Trust Board - Part A May 2024

09 May 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 9 May 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://swlstg.nhs.uk/our-board/	**FR**			
	2.3. Chair's actions	**FE**	**Paper**	**AB**	
	2.4. Minutes of the meeting held on 14 March 2024	**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**	**11:10**
	3.2. Chief Executive's report	**FR**	**Paper**	**VF**	**11:15**
	3.2.1 Priorities 2023/2024 Q4 report 3.2.2 Priorities 2024/2025 – annual delivery plans 3.2.3 Annual Strategy Review	**FA** **FA** **FA**	**Paper** **Paper** **Paper**	**AS** **AS** **AS**	**11:30**
4.	**INCREASING QUALITY YEARS** **REDUCING INEQUALITIES**				
	4.1. Quality and Safety Assurance Committee chair's report	**FR**	**Paper**	**JW**	**11:40**
	4.2. Quality and Performance reports 4.2.1. February 2024 4.2.2. March 2024	**FD**	**Paper**	**JeA**	**11:50**
	BREAK				**12:00**
5.	**REDUCING INEQUALITIES** **MAKING THE TRUST A GREAT PLACE TO WORK**				
	5.1 People Committee chair's report	**FR**	**Verbal**	**SA**	**12:10**
6.	**ENSURING SUSTAINABILITY**				
	6.1. Audit Committee Chair's report	**FR**	**Paper**	**RF**	**12:20**
	6.2. Finance and Performance Committee chair's report	**FR**	**Paper**	**PM**	**12:30**
	6.3. Monthly finance and savings reports	**FD**	**Paper**	**PM**	**12:40**
	6.4. Charitable Funds Committee chair's report	**FR**	**Paper**	**JuA**	**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: 11 July 2024**, Conference Room B, Trinity Building, Springfield Hospital				

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
Jonathan Warren (JW)	Non-Executive Director
Humaira Ashraf (HA)*	Associate Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Dr Billy Boland (BB)	Chief Medical Officer
Sharon Spain (SS)	Chief Nursing Officer
Philip Murray (PM)	Chief Finance and Performance Officer
Jennifer Allan (JeA)	Chief Operating Officer
Amy Scammell (AS)*	Chief Strategy Officer
Katherine Robinson (KR)*	Chief People Officer
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
May 2024

Paper Reference:	
Report Title:	A carers story.
Executive Summary:	The story this month is told by S, the mother of an adult male patient X. The story highlights the difficulties often experienced by carers and family members and was commissioned following the visit of the Chief Nurse, Sharon Spain, to a meeting of carers in Kingston in March 2024. Sharon was so moved by the honest and sometimes upsetting experiences shared by carers that she felt it was appropriate and important for these to be shared with the wider Trust Executive Board. There will be an oral presentation from S. Senior staff from the ward and AUC service line will also be in attendance.
Action Required:	The Board is asked to note this story relating to the AUC Service Line-Lavender Ward
Link to Strategic Objectives:	The Trust launched its five-year Trust Strategy in 2018. The strategy 2018 – 2023 (now extended to 2025) 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 family members and carers must be taken into account and that the valued support they provide to our patients is to be appreciated and recognised.
Risks:	Patient Safety is a domain of the Quality Strategy.
Quality Impact:	Patient Experience is a domain of the Quality Strategy. Listening to and learning from carers and family members informs our services and enables us to improve the experience for all who use our services.
Resource Implications:	S's attendance in person has been facilitated through the Quality Governance Department.
Legal/Regulatory Implications:	None. The patient and carer are referred to as X and S throughout.

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.
Groups Consulted:	S, mother and carer of patient X. Lavender Ward Consultant and Matron.
Author:	Jane Healey, Quality Governance Lead.
Owner:	Sharon Spain, Executive Director of Nursing and Quality Standards

Making life better together

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

A Carer's story.
Acute & Urgent Care Service Line

May 2024

Background

This month's patient story to the Trust Board is told by the mother of an adult patient. This story highlights the difficulties experienced by the patient, X and his parents, while he was an inpatient of the Trust.

X has three older sisters and is now a man of 44 with a diagnosis of Paranoid Schizophrenia. X was first being introduced to drugs when he was around 16. X started showing the first major signs of mental ill health and depression, accompanied by erratic behaviour and a loss of interest in things he had previously enjoyed at about this time, his mother, S, has noted that everything became subsumed into feeding X's addictions.

X was nevertheless academically successful, he passed 12 GCSE's and 3 A-Levels and achieved a BA in History and Politics.

Sadly, when age 24, X experienced a first episode of psychosis in 2005 when his addictions and drug use became destructive. X's mother S has noted that the Merton Community Mental Heath Team provided appropriate intervention at that time and X was diagnosed with psychotic depression.

Background continued

Following this, X responded to medication and treatment was able to spend time teaching and working abroad. On his return however there was a change of care team and X became more less wiling to attend appointments. X's mother S also noted differences in the ways the mental heath teams operated and requests were responded to. X's addictions continued and became far worse than his parents realised, leading to a first hospital admission in 2011.

Shortly after this, X was told by a Consultant that he was a paranoid schizophrenic; this diagnosis was given with no warning and with his parents in the room. X's mother S has noted that there was no preparation for this diagnosis, for X or his family and there was also no opportunity to explore this diagnosis further.

Recent experience with the Trust

X is currently under the care of the North Kingston Integrated Recovery Hub and has had two periods of admission to Trust inpatient wards within the last year while detained under the Mental Health Act. X's mother S needed to raise concerns about certain aspects of his first admission in June 2023; S noted that she did not wish to do so and stressed her support for the NHS and the staff, but felt she had no choice, given the circumstances.

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Recent experience with the Trust continued.

The concerns raised by S in June 2023 centred mainly around communication and mixed messages, between staff and X, between staff and S as well as communication between wards on the Springfield Hospital site. Learning was identified for one staff member in terms of communication with family members and patients.

Experience on Lavender Ward

X was admitted to Lavender Ward on 12th December 2023 following what his mother S has described as a 'slow but inevitable' mental relapse. On admission, S and X's family were concerned that the consultant and the ward team should understand the context of the relapse, as well as the distress and fear that X was experiencing. S noted that, as carers for X, she and the family were best placed to provide this information so they therefore sought a meeting with the consultant to provide this information.

Despite S or another family member being present on the ward nearly every day, no appointment was arranged. S has noted that the ward staff communicated what they could and were helpful and informative but they were not able to arrange an appointment with the consultant.

Lavender experience continued.

S has noted that the consultant was on leave over Christmas, and was then unfortunately unwell, but it appeared that there was no other doctor to whom information could be provided. S has noted that the background information was shared with nursing staff but the family were hoping that this would inform treatment decisions for X, hence the wish to speak with a doctor.

After continued requests, S was asked to attend a meeting with the consultant on 8th January 2024. X was pleased to be able to attend the ward and have the opportunity to share information about X's diagnosis and history as well as knowledge of treatment which X had had in the past. S hoped that, as X was on the ward and accepting treatment, this would be an opportunity for him to also access support for his addictions.

Meeting on Lavender Ward

The day after S and X's family were informed of the meeting, X advised them that he was being discharged on that day. X believed that if he agreed to take a depot injection then he would be able to be discharged, despite the fact that he had asked to be taken off the same depot injection in 2019 due to adverse side effects. X said he just wanted to get out of hospital; S noted her concern as to why a previously tried medication would be suggested and why X was now being discharged without any discussion or communication with family members, despite this being requested repeatedly.

When S and the family attended the meeting on the ward there was no opportunity for them to speak to the team alone and ask any questions, or raise any concerns about the plan to discharge X at that point. S noted that it was difficult to speak in front of X when it was clear that he was desperate to leave the ward and return home.

In addition, S noted that the meeting felt rushed, it was made clear at the start that the staff only had 20 minutes, and that, as the decision to discharge X had already been made, the meeting consisted of X being told the plan and being asked what he wanted which was of course to be discharged.

S noted that there was no scope for discussion and no opportunity for the family to provide any contextual background information. S had specifically wanted to discuss concerns about medication in the light of the previous severe reaction but she was not able to do so. S also noted that there was no representative from the community team invited to the meeting and it felt unplanned and hurried with the sole aim of discharging X from the ward as quickly as possible.

During the meeting X was asked if her had met two staff members whose role is to support patients while planning for discharge. X advised that he had not done so but the meeting carried on and the planned discharge took place and X was discharged home.

S would like to highlight the importance of involving family members and carers in the care of their loved ones when in hospital. Even if the patient does not consent to their involvement, they will often still have valuable insights to provide and should be listened to and involved in the care and support of their loved one where possible.

Identified learning from S's experience and her complaint was that the Clinical Service Lead has been asked to review the arrangements in place for carers to meet with doctors on request, inline with the Triangle of Care principles.

Triangle of Care

The Triangle of Care is a therapeutic alliance between carers, service users and health professionals. It aims to promote safety and recovery and to sustain wellbeing in mental health by including and supporting carers. The Triangle of Care is based on six principles that mental health providers can use to include and support carers

Triangle of Care principles

- Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
- Staff are 'carer aware' and trained in carer engagement strategies.
- Policy and practice protocols regarding confidentiality and sharing information are in place.
- Defined post(s) responsible for carers are in place.
- A carer introduction to the service is available, with a relevant range of information across the care pathway.
- A range of carer support services is available.

The Triangle of Care can also help health professionals by:

- Creating a more helpful, supportive relationship with carers.
- Giving carers and service users realistic expectations and information to support their caring role.
- Ensuring staff have information about the service users from the unique expertise of the carer.
- Partnership working – building stronger relationships between staff, carers and service users. Carers and families are better advocates when they have knowledge about what services they are entitled to and how to access them.
- Reduced admissions – a carer can often recognise signs that a service user is becoming unwell. By listening to carers, steps can be taken to help reduce the need for a service user to be admitted.

Complaints and compliments

Nine complaints about communication with family members or carers were received across the Acute & Urgent Care Service Line in 2023-24. These were spread evenly across the inpatient wards. Further complaints were also received where communication with family members was raised, but was not the main theme of the complaint.

Lavender Ward also received a compliment from the sister of a patient in October 2023; this stated 'thanks for all you do to care for all patients using your service'.

South West London and St George's Mental Health NHS Trust
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Board of Directors (Part A)

Draft minutes of the meeting held on Thursday 14 March 2024, 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
Richard Flatman (RF)	SID 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
Dr Billy Boland (BB)	Chief Medical Officer
David Lee (DL)*	Director of Corporate Governance
Philip Murray (PM)	Chief Finance and Performance Officer
Sharon Spain (SS)	Chief Nurse
Jennifer Allan (JeA)	Chief Operating Officer
Jenna Khalfan (JK)*	Director of Communications and Stakeholder Engagement
Ian Garlington (IG)*	Integrated Programme Director
Amy Scammell (AS)*	Chief Strategy Officer
Katherine Robinson (KR)*	Chief People Officer

*Indicates non-voting member

In attendance:

Abbie	Patient story
Rumbi Mapfumo	Governance Lead
Tom Pursey	CSL, Avalon Ward
Sandra Ike	Avalon Ward
Stefanie Looker	Matron, Avalon Ward
Beverley Baldwin	Head of Nursing
Janet Grimes	Head of Service Delivery
Faiza Waheed	Member of the Public
Martin Haddon	Healthwatch Wandsworth
Darren Blades	Wandsworth Community Empowerment Network
Linton Cassius	Wandsworth Community Empowerment Network
Shariah Williams	Wandsworth Community Empowerment Network
Emma Whitaker (minutes only)	Deputy Director of Corporate Governance

Apologies

Vanessa Ford (VF)	Chief Executive Officer

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24/20 Patient story

Abbie joined the Board to share her story. Abbie was an inpatient on Avalon ward. The ward had been on a journey from a 'requires improvement' CQC rating and a lot of improvement work had gone on. The ward had moved into the new Trinity building and there had been a sense that the transition had not been well organised. The longer Abbie was on Avalon ward she had felt more 'back together'. However her experience on the ward had been challenging. She had Autism but did not know that at the time of her stay. The environment on the new ward in Trinity had not been helpful for her Autism and communication with patients with Autism could have been improved. She felt the staff on the ward were wonderful. Any time she had needed anything they were

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always there and she could not thank them enough. The clinical side of her treatment had not been clear.

Discussed:

The Chair thanked Abbie for sharing her story. It was lovely to hear that the staff were wonderful. The Trust was very proud of its staff. Quite often our patients tell us our staff are great but other things negatively impact their stay with us. Abbie had shared that some of the things on the new ward did not help her Autism. The Chair asked what we could change to make the ward better for Abbie. Abbie responded that it had been hard being in the loudness of the ward. She would have liked more 1-1 times and a more individualised care plan, to specifically help people with neurodivergent needs.

Stefanie, the ward matron, thanked Abbie for coming to Board and sharing her story. It was good to hear what had gone well and what had not, as this would give the ward the opportunity to improve. She said that the ward would take on board Abbie's feedback and aim to increase 1-1s. The ward also had sensory lounges to use if patients found the environment too loud.

SA asked Abbie about the distinction between how she found the staff supporting her and clinical confusion. Abbie said that the support staff were good with communication about care plans, treatment and things like that. She had been to other wards and had found it helpful having MDT meetings and having everything listed down so it was clear for her. There were times on Avalon ward where she wanted to go out for agreed leave and it had not been written down. There had seemed to be a lack of organisation on the ward.

SS told Abbie that the Trust get lots of feedback about lack of consistency, such as consistency with support after meal times. Wards were trying to move away from restrictive practices. She asked how that had impacted on Abbie's treatment. Abbie responded that things like support after the dining room was not there. She was not sure if that was part of the transition of moving from one building to another. She had been very angry at the time at the lack of support with meals and after meals. The move did not go well. The date of the move kept getting pushed back so the patients had not been sure when they were moving. When the move was confirmed, the patients had a week to prepare. The day of the move was well planned but the ward encountered more bumps than originally thought. Abbie understood how hard it was to predict bumps but she did not think they had been dealt with in the right way nor at the right speed. The Chair responded that the Trust had learned from this from the first set of moves. IG had undertaken an after action review. The moves had gone better when wards had moved into Shaftesbury. We want to get better again when the moves happen for Tolworth. All of Abbie's feedback was helpful for learning.

PM looked after catering for the Trust and asked Abbie if she would share her experience. Abbie responded that before the ward had moved to Trinity this had been working fine. After the move there was a new company providing catering. There was a long time where food did not arrive on time; for example, food was sometimes two hours late for lunch. This caused unnecessary anxiety. It would have helped if patients could have made food on the ward. Abbie had been at another hospital with Sodexho providing the catering and had had the same issues. She hoped that it worked better now. It had been hard at the time to deal with the challenges around food. PM asked the ward staff if they felt the situation had improved since Abbie had been a patient. The staff said that it was better. December and January had not been good as someone in the catering team had left. The staff now had monthly meetings with the Director and this had been positive and there had been fewer food concerns raised on

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the ward. There had been some teething issues with timely food delivery but overall service had improved.

BB thanked Abbie for her reflections on the ward environment for patients with Autism. Plans were to make the Tolworth wards more Autism-friendly. The Trust had a lead nurse for Learning Disability and Autism and were working with Autism-friendly environments documents. He asked Abbie if she had any suggestions on ways to make wards more Autism-friendly. Abbie responded that Avalon ward in the Trinity building had sensory bits and quiet spaces. Staff training should be a key part. In other places she had had a lot of sensory input with an Occupational Therapist to design her own sensory profile/ladder to help her remain stable. This had been really helpful.

The Chair again thanked Abbie for coming in and talking to the Board about her experience as a patient of the Trust. She thanked Abbie for being honest. It was important for the Board to know where to do things better and it was important for the Board to hear first hand what it feels like as a patient receiving care.

24/21 Apologies and welcome

Apologies were received as listed on page 1 of these minutes.

24/22 Declarations of Interest

No new declarations of interest were received.

24/23 Chair's Action

No Chair's Actions had been taken since the last meeting.

24/24 Minutes of the last meeting

The minutes of the meeting held on 11th January 2024 were approved as a correct record with the following amendments:

- Page 6 stated that Modernisation Committee were challenging SIREN reports. This was incorrect as the Committee does not see the SIREN reports. They had been reassured by the Executive triangulating data from the reports.
- Page 5 - "outside of SWL" should read "across SWL".
- The asterisks needed review on voting members in the attendance list.

24/25 Action Tracker

The action tracker was noted and updated as below:

24/09: Culturally competent workforce: The PCREF (Patient and carer race equality framework) describes six 'national organisational competencies' that set out what a 'culturally competent' Trust is. QSAC received an update on PCREF in Oct 2023 and would receive the next update in May 2024, which will set out areas of focus and associated actions. These will be explored in consultation with ethnic minority communities and staff. It was agreed that this action be moved to QSAC action tracker and be reported back to the May Board via the QSAC Chair's report – action to be closed.

24/15 Digital Board seminar: The digital seminar was planned for June – action to be closed.

24/26 Chair's Report

Reported:

- This would be the last formal Board meeting for two of our Non-Executive Directors (NEDs):
  - VK was stepping down after seven years at the Trust. He had started as an Associate NED and then progressed to a full NED role and was the Chair of FPC. VK's NED role was out to recruitment at the moment. The Chair thanked VK for his enormous contribution to the Board and for the clarity which he brought to finance.
  - CC was stepping down as University NED as she was busy with work at the University (St George's, University of London - SGUL) and so was unable to

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commit to another term with us. AB thanked her for her challenge. SGUL is merging in August with City University to become City St George's, University of London. Once the merger had been completed, the Trust would liaise with the new Vice-Chancellor about filling the NED vacancy. It was noted that the University merger may have implications for the Trust name.

- The Board would also be looking to recruit an Associate NED with particular focus on Health Inequalities, to strengthen the Board in this area.
- There had been amendments made to the Remuneration Committee Terms of Reference, to ensure it was in line with changes to the new version of the NHS Code of Governance.

The Board noted the Chair's report.

24/27 Chief Executive Officer's Report

Reported:

- The Edenfield report was out for consideration. One of our NEDs, JW, had been involved in the review. The CQC would be doing a special review at Nottingham. There would likely be more special reviews to come in the context of increasing demand for mental health services, increased complexity and acuity and increased waiting times. The Trust was doing all it could to avoid situations like Edenfield, including via review of these reports. BB and SS had completed a self assessment using the Edenfield recommendations. A quality governance health check had also been commissioned; this had now concluded and the recommendations were being monitored via QSAC.
- We held our annual Quality Awards which celebrated our staff.
- Our staff survey results were recently received. There was a large amount of information, which was included in the appendices of the CEO report. There was more work to do but also the need to recognise the good work. This year had one of the best response rates in Trust history - 64% response rate. We were the 15th most improved Trust, going up from 44 to 34. Nearly 60% of our staff would recommend us for care, which was an improvement. 80% of our staff say patient care and safety is important for the organisation. 64% of our staff would recommend us as a good place to work. It was important not to 'comfort seek' and cherry pick the results. It was recognised that certain staff groups were not feeling as positive. Work was ongoing to understand why that was.
- The challenge for the Trust was to do better and take forward learning from the survey with our Annual Delivery Plans (ADPs) for the coming year. Focus would be on three key areas:
  - fair career progression, particularly for BAME staff;
  - reducing violence and aggression; and
  - supporting patients and staff with managing stress and anxiety.
- It was important to continue the journey towards being positively and proactively anti-racist. It was not good enough just to say we were not racist. We needed to show we were anti-racist in all that we did as a Trust.
- The Trust was working on resetting the EMHIP project in Wandsworth. Things would then move on at pace with wider system colleagues, in order to improve health inequalities for our public.

Discussed:

JW raised the very low scores in the staff survey around feeling safe to report incidents and feeling worried about the Trust's response to incidents, especially in light of the Edenfield report findings. He asked what the Trust was doing in response to this. SS responded that clinical front -ine staff had a high percentage for reporting incidents, but there was more to do to ensure clinical front line staff feel safe to report incidents. There were low levels of reporting in corporate functions such as Estates and HR. We needed to understand the exact issue for these functions. The initial plan

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was to remind corporate teams how to report incidents and explain how incidents were responded to and how to escalate; there would be parallel work to unpick the reasons for the low levels of reporting. BB added that he had spoken to consultants and medical staff regarding the Freedom to Speak Up (FTSU) Guardian service. JK had spoken to a group of medical staff this week to discuss the staff survey and deep dive. The Medical Advisory Committee had decided to have a working group to look at how best to improve staff survey responses from clinical staff and their confidence to speak up.

Fair career progression was moving in the right direction but there was still some distance to travel. Our BAME leaders at some bands were stuck, and the staff survey showed that BAME staff across all levels felt that career progression was not fair. This was not just about leadership but about people feeling developed and that there was a future in our organisation for them, and that the leadership want to help push them forward.

JuA supported the focus on key areas, as this had been key to success with the ADPs over the last 12 months. She was pleased that teams would be provided with support to develop their own action plans. She asked what the Trust would be doing where there may be an issue with a specific leader. KR responded that there would be some work to understand the data, to indicate if team effectiveness was not at the right level. There would then be work to look at the reasons why and appropriate interventions e.g. using Organisational Development (OD). AB added that the Trust expected all managers to live its values. The first course of action would be encouraging with interventions to get staff to the right place. We have to be brave enough for those individuals who have not responded as well as we would like, to say we are committed to our values and being an anti-racist organisation, and if you cannot live those values we cannot tolerate that. What we do would send an important message. JK added that the staff survey data had identified a handful of teams showing the least positive experience. Each team would be offered a series of interventions to improve using QI, psychological safety, mentoring and support from improved teams, and potentially bespoke OD support. There would be a point where if we did not start to see engagement and improvement something further would be done. SA added that we know racism and discrimination cause trauma to staff and leads to lower quality care.

HA raised that this Trust had done a lot of work to improve EDI but the data suggested it was not improving. Something more radical or transformative needed to happen. The Board was not as diverse as the staff and populations we serve. Staff had mentioned that the Board was not representative. AB responded that improving diversity was a high priority for our current NED/ANED recruitment.

SS noted that violence and aggression was worrying for our staff. She was hearing similar concerns from Chief Nurses across London in mental health inpatient services.

The Trust remained completely committed to reducing Health Inequalities. BB, AB and VF would be meeting with EMHIP staff in a couple of weeks. BB, Emdad Haque and Malik Gul of EMHIP had been working hard on the reset. The reset was an important next step.

The Board noted the Chief Executive's report.

24/28 Quality and Safety Assurance Committee (QSAC) Chair's report

Reported:

- One of QSAC's long term lived experience members, David Hobbs, had passed away very suddenly in January 2024. The Committee had spent some of the

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February meeting talking about and appreciating the contribution he gave to the Trust, the Committee and the wider community.

- QSAC reviewed the independent review on the Trust's quality governance systems. The helpful report made a number of suggestions for improvement. Overall the feedback on our systems and processes was good.
- There had been focus on some areas consistently - reduction of restrictive practice and observations; and some new areas - emergency responses e.g. the alarm system and the response of staff to both mental and physical health emergencies; plus waiting lists and how to be assured people were waiting well.
- QSAC would continue to look at some staff behaviours that were causing concern.
- The Committee would continue to study in detail the most significant SIs in full.

Discussed:
The Board gave appreciation of the contribution of David Hobbs. He was consistent, thoughtful and helpful and gave advocacy on behalf of our patients and staff.

The QSAC Chair's report needed to be amended as it should not say falsification of records but records being completed retrospectively.

The Board:

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

24/29 Quality and Performance Report

Reported:

- Performance continued to be stable with areas of challenge in acute and urgent care services and some children's services.
- IAPT services were meeting access and recovery rates. It was important to celebrate how well they had done and there would be work on how to improve other services with learning from IAPT.
- Neuro services had extremely high demand and there was not sufficient capacity to meet demand. It was noted that benchmarking showed the Trust were performing better than other Trusts. The Trust continued to work with system partners to design a new neuro pathway and there was an initiative to try to reduce waiting list times. Data on outcomes and on delivering improvements for patients was being collected.
- There would be a deep dive on access and outcomes presented to QSAC.
- There had been a lot of work on adult pathway transformation this year in a challenging context. Improvements for our patients ahead of acute crisis needed to be made in a timely way. This would continue to be a focus.
- There was continued work with liaison services for adults in EDs.
- We were thinking about how we work across the SLP and the ICS on complex care.
- Workforce performance and experience data was being triangulated with SIREN, FTSU and other reporting. Improvements had been made in vacancy turnovers which was positive, but there was more to do around experience.

Discussed:
Whether outcome scales such as paired dialog and paired HoNOS were being phased out. JeA responded that the Trust were moving to using Dialog+ and were phasing out clustering. There would be focus on using HoNOS if this was best for patients.

It was noted that the upper and lower control limits for outcomes scales and turnover rates needed resetting. JeA confirmed that they would be reset this month.

KR raised that concerns remained around some medical posts in the Community. Turnover overall had started to drop, partly due to career progression. Innovation to

Item		Action

create a pipeline into Community from volunteers and apprenticeships was being considered.

The Board noted the Quality and Performance Report.

24/30 People Committee Chair's Report

Report:

- MAST continued to be an important area of focus for the Committee.
- SS had committed to quarterly reporting on post-incident staff support.
- Staff turnover was reducing and vacancies were being filled. People Committee received positive feedback from the community recruitment events. Borough career events were currently being planned.
- Sickness absence cases were reducing. Key issues were stress and burnout. This was reflected in the staff survey results.
- The Committee continued to monitor the agency use target.
- Engagement work to develop a workforce strategy was taking place. The EDI team were setting up a BAME forum and dashboard to go alongside the strategy.
- The Committee received three detailed reports on staff survey, FTSU and the Health and Wellbeing (H&WB) Guardian. There had been a slight increase in the number of concerns raised since this time last year. Positively this showed staff were using the services available. A lot of contacts were to do with communication and engagement with managers. There seemed to be increased anxiety over finances, stress and burnout. The next step would be to triangulate data from these three sources with the Appreciative Inquiry data to give a picture of the culture of the Trust and to consider what was needed to do to improve it.

Discussed:

There would be a focus on teams with concerns that we know from the staff survey rather than waiting for the triangulation work. SA responded that the triangulation work would be part of the OD hub work, which was a longer term piece of work. The OD consultants were reviewing the staff survey themes as part of their work.

KR raised that there was a dedicated MAST lead who would be in place for six months. He had been and would be meeting with Service Lines to give them support to do their training. The visits so far had been well received and it was hoped that there would be an increase in compliance.

PM raised that in January the Trust was at 4.3% agency use, a dramatic improvement of 3% from this time last year. Next year the target would reduce to 3.2%. As the SWL system was likely to be in deficit next year, it may mean national teams would impose a further 0.5% challenge which would bring our target down to 2.7%. Reducing agency use was not just important to meet this target, but our staff and patients do not get as good an experience with agency staff, and every agency person costs around 25% more to the taxpayer. KR, JeA and PM were picking up actions and were sense checking them with BB and SS to ensure that any proposals were best for our patients.

KR raised that five nurses from Ghana attended the community recruitment day. The Trust were working to convert their qualifications and were bringing them onto our workforce as HCAs. Feedback from a ward manager was that they had employed one person from the day who was brilliant. Formal evaluation of the event would go to People Committee this month.

KR raised that a large proportion of agency use was related to medical staff; however, we were one of the few Trusts who did not have any off framework Doctors. Last week

Item		Action

we received up to date agency guidance and the Trust were already complying with the recommendations, which was really positive.

The Board:

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

24/31 Audit Committee Chair's Report

Reported:

- Reporting requirements had not changed and there were no issues coming up for the accounts.
- There had been good progress on the outstanding internal audit actions. There were a few actions on the Data Protection Toolkit but these were in hand as the reporting deadline for the toolkit was 31 March. There would be an update on this for the next Board.
- At next week's Committee the draft annual opinion from internal audit was expected. It was expected to be broadly consistent with what was reported in year.
- There had been helpful discussion about the calibration of risk appetite for the Board Assurance Framework.
- DL had done an excellent piece of work on the changes to the NHS Code of Governance. The Trust was compliant on most of the new recommendations and for those where it was not compliant, actions were in place. For example, the Remuneration Committee Terms of Reference had been updated.
- The Committee reviewed the annual accounts and focused on the valuation approach to Trinity and Shaftesbury buildings.
- The Committee noted the Events After the Reporting Period (EARP). The Committee asked the Board to note that there had not been any EARP and this had been formally reported.
- RF thanked VK and CC for being stalwart members of Audit Committee. Their contributions had been appreciated and valued.

Discussed:

JuA raised that the internal audit plan stated an audit around transformation was planned for 2026/27. As most of the transformation projects would be completed by then, she asked what would be audited and if there was value to waiting.

JuA raised that the gateways review was scheduled to take place next year but may be of value to take place in the year after. RF responded that this did warrant a separate review as it was a large project. He would expect the audit to look at the benefits realisation. PM added that the Committee reflected every year on next year's audit plan and discussed if they were scheduled for the right time or if they should be brought forward. The scope of the audit was negotiated between the lead director and the auditor.

VK asked about the internal audit plan for Cost Improvement Programmes (CIPs). This was supposed to come back to FPC and PM was going to look at it when it came back. RF said that this would be picked up in next week's Audit Committee meeting.

The Board:

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

24/32 Finance and Performance Committee (FPC) Chair's report

Reported:

- The annual modern slavery statement had been reviewed by FPC but also required Board approval.
- The Trust was on track to get to its required position by the end of the financial year, subject to audit.

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

Item **Action**

- The Committee discussed financial performance alongside benchmarking data.
- The Committee received an update on the productivity work. There had been a lot of work to help our clinicians understand how productivity leads to better outcomes for our patients, and to get their buy in to the work. The Committee would do more on this and the best way to demonstrate efficiency.
- The January Committee focused on looking at Health Inequalities from a finance perspective. Thanks to KR, a visitor from NHSE who had been part of the COVID vaccine roll out attended and gave some interesting insights as to how Health Inequalities were considered in the roll out:
  1. It was difficult to pin down the monetary value of how much the Trust spends on Health Inequalities. Trying to work out costs may not deliver value.
  2. Having data that showed where Health Inequalities were was a good starting point. Once you have the data you can use it to address Health Inequalities with either money or resources. The vaccines team had discovered certain social groups were not taking up the vaccine; they then could implement actions to make a real difference. The FPC were focusing on Health Inequalities data at the moment.
  3. Bringing along and getting buy in from clinicians, the public and Board members would be key in moving forwards.

Discussed:
That Estates and Digital were enablers to help deliver the transformation work. A plan for Digital would be designed over the next year, as well as what benefits could be derived from this plan, and this would be overseen by FPC.

AB thanked the FPC for their work. She noted that the Health Inequalities work in the January meeting was prompted by a question from Malik Gul of EMHIP at the last Annual Public Meeting. She suggested asking the community what they would hope to see in terms of addressing Health Inequalities might be helpful to fully answer the question. CC added that it had been a really good presentation, highlighting that it was not just about all groups of patients accessing services but where should the Trust be investing more to provide more or deliver in a different way for particular groups.

The Board

a. approved the Modern Slavery Statement.
b. noted the FPC Chair's report.
c. received the approved Committee minutes.

24/33 Monthly Finance and Savings Reports

Reported:

- The Trust should be delivering a break even or better position. The plan was a £1m surplus.
- Agency use continued to be a concern and there was a need to reduce the use of non-Trust beds. The Trust spent around £15m a year on the latter.
- National had raised that across systems there was an issue in delivering efficiencies and reducing waste. The Trust were not at the target of 62% of recurrent savings this year. Our system would likely remain challenged and next year would be a very challenging year for all of the NHS. It was important to keep our focus on becoming more efficient and ensuring every penny we spend benefits our patients. The Trust had agreed that for next year it would submit a plan of break even. The Trust needed to consider if it could deliver a small surplus of a quarter of a million pounds. That leaves the Trust with a similar efficiency challenge to this year.
- Planning returns were due to be submitted on 21st March 2024. There was still no formal guidance from National.

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

Item		Action

The Board:

a. **noted the finance and savings reports.**
b. **agreed to formally delegate 24/25 planning approval to FPC.**

24/34 Modernisation Committee Chair's report

Reported:

- There had been an extraordinary meeting on the 2nd April to approve the Tolworth Full Business Case which would then require approval by the Board on 11th April before external submission to the Treasury.
- There would be a London Borough of Wandsworth planning committee next Tuesday where plots x, y and z would be on the agenda. If planning permission was received, the sale would fund works at Tolworth. The submission to the planning committee had an officer's recommendation for approval, subject to discussion and debate by the elected members of the committee.
- There had been two deep dives on the Community and AUC transformation work.
- Recruitment into Community had been successful with 40 new roles and 140 new staff. Embedding the roles had been challenging. HR would be reviewing how to make the career pathway between the roles clear.
- There were ongoing recruitment challenges for clinical roles.
- Improvements had been reported in access and waiting times for treatment. This may not be attributed to transformation work as similar improvement was seen in areas where no transformation work was taking place.
- Patient feedback had been positive with an increase in Friends and Family test scores across the transformation boroughs.
- Clinical teams had put a lot of effort into transformation work in AUC. It had been acknowledged how frustrating it had been to see that the desired impact on inpatient flow had not been achieved, however, there had been improvement in patient experience metrics and a reduction in complaints.
- The Trust had increased its voluntary and community sector (VCSE) partners from one to 23.

The Board:

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

24/35 Annual Delivery Plans (ADPs) – Quarter 3

The Board noted the Annual Delivery Plans Quarter 3 update.

24/36 Questions from the public and staff

The Board had received several questions in advance from the public. These were included in a table which is on page 11 of these minutes.

24/37 Meeting review

AB welcomed the increase in the number of questions from members of the public as this helped the Board be more accountable.

Martin from Healthwatch Wandsworth said that from an outsider's perspective the papers for the meeting were as important as the meeting itself and contain a great deal of information on the work of the Committees. He would like a clear description of what SIREN was, on the Trust's website.

24/38 Next Public Board

Thursday 9 May 2024, 10:45am, Conference Room B, Trinity Building, Springfield Hospital.

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

Question	Sender	Response
VANESSA FORD (CEO REPORT) 1. Within Vanessa Ford's report, what are the main recommendations from the 'Too Hot to Handle' report that SWLSTG will be seeking to address and take on board? 2. Within 'Improving the Patient Journey' stated that people with complex mental health needs are being seen in the wrong parts of the system, what are the possible reasons for this?	Shaniah Williams, WCEN	1. The ELT received a paper from the Chief People Officer and Director of Communications, reflecting on the recommendations from Too Hot to Handle the week before last. This covered our current ambitions around anti racism, the commitment from Board, and that anti racism is reflected within our leadership development in partnership with BRAP. We also launched new recruitment and selection training with BRAP this month. The recommendations will continue to be kept under review. 2. One of the main ways we see this happening is patients accessing Emergency departments for urgent mental health care when they do not have a physical health need, which is not always the best environment or most timely way for them to receive the care they need. There are many possible reasons for this, for example access and waiting times for MH services, social support available to patients, training and confidence of primary care and other professionals to work with patients with complex mental health needs, and patient knowledge and confidence in available alternative services. We are working to improve access to community services for patients, particularly those with complex needs, and to enhance our crisis alternative offers. We are also working with partners such as acute trusts and the police and ambulance services to support and train colleagues in mental health skills, as well as improving how we direct patients in crisis to more appropriate settings where possible, such as via the new NHS111 Press 2 for MH service.
3. From Vanessa Ford's report in the section Improving the In-patient Journey, has the reduction in S136 also equated to a similar reduction for black and brown people?	Darren Blades, WCEN	3. The changes around the S136 pathway are being analysed at London level to determine the impact so far for people from different ethnicities and to identify further work that could be done to support our ambition within the London Crisis Concordat of reducing inequalities in the use of S136 for these groups. This work is led by the Joint Mental Health and Policing Group which is overseeing work on the Right Care Right Person programme; and is supported by the NHSE London MH programme of work to improve S136 pathways.
4. Concerning the Patient Experience friends and family test (FFT) scores have been improving, can this data be drilled down into ethnicity and does this	Darren Blades, WCEN	4. Ethnicity data is only collected through SMS or CAMHS ESQs feedback so it is not consistent throughout all feedback mechanisms and not on a large scale. The improvement in the overall performance on FFT is largely down to the focused work around increasing the response rates for FBL submissions. These are anonymous, and ethnicity is not collected. A lot of work has been

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Question	Sender	Response
data show signs of improvement for the BAME community?		done to monitor key KPIs against EDI criteria and we are strengthening the reporting dashboards and reporting via Committee reporting. We also monitor the impact of PCREF and EMHIP work on our communities. We do monitor our compliments, complaints and incidents through an EDI lens.
5. The minutes of a meeting of the Estate Modernisation Committee in September 2023 record concern about the internal waits for psychological therapies and mentioned plans being developed to address this. The same issue was mentioned at a meeting of QSAC in February when it was stated that there was a plan to do a waiting list initiative for the internal waits for psychological therapies. Has any action yet been taken on this and, if so, with what results?	Martin, Healthwatch Wandsworth	5. A waiting list initiative proposal has been formulated and put forward to the SWL Integrated Care System for approval, in line with our current financial authorisation framework. We await the outcome of this. We have already undertaken market testing and identified potential waiting list initiative partners and will be able to start implementation as soon as approval is gained. We would anticipate that the impact on the waiting list would be seen through the first six months of next year. Alongside this, we continue to recruit to vacancies and to support staff through our clinical efficiency programme, in order to do as much as we can internally to achieve and maintain lower waiting times.

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ACTION TRACKER – for March 2024 Board

BOARD OF DIRECTORS (Part A)

Meeting	Ref.[i]	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**	The government's response to the rapid review into data on inpatient Mental Health settings was not yet published. As soon as it has been published the Board would consider a position based on the government's recommendations.
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						
11/01/2024	24/15	**MC Chair's Report**	CC, JuA, PM and JeA to meet to think about what a board seminar on digital might look like.	**CC / JuA / PM / JeA**	**TBC**	The digital seminar was planned for June – action to be closed.
11/01/2024	24/09	**QSAC Chair's Report**	A paper to come back to the Board that lists a shared vision of how the Trust would know that it has a culturally competent workforce and when do we think we might achieve this by.	**BB**	**14/03/2024**	The NHS England's advancing race equality framework, PCREF (Patient and carer race equality framework) describes six 'national organisational competencies' that set out what a 'culturally competent' Trust is. QSAC received an update on PCREF in Oct 2023. It will receive the next update in May, which will set out our areas of

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ACTION TRACKER – for March 2024 Board

BOARD OF DIRECTORS (Part A)

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
						focus and associated actions. These will be explored in consultation with ethnic minority communities and staff. It is suggested that this action be moved to QSAC action tracker and be reported back to the May Board via the QSAC Chair's report. Action to be closed.

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

Report Title:	Chair's report
Name of Meeting:	Trust Board – Part A
Date of Meeting:	9 May 2024
Author:	Ann Beasley, Trust Chair
Transparency:	Public

Purpose:	☒	**Approval**	☒	**Discussion**	☒	**Information**	☐	**Assurance**

What?	This is the Chair of the Trust Board's report to the May 2024 Board.
So What?	The report sets out information on: • NED and ANED recruitment update. • A summary of recent Board activity. • Board visits. • Rapid review into data on mental health inpatient settings: government response.
What Next?	The Board is asked to: 1) note and receive this report.
Appendices/Attachments:	Rapid review into data on mental health inpatient settings: government response

Strategic ambitions this paper supports *If this is not completed the paper will be returned*	☒	Increasing quality years	
	☒	Reducing inequalities	
	☒	Making the Trust a great place to work	
	☒	Ensuring sustainability	

IMPLICATIONS	
Equality analysis *[linking to EDI strategy]*	The new Leadership Competency Framework includes a number of measures around equality issues.
Health Inequalities	The new Leadership Competency Framework includes a number of measures around health inequalities issues.
Service users/ carers	The Board visits programme is designed to ensure that Directors have regular direct contact with patient services and patient experience.
Estates	Board activity has included consideration of a number of commercial estates matters.

Financial	Recruitment for a NED to be the new Chair of the Finance and Performance Committee, with financial qualifications stated as desirable.
Legal	Advice has been sought on the implications of the merger of SGUL with City University, London, which has been reported previously.
Reputational	None specific.
Strategy	None specific.
Workforce	The NED and ANED recruitment is taking place currently.
Sustainability e.g. Green Plan	None specific.
Other (specify):	None

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

CHAIR'S REPORT TO THE MAY 2024 BOARD

NEDs and ANEDs recruitment

Vik Sagar and Charlotte Clark sadly left the Trust Board in April 2024. Arrangements for a new University NED will be confirmed soon, taking into account the current merger process between SGUL and City University, London.

Recruitment for the NED role to Chair Finance and Performance Committee has been successful, and the appointee is currently going through the necessary recruitment checks. Once they are formally appointed I will update the Board further.

As we have two NED vacancies on the Board, it was decided to recruit an Associate NED (ANED) with a focus on Health Inequalities, in order to further our Board commitment to consider Health Inequalities in all we do. Happily we found two wonderful candidates who would further this commitment from a BAME and Disabilities perspective. They are currently going through the necessary recruitment checks. Once they are formally appointed I will update the Board further.

Board activity

The March Board part B discussions covered areas including the Outline Business Case for Soft FM Services, the BAF, risk appetite, committee chairs' reports and serious incidents.

The April Board seminar received two presentations; one on EDI and Health Inequalities, and one on how the Board can embed Quality Improvement (QI) methodology in everything we do, especially in respect of supporting the delivery of our Annual Delivery Plans (ADPs) – to improve flow through our services (most specifically our adult acute pathway) and to value and stabilise our workforce.

Board Visits

The monthly Board visits programme is proceeding with valuable opportunities for Directors to hear regularly and directly from the frontline.

During March and April, the Board visited the following services:

- Oak Unit
- Hume Ward
- Kingston and Richmond EIS
- Sutton Talk Therapies (SPA/PLRS)
- Wimbledon RST
- Kingston
- Single Point of Access Team (SPA)
- Seacole Ward
- Ellis Ward
- Lilacs Ward
- Lotus Assessment Suite and 136 Suite
- Morden IRH
- Wandsworth Physical Health Learning Disabilities Team

In future my report will detail some of the follow up actions that we have taken following our visits. This will also be reported to QSAC.

Rapid review into data on mental health inpatient settings: government response

The Government response to the independent 'rapid review' into mental health patient safety, was published on 21 March 2024. The review was commissioned to produce recommendations to improve the way data and information are used in relation to patient safety in mental health inpatient care settings and pathways, including for people with a learning disability and autistic people.

Recommendation 5 focuses on Provider Boards and recommends that "every provider board should urgently review its membership and skillset and ensure that the board has an expert by experience and carer representative"; and that this would be assessed by the CQC. The government response to this recommendation was that "Provider boards should … consider how the voices of carers and family members are currently heard and acted on at board level. This includes the expectation that there is an expert by experience and carer representative on all provider boards".

It is important for the Board to properly consider this recommendation, and ensure this is taken forward with co-production with patients, considering Health Inequalities, and how it can best work with our current governance structures. Therefore this recommendation is being considered by a small working group being led by the Chief Nurse and including the Trust's Involvement team, and they will report back to the Board in due course on what they recommend as the best way forward. We are keen that this is not just a 'tick box' exercise and brings value to the Board and our patients and carers. I look forward to receiving the recommendations in due course.

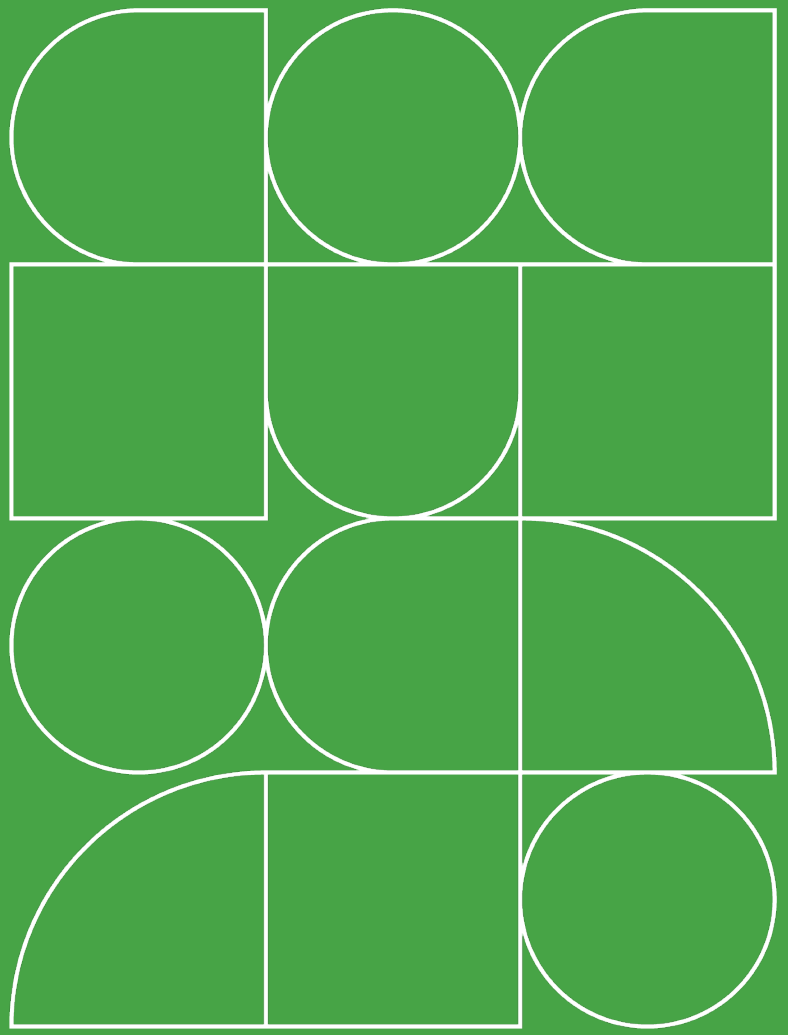
Recommendations

The Board is asked to:

1) note and receive the 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
May 2024
Respectful
Open
Collaborative
Compassionate
Consistent

Contents

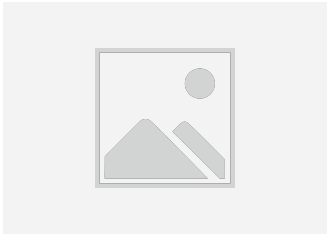


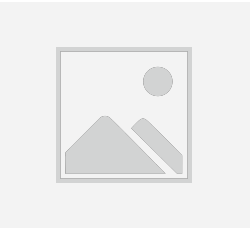
Our Trust

Our staff, alongside our patients, are our main asset. 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!

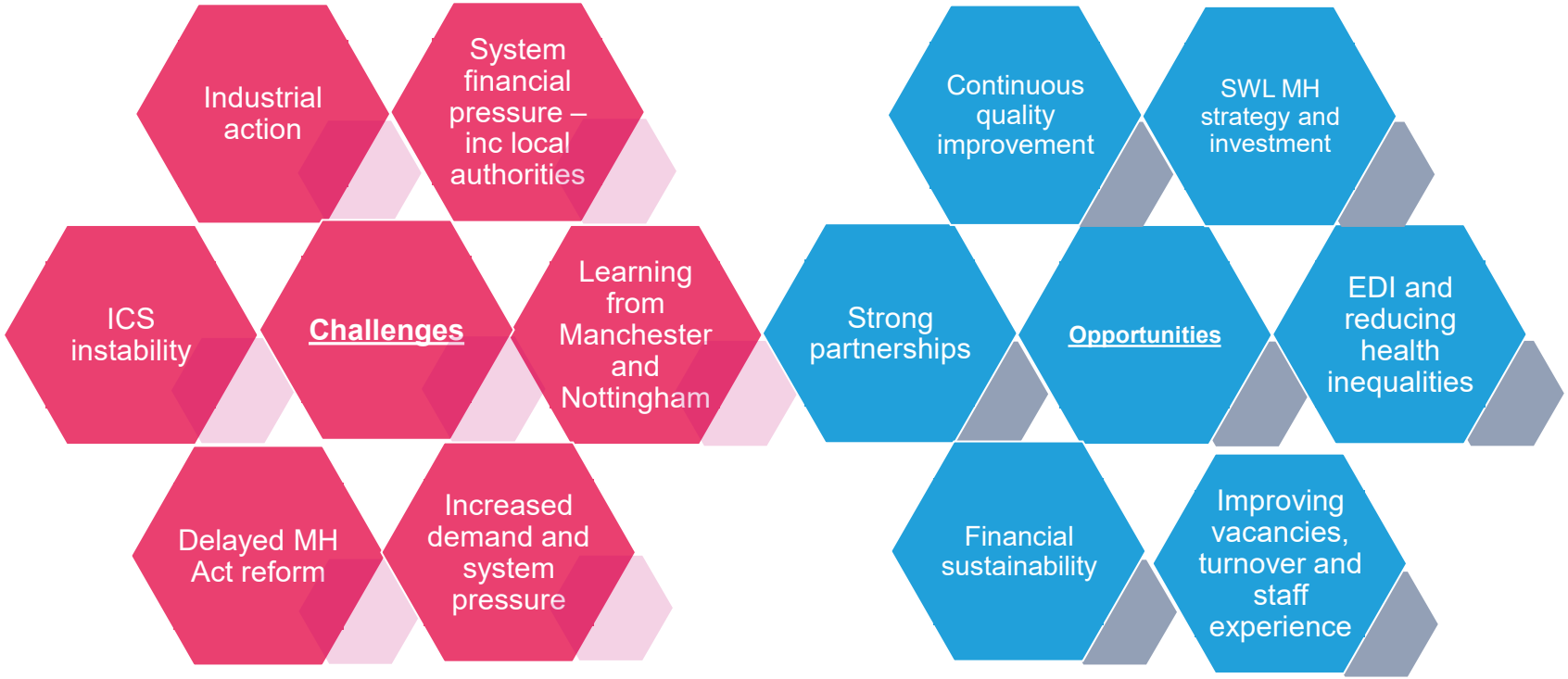
[8 March – Chief Executive update]
[15 March – Chief Executive update]
[22 March – Chief Executive update]
[29 March – Chief Executive update]
[5 April – Chief Executive update]
[12 April – Chief Executive update]
[19 April – Chief Executive update]
[26 April – Chief Executive update]





Our context

There are a number of external pressures on our organisation and the NHS, and there are opportunities too!



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Our context

While there has been increases in investment and access, a treatment gap still remains, and demand and acuity are increasing

ADDITIONAL FUNDING HAS SUPPORTED TRANSFORMATION OF SEVERAL DISTINCT PATHWAYS ACROSS LONDON, INCLUDING:

- Community Mental Health Transformation: £145M to expand and transform integrated models of primary and community mental health care.
- Children and Young People's Mental Health: £70M to improve CYPMH services.
- Perinatal Mental Health: £37M to expand services.
- £30M to expand services for people experiencing mental health crisis and contribute to eliminating out of area placements.

