Trust Board - Part A January 2024

11 January 2024 10:45 AM - 01:30 PM London Standard Time

NHS South West London and St George's Mental Health NHS Trust

Agenda Topic — Page

NHS
South West London and St George's Mental Health NHS Trust

AGENDA

Meeting	**Board of Directors – Part A**
Time of Meeting	**10:45am to 1:30pm**
Date of Meeting	**Thursday 11th January 2024**
Location	**Conference Room B, Trinity Building, Springfield Hospital**

	PART A		**Format**	**Lead**	**Time**
1.	**PATIENT STORY**		**Paper**	**AB**	**10:45**
2.	**STANDING ITEMS**			**AB**	**11:05**
	2.1. Apologies	**FN**			
	2.2. Declarations of interests and register https://www.swlstg.nhs.uk/about-the-trust/trust-board/board	**FR**			
	2.3. Chair's actions	**FE**			
	2.4. Minutes of the meeting held on 9th November 2023	**FA**	**Paper**	**AB**	
	2.5. Action tracker	**FE**	**Paper**	**AB**	
3.	**CHAIR'S and CHIEF EXECUTIVE'S REPORTS**				
	3.1. Chair's report	**FR**	**Paper**	**AB**	**11:15**
	3.2. Chief Executive's report	**FR**	**Paper**	**VF**	**11:25**
4.	**INCREASING QUALITY**				
	4.1. Quality and Safety Assurance Committee chair's report	**FR**	**Paper**	**JW**	**11:40**
	4.2. Quality and Performance reports - October and November 2023	**FD**	**Paper**	**JeA**	**11:45**
	BREAK				**12:05**
5.	**MAKING THE TRUST A GREAT PLACE TO WORK**				
	5.1 People Committee chair's report	**FR**	**Paper**	**SA**	**12:20**
6.	**ENSURING SUSTAINABILITY**				
	6.1. Finance and Performance Committee chair's report	**FR**	**Paper**	**VS**	**12:35**
	6.2. Monthly finance and savings reports	**FD**	**Paper**	**PM**	**12:45**
	6.3. Modernisation Committee chair's report	**FR**	**Paper**	**JuA**	**12:50**
	6.4. Audit Committee chair's report	**FR**	**Verbal**	**RF**	**13:00**
7.	**NOTIFIED QUESTIONS FROM THE PUBLIC AND STAFF**	**FD**	**Verbal**	**AB**	**13:20**
8.	**MEETING REVIEW**	**FD**	**Verbal**	**AB**	**13:25**
9.	**Next Trust Board business meeting in public – 14th March 2024** – Conference Room B, Trinity Building, Springfield Hospital				
	SERVICE VISITS **2:00pm – 4:00pm**				

Attendees:

Ann Beasley (AB)	Chair
Sola Afuape (SA)	Non-Executive Director, Vice Chair
Richard Flatman (RF)	Non-Executive Director, Senior Independent Director
Juliet Armstrong (JuA)	Non-Executive Director
Prof Charlotte Clark (CC)	Non-Executive Director
Vik Sagar (VS)	Non-Executive Director
Jonathan Warren (JW)	Non-Executive Director
Humaira Ashraf (HA)*	Associate Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Dr Billy Boland (BB)	Medical Director
Sharon Spain (SS)	Director of Nursing and Quality Standards
Philip Murray (PM)	Director of Finance and Performance
Jennifer Allan (JeA)	Chief Operating Officer
Amy Scammell (AS)*	Director of Strategy, Transformation and Commercial Development
Katherine Robinson (KR)*	Director of People
Jenna Khalfan (JK)*	Director of Communications and Stakeholder Engagement
David Lee (DL)*	Director of Corporate Governance

In attendance:

Emma Whitaker (EW)	Deputy Director of Corporate Governance

Apologies:

*=non voting

South West London and St George's Mental Health NHS Trust

Trust Board
January 2024

Report Title:	Service User Story
Executive Summary:	The Service User Story for January 2024 is being presented to the Board by Safia, who will share her experience of Carshalton and Wallington IRH, which is an Integrated Care Hub, under the Trust's Community Service Line. This will give an insight to the care and treatment she has received as a patient/client and how this has impacted on her recovery journey. This story will highlight care pathways provided in the recovery journey through the integration of an Employment Specialist within the Community Transformation project and re-skilling of life skills, for taking back control of wellbeing, in the community. The importance is noted of exploring patient's recovery goals and inspiring hope by listening to and evidencing the patient voice in the important processes of collaborative care planning, recovery-focused care and interventions, and treatment reviews. The story identifies key Patient Experience themes that are monitored under Trust and Service Line Quality Governance Groups, such as Patient/Service User Involvement, collaboration, co-production, gathering patient views/feedback about their recovery goals and providing supportive evidence-based interventions. This has been pivotal for the service who have implemented vast the new integrated models under the NHS Community Transformation. • The Carshalton and Wallington IRH provides a specialist Borough based mental health support and recovery service for adults (18-75) with more complex and longer-term needs which, because of their seriousness or complexity, cannot be effectively treated within primary care. • Clinical/professional judgement will determine priority for treatment and support. The team works in close partnership with GPs and other key partners, including voluntary organisations. Care is delivered within the framework of the CPA. The team is committed to providing high quality mental health and social care for the local people of Wallington and Carshalton. • As early adopters of The Transformation project Carshalton and Wallington IRH has embodied the importance of employment specialist within the recovery model as part of reducing the stigma faced by our patients when they attempt to reintegrate into employment. Safia highlights her experience within the psychosis pathway in the community-based team, from being placed on CPA, her experience

of care and treatment as the team progressed post Covid, and most pivotal for recovery, the systems of engagement, support from her Care Coordinator, Consultant Psychiatrist and Employment Specialist, as she navigated returning to employment. Safia has shared positive feedback about all of her interactions and the support she has been given; and she feels positive about a future in the community including attaining employment.

The story also highlights the value of supporting staff to achieve positive outcomes for patients/services users. The value to patients/services users when they are not just listened to but evidently feel listened to and are able to feed this back to the multidisciplinary team. This has provided Safia with the stability to progress attaining confirmed employment within an NHS Trust and to another potential job as a Peer Support Worker.

The Community Service Line and the IRH have provided good evidence of actions taken in response to the patient experience and patients views on what integration in the community looks like. Ongoing workstreams are in place around embedded the new models into practice and maintaining continuous improvements. There is an active positive culture from the staff team of engaging with patients/service users and empowering patients which is evidenced in the team having the highest rates of patient feedback data within the Community Service Line.

The Carshalton and Wallington IRH was an early implementer of Community Transformation in April 2021, with an opportunity to fundamentally rebalance mental health pathways, reduce over-reliance and bend the demand curve on care at the crisis and acute end of the pathway, and begin to reduce the significant treatment gap for adults with severe mental health needs.

The model focuses on earlier identification and intervention, supporting patients to live well in their communities rather than in restrictive settings, and therefore is better for patients and a critical piece of the answer to quality issues identified within mental health inpatient settings. It is also the foundation on which systems will be able to deliver on the vision set out within the Reform of the Mental Health Act, with a focus on choice and autonomy; least restriction; therapeutic benefit; and treating the person as an individual.

There will be oral presentations:

- A Talk from Safia

Attending will also be:

- Ann Nolan, Care Coordinator
- Billy Wong, Employment Specialist
- Ebenezer Obeng, Team Manager and Clinical Service Lead Specialist Service Line Management
- Kiran Toora, Clinical Manager
- Paul Dorrington, Trust Lead Employment Specialist
- Sharon Putt, Deputy Head of Service Delivery
- Paula Robins, Head of Nursing
- Dr Victoria Hill, Clinical Director

	The presentation emphasises the importance of patient/service user involvement and consistently gathering Views and Feedback related to their personal recovery goals, motivations, hopes and aspirations. Thus, keeping the goals at the centre of the care and treatment planning, facilitating experiences and access to opportunities in the community including employment, life-skills and self-management, recovery focused collaborative planning, co-produced interventions and relapse prevention. NHS England monitors the experience of patients and families through the Patient Experience as well as Friends and Family Test survey scores, by providing a summary of results across all NHS funded care settings, including total organisations submitting, total responses, overall response rates. The Trust has noted a marked improvement in the national Patient Experience and Friends and Family Test (FFT) data; scoring above national average for the month of October 2023 with a positive percentage score of 82%. October 2023 Mental Health National Patient Experience FFT Score Trust: SWLStG MH NHS Trust Net Percentage Positive Score: 82% National Ranking England [out of 44]: 22 The impact of the Community Transformation has been actively visible, with enhanced, safe and robust support and follow up for patients, through the new integrated clinical pathways: - • Enhanced Response Pathway • Mental Health and Wellbeing Practitioner Pathway • Social Prescribing and GP Interventions pathway • Enhanced Clinical Pathways for Psychosis, Non-Psychosis and Personality Disorders • Employment Support • Peer Support • Risk and Needs Brief Assessment Consent – Please note that consent has been provided to refer to Safia by her first name, in the written story and during the Board meeting, which should be respected. Should the meeting be recorded, Safia has consented. Rights are reserved for Safia to make any changes to this consent at any time.
Action Required:	The Board is asked to note the Service User/Patient Story relating to Carshalton and Wallington IRH based at the Jubilee Health Centre in Wallington.
Link to Strategic Objectives:	The Trust launched its five-year Trust Strategy in 2018. The strategy 2018 – 2023 includes four strategic ambitions: • **Increasing quality years -** Quality Improvement and Innovation • **Reducing inequalities -** Service users and carers co-production • **Making the Trust a great place to work -** Staff underpin all that we do • **Ensuring sustainability -** Transformation

	These ambitions move the Trust to focus on outcomes, not processes and are held together by the mission – Making Life Better Together – which is at the centre of the Trust's work. This story links to all our strategic ambitions as the Trust recognises that the views of our service users/patients must not only be sought but evidenced to demonstrate that actions have been taken. The Transformation implementation ensures robust sustainability and a commitment to continuous improvements for the communities we serve. The Trust promotes effectiveness of Recovery Approaches through collaboration and co-production with our patients/service users, staff working in the services and external/multi-agency stakeholders.
Risks:	Patient Safety is a domain of the Quality Strategy.
Quality Impact:	Patient Experience is a domain of the Quality Strategy. Positive experience shared which evidence Quality Improvements by the service and Service Line Transformation
Resource Implications:	Safia`s attendance in person has been facilitated through the Quality Governance Department.
Legal/Regulatory Implications:	None. Consent elements have been facilitated by the Carshalton and Wallington Team Manager and discussed with the service user.
Equalities Impact:	The Board is asked to note of equality, diversity, and inclusion as part of the Trust's commitment to Reducing Health Inequalities for those who use our services. Equality, diversity, and inclusion has been considered through Safia's preferences to share her story by reading as part of presenting, has been respected.
Groups Consulted:	Service User – who was supported by the Carshalton and Wallington IRH and staff team. IRH - Team Manager, Care Coordinator, Employment Specialist, Lead Employment Specialist, Consultant Psychiatrist. Service Line Management - Service Leads and Clinicians
Author:	Rumbi Mapfumo, Experience and Governance Lead
Owner:	Sharon Spain, Executive Director of Nursing and Quality Standards

Making life better together

NHS
South West London and St George's Mental Health NHS Trust

Carshalton and Wallington Integrated Recovery Hub (IRH) Community Service Line

11 January 2024

Background

The Service User Story for January 2024 is being presented to the Board by Safia, who will share her experience of Carshalton and Wallington IRH, which is an Integrated Care Hub, under the Trust's Community Service Line. This will give an insight to the care and treatment she has received as a resident and how this has impacted on her recovery journey.

This story will highlight care pathways provided in the recovery journey through the integration of an employment specialists within the Community Transformation and re-skilling of life skills, for taking back control of wellbeing, in the community. The importance is noted of exploring patient's recovery goals and inspiring hope by listening to and evidencing the patient voice in the important processes of collaborative care planning, recovery-focused care and interventions, and treatment reviews.

Carshalton and Wallington Integrated Recovery Hub

Carshalton and Wallington IRH form part of the Sutton Uplift Mental Health and Wellbeing Service and offer services for male and female service users aged between 18-75, with mental health, complex or psychosocial needs. Referrals are accepted from inpatient services, general practitioners via Daily Integrated Allocations Meeting (DIAM), out of area placements, forensic services and any persons with severe mental illness, including schizophrenia, bipolar affective disorder, severe depression, personality disorder.

The team is comprised of medical, nursing, intermediate recovery support workers, employment specialist, occupational therapy, psychology, pharmacy input, clinical leads and service line management. The service works closely with the South London Partnership and its neighboring IRH, Sutton and Cheam.

Recovery Approach in Carshalton and Wallington IRH

The Trust Recovery Model promotes community-based care interventions that use a recovery-focused approach. A Recovery Approach with supportive and therapeutic engagement at Carshalton and Wallington is evidenced by improved patient outcomes which impacts on population health. This reduces the pressures of capacity versus demand currently being experienced within the acute service line in terms of admission capacity.

Recovery is further promoted by patients being offered specialist employment input from the initial stages of their integration into the team and at intervals through their journey within the team. When patients decide to engage with the employment specialist 1:1 meetings are facilitated to assist the patient to identify their strengths and areas to work on, how to disclose their mental illness positively, their CV, their application process and successful interview techniques.

The employment support also coach patients how to use 'Getting Back To Work' and 'Surviving and Thriving at Work' self-help tools as part of their journey to work. This support and engagement continue through the patient`s working experience until they are established in their

employment and feel confident to navigate this phase without the employment specialist.

Care and Treatment

Following acceptance via the multidisciplinary referrals meeting, a holistic plan of the care and support is formulated for the care they will receive, which includes access to voluntary organizations such as Age UK and Off the Record.

Risk assessment and effective risk management plans are discussed with patients as part of Collaborative Crisis Planning, Care Planning and includes identifying individualised Recovery Goals, with Care Coordinators.

Safia`s Story

Experience of Services in Carshalton and Wallington IRH.

I would like to talk about my experience with my care team who are Billy Wong (employment specialist) and Ann Nolan (care coordinator).

Up until I was assigned to Billy I thought that no one would give me a job due to my being mentally ill. That all changed when Billy gave me hope that it is possible to work even with a mental health condition. He was very proactive and never let me down even once.

He would spend many days in the week helping me fill in application forms and assuring me that my mental health would not be a barrier to working.

He thus gave me confidence and I began to look forward to the future as an employed person. I really believe he went above and beyond to help me succeed in my job search. And as it happens, I have been offered a conditional offer of employment! Fairy tales do exist! I am very grateful to Billy for all he has done for me.

My experience with Ann has been a positive one. She has been consistent in checking on me and regularly making sure that I am OK. She is a good listener and easy to talk to about my psychological issues. She gives sound advice and has been proactive about changing the times of my medication to suit my daily routine. She goes to a great deal of effort to accommodate my requests and has gone above and beyond that which is required of her. I am very happy with Ann as my care coordinator. She has always been there for me. She would drop off my prescription to the pharmacy so that I would not have to go all that way myself.

I am very happy with the level of care I am getting from Billy and Ann overall and have no complaints or issues. They have helped me move forward in life for which I am grateful to both for.

Integration of Care in the Community: Integrated Recovery and Employment

Paul Dorrington, Trust Lead Employment Specialist

Billy's role as an Employment Specialist is integral to modern clinical teams.

Integrating Employment Specialists into clinical teams, collaborating with care plans and helping our clients find meaning, purpose, financial security, fulfilment, friendships, relationships, and all that comes from employment is fundamental to the recovery journey.

Sutton Integrated Recovery Hubs (IRHs) are independently moderated and reviewed as part of standardised, evidence-based practice using The Individual Placement and Support Model (IPS).

Our previous fidelity review in Sutton marked a high standard, and in March 2024, Sutton services will undergo their second independent fidelity review.

Beyond the methodology and practice associated with the Individual Placement and Support Model, thousands of service users across the UK are rebuilding meaningful working lives and achieving a life of meaning beyond illness.

‘It's little wonder why Individual Placement and Support Model is one of the primary cornerstones of NHS Transformation.’

A Look Back at the service improvements over the last 12 months:

What Has Been Done

Improvement Audits are completed weekly with emphasis on quality and safe care provision.

- Embedding DIAM into operational duties within the integrated care system.
- Embedding Enhanced Response Clinicians within the integrated care team.
- Embedding Peer support workers and Voluntary organizations within the care team.
- Mock Fidelity review with a good grading outcome.
- Restructuring and reassigning assessment process from Carshalton and Wallington IRH to primary care team.
- Establishing a functional and successful depot clinic.
- Creating a Patient flow fortnightly meeting with triangulated collaboration from primary care teams lead and GP liaison nurse lead. Thus, strengthening joined up continuous working to ensure effective, efficient, and safe care to all patients.
- Integration of NQN within the teams to increase substantive staffing rations.
- Improved Feedback Live Data via continuous improvement methods using PDSA and Kaizen.
- Embedding the new 11 Fundamental Standards of Care into integrated practice.

Care Coordinator Feedback:

"I first met Safia when I joined the team in April 2022. I had a good working relationship with Safia and gradually supported her to overcome her challenges to work towards her goal of getting a paid job.

Safia was very committed and voiced all the problems she was having that would come in the way of her achieving her goal. With Safia's permission I got her mother, the care home staff, psychology involved to support Safia with managing the difficulties she had with her mental health at that time.
Safia's determination to achieve her goal of getting a paid job when from strength to strength. Initially she got a voluntary job in a fruit farm which she enjoyed.

She then asked to be referred to Billy who she worked very closely with.
Billy and I also worked very closely with out consultant, pharmacist, and the dispensing chemist to change the time of her medication to evening as she was sleeping late in the morning and would miss doses which would put her at risk of relapse. Following all the necessary changes to medication and support with sleep hygiene Safia has been able to achieve her goal of getting a job and she also got her certificate as she has completed her training to work as a peer support. This has been a very positive outcome and is evident that client cantered care, a holistic approach and using the skills and expertise of all involved is essential.

I wish Safia all the best and she will continue to be supported during this transition."

Employment Specialist Feedback:

I started employment support with Safia in early May 2023. She was very motivated from the start but struggled with meaningful daily routines and punctuality especially morning meetings. Safia acknowledged these challenges, and we made plans to move meetings to earlier time gradually and started daily schedule which worked very well.

Safia is very open minded and worked closely with me to identify her skills, strengths and areas for improvement. She has made great effort in improving herself by attending an accredited peer-to-peer training and re-learning new digital skills.

Safia confidence has grown so much that the employment journey has evolved from simply getting a job to having a career ahead of her. I can now truly appreciate how IPS could make a real difference to someone's life.

Next Steps and Way Forward

Carshalton and Wallington IRH will continue to strengthen relationships with multi-agency professionals and the collaborations with stakeholders to ensure The Making Life Better together mission is enshrined in operational behaviors and team culture.

Agendas for the coming months are:

- Formal Fidelity Review due in March 2024.
- Phasing out of CPA to Dialogue+ as an approach to care assessment and treatment.
- Carshalton and Wallington IRH will support Sutton Primary Liaison and Recovery Service - SPA and Recovery Team in stepping patients down safely as well as to ensure safe transfers/discharges to the General Practitioners.

Impact of the Community Transformation on assessment, care and treatment

There have been active and visible integrated clinical pathways within the Integrated Recovery Hub, Step Down to Primary Care and Step Up processes via Single Point of Access (SPA) teams.

Enhanced Response Pathway

- Enhanced Response Practitioners support the team in assessing and crisis managing/providing brief interventions to acutely unwell patients who previously would have been reviewed by Care Coordinators and referred to the Home Treatment Team or the Coral Mental Health Crisis Hub.
- Enhanced Response Practitioner provide professional and practical support to Care Coordinators as well as the IRH; which has created better team cohesion and mental wellbeing.
- The impact of this pathway has seen an increased ability for patients to recover in their most familiar environment, with family input remaining integral. This has also been a driver to a strengthened practice of working with family/carers, that is in line with the Triangle of Care and reinforcing their importance in the patient journey and recovery.

Mental Health and Wellbeing Practitioner Pathway

- The impact has been an additional professional support within transformation.

- The MHWP provide low level psychological support for patients who may be on a waiting list for more therapy or waiting for medical reviews. This input has been integral to recovery of the patient, as reviews have shown that this provides a robust safety and quality bridge in service delivery.

Social Prescribing and GP Interventions in primary care pathway

- Pharmacists are readily available to support and discuss issues.

Improvements in the care and treatment provided has had a positive impact through:- -Enhanced Clinical Pathways for Psychosis, Non-Psychosis and Personality Disorders; Employment Support; Peer Support and, Risk and Needs Brief Assessment within SPA teams.

Presentation by:

Service user: Safia

Attending from Service Line:

Ann Nolan, Care Coordinator
Billy Wong, Employment Specialist
Ebenezer Obeng, Team Manager and Clinical Service Lead
Paul Dorrington, Employment Specialist Lead.
Kiran Toora, Clinical Manager

Dr Victoria Hill, Clinical Director for the Community Service Line comments:

“On behalf of the Community Service Line, I would like to thank Safia for sharing her story and experience of our services, especially at a time when staff are really working hard to embed the NHS Community Transformation, New Models and Improvements.

The Community Service Transformation has seen the implementation of new integrated models of care and ways of working. Whilst this has meant a lot of change across all systems, it is great to hear experiences shared. High quality integrated and safe care focuses on working collaboratively with the people who use our services as well as he multi-agency stakeholders we work with; including as highlighted; in the employment sectors.

We are grateful for the commitment of our staff in supporting individuals like Safia to achieve their highest potential.

The Community Service Line is continuing to monitor the Transformation and Integration to ensure continuous improvements and embedding new improved models, and even better outcomes.”

South West London and St George’s Mental Health NHS Trust
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South West London and St George's Mental Health NHS Trust

Board of Directors (Part A)

Draft minutes of the meeting held on Thursday 9 November 2023, 10:45am to 1:30pm, Conference Room B, Trinity Building, Springfield Hospital.

Present:

Ann Beasley (AB)	Chair
Sola Afuape (SA)	Vice Chair and Non-Executive Director
Juliet Armstrong (JuA)	Non-Executive Director
Professor Charlotte Clark (CC)	Non-Executive Director
Vik Sagar (VS)	Non-Executive Director
Jonathan Warren (JW)	Non-Executive Director
Humaira Ashraf (HA)	Associate Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Dr Billy Boland (BB)	Medical Director
David Lee (DL)	Director of Corporate Governance
Philip Murray (PM)	Director of Finance and Performance
Sharon Spain (SS)	Director of Nursing and Quality
Ian Garlington* (IG)	Integrated Programme Director
Jenna Khalfan* (JK)	Director of Communications and Stakeholder Engagement
Amy Scammell* (AS)	Director of Strategy, Transformation and Commercial Development
Katherine Robinson* (KR)	Director of People

*Indicates non-voting member

In attendance:

Calum	Patient story
Zaynah	Peer support worker
Brenda Ndiweni	Experience and Governance Lead
Kwame Fumey	Team Manager
Dr Aileen O'Brien	Consultant Psychiatrist
Daniel Ibukun	Clinical Manager
Jean Pierre Foo Kune	Clinical Service Lead
Rick Dalton	Deputy Head of Service Delivery
Feizal Mohubally	Head of Service Delivery
Tracey Ugbele	Head of Nursing and Quality Standards
Suresh Desai	Staff side chair / Unison Branch Secretary
Martin Haddon	Wandsworth Healthwatch
Geetha Maheshwaran	WCEN Chair
Visitors from Wandsworth EMHIP	
Emma Whitaker (minutes only)	Deputy Director of Corporate Governance

Apologies

Richard Flatman (RF)	SID and Non-Executive Director
Jennifer Allan (JeA)	Chief Operating Officer

Item **Action**

23/75 Patient story

The patient story was presented by Calum, who had received treatment at Burntwood Villas and step-down treatment at Redwood Villas. He told the Board his story, where in 2018 he had begun to hear voices and felt people were following him and trying to kill him. He became an inpatient on Ward 1 for six months, and then an inpatient at Burntwood Villas since July 2022. He was recently stepped down to Redwood Villas. Redwood has less support to encourage independent living. He still hears voices but has exercises to prove to himself that the voices are not real. He has felt well enough to

Item **Action**

begin job hunting and had recently had a trial at Five Guys which went well. He also does some public speaking.

Calum had nothing but good things to say about Burntwood and Redwood Villas. He said whilst a patient at Queen Mary's he did not see a regular doctor, and on Ward 1 sometimes other patients needed to be controlled. He said that he was now in a much better place, thanks to his placement at Burntwood and Redwood, Dr O'Brien and the support staff who he said were very good.

The Board thanked Calum for sharing his story and his thoughts about Trust services.

23/76 Apologies and welcome

Apologies were received as listed above.

The Chair welcomed attendees to the meeting and advised that the meeting times for Part A Board had been changed to 10:45am to 1:30pm going forwards, in order for the Board to do their ward visits in the afternoon, following feedback that this would be easier for services to accommodate.

23/77 Declarations of Interest

No new declarations of interest were received.

23/78 Chair's Action

Two documents had been approved under the provisions of Standing Order 5.2 since the September 2023 Board:

- Revised Terms of Reference for the Modernisation Committee (formerly the Estates Modernisation Committee).
- The Trust's Digital Strategy.

23/79 Minutes of the last meeting

The minutes of the meeting held on 14 September 2023 were approved as a correct record with no amendments.

23/80 Action Tracker

The action tracker was noted and updated as below:

23/45: Consideration of service user and carer representation on the Board: The government's response to the rapid review into data on inpatient mental health settings was not yet published. As soon as it had been published the Board would consider a position based on the government's recommendations. Action to remain open.

23/81 Chair's Report

Reported:

- Professor Deborah Bowman had stepped down from the Board at the end of October 2023. She had made a great contribution to the Trust over her five years with us.
- Following Professor Bowman's departure, the Chair welcomed Sola Afuape as the new Board Vice Chair and Richard Flatman as the Senior Independent Director (SID) and Freedom to Speak Up (FTSU) Non-Executive Director (NED) champion. The new suggested Committee membership was included in the Chair's report for approval.
- There had been a focus on partnerships in Part B of the Board meeting.
- Shaftesbury had now opened and it had gone well, thanks to careful planning.

Item **Action**

- Oak Ward, our Intellectual Disability and Autism unit, had now opened.
- The Trust had held a seminar of their top 100 leaders with discussions around psychological safety.
- The Chair, along with a number of people from the Board, attended the latest "Healing our broken village" event. There had been a lot of good work reported by members of Trust staff and progress had been made on key interventions. The Chair also heard some worrying remarks from members of the community which the Board would be reflecting on.
- The Chair and CEO been on an exceptionally valuable visit to the National Deaf CAMHS service in Cambridge.

The Board

a. noted the Chair's report.
b. noted the updated Committee membership.

23/82 Chief Executive's Report

Reported:

- Pressures across the system remain significant.
- Right Care, Right Person – The Trust had worked with the SLP to launch the section 136 hub this week. There had been a 108% increase in police usage of the hub and this had led to better redirection to ensure the right patient went to the right place. This also helped to reduce police time.
- There had been good engagement with the staff survey so far, with a 53% response rate. At this time last year it had been at 36%. Our best ever response rate was 61%.

Discussed:

That there are a large number of new joiners, which was very welcome. KR reported on the onboarding journey and plans for one, three, six, nine and 12-month check-ins.

That last year's staff survey engagement score by ethnicity showed that our most engaged staff group was our BAME staff. We want to see if this was a sustainable finding, and what do we need to do to build more engagement with this staff group.

The Board noted the Chief Executive's report.

23/83 Quality and Safety Assurance Committee (QSAC) chair's report

Reported:

- Professor Graham Martin from Cambridge University visited the November QSAC. He gave a presentation to help the Committee to read signals in the organisation to identify teams who may be running into difficulties, and the differences between problem sensing and comfort sensing Boards.
- Work on reduction of observations was being overseen by QSAC. There had also been similar conversations about use of restraint. The request for the observations paper came as a query from FPC as the cost for observations was very high, due to the use of bank staff to undertake observations. QSAC had reviewed the data with a quality lens. It was hoped there could be recommendations that benefited patients and improved the quality of observations, as well as reduced the costs where possible and appropriate.

Item **Action**

- QSAC had received the annual Mental Health Act report. Against the national trend, the Trust had seen consistent reduction in the use of the Act over the past five years. This was good news but QSAC have asked to understand this more for assurance.

Discussed:
The Trust was aware that it was an outlier in use of prone restraint and it was important to keep this under review.

Efforts to reduce use of restraint linked into the overall piece of work to reduce incidents of violence and aggression. The Trust had seen an increase in incidents of violence and aggression towards our staff. There was specific action to ensure the right staff support was in place. Positively the Trust had seen a reduction in incidents of violence and aggression towards staff since moving into Trinity and Shaftesbury.

It was noted that reducing the use of restraint was part of the EMHIP objectives. There was a specific workstream looking at observations for BAME patients. This was led by BB, as Medical Director.

The Patient and Carer Race Equality Framework (PCREF) was a national requirement that Boards must take forward and report on. The Framework sets out three different areas that the Board were required to make progress on:

1. Leadership and governance;
2. Organisational competencies; e.g. culture and practice change (such as EMHIP); and
3. Feedback mechanisms, including patient and carers' co-production.

The Trust had an integrated plan for reducing Health Inequalities and EDI which links with the Trust's OD programme.

The Board asked that its thanks be passed on to the Associate Hospital Managers, Mental Health Act team and the Heads of Nursing.

The Board:

a. noted the QSAC Chair's report.
b. received the approved Committee minutes.

23/84 Quality and Performance Report

Reported:

- Performance in some areas remained challenged:
  - Urgent and Emergency Care (UEC) pathway:
    - due to industrial action and some posts being difficult to recruit into;
    - Emergency Departments (EDs) – The Trust were still not seeing the patient journey it would like for patients in EDs; and recognised that this was often not the right place for them to receive the care they needed.
    - DTOC - Trying to discharge patients to ensure the right treatment in the right place in the least restrictive way.
  - JeA continued to work with the South London Partnership (SLP) and the UEC board to create plans to improve flow and the patient journey.
  - ADHD: Patient safety metrics had moved slightly for ADHD. Positively, there was now a voluntary agreement through the LMC to transfer some patients back to the care of their GPs. The ICB would have a scheme in place to support this agreement.
- SIREN: SIREN was the early warning dashboard that Trust staff could use to raise concerns. The Trust had recently refocused its SIREN work. More reds were

Item **Action**

appearing due to changes to some metrics. In particular in CAMHS and AUC there had been good conversations around the dashboard.
Workforce: the Trust were happily seeing positive movement. Service Lines were reporting an increase in good quality applicants to vacancies, and some medical recruitment was increasing.

Discussed:
That the most pressured part of the system at the moment was the UEC pathway. ED challenges were significant. The Trust would need to be honest about the pressures in Winter and what more we could do to support our ED colleagues and other parts of the system. In the short term there was the option to buy more external beds while these other actions start to get traction; but this was not best for patients in the long term. It was noted also that any money invested in the UEC pathway meant less to invest in Community Services.

In the last six months there had been BAME Doctors arriving to work in the Trust and St George's Hospital from overseas. If the Trust wished to retain and attract overseas Doctors in the longer term it would need the right programme of support in place for them. BB thanked Antoinette Bob-Manuel, who had been supporting each of the Doctors in this initial cohort and had gone above and beyond to assist them.

BB confirmed that the Trust were using the DIALOG+ tool to do care planning and that Community transformation was starting to embed DIALOG+.

That in the report, it stated that some quality concerns had been highlighted at Holybourne Hospital. SS advised that there was one incident around communication when a patient was discharged from Holybourne back to the Home Treatment Team. The Trust had a close relationship with them and supported them with their quality reviews. The Trust would prefer to keep its patients in the NHS but sometimes needed to use private providers and somewhere close to home was preferrable for patients.

The Board noted the Quality and Performance Report.

23/85 People Committee Chair's Report

Report:

- The number of Employment Tribunals (ETs) had risen and the impact of this on the workload for the HR Business Partners (HRBPs). The ethnicity data of staff going through the ETs process is monitored.
- The HRBPs had managed to grip some of the longstanding Employee Relations (ER) cases and were progressing them. They continue to be an area of oversight for the Committee in terms of the amount of time that they take away from business as usual work.
- Recruitment and retention: There was a continued and concerted effort in the People team around these areas. SA asked that her thanks to KR and the People team be formally recorded, especially for their persistence in trying circumstances.
- The Committee had requested a clearer profile of people leaving the Trust in order to get a realistic picture of staff experiences. This would look specifically at those leaving in their first 12 months with the Trust.
- SS talked to the Committee about incidents of violence and aggression to our staff and the Committee would now like to look at the equality profile of that. There were some high acuity wards where there are high numbers of BAME staff.
- Industrial action felt very well managed. SA gave her thanks to KR, BB and the Trust staff for ensuring minimal impact on the organisation.

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Discussed:
KR thanked JeA, SS and colleagues for keeping the work of the Trust going during the industrial action.

That the Board often hear that BAME staff are disproportionately victims of bullying and that there is a feeling amongst BAME staff that career progression is not fair.

The Board knows that leadership is key for the organisation and that leadership development offers work. How would the People Committee measure the impact of the offer and over what period of time. The Staff Survey, PADRs, and FTSU cases would be used as soft indicators. The Committee would think about what other metrics and longer term indicators could be used, to allow ample time for change to manifest; such as ER cases and retention; the pulse survey and SIREN. These are parts of wider measures that would come together to enable evaluation of the effectiveness of the offer. BB suggested asking staff what measures would be most meaningful for them. For example, the Evolve Staff Network fed back that they wanted to have more influence on the WRES (Workforce Race Equality Standard) action plan. As a result, this year a webinar would be held inviting staff to coproduce the WRES measures, led by our EDI team.

KR raised that, at the Staff Networks Meeting of the People Committee, the Evolve Network had suggested that racist staff must fully be held to account. Immediately following the meeting KR followed this up with the Network Chairs and would progress this. The Board will re-emphasise the behaviours we expect as an anti-racist organisation. This will be firmly monitored.

The Trust wanted to become an Anchor institution which would involve working with the local community on how we facilitate access to jobs for local people. There was ongoing work linking in with the ICS, the Lord Mayor's Appeal and St George's Hospital to hold a careers event in December. KR had met with local councillors to talk about linking with our local refugee communities. The Trust was considering inviting work experience students in for a week.

IG raised the social value benefits of owning Springfield Park. His team were working on how roles working in the park could be used to help local residents who need a first employment opportunity. The Trust also have employment specialists who work in the borough teams. Lived Experience Members were offered roles working with the Trust too – such as roles on the Tolworth redesign project.

The Board:

a. noted the People Committee chair's report.
b. received the approved Committee minutes.

23/86 Finance and Performance Committee (FPC) chair's report

Reported:
The following points were highlighted by VS:

- FPC monitored efficiency in the Trust, including:
  - Considering patient journey issues;
  - Monitoring the use of agency staff;
- Productivity - for FPC this meant working smarter not harder, by identifying areas where we could standardise practice, which would be good for staff and patients. Productivity programmes had not yet delivered financially but it was hoped these would help deliver future financial opportunities.

Item **Action**

- FPC had been keen to carve out strategic investment money to allow investing time or money in the right place e.g. the leadership programme, clinical systems efficiency, culture and OD programmes, diversity, recruitment and retention.
- In months five and six the position remained on plan. There are concerns about the costs of external beds and agency staff. There were 'green shoots' coming through, especially in Community Transformation.
- The Better Payment Practice Code national target was to pay invoices within 30 days and the Trust were doing very well on meeting the target.
- The Acute and Urgent Care Service Line had done some good targeted work and had helped reduce their use of observations and agency staff. They were treating our patients in a less restrictive way which raises quality of care and improves the patient journey; and we were also seeing a financial advantage to this. Finances should always follow quality.

Discussed:
There was funding applied for to procure a case management solution for the ETs. KR confirmed the bid had gone through to the Digital Oversight Group.

At the moment the Trust were not signalling any risk to hitting the plan submitted to NHSE.

KR informed the Board that there had been an active HCA recruitment drive. There were now no vacancies and 19 HCAs on our waiting list, four of which were bank staff who want to convert to permanent staff. The Trust were still looking into a 'floating' resource of staff who could be deployed flexibly to manage interventions and cover vacancies.

Discussed:

The Board

a. noted the FPC chair's report.
b. received the approved Committee minutes.

23/87 Monthly Finance and Savings Reports

The Board noted the finance and savings reports.

23/88 Modernisation Committee Chair's report

Reported:
JuA reported the following:

- The Committee had been renamed the Modernisation Committee to reflect the broader transformation in the Trust that is overseen by the Committee.
- A second Diversity in Decision Making (DiDM) representative had joined the Committee
- The Committee reflected on the substantial achievement of opening Shaftesbury. Over 50 patients were successfully moved. The amount of work and effort of so many people made it work well: staff, porters, security, the programme team, construction partners, hospital rooms and the Executive team. Although it was early days the staff and patients seem to like their new environments. The Committee would review how they were settling in.
- The Committee received an update on the clinical transformation work to improve flow and reduce Length of Stay (LoS) for adult crisis and urgent care pathways. They saw remodelling of the trajectories which had hoped to save eleven beds but due to

Item **Action**

various factors including workforce challenges and strikes, we were now hoping to save eight beds. The Committee received good assurance around this but probed on what else the team needed to be successful. The Committee requested that the next update include more information on patient feedback and more examples of co-production.

- The Committee heard that the Trust were setting up a new social value vehicle to manage Springfield Park.
- The Committee were explicit in an ask for the next meeting of metrics as to how each part of the transformation work was aiming to improve Health Inequalities and this would come through in the reporting for the next Board.
- Staff engagement for Tolworth began this week. 20 members of staff attended. Tolworth is a nearly 20 acre site and discussions were had around how we could use the buffer to create some outside spaces. The meeting was good and productive.

Discussed:
VF visited Shaftesbury this week. Staff were proud of their new environment. Some patients said that they felt they had moved into five star accommodation.

It was good that the Tolworth engagement events went well. The early building works at Tolworth were important but they would impact staff lives again, such as issues with parking, and local residents also; so the Board must be supportive and mindful.

The Board:

a. **noted the Estates Modernisation Committee chair's report.**
b. **received the approved Committee minutes.**

23/89 Audit Committee Chair's Report

Reported:
The main items covered in the October Audit Committee were the assurance map, a report on the system plan and associated controls, the updated COI policy and the annual report and accounts of the charitable funds. These would come through to the January Board alongside a written Chair's report.

The Board:

a. **noted the Audit Committee chair's report.**
b. **received the approved Committee minutes.**

23/90 Corporate objectives Q2 report

Reported:
AS reported the following:

- The corporate objectives had been renamed "annual delivery plans" as staff found corporate objectives confusing.
- Progress was variable. Some delays were related to the external environment but there were some areas where we were over-optimistic about what could be achieved. The People Strategy would now start in Q4 and digital work had been reprogrammed.

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Discussed:
Financial sustainability was RAG rated 'green' but forecast to be 'amber'. There was a plan on external beds and agency use, and work had started on productivity; however VS felt he could not say with certainty that it would deliver by Q4.

Plan six - developing partnerships – the Board was aware that there was work to do to improve some partnerships. AS felt that there were not any delays or challenges that would take us away from achieving 'green'.

Plan two - inclusivity and EDI – there was a risk related to the EMHIP evaluation which was to be procured by the ICB. VF called a meeting with partners about how we can support third sector partners to plan for two to three years. We would also need to work through how we manage money differently and were we being fair and flexible in treating programmes the same. The Board takes its role in the anti-racism work seriously. We would engage stakeholders including WCEN.

The Board noted the Corporate Objectives Q2 report.

23/91 Questions from the public and staff
The Board had received no questions in advance from the public or staff.

23/92 Meeting review
Geetha Maheshwaran, WCEN Chair, said she had attended both the Board and the 'Healing our broken village' conference. She had felt it was important to come and see how the Board worked. She was heartened by what VF had said about meeting with system partners. She said that the community know EMHIP works and was a vital programme, though there were serious challenges around finances. She looked forward to hearing more about this. She would also be interested to see the Anchor workshops around recruitment taking place in temples and churches.

VF felt Calum had been fantastic.

Martin Haddon said he was heartened to see more members of the public attending the Board and hoped this trend would continue.

Other members of the public felt the meeting had been extremely helpful. They liked that even though the Board were all a team it was good to see them scrutinise each other. It showed that members were willing to affect change and it was more than just a job to them.

Suresh Desai added that it was good to see the Trust encouraging the community to come and see what the Board were doing. As staffside chair he attended every meeting to represent the views of the majority of staff who cannot attend to see the Board in action. He requested that the Board encourage staff to attend. It was noted that the DiDM representatives were a route for staff to do this.

23/93 Next Public Board
Thursday 11 January 2024, 10:45am, Conference Room B, Trinity Building, Springfield Hospital.

NHS
South West London and St George's Mental Health NHS Trust

ACTION TRACKER – for January 2024 Board

BOARD OF DIRECTORS (Part A)

Meeting	Ref.[1]	Minute Topic	Detail	Who	Due	Update
DUE						
13/07/2023	23/45	**Quality and Safety Assurance Committee (QSAC) chair's report** - **Service user and carer involvement**	AB to consider service user and carer representation on the Board more broadly in due course, informed by the government's response to the recommendations on this matter in the Rapid review into data on inpatient mental health settings.	**DL**	**TBC**	
NOT DUE						
11/05/2023	23/39	**People Committee chair's report**	A detailed People plan is due to go to the May People Committee.	**KR**	~~**23/05/2023**~~ **May 2024**	It had been agreed to move the People plan to May 2024 as it would be reported to March 2024 People Committee. This delay was so that a strategy could be included.
			COMPLETED SINCE LAST MEETING			

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Meeting:	Trust Board – Part A
Date of meeting:	11th January 2024
Report title:	Chair's Report
Author:	Ann Beasley, Trust Chair
Purpose:	For report

Board recruitment

As mentioned at November Board, recruitment to a NED vacancy will be going ahead soon. The advert will appear on the NHS England website Non-executive opportunities in the NHS (england.nhs.uk)

Board activity

The November Board part B discussions covered areas including the BAF, commercial estates matters and committee chairs' reports.

The December Board seminar covered a range of issues including well led, CQC assessment framework and NHS IMPACT. Briefings were presented on Mental Health Law, Risk management and Health and Safety.

The Remuneration Committee met in December and has agreed VSM pay for 2023/24 in line with NHS England guidance.

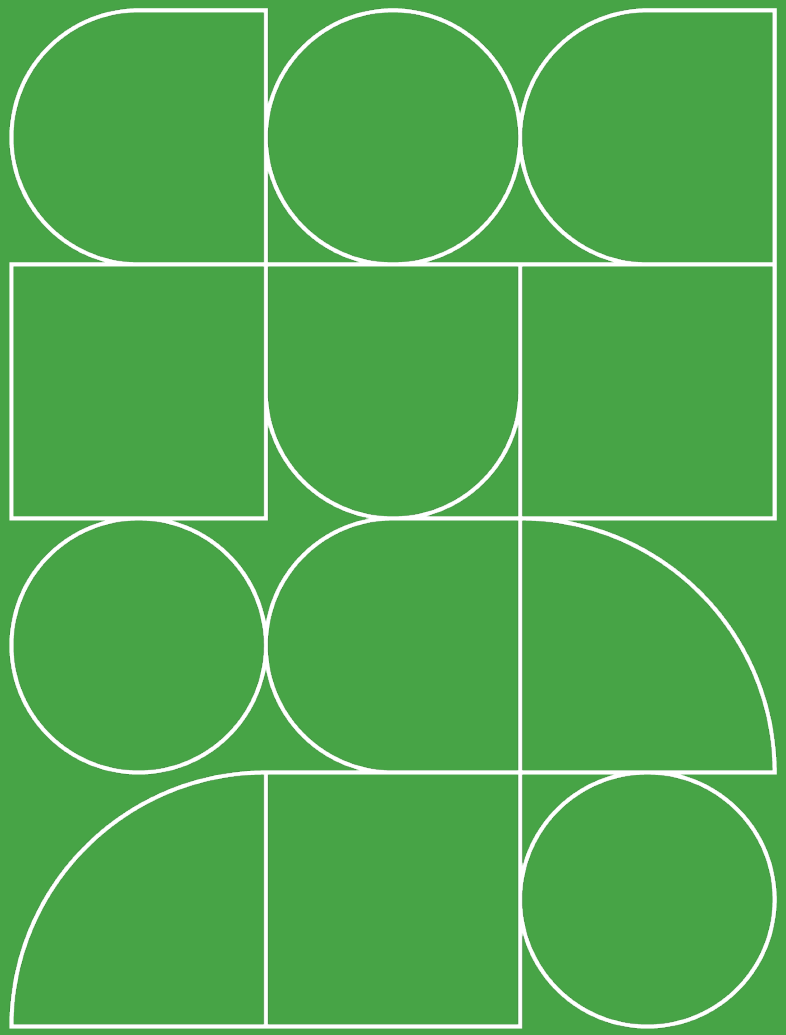
The monthly Board visits programme is proceeding with valuable opportunities for Directors to hear regularly and directly from the frontline. A report summarising issues and actions from recent visits will be presented to the next Board.

RECOMMENDATIONS

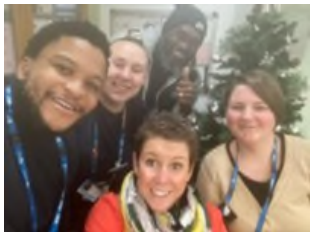
The Board is asked to note this report


Making Life
Better Together
NHS
South West London and
St George's Mental Health
NHS Trust
Vanessa Ford, Chief Executive
Board Report
Part A
January 2024
Respectful
Open
Collaborative
Compassionate
Consistent

Contents



Our Trust



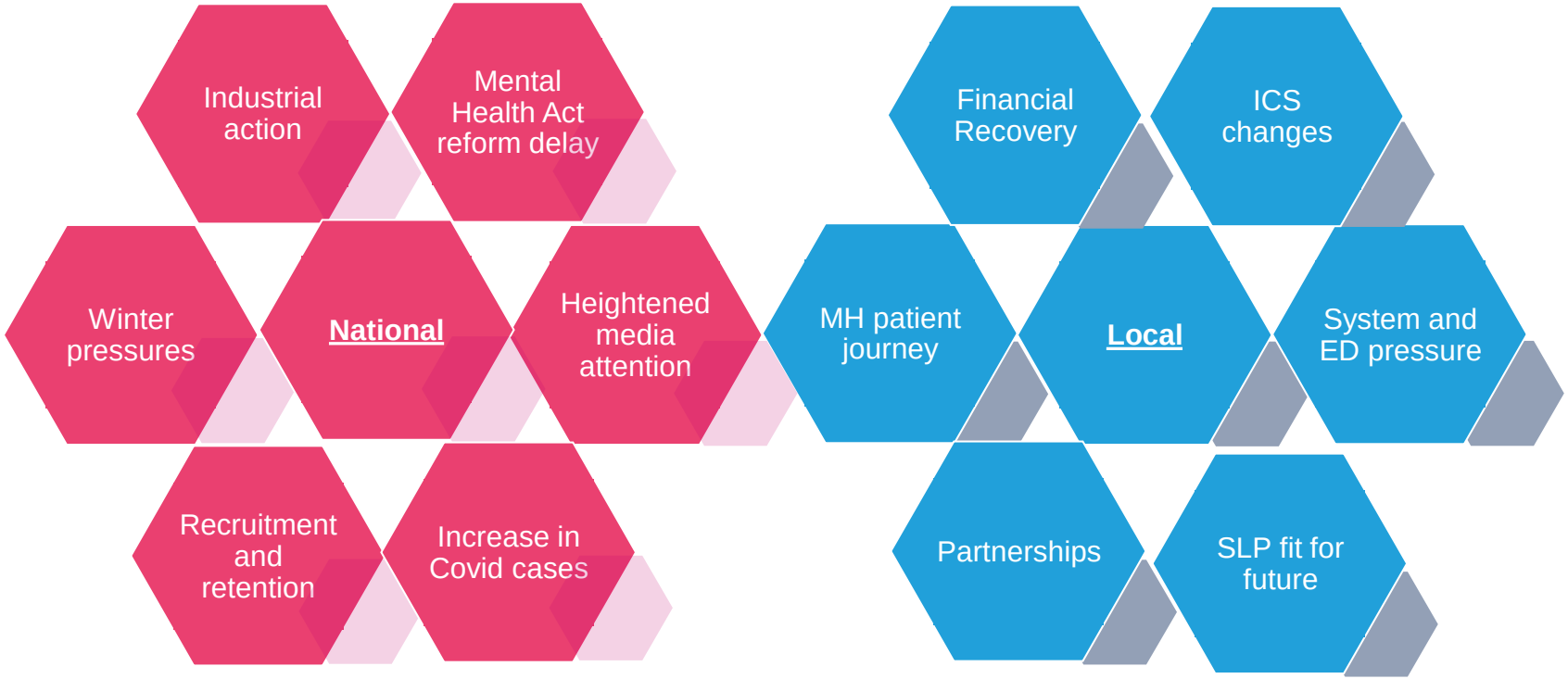
Our staff are our main asset and every week, I write to everyone with key messages and every two weeks I have an all staff Q&A. Alongside this I regularly visit our sites formally and informally.

I always start with a thank you to our staff who put our patients first!

- Chief Executive Update – 3 Nov
- Chief Executive Update – 10 Nov
- Chief Executive Update – 17 Nov
- Chief Executive Update – 24 Nov
- Chief Executive Update – 1 Dec
- Chief Executive Update – 8 Dec
- Chief Executive Update – 15 Dec
- Chief Executive Update – 19 Dec – Christmas Card
- Chief Executive Update – 25 Dec – Christmas Day Message
- Chief Executive Update – 31 December – New Year's Eve Message

Our context

There are a number of external pressures on our organisation.



Improving patient journey across the SWL system:

- We are experiencing high demand across our health system, which has seen increased pressure on mental health - especially adult acute and community services, this is being compounded by further industrial action across the system (see next slide).
- We continue to see people with complex mental health needs using emergency services. This often means more people receiving care in the 'wrong' part of the system.
- In November we declared a Business Continuity Incident to reflect this pressure. The Incident allowed us to understand the barriers around patient flow, receive support from the wider system and develop our thoughts about next steps. Going forward:
  - **Acute and Urgent Care** is working to set expectations around purposeful admission and expected discharge from the moment a patient is admitted.
  - **Community** is working to offer a greater level of support to people who are heading towards crisis. Enhanced Response Practitioners are linking in more intensely with home treatment teams and liaison teams to avoid admissions.
  - **Acute providers** are working with us to enhance mental health care at the front door of A&E.
  - **Local Authorities** are supporting more timely access to the right accommodation when patients are discharged from our wards.

October 2023

Length of stay: 55↑ days vs 38 day end of year aim

Presenting in crisis: 1.7%↔ vs 1.1% end of year aim

Inappropriate out of area: 103↑ days vs 0 end of year aim

Friends and family test: 77%↓ net positive vs 81% end of year aim

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Improving patient journey

- **Industrial action:** Junior Doctor strikes took place in December 2023 and January 2024. This is putting increased pressure on our patients and workforce. We continue to manage the strikes well and we have seen the majority of shifts filled and teams are working together to ensure that patients receive the care they need. However, we know from previous industrial action that there is a high potential for delayed impacts on patient journey.

- **SLP S136 coordination hub**: The Hub can be accessed by police who are at a mental health incident and it went live on 30 Oct 2023. Initial results are promising. The hub is receiving increased calls compared to the baseline. The hub is also seeing a reduction in patients placed on S136 and a significant reduction in ED conveyances.

- **The eating disorder Enhanced Treatment Team (ETT)** has undertaken a six-month review following the launch of the service in February 2023. Early results are showing a significant reduction (50%) in readmittances.

- **Public campaign:** We are working with the ICS and health and care partners on another campaign to support members of the public to get the right mental health support at the right time. We are also supporting GPs and health professionals to better understand and communicate the support on offer.

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Valued and stable workforce: Recruitment and retention

- **People Strategy development:** Engagement with patients, staff and stakeholders has started with launch in Q1 2024/25.
- **Improvements to vacancy and turnover rates:** we continue to see some improvement in our vacancy rates and turnover rates. However, there are still particular hotspots – including high numbers of people leaving under 12 months.
- **Recruitment:** We've seen some important improvements in recruitment. Community-based recruitment and targeted initiatives will launch in 2024, which will improve this further.
- **Retention:** A series of initiatives are now in place to further reduce turnover (particularly under 12 months), including career conversations and stay conversations – with more planned.
- **Leadership Development:** Over 60 members of staff have completed the middle manager STEPS programme and we are in the process of evaluating this. Our senior leadership development is on track to launch in the New Year. We are developing a coaching and mentoring programme, which will launch in Q4 2023/24.
- **Long service awards:** we saw over 50 people attending our long service awards at Tolworth and Springfield for those people who have been with the organisation over 25 years.
- **Staff survey:** We have seen significant engagement with the survey, especially in clinical teams – 64% of our staff completed the survey vs 52% last year.

October 2023

Vacancy rate: 15% ↓ vs 15% end of year aim

Turnover rate: 13.9% ↓ vs 15% end of year aim

Turnover within 12 months: 24% ↑ vs 15% end of year aim

Sickness rates: 4.9% ↑ vs 3.5% aim for LDN MH trusts

Agency rate: 5.2% ↑ vs 3.6% end of year aim

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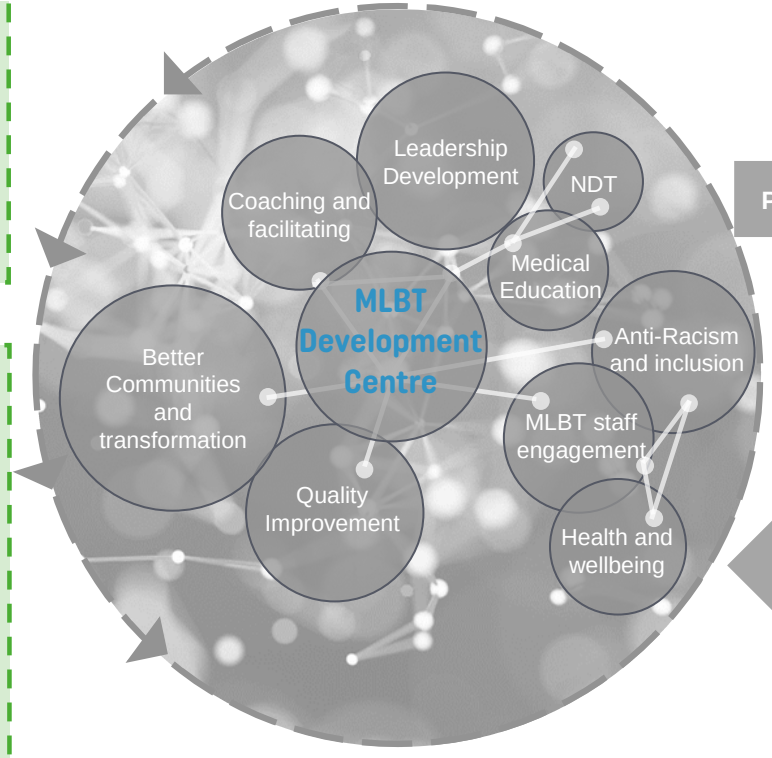
Organisational Development: MLBT Development Center

Purpose: The MLBT Development Centre will act as a catalyst for individual and team development, supporting the evolution of our culture so that we can provide the best care possible to our patients.

Principles:

- The complex and emergent nature of the organisation will shape our approach.
- Its work will be based on the action research model, working with cycles of action, experimentation and review of learning.
- It will deliberately work to amplify helpful patterns and disrupt unhelpful ones.



The Development center will:

Proactive

- Act as the custodian of the MLBT framework
- Ensure connection and integration of all development activities
- Develop and drive the seasonal focus for our OD work
- Design approach to team development and team of internal team coaches
- Support by offering training and facilitation
- Develop resources for leaders to support development in their teams
- Ensure quality improvement approaches are central to all our work
- Be grounded in QI methodologies

Responsive

- Support for those teams that need it (both self referred and targeted)
- Teams will be triaged and offered specific appropriate interventions
- May be internal, or externally commissioned

Supporting inclusion, diversity and active anti racism

Equality and Diversity

- **Anti-Racism values into behaviours:** A series of Action Learning Sets took place in December. The feedback will be developed into a new set of 'values into behaviours' specifically around anti-racism - to help make clear our expectations as part of recruitment and while at work.
- **White Allies:** We are advertising for a new set of White Allies to be part of the NHS London programme and are developing our own leadership of anti-racism programme.
- **WRES:** We are holding WRES workshops to develop our 2023/24 outcome measures and timeline.

Reducing health inequalities

- We held a partnership meeting with leaders in WCEN to develop next steps for the EMHIP programme.
- Through EMHIP we are advertising for Mental Health Mediator as part of the reducing restrictive practice intervention.

Better Communities: Tolworth, Barnes and transformed community services

Better Environments

- Preparations will soon get underway for the £110m redevelopment of Tolworth Hospital in Kingston. Pending final approvals, early works are due to start in 2024 ahead of construction beginning in the spring for delivery in 2027.
- 7,000 flyers were shared with homes around Tolworth inviting residents to sign up to a 'Tolworth Messenger' newsletter. This will launch in 2024 to provide regular updates as works progress with further plans for community engagement events next year too.
- Early works will also begin in early 2024 to support the creation of a new mixed-use community at Barnes Hospital in Richmond. This will include a new outpatient centre alongside an SEMH School and residential housing for delivery in 2025.

Better Care

- A new video animation launched in November highlighting transformed adult community services – Lived Experience Member, Lincoln, provided the voiceover.
- As part of this, the Trust has now partnered with 15 voluntary and community sector organisations across Sutton, Kingston and Richmond to create joined-up peer support and welfare services. The roll-out continues in Wandsworth and Merton from April 2024.
- The Trust is also preparing to launch a refreshed website in early 2024 designed to improve user experience and accessibility.

Better Communities: Our role as an anchor

- **Hold the Hope film:** As part of NHS South West London's Suicide Prevention Programme, volunteers with lived experience of the impact of suicide have produced a new film called Hold the Hope to help break stigma and raise awareness. The film will be part of a new life-saving training course that the volunteers will deliver alongside the Trust's suicide prevention lead, for local schools and British Transport Police during 2024.
- **Christmas light switch on:** A hundred patients, local residents and staff gathered at Chapel Square for our Christmas Tree lights switch on and carol singing. Proceeds from the event along with supporting bake sales raised over £270 for the Trust Charity. The Charity will be attending the Tooting ParkRun on 13 January.
- **Mental Health First Aid Training for residents:** We have held four MHFA training courses so far, with 60 people trained and with two more booked in for January. This is part of a Charity funded programmes to create a mental health aware community, ultimately leading to a local 'Train the trainer.'
- **South London Listens:** Senior NHS leaders, local politicians and community groups came together in November to commit to addressing the biggest challenges impacting the mental health and wellbeing of local communities in south London as part of the South London Listens Programme. Renewed pledges were made, which also celebrated our successes of the last year.

Celebrating our teams

Christmas Card and festive treats to wards and services

Long Service Awards

Exceptional People winners Award

RCPsych Lifetime Achievement Award

NHS Pastoral Care Quality Award

Sutton Outstanding placement of the year

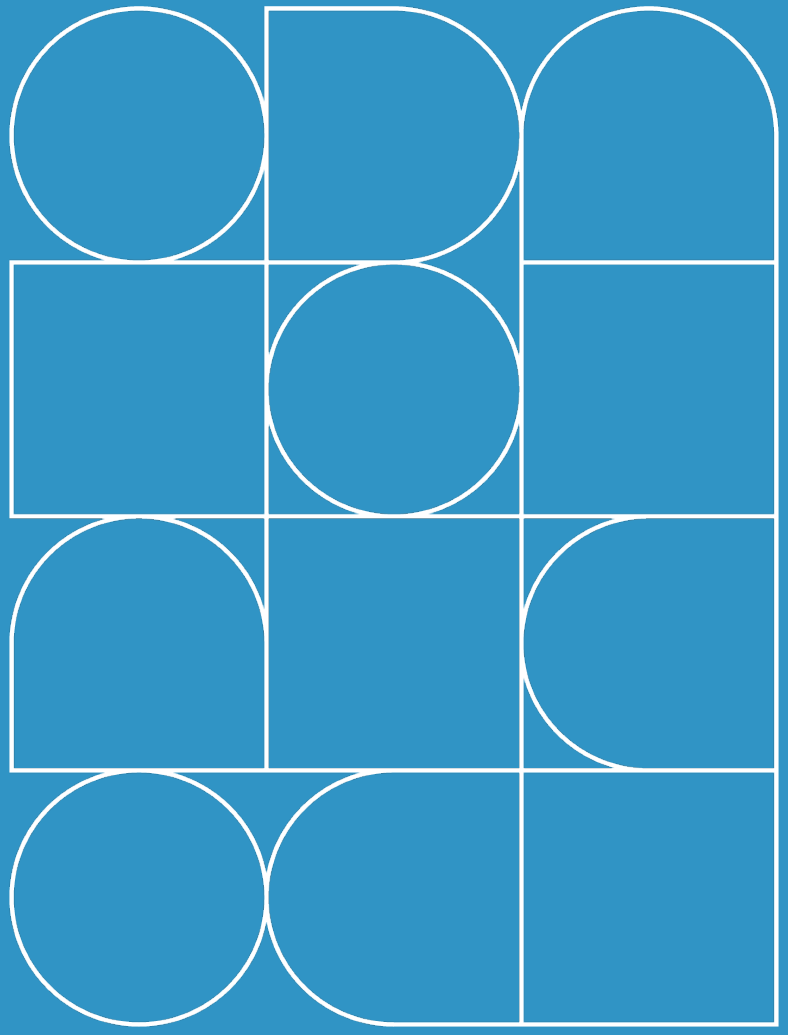
Kingston IPS National Quality Mark award

Veteran Aware Accreditation

Burntwood and Lilac score 100% on their infection prevention control inspection

Questions and points to have in mind

1. With the pressures across the health system, how do we ensure that we exit the most recent industrial action and winter period, in the right place for us to continue our work on effective patient journey and supporting our communities to receive the right care, at the right time, in the right place?
2. How do we continue to improve our vacancy and turnover rates and hold ourselves to account in areas where we aren't seeing as much progress (with a focused lens on anti racism)?
3. When things are pressured, it's easy to slip into bad habits. How do we take what we've learned about our organisational culture: keep things simple, ensure clarity, create psychologically safety, stick with decisions, and prioritise relationships?
4. We have a clear commitment to inclusion, diversity and active anti-racism. How do we ensure that this agenda remains front and centre with all of the other pressures we're experiencing?



Appendix 1: Horizon Scanning

CARE QUALITY

- Annual report of the National Guardian for the NHS
- National system launched to rapidly identify trends in suicides
- NHS England » Patient choice guidance
- Duty of candour review: terms of reference
- Patient safety specialists – NHS England guidance
- Thirlwall Inquiry: terms of reference
- Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) Annual report
- Commissioning of acute mental health inpatient services for adults with a learning disability and autistic adults
- Baroness Hollins' final report: My heart breaks - solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people
- NHS England » Patient and public voice partners and chairs survey 2022/23: summary report
- Visiting in care homes, hospitals and hospices – proposed new fundamental standard
- Electronic patient record systems: recurring themes arising from safety investigations
- Chief Medical Officer's annual report 2023: health in an ageing society
- An overview of the death certification reforms
- Federated data platform (FDP) – improving and connecting our health information

WORKFORCE

- Government and BMA agree offer for NHS SAS doctors
- Cavendish Coalition letter to the Prime Minister about visas for health and care workers
- NHS Pay Review Body remit letter: 2024 to 2025
- NHS England » Enhancing doctors' working lives – 2023 annual report
- NHS England » Growing occupational health and wellbeing together: look back, look forward report

INEQUALITIES

- NHS England's statement on information on health inequalities
- Letter about the EDI improvement plan from NHS England

SYSTEM

- Health and Social Care Secretary sets out priorities for system
- Merger of SGUL with City University
- Health Effects of Climate Change in the UK: state of the evidence 2023
- Oxleas NHS Foundation Trust, Chair recruitment

Appendix 2: Use of Trust seal

Date	Type	Signatories
16/11/2023	Building contract Building contract for the refurbishment of Hulme Ward space in Newton Building. *Between SWLStG and Modus Construction.*	Director of Finance and Integrated Programme Director
19/12/2023	Contract Phase 2a sale of plots at Springfield Hospital site to London Square. *Between SWLStG and London Square.*	Director of Finance and Director of Nursing
20/12/2023	Agreement Agreement for Early Building Works at Tolworth Hospital. *Between SWLStG and EstateCo.*	Director of Nursing and Medical Director

Meeting:	Trust Board
Date of meeting:	11th January 2024
Transparency:	Public
Committee Name	Quality and Safety Assurance Committee (QSAC)
Committee Chair and Executive Report	Jonathan Warren and Sharon Spain

BAF and Corporate Objective for which the Committee is accountable:

QSAC has responsibility for the following BAF risks:

- A failure to effectively respond to equality and diversity issues facing the Trust;
- A failure to meet the increasing demand on services relating to acute care pathways.

QSAC is responsible for the following corporate objectives:

- Objective 1: To improve the quality of services through delivering a stepped change in fundamental standards of care and empowering service users and carers;
- Objective 3: To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences.

Key Questions or Areas of Focus for the Board following the Committee:

1.1. Risk continues to be a key theme at QSAC, specifically the challenge of providing quality care in a context of demand, pressure (including financial, productivity and efficiency expectations) and constrained resource. We have asked those presenting at QSAC to outline discussions and assurance from other internal committees to enhance understanding of the governance process before an item comes to the committee.

1.2. Demand, resource and capacity continue to be the biggest and most persistent challenges that QSAC considers and it imbues most of the papers/agenda items that are discussed, explicitly and implicitly.

1.3. QSAC supports the ongoing focus on improvement in key areas of challenge, namely flow, operations and workforce, recognising that each is inextricably linked to the quality of care we provide to patients.

1.4. The Committee received reports on the progress being made to reduce the use of prone restraint and for the future plans to lead to the elimination of this practice.

