465** | 10,058 |
| Contract receivables - Other (Other receivables) | **7,523** | 4,296 |
| Provision for impaired receivables | **(2,868)** | (1,299) |
| Prepayments | **821** | 1,099 |
| Accrued income | **6,843** | 4,359 |
| Other receivables | **1,165** | - |
| | **24,949** | 18,513 |

| **Allowance for credit losses** | Contract receivables and contract assets | Other receivables | 31 Mar 2019 | 31 Mar 2018 |
|---|---|---|---|---|
| | £ 000's | £ 000's | £ 000's | £ 000's |
| At 1st April | 1,075 | 224 | **1,299** | 2,045 |
| New allowances | 2,301 | 181 | **2,482** | 951 |
| Utilisation of allowances - written off | (26) | (12) | **(38)** | (3) |
| Utilisation of allowances - cancelled | (150) | (4) | **(154)** | (57) |
| Reversal of allowances - paid | (650) | (71) | **(721)** | (1,637) |
| **At 31st March** | **2,550** | **318** | **2,868** | 1,299 |

## 14 Assets classified as held for sale

| | 31 Mar 2019 £ 000's | 31 Mar 2018 £ 000's |
|---|---|---|
| Assets held for sale at 1 April | **10,100** | - |
| Disposal | **(11,838)** | (2,915) |
| Reclassified | **1,738** | 13,015 |
| Assets held for sale at 31 March | **-** | 10,100 |

| 15 Trade and other payables | 31 Mar 2019 | 31 Mar 2018 |
|---|---|---|
| | £ 000's | £ 000's |
| Amounts falling due within one year: | | |
| Payments received on account | **234** | 392 |
| Non-NHS trade creditors | **12,072** | 11,344 |
| Tax and social security costs | **4,987** | 5,053 |
| Pensions relating to staff and directors | **3,515** | 3,374 |
| Dividend payable | **-** | 266 |
| Other payables | **4,929** | 688 |
| NHS payables | **3,690** | 4,980 |
| Accruals | **25,746** | 20,468 |
| Total payables | **55,173** | 46,565 |

## Notes to the Accounts

| 16 Other liabilities | 31 Mar 2019 | 31 Mar 2018 |
|---|---|---|
| Other liabilities due within one year | **£ 000's** | £ 000's |
| Deferred income | **7,781** | 9,069 |
| | **7,781** | 9,069 |

## 17 Provision for liabilities and charges

| | 19.1 Early retirements | 19.2 Injury benefits | 19.3 Pay and restructuring | 19.4 Legal claims | 19.5 Property | Total |
|---|---|---|---|---|---|---|
| | £ 000's | £ 000's | £ 000's | £ 000's | £ 000's | £ 000's |
| **At 1st April 2017** | 2,244 | 1,619 | 1,779 | 1,461 | 2,907 | **10,010** |
| Change in the discount rate | 60 | 27 | - | - | - | **87** |
| Expenditure during the period | (595) | (84) | (1,225) | (746) | (170) | **(2,820)** |
| Arising during the period | 86 | 42 | 379 | 674 | 786 | **1,967** |
| Released unused | (13) | - | (585) | (418) | (515) | **(1,531)** |
| Unwinding of discount | 2 | 1 | - | - | - | **3** |
| **At 31st March 2018** | **1,784** | **1,605** | **348** | **971** | **3,008** | **7,716** |
| Change in the discount rate | 60 | (396) | - | - | - | **(336)** |
| Expenditure during the period | (194) | (86) | (559) | (511) | (173) | **(1,523)** |
| Arising during the period | 66 | 52 | 517 | 752 | 600 | **1,987** |
| Released unused | (211) | - | (196) | (184) | (117) | **(708)** |
| Unwinding of discount | 43 | 33 | - | - | - | **76** |
| **At 31st March 2019** | **1,548** | **1,208** | **110** | **1,028** | **3,318** | **7,212** |
| **Expected timing of cash flows:** | | | | | | |
| Within one year | 248 | 84 | 348 | 486 | 390 | **1,556** |
| Within two - five years | 992 | 336 | - | 485 | 1,114 | **2,927** |
| Over five years | 544 | 1,185 | - | - | 1,504 | **3,233** |
| **At 31st March 2018** | 1,784 | 1,605 | 348 | 971 | 3,008 | **7,716** |
| Within one year | 196 | 88 | 110 | 514 | 427 | **1,335** |
| Within two - five years | 784 | 352 | - | 514 | 1,681 | **3,331** |
| Over five years | 568 | 768 | - | - | 1,210 | **2,546** |
| **At 31st March 2019** | 1,548 | 1,208 | 110 | 1,028 | 3,318 | **7,212** |

### 17.1 Early retirements

Provisions are made for the estimated additional pension costs arising from early retirements. These costs are directly incurred by the NHS Pensions Agency, as pension payments are made, and the Agency seeks reimbursement from the Trust each quarter. There are no provisions for early retirements for former directors.