POST PANDEMIC WE ARE SEEING INCREASING NUMBERS OF PEOPLE ACESSING MENTAL HEALTH SERVICES IN LONDON:

Each month, we see increasing numbers of people supported by our core mental health offer, including:

- Increasing referrals to children and young people's mental health services, 12,5K in February 2024, an increase from 7K in 2019; 15,5K referrals to adult community mental health services in the 12 months to February 2024, an increase from 8K in Feb 2019;
- Long waits for access to community mental health services, with the majority of people still waiting to access 2+ contacts waiting 12 weeks +.
- The percentage of beds occupied by people deemed clinically ready for discharge continues to increase, with significant variation across London – we also know data isn't a true reflection of the pressures, and that true position is likely ~20%.
- The number of bed days for Out of Area Placements is increasing exponentially and London is significantly off-track to deliver expected targets.

DESPITE RECORD INVESTMENT AND INCREASED ACCESS, A SIGNIFICANT TREATMENT GAP REMAINS:

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

- ***London is currently funded to deliver access to talking therapies for 25% of the population, and sees 22% annually.***
- ***Treatment gap: 750K people***

TALKING THERAPIES FOR ANXIETY AND DEPRESSION

- *There are ~400K CYP in London with a mental health need, we currently see 25% of this population.*
- *Treatment gap: 75%*

ADULTS WITH SEVERE MENTAL ILLNESS

- *There are ~800K adults in London with a Severe Mental Illness, currently there are 87K people on the CMH caseload.*
- *Estimated treatment gap: 89%*

= 100k people with MH need.

5

Improving quality

Reviews of Greater Manchester and Nottinghamshire Healthcare Mental Health NHS Foundation Trust

- Further work is on-going in relation to findings from a CQC rapid review from the Nottinghamshire review which will be triangulated with the learning from this Manchester review work (below)
- We have undertaken a comprehensive review of the findings from the Manchester review to consider key areas of learning to enhance our patient care and safety in pursuit of best practice
- The detailed review work is scheduled to be presented at Quality & Safety Assurance Committee (QSAC)

CQC Community Mental Health Survey 2023

- While we have seen some improvements particularly with planning care and support in accessing care, there is further work needed to improve respect and compassion, support while waiting and medication information
- We are looking in detail into these areas to help us fully understand and address any gaps to ensure further improvements are made. This will be supported by the post implementation learning review for community transformation. This will be reported through our Quality & Safety Assurance Committee (QSAC)

Suicide prevention strategy 2024

- We have launched our new strategy which was co-produced with “Hold the Hope”, a group of SWLSTG services users and carers who have a lived/living experience of suicide or supporting those in suicidal crisis.

Draft Annual delivery plans 2024/25

Each year we have set annual plans to support the delivery of the strategic ambitions. This year we are focussing in on our two biggest challenges.

Supporting annual deliver plan areas:

1. **Quality –** holistic care planning; DIALOG; PCREF; EMHIP
2. **Better Care –** acute, community, CAMHS transformation; core offer development. Digital
3. **Partnerships –** SLP; SWLMH Provider Collaborative

Supporting annual deliver plan areas:

4. **People –** Fair career progression; reducing violence and aggression; health and wellbeing; leadership and development; speaking up
5. **Better Environments** – Tolworth; Barnes; Richmond Royal; green programme; anchor and community
6. **Sustainability** – Shift to substantive workforce; increased productivity

QII methodology as the enabler and approach for delivery

Did you know?

- **Average length of stay** – increased to 47.7 days. Led by those with the longest stays (90+ days)
- **Demand** – Increased between pre-Covid and now: 8% in acute, 40% in community
- **External beds** – increased and we are operating with two additional external wards
- **Health inequalities -** Disproportionate representation in the most restrictive settings for Black people
- **Experience** – improvements in FFT scores (86.5% positive)

- **Turnover** – reduction in turnover to 13.3%
- **Recruitment** - reduction in vacancy rate to 15.1%
- **Agency** – reduction in agency spend to 5%
- **Experience** – significant improvements in 5 of 9 staff survey areas.
- **Anti-racism**
  - Ethnic minorities report lack of fair career progression at every band
  - Plateau of progress in increasing Ethnic Minority leaders
  - Reports of microaggressions still prevalent

Improving patient journey

- We are continuing to experience high demand across our health system, which has seen increased pressure on mental health - especially adult acute and community services
- To address these challenges, our Adult Patient Journey transformation programme is being evolved to integrate work across community, crisis and acute settings with a focus on the overall patient journey and supporting teams to work together
- The voice of patients/carers and patient experience is central to the development and delivery of the programme and is being embedded in the programme structure.
- The programme will hone our focus on the fundamental standards of care and recovery outcomes as the measures for our transformation work - care being purposeful, timely and least restrictive, avoiding crisis and recovery focused.
- Specifically we are looking at:
  - **Discharge Challenge** - new purposeful admission content and 3-month pilot of new Enhanced DTOC structure - with positive initial feedback.
  - **Length of Stay** - deep dive analysis into the drivers of length of stay. This will be used to inform next steps for the flow and clinical transformation plans
  - **Mental Health in ED:** Transformation of our Psychiatric Liaison team continues and the Kingston extended triage trial remains in discussion
  - **NHS 111/Section 136** South London hub launched as 24/7 service following full recruitment

Quarter 4 2023/24

Length of stay: 47.7↓ days vs 38 day end of year aim

Presenting in crisis: 1.5% ↔ vs 1.1% end of year aim

Inappropriate out of area: 427↓ bed days vs 0 end of year aim

Reduced delayed transfers of care: 12.9%↑

Friends and family test: 86.5% net↑ positive vs 81% end of year aim

8

Reducing health inequalities

Collaboration with Community Empowerment Network (CEN) and next steps for EMHIP

- We worked in collaboration with CEN and co-Chaired the Healing our Broken Village recall conference. We made pledges around our ambitions to tackle health inequalities, and to further face our services outwards, towards the community

Implementing PCREF

- Ongoing implementation of PCREF, supported by the Task and finish group.
- We have been updating the Part 1 action plan and we commit to completing PCREF Parts 2 and 3 self-assessment and action planning in 2024/25.
- This involves partnering with system stakeholders
- Map of Trust actions to advance race equities

Embedding EMHIP and PCREF into service lines enhances the likelihood of better outcomes.

Now

- Ongoing learning and evaluation
- Expansion of key interventions – inc hubs (Battersea and Roehampton)
- Align EMHIP with community transformation
- Ethnicity audit and dashboard
- Expansion of lived experience project towards a Rights and Justice approach

Next

- Implement new services and support for people with SMI in the community
- Enhanced support for people with longer mental health needs
- Specialist support for those who have multiple MHA admissions
- Community involvement in inpatient care
- Continued work around crisis alternatives
- Cultural mediation

Great Place to Work

- **Continued 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, for example medical vacancies. We are working with teams to develop workforce plans to support them to further improve recruitment and retention. To support a new approach to marketing consultant roles we are currently engaging with a recruitment marketing specialist.
- **Fair Recruitment:** We are committed to deliver a new Recruitment Policy which considers the feedback received to far, and goes further to ensure our processes are fair and open. Recruitment Bias training continues, we are designing a new area on insite to share all internal opportunities via secondments, acting up and project opportunities – this will be live in May 2024.
- **Following from our community careers event:** Of the 114 individuals engaged in meaningful conversations, 93 participants were recommended for job offers, and, so far, 30% have been offered roles within the Trust.
- **Career Progression:** During May we will be engaging with various groups to determine the initiatives needed to deliver an improvement in career progression. We are also planning an internal careers event as we recognise many in the organisation would like to move across service lines but don't know how to or what skills they would need.
- **Leadership Development:** Our Inspire Programme, aimed at our most senior leaders launched on 25th April and 1 to1 career coaching sessions are in place for our Deputies. Cohort 2 of Steps for our Band 8a/7 managers and ACD Action Learning Sets are just about to launch. Finally, 10 of our Black, Asian, and Minority Ethnic Leaders graduated from the South West London leadership course

Quarter 4 2023/24

Vacancy rate: 15.1%↓ vs 15% end of year aim

Turnover rate: 13.3%↓ vs 15% end of year aim

Turnover within 12 months: 24.4%↓vs 15% end of year aim

Staff Survey advocacy score: 6.9↑ vs 6.9 end of year aim

Sickness rates: 5%↑ vs 3.5% aim for LDN MH trusts

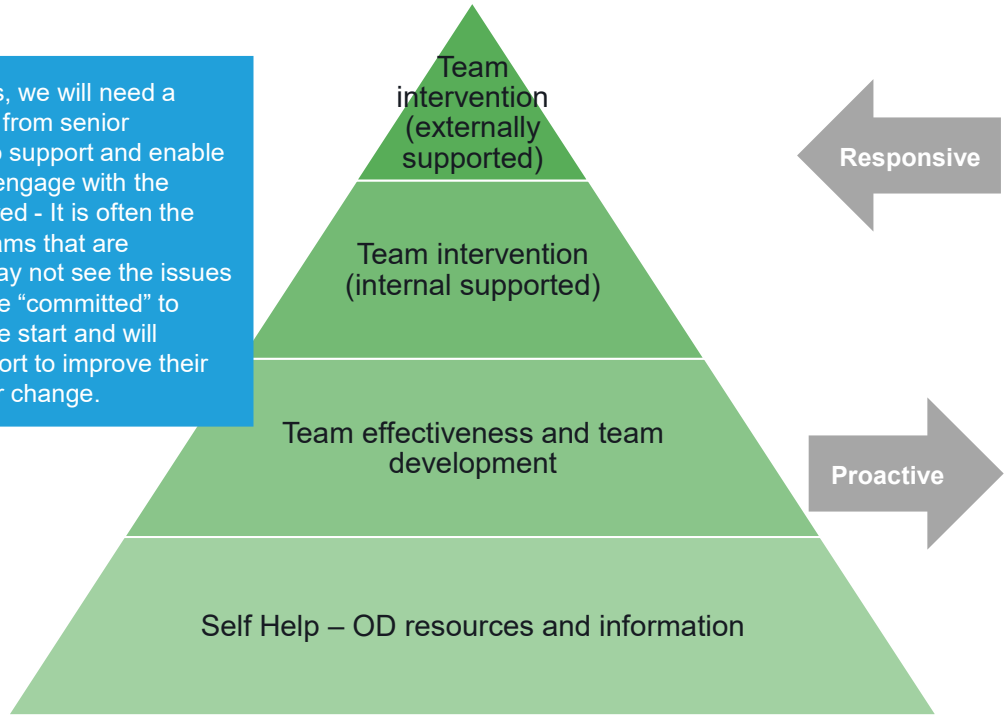
Agency rate: 5%↓ vs 3.6% end of year aim

10

MLBT Development Centre: our offer

The MLBT DC will offer a range of advice, guidance, support and interventions to suit the needs to the team and the team leader (using data and triangulation for example from the staff survey). The DC will also ensure our patients and carers voices are heard and acted upon. This will range from self help – to more formal OD intervention in the team.

- ✓ Within teams, we will need a commitment from senior leadership to support and enable the team to engage with the support offered - It is often the case that teams that are struggling may not see the issues and so not be "committed" to change at the start and will require support to improve their readiness for change.



The Development centre will:

- ✓ Triage all requests for support and prioritize based on SIREN, staff survey and other data
- ✓ Support for those teams that most need it (both self referred and targeted)
- ✓ Teams will be offered specific appropriate interventions
- ✓ May be internal, or externally commissioned

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

MLBT Development Centre: Team Effectiveness

- The Senior Leader's Seminar (for our 100 top leaders) on 30 April was the first in a short series designed by the MLBT Development Centre on team effectiveness, which is a key part of our MLBT Framework.
- This sessions followed three sessions designed to look at different aspects of leading change.
- This session was led by Dr Justin Earl, Associate Medical Director for Quality Improvement and Innovation, and Organisational Development specialists, Demola Soremekun and Giuliano Tosto,
- The April session offered support for leaders to understand their role in team effectiveness, both as a leader and member of a team and specific ideas for experimentation.

Quality improvement and accountability

The four stages of psychological safety

A model for accountability

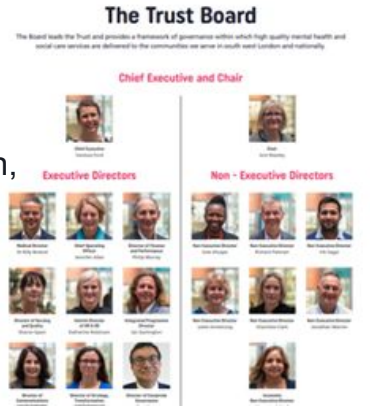
- **Accountable:** The person who is ultimately answerable. There must (almost always) be only one accountable person specified for each task or deliverable
- **Responsible:** Those who do the work to achieve the task. They have responsibility for getting the work done or the decision made
- **Consulted:** The people whose opinions are sought. Typically subject matter experts or key stakeholders
- **Informed:** People that are affected by the outcome of the tasks, so need to be kept up-to- date

'Its not just what you do... its the way that you do it!'
Be intentional and consider impact

- At the worst/most difficult times we (the leaders) must be at our best
- Achievements are made in/by teams - not spectacular individuals (although it is always great to have plenty of these!)
- When times are tough people and teams tend to play out their worst characteristics
- We have a responsibility to be mindful and create environments where team effectiveness is prioritised.
- Remember no team is an island!

The work of our Executive Advisory Group

- **Executive Advisory Group:** Our 5th Executive Advisory Group took place in March. We focused on our work to become an actively anti racist organisation, facilitated by BRAP, the leading national equality and human rights charity.
- The group focused on fair recruitment, career progression, and our response to microaggressions
- We had a deep dive in career progression (which is one of the priorities coming out of the 2023 staff survey) looking at the complexity of the problem. The group will meet again to agree high impact focus areas.
- **Anti-Racism values into behaviours:** Through our Action Learning Sets we have developed 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 have 12 senior leaders on the next London White Ally course.
- **Too hot to handle:** we are looking at the important recommendations that are coming out of this new report and how they can shape our work



Better Communities: A new look and all change at Barnes and Tolworth

Better Environments

Tolworth

- At Tolworth Hospital, early works to dispose of old and unused buildings in the center of the site are progressing well alongside infrastructure and landscaping works
- Construction of new hospital facilities will begin pending final funding and approvals.
- Housing development on the former Springfield University Hospital site in Wandsworth, will unlock £49m to support funding of Tolworth
- Whilst the plans were supported by Wandsworth planning officers, the scheme was narrowly refused by Councillors at Committee in March 2024
- We are confident in the development proposal following two years of work with planning officials. We believe that it offers best value for housing (with 50% affordable) and supports the redevelopment of Tolworth Hospital
- We are supporting Barratt London with appealing the decision

Barnes

- Removals of old and unused buildings at the Barnes Hospital site will also progress this spring following the completion of site set up works in May.

Engagement

- Stakeholder forums and newsletters continue for our communities at both Barnes and Tolworth to ensure the local community is informed and engaged across both programmes of work.

Better Communities: A new look and all change at Barnes and Tolworth

Better Communities

- ‘New-look’ branding has been developed for Better Communities to support the next four years of the Trust transformation programme. Key messaging has been co-created with patients and service users to feature in a refreshed programme brochure to launch in the spring.

Better Care

- Community Transformation is in the process of going ‘live’ in Merton and Wandsworth. Patient leaflets have been updated for issue, and communications updating on the changes have been shared with stakeholders including GPs and other Primary Care colleagues. We are now moving into a period of consolidation and learning.
- We are continuing our move away from the Care Programme Approach (CPA) towards a new model of care for our patients (including the introduction of *DIALOG+*). This is a huge change affecting nearly everyone who works directly with our patients.
- All service pages on the Trust website have been updated accordingly and a celebration event marking the transformation of adult community mental health services across all boroughs in South West London is being planned for Wednesday 19 June.

Celebrating our teams

First Community Careers event

Trust Deaf Advisor featured on TV show

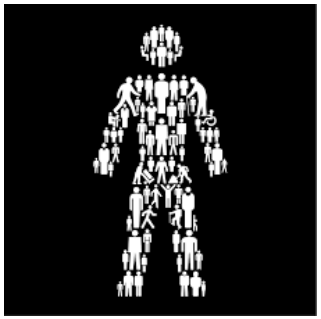
Raising money for Trust Charity at London Marathon

Awarded Silver Lived Experience Charter status

New ACP graduate

NHS Kingston Talking Therapies

Welcome to Kingston Talking Therapies



Men's Support Group delivers prostate cancer awareness

Exceptional People Award winner

Launch of first DBT team in Wandsworth

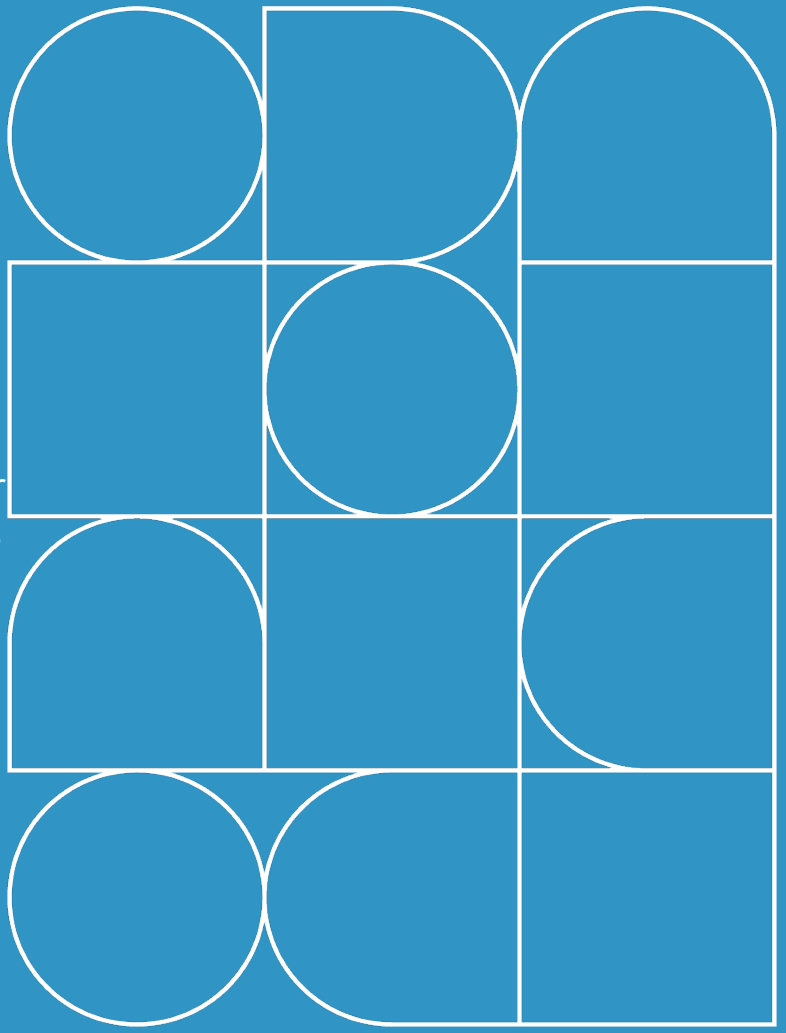
Clozapine monitoring pilot launched

2024 preceptorship quality mark 2024-2026 CAPITAL nurse

Preceptorship programme awarded two Quality Marks

Questions and points to have in mind

1. Are we doing all we can to develop our continuous improvement approach, particularly focusing on our two key challenges: Adult Patient Journey and Great Place to Work?
2. Clinical engagement will be a vital part of turning the dial on our Adult Patient Journey - what can we do to further engage multi-disciplinary clinical decision making in this challenge?
3. It is clear there is more we need to do to reduce health inequalities, especially racial disparities. Are we investing our resources in the best way and using the data we have to target the right areas? And what more can we do to turn our services to face our community?
4. We continue to see challenging national reports into mental health services. How confident are we as a Board that we are cited on the issues and mitigations across our services?



Appendix 1: Horizon Scanning

QUALITY

Duty of candour review - GOV.UK
Government confirms scope of Essex mental health inquiry - GOV.UK (www.gov.uk)
Death certification reform and the introduction of medical examiners - GOV.UK (www.gov.uk)
Regulation 9A: Visiting and accompanying in care homes, hospitals and hospices – CQC guidance
Expert Panel: Evaluation of Government's progress on meeting patient safety recommendations (parliament.uk)
CQC well led guidance: Guidance for NHS trusts and foundation trusts: assessing the well-led key question
CQC patient survey – community mental health: Surveys - Care Quality Commission (cqc.org.uk) [subject of a separate Board briefing]
NHS England » NHS to launch cross-sector ADHD taskforce
Autism: Overview of policy and services - House of Commons Library (parliament.uk)
NHS England » The Reasonable Adjustment Digital Flag action checklist
NHS England's Response to the Final Report of the Independent Review of Gender Identity Services for Children and Young People

WORKFORCE

Sexual safety in the NHS: survey results and update on charter implementation
NHS staff have been shown porn and offered money for sex at work | UNISON
End of NHS consultant strike action as government offer accepted - GOV.UK (www.gov.uk)
NHS Providers submission to DHSC call for evidence on a separate pay spine for nursing
NHS Providers submission to the NHS Pay Review Body 2024/25 pay round
Fit Note Reform: call for evidence - GOV.UK (www.gov.uk)

ESTATES

NHS England » NHS Premises Assurance Model

DIGITAL

Cyber security budget faces 50% cut (HSJ)

RESEARCH

NHS England » Self-assessment of organisational readiness tool (SORT)
NHS England » Managing research finance in the NHS

SUSTAINABILITY

Sustainability reporting in the NHS (hfma.org.uk)

Appendix 2: Use of Trust seal

Date	Type	Signatories
29/02/2024	Deed of Variation Deed of Variation for Tolworth s106 Between SWLStG and Kingston Council.	Chief Finance Officer Chief Strategy Officer
29/02/2024	Early Works Warranty Early Works Warranty and PDG for Tolworth Between SWLStG and Robert McAlpine	Chief Finance Officer Chief Strategy Officer
29/02/2024	Lease Lease of substation 5 plot G Springfield Between SWLStG and the Electricity Network	Chief Finance Officer Chief Strategy Officer
03/04/2024	Lease Tolworth Hospital Telecoms Lease Between SWLStG and EE Ltd.	Chief Finance Officer Director of Communications and Engagement

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

Report Title:	2023/24 Annual Delivery Plans – Q4 delivery
Name of Meeting:	Trust Board
Date of Meeting:	7 May 2024
Author(s):	Leah O'Donovan, Deputy Director of Strategy & Transformation
Executive Sponsor(s):	Amy Scammell, Director of Strategy, Transformation & Commercial Development
Transparency:	Public
Scrutiny Pathway: *If this is not completed the paper will be returned*	ELT – 18 April 2024 People – 23 April 2024 FPC – 25 April 2024 Modernisation Committee – 7 May 2024 Quality & Safety Assurance Committee – 7 May 2024

Purpose: *If this is not completed the paper will be returned*	☐	**Approval**	☒	**Discussion**	☒	**Information**	☐	**Assurance**
Additional information:								

What?	Each year, a set of organisational annual delivery plans (formerly known as corporate objectives) are developed to support delivery of the Trust Strategy. The Trust Board in May 2023 approved the proposed set of annual delivery plans for 2023/24 following discussions at the Executive Leadership Team, within the Executive Advisory Group and at Trust Board development sessions. The agreed priorities for 2023/24 were to (1) improve patient journey through our services (most specifically our adult acute pathway) and (2) value and stabilise our workforce. In this context, we continued to progress strategic delivery through our existing annual delivery plan structure while we also identified and elevated a smaller set of work areas, the aim of which was to support us to successfully address our challenges and deliver against those 'top priorities.' The 2023/24 annual delivery plans were: 1. To empower service users and carers to ensure their experience informs quality improvements in practice and services. Our focus is on the care planning and safety planning. 2. To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences. Our focus is on implementing the Patient and Carer Race Equality Framework (PCREF), delivering the Ethnicity and Mental Health Improvement Project (EMHIP) and embedding EDI and health inequalities in our services.

3. To support our people to grow and develop our organisation to be the best we can be. Our focus is on getting the HR basics right, recruitment, retention and leadership, learning and development.
4. To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL. Our focus is on reducing agency and external bed use and improving clinical and corporate efficiency.
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.
6. To proactively develop partnerships and act as a system leader driving strategic improvements to mental health of the SWL population. Our focus is on mental health provider collaborative development and the SWL MH Strategy delivery.

For each annual delivery plan, key delivery items were outlined with the intended timescale for delivery. Key outcomes or metrics were included to enable monitoring of delivery of the objective. Baseline measures were agreed where these were available. Finally, our first four annual delivery plan were mapped directly to one of the Trust's four strategic ambitions – effectively acting as annual work programmes for that ambition. The remaining two areas – transformation and partnerships – were considered as enablers for all strategic ambitions.

Quarterly reports on progress were made throughout 2023/24 to ELT, committees and the Trust Board using the established RAG rating system illustrating both progress and outcome delivery as follows:

- Progress: Red – milestones off track and unrecoverable; amber – milestones partially on track with recovery planned and manageable; green – milestones all on track.
- Outcomes: Red – undelivered; amber – some improvements delivered but full delivery not achieved; green – metric/ target met in full. Outcomes will be assessed at year end but where data is available through the year (for example financial delivery) a indication of progress towards the outcome will be included

Reporting on the top priorities focused on delivery against target with patient and staff experience as balancing measures. This reporting had greater oversight on a monthly basis via ELT and related metrics are highlighted in red within the report and are included in the below table setting out full year performance against these top priority metrics:

Metric	**Baseline (22/23)**	**Target**	**Final achievement (23/24)**
Friends and Family Test (FFT) net positive score	70.66%	81%	86.5%

Reduction in overall staff turnover and turnover of those with less than 12 months service with the Trust	18% and 21.5%	15% tolerance	15% and 24.9%
Reduction in vacancy rate	19%	15% tolerance	16.8%
Improvement in staff advocacy score in quarterly pulse staff survey and annual staff survey	5.2 and 6.7	6.4 and 6.9	5.98 and 6.9
Reduction in agency spend in line with new national target	7.1%	3.6%	4.4%
Increase in activity per WTE (productivity metric) towards 15 units per month (changed from 15 to exclude Inpatient wards, better reflecting Community activity)	12.45	15	24.5
Bed reductions to original 18 Holybourne and, then to 12	63,435 OBDs	18 beds (60,390 OBDs) 12 beds (58,194 OBDs	66,922 OBDs
Zero inappropriate out of area placements	1,715 OBDs	0 OBDs	2,068 OBDs
Reduction in average Length of Stay	47.7 days	38 days	49.2 days

This paper provides the Q4 2023/24 and year-end annual delivery plans update highlighting a summary of work completed and any outstanding elements. Notes on work that has shifted to 2024/25 have been included.

Key points to note in Q4 include:

	• **Quality:** DIALOG+ training has been delivered on a 'train the trainer' approach and workshops are in development for Q1 24/25 on developing the key worker role. • **EDI and health inequalities:** The evaluation of EMHIP remains delayed with partners externally but we have agreed a revised timetable for the important evaluation, which should be delivered by December 2024. Our internal enabling strategy has been drafted and will be signed off by the end of April 2024. Work to better understand health inequalities across our services is still progressing. This will move forward into 2024/25. • **People:** Significant work continues to be delivered on People milestones, including the establishment of the Coaching and Mentoring network and development of the People Strategy, which shifts to 24/25 for completion. Workforce plans have been completed along with recruitment and retention plans. A significant achievement in February 2024 with the first Community Recruitment Careers Event: 140 attendees with many turning into new recruits. • **Sustainability:** Our work on clinical efficiency is showing positive impacts in some areas supporting our productivity agenda. E-workflows project is now looking at finance and clinical forms. Agency reduction savings remain challenged and it is not likely we did not achieve the year-end target. • **Transformation:** The new Community model has been implemented in Merton and Wandsworth. Discharge Challenge workstreams continue to embed but are not yet having an impact on lengths of stay. The work to improve our psychiatric liaison services continues and will shift to 24/25. There are significant challenges to our Estates Modernisation Programme with much of the delivery needing to shift to 24/25 due, in part, to the refusal of planning permission and its impact on delivery of Tolworth. • **Partnerships:** Good progress with both the ICS and SLP this year in moving forward the SWL MH Strategy, Partnership Delivery Group, Complex Care and SLP cases for change, but timescales for key pieces of work are having to extend due to their complexity.
So What?	Annual delivery plans remain an effective way of defining delivery requirements of the Trust on an annual basis. The identification of top priorities around flow and people for 2023/24 was intended to support the Board and Board committees to focus directly on a small number of work programmes with specific metrics. It was also intended to make progress and delivery more clearly measurable. In terms of delivery there is much for us to be proud with real improvements being seen in some key areas as noted above. The areas for improvement are clear and having fewer priorities has enabled leaders to focus efforts where we believed most impact would be made. There is still work to be done to simplify and clarify communication of priorities through the organisation – the 2024/25 priorities paper streamlines our delivery further. During 2024/25 we will also continue to shift to a focus on outcomes impact.

What Next?	Delivery against any outstanding 2023/24 Annual Delivery Plans has been considered in the development of the 2024/25 Annual Delivery Plans. The Board is asked to: • Note the Q4 and year-end 2023/24 delivery
Any specific issues to note and/or for escalation:	None
Appendices/Attachments:	

Strategic ambitions this paper supports *If this is not completed the paper will be returned*	☒	Increasing quality years	This paper supports all four strategic ambitions as it details delivery against our 2023/24 annual delivery plans, which are directly linked to delivery of our strategic ambitions.
	☒	Reducing inequalities	
	☒	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	
Equality analysis *[linking to EDI strategy]*	**Positive** – Delivery of equality, diversity and inclusivity is everyone's business. EDI work begun in previous years has continued and developed in 2023/24 within a specific annual delivery plan aligned to the 'Reducing Inequalities' strategic ambition within the Trust Strategy.
Health Inequalities	**Positive** – Delivery of health inequalities work is critical for the Trust and this area has progressed in 2023/24 within a specific annual delivery plan aligned to the 'Reducing Inequalities' strategic ambition within the Trust Strategy.
Service users/ carers	**Positive** – Delivery of our annual delivery plans and top priorities supports improving care for our service users and their carers. Impact of our work is being measured through service user and carer feedback and the Trust scores on the nationally recognised Friends and Family Test.
Estates:	**Positive** – Delivery of the Estate Modernisation Programme (EMP) remained a key organisational priority in 2023/24.
Financial:	**Positive** – Financial delivery was a key focus in 2023/24 with a specific annual delivery plan aligned to the 'Ensuring Sustainability' strategic ambition within the Trust Strategy. Work described under the 'top priorities' element all contributed to improving efficiency and reducing financial pressure.
Legal:	N/A
Reputational:	**Positive** – Delivery of annual delivery plans in 2023/24 continued to support the Trust's reputation with stakeholders.
Strategy:	**Positive** – Annual delivery plans continue to support delivery of the four strategic ambitions of the Trust Strategy. Work to progress delivery for the SWL MH Strategy in 2023/24 also added renewed strategic focus.
Workforce:	**Mixed** – Workforce is arguably the greatest risk the Trust faces. Our people remain under pressure and we have challenges with recruitment and retention. The annual delivery plan focused on continuing to develop our HR service and tackling core workforce issues. In addition, 'stabilising and valuing our workforce' is one of our two top priorities for 2023/24 with key targets.
Sustainability e.g. Green Plan:	**Positive** – Work around transformation, EMP and improved flow all contribute to delivering against the sustainability and green agenda within the NHS.

Other (specify):	

Q4 2023/24 Annual Delivery Plans

Annual delivery plan 1: To empower service uses and cares to ensure their experience informs quality improvements in practice and services.
Key outcome: Successfully commence holistic care planning, risk assessment and safety plans as part of changes to Care Programme Approach (CPA).
Outcomes/ Metrics:

- Numbers of service users with a DIALOG in place - % of caseload (**22/23 average: Dialog assessment recorded in the last 6 months (%) – 11.6%) Q1 – 20.9%; Q2 – 23.7%; Q3 – 31%; Q4 – 36.2.%**
- Numbers of service users with a DIALOG care plan - % of caseload **TBC – not yet available as a measure**
- Increase in number of safety plans in place - % of caseload **TBC – not yet available as a measure**
- Increase in % risk assessments reviewed within last 12 months (**22/23 average: Community patients with an up to date risk assessment (%) – 91.9%) Q1 – 91.4%; Q2 – 92.4%; Q3 – 91.8%; Q4 – 91.2%**
- Increase in % Always Ready care planning audits completed **(22/23 average – 78.4%) Q1 – 75.7%; Q2 – 79.6% Q3 – 77.1%; Q4 – 80.8%**
- Friends and Family Test (FFT) net positive score target 81% - **(22/23 average – 70.66%) June 23 – 72.8%; Aug 23 – 79.5%; Nov 23 – 81.0%; Jan 86.5%**
- Patient experience of changes monitored through Feedback Live! and through Service User and Carer Group feedback (to be reported quarterly through narrative). **This is not yet available as a measure due to delays in delivery of the programme; it will not be able to be reported on until 24/25**

Delivery priorities	Q4 2023/24 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 23/24 delivery	Year-end delivery rating
Embedding use of DIALOG/ holistic care planning, through co-production with service users and carers • Set up work completed – Trust-wide project group and service user and carer co-production groups in place; SU and carer development needs identified; DIALOG+ care plan standard operating procedure (SOP) and care planning standards signed off; RiO changes developed and in testing – (Q1) • Care planning training package developed (Q2) and delivered (Q3) • Care planning process piloted (Q3)	**Embedding use of DIALOG/ holistic care planning, through co-production with service users and carers** • Workshops will be delivered in Q1 2024/25 to develop the keyworker role, which will be tested with DIALOG+ and pilot teams in Q2 2024/25 and fully rolled out in Q4 24/25. • DIALOG+ training package due delivered in March on a 'train the trainer' approach to 15 members of staff. Development of in-house training to take place in Q1 24/25	All Q4 milestones delayed to 24/25	• The project group was established with service user and carer representation, and Project Lead recruited. • DIALOG+ care plan SOP created. • DIALOG+ ELFT care planning training package developed.	Safety planning, development of key worker role and care planning process pilot have been delayed due to capacity and recruitment of project support. Although project lead has been in place since January 2024 this has shifted this work to 24/25.	Good progress made on initial and preparatory work but majority of implementation has shifted to 24/25

• OD support for key worker culture changes identified and case management and key worker SOP signed off (Q3) • Dashboard adjustments in place – aligning to measure care planning compliance and quality (Q3) • Key worker role and new case management process piloted (Q3) and then fully rolled out (Q4) **Implementation of safety planning in alignment with a change in risk assessment** • Delivery piloted (Q1) • Pilot evaluated and adaptations made to the framework (Q2) • Interfaces identified between safety planning framework and DIALOG use and agree implementation plan (Q2) • Safety planning implemented (Q3-Q4)	**Implementation of safety planning in alignment with a change in risk assessment** • The implementation of DIALOG+ has been prioritised alongside the introduction of the key worker role. Safety planning has paused, and delivery is now expected to be Q4 2024/25.				

Annual delivery plan 2: To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences.
Key outcome: Anti-racism outcomes delivered for staff and patients.
Outcomes/ Metrics:

- Ethnicity dashboard developed **Achieved**
- Increase in numbers of BAME staff at Band 8A and above **(22/23 average 31.5%) Q1 – 31.2%; Q2 – 31.3%; Q3 – 31.4%; Q4 – 31.5%**
- Numbers of racism complaints reported
  - By patients **(22/23 baseline 7) Q1 – 2; Q2 – 11; Q3 – 10; Q4 – 11**
  - By staff **(22/23 baseline 13) Q1 – 7; Q2 – 22; Q3 – 29; Q4 – 20**
- Maintenance of improved staff survey results on EDI sections[1] (**2022/23: 47.6%; 70.5%; 77.6%) 2023/24 – 49.93%, 73.4%; 78.22%**
- Improved MWRES, WRES[2] and WDES scores[3] **This data is not yet available due to NHS England reporting deadlines; it will be available by end of Q1 24/25**

Delivery priorities	Q4 2023/24 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 24/25 delivery	Year-end delivery rating
Delivery of the integrated EDI Action Plan, including producing resources, tools and capability to support delivery and refresh of the EDI strategy • Health Inequalities and EDI programmes developed with borough system partners and Inclusion Matters Group established (Q1) • Resource portal for managers delivered (Q1) • Diversity in Decision Making, Executive Advisory Group, and Staff Networks evaluated (Q2-Q4) • Anti-racism training and seminars for staff and managers delivered (Q2-Q4) • Leadership Development Seminars and resources focused on anti-racism and culture change delivered (Q2-Q4) • Renewed strategy signed off (Q4)	**Delivery of the integrated EDI Action Plan, including producing resources, tools and capability to support delivery and refresh of the EDI strategy** • Diversity in Decision Making, Executive Advisory Group and Staff Networks evaluations completed. • The Enabling EDI Strategy 2024/25 is still in draft, and it will be finalised and signed off by the end of April 2024. **Embedding EDI and health inequalities** • Service lines have begun to embed work on health inequalities but further work is needed on: ○ Clear health inequalities outcome measures	Q4 deliverables in progress but delayed to 24/25	• Diversity in Decision Making, Executive Advisory Group and Staff Networks evaluations completed. • Anti-racism training and seminars along with culture change have been delivered.	• EDI strategy has been drafted and will be signed off in Q1 24/25. • Embedding of health inequality outcome measures across service lines will be developed with Health Inequalities and EDI teams supporting analysis of data for equality impact assessments. Delivery is now expected to be Q2 2024/25. • EMHIP evaluation is off track. A new timetable has been agreed with partners. Expected completion is now Q3 2024/25.	There continue to be significant delays to the delivery of EMHIP and internally embedding health inequalities in service lines, which shift to 24/25.

[1] For PP element on diversity and equality specifically Q15 (does your organization act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Baseline of 45.% in 2021, 47.6% in 2022), Q18 (2021)/Q20 (2022)/Q21 (2023) (I think that my organization respects individual differences (eg cultures, working styles, background, ideas, etc) Baseline of 67.1% in 2021, 70.5% in 2022) and Q7c (I receive the respect I deserve from my colleagues at work. Baseline of 75.6% in 2021, 77.6% in 2022).

Embedding EDI and health inequalities in service lines • EQIA guidance and template revised (Q1) • Outcome measures embedded and QI work in place across all service lines and analyse the impact on different groups (Q3) **Deliver EMHIP and support the implementation of the Patient and Carers Race Equality Framework (PCREF)** • Project plans agreed for all EMHIP key interventions (Q1) • Ethnicity dashboard completed and functional (Q1)	○ Embedding use of new Equality impact assessments • It is hoped this will be achieved by Q2 of 2024/25. **Deliver EMHIP and support the implementation of the Patient and Carers Race Equality Framework (PCREF)** • EMHIP evaluation has not been completed. A new time-table has been agreed by partners to procure evaluation by June 2024, to be completed by December 2024.				

[2] For WRES indicators improvements in (1) relative likelihood of BME staff entering the formal disciplinary process compared to white staff – 2021 2.24 (2) relative likelihood of white staff being appointed from shortlisting compared to BME staff – 2021 1.43 (3) relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff – 2021 0.77. In addition, gap reduction in WRES staff survey questions between white and BME respondents around (1) % of staff experiencing harassment, bullying or abuse from patients/ service users, relatives or the public, or staff in the past 12 months (Baseline gap of 2.4% and 8% respectively in 2021) (2) % of staff believing that the organisation provides equal opportunities for career progression or promotion (Baseline gap of 20.1% in 2021), and (3) % of staff experiencing discrimination at work from manager/ team leader or other colleagues in the last 12 months (Baseline gap of 10.1% in 2021)..

[3] For WDES indicators improvements in (1) relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff – 2021 0.72 and (2) relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff – 2021 11.45. In addition, gap reduction in WDES staff survey questions between staff without a LTC/ illness and staff with a LTC/ illness around (1) % of staff experiencing harassment, bullying or abuse from patients/ service users, relatives or the public, or staff in the past 12 months (Baseline gap of 2.5% and 8.1% respectively in 2021) (2) % of staff believing that the organisation provides equal opportunities for career progression or promotion (Baseline gap of 7.3% in 2021) (3) % of staff who have felt pressure form their manager to come to work, despite not feeling well enough to perform their duties (Baseline gap of 7.7% in 2021) (4) % of staff satisfied with the extent to which their organisation values their work (Baseline gap of 9.4% in 2021). Finally, also, improvement in % of staff with LTC/ illness who say the organisation has made adequate adjustments to enable their to carry out their work (Baseline value of 74.4% in 2021).

• EMHIP interventions around reducing restrictive practice and cultural capability developed and delivered (Q1) • Patient and Carers Race Equality Framework (PCREF) work programme developed (Q1) • Patient diversity data including impact of services on access, experience and outcomes published (Q2) • EMHIP evaluation commissioned and completed (Q3-Q4)					

Annual delivery plan 3: To support our people to develop and grow and develop our organisation to be the best we can be.
Key outcome: Stable HR function in place with solid improvements in recruitment, employee relations and health and wellbeing.
Outcomes/Metrics:

- Numbers of leaders accessing approach **65 attended in 2023/24**
- Attendance rate of leadership offer sessions **72% (65 of 90 spaces)**
- Reduction in overall staff turnover and turnover of those with less than 12 months service with the Trust (tolerance of 15%) – **(22/23 average – 18% and 21.5% respectively) Q1 – 17% and 24.4% respectively; Q2 – 15.8% and 25.9% respectively; Q3 – 13.8% and 24.7% respectively; Q4 – 13.3% and 24.4% respectively**
- Reduction in sickness absence rate **(22/23 average 4.9%) Q1 – 4.1%; Q2 – 4.4%; Q3 – 5.0%; Q4 – 5.2%**
- Reduction in vacancy rate (target of 15%) **– (22/23 average – 19%) Q1 – 18.3%; Q2 – 18.4%; Q3 – 15.3%; Q4 – 15.1%**
- Improvement in staff advocacy score in quarterly pulse staff survey and annual staff survey (targets 6.4 and 6.9 respectively) – **(22/23 average – 5.2 and 6.7 respectively) Q1 – 6.27; Q2 – 6.26; Q4 – 5.98 and 6.9**
- Maintenance and stretch improvement in staff survey scores (health and safety climate, negative experiences and support for work-life balance people promise elements[4]) and learning development (development people promise element[5]) **(2022/23: 55.4%, 41.1%, 54.1% and 71.1%, 56.5%) 2023/24: 55.7%, 37.5%, 58.5% and 72.4%, 59.8%**
- Qualitative feedback on leadership approach and offer gathered via feedback forms and reported quarterly via narrative update **Not yet available as programmes still in progress**

Delivery priorities	Q4 2023/24 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 23/24 delivery	Year-end delivery rating
Implement the Leadership Framework and associated Leadership Development offer • Leadership Development approach signed off and leadership development centres held to determine priorities (Q1) • Training needs analysis finalised (Q1) • Lunch & learn sessions (difficult conversations, flexible working, absentee management, etc.) delivered for frontline leaders (Q1-Q2) • Coaching and mentoring system established (Q2) • Training needs analysis findings implemented (Q2) • Talent strategy/ plan defined (Q3) • Key HR policies agreed (Q3)	**Implement the Leadership Framework and associated Leadership Development offer** • Talent Strategy is off track and has shifted to Q1 2024/25. Will now ensure it is reflective of feedback from Staff Survey and focus on Black, Asian and minority ethnic career development. **Produce and deliver clear workforce plan for each service line aligning to overarching corporate priorities** • Workforce plans in place with detailed actions for delivery against the plan being delivered by the Service Line with the support of the Business Partner.	Q4 milestones delivered or in progress and some delayed to 24/25	• Sickness Absence Training Established • Coaching and Mentoring Network live and seeking applications. • Stakeholder events took place as part of the development work to support the People Strategy.	• Training Needs Analysis pushed to Q1 – 2024/25 • Talent Strategy pushed to Q1 – 2024/25 • The work on developing a people plan is delayed and a first draft due Q1 2024/25	Signfiicant progress made in delivering the majority of work. Delays with Training Needs Analysis, Talent Strategy and People Plan has shifted to

• Talent strategy/ plan implemented (Q4) • Succession planning development in progress (Q4) **Produce and deliver clear workforce plan for each service line aligning to overarching corporate priorities** • Detailed action plans designed and implemented (Q1-3) • Draft 2024/25 workforce plan in progress (Q3) and completed (Q4) **Produce focused programme of work to attract and retain our people** • Data analysis completed with recommendations for action (Q1) • Revised approach implemented and evaluated (Q2-Q4) **Development work to support future People Plan** • Plan on a page drafted (Q1) and socialised across the Trust (Q2-Q3) • 2024/25 plan in progress: lessons learned and 2024/25 priorities set (Q4)	**Produce focused programme of work to attract and retain our people** • Recruitment and Retention plans included within workforce plan • First Community Recruitment Careers Event held on 2nd Feb – 140 attendees – a number of which have already been recruited • Working with the ICS on the Lord Mayors Programme and possible pilot of an app to support a different recruitment approach.				Q1 2024/25.

[4] For PP element on health and safety climate specifically Q11a (my organization takes positive action on health and wellbeing. Baseline of 56.4% in 2021, 55.4% in 2022). For the PP element on negative experiences specifically Q11c (During the last 12 months has you felt unwell as a result of work related stress? Baseline 43.4% in 2021, 41.1% in 2022). For the PP element on work-life balance Q6c (I achieve a good balance between my work and home life. Baseline 51.7% in 2021, 54.1% in 2022).

[5] For PP element on development specifically Q20c (2021)/Q22c (2022) (I have opportunities to improve my knowledge and skills. Baseline 70.3% in 2021, 71.1% in 2022) and Q20d (2021)/Q22d (2022) (I feel supported to develop my potential. Baseline 54.4% in 2021, 56.5% in 2022).

Annual delivery plan 4: To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL.
Key outcome: Review productivity overall programme governance, including effective oversight and monitoring to deliver productivity and efficiency.
Outcomes/Metrics:

- Reduction in agency spend in line with new national target (3.6% of pay bill) **– (22/23 average – 7.1%); Q1 – 5.6%; Q2 – 5.2%; Q3 – 4.4%**
- Increase in activity per WTE (productivity metric) towards 15 units per month (changed from 15 to exclude Inpatient wards, better reflecting Community activity)– **(22/23 average – 12.45); Q1 – 24.7; Q2 – 24.3; Q3 – 24.4; Q4 – 24.4**

Delivery priorities	Q4 2023/24 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 23/24 delivery	Year-end delivery rating
Implement the agency reduction plan • Existing process embedded and being used to monitor usage (Q1) • Processes reviewed to determine efficacy and monitoring in Q1 with plans for change implemented accordingly (Q2) • Processes reviewed quarterly and necessary changes implemented (Q3-Q4) **Implement Clinical Efficiency programme** • Clinical efficiency assessed by service lines and improvement plans, including use of digital tools, developed (Q1) • Service lines plans implemented and monitored (Q2-Q4) **Align transformation to deliver productivity to reduce the bed base** • Trajectory to deliver bed reduction by year-end agreed (Q1)	**Implement the agency reduction plan** • Agency savings remain behind plan further action required to support delivery. Further questions to the approval forms on Dashboards to be introduced following recent NHSE guidance on agency rules; support with a comms. piece for mgrs. / front line staff. **Implement Clinical Efficiency programme** • Clinical Efficiency - deep dive review presented at Delivering Value/ELT/FPC meetings in Feb 24. Service lines are reporting increased activity delivering above plan from May 23- Feb 24. Dip in activity in Dec 23 and March 24 due to the Christmas and Easter holiday period. • Job planning standard operating procedure to be finalised and issued.	Q4 milestones delivered but not yet impacting on agency reduction	• Further action required for agency savings. • Agency % of pay bill spend figures for M12 is 4.8%, down from 7% last year. • Clinical efficiency - delivery remains marginally higher than plan over the year despite the dip in activity expected over the winter and Easter holiday period.	Slippage on the savings delivery scheme for agency and clinical efficiency will be rolled over into 2024/25.	Good progress made on delivery of initiatives with impact on productivity but not yet on achieving sustained reduction of agency spend

Introduce workflows to improve corporate productivity (e.g. HR) • As-is scoped and opportunities for change identified (Q1) • Workflows amenable to change analysed and plans developed to implement (Q2) • Plans implemented (Q3-Q4)	• DNA reduction target <11%, March 7% change champions in place to support RiO waiting list management and use of Envoy 2 way text messaging service. • Rebooked cancelled slots bookings target >50% 11% in March • Clinical systems programme – Benefits tracking and staff feedback to be presented at the digital oversight group. **Introduce workflows to improve corporate productivity (e.g. HR)** • E-workflows project underway including finance and clinical forms.				

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.
Key outcome: Flow and outcomes improved across our services and Springfield Village now a reality.
Outcomes/ Metrics:

- Bed reductions to original 18 Holybourne (60,390 OBDs) and, then to 12 (58,194 OBDs) – **(22/23 baseline – 63,435 OBDs[6]) Q1 – 16,324; OBDs; Q2 – 16,354 OBDs; Q3 – 17,106 OBDs; Q4 – 17,138 OBDs**
- Zero inappropriate out of area placements[7] **(22/23 baseline – 1,715 OBDs) Q1 – 695 OBDs; Q2 466 OBDs; Q3 – 478 OBDs; Q4 – 429 OBDs**
- Reduction in average Length of Stay (target 38 days) – **(22/23 average – 47.7 days); Q1 – 52.2; Q2 – 45.1; Q3 – 52.2 days; Q4 – 47.7 days**
- Reduction in % of patients on caseload presenting to crisis services (target 1.1%) – **(22/23 average – 1.4%); Q1 – 1.5%; Q2 – 1.5%; Q3 – 1.5%; Q4 – 1.5%**
- Reduced DToCs **(22/23 average – 8.1%); Q1 – 10.6%; Q2 – 10.1 Q3 – 10.1%; Q4 – 12.9%**
- Waiting times in key areas reduced (Patients waiting less than 18 weeks for treatment at month end for Community and CAMHS respectively) **Q1 – 96.5% and 81.6%; Q2 – 96.3% and 72.4%; Q3 – 95.3% and 73.6%; Q4 – 94.2% and 77.2%**
- Number of patients waiting over 30 weeks for complex emotional needs or psychology and psychotherapy support reduced (targets of 20 and 400 respectively) – **Q1 – 64 and 711; Q2 – 47 and 755; Q3 – 25 and 788; Q4 – 31 and 738**
- Reported positive staff engagement in transformation work – (**Increase in staff understanding, confidence and positivity as evidenced on a scale of 1-10 through the Transformation Staff Monthly Survey) Q3: average 5.1; Q4: average 6.2**

Delivery priorities	Q4 2023/24 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 23/24 delivery	Year-end delivery rating
Integrated programme overall • Principles and scope of future integrated programme agreed (Q1) • Refresh of governance and structure completed and in place (Q1) **Clinical transformation** • CEN pathway fully implemented (Q1) • Community enhanced response service and interface team delivered (Q1) • New community model fully implemented in Kingston and Richmond (Q3) and mobilisation underway for Wandsworth and Merton (Q4)	**Clinical Transformation** • The new community model has been implemented in Wandsworth and Merton. • Discharge challenge workstreams have been implemented, with most recent areas of focus being the pilot of the Enhanced DTOC Structure and the launch of the new Gatekeeping Assessment Form that includes the new purposeful admission section. The work has not yet had the desired impact on flow, with an analysis of the drivers of length of stay being finalised to inform next steps in 24/25.	Some Q4 milestones delayed to 24/25	• Shaftesbury move completed. • CAMHS NDT pathway partially delivered with launch of single screening and pilot of digital screening in Kingston & Richmond. • Barnes early works in progress. • SLP patient health record is being co-designed with service users.	• CAMHS NDT pathway - Implementation of improvement ideas for the CAMHS risk support offer are with the quartet who will be reviewing these and identifying leads to roll these out in Q1 24/25. • Barnes main works can only begin once the contract is awarded. Estimated for Q3 24/25. Delay due to re-procurement of contractor.	Delays with moves and planning permission has shifted work considerably into 2024/25.