1.5. The Committee reviewed the plans to ensure that observations are used only for those patients who require them and that compliance with policy expectations continues to improve.

1.6. The Board will need to review its decision to not invest in door alarms following the incident on Ellis Ward. An options appraisal will be considered following the incident review and feedback from other organisations who have installed this product

Areas of Risk Escalation to the Board:
None.

For each item discussed at the Committee there would be a statement against the three areas below:
1 Assurance Position ("What")
2 Evidenced by ("So What")
3 What next?

Professor Graham Martin from Cambridge University visited the November QSAC. He gave a presentation to help the Committee to read signals in the organisation to identify teams who may be running into difficulties. The presentation was well received and a verbal update was given at the November Board.

Executive Risk Register and Board Assurance Framework

What: The Executive Risk Register (ERR) demonstrates how risk is considered and mitigated at different levels within the Trust, and underpins the Board Assurance Framework (BAF). Each Committee monitors its specific risks as outlined in the BAF and the ERR is reviewed by QSAC on a regular basis. QSAC noted:

- Some concerns were raised about restrictive practice on Jasmines Ward. This had been covered at the Service Line Review and raising of the risk had been seen as a positive, as there was a clear line that shows how teams are using their risk registers to highlight service specific issues, concerns or risks.
- The MAST risk was likely to be closed soon.
- There was a new risk in Aquarius Ward around the management of complex patients due to bed closures by the SLP. It clearly identifies mitigations and further actions.
- RIO risk around Information Governance was not a new risk and was being managed well.
- ELT have asked for a revision for the Violence and Aggression and observation risks.
- The ERR was quiet around racial discrimination towards Trust staff and that presented risk to speaking up, being heard and action being taken.
- The COO has been asked to revisit the relationship between Length of Stay and Demand and Capacity.
- Two new risks had been added to the ERR in December: Safe, therapeutic and supportive observations and engagement; and Use of Force.
- No risks on the ERR had been escalated in this reporting period and three had been closed,

So what: QSAC reviewed the mitigations. Discussion focused on whether the SLP closure of children's CAMHS beds should be included as a separate risk as, because of the closure, our CAMHS service had taken in some patients with challenging needs. However, it was an overall SLP risk. A Quality Impact Assessment was being completed by SLaM but for the partnership; so it would assess risk across all three providers, which has never been done before and was a positive step. After the QIA was completed the Trust may need to raise a risk to the Trust ERR. There was also discussion to unpick the Shaftesbury alarm issue to provide assurance. QSAC were informed that it was the second stage response that was the issue and this was being reviewed. There were mitigations, such as reviews during the day, and safe systems in place.

What next? QSAC continues to review the analysis of the risk register, both as a standalone document and in relation to other sources of data and information.

Quality Matters

What: Quality Matters is an essential report that provides triangulation, prompts consideration of the relationship between strategic aims and operational practice and reflects the 'Floor to Board' understanding of quality, safety and the patient experience.

So What: The Committee received a new version of the report in November and December. They noted the level of Patient Incident Reviews (PIRs) not being signed off by the Service Lines and that this has been put back to service managers for resolution. In November there were a high number of upheld complaints but this was seen as positive. The ethnicity breakdown is now monitored. In December, there had been an increase to 77 outstanding complaints compared to 22 in September. The complaints team were now fully staffed so this should improve.

What next? The Committee is particularly concerned about, and interested in, violence and aggression towards staff, restrictive practice and observations.

Quality and Performance Report

What: QSAC received the report and discussed priorities arising, noting that the Trust would be focusing on improvement in key areas of challenge, which were flow, operations and workforce. QSAC noted that focus on these three key areas of challenge are intended to improve performance across the range of metrics.

So What: The Committee noted that:

- The position remained challenging in the context of the external position and industrial action and its effect on flow.
- There were no areas for escalation to QSAC.
- The Trust had agreed a way forward with Primary Care and ICS colleagues for shared care pathways for ADHD patients. This was positive with acknowledgement that the pathways would take time to implement.
- There had been improvement around auditing practice.
- Work was ongoing around reducing observations and restrictive practice.
- Despite focussed work we were struggling to make a shift in our acute pathway patient flow and that was where the biggest risk sat.
- There had been a focused response with the Local Authorities (LAs) in terms of Delayed Transfers of Care (DTOC) and discharges. There was currently significant demand and a lot of patient complexity which was hard to manage with limited resources.
- A project had been started to set up and plan long-term enhancements to mental health services in SWL EDs.

What next? QSAC will continue to monitor performance in specific areas, including assurance around restrictive practices. Members have asked if the Trust could review the data with the most complex patients removed, in order to see if there were any patterns in the rest of the data.

NHS IMPACT Self Assessment

What: the Committee were asked to give consideration to the Trust's current position in the Self Assessment and to decide if it was content to sponsor it on to the Board seminar for discussion.

So What: the Committee considered the position and were content to sponsor it on to the Board seminar.

What next: The Self Assessment went to the Board Seminar in December and would be reported back to the ICS to gain a baseline in terms of the quality improvement journey. We were not expected to report nationally but are expected to debate improvements.

Observations and Engagement and Use of Force reports

What: the Committee had asked to have a report on Observations and Engagement and Use of Force, in order to get assurance that the Trust was reducing use of restrictive practice, including observations.

So what: the Committee were assured to hear of the schemes that the Trust were putting into place to monitor and reduce observations and use of force, which had begun to reduce the use of restrictive practices (use has dropped 40% since June 2023), including:

- EMHIP Mental Health Mediators, to try to prevent restrictive practice;
- Peer Debriefers on wards post-use of restrictive practice;
- Senior nurse ward visits and review of records of observations;
- Code of conduct had been created and was being imbedded;
- Review of ethnicity data to monitor if there is an inequitable use of restrictive practices on BAME patients.

The Committee asked about the balance of use of observations to monitor at risk patients specifically around ligature risks and that it now feels that the balance is right.

What next: QSAC would continue to monitor these areas through review of the quarterly restrictive practice report produced by the Depurty Director of Nursing.

Ligature risk assessment

What: QSAC monitor this via an annual report.

So What: Whilst there had been a slight increase in total incidents, the vast majority had been no or low harm. Over 50% of all incidents were attributed to just two patients. There would be greater analysis of observations in future reports. During the financial year covered by the report there were no moderate to severe harm incidents or deaths.

What next: The Committee discussed how the Board made the decision a year ago not to install door alarms for a range of reasons and following feedback from other Trusts. There had been a ligature death on Ellis Ward caused by a ligature on a door. As part of the ligature review this decision would be reviewed, including any new information and feedback on door alarms from other organisations. The Board decision may require review in light of this.

Quality Governance Health Check

What: The Committee noted and discussed the Quality Governance Health Check Terms of Reference.

So What: An external consultant had been commissioned to do a ‘health check’ on the quality governance of the Trust ‘from floor to Board’, to give assurance that the Trust’s quality arrangements are robust and how the Trust could get to ‘Outstanding’.

What next: The final report was expected to go through the Board sub-Committees, including QSAC, before being presented to the February or March Trust Board.

Annual Reports

The following Annual Reports were reviewed and accepted by the Committee:

- EMHIP and PCREF – and that these reports would be integrated going forwards;
- Duty of Candour;
- CQR;
- MHA;
- Safer Staffing;
- Safe working hours – including the recommendation of annual reporting to QSAC only with the Guardian able to bring an exception report when needed;

- Nursing Revalidation;
- Health and Safety; and
- Ligature Risk Management.

Appendices

- Ratified minutes of the meetings of October 2023 and November 2023.

NHS
South West London and St George's Mental Health NHS Trust

Quality and Safety Assurance Committee (QSAC) (Part A)

Final Minutes of the meeting held on Tuesday 3 October 2023, 10:00am – 12:30pm, in Trinity FF Meeting Room 4, Trinity Building, Springfield Hospital.

Present:

Jonathan Warren (JW)	Committee Chair – Non-Executive Director
Ann Beasley (AB)	Trust Chair
Professor Charlotte Clarke (CC)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive Officer
Sharon Spain (SS)	Director of Nursing and Quality
Billy Boland (BB)	Medical Director
Jennifer Allan (JeA)	Chief Operating Officer
David Lee (DL)	Director of Corporate Governance

Attendees:

Ryan Taylor (RT)	Associate Director of Clinical Governance and Risk
Theresa Pardey (TP)	Head of Quality Governance and Patient Experience (item A23/152 only)
Clara Agyekumhene (CA)	Assistant Manager, RSM (trust internal auditors) (item A23/154 only)
Mike Hever (MH)	Deputy Director of Nursing (items A23/155 and A23/156 only)
Seema Shah (SSh)	Chief Pharmacist (item A23/157 only)

Minutes:

Emma Whitaker (EW)	Deputy Director of Corporate Governance

Apologies:

David Hobbs (DH)	Lived Experience Representative
Richard Flatman (RF)	Non-Executive Director

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A23/144	**Apologies** Apologies were noted as above.	
A23/145	**Declarations of Interest** No new declarations of interest were reported.	
A23/146	**Chair's action** No Chair's actions had been taken since the last meeting.	
A23/147	**Minutes of the previous meeting** The minutes from the meeting of 5 September 2023 were agreed as a true and accurate record with the following amendments: • Page 4 - 3rd paragraph: to be amended to: "AB noted that when patients attend the Board for the Patient Story item the meeting regularly hears issues around treatment criteria. When discharge decisions are made there is often a substantial challenge of striking the right balance and taking into account the needs of patients waiting for a bed". • Page 4 – 6th paragraph: to be amended to: "ensuring equity of access". • Page 8 – 5th paragraph: to be amended to "staff should be utilising NICE guidance".	

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A23/148	**Action Tracker** The action tracker was reviewed and amended as follows: A23/85 – TOR for new post-incident task and finish group – SA confirmed that she had received the TOR but it had not gone to People Committee. SS confirmed that the group was ready to be launched and will report through QSAC. Action to be closed. A23/107 – Use of observations – this item was on the agenda and could be closed from the action log. A23/107 – BAF cover sheet – this was not yet ready. It was also noted that the next time the BAF and Executive Risk Register comes through to QSAC it must include an assessment of culture. Action to remain open.	
A23/149	**Executive Risk Register** The Committee noted and accepted the Executive Risk Register (ERR). **Reported:** RT reported the following: • ELT and QGG considered a new safeguarding risk (2442) and were content with the way in which the risk was phrased and evaluated. • Length of Stay (1409) risk would be reviewed in October. • Quality standards (2439) now captures Freedom to Speak Up changes. • ELT was largely content that People risks were reflective of the current position. QGG had a conversation around the presence of increased workforce risks at team level that were included on local risk registers. QGG noted all risks had good levels of mitigations and actions. It was therefore agreed to not include these on the ERR. Governance processes were being used appropriately by teams to raise and capture risks. It was also noted that these were national risks. The Trust had a specific challenge with retention especially for those in post under 12 months that potentially has patient safety and quality implications. Mitigations were in place and the BAF captures the wider long-term and strategic implications. **Discussed:** That the Cavendish Square Group had requested that all Boards add a BAF risk around 'right care right person'. VF agreed instead that the Trust would consider the scale of risk for the local population and partnership working. ELT was content that this risk did not need to go on the ERR until it was known what was actually happening with 'right care right person'. That systems had been designed with 85% staffing in mind but the Trust was not near that level; and whether processes and systems may need to be reimagined to take this into account. The community transformation work addresses this point. There were concerns around staffing in adult community services as a whole; however, the Transformation Programme in Sutton, Kingston and Richmond community services showed signs of workforce stabilisation and improvement in retention which it was hoped would continue to improve as the Programme continued. That there was another strike happening today (3rd October) and further industrial action was planned. The impact of the junior doctor strike had been mitigated by	

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	ACPs taking on extended and additional responsibilities which has enhanced understanding of their role. The teams had taken advantage of difficult circumstances to consider new ways of working which may enable the Trust to think about the workforce differently. The Committee was assured that there was always at least one nurse on duty on all wards at all times. In regard to the safeguarding risk, there was consideration of the cultural implications of difference of view about risk. SS responded that the Head of Social Work felt that there were not enough resources in the safeguarding team to do all of the necessary work, due to a disconnect between what the team should be doing and what they were doing. The Trust had never had concerns from external stakeholders about the resource. What had shifted lately was pressure from systems on the small resource available. This was being worked through with ICB colleagues and there was a Service Level plan for training and development to ensure staff use the safeguarding resources appropriately. SS confirmed that the Head of Social Work was comfortable with how the risk was now described. It was noted by ELT that there are often staff in leadership roles who feel they need more resources and use risk registers to raise this. The risk team and ELT scrutinise all risks to evaluate whether they should be escalated and/or held at ERR level.	
A23/150	**Quality Matters** The Committee noted and discussed the Quality Matters report. **Reported:** SS and TP reported the following: • Feedback on the report would be helpful as it was the first of a new version coming through QSAC. It had been aligned with the PSIRF and was an in-month snapshot of key quality issues at the Trust. • There was a plan in place for improving planned psychological emergencies figures; and all incidents had been managed safely. Themes from learning were similar to previous incidents which should come through on the quarterly and annual reports. • The report is more focused on what the teams would be able to do to change practice. **Discussed:** That this paper had arrived late yesterday so most of the members had had no time to reflect on it. SS apologised, the delay was in order to incorporate comments from ELT. She would be happy to receive any feedback by email, to be sent to SS and TP. That it was clear how the report could be helpful operationally but whether an in-month position was helpful for the Board and Committees. The report was presented to make sure the Board was sighted on any in-month incidents and complaints. It contained the same detail as the previous report but was in a different format. It was important to acknowledge in-month harms and deaths. The DNA rate for psychological emergencies appears in-month and it was interesting that this had once more increased after focused work on this issue.	
A23/151	**Quality and Performance Report** The Committee noted and accepted the Q&P report.	

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	Reported: JeA reported the following: • SS and JeA have worked together to draw out key messages and these were included in the front of the report. • There was significant pressure on the acute pathway, alongside the impact of the ongoing industrial action and workforce challenges. • It was important to hold fast with the transformation work even though improvement was slower than we would like in some areas. The proposal was to continue to invest in the transformation work and deploy some tactical actions to keep things safe and moving. • The numbers of long waiters were increasing in adult ADHD. • There were long waits in Psychology and Psychotherapies and CAMHS eating disorders; SS and JeA would work with the Service Lines to improve this. • KR and SS had done a lot of work on MAST with grip and control being enhanced. • Use of force remained high. ELT noted that the Trust was aware that it is an outlier on restraint, commenting that there are three complex SLP patients with which has influenced the data and the increase may continue. • There was a new SIREN dashboard and enhanced tool. An explanation was included in the report alongside key messages around teams of concern. ELT had agreed to use SIREN throughout the organisation. SIREN would be discussed in all Service Line Review meetings as the first item of business to discuss concerns and what more could be done. The teams will know issues have been heard and hear what has been done, and management will be engaging local teams on what more can be done. It was reassuring that areas of concern that have been raised by SIREN are those the Executive team would expect to see. There were a number of hotspots across community services. **Discussed:** That the Committee would watch with interest how SIREN becomes embedded. It was asked, if the SLP patients were not inpatients, would the Trust still be an outlier in use of restraint. SS confirmed yes for adult patients. There was a particular challenge in the SLP and in particular, CAMHS ward issues. 18 SLP beds were closed, 15 of which were closed at SLaM, 3 were with the Trust and were closed in a planned way. To have that volume of beds closed in the partnership means South London patients were being placed out-of-area and patients with high acuity were on our wards as SLaM was not taking complex admissions. This has led to difficulties. Unless this could be resolved, Aquarius and Wisteria wards were holding considerable risk. There were conversations that the Executive team needed to have in terms of how this was taken forward. That it was important if staff were reporting an item as 'red' through SIREN that something happens; e.g. they are given feedback on what was being done or not being done about the item. At the virtual welcome tea and chat that she hosts for new staff, AB asked the attendees if they felt safe to raise concerns. Someone raised using SIREN, which was encouraging. That SIREN was not a tool to be used to force management to resolve an issue when they cannot or would not do so, such as managing a challenging service user. It is still important for staff to know they are heard, the problems are known and understood, and management are trying to resolve issues, and that it is everyone's	

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	responsibility to address issues. The Trust was looking to develop an OD hub, made up partly of QII, and partly HR advice and support to help tailor HR interventions. There is a suite of work ongoing. That QSAC generally focuses on the Trust's provision of services but the Trust has a role in SLP and provides SLP-wide services. There is a quality structure within SLP and that quality report did not come to QSAC. CC said she would be keen to revisit the Liaison Psychology service that is based at St Helier Hospital. VF suggested that JeA or the Acute Service Lines could take CC through the transformational work in the Liaison Psychology service. That there was some consternation in the Acute Trusts about mental health but there was a lot of work going on. BB, in his London Regional role, attended an NHSE London roundtable, which had been driven by Acute providers raising concerns about mental health patients staying in A&E. The framing of the morning was to get senior people around a table to plan what could be done before winter. Most of the things suggested however were medium to long-term interventions. There was recognition that people were working on this and there was no quick win. There were many difficult conversations around who 'owns' the problem. The Acute system board patients on their wards and have asked why mental health trusts do not. It was felt that mental health trusts were not taking enough of the risk out of the system. It was a useful meeting in terms of establishing relationships and getting to a collective understanding of the issues. VF added that our South London colleagues and Local Authorities felt positively about our partnership working. Our acute colleagues were content that we do not board but that we instead respond as quickly and effectively as we can. JeA was working on a project considering a mental health A&E and what that may look like. She also felt it would be useful for QSAC to be sighted on the facts with regards to SWL mental health patients in Emergency Departments. The figure had not increased in SWL and had been stable for two and a half years. What had increased was the amount of time mental health patients spend waiting in A&E, due to the increase in length of stay on our wards and that flow has slowed. The Trust purchased spot beds for patients which was the equivalent of boarding. The sustainable way to reduce the problem was to reduce length of stay for the Trust patients. A mental health A&E would probably make patients wait in another location. She was in support of patients being looked after in a more appropriate setting, but this was not the solution to the core of the problem. The Trust needed to work on flow and on the back end of the patient journey and to support people back to community settings of care; and on managing the expectations of our staff, patients and families around care; and to work with the wider system for patients who have housing and social care needs to help patients to return home. It was important to not to exclude patients from accessing A&E if they needed it. The Trust had to continue to put its faith in the transformation programme. BB added that a lot of patients do not want to go to A&E but for some they need to as they have co-morbidities or have physical needs, sometimes connected to mental health and sometimes not. Sometimes patients feel safer there. It is integral to remember to play the voice of the patients into system conversations. JW added that	

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	there were previously two emergency mental health clinics in SWL and both were shut; missing co-morbidities was one of the reasons for closure. AB had read with interest that the Trust's spend on observations had doubled and that this was explained by patients at risk of falling.	
A23/152	**Intellectual Disability and Autism Report** The Committee noted and accepted the report which included the Greenlight Toolkit, Transforming Care (Winterbourne) update and access to Intellectual Disability services. **Reported:** SS and TP reported the following: • This report was received by QSAC six-monthly rather than annually. • There had been some changes in language, such as changing Learning Disabilities to Intellectual Disabilities. • The detail around the Greenlight Toolkit had been reviewed in detail in previous QSAC meetings. • Work was being rolled out around positive behavioural support planning. • The Oliver McGowan training roll out was being worked through. The Board would also need to participate in that training. • The Trust was seeing an increase of referrals which was positive. This was due to the new Lead Nurse identifying referrals across our services. However, equally the increase in referrals was putting pressure on a small service. **Discussed:** That the report was comprehensive; the committee would welcome a strategic lens on this area too. The Committee noted the important points regarding involvement and co-production with service users, carers and families. The Trust is about to open its first Intellectual Disabilities ward and this area of our work is significant. Senior staff increasingly hear about complexity in acute wards connected to service users with Intellectual Disabilities. BB and VF have discussed the profile of patients with Intellectual Disabilities within the Trust. The lead for Intellectual Disabilities sits within the Specialist Service Line under Dr Lola Velazquez. It is felt that Intellectual Disabilities has a higher profile than ever before in the Trust. The next update report would have a more strategic approach as well as looking at the detail of what work was going on around the Trust in this area.	
A23/153	**Patient Led Assessments of the Care Environments (PLACE) Annual Report** The Committee noted and accepted the Annual Report. **Reported:** SS reported the following: • Preparation for 2023 had been delayed due to Covid. • Nine wards (instead of 10) were assessed due to the moves into Trinity. • The biggest issues remain food and hydration. The Trust is aware of these difficulties and is working with the Facilities team on new contract criteria. • Capturing service user voices about food had led to direct conversations at H&S committee and changes to the service.	

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A23/154	**Learning from Complaints Internal Audit Report** The Committee noted and accepted the Internal Audit Report**.** **Reported:** CA reported the following: • This report would be presented to the next Audit Committee. • The overall report was positive and the audit had been given 'reasonable assurance'. • Good controls were identified, including: o the feedback from patients and prevalence of patients using feedback mechanisms; o a combined strategy that included patient experience; o policies around complaints management; and o fora for co-production. • There were three 'medium' actions identified: o learning from complaints – it was clear that patient experience data were captured and themes and trends identified. However it was felt that this could come through further by identifying learning from investigations in the same way. o compliance with process – there was evidence of lack of timeliness and the Trust not meeting its monthly KPI. The audit also identified examples where actions identified following complaint investigations were not followed up in a timely manner. The main risk would be a decrease in patient satisfaction, and an escalation of issues. o training – the Trust had no formal complaints training in place which could lead to complaints not being investigated in a timely manner. It was noted that training would be released in due course. • An action plan around the audit had been agreed. Progress would be reported to Audit Committee on a regular basis. **Discussed:** That this had been a helpful audit and happily had contained no surprises. For example the Trust knew there was a challenge around response timeframes. A complaints review group had been developed and would launch soon. The group would have both user and carer input. Toolbox resources were being released soon and this would tie in with Being Open. It was acknowledged that the team works hard. However it would be good to consider in the next Annual Report, attention to the question of "who do we believe", as often complaint responses seem to err on the side of believing staff. QSAC asked how to make that happen in a thoughtful way and so that staff feel supported. One idea discussed would be to investigate events in a timelier fashion so that the investigation did not have to rely on notes only. It was noted that learning from patient safety events has meant the team would now be encouraging patients to report incidents onto a portal when they occur to enable investigation to begin in a timelier fashion. CC raised that some sexual misconduct cases at the university may offer shared learning about how to negotiate a difficult situation where there are only the reports of the involved parties and limited corroborating evidence.	

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A23/155	**Observations and Engagement paper** The Committee noted and accepted the paper. **Reported:** MH and SS reported the following: • That this report had come about as the Finance and Performance Committee had asked QSAC to look at observations and engagement through a quality lens, including the impact on patient care. • MH had done a piece of QI work looking at the quality of interventions and how they were applied. This had involved the ACPs and senior nurses at MDT meetings, putting in a challenge around process and how observations were employed, and if they were fit for purpose. • Following this, a code of conduct had been developed that set out expectations of care co-ordinators and whoever would be carrying out observations. These expectations included how they were expected to engage with patients; how they should employ observations and advising on communications with patients. • The next step was to develop expectations about what patients should experience from observations; this was being developed by MH in conjunction with the lead OT. This would then be shared with patients. • There was a learning and response group set up to look at restrictive practice associated with observations. • This work linked in with the London Safety Mental Health Group at Cavendish Square, who were looking at a pan-London management of observations and engagement. **Discussed:** That the paper had a financial focus when it could lead with the quality aspect of observations, whilst noting that the request for the paper had come from FPC. It was noted that the reason the Trust discovered the possible overuse or misuse of observations was through FPC querying the increase in costs. It was also discussed that there could be benefit for consultants in appreciating how much observations were costing as part of understanding the implications of their decisions. AB thanked MH for the helpful paper. She discussed a ward visit she did recently, where she saw someone sat on chair watching someone through a door. She talked to them and they had said that they thought they were there to prevent patient falls but as they were sat far away, they may not have been able to prevent a fall. AB asked if there was a better way. AB was also concerned as to why there were so many more observations now than there were a few years' ago. Was it because the patients were more frail and more likely to fall or were staff more anxious and taking extra precautions? MH responded that Covid had raised anxiety with regard to how to manage patients. There was a Trust falls policy and it stated that observations were not indicated for risk of falls as there were more appropriate ways to manage falls. People may be interpreting the 'in line of sight' for continuous observations as it being OK to sit far away from the patient. That was one reason why there was now the code of conduct in place, in order to challenge practice. There was a significant amount of individuals who have complex physical health issues where there is risk in managing them. This was adding to the overall observations profile. More needed to be done in relation to risk appetite.	

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	SS had been speaking with the London Directors of Nursing and each was having a similar challenge. People feel there had been a shift in risk appetite since Covid. MDTs in the Trust were nervous of taking a patient off of observations as sometimes when this has happened there has been a patient incident. That the work around managing expectations for staff undertaking observations would lead to a slow cultural shift to a culture where observations are limited as staff know they are a restrictive, prescribed intervention only. JW discussed that in Essex, an individual nurse was recently prosecuted for not carrying out appropriate observations. A unit in Somerset was reviewing observations via CCTV in a learning way. Whether this report and the plans in place - the training, code of conduct, etc. - meet the complex challenges of observations, especially the cultural dimension. MH responded that the code was important in terms of a clear articulating of what is expected of staff. MH has done the same presentation to consultant colleagues and it focuses on decisions being made on clinical appropriateness not on a financial basis. He would make it clearer that this information was presented for information only and that this was a quality and safety issue not a finance issue. He felt that the work around this area would address the complex challenges. Where this report would go next and how QSAC could continue to review observations use. It was confirmed that future reporting would be made to QSAC through the Q&P report.	
A23/156	**Use of Force Annual Report** The Committee noted and accepted the annual report. **Reported:** MH reported the following: • Work around Use of Force was advancing at pace. A project lead had been employed and the Involvement Team were being used to engage in debriefs with service users following Use of Force incidents. This has been overall a positive intervention and broadens the scope of the Involvement Team. • There had been a reduction in incidents of violence and aggression from the year before. However, 21% of all incidents relate to 15 service users. Ward data fluctuate which may be because of the specific patient profile on a ward. • Violence and Aggression data for the new wards in Trinity (Lavender and Jupiter) show that incidents dropped following moving to the new environment and this reduction has positively persisted. Anecdotally patients appear to be calmer and report feeling less tension. They like the new environment. • The Trust was an outlier in terms of use of restraint. A safety policy had been introduced, with a new process that means staff do not have to put patients in prone restraint. A pilot on the new safety policy was taking place on Jupiter ward as they were a high prone restraint ward. **Discussed:** That being an outlier in use of prone restraint needed to be taken seriously. It was suggested that a change to the reporting of incidents may have increased the figures. MH responded that last year's benchmarking clearly indicates that the Trust was an	

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	outlier with use of prone restraints. The Safety Policy would hopefully begin to address this. He added that Surrey and Boarders had reduced prone restraints to nothing and a number of Trusts including SLaM had moved their Board positions to zero tolerance. The Trust Board had made the decision not to take that approach. However the position could be reconsidered if there was for example more contemporary or better practice that could be adopted by the Trust. That the Trust was meant to be employing mediators to reduce use of restraint. MH explained that these mediators had not yet been employed. The programme was relaunched in April and there had been significant recruitment. As intervention involves patients being watched by staff from outside the ward it may risk infringing dignity and there had been requests from patients to slow the project down and include coproduction. This had been done but it meant the project was now behind its expected timelines.	
A23/157	**Medicines Management and Optimisation Annual Report** The Committee noted and accepted the annual report. **Reported:** SSh reported the following: • Deliverables against the medicines' optimisation strategy had been met. • The electronic prescription system continued to be monitored. GPs get one letter rather than the letter and discharge prescription which helped to reduce errors. This had been implemented on most inpatient wards. • Controlled drug audits provided good assurance. There had been some outliers who had been supported to improve. • Several workstreams support cost improvement. • Community medicines optimisation dashboards were helping to support physical health monitoring and Clozapine prescribing. • Pharmacy automation had been implemented. • The "My Meds" app had been developed with patients and was now available to use. • Challenges included gaps in assurance around medicines management processes; delays to upgrading and business case approval; decommissioning of the LD service at ICB levels. **Discussed:** Kent and Medway social care partnership were given a CQC notice warning about tranquilisation due to concerns around physical health monitoring. SSh, MH and BB had discussed this recently. Good assurance was given that the Trust had processes in place for patients with tranquilisation use. That the pharmacy team should be commended for the support provided during strike action. It had been a very welcome intervention. That the pharmacy team should be congratulated for going from having the worst staff survey results to the best and most improved. The team also had improved retention rates.	

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A23/158	**Medical Revalidation Annual Report** The Committee noted and accepted the annual report and approved it for onward approval at the November Board. **Reported:** Medical Revalidation was well managed within the Trust. Most medical staff had had their appraisal and revalidation; if not it was for a valid reason. There was good assurance around the process. This report would require CEO signature prior to the November Board and so would need a Chair's action. **Discussed:** JW raised that at other Boards he had seen a report on doctors subject to restricted practices and asked if this was a report that went to Part B Board at this Trust. BB clarified that this report included any restrictions including GMC restrictions.	
A23/159	**Quality Governance Group minutes** The Committee noted and accepted the Quality Governance Group and People Matters minutes**.**	
A23/160	**Agenda for the next meeting – November 2023** The Committee noted the agenda for the November meeting, especially that there would be a development session at the start of the meeting, from 10am – 11am, and a Part B if needed would commence at 9:30am. The session would be face to face. At least one additional item for the November meeting would be the NHS impact self-assessment.	
A23/161	**Meeting Review** This had been the first in person meeting since before Covid for many of the attendees. It was discussed whether the Committee made better decisions in person than they would have done by joining via Teams and not travelling. It was also noted that no service users had attended. QSAC needed to be mindful with service users as some changes that had been made had unsettled some of our valued service users. QSAC needed their voice in the room. Virtual meetings were discussed; the new Trust buildings were built on the expectation of some remote working. It may be better for service user attendance if they could attend online. If Committee members were not as good at having difficult conversations online, how could they get better and how could staff be supported to do so? There had been some good quality discussions around use of force, observations and believing service users who raise complaints. QSAC was not as diverse a group of people as it could be and this should be thought through. The Executive members had received more constructive challenge today that might have been harder to do on Teams.	

Item		
	The way in which the meeting was handled was helpful and skilful. AB raised that this meeting would be DBo's last meeting as Chair of QSAC. She had been Chair for five years and had done an outstanding job, Chairing ethically, kindly and professionally. She would be hugely missed. DBo responded that it had been a joy to Chair QSAC. She had learned a huge amount and the relationships she had built had been second to none, even when there had been disagreements. JW would be Chairing QSAC going forwards, with support from Richard Flatman, who Chairs Audit Committee.	
A23/162	**Matters for Escalation for the Board** The following matters would be reported to the Board via the QSAC Chair's report: • Discussion around safeguarding risk. • Q&P report discussion around SIREN and use of restraint • Complaints internal audit report • Observations and engagement paper • The Medical Revalidation Annual report would require CEO signature prior to the November Board and so would need a Chair's action.	
A23/163	**Next meeting:** Monday 7th November 2023, 10am, in person at Trinity First Floor Meeting Room 4. **Report deadline: 9am, Tuesday 31st October 2023.**	

NHS
South West London and St George's Mental Health NHS Trust

Quality and Safety Assurance Committee (QSAC) (Part A)

Minutes of the meeting held on Tuesday 7 November 2023, 10:00am – 12:30pm, in Committee Room A, Trinity Building, Springfield Hospital.

Present:	
Jonathan Warren (JW)	Committee Chair – Non-Executive Director
Ann Beasley (AB)	Trust Chair
Professor Charlotte Clarke (CC)	Non-Executive Director (until 11am)
Vanessa Ford (VF)	Chief Executive Officer
Sharon Spain (SS)	Director of Nursing and Quality
Billy Boland (BB)	Medical Director
Jennifer Allan (JeA)	Chief Operating Officer
David Lee (DL)	Director of Corporate Governance
Bolaji Bello (BBe)	Diversity in Decision Making Member; Ward Manager
Sheila Nsoedo (SN)	Diversity in Decision Making Member; Criminal Justice Mental Health Liaison Nurse
Attendees:	
Professor Graham Martin (GM)	External Guest, THIS Institute, University of Cambridge (item A23/165 only)
Humaira Ashraf (HA)	Associate Non-Executive Director (item A23/165 only)
Ian Garlington (IG)	Integrated Programme Director (item A23/165 only)
Emdad Haque (EH)	Associate Director of EDI
Mike Hever (MH)	Deputy Director of Nursing (items A23/179 and A23/180 only)
Jenna Kaflan (JK)	Director of Communications and Stakeholder Engagement (item A23/165 only)
Tom Lelmezh (TL)	Mental Health Law Manager (item A23/178 only)
Amy Scammell (AS)	Director of Strategy and Commercial Development (item A23/165 only)
Ryan Taylor (RT)	Associate Director of Clinical Governance and Risk
Minutes:	
Emma Whitaker (EW)	Deputy Director of Corporate Governance
Apologies:	
Carol Anne Brennan (CAB)	Lived Experience Representative
Jaydene Campbell (JC)	Lived Experience Representative
David Hobbs (DH)	Lived Experience Representative
Richard Flatman (RF)	Non-Executive Director

Item		
A23/164	**Apologies** Apologies were noted as above.	
A23/165	**Quality Governance Development Session led by Professor Graham Martin from The Healthcare Improvement Studies ('THIS') Institute at the University of Cambridge** Professor Martin gave a well-received presentation on problem sensing as a Board and as Committees of the Board.	

Item		
A23/166	**Declarations of Interest** No new declarations of interest were reported.	
A23/167	**Chair's action** No Chair's actions had been taken since the last meeting.	
A23/168	**Minutes of the previous meeting** The minutes from the meeting of 3 October 2023 were agreed as a true and accurate record with no amendments.	
A23/169	**Action Tracker** The action tracker was reviewed and amended as follows: A23/107 – BAF cover sheet – this was completed. Action to be closed.	
A23/170	**Executive Risk Register** The Committee noted and accepted the Executive Risk Register (ERR). **Reported:** • CC had raised some concerns about the restrictive practice on Jasmines Ward. This had been covered at the Service Line Review chaired by PM. Some problems were identified but the raising of the risk had been seen as a positive, as there was a clear line that shows how teams are using their risk registers to highlight service specific issues, concerns or risks. • MAST – this risk was likely to be closed at the next iteration of the ERR. • There was a new risk in Aquarius Ward around the management of complex patients due to bed closures by the SLP. This risk was written for that particular service and clearly identifies mitigations and further actions. • RIO risk around Information Governance – this is not a new risk and was being managed well. • ELT have asked for a revision to the ERR for the Violence and Aggression and observation risks. • The ERR was quiet around racial discrimination towards Trust staff and that presented risk to speaking up, being heard and action being taken. RT and BB would think through how to articulate this risk. • JeA has been asked to revisit the relationship between Length of Stay and Demand and Capacity. **Discussed:** Whether the SLP closure of children's CAMHS beds should be included as a separate risk on the ERR. QGG and ELT had discussed this. Because of the closure, our CAMHS service had taken in some patients with challenging needs and cannot move them on to somewhere more appropriate for their needs. However, it was an overall SLP risk. A Quality Impact Assessment was being completed by SLaM but for the partnership; so it would assess risk across all three providers, which has never been done before and was a positive step. After the QIA was completed the Trust may need to raise a risk to the Trust ERR.	
A23/171	**Quality Matters** The Committee noted and discussed the Quality Matters report. **Reported:** • The report focused on in-month learning and improvements for all incidents and how they are linked to the Fundamental Standards of Care. • Patient flow is one of the main risks, around demand, capacity and flow; this is reviewed monthly to see if any patient safety concerns have been raised in this area. There were no direct patient incidents last month.	

Item		
	• The level of Patient Incident Reviews (PIRs) not being signed off by the Service Lines has been put back to service managers for resolution. • There were a high number of upheld complaints but this was seen as positive. The ethnicity breakdown is put into the quarterly patient experience report and is monitored. **Discussed:** That the Committee approved of the new version of the report and thanked the team for their hard work. When will the observations plan come to QSAC and what would it look like. The QII team were involved in the initial draft of plan, and then it would be worked through the Service Lines. It would be monitored through QGG and weekly Quality Matters meetings and would be reported to QSAC through the Quality Matters report. SS added that she felt confident there was now a better grip on review of and length of time spent on observations, and that the quality and consistency was being applied across the board. CSLs would also be dip testing observations on wards so there should be some data on compliance gathered by this process. There was a live tablet form used for observations. There had been some issues with the roll out of the form and staff have done workarounds. The programme has been relaunched with the issues resolved and now the quality team could audit real time information. The Chair requested to have an update report on the relaunch for the December meeting, to include the problem that we are trying to solve, The interventions to meet that and a measurement strategy so we would know is the interventions were working including if there were any other measures being tested for observations. That use of restrictive interventions had been rising since 2020. The Chair requested an update paper come to the December meeting. SS added that benchmarking data had been published in the last two weeks. VF and SS have discussed setting up a peer review with a neighbouring organisation not in the SLP as there would be real value and learning from this. The Chair requested that the report covered similar areas as discussed regarding observations. SS agreed this would be available at the next QSAC That it would be helpful to see ethnicity data in all Trust annual reports so that these were always reviewed through that lens; including restrictive practice. It was noted that the in-month position on ethnicity would not work as the data pool would be too small; e.g. when reviewing Mental Health Act (MHA) data variation between months. A patient on Aquarius Ward had called the CQC. The ward manager had responded that there were no concerns. The Chair asked how we are assured as a Committee that there really were no issues. RT had reached out to the CQC for specifics in order to investigate as the patient had raised their concerns confidentially. The CQC acknowledged the request but had not responded further. SS confirmed there had been no incidents of concern raised. The PPI lead worked with the ward on a weekly basis. She felt assured practice was appropriate with advocacy for patients and families present in wards. She thought that no advocates had raised concerns but would double check this. VF raised that there had been one advocacy concern raised for a patient around a level of frustration. It was an appropriate concern. There were also SLP family ambassadors on the children's ward. The Chair asked for confirmation that advocates had been utilised to gain patient experience information. SS thought that was the case and would confirm and feedback at the next QSAC.	

NHS
South West London and St George's Mental Health NHS Trust

Item		
	Agreed: SS to bring an update paper on observations solutions, including the roll out of the live tablet form used for observations, to the December meeting. SS to bring an update paper on use of restrictive interventions to the December meeting.	**SS** **SS**
A23/172	**Learning Response Report** The Committee noted the Learning Response Report.	
A23/173	**Quality and Performance (Q&P) Report** The Committee noted and accepted the Q&P report. **Reported:** JeA reported the following: • The position remained challenging in the context of the external position. • There were no areas for escalation to QSAC. • Challenges had been exacerbated by industrial action and its effect on flow. • Service Lines had started to imbed SIREN as a two-way communications tool. SIREN is now in the first part of all Service Line Review (SLR) meeting agendas and teams had been asked to continue to feed back how to use SIREN as a tool in their meetings. • The Trust had agreed a way forward with Primary Care and ICS colleagues for shared care pathways for ADHD patients. This was positive but the pathways would take time to implement. It would take a year to implement for current patients on the caseload. There was also a definitive plan to improve the waiting list. The waiting list was not in as bad a position as other Trusts and remained stable but there was still a lot of work to do. • Some changes had been made to SIREN reports, such as adding new questions, which had shifted a number of areas from 'green' to 'red'. This also reflected a range of challenges, particularly the AUC team's ongoing pressure from industrial action and demand, and some relational challenges in teams. • This was the first month of using the additional questions in SIREN. These had been added to ensure a flowing two-way conversation, so team members feel they were heard and know when concerns had been escalated, and supportive actions were given. **Discussed:** That specific Service Lines were using SIREN to reflect on what could have been done differently to identify concerns on Jasmines Ward earlier. There had been good conversations at the SLRs. AB asked about the Crisis Liaison services interpersonal issue. Although the report was now much clearer, this seemed to be moving slowly. If the Board was told something every month they need to know what has the team done about it. JeA confirmed that this report would not be shared with the Board in this form, and that individual team issues were not discussed outside of team forums. She assured the Committee that there were the appropriate Employee Relations processes ongoing in the teams involved. Very proactive support had been put in place by management and processes were being well managed. AB asked if there was anything more systemic that the Board and Execs could do in regards to culture in the Crisis Liaison services. VF responded that it was a chronic risk position that the teams sat with for a number of months; our acute crisis teams run too hot, with no bed capacity and flow, and some teams do not get on with each other. The Trust refreshed its patient flow work through the AUC Service Line with	

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	the front line clinicians and leaders less than six months ago. ELT agreed to hold their nerve and make sure actions now get delivered. There was some transformation work coming through to liaison services. There was also the additional pressure of ED colleagues in the system working under sustained pressure, and pressure from external partners to do something about this when the Trust does not have resources to do so. In order to help with flow, ELT had recommended the Trust buy an additional 12 beds. There were some interracial dynamics on some wards and difficult interplay between genuine issues and the struggle to appropriately manage performance in the context of diversity. There was a tendency to escalate to an Employee Relations situation. ELT felt strongly that the transformation work should be continued to be implemented over the remainder of the financial year to have the opportunity to move things forward. Teams were working on relationships with the wider system and undertaking a programme of workshops with EDs to better articulate our programme of work more clearly to help give them assurance. The Chair asked if there could be 10 minutes in the new year to review these issues. JeA confirmed that this report would go to People Committee as well. VF requested that the Executive take this away and think how best to bring the update back and whether it should go through QSAC or People Committee.	
A23/174	**EMHIP and PCREF Annual Reports** The Committee noted and discussed the EMHIP and PCREF Annual Reports. **Reported:** • This was the first time the reports had been reported together. Going forward these reports would be integrated to set EMHIP in the wider context. • The Trust had made good progress in implementing stage one of PCREF. **Discussed:** That this was a helpful report and showed a lot of impressive work going on in Wandsworth. However, this was not reflected in the recent feedback from the "Heal our broken village" event. The Trust would review the work to check if we were doing the best we could or if we could do more.	
A23/175	**NHS IMPACT Self Assessment** The Committee noted and discussed the NHS IMPACT Self Assessment. **Reported:** IG reported the following: • QSAC were asked to give consideration to the Trust's current position (salmon coloured items in the paper) and to decide if it was content to sponsor the Self Assessment onto the Board seminar for discussion. • The Self Assessment had five key areas looking at 22 broad statements. • Originally the Self Assessment was going to be reported back to the ICS then to NHSE, so that NHSE could gain a baseline in terms of the quality improvement journey. We were not expected to report nationally anymore but were expected to debate improvements. • IG worked with Justin Earl in the QII team and then looked at some areas of evidence to support. • The Board seminar would focus on well led areas and QII working. • It was not suggested that this be a new piece of work but it would help to think of areas of current work where the Board can be more inquisitive in order to move our Self Assessment indicators on in the next 12 months.	

Item		
	Discussed: That quality improvement tools had not been used and if the Trust had any that it would be happy to use. The Trust had a quality and improvement department with a QII team who had been involved in the observations and restrictive practice work. This Impact Self Assessment tool had been timely and had started off at one place and had been useful as a tool for self reflection and to consider where we position QII as an organisation going forward. The annual QII report would be coming to QSAC in December and included updates on how QII was used for the restrictive practice work. The broader point about QII driving quality improvement was an important one. The Chair agreed to meet the QI lead with Dr Boland outside of the meeting. **Agreed:** The Committee agreed that the Self Assessment could be taken forward to the Board seminar.	
A23/176	**Care Quality Review (CQR) Report** The Committee noted the Care Quality Review (CQR) Report.	
A23/177	**Duty of Candour Annual Report** The Committee noted the Duty of Candour Annual Report.	
A23/178	**Mental Health Act Law (including Advocacy Service, Section 132 Rights, MCA and Liberty Safeguards) Annual Report** The Committee noted and discussed the Mental Health Act Law Annual Report. **Reported:** TL reported the following: • Ethnicity data was included and was considered closely in the report. There was an over-representation of BAME people detained under the Mental Health Act (MHA). • Juliet Armstrong, NED, had raised a comment on Section 132 rights and inequalities. Analysis from the report does show inequality of use of the MHA as a whole but not on s132 rights. • Juliet Armstrong had also raised that the data shows a decline in use of the MHA in the Trust every year. This was a decline in short term reductions but not in section 3, which was when patients were already known to the Trust. **Discussed:** The Committee thanked TL and his team for the hard work on this report and their work with the MHA in the Trust. Whether there was evidence that AHMs would have benefited from enhanced training, as stated in the report. BB responded that there had been conversation with AHMs with relatively low numbers discharged compared to tribunals. 200 tribunal hearings happen per year. There was no evidence of discrimination but AHMs seem hesitant to challenge clinical opinions. TL will be arranging some training for managers on how to challenge a medical opinion in order to discharge; in order to empower AHMs to discharge more.	

Item		
	The data shows in the last five years use of the MHA has reduced in the Trust. There have been significant reductions year on year when the national picture was of rising use of the MHA.	
A23/179	**Safer Staffing Annual Report** The Committee noted and discussed the Safer Staffing Annual Report. **Reported:** MH reported the following: • This report was written following a review of shift patterns, sickness, vacancy rates, and skill mix. • There were no requests for extra staffing. • For "extra duties"; e.g. escorts, observations etc., the Trust use bank and agency staff. This meant high use of these staff groups over a period of time. A huge amount of work had been done to reduce this. Monitoring had been established using the safer staffing app; a nursing development programme established and preceptorship offered, as this was particularly in demand. The Trust supplies backfill to enable staff to take up these offers. • Vacancy rates averaged at 20%. There would be approximately 160 Newly Qualified Nurses starting with the Trust soon which would bring the average down. • There were no shifts without a registered nurse present for the duration covered by the report. **Discussed:** Whether recognised tools were used to monitor safer staffing levels. For example, the Mental Health Optimal Staffing Tool (MHOST). The Trust had used MHOST back in 2018 with SLaM but had not used it since. The nursing and quality team had developed dashboards for safer staffing and use e-roster. The Trust were in a much stronger position now to bring in tools for the next safer staffing report. The most important thing was that the wards were working well, with registered nurses on shift for every shift. It was also noted that a flexible group of staff to go ward to ward where needed was being considered. SS was going to consider the use of MHOST and feedback to the committee	
A23/180	**Nursing Revalidation Annual Report** The Committee noted and accepted the Nursing Revalidation Annual Report.	
A23/181	**Safe Working Hours Annual Report** The Committee noted and accepted the Safe Working Hours Annual Report. **Reported:** That the guidance for the Guardian of Safe Working Hours had recommended quarterly reporting on Safe Working Hours to the Board. BB advised the Committee that an Annual Report had worked well for the Trust in the past. This paper highlighted that the guidance had been noted and not recommended as quarterly reporting would not add value; and the Guardian of Safe Working Hours had the authority to alert QSAC and bring a quality report by exception whenever this was needed. **Agreed:** That there would be an Annual Report for Safe Working Hours only, with the Guardian of Safe Working Hours having the authority to alert QSAC and bring a quality report by exception whenever this was needed.	

Item		
A23/182	**Quality Governance Group minutes** The Committee noted and accepted the Quality Governance Group and People Matters minutes**.**	
A23/183	**Agenda for the next meeting – December 2023** The Committee noted the agenda for the December meeting.	
A23/184	**Meeting Review** • Members discussed the absence of the Lived Experience Representatives as their presence and viewpoint were sorely missed. SS had been in touch with the Involvement Team and had offered to assist in any way to enable them to attend. • The Diversity in Decision Making representatives were very welcome. SN fed back that she had enjoyed her first meeting and there had been lots of learning for her. • Members thought that the presentation by Professor Martin was fantastic and had given the Committee and Board food for thought. Such as, how do you get through lots of detailed information to a manageable format for the Board to consider; how can the Board switch things so staff are saying what is working well and there is not any silence; and how could the Board "dip in" and check on how things were really working.	
A23/185	**Matters for Escalation for the Board** The following matters would be reported to the Board via the QSAC Chair's report: • A summary of Professor Martin's presentation on problem sensing. • Review of the ERR: • that the December meeting would receive update papers on observations and restrictive interventions; • that ELT have asked for a revision for the Violence and Aggression and observation risks; • that RT and BB would think through how to articulate the risk of racial discrimination towards Trust staff; and • the QIA being undertaken on SLP CAMHS by SLaM. • A summary of discussion around the Q&P report and the embedding of the transformation work. • That the Committee agreed that the NHS IMPACT Self Assessment could be taken forward to the December Board seminar for discussion. • That the following Annual Reports were reviewed and accepted: o EMHIP and PCREF – and that these reports would be integrated going forwards; o Duty of Candour; o CQR; o MHA; o Safer Staffing; o Safe working hours – including the recommendation of annual reporting to QSAC only with the Guardian able to bring an exception report when needed; and o Nursing Revalidation.	
A23/186	**Next meeting:** Tuesday 5 December 2023, 9:30am – 12:00pm, MS Teams **Report deadline: 9am Monday 27 November 2023**	

Trust

NHS
South West London and St George's Mental Health NHS Trust

Quality and Performance Report

October 2023

Glossary

Term	Meaning	Term	Meaning
ALOS	Average length of stay	IAPT	Improving access to psychological therapies
BAF	Board Assurance Framework	IPC	Infection Prevention and Control
BCAG	Business Case Assurance Group	KPI	Key performance indicator
CAMHS	Child and adolescent mental health services	LOS	Length of stay
CE	Capital expenditure	NHS	National Health Service
CCG	Clinical Commissioning Group	NHSI	National Health Service Improvement
CMA	Cardio-metabolic assessment	PALS	Patient Advice and Liaison Service
COO	Chief Operating Officer	PCR	Polymerase Chain Reaction
CPA	Care programme approach	PDU	Psychiatric decision unit
CQC	Care Quality Commission	PPE	Personal protective equipment
CIP	Cost Improvement Programme	PTL	Patient Tracking List
CQUINS	Commissioning for quality and innovation	QII	Quality improvement and innovation
DNA	Did not attend	QSAC	Quality Standards Assurance Committee
EBITDA	Earnings before interest, tax depreciation and amortisation	RTT	Referral to treatment
EDS	Eating disorder service	RIDDOR	Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations
EMP	Estates Modernisation Programme	SI	Serious incident
F&IC	Finance and Investment Committee	SLM	Service line management
FBPW	Finance, Business, Performance and Workforce group	SLT	Senior Leadership Team
FFT	Friends and family test	SOF	Single Oversight Framework
FSOC	Fundamental Standards of Care	Trust	South West London and St Georges Mental Health NHS Trust
GP	General practice	WTE	Whole time equivalent
HoNOS	Health of the Nation Outcome Score	W&ODC	Workforce and Organisational Development Committee
HTT	Home Treatment Team	YTD	Year to date

Contents

Part A: Executive Summary

What

The focus of this report is October 2023 and our priority metrics to ensure patient safety and effective care, along with our integrated approach to quality, workforce and overall productivity and sustainability. The quality and performance framework is supported by detailed executive review and discussion at the bi-monthly Service Line Review (SLR) meetings.

Overall performance remains Amber rated, with continued challenges in similar areas to previous months, particularly in achieving flow through acute pathways and in managing acuity on our CAMHS and adult wards.

There has been significant sustained pressure on acute services during the month, resulting in high use of additional private beds. The south west London (and indeed wider NHS) system is under considerable pressure also and the impact of prolonged waits for mental health patients in emergency departments, primarily due to constrained bed availability, is a concern from a patient experience, safety and wider system resilience perspective. More work to develop the community service offering to support prevention of mental health crisis is in train, including developing the Enhanced Response and Interface teams for patients at risk of deterioration or who are awaiting more complex post-admission care and support.

CAMHS and Specialist services continue to deliver good performance overall but with some concerns relating to ward acuity. Safe care is closely monitored through the Quality Matters and QGG processes. Improvement around CAMHS eating disorders access is noted, while work is continuing to improve pathway management in Adult eating disorders services. A smooth and successful move to the new Shaftesbury wards was led by Forensic services, with no patient safety implications, with the lessons learned from Trinity moves supporting the process.

Performance against Talking Therapies (IAPT) access and recovery standards remains good despite limited investment in recent years due to acute and CAMHS priorities; the service continues to strongly manage utilisation and efficiency within the structured treatment model although workforce availability remains a constraint. Wider waiting lists, including those for secondary care psychological therapies, are rising however, and will be a focus area for Community service line. The work with primary care colleagues to address ADHD assessment waiting times has progressed to agreement of a new more sustainable model for annual medication review and management but this will not impact the waiting times for up to a year while the new model is implemented.

Agency usage remains at a lower level in October and the improvement in vacancy and turnover rates has also been sustained, although medical recruitment remains a concern. A detailed plan focussing on retention is in place and analysis is continuing to understand in more detail what is driving this. However, staff experience requires further improvement and We continue to support staff to complete this year's Staff Survey and to engage with their team leaders and wider Trust leadership to understand what changes have been made in response to feedback, and their ideas for further change. This work links to the embedding of the SIREN process across teams.

The Trust plan is a £0.2m surplus for the year. To achieve this, the Trust needs to deliver savings of £13m. Cumulative savings delivery to Month 7 contributes £9.2m towards this target and the Trust now has 100% confidence in being able to deliver the full £13m during the year. NHSE has required all trusts to undertake a formal reforecast as part of the H2 planning (second half of financial year to 31/3/24) - as part of this the trust is in receipt of an additional c£600k of income and is forecasting a c£1m surplus which will be reflected from M8 reporting onwards. Underlying pressures remain unchanged.

So What

On our acute pathway, and a programme addressing mental health in ED models, as well as preventive action for patients at risk of crisis, is in place. This is being actively led in partnership with the SWL ICS and acute trusts. The revised internal acute transformation programme has been agreed and projects continue to be implemented against the new trajectory of LOS and private bed usage reduction. However, demand from patients in crisis, and increasingly acute presentations continue to present a challenge and we are considering what further actions could be taken.

Newly qualified nurses have now started roles within our community teams and are anticipated to support a more sustainable workforce model. The ongoing leadership development work also aims to support team and senior leadership across community services as the transformed care model is embedded. The next stage of work to implement holistic care planning for all community patients using the Dialog+ tool has now commenced and will be an opportunity to work with community clinicians and service users to design a workflow and care planning tool that truly engages patients in their recovery goals, while being usable and accessible for staff.

Following the Shaftesbury moves, the Forensic teams are settling into their new wards. Across rehab, CAMHS and Eating disorders services, ongoing strategic work through the SLP programmes is in place aiming to support improved patient flow and a sustainable financial and clinical model for these specialist services in South London.

Ongoing focus on agency reduction as well as recruitment and retention are underway. We have been successful in recruiting to all HCA posts and have a surplus of 21 that we are working to over establish. This and work carried out on risk assessing Agency HCA booked for observations has led to a decrease in agency bookings over the past 2 months. The appointment of 6 MTI (middle grade)

Doctors will also start to make a positive impact on agency usage reductions, although Medical Vacancies remain a focus for the Trust. Although the pipeline of new recruits into the organisation is strong, there remains a strong focus on retention of those that leave the organisation within the first 12 months.

The Trust is in a relatively stable financial position in the context of significant challenges across SWL ICS. More recurrent savings plans would support longer term financial sustainability.

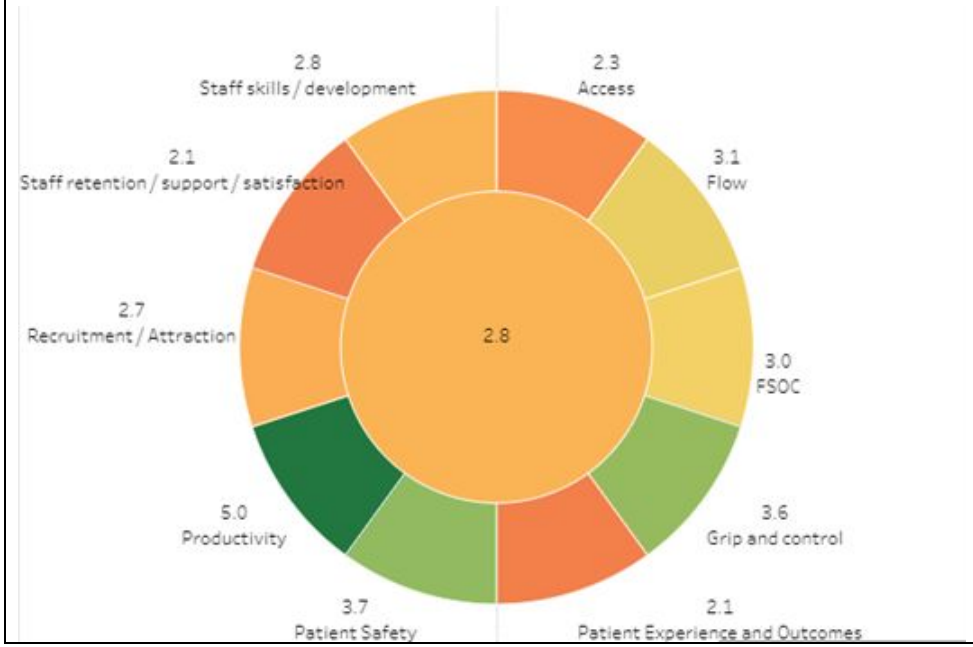
What Next

There is sustained improvement in a number of areas such as talking therapies, specialist pathways, agency usage and MAST compliance, but focus is required to ensure this is maintained.

Further work is being scoped both internally and in partnership with ICS and acute trusts around the crisis and acute pathway, due to ongoing pressure. We will continue to focus on prevention as well as response to mental health crisis demand and to support community based care as the key to a sustainable patient journey. The acute and community service lines are working together to address this. A range of discussions are taking place on acute mental health within the ICS and region, and we are mindful of the related and interacting programmes and initiatives that arise, and the need to be consistent and clear on the work in progress for staff and patients.

Ensuring a stable workforce is key to improving and sustaining high quality care. Improved oversight and management of ER cases, continued engagement with our staff through SIREN, the staff survey, and the pulse survey, as well as enhanced team and service line leadership, and improved HR support, will all contribute to this. Our organisational development framework provides a structure for the Trust wide work and aligns to our clinical transformation work within the Better Communities programme.

Quality & Performance Summary (see appendix 3 for explanation on scoring)



Summary Domain Performance:

Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	5	14	17	52.8%
Quality	7	11	11	62.1%
Workforce	2	3	7	41.7%
Finance	2	1	0	100.0%
Total	**16**	**29**	**35**	**56.3%**

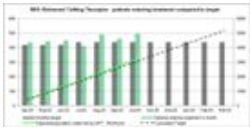
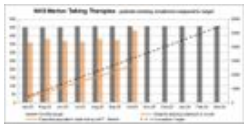
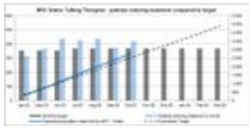
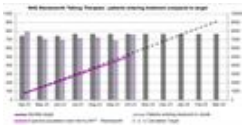
A table showing how many KPIs have full assurance, some assurance and no assurance, split by domain.

Donut Performance over-time (all themes combined):

NHS: Oversight Framework

Theme	Metric		Period	Performance (SOF)	Internal Trust Metric	Internal Trust Metric	Benchmarking
Trust	S035a	Overall CQC Rating	Most Recent	3 - Good	N/A	N/A	N/A
	S059a	CQC Well led rating	Most Recent	3 - Good	N/A	N/A	N/A
Workforce	S067a	Leaver Rate	May-23	10.20%	13.9% (Oct 23)	Staff Turnover	
	S068a	Sickness Absence Rate	Mar-23	4.63%	4.71% (Sept 23)	Yes	TBC
	S071a	BME senior staff %	2022	15.20%	31.5% (Oct 23)	Yes	
	S071b	Female senior staff %	May-23	55.60%		Not reported currently	
Experience	S072a	Staff Survey fair career progression	2022	47.60%		Not reported currently	
	S121a	Staff Survey compassionate culture people promise sub-score	2022	7.08 (out of 10)		Not reported currently	
	S121b	Staff Survey Raising Concerns sub-score	2022	6.49 (out of 10)		Not reported currently	
	S133a	Staff Survey Compassionate theme score	2022	7.34 (out of 10)		Not reported currently	
	S063a	Staff Survey Bullying score (from managers)	2022	11.50%		Not reported currently	
	S063b	Staff Survey Bullying score (from colleagues)	2022	16.40%		Not reported currently	
	S063c	Staff Survey Bullying score (from patients/public)	2022	27.10%		Not reported currently	
	S069a	Staff Survey engagement theme score	2022	6.99 (out of 10)		Not reported currently	
Flow	S038a	Consistency of reporting patient safety incidents	Apr-Sep 2022	50%			
	S125a	Adult Acute LoS over 60 days	May-23	35%		Not reported currently	Provided via NHSBN
	S125b	Older adult LoS over 90 days	May-23	39%		Not reported currently	Provided via NHSBN
	S086a	Inappropriate Out of Area placement bed days	May-23	1010	140 (Oct 23)	Yes	

South West London ICS Long Term Plan (LTP) Priority Metrics

ICS Long Term Plan Metrics	Oct-23	Target	SPC Chart	Comments
Number of children and young people accessing mental health services as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people with severe mental illness receiving a full annual health check and follow up intervention as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people accessing IAPT services (Richmond).	3187	3009		Richmond Wellbeing service is on track to achieve access requirements for 2023/24.
Number of people accessing IAPT services (Merton).	2670	3172		Merton Uplift is below its cumulative access requirements for 2023/24.
Number of people accessing IAPT services (Sutton).	2776	2535		Sutton Uplift is above its cumulative access requirements for 2023/24.
Number of people accessing IAPT services (Wandsworth).	5108	5382		Talk Wandsworth is just below its cumulative access requirements for 2023/24.
Number of adults and older adults with severe mental health accessing community mental health services	11017	-		The Information Management Team have reviewed metric definition and issued guidance of team category inclusion. There is no target for this metric.
Inappropriate out of area placement bed days - Adult Acute & PICU	140	≤0		Trust continues to require use of out of area beds due to high demand. Trust has renegotiated use of 18 beds at Holybourne until end of 23/24 and continues to open surge beds at times of peak demand.

SIREN

vision | Questions Breakdown | Performance Over Time

SIREN Dashboard

Year Month: 202310 | Press F11 for Full Screen

The Trust had 27 red teams in Oct-23.

There were 105 submissions out of a total of 113 in Oct-23.

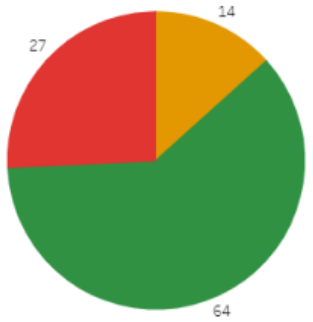
List of Red Rated Teams

Acute And Urgent Care	Lilacs	266
	Ward Two	264
	Ward One PICU	247
	Ward Three	247
	Liaison Psychiatry - Sutton	237
	St Georges Liaison Psychiatry	237
	Mental Health Crisis Hub	208
CAMHS & ED	Aquarius	247
	CAMHS Deliberate Self Harm Team	198
	Sutton CAMHS Referral	174
	Sutton CAMHS Tier 3	150
	CAMHS Complex Learning	146
Community (Adults)	Twickenham IRH	300
	Sutton PLRS - Single Point of Access	294
	Wandsworth Early Intervention	253
	Carshalton & Wallington IRH	237
	Merton Uplift PCRS	237
	Richmond Early Intervention Team	237
	Wandsworth Complex Needs Service	237
Specialist Services	Sutton Adult ADHD Service	310
	Richmond Adult ADHD Service	295
	Neuropsychiatry	287
	Sutton Adult ASD Service	255
	Forensic Outreach Service	237
	Merton Adult ADHD Service	237
	Merton Adult ASD Service	237
	Wandsworth LD – MH & Complex Behaviour	237

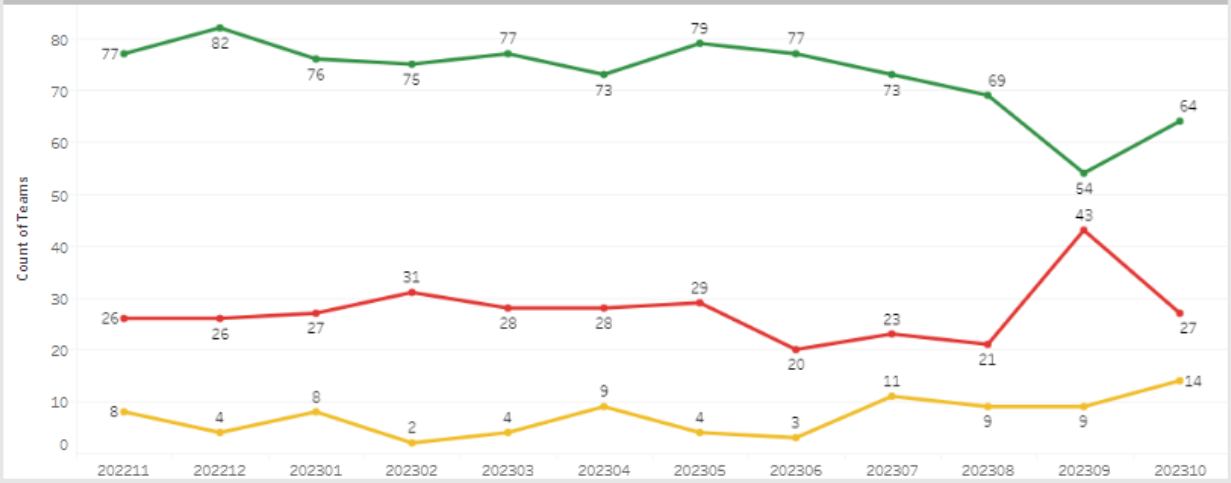
Count of SIREN Ratings by Siren Type

SIREN Type	Green	Amber	Red
CAMHS	4		
CAMHS NP	8	2	4
CMHT	15	6	3
Daycare	1		
EIS	3		2
Hostel	1		
HTT	2	3	1
Inpatient	15	1	5
LD	3		1
Other	12	2	11
Grand Total	64	14	27

SIREN Rating Breakdown



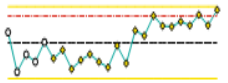
Team Count of SIREN Ratings

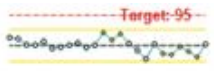
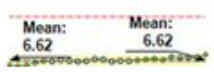
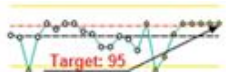
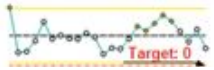


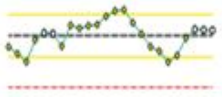
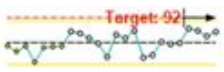
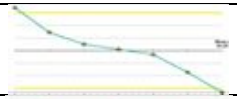
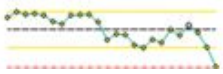
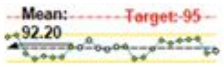
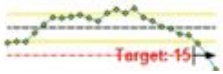
SIREN – November 2023 Summary Commentary

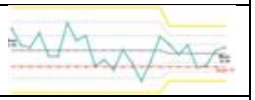
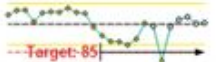
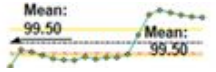
- SIREN continues to be used within team and service line meetings on a regular basis to support discussions on team concerns and actions.
- The number of red rated teams has reduced this month, driven largely by improvement in CAMHS areas relating to discharge of complex patients and a more nuanced view of waiting lists within overall SIREN ratings. Pressure within A&UC and Community teams continues to be seen.
- **CAMHS & AED: (key link to restrictive practice restraints)**
  - ❑ Avalon, Aquarius and Wisteria wards continue to care for extremely complex service users with frequent incidents and high acuity. There is SLP discussion of the situation to optimize quality of care given the constraints of the services.
  - ❑ CAMHS teams are experiencing fluctuation in SIREN results due to caseload thresholds requiring adjustment for CAMHS SPA and T3, this is being corrected. Clinical managers are undertaking fortnightly visits to teams of concern or who report local issues.
- **Community: (key link to caseload LOS and waiting time metrics, plus vacancy rates and use of agency)**
  - ❑ Focused discussion at SLR around specific staffing issues and caseload management in teams of concern, reflecting wider issue across community with team leadership, which is being actively addressed through focused recruitment days and team leader development and support offer. Improvement is being seen as new staff come into post, which is enabling CSLs to be released oversee clinical quality.
  - ❑ It was noted that Community SLR meeting discussed concerns about pressure in Merton teams, which had not flagged yet via SIREN. This is driven by a challenging BAU environment, continued work to roll out community transformation and the recently proposed changes to section 75 integrated working arrangements which have substantial implications for staff. The SL leadership are working closely with Merton borough and will include a discussion around SIREN feedback with the teams in the coming month.
  - ❑ SIREN is being used actively in conversations with teams. Comments are now visible and discussed which has been very helpful.
- **A&UC: (key link to ongoing pressure on the crisis and acute pathway)**
  - ❑ Staffing, including sickness, ER and medical workforce stability continue to be of concern in A&UC teams, with the context of very significant demand and acuity in acute services and constant external pressure to facilitate flow. The SL team continue to work closely to support teams.
    Action to address concern: The service line has been working hard to reduce vacancies within nursing to good effect. We are now reviewing how we maintain grip on Sickness and ER cases given the limitations of capacity within the ER team for the service line. Medical staffing remains a challenge despite close working with Medical HR team
- **Specialist: (key link to ADHD assessment long waits)**
  - ❑ Teams of concern mainly within Neurodevelopmental services, related to very long waiting lists and some workforce issues. SL are aware and addressing these issues with a new pathway for ADHD now agreed but taking time to implement. New pathway for ADHD requires approval at ICB SMT.