### 17.2 Injury benefits

Provision has been made for the expected value of the costs of NHS Injury Benefits claims. Claims are assessed and paid directly by the NHS Pensions Agency and reimbursement is sought from the Trust each quarter.

### 17.3 Pay and restructuring

Provision has been made for the estimate of cost for restructuring services associated with cost improvements and disinvestment plans.

### 17.4 Legal claims

The Foundation Trust provides for the estimated excess payments due to the NHS Resolution under the Liability for Third Parties insurance scheme resulting from non-clinical third party claims. The full costs of such claims is accounted for by NHS Resolution. The Trust provides against other legal claims and inquests.

### 17.5 Property

Provision is made for the estimate of outstanding repairing and reinstatement obligations arising from leasehold and rental property agreements. Provision is also made for the Carbon reduction Commitment Energy efficiency Scheme.

### 17.6 Clinical negligence

The Trust belongs to the Clinical Negligence Scheme for Trusts (CNST) and pays an annual insurance premium to the NHS Resolution. Under the term of this agreement, since 1 April 2002, financial responsibility for clinical negligence claims transferred to NHS Resolution and the liability for claims is provided in their Accounts. At the 31st March 2019 the NHSLA were providing £11.1m on behalf of the Foundation Trust (£5.8m 2017/18).

There are no contingent assets or liabilities.

## Notes to the Accounts

| 18 | Cash flow statement | 2019 £ 000's | 2018 £ 000's |
|---|---|---|---|
| 18.1 | **Net cash inflow from operating activities** | | |
| | Operating surplus | **1,876** | 12,454 |
| | Non-cash items: | | |
| | depreciation and amortisation | **9,468** | 8,776 |
| | impairment of tangible fixed assets | **1,274** | 4,105 |
| | impairment reversal of tangible fixed assets | **(207)** | (9,942) |
| | Changes in operating working capital: | | |
| | decrease in inventories | **31** | 12 |
| | (increase) / decrease in receivables | **(6,372)** | 2,421 |
| | increase / (decrease) in payables | **6,000** | (3,086) |
| | increase / (decrease) in other liabilities | **(1,288)** | 4,050 |
| | (decrease) in provisions for liabilities and charges | **(580)** | (2,297) |
| | **Net cash inflow from operating activities** | **10,202** | 16,493 |

| 18.2 | Reconciliation of net cash flow to movement in net funds | 2019 £ 000's | 2018 £ 000's |
|---|---|---|---|
| | **Increase in cash during the period** | **13,840** | 15,079 |
| | Government bank services | **13,837** | 15,077 |
| | Commercial banks | **5** | - |
| | Cash in hand | **(2)** | 2 |
| | **Movement in net funds in the period** | **13,840** | 15,079 |
| | **Net funds at 1st April** | **70,174** | 55,095 |
| | **Net funds at 31st March** | **84,014** | 70,174 |

| 18.3 | Analysis of changes in net funds | 31 Mar 2019 £ 000's | 31 Mar 2018 £ 000's |
|---|---|---|---|
| | Cash at bank held with Government Banking Services | **83,943** | 70,106 |
| | Cash at bank held within commercial banks | **5** | - |
| | Cash in hand | **66** | 68 |
| | | **84,014** | 70,174 |

## 19 Lease commitments

| **Operating leases as lessee** | **Mar 2019** | Mar 2018 |
|---|---|---|
| Payments recognised as expenses | **£ 000's** | £ 000's |
| Property | **2,988** | 2,841 |
| Plant and equipment | **100** | 100 |

Minimum annual lease payment commitments under operating leases were as follows:

| | Property | | Plant and equipment | | **Total** | Total |
|---|---|---|---|---|---|---|
| | **Mar 2019** | Mar 2018 | **Mar 2019** | Mar 2018 | **Mar 2019** | Mar 2018 |
| | **£ 000's** | £ 000's | **£ 000's** | £ 000's | **£ 000's** | £ 000's |
| Within one year | **3,044** | 3,089 | **100** | 100 | **3,144** | 3,189 |
| Between one and five years | **5,832** | 6,485 | **95** | 95 | **5,927** | 6,580 |
| After five years | **5,552** | 6,560 | **-** | - | **5,552** | 6,560 |
| | **14,428** | 16,134 | **195** | 195 | **14,623** | 16,329 |

| **Operating leases as lessor** | **Mar 2019** | Mar 2018 |
|---|---|---|
| Receipts recognised as income | **£ 000's** | £ 000's |
| Property | **855** | 920 |