• Discharge challenge workstreams mobilised (Q2) and impact being delivered (Q4) • System level work to enable individuals to return to their own accommodation post admission progressed (Q3) • Psychiatric Liaison work to reduce readmission and re-presentation finalised (Q2) and implemented (Q3-Q4) • CAMHS communications protocol published (Q2) and pathway improvements implemented to the NDT and emotional difficulties and complex needs pathways (Q3) **Digital** • Clinical systems cleaned-up and RiO useability and functionality improved (Q1) • Ward workflows implemented across all wards (Q1) • Digital skills programme rolled-out (Q2-Q3) • IAPTus useability improved (Q4) • Patient health records implemented (Q4) **Organisational development and change support** • OD framework in place (Q1)	• Psychiatric Liaison – A working programme plan covering all work across the Crisis Pathway has been drafted. Completion now 24/25. • CAMHS NDT single screening went live in Q4 and the NDT digital screening pilot is in progress in Kingston & Richmond. **Digital** • Clinical systems programme refreshed and governance set up; scope and projects defined. Detailed programme plan to be signed off by SRO. • SLP patient health record programme scoped and preparing for tender. Co-designing key requirements with service users. **EMP** • Tolworth work delayed due to refusal of planning application.			• Richmond Royal estimated to be a year behind schedule with CAMHS move scheduled for Q3 24/25. • 5th Ward options appraisal is paused until the Tolworth FBC is approved. • Tolworth FBC – Submission of the business case delayed due to the refusal of planning permission at Springfield. • Tolworth Main Construction cannot begin until the Tolworth FBC is approved, which is paused until the planning process is completed. • Psychiatric Liaison – off track with completion shifting to 24/25. Workshops for digital and service improvement workstreams are in progress to finalise areas of focus for the working groups within these two	

[6] This includes only Adult Acute Beds

[7] This includes only Adult Acute Out of Area Placements

• Change support menu of options being accessed by staff (Q2) **EMP** • QMH moves completed (Q1) • Springfield Village park open (Q2) • Shaftesbury building completed and services operating (Q3) • Barnes construction commenced (Q2) • Richmond Royal completed and services operating (Q3) • Fifth acute ward options appraisal completed (Q2) • Tolworth business case approved externally (Q2) and conditions precedent met (Q4) • Tolworth enabling works package (Q3) and main construction (Q4) commenced				areas to take forward in 24/25	

Annual delivery plan 6: To proactively develop partnerships and act as a system leader driving strategic improvements to mental health of the SWL population.
Key outcome: SWL MH Provider Collaborative in place with first phase of delegation completed and delivery of SWL MH Strategy underway.
Outcomes/Metrics:

- SWL MH Strategy year 1 work delivered – Met, year 1 work complete; positive progress made. Year 2 plan developed.
- SWL MH strategic financial and delivery review completed – Partially met, work partially completed and will continue into 2024/25.
- Complex Care phase 2 year 1 delivered – Partially met, programme has taken longer to establish than planned and year 1 outputs not fully delivered.
- Perinatal provider collaborative in place – Met, with work now to move work forward needed.
- CAMHS and Adult Eating Disorder cases for change agreed – Partially met, AED case agreed and CAMHS case still to be developed.
- SLP business support revised and processes amended – Not met, will form part of work to implement SLP Fitness for Future review in 2024/25.

Delivery priorities	Q4 2023/24 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 23/24 delivery	Year-end delivery rating
SWL • SWL MH provider collaborative partnership delivery agreement in place (Q1) • SWL MH Partnership Delivery Group elements – planning, performance and oversight, sub-groups – in place and operating effectively (Q2) • SWL MH strategic financial and delivery review completed (Q3) • SWL MH Strategy year 1 delivery completed (Q4) **SLP** • Complex care delivery mechanisms updated to support phase 2 (Q1) • SLP business processes and structures refreshed (Q2) • Perinatal provider collaborative live (Q3) • CAMHS and AED cases for change agreed (Q4)	**SWL** • The SWL MH Strategy year 1 work is being reviewed and PDG will receive the final outputs on 23.04.24. A year plan 2 has been developed. • Work on the SWL MH Partnership Delivery Group (PDG)has progressed well over Q4 with a workshop held on 07.03.24 to discuss how to evolve our ways of working in 2024/25. • The SWL strategic financial and delivery review remains underway and this work, and lessons learned on the process, will move forward into next year. **SLP** • AED case for change has been agreed but CAMHS case for change has not been completed. Work across partners has been impacted by wider issues	Strategy delivery completed but SLP cases for change not completed	Positive work has been completed in both SWL and SLP partnerships during 2023/24. Many elements have progressed but timescales have extended due to complexity of work involved.	These work areas will continue into 2024/25 and form the core part or the enabling area around partnerships, led by the Chief Strategy Officer.	All areas have progressed but some goals – CAMHS case for change, SWL strategic financial and delivery review and SLP business processes and structures - have not been

	• Work on complex care and perinatal continue to move forward. • Work to implement recommendations to implement the SLP Fitness to Future review continues. This will carry forward into 2024/25.				progressed .

Report Title:	**2024/25 priorities**
Name of Meeting:	Trust Board
Date of Meeting:	9 May 2024
Author(s):	Leah O'Donovan, Deputy Director of Strategy & Transformation Amy Scammell, Chief Strategy Officer
Executive Sponsor(s):	Amy Scammell, Chief Strategy Officer
Transparency:	Public
Scrutiny Pathway:	Iterations of this paper have gone to: ELT: 21 Dec 23/8 Jan 24, 18 Jan 24, 1 Feb 24, 22 Feb 24, 7 March 24, 28 March 24 Board seminar: 8 Feb 24 Board: 14 March 24 People Committee: 23 April 24 Finance & Performance Committee: 25 April 24 Modernisation Committee: 7 May 24 Quality & Safety Advisory Committee: 7 May 24

Purpose: *If this is not completed the paper will be returned*	☒	**Approval**	☒	**Discussion**	☐	**Information**	☐	**Assurance**
Additional information:	N/A							

What?	Each year, a set of organisational Annual Delivery Plans (ADPs) are developed to support delivery of the Trust Strategy. In developing these, the Trust considers a number of key factors – delivery in the preceding year, existing pressures and challenges, our capacity and the external environment, for example. We aim, each year, to set ambitious yet realistic targets that will support the ongoing development of the Trust. Since December 2023, iterations of our proposed priorities and ADPs for 2024/25 have been discussed at ELT, the Executive Advisory Group and subject to a Board Seminar and Board Part B discussion and then through sub-committees in April 2024. Throughout these discussions, we have agreed that we need to continue to focus on a small number of high impact areas and communicate these clearly across our organisation. We also recognise that the work we need to deliver may not be completed in one year, and this speaks to the complexity of some of the challenges that we face. For 2024/25 we want to focus on 2 areas which provide opportunities to address our greatest challenges of flow through our adult services and workforce. Our proposed priorities are: 1. Improving our Adult Patient Journey 2. Making the Trust a Great Place to Work Following Board and ELT feedback, we have developed a vision and objective for each priority, defined the proposed outcomes and identified work to be delivered. We have also aligned enabling work to each area. We have also considered how Quality Improvement (QI)

	methodology and our Organisational Development (OD) framework can support delivery and will be aligning QI resource to each priority, with further plans for QI-informed staff engagement to shape the work to be delivered. The most recent iteration of this paper was considered at Board on 14.03.24 where the content was supported. It was agreed at that session that further work would be carried out to ensure each of the key areas is clearly focused with all necessary inclusions, has appropriately aligned outcomes and that QI and OD approaches are developed. This paper covers all these areas and provides the final content for our 2024/25 priorities for approval. Quarterly updates on progress will come to Board throughout the year.
So What?	Defining an annual set of priorities enables the Trust to direct attention and capacity. The iterative process of development allows us to learn from preceding years and take into account views from across the Trust. Focusing on fewer priorities enables the Board to direct energy into work that will have the greatest impact. This year we want to focus on not just *what* we do but also *how* we deliver. Building on both our QI and OD work in 2023/24 enables us to tackle some of our identified cultural patterns and also to further embed a QI mindset. We have an opportunity to define and embed a new approach to delivery through a QI lens by defining challenges and then constructing our aims and measures and deciding what changes to implement. Our work on our approach will provide us with rich feedback to support our ongoing organisational development.
What Next?	The Board is asked to: • Approve the 2024/25 priorities and Annual Delivery Plans and associated work programmes, targets and outcomes. ELT will progress next steps to ensure clarity around defined metrics, final targets and to communicate the priorities through the organisation, clearly, learning from previous years, and set up reporting and monitoring.
Any specific issues to note and/or for escalation:	N/A
Appendices/Attachments:	N/A

Strategic ambitions this paper supports	☒	Increasing quality years	This paper supports all four strategic ambitions as it outlines priorities for 2024/25 all of which support delivery of the Trust Strategy.
	☒	Reducing inequalities	
	☒	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	
Equality analysis *[linking to EDI strategy]*	**Positive** – EDI remains a core Trust priority and for 2024/25, recognising the progress made to date, EDI elements are embedded across both top priority areas.
Health Inequalities	**Positive** – Health inequalities remains a core Trust priority and for 2024/25, recognising the progress made to date, health inequalities elements are embedded across both top priority areas.
Service users/ carers	**Positive** – Service users and carers play a direct part in development and ongoing monitoring of annual priorities through participation in the Strategy Stakeholder Steering Group and other fora aligned to delivery of the Strategy.
Estates:	**Positive** – Delivery of EMP remains a key focus for the Trust and this is covered by a specific enabling area for 2024/25.
Financial:	**Positive** – The proposed top priorities for 2024/25 support the Trust to continue to move towards a position of financial sustainability.
Legal:	N/A
Reputational:	**Positive** – The Trust sets high standards, which are evident in our annual plans, and we hold ourselves accountable for their delivery. This, alongside achievement of targets and milestones, positively supports our reputation.
Strategy:	**Positive** – Determining annual priorities supports the delivery of the Trust's strategy in identifying 2024/25 plans and their detailed delivery.
Workforce:	**Positive** – People elements form the core of Making the Trust a Great Place to Work.
Sustainability e.g. Green Plan:	**Positive** – Delivery of our priorities in 2024/25 will support our sustainability including our green plan.
Other (specify):	None

2024/25 priorities

1. Introduction and this year's approach

1.1. Each year the Trust develops a set of priorities to support annual progress towards delivery of the Trust Strategy. Our annual priorities act as an organisational programme of work defining the critical elements for delivery and targets to meet.

1.2. We take account of a number of considerations when setting our annual priorities including delivery in the preceding year, challenges being faced, the external context and environment, national targets and expectations, input from senior leaders, and our capacity, for example.

1.3. Drawing on learning from the past two years, we have developed our priorities for 2024/25 in an iterative manner. We began this process in December 2023 and it has involved discussions across our Executive Leadership Team, with our Executive Advisory Group and in our February 2024 Board development session and March 2024 Board Part B. Our discussions have been mindful of the pressured context across the NHS and hinged around considering the balance of ambition and stretch with realistic delivery expectations. We have challenged ourselves to continue to focus on outcomes and the work that will deliver the biggest impact with a clear measurement of delivery.

1.4. For 2024/25 we are proposing to continue with the top two priorities that were identified in 2023/24, of Improving our Adult Patient Journey and Making the Trust a Great Place to Work (previously referred to as 'flow' and 'valued and stable workforce'). These areas will be supported by 4 enabling areas of work as can be seen below:

1.5. For our two priority areas we are focusing on key elements of work where we believe we will see the greatest impact. For Improving our Adult Patient Journey, this primarily involves connecting our acute and community adult transformation programmes to focus on ensuring that our approach is recovery oriented, purposeful, least restrictive and prevents crisis. It also considers wider partnership working with primary care, social care and into our more specialist rehabilitation pathways with SLP. For Making the Trust a Great Place to Work, we are focused on our medical workforce and new role development, tackling reported unfair

career progression from our black and minority ethnic staff, offering leadership development opportunities, improving wellbeing and our confidence in reporting incidents. This work builds on foundations laid in 2023/24 and will extend further than 2024/25 forming multi-year programmes which will be defined as we progress through Q1 and Q2 this year. We are planning to more fully utilise both our QI approach and OD framework to support successful delivery in 2024/25.

1.6. This paper outlines the content of the priorities in Section 2 – including vision, objectives, outcomes, measures and targets – and approach to delivery in Section 3. Finally, we include the enabling and supporting areas as an appendix.

2. 2024/25 Top priorities draft, proposed content

2.1. The proposed content for our two top priorities is outlined below. This is also categorised in relation to our strategic ambitions with the Trust Strategy:

Priority	Delivery areas	Outcomes/ Metrics	Strategic ambition[1]			
			I	R	G	E
(1) Improving our Adult Patient Journey **Vision: Service users and their families receive the right care, in the right place, at the right time. Our model of care is equitable, digitally enabled and focuses on recovery outcomes allowing us to optimise experience of the whole adult pathway, supporting people to live as well and independently as possible.** **Objective: To improve access, experience and outcomes in our**	**Programme Development** • Completion of engagement approach to ensure colleagues, service users and carers are involved in the development of our plans (Q1) • Confirmation of our QI and OD approach to the work and resourcing and leadership secured (Q1) • Confirmation of technical and clinical leadership for digital development and parameters of change (Q1) • Development and implementation of digital training and skills programme to support digital changes (Q3) • Evaluation of delivery (Q4) **Care is purposeful** • Development of our transformation approach to embed equity as a core element of our care planning work (Q2) • Confirming and communicating our approach to Fundamental Standards of Care and adapting our processes to enable this (Q4) • Implementation of DIALOG+ care planning (by Q4) • Digitising and automating care planning and DIALOG+ patient record elements to support proactive engagement and involvement of service (Q4) **Care is supportive of avoiding crisis** • Development of work package across the adult pathway which will allow services to successfully identify and respond to signs of service user deterioration (Q2)	**Purposeful** • Increased access to community MH care by for people from black and minority ethnic backgrounds – number of adults and older adults receiving 2+ contacts in Community services • Improved adherence to fundamental standards of care, in particular around care planning, and improved measurement of recovery outcomes **Avoiding crisis** • Reduced numbers of people known to the Trust presenting in crisis • Reduced numbers of patients waiting over 12 hours in A&E for a bed • Improved completion and quality of crisis plans **Least restrictive**				

[1] The mapping to the Trust Strategy Strategic Ambitions uses the following key: I = Increasing quality years; R = Reducing inequalities; G = Great place to work; E = Ensuring sustainability.

adult services providing a smooth, digitally-enabled and prompt patient journey with the best and least restrictive intervention when needed, delivering improved equitable recovery and outcomes.	• Implementation of work to identify and response to signs of deterioration, including support for physical health (Q4) • Completion of existing Crisis and Psychiatric Liaison Improvement Projects, ongoing development of mental health in ED programme and implementation of NHS111 and s136 hubs (Q4) • Enhancing our digital capability within urgent mental health care by developing improved quality crisis plans and enhancing how we share these with service users and wider system colleagues (Q3) • Implementing key worker roles with plans for implementation of safety planning in alignment with a change in risk assessment the following year (Q4) **Care is least restrictive and not longer than necessary** • Development of our transformation approach to embed equity as a core element of our work around reducing restrictive interventions and reducing LoS (Q1) • Full understanding available of drivers of Length of Stay (LoS) and development of approach to address long Lengths of Stay (Q1) • Implementation of focused work on the areas identified as drivers of LOS (Q4) • Completion of best practice acute inpatient care transformation work, in line with guidance (Q3) • Successfully implementing the Patient and Carer Race Equality Framework (PCREF) (Q4) **Care supports recovery** • Full understanding available of drivers of caseload length of stay (Q1) • Reconsideration of our model of intensive home treatment for adults and older adults and implementing improvements to this (Q4) • Completion of review of Primary Care mental health support and models (Q3) and supporting teams to work with service users and carers to enable step down to primary care as part of the recovery journey (Q4)	• Reduced numbers of inpatients staying longer than 90 days • Reduced inappropriate out of area bed use • Reduced use of restraint for people from black and minority ethnic backgrounds – total number of restraints (physical restraints and rapid tranquilisation) and prone restraints **Recovery** • Improved scores across paired DIALOG+ and HONOS scales • Improved FFT net positive score recommending as a place to receive care • Reduced community team caseload LOS – average time on caseload				

	• Delivery of agreed SLP Complex Care programme and improvements to rehabilitation pathways and services (Q4) • Embedding our commitment to improved communication with service users and professionals by improving the structure and content of information shared and utilising shared records effectively (Q4)					
(2) Making the Trust a Great Place to Work **Vision: Our staff are skilled, equipped and supported to provide the best care possible. We provide opportunities for development and career progression for everyone through established structures and programmes. People want to come to work for the Trust because it is known as a good employer that values its workforce and is actively anti-racist.** **Objective: To deliver quality services by having exceptional, stable workforce that represents the**	**Positive action to support anti-racism** • Proactive borough-based working with VCSE and community organisations to diversify our recruitment pool (Q2) • Embedding anti-racism values into recruitment and career progression practices (Q4) • Delivery of small QI-informed trials to support new ways of offering colleagues from ethnic minorities development and opportunities across the organisation (Q4) **Attracting new talent to the Trust** • Identification of core Consultant skills through workshops and identify areas for new roles or skill mix (Q1) • Benchmarking of medical vacancies and development of a clear recruitment plan for existing medical vacancies (Q1) • Development of new roles with focus in Community (Q2) followed by introduction and evaluation of new roles (Q4) **Supporting development and fair career progression** • Finalisation (Q1) and implementation (Q2) of talent approach, including focus on colleagues from ethnic minorities • Definition and commissioning of leadership programme and delivery of core elements including second STEPS cohort and senior leadership development programme (Q1) followed by evaluation of these (Q4) • Implementation of structures to support leadership and development including establishment of a diverse coaching & mentoring network and action learning set facilitator network (Q2) • Implementation of enhanced appraisal process for Core Leadership Group (Execs and Deputies) (Q1) and evaluation at completion of the cycle (Q3)	**Attracting** • Reduced vacancy rate • Reduced medical vacancies – Community • Proportion of managers taking part in fair recruitment training **Fair progression** • Improved Staff survey measure: Organisation acts fairly: career progression • Increased proportion of colleagues from ethnic minorities recruited into organisation into leadership positions at B7+ • Improved retention for all staff and, specifically, for those from ethnic minorities – turnover within 12 months • Improved proportion of black and minority ethnic managers at B7+ engaged in leadership development at all levels **Experience, wellbeing & support** • Reduced sickness rate, overall and, specifically, for Acute & Urgent Care and Specialist service lines				

communities we serve and who feel valued with support to develop skills and careers with the Trust.	• Full analysis of fair career progression data and agreement of highest impact/priority areas to support staff from black and minority ethnic communities (Q1) followed by development of support for managers and implementation of work packages (Q2), embedding of work (Q3) and evaluation of approaches (Q4) **Experience, wellbeing and support – flexible working and violence & aggression** • Listening and analysis exercise to understand core issues around staff feeling secure to raise concerns (Q1) followed by agreement of work to be carried out and refreshed communications on existing processes (Q2) • Establish flexible working group to lead initiatives, including small scale trials, designed to create increased flexible working opportunities that are equitable, including developing leadership capability in the application of flexible working • Work with teams to identify drivers of burnout/stress (Q1) followed by development and implementation of actions to address issues (Q2-4) • Work with teams to develop further approaches to tackling violence and aggression (Q1-2) and to implementation of these (Q3) • Evaluation of impact (Q4)	• Coaching network developed • Action learning set facilitators in place and in use				

2.2. We will measure success using specific metrics, largely available within existing reporting. We will also report metrics broken down by ethnicity where this is relevant to delivery. Where we are not yet able to provide this breakdown, we will do work to enable it by year-end. We have set year-end targets for delivery in most cases. Where metrics require further definition and/or agreement of a target, this will be finalised by end of Q1.

Priority	Measures of success	Baseline 31.03.24	Target by 31.03.25
Improving the Adult Patient Journey	**Purposeful**		
	Number of adults and older adults receiving 2+ contacts in Community services [2] – to include number of black and minority ethnic adults	5,964 [3] Black and minority ethnic breakdown will be available by end of Q1	9,871
	Paired DIALOG completed – % of caseload [4]	15.5%	20%
	Avoids crisis		
	A&E Attenders that are open to a CMHT [5] (annual total)	1,509	1,400
	People waiting over 12 hours in A&E for a bed (annual total)	516	400
	Least restrictive		
	Proportion of adult inpatients with a length of stay over 90 days (annual average)	19%	17%
	Reduced inappropriate out of area placements (OBDs) [6]	2,069	0
	Reduced use of additional beds used over EMP bed base and contracted Holybourne (18) (OBDs)	66,923 OBDs	EMP bed base plus 18 beds = 60,225 OBDs EMP bed base plus 12 beds = 58,035 OBDs

[2] This is a national metric aligned to Community transformation that counts patients seen twice in rolling 12-month period at end of month.

[3] Baseline data includes Kingston, Richmond and Sutton only. Merton and Wandsworth are not yet defined as transformed in line with national guidelines but are expected to be by end of Q1 and will be included in data submissions from that point.

[4] Proportion of patients with a DIALOG in place who have a paired DIALOG

[5] Count of individuals attending A&E who are also open to a CMHT at time of attendance

[6] An inappropriate 'out of area placement' is a national definition for when a person with assessed acute mental health needs who requires adult mental health acute inpatient care is admitted to a unit that does not form part of the usual local network of services.

	Reducing restraint for black and minority ethnic patients: Number of Restraints, including physical restraints and rapid tranquilisation, and Number of Prone restraints (Acute & Urgent Care)	Total – 779 and 348 Black & minority ethnic – 452 and 218 White – 320 and 124 [7]	700 and 300 respectively
	Supports recovery		
	Paired DIALOG - Improvement Observed (%) [8]	New metric – available by end of Q1	
	Paired HoNOS - Improvement Observed (%) [9]	New metric – available by end of Q1	
	Friends and family test (FFT) net positive score[10]	86.5 (latest available January 24)	88
	Average time on Community caseload (days) [11]	426.7	400
Making the Trust a Great Place to Work	**Attracting new talent**		
	Vacancy rate	14.98%	13%
	Medical vacancy rate (Community) [12]	15.82%	13%
	Numbers of managers taking part in fair recruitment training - % of managers	35%	85%
	Fair progression		
	Improved staff survey measure: organisation acts fairly: career progression [13]	49.93%	60%
	Numbers of colleagues from ethnic minorities recruited into leadership positions (7+) [14]	36.88%	At least 50%

[7] Work to identify targets within ethnicity to be finalised by end of Q1 as data availability improves.

[8] Data definition is being built; to be available at end of Q1.

[9] Data definition is being built; to be available at end of Q1.

[10] The FFT net positive score is a national measure which is asks patients to tell us how likely they would be to recommend our trust as a place to be treated. There are four possible answers, extremely likely and likely (positive responses) and unlikely and extremely unlikely (negative responses). Organisations are told the percentage of respondents who expressed positive and negative answers – the net of these two positions is the Net Positive Score that is used for benchmarking purposes. E.g. if of 100 answers 80 were positive and 20 were negative the net positive score would be 60% (80%-20%).

[11] Time on caseload in days from team start to end of month against total caseload at end of month

[12] Particular concern has been expressed about medical recruitment in Community service line, thus we are specifically monitoring rates of improvement

[13] Q15 (2023) Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

[14] Proportion of people from an ethnic minority recruited into a B7 or above role

	Turnover rate within 12 months [15]	23.9%	Below 20%
	Turnover within 12 months for black and ethnic minorities	27.6%	Below 20%
	Numbers of black and minority ethnic managers/leaders at B7+ accessing leadership development offer. [16]	28.57%	At least 50%
	Experience, wellbeing & support		
	Sickness rate, overall	4.7%	3.5%
	Sickness rate (Acute & Urgent Care and Specialist) [17]	7.0% and 5.8%	3.5%

[15] Proportion of whole time equivalent employees leaving in the past 12 months who have been at the Trust for less than one year

[16] Proportion of black and minority ethnic staff in B7 or above accessing leadership courses

[17] Particular concern has been expressed about sickness rates in Acute & Urgent Care and Specialist service lines, thus we will specifically monitor rates of improvement

3. Our delivery approach

3.1. We know that how we deliver work has a significant impact on its success and the way those involved feel about the work. During 2023/24 we have made good progress on considering both our QI approach and our OD framework and we will be utilising these to support our delivery of our 2024/25 priorities.

3.2. For both QI and our OD framework we have a set of principles that we will work within as outlined below:

QI principles	OD framework principles
• Giving those closest to the issues affecting quality the time, permission, skills and resources they need to solve them. • Understanding the problem from a range of perspectives with emphasis on using and interpreting data. • Developing a theory of change. • Applying a systematic approach using a set of tools and techniques. • Identifying and testing potential solutions; using data to measure the impact and gradually refining the solution to the problem. • Focusing on the relational aspects of improvement.	• The complex nature of our organisation will shape our approach. • We will use data and experience (from the staff survey etc) to shape our work plan and priorities. • Our work will be based on the action research model, working with cycles of action, experimentation and review of learning. • We will be actively anti racist and inclusive in our work. • We will deliberately work to amplify helpful patterns and disrupt unhelpful ones

3.3. Our approach to QI is driven by the Model for Improvement and our OD approach is driven by the cultural patterns that we have uncovered within our organisation:

Our cultural patterns	Cultural patterns we wish to strengthen
Making things more complicated than necessary	Keeping things simple and not over complicated
Lack of clarity	Ensuring clarity
An environment which does not always feel psychologically safe for people to speak with candour	An environment which is psychologically safe for people to speak with candour
Decisions being changed	Making carefully considered decisions and stick with these; change only if necessary
Focus on task and process rather than relationships	Paying attention to both the relationships and the task / process when working together

3.4. In order to successfully deliver our priorities, this year we will be:

- Ensuring we all develop and use a **QI mindset** to problem solving, organisational learning and development. This involves creating a clear definition of the problem, establishing the aim and being clear on what we are trying to accomplish, defining the measures that will help us determine if a change is an improvement and deciding on what we will test/ implement.
- Developing and promoting a **clear approach to standardisation and scale-ability** so that staff know what is expected. This also includes tackling resistance and promoting opportunities where tailoring or local development can be encouraged.
- Reconsidering and **reframing 'failure'** where we cease fearing to fail and instead use this as a positive learning experience. This will also increase our confidence around testing ideas and stopping work if shown to be unsuccessful.
- Continuing to **support colleagues to create space and capacity** to work in different ways and recognising the tension that can exist around 'pace-setting' behaviours.
- **Reviewing resourcing** across our transformation, service improvement and quality improvement portfolios to ensure we have an efficient, effective and skilled set of colleagues to lead and support delivery of the 2024/25 priorities. This will also support resilience across teams and promote collective ownership.

3.5. We have agreed an approach to align our existing QI resource to our two top priorities, with a QI Coach for Improving Patient Journey and for Making the Trust a Great Place to Work. We are adopting a QI approach to the development of both programmes, including defining our problem statements and co-producing solutions, and will deliver further staff engagement in Q1 to finalise and confirm the work plans.

3.6. A leadership proposal has been agreed by ELT to deliver the Adult Patient Journey programme, which includes a formalised partnership of senior clinical, operational and corporate leaders to direct and drive the work forward through revised governance structures. Clear accountability and responsibility definitions as well as involvement practises are also being developed. QI methodologies will be applied to all project delivery through existing trained staff and ensuring all relevant staff attend QI training in the year.

3.7. Communicating our priorities is critical and we are simplifying our messages around our priorities to ensure that our Fundamental Standards of Care is the primary driver – improving quality is the key to our success. Communications will be developed in Q1 to support this plan.

4. Next steps

4.1. Progress against our priorities will be reported quarterly to ELT, Board committees and the Trust Board in the standard reporting cycle. Further work to define new and revised metrics will consider pragmatic but meaningful targets and will be completed by the end of Q1. As we begin delivery we will also update and improve our reporting approaches ensuring we have clarity of delivery and impact during 2024/25.

4.2. Finally, we will ensure messaging out to the organisation on this year's priorities is clear and specific on ambition and expectations, linking to the Trust Strategy and focusing on improving our Fundamental Standards of Care.

Appendix – enabling/ supporting areas of work

Supporting area	Delivery priorities	Outcome/ Metric	Strategic ambition			
			I	R	G	E
1. Better Communities **Objective: To deliver our Better Care programme enabling service users to experience care as close to home as possible with a focus on recovery and outcomes**	**2024/25 priorities:** • Improving patient flow, access and outcomes with a focus on ensuring all patients are treated as close to home as possible • Increasing our digital capability as an enabler of excellent patient care • Delivering the Tolworth Business Case **Key pieces of work:** • Refreshing our community and AUC transformation into one programme around adult patient journey to ensure we have internal partnership working and appropriate integration to deliver outcomes and change (Q1) • Delivering our digital programme 24/25 milestones (Q4) • Developing core offers at SWL level for CYP and adult mental health alongside system partners (Q4) • Evaluating EMHIP delivery (Q4) • Embedding reduction of health inequalities work into our transformation programmes – evidence base for areas of focus (Q4)	• Friends and Family Test (FFT) net positive score • Maintenance of improved staff survey results on EDI sections – to be defined • Improved MWRES, WRES and WDES scores – to be defined				
2. Partnerships **Objective: To proactively develop partnerships and act as a system leader driving strategic improvements to mental health of the SWL population**	**2024/25 priorities:** • Implementing the SWL Mental Health Provider Collaborative (SWL MHPC) • Refreshing the South London Partnership following fitness for future review **Key pieces of work:** • Moving to new shadow contractual arrangements for the SWL MHPC including agreeing an assurance framework with the SWL ICB, developing an operating model between ourselves and SLaM and developing an integrated mental health commissioning and transformation team in MH	• SWL MHPC formally in place				

	• Proactively including mental health in SWL ICP wide programmes such as health inequalities Progressing cases for change around delegation of commissioning responsibilities • Working with VCSE mental health partners to strengthen the third sector strategic involvement in mental health across SWL • Evolving SLP ways of working around governance, delivery and commissioning support • Delivering year 2 of SWL MH Strategy • Working with SWL ICB to the develop business case for future additional investment					

3. Better Environments
 	
Objective: To create Better Environments providing state of the art mental health facilities, improving access and outcomes and reinvigorating working practices for staff and service users alike
	2024/25 priorities:
	• Delivering the Tolworth Business Case
	
	Key pieces of work:
	• Successful continued development of the Springfield Village
	  ○ Disposal of X, Y, Z plots (Q4)
	• Progressing Barnes (Q2), Richmond Royal (Q3) and Tolworth (Q4) programmes and building works to plan
	• Increasing our community engagement and supporting work to address stigma related to mental health services
	  ○ Deliver Springfield Park social purpose vehicle (Q4)
		Sign-off of Tolworth Business Case				

4. Sustainability **Objective: To continue to work towards financial and operational sustainability supporting best value and efficiency in health and care in SWL**	**2024/25 priorities:** • Increasing proportion of substantive staff • Increasing clinical and corporate efficiency **Key pieces of work:** • Clinical productivity programme delivery (Q4) • Conversion of agency and locum staff to substantive appointments (Q4) • Corporate services review (Q1)	• Proportion of agency spend in line with national target – 3.2% • Activity per WTE – reduction of 2% • DNA rate – maintain 11%				

Report Title:	**24/25 Trust Strategy Review**
Name of Meeting:	Trust Board
Date of Meeting:	9 May 2024
Author(s):	Leah O'Donovan, Deputy Director of Strategy & Transformation Amy Scammell, Chief Strategy Officer
Executive Sponsor(s):	Amy Scammell, Chief Strategy Officer
Transparency:	Public
Scrutiny Pathway:	ELT – 25 April 2024

Purpose: *If this is not completed the paper will be returned*	☒	**Approval**	☒	**Discussion**	☐	**Information**	☐	**Assurance**
Additional information:	N/A							

What?	The Trust Strategy was published following extensive engagement and development work in September 2018 and covers the period 2018-2023. In 2023, the Board recognised that, due to the impact of Covid and a challenging external environment, delivery of the Strategy was not completed. Following a thorough review in summer 2023, which included data analysis, stakeholder engagement and a summary of delivery against programmes, the Board agreed to extend the Strategy by at least two years, with an annual review to take place at the end of each financial year. This paper presents the first of these annual reviews. We have reviewed delivery for 2023/24 through refreshed analysis of our data set and our analysis of programme delivery, which includes 23/24 data and reflections on 23/24 delivery.
So What?	Delivery in 2023/24 against our original outcomes remains mixed, with significant improvements in our numbers of serious incidents, our sickness, vacancy and turnover rates and our service user feedback through Friends and Family Test. Against this, however, our length of stay, delayed transfers of care and use of external beds remain high and have continued to increase. Our programme delivery has seen the successful implementation of the final year of community transformation for adults with serious mental illness and the opening of Shaftesbury and parts of Springfield Village through the Estates Modernisation Programme. We continue to strive for involvement and co-production in all that we do and have begun to embed Quality Improvement methodology throughout the organisation. We are taking a leading role in south west London (SWL) in partnership with colleagues in the integrated care system (ICS) and the South London Mental Health and Community Partnership (SLP). Overall, the picture shows improvement in our ambitions of Making the Trust a Great Place to work and Ensuring Sustainability as we are seeing positive movement in our key workforce metrics and continue to operate in financial balance while delivering our commitment to build

	new facilities. We have progress across elements of our other two ambitions of Increasing Quality Years and Reducing Inequalities but significantly more work to do to deliver against outcomes under these, much of which has been prioritised for 2024/25.
What Next?	Priorities for 2024/25 have been agreed through significant engagement at all levels and are due to be signed off by Trust Board, alongside this review. The outputs of this review demonstrate that these are the right priorities, and we will review delivery again at the end of 2024/25. The Board is asked to note the progress in delivering the Strategy and its relation to 2024/25 priorities.
Any specific issues to note and/or for escalation:	ELT received this paper on 25 April 2024 and welcomed the review and its highlighting of both good progress and continuing challenges in delivering our strategic ambitions.
Appendices/Attachments:	N/A

Strategic ambitions this paper supports	☒	Increasing quality years	This paper supports all four strategic ambitions as it outlines a review of delivery of the Trust Strategy
	☒	Reducing inequalities	
	☒	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	
Equality analysis *[linking to EDI strategy]*	**Positive** – The review considers EDI elements in both data and discussion with stakeholders and identifies areas for improvement, linked to the Trust EDI strategy.
Health Inequalities	**Positive** – The review considers HI elements in both data and discussion with stakeholders and identifies areas for improvement, linked to the Trust EDI strategy.
Service users/ carers	**Positive** – The review has directly engaged with service users and carers to obtain their views on Strategy delivery and future priorities for the Trust
Estates:	**Positive** – The review considers the delivery of EMP and its impact on delivery of the strategy to date and in the future.
Financial:	**Positive** – The review considers financial aspects related to Strategy delivery and will identify lessons learned around investment and outcomes which can support improving future planning.
Legal:	N/A
Reputational:	**Positive** – The review has included discussions with wider stakeholders who have expressed positive opinions of Trust's transparency and openness in assessing its strategy delivery and plans. Completing the review will positively support the Trust's reputation.
Strategy:	**Positive** – The review supports the delivery of the Trust strategy.
Workforce:	**Mixed** – The review has required input from members of staff, some of whom have had to balance priorities and find capacity to support it, but engagement has been positive. The review has identified areas of improvement for the Trust, some of which are challenging and complex and will require focused action.
Sustainability e.g. Green Plan:	**Positive** – The review offers the opportunity to consider strategic elements such as the Green Plan which was not in place when the Trust Strategy was developed.
Other (specify):	None

Trust Strategy Annual Review

1. Background

1.1. The Trust's Strategy covers the period 2018-2023. It was produced through extensive stakeholder engagement and by drawing on internal and external data and an understanding of the external environment. The Strategy aimed to build on the Trust's mission of Making Life Better Together and the Trust values, defining the work around four new strategic ambitions:
   a. Increasing quality years
   b. Reducing inequalities
   c. Making the Trust a great place to work, and
   d. Ensuring sustainability

1.2. It also includes a clear philosophy of using co-production, involvement and engagement and remaining recovery oriented with expectations of being outcomes focused, asset-based, more focused on prevention and early intervention, collaborative and finally influential.

1.3. In its first two years the delivery of the Strategy was guided by a set of stretching corporate objectives. The onset of the Covid pandemic changed the approach as we focused on core priorities of safe clinical care and staff health and wellbeing. This approach extended for 2020/21 and 2021/22, with the re-development of annual delivery plans linked to our strategic ambitions only possible eventually from 2022/23 onwards. For these reasons, delivery of the Strategy is not yet complete, and we have recognised the need to extend the life of the Strategy.

1.4. In March 2023, The Board commissioned a review of delivery of the Strategy, which took place across the summer and involved a number of phases:
   a. Mapping of expected delivery outcomes under each of our four strategic ambitions to KPIs and programmes of work
   b. Quantitative data analysis of KPIs
   c. Qualitative inputs from stakeholders
   d. Review of work programmes delivered

1.5. The Board received the final report in September 2023 and agreed to extend the life of the Strategy for two years. The Board was clear that this was not a refresh, but an extension of the original Strategy and, thus, also agreed that an annual review of outcomes, structure and processes be implemented with an annual report back to the Board.

1.6. This report covers the review of delivery in 2023/24. The expected outcomes, structures and processes and core programmes are provided in Appendix 1 for reference.

2. Delivery in 2023/24

2.1. The 2023 review included quantitative data (standardised metrics related to the outcomes outlined above), feedback from stakeholders and an assessment of the five core enabling programmes of work. For the annual review, we have updated this full data set with available 2023/24 data, presented below:

KPI Description[1]	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Increasing Quality Years						
Death - Suspected suicide[2]	22	25	22	44	44	37
Significant Incidents (STEIS) formally known as Serious Incidents	74	88	103	121	80	15
CYP self-harm (% of all referrals) [3]	1.21	6.29	12.53	14.53	8.94	8.49
CYP self-harm (% of referrals that accessed a service)	2.42	7.73	15.65	16.6	8.26	10.43
Adult Acute monthly average LoS (excl. other ward types)	33.12	37.6	37.25	40.96	47.71	49.18
Delayed transfers of care (%)	2.31	1.88	3.34	4.64	8.11	11.11
Discharges From the Trust	77753	75651	37617	48109	72426	102371
Cardiometabolic Assessments (%) [4]	-	75.83	83.76	84.45	85.14	83.34
Inappropriate out of area placement bed days - Adult Acute & PICU	1486	2850	157	2318	2566	3488
Physical Health Assessment attempted within 48 hours of admission (%)	91.97	92.84	92.77	96.51	94.59	93.98
Physical Health Assessment completed within 7 days of admission (%)	79.38	79.53	75.15	78.6	82.95	81.33
Patient Friends and Family Test (%)	69.83	81.74	81.83	81.74	82.9	86.81
Reducing Inequalities						
Talking Therapies recovery rate (%)	-	51.52	55.11	52.92	51.59	51.45
Talking Therapies: The proportion of BAME people who are moving to recovery (%)	45.19	47.87	51.88	48.26	47.82	47.6
Settled Accommodation (On CPA 18-69 yrs only) (%)	80.62	83.01	81.42	82.37	75.95	63.37
Employed (On CPA 18-69 yrs only) (%)	11.71	12.33	11.57	10.42	11.48	9.29
Inpatient admissions, adult acute (% Ethnic Minority) [5]	37.9	41.4	39.4	40.6	40.3	44.4

[1] In two instances data for 18/19 is not available as it was not collected at this point. These instances are marked with a – in the table.
[2] The numbers of suspected suicides have historically fluctuated annually with a sustained fall prior to 18/19. These numbers should also be considered in the wider context of external factors, such as the pandemic and economic challenges. Further analysis through the Trust's mortality governance would support a more thorough assessment of this outcome.
[3] Reducing CYP self-harm is a complex outcome to properly measure since some referrals for self-harm will be signposted elsewhere and thus care sits outside the Trust remit. Secondly, it has not been possible to map through outcomes for those that do enter treatment to add to the assessment on reducing self-harm through Trust service delivery. Data is presented as all referrals for self-harm and then those referrals for self-harm that accessed a Trust service. As with suicides, the rise can be at least partially attributed to the impact of the pandemic and could benefit from additional analysis.
[4] Community & EIS - Service Users included are those with a diagnosis of psychosis, are on CPA and have been on the case load for a minimum of 12 months (or 6 months for EIS teams)
[5] The 2021 census indicates that the ethnic minority population in the five boroughs served by the Trust is 31.3%. The data provided is the % of admissions from people from ethnic minority backgrounds and can be compared to the overall population percentage.

KPI Description[1]	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Talking Therapies referrals accepted (% Ethnic Minority) [6]	23.8	27.9	27.6	31.6	32.2	29.0
Making the Trust a great place to work						
Turnover Rate (%)	16.01	16.1	14.12	15.42	18.03	14.96
Vacancy Rate (%)	15.79	16.63	16.56	20.09	18.99	16.78
Sickness rate (%) (reported month in arrears)	3.84	4.26	4.08	4.8	4.89	4.71
Workforce diversity - BAME (%)	47.8	48.5	50	50.2	50.3	52.5
Workforce diversity - disability (%)	8.4	8.4	8.6	8.9	8.8	11.0
BAME staff - Band 8+ and Medical (%)	25.39	25.58	26.6	27.19	30.7	31.38
Agency spend as % to NHI target	88.36	104.63	113.88	128	124.84	96.61
Staff Survey - Care of patients / service users is my organisation's top priority (%) [7]	72.2	76.5	79.9	77.8	77	80.49
Staff Survey - My organisation acts on concerns raised by patients/service users (%)	71.6	71.7	76.2	73.8	73.7	75.46
Staff Survey - I would recommend my organisation as a place to work (%)	56.7	58.1	63.9	60	58.2	64.7
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided (%)	58	60.7	65.7	58.3	56.1	59.56
Staff Survey - Does your organisation act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? (%)	44.3	46.6	47	45.1	47.6	49.93
Staff Survey - In the last 12 months have you personally experienced discrimination at work from patients/service users, their relatives or other members of the public? (%)	14.8	13.1	13.3	12.3	12.4	13.1
Staff Survey - In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues? (%)	12.1	12.7	11.3	11.8	11.1	10.04

[6] The 2021 census indicates that the ethnic minority population in the five boroughs served by the Trust is 31.3%. The data provided is the % of admissions from people from ethnic minority backgrounds and can be compared to the overall population percentage.
[7] The annual Staff Survey questions changed in 2021 to align to the NHS People Promise themes. Analysis of all questions asked every year from 2018-2024 was completed but only data for the We are Compassionate and Inclusive domain has been presented as the questions cover a broad range of themes well-aligned to assessing performance against the outcome of improving Staff Survey results.

KPI Description[1]	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Friends & Family Test - Staff would recommend organisation as place to work (%)[8]	58	62	N/A	N/A	N/A	N/A
Friends & Family Test - Staff would recommend organisation for care (%)	66	65	N/A	N/A	N/A	N/A
National Pulse - Advocacy (replaced FFT 2021/22)	N/A	N/A	N/A	5.88	5.18	5.98
Gender Pay Gap - as a mean average (%) [9]	10.32	8.19	3.82	7.56	7.61	TBC
Ensuring sustainability						
Annual turnover - income (£000s)	170,341	192,038	220,307	249,955	275,161	316,500

[8] The Friends & Family Test – Staff element ceased in 2019/20 and changed to the National Quarterly Pulse Survey in 2021/22 incorporating questions around recommending the organisation as a place to work and receive care into the overall Advocacy theme. Results for the first two years of the FFT and the subsequent years' Pulse survey are presented. There was neither survey in 2020/21.
[9] The Gender Pay Gap report is published annually by March of the following year, so data for 2023/24 is not yet available.

2.2. As can be seen from the data above, delivery remains mixed. We are maintaining the improvements reported in the 2023 review around cardiometabolic and physical health assessments and our Friends and Family Test (FFT) also continues to improve. We have seen a considerable reduction of Significant Incidents (STEIS) in 2023/24 as well as a reduction in the numbers of suspected suicides, but this is not yet back to pre-pandemic levels. On the other hand, despite discharging more people than any year previous (up 32% from 2018/19 and 41% from 2022/23) our adult acute length of stay, delayed transfers of care and out of area placements continue to rise. We also continue to see more people from an ethnic minority in our inpatient acute services compared to the SWL population, and it is increasing.

2.3. For our workforce, we see an improving picture, both in terms of Staff Survey results around care as a priority and recommending the Trust as a place to work and reductions in turnover, vacancy and sickness rates. However, with still less than half of our staff reporting they believe the organisation acts fairly in terms of career progression, we have decided to prioritise programmes to improve this in 2024/25. Most concerning is the increase in the numbers of staff reporting discrimination from patients/service users, their relatives or other members of the public, which is also featuring in our 2024/25 Making the Trust a Great Place to work priority.

2.4. Programme delivery

We have considered ongoing progress and delivery around the enabling programmes outlined in 2018. This is described below:

a. **Quality improvement and innovation (QII)** remains a high priority programme of work within the Trust. Embedding the QI approach across the organisation has been identified as a priority enabler in 2024/25 and the approach is already informing our development of annual priorities and programmes of work. A full paper on our future strategy for QI will come to the Trust Quality Safety Assurance Committee in June 2024. Our QII team remain focused across delivering training for staff and providing support to Trust wide and service specific projects. In addition, the QII team also support organisational development (OD) work in the Trust.

b. **Co-production and service user and carer involvement** continues to be an area of strength for the Trust with a growing involvement network, a focus on volunteering opportunities, participation in service visits and membership of external SWL Integrated Care Board (ICB) groups – for example the People and Communities Engagement Group. Additionally, we are developing a strategic approach to this area through the SWL Mental Health Partnership Delivery Group (SWL MHPDG) to ensure that we can collectively deliver the SWL Mental Health Strategy. Through our transformation programmes we have increased peer support roles most notably in our community adult services.

c. **Collaboration and partnership working** is now a crucial element of how we deliver our work. During 2023/24 we have strengthened the SWL MHPDG and continued to collaboratively lead the SLP, implement EMHIP and support development of work at place. We have worked to set up and lead the positive mental wellbeing priority in the SWL ICP strategy. In 2024/25 we will be working to develop further links with VCSE partners.

d. The **Estate Modernisation Programme (EMP)** In 23/24 the Estate Modernisation Programme has completed Phase 1 including moving into the new secure care unit, Shaftesbury, and consolidated our inpatient wards at Springfield and Tolworth with the relocation of wards from Queen Mary's Hospital temporarily to Springfield. Springfield

Village is starting to take shape with the first section of the park opened to the public, and a new restaurant and gym operational around Chapel Square. Buildings such as High Trees and the Diamond Estate have been vacated and cleared in readiness for future construction phases. Phase 2 of the programme is underway with the sale of Phase 2a plots to London Square completed. The Tolworth Early Works have commenced, rationalising the site and its infrastructure and preparing it for future development. In addition, Barnes teams were temporarily relocated to Teddington and planning has been approved for the new redevelopment at Barnes with early works already underway.

e. **Transformation** programme activities continue to have a high profile during 2023/24. The Community service line has completed its three-year transformation programme for adults with serious mental illness, with Merton and Wandsworth the last two boroughs to go live with transformed models of care. This transformation has included 14 new roles across 137 whole time equivalents (WTE), including an expanded peer support offer. In Acute & Urgent Care, we delivered on the national 100-day discharge challenge, including new forms to support purposeful admission, new digital solutions to support improved ward workflows and piloting Red to Green methodology. We also trained staff on a new protocol for supporting people with Complex Emotional Needs aimed at improving care and reducing length of stay.

These enabling five enabling programmes remain relevant and central to supporting the Trust to deliver against its ambitions and outcomes and progress in these areas is part of the 2024/25 priorities.