Priority Metrics

	Priority Metrics	Oct-23	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 12)	82.4	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 13)	41	= 0	↗	X	
	Access					
	Referral to treatment (RTT): 52 week breaches (see page 15)	547	= 0	↗	X	
	Access					
	Expected population need IAPT – Trust (see page for service breakdown 15)	2113	>=2032	-	-	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 16)	100.0	≥ 95.0	↗	?	
	Access					
	Adult Acute Bed Occupancy (see page 18)	99	≤ 90	→	X	
	Flow					
	Number of adults and older adults receiving 2+ contacts in new integrated model across the core and dedicated service provision (see page 19)	11017	-	↗	-	
	Flow					

	Priority Metrics	Oct-23	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (See page 12)	77.8	≥ 95.0	↘	X	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 14)	64.9	≥ 92.0	↘	X	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 16)	7.1	≥ 10.0	↗	X	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 17)	66.3	≥ 80.0	→	?	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 16)	100.0	≥ 95.0	↗	?	
	Adult acute average length of stay (Excluding PICU) (see page 18)	55.2	≤ 38	→	?	
	Flow					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 19)	140	≤ 0	↗	X	
	Flow					

	Priority Metrics	Oct-23	Target	Trend	Assurance*	SPC Chart
Quality	Cardiometabolic Assessments - Community and EIS (%) (see page 20)	84.6	≥ 75.0	↘	✓	
	Fundamental Standards of Care					
	Patient Friends and Family Test (%) (see page 21)	86.7	≥ 92.0	→	✗	
	Patient Experience and Outcomes					
	Paired HoNOS Completed (See Page 22)	37	-	↘	-	
	Patient Experience and Outcomes					
	Death - Suspected suicide (see page 23)	0	-	→	-	
	Patient Safety					
Workforce	Vacancy Rate (%) (see page 24)	15	≤ 15	↘	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 1 (%) (see page 26)	91.9	≥ 95.0	↗	✗	
	Staff Skills/Development					
	Turnover (%) (see page 27)	13.9	≤ 15	↘	✗	
	Staff Retention/ Support / Satisfaction					
Finance	% Forecast Overspend (See Page 28)	0	≤ 0	→	✓	
	Grip & Control					

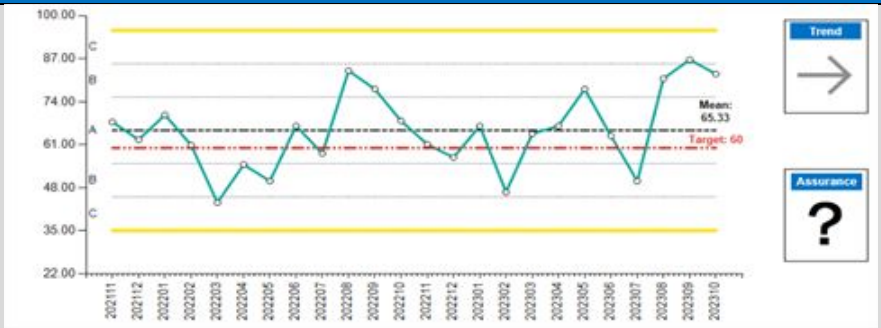
	Priority Metrics	Oct-23	Target	Trend	Assurance*	SPC Chart
Quality	Safe Staffing: National Compliance - Inpatients (%) (see page 20)	126.7	≥ 95.0	↗	✓	
	Fundamental Standards of Care					
	IAPT recovery rate – Trust (%) (see page 22)	52.3	**>=50**	→	?	
	Patient Experience and Outcomes					
	Paired Dialog Completed % (see page 22)	15.9	≥ 40.0	→	✗	
	Patient Experience and Outcomes					
Workforce	Percentage of BAME staff - Band 8+ and Medical (see page 25)	31.3	≥ 50.0	↗	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 2 (%) (see page 26)	88.8	≥ 85.0	→	✓	
	Staff Skills/ Development					
Finance	Activity vs Plan (Local Contract) (Se e Page 28)	110.1	≥ 95.0	↗	✓	
	Productivity					

* This refers to assurance that the performance of a metric will consistently exceed the target

Operations Domain

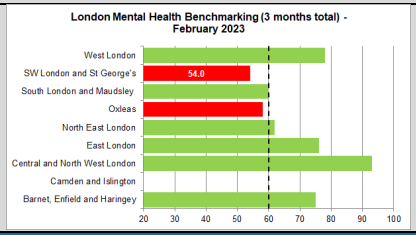
1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) Target ≥ 60%

Access



Team Breakdown – October 2023

Team	Treatment Within 14 Days	Referrals	% Treatment Within 14 Days
Richmond Early Intervention Team	3	3	100.0%
Wandsworth Early Intervention	3	3	100.0%
Merton Early Intervention	4	5	80.0%
Sutton Early Intervention	2	3	66.7%
Kingston Early Intervention Service	2	3	66.7%
Trust Total	14	17	82.4%



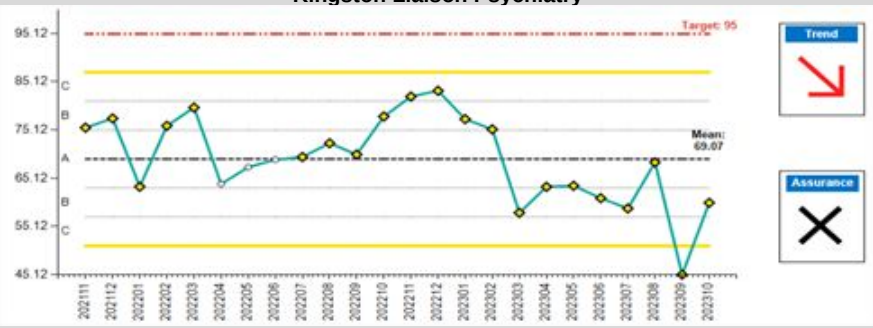
Background
There is good evidence that early intervention, when delivered in accordance with NICE standards, helps people to recover from a first episode of psychosis and to gain a better quality of life.
What the chart tells us
The Trust can be expected to frequently exceed the target which is below average performance.
Underlying issues
- Inconsistent clinical oversight of waiting list and validation is not always completed promptly.
- Some inpatient wards and adult assessment teams are slow to refer patients on to EI services once psychosis is identified making it much harder for them to meet the waiting time targets.
- RiO is not configured to allow the accurate recording of first episode of psychosis and provide a workflow; as a result, there is an administrative burden on teams to manually validate all waiters.
- Wandsworth EIS using agency staff and further work is required relating to induction of said staff.
- Feedback from National Clinical Audit of Psychosis 2023 scored all 5 Borough's as "top performing" in regard to timely access.

Actions:
- Targeted training for SPA teams to continue in order to reinforce the importance of timely referrals.
- Alert system is now available in RiO which will support workflow for recording first episode psychosis.
- Ensure EIS teams use duty system to check FEP waiters daily on dashboards. Ensure team seniors (manager and deputy) have daily oversight on new referrals/waiters.
- Teams to proactively in-reach and work with wards if suspected FEP present.
- Community Service line to engage with acute services to improve processes for timely referrals to EIS.
- Wandsworth EIS to ensure agency staff are thoroughly inducted in local systems to avoid referral breaches.

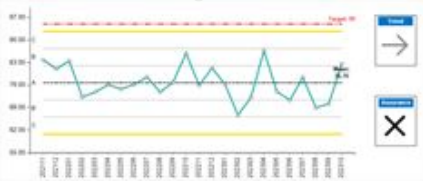
Liaison psychiatry - Seen within 1 hour in A&E (%) Target ≥ 95%

Access

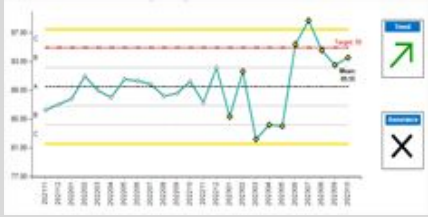
Kingston Liaison Psychiatry



St Georges Liaison



St Helier Liaison



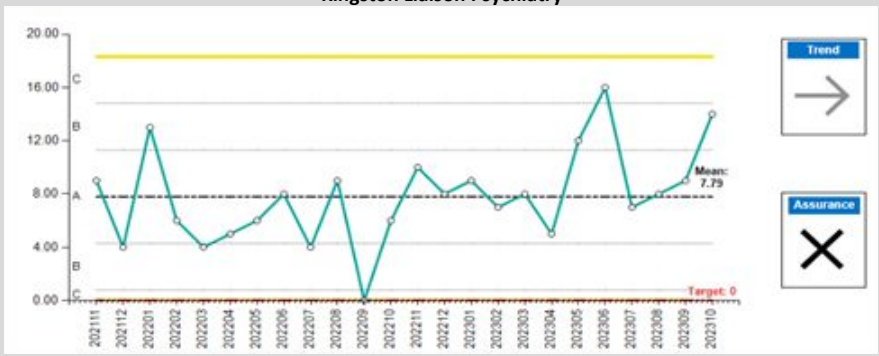
Background
Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care' published by NICE in 2015 states that an emergency liaison mental health service should respond within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment.
What Chart Tells Us:
Mean performance is below target across all 3lLiaison services.
Underlying Issues:
- The process of managing Emergency Referrals is impacted by many factors such as staffing shortages (including sickness and vacancy rate, cubicle space (St George's), other activities such as handover and multiple referrals from both ED and wards.
- Impact of extended number of patients waiting for MH beds in general hospital requiring further reviews.
- Acute hospitals have been experiencing a high level of acuity and this has had an impact on referrals into liaison services capacity.
- Variation in performance between services Kingston Liaison is an outlier service.
- Administrative burden for liaison staff as they have to update both Trust and acute hospital clinical records.

Actions:
- Liaison Transformation Plan: The initial steering group meeting has taken place. Transformation workstream will consider MH triage functions to support 1 hour KPI and ward referrals.
- Shift patterns has been reviewed as part of Pilot evaluation and Core24 compliance. Proposals sent to Finance to cost before engagement/consultation work begins. Timeframe for completion is 3-4 months.
- Clinical Service Lead and Matron undertaking staffing review in regard to demand and capacity and CORE24 compliance. This is a longer term piece of work and will be trialled in Kingston Liaison initially.
- Service line is in discussion with Kingston Hospital to pilot Rapid Assessment Clinic on site at Kingston for one week. Timeframe for roll out is November/December 2023.
- Trust engaging with Mental Health in Emergency Departments workshops led by ICB. Workshop scheduled for November 2023.

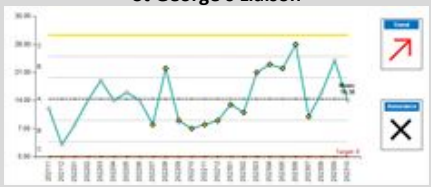
Access

Liaison psychiatry – People waiting over 12 hours in A&E for a bed — Target = 0

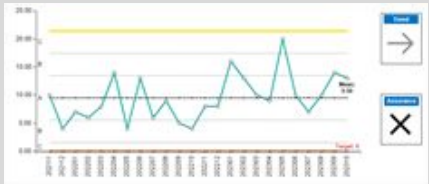
Kingston Liaison Psychiatry



St George's Liaison



St Helier Liaison



Background
Patients assessed at A&E by Liaison Psychiatry should not experience long waiting times if access to a bed is required.

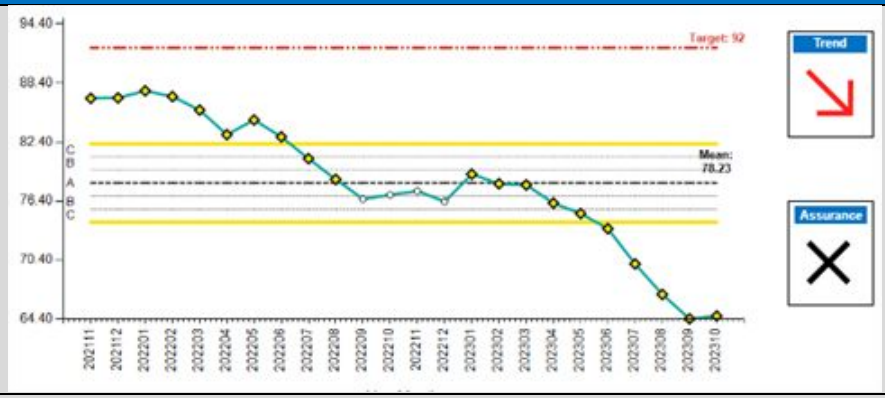
What the charts tells us
The level of 12-hour breaches is increasing across the three services with occasional variation.

Underlying issue
- A lack of available adult acute beds will lead to an increase in waits over 12 hours.
- Increased LOS and D
- TOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital step down beds.

Actions
- Matron and CSL meeting with Associate Director of Transformation to discuss review method of providing assurance that patients are being reviewed at least once a day. Diary contact assurance is not reliable.
- Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds.
- Substantive recruitment of Consultant Psychiatrist to Kingston Liaison Psychiatry and also successful recruitment across services.
- The Trust has contract for use of 18 beds at Holybourne in Roehampton until the end of the financial year.
- Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds.
- Service line is in discussion with Kingston Hospital to pilot Rapid Assessment Clinic on site at Kingston for one week. Timeframe for roll out is November/December 2023.
- Trust engaging with Mental Health in ED workshops, led by ICB. Workshop to be held in November 2023.

Access

Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) — Target ≥ 92%



October RTT Waiting by Service Line and Team Category

Service Line	Team Category	Count of Clients	18 Week Breaches	% Within 18 Wks	30 Week Breaches	52 Week Breaches
Acute And Urgent Care	Home Treatment	20	0	100.0%	0	0
	Liaison	64	1	98.4%	0	0
	Specialist Services	205	0	100.0%	0	0
CAMHS & ED	CAMHS Access/Referral	1,952	411	78.9%	71	0
	CAMHS Tier 3	618	285	53.9%	153	15
	CAMHS Tier 4	2	0	100.0%	0	0
	Deaf Services	58	14	75.9%	1	0
	Eating Disorders	170	76	55.3%	38	3
	Liaison	10	0	100.0%	0	0
Community (Adults)	Adult CMHT	1,280	50	96.1%	5	0
	Early Intervention	12	0	100.0%	0	0
	Psychological therapies	18	0	100.0%	0	0
	Specialist Services	20	0	100.0%	0	0
Specialist Services	ADHD/ASD	2,041	1,550	24.1%	1,143	529
	Forensic Services	10	0	100.0%	0	0
	Learning Disabilities	18	0	100.0%	0	0
	OCD/BDD	15	0	100.0%	0	0
	Older People	326	0	100.0%	0	0
	Specialist Services	350	135	61.4%	12	0
Total		**7,189**	**2,522**	**64.9%**	**1,423**	**547**

Background

The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to start of treatment (RTT) by a consultant led service.

What the chart tells us

Mean performance is below target (which is above upper control limit) and there has been a significant downturn trend in performance. A change in process is required.

Underlying issue

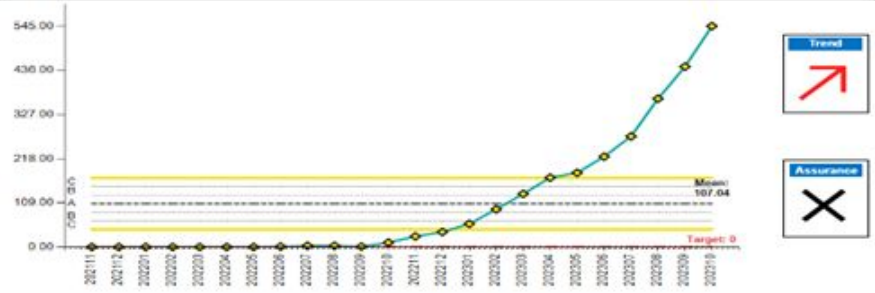
- **Adult ADHD:** There are known demand and capacity issues within the service; in October 2023, 61.4% (1549/2522) of the 18-week breaches relate to this service (see below for further information). Continued increase in caseload (for annual medication review) will impact on service assessment capacity. Team Manager post will become vacant in September which may have temporary impact on the actions in place. Clinical Manager will be providing oversight in this period.
- **Neuropsychiatry:** Reduced medical capacity has led to increase in long waiters. Cancellations and re-scheduling of clinics due to staff leaving has also impacted.
- **CAMHS Tier 3:** ADHD medication titration waiters due to on-going psychiatry staffing shortages and Psychiatry case managing increase for psychology waiters.
- Individual therapy waiters due to on-going staffing shortages in Clinical Psychology positions (especially in Richmond and Wandsworth Tier 3).
- **CAMHS SPA:** Longest waits are linked to cases awaiting of completion of Neurodevelopment screening.
- **Adult Eating Disorders (AED):** Service only outcome an appointment as "treatment" when it meets NICE evidence based guidance. Therefore some clients who are being seen for i.e. dietetics outreach or step for changes group will remain as waiters as their appointment don't meet threshold for evidence based NICE treatment.

Actions

- **Adult ADHD:** Trust working with ICS to develop a sustainable solution for Adult ADHD pathway management.
- An ICB led Task and Finish Group with SWLSTG and Primary Care representation commenced in July 23 to progress the development of a discharge pathway. This concluded in October 2023 and a draft service specification for primary care presented to ICB SMT in November 2023.
- Internally there is focused work under way on caseload cleansing and ensuring clinical screening is completed on referral backlog.
- Neuropsychiatry: New manager in post and there has been successful medical recruitment, improvement expected from December once workforce gaps are filled.
- Recruitment of 2wte Non Medical Prescribers roles in Sutton and Merton - estimated operational date 1st Dec. Continue to utilise 1.1 WTE Locum Medical. Aiming for full recruitment into vacancies by end of Nov ember.
- CAMHS: Continue to recruit to T3 investment across the five teams to increase choice assessment resource.
- Non-medical prescriber newly recruited for Kingston and Richmond CAMHS Tier 3 to address the ADHD medication backlog across both teams. Locum non-medical prescriber recruited for Wandsworth. GP with specialist interest in ADHD working alongside psychiatry on wait list reduction in Richmond.
- Therapy waiting cases are reviewed through 8 weekly review calls and all waiting patients are provided with a While you Wait support pack.
- Adult Eating Disorders (AED): AED: Pathway and process review being undertaken with clinical lead and ACD in order to maximise use of resource for treatment.

Access

Referral to treatment (RTT): 52 week breaches — Target = 0



52 Week Breaches – October 2023

Team	Oct
Sutton Adult ADHD Service	277
Merton Adult ADHD Service	148
Richmond Adult ADHD Service	104
Richmond CAMHS Tier 3	8
Kingston CAMHS Tier 3	5
Adult Eating Disorders Outpatients	3
Wandsworth CAMHS Tier 3	1
Merton CAMHS Tier 3	1
Total	547

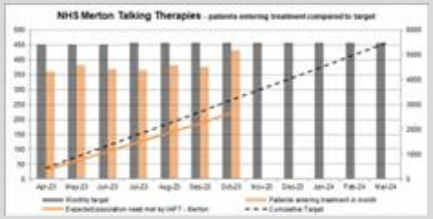
What the chart tells us:
Historic performance consistently met target; however recent months have seen significant increase in 52 week breaches with performance above upper control limit in last 6 months; a change in process is required.

Underlying issues that prevent us from consistently reaching the target:
- Adult ADHD: There are known demand and capacity issues within adult ADHD services and there is a continued risk of further increase in 52 week breaches. The levels of 52 breaches will continue to rise as diagnosed cases remain on the adult caseload for annual medication review.
- CAMHS Tier 3: Breaches were linked to waits for ADHD medication commencement.
- Adult Eating Disorders service incurred three breaches. The patients are receiving regular review while on DBT therapy waitlist with treatment set to commence in January 2024.

Actions:
- Adult ADHD: An ICB led Task and Finish Group commenced July 23 to progress the development of a discharge pathway. This concluded in October 2023 and a draft service specification for primary care will be presented to ICB SMT in November 2023.
- Internally there is focused work under way on caseload cleansing and ensuring clinical screening is completed on referral backlog.
- Recruitment of 2wte NMP roles in Sutton and Merton - estimated operational date 1st Dec. Continue to utilise 1.1 WTE Locum Medical Staff.
- Bi-weekly administration meetings are held to ensure cancellations are managed promptly and 52 weeks breach lists are cleansed routinely and prioritised. Management oversight to ensure clinicians are outcoming all appointments (and specifically 52 week breach appts) on the same day.
- CAMHS: Non-medical prescriber newly recruited for Kingston and Richmond CAMHS Tier 3 to address the ADHD medication backlog across both teams. Locum non-medical prescriber recruited for Wandsworth. GP with specialist interest in ADHD working alongside psychiatry on wait list reduction in Richmond.
- Adult Eating Disorders (AED): Pathway and process review being undertaken with clinical lead and ACD in order to maximise use of resource for treatment.

Access

Expected population need met by IAPT (numbers entering treatment)



Background
Improving Access to Psychological Therapies (IAPT) is an NHS programme in England that offers interventions approved by NICE for treating people with depression or anxiety. In 2021/22 NHSE (agreed with Commissioners) have set a flat rate of cases entering treatment for each CCG area.

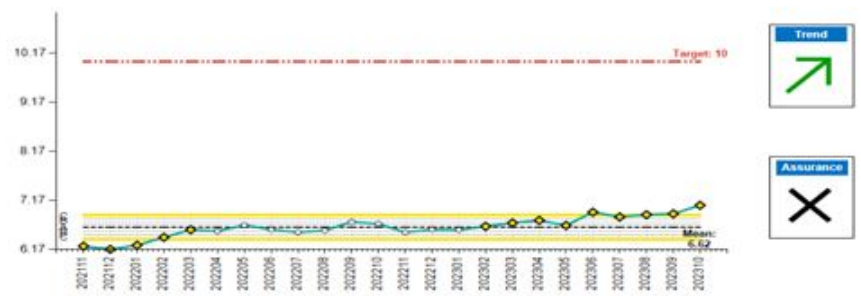
What the chart tells us
Two (Sutton IAPT & Richmond Wellbeing Service) of the four IAPT services are above their cumulative access requirements for 23/24. Merton Uplift is considerably below its requirement whilst Talk Wandsworth performance is just below target. Trustwide access performance is now above target.

Underlying issue
- There is insufficient resource in Wandsworth, Merton, and Sutton and therefore meeting access requirements whilst maintaining (already long) stable waiting times, and achieving recovery rates, will continue to be an ongoing challenge.
- There are insufficient referrals in Merton and Wandsworth, although this is improving with the use of iPlato.
- IESO self-referrals were switched off on 16th November due to high demand and insufficient resource within Talking Therapies budgets to keep this option available to patients.
- There was a total deficit of 370 across all 4 boroughs at end of Q2, and talking therapies services are continuing to closely monitor this.

Actions
- iPlato (3rd party provider) has been commissioned across all 4 boroughs to help us achieve our access targets (marketing).
- Service managers are closely monitoring referral numbers (daily) and ensuring there are sufficient assessment slots available to meet access targets.
- Bookings are being closely monitored to ensure all assessment appointments are being fully utilised and there a no lost appointments.
- Improved capacity monitoring to ensure that clinicians are adhering to productivity expectations in job plans.
- Once all internal first appointments have been filled, excess referrals are being sent to sub providers (as these count towards our access), meaning we can go above our capacity ceiling – budget permitting.
- Service Managers will raise any concerns which bears any risk to target or wait lists to IAPT/Community Service Line senior management who will raise with ICB as appropriate.

Access

Perinatal: women accessing specialist PMH services as a proportion of births — Target ≥ 10%



Perinatal Access: The metric is based on a rolling 12-month period. To be included in the numerator, the patient has to have been seen FTF or via e-consultation in the preceding 12 months. This is a count of distinct patients not referrals.

Measure	202212	202301	202302	202303	202304	202305	202306	202307	202308	202309	202310
Women accessing PMH services *	1,025	1,024	1,035	1,046	1,054	1,038	1,080	1,065	1,072	1,075	1,102
Estimated births	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595
Nationally Published Figures: Service use per birth (ONS)	6.6	6.6	6.6	6.7	6.8	6.7	6.9	6.8	6.9	6.9	7.1
Service use per birth (For Context Only)	*7.7*	*7.7*	*7.8*	*7.9*	*8*	*7.8*	*8.2*	*8*	*8.1*	*8.1*	*8.3*

Background
Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of new and expectant mums and covers a wide range of conditions. The NHS Long Term Plan is for improved access to perinatal care for mums who with moderate / severe Perinatal Mental Health.

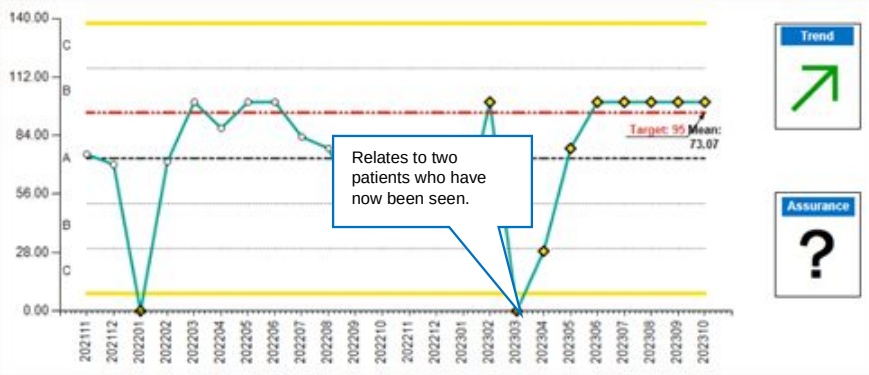
What the chart tells us
Although a slight upward trend is observed mean performance is below national requirement (target).

Underlying issue
- National target is based on predicted birth rate (2016 census data) which is higher than the actual local birth rate in 2022.
- Number of referrals received progressing to assessment is too low in order to reach access requirements of 10% of PMH population.
- High DNA rate.

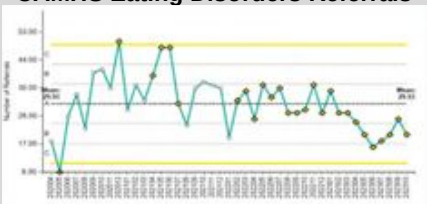
Actions
- Ongoing development of Perinatal Trauma and Loss Service with review of additional capacity and impact on access. Service has now been rolled out across the three South West London.
- Following investment there has been recruitment into newly funded posts (nursing, nursery nurse, P&P) this will be completed in November 2023.
- Peer Support Worker posts to be recruited into in October/November, with focus of roles on DNA project.
- 12-24 month long term plan work currently being progressed.

Access

CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) — Target ≥ 95%



CAMHS Eating Disorders Referrals



Waiting for Treatment Summary October 2023

		00 - 01	01 - 02	03 - 04	Total
Waited	Standard	2	3	0	5
	Urgent (7days)	3	0	0	3
Waiting	Standard	3	2	1	6
	Urgent (7days)	1	0	0	1

Background
To ensure that young people in urgent need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target. Recent months performance has shown improvement with full compliance for last five months.

Underlying issue
- Long term demand and capacity issues within the team.
- Over-reliance on part time staff to maintain administrative systems.
- The denominator for this KPI is low (n=5) in October 2023, so any case seen outside 28 days is likely to lead to target being missed. Full compliance noted for last three months.
- Recruitment into the service has been challenging with certain posts difficult to recruit to.

Actions
- The CAMHS Eating Disorders Service are continuing recruitment process.

Access

CAMHS - Non-Urgent referrals assessed within 8 weeks (%) — Target ≥ 80%

Team Breakdown – October 2023

Team	Seen Within 8 Weeks	Assessed	%
Kingston CAMHS Tier 3	9	23	39.1%
Merton CAMHS Tier 3	11	16	68.8%
Richmond CAMHS Tier 3	11	14	78.6%
Sutton CAMHS Tier 3	21	25	84.0%
Wandsworth CAMHS Tier 3	15	23	65.2%
Total	**67**	**101**	**66.3%**

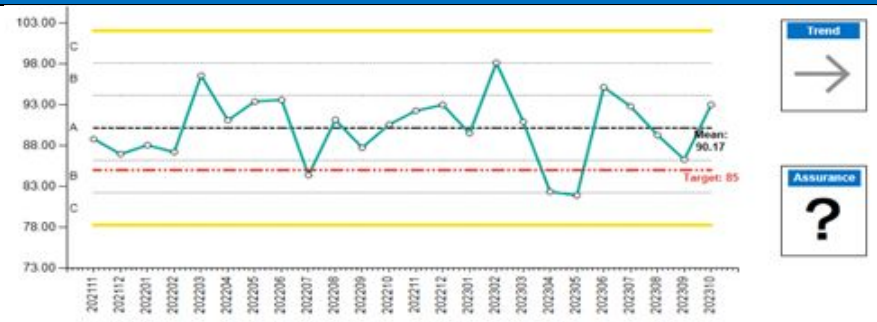
Background
To ensure that young people in need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target indicating compliance on occasion. Recent months have deteriorated with September 2023 performance below control limit.

Underlying issue
- Most breaches relate to waits for ADHD medication and Psychiatry shortage across community CAMHS. As T3 CAMHS continues to assess more of the backlog of ADHD waiters this KPI will continue to deteriorate of until the backlogs are cleared.
- There are delays in ADHD medication due to the prioritisation of urgent referrals, screening forms being returned late, cancelling appointments and a small number of errors in recording.
- Psychiatry continues to priorities higher risk referrals for appointments, meaning ADHD medication waiters (who are of less risk) will continue to be reason for most 8-week breaches.

Actions:
- Non-medical Prescriber (NMP) is increasing assessment activity for long-term ADHD medication waiters (will continue to breach 8 week until backlog is cleared).
- Locum NMP starting in November 2023 in Wandsworth CAMHS to support psychiatry with ADHD caseload.
- Continue to recruit to T3 following investment to increase choice assessment resource.
- Pilot of GP with specialist interest for ADHD medication commenced in Kingston & Richmond.

Dementia diagnosis within 6 weeks of referral to a memory assessment service (%) — Target ≥ 85%



Team Breakdown – October 2023

Team	Diagnosed within 6 weeks	Diagnosis Required	%
Kingston Memory Service	13	14	92.9%
Memory Assessment Service Wandsworth	25	29	86.2%
Merton Memory Assessment Service	22	22	100.0%
Richmond Memory Assessment Service	17	20	85.0%
Sutton Memory Assessment Service	30	30	100.0%
Total	**107**	**115**	**93.0%**

What the chart tells us
Mean performance is comfortably above target indicating frequent compliance with occasional variation.

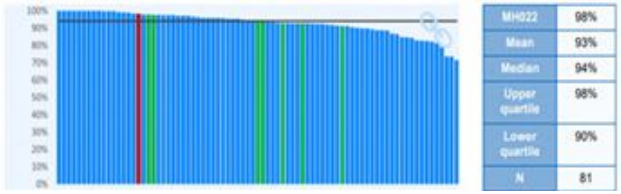
Underlying issue
- 8 breaches reported in October 2023.
- All 5 MAS services met target in October 2023.

Actions
- **Trust:** Work with CCG to increase referral activity where DDR rate is low- e.g. Kingston.
- Continued monitoring and additional support for teams where needed.

Flow

Bed Occupancy on acute adult wards (%) — Target ≤ 90%

2022/23 Benchmarking (Trust is highlighted red, other London Trusts are highlighted green)



MH022	98%
Mean	93%
Median	94%
Upper quartile	98%
Lower quartile	90%
N	81

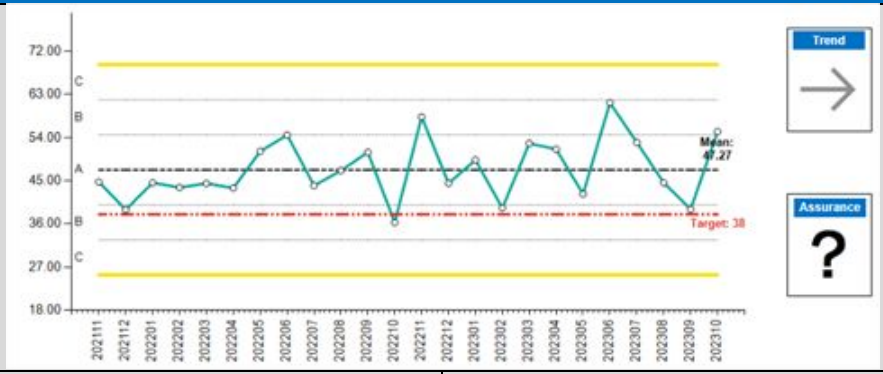
Background
Occupancy rate is the number beds occupied divided by the number of available bed days.

What the chart tells us
Low level variation with mean performance considerably above target.

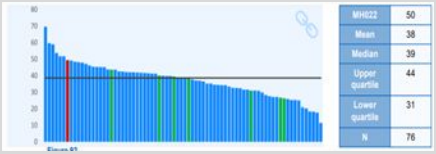
Underlying issue
- Demand for inpatient services remains high, with over performance on occupancy rates resulting in use of out of area placements.
- Out of area placements have increased through August.
- Work to address occupancy rates is outlined within the 100 day challenge work within inpatient transformation.

Actions
- The Trust has extended its contract for use of 18 beds at Holybourne in Roehampton until the end of 23/24.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- 100 discharge challenge flow interventions have been implemented and AUC service line continue to work on embedding transformational change.
- A revised KPI definition for Adult Acute Bed Occupancy reporting is in process of being finalised.

Adult Acute monthly average length of stay (excluding PICU) — Target ≤ 38



2022/23 Benchmarking (Trust is highlighted red, other London Trusts are highlighted green)



MH022	50
Mean	38
Median	39
Upper quartile	44
Lower quartile	31
N	76

Background
Average length of stay is important as it informs future bed planning. This definition was agreed by the Bed Management Project Group and approved by Trust Executive. It includes out of area placements and excludes stays on PICU wards and leave.

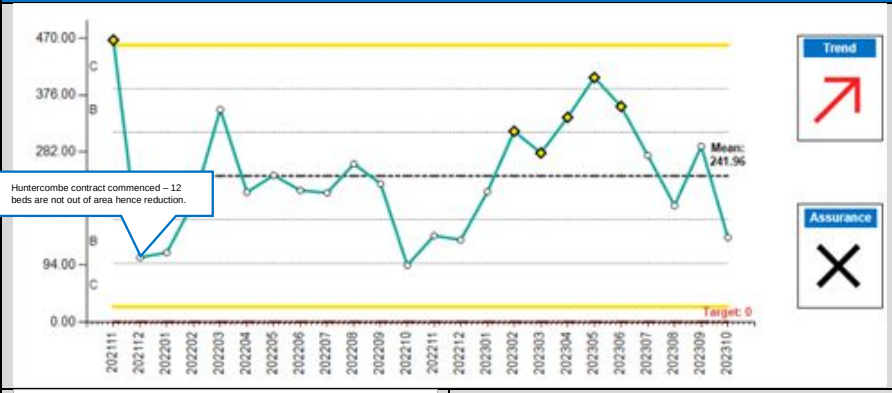
What the chart tells us:
Trust average performance consistently exceeds target.

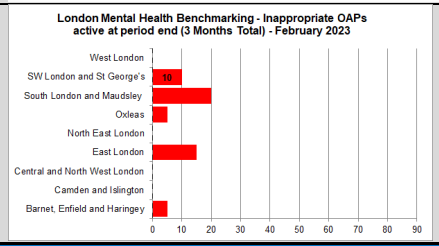
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds as the overall bed stock is reduced with less complex cases now being treated in the community.
- DTOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital.
- Reduced flow in the wider system - social services and supported accommodation providers.
- Increased demand can lead to increased acuity on admission and longer time to recover.
- There is variation on LOS between adult acute ward.

Action
- Continuing to embed 100 day challenge including engagement of Holybourne.
- CSLs are continuing to support ward managers to embed the inpatient admission and discharge checklist.
- Contract meeting being booked for ELFT to review pathways and LOS alongside other quality metrics.
- Complex Emotional Needs (CEN) pathway training to be undertaken in November 2023.
- Mini MADE events held in October 2023.

Inappropriate Out of area placement bed days - Adult Acute & PICU — Target = 0

Flow





Background
The Five Year Forward View for Mental Health aims to end entirely the practice of sending people out of area due to local adult acute bed pressures by no later than 2020/21. The data includes 5 beds purchased at East London Foundation Trust that from April 2020 meet the DOH criteria, including continual record sharing, as appropriate. Typically, an inappropriate placement would relate to the patients admitted to the private sector. In this instance regular reviews and follow-ups are conducted by Trust staff to ensure the delivery of effective care.

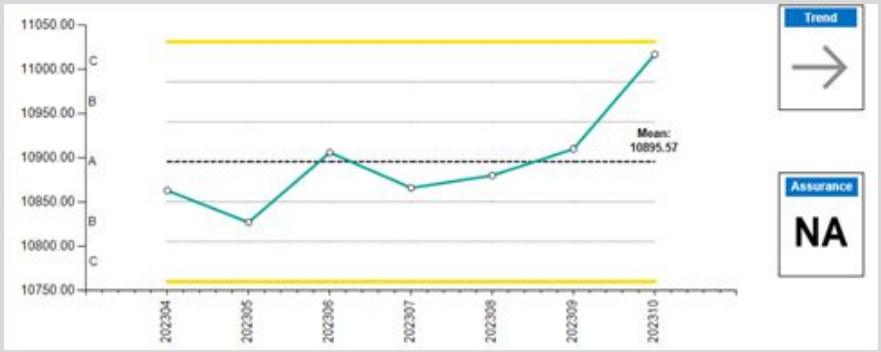
What the chart tells us
The levels of out of areas placements is subject to variation aligned to demand for beds (i.e. adult acute beds).

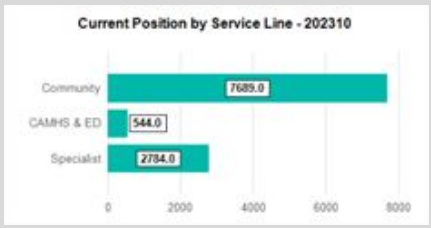
Underlying issue
- Performance is related to the demand for adult acute and PICU beds. High and continual occupancy rates that exceed 95% inevitably lead to the use of out of area beds at times of peak demand.
- DTOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital. The apparent correlation between external occupied bed days used and increased DToC days is being explored.
-

Actions
- The Trust has extended its contract for use of 18 beds at Holybourne in Roehampton until the end of 23/24.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- Updates reported in daily pathways meeting with a focus on trying to repatriate patients to trust provision as quickly as possible.
- Key to reduction in use of OOA provision is the work to decrease LOS and create capacity locally, alongside community transformation.
- The 100 day challenge plan should support reduction in LOS - workstream meetings have commenced and implementation plan is in place.
- Holybourne now included in 100 day discharge work streams.

Number of adults and older adults receiving 2+ contacts in new integrated model across the core and dedicated service provision — No Target

Flow





What the chart tells us the chart tells us
New metric for 2023/24 low level variation since April 2023.

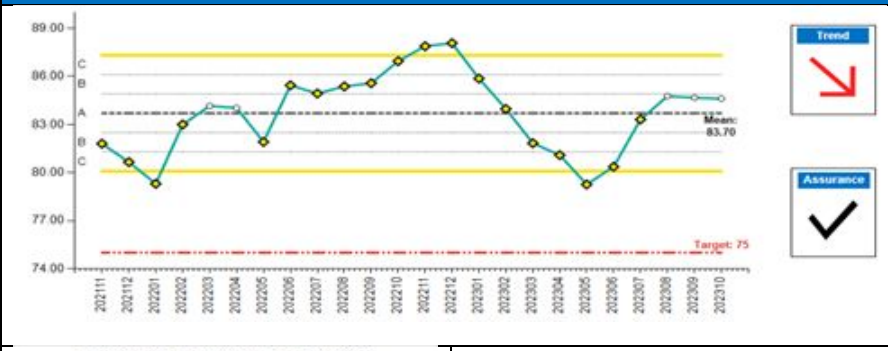
Underlying issue
- There is a lack of understanding across the Trust on this metric and clarification is required in order for clinical services to address.
- Metric requires review to ensure correct cohorts are reflected.

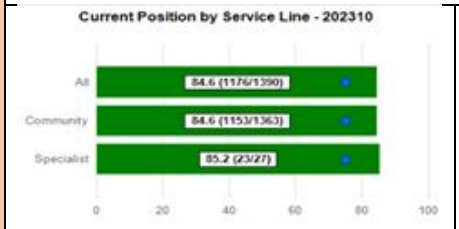
Actions
- DHOSD to work with the performance to understand this metric further.
- Ensuring appointments are booked and outcomed in timely fashion will aid improvement.
- A KPI definition is required to aid clinical services.
- The Information Management Team have reviewed metric definition and issued guidance of team category inclusion.
- Community: Familiarisation of this metric discussed with Associate Clinical Director and Clinical Managers in Kingston, Sutton and Richmond leadership meeting in September.
- Older People's Services: It is anticipated that with the progression of the older adult transformation work - there will be increased access to services and increased activity for patients (upward trend send in CMHTs).

Quality Domain

Fundamental Standards of Care

Cardio metabolic Assessments – Community and EIS (%) — Target ≥ 75%





Background
Clients with a diagnosis of psychosis are at a higher risk of developing serious physical health problems. Cardio-metabolic assessment (CMA) reporting monitors Trust performance in key factors associated with physical health i.e. blood pressure monitoring, BMI, and glucose regulation.

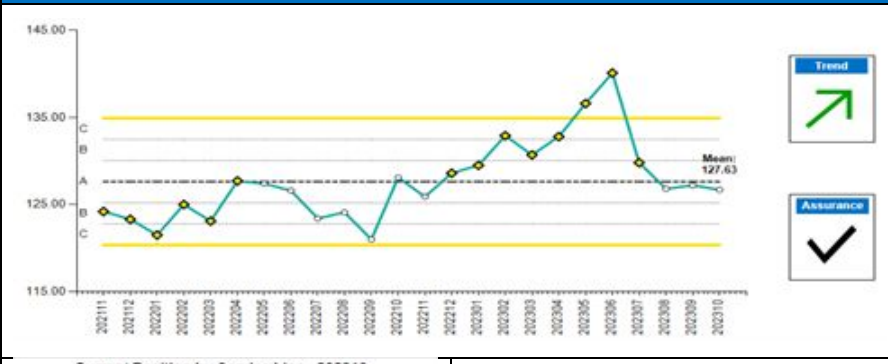
What the chart tells us
It is likely that the target will consistently be exceeded; however recent months have improved.

Underlying issue:
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised. Trust clinical systems do not support workflow and performance is expected to dip in Q3 when annual re-reviews are required.
- Number of community patients have declined assessments. Attempts made to try and intensively engage patients to attend are not recorded within the system.
- Although this target appears to be met overall. The National Clinical Audit of Psychosis 2023 recorded that all 5 Borough's require a specific focus on physical health screening and interventions.

Actions:
- Community: Kingston & Richmond EIS improvement plans reviewed with updated actions. Clinical Manager to lead and embed within the team.
- Richmond EIS is being supported by a member of staff from Richmond RST to undertake CMA clinics. GP trainees are now cold calling patients to encourage CMA commenced Oct'23.
- Weekly/twice weekly physical health clinics in all boroughs continue.
- Wandsworth developed Holistic Hub in Trinity Building due to commence on 1st November. The hub will offer a range of services with a community focus i.e. depot/clozapine clinics, employment advice, peer support OT and input from Primary Care plus to step people back to GP and help with overall flow.
- Lead nurse to undertake Physical Health training this is to commence in Wandsworth.
- Kingston QII scooping how to increase full compliance with CMA checks.

Fundamental Standards of Care

Safe Staffing: national Compliance - Inpatients (%) — Target ≥ 95%



Background:
To provide assurance that inpatient wards were adequately staffed in the reporting period.

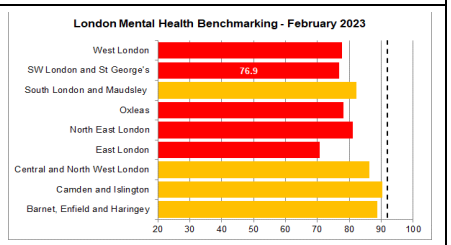
What the chart tells us:
Trust performance is consistently above target which is below lower control limit.

Underlying issue:
- In Acute & Urgent care services and Specialist all wards were safely staffed. Additional staff are required to manage constant and enhanced observations.
- CAMHS & ED: All ward areas were safely staffed; Corner House is minimally staffed due to very low occupancy and some team members are supporting other services. The Trust has also agreed a bespoke provision for a client; both Aquarius and Wisteria send staff to support. This is funded via the SLP.

Actions:
- Daily staff meetings held across all service lines are in place to monitor staffing requirements and issues on staffing numbers are escalated to senior management if there are concerns.
- Acute & Urgent Care: Focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.
- Training has been provided for Ward Managers & Team Leaders on the Fundamental Standards of Care Dashboard.

Patient Experience and Outcomes

Patient Friends and Family Test (%) — Target ≥ 85%



Background

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed.

What the chart tells us:

Mean performance is consistently below target a change of process required.

Underlying issues:

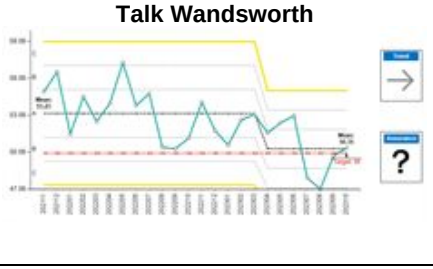
- Challenges with engaging patients to complete at appropriate points in their pathway and staff not actively seeking feedback.
- Using the results in a meaningful way to identify and make improvements within the clinical services.
- Acute and Urgent Care: Most under performance linked to crisis pathway (who may be less likely to complete questionnaires. Improvement noted in home treatment and perinatal services.
- Specialist Services: System concerns have been raised to Governance Team for service lines older adult, Learning Disabilities and ADHD/ASD services as they are not consistently accessible for our patient and carer populations.

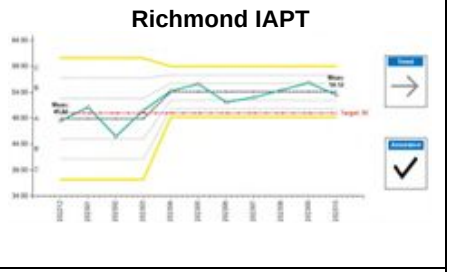
Actions:

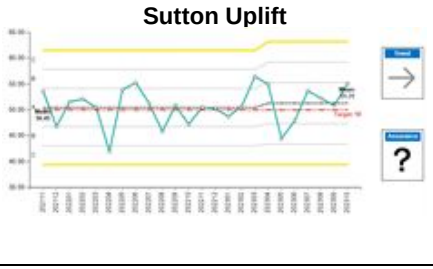
- Feedback live has recently been relaunched as a platform for completing Friends and Family Test. First question on system is linked to the Friends and Family Test.
- Staff encouraged to promote use of the FBL QR code for service users and carers.
- Promoting use of the FBL QR code for service users and carers (FBL first question is the FFT).
- Community Service Line: Governance Leads attended Community QGG to relaunch FFT and now working with Borough teams to promote good practice.
- Holistic Hub in Wandsworth launching peer support who will engage with walk in patients to encourage FFT completion.
- Acute and Urgent Care: FBL will be an agenda item within Community Meetings to promote service user engagement. QR codes are displayed in ward areas and teams are giving out laminated cards with QR codes.
- CAMHS & ED: Service-related project in progress looking at ESQ response rates from children and families.

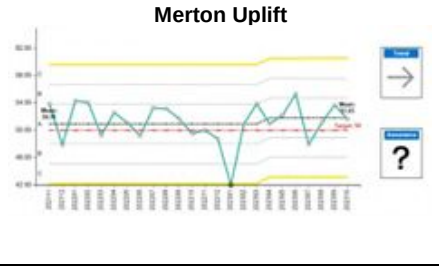
Patient Experience and Outcomes

IAPT recovery rate (%) — Target ≥ 50%









Background

Improving Access to Psychological Therapies (IAPT) is an NHS programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety.

What the chart tells us

All talking therapies are above 50% national target YTD; Merton Uplift is just below their locally agreed stretch target of 52%. Monthly variation is expected.

Underlying issues

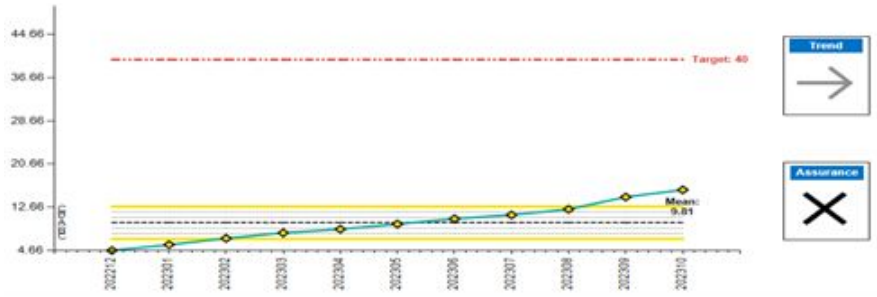
- Recovery rates in all services has deteriorated over 18 months, although some improvements seen in September since the launch of the cross-borough recovery workgroup. Initial audits indicate recovery deterioration is due to dropouts and people declining treatment due to waiting times.
- Clients who drop-out and fail to attend appointments (DNA) may be discharged before they have recovered. A new cross-borough recovery workgroup has identified that this is happening more often as waiting lists increase, as patients seek treatment elsewhere during this period.
- The cross-borough recovery workgroup has identified that recovery rates for people who complete treatment is above 70%. There needs to be focus on reducing dropouts.

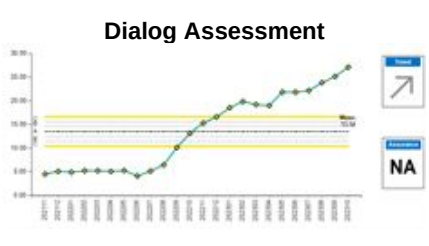
Actions:

- Ensuring service clinical leads complete data quality checks in advance of the monthly recovery audits.
- Cross-borough recovery workgroup continues to meet monthly. Training in development to support clinicians to treat psychological conditions where there is evidence that the service could improve treatment delivery or existence of any skills/training needs.
- Individual recovery rates for clinicians have been reintroduced and are monitored monthly and shared with staff at LMS to support improvements in capacity and caseload.
- Clinical leads implementing a programme of work intended to improve diagnostic assessment and treatment planning decisions. New "feedback call" stage launched between assessment and being placed on waiting list, patients now attend a structured treatment planning call in order to reduce dropout rates.
- Sharing of SilverCloud best practice planned for this month to enable services who perform better in this modality to support the skilling up of staff in services that are currently performing less well in CCBT.

Patient Experience and Outcomes

Paired Dialog Completed — Target ≥ 40%





Background
DIALOG is an 11-question survey whereby people with a mental health illness are asked to rate their satisfaction and needs for care on 8 life domains and 3 treatment aspects. It is a tool that is completed by the service user and its content helps to highlight areas they may want support with.

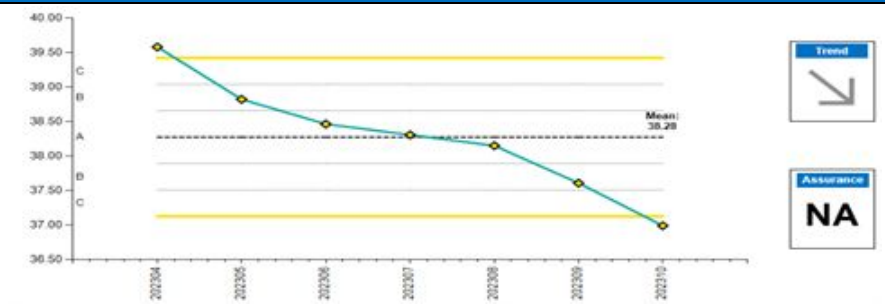
What the chart tells us
There is steady improvement in the paired dialog recording rates.

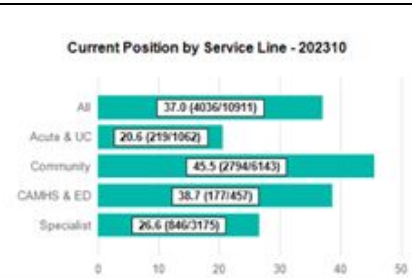
Underlying issue
- Reporting on paired dialog is a new priority metric for 23/24; local practice is being embedded.
- Review of team inclusions for DIALOG is ongoing across service lines.
- Change in clinical practice that will require time to embed.
- Trust is currently benchmarking well on Paired Prom measure – 6% compared to national average of 3% (based on November 2022).
- The Trust has been invited to showcase the work undertaken on the Mental Health Outcomes CQUIN at the National (NHS-E) outcomes CQUIN webinar.
- Trust benchmarks well across London for Dialog Assessment.
- DIALOG is not yet linked to care planning - when this is launched the paired DIALOG scores are expected to increase significantly.
- Patients remaining on community caseloads for long periods are not completing more than one DIALOG currently i.e. no discharge DIALOG.

Actions
- SOP for dialog use has been developed and issued to across the Trust.
- Specialist Service Line to raise exclusions queries with Patient Outcomes Group.
- Baseline DIALOG completeness to be discussed at Improving Patient Outcomes Group (IPO) and further strategy for improvement to be recommended.
- Community: DIALOG refresher training was completed in June 2023.
- Baseline DIALOG completeness to be discussed at IPO and further strategy for improvement to be recommended.
- Focused work within HTT teams to improve compliance with paired dialog.

Patient Experience and Outcomes

Paired HONOS Completed — No Target

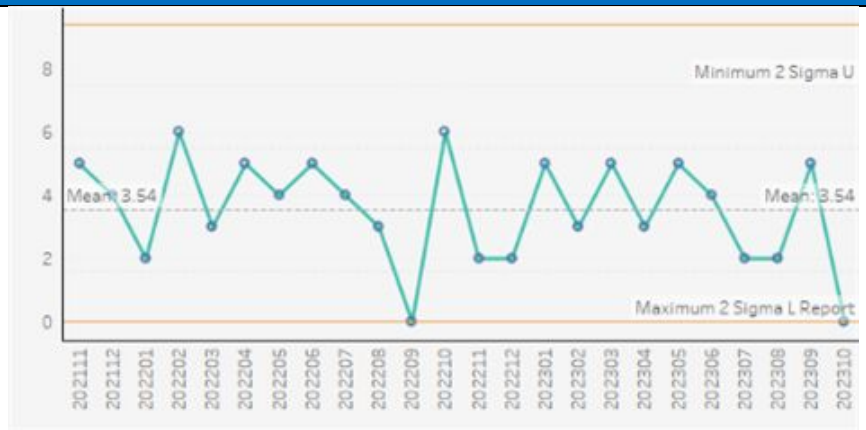




What Chart Tells Us:
There is a consistent negative downward trend in paired HONOS recording.

Underlying Issue:
- Community: HONOS as a standalone outcome measure (separate from Clustering) is not embedded in Community/Trust as a routine clinical activity.
- The Trust has de-prioritised clustering and as HoNOS is a requirement for clustering this has had a detrimental effect on HONOS completion.

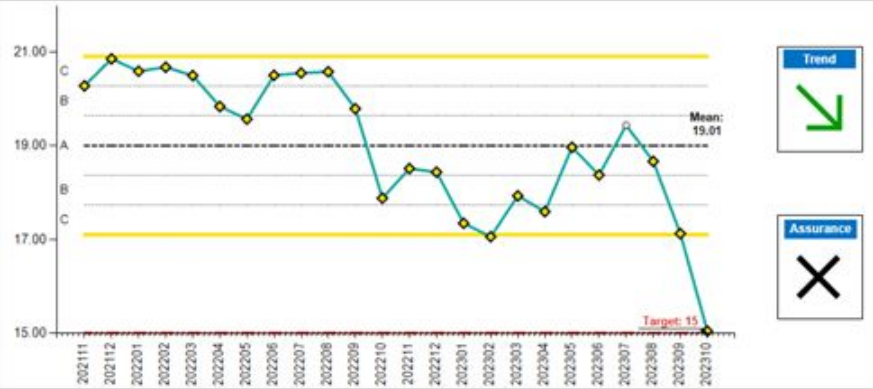
Actions:
Community:
- HONOS to be presented and the community awareness event 20th Nov.
- HONOS to be discussed at team leaders' development (9th Nov)
- HONOS SOP to be recirculated.
- Discuss development of a community workflow for discharge on Rio which includes PROMS, PREMS and CROMS including HONOS and DIALOG

	Death - Suspected suicide		No Target
Patient Safety			**What the chart tells us** The number of suicides each month is low with common cause variation. **Underlying Issue:** - There were no suspected suicides reported in October 2023. - The number of suicides being reported month to month continues to vary. This data is reviewed in the bi-monthly Mortality & Suicide Prevention Committee. The mean monthly average has increased from 2.9 (pre-April 2020) to 3.9 (post April 2020). **Actions:** - All such incidents will be subject to a review in line with the Patient Safety Incident Response Framework (PSIRF). - The milestones from the Trusts Suicide Prevention Strategy continue to be monitored via the Mortality & Suicide Prevention Group. - The Annual NCISH report was reviewed in the Mortality & Suicide Prevention Group and key Clinical Messages will be shared in the monthly learning bulletin. - Community: Learning events now in place and action plan against thematic review of patient deaths being progressed.
	No cases reported in October 2023	**Suspected Suicides – Step Change Applied April 2020 via Mortality Committee** 	

Workforce Domain

Recruitment / Attraction

Vacancy Rate (%) — **Target ≤ 15%**



Benchmarking – NHS Digital Q4 22/23

Trust	%
North East London NHS Foundation Trust	20.9%
West London NHS Trust	17.3%
South West London and St George's Mental Health NHS Trust	17.2%
South London and Maudsley NHS Foundation Trust	16.3%
Oxleas NHS Foundation Trust	14.8%
Central and North West London NHS Foundation Trust	13.5%
Barnet, Enfield And Haringey Mental Health NHS Trust	12.9%
East London NHS Foundation Trust	8.1%
Camden and Islington NHS Foundation Trust	4.1%
London	**13.9**
National	**11.3**

Vacancies by Staff Group

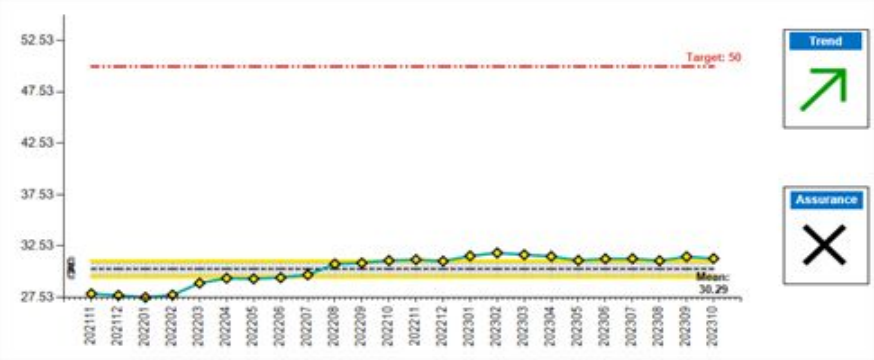
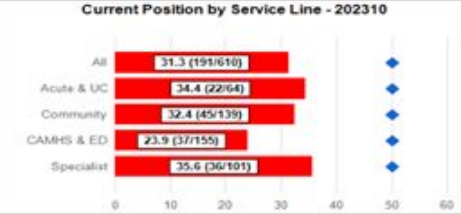
Staff Group	Post Fte	Assign Fte	Vacant FTE	Vacancy Rate FTE
Allied Health Professionals	165.7	130.6	35.1	21.2%
Add Prof Scientific and Technic	490.2	405.6	84.6	17.3%
Additional Clinical Services	719.3	602.2	117.1	16.3%
Nursing and Midwifery Registered	901.7	761.8	139.9	15.5%
Administrative and Clerical	650.2	573.3	76.9	11.8%
Medical and Dental	243.9	218.4	25.5	10.5%
Estates and Ancillary	35.0	31.9	3.0	8.6%
Healthcare Scientists	2.0	2.0	0.0	0.0%
Total	**3,208.0**	**2,725.8**	**482.2**	**15.0%**

Background
Ensuring that the Trust has suitably recruited to establishment leads to better continuity of care. A high vacancy rate may adversely affect the continuity/ quality of patient care, increase demands on existing staff and results in increased use of more expensive agency staff.

What the chart tells us
There is an overall downward trend in vacancy rate with performance consistently above target. October performance improved has improved and is now below lower control limit and in line with target.

Underlying issue:
- Trust met target in October 2023 this follows downward trend in vacancy rate over the period.
- Improvements in number of applicants through open events, careers day attendance and number of people directly applying together with improved recruitment processes are driving this.
- Each Service Line has created a workforce plan to ensure there is a continued focus on recruitment, including bank and agency conversions into vacant positions.
- Even with this positive shift in the number of applicants and recent successes from mass recruitment campaigns there are still some professions which are continually providing difficult to recruit to. These are areas where we will need to think about alternatives in support whilst we carry vacancies to ensure we reduce the pressure for those in the team and retain them.

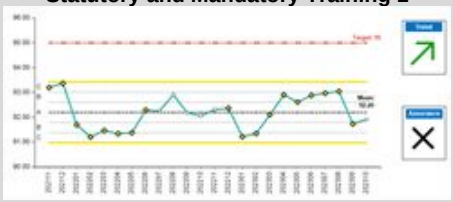
Actions:
- Recruitment Annual Timetable: A detailed recruitment activity timetable for the year is in place and outlines key dates for mass recruitment, recruitment fairs and open days, which has been operationalized via the recruitment delivery group. It focuses on building recruitment opportunities and ensure Trust-wide mass recruitment campaigns are scheduled effectively to meet the organisational need.
- Recruitment Delivery Group: Has been operationalized with stakeholders across the services to ensure detailed planning and approach is planned for each recruitment campaign and input to what might be needed in the future months is highlighted.
- We are progressing plans to expand our recruitment and attraction work into community based recruitment including our local refugee community. Mtgs have been held with neighbouring Trusts to explore how others have been successful in this before progressing our next steps on this. Further updates to follow.
- Funds from our Strategic investment funds have been provided to develop some specific initiatives around Community Services; predominantly focussed on medical staff.
- We are currently recruiting resources to support Apprenticeships which has also been funded through our strategic investment fund.