Minimum annual lease commitments under operating leases were as follows:

| | Property | | **Total** | Total |
|---|---|---|---|---|
| | **Mar 2019** | Mar 2018 | **Mar 2019** | Mar 2018 |
| | **£ 000's** | £ 000's | **£ 000's** | £ 000's |
| Within one year | **925** | 995 | 925 | 995 |
| Between one and five years | **928** | 816 | 928 | 816 |
| After five years | **75** | 57 | 75 | 57 |
| | **1,928** | 1,868 | **1,928** | 1,868 |

## 20 Financial instruments

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with NHS commissioning organisations and the way those NHS organisations are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

### Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has negligible overseas operations and therefore has low exposure to currency rate fluctuations.

### Liquidity risk

The Trust's net operating costs are incurred under contracts with NHS commissioning organisations and other public sector bodies, which are financed from resources voted annually by Parliament. The Trust finances its capital expenditure from funds internally generated but has the ability borrow. The Trust is not, therefore, exposed to significant liquidity risks.

### Interest-rate risk

The Trust financial assets and liabilities carry nil or fixed rates of interest and the Trust has no borrowings. The Trust is not therefore, exposed to significant interest-rate risk. All financial assets and liabilities are held in sterling.

### Credit risk

The carrying amount of financial assets recorded in the financial statements, which is net of impairment losses, represents the Group's maximum exposure to credit risk.

| | **31 Mar 2019** | 31 Mar 2018 |
|---|---|---|
| | **£ 000's** | £ 000's |
| | **Financial assets at amortised cost** | Loans & receivables |
| **Financial assets** | | |
| | **£ 000's** | £ 000's |
| NHS receivables | **11,465** | 10,058 |
| Other debtors | **7,464** | 4,296 |
| Allowances for credit losses | **(2,868)** | (1,299) |
| Accrued income | **6,843** | 4,359 |
| Cash | **84,014** | 70,174 |
| **Total financial assets** | **106,918** | 87,588 |
| | **Other financial liabilities** | Other financial liabilities |
| **Financial liabilities** | | |
| | **£ 000's** | £ 000's |
| Borrowings | **-** | 207 |
| NHS payables and accruals | **3,690** | 4,980 |
| Other creditors | **20,516** | 15,406 |
| Accruals | **25,746** | 20,468 |
| Provisions under contract | **6,184** | 6,745 |
| **Total financial liabilities** | **56,136** | 47,806 |

Provisions under contract fair value are not significantly different from book value since, in the calculation of book value, where applicable, the expected cash flows have been discounted by the Treasury discount rate for employee benefits of 2.9% nominal rate (0.1% real rate).

## 21 Related party transactions

South London and Maudsley NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the period none of the Board members, the Members Council or members of key management staff or parties related to them has undertaken any material transactions with the Trust. Remuneration of Board members is shown in the Remuneration report.

Roger Paffard, Chair, is Vice-Chair of the Kings Health Partners Academic Health Sciences Board.

Matthew Patrick, Chief Executive, is a stakeholder member of the Board of Governors of Guy's and St Thomas' Hospital NHS Foundation Trust and a Director of Kings Health Partners Ltd.

Matthew Patrick and June Mulroy are Trustees of the Maudsley Charity.

Beverley Murphy, Director of Nursing is a Trustee of the Bethlem Art and History Collection Trust (operating as Bethlem Museum of the Mind).

Ian Everall is Executive Dean of the Institute of Psychiatry, Psychology and Neuroscience at Kings College London

Geraldine Strathdee, Non-Executive Director, is a Non-Executive Director of Community Health Partnerships (CHP) a wholly owned subsidiary of the Department of Health and Social Care providing community health premises. During 2018-19 the Trust spent £407k on premises costs from CHP.

The Trust is a member of Kings Health Partners, a federated Academic Health Sciences Centre. Membership comprises the Trust; Guy's and St Thomas' NHS Foundation Trust; Kings College Hospital NHS Foundation Trust; and Kings College London. The Trust had the following income and expenditure with KHP members.

| | **2019** | **2019** | 2018 | 2018 |
|---|---|---|---|---|
| | **£ 000's** | **£ 000's** | £ 000's | £ 000's |
| | **Income** | **Expenditure** | Income | Expenditure |
| Guy's and St Thomas' NHS Foundation Trust | **3,255** | **(1,673)** | 3,154 | (1,809) |
| Kings College Hospital NHS Foundation Trust | **1,662** | **(1,469)** | 1,569 | (1,528) |
| Kings College London | **2,163** | **(16,891)** | 2,418 | (23,743) |