3. Assessment of achievement and work still to do

3.1. Reflecting back to the outcomes, structures and processes outlined in Appendix 1, our assessment is that many elements are underway with progress being made as can be seen from the table below:

	Strategic ambitions			
	Increasing Quality Years	**Reducing inequalities**	**Making the Trust a Great Place to Work**	**Ensuring Sustainability**
Fully achieved	• Trust part of integrated care systems in all boroughs	N/A	• Executive equality objectives in place • Staff networks strengthened	• CQC Always Ready programme in place

Delivery underway	• Improvement in service users safety indicators:
	  ○ Fewer serious incidents occur
	• Increase in positive feedback from service users and carers
	• Increase in the number of people who experience care in the least restrictive setting
	• Improvement in physical health indicators for service users
	• Use of quality of life and outcomes measures
	• Community partners delivering mental health events
	• Social prescribing models in place
	• Health checks in place
	• Dialog linked to care planning
	• QII model embedded
	• Recovery College availability extended
		• Increase in access to talking therapies for people from protected characteristic groups
		• Data collection and analysis
		• Community development and peer support work underway
		• Development work around culturally appropriate models of services and use of culturally specific measures of mental health and illness
		• Cultural competency and change programme in place for staff
		• Implementation of full recommendations from reports
		• Co-production and involvement strategy, plan and processes
		• Expert panels in place
			• Improvement in staff retention
			• Increase in vacant posts filled
			• Reduction in sickness absence
			• Improvement in staff element of Friends and family Test results
			• Increase in workforce diversity
			• Increase in staff from protected characteristics groups in leadership positions
			• Improvement in staff survey results
			• Increase in permanent staffing levels
			• Stabilisation and then equalisation of the gender pay ratio
			• Making Life Better Together programme delivering change for staff
			• Quality leadership programme available
				• Financial balance delivered annually and 3-year plan in place
				• KPIs delivered (operational and contracting)
				• Improvement in corporate service efficiency
				• New inpatient facilities delivered through EMP
				• Services expanded through additional investment
				• Information on and access to services streamlined
				• Increase in service accessibility
				• CIP planning and delivery in place
				• Model Hospital and corporate benchmarking programmes in place
				• Transformation programmes in place and delivering around:
				  ○ Operational processes and flow

			• Apprenticeship, staff mentoring, community mentoring, work experience and community recruitment programmes underway • Freedom to Speak Up Strategy developed • Health and wellbeing activities in place for staff • Increase in positive and support behaviours	○ Service development and redesign ○ Smarter Ways of Working ○ Digital • Lessons learned reviews carried out to support change • Stakeholder engagement, influencing and thought leadership programme in place
Delivery delayed and/or challenges exist	• Improvement in service users safety indicators: ○ Fewer people take their own life ○ Fewer children and young people self harm • Measurement for mortality gap underway • Secondary prevention activities in place • Physical healthcare pathways in place with providers	• Equality across population groups in terms of services who: ○ Feel they have recovered from their illness ○ Are in settled accommodation ○ Are in employment • Reduction in inpatient admissions for people from BAME groups	• Succession planning underway	• Standardisation of clinical delivery across services • Outstanding rated organisation

3.2. For **Increasing Quality Years**, building on the improvements seen in the September 2023 review around least restrictive care, reduced restraint and support for physical health, positive service user feedback has remained relatively steady. Following the increase in our rate of serious incidents during the pandemic, we are now seeing this decrease back to below pre-pandemic levels, with considerable improvement in 2023/24 compared with other years. We are continuing to focus on reducing suicides and self-harm with the recent publication of a refreshed Suicide Prevention strategy.

3.3. For **Reducing Inequalities**, we reported improvements in the September 2023 review around more people from non-white backgrounds accessing support through Talking Therapies, embedding anti-racism across the Trust and positive work on the Health Inequalities and Equality, Diversity and Inclusion programme. For 2023/24, the access via Talking Therapies has continued, but equally so has the disparity in those from non-white backgrounds in our inpatient beds. We have begun the work to move away from the Care Programme Approach to more holistic care planning and the piloting of the use of DIALOG+ with increasing numbers of people having this as part of their care plan.

3.4. For **Making the Trust a Great Place to Work**, the September 2023 review showed that we were seeing small improvements across retention, sickness absence and vacancies against a challenging NHSE workforce background and our own Trust HR recovery. In 2023/24, we have seen continued improvements across these metrics and a further increase in colleagues from non-white backgrounds in senior leadership positions. Improving our retention and recruitment and creating fair career progression are remaining as top priorities as we move into 2024/25 so that we can sustain and further improve in this area..

3.5. For **Ensuring Sustainability**, we showed in the September 2023 review that the Trust had delivered financial annual commitments over the five-year period while growing substantially since 2018/19. This has continued in 2023/24 with our turnover increasing again. We opened Shaftesbury and parts of Springfield Village opened to the public and our community transformation programme has now transformed services in all our five boroughs. We are continuing to deliver transformation across all service lines with plans to work in an even more joined up way to deliver an Improved Patient Journey in 2024/25.

4. Conclusions and recommendations

4.1. The act of annually reviewing delivery of our Trust Strategy, enabling us to reflect on elements of success and challenges is positive in supporting a better understanding of where we need to continue focusing our efforts. We are seeing progress in more areas this year than last, and some pre-Covid, but there remains significant work to do.

4.2. Our strategic ambitions continue to be relevant, alongside the outcomes, structures and processes and we have worked to build delivery of the Strategy into this year’s annual planning and priority setting processes. We also continue to work very closely with system partners to deliver the new SWL Mental Health Strategy. The opportunities for collaboration will continue in 2024/25.

Appendix 1: Expected outcomes, structures and processes and core programmes

The expected outcomes, structures and processes to measure delivery were defined for each of the four strategic ambitions in the first year of the Strategy, with the original expectation that these would be achieved by the end of 2023/24. These are outlined below for reference:

Increasing quality years	Reducing inequalities	Making the Trust a great place to work	Ensuring sustainability
Outcomes			

• Improvement in service users safety indicators:
  ○ Fewer people take their own life
  ○ Fewer serious incidents occur
  ○ Fewer children and young people self harm
• Increase in the number of people who experience care in the least restrictive setting
• Improvement in physical health indicators for service users
• Increase in positive feedback from service users and carers
	• Equality across population groups in terms of services who:
	  ○ Feel they have recovered from their illness
	  ○ Are in settled accommodation
	  ○ Are in employment
	• Reduction in inpatient admissions for people from BAME groups
	• Increase in access to talking therapies for people from protected characteristic groups
		• Improvement in staff retention
		• Increase in vacant posts filled
		• Reduction in sickness absence
		• Increase in positive and support behaviours
		• Increase in workforce diversity
		• Increase in staff from protected characteristics groups in leadership positions
		• Improvement in staff survey results
		• Improvement in staff element of Friends and family Test results
		• Increase in permanent staffing levels
		• Stabilisation and then equalisation of the gender pay ratio
			• Financial balance delivered annually and 3 year plan in place
			• KPIs delivered (operational and contracting)
			• Standardisation of clinical delivery across services
			• Improvement in corporate service efficiency
			• Outstanding rated organisation
			• New inpatient facilities delivered through EMP
			• Services expanded through additional investment
			• Information on and access to services streamlined
			• Increase in service accessibility

Structures and processes			
• Measurement for mortality gap underway • Use of quality of life and outcomes measures • Community partners delivering mental health events	• Data collection and analysis • Co-production and involvement strategy, plan and processes • Community development and peer support work underway • Development work around culturally appropriate models of services and use of culturally	• Making Life Better Together programme delivering change for staff • Executive equality objectives in place • Quality leadership programme available	• CQC Always Ready programme in place • CIP planning and delivery in place • Model Hospital and corporate benchmarking programmes in place

• Social prescribing models in place • Recovery College availability extended • Health checks in place • Secondary prevention activities in place • Trust part of integrated care systems in all boroughs • Physical healthcare pathways in place with providers • Dialog linked to care planning • QII model embedded	specific measures of mental health and illness • Expert panels in place • Cultural competency and change programme in place for staff • Implementation of full recommendations from reports	• Apprenticeship, staff mentoring, community mentoring, work experience and community recruitment programmes underway • Succession planning underway • Freedom to Speak Up Strategy developed • Staff networks strengthened. • Health and wellbeing activities in place for staff	• Transformation programmes in place and delivering around: ○ Operational processes and flow ○ Service development and redesign ○ Smarter Ways of Working ○ Digital • Lessons learned reviews carried out to support change • South London Mental Health and Community Partnership (SLP) further developed • Stakeholder engagement, influencing and thought leadership programme in place

In addition to outcomes, structures and processes, the Strategy defines five significant programmes aimed at moving enabling delivery. These are:

a. Quality improvement and innovation (QII)
b. Co-production and service user and carer involvement
c. Collaboration and partnership working
d. The Estate Modernisation Programme (EMP)
e. Transformation

Meeting:	Trust Board
Date of meeting:	9th May 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 quality and safety 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. Demand, resource and capacity, and violence and aggression continue to be the biggest and most persistent challenges that QSAC considers.

1.2. 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. The Committee also supports the relaunch of the Funamental Standards of Care in order to bolster improvement in these challenging areas.

1.3. The Committee continued to receive 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.

1.4. The Committee has asked for further papers on the current situation regarding waits across the Trust, the effectiveness of the emergency response procedures for both physical and mental health emergencies, inappropriate behaviour of staff and the continued work around observations including the falseification of records.

1.5. The Committee will be reviewing the self assessments against the Greater Manchester report (a.k.a. the Edenfield Inquiry) and Nottingham CQC report.

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?

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:

- From March 2024, QSAC would only review the ERR which contains the most significant and serious operational risks across the Trust, rather than all the amber level risks within the service lines, allowing QGG to take accountability for oversight of those risks. This would allow greater focus on more serious operational risks.
- No risks were increased since the last Board.
- A new risk was added in March – the risk of not meeting the Trust's strategy, due to the flux of the external environment, partnerships and other factors. A suite of mitigations were in place and captured in the ERR.
- A new risk was added in April - around bed capacity for CAMHS and ED, with mitigations and controls in place.
- Two risks were reduced in March – Employment Tribunals and Medical Workforce. There had been a lot of good discussion for assurance before the risk scores were reduced. Whilst it was acknowledged that both risks were far from being resolved, QGG and ELT had been satisfied that the work and actions to date justify the risk reduction. This would be kept under close review.
- The Trust benchmarked favourably for medical workforce vacancies in March but were at a significant deficit, particularly in community services. There would be a watching brief in this area.
- Two risks were closed in April and integrated into other risks - lack of integrated electronic record across CAMHS and adult services and effective patient flow within the acute in-patient beds (demand and capacity).

So what: QSAC reviewed the mitigations. The Committee discussed why the patient flow and acute inpatient beds risk was scored 16, given the impact of lack of flow. It was agreed that there was a need to be clearer that the risk being managed was to patient care and quality, but this was being mitigated to a score of 16. This would be revised via the BAF before the next meeting, then the summary update would be reflected in a revised update in the ERR.

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. It was agreed that the ERR would have a standalone risk appetite rather than for each risk on the register. There would be consideration of a financial risk should the system go into Oversight Framework (OF) rating OF4.

The following risks would be reviewed for the May meeting:

- Violence and Aggression
- Physical Health (following a review of the service)
- Industrial action
- Tolworth Development
- Car Parking (for indirect consequences e.g. recruitment and retention impact).

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 noted the following:

- There would be a Physical Healthcare risk following four unexpected patient deaths of young patients (in their 40s).
- The Committee remains concerned about, and interested in, violence and aggression towards staff, restrictive practice and observations. Incidents on Ward 1 (PICU) were a particular concern. The Committee heard assurance that the Service Line leadership team were working closely with the ward. In addition, in March and April, to support the team, three beds had been closed as a short term measure. This reduced both the levels of observations required and the number of staff per shift; however the level of concern held by staff had not reduced. The reduction in beds was also a significant risk to other acute wards as it moved pressure to other areas. Ward 1 had been working on culture change/quality improvement over a few years. There were some longstanding staff and very new staff and that combination was challenging. An Appreciative Inquiry had been commissioned, which would not be an immediate fix and it would be important to make sure the Inquiry was framed in a way to ensure our front line staff were heard and felt heard. There was a strong racial element to the work as well as the majority of staff on Ward 1 were BAME staff.
- Concerns remained around alarms in the new buildings. The Committee heard that Mike Hever had been working on this.
- Emergency responses were being reviewed weekly at Quality matters.
- The Committee liked the addition of the learning from other organisation's inquests

What next? QSAC would look to receive updates on the issues in Ward 1, with the alarms and emergency responses. It looked forward to receiving the outputs of the physical healthcare review. An emergency response update was requested for the May QSAC meeting.

In March I raised that there were two cases within the Quality Matters escalation report with immediate and troubling learning; I requested a paper to come back to QSAC identifying immediate learning after an incident and how the Committee could be assured the learning was producing the changes we would want.

<u>Quality and Performance Report</u>

What: QSAC received the report and discussed priorities arising, noting that the Trust would be continuing the focus 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 Trust continued to deliver and maintain safe care during a challenging time. The transformation work was becoming more integrated transformation across acute and community, to look at the patient flow across the Trust.
- The Trust were continuing to work across the SLP around CAMHS beds. Community were working well to streamline pathways and align them more closely at place level, but the service was still quite challenged for inpatient capacity.
- Some of the Trust's quality indicators were improving, such as vacancy rates and around observations and compliance (however, there were still gaps being found in this area through audits).
- Overall performance was RAG rated "amber" due to the continued pressures across AUC and neurodevelopmental waits for both adults and CAMHS services. ADHD waiting lists remain high. There would be a deep dive during the summer regarding access. A waiting list initiative had started. The stepped care pathway will be raised again with the ICS and the waiting list initiative will be reviewed in a few months' time to see if there had been any impact.
- There had been an improvement in Friends and Family Test scores.

- This month in the Community Services and CAMHS service line reviews there had been a focus on Fundamental Standards of Care (FSOC), as if these were done right we should see improved inpatient Length of Stay and caseloads.
- MAST compliance remained a concern.
- A priority for the coming year was violence and aggression and its impact on patient safety and staff.
- Service Line reviews would be strengthened so that those teams who were of concern would be discussed as to how QI resourcing could be used to go into teams to do something different and make change happen.

What next? QSAC will continue to monitor performance in specific areas, including assurance around restrictive practices, use of and compliance with observations, wait times, the efficacy of the emergency response procedures, and inappropriate behaviour of staff. A refresh of the QSAC focussed session on access would come to QSAC in Summer 2024.

That despite the hard work the Trust were now out of benchmark for length of stay (ten days longer than a number of other areas). Exec Leads and teams had commissioned a piece of work to look at length of stay as it was a big patient quality issue as well as a financial and sustainability issue.

Edenfield Self Assessment and Nottingham Self Assessment
What: There had been a letter from Clare Murdoch when the Edenfield Panorama programme was first on television. There were four key areas in the letter and the Trust were asked to provide an assurance position on all four. This had been presented to Board in October 2022. When the Edenfield report was published this piece of work was refreshed as a self assessment. When the Nottingham report was published this was included within the self assessment.

So What: ELT had agreed each executive would review the areas within their own portfolio, and would complete a self assessment against each of those areas.

What Next: QSAC would continue to review the self assessment document.

Board Visits Reporting
What: QSAC reviewed the feedback from the Board visits. These take place after each Board meeting in public and Board seminar. Feedback is being formalised and taken through QGG and QSAC, to get assurance that these visits are making a difference to staff and services.

Board members had visited 57 teams over the last 15 months. There had been a good proportion across all service lines.

So What: Feedback included issues around feedback across services, morale of staff, leadership engaging with staff, recruitment, parking at Springfield and its impact e.g. patients being late for appointments.

What next: The Quality Governance team were to establish a more robust system for when they get Board member feedback as to how it was shared with Service Lines and how it was taken forward.

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

- CQR report
- Mental Health Law report Q3
- Quality Priorities
- Always Ready

○ CQUIN/Quality Accounts Q3 ○ Duty of Candour ○ Medicines Management six monthly update – it was agreed to receive this report annually only going forwards.
Appendices • Ratified minutes of the meeting of February 2024.

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 6 February 2024, 10:00am – 12:00pm, Trinity FF Meeting Room 4, Springfield Hospital

Present:

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

Attendees:

Carol Anne Brennan (CAB)	Lived Experience Representative
Emdad Haque (EH)	Associate Director of Health Inequalities and EDI
Mike Hever (MH)	Deputy Director of Nursing
Tom Lelmezh (TL)	Mental Health Law Manager (item A24/32)
Dr Iram Sattar (IS)	General Practitioner (observing)
Ryan Taylor (RT)	Associate Director of Clinical Governance and Risk

Minutes:

Emma Whitaker (EW)	Deputy Director of Corporate Governance

Apologies:

Jaydene Campbell (JC)	Lived Experience Representative

Item		Action
A24/23	***Welcome and Apologies** Apologies were noted as above. The Chair noted that there were no Diversity in Decision Making representatives in attendance and no apologies were received from them. He asked for this to be explored with them after the meeting.	**SS**
A24/24	***Declarations of Interest** No new declarations of interest were reported.	
A24/25	***Chair's action** No Chair's actions had been taken since the last meeting.	
A24/26	***Minutes of the previous meeting** The minutes from the meeting of 9 January 2024 were agreed as a true and accurate record with the following amendments: Page 2 – It was asked that the discussion around how the Committees would only review risks that had already been to ELT and QSAC would only review ERR risks rated over 12 be made clearer. Page 4 – The first discussion sentence on the Q&P report should be amended to say: "It was recognised that the Trust had a number of metrics in the Q&P report that were not performing".	

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

Item		Action
A24/27	***Action Tracker** The action tracker was noted and amended as follows: A23/107 – BAF cover sheet – This action had been completed and was closed. A23/194 – Triangulation between SIREN and CQRs – The quality team were going to use Service Line Review (SLR) discussions, the Q&P report and SIREN to triangulate with those teams coming out as "requires improvement" in the Care Quality Reviews (CQRs). Claire Reid, CQUIN, Quality Account and Compliance Manager, would pick this up in the next CQRs. These would come back to QSAC through the CQR report. This action was now completed and was closed.	
A24/28	***Executive Risk Register** The Committee noted and accepted the Executive Risk Register (ERR). **Reported:** • There were no risk changes in month. • There were two new risks around the Romeo system; previously these had been incorporated into the overarching observations and engagement risk. • There was a new risk around the malnutrition screening tool used within acute and specialist services. • The CAMHS RIO interface risk had been closed. There was a similar risk with IAPTus services. • Recent allegations of professional misconduct against staff chimed with the findings of the Edenfield / Greater Manchester review. • Right Care Right Time – This was initially thought not to need an individual risk but this needed to be reviewed. • It was noted that risks around EDI/Health Inequalities directly were in the Board Assurance Framework (BAF) and not the ERR. After reflecting on the staff survey full results this would be reviewed to see if any particular risks were needed on the ERR. • Next month the QSAC would review the ERR only (rather than the ERR and risks over 12 from the Service Line risk registers) to allow greater focus on more serious operational risks. **Discussed:** The paper cover sheet needed a word added (in italics): "It was felt that the board-subcommittee receiving risk information that had not been seen by ELT was *not* conducive to good governance or logical". There was a key theme around professional conduct issues. These included inappropriate behaviour of staff to patients, and poor and inaccurate record keeping most noteworthy around observations. It was asked what actions were being taken and when this would come back to QSAC. This was clearly a high risk and would be put onto the ERR. The Chair added that there was a separate Cavendish Square piece of work around inaccurate record keeping particularly around observations. It had been agreed at the last QSAC meeting that the quality risk and other risks with quality components on the BAF should come for review on a regular basis and this had not yet happened. RT responded that the cover sheet points out that the only change to the Quality and Safety BAF entry was adding the risk appetite. CAB raised that there had been a recent report on Valporate. The ERR stated that it was not clear at the moment which patients were using it for mental health and which were using it for epilepsy. The report had stated that women and men under a certain age should not take this drug; she asked if this should be included in the	

Item		Action
	ERR. BB responded that national guidance on Valporate had changed recently and the Chief Pharmacist was working on this with BB and SS.	
A24/29	***Quality Matters** The Committee noted and discussed the Quality Matters report. **Reported:** • The external quality governance health check report had been shared with the Service Line leadership teams and deputies. This would come back through QSAC in March. Some actions were already underway; for example, the QCG had been streamlined to once a month. The Service Lines and corporate teams continue to scope actions required to meet the recommendations within the report. • Complaints responses had improved but dipped down again and the team were still struggling to meet the KPI. There had been changes made in the team so it was hoped to see improvement in the next two months. • The number of Feedback live responses was increasing which was pleasing. Work still needs to be done at utilising this information to make meaningful changes. • We continue to struggle to sign off PIRs in a timely fashion. Work continues with the relevant managers to ensure that this happens. **Discussed:** In the refreshing of reports to QSAC the single sex breech report had been lost. This will be rectified in future reports. SS confirmed there had been no single sex breeches and no children placed on adult wards within the month. The Executive will review the risk around the current single sex arrangement and report back to QSAC It was noted that the papers noted a number of issues regarding emergency responses. This included individual cases as well as overall figures of DNA rates. It was also noted that the alarms on the Springfield site also remained on the risk register. SS responded that resus was a challenge and this had been bought up at the London Chief Nurses meetings. Regionally there had been an increase in coroners focusing on mental health services not providing resus consistently. The Trust had mandatory Basic Life Support training and simulations. DNA rates were monitored through Quality Matters. The Chair requested a one-off assurance position paper around emergency responses, what the challenges were, what was in place and how was this being monitored to ensure it was improving quality; including the number of resus incidents. The Appreciative Inquiry (AI) was due for discussion at People Committee in April when the People Strategy was discussed. If things have improved in the teams we would expect to see changes in SIREN but this had not seemed to have changed since the AI. The AI raised concerns around management, how leadership functioned and clear communication. Feedback from managers should show improvement in this. The AI team interviewed staff at 8a and above and the SIREN report is raised by band 7 managers. A full discussion on progress will be had within the people committee which the Chair attends. There was a variation in caseload size amongst community teams. JeA was leading on a piece of work around this. The teams were the same size as each other. For some teams, there were 250 cases and in other teams that increased to 750 with an impact on quality.	

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

Item		Action
	Agreed: A one-off position paper around emergency responses to come to QSAC. To include: what the challenges were, what was in place and how was this being monitored to ensure it was improving quality; and the number of resus incidents. The Executive will review the risk around the current single sex arrangement and report back to QSAC.	**SS** **SS**
A24/30	**David Hobbs** A minutes' silence was held for David Hobbs, a Lived Experience Member of QSAC for many years, who had recently passed away unexpectedly. His work with the Trust, his community work and the work he did with the wider SWL system had been invaluable. He had been a champion of patient experience, lived experience and always promoted co-production. He was the Chair of the Patient Quality Forum and had an amazing way of supporting all members of the Forum. QSAC and the wider Trust were very sorry to hear of his passing and wanted to ensure his importance to the Trust was noted and that his memory was honoured in this meeting.	
A24/31	***Quality and Performance (Q&P) Report** The Committee noted and accepted the Q&P report. **Reported:** • The Trust continued to remain in a stable position but continued to be challenged around flow and access, particularly for the neurodevelopment assessment services, adult services, CAHMS and some internal access to psychological therapies. The teams had seen some gradual improvements. • Work continues on observations and restraint. • Access to CAMHS beds across south London remains difficult. There were some complex patients with additional packages of care in place that were on wards in the Trust because of access to beds. • There was slow but ongoing improvement in the workforce and finance positions. Vacancies had been filled and the concern with the turnover under 12 months had been a false alarm. The presence and engagement of our workforce was significant in being able to make improvements on quality and effectiveness of care. It was an important factor for ongoing sustained quality of care. The Trust was delivering broadly on position and supporting a system which had a significant financial challenge. • We are looking to bring the adult pathway closer in more integrated way with partners in acute hospitals, social care and primary care. The focus on clinical outcomes was a key 'what next' for the Trust. It would remain important to understand the quality and efficiency of processes but there was also a need to measure if this work was helping patients recover. The Trust were commissioning a piece of work around clinical outcomes and this would be bought to QSAC in a once it is completed. • Work is ongoing around broader partnership working across SLP on acute services, complex care and eating disorders. Thinking about how we work with partners was important. The neuro service could not be sustained without negotiation of a better pathway with our Primary Care partners. • There was continued focus on workforce and a recruitment day held on Friday was successful, with a focus on fair and inclusive recruitment. **Discussed:** CAB asked about recovery and clinical outcomes. In Sutton it was hard to see a GP, there were a lot of changes going on to services and the feedback about the transformation of services from patients had not been positive. She asked how we monitor outcomes instead of inputs Trust wide. JeA responded that work had	

Item		Action
	commenced to understand the opportunities to work with patients and carers to co-produce the next phase of improvement on the whole patient pathway. She added that she would value CAB's engagement and support with this work. In terms of measuring clinical outcomes we have committed to the use of DIALOG +. We are making good and steady progress in this work. Concern was expressed that the scale of the waits across the neurological pathway was masking other waits that could not be seen in the aggregated data. JeA responded that the 52 week waits were the main issue and access was improving in most other areas. There was a plan to do a waiting list initiative for the internal waits for psychological therapies. There was the access and flow meetings that fed into Service Line Reviews. There was much better oversight of waiting lists as they were now all on RIO. There had been a QSAC focussed session on access more than six months ago. JeA suggested a refresh of this to come to QSAC in a few months for assurance. She would be keen to do this as her teams had done a lot of work on waiting list visibility and management since the focussed session. The Chair agreed for this to come back to QSAC. How work was going with ED colleagues. The Trust and ED colleagues were working well together and relationships were good. The work was starting to take effect and things were improving but this was in the context of pressure and anxiety. JeA would be working with Mike Hever to ensure appropriate grip and control. There had been some anxiety about the many initiatives happening in the Acute Service Line which were being worked through. VF and JeA meet with the teams often. The Liaison team had been flagged consistently as a team of concern, having leadership and recruitment issues. These issues had been addressed and improved but it would take time to embed the change. **Agreed:** A report to come to April QSAC with a programme focus in CAMHS and adult community services, regarding collecting and using clinical outcomes. A refresh of the QSAC focussed session on access to come to QSAC in May 2024.	**JeA** **JeA**
A24/32	***Mental health Law six month report** The Committee noted and discussed the Mental health Law six month report. **Reported:** • The report provided good and positive assurance. Compliance was very high in many areas. Some areas were challenging due to things outside of the Trust's control, such as the Mental Health Act reforms being postponed until after the next election. This meant that the Deprivation of Liberty Safeguards (DOLS) framework would remain in place for now. This would cause delays when applying for these authorisations and our patients end up in legal limbo with de facto detentions. This risk had been put onto the ERR. • The quality of recording the Mental Capacity Act on RiO has improved and training compliance had increased. • Last month there had been 92% compliance across the Trust for section 132 rights. This was supported through Feedback Live responses, where 83% of patients reported that they have been told their rights, and that these had been regularly repeated and reinforced. • There had been recruitment of Associate Hospital Managers which focused on BAME groups and Health Inequalities. • Use of the Mental Health Act had returned to pre-pandemic levels.	

Item		Action
	• The Courts have clarified s117 aftercare for when a patient moves boroughs; the responsibility for s117 funding moves with the patient. • The CQC were planning a focussed visit about Advocacy as they have concerns as to why, after the pandemic, the visibility of advocates on wards had decreased and referrals to advocacy services had declined. Wards need to be more proactive in referring patients to advocacy and inviting advocates to come to the wards to engage them. There were monthly meetings with local commissioners in Kingston, Richmond and Wandsworth, trying to improve referrals. The landscape was fragmented as each borough commissions different advocacy services. It is hoped to establish a single point of contact for advocacy referrals. This would be starting in Tolworth but hopefully would also move to Springfield. **Discussed:** The Trust often note in Community Treatment Orders (CTOs) the disproportionate treatment of Black men. There was not a specific programme around CTOs as there were other EMHIP interventions in place which were trying to deliver reduction in ethnic Health Inequalities. Associate Hospital Manager hearings rarely take patients off of CTOs. The Committee discussed that it would like to see some progress regarding this. The complexity of the issues were noted and a commitment to continue the work under the EMHIP workstream CAB asked if people from Sutton were involved in the Advocacy work. TL responded that the SPOC for advocacy would cover all five boroughs covered by the Trust.	
A24/33	**Mental Health Law scheme of delegation** The Committee noted the Mental Health Law scheme of delegation which had been reviewed at the Board seminar	
A24/34	***Clinical Effectiveness annual report** The Committee noted and discussed the Clinical Effectiveness annual report. **Reported:** • The team were on track with the commitments for the year with both business as usual and transformation. Progress was on track in a number of areas and all targets had shown some improvement. **Discussed:** RF raised that there had been an internal audit on Clinical Effectiveness reviewed in Audit Committee. RSM gave the audit Partial Assurance. It was good to hear that all of the audit actions were in hand. The paper says they are set out in the report but they were not included. SW responded that this was an error and he would email RF with the actions. The performance of the EIP team meeting their quality targets were raised in the report. It was asked if the team were on top of the issues that the audit picked out. SW confirmed that there was an internal programme of work focusing on the issues. **Agreed:** SW to provide a brief Clinical Effectiveness assurance position on progress made on to meet the quality standards within the EIP.	**SW**
A24/35	***Ethnicity and Mental Health Improvement Project (EMHIP) six month report** The Committee noted and discussed the EMHIP six month report. **Reported:** • This report had been to QGG and ELT and all comments received had been incorporated. • The EMHIP reset work was the main item for Committee attention. Following the meeting between Trust leaders, the ICB and the Wandsworth Community	

Item		Action
	Empowerment Network (WCEN), it was agreed to go ahead with some reset workshops. Outputs and outcomes would be measured. External consultants were being procured to lead on this work. **Discussed:** That progress on the EMHIP reset seemed frustratingly slow. A further meeting was planned with WCEN at the end of March and an update position on progress was expected in mid-February. The update needed to be clear and precise about what we have done and what we have not been able to do, and why. IS discussed one of the EMHIP key interventions around cultural capability - pastoral care being part of the assessment / care plan. She noted that Black and Asian people often say their faith and culture was not addressed in their care plans. From a Health Inequalities point of view it was important to do this. IS was talking with Wandsworth IAPT at the moment about incorporating this into care plans and she was also going to meet with EH about this. She added that it could be non-religious, it was more about using what sources of hope a patient has and considering these in care plans. BB added that EMHIP model two hubs are based within faith spaces and work with faith leaders. CAB raised that this work was not coming out in Sutton yet due to funding. Sutton had a different patient demographic than Wandsworth but within that the smaller ethnic demographic of Sutton might get left out. It was a hidden need in Sutton whereas it was more obvious in other borough demographics. VF thanked EH for his work on this. There had been a detailed conversation at ELT. It had been noted that there was a 15 month delay of the recruitment of the band 7 team leader. She did not think this would have been tolerated for any other team. The challenge to ELT from VF was how this had been allowed to happen. This had not been drawn out in the report, and should be included within the implication table alongside the impact and what we were going to do about it. If we are serious as a Trust about reducing Health Inequalities we need serious analysis in the report to allow a meaningful conversation.	
A24/36	***Use of Force update** The Committee noted and discussed the Use of Force update**.** **Reported:** • This report had been reviewed by Quality Matters and QGG. • For prone restraint data the Trust were an outlier, nationally and in London. In Q2 a significant piece of work to reduce prone restraints. We had supported our staff and trained them to do rapid tranquilisation injections. This was having the biggest positive effect on our data; in Q3 we halved the amount of prone restraints from Q2. • The data shows that BAME patients were experiencing more restrictive practice, such as rapid tranquilisation and exclusion. MH was leading a programme for the Cavindish Square Group to reduce inequalities in use of prone restraints in inpatients. It was noted that it was not a unique problem to our Trust. • There had been a significant increase over Q2 and Q3 of incidents of violence and aggression. The Q3 increase was linked to a higher number of patients being admitted under the Mental Health Act. EMHIP had recruited mediators, and they will be available on pilot wards, to try to avoid using restraint. Peer Reviewers will also be on wards, and this should help gather data around restraint as patients were more likely to engage with them rather than the staff who may have restricted them.	

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Item		Action
	• Handcuff use had reduced over time. We now only use them to convey patients from forensic wards to other locations. This was a Ministry of Justice requirement. • There had been a reduction in observations but these had risen again in Q3. The focus was a reduction in bank and agency staff use. CSLs do unannounced spot check audits to check observations, quality of recording, and will talk to staff about the code of conduct. This had helped with the reduction. **Discussed:** The chair noted that the prone restraint data remained above the mean in Q2 and was above the levels in Q1. Whilst there had been a drop from an 'astronomical' high point the trend remained high. This needed continued monitoring by the Committee and by the Executive and RRI group. Letters of concern around professional conduct had been sent to members of staff who were not compliant with observations. The letter included what the Trust expected with respect to compliance. That in the patient incident received in Part B of QSAC today showed that observations had continued to be recorded when a patient may be deceased. When the patient had left the ward the observations had also been recorded. This would be falsifying records. The Chair of QSAC would like to revisit this in a future meeting.	
A24/37	**Emergency Preparedness, resilience and response Annual Assurance Report 2023-24** The Committee noted the Emergency Preparedness, resilience and response Annual Assurance Report 2023-24.	
A24/38	**Quality Governance Group minutes** The Committee noted and accepted the minutes**.**	
A24/39	**Agenda for the next meeting – March 2024** The Committee noted the agenda for the March meeting.	
A24/40	**Meeting Review: (a) Patient focus (b) Quality of challenge and (c) Health Inequalities focus** This item was not discussed due to the main agenda items overrunning.	
A24/41	**Matters for Escalation for the Board** The following matters would be reported to the Board via the QSAC Chair's report: • Q&P report discussion; • ERR discussion; • Quality Matters discussion; • Review of the Mental Health Law and EMHIP six monthly reports; • Review of the Clinical Effectiveness annual report; • That QSAC will be reviewing the external quality governance health check report and implementation plan.	
A24/42	**Next meeting:** Tuesday 5 March 2024, 9:30am – 12:00pm, MS Teams **Report deadline: 5pm on the 26 February 2024**	

Trust

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

Quality and Performance Report

February 2024

Glossary

Term	Meaning	Term	Meaning
ALOS	Average length of stay	IPC	Infection Prevention and Control
BAF	Board Assurance Framework	KPI	Key performance indicator
BCAG	Business Case Assurance Group	LOS	Length of stay
CAMHS	Child and adolescent mental health services	NHS	National Health Service
CMA	Cardio-metabolic assessment	NHSE	National Health Service England
CQC	Care Quality Commission	PALS	Patient Advice and Liaison Service
CIP	Cost Improvement Programme	PPE	Personal protective equipment
CQUINS	Commissioning for quality and innovation	QII	Quality improvement and innovation
DNA	Did not attend	QSAC	Quality and Safety Assurance Committee
EDS	Eating disorder service	RTT	Referral to treatment
EC	Modernisation Committee	RIDDOR	Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations
F&P	Finance and Performance Committee	SIs	Significant incidents
FFT	Friends and family test	SLM	Service line management
FSOC	Fundamental Standards of Care	OF	Oversight Framework
GP	General practice	Trust	South West London and St George's Mental Health NHS Trust
HoNOS	Health of the Nation Outcome Score	WTE	Whole time equivalent
HTT	Home Treatment Team	YTD	Year to date

Contents

Part A: Executive Summary

What

The focus of this report is February 2024 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. The key areas of underperformance remain around adult acute flow and long waits for access to neurodevelopmental screening and treatment within adults and CAMHS services. There is continued stronger performance on a range of priority clinical indicators, including impressive achievement of Talking Therapies access and recovery rates (despite very limited investment in services). Patient feedback has shown sustained improvement in the patient FFT scores. However, we are concerned about compliance with Fundamental Standards of Care more broadly, where improvement work is ongoing to address areas of underperformance across both acute and community services as discussed in the SLR meetings. CAMHS services have experienced challenges with Tier 4 bed availability across SLP placing pressure on SWLSTG inpatient services.

Our workforce indicators are showing some improvement with reduction in vacancy and turnover rates sustained, and with Staff Survey results moving in the right direction; albeit with much more to do in some areas. Our SIREN tool shows concerns with teams reporting the pressure and challenges they face, which aligns with the external environment and the level of demand for our services, as well as gaps in our workforce recruitment and retention. We are concerned about MAST compliance especially as the mandatory training burden increases over time as we aspire to ensure our staff are best skilled to meet patient needs.

The opening Trust plan was a £0.2m surplus for the year. To achieve this, the Trust needs to deliver savings of £13m. Cumulative savings delivery to Month 11 contributes £12.6m towards this target and the Trust now has 100% confidence in being able to deliver the full £13m during the year. NHSE required all trusts to undertake a formal reforecast as part of the H2 planning (second half of financial year to 31/03/2024) - as part of this the trust will receive an additional c£0.6m of income and is forecasting a c£1.0m surplus which is reflected from M11 reporting onwards. Underlying pressures remain unchanged.

So What

The challenges facing us are considerable, and we continue to deliver across a range of care standards despite significant demand and capacity pressures that cannot be mitigated entirely. There remain risks to our acute patient pathway both in timeliness and quality of care and we are working hard with our clinical leaders and teams to mitigate these through short and longer term actions, including a focus on immediate patient flow and fundamental standards of care, as well as our integrated transformation programme, which builds on a lot of work and investment into our community and acute pathways over the last few years.

We continue to work collaboratively with system partners including acute and Local Authority colleagues to deliver changes to flow and patient pathways across a range of settings and projects and are maintaining good relationships despite the significant pressures. Our relationships across SWL and South London are becoming increasingly complex as we work across systems and we are actively engaged at place, ICB and regional level to ensure we can influence and improve the quality of services where this is needed, for example through the implementation of NHS111 press 2 for MH and its impact on our local MH crisis line, and in terms of increasing CAMHS inpatient bed capacity and the right and timely care for young people from South London.

Improvements around our workforce are positive and we must build on these to create the leadership and front line clinical capacity to deliver the best care and continuously enhance our services. Patient and staff feedback shows progress towards the experience we aspire to, but it is critical that we do further work as we know that our staff do not always have an equitable experience and our patients do not always receive equitable care. The Trust is in a relatively stable financial position in the context of significant deficits across SWL ICS. More recurrent savings plans would support longer term financial sustainability.

What Next

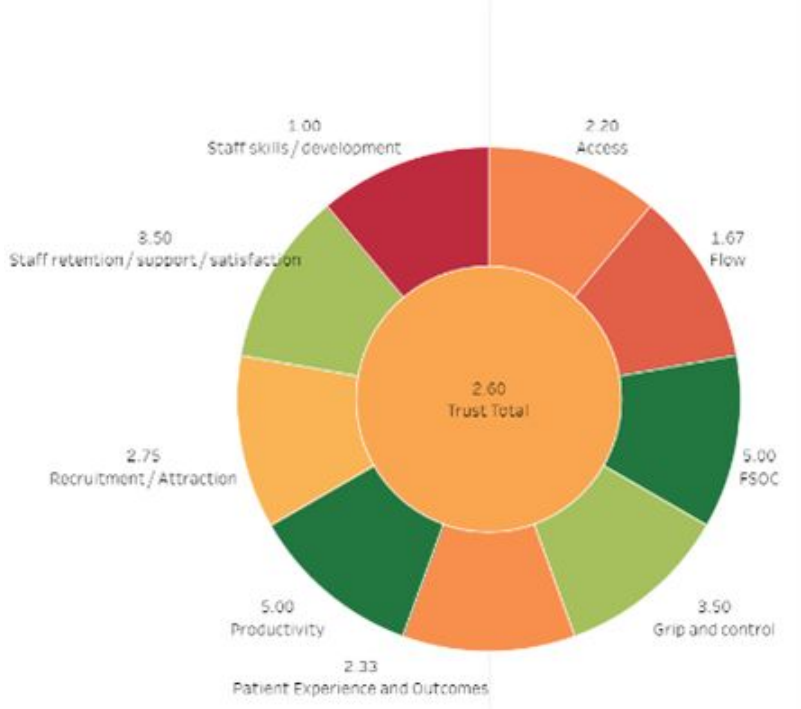
Our Adult Patient Journey transformation and Making the Trust a great place to work objective are in development as our key annual delivery priorities for the coming year. Significant staff and patient engagement is planned to ensure there is buy in to the work, as well as a shift to focus on clinical outcomes as well as quality improvement, including aligning to the roll out of Dialog+ and recovery measures.

We are building on partnership working across SLP to address challenges in our specialist and CAMHS pathways, and with our Place and ICS partners on prevention, interface with primary care, and investments to address significant demand pressures across our services.

We will build on improvements in our workforce metrics to further enhance our workforce stability and morale, particularly looking at local recruitment, as part of our commitment to being an anchor institution, and on anti-racism and inclusivity in everything we do for and with our staff. The SIREN remains an important tool through which we understand team experience and we will continue to embed this in practice across management teams, with a view to empowering local clinicians and team leaders to improve on the challenges they report. Our People Strategy is in development and our leadership offer to our staff is in progress, which will align with developing the capability to address ongoing challenges across our services in staff experience as well as broad buy in and commitment to transformation work.

Moving towards 2024/25 we will refresh our Q&P framework to ensure focus on the Oversight Framework and ICS measures, recovery outcomes, as well as those metrics which measure the success of our integrated transformation.

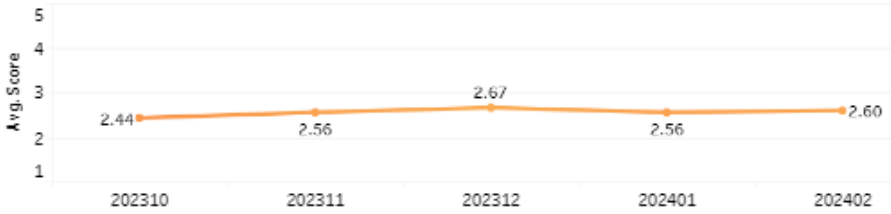
Quality & Performance Summary (see appendix 3 for explanation on scoring)



Summary Domain Performance:

Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations		6	7	46.2%
Quality	2	1	2	60.0%
Workforce		2	2	50.0%
Finance	1	1		100.0%
Total	3	10	11	54.2%

Donut Performance over-time (all themes combined):



NHS: Oversight Framework

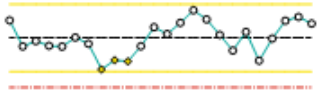
Theme	Metric		Period	Previous (OF) Update	Performance (OF)	Internal Trust Metric	Internal Trust Metric
Trust	S035a	Overall CQC Rating	Most Recent	3 - Good	3 - Good	N/A	N/A
	S059a	CQC Well led rating	Most Recent	3 - Good	3 - Good	N/A	N/A
Workforce	S067a	Leaver Rate	Jan-24	10.20%	9.1%	13.4% (Feb 24)	Staff Turnover
	S068a	Sickness Absence Rate	Jan-24	4.63%	4.8%	5.27% (Jan 24)	Yes
	S071a	BME senior staff %	2022	15.20%	15.20%	31.3% (Feb 24)	Yes
	S071b	Female senior staff %	May-23	55.60%	55.60%	68.8%	New metric for 24/25
Experience	S072a	Staff Survey fair career progression	2023	47.60%	49.93%		N/a External Survey
	S121a	Staff Survey compassionate culture people promise sub-score	2023	7.08 (out of 10)	7.24 (out of 10)		N/a External Survey
	S121b	Staff Survey Raising Concerns sub-score	2023	6.49 (out of 10)	6.50 (out of 10)		N/a External Survey
	S133a	Staff Survey Compassionate theme score	2023	7.34 (out of 10)	7.44 (out of 10)		N/a External Survey
	S063a	Staff Survey Bullying score (from managers)	2023	11.50%	8.76%		N/a External Survey
	S063b	Staff Survey Bullying score (from colleagues)	2023	16.40%	16.12%		N/a External Survey
	S063c	Staff Survey Bullying score (from patients/public)	2023	27.10%	27.51%		N/a External Survey
	S069a	Staff Survey engagement theme score	2023	6.99 (out of 10)	7.11 (out of 10)		N/a External Survey
Flow	S038a	Consistency of reporting patient safety incidents	Jan 23-Jun 2023	50%	50%		TBC clarification required
	S125a	Adult Acute LoS over 60 days	May-23	35%	35%	29.2%	New metric for 24/25
	S125b	Older adult LoS over 90 days	May-23	39%	39%	37.5%	New metric for 24/25
	S086a	Inappropriate Out of Area placement bed days	May-23	1010	1010	335 (Feb 24)	Yes

NHS: Oversight Framework – Commentary, Actions and Risks

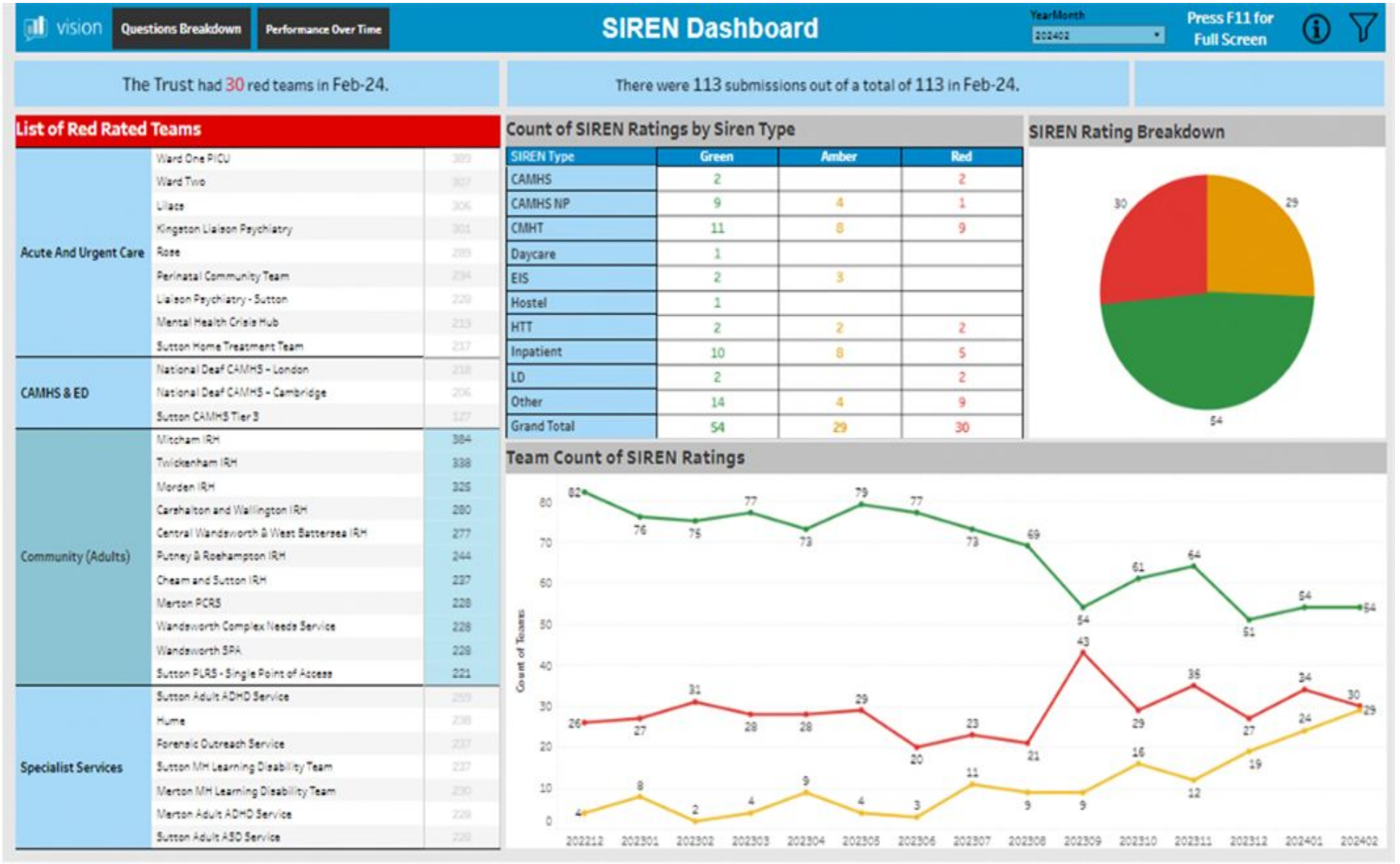
Theme	Metric		Comment	Actions in train	Areas of risk
Trust	S035a	Overall CQC Rating	CQC rating remains in situ until next inspection, timeframe unknown.	Continuing programme of quality improvement, including FSOC, to enhance standards of care.	Significant areas of non-compliance with FSOC in some areas, refer to FSOC page. Recent trend in incidents relating to PH care and V&A with action being taken to explore and support improvement plans, linking V&A to broader staff survey theme.
	S059a	CQC Well led rating			
Workforce	S067a	Leaver Rate	Unable to reconcile to internal Trust metrics but broadly improving position around turnover / sickness following HR recovery.	• Turnover rates continue to improve and we are seeing a direct link to improvements in areas where we have had success in recruiting substantively. • Our retention plans continue to make progress and we are gaining information from our Stay interviews about what encourages people to stay. We have legacy mentors (learning from the national vanguard teams) in recruitment. • The Health & Well Being Strategy update went to People committee in February 2024. We have met with Occupational Health and this is proving helpful in identifying themes, enabling us to target actions to respond. • Sickness Absence Policy is currently in consultation with our Staff side with a view to have this agreed by May 2024. • We have recently had an internal audit on sickness absence, which identified some actions related to clarity over responsibilities between HR and managers, record keeping and updates to the policy. Sickness absence sessions to be booked in for managers to provide increased support and capacity.	Sickness absence cases have increased but this has resulted from our proactive management of identifying cases and working more productively with leaders.
	S068a	Sickness Absence Rate			
	S071a	BME senior staff %	Trust performs well on BME / female representation at senior level, unclear how high performance reflects into OF due to the way it is assessed as quartiles.	Our annual delivery plans focus on fair recruitment and the career progression of our BAME colleagues. We have data to determine where our interventions should be focussed. The WRES action plan which has been co designed with our Evolve network focusses on career development. Our Talent Strategy is due to be shared in April 2024 which will further support development of BAME colleagues.	Concern remains due to poor reported experience of BME staff around fair career progression, which would undermine progress on this metric
	S071b	Female senior staff %			
Experience	S072a	Staff Survey fair career progression	Significant challenges around key areas of staff survey results for a number of years. Our latest staff survey in 2023 highlights that while we have made a great deal of progress in improving people's experience of working here, there is still distance to travel in a number of key areas.	Following detailed data analysis (and improvements that were made in each of the three areas of focus last year), we have set ourselves another three areas of focus for 2024: • Fair Career Progression – with a particular focus on BAME and staff with disabilities. • Health and wellbeing – increased support for stress, anxiety, burnout including building resilience and equitable flexible working opportunities. • Feeling safe to report and follow up – including increased support around violence from patients and public. These will form part of our Annual Delivery Plans and service line workplans and updates will continue to be regularly offered through internal communications. Progress against these areas will be monitored through People Committee. Detailed action plans are in place for the staff survey, new OD hub development, new board and EAG, and anti-racism learning into action.	Bullying and harassment from patients: 27.51% • We have deteriorated in this area, and as noted above, this will be a particular focus from the themes coming from our 2023 staff survey results. Specifically: • New working group to develop our approach to violence and aggression, led by Chief Nursing Officer • This will absorb the work of the post incident support group. Raising concerns sub score: 6.5 • New area of focus requiring continued action.
	S121a	Staff Survey compassionate culture people promise sub-score			
	S121b	Staff Survey Raising Concerns sub-score			
	S133a	Staff Survey Compassionate theme score			
	S063a	Staff Survey Bullying score (from managers)			
	S063b	Staff Survey Bullying score (from colleagues)			
	S063c	Staff Survey Bullying score (from patients/public)			
	S069a	Staff Survey engagement theme score			

Flow	S038a	Consistency of reporting patient safety incidents	Unable to fully understand definition of this metric - relates to CAS alerts. Internal information suggests 83% compliance for the relevant period	We are amending our CAS policy and method of reporting performance on this metric to QSAC to drive performance to 100% going forward. Since October 23 last year (when this came up) we have met the acknowledgement timeframe and the completion deadlines for the 6 Alerts issued (i.e. 100% performance). One outstanding CAS alert from Aug 23 has met its scheduled completion date of 1 Mar 24.	Appears low risk following improvement to processes.
	S125a	Adult Acute LoS over 60 days	Improvement noted on all three metrics since previous OF report. However, still significant improvement required. Long LOS likely to be a key focus of future transformation – these two KPIs now added to Board Q&P OOAPs trajectory to zero will be required for 24/25 – we have reduced OOAP numbers due to consolidation to use of in-area private beds, to support better care but creating financial cost pressure	A range of actions are in place to address acute WAA and OA LOS primarily through our Acute, Community and Older Adult transformation programmes. Much work has been completed around improved crisis services, discharge planning, and supporting patients with complex emotional needs, as well as improving services for patients in community with a focus on preventing deterioration and supporting discharge. However, significant impact on LOS has not yet been seen. There has been greater complexity amongst our acute inpatients, as well as an increasing level of challenge in finding the right onward accommodation and support for these individuals. This impacts on the level of longer staying patients, which significantly drives longer LoS. We are addressing this through our Strategic Operational Interface meeting with Local Authorities and our Complex Care SLP programme, to enhance system wide working, for example through adopting a common SWL Discharge and Choice policy and through developing step-down rehab facilities for our patients. There are ongoing discussions with Local Authority directors and a development of the complex care work to enhance acute interfaces including step down beds. For older adult acute care, there are similar challenges in discharge pathways due to patient complexity and limitations of the support/ capacity available in community settings (especially higher/ comorbid needs nursing care). We have moved to electronic bed management for better oversight of flow, have instituted a new DTOC escalation meeting, and are working on complex discharge pathways with SWL ICS and local authority colleagues. Moving forward, the Adult Patient Journey programme will bring acute and community transformation work together into a more integrated form with a focus on purposeful care; prevention of crisis; timely and least restrictive care (including reducing LOS) and recovery and step down. An analysis of the drivers of long LOS is underway and will inform specific interventions, while more integrated programme structures and leadership are planned to support delivery.	Complexity of patients leading to there being both DTOC and not CRFD patients with long LOS. Social care resources and Community resources limitations, which lead to longer LOS and therefore need to use additional beds. Trust across teams (internal and external) needs to be built through integrated transformation and development of cross-SL pathways, avoiding hand offs and building a more collaborative approach to care.
	S125b	Older adult LoS over 90 days			
	S086a	Inappropriate Out of Area placement bed days			

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

ICS Long Term Plan Metrics	Feb-24	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 Talking Therapies (Trust)	22,407	22,166		Trust is slightly above its cumulative access requirements for 2023/24.
Number of adults and older adults with severe mental health accessing community mental health services	11394	-		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	335	≤0		Trust continues to require use of out of area beds due to high demand. Trust has renegotiated use of beds at Holybourne, now has use of 30 beds which commenced on 1 December 2023 for a year to December 2024.