	Percentage of BAME staff - Band 8+ and Medical	Target ≥ 50%
Recruitment / Attraction	 	**What Chart Tells Us:** Mean position is below target indicating target position seems to have plateaued in recent months following period of improvement. **Underlying issues:** - The number of black, asian and minority ethnic colleagues being appointed at Band 8a is steadily increasing. - The pace of change is slower than needed in order to meet target. **Actions:** - Talent Strategy being developed, with a strong lens in terms of career progression and commitment to Black, Asian and Minority Ethnic Groups. - Reviewing Recruitment & Selection Training for all recruiting managers to be launched in January 2024. - Further analysis around appointments at senior bands to commence in new year. - The action plan in response to the WRES is being built this year in partnership with our Evolve network. Our response to how we affect career development is featuring in this plan. The action plan is due to be published in Jan 2023

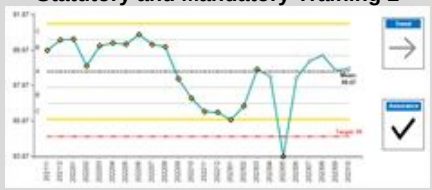
Staff Skills / Development

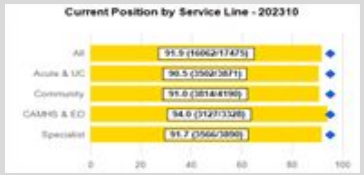
Statutory and Mandatory training 1 (%), Statutory and Mandatory training 2 (%) — Target ≥ 95%, Target ≥ 85%

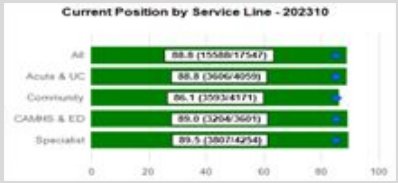
Statutory and Mandatory Training 1



Statutory and Mandatory Training 2



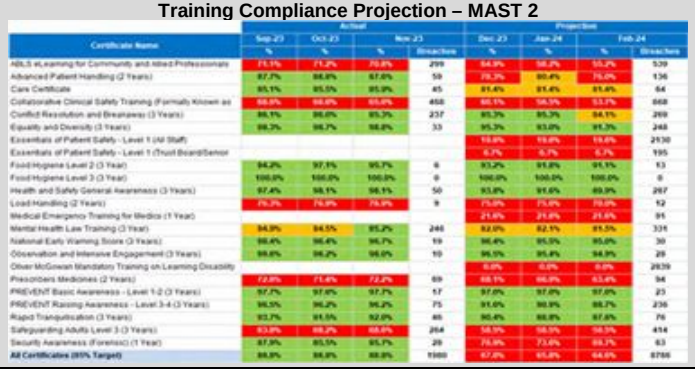




Training Compliance Projection – MAST 1

Certificate Name	Actual				Projection			
	Sep-23	Oct-23	Nov-23		Dec-23	Jan-24	Feb-24	
	%	%	%	Breaches	%	%	%	Breaches
Adult Basic Life Support (1 year)	79.8%	83.9%	84.1%	71	82.5%	78.8%	76.6%	108
Fire Safety Awareness (Community) (2 Year)	94.8%	94.6%	94.3%	75	90.5%	87.9%	84.5%	216
Fire Safety Awareness (Inpatient) (1 Year)	77.4%	76.7%	76.3%	159	80.9%	76.1%	68.3%	227
Fire Safety Awareness (Non-Clinical) (2 Years)	95.6%	95.9%	95.9%	30	90.5%	87.8%	84.0%	118
Infection Prevention and Control L1 (3 Years)	94.1%	93.7%	93.5%	33	92.2%	92.0%	92.0%	41
Infection Prevention and Control L2 (1 Year)	93.4%	92.8%	92.6%	165	80.7%	73.3%	66.7%	784
Information Governance (1 Year)	95.5%	95.8%	95.4%	125	83.7%	73.3%	65.2%	990
Medical Emergency Training for Nurses (1 Year)	66.7%	72.0%	67.6%	79	62.0%	58.6%	53.7%	151
Medicines Management (Community) (2 Years)	89.0%	88.2%	88.4%	52	82.8%	79.4%	76.8%	108
Medicines Management (Inpatient) (2 Years)	93.6%	93.7%	93.9%	17	88.5%	85.2%	83.9%	49
Proactive Physical Interventions (3 Years)	85.8%	81.0%	80.4%	109	83.2%	82.8%	81.6%	109
Safeguarding Adults Basic Awareness - Level 1 (3 Years)	96.9%	96.7%	96.8%	88	92.7%	90.9%	88.1%	340
Safeguarding Adults Level 2 (3 Years)	94.8%	95.0%	94.8%	103	91.3%	90.1%	88.8%	234
Safeguarding Children and Young People Level 1 (3 Years)	94.5%	94.4%	94.3%	32	90.6%	88.7%	85.9%	81
Safeguarding Children and Young People Level 2 (3 Years)	91.4%	92.7%	92.3%	65	87.6%	86.1%	85.1%	141
Safeguarding Children and Young People Level 3 (3 Years)	76.2%	77.7%	75.8%	256	72.1%	70.5%	69.3%	357
Safeguarding Children and Young People Level 3 CAMHS	91.4%	90.9%	88.2%	33	82.1%	80.5%	79.2%	65
All Certificates (95% Target)	91.8%	91.9%	91.5%	1492	85.7%	81.8%	77.9%	4119

Training Compliance Projection – MAST 2



Background

Statutory and mandatory training (MAST) is compulsory training that is determined essential for the safe and efficient delivery of services. This type of training is designed to reduce risks and comply with local or national policies and government guidelines.

What the chart tells us

MAST 1: MAST 1 levels remain consistent whilst work continues to refresh the training and the audiences. This work is progressing between the L & D, SMEs and IT teams.

MAST 2: Performance for MAST 2 remains above target.

Improvement Initiative:

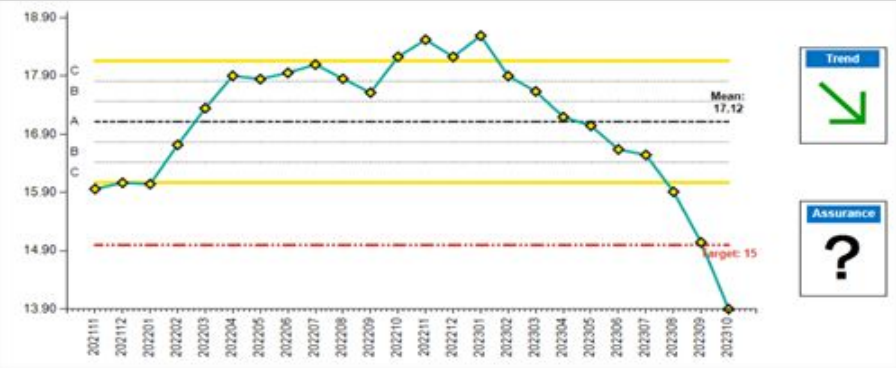
The work continues to build improvements into MAST offer, systems and accessibility. This work includes:-

- Review of all MAST training content with SMEs, audiences and then being reflected within our Compass and Dashboard systems.
- A diary of all mandatory training in place with bookings for each up to six months in advance in order for staff to plan more effectively to enable release.
- Technical issues associated with Dashboard, COMPASS and e-LFH platform have been investigated and resolved. The ongoing review of the historical technical issues did not identify any further issues since the resolution was put in place in July. However the new audiences for each MAST course take time to update and L & D are working with IT to ensure this is delivered as quickly as possible.
- Oliver McGowan training is now live but will not affect compliance data until six month post launch to enable colleagues time to attend.
- Review of MAST 1 and MAST 2 offer is now complete and implemented and is reflected in the list of training shown in this report.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%

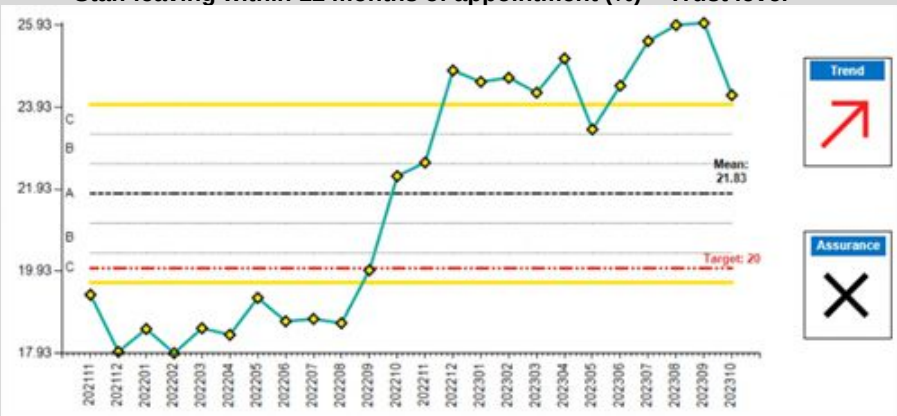


Annual Turnover FTE – June 2022 – June 2023

Org name	Leavers	Leaver rate
Barnet, Enfield and Haringey Mental Health NHS Trust	966.4	33.0%
Camden and Islington NHS Foundation Trust	426.6	19.6%
Tavistock and Portman NHS Foundation Trust	117.7	17.9%
South West London and St George's Mental Health NHS Trust	406.4	16.9%
East London NHS Foundation Trust	1058.2	16.8%
Central and North West London NHS Foundation Trust	1159.0	15.9%
Oxleas NHS Foundation Trust	602.5	15.8%
North East London NHS Foundation Trust	942.1	15.3%
West London NHS Trust	602.2	15.2%
South London and Maudsley NHS Foundation Trust	752.1	14.5%
London Average	**703.3**	**18.1%**
National	**564**	**13.8%**

Please note: NHS Digital inclusion criteria is slightly different to Trust's definition.

Staff leaving within 12 months of appointment (%) – Trust level



Background

Turnover describes the rate that employees leave an establishment and can disrupt the continuity of care and involves a financial cost to the establishment for replacing staff that leave. The metric is defined as the number of staff that have left the Trust over the last 12 months divided by the average number of staff over the same period. The retention of staff has been highlighted as a risk and priority by NHS England.

What the chart tells us

The overall turnover rate has improved with positive downward trend with recent performance below lower control limit and target, however the turnover under 12 months is not improving at the same rate and remains stubbornly high.

Underlying issue

- Turnover has been decreasing and position is now below target for the first time in the reporting period.
- Turnover for colleagues with less than 12 months service levels which are still concerning but noted reduction in October 2023. Analysis of what is driving this is currently being undertaken.
- Suggested reasons for leaving is cost of living, career progression however the data from exit interviews is limited (only 197 responses in the past two years)
- Analysis to understand key hot spots, shows that 20% of AHPs are leaving within 12 months and nurses at 18%. HR colleagues are working with professional leads to understand what more can be done to reduce turnover in these areas.
- Identified those areas with most improved turnover in the past 12 months, versus those with consistently high turnover. The highest areas are within CAMHS and most improved seem to be within Specialist Services
- Increased support to develop our managers is key knowing that often individuals experience at work is how they are managed by their line manager.

Actions:

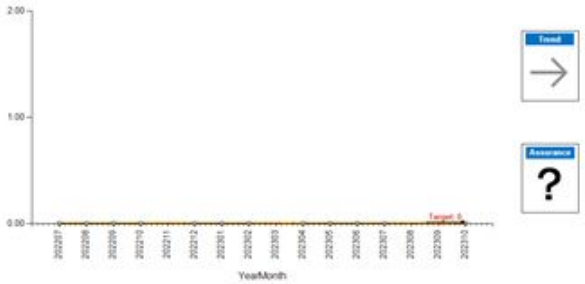
- Work with teams identified to understand what can be learnt to improve turnover across the board ensuring that lessons are learned and shared
- Recognising that this is a whole organisation objective, top tips and management webinars are being prepared to support managers in supporting stay conversations and Insite updated with information that will be useful.
- Initiatives to build conversations earlier with colleagues who might be thinking of leaving including stay webinars, career conversations, etc.
- Exit Interview process has been updated and will go live in December 2023 with some communication
- The Trust is currently undertaking a deep dive into the ethnicity data behind our turnover.
- A comprehensive package of work to support retention is in place and has been discussed with People Matters and People Committee, focussed in three areas; my start, my development and my future. These three themes have been used to categorise the different initiatives.
- In addition to the Retention programme, we must ensure all take responsibility within the organisation to engage with colleagues, understand any concerns which might be leading to people thinking of leaving and also ensure that those who have recently joined are supported.
- The oversight of the retention work programme is overseen by the People Matters Meeting which then reports to the People Committee.

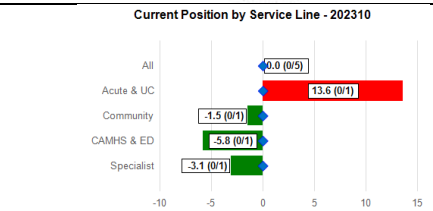
Finance Domain

Grip & Control

% Forecast budget overspend

Target TBC





What Chart Tell us:
The chart indicates that Trust forecast is currently at break-even position.

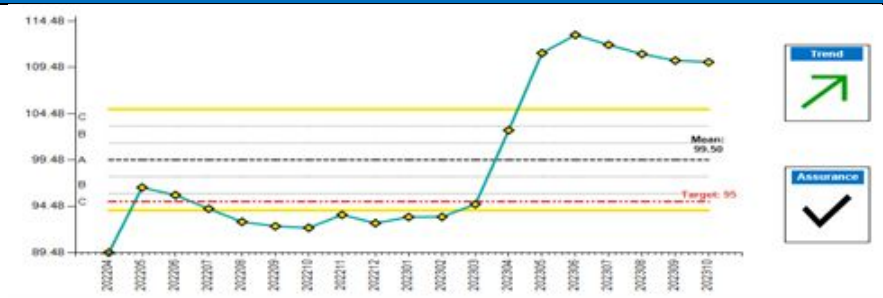
Underlying Issues:
- Trust is breaking even after month 8 compared to plan and forecasting to achieve the planned £0.2m surplus at year end.
- Agency whilst below plan remains above the national requirement of 3.6% of total pay bill.
- The Trust needs to increase recurrent savings delivery; delivery to date is underpinned by non recurrent vacancy factor and other non recurrent means impacting on longer term financial sustainability. Trajectory is needed on productivity savings.
- External beds pressures continue creating a financial risk.
- Acute & Urgent Care: The projected overspend continues to be due to staffing pressures within inpatient services and high external bed usage. Costs associated with specialling have reduced over recent months.

Actions:
- Work with ICB to identify and remaining Agency control gaps or collaborative actions to reduce agency spend.
- Finalise costed agency trajectories to identify potential shortfall against agency targets and further mitigations.
- Ensure plans are in place and being monitored to deliver 100% of the £13m target i.e. move all schemes out of red.
- Overspends due to agency – addressed through review of agency, discussion with individuals to convert to bank or FTC where appropriate and work with medical staffing.
- Acute Urgent Care: Pay overspends on wards (mainly due to observation) continue to be addressed through FSOC and review of observations and engagement- fidelity to the trust policy and recruitment to vacancies with continued good impact in month on most wards. Costs have reduced for the past few months.
- External beds addressed through LoS stay work and DToC work programs and focus on flow in the context of continued high demand and proposed new contract to reduce bed day costs.

Productivity

Contracted activity - Local CCG contract (%)

Target ≥ 95%



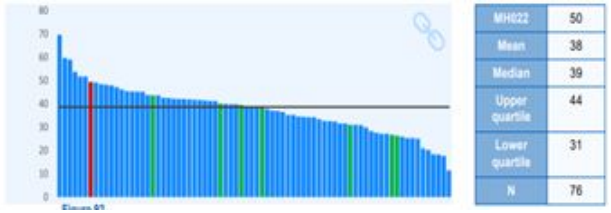
What Chart Tells Us:
Mean performance is above target indicating frequent compliance. 23/24 compliance is comfortably above target and has exceeded upper control limits in recent months.

Underlying Issue:
- Activity plans for 23/24 have been finalised with activity post April 23 based.
- Community: Poor compliance with activity recording in some teams.
- Clinicians may review patients from different teams, but they do not have access to this team's diary on RIO e.g. Depot, CMA and Clozapine Clinics.

Actions:
- Community: Activity recording training within service line has been completed.
- Clinics staff to be given access to all RIO team diaries of patients that they review.

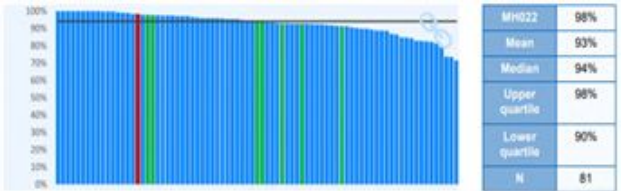
Appendix 1: Benchmarking

The NHS Benchmarking Network's 2022/23 Inpatient and Community Mental Health Benchmarking Report was issued in November 2023 and allows Trusts to benchmark their performance against other participating Trusts throughout England and within their local region. Our Trust is highlighted red in the graphs below, London Trusts are highlighted green and all other Trusts are highlighted blue.



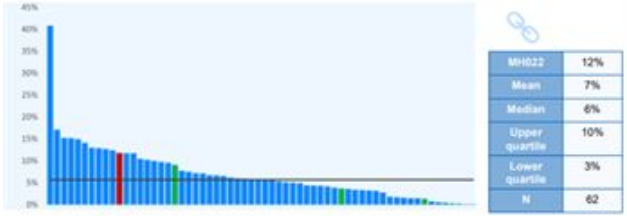
- **Adult acute average length of stay (days):**

2022/23		2023/24	
Trust	England	Oct-23	YTD
50.0	38.0	55.2	51.1



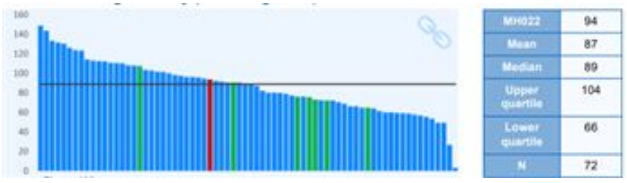
- **Adult acute bed occupancy rate (%):**

2022/23		2023/24	
Trust	England	Oct-23	YTD
98.0%	93.0%	99.0%	98.4%



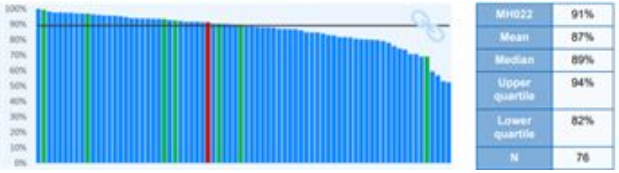
- **Adult acute delayed transfers of care (%):**

2022/23	
Trust	England
12.0%	7.0%



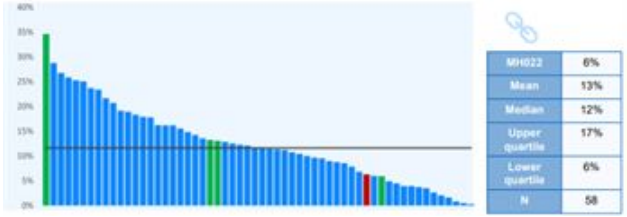
- **Older people's average length of stay (days):**

2022/23		2023/24	
Trust	England	Oct-23	YTD
94.0	87.0	91.8	96.6



- **Older people's bed occupancy rate (%):**

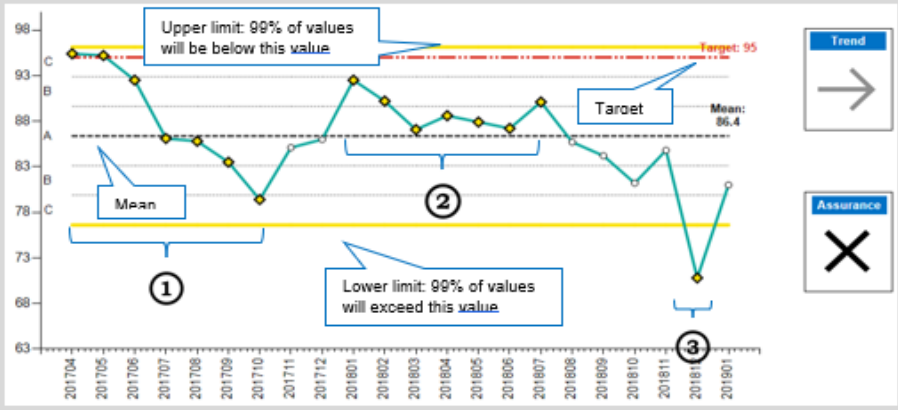
2022/23		2023/24	
Trust	England	Oct-23	YTD
91.0%	87.0%	94.8%	96.7%



- **Older people's delayed transfers of care (%):**

2022/23	
Trust	England
6.0%	10.3%

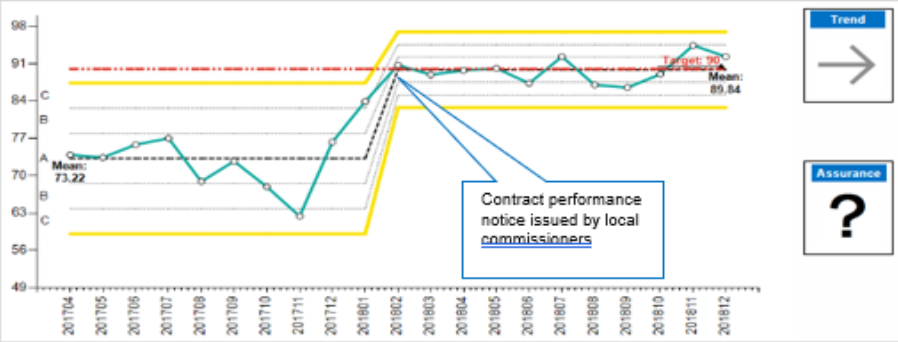
Appendix 2: Statistical Process Control (SPC) Charts & Performance Donut



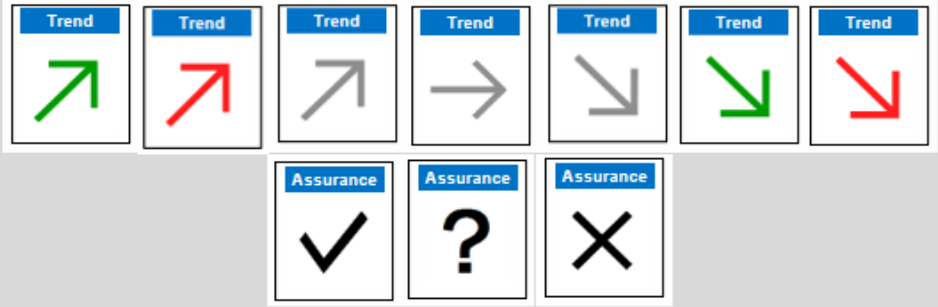
What is an SPC chart?
A Statistical Process Control (SPC) chart is a time series graph (we try to use 2 years) with three reference lines – the mean, upper and lower control limits. The limits help you understand the variability of the data. The variance of the data determines the process limits and you can expect 99% of data points to fall between them in normal circumstances.

Why we use SPC charts
They are used to distinguish between natural variation ('**common-cause**' and not caused by anything in particular) in performance and unusual patterns ('**special cause**', unexpected events) in the data which are unlikely to have occurred due to chance and require investigation. They also give us assurance on whether a target will reliably be met or whether we will never improve without doing things differently and show the impact of any changes made to improve performance.

Evidence suggests that we make better decisions when we've analysed data using SPC



Special-cause variation
These are statistically significant patterns in data which may require investigation and includes the following (as illustrated in the chart above):
Trend: 7 consecutive points trending up or trending down (a 0.8% chance of this happening naturally).
Zone A: 7 or more consecutive points on one side of the average (Zone A or beyond).
Beyond limits: beyond upper or lower control limit.
A full list of the statistical tests applied to determine special cause variation can be viewed under the charts in the Trust's SPC Suite (My Dashboards > Quality > SPC Reports > SPC Suite).
Use of a 'step-change' in SPC charts
Where performance has been permanently affected by a change in process (and the process change is known) then a **'step change'** should be applied to the SPC charts. For example, in the chart opposite the Trust was issued with a contract performance notice and the resulting improvement plan led to a change in process and improvement in performance. In these cases, the mean, upper and lower control limits are recalculated after the change in process.

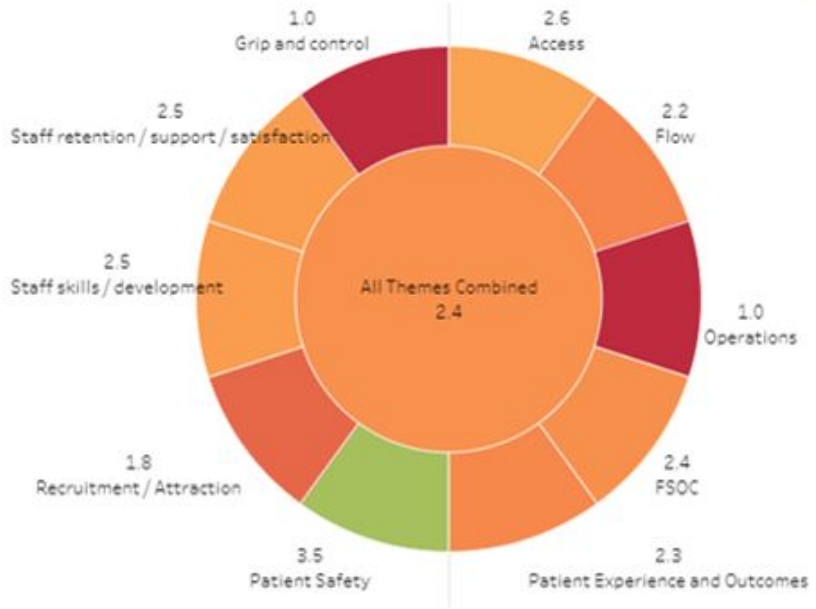


Use of icons to interpret charts
The Trend icon is shown as one of seven upward, horizontal or downward arrows depending on which direction the data is heading, coloured green, grey or red to indicate whether this is an improvement or deterioration in performance (or neutral where there is no target set); the icon is based on any trends identified involving any of the last **SIX** data points.
The Assurance icon
Assurance given: Target is in zone C or beyond (3+ standard deviations) and below the mean; reversed for when target goal is low and target is above the mean.
Questionable Assurance: Target is within zones A and B (1-2 standard deviations).
Assurance not given: Target is in zone C or beyond (3+ standard deviations) and above the mean; reversed for when target goal is low and target is below the mean.
If *Assurance is given* as above, but target has been missed in last 3 months then set to "*Questionable Assurance*" (and reversed for when assurance not given).
If "*Questionable Assurance*", however target has been hit for last 6 months and positive trend identified then set to "*Assurance Given*" (and vice versa for "*Assurance not given*").

Performance Donut Summary

Board Assurance Framework – Latest Risk

A failure to effectively position the organisation within the external environment.



Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	4	16	21	48.8%
Quality	4	8	6	66.7%
Workforce	3	1	7	36.4%
Finance	0	0	2	0.0%
Total	**11**	**25**	**36**	**50.0%**

A table showing how many KPIs have full assurance, some assurance and no assurance, split by domain.

- Overall performance is measured on statistically significant improvement or deterioration and trends and follows NHSI best practice. This replaces performance based on year to date averages and in month performance that are affected by natural variation (RAG rating).
- The new methodology is based on the metrics' assurance on consistently meeting target and whether there is a positive or negative data trend – see appendix 7 for detailed explanation
- The metrics in each of the nine themes are given a score and the average is used to determine the colour rating (shown below).
- The middle section of the 'donut' represents the average score across all 9 themes.
- The table below shows the scores given to each pairing of the 'level of assurance' and 'trend'.
- The best ranking (a positive trend with a 'tick' for assurance) gives a score of 5, while the worst ranking (a negative trend with a 'cross' for assurance) gives a score of 1.

Possible Donut ranking: 5 = best, 1 = worst

Trend \ Assurance	✓	?	✗
↗	5	3.5	2
↘	5	3.5	2
→	5	3	1
↗	4	2.5	1
↘	4	2.5	1

RAG Rating:

Score 1.0 — 5.0

Trust

NHS
South West London and St George's Mental Health NHS Trust

Quality and Performance Report

November 2023

Glossary

Term	Meaning	Term	Meaning
ALOS	Average length of stay	IAPT	Improving access to psychological therapies
BAF	Board Assurance Framework	IPC	Infection Prevention and Control
BCAG	Business Case Assurance Group	KPI	Key performance indicator
CAMHS	Child and adolescent mental health services	LOS	Length of stay
CE	Capital expenditure	NHS	National Health Service
CCG	Clinical Commissioning Group	NHSI	National Health Service Improvement
CMA	Cardio-metabolic assessment	PALS	Patient Advice and Liaison Service
COO	Chief Operating Officer	PCR	Polymerase Chain Reaction
CPA	Care programme approach	PDU	Psychiatric decision unit
CQC	Care Quality Commission	PPE	Personal protective equipment
CIP	Cost Improvement Programme	PTL	Patient Tracking List
CQUINS	Commissioning for quality and innovation	QII	Quality improvement and innovation
DNA	Did not attend	QSAC	Quality Standards Assurance Committee
EBITDA	Earnings before interest, tax depreciation and amortisation	RTT	Referral to treatment
EDS	Eating disorder service	RIDDOR	Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations
EMP	Estates Modernisation Programme	SI	Serious incident
F&IC	Finance and Investment Committee	SLM	Service line management
FBPW	Finance, Business, Performance and Workforce group	SLT	Senior Leadership Team
FFT	Friends and family test	SOF	Single Oversight Framework
FSOC	Fundamental Standards of Care	Trust	South West London and St Georges Mental Health NHS Trust
GP	General practice	WTE	Whole time equivalent
HoNOS	Health of the Nation Outcome Score	W&ODC	Workforce and Organisational Development Committee
HTT	Home Treatment Team	YTD	Year to date

Contents

Part A: Executive Summary

What

The focus of this report is November 2023 and our priority metrics to ensure patient safety and effective care, along with our integrated approach to quality, workforce and overall productivity and sustainability. The quality and performance framework is supported by detailed executive review and discussion at the bi-monthly Service Line Review (SLR) meetings.

Overall performance remains Amber rated, with continued challenges around Neurodevelopment service access, flow through adult acute pathways, and workforce stability in acute and community services.

Pressure on the adult crisis and acute pathway continues at a significant level particularly around patient acuity and complexity, with waits for care due to low discharge levels and therefore increasing use of additional private beds. During November, the Trust piloted a Business Continuity response to the adult pathway flow challenges but with limited immediate impact; learnings have been captured and incorporated into relevant programmes of improvement work. The Trust's position is similar to other London Mental Health trusts who have also seen an increase in LOS and waits to access beds, and to the wider London acute hospital position where there is unrelenting pressure on the emergency pathway. We are leading a collaborative work programme with acute trust colleagues on MH in ED which is being overseen by the SWL UEC board. We are also continuing to evolve the role of the transformed Community teams in the Integrated Recovery Hubs and Enhanced Response Practitioners. During November, the Trust played a leading role in launching the SLP led S136 Coordination Hub and NHS 111 Press 2 for MH call centres, which are showing good initial impact on crisis pathways.

CAMHS and Specialist services continue to deliver good performance overall but with some concerns relating to ward acuity. Safe care is closely monitored through the Quality Matters and QGG processes and in collaboration across SLP to manage patient flow. Further work is taking place on the ADHD assessment service with SWL ICS looking to agree the proposal for a more sustainable primary care led medication review process, but waiting times remain high with increasing numbers of 52 week breaches. The Trust's clinical efficiency work is supporting community teams to ensure they optimise capacity by effective job planning, contact recording, DNA reduction and efficient scheduling, and improvement in contact levels is starting to be seen. Community services are also delivering consistent levels of EIS treatment compliance, CMA and Talking Therapies access and recovery rates, while Perinatal access rates are slowing increasing.

There is ongoing work on staff recruitment, retention and development, including the Trust's leadership development offer, contributing to improving vacancy and turnover rates. There is still significant usage of long term high cost agency within Community service line and for medical posts in Acute and Community services, which is a focus of the Service Line workforce plans and the financial sustainability programme. There is improvement in the level of agency HCA usage associated with more robust controls and improved practice around Therapeutic Observations led by the Acute service line. Work continues to engage with teams through the SIREN monthly process, embedding this within service line structures, and supporting Team Leaders with further soft skills training.

The Trust plan is a £0.2m surplus for the year. To achieve this, the Trust needs to deliver savings of £13m. Cumulative savings delivery to Month 8 contributes £10.6m towards this target and the Trust now has 100% confidence in being able to deliver the full £13m during the year. NHSE has required all trusts to undertake a formal reforecast as part of the H2 planning (second half of financial year to 31/3/24) - as part of this the trust is in receipt of an additional c£600k of income and is forecasting a c£1m surplus which will be reflected from M9 reporting onwards. Underlying pressures remain unchanged.

So What

Further focus is required on our adult acute pathway, building on both transformation and wider system improvement work, due to the ongoing high level of private bed usage driven by long LOS and significant numbers of delayed transfers of care. There are risks to the quality of patient care due to extended waits in crisis for an inpatient bed, as well as a risk of staff burnout due to the continued pressure, exacerbated by workforce shortages and industrial action. Integrated approaches across acute and community services are required and the recent business continuity pilot enabled these to be evolved, for example by explicitly linking inpatient ward, HTT and community consultants as a virtual team to manage flow and bringing Enhanced response practitioners into ED to work alongside Liaison staff. This focus will continue in line with our priority of improved patient journey. Given the importance of this work to the Trust as well as the significant external system pressure on acute MH pathways the Exec continue to support clinical and operational leaders within adult acute and community services with this work, including through OD and leadership interventions.

Relationships with the SWL ICB and with SLP partners are a focus for both acute and specialist services, with the need for partnership working ever stronger. The SWL system sponsorship of our acute MH in ED work, SLP wide acute pathways work including the launch of the S136 hub and NHS 111 press 2 for MH services, and the role of the Complex Care programme in enhancing quality of care and supporting flow, are critical. This is similarly the case to address challenges in our ADHD assessment, Eating disorder and CAMHS bed base and patient flow management, and Forensic development of services.

Ongoing focus on agency reduction as well as recruitment and retention needs to continue, in line with our need for a valued and stable workforce. We look forward to early staff survey results as well as continuing to roll out our leadership offer and support staff engagement and wellbeing. Recruitment improvements mean that we have made progress on HCA and nursing vacancies with more work to

do on medical recruitment, retention and management. Although the pipeline of new recruits into the organisation is strong, there remains a strong focus on better retention of new starters, and on enhancing staff and managers' skills and confidence to deliver and lead our services in a very challenging period.

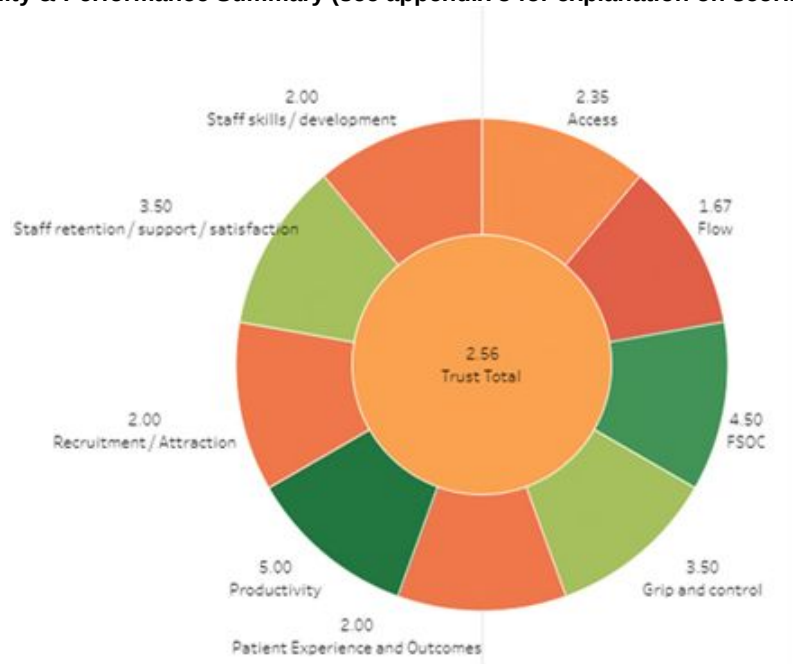
The Trust is in a relatively stable financial position in the context of significant challenges across SWL ICS. More recurrent savings plans would support longer term financial sustainability.

What Next

Further work is being scoped both internally and in partnership with ICS and acute trusts around the crisis and acute pathway, due to ongoing pressure. We will continue to focus on prevention as well as response to mental health crisis demand and to support community based care as the key to a sustainable patient journey. We are working to use recent NHS Benchmarking information demonstrating that our LOS is high compared to other London MH Trusts and we will engage with staff and clinical leaders to understand the drivers behind this and therefore what else we can do to address and reduce our LOS. Looking forward we will be considering how to focus future transformation work on adult services across the whole patient journey and identify how this can support patient flow in its widest sense as well as enhancing quality of care and outcomes for our patients.

We will continue to build on improvements in our workforce metrics to sustain and further enhance our position, particularly looking at local recruitment, retention of new starters and our leadership and development offerings to staff. Medical workforce as well as more robust employee relations support will also be key to this. A range of workforce improvement programmes are in place delivered in partnership between the strengthened HR function and the service line and corporate departments.

Quality & Performance Summary (see appendix 3 for explanation on scoring)



Summary Domain Performance:

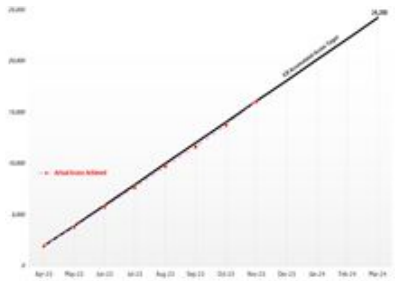
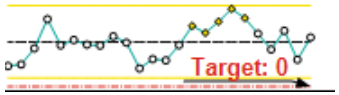
Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	1	5	7	46.2%
Quality	2	1	2	60.0%
Workforce		1	3	25.0%
Finance	1	1		100.0%
Total	4	8	12	50.0%

Donut Performance over-time (all themes combined):

NHS: Oversight Framework

Theme	Metric		Period	Performance (SOF)	Internal Trust Metric	Internal Trust Metric	Benchmarking
Trust	S035a	Overall CQC Rating	Most Recent	3 - Good	N/A	N/A	N/A
	S059a	CQC Well led rating	Most Recent	3 - Good	N/A	N/A	N/A
Workforce	S067a	Leaver Rate	May-23	10.20%	13.7% (Nov 23)	Staff Turnover	
	S068a	Sickness Absence Rate	Mar-23	4.63%	4.9% (Oct 23)	Yes	TBC
	S071a	BME senior staff %	2022	15.20%	31.2% (Nov 23)	Yes	
	S071b	Female senior staff %	May-23	55.60%		Not reported currently	
Experience	S072a	Staff Survey fair career progression	2022	47.60%		Not reported currently	
	S121a	Staff Survey compassionate culture people promise sub-score	2022	7.08 (out of 10)		Not reported currently	
	S121b	Staff Survey Raising Concerns sub-score	2022	6.49 (out of 10)		Not reported currently	
	S133a	Staff Survey Compassionate theme score	2022	7.34 (out of 10)		Not reported currently	
	S063a	Staff Survey Bullying score (from managers)	2022	11.50%		Not reported currently	
	S063b	Staff Survey Bullying score (from colleagues)	2022	16.40%		Not reported currently	
	S063c	Staff Survey Bullying score (from patients/public)	2022	27.10%		Not reported currently	
	S069a	Staff Survey engagement theme score	2022	6.99 (out of 10)		Not reported currently	
Flow	S038a	Consistency of reporting patient safety incidents	Apr-Sep 2022	50%			
	S125a	Adult Acute LoS over 60 days	May-23	35%		Not reported currently	Provided via NHSBN
	S125b	Older adult LoS over 90 days	May-23	39%		Not reported currently	Provided via NHSBN
	S086a	Inappropriate Out of Area placement bed days	May-23	1010	256 (Nov 23)	Yes	

South West London ICS Long Term Plan (LTP) Priority Metrics

ICS Long Term Plan Metrics	Nov-23	Target	SPC Chart	Comments
Number of children and young people accessing mental health services as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people with severe mental illness receiving a full annual health check and follow up intervention as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people accessing IAPT (Trust)	16,067	16,070		Trust is slightly below its cumulative access requirements for 2023/24.
Number of adults and older adults with severe mental health accessing community mental health services	11143	-		The Information Management Team have reviewed metric definition and issued guidance of team category inclusion. There is no target for this metric.
Inappropriate out of area placement bed days - Adult Acute & PICU	256	≤0		Trust continues to require use of out of area beds due to high demand. Trust has renegotiated use of 18 beds at Holybourne until end of 23/24 and continues to open surge beds at times of peak demand.

SIREN

vision | Questions Breakdown | Performance Over Time

SIREN Dashboard

Year Month: 202311 | Press F11 for Full Screen

The Trust had 35 red teams in Nov-23.

There were 111 submissions out of a total of 113 in Nov-23.

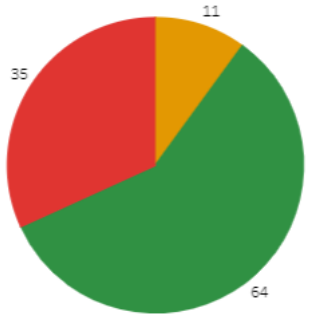
List of Red Rated Teams

Acute And Urgent Care	Lilacs	253
	Ellis	248
	Liaison Psychiatry - Sutton	246
	St Georges Liaison Psychiatry	239
	Ward One PICU	230
	Kingston Liaison Psychiatry	228
	Mental Health Crisis Hub	226
	Ward Two	226
	Perinatal Trauma and Loss Team	224
	Ward Three	202
	Merton Home Treatment Team	200
	Sutton Home Treatment Team	199
CAMHS & ED	Aquarius	210
	CAMHS Complex Learning	139
Community (Adults)	Wimbledon Recovery and Support Team	310
	Wandsworth Early Intervention	303
	Wandsworth SPA	295
	Carshalton & Wallington IRH	293
	Twickenham IRH	277
	Central Wandsworth & West Battersea CMHT	264
	Morden Recovery and Support Team	258
	Merton Adult Assessment Team	249
	Mitcham Recovery and Support Team	245
	Merton Uplift PCRS	228
	Sutton and Cheam IRH	228
	Wandsworth Complex Needs Service	228
	Sutton PLRS - Single Point of Access	221
Specialist Services	Sutton Adult ADHD Service	316
	Richmond Adult ADHD Service	276
	Merton Adult ADHD Service	267
	Sutton Adult ASD Service	260
	Forensic Outreach Service	228
	Sutton MH Learning Disability Team	228
	Merton MH Learning Disability Team	221
	Merton Adult ASD Service	209

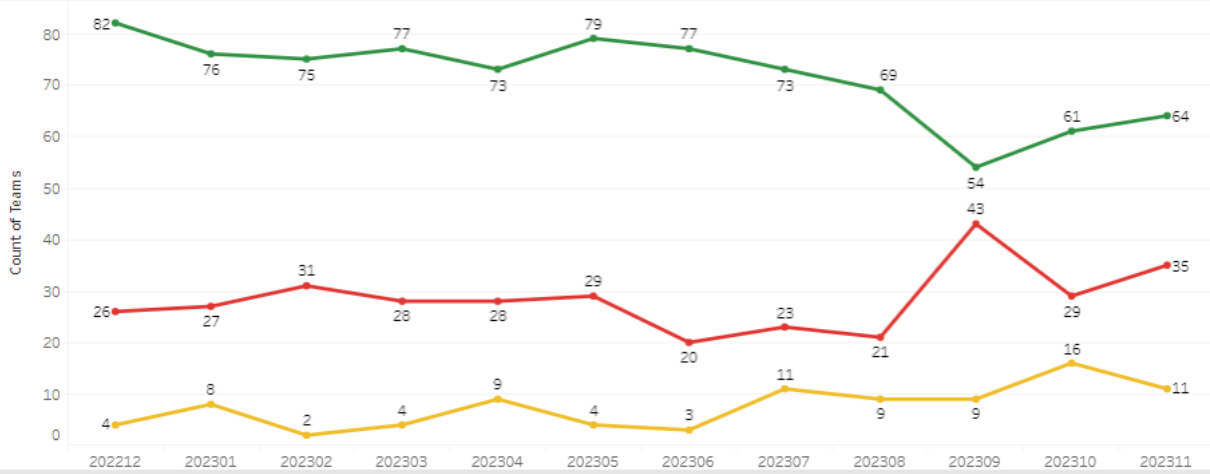
Count of SIREN Ratings by Siren Type

SIREN Type	Green	Amber	Red
CAMHS	4		
CAMHS NP	11	1	1
CMHT	12	5	10
Daycare	1		
EIS	4		1
Hostel	1		
HTT	2	1	3
Inpatient	14	2	6
LD	2		2
Other	13	2	12
Grand Total	64	11	35

SIREN Rating Breakdown



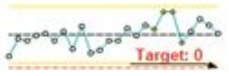
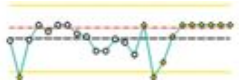
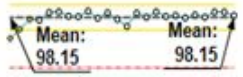
Team Count of SIREN Ratings

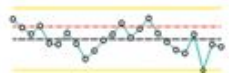
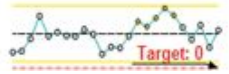


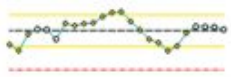
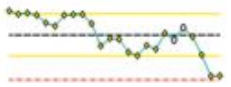
SIREN – November 2023 Summary Commentary

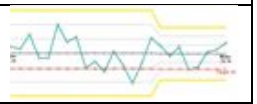
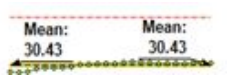
- SIREN continues to be used within team and service line meetings on a regular basis to support understanding and action on concerns. New overview SIREN dashboard very well received showing detail of drivers behind red and amber areas enabling more detailed discussion.
- The number of red rated teams has increased slightly, driven by continued challenges within A&UC and Community teams where most of the teams of concern are.
- **CAMHS & AED: (link to ward acuity)**
  - ❑ CAMHS showing only 2 red teams as correction to caseload thresholds and improved stability within community teams has fed through
  - ❑ Aquarius ward flagging red, related to staff turnover/vacancies in the context of ongoing bed pressures across CAMHS SLP. This is being actively managed at exec level and the team on Aquarius supported.
- **Community: (key link to caseload LOS and waiting times, vacancy rates and use of agency, and team morale)**
  - ❑ High number (13) of red teams spread across the boroughs. Workforce gaps (particularly medical roles), supervision levels, high caseload, turnover/ leadership change, and use of agency are all flagged as challenges. There are known pressures on these teams due to both internal (eg recruitment & transformation programme) and external (eg expected changes to section 75 integrated working in Merton) factors. The Dep HOSD are working to support the clinical managers and their teams. The Enhanced response practitioners and ACPs are also being deployed to teams to support their risk management and clinical oversight especially in the context of high pressures within the crisis pathway and discharge flow.
  - ❑ Further work required to embed enhanced leadership support and OD work and to continue to integrate approaches for adult services across the pathway.
- **A&UC: (key link to ongoing pressure on the crisis and acute pathway)**
  - ❑ Significant challenges with 12 red rated teams. Tolworth wards Lilacs and Ellis both flagging as of high concern – some ER issues driving this, relating to concerns over practice which are being addressed, and associated complaints. Supporting ward manager to build the team, esp with other new MDT members. Tolworth wards often struggle with getting bank staff and have challenges with the use of agency who do not have Rio access, a high vacancy rate on Ellis ward is of concern. Actions agreed in particular to support more proactive deployment of HCA staff into vacancies
  - ❑ Liaison psychiatry teams have significant vacancies interacting with stress, workload and morale in the crisis pathway and ED environment. Focused recruitment efforts but remains challenging. Considering how to connect the teams most effectively with improvement work in train ensuring local ownership.
  - ❑ Ward 1 has known challenges around leadership and complex patients; improvement plan in place. CSL overseeing directly.
- **Specialist: (key link to ADHD assessment long waits)**
  - ❑ Overall 8 teams showing red. ADHD and ASD teams issues reflect turnover, changes in leadership roles and high caseload. This is a recognized issue with support being offered but there is a challenge in addressing the waiting list due to delay in agreeing a new model by SWL ICB. Meeting now set for end Jan but teams are being kept informed. MHLD teams showing red due to vacancy (and use of agency) and turnover rate relating to psychology and CPN roles.
  - ❑ Jasmines ward noted as not flagging red on SIREN which is a concern. SL leadership feel this should be flagged due to ongoing incident and culture concerns and will be addressing with the team, significant plan of improvement in place.

Priority Metrics

	Priority Metrics	Nov-23	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 12)	63.2	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 13)	33	= 0	↗	X	
	Access					
	Referral to treatment (RTT): 52 week breaches (see page 15)	618	= 0	↗	X	
	Access					
	Expected population need IAPT – Trust (see page for service breakdown 15)	2301	>=2032	↗	?	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 16)	100.0	≥ 95.0	↗	?	
	Access					
	Adult Acute Bed Occupancy (see page 18)	98.4	≤ 90	→	X	
	Flow					
	Number of adults and older adults receiving 2+ contacts in new integrated model across the core and dedicated service provision (see page 19)	11142	-	↗	-	
	Flow					

	Priority Metrics	Nov-23	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (See page 12)	75.3	≥ 95.0	→	X	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 14)	64.1	≥ 92.0	↘	X	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 16)	7.2	≥ 10.0	↗	X	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 17)	63.4	≥ 80.0	→	?	
	Access					
	Dementia diagnosis within 6 weeks of referral to a memory assessment service (%) (see page 17)	88.3	>= 85	→	?	
	Access					
	Adult acute average length of stay (Excluding PICU) (see page 18)	53.8	≤ 38	→	?	
	Flow					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 19)	256	≤ 0	↗	X	
	Flow					

	Priority Metrics	Nov-23	Target	Trend	Assurance*	SPC Chart
Quality	Cardiometabolic Assessments - Community and EIS (%) (see page 20)	84.1	≥ 75.0	↘	✓	
	Fundamental Standards of Care					
	Patient Friends and Family Test (%) (see page 21)	87.2	≥ 92.0	↗	✗	
	Patient Experience and Outcomes					
	Paired HoNOS Completed (See Page 22)	35.9	-	↘	-	
	Patient Experience and Outcomes					
	Death - Suspected suicide (see page 23)	5	-	→	-	
	Patient Safety					
Workforce	Vacancy Rate (%) (see page 24)	15.4	≤ 15	↘	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 1 (%) (see page 26)	91.7	≥ 95.0	↗	✗	
	Staff Skills/Development					
	Turnover (%) (see page 27)	13.7	≤ 15	↘	✗	
	Staff Retention/ Support / Satisfaction					
Finance	% Forecast Overspend (See Page 28)	0	≤ 0	↘	✓	
	Grip & Control					

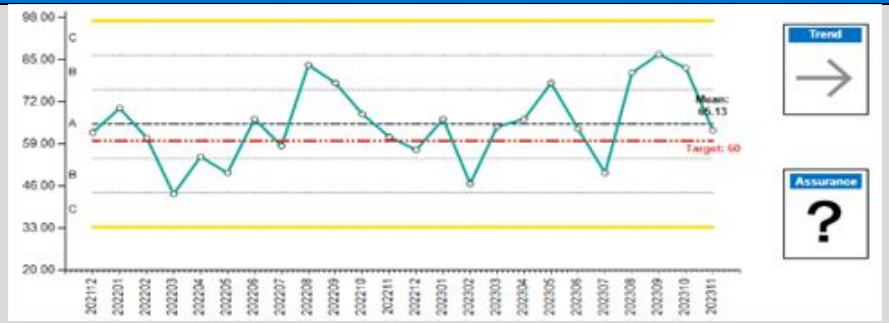
	Priority Metrics	Nov-23	Target	Trend	Assurance*	SPC Chart
Quality	Safe Staffing: National Compliance - Inpatients (%) (see page 20)	125.7	≥ 95.0	↗	✓	
	Fundamental Standards of Care					
	IAPT recovery rate – Trust (%) (see page 21)	53	>=50	→	?	
	Patient Experience and Outcomes					
	Paired Dialog Completed % (see page 22)	19.2	≥ 40.0	→	✗	
	Patient Experience and Outcomes					
Workforce	Percentage of BAME staff - Band 8+ and Medical (see page 25)	31.3	≥ 50.0	↗	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 2 (%) (see page 26)	89.8	≥ 85.0	→	✓	
	Staff Skills/ Development					
Finance	Activity vs Plan (Local Contract) (See Page 28)	110.9	≥ 95.0	↗	✓	
	Productivity					

* This refers to assurance that the performance of a metric will consistently exceed the target

Operations Domain

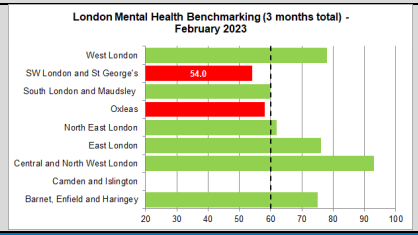
Access

1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) Target ≥ 60%



Team Breakdown – November 2023

Team	Treatment within 14 days	Referrals	% Treatment within 14 days
Kingston Early Intervention Service	2	2	100%
Merton Early Intervention	3	4	75%
Richmond Early Intervention Team	1	2	50.0%
Sutton Early Intervention	3	4	75%
Wandsworth Early Intervention	3	7	42.9%
Trust Total	12	19	63%



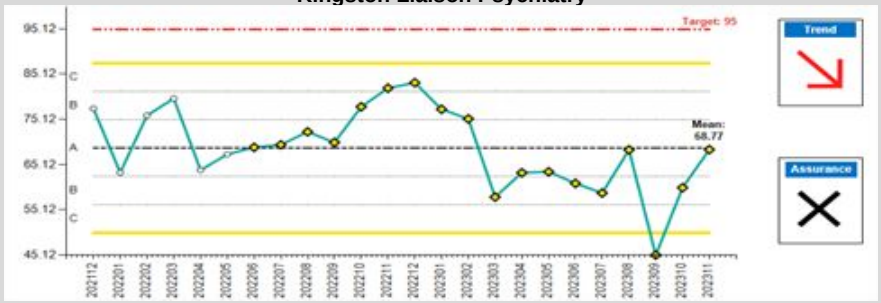
Background
There is good evidence that early intervention, when delivered in accordance with NICE standards, helps people to recover from a first episode of psychosis and to gain a better quality of life.
What the chart tells us
The Trust can be expected to frequently exceed the target which is below average performance.
Underlying issues
- Inconsistent clinical oversight of waiting list and validation is not always completed promptly.
- Some inpatient wards and adult assessment teams are slow to refer patients on to EI services once psychosis is identified making it much harder for them to meet the waiting time targets.
- RiO is not configured to allow the accurate recording of first episode of psychosis and provide a workflow; as a result, there is an administrative burden on teams to manually validate all waiters.
- Wandsworth EIS using agency staff and further work is required relating to induction of said staff.
- Feedback from National Clinical Audit of Psychosis 2023 scored all 5 Borough's as "top performing" in regard to timely access.

Actions:
- Targeted training for SPA teams to continue in order to reinforce the importance of timely referrals.
- Alert system is now available in RiO which will support workflow for recording first episode psychosis.
- Ensure EIS teams use duty system to check FEP waiters daily on dashboards. Ensure team seniors (manager and deputy) have daily oversight on new referrals/waiters.
- Teams to proactively in-reach and work with wards if suspected FEP present.
- Community Service line to engage with acute services to improve processes for timely referrals to EIS.
- Teams to prioritise medical slots for FEP assessments to help capacity management.

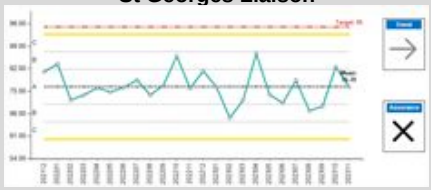
Access

Liaison psychiatry - Seen within 1 hour in A&E (%) Target ≥ 95%

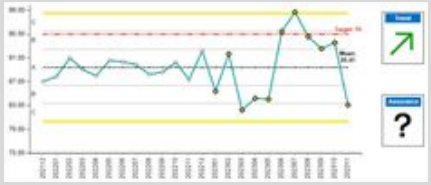
Kingston Liaison Psychiatry



St Georges Liaison



St Helier Liaison



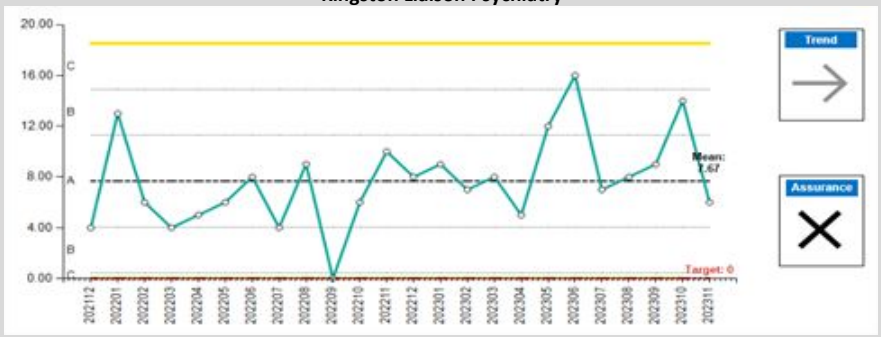
Background
Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care' published by NICE in 2015 states that an emergency liaison mental health service should respond within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment.
What Chart Tells Us:
Mean performance is below target across all 3 Liaison services.
Underlying issue:
- The process of managing Emergency Referrals is impacted by many factors such as staffing shortages (including sickness and vacancy rate, cubicle space (St George's), other activities such as handover and multiple referrals from both ED and wards.
- Impact of extended number of patients waiting for MH beds in general hospital requiring further reviews.
- Acute hospitals have been experiencing a high level of acuity and this has had an impact on referrals into liaison services capacity.
- Administrative burden for liaison staff as they have to update both Trust and acute hospital clinical records.

Actions:
- Liaison Transformation Plan: The transformation workstream that will consider MH triage functions to support 1 hour KPI and ward referrals.
- Shift patterns have been reviewed as part of Pilot evaluation and Core24 compliance. Proposals sent to Finance to cost before engagement/consultation work to begin with Teams.
- Clinical Service Lead and Matron undertaking staffing review in regard to demand and capacity and CORE24 compliance. This is a longer term piece of work and will be trialled in Kingston Liaison initially.
- Service line is in discussion with Kingston Hospital to pilot Rapid Assessment Clinic on site at Kingston for one week. Timeframe for rollout is November/December.
- The Trust is part of the SWL ICB Task & Finish Group to commence in the New Year. The group will be looking at MH in ED challenges and work out best options to support system pressure, flow and impact on existing resources.

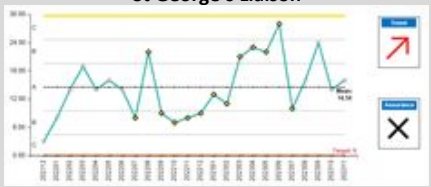
Access

Liaison psychiatry – People waiting over 12 hours in A&E for a bed — Target = 0

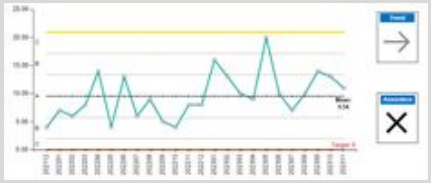
Kingston Liaison Psychiatry



St George's Liaison



St Helier Liaison



Background
Patients assessed at A&E by Liaison Psychiatry should not experience long waiting times if access to a bed is required.

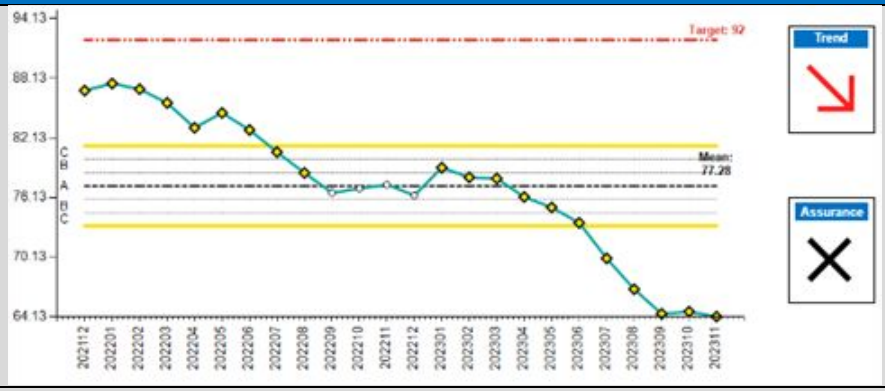
What the charts tells us
The level of 12-hour breaches is increasing across the three services with occasional variation.

Underlying issue
- A lack of available adult acute beds will lead to an increase in waits over 12 hours.
- Increased LOS and D
- TOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital step down beds.

Actions
- Matron and CSL meeting with Associate Director of Transformation to discuss review method of providing assurance that patients are being reviewed at least once a day. Diary contact assurance is not reliable.
- Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds.
- Substantive recruitment of Consultant Psychiatrist to Kingston Liaison Psychiatry and also successful recruitment across services.
- The Trust has contract for use of 18 beds at Holybourne in Roehampton until the end of the financial year.
- Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds.
- Service line is in discussion with Kingston Hospital to pilot Rapid Assessment Clinic on site at Kingston for one week. Timeframe for rollout is November/December
- The Trust is part of the SWL ICB Task & Finish Group to commence in the New Year. The group will be looking at MH in ED challenges and work out best options to support system pressure, flow and impact on existing resources.

Access

Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) — Target ≥ 92%



November 2023 RTT Waiting by Service Line and Team Category

Service Line	Team Category	Count of Clients	18 Week Breaches	% Within 18 Wks	30 Week Breaches	52 Week Breaches
Acute And Urgent Care	Home Treatment	9	0	100.0%	0	0
	Liaison	78	0	100.0%	0	0
	Specialist Services	196	3	98.5%	0	0
CAMHS & ED	CAMHS Access/Referral	2,071	446	78.5%	88	2
	CAMHS Tier 3	586	259	55.8%	127	14
	CAMHS Tier 4	6	0	100.0%	0	0
	Deaf Services	61	22	63.9%	2	0
	Eating Disorders	171	85	50.3%	44	5
	Liaison	10	0	100.0%	0	0
Community (Adults)	Adult CMHT	1,243	52	95.8%	7	2
	Early Intervention	15	0	100.0%	0	0
	Psychological therapies	15	0	100.0%	0	0
	Specialist Services	20	0	100.0%	0	0
	Other	7	0	100.0%	0	0
Specialist Services	ADHD/ASD	2,146	1,632	24.0%	1,219	595
	Forensic Services	9	0	100.0%	0	0
	Learning Disabilities	17	0	100.0%	0	0
	OCD/BDD	19	1	94.7%	0	0
	Older People	320	1	99.7%	0	0
	Specialist Services	355	137	61.4%	3	0
Total		**7354**	**2638**	**64.1%**	**1490**	**618**

Background

The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to start of treatment (RTT) by a consultant led service.

What the chart tells us

Mean performance is below target (which is above upper control limit) and there has been a significant downturn trend in performance. A change in process is required.

Underlying issue

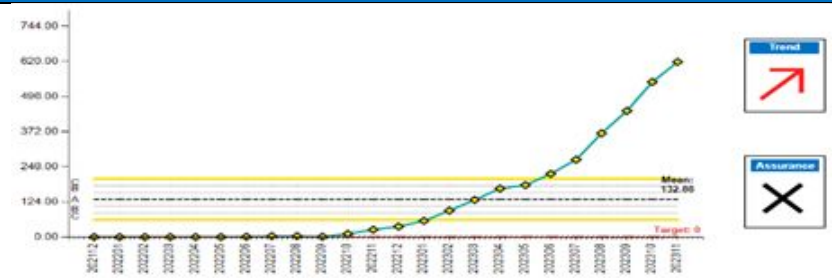
- **Adult ADHD:** There are known demand and capacity issues within the service; in November 2023, 61.9% (1632/2638) of the 18-week breaches relate to this service (see below for further information). Continued increase in caseload (for annual medication review) will impact on service assessment capacity.
- **Neuropsychiatry:** Reduced medical capacity has led to increase in long waiters. Cancellations and re-scheduling of clinics due to staff leaving has also impacted.
- **CAMHS Tier 3:** ADHD medication titration waiters due to on-going psychiatry staffing shortages and Psychiatry case managing increase for psychology waiters.
- Individual therapy waiters due to on-going staffing shortages in Clinical Psychology positions (especially in Kingston, Richmond and Wandsworth Tier 3).
- **CAMHS SPA:** Longest waits are linked to cases awaiting of completion of Neurodevelopment screening.
- **Adult Eating Disorders (AED):** Service only outcome an appointment as "treatment" when it meets NICE evidence based guidance. Therefore some clients who are being seen for i.e. dietetics outreach or step for changes group will remain as waiters as their appointment don't meet threshold for evidence based NICE treatment.
- **Community Service Line:** There is a lack of oversight on RTT dashboard by Team Managers – updates on cases are not contemporaneous.

Actions

- **Adult ADHD:** Trust working with ICS to develop a sustainable solution for Adult ADHD pathway management.
- An ICB led Task and Finish Group with SWLSTG and Primary Care representation commenced in July 23 has now concluded and a draft service specification for primary care was presented to ICB SMT in November 2023.
- Recruitment of 2wte Non Medical Prescriber roles in Sutton and Merton – estimated start January 2024. Continue to utilise 1.1 WTE Locum Medical Staff.
- Neuropsychiatry: Recruitment for medical vacancies. Aiming for full recruitment by end of January 2024. The team has also tightened its administration around management of DNA's.
- CAMHS: Continued recruitment across T3 teams following investment.
- Non-medical prescriber newly recruited for Kingston and Richmond CAMHS Tier 3 to address the ADHD medication backlog across both teams. Locum non-medical prescriber recruited for Wandsworth. GP with specialist interest in ADHD working alongside psychiatry on wait list reduction in Richmond.
- Therapy waiting cases are reviewed through 8 weekly review calls and all waiting patients are provided with a While you Wait support pack.
- Adult Eating Disorders (AED): AED: Pathway and process review being undertaken with clinical lead and ACD in order to maximise use of resource for treatment.
- Demand and capacity work completed and the team have increased their activity which is being sustained.