The Department of Health is regarded as a related party. During the period the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent. The Trust received the following income for health care and other service from the main local commissioners:

| | **2019** | **2019** | 2018 | 2018 |
|---|---|---|---|---|
| | **£ 000's** | **£ 000's** | £ 000's | £ 000's |
| | **Income** | **Expenditure** | Income | Expenditure |
| Lambeth CCG | **63,219** | **(123)** | 62,371 | - |
| Southwark CCG | **60,000** | **(247)** | 59,399 | (81) |
| Lewisham CCG | **65,667** | **(18)** | 65,465 | (25) |
| Croydon CCG | **46,384** | **-** | 43,489 | (159) |
| | **235,270** | **(388)** | 230,724 | (265) |

The Trust has transacted with a number other CCGs, NHS Trusts, NHS Foundation Trusts as well as the NHS England and the Department of Health. Income received from:

| | **2019** | **2019** | 2018 | 2018 |
|---|---|---|---|---|
| | **£ 000's** | **£ 000's** | £ 000's | £ 000's |
| | **Income** | **Expenditure** | Income | Expenditure |
| NHS England | **63,608** | **(13)** | 59,172 | (65) |
| Department of Health | **26,117** | **-** | 19,667 | (20) |
| Health Education England | **17,114** | **(5)** | 16,629 | 15 |
| Oxleas NHS Foundation Trust | **3,095** | **(757)** | 315 | (223) |
| St Georges University Hospital NHS Foundation Trust | **2,747** | **(931)** | 2,164 | (880) |
| South West London & St Georges Mental Health NHS Trust | **465** | **(1,671)** | (567) | (372) |
| Lewisham and Greenwich NHS Trust | **143** | **(2,895)** | 147 | (3,180) |
| East London NHS Foundation Trust | **36** | **(1,485)** | 54 | (87) |
| Bromley CCG | **2,545** | **-** | 2,215 | (32) |
| Other NHS bodies | **16,147** | **(3,631)** | 16,675 | (4,047) |

The Trust contracted with NHS Professionals, which is a limited company wholly owned by the Department of Health, for the supply of temporary bank and agency staff:

| | **2019** | **2019** | 2018 | 2018 |
|---|---|---|---|---|
| | **£ 000's** | **£ 000's** | £ 000's | £ 000's |
| | **Income** | **Expenditure** | Income | Expenditure |
| NHS Professionals | **49** | **(46,295)** | 44 | (41,106) |

In addition the Trust has had a number of transaction with other government departments and central and local government bodies including:

| | **2019** | **2019** | 2018 | 2018 |
|---|---|---|---|---|
| | **£ 000's** | **£ 000's** | £ 000's | £ 000's |
| | **Income** | **Expenditure** | Income | Expenditure |
| Southwark London Borough Council | **5,347** | **(1,069)** | 1,592 | (1,278) |
| Lambeth London Borough Council | **4,930** | **(2,032)** | 5,027 | (605) |
| Wandsworth London Borough Council | **3,368** | **(2)** | 3,334 | (9) |
| Lewisham London Borough Council | **2,108** | **(551)** | 2,080 | (871) |
| Croydon London Borough Council | **2,036** | **(840)** | 1,811 | (1,044) |
| Bexley London Borough Council | **1,596** | **(1)** | 1,449 | - |
| Greenwich London Borough Council | **1,342** | **(1)** | 1,427 | (3) |

The Trust has also received revenue payments from Maudsley Charity £1.4m (£3.4m 2017/18) and Guy's and St Thomas' Charitable Foundation of £0.5m (£1.2m 2017/18).

## 22 Losses and special payments

| | 2019 | | 2018 | |
|---|---|---|---|---|
| **Losses** | **£ 000's** | **Claims** | £ 000's | Claims |
| Cash losses | **4** | **2** | - | 1 |
| Bad debts and claims abandoned | **15** | **22** | 91 | 11 |
| Damage to property and stores losses | **32** | **89** | 26 | 100 |
| | **51** | **113** | 117 | 112 |
| **Special payments** | | | | |
| Compensation under legal obligation | **99** | **6** | 72 | 5 |
| Ex-gratia payments | **121** | **72** | 94 | 52 |
| Special severance payments | **-** | **-** | - | - |
| | **220** | **78** | 166 | 57 |
| | **271** | **191** | 283 | 169 |

There were no individual losses exceeding £250k

## 23 Initital application of accounting standards

### IFRS 9 Financial Instruments

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

### IFRS 15 Revenue from Contracts with customers

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

**24 Events after the statement of financial position date**

There are no events after the statement of financial position date having a material effect on the Accounts