SIREN


vision
Questions Breakdown
Performance Over Time
SIREN Dashboard
YearMonth
202402
Press F11 for Full Screen
The Trust had 30 red teams in Feb-24.
There were 113 submissions out of a total of 113 in Feb-24.
List of Red Rated Teams
Acute And Urgent Care
Ward One PICU
Ward Two
Lilace
Kingston Liaison Psychiatry
Rose
Perinatal Community Team
Liaison Psychiatry - Sutton
Mental Health Crisis Hub
Sutton Home Treatment Team
CAMHS & ED
National Deaf CAMHS - London
National Deaf CAMHS - Cambridge
Sutton CAMHS Tier 3
Community (Adults)
Mitcham IRH
Twickenham IRH
Morden IRH
Carshalton and Wallington IRH
Central Wandsworth & West Battersea IRH
Putney & Roehampton IRH
Cheam and Sutton IRH
Merton PCRS
Wandsworth Complex Needs Service
Wandsworth SPA
Sutton PLRS - Single Point of Access
Specialist Services
Sutton Adult ADHD Service
Hume
Forensic Outreach Service
Sutton MH Learning Disability Team
Merton MH Learning Disability Team
Merton Adult ADHD Service
Sutton Adult ASD Service
Count of SIREN Ratings by Siren Type
SIREN Type | Green | Amber | Red
CAMHS | 2 | | 2
CAMHS NP | 9 | 4 | 1
CMHT | 11 | 8 | 9
Daycare | 1 | |
EIS | 2 | 3 |
Hostel | 1 | |
HTT | 2 | 2 | 2
Inpatient | 10 | 8 | 5
LD | 2 | | 2
Other | 14 | 4 | 9
Grand Total | 54 | 29 | 30
SIREN Rating Breakdown
30
29
54
Team Count of SIREN Ratings
Count of Teams
202212 202301 202302 202303 202304 202305 202306 202307 202308 202309 202310 202311 202312 202401 202402

SIREN – February 2024 Summary Commentary

- SIREN continues to be used within team and service line meetings on a regular basis to support understanding and action on concerns. The number of red rated teams has remained static, but there has been a shift from green to amber rating of teams overall, likely to reflect the ongoing pressures on our services and workforce.

- **Community: (key link to caseload LOS and waiting times, vacancy rates and use of agency, and team morale)**

❑ The number of red teams has reduced since the past month (from 15 to 11 out of 35). Common themes remain underlying workforce pressures (particularly with gaps in medical roles and Community RMNs – 30% vacancy rate in both – resulting in a reliance on temporary staff), sickness rates, continued high caseloads leading to poor staff wellbeing & burnout. Supervision levels and workload.

❑ A series of actions are in place for the Service Line: a new performance framework with each borough leadership team & the quartet where SIREN results are explored and responses agreed; a clear workforce plan to address recruitment challenges – a focus on improving the quality of supervision; initiatives to implement retention initiatives aligned with outputs of staff survey 2023 results.

- **A&UC: (key link to ongoing pressure on the crisis and acute pathway)**

❑ Slightly reduced (9) red rated teams (4 of which are inpatient wards). Rose Ward and Ward 2 saw an increase of unfilled shifts, complaints, sickness, low supervision rate and Bank usage. Unfilled shifts and Bank usage is monitored by the ward manager and Clinical Service Lead (CSL). CSL is supporting the ward manager with addressing complaints and supervision structure. Ward manager is managing sickness with HR support.

❑ Lilacs Ward: Increased staff investigations, unfilled shifts and sickness have resulted in an increased use of agency and bank. Recruitment and retention still an issue on Tolworth site, a standalone mass recruitment being considered for Tolworth due to the unsuccessful recruitment drive on the 28th Feb.

❑ Ward 1: Increased numbers of patients on constant observations which team are reporting increased stress levels. Levels of unfilled shifts increases as did bank usage and low supervision rates were low. Discussions of a support plan to focus and address immediate concerns with the exec team taken place and actions will be agreed by the management team. Sickness is being managed in line with policy and the workforce plan. To continue explore areas for development for management team through supervision and staff development.

❑ Concerns remain around Liaison psychiatry /crisis teams; the teams have vacancies which are yet to recruit however B7 nurse is acting up in team manager position, Consultant Psychiatrist retiring in March, with no locum cover confirmed. Long term sickness absence and vacancy rate means high number of unfilled shifts that are not consistently covered with bank. The vacancy factor continues to interact with stress levels, workload, and morale with high demand within the ED environment. Transformation work is ongoing focussing on process mapping in context of data requirements for each Liaison team and acute colleagues.

❑ Sutton Home Treatment Team high caseload, staff sickness and Band 6 vacancies. Low staff morale. New Team Manager (acting up) recently commenced in post, increase of patients with social issues meaning they remain on the caseload longer. Active recruitment for band 6 nurses and permanent Team Manager. Ongoing reflective practice for the team.

❑ Perinatal community team: Staff sickness, lack of admin cover, poor staff morale. No second Team Manager and CSL is due to leave with no immediate cover. Patients waiting longer than 28 days for initial assessment. On going active recruitment for TM and CSL cover.

- **CAMHS & AED: (link to demand in community deaf CAMHS teams)**

❑ Cambridge and London deaf CAMHS teams are experiencing high stress levels associated with increased demand, are also having to hold on to cases waiting for local CAMHS in Cambridge as waiting lists have increased to a year.

❑ Sutton Tier 3 Siren is red due to covering a psychiatry vacancy with an agency doctor who is also needing to cover Wandsworth CAMHS.

- **Specialist: (key link to ADHD assessment long waits)**

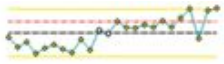
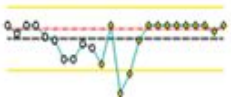
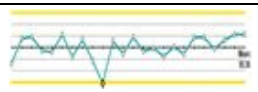
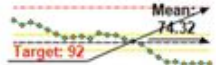
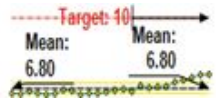
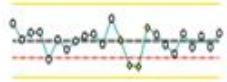
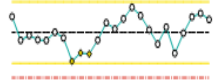
❑ Overall 6 teams showing red.

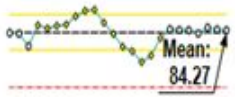
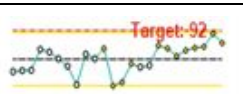
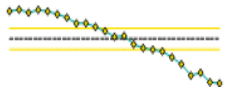
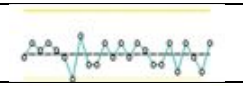
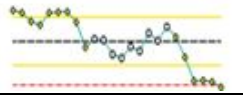
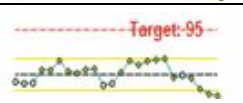
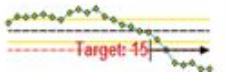
❑ 3 ADHD and ASD teams - issues reflect turnover, changes in leadership roles and high caseload. This is a recognized issue with support being offered but there is a challenge in addressing the waiting list due to delay in agreeing a new model by SWL ICB. Proposal to progress a waiting list initiative for ASD will address some of the 52 week breaches.

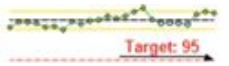
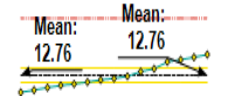
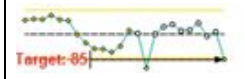
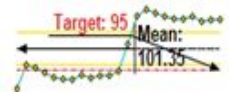
❑ 1 MHLD team showing red due to vacancy (and use of agency) and turnover rate relating to psychology and CPN roles.

❑ Jasmines ward improvement plan continues to be embedded and improvement and learning is being supported by SL leadership team.

Priority Metrics

	Priority Metrics	Feb-24	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 14)	42.9	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 15)	60	= 0	→	✗	
	Access					
	Referral to treatment (RTT): 52 week breaches (see page 17)	870	= 0	↗	✗	
	Access					
	Expected population need Talking Therapies – Trust (see page for service breakdown 17)	2320	>=2032	↗	?	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 18)	100	≥ 95.0	↗	?	
	Access					
	Adult Acute Bed Occupancy (see page 20)	99.2	≤ 90	→	✗	
	Flow					
	Number of adults and older adults receiving 2+ contacts in new integrated model across the core and dedicated service provision (see page 21)	11394	-	↗	-	
	Flow					
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (See page 14)	73.7	≥ 95.0	→	✗	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 16)	63.6	≥ 92.0	↘	✗	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 18)	7.4	≥ 10.0	↗	✗	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 19)	61.2	≥ 80.0	→	?	
	Access					
	Dementia diagnosis within 6 weeks of referral to a memory assessment service (%) (see page 19)	93.3	>= 85	→	?	
	Access					
	Adult acute average length of stay (Excluding PICU) (see page 20)	46.7	≤ 38	→	?	
	Flow					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 21)	335	≤ 0	→	✗	
	Flow					

	Priority Metrics	Feb-24	Target	Trend	Assurance*	SPC Chart
Quality	Cardiometabolic Assessments - Community and EIS (%) (see page 22) **Fundamental Standards of Care**	84.6	≥ 75.0	→	✓	
Quality	Patient Friends and Family Test (%) (see page 23) **Patient Experience and Outcomes**	88.6	≥ 92.0	↗	✗	
Quality	Paired HoNOS Completed (See Page 24) **Patient Experience and Outcomes**	35.2	-	↘	-	
Quality	Death - Suspected suicide (see page 25) **Patient Safety**	5	-	→	-	
Workforce	Vacancy Rate (%) (see page 26) **Recruitment/ Attraction**	14.9	≤ 15	↘	?	
Workforce	Statutory and Mandatory Training: 1 (%) (see page 28) **Staff Skills/Development**	90.5	≥ 95.0	↘	✗	
Workforce	Turnover (%) (see page 29) **Staff Retention/ Support / Satisfaction**	13.4	≤ 15	↘	?	
Finance	% Forecast Overspend (See Page 30) **Grip & Control**	-0.3	≤ 0	↘	?	

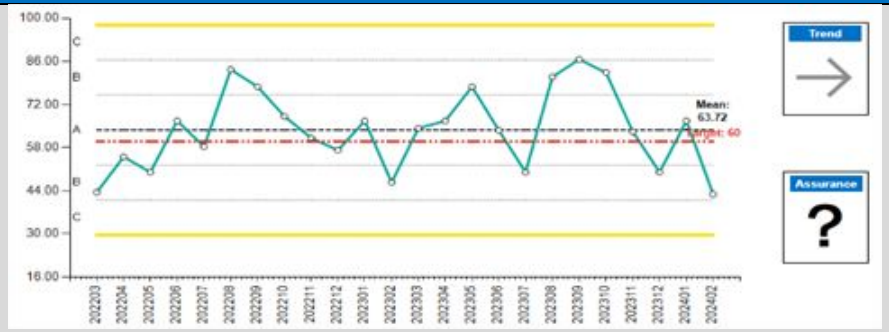
	Priority Metrics	Feb-24	Target	Trend	Assurance*	SPC Chart
Quality	Safe Staffing: National Compliance - Inpatients (%) (see page 22) **Fundamental Standards of Care**	135.3	≥ 95.0	↗	✓	
Quality	Talking Therapies recovery rate – Trust (%) (see page 23) **Patient Experience and Outcomes**	50.3	>=50	→	?	
Quality	Paired Dialog Completed % (see page 24) **Patient Experience and Outcomes**	22.7	≥ 40.0	↗	✗	
Workforce	Percentage of BAME staff - Band 8+ and Medical (see page 27) **Recruitment/ Attraction**	31.4	≥ 50.0	↗	✗	
Workforce	Statutory and Mandatory Training: 2 (%) (see page 28) **Staff Skills/ Development**	85	≥ 85.0	→	✓	
Finance	Activity vs Plan (Local Contract) (See Page 30) **Productivity**	110	≥ 95.0	↗	✓	

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

Operations Domain

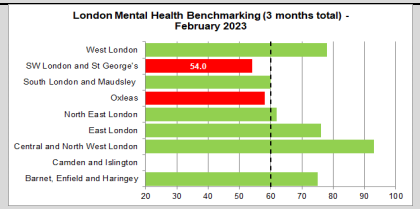
1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) Target ≥ 60%

Access



Team Breakdown –February 2024

Team	Treatment Within 14 Days	Referrals	% Treatment Within 14 Days
Richmond Early Intervention Team	2	3	66.7%
Sutton Early Intervention	1	2	50.0%
Wandsworth Early Intervention	2	5	40.0%
Merton Early Intervention	1	3	33.3%
Kingston Early Intervention Service	0	1	0.0%
Trust Total	6	14	42.9%



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.

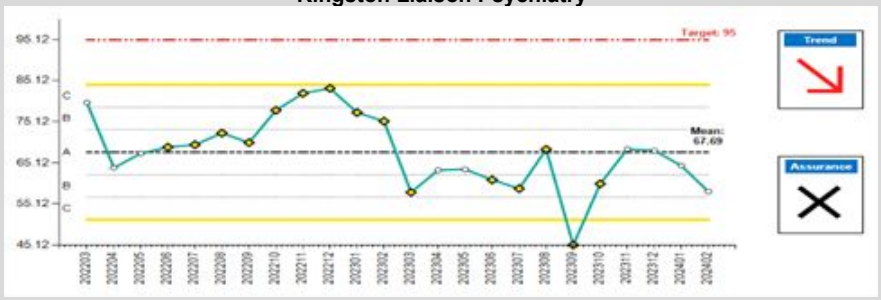
Underlying issues
- Some inpatient wards and adult assessment teams are slow to refer patients on to EI services once psychosis is identified making it much harder for them to meet the waiting time targets.
- RiO is not configured to allow the accurate recording of first episode psychosis and provide a workflow; as a result, there is an administrative burden on teams to manually validate all waiters.
- Wandsworth EIS has had some staffing challenges due to sickness and the team have vacancies which they are finding difficult to recruit.
- Kingston/Richmond EIS have been without Team Manager since December 2023.
- Feedback from National Clinical Audit of Psychosis 2023 scored all 5 Borough's as "top performing" in regard to timely access.

Actions:
- 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.
- Successful recruitment of Team Manager for Kingston/Richmond EIS who commenced in post March 2024.
- Teams to prioritise medical slots for FEP assessments to help capacity management.

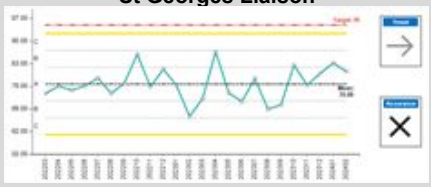
Liaison psychiatry - Seen within 1 hour in A&E (%) Target ≥ 95%

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 3 Liaison services.

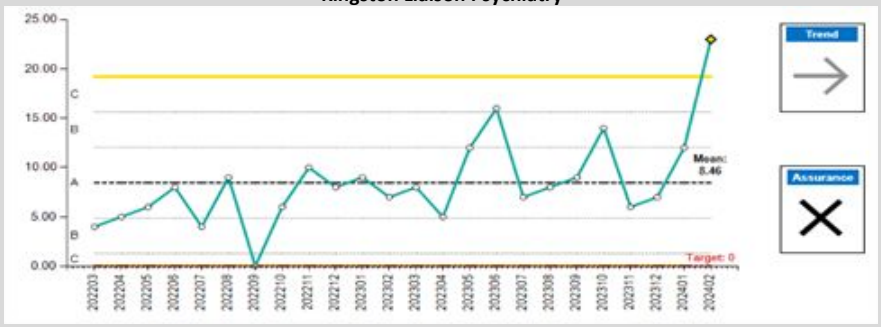
Underlying issue:
- The process of managing Emergency Referrals is impacted by many factors such as staffing shortages (including sickness and vacancy rate, cubicle space (St George's), other activities such as handover and multiple referrals from both ED and wards.
- Impact of extended number of patients waiting for MH beds in general hospital requiring further reviews.
- 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.
- Liaison Psych Service Review has been completed; recommendations are being reviewed for next steps in transformation work.
- 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.
- Kingston Rapid Assessment Clinic Pilot ran for 2 weeks in December 2023. The evaluation has been shared with service line and SWL ICB to inform on further mental health emergency department work.
- 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.

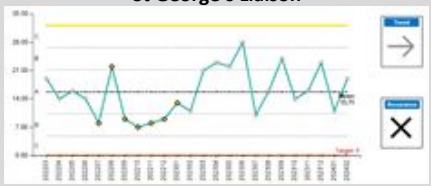
Access

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

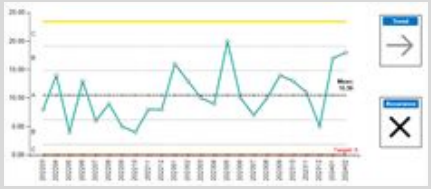
Kingston Liaison Psychiatry



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.

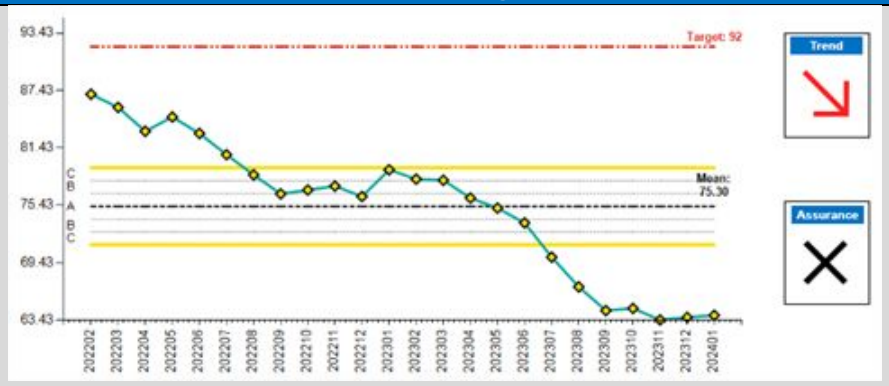
What the charts tells us
The level of 12-hour breaches is increasing across the three services with occasional variation.

Underlying issue
- A lack of available adult acute beds will lead to an increase in waits over 12 hours.
- Increased LOS and DTOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital step down beds.
- Kingston Liaison saw spike in acuity including one day where service received 20 referrals in 24 hour period. This has led to increase in mental health patents within the emergency department and higher numbers referred for 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.
- 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.
- Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds.
- Kingston Rapid Assessment Clinic Pilot ran for 2 weeks in December 2023. The evaluation has been shared with service line and SWL ICB to inform on further mental health emergency department work.
- 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%



February 2024 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	13	0	100.0%	0	0
	Liaison	70	0	100.0%	0	0
	Specialist Services	176	9	94.9%	0	0
CAMHS & ED	CAMHS Access/Referral	2,214	366	83.5%	91	0
	CAMHS Tier 3	542	228	57.9%	97	7
	CAMHS Tier 4	8	0	100.0%	0	0
	Deaf Services	75	16	78.7%	3	0
	Eating Disorders	131	71	45.8%	31	6
	Liaison	17	0	100.0%	0	0
Community (Adults)	Adult CMHT	1,249	67	94.6%	6	0
	Early Intervention	15	0	100.0%	0	0
	Psychological therapies	11	0	100.0%	0	0
	Specialist Services	11	0	100.0%	0	0
Specialist Services	ADHD/ASD	2,326	1,846	20.6%	1,537	856
	Forensic Services	3	0	100.0%	0	0
	Learning Disabilities	17	1	94.1%	0	0
	OCD/BDD	34	2	94.1%	0	0
	Older People	386	0	100.0%	0	0
	Specialist Services	385	186	51.7%	52	0
Total		7,683	2,792	63.7%	1,817	869

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.

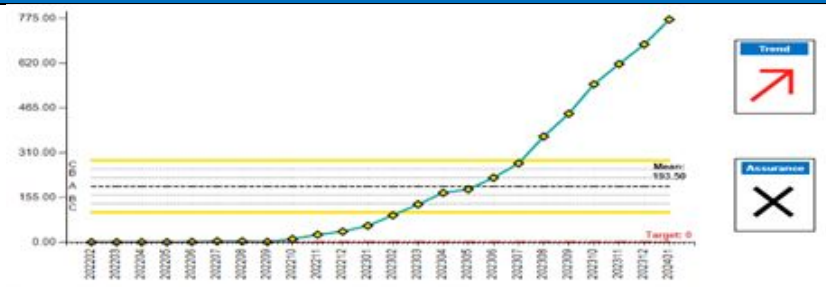
What the chart tells us
Mean performance is below target (which is above upper control limit) and there has been a significant downturn trend in performance. A change in process is required.

Underlying issue
- **Adult ADHD:** There are known demand and capacity issues within the service; in February 2024 66.1% (1846/2792) 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:** Capacity issues within the team. New staff are in place to support but they are being inducted / trained throughout February 2024. Admin sickness impacting assessment booking.
- **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):** There are capacity issues within the AED team with three staff member due to leave in near future which will further impact on the waitlist.

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.
- Alternative models (that do not require GPs providing an enhanced service) are being considered, led by SWLSTG and ICB medical directors. No formal agreement has been reached regarding the discharge pathway.
- Recruitment of 2wte Non Medical Prescriber roles in Sutton and Merton.
- There remain patients at the top of the RTT waiting lists (90 weeks +) that require initiation of medication. These patients will remain on the waiting list in line with recent pharmacy guidance which stipulates service should not initiate medication for new patients unless they are high risk.
- **Neuropsychiatry:** Successful recruitment for medical vacancies with staff commencing in post in February 2024. The team has also tightened its administration processes around management of DNA's. Clinical Manager is undertaking a demand and capacity review which will have oversight via Deputy Head of Service Delivery.
- Service Line completing a full review of service to explicitly lay out the barrier to achieving target and propose potential options to mitigate gap and sustain any improvement.
- CAMHS: Continued recruitment across T3 teams following investment.
- There is continued ADHD medication backlog clearance via Non Medical Prescriber Nurse in Kingston and 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.
- New treatment groups (MANTRA) are will now accept pts as patients drop out. Team exploring the same for CBT/DBT group.

Access

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



52 Week Breaches – February 2024

Team	52 Week Breaches	Max. True Wks Wait	Min True Wks Wait
Sutton Adult ADHD Service	393	102	53
Merton Adult ADHD Service	233	101	53
Richmond Adult ADHD Service	230	85	53
Richmond CAMHS Tier 3	2	66	54
Merton CAMHS Tier 3	2	68	56
Wandsworth CAMHS Tier 3	1	60	60
Kingston CAMHS Tier 3	1	54	54
CAMHS Learning Disabilities	1	67	67
Total	**863**	**102**	**53**

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:
- 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.
- There is a national shortage of ADHD medication which will mean the service will need to re-direct some clinical capacity to appointments for existing patients to change medication and establish new shared care arrangements, which will cause further 52 weeks breaches.
- CAMHS Tier 3: Most Breaches were linked to waits for ADHD medication commencement. There are currently no 52 week breaches Kingston or Richmond T3 following focused work on longest waits by Non-Medical Prescriber and Special Interest GP.
- 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:
- **Adult ADHD:** Actions as above. Additionally bi-weekly administration meetings are held to ensure cancellations are managed promptly and 52 weeks breach lists are cleansed routinely and prioritised.
- **CAMHS:** There is continued ADHD medication backlog clearance via Non Medical Prescriber Nurse in Kingston and Richmond.
- Adult Eating Disorders (AED): Pathway and process review being undertaken with clinical lead and ACD in order to maximise use1 of resource for treatment.
- New treatment groups (MANTRA) will now accept patients as patients drop out. Team exploring the same option for CBT/DBT group.

Access

Expected population need met by Talking Therapies (numbers entering treatment)

Background
Talking Therapies 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 local contract area.

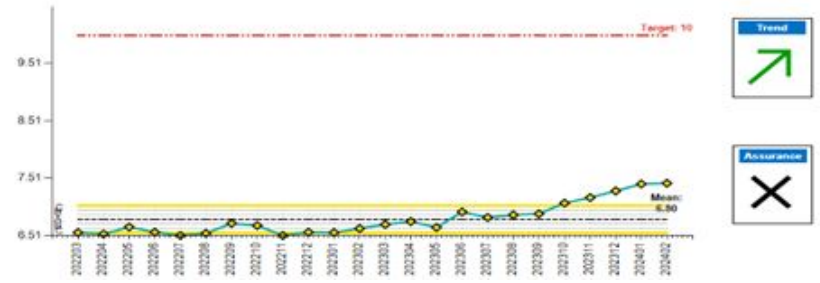
What the chart tells us
Two (Sutton Talking Therapies & Richmond Wellbeing Service) of the four Talking Therapies services are above their cumulative access requirements for 23/24. Merton Uplift is considerably below its requirement whilst Talk Wandsworth performance is just below target. Trustwide performance is above access 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, continues to be an ongoing challenge.
- The self-referral option for one of our digital partner's (IESO) was switched off at the end of November 2023, as demand and performance has exceeded the subcontract agreement.

Actions
- Service managers are closely monitoring referral numbers as well as ensuring there are sufficient assessment appointments available to meet access targets.
- Appointment bookings are being monitored to ensure all appointments are used and there are no lost appointments. The availability of appointments is being adjusted to match the most popular times of day.
- Service managers are continuing to monitor productivity within services to ensure resources are being fully utilised.
- 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).
- Excess referrals are being sent to sub providers (as these count towards our access), meaning we can go above our capacity ceiling (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	202304	202305	202306	202307	202308	202309	202310	202311	202312	202401	202402
Women accessing PMH services *	1,054	1,038	1,080	1,065	1,072	1,075	1,104	1,119	1,137	1,156	1,159
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)	**6.8**	**6.7**	**6.9**	**6.8**	**6.9**	**6.9**	**7.1**	**7.2**	**7.3**	**7.4**	**7.4**
Service use per birth (For Context Only)	*6*	*7.0*	*6.2*	*6*	*6.1*	*6.1*	*6.3*	*6.4*	*6.6*	*6.7*	*6.7*

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.

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.
- Peer Support Worker posts to be recruited into in October/November, with focus of roles on DNA project.
- Pilot for the Pre-conception Consultation Clinics are progressing well and with a new due to commence in Richmond in February 2024.
- Medical staffing model agreed. As a new post Royal College Psychiatry approval is required, job specification has been prepared and submitted.

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

Access

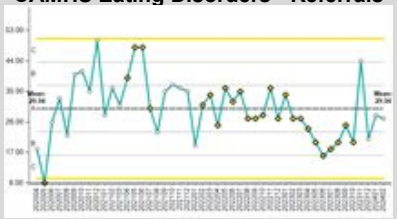
Background
To ensure that young people in urgent need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target. Recent months performance has shown improvement with full compliance in eight of the last nine months.

Underlying issue
- Over-reliance on part time staff to maintain administrative systems.
- The denominator for this KPI is low (n=12) in February 2024, so any case seen outside 28 days is likely to lead to target being missed.
- 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.

CAMHS Eating Disorders - Referrals

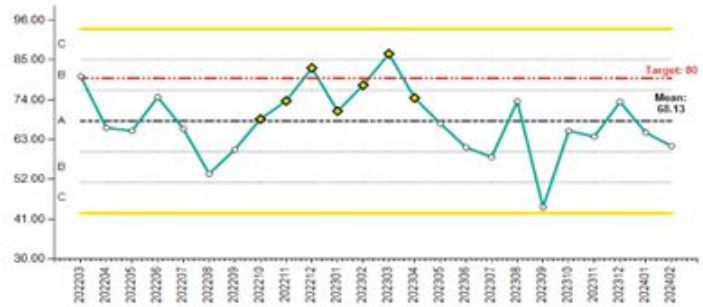


Waiting for Treatment Summary February 2024

		00 - 01	01 - 02	02 - 03	03 - 04	Total
Waited	Standard	1	3	5	3	**12**
	Urgent (7days)	2	0	0	0	**2**
Waiting	Standard	4	2	1	0	**7**

Access

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



Team Breakdown – February 2024

Team	Assessed Within 8 Weeks	Assessments	% Assessed Within 8 Weeks
Sutton CAMHS Tier 3	12	15	80.0%
Wandsworth CAMHS Tier 3	13	17	76.5%
Merton CAMHS Tier 3	19	31	61.3%
Richmond CAMHS Tier 3	8	14	57.1%
Kingston CAMHS Tier 3	8	21	38.1%
Trust Total	**60**	**98**	**61.2%**

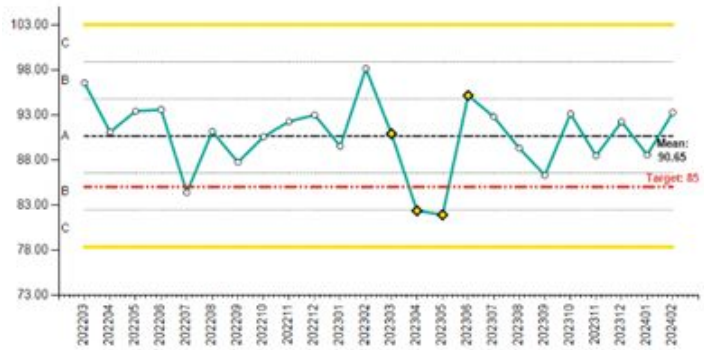
Background
To ensure that young people in need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target indicating compliance on occasion. Recent months have deteriorated with performance below mean in 5 of last 6 months.

Underlying issue
- Most breaches relate to waits for ADHD medication in community CAMHS i.e. 30 out of 38. 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.
- Psychiatry continues to prioritise 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) and GP with special interest in ADHD are increasing assessment activity for long-term ADHD medication waiters (will continue to breach 8 week until backlog is cleared).
- Continue to recruit to T3 following investment to increase choice assessment resource.
- Seek solutions to supporting psychiatry related functions across community CAMHS (E.g. more Non-medical Prescriber).

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



Team Breakdown – February 2024

Team	Diagnosed within 6 weeks	Diagnosis required	%
Kingston Memory Service	10	10	100.0%
Memory Assessment Service Wandsworth	25	26	96.2%
Merton Memory Assessment Service	8	9	88.9%
Richmond Memory Assessment Service	13	16	81.3%
Sutton Memory Assessment Service	27	28	96.4%
Total	83	89	93.3%

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

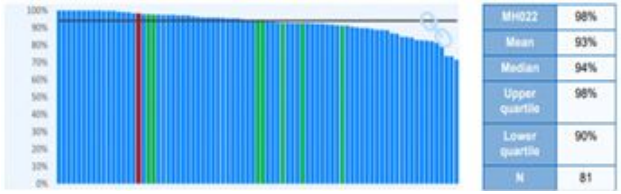
Underlying issue
- 6 breaches reported in February 2024
- Reduced capacity contributory factor in Richmond MAS performance. Denominator very low (n=16) so small number of breaches can lead to target being missed.

Actions
- **Trust:** Work with local commissioners to increase referral activity where DDR rate is low- e.g. Kingston.
- Continued monitoring and additional support for teams where needed.
- New Band 7 Nurse for Richmond MAS has been recruited with anticipated start in March 2024.

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.

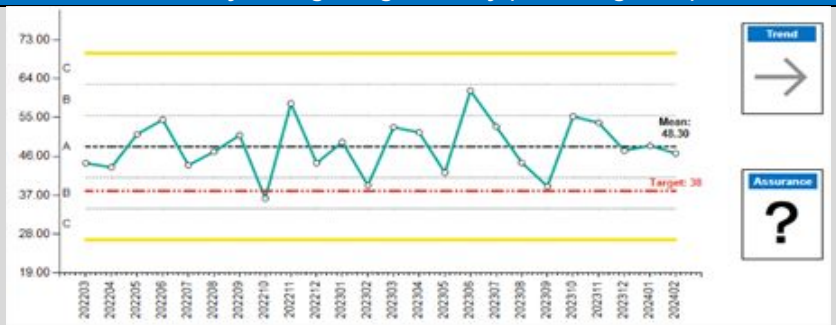
What the chart tells us
Low level variation with mean performance considerably above target.

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

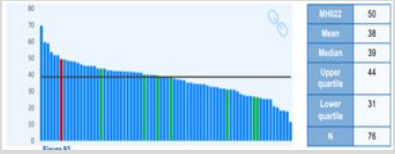
Actions
- New contract with Holybourne 30 beds commencing on 1 December 2023 for a year to December 2024. This means the block has increased from 18 – 30 beds.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- 100 discharge challenge flow interventions have 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.

Flow

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

February 2024

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.

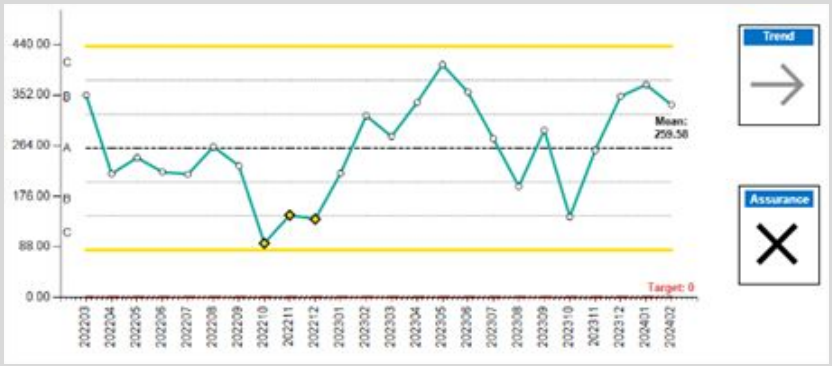
What the chart tells us:
Trust average performance consistently exceeds target.

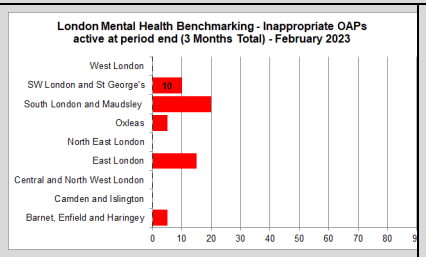
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds 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.

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 booked for ELFT to review pathways and LOS alongside other quality metrics.
- Implementation of the Complex Emotional Needs protocol.
- Training for the Complex Emotional Needs (CEN) pathway was undertaken in November 2023 and a course is now available online.
- Monthly mini MADE events continue to be held.

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.

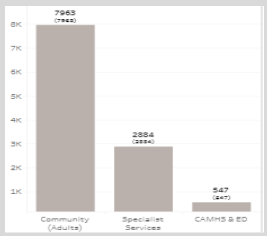
What the chart tells us
The levels of out of areas placements is subject to variation aligned to demand for beds (i.e. adult acute beds).

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.
- Continued high demand across the crisis pathway and wider system.

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.
- Patients in Out of area beds are reviewed by the community team where there is a care coordinator, or HTT where the patient is not known to community services.

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. Recent months have seen an increase in clients receiving 2+ contacts.

Underlying issue
- This measure aligns with the LTP ambition for increasing access to adult community MH services. The figures show a rolling 12 months, as per the national definition. The metric includes all services included in the national definition (MHS108). It reflects the position for the three transformed boroughs (Kingston, Richmond & Sutton).

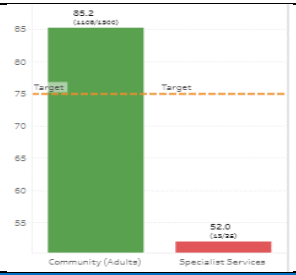
Actions:
- Community: Mobilisation of transformation in Merton & Wandsworth - both boroughs will go live on 1 April 2024 which will result in those services being included in the KPI.
- Job planning and productivity focus to increase direct clinical care - job plans implemented for all clinical roles with activity tracked through supervision dashboard. The service line is ahead of plan by 9% as of M10.
- Job planning and productivity focus to increase direct clinical care - job plans implemented for all clinical roles with activity tracked through supervision dashboard. The service line is ahead of plan by 9% as of M10.
- Specialist: This is a new KPI. 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).
- 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).
- Trust: A KPI definition is currently being developed to support reporting and provide additional guidance.

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.

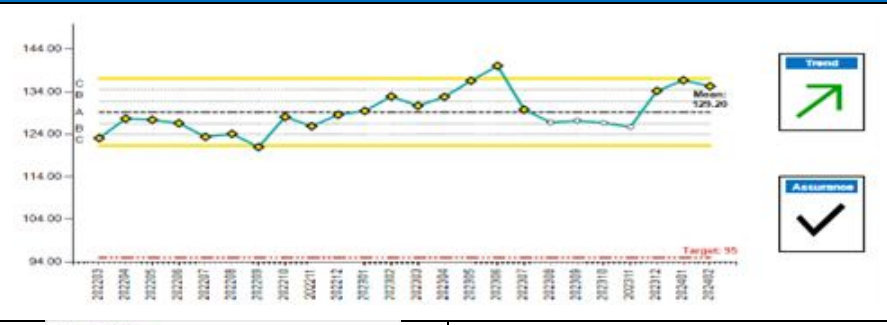
What the chart tells us
It is likely that the target will consistently be exceeded.

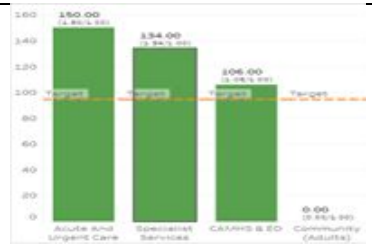
Underlying issue:
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised.
- Number of community patients have declined assessments. Attempts made to try and intensively engage patients to attend are 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.
- Within community there is some focus on EIS performance which needs improvement in some areas.

Actions:
- Community: Kingston & Richmond EIS improvement plans reviewed with updated actions. Clinical Manager to lead and embed within the team.
- Weekly/twice weekly physical health clinics in all boroughs continue.
- Wandsworth developed Holistic Hub in Trinity Building which commenced on in 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.
- Kingston QII scoping how to increase full compliance with CMA checks.
- Teams Managers in EIS in conjunction with Deputy Head of Service Delivery to form action plan to improve physical health monitoring.

Safe Staffing: national Compliance - Inpatients (%)

Target ≥ 95%





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

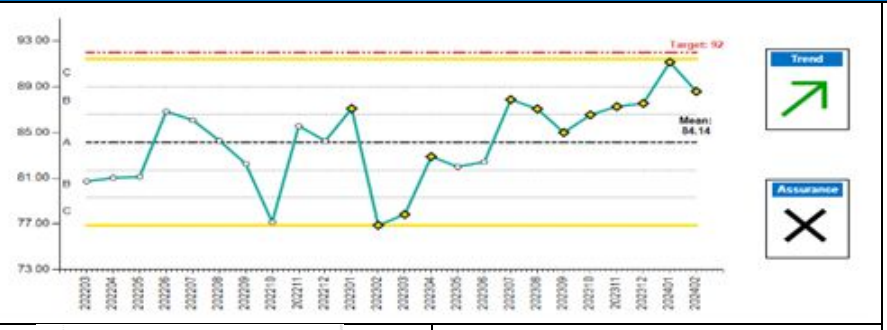
What the chart tells us:
Trust performance is consistently above target which is below lower control limit.

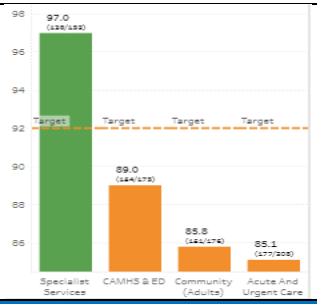
Underlying issue:
- Acute and urgent care: All wards were safely staffed in February 2024. Additional staffing is required to support constant or enhanced observations which is reviewed daily.
- CAMHS & ED: All ward areas were safely staffed; Corner House is minimally staffed due to very low occupancy 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.
- Specialist: No issues reported service line consistently exceeds target.

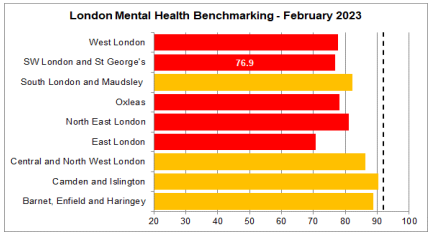
Actions:
- Daily staff meetings held across all service lines are in place to monitor staffing requirements and issues on staffing numbers are escalated to senior management if there are concerns.
- Acute & Urgent Care: Continued focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.
- The roster meeting is attended monthly by ward managers and CSLs and matrons reviewing roster completion and sign off fully.
- 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%





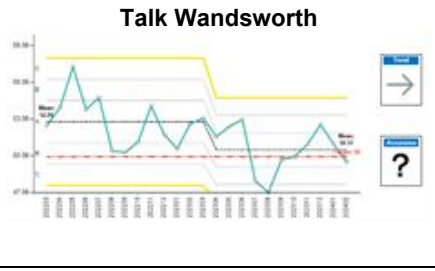


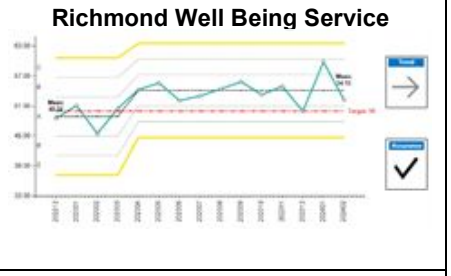
Background
The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed.
What the chart tells us:
Mean performance is consistently below target, however performance in recent months has improved with target being met for first over the period in January 2024 although this has not been maintained.
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.

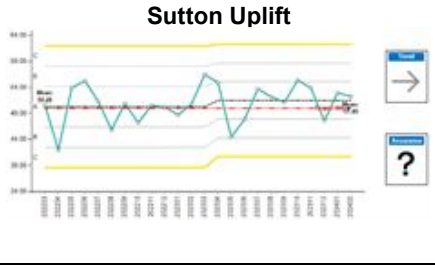
Actions:
- Feedback live has recently been relaunched as a platform for completing Friends and Family Test. First question on system is linked to the Friends and Family Test.
- Staff encouraged to promote use of the FBL QR code for service users and carers.
- Promoting use of the FBL QR code for service 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.
- 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.

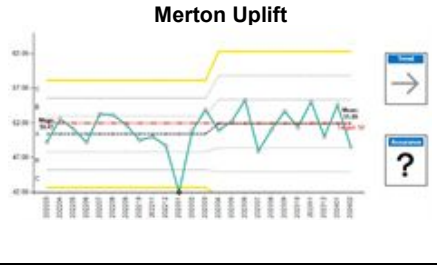
Patient Experience and Outcomes

Talking Therapies recovery rate (%) — Target ≥ 50%









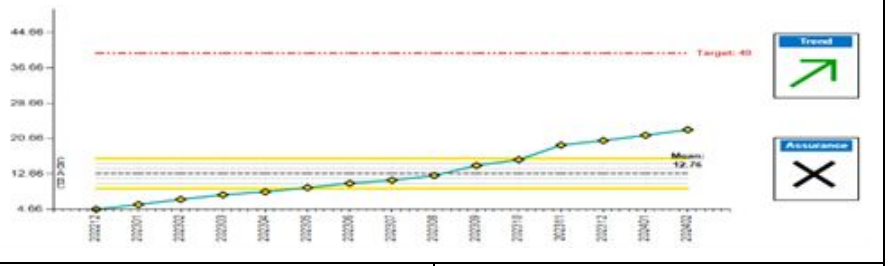
Background
Talking Therapies (formally known as IAPT) is an NHS programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety.
What the chart tells us
All talking therapies are above 50% national target YTD; Merton Uplift is in line with 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.
- Audits indicate recovery deterioration is due to dropouts, and people declining treatment due to waiting times. Poorer recovery is also associated with missing or incorrect diagnostic labels, absence of repeat symptom measures, and lack of fidelity to treatment protocols.

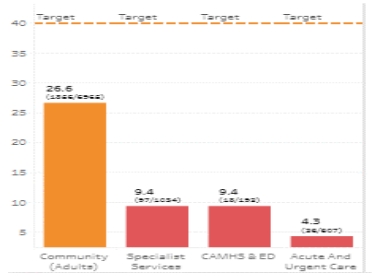
Actions:
- Service clinical leads are completing data quality checks in advance of the monthly recovery audits which then take place each month by 9th. Audit outcomes are investigated, and action plans implemented.
- Individual monthly recovery rates are now being shared with clinicians in supervision.
- The cross-borough recovery workgroup continues to meet monthly.
- Training has been delivered to support clinicians with treatment, focusing on ensuring accurate diagnostic assessment and routine ADSM completion.
- New "feedback call" stage between assessment and being placed on waiting list has been introduced - patients attend a structured treatment planning call to discuss treatment options, and requirements for engagement, to reduce dropout rates.
- Sharing of SilverCloud best practice has happened between services.
- Training on treatment choice conversations and diagnostic assessment is planned for January 2024.

Patient Experience and Outcomes

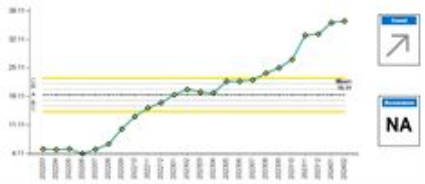
Paired Dialog Completed

Target ≥ 40%





Dialog Assessment



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.

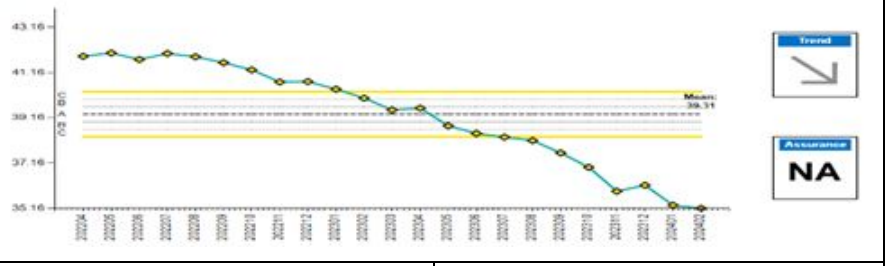
Underlying issue
- Reporting on paired dialog is a new priority metric for 23/24; local practice is being embedded.
- Review of team inclusions for DIALOG is ongoing across service lines.
- Change in clinical practice that will require time to embed.
- Trust is currently benchmarking well on Paired Prom 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.

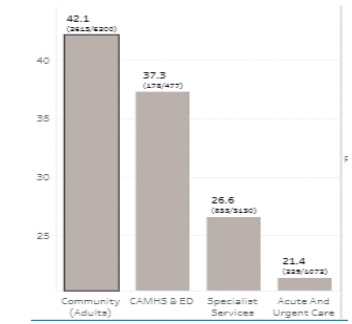
Actions
- SOP for dialog use has been developed and issued to across the Trust.
- Specialist Service Line to raise exclusions queries with Patient Outcomes Group.
- Baseline DIALOG completeness to be discussed at Improving Patient Outcomes Group (IPO) and further strategy for improvement to be recommended.
- Community: Refresher training completed.
- Acute & Urgent Care: Focused piece of work to be undertaken with teams to input data via the dashboard with a pin number. This will be monitored weekly with Team Managers/Advanced Clinical Practitioners.

Patient Experience and Outcomes

Paired HONOS Completed

No Target

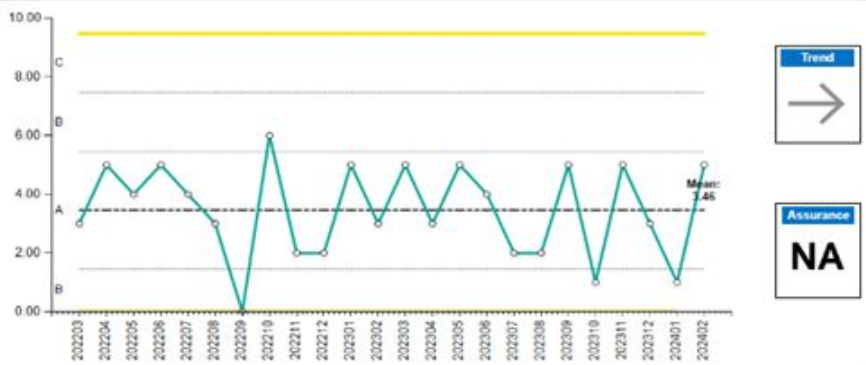
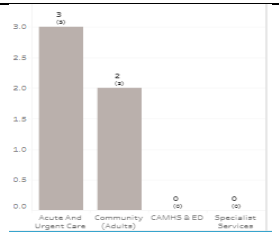
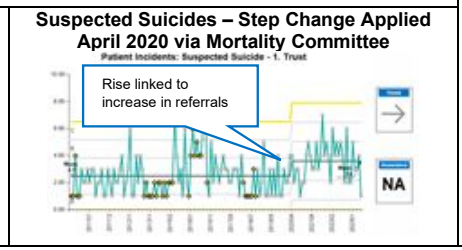




What Chart Tells Us:
There is a consistent negative downward trend in paired HONOS recording.