Referral to treatment (RTT): 52 week breaches — Target = 0

Access



52 Week Breaches – November 2023

Team	Nov
Sutton Adult ADHD Service	309
Merton Adult ADHD Service	156
Richmond Adult ADHD Service	130
Adult Eating Disorders Outpatients	5
Richmond CAMHS Tier 3	5
Kingston CAMHS Tier 3	3
Merton CAMHS Tier 3	3
CAMHS Complex Learning	2
Merton CAMHS Referral	1
North Kingston Integrated Recovery Hub	1
Twickenham IRH	1
Wandsworth CAMHS Referral	1
Wandsworth CAMHS Tier 3	1
Total	618

What the chart tells us:
Historic performance consistently met target; however recent months have seen significant increase in 52 week breaches with performance above upper control limit in last 6 months; a change in process is required.

Underlying issues that prevent us from consistently reaching the target:

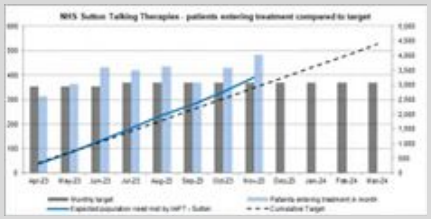
- Adult ADHD: There are known demand and capacity issues within adult ADHD services and there is a continued risk of further increase in 52 week breaches. The levels of 52 breaches will continue to rise as diagnosed cases remain on the adult caseload for annual medication review.
- CAMHS Tier 3: Most Breaches were linked to waits for ADHD medication commencement.
- Adult Eating Disorders service currently has 5 breaches - all patients are regularly reviewed whilst on therapy waitlist.
- CAMHS Complex Learning: There are currently two breaches linked to demand and capacity issues.

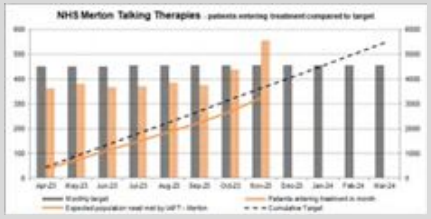
Actions:

- An ICB led Task and Finish Group with SWLSTG and Primary Care representation commenced in July 23 has now concluded and a draft service specification for primary care was presented to ICB SMT in November 2023.
- **Adult ADHD:** Recruitment of 2wte Non Medical Prescriber roles in Sutton and Merton - estimated operational date 1st January 2024. Continue to utilise 1.1 WTE Locum Medical Staff.
- Bi-weekly administration meetings are held to ensure cancellations are managed promptly and 52 weeks breach lists are cleansed routinely and prioritised.
- CAMHS: Non-medical prescriber newly recruited for Kingston and Richmond CAMHS Tier 3 to address the ADHD medication backlog across both teams. Locum non-medical prescriber recruited for Wandsworth. GP with specialist interest in ADHD working alongside psychiatry on wait list reduction in Richmond.
- Adult Eating Disorders (AED): Pathway and process review being undertaken with clinical lead and ACD in order to maximise use of resource for treatment.
- New treatment groups (MANTRA) are will now accept pts as patients drop out. Team exploring the same for CBT/DBT group.

Expected population need met by IAPT (numbers entering treatment)

Access





Background
Improving Access to Psychological Therapies (IAPT) is an NHS programme in England that offers interventions approved by NICE for treating people with depression or anxiety. In 2021/22 NHSE (agreed with Commissioners) have set a flat rate of cases entering treatment for each CCG area.

What the chart tells us
Two (Sutton IAPT & Richmond Wellbeing Service) of the four IAPT services are above their cumulative access requirements for 23/24. Merton Uplift is considerably below its requirement whilst Talk Wandsworth performance is just below target. Trustwide access performance is now above target.

Underlying issue

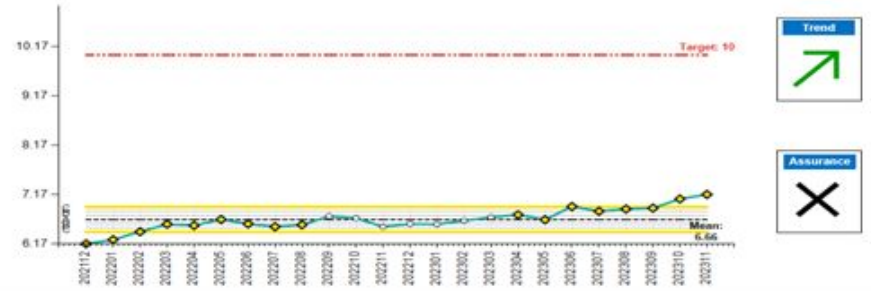
- There is insufficient resource in Wandsworth, Merton, and Sutton and therefore meeting access requirements whilst maintaining (already long) stable waiting times, and achieving recovery rates, will continue to be an ongoing challenge.
- There are insufficient referrals in Merton and Wandsworth, although this is improving with the use of iPlato.
- IESO self-referrals were switched off as demand and performance has exceeded the subcontract agreement.

Actions

- iPlato (3rd party provider) has proven to be very successful in increasing the numbers of referrals across all 4 boroughs to help achieve access (marketing).
- Service managers are closely monitoring referral numbers (daily) and ensuring there are sufficient assessment slots available to meet access targets.
- Bookings are being closely monitored to ensure all assessment appointments are being fully utilised and there a no lost appointments.
- Service managers are continuing to monitor capacity to ensure that clinicians are adhering to job plans.
- Excess referrals are being sent to sub providers (as these count towards our access), meaning we can go above our capacity ceiling (but at a cost).

Perinatal: women accessing specialist PMH services as a proportion of births — Target ≥ 10%

Access



Perinatal Access: The metric is based on a rolling 12-month period. To be included in the numerator, the patient has to have been seen FTF or via e-consultation in the preceding 12 months. This is a count of distinct patients not referrals.

Measure	202301	202302	202303	202304	202305	202306	202307	202308	202309	202310	202311
Women accessing PMH services *	1,024	1,035	1,046	1,054	1,038	1,080	1,065	1,072	1,075	1,104	1,118
Estimated births	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595
Nationally Published Figures: Service use per birth (ONS)	6.6	6.6	6.7	6.8	6.7	6.9	6.8	6.9	6.9	7.1	7.2
Service use per birth (For Context Only)	*7.7*	*7.8*	*7.9*	*8*	*7.8*	*8.2*	*8*	*8.1*	*8.1*	*8.3*	*8.4*

Background
Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of new and expectant mums and covers a wide range of conditions. The NHS Long Term Plan is for improved access to perinatal care for mums who with moderate / severe Perinatal Mental Health.

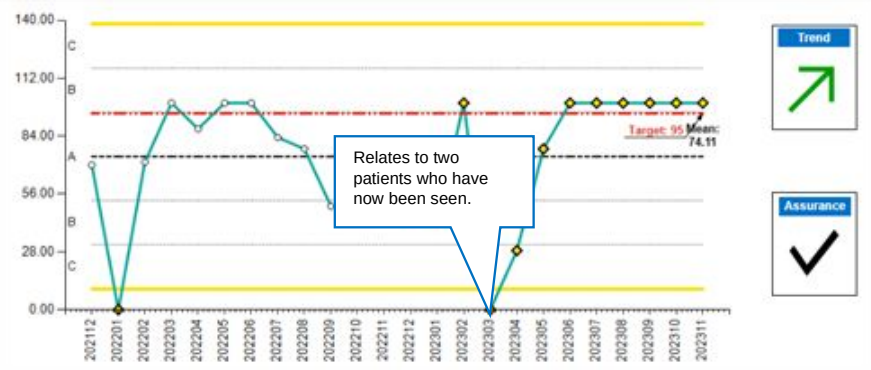
What the chart tells us
Although a slight upward trend is observed mean performance is below national requirement (target).

Underlying issue
- National target is based on predicted birth rate (2016 census data) which is higher than the actual local birth rate in 2022.
- Number of referrals received progressing to assessment is too low in order to reach access requirements of 10% of PMH population.
- High DNA rate.

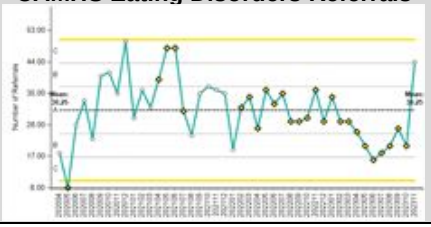
Actions
- Ongoing development of Perinatal Trauma and Loss Service with review of additional capacity and impact on access. Service has now been rolled out across the three South West London acute hospitals.
- Following investment there has been recruitment into newly funded posts (nursing, nursery nurse, P&P) this will be completed in November 2023.
- Peer Support Worker posts to be recruited into in October/November, with focus of roles on DNA project.
- 12-24 month long term plan work currently being progressed.

CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) — Target ≥ 95%

Access



CAMHS Eating Disorders Referrals



Waiting for Treatment Summary November 2023

		00 - 01	01 - 02	02 - 03	Total
Waited	Standard	5	0	3	8
	Urgent (7days)	1	2	0	3
Waiting	Standard	8	3	3	14
	Urgent (7days)	0	1	0	1

Background
To ensure that young people in urgent need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target. Recent months performance has shown improvement with full compliance for last five months.

Underlying issue
- Long term demand and capacity issues within the team.
- Over-reliance on part time staff to maintain administrative systems.
- The denominator for this KPI is low (n=8) in November 2023, so any case seen outside 28 days is likely to lead to target being missed. Full compliance noted for last three months.
- Recruitment into the service has been challenging with certain posts difficult to recruit to.

Actions
- More robust scrutiny of long waiters from service has led to improvement in recent months.

Access

CAMHS - Non-Urgent referrals assessed within 8 weeks (%) — Target ≥ 80%

Row Labels	Seen within 8 weeks	Assessed	%
Wandsworth CAMHS Tier 3	18	19	94.7%
Sutton CAMHS Tier 3	17	23	73.9%
Kingston CAMHS Tier 3	6	12	50.0%
Merton CAMHS Tier 3	7	14	50.0%
Richmond CAMHS Tier 3	11	25	44.0%
Total	59	93	63.4%

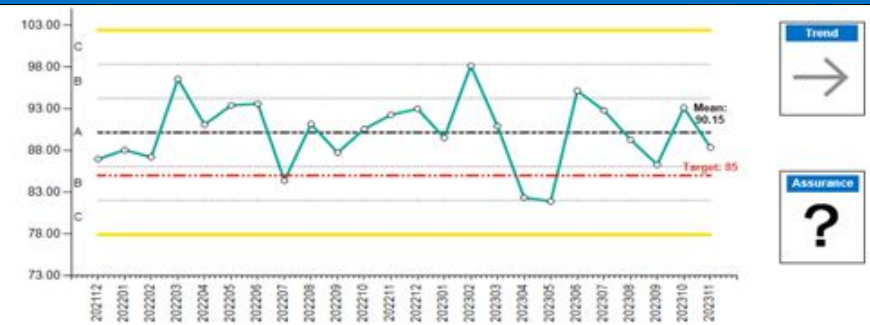
Background
To ensure that young people in need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target indicating compliance on occasion. Recent months have deteriorated with September 2023 performance below control limit.

Underlying issue
- Most breaches relate to waits for ADHD medication and Psychiatry shortage across community CAMHS. As T3 CAMHS continues to assess more of the backlog of ADHD waiters this KPI will continue to deteriorate of until the backlogs are cleared.
- There are delays in ADHD medication due to the prioritisation of urgent referrals, screening forms being returned late, cancelling appointments and a small number of errors in recording.
- Psychiatry continues to priorities higher risk referrals for appointments, meaning ADHD medication waiters (who are of less risk) will continue to be reason for most 8-week breaches.

Actions:
- Non-medical Prescriber (NMP) is increasing assessment activity for long-term ADHD medication waiters (will continue to breach 8 week until backlog is cleared).
- Locum NMP starting in November 2023 in Wandsworth CAMHS to support psychiatry with ADHD caseload.
- Continue to recruit to T3 following investment to increase choice assessment resource.
- Pilot of GP with specialist interest for ADHD medication commenced in Kingston & Richmond.

Dementia diagnosis within 6 weeks of referral to a memory assessment service (%) — Target ≥ 85%



Team Breakdown – November 2023

Team	Diagnosed within 6 weeks	Diagnosis required	%
Kingston Memory Service	14	14	100.0%
Memory Assessment Service Wandsworth	35	44	79.5%
Merton Memory Assessment Service	10	10	100.0%
Richmond Memory Assessment Service	12	14	85.7%
Sutton Memory Assessment Service	20	21	95.2%
Total	91	103	88.3%

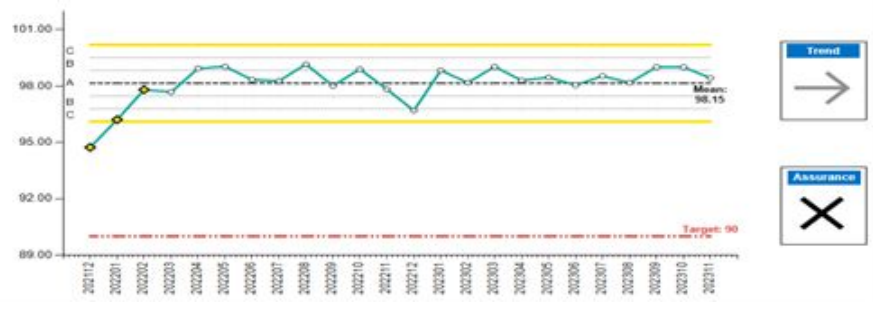
What the chart tells us
Mean performance is comfortably above target indicating frequent compliance with occasional variation.

Underlying issue
- 12 breaches reported in November 2023.
- 4/5 MAS services met target in November 2023. Memory Assessment Service Wandsworth has had increased demand in October and November and this has contributed to diagnostic delay.

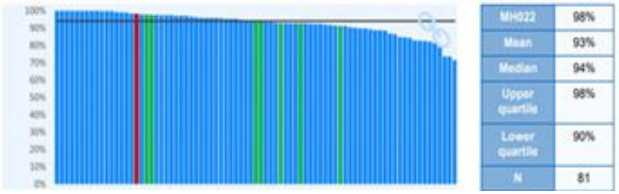
Actions
- **Trust:** Work with CCG to increase referral activity where DDR rate is low- e.g. Kingston.
- Continued monitoring and additional support for teams where needed.

Bed Occupancy on acute adult wards (%) — Target ≤ 90%

Flow



2022/23 Benchmarking (Trust is highlighted red, other London Trusts are highlighted green)



MH022	98%
Mean	93%
Median	94%
Upper quartile	98%
Lower quartile	90%
N	81

Background
Occupancy rate is the number beds occupied divided by the number of available bed days.

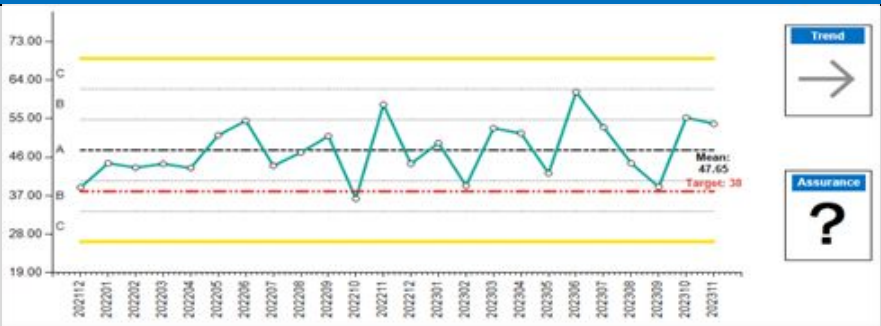
What the chart tells us
Low level variation with mean performance considerably above target.

Underlying issue
- Demand for inpatient services remains high, with over performance on occupancy rates resulting in use of out of area placements.
- Out of area placements have increased through August.
- Work to address occupancy rates is outlined within the 100 day challenge work within inpatient transformation.

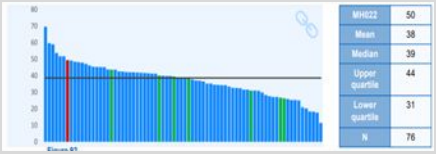
Actions
- The Trust has extended its contract for use of 18 beds at Holybourne in Roehampton until the end of 23/24.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- 100 discharge challenge flow interventions have been implemented and AUC service line continue to work on embedding transformational change.
- A revised KPI definition for Adult Acute Bed Occupancy reporting is in process of being finalised.

Adult Acute monthly average length of stay (excluding PICU) — Target ≤ 38

Flow



2022/23 Benchmarking (Trust is highlighted red, other London Trusts are highlighted green)



MH022	50
Mean	38
Median	39
Upper quartile	44
Lower quartile	31
N	76

November 2023

Background
Average length of stay is important as it informs future bed planning. This definition was agreed by the Bed Management Project Group and approved by Trust Executive. It includes out of area placements and excludes stays on PICU wards and leave.

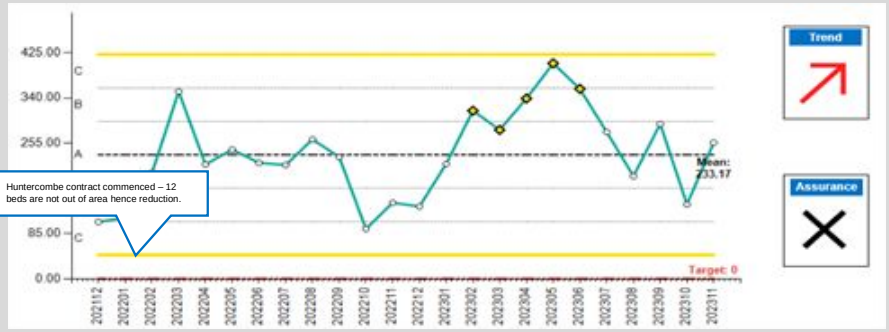
What the chart tells us:
Trust average performance consistently exceeds target.

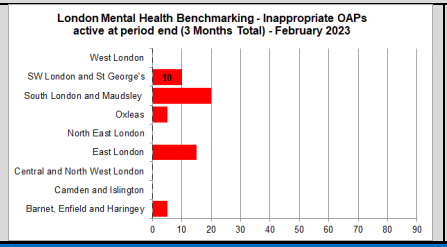
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds as the overall bed stock is reduced with less complex cases now being treated in the community.
- DTOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital.
- Reduced flow in the wider system - social services and supported accommodation providers.
- Increased demand can lead to increased acuity on admission and longer time to recover.
- There is variation on LOS between adult acute ward.

Action
- Continuing to embed 100 day challenge including engagement of Holybourne.
- CSLs are continuing to support ward managers to embed the inpatient admission and discharge checklist.
- Contract meeting being booked for ELFT to review pathways and LOS alongside other quality metrics.
- Complex Emotional Needs (CEN) pathway training to be undertaken in November 2023.
- Mini MADE events held in October 2023.

Inappropriate Out of area placement bed days - Adult Acute & PICU — Target = 0

Flow





Background
The Five Year Forward View for Mental Health aims to end entirely the practice of sending people out of area due to local adult acute bed pressures by no later than 2020/21. The data includes 5 beds purchased at East London Foundation Trust that from April 2020 meet the DOH criteria, including continual record sharing, as appropriate. Typically, an inappropriate placement would relate to the patients admitted to the private sector. In this instance regular reviews and follow-ups are conducted by Trust staff to ensure the delivery of effective care.

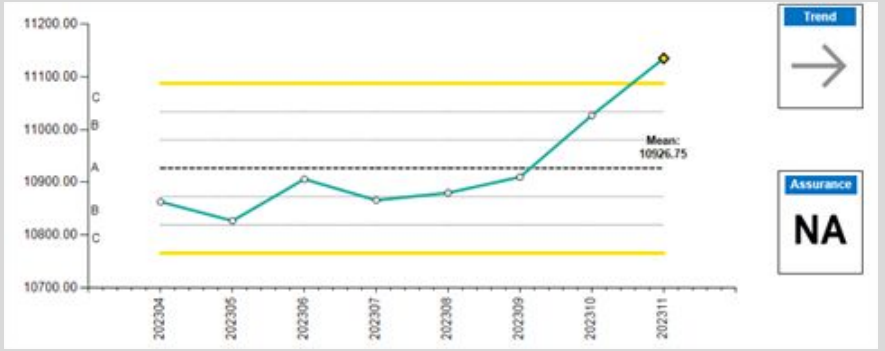
What the chart tells us
The levels of out of areas placements is subject to variation aligned to demand for beds (i.e. adult acute beds).

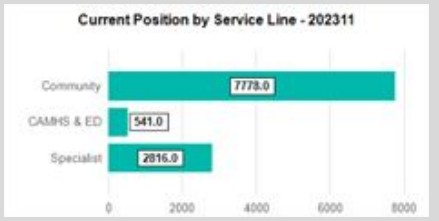
Underlying issue
- Performance is related to the demand for adult acute and PICU beds. High and continual occupancy rates that exceed 95% inevitably lead to the use of out of area beds at times of peak demand.
- DTOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital. The apparent correlation between external occupied bed days used and increased DToC days is being explored.
-

Actions
- New contract with Holybourne 30 beds commencing on 1 December 2023 for a year to December 2024. This means the block has increased from 18 – 30 beds.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- Updates reported in daily pathways meeting with a focus on trying to repatriate patients to trust provision as quickly as possible.
- Key to reduction in use of OOA provision is the work to decrease LOS and create capacity locally, alongside community transformation.
- The 100 day challenge plan should support reduction in LOS - workstream meetings have commenced and implementation plan is in place.
- Holybourne now included in 100 day discharge work streams.

Number of adults and older adults receiving 2+ contacts in new integrated model across the core and dedicated service provision — No Target

Flow





What the chart tells us the chart tells us
New metric for 2023/24 low level variation since April 2023.

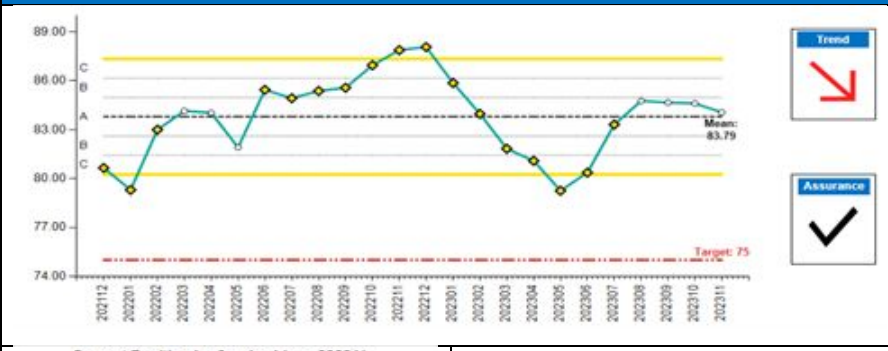
Underlying issue
- There is a lack of understanding across the Trust on this metric and clarification is required in order for clinical services to address.
- Metric requires review to ensure correct cohorts are reflected.

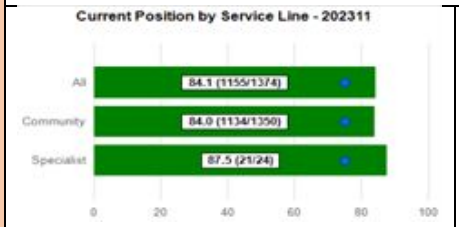
Actions
- DHOSD to work with the performance to understand this metric further.
- Ensuring appointments are booked and outcomed in timely fashion will aid improvement.
- A KPI definition is required to aid clinical services.
- The Information Management Team have reviewed metric definition and issued guidance of team category inclusion.
- Community: Familiarisation of this metric discussed with Associate Clinical Director and Clinical Managers in Kingston, Sutton and Richmond leadership meeting in September.
- Older People's Services: It is anticipated that with the progression of the older adult transformation work - there will be increased access to services and increased activity for patients (upward trend send in CMHTs).

Quality Domain

Fundamental Standards of Care

Cardio metabolic Assessments – Community and EIS (%) — Target ≥ 75%





Background:
Clients with a diagnosis of psychosis are at a higher risk of developing serious physical health problems. Cardio-metabolic assessment (CMA) reporting monitors Trust performance in key factors associated with physical health i.e. blood pressure monitoring, BMI, and glucose regulation.

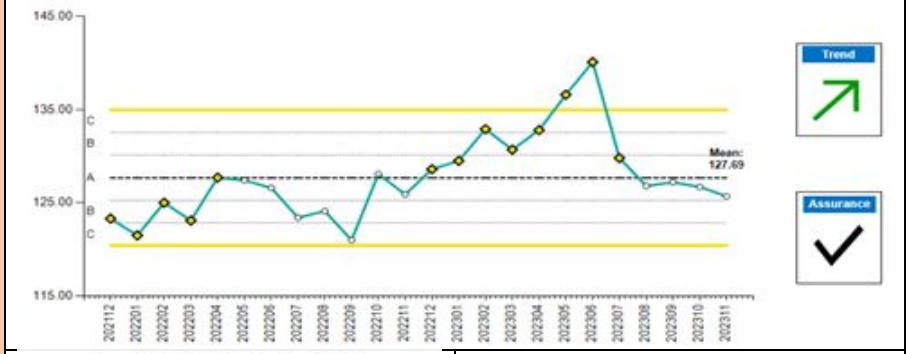
What the chart tells us
It is likely that the target will consistently be exceeded; however recent months have improved.

Underlying issue:
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised. Trust clinical systems do not support workflow and performance is expected to dip in Q3 when annual re-reviews are required.
- Number of community patients have declined assessments. Attempts made to try and intensively engage patients to attend are not recorded within the system.
- Although this target appears to be met overall. The National Clinical Audit of Psychosis 2023 recorded that all 5 Borough's require a specific focus on physical health screening and interventions.

Actions:
- Community: Kingston & Richmond EIS improvement plans reviewed with updated actions. Clinical Manager to lead and embed within the team.
- Richmond EIS is being supported by a member of staff from Richmond RST to undertake CMA clinics. GP trainees are now cold calling patients to encourage CMA commenced Oct'23.
- Weekly/twice weekly physical health clinics in all boroughs continue.
- Wandsworth developed Holistic Hub in Trinity Building due to commence on 1st November. The hub will offer a range of services with a community focus i.e. depot/clozapine clinics, employment advice, peer support OT and input from Primary Care plus to step people back to GP and help with overall flow.
- Lead nurse to undertake Physical Health training this is to commence in Wandsworth.
- Kingston QII scooping how to increase full compliance with CMA checks.

Fundamental Standards of Care

Safe Staffing: national Compliance - Inpatients (%) — Target ≥ 95%



Background:
To provide assurance that inpatient wards were adequately staffed in the reporting period.

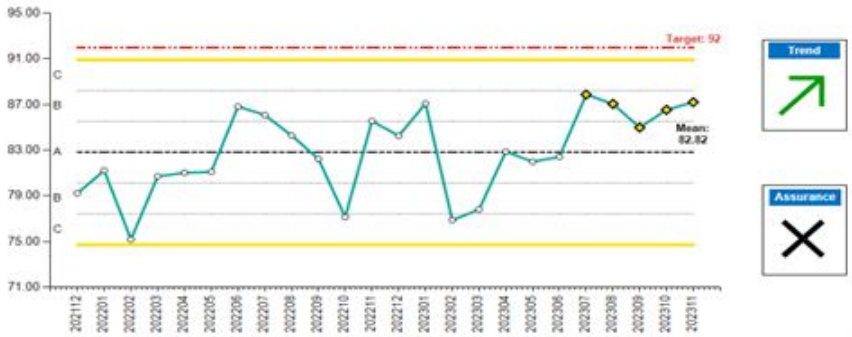
What the chart tells us:
Trust performance is consistently above target which is below lower control limit.

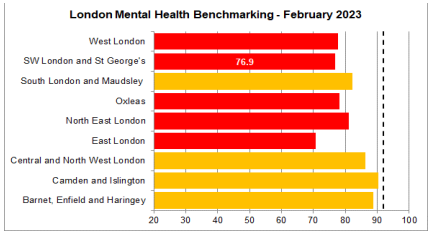
Underlying issue:
- Acute and urgent care:All wards were safely staffed in November 2023. Additional staff are required to manage constant and enhanced observations.
- CAMHS & ED: All ward areas were safely staffed; Corner House is minimally staffed due to very low occupancy and some team members are supporting other services. The Trust has also agreed a bespoke provision for a client; both Aquarius and Wisteria send staff to support. This is funded via the SLP.

Actions:
- Daily staff meetings held across all service lines are in place to monitor staffing requirements and issues on staffing numbers are escalated to senior management if there are concerns.
- Acute & Urgent Care: Continued focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.
- Training has been provided for Ward Managers & Team Leaders on the Fundamental Standards of Care Dashboard.

Patient Experience and Outcomes

Patient Friends and Family Test (%) — Target ≥ 85%





Background

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed.

What the chart tells us:

Mean performance is consistently below target a change of process required.

Underlying issues:

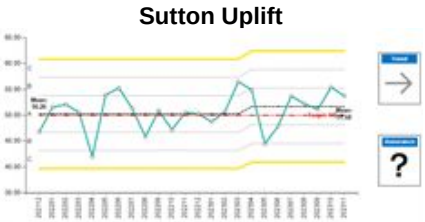
- Challenges with engaging patients to complete at appropriate points in their pathway and staff not actively seeking feedback.
- Using the results in a meaningful way to identify and make improvements within the clinical services.
- Acute and Urgent Care: Most under performance linked to crisis pathway (who may be less likely to complete questionnaires. Improvement noted in home treatment and perinatal services.
- Specialist Services: System concerns have been raised to Governance Team for service lines older adult, Learning Disabilities and ADHD/ASD services as they are not consistently accessible for our patient and carer populations.

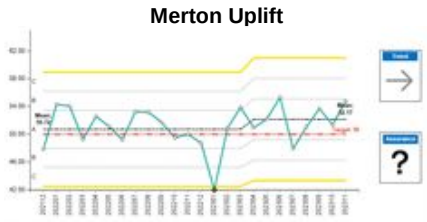
Actions:

- Feedback live has recently been relaunched as a platform for completing Friends and Family Test. First question on system is linked to the Friends and Family Test.
- Staff encouraged to promote use of the FBL QR code for service users and carers.
- Promoting use of the FBL QR code for service users and carers (FBL first question is the FFT).
- Community Service Line: Governance Leads attended Community QGG to relaunch FFT and now working with Borough teams to promote good practice.
- Holistic Hub in Wandsworth launching peer support who will engage with walk in patients to encourage FFT completion.
- Acute and Urgent Care: FBL will be an agenda item within Community Meetings to promote service user engagement. QR codes are displayed in ward areas and teams are giving out laminated cards with QR codes.
- CAMHS & ED: Service-related project in progress looking at ESQ response rates from children and families.

Patient Experience and Outcomes

IAPT recovery rate (%) — Target ≥ 50%





Background

Improving Access to Psychological Therapies (IAPT) is an NHS programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety.

What the chart tells us

All talking therapies are above 50% national target YTD; Merton Uplift is just above their locally agreed stretch target of 52%. Monthly variation is expected.

Underlying issues

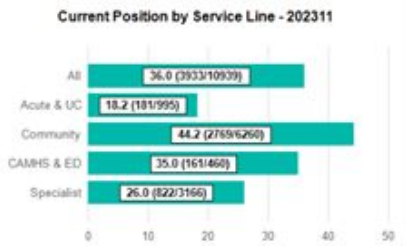
- Recovery rates are improving since the launch of the cross-borough recovery workgroup this summer.
- Initial audits indicate recovery deterioration is due to drop outs and people declining treatment due to waiting times. Poorer recovery also associated with missing or incorrect diagnostic labels, absence of repeat symptom measures, and lack of fidelity to treatment protocols.

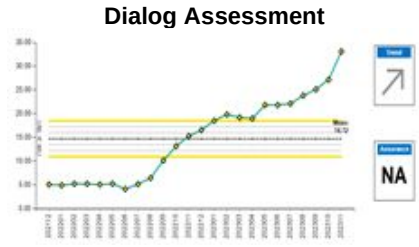
Actions:

- Ensuring service clinical leads complete data quality checks in advance of the monthly recovery audits which then take place each month by 9th. Investigate audit outcomes and follow through on their action plan.
- Sharing of routine individual monthly recovery rates have now been implemented.
- Cross-borough recovery workgroup continues to meet monthly.
- Training already delivered and more in development to support clinicians with treatment - Focus on ensuring accurate diagnostic assessment and routine ADSM completion.
- New "feedback call" stage between assessment and being placed on waiting list introduced, where patients attend a structured treatment planning call to discuss treatment options, and requirements for engagement, in order to reduce drop out rates.
- Sharing of SilverCloud best practice has happened between services.
- Training on treatment choice conversations and diagnostic assessment planned for January 2024.

Patient Experience and Outcomes

Paired Dialog Completed — Target ≥ 40%





Background
DIALOG is an 11-question survey whereby people with a mental health illness are asked to rate their satisfaction and needs for care on 8 life domains and 3 treatment aspects. It is a tool that is completed by the service user and its content helps to highlight areas they may want support with.

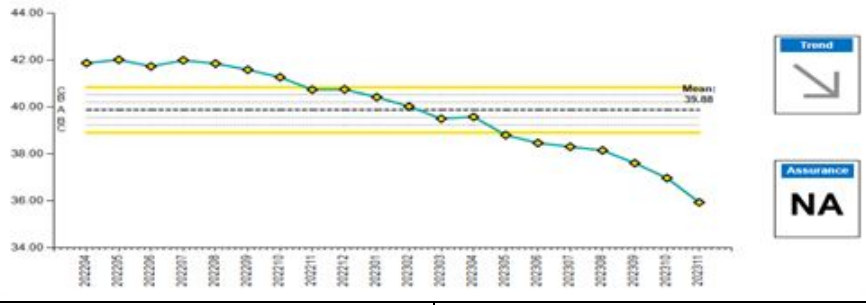
What the chart tells us
There is steady improvement in the paired dialog recording rates.

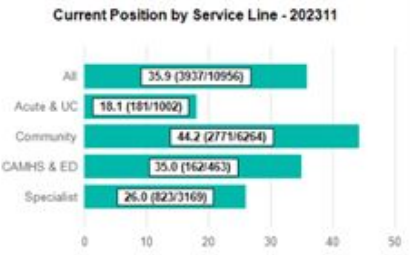
Underlying issue
- Reporting on paired dialog is a new priority metric for 23/24; local practice is being embedded.
- Review of team inclusions for DIALOG is ongoing across service lines.
- Change in clinical practice that will require time to embed.
- Trust is currently benchmarking well on Paired Prom measure – 6% compared to national average of 3% (based on November 2022).
- The Trust has been invited to showcase the work undertaken on the Mental Health Outcomes CQUIN at the National (NHS-E) outcomes CQUIN webinar.
- Trust benchmarks well across London for Dialog Assessment.
- DIALOG is not yet linked to care planning - when this is launched the paired DIALOG scores are expected to increase significantly.
- Patients remaining on community caseloads for long periods are not completing more than one DIALOG currently i.e. no discharge DIALOG.

Actions
- SOP for dialog use has been developed and issued to across the Trust.
- Specialist Service Line to raise exclusions queries with Patient Outcomes Group.
- Baseline DIALOG completeness to be discussed at Improving Patient Outcomes Group (IPO) and further strategy for improvement to be recommended.
- Community: DIALOG refresher training was completed in June 2023.
- Baseline DIALOG completeness to be discussed at IPO and further strategy for improvement to be recommended.
- Acute & Urgent Care: Focused work within HTT teams to improve compliance with paired dialog.

Patient Experience and Outcomes

Paired HONOS Completed — No Target

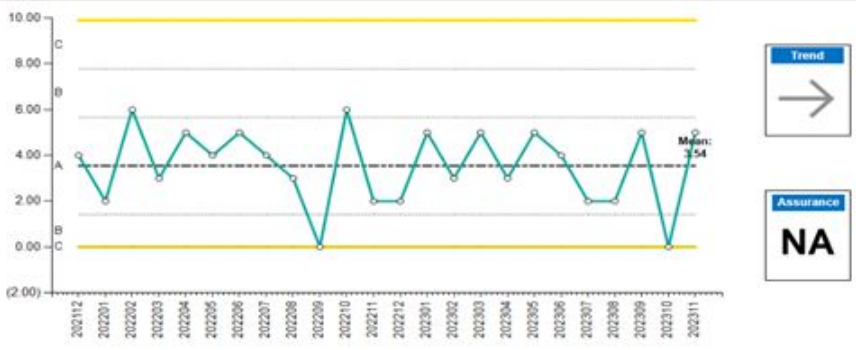
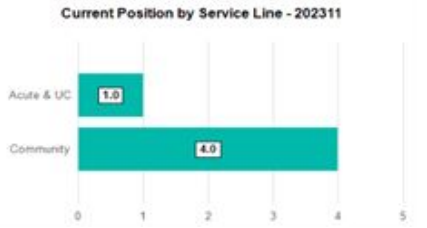
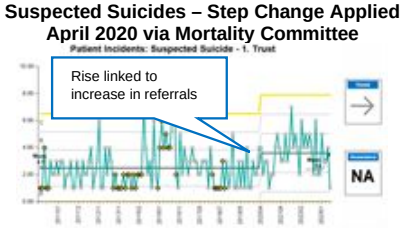




What Chart Tells Us:
There is a consistent negative downward trend in paired HONOS recording.

Underlying Issue:
- Community: HONOS as a standalone outcome measure (separate from Clustering) is not embedded in Community/Trust as a routine clinical activity.
- The Trust has de-prioritised clustering and as HoNOS is a requirement for clustering this has had a detrimental effect on HONOS completion.

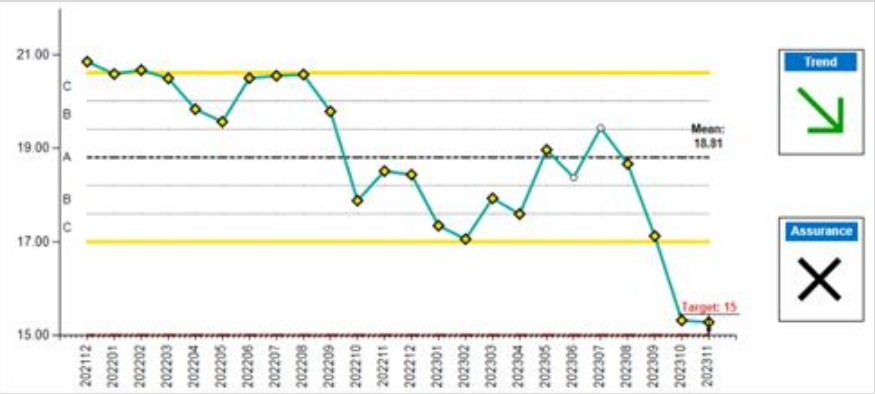
Actions:
Community:
- HONOS to be presented and the community awareness event 20th Nov.
- HONOS to be discussed at team leaders' development (9th Nov)
- HONOS SOP to be recirculated.
- Discuss development of a community workflow for discharge on Rio which includes PROMS, PREMS and CROMS including HONOS and DIALOG

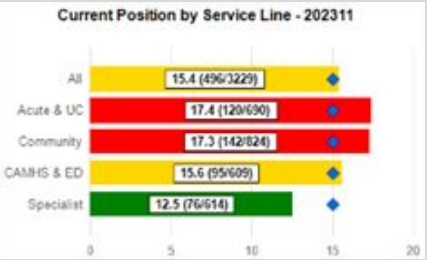
	Death - Suspected suicide	No Target
Patient Safety		**What the chart tells us** The number of suicides each month is low with common cause variation. **Underlying Issue:** - There were five suspected suicides reported in November 2023. - The number of suicides being reported month to month continues to vary. This data is reviewed in the bi-monthly Mortality & Suicide Prevention Committee. The mean monthly average has increased from 2.9 (pre-April 2020) to 3.9 (post April 2020). **Actions:** - All such incidents will be subject to a review in line with the Patient Safety Incident Response Framework (PSIRF). - The Trusts Suicide Prevention Strategy is due to be reviewed and the Mortality & Suicide Prevention Group will monitor the content and completion of this. - The Annual NCISH report was reviewed in the Mortality & Suicide Prevention Group and key Clinical Messages will be shared in the monthly learning bulletin. - A one page document has been developed around Thematic Reviews to support those staff who are responsible for undertaking reviews and expectation on sharing these within the Mortality & Suicide Prevention Committee. - Community: Learning from incidents shared across Borough's in Clinical safety meetings (monthly).
		

Workforce Domain

Recruitment / Attraction

Vacancy Rate (%) — **Target ≤ 15%**





Benchmarking – NHS Digital Q4 22/23

Trust	%
North East London NHS Foundation Trust	20.9%
West London NHS Trust	17.3%
South West London and St George's Mental Health NHS Trust	17.2%
South London and Maudsley NHS Foundation Trust	16.3%
Oxleas NHS Foundation Trust	14.8%
Central and North West London NHS Foundation Trust	13.5%
Barnet, Enfield And Haringey Mental Health NHS Trust	12.9%
East London NHS Foundation Trust	8.1%
Camden and Islington NHS Foundation Trust	4.1%
London	13.9
National	11.3

Vacancies by Staff Group – November 2023

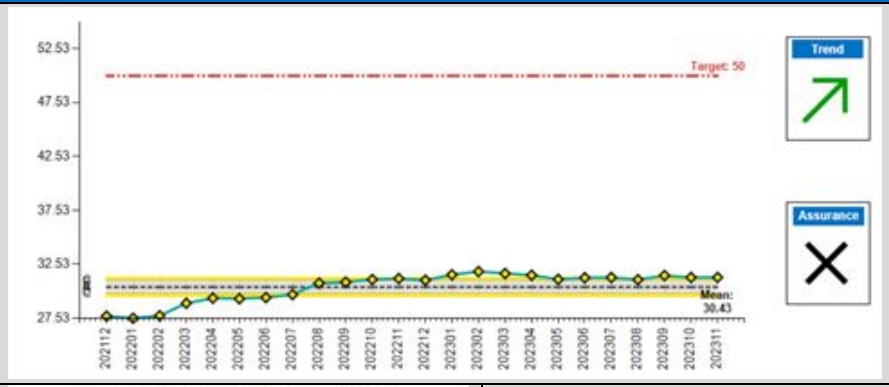
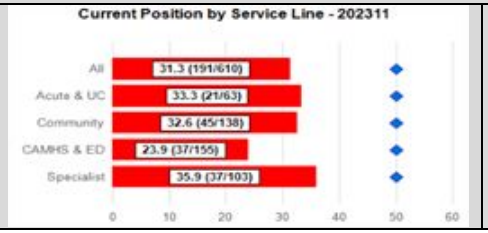
Staff Group	Post Fte	Assign Fte	Vacant FTE	Vacancy Rate
Healthcare Scientists	2	1	1	50.0%
Allied Health Professionals	166	127	39	23.7%
Add Prof Scientific and Technic	492	406	86	17.6%
Additional Clinical Services	724	603	121	16.7%
Nursing and Midwifery Registered	907	765	142	15.7%
Administrative and Clerical	659	580	80	12.1%
Medical and Dental	243	220	23	9.5%
Estates and Ancillary	36	33	3	8.3%
Total	3229	2734	496	15.4%

Background
Ensuring that the Trust has suitably recruited to establishment leads to better continuity of care. A high vacancy rate may adversely affect the continuity/ quality of patient care, increase demands on existing staff and results in increased use of more expensive agency staff.

What the chart tells us
There is an overall downward trend in vacancy rate with performance consistently above target. Recent performance has improved and remains below lower control limit and in line with target.

Underlying issue:
- Trust was just above target in November this follows downward trend in vacancy rate over recent months.
- Improvements in number of applicants through open events, careers day attendance and number of people directly applying together with improved recruitment processes are driving this.
- Each Service Line has created a workforce plan to ensure there is a continued focus on recruitment, including bank and agency conversions into vacant positions.
- Even with this positive shift in the number of applicants and recent successes from mass recruitment campaigns there are still some professions which are continually proving difficult to recruit to. These are areas where we will need to think about alternatives in support whilst we carry vacancies to ensure we reduce the pressure for those in the team and retain them.
- In community there is a low % of cases being actively recruited (67%) currently advertised.

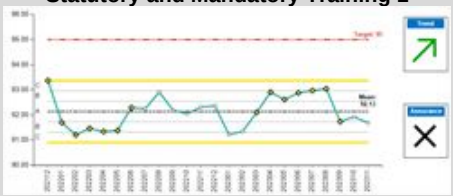
Actions:
- Recruitment Annual Timetable: A detailed recruitment activity timetable for the year is in place and outlines key dates for mass recruitment, recruitment fairs and open days, which has been operationalized via the recruitment delivery group. It focuses on building recruitment opportunities and ensure Trust-wide mass recruitment campaigns are scheduled effectively to meet the organisational need.
- Recruitment Delivery Group: Has been operationalized with stakeholders across the services to ensure detailed planning and approach is planned for each recruitment campaign and input to what might be needed in the future months is highlighted.
- We are progressing plans to expand our recruitment and attraction work into community based recruitment including our local refugee community. Mtgs have been held with neighbouring Trusts to explore how others have been successful in this before progressing our next steps on this. Further updates to follow.
- Funds from our Strategic investment funds have been provided to develop some specific initiatives around Community Services; predominantly focussed on medical staff.
- We are currently recruiting resources to support Apprenticeships which has also been funded through our strategic investment fund.

	Percentage of BAME staff - Band 8+ and Medical	Target ≥ 50%
Recruitment / Attraction	 	**What Chart Tells Us:** Mean position is below target indicating target position seems to have plateaued in recent months following period of improvement. **Underlying issues:** - The number of black, asian and minority ethnic colleagues being appointed at Band 8a is steadily increasing. - The pace of change is slower than needed in order to meet target. **Actions:** - Talent Strategy being developed, with a strong lens in terms of career progression and commitment to Black, Asian and Minority Ethnic Groups. - Reviewing Recruitment & Selection Training for all recruiting managers to be launched in January 2024. - Further analysis around appointments at senior bands to commence in new year. - The action plan in response to the WRES is being built this year in partnership with our Evolve network. Our response to how we affect career development is featuring in this plan. The action plan is due to be published in Jan 2023. - Community: Borough based CSL's to become the EDI leads for their respective areas.

Staff Skills / Development

Statutory and Mandatory training 1 (%), Statutory and Mandatory training 2 (%) — Target ≥ 95%, Target ≥ 85%

Statutory and Mandatory Training 1



Statutory and Mandatory Training 2

Training Compliance Projection – MAST 1

Certificate Name	Actual				Projection			
	Oct-23	Nov-23	Dec-23		Jan-24	Feb-24	Mar-24	
	%	%	%	Breaches	%	%	%	Breaches
Adult Basic Life Support (1 year)	83.9%	85.3%	85.1%	65	82.8%	80.5%	73.4%	132
Fire Safety Awareness (Community) (2 Year)	94.6%	94.6%	94.4%	76	90.3%	87.3%	84.2%	254
Fire Safety Awareness (Inpatient) (1 Year)	76.7%	77.6%	77.3%	160	78.9%	74.2%	67.5%	233
Fire Safety Awareness (Non-Clinical) (2 Years)	95.9%	97.1%	96.7%	24	91.8%	88.4%	84.4%	116
Infection Prevention and Control L1 (3 Years)	93.7%	94.1%	93.5%	33	92.5%	92.5%	92.3%	40
Infection Prevention and Control L2 (1 Year)	92.8%	91.9%	91.8%	188	88.0%	73.9%	63.9%	806
Information Governance (1 Year)	95.8%	95.7%	95.8%	116	80.3%	72.7%	63.8%	1040
Medical Emergency Training for Nurses (1 Year)	72.8%	78.4%	78.8%	49	60.2%	59.6%	55.2%	143
Medicines Management (Community) (2 Years)	88.2%	88.5%	88.5%	53	83.2%	80.9%	76.2%	112
Medicines Management (Inpatient) (2 Years)	93.7%	94.5%	93.5%	19	87.1%	85.4%	84.4%	47
Proactive Physical Interventions (3 Years)	81.8%	83.0%	81.8%	105	81.6%	80.5%	78.8%	125
Safeguarding Adults Basic Awareness - Level 1 (3 Years)	96.7%	96.0%	95.9%	114	92.1%	89.5%	85.0%	429
Safeguarding Adults Level 2 (3 Years)	95.0%	94.3%	94.2%	118	91.2%	90.0%	88.9%	234
Safeguarding Children and Young People Level 1 (3 Years)	94.4%	95.2%	95.2%	27	90.5%	87.7%	85.3%	85
Safeguarding Children and Young People Level 2 (3 Years)	92.7%	90.8%	90.7%	83	86.4%	85.7%	83.8%	154
Safeguarding Children and Young People Level 3 (3 Years)	77.7%	75.9%	76.5%	252	69.8%	69.1%	67.8%	378
Safeguarding Children and Young People Level 3 CAMHS Only (3 Years)	90.9%	87.1%	87.7%	35	78.3%	77.4%	76.8%	73
All Certificates (95% Target)	91.9%	91.7%	91.6%	1517	84.7%	81.3%	76.7%	4361

Training Compliance Projection – MAST 2

Certificate Name	Actual				Projection			
	Oct-23	Nov-23	Dec-23		Jan-24	Feb-24	Mar-24	
	%	%	%	Breaches	%	%	%	Breaches
ABUS eLearning for Community and Allied Professionals	71.2%				50.6%	57.2%	49.5%	652
Advanced Patient Handling (2 Years)	88.8%	86.6%	85.4%	72	78.9%	75.7%	71.8%	159
Care Certificate	85.5%	85.2%	85.4%	46	82.5%	82.5%	82.5%	58
Collaborative Clinical Safety Training (Formally Known as RATE) (3 Year)	66.6%	61.9%	60.8%	504	55.6%	52.8%	51.8%	712
Conflict Resolution and Breakaway (3 Years)	86.0%	85.1%	84.7%	253	83.5%	82.5%	80.4%	335
Cyber Security - Stay Safe Online					18.5%	18.5%	18.5%	2337
Equality and Diversity (3 Years)	98.7%	98.5%	98.5%	42	93.9%	92.3%	90.8%	263
Essentials of Patient Safety - Level 1 (All Staff)					35.2%	35.2%	35.2%	1728
Essentials of Patient Safety - Level 1 (Trust Board/Senior Leaders and Senior Med					16.4%	16.4%	16.4%	173
Food Hygene Level 2 (3 Year)	97.1%	97.0%	96.2%	5	91.2%	90.4%	88.2%	16
Food Hygene Level 3 (3 Year)	100.0%	100.0%	100.0%	0	100.0%	100.0%	100.0%	0
Health and Safety General Awareness (3 Years)	98.1%	98.0%	97.9%	57	92.9%	91.3%	89.8%	293
Load Handling (2 Years)	76.9%	75.0%	75.0%	50	73.2%	68.3%	68.3%	13
Medical Emergency Training for Medics (1 Year)		100.0%	100.0%	0	30.2%	30.2%	30.2%	88
Mental Health Law Training (3 Year)	84.5%	85.1%	85.0%	258	83.0%	82.7%	82.2%	319
National Early Warning Score (3 Years)	96.4%	98.3%	98.3%	10	96.8%	96.3%	95.5%	27
Observation and Intensive Engagement (3 Years)	98.2%	98.7%	98.5%	8	96.9%	96.3%	95.7%	23
Oliver McGowan Mandatory Training on Learning Disability and Autism					0.0%	0.0%	0.0%	2866
Prescribers Medicines (2 Years)	71.4%	72.2%	72.6%	69	68.3%	64.9%	63.7%	95
PREVENT Basic Awareness - Level 1-2 (3 Years)	97.6%	97.5%	97.4%	59	95.9%	95.9%	95.9%	31
PREVENT Raising Awareness - Level 3-4 (3 Years)	96.2%	96.2%	95.8%	84	92.2%	90.1%	86.3%	289
Rapid Tranquilisation (3 Years)	91.5%	94.6%	94.6%	32	92.0%	91.0%	89.1%	67
Safeguarding Adults Level 3 (3 Years)	68.2%	70.8%	71.3%	246	68.7%	68.7%	68.7%	398
Security Awareness (Forensic) (1 Year)	85.5%	89.3%	87.9%	24	82.4%	78.9%	73.5%	54
All Certificates (85% Target)	88.8%	89.8%	89.5%	1789	63.0%	62.8%	60.6%	10996

Background

Statutory and mandatory training (MAST) is compulsory training that is determined essential for the safe and efficient delivery of services. This type of training is designed to reduce risks and comply with local or national policies and government guidelines.

What the chart tells us

MAST 1: MAST 1 levels remain consistent whilst work continues to refresh the training and the audiences. This work is progressing between the L & D, SMEs and IT teams.

MAST 2: Performance for MAST 2 remains above target.

Improvement Initiative:

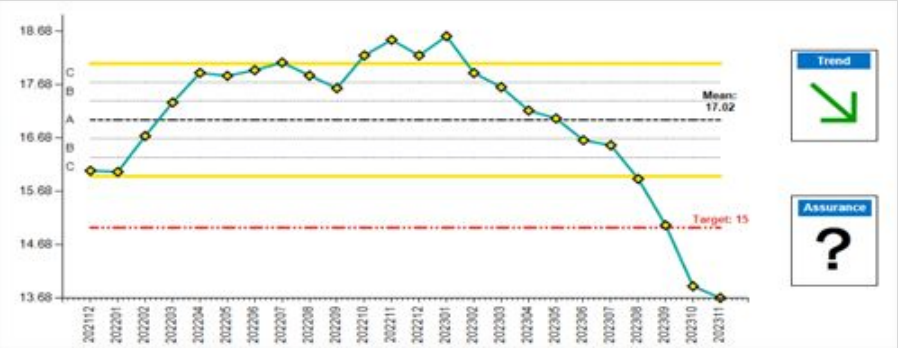
The work continues to build improvements into MAST offer, systems and accessibility. This work includes:-

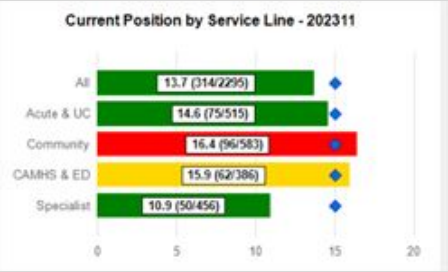
- Successful recruitment into the MAST Lead post, appointed candidate will start late December.
- Review of all MAST training content with SMEs, audiences and then being reflected within our Compass and Dashboard systems.
- A diary of all mandatory training in place with bookings for each up to six months in advance in order for staff to plan more effectively to enable release.
- Technical issues associated with Dashboard, COMPASS and e-LFH platform have been investigated and resolved. The ongoing review of the historical technical issues did not identify any further issues since the resolution was put in place in July. However the new audiences for each MAST course take time to update and L & D are working with IT to ensure this is delivered as quickly as possible.
- Oliver McGowan training is now live but will not affect compliance data until six month post launch to enable colleagues time to attend.
- Review of MAST 1 and MAST 2 offer is now complete and implemented and is reflected in the list of training shown in this report.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%





Annual Turnover FTE – June 2022 – June 2023

Org name	Leavers	Leaver rate
Barnet, Enfield and Haringey Mental Health NHS Trust	966.4	33.0%
Camden and Islington NHS Foundation Trust	426.6	19.6%
Tavistock and Portman NHS Foundation Trust	117.7	17.9%
South West London and St George's Mental Health NHS Trust	406.4	16.9%
East London NHS Foundation Trust	1058.2	16.8%
Central and North West London NHS Foundation Trust	1159.0	15.9%
Oxleas NHS Foundation Trust	602.5	15.8%
North East London NHS Foundation Trust	942.1	15.3%
West London NHS Trust	602.2	15.2%
South London and Maudsley NHS Foundation Trust	752.1	14.5%
London Average	**703.3**	**18.1%**
National	**564**	**13.8%**

Please note: NHS Digital inclusion criteria is slightly different to Trust's definition.

Background

Turnover describes the rate that employees leave an establishment and can disrupt the continuity of care and involves a financial cost to the establishment for replacing staff that leave. The metric is defined as the number of staff that have left the Trust over the last 12 months divided by the average number of staff over the same period. The retention of staff has been highlighted as a risk and priority by NHS England.

What the chart tells us

The overall turnover rate has improved with positive downward trend with recent performance below lower control limit and target, however the turnover under 12 months is not improving at the same rate and remains stubbornly high.

Underlying issue

- Turnover has been decreasing and position is now below target for the first time in the reporting period.
- Turnover for colleagues with less than 12 months service levels which are still concerning but noted reduction in October 2023. Analysis of what is driving this is currently being undertaken.
- Suggested reasons for leaving is cost of living, career progression however the data from exit interviews is limited (only 197 responses in the past two years)
- Analysis to understand key hot spots, shows that 20% of AHPs are leaving within 12 months and nurses at 18%. HR colleagues are working with professional leads to understand what more can be done to reduce turnover in these areas.
- Identified those areas with most improved turnover in the past 12 months, versus those with consistently high turnover. The highest areas are within CAMHS and most improved seem to be within Specialist Services
- Increased support to develop our managers is key knowing that often individuals experience at work is how they are managed by their line manager.

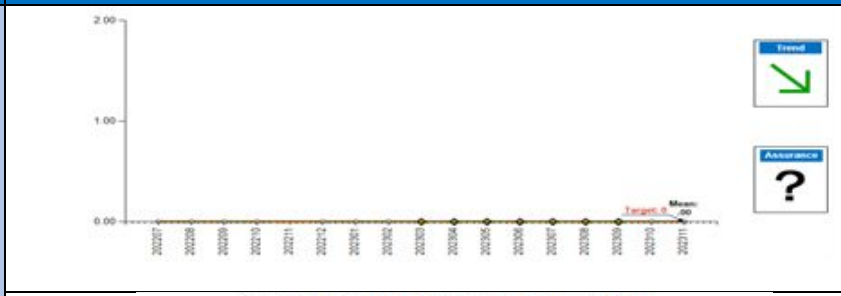
Actions:

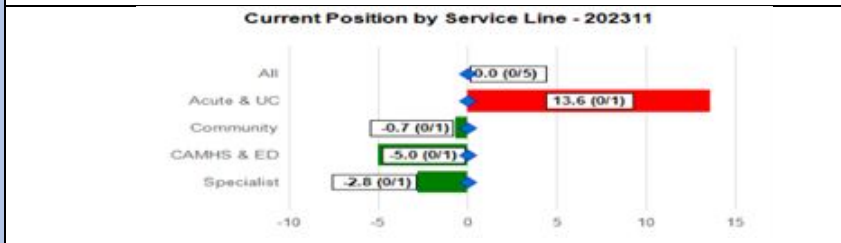
- Work with teams identified to understand what can be learnt to improve turnover across the board ensuring that lessons are learned and shared
- Recognising that this is a whole organisation objective, top tips and management webinars are being prepared to support managers in supporting stay conversations and Insite updated with information that will be useful.
- Initiatives to build conversations earlier with colleagues who might be thinking of leaving including stay webinars, career conversations, etc.
- Exit Interview process has been updated and will go live in December 2023 with some communication
- The Trust is currently undertaking a deep dive into the ethnicity data behind our turnover.
- A comprehensive package of work to support retention is in place and has been discussed with People Matters and People Committee, focussed in three areas; my start, my development and my future. These three themes have been used to categorise the different initiatives.
- In addition to the Retention programme, we must ensure all take responsibility within the organisation to engage with colleagues, understand any concerns which might be leading to people thinking of leaving and also ensure that those who have recently joined are supported.
- The oversight of the retention work programme is overseen by the People Matters Meeting which then reports to the People Committee.
- Following review it appears the increase in % staff leaving within 12 months has been impacted by a drop in overall leavers from the Trust.

Finance Domain

Grip & Control

% Forecast budget overspend — **Target TBC**





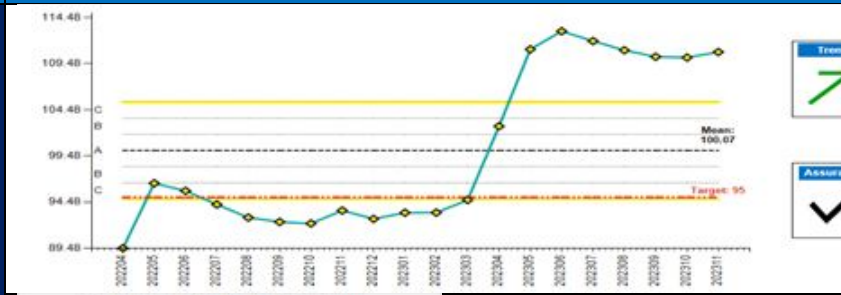
What Chart Tell us:
The chart indicates that Trust forecast is currently at break-even position.

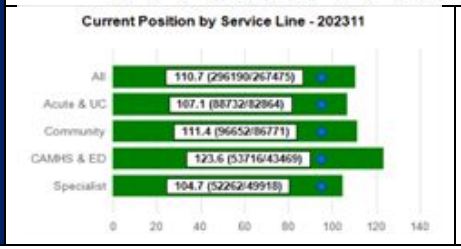
Underlying Issues:
- Trust is breaking even after month 8 compared to plan and forecasting to achieve the planned £0.2m surplus at year end.
- Agency whilst below plan remains above the national requirement of 3.6% of total pay bill.
- The Trust needs to increase recurrent savings delivery; delivery to date is underpinned by non recurrent vacancy factor and other non recurrent means impacting on longer term financial sustainability. Trajectory is needed on productivity savings.
- External beds pressures continue creating a financial risk.
- Acute & Urgent Care: The projected overspend continues to be due to staffing pressures within inpatient services and high external bed usage. Costs associated with specialling have reduced over recent months.

Actions:
- Work with ICB to identify and remaining Agency control gaps or collaborative actions to reduce agency spend.
- Finalise costed agency trajectories to identify potential shortfall against agency targets and further mitigations.
- Ensure plans are in place and being monitored to deliver 100% of the £13m target i.e. move all schemes out of red.
- Acute: Pay overspends on wards are mainly due to observation levels, although this is reduced. This continues to be addressed through FSOC and review of observations and engagement- fidelity to the trust policy and recruitment to vacancies with continued good impact in month on most wards.
- External beds addressed through LoS stay work and DToC work programs and focus on flow in the context of continued high demand and proposed new contract to reduce bed day costs.

Productivity

Contracted activity - Local CCG contract (%) — **Target ≥ 95%**





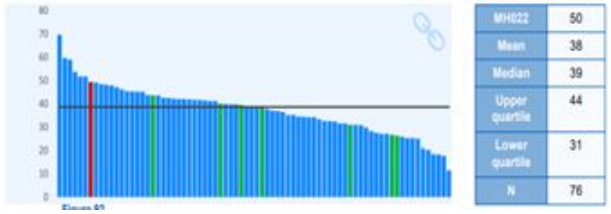
What Chart Tells Us:
Mean performance is above target indicating frequent compliance. 23/24 compliance is comfortably above target and has exceeded upper control limits in recent months.

Underlying Issue:
- Activity plans for 23/24 have been finalised with activity post April 23 based.
- Community: Poor compliance with activity recording in some teams.
- Clinicians may review patients from different teams, but they do not have access to this team's diary on RIO e.g. Depot, CMA and Clozapine Clinics.

Actions:
- Community: Activity recording training within service line has been completed.
- Clinics staff to be given access to all RIO team diaries of patients that they review.

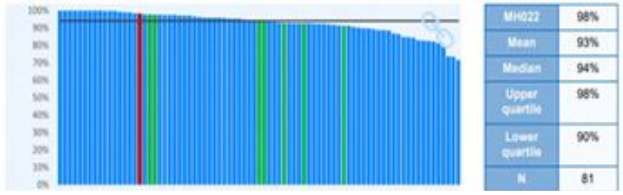
Appendix 1: Benchmarking

The NHS Benchmarking Network's 2022/23 Inpatient and Community Mental Health Benchmarking Report was issued in November 2023 and allows Trusts to benchmark their performance against other participating Trusts throughout England and within their local region. Our Trust is highlighted red in the graphs below, London Trusts are highlighted green and all other Trusts are highlighted blue.