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.
- Change required in RiO to highlight HoNOS reporting.

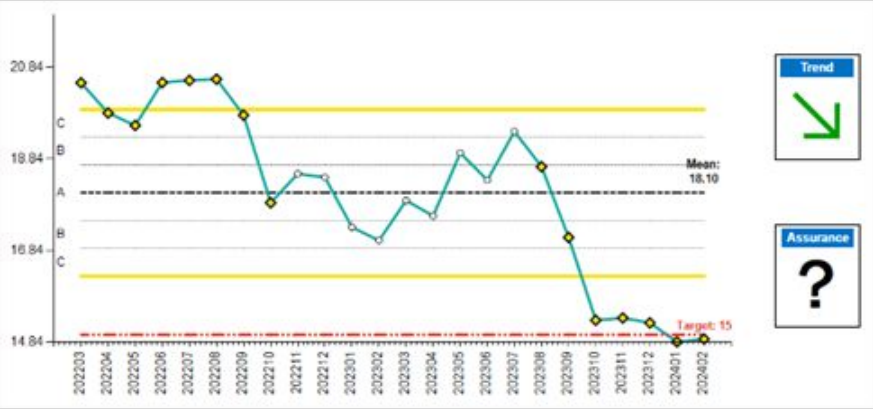
Actions:
- IPO Chair to issue communication to highlight importance for completion of HoNOS as standalone outcome measure.
- Community:
- HONOS was presented and the community awareness event in November 2023.
- HONOS to be discussed at team leaders' development (9th Nov)
- HONOS SOP to be recirculated.
- Discuss development of a community workflow for discharge on Rio which includes PROMS, PREMS and CROMS including HONOS and DIALOG.
- Re-circulating IRH checklist for new and discharged patients which now includes HONOS.

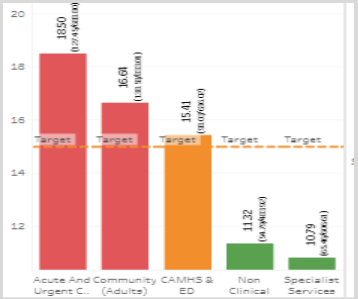
	Death - Suspected suicide	No Target
Patient Safety	  	**What the chart tells us** The number of suicides each month is low with common cause variation. **Underlying Issue:** - There was five suspected suicide reported in February 2024. - The number of suicides being reported month to month continues 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: Thematic review completed and presented at Mortality Committee with action plan. The service line has set up Special Interest Group in Suicide and Suicide Prevention to be rolled out across 2024 and will also address themes and how to improve risk assessments and practice.

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 – February 2024

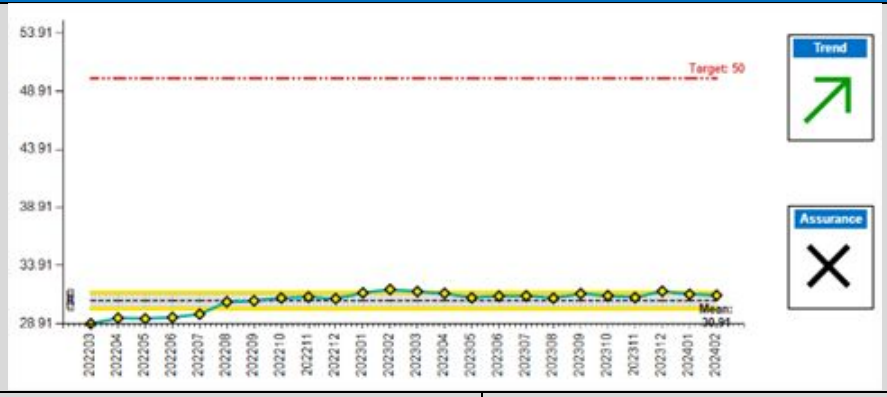
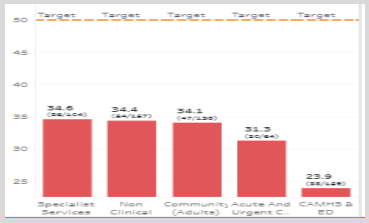
Staff Group	Post Fte	Assign Fte	Vacant FTE	Vacancy Rate
Add Prof Scientific and Technic	497.8	408.0	89.8	16.01%
Additional Clinical Services	731.1	611.5	119.6	14.34%
Administrative and Clerical	648.7	586.3	62.4	9.57%
Allied Health Professionals	170.8	135.4	35.4	19.21%
Estates and Ancillary	36.0	33.9	2.0	5.41%
Healthcare Scientists	2.0	2.0	0.0	0.00%
Medical and Dental	247.2	224.3	22.9	9.00%
Nursing and Midwifery Registered	914.9	762.7	152.2	16.72%
Grand Total	3,248.4	2,764.1	484.3	14.06%

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. Recent performance has improved and has been consistently below lower control limit for last five months with target being met in the last two months.

Underlying issue:
- Improvements in number of applicants through open events, careers day attendance and number of people directly applying together with improved recruitment processes have helped to improve vacancy position.
- 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 the Trust will need to think about alternatives in support whilst carrying vacancies to reduce pressure for those in the team and also to retain staff.

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. First event held on 2nd February 2024 with 140 people And through 70 people through recruitment pipeline (bank and substantive).
- The Trust is going to repeat the event Tolworth and there are plans to hold borough wide events.
- Workforce planning conversations produced a number of initiatives to support recruitment and attraction for each professional group. Focus on building links with universities, flexible working, staff survey, embedding new roles and health & wellbeing. Professional Leads to lead Trust-wide initiatives.

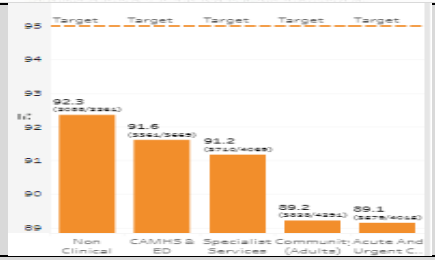
	Percentage of BAME staff - Band 8+ and Medical	Target ≥ 50%
Recruitment / Attraction	 	**What Chart Tells Us:** Mean position is below target indicating target position seems to have plateaued in recent months following period of improvement. **Underlying issues:** - The number of black, asian and minority 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. - Action plan was agreed in March 2024 training is live now. The Trust is developing and EDI Dashboard for People Committee. - Human Resources Department have launched training on bias within interviews for recruitment managers commencing in March 2024 to start our focussed work around fair recruitment and improved career development specifically focused at our Black, Asian and minority ethnic staff. - Community: Borough based CSL's to become the EDI leads for their respective areas. - CAMHS Service line has staff members on the HEE Ethnic Minority Psychological Professions Leadership Mentoring Scheme.

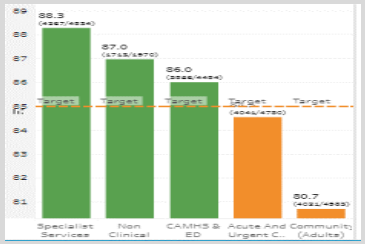
Staff Skills / Development

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 Jan-24 %	Actual Feb-24 %	Actual Mar-24 %	Actual Mar-24 Breaches	Projection Apr-24 %	Projection May-24 %	Projection Jun-24 %	Projection Jun-24 Breaches
Adult Basic Life Support (ABLS)	87.4%	88.9%	87.6%	56	86.4%	79.0%	71.3%	131
Fire Safety Awareness (Community)	93.7%	93.8%	93.9%	84	91.1%	89.6%	87.9%	171
Fire Safety Awareness (Inpatient)	77.3%	74.6%	73.3%	188	72.5%	70.1%	68.6%	226
Fire Safety Awareness (Non-Clinical)	95.8%	95.1%	94.7%	39	91.1%	89.5%	86.4%	104
Infection Prevention and Control - Level 1	93.7%	93.9%	94.2%	30	92.1%	91.9%	91.5%	45
Infection Prevention and Control - Level 2	91.4%	91.3%	90.8%	215	80.4%	74.2%	68.4%	755
Information Governance	93.2%	92.3%	92.0%	228	81.6%	75.3%	69.8%	881
Medical Emergency Training (Nurses)	57.9%	66.5%	68.9%	95	79.8%	78.3%	74.2%	83
Medicines Management (Community)	88.6%	88.4%	88.0%	56	82.3%	79.1%	75.7%	114
Medicines Management (Inpatient)	91.8%	92.9%	93.6%	19	90.6%	88.6%	86.6%	40
Proactive Physical Interventions (PPI)	88.4%	88.2%	88.2%	67	91.1%	91.8%	91.8%	47
Safeguarding Adults - Level 1	95.9%	95.5%	94.8%	148	87.9%	83.5%	79.9%	585
Safeguarding Adults - Level 2	94.6%	94.3%	93.8%	129	91.8%	91.1%	90.2%	209
Safeguarding Children - Level 1	94.8%	93.2%	93.1%	40	89.2%	86.7%	84.6%	91
Safeguarding Children - Level 2	90.6%	90.9%	89.6%	94	86.1%	84.6%	83.8%	155
Safeguarding Children - Level 3	74.0%	75.1%	75.7%	277	73.5%	72.0%	71.0%	344
Safeguarding Children - Level 3 (CAMHS)	84.2%	84.4%	84.1%	48	77.3%	74.8%	72.4%	91
All Certificates (95% Target)	90.6%	90.5%	90.2%	1813	85.0%	81.7%	78.5%	4072

Training Compliance Projection – MAST 2

Certificate Name	Actual Jan-24 %	Actual Feb-24 %	Actual Mar-24 %	Actual Mar-24 Breaches	Projection Apr-24 %	Projection May-24 %	Projection Jun-24 %	Projection Jun-24 Breaches
ABLS eLearning for Community and Allied	68.0%	70.4%	68.7%	389	66.4%	63.0%	60.4%	517
Advanced Patient Handling (APH)	79.9%	79.3%	79.3%	109	91.9%	86.9%	87.3%	70
Care Certificate Programme (CCP)	95.9%	87.1%	86.5%	42	86.5%	86.5%	86.5%	44
Collaborative Clinical Safety Training	62.0%	61.0%	61.5%	546	58.4%	54.8%	50.0%	610
Conflict Resolution and Breakaway	94.8%	84.9%	83.5%	278	83.5%	84.5%	83.9%	277
Cyber Security - Stay Safe Online		63.4%	68.1%	904	67.8%	67.8%	67.8%	936
Equality, Diversity and Human Rights -	98.3%	97.7%	97.5%	70	95.4%	94.0%	92.2%	228
Essentials of Patient Safety - Level 1 (All					64.3%	64.3%	64.3%	966
Essentials of Patient Safety - Level 1					43.8%	43.8%	43.8%	118
Food Hygiene - Level 2	95.5%	96.9%	95.4%	6	91.2%	91.2%	89.7%	14
Food Hygiene - Level 3	100.0%	100.0%	100.0%	0	100.0%	100.0%	100.0%	0
Health and Safety General Awareness	97.9%	96.6%	96.5%	99	93.9%	92.3%	90.4%	278
Load Handling (2 Years) - (Discontinued)	74.4%							
Medical Emergency Training (Medics)			42.0%	69	57.8%	57.8%	57.8%	54
Medical Emergency Training (Medics) -	100.0%							
Mental Health Law	86.6%	87.2%	86.7%	231	85.1%	84.9%	83.8%	292
Moving and Handling - Level 1	100.0%				41.5%	41.5%	41.5%	1349
National Early Warning Score (NEWS) 2	98.1%	98.1%	98.1%	11	97.1%	96.4%	95.9%	24
Observation and Intensive Engagement	98.4%	98.7%	98.8%	6	97.5%	96.4%	92.8%	38
Oliver McGowan Mandatory Training on					41.1%	41.1%	41.1%	1713
Prescribers' Medicines	72.3%	73.3%	72.8%	68	66.0%	64.5%	63.7%	95
Preventing Radicalisation - Awareness of	95.8%	95.9%	95.2%	98	86.2%	81.4%	78.0%	467
Preventing Radicalisation - Basic Prevent	98.1%	97.6%	97.6%	18	95.8%	95.8%	95.8%	33
Rapid Tranquillisation	94.8%	94.3%	94.7%	32	92.0%	90.8%	89.2%	66
Safeguarding Adults - Level 3	75.4%	77.2%	78.2%	190	67.1%	67.0%	67.0%	337
Security Awareness (Forensic) (1 Year)	93.0%							
All Certificates (85% Target)	88.6%	85.0%	85.1%	3178	73.5%	72.7%	71.8%	8526

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.

Following review MAST 1 requirements are now aligned with the Core Skills Competency Framework (CSCF), all other mandatory training is MAST 2.

Three new MAST requirements have been added in the past quarter as follows:-

- Cyber Security – recommended from a recent audit and agreed at Audit Committee
- Oliver McGowan Training – all health and care providers registered with the CQC can meet the legislative requirement introduced by the Health & Care Act 2022 to ensure staff receive training on learning disability and autism, appropriate to their roll.
- Patient Safety Training: Essentials of Patient Safety Level 1, will be going live on the MAST dashboards as of 18 April 2024, after a 3 month introductory period which began in January 2024, and is required to be completed by all staff. This is an eLearning package which is completed through Compass, along with additional eLearning required for board members and senior leaders.

These have all be added into MAST 2.

What the chart tells us

MAST 1: MAST 1 levels remain below target with recent months deteriorating.
MAST 2: Performance for MAST 2 remains above target although significant deterioration (special cause variation) noted in February 2024.

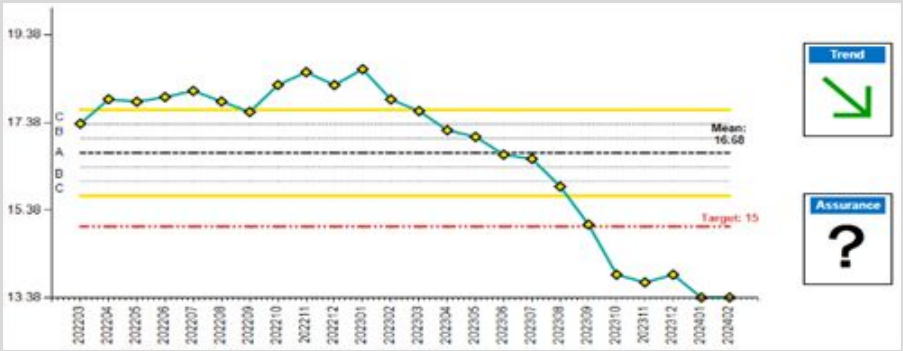
Underlying Issues and mitigations:

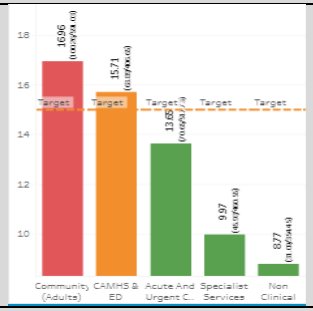
- MAST 1 and MAST 2 courses were not being reported on Dashboard against correct categories, a number of courses needed to be re-categorised to ensure correct reporting on dashboard. This work is currently being progressed and we have noticed a reduction in some compliance – which is also linked to the point below
- The audiences have had to be updated, this is a complex process working with SMEs. Learning & Development, subject matter experts & Informatics are working together to resolve and in the meantime has further decreased our compliance.
- CCST (RATE) Training has had high breaches owing to capacity with no available trainers. The service lines have now identified trainers to deliver this training so it is expected that this will improve.
- Cyber security became a MAST 2 requirement in February 2024 (904 breaches) at time of reporting which has impacted overall compliance score. This is expected to improve in the next month.
- Work is being undertaken to align all MAST 1 courses with the Core Skills Training Framework (CSTF), once achieved, this should help streamline the verification of training which has previously been completed at other Trusts.
- MAST compliance will be displayed in each staff members' supervision record and will be RAG rated. A compulsory text box will be embedded within current supervision record template, which will prompt the line manager to review each staff member's MAST training compliance via a quick link to the Dashboard report. Line manager will be required to provide a MAST compliance action plan. This will go live in April 2024.
- The People Committee have asked for a report in April 2024 which details the actions that will be taken to meet compliance specifically in relation to ABLS, PPI and Safeguarding Level 3.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%





Annual Turnover FTE – November 2022 – November 2023

Trust	Leavers	Leaver Rate
North East London NHS Foundation Trust	849	12.0%
West London NHS Trust	606	14.0%
South London and Maudsley NHS Foundation Trust	823	14.4%
South West London and St George's Mental Health NHS Trust	397	14.4%
Central and North West London NHS Foundation Trust	1228	14.9%
Oxleas NHS Foundation Trust	671	15.3%
East London NHS Foundation Trust	1097	15.5%
Tavistock and Portman NHS Foundation Trust	147	18.4%
Camden and Islington NHS Foundation Trust	468	19.0%
Barnet, Enfield and Haringey Mental Health NHS Trust	1042	32.0%
London Average	732.8	17.0%
National Average	**630**	**13.0%**

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.

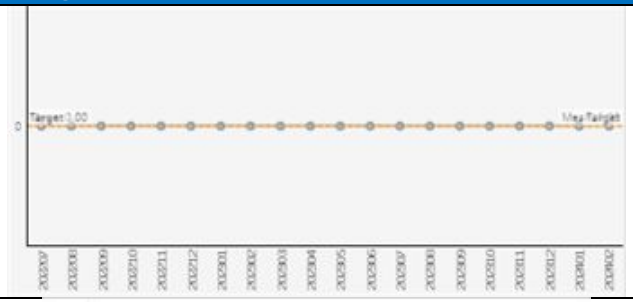
Underlying issue
- Turnover has been decreasing and has been below target for last four months.
- Suggested reasons for leaving is cost of living, career progression however the data from exit interviews is limited (only 197 responses in the past two years).
- Analysis to understand key hot spots, shows 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.

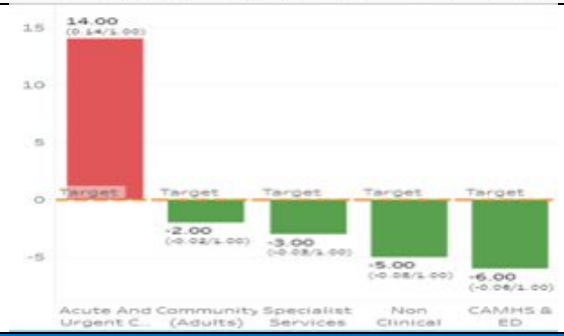
Actions:
- Exit Interview process has been updated and has gone live. It is hoped this will increase response rates.
- The Trust is currently undertaking a deep dive into the ethnicity data behind our turnover.
- A comprehensive package of work to support retention is in place and has been discussed 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 Trust is currently analysing and sharing the results of the national staff survey which 64% of our staff responded too; increases in engagement and advocacy scores noted.
- The Trust is working to develop key themes (from the staff survey) and is working with service lines/teams on simple actions for managers to take.
- Following review it appears the increase in % staff leaving within 12 months has been impacted by a drop in overall leavers from the Trust. The amount of staff leaving within 12 months is reducing.
- National evidence around retention suggests that the key lever to improving retention (through the research done by the vanguard Trusts) is in creating greater flexibility for staff. This could include a variety of options i.e. agile working, self-rostering, etc. A working group looking at this specific issue is live and hoping to set up a series of pilots. The need for greater flexibility is also referenced in our staff survey responses this year.

Finance Domain

Grip & Control

% Forecast budget overspend — Target TBC





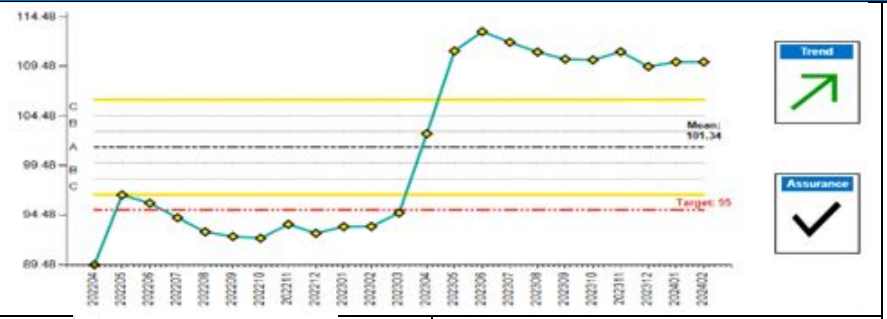
What Chart Tell us:
The chart indicates that Trust forecast is currently at break-even position.

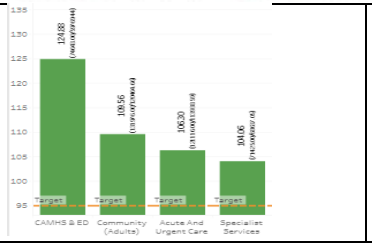
Underlying Issues:
- Trust is breaking even after month 11 compared to plan and forecasting to achieve the reforecast £1.0m surplus at year end before impairment and profit/loss on asset sales.
- Agency whilst below plan remains above the national requirement of 3.6% of total pay bill.
- The Trust needs 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.

Actions:
- Work with ICB to identify any 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.
- 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.
- 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 contract (%) — Target ≥ 95%





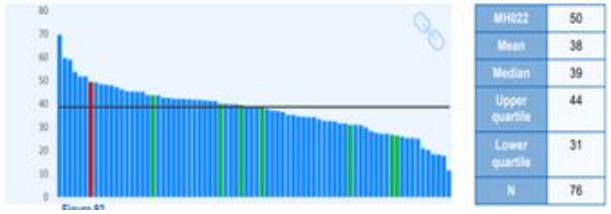
What Chart Tells Us:
Mean performance is above target indicating frequent compliance. 23/24 compliance is comfortably above target and has exceeded upper control limits in recent months.

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 but position remains comfortably above target.
- 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.
- Changes to service model and delivery (e.g. teams disbanding, previous functions/staff members being moved to other teams, periods of temporary out of hours working).

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.
- Ensure service changes are understood, documented and where appropriate, reflected in the service's activity targets.

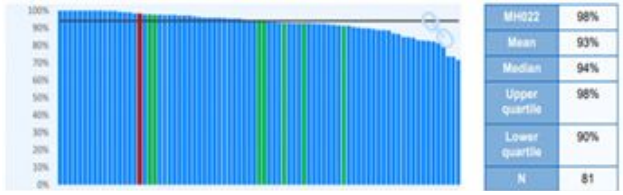
Appendix 1: Benchmarking

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.



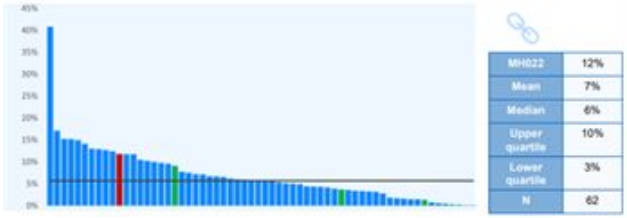
- **Adult acute average length of stay (days):**

2022/23		2023/24	
Trust	England	Feb-24	YTD
50.0	38.0	46.7	50.8



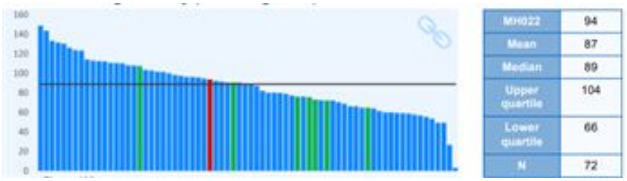
- **Adult acute bed occupancy rate (%):**

2022/23		2023/24	
Trust	England	Feb-24	YTD
98.0%	93.0%	99.2%	98.6%



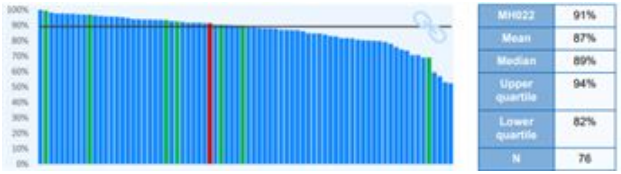
- **Adult acute delayed transfers of care (%):**

2022/23	
Trust	England
12.0%	7.0%



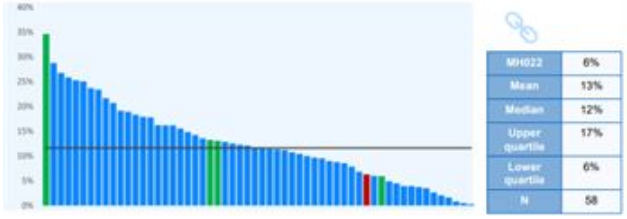
- **Older people's average length of stay (days):**

2022/23		2023/24	
Trust	England	Feb-24	YTD
94.0	87.0	92.3	93.5



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

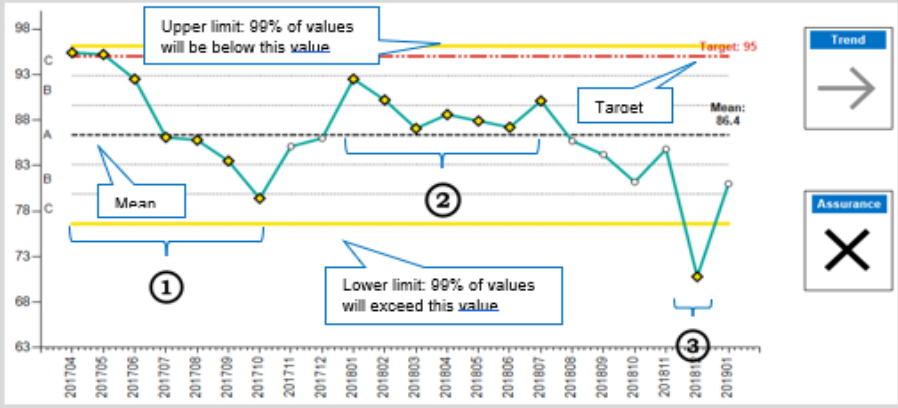
2022/23		2023/24	
Trust	England	Feb-24	YTD
91.0%	87.0%	97.4%	95.8%



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

2022/23	
Trust	England
6.0%	10.3%

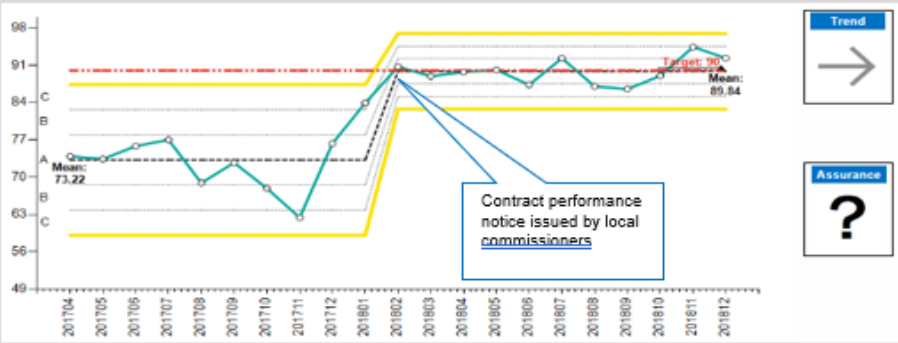
Appendix 2: Statistical Process Control (SPC) Charts & Performance Donut



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.

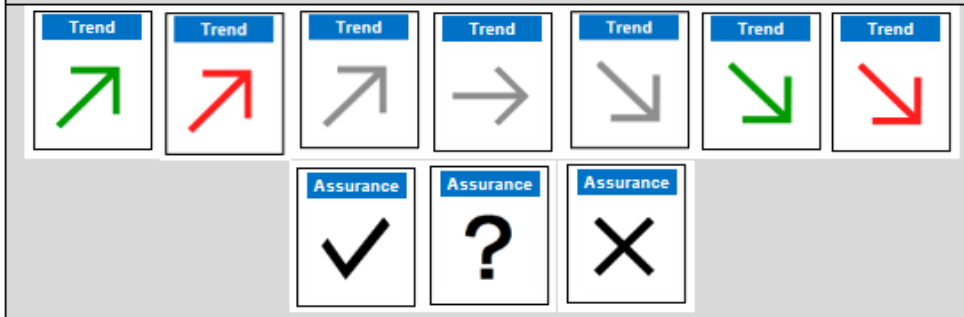
Why we use SPC charts
They are used to distinguish between natural variation ('**common-cause**' and not caused by anything in particular) in performance and unusual patterns ('**special cause**', unexpected events) in the data which are unlikely to have occurred due to chance and require investigation. 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.



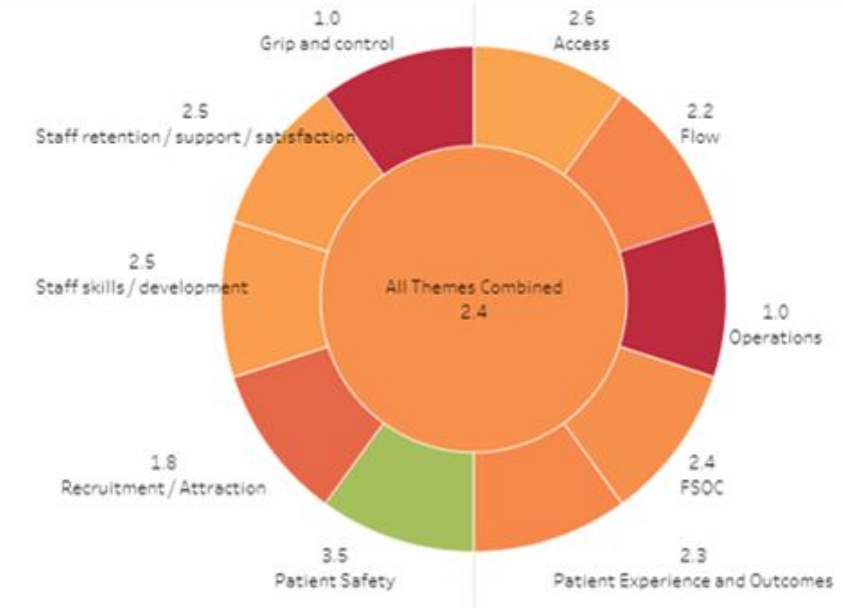
Use of icons to interpret charts
The Trend icon is shown as one of seven upward, horizontal or downward arrows depending on which direction the data is heading, coloured green, grey or red to indicate whether this is an improvement or deterioration in performance (or neutral where there is no target 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

Trust

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

Quality and Performance Report

March 2024

Glossary

Term	Meaning	Term	Meaning
ALOS	Average length of stay	IPC	Infection Prevention and Control
BAF	Board Assurance Framework	KPI	Key performance indicator
BCAG	Business Case Assurance Group	LOS	Length of stay
CAMHS	Child and adolescent mental health services	NHS	National Health Service
CMA	Cardio-metabolic assessment	NHSE	National Health Service England
CQC	Care Quality Commission	PALS	Patient Advice and Liaison Service
CIP	Cost Improvement Programme	PPE	Personal protective equipment
CQUINS	Commissioning for quality and innovation	QII	Quality improvement and innovation
DNA	Did not attend	QSAC	Quality and Safety Assurance Committee
EDS	Eating disorder service	RTT	Referral to treatment
EC	Modernisation Committee	RIDDOR	Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations
F&P	Finance and Performance Committee	SIs	Significant incidents
FFT	Friends and family test	SLM	Service line management
FSOC	Fundamental Standards of Care	OF	Oversight Framework
GP	General practice	Trust	South West London and St George's Mental Health NHS Trust
HoNOS	Health of the Nation Outcome Score	WTE	Whole time equivalent
HTT	Home Treatment Team	YTD	Year to date

Contents

Part A: Executive Summary

What

The focus of this report is March 2024 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 consistent areas of challenge and achievement to previous months. Key areas of underperformance remain the adult crisis and acute pathway, including liaison indicators not being met, high bed occupancy and delayed transfers of care, and long waits for access to neurodevelopmental screening and treatment within adults and CAMHS services. Metrics continue be achieved in a number of wider clinical indicators, including CMA, Dementia Diagnosis, Talking Therapies access and recovery rates, and the collection of Dialog outcomes continues to increase. Patient feedback is stable. We are focusing on Fundamental Standards of Care across inpatient and community areas with more detailed oversight at SLR meetings and commentary included in this report, some improvement has been seen in inpatient standards with improvement needed in community key areas such as care planning audit.

Our workforce indicators are showing sustained reduction in vacancy and turnover rates, but there remain considerable concerns in a number of teams where the SIREN tool is showing red and improvement plans have not yet impacted positively. Pressures relate to leadership gaps, staff turnover, high caseloads and incidents, with particular concern in some of our ward teams, and are discussed in detail at SLR. MAST compliance is also not meeting standards and is an urgent issue in the context of ensuring staff are well equipped to manage complex physical health presentations and reduce violence & aggression within ward environments, so this is a particular focus for our leadership teams.

The opening Trust plan was a £0.2m surplus for the year. To achieve this, the Trust needed to deliver savings of £13m. Cumulative savings delivery to Month 12 contributes the full £13m towards this target. NHSE required all trusts to undertake a formal reforecast as part of the H2 planning (second half of financial year to 31/03/2024) - as part of this the Trust I received an additional c£0.6m of income and is forecasting a c£1.0m surplus. Draft M12 out-turn is indicating delivery of a pre-impairment surplus of £1.1m (c£47m trading deficit including impairments). In respect to capital we forecast delivering a £31.9m spend c£20k under our CDEL limit.

So What

The challenges facing us are considerable, and we continue to work to improve our patient flow, standards of care and support to our staff despite significant demand and capacity pressures and workforce constraints. There remain risks to our acute patient pathway both in timeliness and quality of care and we are working hard with our clinical leaders and teams to mitigate these through short and longer term actions, including a focus on immediate patient flow and fundamental standards of care, and improvement plans for a number of crisis teams and ward teams. The continued embedding of SIREN and FSOC as our key oversight tools within the quality and performance framework is helpful in ensuring we support staff and focus on the core quality of our services for our patients.

We continue to work collaboratively with system partners including acute and Local Authority colleagues to deliver improvements to MH in ED pathways and to transfers of care; we work hard to maintain good relationships despite the significant pressures and communicate proactively with partners to support patient care. This is important to enable us to best use resources to get patients the right care at the right time, both on the urgent care pathway such as through NHS111 press 2 for MH, and in community care where we are working with GPs to develop primary care based pathways for patient step down and support. There has not as yet been agreement within the ICS to support a more sustainable pathway for ADHD/ASD services and hence waiting times continue to increase; this issue is being escalated with ICB leaders.

Improvements around our workforce are positive and we must build on these through our leadership programme to create the clinical capacity to deliver the best care and continuously enhance our services. Patient and staff feedback shows progress towards the experience we aspire to, but there are real concerns around ensuring staff are trained and equipped to deliver safe care and we continue to focus on psychological safety and continuous improvement within our teams. The Trust is in a relatively stable financial position in the context of significant deficits across SWL ICS. More recurrent savings plans for 2024/25 are required to support longer term financial sustainability, and the flow pressures are driving considerable financial pressure in terms of external bed costs.

What Next

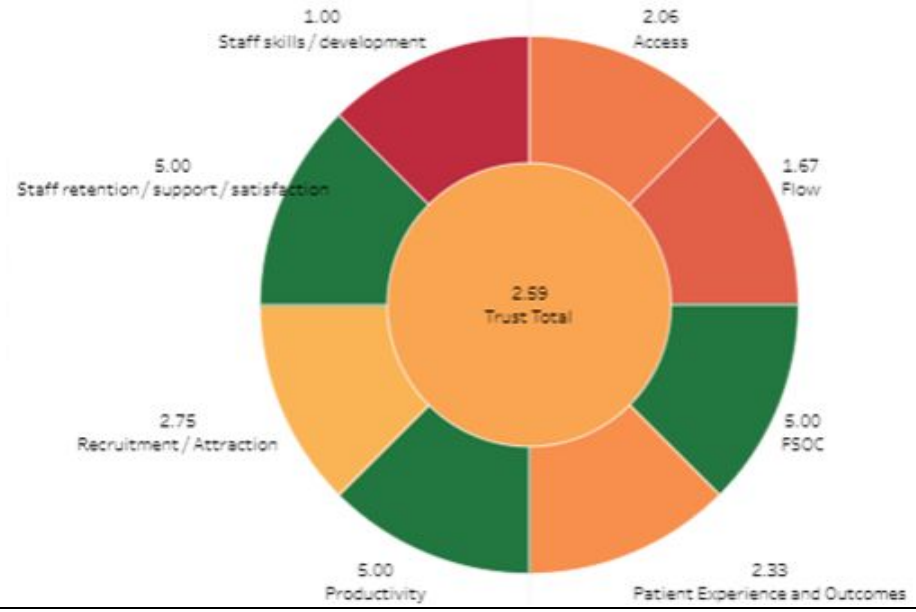
Our Adult Patient Journey transformation programme is being evolved to integrate work across community, crisis and acute settings with a focus on the overall patient journey and supporting teams to work together to address the challenges, as this has been a key theme of learning from transformation work to date. The voice of patients/carers being heard and patient experience is central to the development and delivery of this programme and is being embedded in the programme structure. We are also looking to further hone our focus on fundamental standards of care and recovery outcomes as the measures for our transformation work, engaging staff in care being purposeful, avoiding crisis, being timely and least restrictive and recovery focused, and using these as our themes through the quality performance framework for the coming year.

We are building on partnership working across SLP to address challenges in our specialist and CAMHS pathways, and with our Place and ICS partners on prevention, interface with primary care, and investments to address significant demand pressures across our services.

We will continue to enhance our workforce stability and morale, particularly looking at local recruitment, as part of our commitment to being an anchor institution, and on anti-racism and inclusivity in everything we do for and with our staff. The SIREN as well as QI and psychological safety within our organisational development hub structure will be key to ensuring our staff and leaders are engaged and empowered in developing their teams and delivering high quality care. Our People Strategy is in development and our leadership offer to our staff is in progress.

Moving towards 2024/25 we will refresh our Q&P framework with consideration to the Oversight Framework and ICS measures, recovery outcomes, as well as those metrics which measure the success of our integrated transformation as outlined above.

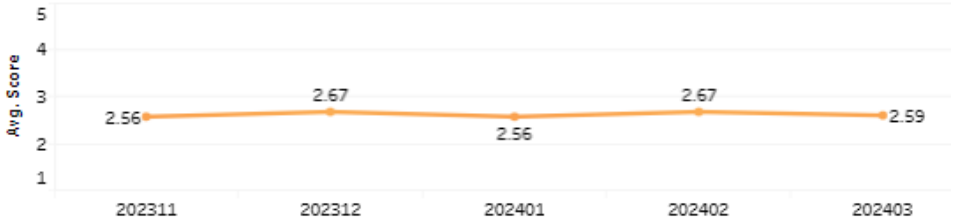
Quality & Performance Summary (see appendix 3 for explanation on scoring)



Summary Domain Performance:

Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations		5	7	41.7%
Quality	2	1	2	60.0%
Workforce	1	1	2	50.0%
Finance	1			100.0%
Total	4	7	11	50.0%

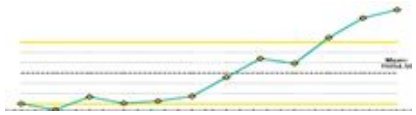
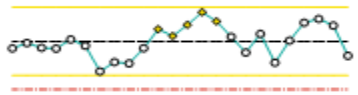
Donut Performance over-time (all themes combined):



NHS: Oversight Framework

Theme		Metric	Previous (OF) Update	Latest Performance (OF)	Internal Trust Metric	Internal Trust Metric
Trust	S035a	Overall CQC Rating	3 - Good	3 - Good	N/A	N/A
	S059a	CQC Well led rating	3 - Good	3 - Good	N/A	N/A
Workforce	S067a	Leaver Rate	10.20% (May 23)	9.1% (Jan 24)	13.1% (Mar 24)	Staff Turnover
	S068a	Sickness Absence Rate	4.63% (May 23)	4.8% (Jan-24)	4.63% (Feb 24)	Yes
	S071a	BME senior staff %	15.20% (2022)	15.20% (2022)	31.6% (Mar 24)	Yes
	S071b	Female senior staff %	55.60% (May 23)	55.60% (May 23)	68.5%	New metric for 24/25
Experience	S072a	Staff Survey fair career progression	47.60% (2022)	49.93% (2023)		N/a External Survey
	S121a	Staff Survey compassionate culture people promise sub-score (out of 10)	7.08 (2022)	7.24 (2023)		N/a External Survey
	S121b	Staff Survey Raising Concerns sub-score (out of 10)	6.49 (2022)	6.50 (2023)		N/a External Survey
	S133a	Staff Survey Compassionate theme score (out of 10)	7.34 (2022)	7.44 (2023)		N/a External Survey
	S063a	Staff Survey Bullying score (from managers)	11.50% (2022)	8.76% (2023)		N/a External Survey
	S063b	Staff Survey Bullying score (from colleagues)	16.40% (2022)	16.12% (2023)		N/a External Survey
	S063c	Staff Survey Bullying score (from patients/public)	27.10% (2022)	27.51% (2023)		N/a External Survey
	S069a	Staff Survey engagement theme score (out of 10)	6.99 (2022)	7.11 (2023)		N/a External Survey
Flow	S038a	Consistency of reporting patient safety incidents	50% (Apr-Sep 2023)	50% (Jan-Jun 2023)		TBC clarification required
	S125a	Adult Acute LoS over 60 days	35% (May 23)	35% (May 23)	26.2% (Mar 24)	New metric for 24/25
	S125b	Older adult LoS over 90 days	39% (May 23)	39% (May 23)	42.9% (Mar 24)	New metric for 24/25
	S086a	Inappropriate Out of Area placement bed days	1010 (May 23)	1010 (May 23)	176 (Mar 24)	Yes

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

ICS Long Term Plan Metrics	Mar-24	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 Talking Therapies (Trust)	24,471	24,200		Trust is slightly above its cumulative access requirements for 2023/24.
Number of adults and older adults with severe mental health accessing community mental health services	11447	-		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	176	≤0		Trust continues to require use of out of area beds due to high demand. Trust has renegotiated use of beds at Holybourne, now has use of 30 beds which commenced on 1 December 2023 for a year to December 2024.

SIREN

vision | Questions Breakdown | Performance Over Time

SIREN Dashboard

YearMonth 202403 | Press F11 for Full Screen

The Trust had 24 red teams in Mar-24.

There were 115 submissions out of a total of 115 in Mar-24.

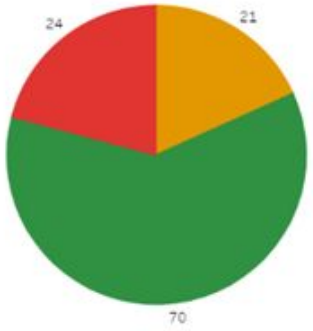
List of Red Rated Teams

Acute And Urgent Care	Kingston Liaison Psychiatry	383
	Ward One PICU	324
	Ward Two	239
	St Georges Liaison Psychiatry	233
	Liaison Psychiatry - Sutton	228
CAMHS & ED	Aquarius	229
	National Deaf CAMHS - London	209
	Wandsworth CAMHS Tier 3	159
Community (Adults)	Wandsworth SPA	306
	Twickenham IRH	300
	Mitcham IRH	280
	Putney & Roehampton IRH	258
	Wimbledon IRH	248
	Richmond SPA	242
	Central Wandsworth & West Battersea IRH	228
	Wandsworth Complex Needs Service	228
	SUN Project	221
	Wandsworth EIS	215
Specialist Services	Forensic Outreach Service	228
	Merton Adult ADHD Service	228
	Sutton Adult ADHD Service	228
	Sutton MH Learning Disability Team	228
	Merton MH Learning Disability Team	221
	Ruby	217

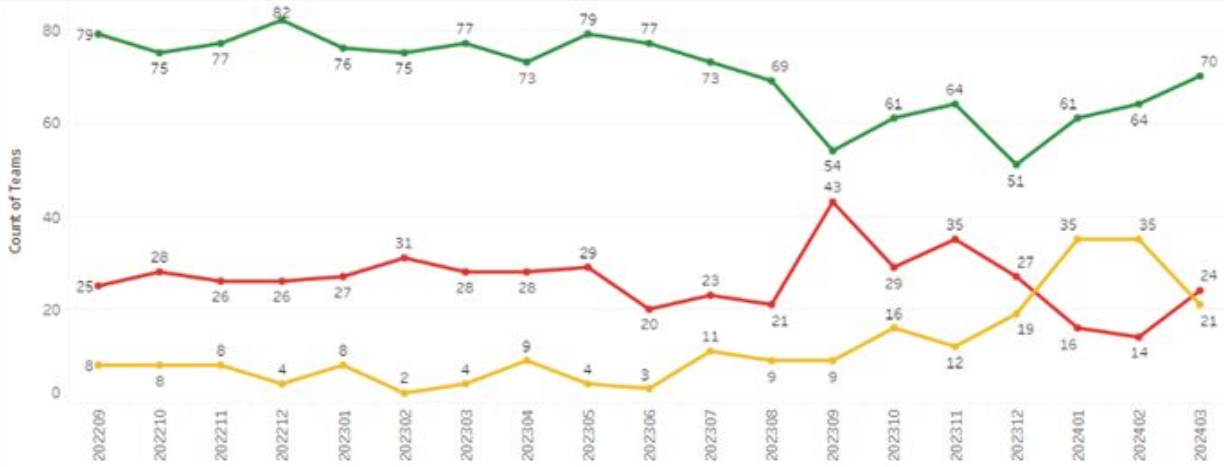
Count of SIREN Ratings by Siren Type

SIREN Type	Green	Amber	Red
CAMHS	3		1
CAMHS NP	12		1
CMHT	14	7	7
Daycare	1		
EIS	1	3	1
Hostel	1		
HTT	3	3	
Inpatient	13	6	4
LD	2		2
Other	20	2	8
Grand Total	70	21	24

SIREN Rating Breakdown



Team Count of SIREN Ratings



SIREN – March 2024 Summary Commentary

- SIREN continues to be used within team and service line meetings on a regular basis to support understanding and action on concerns. There has been a shift from amber to red rating of teams, likely to reflect the ongoing pressures on our services and workforce.

- **Community: (key link to caseload LOS and waiting times, vacancy rates and use of agency, and team morale)**

❑ Teams that have reported red SIREN results for 2+ months have been proactively reviewed, and include 3 teams across Wandsworth, one in Richmond and two in Merton. Key themes driving concern include recruitment challenges associated with high agency usage, high team caseloads, gaps or changes in team leadership also impacting on supervision rates and high levels of stress. Actions are in train to support recruitment, particularly to leadership roles, to improve clinical capacity and staff support.

❑ Similar themes of concern are seen in a number of teams newly reporting a red SIREN this month, with newly red teams mainly in Wandsworth and Richmond. SL leadership are supporting local managers to address concerns in these two boroughs, but challenges remain. Specific actions are being taken around the Service User Network team (including an internal review of the service as part of the transformation of the PD pathway) and the Wandsworth CNS team (meeting in April to explore their concerns in relation to an inquest and learning)

❑ Wider service line actions to support teams include a new SLR performance framework for all boroughs bringing borough leadership team & the quartet together to review SIREN results and wider performance priorities including FSOC. The Community workforce plan 24/25 has a focus on recruitment challenges and improving the quality of supervision. Ideas on new retention initiatives are being reported into the wider retention group for the Trust.

Acute & Urgent Care: (key link to ongoing pressure on the crisis and acute pathway)

❑ Reduction from last month with a total of 5 teams red rated (2 of which are inpatient wards and all three Psych Liaison Services). Ward 1 and Ward 2 saw an increase of unfilled shifts, complaints, sickness, low supervision rate and Bank usage.

❑ Ward 1 is an area of ongoing concern due to high patient acuity, high number of incidents and violence and aggression towards staff and patients, and with the team reporting high stress levels, low supervision rate and increasing numbers of unfilled shifts. An improvement plan is in place, focusing on three specific areas: physical health, observations and medicine optimisation. Sickness is being managed and the Ward Manager and deputies supported to work with staff to deliver improvements, including peer visits to learn from other PICU units. Bed numbers have been reduced to support safe care and staff pressures and reviewed daily.

❑ Concerns remain around Liaison psychiatry; the teams have vacancies, including a team manager and a consultant psychiatrist, where temporary cover is being put in place. Long term sickness absence and high vacancy rate means there are unfilled shifts that are not consistently covered with bank. This interacts with stress levels, workload, and morale with high demand within the ED environment to create long term challenges for these teams. Transformation work is ongoing and current focus is on improving digital systems and streamlining process, while the CSL is auditing caseloads and initiating improvement work in this area.

- **CAMHS & AED: (link to acuity within inpatient areas and demand within community)**

❑ London Deaf CAMHS team continues to experience high stress levels associated with increased demand, there has been an increase in sickness. They have introduced additional assessment capacity. The Wandsworth Tier 3 locum psychiatrist left at short notice meaning the team have reduced psychiatry cover and in addition there has been a complex family escalation which has required significant consultant and management time. The issue is being actively managed.

❑ Aquarius has been caring for a complex young person with an EPOC agreed by SLP, which required additional agency usage and resulted in the number of incidents increasing. This individual has now been transferred more locally although general acuity and complexity in the GAU setting is high.

- **Specialist: (key link to ADHD assessment long waits)**

❑ Overall 6 teams showing red. 2 ADHD and ASD teams, with extremely long waiting list as well as high 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. Proposal to progress a waiting list initiative for ASD will address some of the 52 week breaches.

❑ Jasmines ward improvement plan continues to be embedded and improvement and learning is being supported by SL leadership team.

❑ FOS are experiencing high demand in the context of ongoing difficulties with recruitment. IT issues with the service are being investigated.

❑ Ruby ward admitted a patient with complex needs requiring segregation and management of significant self-harm. A care plan to manage is in place.

Fundamental Standards of Care - Inpatients

vision

Fundamental Standards of Care - Inpatients

Press F11 for Full Screen

This dashboard is currently displaying information for **All Wards**. Click the filter icon at the top right of the page to view a single Ward, Ward Category or Service Line.