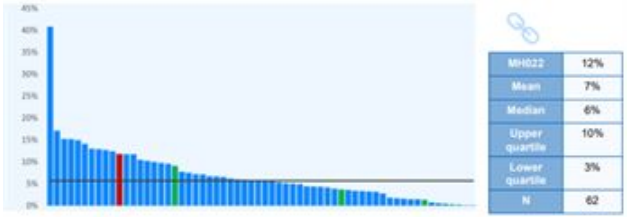
- **Adult acute average length of stay (days):**

2022/23		2023/24	
Trust	England	Nov-23	YTD
50.0	38.0	54.0	51.1



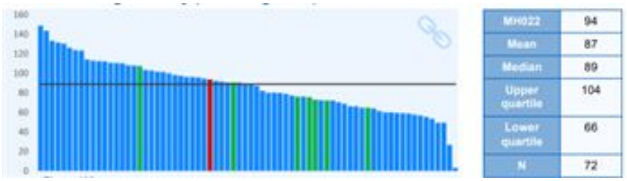
- **Adult acute bed occupancy rate (%):**

2022/23		2023/24	
Trust	England	Nov-23	YTD
98.0%	93.0%	98.0%	98.4%



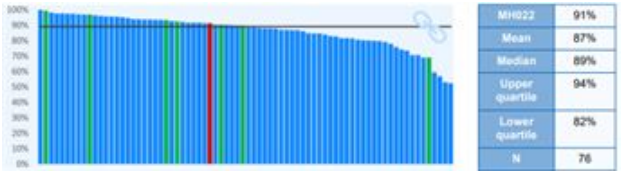
- **Adult acute delayed transfers of care (%):**

2022/23	
Trust	England
12.0%	7.0%



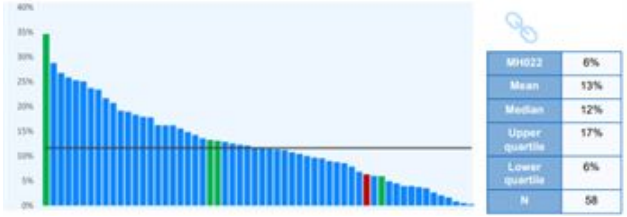
- **Older people's average length of stay (days):**

2022/23		2023/24	
Trust	England	Nov-23	YTD
94.0	87.0	61.1	92.9



- **Older people's bed occupancy rate (%):**

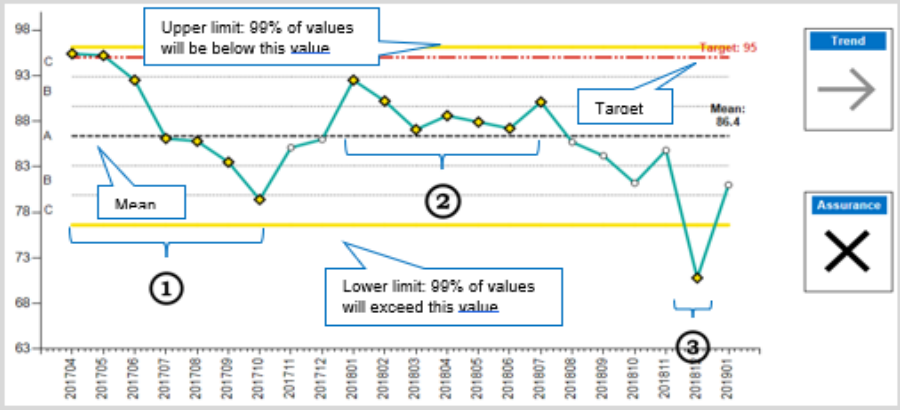
2022/23		2023/24	
Trust	England	Nov-23	YTD
91.0%	87.0%	91.1%	95.8%



- **Older people's delayed transfers of care (%):**

2022/23	
Trust	England
6.0%	10.3%

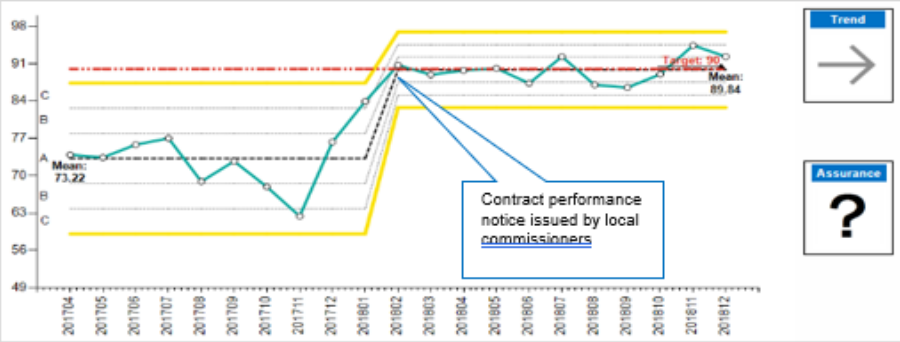
Appendix 2: Statistical Process Control (SPC) Charts & Performance Donut



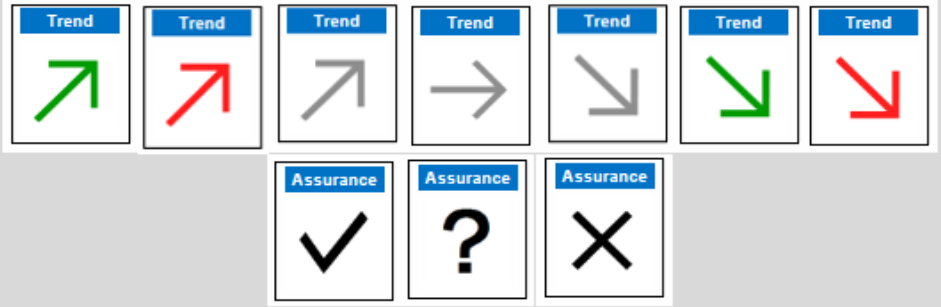
What is an SPC chart?
A Statistical Process Control (SPC) chart is a time series graph (we try to use 2 years) with three reference lines – the mean, upper and lower control limits. The limits help you understand the variability of the data. The variance of the data determines the process limits and you can expect 99% of data points to fall between them in normal circumstances.

Why we use SPC charts
They are used to distinguish between natural variation ('**common-cause**' and not caused by anything in particular) in performance and unusual patterns ('**special cause**', unexpected events) in the data which are unlikely to have occurred due to chance and require investigation. They also give us assurance on whether a target will reliably be met or whether we will never improve without doing things differently and show the impact of any changes made to improve performance.

Evidence suggests that we make better decisions when we've analysed data using SPC



Special-cause variation
These are statistically significant patterns in data which may require investigation and includes the following (as illustrated in the chart above):
Trend: 7 consecutive points trending up or trending down (a 0.8% chance of this happening naturally).
Zone A: 7 or more consecutive points on one side of the average (Zone A or beyond).
Beyond limits: beyond upper or lower control limit.
A full list of the statistical tests applied to determine special cause variation can be viewed under the charts in the Trust's SPC Suite (My Dashboards > Quality > SPC Reports > SPC Suite).
Use of a 'step-change' in SPC charts
Where performance has been permanently affected by a change in process (and the process change is known) then a **'step change'** should be applied to the SPC charts. For example, in the chart opposite the Trust was issued with a contract performance notice and the resulting improvement plan led to a change in process and improvement in performance. In these cases, the mean, upper and lower control limits are recalculated after the change in process.

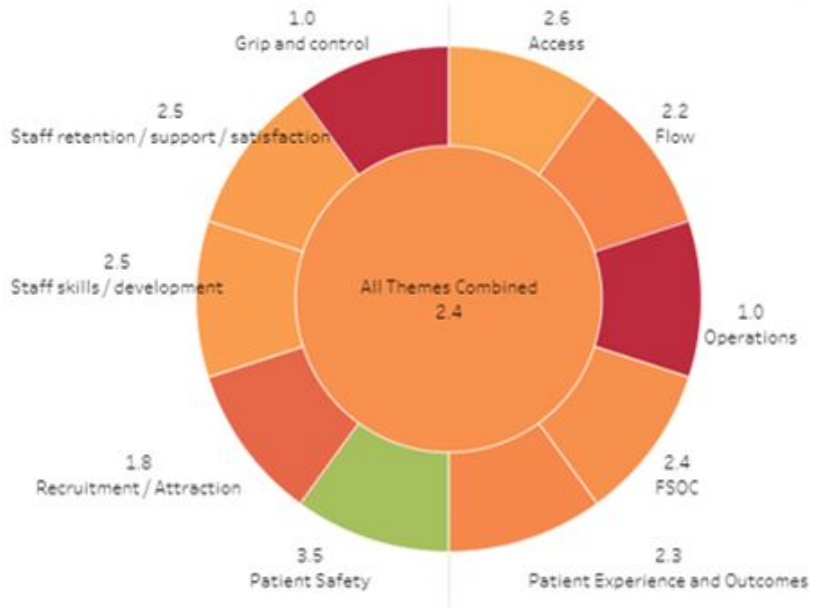


Use of icons to interpret charts
The Trend icon is shown as one of seven upward, horizontal or downward arrows depending on which direction the data is heading, coloured green, grey or red to indicate whether this is an improvement or deterioration in performance (or neutral where there is no target set); the icon is based on any trends identified involving any of the last **SIX** data points.
The Assurance icon
Assurance given: Target is in zone C or beyond (3+ standard deviations) and below the mean; reversed for when target goal is low and target is above the mean.
Questionable Assurance: Target is within zones A and B (1-2 standard deviations).
Assurance not given: Target is in zone C or beyond (3+ standard deviations) and above the mean; reversed for when target goal is low and target is below the mean.
If *Assurance is given* as above, but target has been missed in last 3 months then set to "*Questionable Assurance*" (and reversed for when assurance not given).
If "*Questionable Assurance*", however target has been hit for last 6 months and positive trend identified then set to "*Assurance Given*" (and vice versa for "*Assurance not given*").

Performance Donut Summary

Board Assurance Framework – Latest Risk

A failure to effectively position the organisation within the external environment.



Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	4	16	21	48.8%
Quality	4	8	6	66.7%
Workforce	3	1	7	36.4%
Finance	0	0	2	0.0%
Total	**11**	**25**	**36**	**50.0%**

A table showing how many KPIs have full assurance, some assurance and no assurance, split by domain.

- Overall performance is measured on statistically significant improvement or deterioration and trends and follows NHSI best practice. This replaces performance based on year to date averages and in month performance that are affected by natural variation (RAG rating).
- The new methodology is based on the metrics' assurance on consistently meeting target and whether there is a positive or negative data trend – see appendix 7 for detailed explanation
- The metrics in each of the nine themes are given a score and the average is used to determine the colour rating (shown below).
- The middle section of the 'donut' represents the average score across all 9 themes.
- The table below shows the scores given to each pairing of the 'level of assurance' and 'trend'.
- The best ranking (a positive trend with a 'tick' for assurance) gives a score of 5, while the worst ranking (a negative trend with a 'cross' for assurance) gives a score of 1.

Possible Donut ranking: 5 = best, 1 = worst

Trend \ Assurance	✓	?	✗
↗	5	3.5	2
↘	5	3.5	2
→	5	3	1
↗	4	2.5	1
↘	4	2.5	1

RAG Rating:

Score 1.0 … 5.0

NHS
South West London and St George's Mental Health NHS Trust

Meeting:	Trust Board
Date of meeting:	11th January 2024
Transparency:	Public
Committee Name	People Committee
Committee Chair and Executive Report	Sola Afuape (Chair) Katherine Robinson (Executive)

BAF and Corporate Objective for which the committee is accountable:
People Committee is responsible for the following corporate objectives:

- Failure to have the right staff with the right skills at the right time.
- Failure to effectively respond to EDI issues facing the Trust.
- To support our people to develop and grow and develop our organisation to be the best that we can be
- To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences

Achieving effective workforce and workflow continue to be the Committee's two main drivers for consideration of assurance as aligned to the key organisational priorities for improvement.

The Report covers assurance and matter discussed at the November and December Committee. The key agenda item for the December Committee was a discussion inputting into the development of the new People Strategy.

Key Questions or Areas of Focus for the Board following the Committee:
The following are the key themes that informed and reflect the discussion at the November and December meetings of People Committee:

1. HR Function (officially out of recovery and into Business as Usual)
2. EDI BAF
3. People BAF
4. ER cases
5. Retention
6. Medical staffing
7. Leadership Programme
8. Changes to the Fit and Proper Persons Test
9. Staff well-being and experience
10. Development of a new People Strategy.

Areas of Risk Escalation to the Board:

- Employee Relations (ER) cases continue to be a concern, despite greater operational grip and control and monitoring of the data e.g. operational oversight and action on cases extending over 90 days.
- The importance of identifying the equality profile of people leaving the organisation to assess for inclusivity and ensure the approach to retention and mitigations needed are robust.
- Committee discussion about refreshing the governance of the Committee towards a greater strategic focus following formal shift from HR recovery and balance between operational delivery and reporting.

For each item discussed at the Committee there would be a statement against the 3 areas below:
What
So What
What Next

Board Assurance Frameworks (BAFs)
What: The Committee reviewed the People and the Health Inequalities (HI) and EDI BAFs.

So What: The Committee noted that all actions were mostly on track for delivery by the end of the financial year, despite some slippage on procurement.

What next: The next version of the People BAF will review the risk ratings and determine whether some elements of the retention risk should be moved to QSAC oversight. It would also take into account the People Strategy which would be drafted over the next few Committee meetings.

Executive Risk Register (ERR)
What: the Committee regularly receive updates on the ERR to ensure People risks are being mitigated and monitored appropriately.

So what: Risk scores were reviewed but remained the same, with the Committee agreeing that despite improvements, it was too early to reduce the scores. The Committee noted that medical vacancies were impacting some teams being able to progress work. Funding has been obtained from the Strategic Investment Fund for more professional branding to support more effective recruitment within Community, and it was noted that recruitment of psychiatrists remains a local and national problem. The number of Employment Tribunals although reduced, which was positive, still remained high, and much higher than what would be considered a normal level in other organisations.

What next: industrial action remained on the ERR as the pay deal was still awaiting agreement for medical staff. The ERR would continue to be monitored monthly. Risks associated with medical staffing and ER cases would be heightened in the BAF to reflect them as on-going areas of concern.

Director of People (DoP) Report
What: The Committee regularly receives this fulsome report as it provides timely updates and useful context for the Quality and Performance (Q&P) report.

So What: The Committee were pleased to hear that the HR function was now formally out of recovery and into business as usual. The Committee noted that there were changes to the Fit and Proper Persons Test which would have impact on information recorded on ESR.

The Committee heard that there was some anxiety within the People Directorate as it undergoes recruitment into the new posts within the Structure, but there was also a good deal of internal interest in the available roles. The Chair sought and received assurances that the recruitment process modelled best practice.

What next: The Committee asked to be informed about the posts being filled in the new People structure, as this would be helpful in having oversight of the transition and understanding the impact of these changes to the team and its function. The Committee would also like an update on the effectiveness of the recruitment measures to improve recruitment and retention, such as over-recruitment of HCAs, to include things such as whether reduction in vacancies contributed to higher MAST compliance.

The Committee noted there would be feedback of the outcome of community-based recruitment and other initiatives that will be undertaken in 2024, i.e., the community recruitment event on 2nd February 2024, being held in collaboration with the ICB.

Quality and Performance Report
What: The report was presented in a new format that brought out key themes from People Matters and SIREN. The main priority area of concern arising from the report was still retention (especially those leaving under 12 months).

So What: Whilst ad hoc Agency usage has reduced, a focus on strategies to bring about long-term reduction of Agency numbers is required. The Committee asked for the progress of reducing Agency use as well as temporary staffing, and future reporting should by default include medical staffing.

ER cases over 30 days were reported as being mainly related to sickness. The reason for the increase was attributed to dedicated resource tackling the pre-existing backlog. The Committee requested future reporting substantiating this. The Committee noted that Disciplinary cases are currently low.

What Next: The Committee asked for assurance around how to improve PADR KPIs in corporate teams. They would also like more granular insight into the reasons for the high turnover and sickness rates in medical teams. The report states that the numbers of BAME staff in band 8a roles has been increasing, but it appears to have been stagnant for the last two years and the Committee requested future commentary be included to clarify plans in place for active improvements. Oversight of Agency usage and reduction remains a standing item of discussion.

Staff Survey and Pulse Survey Report
What: The Committee received a paper on the Staff Survey and Pulse Survey Report.

So What: The Committee were assured by the work that had taken place to encourage higher uptake of the surveys. A significant increase was noted in response from teams who previously fielded low response rates e.g., liaison, home treatment, inpatient teams and acute and urgent care. The overall response rate was over 60% which was a great achievement. Advocacy (i.e., staff and patient recommendations) is, however, one area where improvement is needed.

What Next: High-level themes would be received by the Trust in December/January with detailed findings received end of February/early March 2024.

FTSU Guardian Report
What: The Committee receives a regular FTSU report for oversight of access, uptake and effectiveness of the FTSU service and to review any issues that are raised by the guardian on behalf of Trust staff.

So What: There were three reports that are patient safety related, following a period where there had been none. The Trust continues to support the Guardian reach a wider pool of staff and encourage confidence in the service. The Trust now pays an additional fee as cases in the year to date have shown an upward increase and exceeded the prior case load threshold. After some discussion this was noted, at this stage, as being positive and an indication the system is working. The new HR system, when in place, will be able to receive appropriate redirected HR related matters, freeing up capacity for the Guardian.

The Committee noted that Health and Care Regulators have reported a reduction in whistleblowing reports to the GMC.

What Next: The Committee would keep reviewing the FTSU reports and support continued outreach into low use teams. The SID NED has been invited to attend future Committees when FTSU or related matters are on the agenda.

Wellbeing Staff Report
What: The framework for staff health and wellbeing will be reporting regularly to the Committee.

So what: This report will provide oversight of the Trust Health and Wellbeing offer for staff and triangulation with other staff KPIs.

What next: A self-assessment and evaluation of the Trust's Health and Wellbeing framework has been undertaken. The Committee requested, for transparency and assurance of inclusivity and diversity, the next iteration of the report should include the staff involved in the self-assessment. Triangulation with the transformation agenda should also be included, to ensure there is oversight of any impact of transformation work on health and well-being of staff.

Workforce Planning Progress Report
What: the Committee received a progress report on the annual workforce planning.

So what: The plans should address areas of known concern i.e. diversifying the workforce, addressing young people leaving, and increased focus on hard to recruit professional roles. There will also be some cross-cutting corporate themes and a focus on being an Anchor institution. The report included that the People team were working with ICB colleagues on recruitment initiatives such as joint recruitment assessment days.

What next: The plans are to be reviewed against dashboard data in January, to create plans in place for March.

Retention programme
What: the Committee were updated on the work of the retention programme, which had been developed using the NHSE retention pilot and its learning.

So What: the Committee heard that overall turnover was reducing but there were pockets of high rates and staff leaving under 12 months remained high. Further analysis suggested that this be disaggregated further to look at BAME staff turnover under 12 months, which on initial analysis seemed disproportionally higher.

What next: Comparison of turnover between different teams showed that the highest turnover was in CAHMS, while Community teams had higher long-term turnover. The lowest turnover was in specialist services. The team plan to talk to the relevant teams to understand the reasons for this. The People Team were tracking 330 new staff recruited between September and October 2023 over the next 12 months, to monitor their experiences. It is estimated that feedback will begin to become available after about three months.

EDI Enabling Strategy action plan progress report (exception and highlight)
What: The Committee regularly review the EDI Enabling Strategy action plan to gain assurance that work is ongoing and improvements are being made. The WRES, WDES, NHS HEIDI action plan and PCREF all feed into the EDI action plan.

So what: 12 of the actions are progressing as planned. 12 of the actions will require additional time, but are still expected to be complete within the current financial year.

What next: Some updates in the report were out of date, so more assurance would be needed about the effectiveness of the interventions relating to these. There may be a need to look at band 7 and talent pipeline leading into Band 8 to understand any underlying structural barriers

Q2 objective updates
What: The Committee receives regular updates on the Corporate Objectives (now called Annual Delivery Plans) in support of delivery of the Trust strategy.

So what: The People aspects were showing amber as they were a month behind, but the Committee were given assurances that key actions were progressing; namely the launch of the first leadership events and workforce plans. No concerns were raised.

What next: these would continue to be monitored going forwards. The Committee suggested the Training Needs Analysis approach also be included in the monthly Director of People report to ensure this was being given more specific monitoring.

People Strategy

What: The People Strategy had been on hold until the People team / HR function had stabilised and had come out of recovery. Work to develop the People Strategy had now commenced with launch planned for Q1 2024/25.

So what: Consultation is underway to shape the next People strategy. Whilst there will be alignment with the NHS People Plan, NHS long-term plan and the workforce priorities relating to the Integrated Care System, the Trust anti-racism work and MLBT will be key themes that run throughout it.

The Strategy would be focussed on a number of areas:

- Workforce shortages;
- Retention;
- Inclusivity;
- Staff health and wellbeing;
- Flexibility i.e. work/life balance;
- Becoming an Anchor Institution;
- Learning and Development to meet the changing needs of services; and
- How to deliver transformation whilst remaining compassionate, e.g., balancing financial performance with how people are treated.

What next: Timeline and delivery of a series of engagement events in the new calendar year to ensure the draft strategy is co-produced.

Items for note

There was a proposal to consider changing the frequency of People Committee meetings to bi-monthly from the current frequency of monthly. This will be reported back when a decision is made.

Appendices

- Ratified minutes of the November 2023 meeting.

NHS
South West London and St George's Mental Health NHS Trust

PEOPLE COMMITTEE

Minutes of the meeting held on **Tuesday 28 November 2023**, 14:30-17:00 via MS Teams.

Present:

Sola Afuape (SA)	Non–Executive Director (Chair)
Ann Beasley (AB)	Trust Chair
Humaira Ashraf (HA)	Associate Non-Executive Director
Jonathan Warren (JW)	Non-Executive Director
Jen Allan (JeA)	Chief Operating Officer
Jenna Khalfan (JK)	Director of Communications and Engagement
David Lee (DL)	Director of Corporate Governance
Katherine Robinson (KR)	Director of People
Sharon Spain (SS)	Director of Nursing and Quality

Attendees:

Emdad Haque (EH)	Associate Director of Health Inequalities and EDI
Nisha Proietti (NP)	Diversity in Decision Making Representative and Deputy Senior Employment Advisor, Sutton Uplift
Pam Warren (PW)	Deputy Director of People

Apologies:

Lincoln Murray (LM)	Operations Manager and Guardian
Jeremy Coutinho (JC)	Diversity in Decision Making Representative and Recovery College Manager
Mia Kruber (MK)	Head of Resourcing
Juliet Armstrong (JuA)	Non-Executive Director

Minutes:

Andy Glass (AG)	Corporate Governance Manager

	Item	Action
	Standing Items	
26/88	**Welcome and Apologies** The Chair welcomed attendees to the meeting.	
26/89	**Declarations of Interest** No new declarations were reported.	
26/90	**Quorum** The Chair confirmed that the meeting was quorate.	
26/91	**Chair's Actions** No Chair's Actions had been taken since the last meeting.	
26/92	**Minutes of the meetings held on 26 September 2023 and 5 October 2023** The minutes of the meetings held on 26th September were agreed as an accurate record of the meeting, subject to the following amendments: P6, item 26/68 – HA was recorded as saying that if the basics weren't in place the leadership would "topple" – this would be modified to say that it would not be sustainable, in line with her intended meaning.	

P4, item 26/67 – a stated target was attributed to Philip Murray (PM - Director of Finance and Performance), when in fact it was noted by SA as a target often cited by PM.

The minutes of the meeting on 5th October 2023 were agreed as an accurate record of the meeting.

At the meeting, one issue had been identified for each staff network, that they would like to see change in the coming year.

Staff network highlighted, in the October 2023 Committee, one key action that they wanted to see improvements on. These are to be collated into a separate Staff Network Action Tracker, placed on the Forward plan and reviewed after six months and one year and to be added to a future Chair's report. **EH/KR**

26/93 Action Tracker

The Committee received and noted the action tracker.

26/6(i) – inclusion of a quarterly EDI dashboard in the Director of People report. This has been moved to the January Committee.

26/63 (i) – actions from Corporate Services Review to be shared (this has been done). Action to be closed.

26/63(ii) - Committee to be sighted on the People bids from the strategic investment bids paper (this has been done). Action to be closed.

26/63 (iii) – Board disability disclosures. To be included in the Chair's report for Board. Action to be closed.

26/65 Staff Survey – there is an agenda item for this.

26/67 Q&P report – there is an agenda item for this.

26/68 Leadership development programme attendance. 90 staff have signed up for this; an overview of the evaluation will be presented at the 19th December People Committee. Positive feedback so far.

26/94 Director of People Report.

The Committee received and noted the report.

Reported:

- Since last the last People Committee, HR is now officially out of recovery following the review by Ann MacIntyre.
- Fit and proper persons test – there is new guidance in place, and a recent Non-Executive member fits criteria for exit changes. Details of Fit and Proper tests are to be recorded on ESR.
- People function advertised to recruit new members into the new structure. There is some anxiety among existing staff, but more positively there is a good deal of internal interest in the roles. Interviews to start week beginning 8th December 2023.

Discussed:

The paper makes reference to an Inclusion Report to sit alongside the Director of People Report. This is currently being explored.

HR being "out of recovery" refers to the fact that the team has been subject to additional scrutiny and assurance requirements whilst concerns about performance were ongoing. This has diminished with improving KPIs. Previously, the additional measures meant that the Trust couldn't fulfil its full potential in terms of recruitment and retention and team morale was low, and so an end to the recovery phase is a positive step.

HA requested regular updates on posts filled within the People Team structure. There were some debate as to why this was necessary if the recovery phase is over, but overall it was felt that some information would be helpful in having oversight of the transition and understanding the impact of these changes to the team and its function.

Agreed:
People team to report to ELT on whether an Inclusion Report will be produced in future. **KR**

People Team to provide HR team updates through the Director of People Report. **KR**

2 Culture

26/95 Staff Survey and Pulse Survey Report
The Committee received and noted the report and supported the suggested approach.

Reported:
- The Staff Survey has just closed. The Trust has made efforts to get as many responses as possible.
- There have been changes to messaging compared with previous years, with more focus on managers and engagement to try to increase responses. An overall response rate 64-65% in anticipated.
- Further feedback on the content is expected over the next month or so.
- A significant increase was noted in response for teams with low response rates e.g., liaison, home treatment, inpatient teams and urgent and acute care. This relates to action 26/65 above.
- High level themes from the survey are expected by the end of December, with more detailed findings by the end of February.
- Pulse Survey is short quarterly survey by NHSE. It doesn't contain the same level of detail but offers a "temperature check" of how staff are feeling.
- The response rate has been around 8-9% for the last two quarters, which is about average and up from historic levels of 1.5%
- Results show progress in some areas and deterioration in others.
- Advocacy (i.e., staff and patient recommendations) is one area where improvement is needed.
- Questions were tailored to why people feel the way they do, with workloads, staff shortage and stress being the key reasons for negative responses.
- This indicated that the priorities we have around improving patient journeys and workforce experience are the right ones.

Discussed:
That the response rate of over 60% was an extremely positive outcome. The team were praised for their efforts.

The Pulse Survey results are challenging – there may be a correlation with the discussion around the Q&P report.

NP noted that this year's Staff Survey is very different from previous years, citing the experience of Sutton Community Services, where there was much more local focus as

well as opportunities for staff to suggest changes. (Sutton Community services came out top for engagement.)

Discussion of how to ensure that staff know the survey is being acted upon. Board themes are important to this, and actions will be communicated weekly through Vanessa's Chief Executive update. It will also be important to empower leaders to make local changes in order to engage their teams.

SA asked the group and presenting team to reflect of the following points and consideration of these be incorporated in future update:

- To what degree we present the information routinely to staff networks.
- How effective strategies are at engaging seldom-heard groups of staff.
- How we can further increase engagement around the staff survey.

26/96 Freedom To Speak Up (FTSU) Guardian Report

The Committee received and noted the report.

Reported:

- Three reports that are patient safety related, following a period where there were none.
- It is important to understand the dynamic between formal reporting systems and the FTSU framework and which is the most effective for reporting patient safety issues.
- The previous report of no patient safety reports was an outlier.
- Report includes a link to the Guardian Officer's report to Parliament, which Committee members were encouraged to read.
- Health and Care Regulators have reported a reduction in whistleblowing reports to the GMC.

Discussed:

The Committee discussed that when an issue is reported, the process is that the Guardian role makes a decision on whether to refer the case to HR and/or Nursing and Quality, or deal with it directly. Some cases had been remaining with the Guardian that ought to be referred to HR, but this had decreased. Whistle blowing incidents are referred to the Quality and Safety Committee.

Cases in the year to date have shown an upward increase. The Trust is working to support the Guardian with outreach work and encourage staff to have confidence in the Guardian. The Trust has begun to pay an additional fee because a certain threshold of cases has been reached; this was flagged as a positive point as means the system is working. The previous Committee had looked for a higher number of incidents to be reported, and this has happened.

The difference between "permission to escalate anonymously" and "permission to escalate without name." This was something to confirm with LM, but it was suggested that the latter is slightly more permissive.

LM has regular contact with KR and PW regarding cases that are not being progressed, and they meet on a 6-weekly basis to capture process/policy changes.

Regarding the increase in numbers of cases to the Guardian, this is likely to be offset by a new HR system, which is being implemented next year.

It was noted that LM had not been to the Committee for some time was agreed to invite LM to next committee, and ask him to update members on: **DL**

- the pathway of reported incidents
- ongoing capacity and how this is affected by an increased number of cases
- the distinction with "anonymous" and "without name" outlined above

Richard Flatman (FTSU Non-Executive Director) to be invited to a People Committee when FTSU is an agenda item. **SA**

26/97 Wellbeing Staff Report

Reported:

- This report is the first step of our self-assessment and evaluation of our forthcoming Health and Wellbeing framework at the Trust
- NHSE have produced tools and guidance which have been used for this work.
- The report includes commentary and a summary of the framework.
- The Trust is currently developing offer and plans communicating this to staff soon.

Discussed:

That the next iteration should indicate the types of staff that were involved in the self-assessment, in order for the Committee to be assured of a representative input. The SA, as the Health and Wellbeing NED, is to be included for additional input.

Triangulation with the transformation agenda to ensure a consideration of any impact on health and well-being of staff and the importance of links with the various relevant networks.

That group discussions included ensuring that understand what staff might want was also framed to manage expectations of what was possible.

Next iteration of Staff Wellbeing Report to include: **JK**

- Types of staff involved
- Input from Health and Well-being NED
- Links to transformation work and the various staff networks

3 Performance

26/98 People Committee Q&P Report

The Committee received and noted the report.

Reported:

- PW shared the Report Summary.
- Temporary staffing is now showing as green, with Agency usage down to 3.2% against a target of 3.6%. Temporary staffing is highest in acute and urgent care.
- The two remaining non-framework consultants have been given notice.
- Time to hire shows a slight increase, mainly due to high level of candidates in pipeline. A reduction is anticipated
- Vacancy rate is reduced to 15%; it is reasonable to expect that this will reduce further.
- ER cases have increased due to an increase in sickness (to 67 cases). Work is ongoing to reduce this, including management training on moving sickness cases from stage 2 to stage 3, and greater strategic oversight of sickness management

with the Occupational Health contractor. Details are to be brought to People Committee in January.
- PADR is static, while turnover rate have reduced but remain high overall, especially for staff with less than 12 months' service.
- MAST technical issues have largely been resolved, and an upward trajectory is now anticipated.

Discussed:
It was noted in the discussion that there is a distinction between Agency and Temporary Staff (the latter of which includes Bank staff), and the progress described has plateaued. Whilst ad hoc Agency usage has reduced, a focus on strategies to bring about long-term reduction of Agency numbers is required. The commentary in report should include sighting the Committee on the progress of Agency as well and temporary staffing, and regularly include medical staffing.

There has been a reduction in the use of agency workers in administrative roles, and controls in the agency booking process has improved.

SIREN continues to be embedded in our practice and a rise in ER cases noted. Cases over 30 days are mainly related to sickness – the reason for the increase was attributed to dedicated resource tackling the pre-existing backlog. Disciplinary cases are currently low. The People Team is currently looking at a knowledge management system to try to present the workforce data more meaningfully, with interim improvements expected for the next People Committee. A new change in procedure includes Managers being required to hold a conversation with the People Team in advance of suspending a member of staff.

MAST – the current forecasting predicts a declining position. A lot of work has been done, but there are still a few technical issues. New training courses also add to the strain on services, and further work around L&D is being done. Are there MAST areas that are essential such as BLS training

SA raised some issues for reflection and action:
- PADR KPI in corporate teams are not performing well – what is needed to see improvements
- More granular insight required into the reasons for the high turnover and sickness in medical teams.
- Supervision KPI to be included in future reports.
- The report states that BAME staff in band 8a has been increasing, but it appears to have been stagnant for the last two years. Could future commentary be included to clarify this with the plans for active improvements **KR**

Agreed:
SA and KR to discuss separately whether more work needs to be done to gain assurance on the content of and reasons behind the increase in ERs as well as the process, and consider bringing a more in depth look at the ER cases to part B of a future People Committee. **SA/KR**

26/99 Workforce Planning Progress Report

Reported:
- PW showed slides.
- 2023-24's workforce plan was the first where HR led the work
- The team carried out interviews with different departments against a key data set and created workforce plans to achieve upper thresholds of KPIs.

- A consistent approach was taken across the organisation, reviewing the existing improvement plans.
- Quarterly workforce deep-dives were undertaken, with regular meetings to review them.
- Progress has been made on KPIs, but further improvements are needed.
- Part of our reflection was that some workforce plans became too large and effectively more of a "wish list" of what service lines wanted rather than SMART plans.
- The plans will need to be reviewed against the latest dashboard data in January, to create plans for the end of March.
- A set of principles have been written for next year's plan. The approach is to choose two or three issues to focus on and triangulate with Trust objectives, Finance CIPs and Agency targets.

Discussed:
The degree to which workforce plans take into consideration plans to diversify the workforce, young people leaving, hard to recruit to professional areas. The team are working with ICB colleagues on recruitment initiatives such as joint recruitment assessment days. There will also be some cross-cutting corporate themes and a focus on being an anchor institution.

Governance for the oversight of the plans; this will be mainly scrutinised by the People Matters Group, but can also be brought to People Committee once complete. **PW**

Add Workforce Plans Report to People Committee forward plan for April 2024 Committee. **KR**

26/100 Retention Programme Overview

Reported:
- KW shared report.
- Turnover is reducing, but turnover for staff with under 12 months' service is still high.
- Whilst there are numerous corporate actions being undertaken around retention, it is ultimately day to day leadership engagement that will change this.
- The work in action plans has been developed by drawing on the results of an NHSE pilot around retention, which involved numerous other Trusts. The learning from this has been embedded into the work the Trust has done.
- Turnover by ethnicity slide shows more people from a BAME background leaving under 12 months. More work to be done to understand this and link to our anti-racism work.
- More detailed analysis indicates that the number of BAME staff leaving in the first four months is similar to the average. It is during the four-to-seven-month period that this diverges.
- Only 197 forms completed an exit form in last two years, so it is hard to get comprehensive information from this.
- Comparison of turnover between different teams showed that the highest turnover was in CAHMS, while Community teams had higher long-term turnover. The lowest turnover in specialist services. The team plan to talk to the relevant teams to understand the reasons for this.
- The report was broken down into three areas – My start, My development, My future, to encompass the three main phases of staff's time with the Trust.

Discussed:
HA raised concerns about leaver percentages and cited the Merton Community Team, where recent recruitment had taken place, but further OD support was needed to wrap around integrating new recruits. Managers and business partners are aware of which teams have recruited at scale. The People Team are tracking 330 new staff recruited between September and October 2023; there is work going on to track their experiences over the next 12 months. It is estimated that feedback will begin to become available after about 3 months. This would mean a lot of people would have left; KW to consider this.

There may be capacity issues with some of the retention programme, given HR's transition from recovery. However, the work is being distributed more widely than HR; for example there are Head of Professions meetings in which other service leaders have indicated that they would like to take on some of the work around career conversations.

It was clarified that leavers in the data excludes those on fixed term contracts, and Junior Doctor rotations.

It was suggested that feedback from line managers might be useful in understanding why staff chose to leave, especially if they have been incorrectly recruited.

Agreed:
Consider how monitoring the 330 joiners should fit into reporting to the Committee. **KR**

Consider outside committee whether further retention questions could be added to Director of People Report in future. **HA**

26/101 HR Internal Audit Recommendations Update
The Committee noted the update.
Reported:
- The report has been submitted to FPC and Audit Committee.

26/102 HR Recovery Recommendations
The Committee noted to report.
Reported:
- The recommendations from the HR MOT Report are shared here.
- The report contains 8 "must dos", which are grouped into themes and intended actions have been fed back to ELT.

Agreed:
Ongoing management of this will be sighted through ELT.

26/103 EDI Enabling Strategy action plan progress report (exception and highlight)

Reported:
- The WRES, WDES, NHS HEIDI action plan, and PCREF all feed into the EDI action plan.
- The cover paper provides some information on areas with significant progress on five of the actions; these can be closed.
- 12 of the actions are progressing as planned.
- 12 of the actions will require additional time, but are still expected to be complete within the current financial year.

- The previous Secretary of State letter to ICBs about EDI was highlighted for information.

Discussion:
HA highlighted a question raised by a new member of staff at her induction question, regarding the lack of BAME Board Members despite the Board being diverse, although it was noted this was in the NED membership. The Trust is stronger on recruitment of BAME staff to band 8 than some other Trusts and was suggested that Trust should publicise that, whilst recognising that there is still work to do. Board development days are an opportunity to discuss this issue further.

It was noted that bullying and harassment figures are comparable to other trusts, and therefore not an outlier, although this view was not always echoed among staff.

The recent WRES planning webinars were poorly attended. However, the outcomes and targets have been captured for these, and valuable information was obtained.

Some updates in the report were out of date, so more assurance would be needed about the effectiveness of the interventions relating to these.

SA questioned what evaluation would be carried out around the effectiveness of the plans.

There was a discussion around the increase in BAME staff recruited to Band 8a. The Q&P Report (Item 26/98) shows a small increase from 31-32% of staff recruited at this level. This translates to approximately a 12% increase in the actual number of BAME staff recruited to Band 8a positions. However, neither of these was statistically significant. There may be a need to look at band 7 to understand any issues with the route BAME staff are taking to Band 8.

Agreed:
People Team to consider examining career progression for BAME staff at band 7. **KR/EH/ JA**

That the Director of HEIDI will look into how we test that actions in the EDI plan to reflect the views of wide range of staff. **EH**

That the Director of HEIDI will clarify the point around the increase in BAME staff being recruited to Band 8a. **EH**

26/104 Nurse revalidation annual report
The Committee noted the report.

Reported:
- The Trust is compliant.

KR to discuss bringing the medical validation report to Committee once a year for noting with the Medical Director. **KR/BB**

4 Strategy

26/105 Q2 Corporate Objectives Update
The Committee received and noted the report.

Reported:

- The People aspects were showing amber as they were a month behind, but they are still progressing. These included the launch of the first leadership events, workforce plans, and EMHIP.

Discussed:
Sequencing of People Plan had been agreed previously.

Whether the Training Needs Analysis (TNA) approach should be included in the Director of People Report – it was noted that Head of Professions meeting is being used as a forum to work on this

Director of People to add TNA in the DoP report. **KR**

To discuss implementing a KPI to measure HR function. **KR/SA**

5. Accountability

26/106 Executive Risk Register (ERR)
The Committee received and noted the ERR.

Reported:

- Medical vacancies are hampering the work of some teams.
- Funding has been obtained from the Strategic Investment Fund for more professional branding to support recruitment, but recruitment of psychiatrists remains a local and national problem.
- Conversations are ongoing about how to support services whilst recruitment problems persist.
- Employment Tribunals have reduced from 16 to 9, but this remains high.
- The HR and OD risk score remains high, as it is felt that, despite improving numbers, it is still too early to reduce the score.
- On Industrial action, the consultant pay deal was awaiting agreement. There was no agreement for Junior Doctors yet. There were currently no firm dates for further action, but the risk remained on the ERR.

26/107 People Board Assurance Framework (BAF)
The Committee received and noted the People BAF.

Reported:

- The BAF had moved from an operational to a strategic approach, to reflect the need for long-term risk management.
- Community base recruitment work was positive in terms of reducing vacancies. Other Trusts who have made strong progress were engaged to feed into this work.
- Flexible working was highlighted as being important to retention, with the recognition that it means different things to different people. A working group has been established to progress this, and findings will be report to a future Committee.
- The Team had structured its work into various work streams, that would feed into the People Matters Group and from there to the People Committee.

Discussed:
Risks associated with medical staffing and ER cases could be strengthened more in the BAF.

HA questioned some ratings, and plans to discuss with DL how these are calculated, prior to querying whether some Reds could be Amber.

Agreed:
BAF to be discussed at next Committee. **KR**

JW and SS to consider how the People risks feed into Quality and Safety KPIs, for QSAC. **JW/SS**

26/108 EDI BAF
The Committee noted the BAF
Reported:

- No red risks were identified in the current intervention
- EMHIP delivery actions were flagged. There are delays to implementation and future funding is still under discussion.
- There were actions around PCREF. A self-assessment has been completed. PCREF is triangulated with the work of WRES to ensure these align.

Discussed:
The EMHIP action around cultural competency has relevance to the People Committee and its oversight of the work around anti-racism, and so it would be useful for the Committee to be updated on this.

It was discussed that the newly highlighted risk of BAME staff turnover within 12 months is not captured as the data were not previously available, but this will be included in future iterations of the EDI BAF.

6. Key Matters to Report to the Board or other Committees

26/109

- A deep dive is recommended on medical staffing, ER cases and sickness absence.
- EMHIP and the vulnerability of the interventions in the action plan.
- Engagement with staff survey has increased significantly and this is very positive.
- Significant work is being done to understand the Trust's staff retention problems and how to improve the position.

7. Meeting Review
Members spent significant time on culture and less time of other areas.
The meeting seemed to flow well and priority areas were clear.
The Chair expressed appreciation of member's efforts in various areas, such as engagement, workforce, and EDI.

8. For Information Items

26/110 People Matters Group Minutes
The Committee noted the Minutes.

26/111 Long-term Workforce Briefing
The Committee noted the forward plan.

26/112 GMC Workforce Report
The draft agenda was bought to Committee for note.

9. Forward plan and draft agenda items for next meeting

26/113 Committee Forward Plan
The Committee noted the Forward plan and proposed agenda for the next meeting.

People Committee Acronyms List

BAF	Board Assurance Framework
DiDM	Diversity in Decision Making
EAG	Employee Advisory Group
EDI	Equalities, Diversity and Inclusion
ELT	Executive Leadership Team
ER	Employee Relations
ERR	Executive Risk Register
FPC	Finance and Performance Committee
HRBP	HR Business Partners
ICB	Integrated Care Board
ICS	Integrated Care System
KPI	Key Performance Indicator
LDA	Learning Disability and Autism
LMC	Local Medical Committee
LNC	Local Negotiating Committee
MAST	Mandatory and Statutory Training
NHSE	NHS England
OD	Organisational Development
OH	Occupational Health
OHW	Occupational Health Works (current trust OH provider)
ORAF	Operational Resilience Assurance Forum
PSED	Public Sector Equality Duty
PSIF	Patient Safety Incident Framework
QSAC	Quality and Safety Assurance Committee
RAG rated	Red, Amber, Green rated (usually used on action plans and the BAF)
SLaM	South London and the Maudsley NHS Trust
TOR	Terms of Reference
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

NHS
South West London and St George's Mental Health NHS Trust

Meeting:	Trust Board
Date of meeting:	11 January 2024
Transparency:	Public
Committee Name	Finance and Performance Committee
Committee Chair and Executive Report	Vik Sagar Philip Murray

BAF and Corporate Objective the committee is accountable for:

BAF Risk Description
A failure to achieve financial targets

Corporate Objective
Objective 6: To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL.

Key Questions or Areas of Focus for the Board following the Committee:

The following are themes that informed and reflect the discussion at the November and December meetings of Finance and Performance Committee:

1. Financial Position – The Trust is on track to achieve the required position for 2023/24, focus must be maintained on reducing external beds and agency whilst increasing delivery of recurrent savings.

Areas of Risk Escalation to the Board:
None.

For each item discussed at the Committee there would be a statement against the 3 areas below:

Performance Report
What: The Committee regularly receives and reviews this report for assurance.

So What: The Committee noted the report; overall position is stable and focus remains on incremental sustainable improvements. The moderate improvement in length of stay reporting in August/September has now reverted to Q1 levels, agency numbers have increased marginally despite increased substantive recruitment, retention remains a problem. DNAs and DTOC remain broadly flat. Patient flow remains a significant area of concern and the use of external beds remains under review.

What next: The Committee acknowledged the improvements and will keep monitoring the KPIs with particular focus on agency and flow which are key drivers of the underlying financial position. Recently published NHS Benchmarking data is being reviewed to determine areas of best practice and where lessons can be learnt such that further improvements can be made.

Monthly finance and savings reports
What: The FPC receives a monthly report on the finances in the Trust.

So What: The Trust's financial position remains broadly on track. Whilst areas remain a concern (agency, acuity, external beds) the Trust is relatively confident of achieving the £250k required surplus position.

What Next: The Committee will continue to monitor the finances via the monthly report.

Health Inequalities
What: The Committee recognises the importance of reducing Health Inequalities and is considering how it can best support.

So What: The Committee is reviewing Health Inequalities from a Finance and Performance perspective and received a guest speaker from NHSE to assist in their understanding. Following an in-depth discussion at the December meeting Committee is looking to agree actions and reporting during Q4.

Adult Eating Disorders
What: The Committee receives updates on programmes of work within the Strategy, Transformation and Commercial Portfolio.

So What: The Committee was updated on the successes and challenges of the Adult Eating Provider Collaborative that went live in October 2020. Committee were supportive of the progress being made and the proposed actions going forward.

Workplan
What: The Committee regularly reviews its workplan to ensure focus on appropriate topics and issues.

So What: The Committee reviewed the work of the Estates and Digital departments to agree future reporting and to ensure no duplication with other committees. Committee approved the Terms of Reference for the Capital Savings Board.

Items for note

None

Appendices

Appendix 1 - 2023/24 M7 Finance Report Part A – Cover
Appendix 2 - 2023/24 M7 Finance Report Part A - Powerpoint
Appendix 3 - 2023/24 M8 Finance Report Part A – Cover
Appendix 4 - 2023/24 M8 Finance Report Part A - Powerpoint

NHS
South West London and St George's Mental Health NHS Trust

Report Title:	**Finance Report 2023/24 Month 7**
Meeting:	FPC
Date of Meeting:	30 November 2023
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Transparency:	Public
Scrutiny Pathway	Director review / ELT / FPC / Trust Board

Purpose:	☒	Approval	☒	Discussion	☒	Information	☒	Assurance
Additional information:	The purpose of the paper is to report on the financial position of the Trust and provide updates on the financial targets against which the Trust is performance monitored against.							

What?	Key items to note are: ➢ **Year End Forecast** – forecast in line with plan at £250k surplus before impairments, impairments estimated at £50m for planning purposes. ➢ **In Month / cumulative position** - £0.1m surplus in month, £0.3m deficit cumulatively, in line with plan. ➢ **Agency** – a decrease in spend compared to 2022/23 and £0.7m below plan for 2023/24. NHSE target not being achieved, ytd at 5.2% of pay bill - % improvement in month due to risk contingency assigned to paybill. Trajectories indicate further work required to achieve NHSE target by end of March. ➢ **External Beds** – Costs reduced in month however indications are a high level anticipated for November – currently at 41 beds. Year to date costs £1.8m more than budget. ➢ **Savings** – identified schemes forecast more than delivers the £13.0m target. Due to overprogramming and following a RAG improvement in month risk assessed delivery is now greater than 100%. Recurrent Delivery is currently 56% (54% last month). The plan is to achieve a minimum of 62% £8.1m recurrent delivery at year end. ➢ **Capital** – underspend of £7.6m ytd due mainly to slippage on Tolworth, Barnes and Richmond Royal schemes. ➢ **Cash** – the cash balance is £22.2m.
So What?	The report provides full assurance that the Trust can achieve its revenue and capital target for the year. The report provides partial assurance that the Trust is on track to achieve this position in accordance with the plan for the year and progress is required against recurrent savings delivery. The Executive Team have reviewed and support the items FPC

	are asked to approve/note below. ➢ **External Beds** – A plan is in place and ELT remain confident this will deliver and focus must be maintained on these existing actions and service lines supported to deliver them. Recognising that bed usage has not reduced as fast as planned consideration is being given to increasing block contracts to reduce the cost. ➢ **Agency** – Improved Oversight is in place however the Trust is not achieving the national requirement of agency spend not exceeding 3.6% of pay bill. Costed forecast trajectories have been produced by service lines and the consolidated overall picture indicates further work required to achieve the target. Actions continue to be monitored and trajectories refined. Forecast to be held in line with plan. Other Key items to note are: ➢ **Savings** – Delivery to date is improved compared to prior years and schemes are in place to deliver. Delivery is ahead of plan cumulatively. Forecast recurrent delivery remains below plan. Overprogramming now far exceeds the value of 'red' rated schemes reducing the likelihood of external scrutiny. Overprogramming has proven to be beneficial in reducing external scrutiny and improving financial confidence earlier in the year, with risk assessed delivery now greater than 100%. Progress is needed to turn more schemes recurrent. ➢ **Cash** - The Trust has sufficient cash to manage its business and must not lose sight of the requirement to start repaying the loan in 2023/24.
What Next?	Actions have been identified as follows: ➢ Continued monitoring of the position.
Any specific issues to note and/or for escalation:	1. All committees are asked to ensure that focus is maintained on reducing external beds, reducing agency and delivering recurrent savings

Strategic ambitions this paper supports	☐	Increasing quality years	This paper supports by outlining how the Trust will achieve its financial goals, highlighting key cost drivers and their impact on underlying financial sustainability.
	☐	Reducing inequalities	
	☐	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	Outlined below are the key implications which may result from the proposals or information contained within this report
Equality analysis	Positive impact – The Trust spends money to improve

[linking to EDI strategy]	equality and diversity for patients and staff
Service users/ carers	Positive impact – Trust Funds are spent to get the best value to support our clinical services and patients
Estates:	Positive impact – The Trust is investing in its Estate to provide modern mental health facilities
Financial:	Positive impact - Provides information on the delivery of key financial targets
Legal:	Positive impact - Provides information on the statutory requirement of achieving break even
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Strategy:	Positive impact – The Trust has a good reputation for achieving financial targets
Workforce:	Positive impact – The Trust has a good reputation for achieving financial targets
Sustainability Eg. Green Plan.	Positive impact – The Trust knows its cost drivers and is taking positive action to ensure financial sustainability
Other (specify):	n/a

Appendices/Attachments:	One Power Point accompanies this cover sheet.

NHS
South West London and St George's Mental Health NHS Trust

Finance Report 2023/24
7 Months to October 2023

Meeting	ELT
Date of Meeting	November 2023
Report Title	Finance Report 2023/24 – 7 Months to October 2023
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Director of Finance & Performance
Purpose	For Information
Scrutiny Path	Director review/ELT/FPC/Trust Board
Transparency	Public
Recommendation	None
The Board is asked to	Discuss and Note

South West London and St George's Mental Health NHS Trust

Contents

South West London and St George's Mental Health NHS Trust

Overall – I & E Position

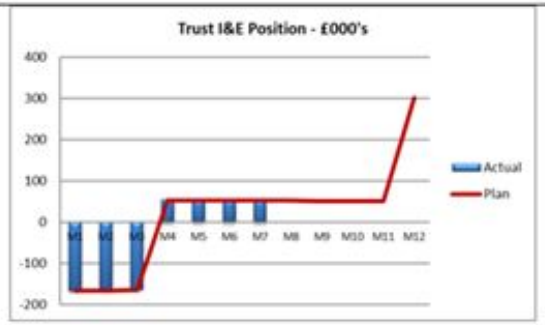
- In October, the Trust recorded a £0.1m surplus in line with plan, bringing the cumulative deficit to £0.3m, also in line with plan. The planned and actual deficit to date are due to costs associated with new buildings being incurred before associated savings from moving out of old buildings are delivered. The improved monthly position from Q2 onwards is associated with rental savings as the Trust moves into the new build
- The forecast remains a surplus of £0.2m for the year before impairments. It is likely that the Trust will be required to end the year on a surplus better than plan to support the SWL System. The position across all SWL providers is currently under review
- Completion of two new hospital buildings in 2023/24 will generate significant impairments (approx. £50m). The Trust is performance managed before impairments
- The Month 7 position contains some material shifts: a significant reduction in PDC has enabled the inclusion of significant known risks into the forecast and year to date position
- This has resulted in in-month spikes in both pay and non-pay expenditure but remains revenue neutral and has enabled the mitigation of the known in-year risks
- Continued diligence and strong financial control is required to ensure that the Trust remains on track and delivers its year-end forecast

Financial Reports 2023/24	Current Month			YTD month 7			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	25.0	25.8	0.8	168.7	171.8	3.0	291.7	295.3	3.6
Pay	(15.7)	(16.9)	(1.2)	(111.4)	(112.2)	(0.8)	(193.4)	(191.9)	1.5
Non Pay	(7.8)	(11.4)	(3.6)	(46.5)	(52.9)	(6.4)	(79.9)	(89.3)	(9.4)
EBITDA	**1.5**	**(2.5)**	**(4.0)**	**10.8**	**6.7**	**(4.2)**	**18.3**	**14.0**	**(4.3)**
Cap Charges - Depreciation	(0.9)	(0.9)	(0.0)	(6.8)	(6.9)	(0.1)	(11.2)	(11.2)	0.0
Cap Charges - Interest & Div	(0.6)	3.4	4.0	(4.4)	(0.4)	4.0	(7.6)	(3.6)	4.0
Interest	0.1	0.1	(0.0)	0.1	0.4	0.3	0.7	1.1	0.4
Post EBITDA	(1.4)	2.5	4.0	(11.1)	(6.9)	4.2	(18.1)	(13.8)	4.4
Underlying Surplus / (Deficit)	**0.1**	**0.1**	**0.0**	**(0.3)**	**(0.3)**	**0.0**	**0.2**	**0.2**	**0.0**
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	(50.0)	(50.0)	0.0
Net Surplus / (Deficit)	**0.1**	**0.1**	**0.0**	**(0.3)**	**(0.3)**	**0.0**	**(49.8)**	**(49.8)**	**0.0**

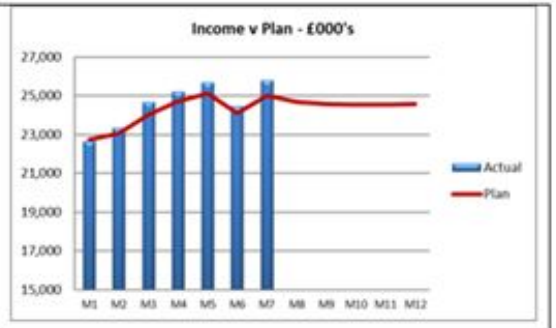
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

- Baseline surplus of £0.1m reported in month, in line with plan
- Cumulative deficit of £0.3m, also in line with plan
- Deficit driven by EMP phasing
- In month external bed pressures offset by investment slippage
- Risks included in position, offset by reduced PDC



- Income received in month, £25.8m, £0.8m above plan
- In month increase incorporates: SLP Legacy funding (£0.2m), Education inflation (£0.1m) and additional specialling income (£0.1m)
- Expected additional income flows in year include Complex care (CNWL) £1.7m, and £0.8m for 2 Autism pilots

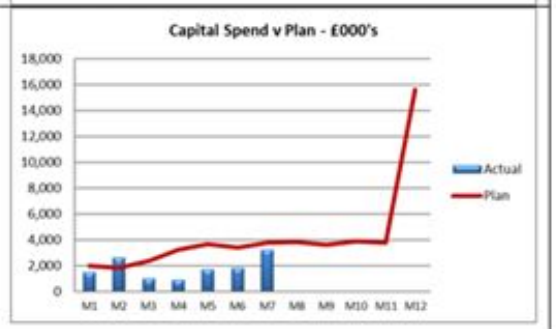


- Spend of £28.3m, £4.8m adverse to plan
- Spike caused by inclusion of all known risks, offset by post EBITDA PDC savings
- External bed expenditure of £0.8m in month, £0.2m above 2022/23 average
- Cumulative overspend on external beds of £1.8m, funded from slippage
- High external bed usage continues into M8

- Agency spend in month £0.7m, £0.3m below 2022/23 average spend
- £0.05m below plan
- Small increase on M6
- Equates to 4.4% of pay bill, 0.8% above NHSE target of 3.6%
- 44% of monthly spend on Nursing, 38% on Medical
- Community Service Line spend amounts to 61% of cumulative spend

- Cash balance at end of October £22.2m
- £26.6m adverse to plan
- Result of delayed asset sale, completion now expected in Q3
- Loan repayments of £99m to commence in 2023/24
- Movement in cash during the year due to asset sales, deferred receipts, and loan repayments

- Cumulative capital spend of £12.7m.
- £7.6m behind plan
- £7.5m relates to slippage on significant site developments – Richmond Royal, Barnes & Tolworth
- £0.1m relates to BAU capital
- Forecast spend of £51m
- Spike in M12 the result of uncertainties around the timings in spend on the Tolworth redevelopment



South West London and St George's Mental Health NHS Trust

Income Position

- Cumulatively, income is £3.0m favourable to plan
- Local contract income is £0.7m ahead of plan due to additional funding after the initial contracting round on which the plan was set, primarily hostel income
- NPSA income is £0.1m behind plan as external referrals are below planned levels
- Provider Collaborative income is £0.8m below plan due to reduced Adult Eating Disorders inflow income
- Other NHS Clinical income is over-recovered by £2.0m due to the release of deferred income to cover the AED shortfall alongside additional investments in CAMHS and Complex Care and Legacy Cost pressure funding
- Other Non Clinical Income is £0.9m ahead of plan, primarily due to additional SLP allocations
- Non-NHS Clinical income is showing a £0.3m favourable variance due to Local Authority grants and reimbursement for above plan deaf interpreter costs
- Other income flows are approximately break-even

Financial Reports 2023/24	Current Month			YTD month 7			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	19.5	19.6	0.1	130.6	131.3	0.7	226.6	227.3	0.7
Nhs England	1.7	1.7	0.0	12.1	12.1	0.0	20.6	20.5	(0.0)
Npsa Income	0.0	0.0	(0.0)	0.3	0.2	(0.1)	0.6	0.3	(0.3)
Provider Collaborative Income	2.2	2.1	(0.1)	15.2	14.4	(0.8)	26.3	24.8	(1.5)
Other Nhs Clinical Income	0.2	0.7	0.5	1.4	3.4	2.0	2.2	5.6	3.4
Nhs Clinical Income	**23.7**	**24.2**	**0.5**	**159.6**	**161.3**	**1.7**	**276.2**	**278.5**	**2.3**
Education & Training	0.7	0.8	0.1	4.8	4.9	0.1	8.0	8.3	0.4
Other Non Clinical Income	0.2	0.3	0.1	1.6	2.5	0.9	2.5	3.4	0.9
Merit Award Income	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.1	0.0
Non Clinical Income	**0.9**	**1.1**	**0.2**	**6.4**	**7.4**	**1.0**	**10.5**	**11.8**	**1.3**
Non NHS Clinical Income	0.4	0.6	0.1	2.7	3.0	0.3	4.9	4.9	(0.0)
Non Nhs Clinical Income	**0.4**	**0.6**	**0.1**	**2.7**	**3.0**	**0.3**	**4.9**	**4.9**	**(0.0)**
Income	**25.0**	**25.8**	**0.8**	**168.7**	**171.7**	**3.0**	**291.7**	**295.3**	**3.6**

South West London and St George's Mental Health NHS Trust

Pay Position

- Pay amounted to £16.9m in-month, a £1.2m overspend. Cumulatively, pay is £0.8m overspent
- Month 7 was not a typical month: £0.8m of risk was incorporated into the pay position along with a £0.5m reduction due to CIP clearance – without these an underspend would have been returned
- Medical staffing are cumulatively overspent by £0.5m. The largest single driver of this is the premium paid for agency medical staff to cover vacancies
- Nursing budgets are now overspent by £2.9m. Of this, approximately £0.9m relates to extra packages of care funded by the SLP with a further £0.3m relating to specialling for off-site patients. The balance encompasses: risk, acuity pressures, and the costs of the additional bank holiday in May.
- The underspend of £2.6m on Other Clinical staff primarily consists of Psychologist vacancies and continues the trend seen in this and previous years
- Non-clinical staff are broadly break-even

Financial Reports 2023/24	Current Month			YTD month 7			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.5)	(2.8)	(0.2)	(17.8)	(18.3)	(0.5)	(31.1)	(31.8)	(0.6)
Nursing	(6.4)	(7.2)	(0.8)	(45.3)	(48.2)	(2.9)	(78.4)	(82.4)	(4.0)
Other Clinical	(3.9)	(3.9)	0.0	(28.3)	(25.7)	2.6	(49.5)	(43.7)	5.8
Non Clinical	(2.9)	(3.0)	(0.2)	(19.9)	(20.0)	(0.0)	(34.4)	(34.1)	0.3
Total Pay	**(15.7)**	**(16.9)**	**(1.2)**	**(111.4)**	**(112.2)**	**(0.8)**	**(193.4)**	**(191.9)**	**1.5**

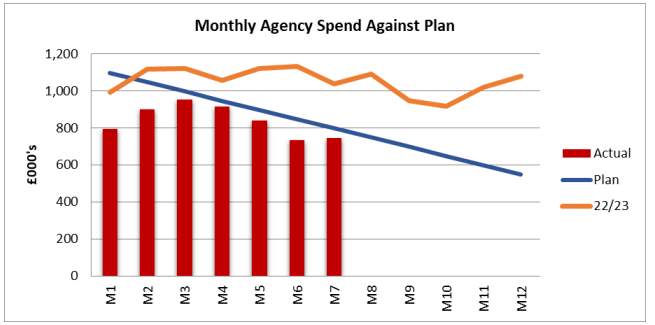
- Spend on agency staffing is cumulatively £0.7m favourable to plan, including a marginal underspend recorded in October. This is positive and health warnings should continue to be applied as the plan assumes improvement each month until NHSE target monthly expenditure is achieved in March.
- Bank is now £1.6m adverse to plan with the overspend being driven by the Nursing overspends detailed above
- Permanent staffing is now showing a break-even position but does incorporate £0.8m of risk contingency

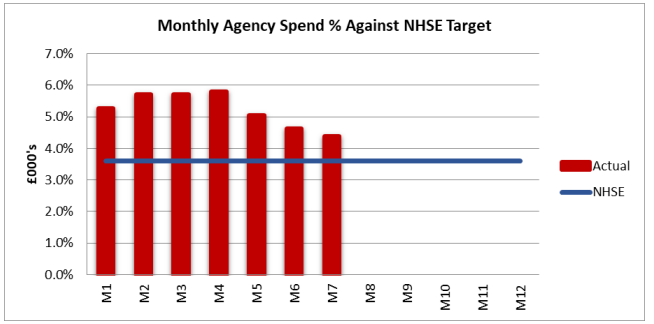
Financial Reports 2023/24	Current Month			YTD month 7			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(13.0)	(14.1)	(1.1)	(91.2)	(91.1)	0.0	(160.3)	(155.8)	4.5
Bank	(1.9)	(2.1)	(0.2)	(13.6)	(15.2)	(1.6)	(23.3)	(26.3)	(3.0)
Agency	(0.8)	(0.7)	0.1	(6.6)	(5.9)	0.7	(9.9)	(9.9)	0.0
Total Pay	**(15.7)**	**(16.9)**	**(1.2)**	**(111.4)**	**(112.2)**	**(0.8)**	**(193.4)**	**(191.9)**	**1.5**

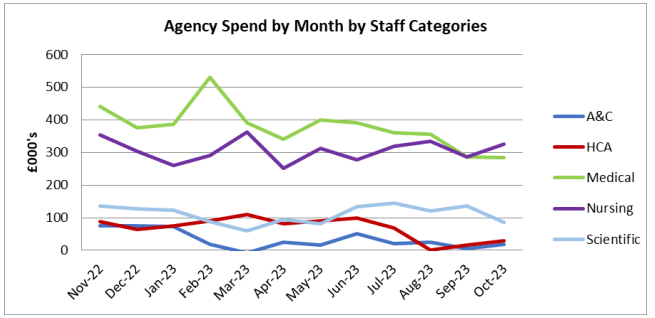
South West London and St George's Mental Health NHS Trust

Agency - in month and cumulative position

- In 2022/23 Trust agency expenditure was 7.1% of total pay costs; the Trust needed to halve its agency expenditure to meet the 2023/24 NHSE target of 3.6%
- Through system wide agreement the Trust set agency targets which started at 2022/23 actuals and exited the year at the required 3.6%
- Month 7 performance was better than plan: expenditure of £745k was £51k favourable to plan and amounted to 4.4% of the total pay bill. It was also £292k less than expenditure this time last year (October 2022)
- Cumulative expenditure amounts to 5.2% of the pay bill and is £748k below plan but £1,834k above the NHSE target.
- Expenditure in October was £13k below above September levels.
- The top graph shows a sustained fall in Agency expenditure compared to 2022/23 expenditure
- Whilst this is positive, significant work remains; for the M12 spend target to be achieved, a further 26% reduction on October cost is required
- Of October expenditure, Nursing was the highest cause at £326k. Medical spend amounted to £284k with the next highest being Scientific at £87k
- As shown on the next page, the Community Service Line remains the highest user of agency staffing. Cumulative expenditure of £3,572k equates to 61% of the Trust total
- The Trust is required to produce an agency forecast for NHSE. Despite currently being below plan, the forecast will be maintained at planned levels until further assurance is gained to enable the forecast to be varied



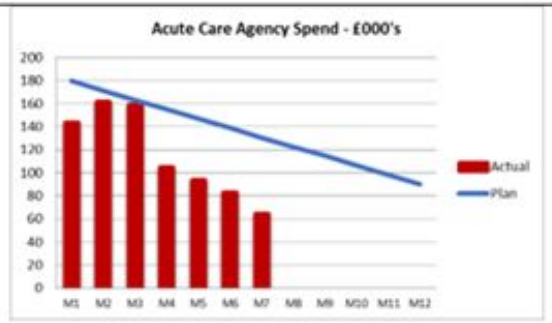




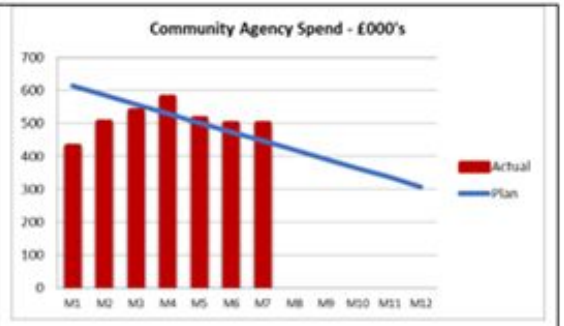
South West London and St George's Mental Health NHS Trust

Agency – Service Line and Corporate Analysis

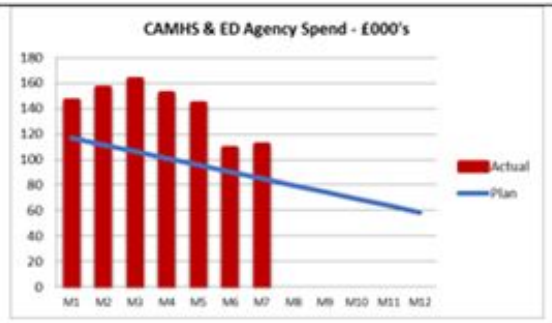
- In month spend of £64k
- £67k below plan
- £19k below M6 spend
- Cumulative spend of £810k, £276k below target
- Largest type of spend: Medical (£394k) followed by HCA (£256k), Nursing (£143k) and Scientific (£17k)
- £666k of total spend on wards, with £72k in Liaison Services and £73k in HTTs
- Highest area of spend: Ellis Ward (£211k)



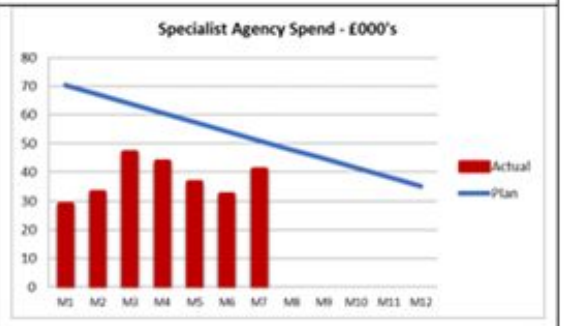
- In month spend of £500k
- £54k above plan
- In line with M6 spend
- Cumulative spend £3,572k. £142k below plan
- Largest type of spend: Medical (£1,632k), followed by Nursing (£1,626k), and Scientific (£314k)
- Highest areas of spend: Carshalton IRH (£390k) and Central Wandsworth CMHT (£288k)



- In month spend of £112k
- £27k above plan
- £3k above M6 spend
- Cumulative spend of £982k
- Largest spends: Medical (£388k), Scientific (£378k), Nursing (£177k), HCAs (£39k)
- £822k of spend in community, £160k on wards
- Highest area of spend: Tier 3 Wandsworth (£184k)

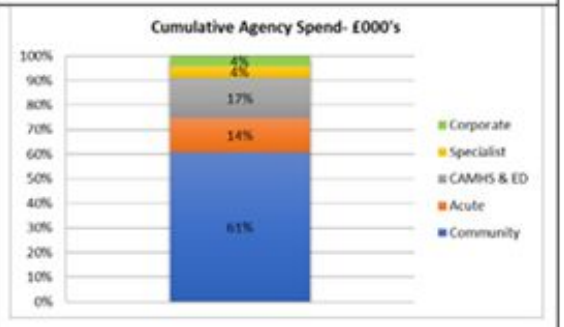


- In month spend of £41k
- £10k below plan
- £9k above M6 spend
- Cumulative spend of £262k
- Spend: HCA (£91k), Nursing (£157k), Scientific (£14k)
- £102k of spend in wards, £160k in community settings
- Highest single area of spend: Jasmine Ward (£44k)



- Spend of £28k in month
- £55k below target
- £20k above M6 spend
- Cumulative spend of £247k
- Largest area of spend: Digital Services (£89k)

- Largest area of cumulative spend = Community (61%)
- CAMHS ED – 17%, Acute = 14%
- Specialist = 4%, Corporate = 4%
- Service line and Corporate split = 96/4. Last year amounted to 89/11



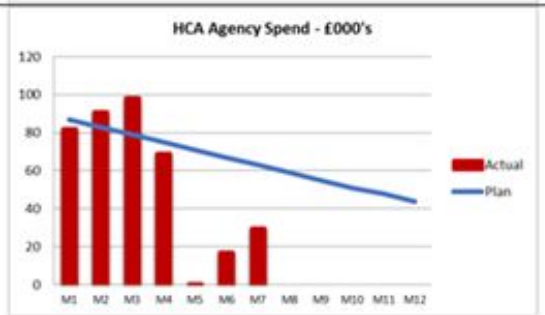
South West London and St George's Mental Health NHS Trust

Agency – Analysis by Pay Type

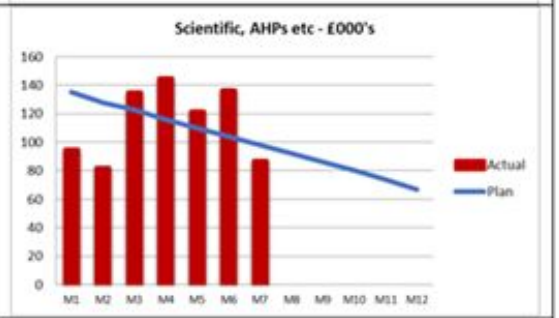
- In month spend of £284k
- £73k below plan
- £2k below M6 spend
- Cumulative spend of £2,415k, £556k below target
- £411k of total spend on wards, with £1,932k in Community settings and £73k in HTTs
- Highest area of spend: Carshalton IHR (£284k)

- In month spend of £326k
- £90k above plan
- £39k above M6 spend
- Cumulative spend £2,106k. £145k above plan
- £1,933k of spend in in Community settings, £102k on wards, and £72k within Liaison
- Highest area of spend: Central Wandsworth CHMT (£116k)

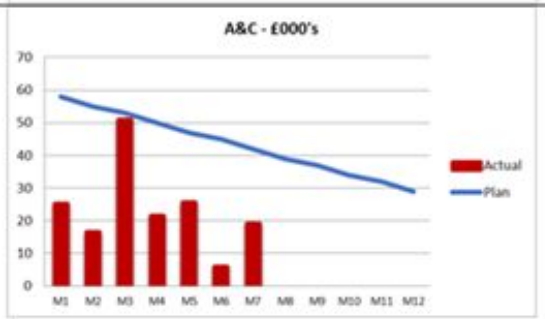
- In month spend of £30k
- £33k below plan
- £13k above M6 spend
- Cumulative spend of £386k, £39k below plan
- Fall since M4 caused by change to booking procedures
- Totality of spend on wards
- Highest area of spend: Lilacs Ward (£51k)



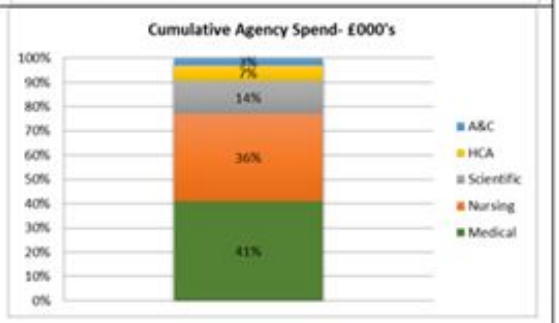
- In month spend of £87k
- £11k below plan
- £49k below M6 spend
- Cumulative spend of £801k, £13k below plan
- £736k of spend in Community, £38k in Pharmacy, and £27k in wards
- Highest single area of spend: Rehab Team (£69k)



- Spend of £19k in month
- £23k below target
- £13k above M6 spend
- Cumulative spend of £165k, £185k below target
- Largest area of spend: Digital Services (£89k)



- Largest area of cumulative spend = Medical (41%)
- Nursing = 36%
- Scientific = 14%, HCA = 7%, A&C = 3%
- Clinical/Non-Clinical split = 97/3, last year amounted to 84/16



South West London and St George's Mental Health NHS Trust

Non-Pay & Post EBITDA

- Non-Pay budgets overspent by £3.6m in the month to take the cumulative overspend to £6.4m. This position incorporated the inclusion of £3.2m of risk contingency
- The area causing major financial pressure continues to be external beds, accounting for £1.8m of the £3.5m Secondary Commissioning costs overspend. The balance relates to hostels and Complex Care investment, both of which are covered by additional income. The position incorporates £1.3m of risk contingency
- Other costs overspent by £2.3m in the month, of which £1.9m related to risk provision. The key underlying pressure remains energy in the new hospitals which is forecast to overspend by £1.4m this year

Financial Reports 2023/24	Current Month			YTD month 7			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Drug Costs	(0.2)	(0.2)	(0.0)	(1.3)	(1.4)	(0.1)	(2.3)	(2.3)	(0.1)
Clinical Supplies & Servs Cost	(0.1)	(0.1)	(0.0)	(0.4)	(0.4)	(0.0)	(0.6)	(0.7)	(0.0)
Secondary Commisioning Costs	(4.6)	(5.8)	(1.2)	(26.4)	(29.9)	(3.5)	(47.9)	(53.8)	(5.9)
Other Costs	(3.0)	(5.3)	(2.3)	(18.5)	(21.3)	(2.8)	(29.1)	(32.5)	(3.4)
Contingency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Pay	**(7.8)**	**(11.4)**	**(3.6)**	**(46.5)**	**(52.9)**	**(6.4)**	**(79.9)**	**(89.3)**	**(9.4)**

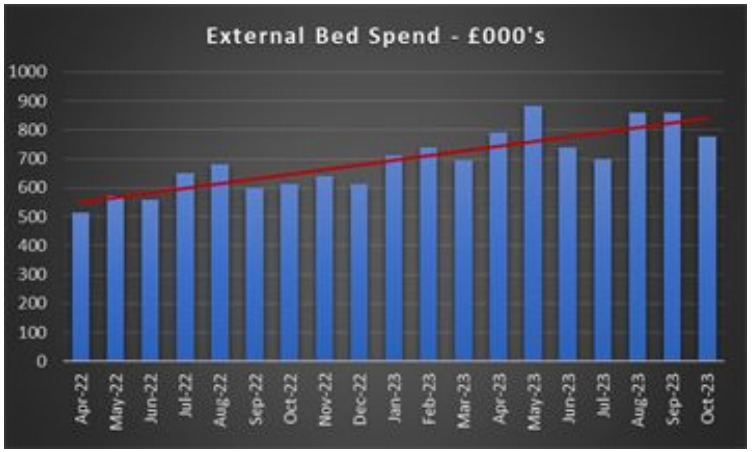
- Post EBITDA costs are now £4.2m favourable to plan.
- The significant majority of this (£4.0m) relates to a PDC reduction resulting from delays to the go live date of the new hospitals. This has been enacted in Month 7
- A significant impairment of approximately £50m is expected to be occurred due to market valuation when the two new hospitals on the Springfield site complete in 2023/24.

Financial Reports 2023/24	Current Month			YTD month 7			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Cap Charges - Depreciation	(0.9)	(0.9)	(0.0)	(6.8)	(6.9)	(0.1)	(11.2)	(11.2)	0.0
Cap Charges - Pdc Dividend	(0.6)	3.4	4.0	(4.4)	(0.4)	4.0	(7.6)	(3.6)	4.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	(50.0)	(50.0)	0.0
Interest	0.1	0.1	(0.0)	0.1	0.4	0.3	0.7	1.1	0.4
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Post EBITDA	**(1.4)**	**2.5**	**4.0**	**(11.1)**	**(6.9)**	**4.2**	**(68.1)**	**(63.8)**	**4.4**

NHS
South West London and St George's Mental Health NHS Trust

External Beds

- This analysis of external beds incorporates unplanned external bed usage as well as contracted beds at ELFT (both Female PICU and Acute)
- Significant external bed costs incurred in 2022/23 continue into 2023/24
- October expenditure amounted to £0.8m, a £0.1m fall on September costs
- This was £0.1m above the monthly average for 2022/23
- Cumulatively, external beds are now overspent by £1.8m
- The budgetary base for October covered 744 days, actual utilisation amounted to 1,064 days, 320 days above plan and 50 days below September actuals
- The cumulative overspend has been covered by slippage against 2023/24 new investments. Available slippage is at reduced levels compared to 2022/23 impacting on the ability to cover external bed costs should the current high usage continue
- Modelling shows, that at current usage levels, excess external bed usage will outstrip available slippage and the Trust will have to find an additional £0.8m to fund this excess
- Of the cumulative expenditure: £3.5m was at Hollybourne, £1.1m was spent on Female PICU, £1.0m has been spent on other acute beds, and £0.1m spent on Male PICU beds
- The daily bed occupancy report produced by Information Management indicates that external acute bed usage has increased in November



NHS
South West London and St George's Mental Health NHS Trust

Service Line Positions

- Whilst the overall position remains on plan, there is significant variation in Service Line performance
- All positions reflect the devolvement of CIP targets which was enacted in Month 1.
- Acute Care is £3.1m overspent due to acuity and external bed pressures, alongside additional nursing pressures outlined earlier in the report
- CAMHS & ED is £1.4m underspent due to continued recruitment slippages
- Community is £0.5m underspent as a result of recruitment slippages
- Specialist is £0.5m underspent, again predominantly non-recurring recruitment slippages
- The Corporate overspend of £3.5m primarily caused by the incorporation of risk into the Month 7 position. This position is expected to improve to a £1.6m overspend at year end once non-recurrent mitigations are applied
- Capital costs are £4.2m underspent in relation to: reduced PDC, interest income and reduced interest payable on the EMP loan
- The forecast for the year is (before impairments of £50m) for a £0.2m surplus.

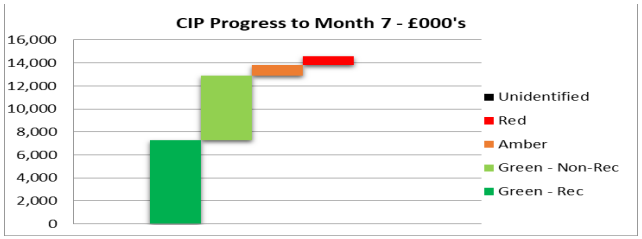
Financial Reports 2023/24	Current Month			YTD month 7			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Acute And Urgent Care	(4.1)	(4.5)	(0.4)	(28.7)	(31.8)	(3.1)	(49.0)	(55.7)	(6.7)
Camhs & Ed	(2.8)	(2.5)	0.3	(19.1)	(17.8)	1.4	(33.4)	(31.5)	2.0
Community (Adults)	(4.4)	(4.6)	(0.2)	(31.8)	(31.3)	0.5	(54.7)	(53.8)	0.8
Specialist Services	(2.7)	(2.8)	(0.1)	(19.5)	(18.9)	0.5	(33.8)	(32.8)	1.0
Corporate	15.4	11.8	(3.6)	110.0	106.5	(3.5)	189.2	187.7	(1.6)
Capital Costs	(1.4)	2.6	4.0	(11.1)	(6.9)	4.2	(68.1)	(63.7)	4.4
Total	**0.1**	**0.1**	**0.0**	**(0.3)**	**(0.3)**	**0.0**	**(49.8)**	**(49.8)**	**0.0**

South West London and St George's Mental Health NHS Trust

Savings – YTD Position

- **Target £13m** – total of £14.6m schemes identified; Green £12.9m (99%), Amber £0.9m (7%), Red £0.8m (6%)
- **Overprogramming** of £1.6m offsets outstanding Red and some Amber schemes enabling external reporting to have zero Red and minimal Amber balances
- **In month Delivery** - £2.3m delivered, £1.2m ahead of plan
- **YTD Delivery** - £9.2m delivered, £1.6m ahead of plan
- **Delivery Confidence** – Significant improvement in RAG ratings in month means risk assessed delivery now exceeds target at £13.6m, 104%, 8% improvement from last month (96%)
- **Recurrent Target £8.1m (62%)** - forecast delivery of green schemes is £7.3m (56%), £0.8m behind plan. Improvement of 26% in recurrent CIP delivery when compared to the 2022/23 delivered position (30%)

Status	2023/24 £000's	Risk Level %	Expected £000's
Green - Rec	7,285	0%	7,285
Green - Non-Rec	5,618	0%	5,618
Amber	898	50%	449
Red	798	75%	200
Overprogramming	-1,624	100%	0
Unidentified	0	100%	0
Total	12,974	104%	13,551
Over delivery			577



		In Month			YTD		
Service Line £k	Total Target	Plan	Actuals Total	Variance	YTD Plan	YTD Actuals	YTD Variance
Acute And Urgent Care	1,439	120	486	366	839	857	17
Camhs & ED	1,042	87	114	27	608	894	286
Community (Adults)	2,228	186	674	489	1,300	1,458	158
Specialist Services	1,056	88	234	146	616	810	194
Operations total	5,765	480	1,509	1,028	3,363	4,018	655
Corporate total	1,833	153	324	171	1,069	1,105	35
Technical Savings	7,000	582	522	-60	4,069	4,067	-2
Adjustment for YTD position	0	0	-73	-73	0	0	0
Overprogramming	-1,624	-135	0	135	-947	0	947
Total	12,974	1,080	2,282	1,202	7,554	9,190	1,636

South West London and St George's Mental Health NHS Trust

Capital

	Month			YTD			Annual		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Schemes									
EMP	3.5	2.9	0.6	18.6	11.1	7.5	48.1	48.1	0.0
Estates Maintenance	0.1	0.1	0.0	0.8	0.6	0.2	1.4	1.4	0.0
IT/Digital	0.1	0.1	(0.0)	0.8	1.0	(0.1)	1.4	1.4	0.0
Operational Total	3.8	3.2	0.6	20.3	12.7	7.6	51.0	51.0	0.0
Leases	0.0	0.0	0.0	0.0	0.0	0.0	7.5	7.2	0.3
Total Capital Expenditure	**3.8**	**3.2**	**0.6**	**20.3**	**12.7**	**7.6**	**58.5**	**58.1**	**0.3**

- The capital plan has a value of £58.5m, predominantly Phase 2 EMP £33.5m, Barnes £11.1m and £3.5m for other EMP schemes.
- The plan includes £0.5m relating to new leases that were expected to materialise in 2023/24 and £7.0m of leases due for renewal during the year. A recent review, in conjunction with the ICB, of the IFRS 16 leases has led to a forecast reduction of £0.3m to £7.2m.
- Capital expenditure for the month is £3.2m (£0.6m below plan). The underspend continues to be predominantly in EMP due to delays in Tolworth, Barnes and Richmond Royal offset by cost of sales of Phase 2. Estates and IT are broadly on plan.
- The Trust has a planned CRL target of £2.6m and an EFL plan of (£33.8m). The Trust is forecasting to achieve both targets

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Statement of Financial Position

Statement of Financial Position (£m)	Plan as at end October 2023	Actuals as at end October 2023	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	6.2	6.4	0.2
Plant, Property and Equipment	344.3	347.1	2.8
Receivables	16.0	15.9	(0.2)
Right of Use Asset	0.0	10.2	10.2
Total Non-Current Assets	**366.6**	**379.7**	**13.1**
Total Non-Current Assets Held for sale	**0.0**	**0.0**	**0.0**
CURRENT ASSETS:			
Inventories	0.2	0.2	0.0
Receivables due in less than 1 year	16.3	15.0	(1.3)
Other Financial Assets	0.9	0.1	(0.7)
Prepayments	0.0	0.0	0.0
Cash and Cash Equivalents	48.8	22.2	(26.6)
Total Current Assets	**66.1**	**37.5**	**(28.6)**
CURRENT LIABILITIES:			
Trade Payables	(6.8)	(8.0)	(1.2)
PDC Dividend Payable	(0.0)	(1.9)	(1.9)
Capital Payables	(10.0)	(11.0)	(1.0)
Provisions	(4.2)	(4.3)	(0.1)
Other Financial Liabilities (Accruals)	(30.5)	(32.6)	(2.1)
Deferred Revenue	(9.7)	(5.4)	4.3
Borrowings	(5.0)	(11.8)	(6.8)
Total amounts falling due within one year	**(66.1)**	**(75.0)**	**(8.9)**
NET CURRENT ASSETS/(LIABILITIES)	**(0.0)**	**(37.5)**	**(37.5)**
NON CURRENT LIABILITIES:			
Provision for Liabilities and Charges	(1.7)	(2.1)	(0.4)
Capital Payables	(5.2)	(6.1)	(0.9)
Borrowings	(89.4)	(89.4)	0.0
Lease Liability	0.0	(8.7)	(8.7)
Total amounts falling due after one year	**(96.2)**	**(106.2)**	**(1.3)**
TOTAL ASSETS EMPLOYED	**270.4**	**236.0**	**(34.4)**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	149.7	145.9	(3.8)
Retained Earnings (accumulated losses)	30.6	28.6	(2.0)
Retained Surplus(Deficit) in year	35.8	(0.3)	(36.1)
Revaluation Reserve	54.3	61.8	7.5
TOTAL TAXPAYERS EQUITY	**270.4**	**236.0**	**(34.4)**

- Current Receivables stand at £15.0m, £1.3m lower than plan, of which prior year is £0.7m (£0.3m lower than last month). This plan includes the deferred receipt from plot sales in 2019/20 due during 2023/24.
- Cash is £22.2m, £26.6m lower than plan, see next slide.
- There have been no loan repayments with the loan remaining at £99.4m.

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Cash

All figures £k	Plan as at end October 2023	Actuals as at end October 2023	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	4,579	384	(4,195)
Non Cash Adjustments			
Depreciation and Amortisation	6,826	6,902	76
Interest Received	(570)	(635)	(65)
Increase/(Decrease) in Working Capital	(4,202)	11,990	16,192
Net Cash Inflow/(Outflow) from Operating Activities	6,633	18,641	12,008
Cash Flows from Investing Activities			
Interest Received	570	635	65
(Payments) for Property, Plant and Equipment	(21,933)	(18,703)	3,230
Proceeds from sales of property, plant and equipment	40,872	0	(40,872)
Net Cash Inflow/(Outflow) from Investing Activities	19,509	(18,068)	(37,577)
Net Cash Inflow/(Outflow) before financing	26,142	573	(25,569)
Cash Flows from Financing Activities			
Public dividend capital received	5,749	1,837	(3,912)
Loans from Department of Health and Social Care - repaid	(5,000)	0	5,000
Interest paid	(210)	(185)	25
Interest element of finance lease	(236)	(236)	0
PDC dividend (paid)/refunded	(3,792)	(2,476)	1,316
Net Cash Inflow/(Outflow) from Financing Activities	(3,489)	(1,060)	2,429
Net Increase/(Decrease) In Cash And Cash Equivalents	22,653	(487)	(23,140)
Cash / Cash Equivalents at beginning of month	26,148	22,680	(3,468)
Cash / Cash Equivalents at end of month	48,801	22,193	(26,608)

- The cash balance at the end of the month was £22.2m compared with the plan of £48.8m.
- Funds held in escrow accounts have now been returned to the Trust.
- There have been no further PDC draw downs relating to the Barnes scheme in July, the balance remains £1.8m
- The main variance to the plan is due to delays in asset sale receipts compared to plan expectations. The asset sale is now expected to complete during Q3.
- The loan repayment of £5m has been deferred to March.

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Report Title:	**Finance Report 2023/24 Month 8**
Meeting:	FPC
Date of Meeting:	21 December 2023
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Transparency:	Public
Scrutiny Pathway	Director review / ELT / FPC / Trust Board

Purpose:	☒	Approval	☒	Discussion	☒	Information	☒	Assurance
Additional information:	The purpose of the paper is to report on the financial position of the Trust and provide updates on the financial targets against which the Trust is performance monitored against.							

What?	Key items to note are: ➢ **Year End Forecast** – forecast in line with plan at £250k surplus before impairments, impairments estimated at £50m for planning purposes. ➢ **In Month / cumulative position** - £0.1m surplus in month, £0.2m deficit cumulatively, in line with plan. ➢ **Agency** – November was the first month in 2023/24 that agency costs were above plan. Cumulatively there is a decrease in spend compared to 2022/23 and £0.7m below plan for 2023/24. NHSE target is not being achieved, ytd at 5.2% of pay bill, 4.9% in month. Further work required to achieve NHSE target by end of March. ➢ **External Beds** – Costs increased in month and were the highest monthly spend to date. Indications are that the high level of usage has continued into December. Year to date costs £2.2m more than budget. ➢ **Savings** – identified schemes forecast more than delivers the £13.0m target. Recurrent Delivery remains at 56% (£7.3m). The plan is to achieve a minimum of 62% (£8.1m) recurrent delivery at year end. ➢ **Capital** – underspend of £9.7m ytd due mainly to slippage on Tolworth, Barnes and Richmond Royal schemes. Forecast also adjusted. A formal application to NHSE has been made to transfer budget for the Barnes scheme to 2024/25. ➢ **Cash** – the cash balance is £19.2m.
So What?	The report provides full assurance that the Trust can achieve its revenue and capital target for the year. The report provides partial assurance that the Trust is on track to achieve this position in accordance with the plan for the year and progress is required against recurrent savings delivery.

	The Executive Team have reviewed and support the items FPC are asked to approve/note below. ➢ **External Beds** – A plan is in place and ELT remain confident this will deliver and focus must be maintained on these existing actions and service lines supported to deliver them. Recognising that bed usage has not reduced as fast as planned consideration is being given to increasing block contracts to reduce the cost. ➢ **Agency** – Improved Oversight is in place however the Trust is not achieving the national requirement of agency spend not exceeding 3.6% of pay bill and overspent against plan in the month. If costs continue at the November level then the total spend for the year will be above the annual plan. Focus on strategies to reduce agency costs must be maintained and/or refreshed. Forecast to be held in line with plan. Other Key items to note are: ➢ **Savings** – Forecast recurrent delivery remains below plan and a further £0.8m needs to be identified as recurrent by year end. Consideration as to whether the Observations savings are embedded and therefore recurrent will take place in Q4 however this is unlikely to fully bridge the shortfall. ➢ **Cash** - The Trust has sufficient cash to manage its business and must not lose sight of the requirement to start repaying the loan in 2023/24.
What Next?	Actions have been identified as follows: ➢ Continued discussions on the loan deferral and Barnes funding requests ➢ The most challenged service lines have been asked to review their agency postholders and be clear on the implications of reducing usage.
Any specific issues to note and/or for escalation:	1. All committees are asked to ensure that focus is maintained on reducing external beds, reducing agency and delivering recurrent savings

Strategic ambitions this paper supports	☐	Increasing quality years	This paper supports by outlining how the Trust will achieve its financial goals, highlighting key cost drivers and their impact on underlying financial sustainability.
	☐	Reducing inequalities	
	☐	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	Outlined below are the key implications which may result from the proposals or information contained within this report

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Equality analysis *[linking to EDI strategy]*	Positive impact – The Trust spends money to improve equality and diversity for patients and staff
Service users/ carers	Positive impact – Trust Funds are spent to get the best value to support our clinical services and patients
Estates:	Positive impact – The Trust is investing in its Estate to provide modern mental health facilities
Financial:	Positive impact - Provides information on the delivery of key financial targets
Legal:	Positive impact - Provides information on the statutory requirement of achieving break even
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Strategy:	Positive impact – The Trust has a good reputation for achieving financial targets
Workforce:	Positive impact – The Trust has a good reputation for achieving financial targets
Sustainability Eg. Green Plan.	Positive impact – The Trust knows its cost drivers and is taking positive action to ensure financial sustainability
Other (specify):	n/a

Appendices/Attachments:	One Power Point accompanies this cover sheet.

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Finance Report 2023/24
8 Months to November 2023

Meeting	ELT
Date of Meeting	December 2023
Report Title	Finance Report 2023/24 – 8 Months to November 2023
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Director of Finance & Performance
Purpose	For Information
Scrutiny Path	Director review/ELT/FPC/Trust Board
Transparency	Public
Recommendation	None
The Board is asked to	Discuss and Note

South West London and St George's Mental Health NHS Trust

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Overall – I & E Position

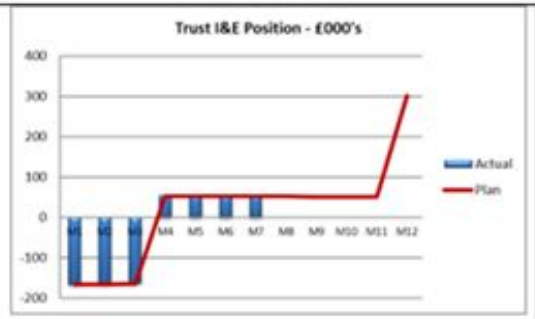
- In November, the Trust recorded a £0.1m surplus in line with plan, bringing the cumulative deficit to £0.2m, also in line with plan. The planned and actual deficit to date are due to costs associated with new buildings being incurred before associated savings from moving out of old buildings are delivered. The improved monthly position from Q2 onwards is associated with rental savings as the Trust moves into the new buildings
- The forecast remains a surplus of £0.2m for the year before impairments. It is now extremely likely that the Trust will be required to end the year on a surplus better than plan to support the SWL System. The position across all SWL providers is currently under review
- Completion of two new hospital buildings in 2023/24 will generate significant impairments (approx. £50m). The Trust is performance managed before impairments
- The Month 8 position contains an additional £1.1m of income in relation to Complex Care that is effectively a pass-through payment. This had led to spikes in both income and non-pay expenditure
- Continued diligence and strong financial control is required to ensure that the Trust remains on track and delivers its year-end forecast

Financial Reports 2023/24	Current Month			YTD month 8			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	26.0	27.3	1.3	194.7	199.1	4.3	294.6	299.0	4.5
Pay	(16.0)	(16.2)	(0.2)	(127.3)	(128.4)	(1.0)	(193.4)	(192.1)	1.3
Non Pay	(8.6)	(10.2)	(1.7)	(55.1)	(63.1)	(8.0)	(82.9)	(93.6)	(10.7)
EBITDA	**1.5**	**0.9**	**(0.6)**	**12.3**	**7.6**	**(4.7)**	**18.3**	**13.4**	**(4.9)**
Cap Charges - Depreciation	(0.9)	(0.9)	(0.0)	(7.7)	(7.8)	(0.1)	(11.2)	(11.2)	0.0
Cap Charges - Interest & Div	(0.6)	(0.0)	0.6	(5.1)	(0.5)	4.6	(7.6)	(3.0)	4.6
Interest	0.1	0.1	(0.0)	0.2	0.5	0.3	0.7	1.1	0.4
Post EBITDA	(1.4)	(0.9)	0.6	(12.6)	(7.8)	4.8	(18.1)	(13.2)	5.0
Underlying Surplus / (Deficit)	**0.1**	**0.1**	**0.0**	**(0.2)**	**(0.2)**	**0.0**	**0.2**	**0.2**	**0.0**
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	(50.0)	(50.0)	0.0
Net Surplus / (Deficit)	**0.1**	**0.1**	**0.0**	**(0.2)**	**(0.2)**	**0.0**	**(49.8)**	**(49.8)**	**0.0**

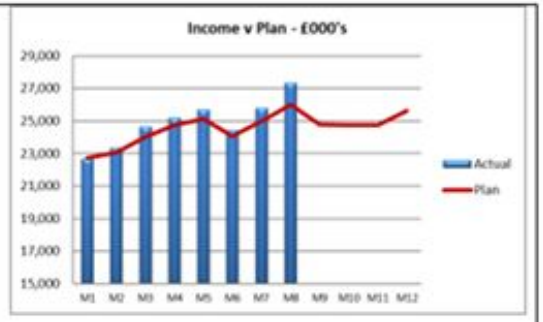
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

- Baseline surplus of £0.1m reported in month, in line with plan
- Cumulative deficit of £0.2m, also in line with plan
- Deficit driven by EMP phasing
- In month external bed pressures offset by investment slippage
- Risks included in position, offset by reduced PDC



- Income received in month, £27.3m, £1.3m above plan
- In month increase incorporates: SLP Complex Care Funding (£1.1m) and Industrial Action reimbursement funding (£0.6m)
- £0.8m additional funding now secured for 2 Autism pilots
- Further £0.2m expected to fund depreciation increases

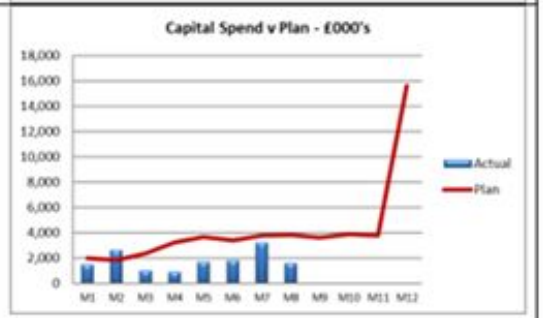


- Spend of £26.4m, £1.9m adverse to plan
- Includes additional £1.1m for Complex Care
- External bed expenditure of £1.0m in month, £0.3m above 2022/23 average
- Cumulative overspend on external beds of £2.2m, funded from slippage
- High external bed usage continues into M9

- Agency spend in month £0.8m, £0.2m below 2022/23 average spend
- £0.06m above plan
- £0.06m increase on M7
- Equates to 4.9% of pay bill, 1.3% above NHSE target of 3.6%
- 42% of monthly spend on Medical, 38% on Nursing
- Community Service Line spend amounts to 62% of cumulative spend

- Cash balance at end of November £22.2m
- £27.0m adverse to plan
- Result of delayed asset sale, completion now expected in Q3
- Loan repayments of £99m to commence in 2023/24
- Movement in cash during the year due to asset sales, deferred receipts, and loan repayments

- Cumulative capital spend of £14.3m.
- £9.8m behind plan
- Totality relates to slippage on significant site developments – Richmond Royal, Barnes & Tolworth
- Forecast spend of £31m, £20m less than plan
- Spike in M12 the result of uncertainties around the timings in spend on the Tolworth redevelopment



South West London and St George's Mental Health NHS Trust

Income Position

- Cumulatively, income is £4.3m favourable to plan
- Local contract income is £1.3m ahead of plan. This positive position is caused by additional funding awarded for Winter Pressures (Hostels) and to cover industrial action costs
- NPSA income is £0.1m behind plan as external referrals are below planned levels
- Provider Collaborative income is £0.2m below plan due to reduced Adult Eating Disorders inflow income partially offset by additional funding made available for a complex patient on Wisteria Ward. The in-month spike in income relates to the move of the Wisteria income to this category after it was formally added to the CAMHS contract schedule
- Other NHS Clinical income is over-recovered by £1.8m due to the release of deferred income to cover the AED shortfall alongside additional investments in CAMHS and Complex Care and Legacy Cost pressure funding
- Other Non Clinical Income is £1.1m ahead of plan, primarily due to additional SLP allocations
- Non-NHS Clinical income is showing a £0.4m favourable variance due to Local Authority grants and reimbursement for above plan deaf interpreter costs
- Other income flows are approximately break-even

Financial Reports 2023/24	Current Month			YTD month 8			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	20.5	21.2	0.7	151.1	152.5	1.3	229.5	231.4	1.9
Nhs England	1.7	1.7	(0.0)	13.8	13.8	(0.0)	20.6	20.5	(0.0)
Npsa Income	0.0	0.0	(0.0)	0.4	0.234	(0.1)	0.6	0.4	(0.2)
Provider Collaborative Income	2.2	2.8	0.6	17.4	17.2	(0.2)	26.3	25.8	(0.5)
Other Nhs Clinical Income	0.2	(0.0)	(0.2)	1.6	3.4	1.8	2.2	4.0	1.8
Nhs Clinical Income	**24.7**	**25.7**	**1.0**	**184.3**	**187.1**	**2.8**	**279.1**	**282.1**	**3.0**
Education & Training	0.7	0.7	0.0	5.4	5.6	0.1	8.0	8.1	0.2
Other Non Clinical Income	0.2	0.3	0.1	1.8	2.8	1.1	2.5	3.5	1.0
Merit Award Income	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.1	0.0
Non Clinical Income	**0.9**	**1.0**	**0.2**	**7.3**	**8.4**	**1.2**	**10.5**	**11.7**	**1.2**
Non NHS Clinical Income	0.4	0.5	0.1	3.2	3.6	0.4	4.9	5.3	0.3
Non Nhs Clinical Income	**0.4**	**0.5**	**0.1**	**3.2**	**3.6**	**0.4**	**4.9**	**5.3**	**0.3**
Income	**26.0**	**27.3**	**1.3**	**194.7**	**199.1**	**4.3**	**294.6**	**299.0**	**4.5**

South West London and St George's Mental Health NHS Trust

Pay Position

- Pay amounted to £16.2m in-month, a £0.2m overspend. Cumulatively, pay is £1.0m overspent
- Medical staffing are cumulatively overspent by £0.6m. The largest single driver of this remains the premium paid for agency medical staff to cover vacancies
- Nursing budgets are now overspent by £3.3m. Of this, approximately £1.0m relates to extra packages of care funded by the SLP with a further £0.4m relating to specialling for off-site patients. The balance encompasses: risk, acuity pressures, and the costs of the additional bank holiday in May.
- The underspend of £2.9m on Other Clinical staff primarily consists of Psychologist vacancies and continues the trend seen in this and previous years
- Non-clinical staff are overspent by £0.1m

Financial Reports 2023/24	Current Month			YTD month 8			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.5)	(2.7)	(0.1)	(20.4)	(21.0)	(0.6)	(31.1)	(31.5)	(0.4)
Nursing	(6.5)	(7.0)	(0.4)	(51.9)	(55.1)	(3.3)	(78.5)	(82.5)	(4.0)
Other Clinical	(4.1)	(3.7)	0.4	(32.4)	(29.4)	2.9	(49.4)	(44.2)	5.3
Non Clinical	(2.8)	(2.9)	(0.1)	(22.7)	(22.8)	(0.1)	(34.3)	(34.0)	0.4
Total Pay	**(16.0)**	**(16.2)**	**(0.2)**	**(127.3)**	**(128.4)**	**(1.0)**	**(193.4)**	**(192.1)**	**1.3**

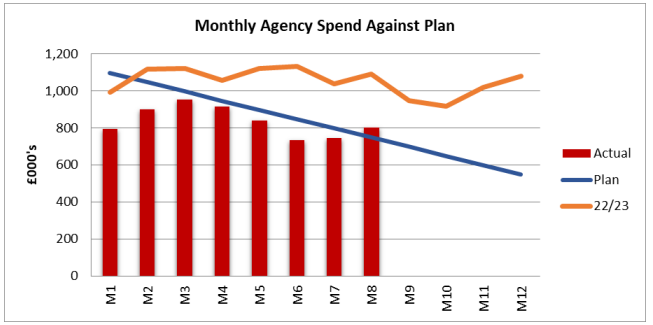
- Spend on agency staffing is cumulatively £0.7m favourable to plan, despite an overspend of £0.1m in November. This will continue to be increasingly challenging as the monthly target falls (see next slide)
- Bank is £1.6m adverse to plan with the overspend being driven by the Nursing overspends detailed above
- Permanent staffing is now showing a £0.1m overspend

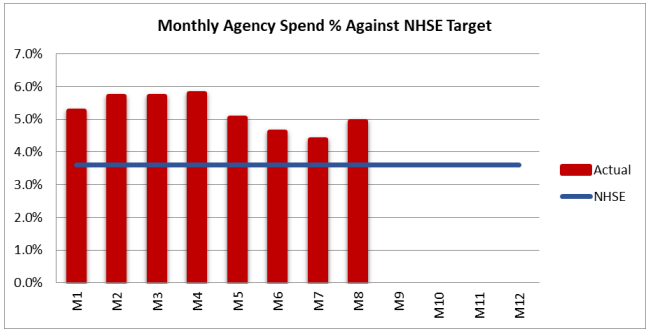
Financial Reports 2023/24	Current Month			YTD month 8			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(13.3)	(13.4)	(0.1)	(104.4)	(104.5)	(0.1)	(160.2)	(156.2)	4.1
Bank	(1.9)	(2.0)	(0.0)	(15.5)	(17.2)	(1.6)	(23.3)	(26.0)	(2.8)
Agency	(0.7)	(0.8)	(0.1)	(7.4)	(6.7)	0.7	(9.9)	(9.9)	0.0
Total Pay	**(16.0)**	**(16.2)**	**(0.2)**	**(127.3)**	**(128.4)**	**(1.0)**	**(193.4)**	**(192.1)**	**1.3**

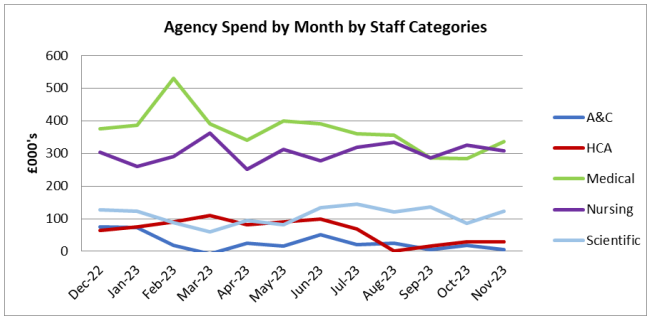
South West London and St George's Mental Health NHS Trust

Agency - in month and cumulative position

- In 2022/23 Trust agency expenditure was 7.1% of total pay costs; the Trust needed to halve its agency expenditure to meet the 2023/24 NHSE target of 3.6%
- Through system wide agreement the Trust set agency targets which started at 2022/23 actuals and exited the year at the required 3.6%
- Month 8 performance was adverse to plan: expenditure of £802k was £55k higher than plan and amounted to 4.9% of the total pay bill. It was, however, £290k less than expenditure this time last year (November 2022)
- Cumulative expenditure amounts to 5.2% of the pay bill and is £693k below plan but £2,053k above the NHSE target.
- Expenditure in November was £57k above October levels.
- November was the first time during 2023/24 that expenditure was above plan: if expenditure remained at November levels for the remainder of the year, total spend would be above the annual plan
- Of November expenditure, Medical was the highest cause at £337k. Nursing spend amounted to £307k with the next highest being Scientific at £123k
- As shown on the next page, the Community Service Line remains the highest user of agency staffing. Cumulative expenditure of £4,126k equates to 62% of the Trust total
- The Trust is required to produce an agency forecast for NHSE. Despite currently being below plan, the forecast will be maintained at planned levels until further assurance is gained to enable the forecast to be varied



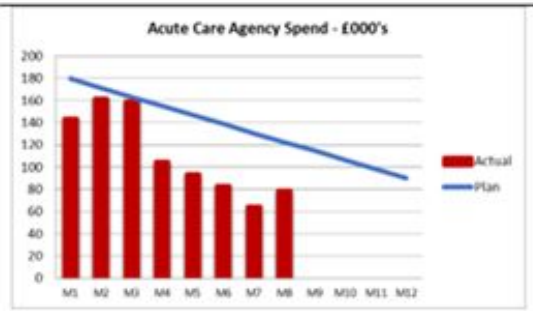




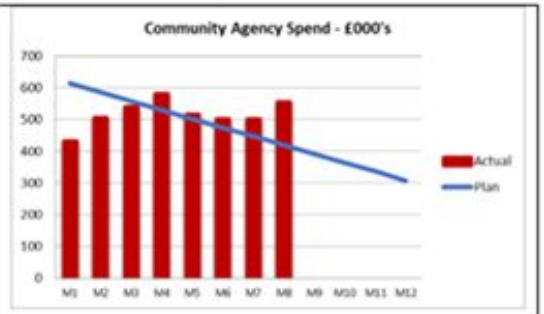
South West London and St George's Mental Health NHS Trust

Agency – Service Line and Corporate Analysis

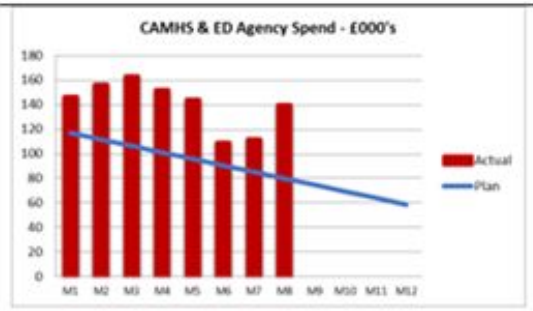
- In month spend of £79k
- £44k below plan
- £15k above M7 spend
- Cumulative spend of £889k, £320k below target
- Largest type of spend: Medical (£441k) followed by HCA (£278k), Nursing (£155k) and Scientific (£14k)
- £737k of total spend on wards, with £79k in Liaison Services and £73k in HTTs
- Highest area of spend: Ellis Ward (£220k)



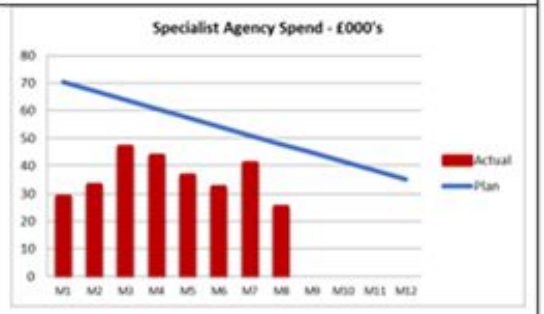
- In month spend of £555k
- £136k above plan
- £55k above M7 spend
- Cumulative spend £4,126k. £6k below plan
- Largest type of spend: Medical (£1,869k), followed by Nursing (£1,869k), and Scientific (£385k)
- Highest areas of spend: Carshalton IRH (£458k) and Central Wandsworth CMHT (£330k)



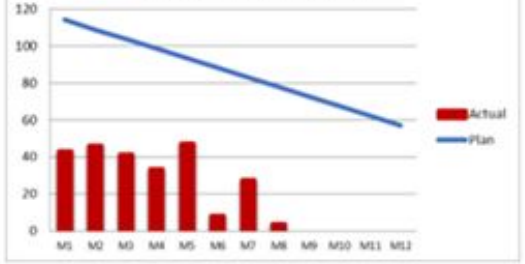
- In month spend of £139k
- £59k above plan
- £27k above M7 spend
- Cumulative spend of £1,121k, £334k above plan
- Largest spends: Medical (£438k), Scientific (£432k), Nursing (£211k), HCAs (£40k)
- £949k of spend in community, £172k on wards
- Highest area of spend: Tier 3 Wandsworth (£233k)



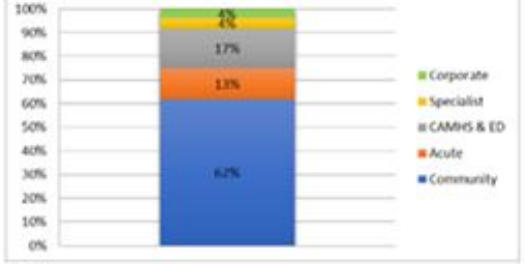
- In month spend of £25k
- £23k below plan
- £16k below M7 spend
- Cumulative spend of £287k
- Spend: HCA (£98k), Nursing (£175k), Scientific (£14k)
- £110k of spend in wards, £177k in community settings
- Highest single area of spend: Jasmine Ward (£47k)



- Spend of £4k in month
- £74k below target
- £24k below M7 spend
- Cumulative spend of £251k
- Largest area of spend: Digital Services (£95k)



- Largest area of cumulative spend = Community (62%)
- CAMHS ED – 17%, Acute = 13%
- Specialist = 4%, Corporate = 4%
- Service line and Corporate split = 96/4. Last year amounted to 89/11



South West London and St George's Mental Health NHS Trust

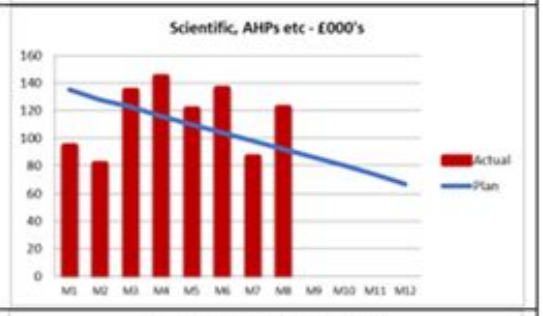
Agency – Analysis by Pay Type

- In month spend of £337k
- £1k above plan
- £53k above M7 spend
- Cumulative spend of £2,752k, £555k below target
- £467k of total spend on wards, with £2,212k in Community settings and £73k in HTTs
- Highest area of spend: Carshalton IHR (£332k)

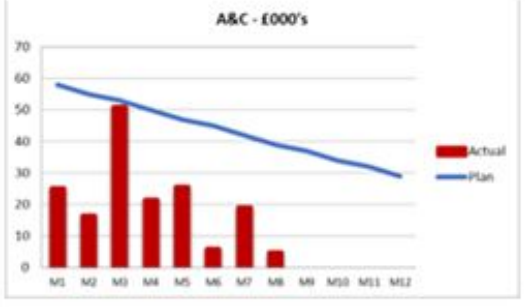
- In month spend of £307k
- £86k above plan
- £19k below M7 spend
- Cumulative spend £2,413k. £231k above plan
- £2,223k of spend in in Community settings, £111k on wards, and £79k within Liaison
- Highest area of spend: Central Wandsworth CHMT (£131k)

- In month spend of £30k
- £29k below plan
- In line with M7 spend
- Cumulative spend of £416k, £168k below plan
- Fall since M4 caused by change to booking procedures
- Totality of spend on wards
- Highest area of spend: Lilacs Ward (£55k)

- In month spend of £123k
- £31k above plan
- £36k above M7 spend
- Cumulative spend of £923k, £17k above plan
- £852k of spend in Community, £45k in Pharmacy, and £26k in wards
- Highest single area of spend: Early Intervention Sutton (£70k)



- Spend of £5k in month
- £34k below target
- £14k below M7 spend
- Cumulative spend of £169k, £220k below target
- Largest area of spend: Digital Services (£95k)



- Largest area of cumulative spend = Medical (41%)
- Nursing = 36%
- Scientific = 14%, HCA = 6%, A&C = 3%
- Clinical/Non-Clinical split = 97/3, last year amounted to 84/16

South West London and St George's Mental Health NHS Trust

Non-Pay & Post EBITDA

- Non-Pay budgets overspent by £1.7m in the month to take the cumulative overspend to £8.0m. This position incorporates the inclusion of £3.8m of risk contingency
- The area causing major financial pressure continues to be external beds, accounting for £2.2m of the £4.7m Secondary Commissioning costs overspend. The remain balance incorporates externally funded Hostels and Complex Care (£0.9m), £1.4m of risk contingency and other smaller overspends of £0.2m (e.g. digital therapies)
- Other costs overspent by £0.5m in the month with the key drivers being risk provision, energy, rates and IT costs. The key underlying pressure remains energy in the new hospitals which is forecast to overspend by £1.4m this year

Financial Reports 2023/24	Current Month			YTD month 8			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Drug Costs	(0.2)	(0.2)	(0.0)	(1.5)	(1.6)	(0.1)	(2.3)	(2.3)	(0.1)
Clinical Supplies & Servs Cost	(0.1)	(0.1)	(0.0)	(0.4)	(0.5)	(0.0)	(0.6)	(0.7)	(0.0)
Secondary Commisioning Costs	(5.4)	(6.6)	(1.2)	(31.7)	(36.4)	(4.7)	(49.6)	(55.9)	(6.4)
Other Costs	(2.9)	(3.4)	(0.5)	(21.4)	(24.6)	(3.2)	(30.4)	(34.7)	(4.2)
Contingency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Pay	**(8.6)**	**(10.2)**	**(1.7)**	**(55.1)**	**(63.1)**	**(8.0)**	**(82.9)**	**(93.6)**	**(10.7)**

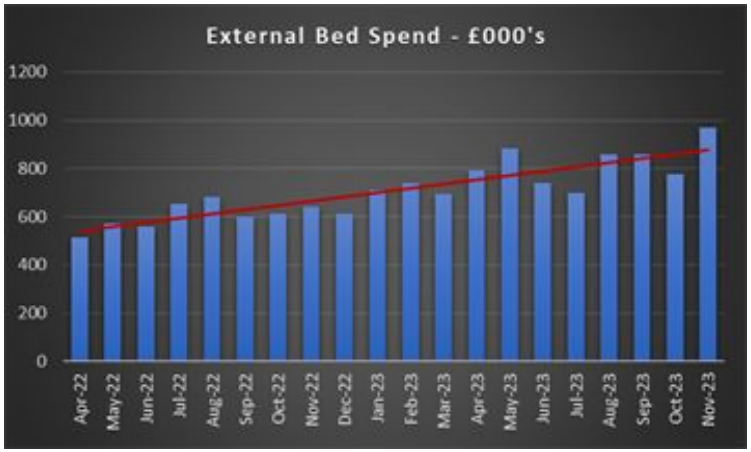
- Post EBITDA costs are now £4.8m favourable to plan.
- The significant majority of this (£4.6m) relates to a PDC reduction resulting from delays to the go live date of the new hospitals.
- A significant impairment of approximately £50m is expected to be occurred due to market valuation when the two new hospitals on the Springfield site complete in 2023/24.

Financial Reports 2023/24	Current Month			YTD month 8			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Cap Charges - Depreciation	(0.9)	(0.9)	(0.0)	(7.7)	(7.8)	(0.1)	(11.2)	(11.2)	0.0
Cap Charges - Pdc Dividend	(0.6)	(0.0)	0.6	(5.1)	(0.5)	4.6	(7.6)	(3.0)	4.6
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	(50.0)	(50.0)	0.0
Interest	0.1	0.1	(0.0)	0.2	0.5	0.3	0.7	1.1	0.4
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Post EBITDA	**(1.4)**	**(0.9)**	**0.6**	**(12.6)**	**(7.8)**	**4.8**	**(68.1)**	**(63.2)**	**5.0**

NHS
South West London and St George's Mental Health NHS Trust

External Beds

- This analysis of external beds incorporates unplanned external bed usage as well as contracted beds at ELFT (both Female PICU and Acute)
- Significant external bed costs incurred in 2022/23 continue into 2023/24
- November expenditure amounted to £1.0m, a £0.2m increase on October costs
- This was £0.3m above the monthly average for 2022/23
- It was also the highest single monthly expenditure experienced by the Trust
- Cumulatively, external beds are now overspent by £2.2m
- The budgetary base for November covered 720 days, actual utilisation amounted to 1,230 days, 510 days above plan and 166 days above October actuals
- The cumulative overspend has been covered by slippage against 2023/24 new investments. Available slippage is at reduced levels compared to 2022/23 impacting on the ability to cover external bed costs should the current high usage continue and is close to running out
- Modelling shows, that at current usage levels, excess external bed usage will outstrip available slippage and the Trust will have to find an additional £1.2m to fund this excess
- Of the cumulative expenditure: £4.1m was at Hollybourne, £1.2m was spent on Female PICU, £1.1m has been spent on other acute beds, and £0.1m spent on Male PICU beds
- The daily bed occupancy report produced by Information Management indicates that external acute bed usage has continued at an extremely high level during December



NHS
South West London and St George's Mental Health NHS Trust

Service Line Positions

- Whilst the overall position remains on plan, there is significant variation in Service Line performance
- All positions reflect the devolvement of CIP targets which was enacted in Month 1.
- Acute Care is £3.6m overspent due to acuity and external bed pressures, alongside additional nursing pressures outlined earlier in the report
- CAMHS & ED is £1.6m underspent due to continued recruitment slippages
- Community is £0.4m underspent due to recruitment slippages
- Specialist is £0.4m underspent, again predominantly non-recurring recruitment slippages
- The Corporate overspend of £3.5m primarily caused by the incorporation of risk contingency into the Month 7 and 8 positions. This position is expected to improve to a £1.3m overspend at year end once non-recurrent mitigations are applied
- Capital costs are £4.8m underspent in relation to: reduced PDC, interest income and reduced interest payable on the EMP loan
- The forecast for the year is (before impairments of £50m) for a £0.2m surplus.

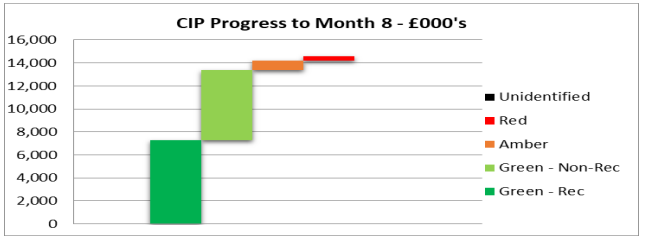
Financial Reports 2023/24	Current Month			YTD month 8			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Acute And Urgent Care	(4.1)	(4.6)	(0.5)	(32.8)	(36.5)	(3.6)	(49.1)	(55.8)	(6.7)
Camhs & Ed	(2.9)	(2.7)	0.2	(22.0)	(20.4)	1.6	(33.6)	(31.9)	1.7
Community (Adults)	(4.4)	(4.6)	(0.1)	(36.2)	(35.9)	0.4	(54.8)	(54.4)	0.4
Specialist Services	(2.7)	(2.8)	(0.1)	(22.2)	(21.8)	0.4	(33.9)	(32.9)	1.0
Corporate	15.7	15.6	(0.0)	125.6	122.1	(3.5)	189.7	188.3	(1.3)
Capital Costs	(1.4)	(0.8)	0.6	(12.6)	(7.8)	4.8	(68.1)	(63.1)	5.0
Total	**0.1**	**0.1**	**0.0**	**(0.2)**	**(0.2)**	**0.0**	**(49.8)**	**(49.8)**	**0.0**

South West London and St George's Mental Health NHS Trust

Savings – YTD Position

- **Target £13m** – total of £14.6m schemes identified; Green £13.4m (103%), Amber £0.8m (6%), Red £0.4m (3%)
- **Overprogramming** of £1.6m offsets outstanding Red and Amber schemes in full and part of green balances enabling external reporting to have zero Red and Amber balances
- **In month Delivery** - £1.4m delivered, £0.3m ahead of plan
- **YTD Delivery** - £10.6m delivered, £1.9m ahead of plan
- **Delivery Confidence** –improvement in RAG ratings in month. Risk assessed delivery exceeds target at £13.9m, 107%, 1% improvement from last month (106%)
- **Recurrent Target £8.1m (62%)** - forecast delivery of green schemes remains at £7.3m (56%), £0.8m behind plan. Improvement of 26% in recurrent CIP delivery when compared to the 2022/23 delivered position (30%)

Status	2023/24 £000's	2023/24 %	Risk Level %	Expected £000's
Green - Rec	7,285	56%	0%	7,285
Green - Non-Rec	6,120	47%	0%	6,120
Amber	773	6%	50%	387
Red	420	3%	75%	105
Overprogramming	-1,624	-13%	100%	0
Unidentified	0	0%	100%	0
Total	**12,974**	**100%**	**107%**	**13,897**
Over delivery				**923**



		In Month			YTD		
Service Line £k	Total Target	Plan	Actuals Total	Variance	YTD Plan	YTD Actuals	YTD Variance
Acute And Urgent Care	1,439	120	124	4	959	981	21
Camhs & ED	1,042	87	30	-57	695	923	229
Community (Adults)	2,228	186	380	194	1,485	1,838	352
Specialist Services	1,056	88	218	130	704	1,028	324
Operations total	5,765	480	752	271	3,843	4,770	926
Corporate total	1,833	153	44	-109	1,222	1,149	-74
Technical Savings	7,000	585	585	-0	4,654	4,652	-3
Overprogramming	-1,624	-135	0	135	-1,083	0	1,083
Total	12,974	1,083	1,380	297	8,637	10,570	1,933

South West London and St George's Mental Health NHS Trust

Capital

	Month			YTD			Annual		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Schemes									
EMP	3.6	1.4	2.2	22.2	12.6	9.7	48.1	18.7	29.4
Estates Maintenance	0.1	0.1	0.0	0.9	0.7	0.2	1.4	1.4	0.0
IT/Digital	0.1	0.1	(0.0)	1.0	1.1	(0.2)	1.4	1.4	0.0
Operational Total	3.8	1.6	2.2	24.1	14.3	9.7	51.0	21.6	29.4
Leases	0.0	0.0	0.0	0.0	0.0	0.0	7.5	7.2	0.3
Total Capital Expenditure	**3.8**	**1.6**	**2.2**	**24.1**	**14.3**	**9.7**	**58.5**	**28.8**	**29.7**

- The capital plan has a value of £58.5m, predominantly Phase 2 EMP £33.5m, Barnes £11.1m and £3.5m for other EMP schemes. The external forecast has been reduced to £28.8m due to asset sale delays matched by underspends on the Tolworth scheme, and to reflect slippage on the Barnes scheme. An application has been made to NHSE for the Barnes Scheme budget to move to 24/25.
- The plan includes £0.5m relating to new leases that were expected to materialise in 2023/24 and £7.0m of leases due for renewal during the year. A recent review, in conjunction with the ICB, of the IFRS 16 leases has led to a forecast reduction of £0.3m to £7.2m.
- Capital expenditure for the month is £1.6m (£2.2m below plan). The underspend continues to be predominantly in EMP due to delays in Tolworth, Barnes and Richmond Royal offset by cost of sales of Phase 2. Estates and IT are broadly on plan.
- The Trust has a planned CRL target of £2.6m and an EFL plan of (£33.8m). The Trust is forecasting to achieve both targets

South West London and St George's Mental Health NHS Trust

Capital Forecast

- The latest forecast submitted to the M7 Capital Programme Board was £38.0m. This is £20.5m less than the budget of £58.5m. The main movements from plan are Phase 2b Parcel 1 and Edward Wilson House will not sell in 2023/24 as planned (£20.2m), and therefore spend has been reduced in line with this to offset this reduction in CDEL and minor slippage against leases estimated at £0.3m.
- Since the forecast, there have been further changes in spend, notably:
    - the Trust has submitted a request to defer the drawing down of the remainder of the Barnes funds (£9.3m), which will reduce spend by that amount in the forecast;
    - the two large leases relating to Substance Misuse (£2.5m) and Kingston IAPT (£1.8m) are now not likely to be signed prior to 31 March 2024 (CDEL cover is available for these). The trust is awaiting confirmation from the ICB on whether any underspends on leases can be used to fund non lease capital expenditure.
    - The Trust is expecting £0.2m funding for digital projects in Q4.
    - The cost of sales for Phase 2b is currently being finalised by the EMP team.
- An updated forecast will be presented to CPB in January (based on M9 figures).

All figures £k	Original Plan	Forecast	Variance
EMP Phase 1	-	-	-
EMP Phase 2	32,605	12,455	20,150
EMP Phase 2b Cost of Sales	-	3,465	(3,465)
Additional ward (national PDC)	920	920	-
Retail Units	-	-	-
Barnes (national PDC)	11,100	11,100	-
Richmond Royal	2,400	2,400	-
Hume	864	864	-
Jupiter	200	200	-
Cost of Sales Phase 2a	-	(3,465)	3,465
Loan Interest	-	-	-
EMP CRL	*48,089*	*27,939*	*20,150*
Estates	1,420	1,420	-
Estates BAU CRL	*1,420*	*1,420*	-
IT	1,443	1,443	-
IT BAU CRL	*1,443*	*1,443*	-
CRL Excluding Leases	**50,952**	**30,802**	**20,150**
Leases	7,500	7,174	326
Leases CRL	*7,500*	*7,174*	*326*
CRL Including Leases	**58,452**	**37,976**	**20,476**
System CDEL	**38,932**	**18,782**	**20,150**
National Other	**12,020**	**12,020**	**-**
National Leases	**7,500**	**7,174**	**326**

South West London and St George's Mental Health NHS Trust

Statement of Financial Position

Statement of Financial Position (£m)	Plan as at end November 2023	Actuals as at end November 2023	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	6.2	6.3	0.1
Plant, Property and Equipment	347.2	348.3	1.1
Receivables	16.0	15.9	(0.2)
Right of Use Asset	0.0	10.2	10.2
Total Non-Current Assets	**369.5**	**380.8**	**11.3**
Total Non-Current Assets Held for sale	**0.0**	**0.0**	**0.0**
CURRENT ASSETS:			
Inventories	0.2	0.2	0.0
Receivables due in less than 1 year	16.9	15.8	(1.0)
Other Financial Assets	1.6	7.5	5.9
Prepayments	0.0	0.0	0.0
Cash and Cash Equivalents	46.2	19.2	(27.0)
Total Current Assets	**64.8**	**42.7**	**(22.1)**
CURRENT LIABILITIES:			
Trade Payables	(6.8)	(8.2)	(1.4)
PDC Dividend Payable	(0.0)	(2.6)	(2.6)
Capital Payables	(10.0)	(9.3)	0.7
Provisions	(4.2)	(4.3)	(0.1)
Other Financial Liabilities (Accruals)	(30.6)	(39.6)	(9.0)
Deferred Revenue	(9.7)	(5.5)	4.2
Borrowings	(5.0)	(11.8)	(6.8)
Total amounts falling due within one year	**(66.3)**	**(81.3)**	**(15.0)**
NET CURRENT ASSETS/(LIABILITIES)	**(1.4)**	**(38.5)**	**(37.1)**
NON CURRENT LIABILITIES:			
Provision for Liabilities and Charges	(1.7)	(2.1)	(0.4)
Capital Payables	(5.2)	(6.1)	(0.9)
Borrowings	(89.4)	(89.4)	0.0
Lease Liability	0.0	(8.7)	(8.7)
Total amounts falling due after one year	**(96.2)**	**(106.2)**	**(1.3)**
TOTAL ASSETS EMPLOYED	**271.8**	**236.0**	**(35.8)**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	151.1	145.9	(5.3)
Retained Earnings (accumulated losses)	30.6	28.6	(2.0)
Retained Surplus(Deficit) in year	35.9	(0.2)	(36.1)
Revaluation Reserve	54.3	61.8	7.5
TOTAL TAXPAYERS EQUITY	**271.9**	**236.0**	**(35.8)**

- Current Receivables stand at £15.8m, £1m lower than plan, of which prior year is £0.7m (the same value as last month). This plan includes the deferred receipt from plot sales in 2019/20 due during 2023/24.
- Cash is £19.2m, £27m lower than plan, see next slide.
- There have been no loan repayments with the loan remaining at £99.4m.

NHS
South West London and St George's Mental Health NHS Trust

Cash

All figures £k	Plan as at end November 2023	Actuals as at end November 2023	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	5,325	17	(5,308)
Non Cash Adjustments			
Depreciation and Amortisation	7,709	7,796	87
Interest Received	(720)	(251)	469
Increase/(Decrease) in Working Capital	(5,994)	11,499	17,493
Net Cash Inflow/(Outflow) from Operating Activities	**6,320**	**19,061**	**12,741**
Cash Flows from Investing Activities			
Interest Received	720	738	18
(Payments) for Property, Plant and Equipment	(25,739)	(22,376)	3,363
Proceeds from sales of property, plant and equipment	40,872	0	(40,872)
Net Cash Inflow/(Outflow) from Investing Activities	**15,853**	**(21,638)**	**(37,491)**
Net Cash Inflow/(Outflow) before financing	**22,173**	**(2,577)**	**(24,750)**
Cash Flows from Financing Activities			
Public dividend capital received	7,191	1,837	(5,354)
Loans from Department of Health and Social Care - repaid	(5,000)	0	5,000
Interest paid	(240)	(268)	(28)
Interest element of finance lease	(268)	0	268
PDC dividend (paid)/refunded	(3,792)	(2,476)	1,316
Net Cash Inflow/(Outflow) from Financing Activities	**(2,109)**	**(907)**	**1,202**
Net Increase/(Decrease) In Cash And Cash Equivalents	**20,064**	**(3,484)**	**(23,548)**
Cash / Cash Equivalents at beginning of month	**26,148**	**22,680**	**(3,468)**
Cash / Cash Equivalents at end of month	**46,212**	**19,196**	**(27,016)**

- The cash balance at the end of the month was £19.2m compared with the plan of £46.2m.
- Funds held in escrow accounts have now been returned to the Trust.
- There have been no further PDC draw downs relating to the Barnes scheme in July, the balance remains £1.8m
- The main variance to the plan is due to delays in asset sale receipts compared to plan expectations. The asset sale is now expected to complete during Q3.
- The loan repayment of £5m has been deferred to March.