Summary Table

Group	KPI	Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
FSOC 1	Annual care plan review (%)	95%	97	93	93.1	94.8	95.7	94.4	86.1	87.7	89.6	93.2	95.5
	Care planning audit compliance (%)	90%	94.4	94.5	96	94.9	95.3	95.6	94.7	94.7	95.4	96.4	96.8
	Care planning audits completed (%)	90%	91	90.5	96.3	91	94	91.7	87.7	92.6	89.8	85.9	91.2
FSOC 2	Cardiometabolic Assessments - Inpatients (%)	90%	86.8	81.9	81.1	85.2	85.3	85.3	82.3	77.8	83.2	82.1	82.6
	Physical Health Assessment attempted within 4..	95%	91.4	95.6	93.6	95.4	88.6	97.4	97.2	94.2	96.4	92.9	96.2
	Physical Health Assessment completed within 7..	90%	78.1	87.9	82.3	73.8	79.3	88.3	83.7	71.9	87.5	86.8	81
FSOC 3	Risk Assessments within 48 hours of admission ..	95%	98.7	96.3	97.2	98.2	98.3	99.1	98.1	98.5	97.2	99.5	98.5
FSOC 4	Observation reviews completed against standar..	Null	62.4	67.8	76.2	75.4	73.4	77.6	70.2	74.4	80.8	71.4	67.2
	Observations required vs completed (%)	Null	81.9	82.5	83.3	86.1	84.5	85.8	83.9	86.4	90.1	79.7	86.4
FSOC 5	Number of safeguarding adults alerts	Null	26	11	11	16	6	15	20	12	23	19	13
	Number of safeguarding children incidents repo..	Null	9	4	10	11	8	12	6	8	12	9	3
	Safeguarding adults training (%)	95%	95.1	95.5	96.4	96.9	96.5	95.7	96.1	96.3	96.4	95.6	96.1
	Safeguarding children training (%)	95%	88.7	88.3	88	87.9	87.7	88.1	87.6	87.5	84.9	85.4	86.1
FSOC 6	Infection Prevention and Control Training (%)	95%	94.8	95.8	95.7	95.3	94.6	94.3	93.5	93.5	93.9	93.4	93.2
	Infection prevention control audit compliance (..	90%	99.1	98.7	98.6	99	99	98.7	99	98.6	98.8	98.9	99.1
	Infection prevention control audits completed (..	90%	92.5	94.2	94.4	91.8	94.8	91.5	90.3	94.5	94.1	93.2	95.7
FSOC 7	Pharmacy audit compliance (%)	90%	92.4	89.2	92.8	92	93.3	82.9		97.1			
	Pharmacy audits completed (%)	90%	95.2	100	100	87	30.4	8.7		100			
FSOC 8	Mental health act audit compliance (%)	90%	96.6	94.6	95.9	93.6	92.5	93.8	95	93.2	94	94.8	91.7
	Mental health act audits completed (%)	90%	94.3	97.2	95.3	96.2	98.1	94.6	89.4	97.8	93.9	94.7	99.3
	Mental Health Law Training (3 Year)	85%	78.7	84.2	84.3	85.7	83.2	83.1	83.7	83.1	86.7	87.5	88.6
	Section 132 Patient Rights Repetition	100%	86	91.1	88.8	85.1	85	90.7	85.6	89.8	96.9	96	98.9
FSOC 9	Duration of physical restraint (average minutes)	Null	8.6	10.8	11	13.1	13.4	9.8	11.6	8.7	7.7	11.8	9.2
	Duration of prone restraint (average minutes)	Null	7.3	8.9	11.4	2.9	11.3	9.8	5.3	4.8	3.9	13.2	6
	Reducing restrictive practices - Prone restraint	Null	64	48	33	46	51	35	21	21	26	19	23
	Seclusions	Null	20	40	26	20	39	36	30	27	22	24	23
	Total number of restraints (physical restraints ..	Null	239	264	269	192	231	256	250	256	227	221	226
FSOC 10	Incidents Waiting for Managers closed within 4..	95%	52.1	38.7	43.1	35.5	30.7	28.4	28.9	36.5	34.5	39.5	23.3
	Patient Safety Incident Actions completed by ta..	100%						100	100	100	100	100	100
	Patient Safety incidents	Null	298	293	312	336	283	339	352	330	348	330	362
	Percentage of Low/No Harm Incidents where Ac..	95%	99.2	99.1	98.6	99	97.7	97.2	99.1	99.3	99.3	99.2	99
	Post Incident Review Actions closed within 48 h..	95%							50	0	100		
	Post Incident Reviews completed by managers ..	95%	100	0	25	50	40	100	100	100		50	50
	Post Incident Reviews completed by Matron/CM..	95%	0	25	50	25	20	50	100	0	50	100	100
	Root Cause Analysis (RCA) actions that are over..	0	7	1	2	3	2	1	1	2	3	0	1
	Significant Incidents, formerly reported to STEIS	Null			2	1	2	3	2	1	1	1	0
	Significant Incidents, previously serious inciden..	Null	11	3	9	3	7	13	12	3	13	22	3
FSOC 11	Safe Staffing: Shift Assurance, Inc Obs Require..	Null	83.3	91.6	88.3	80.9	72.5	89.2	73	83.1	84.1	87.7	90.9
	Supervision (%)	85%	78.3	90.4	85.1	80.1	86.5	81.6	89.2	88.6	87.4	83.8	85.9

FSOC Service Line Feedback – Inpatient: Improvement has been seen overall in inpatient FSOC metrics.

Acute & Urgent Care:

- There has been steady improvement in meeting the set standards. Quarterly KPI meetings have been taking place to go through FSOC which have been attended by FSoC Lead and Ward Managers. The focus for the next three months will be to monitor 6 identified FSoC through the ward workflow daily meetings, including Risk Assessment, Physical Health, Observation, MHA, NEWS and Care plan.
- Observation audit: continue weekly meetings with CSL to monitor constant/enhanced observation and to have assurance of process in place to daily reviews are taking place by MDT. Ward Manager to ensure compliance with intermittent / general observation through submission of a weekly audit.
- Care plan still showing concerns of lack of reviews which require in depth discussion with teams by CSL's as well as to source training to support staff in creating and writing a meaningful care plan with patient's involvement and engagement. To date 10 sessions of care plan training delivered which have been well attended by MDT and received positive feedback on the contents of the training. The SL will ensure there is a process to audit care plans as well as ongoing updates through training.
- A snap audit carried out on physical health needs showed that improvement is needed in ensuring a physical health care plan is created and support sought from the PH team as needed.
- Training on safeguarding and MHA remains as a challenge, where managers are unable to book their staff to attend these training due to not enough places available but at the same managers are being asked to closely monitor DNA's.

CAMHS & Eating Disorders Service Line:

- Always ready audit compliance is breaching due to administrative questions "do you wish to opt out of this audit" and "are the RIO numbers provided correct" incorrectly flagging as a breach. Raised with App Dev awaiting resolution.
- Training impacting on compliance, staff booked onto training and informed of safeguarding level 3 resources on compass. Bespoke ED RATE training being arranged for April 2024 for Avalon ward. Safeguarding children training is being prioritised for Aquarius ward to improve performance. Corner House are addressing a range of training deficits. Wisteria ward have overall good compliance with FSOC, incidents waiting for managers to close is breaching, WM allocating incident management on weekly management days for deputies.

Specialist:

- Forensic Inpatient teams sustain a very stable and good progress. Only 2 breaches including 'Safeguarding Children Training' and 'Incidents managed within 48 hours (high acuity on units noted with all incidents monitored daily by Ward Managers and by Matron). Effective fortnightly FSOC review meeting with Ward Managers, Matron and Lead Nurse remains in place with Deputy Ward Managers more involved in the follow-up of any subsequent action plan.
- Areas flagged as red on Dashboard across adult specialist and CMHA units are being closely monitored and followed up include Safeguarding Children Training, IPC, CCST, Incidents managed within 48 hours and Supervision. Proactive and effective action plan in place for all mentioned areas. On older adults ward, there are ad hoc audits into NEWS2 and observations.

Fundamental Standards of Care - Community

vision

Fundamental Standards of Care - Community

Press F11 for Full Screen

This dashboard is currently displaying information for **All Teams**. Click the filter icon at the top right of the page to view a single Team, Team Category or Service Line.

Summary Table

Group	KPI	Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
FSOC 1	Annual care plan review (%)	95%	92.8	91.8	90.6	91.4	90.2	90.5	90.8	89.2	89.5	90.4	89.9
	Care planning audit compliance (%)	90%	76.2	75.9	80.7	79.9	83.7	80.4	80.8	85.5	83.2	85.3	87.5
	Care planning audits completed (%)	90%	25	30.5	34.5	38.1	35	30.8	30.3	25.5	32.1	36	33.1
	Carers of Clients on CPA who have been offered ..	85%	84.8	78.3	83.2	91.8	88.7	93.9	94.4	94.3	91.3	88.2	89.9
	Dialog assessment recorded in the last 6 month..	Null	21.8	21.8	22.1	23.8	25.1	27.2	33.1	33.4	36.2	36.6	36
	Employment, education and training informatio..	90%	84.1	83	82.6	82.9	80.6	75.8	79.9	73.4	68.4	71.3	72.7
	Feedback Offered (%)	90%	88.8	80.2	82.2	80.6	80	78	83.6	76	76.9	86.4	68.2
	Goals Set (%)	90%	78.2	73.9	82.9	78.7	77.1	71.7	79.1	70.9	76.6	75.6	77.2
	Paired Measures (%)	80%	76.1	75	72.9	78.3	67.1	64.4	82.9	62.8	69.4	65.9	61.7
FSOC 2	Cardiometabolic Assessments - Community & EI..	75%	79.3	80.4	83.3	84.8	84.7	84.6	84.1	85.1	84.7	84.6	84.3
	Cardiometabolic Assessments - EIS (%)	90%	82	85.8	84.7	82.6	81	81.6	85	88.4	85.3	89.5	92.6
FSOC 3	CAMHS IAPTUS patients with an up to date risk ..	95%	78	80.2	80	70.6	74.5	74.3	76.3	81.1	84.9	86.2	85.7
	Community patients with an up to date risk ass..	95%	91	91	92.1	92.5	92.5	92.5	91.8	91.1	91	90.7	91.9
	Risk Assessments within 48 hours of admission ..	95%	92.3	90.4	93.6	93.6	93.4	90.9	94.6	95.4	94.4	94.7	92.3
FSOC 5	Number of safeguarding adults alerts	Null	43	45	42	50	46	43	42	43	56	40	40
	Number of safeguarding children incidents repo..	Null	18	21	21	25	18	12	27	23	30	28	23
	Safeguarding adults training (%)	95%	95.8	96	95.8	95.9	95.8	96	94.7	94.6	94.8	94.8	93.4
	Safeguarding children training (%)	95%	90	87.4	86.3	86.2	84.7	86	83.9	83.7	82.9	83.5	83.8
FSOC 6	Infection Prevention and Control Training (%)	95%	94.9	94.3	94.4	93.7	93.4	92.5	91.5	90	90	90.1	89.8
	Infection prevention control audit compliance (..	90%	98.6	100	100	100	100	100	100	100	100	100	100
	Infection prevention control audits completed (..	90%	46.4	68.2	73.3	100	100	100	100	100	50	50	50
FSOC 7	Pharmacy audit compliance (%)	90%			88					85			
	Pharmacy audits completed (%)	90%			100					94.6			
	Valid Clozapine Prescriptions (%)	Null	99.4	99.1	97.9	96.3	99	96.9	97.5	95.8	98.9	98.4	93.8
FSOC 8	Mental Health Law Training (3 Year)	85%	80.6	85.3	86.5	88.4	86.5	86.3	86.6	84.7	86.7	87.2	86
	Section 132 Patient Rights Repetition	100%	77.9	77.1	76	79.1	69.1	68.5	79.9	88.2	84.9	87.5	81.8
FSOC 10	Incidents Waiting for Managers closed within 4..	95%	37.3	22.8	26.7	25.4	25	31.4	19.1	30	21.9	29	26.6
	Patient Safety Incident Actions completed by ta..	100%						100	100	100	100	100	100
	Patient Safety incidents	Null	114	151	104	137	110	142	167	130	158	152	108
	Percentage of Low/No Harm Incidents where Ac..	95%	94	92.4	91.9	94.9	91.3	92.7	89.7	90.4	89.7	90.8	91.3
	Post Incident Review Actions closed within 48 h..	95%		100					100	72.7	100		100
	Post Incident Reviews completed by managers ..	95%	90	66.7	87.5	66.7	66.7	70	75	60	37.5	40	71.4
	Post Incident Reviews completed by Matron/CM..	95%	25	8.7	58.3	62.5	100	33.3	40	20	22.2	62.5	70.8
	Root Cause Analysis (RCA) actions that are over..	0	5	5	5	5	4	4	0	1	3	2	
	Significant Incidents, formerly reported to STEIS	Null			3	0	2	1	0	0	0	0	0
	Significant Incidents, previously serious inciden..	Null	10	10	8	10	16	12	17	11	11	13	8
FSOC 11	Supervision (%)	85%	82.4	85.7	85	81.4	84.5	84.1	85.7	79.3	81.4	81.8	79.5

FSOC Service Line Feedback – Community: Overall the Community FSOC standards are of concern and improvements are being prioritised with teams.

Acute & Urgent Care:

- There has been steady improvement in meeting the set standards, training on safeguarding and MHA remains as a challenge though there has been some improvement as compliance as at between 70 – 80%. Managers are unable to book their staff to attend these training due to not enough places available but at the same time managers are being asked to closely monitor DNA's. SL continues to oversee FSOC closely with teams.

Community:

Immediate (April):

- Key drivers for FSOC performance are inconsistent compliance with processes of documentation (e.g. risk assessment recorded in progress notes rather than on Rio forms) and staff vacancies in key roles (band 6 care coordinator, team manager and medical posts, including leadership roles such as ACD); and challenges with the Always Ready app for Community teams.
- Improvements have been seen in Merton with risk assessment compliance increasing from 83% in Feb to 91% in April. Richmond is showing as the lowest performing borough against FSOC – this is a priority focus for the clinical manager and CSL who are providing extensive support to staff while new team managers are onboarded. Staff level compliance with FSOC is routinely discussed in SLR meetings with a focus on outlying areas.
- Following discussion on the limitations of the Always Ready app in the March Community SLR, a new audit tool will be developed as replacement to provide effective assurance of quality reviews of key patient documentation including crisis and care plans.
- Community QGG key focus on FSOC for the next 3 months, with specific focus on improving quality of risk assessments, crisis plans and care planning.
- Quartet and team leader meetings in April have been used to undertake benchmarking discussions following the CQC findings in Nottinghamshire.

Medium term (May +):

- CSLs will work with TMs to audit 10 care plans, risk assessments and crisis plans per month for each IRH in their Borough.
- Physical health: 2 day physical health/ABLS practical training being led by Community physical health nurse lead for nurses and AHPs. Holistic hubs being rolled out across the service line to support the Physical health of our patients. QII project underway to support an improvement in our CMA compliance across EIS.

Improving practice:

- A new crisis plan SOP will be developed and rolled out across the service line.
- Communication to all staff on where to access standards of practice on the shared drive for easy reference including Care plan practice standards; Examples of good practice for care plans; Risk assessments and crisis plans; SOP risk assessment and crisis plans.

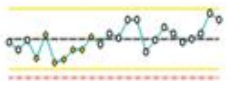
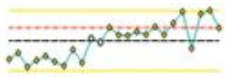
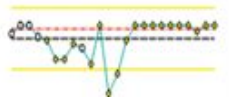
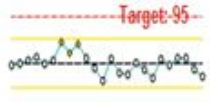
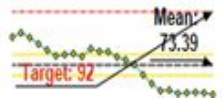
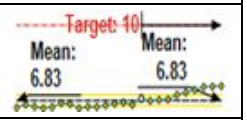
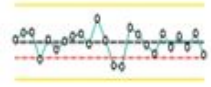
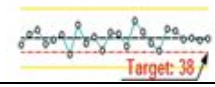
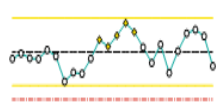
CAMHS & ED:

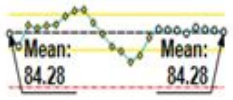
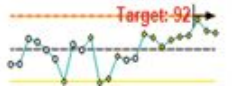
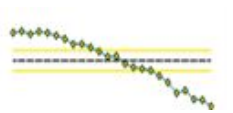
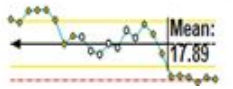
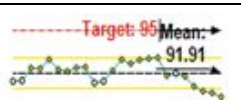
- Care plan compliance below target and at this point only includes RIO teams, IAPTUS teams will be pulled through, there was an issue submitting these which has been resolved and position should improve next month.
- Risk assessments in IAPTUS have been improved, NDT remains an outlier process change which will take a while to improve the position, in the meantime spot checks and deep dive audits in place to monitor quality and safety. Change to trigger metrics to exclude indirect contacts and include telephone contacts.
- Always ready audit compliance is breaching due to administrative questions "do you wish to opt out of this audit" and "are the RIO numbers provided correct" incorrectly flagging as a breach. Raised with App Dev awaiting resolution
- Safeguarding children's training breaching, new starters gathering evidence and making use of compass resources for completion.
- Deaf CAMHS services- safeguarding children and adult training, mental health law training, care plan audit and supervision impacting on the overall compliance. Breaches are routinely monitored and tracked by the matron we should see an improved position by next month.

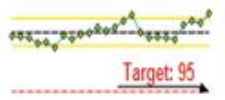
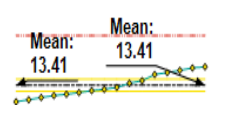
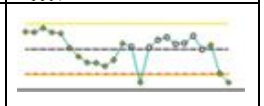
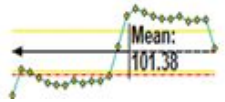
Specialist:

- CMHA and NDD are undertaking focused work on crisis / contingency plans to support compliance in care planning. Some issues with supervision levels are being addressed. Training levels are a concern in NDD/LD services and are a focus for the team leaders.
- Adult specialist (OCD/BDD, Neuropsychiatry and Deaf Community): Maintain steady position with weekly monitoring and FSOC review meeting in place. Action plan for training breaches also completed and being monitored by Clinical manager and clinical lead.
- FOS/Support plus areas for improvement are care plan audit completion. Good monitoring is in place though work needs to be done around covering this during annual leave and particularly acute periods as numbers are low. There have been improvements in risk assessment and 132 rights with good oversight.

Priority Metrics

	Priority Metrics	Mar-24	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 16)	50	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 17)	54	= 0	→	X	
	Access					
	Referral to treatment (RTT): 52 week breaches (see page 19)	981	= 0	↗	X	
	Access					
	Expected population need Talking Therapies – Trust (see page for service breakdown 19)	2029	>=2032	↗	-	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 20)	100	≥ 95.0	↗	?	
	Access					
	Adult Acute Bed Occupancy (see page 22)	99.2	≤ 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 23)	11450	-	↗	-	
	Flow					
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (See page 16)	70.8	≥ 95.0	→	X	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 18)	63.1	≥ 92.0	↘	X	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 20)	7.4	≥ 10.0	↗	X	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 21)	75.7	≥ 80.0	→	?	
	Access					
	Dementia diagnosis within 6 weeks of referral to a memory assessment service (%) (see page 21)	86	>= 85	→	?	
	Access					
	Adult acute average length of stay (Excluding PICU) (see page 22)	48	≤ 38	→	?	
	Flow					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 23)	176	≤ 0	→	X	
	Flow					

	Priority Metrics	Mar-24	Target	Trend	Assurance*	SPC Chart
Quality	Cardiometabolic Assessments - Community and EIS (%) (see page 24) **Fundamental Standards of Care**	84.3	≥ 75.0	→	✓	
	Patient Friends and Family Test (%) (see page 25) **Patient Experience and Outcomes**	88.1	≥ 92.0	↗	✗	
	Paired HoNOS Completed (See Page 26) **Patient Experience and Outcomes**	34.6	-	↘	-	
	Death - Suspected suicide (see page 27) **Patient Safety**	1	-	→	-	
Workforce	Vacancy Rate (%) (see page 28) **Recruitment/ Attraction**	15.1	≤ 15	↘	?	
	Statutory and Mandatory Training: 1 (%) (see page 30) **Staff Skills/Development**	90.2	≥ 95.0	↘	✗	
	Turnover (%) (see page 31) **Staff Retention/ Support / Satisfaction**	13.1	≤ 15	↘	✓	
Finance	% Forecast Overspend (See Page 32) **Grip & Control**	-0.3	≤ 0	↘	?	

	Priority Metrics	Mar-24	Target	Trend	Assurance*	SPC Chart
Quality	Safe Staffing: National Compliance - Inpatients (%) (see page 24) **Fundamental Standards of Care**	141.1	≥ 95.0	↗	✓	
	Talking Therapies recovery rate – Trust (%) (see page 25) **Patient Experience and Outcomes**	53.7	>=50	→	?	
	Paired Dialog Completed % (see page 26) **Patient Experience and Outcomes**	23.3	≥ 40.0	↗	✗	
Workforce	Percentage of BAME staff - Band 8+ and Medical (see page 29) **Recruitment/ Attraction**	31.6	≥ 50.0	↗	✗	
	Statutory and Mandatory Training: 2 (%) (see page 30) **Staff Skills/ Development**	83.9	≥ 85.0	↘	✓	
Finance	Activity vs Plan (Local Contract) (See Page 32) **Productivity**	102.2	≥ 95.0	↗	✓	

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

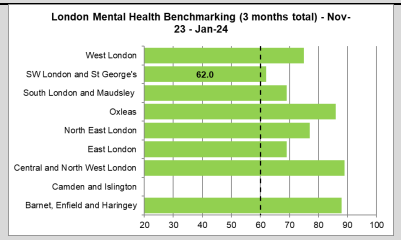
Operations Domain

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

Access

Team Breakdown – March 2024

Team	Treatment Within 14 Days	Referrals	% Treatment Within 14 Days
Merton Early Intervention	4	5	80.0%
Kingston Early Intervention Service	2	3	66.7%
Sutton Early Intervention	1	2	50.0%
Wandsworth EIS	1	4	25.0%
Richmond Early Intervention Team	0	2	0.0%
Trust Total	8	16	50.0%



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.

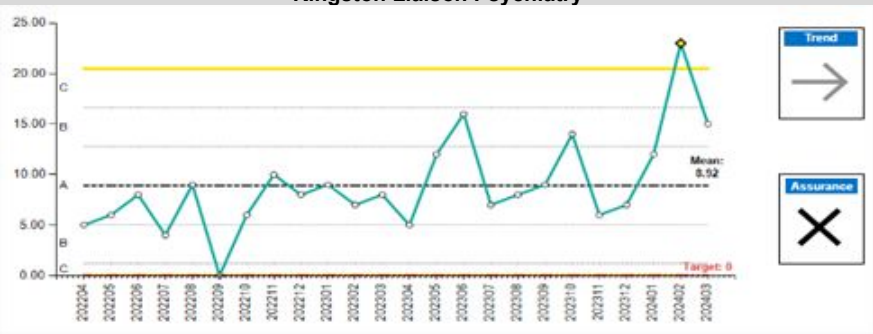
Underlying issues
- Some inpatient wards and adult assessment teams are slow to refer patients on to EI services once psychosis is identified making it much harder for them to meet the waiting time targets.
- RiO is not configured to allow the accurate recording of first episode of psychosis and provide a workflow; as a result, there is an administrative burden on teams to manually validate all waiters.
- Wandsworth EIS has had some staffing challenges due to sickness and the team have vacancies which they are finding difficult to recruit.
- Kingston/Richmond EIS have been without Team Manager since December 2023.
- Feedback from National Clinical Audit of Psychosis 2023 scored all 5 Borough's as "top performing" in regard to timely access.

Actions:
- 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.
- Successful recruitment of Team Manager for Kingston/Richmond EIS who commenced in post March 2024.
- Teams to prioritise medical slots for FEP assessments to help capacity management.

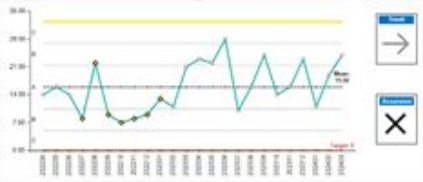
Liaison psychiatry - Seen within 1 hour in A&E (%) Target ≥ 95%

Access

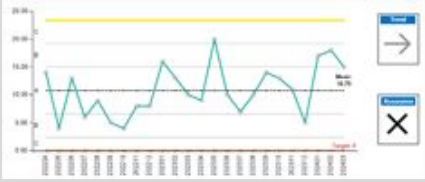
Kingston Liaison Psychiatry



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 3 Liaison services.

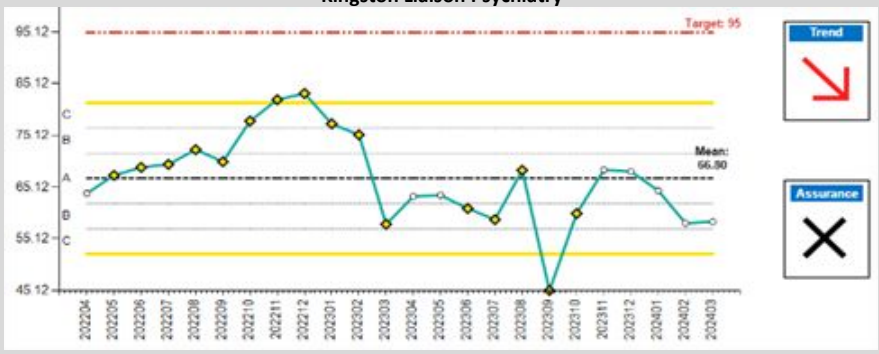
Underlying issue:
- The process of managing Emergency Referrals is impacted by many factors such as staffing shortages (including sickness and vacancy rate, cubicle space (St George's), other activities such as handover and multiple referrals from both ED and wards.
- Impact of extended number of patients waiting for MH beds in general hospital requiring further reviews.
- 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.
- Liaison Psych Service Review has been completed; recommendations are being reviewed for next steps in transformation work.
- 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.
- Enabling work in advance of Kingston Rapid Access pilot to be completed by 15th April i.e. IT logins, and honorary contracts.
- The Trust is part of the SWL ICB Task & Finish Group which is looking at Mental Health in ED challenges and work out best options to support system pressure, flow and impact on existing resources.

Access

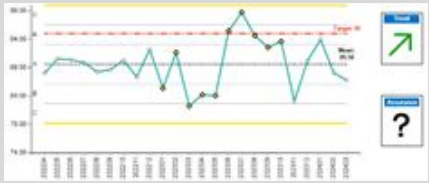
Liaison psychiatry – People waiting over 12 hours in A&E for a bed — Target = 0

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.

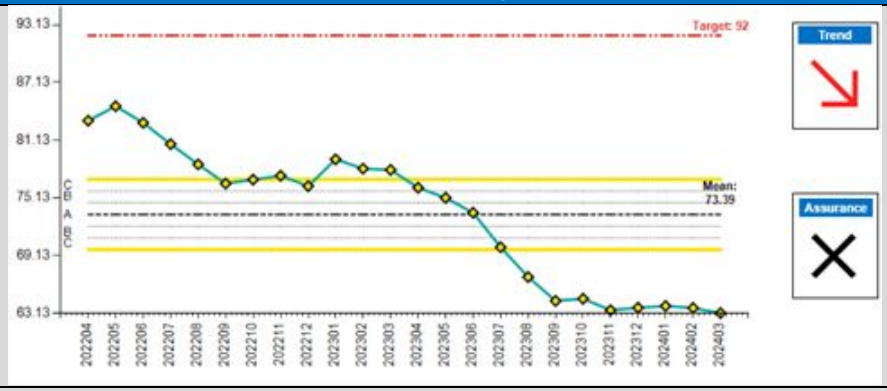
What the charts tells us
The level of 12-hour breaches is increasing across the three services with occasional variation.

Underlying issue
- A lack of available adult acute beds will lead to an increase in waits over 12 hours.
- Increased LOS and DTOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital step down beds.
- Kingston Liaison saw spike in acuity including one day where service received 20 referrals in 24 hour period. This has led to increase in mental health patents within the emergency department and higher numbers referred for 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.
- 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.
- Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds.
- Enabling work in advance of Kingston Rapid Access pilot to be completed by 15th April i.e. IT logins, and honorary contracts.
- The Trust is part of the SWL ICB Task & Finish Group which is looking at Mental Health in ED challenges and work out best options to support system pressure, flow and impact on existing resources.

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

Access



March 2024 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	10	0	100.0%	0	0
	Liaison	82	1	98.8%	1	1
	Specialist Services	171	2	98.8%	0	0
CAMHS & ED	CAMHS Access/Referral	2,432	449	81.5%	71	1
	CAMHS Tier 3	584	250	57.2%	99	14
	CAMHS Tier 4	5	0	100.0%	0	0
	Deaf Services	67	10	85.1%	0	0
	Eating Disorders	124	67	46.0%	32	3
	Liaison	18	0	100.0%	0	0
Community (Adults)	Adult CMHT	1,339	92	93.1%	9	0
	Early Intervention	14	0	100.0%	0	0
	Psychological therapies	10	0	100.0%	0	0
	Specialist Services	13	0	100.0%	0	0
Specialist Services	ADHD/ASD	2,371	1,915	19.2%	1,580	960
	Deaf Services	1	0	100.0%	0	0
	Forensic Services	5	0	100.0%	0	0
	Learning Disabilities	22	0	100.0%	0	0
	OCD/BDD	55	18	67.3%	5	1
	Older People	401	0	100.0%	0	0
	Specialist Services	396	187	52.8%	54	0
Grand Total		**8,120**	**2,991**	**63.2%**	**1,851**	**980**

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 March 2024 64.0% (1915/2991) 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:** Capacity issues within the team have led to increase in 18 week breaches.
- **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):** There are capacity issues within the AED team with three staff member due to leave in near future which will further impact on the waitlist.

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.
- Alternative models (that do not require GPs providing an enhanced service) are being considered, led by SWLSTG and ICB medical directors. No formal agreement has been reached regarding the discharge pathway.
- Recruitment of 2wte Non Medical Prescriber roles in Sutton and Merton.
- There remain patients at the top of the RTT waiting lists (90 weeks +) that require initiation of medication. These patients will remain on the waiting list in line with recent pharmacy guidance which stipulates service should not initiate medication for new patients unless they are high risk.
- **Neuropsychiatry:** Successful recruitment for medical vacancies with staff commencing in post in February 2024. The team has also tightened its administration processes around management of DNA's. Clinical Manager is undertaking a demand and capacity review which will have oversight via Deputy Head of Service Delivery.
- Service Line completing a full review of service to explicitly lay out the barrier to achieving target and propose potential options to mitigate gap and sustain any improvement.
- CAMHS: Continued recruitment across T3 teams following investment.
- There is continued ADHD medication backlog clearance via Non Medical Prescriber Nurse in Kingston and 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.
- New treatment groups (MANTRA) are will now accept pts as patients drop out. Team exploring the same for CBT/DBT group.

Access

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

52 Week Breaches – March 2024

Team	52 Week Breaches	Max Wait	Min wait
Sutton Adult ADHD Service	426	101	53
Richmond Adult ADHD Service	268	89	53
Merton Adult ADHD Service	266	98	53
Kingston CAMHS Tier 3	6	67	53
Merton CAMHS Tier 3	4	78	53
Wandsworth CAMHS Tier 3	3	56	54
Adult Eating Disorders	3	63	58
St Georges Liaison Psychiatry	1	54	54
National OCD/BDD Service	1	116	116
Merton CAMHS Referral	1	56	56
CAMHS Learning Disabilities	1	71	71

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:

- 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.
- There is a national shortage of ADHD medication which will mean the service will need to re-direct some clinical capacity to appointments for existing patients to change medication and establish new shared care arrangements, which will cause further 52 weeks breaches.
- CAMHS Tier 3: Most Breaches were linked to waits for ADHD medication commencement.
- Adult Eating Disorders service currently has 3 breaches - all patients are regularly reviewed whilst on therapy waitlist.
- CAMHS Complex Learning: One breach linked to demand and capacity issues.

Actions:

- **Adult ADHD:** Actions as above. Additionally bi-weekly administration meetings are held to ensure cancellations are managed promptly and 52 weeks breach lists are cleansed routinely and prioritised.
- **CAMHS:** There is continued ADHD medication backlog clearance via Non Medical Prescriber Nurse in Kingston and Richmond.
- **Adult Eating Disorders (AED):** Pathway and process review being undertaken with clinical lead and ACD in order to maximise use1 of resource for treatment.
- New treatment groups (MANTRA) will now accept patients as patients drop out. Team exploring the same option for CBT/DBT group.

Access

Expected population need met by Talking Therapies (numbers entering treatment)

Background
Talking Therapies 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 local contract area.

What the chart tells us:
The Trust has met its access requirements for 2023/24.
Three (Sutton Talking Therapies & Richmond Wellbeing Service & Talk Wandsworth) of the four Talking Therapies services are above their cumulative access requirements for 23/24. Merton was below its requirement but has shown considerable improvement in quarter 4 to reduce the year end deficit.

Underlying issue:

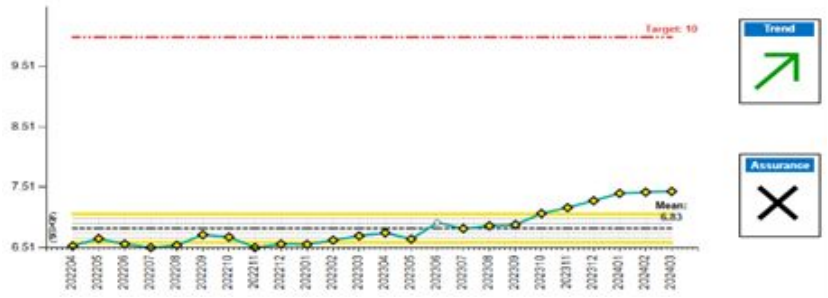
- There is insufficient resource in Wandsworth, Merton, and Sutton and therefore meeting access requirements whilst maintaining (already long) stable waiting times, and achieving recovery rates, continues to be an ongoing challenge.
- The self-referral option for one of our digital partner's (IESO) was switched off at the end of November 2023, as demand and performance has exceeded the subcontract agreement and there were no additional monies which could be repurposed for this function.

Actions (all now embedded as business as usual):

- Service managers are closely monitoring referral numbers as well as ensuring there are sufficient assessment appointments available to meet access targets.
- Appointment bookings are being monitored to ensure all appointments are used and there are no lost appointments. The availability of appointments is being adjusted to match the most popular times of day.
- Service managers are continuing to monitor productivity within services to ensure resources are being fully utilised.
- 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).
- Excess referrals are being sent to sub providers (as these count towards our access), meaning we can go above our capacity ceiling (at a cost).

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	202305	202306	202307	202308	202309	202310	202311	202312	202401	202402	202403	202404
Women accessing PMH services *	1,038	1,080	1,065	1,072	1,075	1,104	1,119	1,137	1,156	1,159	1,161	1,128
Estimated births	15,595	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)	6.7	6.9	6.8	6.9	6.9	7.1	7.2	7.3	7.4	7.4	7.4	7.2
Service use per birth (For Context Only)	*7.8*	*8.2*	*8*	*8.1*	*8.1*	*8.3*	*8.4*	*8.6*	*8.7*	*8.7*	*8.8*	*8.5*

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.

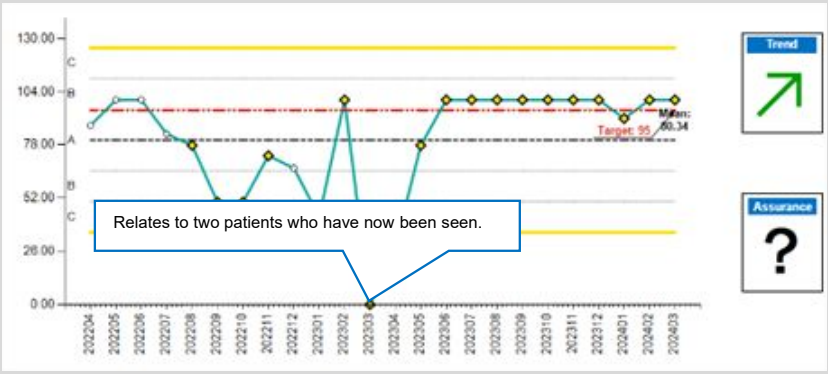
What the chart tells us
Although a slight upward trend is observed mean performance is below national requirement.

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.
- Peer Support Worker posts to be recruited into in October/November, with focus of roles on DNA project.
- Pilot for the Pre-conception Consultation Clinics are progressing well and with a new due to commence in Richmond in February 2024.
- Medical staffing model agreed. As a new post Royal College Psychiatry approval is required, job specification has been prepared and submitted.
- Initiation of QI project to address high DNA rates completed. First Plan, Do, Study Act (PDSA) cycle started in April 2024.

Access

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



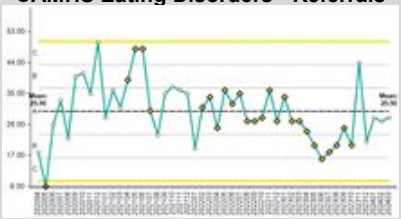
Background
To ensure that young people in urgent need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target. Recent months performance has shown improvement with full compliance in eight of the last nine months.

Underlying issue
- Over-reliance on part time staff to maintain administrative systems.
- The denominator for this KPI is low (n=8) in March 2024, so any case seen outside 28 days is likely to lead to target being missed.
- 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.

CAMHS Eating Disorders - Referrals



Waiting for Treatment Summary March - 2024

		00 - 01	01 - 02	02 - 03	03 - 04	04 - 05	Total
Waited	Standard	1	4	2	1	0	8
	Urgent (7days)	3	0	0	0	0	3
Waiting	Standard	3	6	2	0	1	12

Access

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

Team Breakdown – March 2024

Team	Assessed Within 8 Weeks	Assessments	% Assessed Within 8 Weeks
Sutton CAMHS Tier 3	16	17	94.1%
Wandsworth CAMHS Tier 3	25	28	89.3%
Merton CAMHS Tier 3	15	17	88.2%
Richmond CAMHS Tier 3	13	21	61.9%
Kingston CAMHS Tier 3	9	19	47.4%
Trust Total	**78**	**102**	**76.5%**

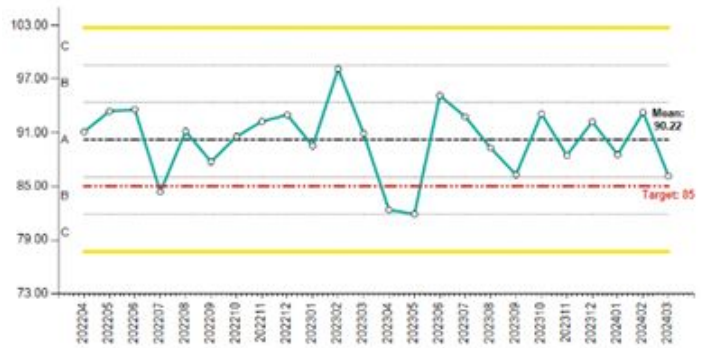
Background
To ensure that young people in need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target indicating compliance on occasion. Recent months have deteriorated with performance below mean in 4 of last 6 months.

Underlying issue
- Most breaches relate to waits for ADHD medication in community CAMHS i.e. 17 out of 22. 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.
- Psychiatry continues to prioritise 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) and GP with special interest in ADHD are increasing assessment activity for long-term ADHD medication waiters (will continue to breach 8 week until backlog is cleared).
- Continue to recruit to T3 following investment to increase choice assessment resource.
- Seek solutions to supporting psychiatry related functions across community CAMHS (E.g. more Non-medical Prescriber).

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



Team Breakdown – March 2024

Team	Diagnosed within 6 weeks	Diagnosis required	%
Kingston Memory Service	6	7	85.7%
Memory Assessment Service Wandsworth	25	32	78.1%
Merton Memory Assessment Service	6	10	60.0%
Richmond Memory Assessment Service	16	18	88.9%
Sutton Memory Assessment Service	35	35	100.0%
Total	88	102	86.3%

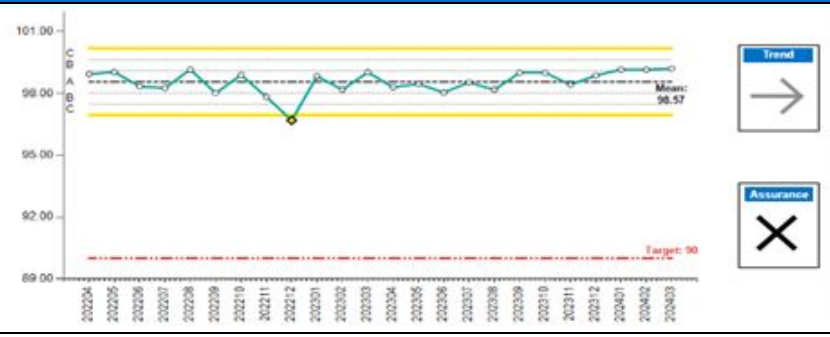
What the chart tells us
Mean performance is comfortably above target indicating frequent compliance with occasional variation.

Underlying issue
- 15 breaches reported in March 2024
- Reduced capacity contributory factor in Merton MAS performance.
- Whilst Wandsworth MAS saw an increase in referrals.

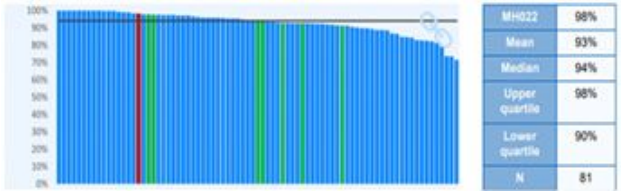
Actions
- **Trust:** Work with local commissioners to increase referral activity where DDR rate is low- e.g. Kingston.
- Continued monitoring and additional support for teams where needed.

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.

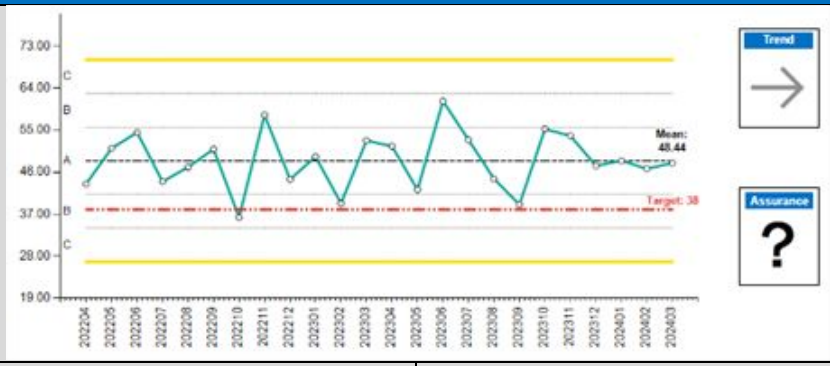
What the chart tells us
Low level variation with mean performance considerably above target.

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

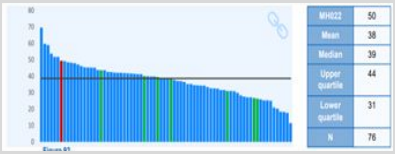
Actions
- New contract with Holybourne 30 beds commencing on 1 December 2023 for a year to December 2024. This means the block has increased from 18 – 30 beds.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- 100 discharge challenge flow interventions have 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.

Flow

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

March 2024

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.

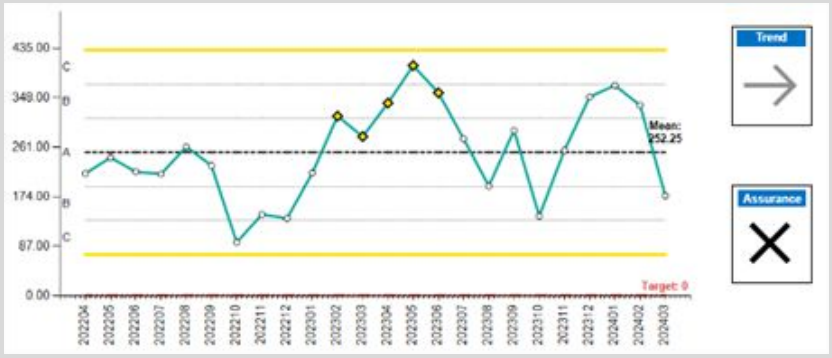
What the chart tells us:
Trust average performance consistently exceeds target.

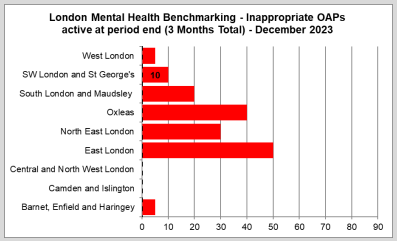
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds as the overall bed stock is reduced with less complex cases now being treated in the community.
- Increased comorbidity of complex Physical and Mental Health issues across all wards leading to increased LoS and Delayed transfer of care. 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.

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 booked for ELFT to review pathways and LOS alongside other quality metrics.
- Implementation of the Complex Emotional Needs protocol.
- Training for the Complex Emotional Needs (CEN) pathway was undertaken in November 2023 and a course is now available online.
- Benchmarking reviewed which demonstrated that our systems and process are in line with and in advance of SLP counterparts.
- Monthly review of patients with LOS over 90 days undertaken by Associate Clinical Director and Head of Service Delivery.
- Monthly mini MADE events continue to be held.

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. 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.

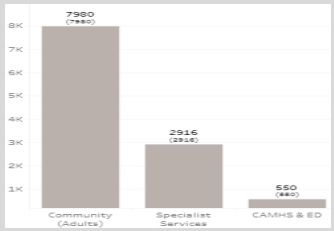
What the chart tells us
The levels of out of areas placements is subject to variation aligned to demand for beds (i.e. adult acute beds).

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.
- Continued high demand across the crisis pathway and wider system.

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.
- Monthly review of patients with LOS over 90 days undertaken by Associate Clinical Director and Head of Service Delivery.
- Holybourne now included in 100 day discharge work streams.
- Patients in Out of area beds are reviewed by the community team where there is a care coordinator, or HTT where the patient is not known to community services.

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. Recent months have seen an increase in clients receiving 2+ contacts.

Underlying issue
- This measure aligns with the LTP ambition for increasing access to adult community MH services. The figures show a rolling 12 months, as per the national definition. The metric includes all services included in the national definition (MHS108). It reflects the position for the three transformed boroughs (Kingston, Richmond & Sutton).

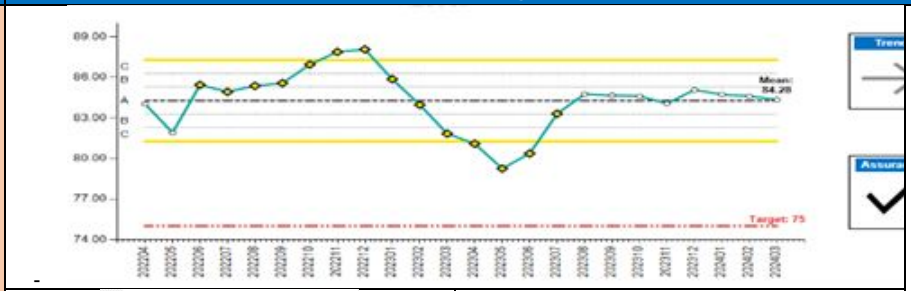
Actions:
- Community: Mobilisation of transformation in Merton & Wandsworth - both boroughs will go live on 1 April 2024 which will result in those services being included in the KPI.
- Job planning and productivity focus to increase direct clinical care - job plans implemented for all clinical roles with activity tracked through supervision dashboard.
- Activity recording for VCSE peer support - discussions with VCSE partners in Q4 23/24 to adopt MHSDS reporting which is expected to drive a step change in contacts delivered.
- Specialist: This is a new KPI. 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).
- 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).
- Trust: A KPI definition is currently being developed to support reporting and provide additional guidance.

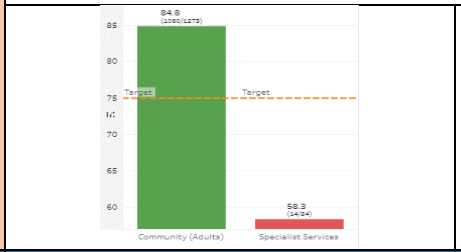
Quality Domain

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.

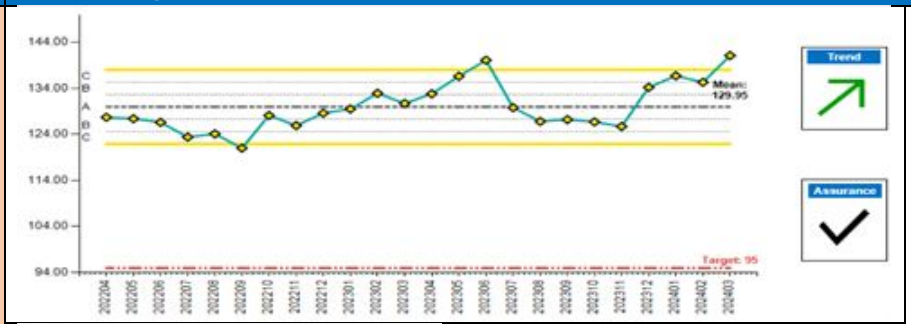
Underlying issue:
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised.
- Number of community patients have declined assessments. Attempts made to try and intensively engage patients to attend are 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.
- Variable use of the Health Information Exchange (HIE).

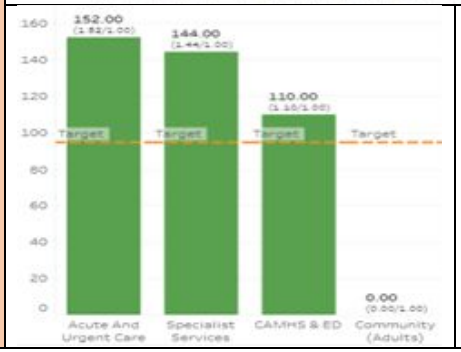
Actions:
- Community: Kingston & Richmond EIS improvement plans reviewed with updated actions. Clinical Manager to lead and embed within the team.
- Weekly/twice weekly physical health clinics in all boroughs continue.
- Introduction of Holistic Hubs across all boroughs being rolled out to ensure when receiving one intervention physical health assessments and health promotion is provided as part of the offer/visit.
- HON working with ICS re providing support across community services with GPs to support improvement in CMA.
- Kingston QII scoping how to increase full compliance with CMA checks.