Meeting:	Charitable Funds Committee meeting
Date of meeting:	27 November 2023
Transparency:	Public
Committee Name	Charitable Funds Committee (CFC)
Committee Chair and Executive Report	Juliet Armstrong (Chair) Ian Garlington (Executive)

BAF and Corporate Objective the committee is accountable for:

The committee does not support the corporate objectives directly but indirectly contributes towards:

Corporate Objective:

- **Objective 3:** To support our people to grow and develop our organisation to be the best we can be

Key Questions or Areas of Focus for the Board following the Committee:

1. Recommendation for approval to the Board of the 22/23 Charitable Funds Accounts and Independent Examiners Report
2. Fund balances (as at end October 23) are £123k but of this, £103k is already committed. The importance of further fundraising was highlighted and the charity is in the process of recruiting a part-time fundraiser as well as investigating how best to access other Funds/Grants if the fundraiser does not have this knowledge/experience. Controls and procedures are being reviewed to ensure the charity does not spend beyond its current funding
3. Dormant unrestricted funds will be amalgamated into the general fund.

Areas of Risk Escalation to the Board:

- None

<u>Item discussed- Charitable Funds finance report:</u>

Assurance Position

The balance of the charity funds as at October 23 is £123k. As agreed at the previous meeting, the approach if there is continued non-response from fundholders of dormant funds (£10,367) will be to amalgamate the monies into the general fund. The Ethical fund has been opened and funds transferred in October 23. The committee agreed to receive performance updates about the fund and report to the Board on an annual basis.

Of the £123k available, £55k is already committed to Mental Health First Aid training, £30k to the development grant and £18k to other funding. Controls and procedures will be reviewed at the next meeting to ensure optimal management of spend, and there will be greater emphasis on fundraising, including recruiting a part-time fundraiser (funding available for one year) to

support events and consideration (if needed) for interim skills and experience with foundations and grantgivers.

Evidenced by
- Finance report
- Independent examiner sign-off of latest annual accounts

What next?
- Controls and procedures review
- Recruitment of fund-raising capability
- Amalgamation of dormant funds into general fund.

Item discussed- 22/23 Charitable Funds Annual Report and Accounts:

Assurance Position
The report and accounts have already been reviewed by the Audit Committee and after CFC committee review, recommends approval by the Board. The committee discussed that in future the independent examiner (GSM) should be invited to the meeting where the accounts are discussed, and that the charity's governance document should also be updated.

Evidenced by
- Report

What next?
- Invite GSM to the Autumn CFC meeting in future
- Review charity governance document at next meeting.

Item discussed – Working Group update:

Assurance Position
The committee heard that despite no paid officers and not being fully launched, the charity is carrying out fundraising and other awareness-raising activity as well as enabling projects that will positively impact staff and patients including the Kingston memory clinic. The committee thanked the working group who are voluntarily making this happen. The committee also discussed and approved the payment of the annual fee for membership of NHS Charities Together (£750). The committee also asked for an update on when/how the charity would be considered "fully launched".

Evidenced by
- Report

What next?
- Keep membership of NHS Charities Together under review to ensure value for money and consider membership of other charity bodies in future
- Review position of full charity launch at next meeting (branding, website, awareness etc).

Appendices
All annual reports and other items that require to be in the full Board papers will be appended to the Committee Report
- 22/23 Charitable Funds Accounts and Report
- Minutes

South West London and St George's Mental Health NHS Trust Charitable Fund

South West London and St George's Mental Health NHS Trust Charitable Fund

Annual Report and Financial Statements

31 March 2023

Registered Charity No. 1060944

Legal and Administrative Information

South West London and St George's Mental Health NHS Trust Charitable Fund (The Charity) is a registered Charity (registered number 1060944) with the Charity Commission, the Board of South West London and St George's Mental Health NHS Trust (the Trust) being the Corporate Trustee.

The Charity was registered in the name of South West London and St George's Mental Health NHS Trust Charitable Fund on 25 February 1997. Prior to this, the declaration of trust as a Special Purposes Charity was made on 1st August 1996 to Pathfinder NHS Trust Endowment Fund.

The Charity is managed under delegated authority by a Charitable Funds Committee (The Committee), which provides detailed scrutiny of the Charity. The Committee also make appropriate recommendations to the Trust Board in their position as Corporate Trustees. The Committee has formal contacts with our external auditors/independent examiners.

The Charity produces its Trustees' annual report as a dual purpose document so that the annual report can be distributed with the accounts or as a freestanding document. Therefore, the Charity includes summary financial statements in its annual report.

Our Trustees

The Trustees are responsible for deciding policy and ensuring that it is implemented. There is a scheme of delegation to fund managers or senior managers in the Trust.

The Trustees give of their time freely and do not receive any pay, emoluments or other financial benefit. Whilst the Trustees are not paid for their time, they can claim expenses, details of which are disclosed in the accounts (note 12). For 2022/23 no expenses were claimed.

During the year, the following Trustees held office:

Trustee name	**Office (if any)**	**Dates acted if not for whole year**
Ann Beasley	Chair	Full Year
Vanessa Ford	Chief Executive	Full Year
Philip Murray	Director of Finance and Performance	Full Year
Sharon Spain	Director of Nursing and Quality Standards	Full Year
Dr Billy Boland	Medical Director	Full Year
Jennifer Allan	Chief Operating Officer	Full Year
Amy Scammell	Director of Strategy and Commercial Development	Full Year
Katherine Robinson	Director of People	Full Year
Richard Flatman	Non-Executive Director	Full Year
Sola Afuape	Non-Executive Director	Full Year
Juliet Armstrong	Non-Executive Director	Full Year
Vikas Sagar	Non-Executive Director	Full Year
Doreen McCollin	Non-Executive Director	Full Year
Deborah Bowman	Non-Executive Director	Full Year
Charlotte Clark	Non-Executive Director	Full Year

Trustees are required to disclose all relevant interests and register them with the trust fund director and withdraw from decisions where a conflict of interest arises. All related party transactions are disclosed in the accounts (note 3).

Our staff

The Charity does not have any employees of its own. The Charity's administration and finances are managed by the employees of the Trust, the cost of which is recharged to the Charity, on the basis of the estimated time spent administering the Charity's finance. For 2022/23 accounts the Charity was charged £4,000 (2021/22 £10,000).

Our advisors

Investment Managers
CCLA Fund Managers Limited
Senator House
85 Queen Victoria Street
London
EC4V 4ET

Independent Examiners
Griffin Stone Moscrop & Co
21-27 Lamb's Conduit Street
London
WC1N 3GS

Internal Auditors
RSM UK Risk Assurance Services LLP
6th Floor
25 Farringdon Street
London
EC4A 4AB

Legal Advisors
Capsticks Solicitors
1 St. George's Road
Wimbledon
London
SW19 4DR

Bankers
Lloyds Bank
125 Balham High Road
London
SW12 9AT

The Charity office and principal address of South West London and St George's Mental Health NHS Trust Charitable Fund is:

South West London and St George's Mental Health NHS Trust Charitable Fund
Trinity Building
Springfield University Hospital
15 Springfield Drive
Tooting
London
SW17 0YF

Tel: 020 3513 5000

Trustees' Annual Report

Foreword by the Chair of Trustees of the South West London and St George's Mental Health NHS Trust Charitable Fund.

Welcome to our annual report for 2022/23. We are the corporate Trustees of South West London and St George's Mental Health NHS Trust Charitable Fund.

1. We exist to provide resources and facilities to meet the needs of patients and staff of South West London and St George's Mental Health NHS Trust. I am delighted to be reviewing another year where we raised additional funds and provided grants to support patients to accelerate their recovery and to integrate them into the wider community. We will continue to have as our aim, to raise more funds in order to support the needs of our patients and staff and in order to fulfil our charitable objectives through our close partnership with South West London and St George's Mental Health NHS Trust. This partnership is the key to our success and continues to go from strength to strength.

2. Funds raised by the Charity itself in 2022/23 helped fund £5,962 on Well Being/Training Hubs, £4,244 on musical instruments for patients, £1,984 on patient trips/social functions, £1,969 on furniture for patients and £985 on patient Christmas parties and decorations.

3. I would like to thank the volunteers who fundraise and help us, my fellow trustees, and the volunteers who work alongside the professional staff of the South West London and St George's Mental Health NHS Trust.

4. I hope that like me you will be inspired by our plans to help patients and staff and want to continue to be a part of our story. If you would like to donate, you may do so via the Charity's webpage or as an employee through the Trust's Give As You Earn (GAYE). Please support us, every generous gift makes a difference.

Ann Beasley

Date:

What we aim to do: our objectives and activities

Our Objectives

The Charity's objectives are to improve the welfare of patients and staff at South West London and St George's Mental Health NHS Trust both in hospital and community services.

Our mission

Our key aim is to serve the NHS patients of the Trust for the public benefit. By working with the NHS, we assist patients from every walk of life, irrespective of race, creed, ethnicity or personal or family financial circumstances. We put this aim into practice in a variety of ways which help the patients, such as:

- Funding for away day activities
- Funding for basic new furniture and equipment when they move into a new accommodation
- Investing in people and creating a caring environment for the patients receiving care
- Providing direct support to patients by way of information and networking support
- Improving facilities and providing small grants

What we have achieved: highlights from the activities undertaken in the year

By raising new funds and through careful management of our existing funds, the Charity was able to make small grants to various activities initiated by both staff and patients. These activities included, away days, Christmas lunches and small Christmas gifts for patients. For staff, expenditure concentrated on areas that supported health and wellbeing and improving the work environment.

Grants and expenditures are made in accordance with charity law, our constitution and the wishes and directions of donors. In making grants and expenditures, we endeavour to reflect the wishes of patients and staff by directing funds towards areas they tell us are most in need.

During the year 2022/23, grants and expenditure on patients totalling £11,587 were made and £4,024 was spent on staff welfare. A further £6,513 was sent on support costs, including administration, audit fees and bank charges. The majority of income, £29,021 related to a donation by the Surbiton and Tolworth League of Friends. Our future plans are to raise our level of income through fundraising by organising different events to achieve higher levels of income so that we can support more activities our patients will enjoy.

How we funded our work, our achievements and performance

The following figures are taken from the full accounts which have been approved by an independent examination report.

Statement of Financial Activities for the year ending 31 March 2023

	Total 2022/23 £k	Total 2021/22 £k
Income	38	8
Expenditure	(23)	(27)
Net Gain/(Loss) on Investments	(2)	(1)
Net income/(expenditure)	13	(20)
Total Funds brought forward	75	94
Total Funds carried forward	**88**	**75**

The Charity can only continue to support future activities if more donations or funds are raised. Almost all our income comes from direct donations and dividend/interest income from fixed investments.

Money received: where we got our money from

Total income received was £37,857 (2021/22: £8,190). The main sources of income were donations from individuals amounting to £5,773 and corporate donations of £31,121. A further £963 was earned from investment in the form of dividends and interest. The main movement between 2021/22 and 2022/23 was due to a significant donation of £29k received from the League of Friends for Surbiton and Tolworth.

Money spent: what we spent the money on

Our charitable work was mainly concentrated on the following areas:

- Patients' comfort, recreation, functions, training and other activities. We spent £11,587 in supporting our patients on various items and activities which contributes to their wellbeing and comfort.
- Staff welfare. We spent £4,024 on initiatives to support the staff that care for patients, providing wellbeing opportunities.

The Trustees continue to explore initiatives for funding that will benefit both patients and staff, whilst also progressing alternative sources of income.

Performance against objectives

During 2022/23 Trust focus was on the opening of a brand new 21st century facility and community hub at Tooting, including four inpatient wards, outpatient services and teaching and learning facilities This reduced capacity to further the Trustees' aims of increasing fundraising from different sources, however the Charity's membership of NHS Charities Together remains productive as bids totalling £85,000 were successfully submitted during the year and are due to be received in 2023/24. One of these bids (£30k) is a Development Grant and will directly fund a part-time fundraising officer for one year. In addition to fundraising, foundations have been built to create a successful 2023/24, for example the new branding will support future fundraising campaigns and awareness of the Charity.

Our reserves policy

The policy is that the funds must be spent for the purposes for which they were received. Funds should not be accumulated, unless for a specific purpose, and should be spent promptly.

- **General funds** – these funds are received by the Charity with no preference on how they are spent expressed by donors. Grants or funding to various small projects are made as and when needed. Representatives from the clinical or corporate services make applications to the Trustees expressing their levels of funding required along with a clear aim for the application and how the funding will benefit the services users. The bid is then considered by the Committee for a decision. Funding is particularly targeted on projects in areas of the hospital that do not have available designated funds to assist them.
- **Designated non restricted funds** – these funds are for a specific part of the hospital or activity nominated for support by the donor. They are overseen by fund holders who can make decisions on how to spend the money within their delegated responsibility and within the designated conditions of the fund. Fund holders are actively encouraged to draw on the fund for the benefit of patients and staff.
- **Restricted funds** – these are funds which are restricted by the donors as to where it can be spent. These funds were transferred from Epsom and St Helier NHS Trust which previously managed the Sutton Mental Health Services. Many of these funds have been dormant but recently there has been active encouragement for fund holders to use the funds.

Our financial health: our balance sheet

The net assets and fund balances are stated below and show an increase in the level of funds compared to last year. This is largely due to the donation from the Surbiton and Tolworth League of Friends which will be spent during2023/24 on activities that benefit both patients and staff.

	Total 2022/23 £k	Total 2021/22 £k
Fixed Asset Investments	36	39
Net Current Assets/(Liabilities)	52	36
Total Net Assets	**88**	**75**

About our investments

Investment is managed by CCLA Fund Managers Ltd. The investments are in the form of COIF Charities Investment fund, the Fixed Interest fund and the Deposit fund. Dividends are paid to the Charity's separate bank account on a quarterly basis. Investment reports are provided by CCLA on a quarterly basis, and are then reviewed to determine any change needed. Investments are sold when needed to meet the expenditure requirements.

The total return last year, including dividends and interest was £963. During the year, the Trustees reviewed the investment policy to support the intention to invest ethically and to ensure that funds were not used to support businesses that conflict with the aims of the Charity or its supporters.

Risk management

As part of their business planning exercise carried out during the year, the Trustees have considered the major risks to which the Charity is exposed. They have reviewed systems and identified steps to mitigate those risks. Two major risks have been identified and arrangements have been put in place to mitigate those risks.

- **Future levels of income** – The Charity is reliant on donations to allow it to make grants/expenditure to patients or staff. If income falls, then the Charity would not be able to make as many grants/expenditure or enter into longer term commitments to support the patients. The Trustees have put in place plans to mitigate the risk that income will fall by involving various organisations including the League of Friends and NHS Charities Together, by engaging with fresh bidding rounds for funds and working with departments within the hospital to raise the profile of the Charity and to increase fundraising activities.

- **Fall in investment returns** – The Charity generates additional income from investing its cash balances. The Trustees consider the loss of investment income to be a financial risk. The risk is mitigated by retaining expert investment managers, having a diversified investment portfolio, and regularly reviewing that portfolio. The Trustees make use of benchmarking information when reviewing the portfolio.

Related parties

The Charity works closely with, and provides most of its grants and expenditure, on patients and staff at the Trust.

Our relationship with the wider community

The Trust's transformation programme has provided a platform to increase community engagement, and the Charity is linking into this to maintain and increase donations from the public.

Acknowledgements

The Trustees would like to pay tribute to:

- Our volunteers for their time, support, and commitment
- The members of staff who give their time out of hours in support of the work on the committees, in developing ideas and working with us to identify how we can help our patients.
- Our fundraisers who do so much to encourage others to enrich the lives of patients and staff through donations and fundraising activities.

Signed on behalf of the Trustees:

Ann Beasley Date:

Statement of Trustees' responsibilities in respect of the Trustees' annual report and accounts

Under charity law, the Trustees are responsible for preparing the Trustees' annual report and accounts for each financial year which show a true and fair view of the state of affairs of the Charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice requires that the Trustees:

- Select suitable accounting policies and then apply them consistently
- Make judgments and estimates that are reasonable and prudent
- State whether the recommendations of the Statement of Recommended Practice (SORP) have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue its activities.

The Trustees are required to act in accordance with the trust deed and the rules of the Charity, within the framework of trust law. The Trustees are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the Charity at that time, and to enable the Trustees to ensure that, where any statements of accounts are prepared by the Trustees under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The Trustees have general responsibility for taking such steps as are reasonably open to the Trustees to safeguard the assets of the Charity and to prevent and detect fraud and other irregularities.

Signed on behalf of the Trustees:

Ann Beasley

Date:

Statement of Financial Activities for the year ending 31 March 2023

	Note	Unrestricted Funds	Restricted Funds	Total Funds 2023	Total Funds 2022
		£'000	£'000	£'000	£'000
Income and endowments from:					
Donations and legacies	4	7	30	37	7
Charitable activities		-	-	-	-
Other trading activities	5	-	-	-	-
Investments	6	1		1	1
Total incoming resources		**8**	30	**38**	**8**
Expenditure on:					
Charitable activities	8				
· Admin and Audit fees		(8)	-	(8)	(12)
· Patients comfort &		(12)	-	(12)	(12)
· Staff welfare		(4)	-	(4)	(3)
		(23)	**-**	(23)	(27)
Total expenditure		**(23)**	**-**	**(23)**	**(27)**
Net gains/(losses) on investments	15	**(2)**		(2)	(1)
Net income/(expenditure)		**(17)**	30	**13**	**(20)**
Transfers between funds					
Net Movement in funds		**(17)**	30	**13**	**(20)**
Reconciliation of Funds					
Total Funds brought forward	20	56	19	75	94
Total Funds carried forward	20	**39**	**49**	**88**	**75**

Balance Sheet as at 31 March 2023

	Note	Unrestricted Funds	Restricted Funds	Total Funds 2023	Total Funds 2022
		£'000	£'000	£'000	£'000
Fixed assets:					
Investments	15	21	14	36	39
Total Fixed Assets		**21**	**14**	**36**	**39**
Current assets:					
Debtors	16			0	1
Cash and cash equivalents	17	60		60	46
Total Current Assets		**60**	**0**	**60**	**47**
Liabilities:					
Creditors falling due within one year	18	(8)	-	(8)	(10)
Net Current assets/(liabilities)		**52**	**0**	**52**	**36**
Total assets less current liabilities		74	14	88	75
Creditors falling due after more than one year	18	0	0	0	0
Total net assets or liabilities		**74**	**14**	**88**	**75**
The funds of the charity:	20				
Restricted income funds			14	14	19
Unrestricted income funds		74		74	56
Total charity funds		**74**	**14**	**88**	**75**

The Trustees have not required the Charity to obtain an audit of its accounts for the year in question. The Trustees acknowledge their responsibilities for complying with the requirements of the Act with respect to accounting records and the preparation of accounts. These accounts have been prepared in accordance with the provisions subject to the small entities' regime.

The notes at pages 12 to 20 form part of these accounts

Signed:

Ann Beasley

Date:

Statement of Cash Flows for the year ending 31 March 2023

	Note	Total funds 2023	Total funds 2022
		£'000	£'000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	19	13	(134)
Cash flows from investing activities:			
Dividends, interest and rents from investments	6	1	1
Proceeds from the sale of investments	19	-	-
Purchase of investments	19	-	-
Net cash provided by (used in) investing activities		1	1
Change in cash and cash equivalents in the reporting period		14	(133)
Cash and cash equivalents at the beginning of the reporting period	17	46	179
Cash and cash equivalents at the end of the reporting period	**17**	**60**	46

Notes on the accounts

1. Accounting Policies

(a) Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

(b) Reconciliation with previous generally accepted accounting practice

In preparing these accounts, the Trustees have considered whether any restatement of comparatives was required to comply with FRS 102 and the Charities SORP FRS 102.

(c) Cash and cash equivalents

These are cash held in hand and in the current bank account.

(d) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- A restricted fund or
- An endowment fund

The Charity does not have an endowment fund.

Those funds which are neither endowment nor restricted income funds, are unrestricted income funds. These are sub-analysed between earmarked funds, where the Trustee has set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and those that are at the Trustee's discretion, including the general fund which represents the Charity's reserves. The major funds held in each of these categories are disclosed in note 20.

(e) Incoming resources

All incoming resources are recognised once the Charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point.

Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

(f) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the Charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

(g) Incoming resources from endowment funds

The Charity does not have any endowment funds.

(h) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(i) Recognition of expenditure and associated liabilities as a result of grant

Grants payable are payments made to patients of the Trust in accordance with the charitable objectives of the funds held on trust, primarily relief of those who are mentally not well.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:

We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant

- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant
- There is an established pattern of practice which indicates to the recipient that we will honour our commitment.

The Trustees have control over the amount and timing of grant payments and consequently where approval has been given by the Trustees and any of the above criteria have been met then a liability is recognised. Grants are not usually awarded with conditions attached. However, when they are then those conditions have to be met before the liability is recognised.

Where an intention has not been communicated, then no expenditure is recognised, but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met, then no liability is recognised, but a contingent liability is disclosed.

(j) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include

some staff costs, costs of administration, internal and external audit costs and IT support. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 11.

(k) Fundraising costs

There were no fundraising costs incurred in 2022/23.

(l) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objectives of the Charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 8.

(m) Fixed asset investments

Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair value (market value) as at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the Balance Sheet at the current market value quoted by the investment analyst, excluding dividend. Other investments are included at the Trustees' best estimate of market value.

The main form of financial risk faced by the Charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk, and changes in sentiment concerning equities and within particular sectors or sub sectors. Further information on the Charities fund investments can be found in note 15.

(n) Debtors

Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

(o) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due.

(p) Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long-term creditors. The Charity does not have long term creditors.

(q) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

(r) Pensions

The Charity does not have directly employed staff. The staff who run the Charity are employees of the Trust.

(s) Going concern

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the Charity are a fall in income from donations or investment income but the Trustees have arrangements in place to mitigate those risks (see the risk analysis sections of the annual report for more information).

2. Prior year comparatives by type of fund

	Unrestricted Funds	Restricted Funds	Total Funds 2022
	£	£	£
Income and endowments from:			
Donations and legacies	7	0	7
Investments	1	0	1
Total incoming resources	**8**	**0**	**8**
Expenditure on:			
Charitable activities			
• Admin and Audit fees	(6)	-	(6)
• Patients comfort & other	(12)	-	(12)
Other			
• Staff welfare	(9)	-	(9)
Total expenditure	**(27)**	**0**	**(27)**

3. Related party transactions

None of the trustees or members of the South West London and St George's Mental Health NHS Trust board or parties related to them has undertaken any transactions with South West London and St George's Mental Health NHS Trust Charitable Fund or received any benefit from the charity in payment or kind. The trustees received no honoraria or emoluments in the year and no expenses were paid.

South West London and St George's Mental Health NHS Trust makes a number of clerical and transaction services available to the charity, by agreement with the trustees. These include administrative services at a cost of £4,000 (£10,000 in 2021/22) in running the charity accounts which includes preparing the charity's final accounts.

4. Income from donations and legacies

	Unrestricted funds	Restricted Funds	Total 2023	Total 2022
	£'000	£'000	£'000	£'000
NHS Charities Together			0	0
Donations from individuals	5	1	6	4
Corporate donations	2	29	31	3
Legacies			0	0
Grants			0	0
	7	**30**	**37**	**7**

5. Analysis of income from other trading activities

The charity was not involved in any trading activities during 2022/23 (£0 in 2021/22).

6. Gross Investment income

	Unrestricted funds	Restricted funds	Total 2023	Total 2022
	£'000	£'000	£'000	£'000
Fixed Asset Equity and similar investments		-	-	-
Short term Investments & deposits & cash on deposit	1	-	1	1
	1	**0**	1	**1**

7. Analysis of expenditure on raising funds

The charity did not incur any expense in raising funds in 2022/23 (£0 in 2021/22).

8. Analysis of charitable expenditure

The charity did not undertake any direct charitable activities on its own account during the year. The charitable expenditure is shown below in summary:

	Grant funded Activity	Support Costs	Total 2023	Total 2022
	£'000	£'000	£'000	£'000
Patients comfort, functions & other	12	5	16	18
Staff education and welfare	4	5	9	9
Total	**16**	**9**	**25**	**27**

9. Analysis of grants

The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and the actual funds spent on each category of charitable activity, is disclosed in note 8.

The trustees operate a scheme of delegation for the majority of the charitable funds, under which fund advisors manage the day-to-day disbursements on their projects in accordance with the directions set out by the trustees in charity standing orders and financial instructions. Funds

managed under the scheme of delegation represent ongoing activities and it is not possible to segment these activities into discrete individual grant awards.

10. Movements in funding commitments

	Note	Current liabilities	Non-current	Total 2023	Total 2022
		£'000	£'000	£'000	£'000
Opening balance at 1 April	18	10		10	124
Additional commitments made during				0	0
Movement from current to non-current				-	-
Amounts paid during the year		(2)		(2)	(124)
Closing balance at 1 April	18	**8**	**0**	**8**	**0**

Expenditures are approved and paid out in the same financial year. As the charity has control over the award and timing of grants there is little uncertainty around these payments.

11. Allocation of support costs and overheads

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic and day to day management of a charity.

The basis of allocation used is as follows:

- Expenditure: this is a proportion based on the fund balance at the end of the year before governance cost. This is used where the trustees consider this is a more equitable treatment to avoid disadvantaging funds with high volume, low value transactions. The charity did not pay any money for salaries directly but a percentage of staff costs who were involved in the running of the charity's accounts was recharged.

	Raising funds	Charitable activities	2023 Total	2022 Total	Basis
	£'000	£'000	£'000	£'000	
Independent Examination		2	2	2	Expenditure
Accountancy Costs			-	0	Expenditure
Staff salary recharges		4	4	10	Expenditure
Governance costs	**-**	**6**	**6**	**12**	
Office Admin Charge	-	-	-	0	
Total	**-**	**6**	**6**	**12**	

	Unrestricted funds	Restricted funds	Endowment funds	2023	2022
				Total	Total
	£'000	£'000	£'000	£'000	£'000
Charitable Activities	6	-	-	6	0
	6	**-**	**-**	**6**	**0**

12. Trustees' remuneration, benefits and expenses

The charity's trustees give their time freely and receive no remuneration for the work that they undertake as trustees.

13. Analysis of staff costs and remuneration of key management personnel

There were no staff directly employed by the charity.

14. Independent Examiner's remuneration

The independent examiners remuneration is the same as 2021/22 (£2,280)

15. Fixed asset investments

Movement in fixed asset	2023	2022
	£'000	£'000
Market value brought forward	37	39
Add: additions to investments at cost	-	-
Less disposals at carrying value	0	0
Add net gain (loss) on revaluation	(2)	(2)
Market value as at 31st March	**36**	**37**

Fixed asset investments by type	2023	2022
	£'000	£'000
COIF Charities Fixed Interest Fund	21	23
COIF Charities Investment Fund	10	10
Total listed investments	**31**	**33**
Deposit Fund interest bearing	4	4
Total	**36**	**37**

All investments are carried at their fair value.

South West London and St George's Mental Health NHS Trust Charitable Fund investments are mainly traded in markets with good liquidity and high trading volumes. The charity has no material investment holdings in markets subject to exchange controls or trading restrictions.

The charity manages these investment risks by retaining expert advisors and operating an investment policy that provides for a high degree of diversification of holdings within investment asset classes. All investments were made in companies listed on a UK stock exchange or incorporated in the UK and therefore all investments are treated as investment assets in the UK. Restricted appeals to fund specific equipment or assets are held on notice deposit or overnight on the money markets in accordance with the trustees' investment policy.

16. Analysis of current debtors

Debtors under 1 year	2023	2022
	£'000	£'000
Accrued income	-	-
Total	**-**	**-**

17. Analysis of cash and cash equivalents

	2023	2022
	£'000	£'000
Cash in hand	1	1
Current Account	59	45
Total cash and cash equivalents	**60**	**46**

No cash or cash equivalents or current asset investments were held in non-cash investments or outside of the UK.

18. Analysis of liabilities

	2023	2022
	£'000	£'000
Creditors under 1 year		
Trade creditors	2	8
Other accruals	6	2
	8	**10**
Creditors falling due after more than 1 year	-	-
Total	**8**	**10**

19. Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2023	2022
	£'000	£'000
Net income/(expenditure) (as per the Statement of Financial	**13**	**6**
Adjustments for:		
(Gains)/losses on investments	2	2
(Purchase)/Sale of Investments	0	0
Dividends, interest and rents from	(1)	(1)
(Increase)/decrease in debtors	1	
Increase/(decrease) in creditors	(2)	(124)
Net cash provided by (used in) operating activities	**13**	**(117)**

20. Analysis of charitable funds

a) Analysis of endowment fund movements

The charity does not have any endowment funds.

b) Analysis of restricted fund movements

	Balance b/ f	Income	Expenditure	Transfers Gains	Balance c/f
	£'000	£'000	£'000	£'000	£'000
Child Psychiatry	2	-	-	-	2
Henderson Staff Training	2	-	-	-	2
Sutton Community Older People fund	2	-	-	-	2
Crocus ward	9	-	-	-	9
Surbiton And Tolworth Fund			29		29
Others (below £1k)	3		1	-	4
Total	**19**	**0**		**0**	**48**

All the remaining restricted funds were transferred from Epsom and St Helier Hospitals and the main purpose of them is to improve the welfare of patients and staff.

c) Analysis of unrestricted and material designated fund movements

	Balance b/f	Income	Expenditure	Transfers	Gains & Losses	Balance c/f
	£'000	£'000	£'000	£'000	£'000	£'000
Aquarius	9					9
Deaf & Family contingency	8					8
Pharmacy MHU	1					1
Richmond Comm. MH team	5					5
Other designated funds	12		1			14
General fund	22		(16)		(2)	4
Total	**56**	**0**	**(15)**	**-**	**(2)**	**39**

The trustees reported all the unrestricted funds in the above table without limiting it to a threshold. The objects of each of the designated unrestricted funds, greater than £1,000, are as follows:

The **Aquarius Ward** fund is designated to support the children on the ward with their activities and improving the ward environment.

The **Deaf & Family Contingency Centre** is a fund designated for the welfare and benefit of staff and patients on the relevant wards.

The **Pharmacy MHU** fund is designated for the welfare and benefit of staff in the Pharmacy department.

The **Richmond Community MH team** is a fund designated for the welfare and benefit of staff and patients on the relevant wards. It was donated by a family of a former patient.

Other **designated funds** relate to assisting patients on other wards and clinical departments within the SWLSTG MH NHS Trust for which donors have indicated their non-binding wishes when making their generous gifts. In the interests of accountability and transparency a complete breakdown of all such funds is available upon written request.

The total restricted and non-restricted funds amount to £88k, which includes a £2k loss in 2021/22 which was accounted for in 2022/23.

Independent examiner's report to the Trustees of South West London and St George's Mental Health NHS Trust Charitable Fund (the 'charity')

I report to the charity Trustees on my examination of the accounts of the charity for the year ended 31 March 2023.

This report is made solely to the charity's Trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008. My work has been undertaken so that I might state to the charity's Trustees those matters I am required to state to them in an Independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's Trustees as a body, for my work or for this report.

Responsibilities and basis of report

As the Trustees of the charity you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the 2011 Act').

I report in respect of my examination of the charity's accounts carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act.

Independent examiner's statement

Your attention is drawn to the fact that the charity has prepared the accounts in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) in preference to the Accounting and Reporting by Charities: Statement of Recommended Practice issued on 1 April 2005 which is referred to in the extant regulations but has been withdrawn.

I understand that this has been done in order for the accounts to provide a true and fair view in accordance with the Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

I have completed my examination. I can confirm that no matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the charity as required by section 130 of the 2011 Act; or
2. the accounts do not accord with those records; or
3. the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Signed: Dated:

Robert Smith ACA

Griffin Stone Moscrop & Co
Chartered Accountants
21-27 Lamb's Conduit Street
London
WC1N 3GS

DRAFT – for approval by Trustees

South West London and St George's Mental Health NHS Trust Charitable Fund
Trinity Building, Springfield University Hospital, 15 Springfield Drive, London. SW17 0YF

Griffin Stone Moscrop & Co.
21-27 Lamb's Conduit Street
London
WC1N 3GS

Dear Sirs,

The following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience such as we consider necessary in connection with your independent examination of the charity's financial statements for the year ended 31 March 2023. These enquiries have included inspection of supporting documentation where appropriate and are sufficient to satisfy ourselves that we can make each of the following representations. All representations are made to the best of our knowledge and belief.

1) Audit exemption
We acknowledge that the work performed by you is substantially less in scope than an audit performed in accordance with International Standards on Auditing (UK) and that you do not express an audit opinion. We confirm that the charity was entitled to exemption under section 144 of the Charities Act 2011 from the requirement to have its financial statements for the year ended 31 March 2023 audited.

2) Financial records
We have fulfilled our responsibilities as trustees, as set out in the terms of your engagement letter dated 24 August 2018 under the Charities Act 2011 for preparing financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), for being satisfied that they give a true and fair view and for making accurate representations to you.

All the accounting records have been made available to you for the purpose of your independent examination and all the transactions undertaken by the charity have been properly reflected and recorded in the accounting records. We have provided you with unrestricted access to all appropriate persons within the charity, and with all other records and related information, including minutes of all trustees' and management meetings and correspondence with the Charity Commission.

3) Immaterial adjustments
We confirm the financial statements are free of material misstatements, including omissions. There were no uncorrected misstatements found during the examination, other than those of a trivial nature, and we confirm that no adjustment need be made for them in the financial statements as their effect is immaterial, both individually and in total.

4) Going concern
As trustees we have considered the financial position of the charity. We believe that the charity's financial statements should be prepared on the going concern basis on the grounds that current and future sources of funding or support will be more than adequate for the charity's needs. We have considered a period of twelve months from the date of approval of the financial statements. We believe that no further disclosures relating to the charity's ability to continue as a going concern need to be made in the financial statements.

5) Related parties
Related party relationships and transactions have been appropriately accounted for and disclosed in the financial statements. We have disclosed to you all relevant information concerning such relationships and transactions and are not aware of any other matters which require disclosure in order to comply with legislative and accounting standards requirements.

6) Assets and liabilities
We confirm the charity has satisfactory title to all assets and there are no liens or encumbrances on the charity's assets, except for those that are disclosed in the notes to the financial statements.

We have recorded or disclosed, as appropriate, all liabilities, both actual and contingent, and have disclosed in the notes to the financial statements all guarantees that we have given to third parties.

We have no plans or intentions that may materially alter the carrying value and, where relevant, the fair value measurements or classification of assets and liabilities reflected in the financial statements.

7) Accounting estimates
The methods, data and significant assumptions used by us in making accounting estimates, and their related disclosures, are appropriate to achieve recognition, measurement and disclosure that is reasonable in the context of the applicable financial reporting framework.

8) Capital commitments
There were no material capital commitments at the year-end other than as disclosed in the financial statements.

9) Legal claims
We have disclosed to you all claims in connection with litigation that have been, or are expected to be, received and such matters, as appropriate, have been properly accounted for and disclosed in the financial statements.

10) Subsequent events
All events subsequent to the date of the financial statements which require adjustment or disclosure have been properly accounted for and disclosed. Should further material events occur we will advise you accordingly.

11) Laws and regulations
We acknowledge as trustees our responsibilities to take appropriate steps to provide reasonable assurance that the charity has complied with laws and regulations applicable to its activities and to establish arrangements for preventing any non-compliance with laws and regulations and detecting any that occur.

We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

12) Grants and donations
All grants, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions in the application of such income.

Yours faithfully

Trustee
On behalf of the board

NHS
South West London and St George's Mental Health NHS Trust

Meeting:	Trust Board
Date of meeting:	11th January 2024
Transparency:	Public
Committee Name	Modernisation Committee (MC) – 7th November meeting
Committee Chair and Executive Report	Juliet Armstrong (Chair) Ian Garlington (Executive)

BAF and Annual Delivery Plan the committee is accountable for:

BAF Risk Description 1347
A failure to deliver transformed models of care, working practices and environments within available resources

Annual Delivery Plan 5: To deliver our integrated transformation programme improving access and outcomes, reinvigorating working practices for staff and service users alike and providing state-of-the-art mental health facilities. Our focus is on delivering clinical transformation elements and supporting change within the Trust.

Key Questions or Areas of Focus for the Board following the Committee:

The Board to note:

- Successful move into the new Shaftesbury building. This is a huge achievement and the committee thanked all teams. A small number of post-move tasks are being completed
- Clinical transformation AUC remodelling of trajectory of bed reductions due to delays in delivering clinical transformation projects, ongoing industrial action and vacancies/absences in key roles. The end of 23/24 forecast is revised from a reduction of 11 adult acute beds to now 8 beds. The committee heard that the programme has the resources it needs in the short-term, including for OD and project leadership, and asked for an update on patient feedback and more examples of co-production at the next deep dive
- A social value vehicle will be set up to manage Springfield Park and the committee will receive a wider update as to how all the different parts of Springfield Village might evolve together
- The Modernisation Committee will now meet every two months, as agreed post the move into Shaftesbury.

Areas of Risk Escalation to the Board:

- None

Item discussed- Acute & Urgent Care: Updated Impact Modelling

Assurance Position

Reasonable assurance was provided with the following noted:

- Re-modelling of the projected impact of Clinical Transformation was undertaken due to i) delays in delivery due to funding and recruitment delays ii) compound effect of on-going industrial action and iii) key vacancies and absences
- This shows the end of FY position reduction of beds is 8 adult acute beds vs. original trajectory of 11
- The importance of community transformation and wider system work, and also the need to keep the patient at the centre and to work in an integrated way
- The team was optimistic about achieving the revised trajectory, recognising the on-going challenges. They believe they have the support they currently need; there is Organisational Development (OD) support coming in
- The importance that the next phase of work is co-produced.

Evidenced by

Papers presented to MC.

What next?

- The committee asked for examples of co-production to be brought to the next update, including patient feedback on the work to date
- Continue to monitor the work, acknowledging that maintained increase demand or further increases could result in no net reduction in bed usage compared to last year.

Item discussed- Shaftesbury Post-Implementation Review

Assurance Position

A verbal update was provided and the following noted:

- The moves into the new Shaftesbury wards went smoothly and to plan
- The panic alarms work differently in the new building and some work is on-going to ensure the new alarm is more audible in the ward
- This is a significant achievement for the Trust and a visit by the committee chair will be organised to thank teams in person.

Evidenced by

Verbal update only.

What next?

- Formal pre and post move review will continue to be collected and reported to the next committee, together with benefits data per the Full Business Case (FBC) benefits tracking.

Item discussed- Park Update

Assurance Position

The following was noted:

- The Trust has now adopted Springfield Park and all Judicial Review issues passed; Park area B is now open to the public. The park is an important and integral part of our vision for Springfield Village to reduce the mental ill-health stigma
- We are aware there is some misinformation being spread about the park through a campaign and petition
- We have identified experienced resources to help us with the next phase of park development, to mitigate capacity constraints within the Trust
- Springfield Village development partners are keen to develop joint Village branding with the Trust
- The importance of regular communication and feedback on this topic, including with residents. No new significant issues have been raised recently by residents.

Evidenced by

Papers presented to MC.

What next?

- Provide update at the next meeting for how broader aspects of Springfield Village will evolve, including the park and retail units.

Item discussed- 23/24 Annual Delivery Plans – Q2 Delivery

Assurance Position

The committee noted the amber RAG ratings for Delivery plan no. 5, which relates to the Integrated Programme and that more metrics will be added to the paper that goes to Board.

Evidenced by

Papers presented to MC.

What next?

- Review at next quarterly review point.

Appendices

All annual reports and other items that require to be in the full Board papers will be appended to the Committee Report

Meeting:	Trust Board
Date of meeting:	11th January 2024
Transparency:	Public
Committee Name	Audit Committee
Committee Chair and Executive Report	Richard Flatman and Philip Murray

BAF and Corporate Objective for which the Committee is accountable:

Audit Committee is not responsible for the delivery of the Corporate Objectives or managing BAF risks. Its work supports them all through ensuring appropriate controls and oversight are in place in the Trust and that they are operating effectively. The internal audit review of risk management (undertaken in 2022-23) found there to be a sound governance structure around the BAF and risk management and confirmed that the structure is operating as intended.

Key Questions or Areas of Focus for the Board following the Committee:

1. Updated internal audit progress.
2. The good work on the system plan and associated controls.
3. The Finance BAF risk reduction to 16 and planned reduction to 12 over the next 12 – 18 months.

Areas of Risk Escalation to the Board:

1. The judgement on the Shaftesbury and Trinity valuation approach.

For each item discussed at the Committee there would be a statement against the three areas below:
1 Assurance Position ("What")
2 Evidenced by ("So What")
3 What next?

External audit
What: the Committee continues to monitor external audit progress.

So what: the Committee noted:

- Planning for 2024-25 was about to commence.
- KPMG have begun debriefings for actions for next year's audit.

What next: the audit plan for next year would come to the next Audit Committee on 18th January 2024.

Internal audit actions
What: the Committee continues to monitor internal audit action plan progress, noting that good progress was being made against the plan. Four reports were finalised since the last Audit Committee, with only two audits left to start.

So What: the Committee noted:

- Good progress was being made on follow-up of actions, with 23 actions being closed since last meeting. All outstanding actions are in progress, and RSM are confident that we will be able to close these soon.
- RSM included details of actions not yet due, in response to a request from the Committee.
- Cyber security training is now mandatory.
- The next DSP Toolkit would be submitted by 31 March 2024 and so actions would be completed ahead of the next audit.

What next: All overdue actions to be followed up and an updated report to be provided at the next Committee meeting.

Internal Audits

What: the Committee continues to monitor internal audits.

So what: the Committee noted the following:

- Temporary staffing and E-Rostering – received 'partial assurance' including rosters not being appropriately signed off, delays to assignments of shifts, timesheets not signed. However there were also good controls highlighted.
- Patient experience – received 'reasonable assurance'. There were no significant concerns but it was noted some complaints were not dealt with in a timely manner.
- Health and Safety – received 'reasonable assurance'. MAST was currently being reviewed and the refresh work would be completed by end of March 2024. The report details on violence and aggression were as expected for a Mental Health Trust.
- Transformation and Cost Improvement Plans (CIPs) – received 'reasonable assurance'. Some CIPs were underperforming and some were non-recurrent.

What next: these audits would continue to be monitored especially the outstanding actions.

Internal Audit benchmarking

What: the Committee received benchmarking reports on the DSP Toolkit, payroll overpayments, healthcare internal audit findings and single tender waivers.

So What: the Committee wanted assurance that the Trust was in line with or above the average benchmarking in these areas, which was generally the case. We did have more audits with partial assurance and more actions than others in the sector but RSM said there were no concerns as it showed the internal audits were focusing in the right areas.

Internal Audit Assurance Map

What: RSM had produced a draft Assurance Map which maps out key areas of assurance across the Trust, links them to their relevant BAF risks and shows how the Trust will know it has adequate assurance in these areas, alongside if and when an internal audit had taken place.

So What: this piece of work would help the Committee and the Board to gain further assurance in one place in an easy to review format.

What Next: RSM had met with all of the Executive Leads and some Assistant Directors to get their input into the first and second lines of defence on the map. RSM identified eight areas where there could be a lack of assurance; however, since issuing the papers, more evidence came in for procurement and estates which RSM still needed to examine at the time of the meeting. When finished the map would help inform future audit planning.

Counter Fraud Update Report

What: The Committee receives regular update reports from the Counter Fraud team, benchmarked against RSM's wider client base and other similar trusts, to provide assurance that the trust is reviewing fraud regularly and not becoming an outlier in any area.

So What: This month's report showed no new risks .It mentioned a new scheme where criminals get cycle to work scheme vouchers, which are not traceable once given. It reported RSM had held training on cyber fraud which had been attended by members of the Trust.

What next: RSM would work to increase referrals, to ensure staff were confident to report to them; referrals from the trust were not too low. RSM have asked the Trust to look at potential Conflicts of Interest (COI) and ensure staff members are adhering to policy.

System Plan and associated controls
What: the Committee received and noted the System Plan.

So What: compliance with the system plan is monitored by Audit Committee.

What next: The Trust will assess progress on the controls and provide evidence by mid-November. The Trust, Royal Marsden and ICB are to assess each other's self-assessments on the controls. RSM were finalising the key control audit at the moment. This will give the Trust assurance that are basic processes are still working as designed. A report on the System Plan and associated controls will come to January Audit Committee.

Board Assurance Framework (BAF) and Executive Risk Register (ERR)
What: the Committee regularly reviews the BAF and ERR.

So What: the Committee heard that, following discussion at the September Board, all BAF entries were reviewed from the perspective of organisational culture. Updates had been made to the Health Inequalities and EDI (HIEDI) BAF risk as a result. The Quality and Safety risk had been updated following the government announcement on the Countess of Chester incident. The HR risk had been amended and the Committee were assured because HR was now out of recovery and into Business as Usual. The finance risk had been reduced from 20 to 16 and there was a plan to reduce it further, if appropriate, to 12 over the next 12 – 18 months. A risk appetite commentary was now included with the BAF.

The Committee were assured by ELT continuing to discuss the BAF at a meeting where Clinical Directors and Deputies are in attendance.

What next: the Committee would continue to monitor the BAF and ERR as well as the risk appetite.

Gifts and Hospitality Register Update
What: due to a low return on gifts and hospitality, the Committee had asked for a relaunch of the register and policy for both COI and gifts and hospitality.

So what: this would provide assurance that staff were declaring gifts and hospitality and COIs appropriately.

What next: there would be a further report coming to the January Committee.

Annual Accounts update
What: the Committee noted the update on the Annual Accounts following submission.

So what: the Committee heard that there were no Events After the Reporting Period to declare; that a lessons learned meeting was held about the year end accounts and audit; that the scheme of delegation may need amending following suggestion that financial authority levels be increased.

What next: the committee agreed the management judgement approach on the Shaftesbury and Trinity buildings. This would also come back to the Committee early in 2024 together with the changes to the Scheme of Delegation.

Valuation Report
What: the Committee reviewed the Valuation Report and any approaches needed in respect of valuation.

So What: the Committee heard that due to an approach to in-year valuation this could create a positive financial benefit for the Trust. The magnitude of profit on Springfield 2b (1) is such that the ICS would need to cover the gap if they objected to fair value, so the ICB and KPMG would need to be consulted.

What next: the impact on profit and loss following ICB discussions will go through Finance and Performance Committee, with an update available by January Committee. KPMG will consider this as part of their pre-audit.

Losses report
What: the Committee reviews any financial loss to the Trust within the scope of its Terms of Reference.

So What: the Committee heard that the Trust had taken legal advice to recover some overpayment of wages and had been advised to only reclaim 25%. The excess amount needed Committee approval to be written off, which was given.

What next: the Committee would continue to monitor losses to the Trust to get assurance that all losses are managed appropriately.

Debtors report
What: the Committee reviews any debt owed to the Trust within the scope of its Terms of Reference.

So What: the Committee heard that the majority of debts were those up to 30 days' old and the finance team were focusing on debts under £20k to ensure they were not aging inappropriately.

What next: the Committee would continue to monitor debt owed to the Trust to get assurance that debt and debt collection is being managed appropriately.

Waivers report
What: the Committee reviews any tender waivers that the Trust makes to ensure that procurement processes are being followed.

So What: the Committee heard that there were two current waivers and felt they were appropriate as one was an existing contract and one was additional costs to an existing supplier.

What next: the Committee would continue to monitor use of tender waivers in the Trust to get assurance that waivers are managed and used appropriately.

Charitable Funds Accounts
What: the Committee reviews the annual accounts of the Trust's Charitable Funds.

So What: the Committee noted the accounts and found no significant issues.

What next: the Committee recommended the accounts to the Charitable Funds Committee.

Appendices
The July 2023 Committee minutes.

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Audit Committee

Minutes of the meeting held via MS Teams on Tuesday 11 July 2023, 14:00-16:30.

Present:

Richard Flatman (RF)	Non-Executive Director (Chair)
Vik Sagar (VS)	Non-Executive Director

Attendees:

Vanessa Ford (VF)	Chief Executive
Philip Murray (PM)	Director of Finance and Performance
Clive Makombera (CM)	Internal Audit – RSM
Sharonjeet Kaur (SK)	Internal Audit – RSM
Matt Wilson (MW)	Internal Audit – RSM
Joanne Lees (JL)	External Audit – KPMG
Debbie Hollinghurst (DH)	Deputy Director of Finance
Katherine Robinson (KR)	Director of People (item 24/48 only)
David Lee (DL)	Director of Corporate Governance (from 3:30pm)

Apologies:

Charlotte Clark (CC)	Non-Executive Director
Emma Whitaker (EW)	Deputy Director of Corporate Governance

Minutes:

Emma Whitaker	Deputy Director of Corporate Governance (from video recording)

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Standing Items

24/40 Welcome and apologies
Apologies for absence were noted as listed above.

24/41 Declarations of interest
No new declarations of interest were reported.

24/42 Chair's action
No Chair's actions had been taken since the last meeting.

24/43 Minutes of the previous meeting held on 13 June 2023
The minutes of the previous meeting held on 13 June 2023 were approved as an accurate record of the meeting with no amendments.

24/44 Action Tracker
The Committee received the action tracker and noted the following updates:

23/8 – Gifts and Hospitality Register – this action was on the agenda for the July meeting. **Action to be closed**.

24/8 (iv) – Clinical audit programme peer conversation – RSM were in the process of setting up a peer-to-peer conversation with Berkshire and would advise the trust once a date had been agreed. **Action to remain open.**

24/8 (v) – Clinical audit programme IA report to go to QSAC – **Action to be closed.**

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24/8 (vi) – Audit committee to receive regular updates on the clinical audit programme via QSAC – this had been referred to QSAC. **Action to be closed – the Committee would receive regular updates from QSAC going forwards as business as usual.**

24/20 – Internal Audit assurance map – this action was on the agenda for the July meeting. **Action to be closed**.

24/27 – Internal Audit status report – this action was on the agenda for the July meeting. **Action to be closed**.

24/34 – BAF risk appetite overview – this action was not ready for this meeting so would be rolled over to October. **Action to remain open.**

24/37 – Audit Committee Annual Report – this action was on the agenda for the July meeting. **Action to be closed**.

EXTERNAL AUDIT

24/45 External Audit Progress Update

The Committee received and noted the External Audit Progress Update.

Reported:

- The trust Annual Report and Accounts were submitted on 30 June 2023, in line with the national deadline, and with positive opinions.
- All the actions identified regarding procedures had been closed.

24/46 Final Audit Opinion including ISA260

The Committee received and noted the Final Audit Opinion including ISA260.

24/47 Auditors Annual Report

The Committee received and noted the Auditors Annual Report.

Reported:

- The Value for Money (VfM) section of this report would be the part which would be published alongside the trust's Annual Report.
- The report summarised the work done by the auditors across the financial statements.

Discussed:

There were some conclusions included in this report around financial sustainability, improving economy, efficiency, effectiveness and governance, which were all positive.

That in risks and findings there was a misstatement of £1.8m under the heading of 'fraudulent expenditure', which it was not.

Agreed:

JL to clarify the language of the misstatement of £1.8m section before the auditors annual report was published. **JL**

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INTERNAL AUDIT

24/48 Internal Audit Progress Report inc. tracker / outstanding internal audit actions update

The Committee received and noted the Internal Audit Progress Report.

Reported:

- Good progress was being made against the audit plan.
- Two reports had been finalised since the last meeting – Data Security and Protection Toolkit (DSPT) and HR transformation.
- The DSPT audit had been assigned a 'moderate assurance' rating. It was recognised that this had improved since last year (when it was rated 'limited assurance'). The toolkit was submitted on time.
- The HR transformation audit was an advisory report and had been signed off along with an associated action plan by the Director of People.
- 15 of the outstanding actions in the Internal Audit action plan had been closed since the last meeting; only seven historic actions remain 'in progress' and all now had revised completion dates.
- The trust was on plan and broadly where RSM would expect them to be at this point in the year.
- The Committee noted that there is a fund of £21m for rolling out Artificial Intelligence across the NHS, although a lot of the pots are targeted at Acute trusts.
- New guidance on procurement and contract management was due to be published, and this might change the trust's procurement process. It was noted that Martin Kelly, trust Head of Procurement, was involved in some of the working groups around this new guidance.

Discussed:

<u>DSPT</u>

That 'moderate assurance' was the RSM benchmark assurance for DSPT – no client had received a higher rating. CM reported that the deviation between trust and RSM opinion does not impact upon toolkit submission.

That the back-up testing was a mirror finding of what came out of the cyber audit. The trust had back-up testing in place but not for the full year covered by the DSPT. This item should be turned 'green' next year.

<u>HR transformation</u>

The RSM HR consultant had led the audit, which had looked at people, planning and priorities; governance, set up and reporting of the team; as well as team culture and capacity. The report was advisory as it was recognised that the trust was on a journey in this area. There was a comprehensive action plan produced which was shared with KR.

The original scope was to review the 10 recommendations from the external review that Ann McIntyre previously undertook; however, those recommendations were only relevant to the trust if they had kept the joint function with SLaM. KR had taken those recommendations through the Workforce and OD Committee (now known as the People Committee); these had closed as no longer relevant after the decision to separate. There was then a more general HR governance and process audit.

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KR noted the challenges due to the complexities of separating the HR function. The People plan on a page would be done in Q3 – Q4 of 2023-24, to allow the People team to get 'brilliant at the basics' before work began on designing a strategy.

There was an action around ensuring improved governance and processes for reporting the progress of the HR functions. Since then the Q&P report had become the 'single source of the truth' and was presented at every People Committee. The Committee had commented, that as a result, over the last two meetings that they feel they are now getting more assurance. VF noted that she felt more assured too with the improvement in some of the KPIs

RF added that, although advisory, this was a hard-hitting report. He asked for a sense of where things were on the journey, what still needed to be done and how this could be driven forwards. KR and VF both felt that things had moved forward; the next round of internal audit reports would look at the 'brilliant at the basics', the trust's aspiration of the past year, to provide assurance. Additionally VF and AB have commissioned Ann MacIntyre to produce an "MOT" report to explore whether, given where the trust were two years' ago, it was now where it needed to be; VF was about to approve the TOR for this review. A temporary structure was created when the trust split with SLaM, and work was ongoing around how the permanent structure should look. Once agreed, this would allow recruitment to key posts to take place; with the caveat that getting good recruits may be difficult due to the competitive market and the trust's financial pressures.

It was agreed to triangulate the findings from Ann MacIntyre's MOT report with the internal audit report, and to drill down into the separate People areas, as the different departments were at different stages along the process.

It was noted that the report ought to have gone to People Committee prior to Audit Committee with Chair of People providing assurance to Audit Committee; however this report would be going to People Committee in July. It was made clear that Internal Audit reports should be signed off by the Executive Director, then the Committee that was responsible for the item, and then should come to Audit Committee. If there was an issue with timing, then the report could be approved by Chair's action prior to coming to Audit Committee. RSM confirmed that they would do this going forward.

<u>Other</u>
The Chair asked RSM if there was a wider follow-up plan with the other recommendations, which could be shared with the Committee for information. The Chair requested that it be set out like the Committee action tracker with overdue, due and not yet due actions grouped together. CM clarified that there were 38 actions in total and that RSM would provide the full breakdown in future reports.

The Chair asked whether the revised dates of the seven outstanding actions are a sign that the trust had been too ambitious in regards to implementation timeframes. SK responded that the trust were in a good place; and going forwards, RSM would be tighter on implementation dates and would hold Executives to account to ensure that timeframes were realistic. VF added that she would like RSM to remind Executives that, unless an immediate patient safety issue, there was time to think things through and not be 'jumpy'.

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24/49 Internal Audit assurance map

The Committee received and noted the Internal Audit assurance map.

Reported:

- The assurance map was still a work in progress but RSM were making good progress with it.
- RSM would be arranging meetings with all of the Executive Leads and some Assistant Directors to get their input into the first and second lines of defence. There would then be a cleansing exercise on the third line, after which the map would be bought back to Audit Committee.
- The map would come back to Committee with a summary page highlighting any gaps and the next steps needed.

Discussed:

The Chair would like to share the map with the Board when this work had been completed. This would then feed into the overall audit planning process.

24/50 Counter Fraud Update Report

The Committee received and noted the Counter Fraud Update Report.

Reported:

- Secondary working guidance had been included in the report as it was an area of increasing risk to the NHS that people were looking to exploit. This was when an individual, usually interims or agency staff, has a second job.
- Another emerging risk was fraudsters exploiting salary sacrifice schemes, by impersonating staff to fraudulently request vouchers. The Finance team had been made aware of this risk.

24/51 Reactive Benchmarking Report

The Committee received and noted the Reactive Benchmarking Report.

Reported:

- This report shows the number of cases received from the trust compared against RSM's client base.
- There was a sharp increase in referrals from the trust but the rate was still below the number seen in the sector. RSM would work to increase referrals, to ensure staff were confident to report to them; but referrals from the trust were not too low.
- There were currently low referral numbers from recruitment which usually would be an area where a lot of referrals were made. RSM would work with the recruitment team on this.
- RSM undertook a gifts and hospitality survey across their client base, including with trust staff. There was not enough of a response from the trust to give a personalised report so they reported the overall findings within their report.

Discussed:

The trust's policy that covered gifts and hospitality (the Conflicts of Interest policy) had been reviewed by RSM in June 2022 and they had suggested some minor recommendations which still needed to be included. The policy itself follows the NHS England policy and RSM had no concerns.

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Internal Governance

24/52 Audit Committee Annual Report

The Committee noted and approved for Board the Audit Committee Annual Report.

Reported:

- This report pulls together the outcome for all Committee meetings to March 2023.
- The report included an assurance and position statement that sought to provide an opinion to the Board in terms of the adequacy and effectiveness of systems of control, governance, risk management and VfM. There was a positive assurance statement with the basis for that self-assessment clearly set out.

24/53 Board Assurance Framework (BAF) and Executive Risk Register (ERR)

The Committee received and noted the BAF and ERR.

Reported:

- The new Quality and Safety risk was included and needed approval to go to Board. It had been through QSAC.
- There was annotation included of ELT discussions around the BAF, which included attendance from Deputies and Clinical Leads.
- Audit Committee were asked to discuss what information from the BAF should be shared with the Board going forwards, taking into account that the sub-Committees had greater ownership of their BAF risks, and these were reported to Board within the Committee Chair's reports.

Discussed:

The Chair was comfortable with this iteration of the BAF and the new Quality risk. He had also attended the QSAC where the Quality risk had been discussed in detail and he was satisfied with the process it had gone through and that it was comprehensive.

The risk appetite commentary had been missed from this iteration.

That the Board should see the BAF summaries so that they would still see the oversight of the total risks, but they would leave the sub-Committees responsible for the delivery of the action plans that sit underneath these risks.

Agreed:

- That the Board should see the BAF summaries and risk appetite commentary going forwards.
- The Quality risk and its onward travel to Board for approval.

24/54 Gifts and Hospitality Register Update

The Committee received and noted the Gifts and Hospitality Register Update.

Reported:

- The trust Conflicts of Interest (COI) Policy, which also covered gifts and hospitality, had been updated with minor amendments.
- The Audit Chair had previously requested that the gifts and hospitality register and the COI register be separated – they had been on the same register as they were covered by the same policy.

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- The updated policy, new separate registers, the new declaration form (based on the NHSE template) and the press release to 'launch' the above and garner more declarations, were presented to the Committee for approval.

Discussed:
That the COI policy would not be approved today, as there were some minor amendments that needed to be added from RSM (as discussed under item 24/51 above). RSM were comfortable with the substantive part of the Policy.

The Committee found the policy on a page was potentially confusing.

The thinking around comms and how the communications team would be helping to push out the message. This response would be sought and sent offline.

That there seemed to be two forms included – this was confusing. The Chair asked that this be clarified.

That pharmaceutical companies declare information every year about gifts and events which involve trust staff, but that trust staff do not always think to declare; as, for example, they see attending the events as training to understand how to prescribe a drug. The wider organisation may need some information on what to declare. RSM confirmed that low declarations of gifts and hospitality were not uncommon.

It was confirmed that the registers and returns should come back to the Committee twice a year.

Agreed:

- MW to feed back to EW about the minor changes required to the Policy. **MW/EW**
- To review the forms to ensure they are correct. **EW**
- To confirm how this update would be rolled out and communicated. **EW**
- That the registers and returns should come back to the Committee twice a year. **EW**

24/55 Annual Accounts update, including Earnings After the Reporting Period (EARP)

The Committee received and noted the Annual Accounts update, including EARP.

Reported:

- The accounts were submitted on time.
- Reflections on the process – what worked well and what could work better next time – were included in the paper.
- One key area was communications. The finance team felt that KPMG slowed their approach and process after the last Audit Committee. JL felt that was not the case; a lot of the work that then happened was internal to KPMG, so the trust would not have been sighted on it. This would be discussed by both sides.
- It had been previously approved that the auditors GSM would be retained for the Charitable Funds accounts as long as their rates remained reasonable. It was confirmed that they had maintained their rate this year at the same rate as last year.
- HCAS error – this triggered a review which had taken a considerable time to finalise. It had now been finalised and any individual who had been overpaid had been spoken to by HR colleagues. HR had fed back that these individuals

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had recognised that their pay would be adjusted to a lower salary following an appropriate notice period. The trust would not be pursuing individuals for the debt, which totalled £145,000. This had been approved previously at the Committee on the understanding that the staff involved agreed to their lower salary.

- There had not been any EARP as of this meeting; it was noted that the national request would be in Q3.

Discussed:
RF was encouraged to hear that the HCAS error had now been resolved.

RF requested that he be informed of any EARP that arise between now and the submission date in December. He confirmed that if nothing arises, PM had the authority to make a negative return. PM agreed.

24/56 Losses report July 2023
The Committee noted the Debtor's report June 2023.

Reported:
- There was a loss to note in respect of some equipment damaged by a patient, at the value of £4,000.
- The finance team had done a lot of work over the last few years to make sure that loss information was being captured, but that even with that extra work, reported losses remained low.

Discussed:
The trust were not pursuing the patient for the £4,000 so this was not technically a write-off, but came to the Committee as a matter of good practice. The Chair was assured that the incident itself would have been considered and robustly reviewed by the Director of Nursing, the Quality Matters Committee and QSAC.

Agreed:
The loss of £4,000 was noted by the Committee.

24/57 Debtor's report July 2023
The Committee received and noted the Debtor's report.

Reported:
- The overall debt over £20,000 had come down by £2.3m.
- The trust had not collected anything that was 'older than nine months' due to year end and onboarding of a new post holder. Now that person was embedded and year end was over, it was expected that the new person would begin working with debtors and the contract team to bring those numbers down.
- Non-aged debt had continued to be collected.

24/58 Waivers Report
The Committee received and noted the Waiver Report.

Reported:
- That there had been no quote or tender waivers to report.

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- PM had rejected a quote waiver request on the basis that there was reasonable time to obtain quotes. The quote process had not secured savings though PM felt this had given assurance that the process was working and was robust.
- The RSM work on benchmarking tender waivers would come to the next Committee.

24/59 Salary Overpayments

The Committee noted the Salary Overpayments report.

Reported:

- Incidents of overpayment remain flat, allowing for small, non-material fluctuations, such as the values for pay awards and inflation.
- The trust was not an outlier for overpayments; it benchmarked marginally under the national median for errors (.07% versus the national median of .08%).
- Despite the extra scrutiny of the payroll and HR processes, it was disappointing that the incidents were not coming down. This was largely due to late notification from managers of people being sick or having left the organisation. On the positive side, there were not any significant concerns.
- Hastee pay – the numbers were gradually climbing and there did seem to be a statistical step change from January 2023.
- Salary underpayments were included for reference.

Discussed:

That this report was regularly monitored at FPC.

Whether there was anything that could be done to reduce late notifications, e.g. a financial penalty. PM confirmed that departments budgets would pick up the cost of overpayments and thus were penalised. PM and DB were looking at corporate systems and processes to see if these could be digitised and made leaner, to prevent overpayments. There was not felt to be a standout part of the process that was causing any issues. PM felt that late notifications were genuinely because people were very busy and forgot to do the paperwork on time.

The Committee were assured by the fact that the trust was not an outlier for overpayments.

24/60 System Plan sign off letter and associated controls

The Committee received and noted the System Plan sign off letter and associated controls.

Reported:

- This report spans a number of Committees: People, FPC and Audit, because of the additional controls listed in appendix 1.
- Anything over £25k non-pay has to go through ICB and NHSE sign-off, as do any administrative agency requests; this was known as the "triple-lock".
- There was now more granularity in the appendix; and there were some conflicts between the content of the main letter and the appendix. The ICB was working through those disparities and were to clarify.
- All trusts were required to create a waterfall diagram that explained how they got from the head count and whole time equivalent at March 2020 (from the start of the pandemic) to now. As a mental health trust there had been underlying investment because of the Mental Health Investment Standard and

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the SDF; the diagram showed legitimate increases linked to national investment.

Discussed:
As the report spans a number of Committees, how would Audit Committee gain assurance that these controls were operating effectively. PM confirmed that ELT and People Committee, plus the Board, had reviewed it as the 'break glass' agency use process had needed to be signed off at Board level. Technically, it should then come back to Audit Committee, to say it had been signed off with the various Committees (including FPC) and then up to the Board. 'Break glass' use would be reported into FPC.

Agreed:
For the next Audit Committee, a short report to be presented on how the Executive think the trust had complied with the system plan and controls; and for a report to come back to Committee on an ongoing basis. **PM/DB**

24/61 Review of Committee forward plan
The Committee noted the forward plan.

24/62 Matters to report to the Board
The Committee agreed that the following should be reported to the Board:

- Annual accounts update and the opinions.
- The Internal Audit progress report, with particular focus on the HR transformation audit and ongoing challenges around HR.
- The BAF.
- The progress of the gifts and hospitality work.
- Audit Committee annual report and opinion.
- System plan and associated controls, oversight, governance; and ensuring that all works effectively.

24/63 Information items
These items were noted with no comments:

- Quality and Safety Assurance Committee minutes.
- Estates Management Committee minutes.

24/64 Date of Next Meeting
Tuesday 31 October 2023, 14:00 -16:30 MS Teams.