Fundamental Standards of Care

Safe Staffing: national Compliance - Inpatients (%)

Target ≥ 95%



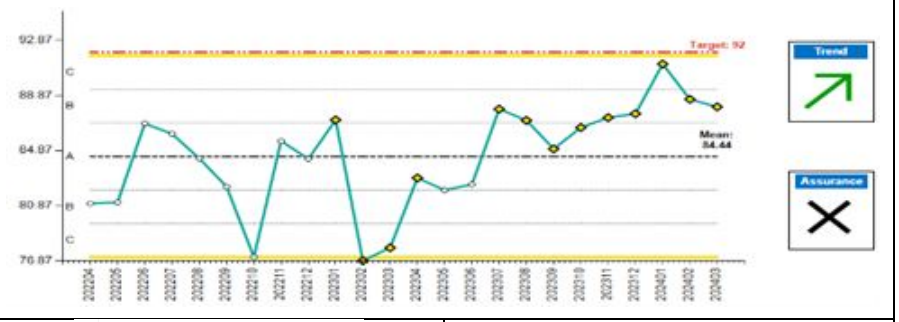


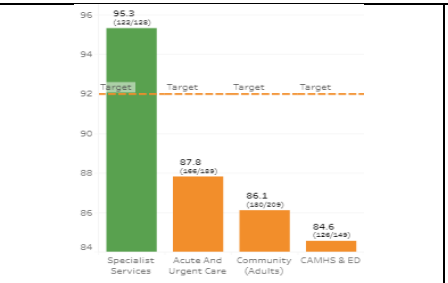
Background:
To provide assurance that inpatient wards were adequately staffed in the reporting period.
What the chart tells us:
Trust performance is consistently above target which is below lower control limit.
Underlying issue:
- Acute and urgent care: All wards were safely staffed in March 2024. Additional staffing is required to support constant or enhanced observations which is reviewed daily.
- 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.
- Specialist: No issues reported service line consistently exceeds target.

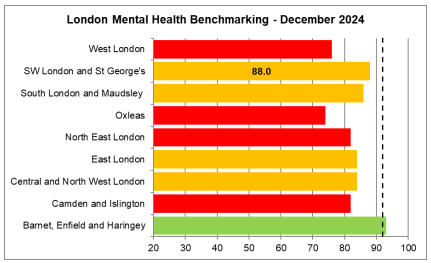
Actions:
- Daily staff meetings held across all service lines are in place to monitor staffing requirements and issues on staffing numbers are escalated to senior management if there are concerns.
- Acute & Urgent Care: Continued focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.
- The roster meeting is attended monthly by ward managers and CSLs and matrons reviewing roster completion and sign off fully.
- 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, however performance in recent months has improved with target being met for first over the period in January 2024 although this has not been maintained.

Underlying issues:

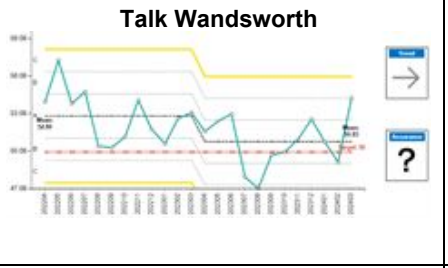
- Challenges with engaging patients to complete at appropriate points in their pathway and staff not actively seeking feedback.
- Using the results in a meaningful way to identify and make improvements within the clinical services.
- Acute and Urgent Care: Most under performance linked to crisis pathway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

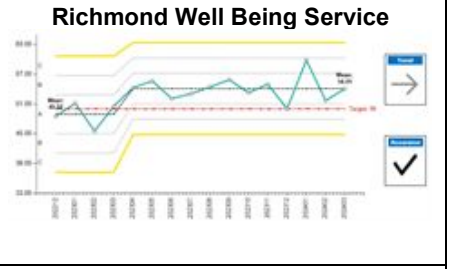
Actions:

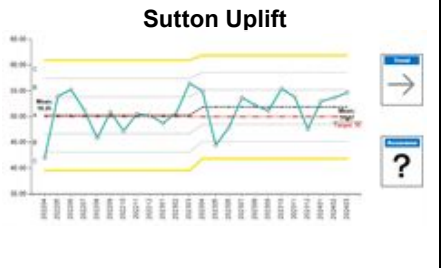
- Feedback live has recently been relaunched as a platform for completing Friends and Family Test. First question on system is linked to the Friends and Family Test.
- Staff encouraged to promote use of the FBL QR code for service users and carers.
- Promoting use of the FBL QR code for service users 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.
- 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.

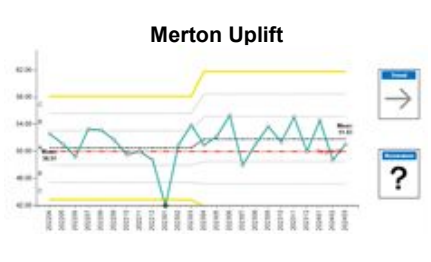
Patient Experience and Outcomes

Talking Therapies recovery rate (%) — Target ≥ 50%









Background

Talking Therapies 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 services are above 50% national target YTD; Merton is in line with 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.
- Audits indicate recovery deterioration is due to dropouts, and people declining treatment due to waiting times. Poorer recovery is also associated with missing or incorrect diagnostic labels, absence of repeat symptom measures, and lack of fidelity to treatment protocols.

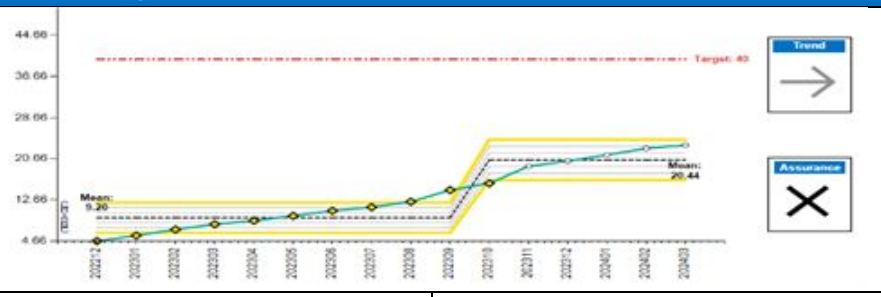
Actions:

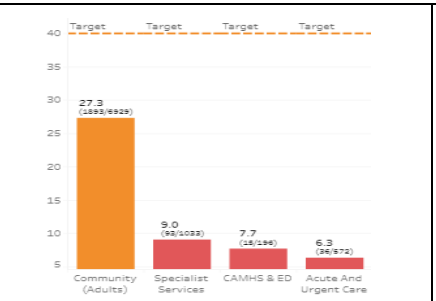
- Service clinical leads are completing data quality checks in advance of the monthly recovery audits which then take place each month by 9th. Audit outcomes are investigated, and action plans implemented.
- Individual monthly recovery rates are now being shared with clinicians in supervision.
- The cross-borough recovery workgroup continues to meet monthly.
- Training has been delivered to support clinicians with treatment, focusing on ensuring accurate diagnostic assessment and routine ADSM completion.
- New "feedback call" stage between assessment and being placed on waiting list has been introduced - patients attend a structured treatment planning call to discuss treatment options, and requirements for engagement, to reduce dropout rates.
- Sharing of SilverCloud best practice has happened between services.
- Training on treatment choice conversations and diagnostic assessment is planned for January 2024.

Patient Experience and Outcomes

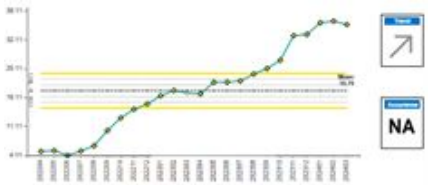
Paired Dialog Completed

Target ≥ 40%





Dialog Assessment



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.

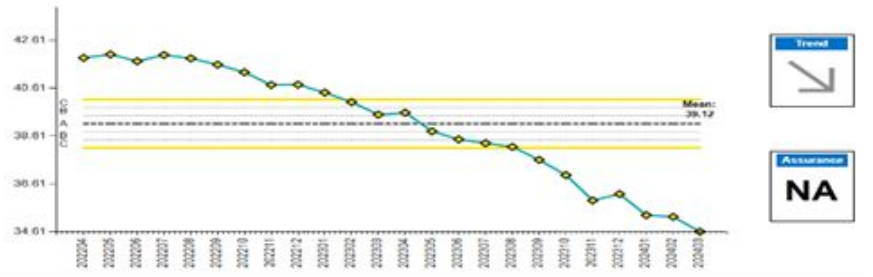
Underlying issue
- Reporting on paired dialog is a new priority metric for 23/24; local practice is being embedded.
- Review of team inclusions for DIALOG is ongoing across service lines.
- Change in clinical practice that will require time to embed.
- Trust is currently benchmarking well on Paired Prom measure – 6% compared to national average of 3% (based on November 2022).
- Trust benchmarks well across London for Dialog Assessment.
- 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.

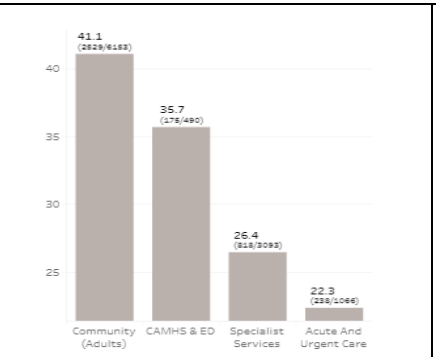
Actions
- SOP for dialog use has been developed and issued to across the Trust.
- Specialist Service Line to raise exclusions queries with Patient Outcomes Group.
- Baseline DIALOG completeness to be discussed at Improving Patient Outcomes Group (IPO) and further strategy for improvement to be recommended.
- Community: Refresher training completed.
- Acute & Urgent Care: Focused piece of work to be undertaken with teams to input data via the dashboard with a pin number. This will be monitored weekly with Team Managers/Advanced Clinical Practitioners.

Patient Experience and Outcomes

Paired HONOS Completed

No Target

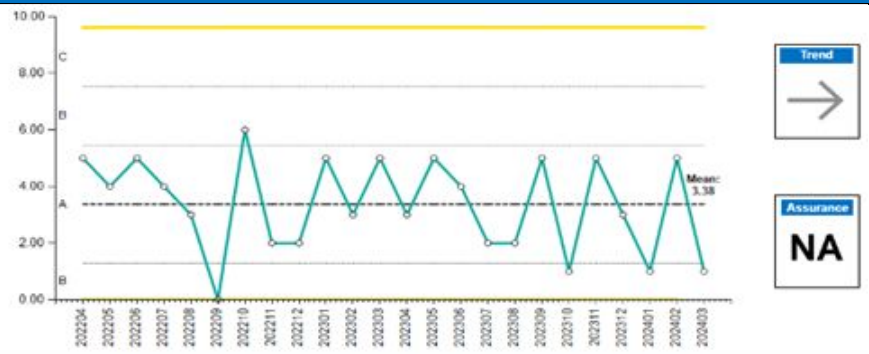
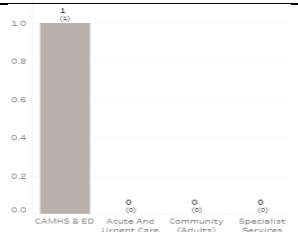
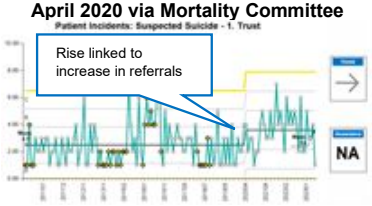




What Chart Tells Us:
There is a consistent negative downward trend in paired HONOS recording.

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.
- Change required in RiO to highlight HoNOS reporting.

Actions:
- IPO Chair to issue communication to highlight importance for completion of HoNOS as standalone outcome measure.
- Community:
- HONOS was presented and the community awareness event in November 2023.
- 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.
- Re-circulating IRH checklist for new and discharged patients which now includes HONOS.
- KPI document to support services is currently being progressed.

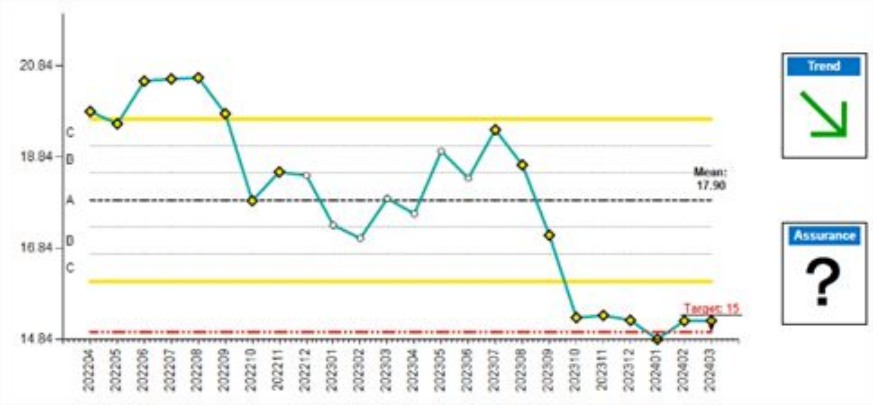
	Death - Suspected suicide	No Target
Patient Safety	  **Suspected Suicides – Step Change Applied April 2020 via Mortality Committee** 	**What the chart tells us** The number of suicides each month is low with common cause variation. **Underlying Issue:** - There was one suspected suicide reported in March 2024. - 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: Thematic review completed and presented at Mortality Committee with action plan. The service line has set up Special Interest Group in Suicide and Suicide Prevention to be rolled out across 2024 and will also address themes and how to improve risk assessments and practice.

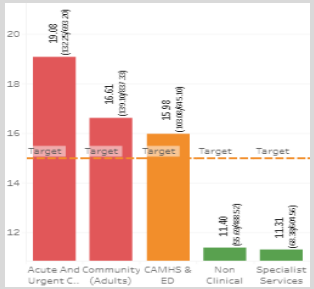
Workforce Domain

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 – March 2024

Staff Group	Post Fte	Assign Fte	Vacant FTE	Vacancy Rate FTE
Add Prof Scientific and Technic	501.3	417.4	83.8	16.7%
Additional Clinical Services	731.2	611.7	119.5	16.3%
Administrative and Clerical	657.2	584.8	72.4	11.0%
Allied Health Professionals	172.9	135.0	37.9	21.9%
Estates and Ancillary	37.0	34.9	2.0	5.4%
Healthcare Scientists	2.0	2.0	0.0	0.0%
Medical and Dental	246.4	220.3	26.1	10.6%
Nursing and Midwifery Registered	914.1	763.3	150.8	16.5%
Grand Total	3,262.0	2,769.4	492.6	15.1%

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

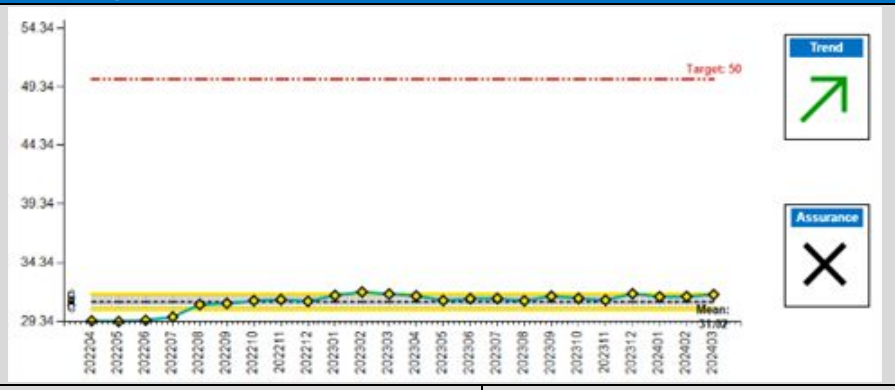
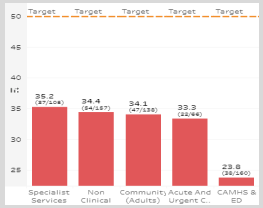
There is an overall downward trend in vacancy rate. Recent performance has improved and has been consistently below lower control limit for last five months with target being met in the last two months.

Underlying issue:

- There were move leavers than starters in March, which has increased the vacancy rate.
- Improvements in number of applicants through open events, careers day attendance and number of people directly applying together with improved recruitment processes have helped to improve vacancy position.
- 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 the Trust will need to think about alternatives in support whilst carrying vacancies to reduce pressure for those in the team and also to retain staff.

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.
- Funds from our Strategic investment funds have been provided to develop some specific initiatives around Community Services; predominantly focused on medical staff.
- The Trust is currently recruiting resources to support apprenticeships which has also been funded through our strategic investment fund.
- Workforce planning conversations produced a number of initiatives to support recruitment and attraction for each professional group. Focus on building links with universities, flexible working, staff survey, embedding new roles and health & wellbeing. Professional Leads to lead Trust-wide initiatives.

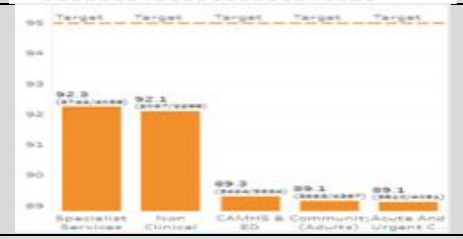
	Percentage of BAME staff - Band 8+ and Medical	Target ≥ 50%
Recruitment / Attraction	 	**What Chart Tells Us:** Mean position is below target indicating target position seems to have plateaued in recent months following period of improvement. **Underlying issues:** - The number of black, asian and minority 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. - Action plan was agreed in March 2024 training is live now. The Trust is developing and EDI Dashboard for People Committee. - Human Resources Department have launched training on bias within interviews for recruitment managers commencing in March 2024 to start our focussed work around fair recruitment and improved career development specifically focused at our Black, Asian and minority ethnic staff. - Community: Borough based CSL's to become the EDI leads for their respective areas. - CAMHS & ED: The CAMHS 24/25 workforce plan includes an action to increase BAME staff representation at Band 7 and above, through career pathways and DIR reps included on recruitment panels.

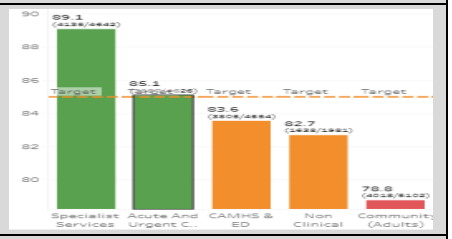
Statutory and Mandatory training 1 (%), Statutory and Mandatory training 2 (%) — **Target ≥ 95%, Target ≥ 85%**

Staff Skills / Development

Statutory and Mandatory Training 1

Statutory and Mandatory Training 2





Training Compliance Projection – MAST 1

Certificate Name	Actual				Projection			
	Feb-24	Mar-24	Apr-24		May-24	Jun-24	Jul-24	
	%	%	%	Breaches	%	%	%	Breaches
ABLS eLearning for Community and Allied	70.4%	67.6%	74.8%	292	65.1%	62.9%	60.6%	533
Adult Basic Life Support (ABLS)	88.9%	87.9%	87.5%	55	84.5%	78.9%	71.0%	129
Advanced Patient Handling (APH)	79.3%	78.7%			83.1%	86.8%	86.1%	78
Conflict Resolution and Breakaway	84.9%	82.2%	87.3%	182	75.8%	76.6%	75.3%	427
Equality, Diversity and Human Rights +	97.7%	97.7%	97.9%	60	93.9%	92.2%	90.4%	283
Fire Safety Awareness (Community)	93.8%	94.4%	94.3%	79	91.5%	89.8%	88.1%	173
Fire Safety Awareness (Inpatient)	74.0%	71.1%	73.3%	188	75.3%	74.8%	73.2%	190
Fire Safety Awareness (Non-Clinical)	95.1%	95.1%	95.5%	34	93.1%	90.4%	87.8%	95
Health and Safety General Awareness	96.6%	97.1%	97.2%	78	93.0%	91.2%	90.0%	296
Infection Prevention and Control - Level 1	93.9%	94.4%	94.6%	28	93.4%	93.0%	92.8%	38
Infection Prevention and Control - Level 2	91.3%	90.7%	91.4%	202	80.1%	74.8%	69.1%	753
Information Governance	92.3%	90.8%	91.3%	247	81.3%	76.2%	71.0%	857
Medical Emergency Training (Medics)		45.6%	49.6%	61	59.3%	61.0%	61.0%	48
Medical Emergency Training (Nurses)	66.5%	74.8%	77.6%	72	85.0%	80.7%	77.0%	75
Medicines Management (Community)	88.4%	88.1%	87.0%	60	81.3%	77.9%	75.6%	115
Medicines Management (Inpatient)	92.9%	93.0%	94.3%	17	92.7%	90.7%	88.3%	35
Moving and Handling - Level 1		52.3%			54.0%	54.0%	53.9%	1105
Preventing Radicalisation - Awareness of	95.9%	95.4%	95.1%	100	84.3%	81.0%	78.7%	461
Preventing Radicalisation - Basic Prevent	97.6%	98.0%	98.2%	14	96.6%	96.6%	96.6%	27
Proactive Physical Interventions (PPI)	88.2%	90.0%	92.9%	38	90.4%	90.6%	89.5%	59
Safeguarding Adults - Level 1	95.5%	94.8%	94.5%	157	86.7%	83.4%	81.1%	558
Safeguarding Adults - Level 2	94.3%	93.9%	94.1%	122	90.6%	89.8%	88.9%	240
Safeguarding Adults - Level 3	77.2%	78.6%	79.2%	183	65.7%	65.7%	65.7%	365
Safeguarding Children - Level 1	93.2%	94.4%	94.2%	34	88.8%	86.8%	86.0%	85
Safeguarding Children - Level 2	90.9%	90.3%	90.5%	85	82.9%	82.2%	81.3%	183
Safeguarding Children - Level 3	75.1%	76.5%	77.2%	258	69.8%	68.9%	68.0%	393
Safeguarding Children - Level 3 (CAMHS)	84.4%	84.1%	84.6%	47	76.3%	74.0%	71.6%	95
All Certificates (95% Target)	90.5%	90.2%	91.2%	2578	82.1%	80.1%	78.0%	7487

Training Compliance Projection – MAST 2

Certificate Name	Actual				Projection			
	Feb-24	Mar-24	Apr-24		May-24	Jun-24	Jul-24	
	%	%	%	Breaches	%	%	%	Breaches
Care Certificate Programme (CCP)	87.1%	85.6%	85.0%	47	87.4%	87.4%	87.4%	41
Collaborative Clinical Safety Training	61.0%	61.5%	61.3%	551	58.1%	57.3%	56.0%	649
Cyber Security - Stay Safe Online	63.4%				72.9%	72.9%	72.9%	800
Essentials of Patient Safety - Level 1 (All					69.3%	69.3%	69.3%	845
Essentials of Patient Safety - Level 1					52.4%	52.4%	52.4%	99
Food Hygiene - Level 2	96.9%	93.8%	93.2%	9	91.2%	89.7%	88.2%	16
Food Hygiene - Level 3	100.0%	100.0%	100.0%	0	100.0%	100.0%	100.0%	0
Mental Health Law	87.2%	86.7%	85.3%	261	84.4%	83.8%	84.0%	296
National Early Warning Score (NEWS) 2	98.1%	98.3%	98.3%	10	97.8%	97.3%	96.6%	20
Observation and Intensive Engagement	98.7%	99.4%	99.4%	3	98.3%	94.9%	91.8%	43
Oliver McGowan Mandatory Training on					39.9%	39.9%	39.9%	1774
Prescribers' Medicines	73.3%	74.7%	73.7%	66	68.6%	67.8%	67.5%	83
Rapid Tranquilisation	94.3%	95.5%	95.9%	25	94.2%	92.8%	90.8%	56
All Certificates (85% Target)	85.0%	83.9%	84.2%	1087	70.1%	69.6%	69.1%	4931

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.

Following review MAST 1 requirements are now aligned with the Core Skills Competency Framework (CSCF), all other mandatory training is MAST 2.

Three new MAST requirements have been added in the past quarter as follows: -

- Cyber Security – recommended from a recent audit and agreed at Audit Committee
- Oliver McGowan Training – all health and care providers registered with the CQC can meet the legislative requirement introduced by the Health & Care Act 2022 to ensure staff receive training on learning disability and autism, appropriate to their roll.
- Patient Safety Training: Essentials of Patient Safety Level 1 will be going live on the MAST dashboards as of 18 April 2024, after a 3 month introductory period which began in January 2024, and is required to be completed by all staff. This is an eLearning package which is completed through Compass, along with additional eLearning required for board members and senior leaders.

These have all be added into MAST 2.

What the chart tells us

MAST 1: MAST 1 levels remain below target with recent months deteriorating.
MAST 2: Performance for MAST 2 remains above target although significant deterioration (special cause variation) noted in recent months.

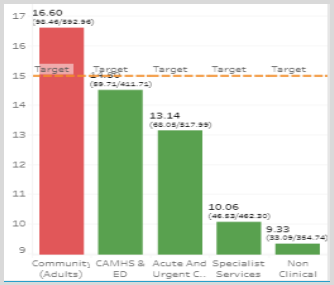
Underlying Issues and mitigations:

- MAST 1 and MAST 2 courses were not being reported on Dashboard against correct categories, a number of courses needed to be re-categorised to ensure correct reporting on dashboard. This work is currently being progressed and we have noticed a reduction in some compliance – which is also linked to the point below.
- The audiences have had to be updated; this is a complex process working with SMEs. Learning & Development, subject matter experts & Informatics are working together to resolve and in the meantime has further decreased our compliance.
- CCST (RATE) Training has had high breaches owing to capacity with no available trainers. The service lines have now identified trainers to deliver this training so it is expected that this will improve.
- Cyber security became a MAST 2 requirement in February 2024 (904 breaches) at time of reporting which has impacted overall compliance score. This is expected to improve in the next month.
- Work is being undertaken to align all MAST 1 courses with the Core Skills Training Framework (CSTF), once achieved, this should help streamline the verification of training which has previously been completed at other Trusts.
- MAST compliance will be displayed in each staff members' supervision record and will be RAG rated. A compulsory text box to be embedded within current supervision record template, which will prompt the line manager to review each staff member's MAST training compliance via a quick link to the Dashboard report. Line manager will also be required to provide a MAST compliance action plan. This will go live in April 2024.
- The People Committee have asked for a report in April 2024 which details the actions that will be taken to meet compliance specifically in relation to ABLS, PPI and Safeguarding Level 3.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%



Annual Turnover FTE – December 2022 – December 2023

Trust	Leavers	Leaver Rate
Barnet, Enfield and Haringey Mental Health NHS Trust	919.4	30.7%
Tavistock and Portman NHS Foundation Trust	115.4	17.4%
Oxleas NHS Foundation Trust	630.1	15.6%
East London NHS Foundation Trust	946.7	14.5%
South West London and St George's Mental Health NHS Trust	360.7	14.3%
Central and North West London NHS Foundation Trust	1071.6	14.2%
South London and Maudsley NHS Foundation Trust	748.2	14.0%
West London NHS Trust	580.9	14.0%
North East London NHS Foundation Trust	738.3	11.6%
London Average	679	16.20%
National Average	**556**	**11.60%**

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.

Underlying issue
- Turnover has been decreasing and has been below target for last four months.
- 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.

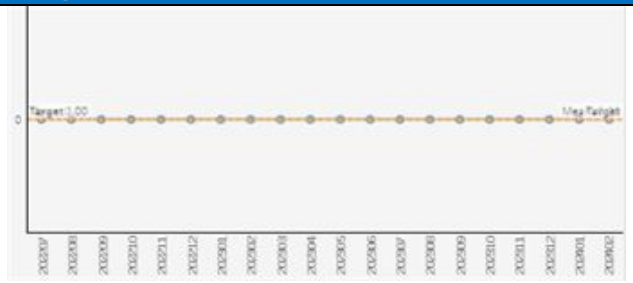
Actions:
- Exit Interview process has been updated and has gone live. It is hoped this will increase response rates.
- The Trust is currently undertaking a deep dive into the ethnicity data behind our turnover.
- A comprehensive package of work to support retention is in place and has been discussed 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 Trust is currently analysing and sharing the results of the national staff survey which 64% of our staff responded too; increases in engagement and advocacy scores noted.
- The Trust is working to develop key themes (from the staff survey) and is working with service lines/teams on simple actions for managers to take.
- Following review it appears the increase in % staff leaving within 12 months has been impacted by a drop in overall leavers from the Trust. The amount of staff leaving within 12 months is reducing.
- National evidence around retention suggests that the key lever to improving retention (through the research done by the vanguard Trusts) is in creating greater flexibility for staff. This could include a variety of options i.e. agile working, self-rostering, etc. A working group looking at this specific issue is live and hoping to set up a series of pilots. The need for greater flexibility is also referenced in our staff survey responses this year.

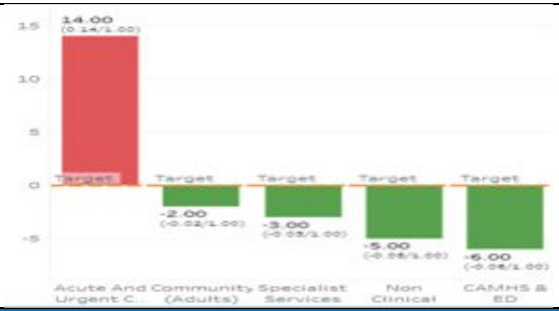
Finance Domain

Grip & Control

% Forecast budget overspend

Target TBC





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

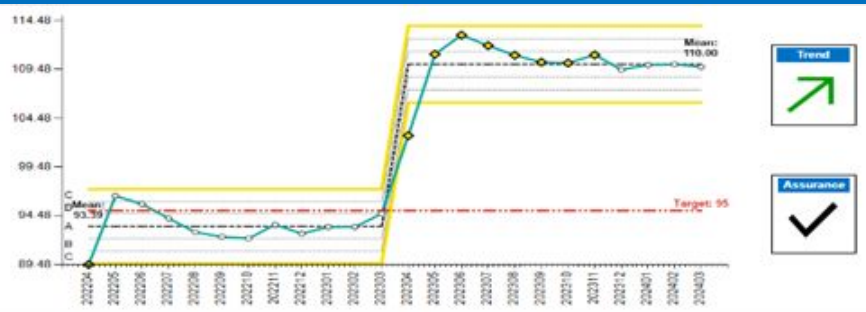
Underlying Issues:
- Draft figures shows that the trust has achieve the revised H2 forecast, delivering a £1.1m surplus pre impairments.
- Agency whilst below plan remains above the national requirement of 3.6% of total pay bill.
- The Trust achieved its target of 62% recurrent savings; an 80% recurrent target has been set for 2024/25.
- 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.

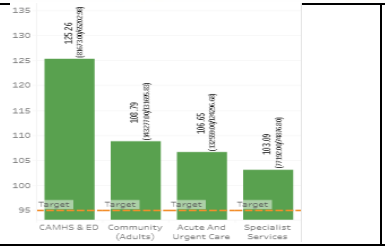
Actions:
- Work with ICB to identify any remaining Agency control gaps or collaborative actions to reduce agency spend.
- Acute: Pay overspends on wards are mainly due to observation levels, although this is reduced. This continues to be addressed through FSOC and review of observations and engagement- fidelity to the trust policy and recruitment to vacancies with continued good impact in month on most wards.
- 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.
- 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.
- As we move into 2024/25 we need to reframe our approach to agency control and focus our recruitment efforts. The national target of agency to pay-bill ratio reduces to 2.9%; the trust did not achieve the 2023/24 target of 3.6%.

Productivity

Contracted activity - Local contract (%)

Target ≥ 95%





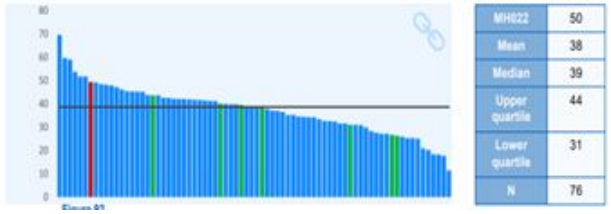
What Chart Tells Us:
Mean performance is above target indicating frequent compliance. 23/24 compliance is comfortably above target and has exceeded upper control limits in recent months.

Underlying Issue:
- The Trust has comfortably exceeded its local activity plans for 23/24 consistently over performing for 23/24 with average performance at 110%.
- Community: Poor compliance with activity recording in some teams but position remains comfortably above target.
- 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.
- Changes to service model and delivery (e.g. teams disbanding, previous functions/staff members being moved to other teams, periods of temporary out of hours working).

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.
- Ensure service changes are understood, documented and where appropriate, reflected in the service's activity targets.
- Activity plans for 24/25 are currently in the process of being finalised draft plans have been issued to service lines for review and feedback.

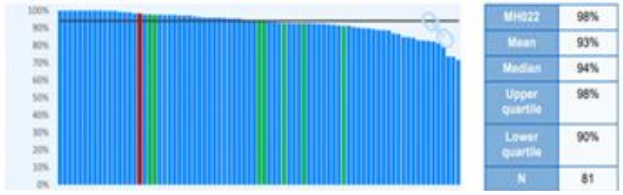
Appendix 1: Benchmarking

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.



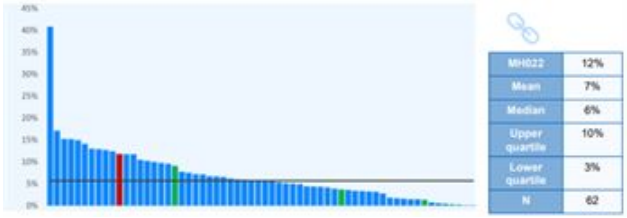
- **Adult acute average length of stay (days):**

2022/23		2023/24	
Trust	England	Mar-24	YTD
50.0	38.0	48.0	50.5



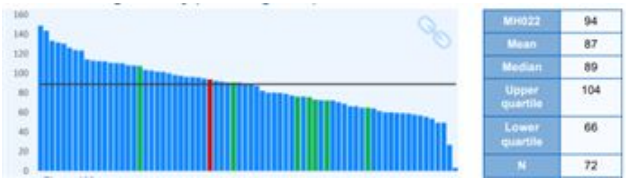
- **Adult acute bed occupancy rate (%):**

2022/23		2023/24	
Trust	England	Mar-24	YTD
98.0%	93.0%	99.2%	98.7%



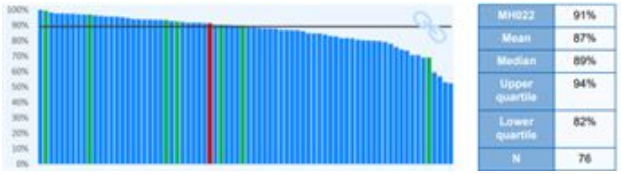
- **Adult acute delayed transfers of care (%):**

2022/23	
Trust	England
12.0%	7.0%



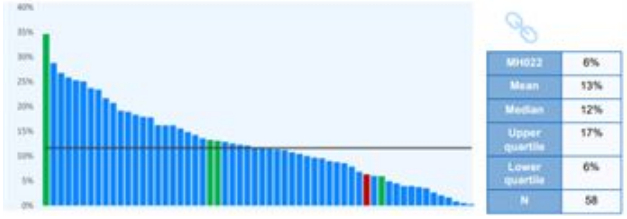
- **Older people's average length of stay (days):**

2022/23		2023/24	
Trust	England	Mar-24	YTD
94.0	87.0	94.3	93.5



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

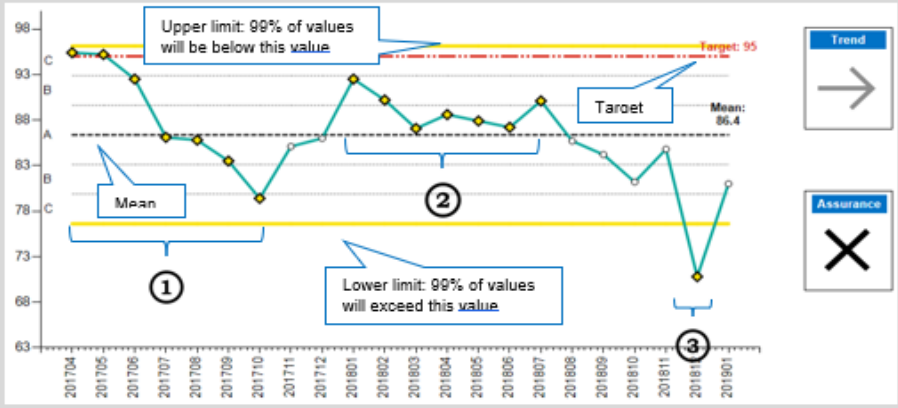
2022/23		2023/24	
Trust	England	Mar-24	YTD
91.0%	87.0%	74.4%	94.0%



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

2022/23	
Trust	England
6.0%	10.3%

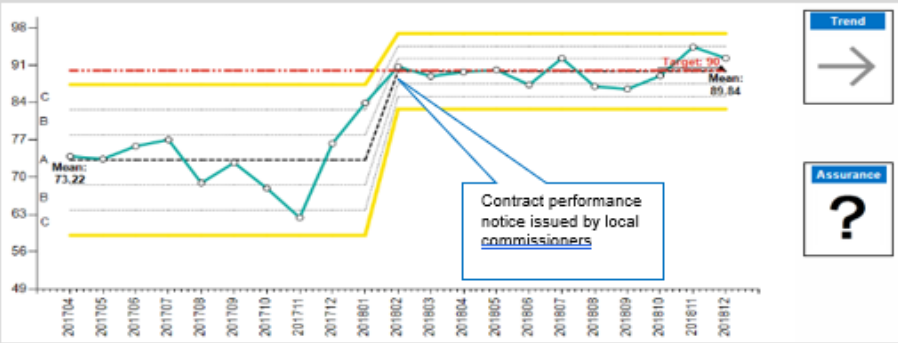
Appendix 2: Statistical Process Control (SPC) Charts & Performance Donut



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.

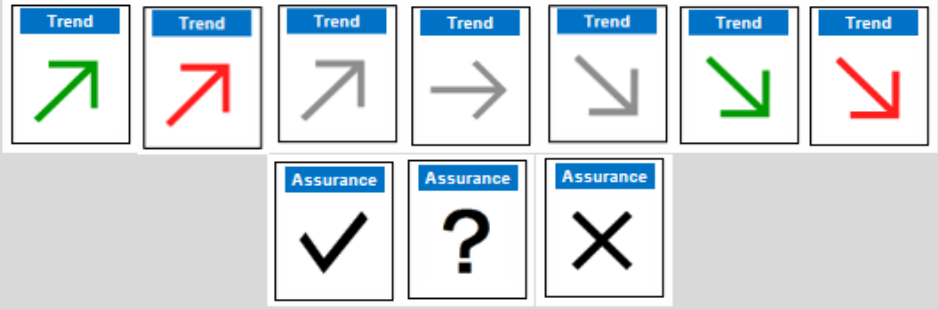
Why we use SPC charts
They are used to distinguish between natural variation ('**common-cause**' and not caused by anything in particular) in performance and unusual patterns ('**special cause**', unexpected events) in the data which are unlikely to have occurred due to chance and require investigation. 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.



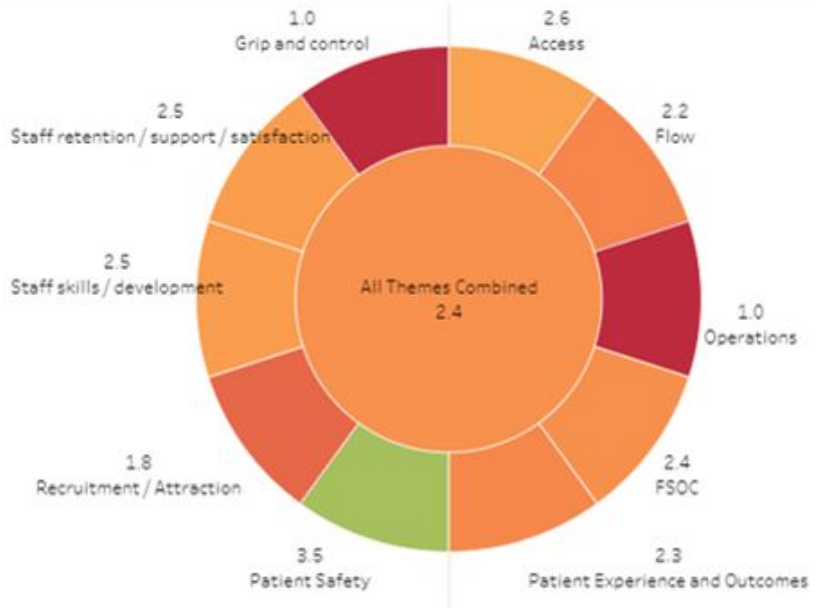
Use of icons to interpret charts
The Trend icon is shown as one of seven upward, horizontal or downward arrows depending on which direction the data is heading, coloured green, grey or red to indicate whether this is an improvement or deterioration in performance (or neutral where there is no target 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

Meeting:	Trust Board
Date of meeting:	9th May 2024
Transparency:	Public
Committee Name:	Audit Committee
Committee Chair and Executive Lead:	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:

This report relates to the March 2024 meeting. For note, it was the last Committee meeting for NEDs Vik Sagar and Prof. Charlotte Clark. The Committee thanked them for their contributions to Audit Committee over many years.

1. The approval of the external audit plan for 24-25.
2. The draft head of internal audit opinion.
3. The internal audit progress report, including the Partial Assurance rating on the sickness absence internal audit, which was discussed in detail during the March meeting.
4. The approval of the counter fraud plan and the Counter Fraud Functional Standard Return (CFFSR).
5. Review of the Board Assurance Framework (BAF).
6. The approval of the bad debt provision methodology.
7. The approval of the accounting policies.
8. The support of the Trust as a going concern basis.
9. The agreement to the ongoing asset valuation and impairment.
10. The gifts and hospitality registers were reviewed and the Committee noted that the new process was beginning to move in the right direction but there was still concern that declarations were not being made. This was now a regular report in the Audit Committee workplan and would be monitored accordingly.

Areas of Risk Escalation to the Board:

1. There were no matters for escalation to the Board.

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 Progress
What: KPMG updated the Committee on the annual progress of auditing the Trust accounts. The Committee heard that there were no emerging concerns.

Many of the risks outlined are similar to those from previous years, such as valuation of land and buildings. An initial calculation of materiality has been included, which has no additional risk factors built in. The methodology is consistent with prior years; the changes that are observed reflect revenue movement within the Trust. The Value for Money (VFM) risk assessment had been completed and no significant weaknesses had been identified.

So what: The Committee will receive the next iteration of the audit at the June Committee where it will be approved formally.

What next: Key audit requirements on VFM and Quality Accounts will not change. The Quality Accounts will not be audited this year, in line with previous years.

Head of Internal Audit draft Opinion
What: the Committee receives the Head of Internal Audit Opinion annually and this would be included in the Trust annual Accounts when they are submitted.

So What: the Committee noted:
- The overall Opinion was a positive opinion (level 2).
- The two partial assurance audit reports were highlighted (sickness absence and temporary staffing).

What next: The 23/24 work had been completed. Draft reports for the outstanding two audits would be released before the next meeting and RSM confirmed that they were unlikely to impact on the overall opinion.

The weaknesses identified in the sickness absence and temporary staffing audits would be addressed in the Annual Governance Statement.

Internal audit Progress Report including tracker, assurance map and outstanding internal audit actions
What: the Committee continues to monitor internal audit action plan progress, noting that good progress was being made against the plan.

So What: the Committee noted:
- Good progress was being made on follow-up of actions, with nine outstanding actions in progress, and RSM are confident that we will be able to close these soon following management updates.
- RSM included details of actions not yet due. There were a large number of actions due 31 March, and RSM were working to get updates and close those actions where they could. Many of these related to the Data Security Protection Toolkit which was submitted by 31 March 2024, and these actions will be completed ahead of the next Committee.
- The remaining audits on the plan were risk management and discharges. These were being quality checked and draft reports would be issued prior to the next Committee. This would conclude the 23-24 plan.
- Emerging risk radar - fraud risks for the Trust were similar to those seen elsewhere: financial challenge, digital and workforce.

What next: All overdue actions to be followed up and an updated report to be provided at the next Committee meeting.

Sickness Absence Audit

What: the Committee reviewed the report for this audit as it received 'partial assurance'. Sample testing took place in terms of HR forms. Managers gave assurance that these things were in place but documentation was lacking. Governance wise, sickness absence was reported but there could be improved reporting at divisional level.

So what: The Chief People Officer attended the Committee to give assurance on the actions taken following receipt of the report. She agreed that there was a lack of consistency for responsibility and ownership within sickness absence. It had been suggested to use some of the technical skills training to include managing sickness absence and required documents. Managers needed to get and store FIT notes and HR needed to understand their responsibilities within the process. Key documents needed to be updated to reflect current processes.

Sickness absence does get reported to some Committees but had been removed from the Q&P report when that was refreshed. This information would likely be incorporated within the Service Lines workforce reports which were being refreshed currently. This item was on the agenda for the March People Committee.

The People Committee Chair attended the Committee. She informed the Committee that there were some actions which would be taken forward by People Committee, such as looking at KPIs and MAST; and sense checking compliance with policies. She was mindful that there were a number of different things being managed and that a lot of the improvements would be sequential e.g. with the HR team new structure in place and embedded in a few months' time. She would update on these actions and those from the temporary staffing audit report via the People Committee Chair's report to Board, and would describe what that change looked like for the Committee.

What next: the Committee would receive updates to the actions from this audit via the regular Internal Audit progress reports.

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: RSM reported that Cyber training had been delivered at the Trust and had 11 Trust attendees. The team had worked with the Trust L&D team to improve its presence and were now attending the fortnightly face to face Trust induction. They attended their first meeting in March 2024 and spoke to 23 staff. By joining each induction they predict that they would have trained around 280 staff in the coming year.

The proactive review into agency staffing had begun.

Two new referrals had been received since the last meeting but both were closed as they were outside the remit of the counter fraud team. There was one ongoing case.

The Counter Fraud Functional Standard Review annual submission was due by 31 May 2024. The 1b rating from last year RAG rated 'amber' was now 'green' now there was a nominated Counter Fraud champion at the Trust. The Trust were confident they were fully compliant in all 12 areas. Conflicts of Interest was rated 'amber' as there have recently been low levels of engagement. This has recently been the subject of focus at audit committee and changes have been made with a view to get to 'green' next year.

The Counter Fraud work plan was risk based. It was proposed to undertake three proactive reviews. Two will be joint with internal audit and one will be an independent conflict of interest review. The timings could be flexible apart from the procurement exercise because that was run by the Counter Fraud Authority during set dates.

What next: RSM will work to ensure staff are confident to report issues although it has assured the Committee that the Trust is not an outlier in terms of numbers of referrals from the trust. The Counter Fraud Functional Standard Review annual submission would be made by end May. The Committee approved the Counter Fraud work plan.

Board Assurance Framework (BAF) and Executive Risk Register (ERR)
What: the Committee regularly reviews the BAF and ERR to ensure the right processes for risk management were in place and were working across the Trust.

So What: there were no changed scores in the BAF. All risks in the BAF had been updated, and the BAF included new risk appetite commentary. There was a graphical presentation around current, tolerable and optimal risk positions, which could be read across to BAF scores.

The Trust had continued high levels of external bed use, length of stay, delayed transfers of care, and vacancies in Community Services. These all impacted on and were reflected in the BAF risks.

The annual risk management framework would be reporting soon and would have recommendations for the format of the BAF going forwards.

What next: the Committee would continue to monitor the BAF and ERR as well as the risk appetite. The risk appetite commentary was helpful to the Committee and helped demonstrate that the process was working.

Annual Accounts update
What: the Committee noted the update on the Annual Accounts prior to submission.

So what: The Committee approved the reduction to the asset lives of assets building 32 and some IT/digital items. This would lead to a higher depreciation charge but it was taken account for already in the profit and loss account.

The Committee approved the continued approach to non-NHS bad debt provision.

The Committee noted the potential changes to asset valuation which were out to consultation. The proposals would prevent the assumption that assets could theoretically be located in alternate locations. If this change was approved it would increase revenue impact by increasing depreciation and the public dividend capital return that would be applicable to it. The new valuation would be in place from April 2025 although it may take longer to implement. This would potentially have a significant impact on the Trust accounts.

What next: The Trust and KPMG would contribute to the asset valuation consultation. The Committee would receive an updated set of accounts at the June meeting.

Valuation and Impairments report
What: the Committee reviews the valuations and impairments report prior to its inclusion in the Trust Annual Accounts.

So What: the Committee noted that the finance team, having done a site by site review, proposed that for Barnes and Parcel 2B 1 we move away from Modern Equivalent Asset (MEA) to fair value. Site 2B 2 would not be changed from MEA as the Trust were using some of it (Morrison building is on this parcel of land).

IT and Building 32 reduction of asset life would be treated as an accelerated depreciation transaction, not an impairment transaction.

The Trust had initially planned to revalue Barnes mid-year due to the planned sale timetable; ultimately it was not sold and would be revalued as at 31 March 2024.

KPMG were generally satisfied with the Trust approach to the General Accounting Manual (GAM) but this would be an ongoing conversation.

What next: the Committee would continue to monitor this area. The draft District Valuer's report was received but it would need to wait for the March index before being included, so would be reviewed again in June Committee. If anything changes in terms of valuation between March and June, the next Committee meeting, members will be informed outside of the meeting dates as it could have a material impact on the accounts.

Losses report
What: the Committee reviews any financial loss to the Trust within the scope of its Terms of Reference.

So What: the Committee noted that losses remain small.

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 there had been a large increase in debt however this was all current debt and not a concern at this time.

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 had been two instances where the Trust did not go out to tender. For one of these, quotations were sought which were above the formal tender limit; it was not felt that there would be significant value added in going back out to the market and doing a full tender. The second was for welfare advice provision from CAB Wandsworth. This was a joint decision with the system (ICS) on who could reasonably provide the service.

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.

Appendices
The January 2024 Committee minutes.

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

Audit Committee
Minutes of the meeting held via MS Teams on Thursday 18 January 2024, 14:00-16:30.

Present:

Richard Flatman (RF)	Non-Executive Director (Chair)
Charlotte Clark (CC)	Non-Executive Director (until 3:30pm)
Vik Sagar (VS)	Non-Executive Director

Attendees:

Philip Murray (PM)	Director of Finance and Performance
David Lee (DL)	Director of Corporate Governance
Heather Greenhowe (HG)	Internal Audit – RSM
Clive Makombera (CM)	Internal Audit – RSM
Joanne Lees (JL)	External Audit – KPMG (until 15:00)
Eric Sibisi (ES)	External Audit - KPMG
Debbie Hollinghurst (DH)	Deputy Director of Finance

Apologies:

Vanessa Ford (VF)	Chief Executive
Ruth Goddard	Internal Audit - RSM

Minutes:

Andy Glass	Corporate Governance Manager

Item		Action
Standing Items		
24/91	**Welcome and apologies** Apologies for absence were noted as listed above. Action: Pre-meet to be set up with RF and auditors.	**DL**
24/92	**Declarations of interest** No new declarations of interest were reported.	
24/93	**Chair's action** RF had given approval for the Events after the Reporting Period (EARP) submission.	
24/94	**Minutes of the previous meeting held on 31 October 2023** The Committee approved the minutes with no changes.	
24/95	**Action Tracker** The Committee received the action tracker and noted the following updates: **24/70 – Internal Audit Progress Report:** All overdue actions to be followed up and an updated report to be provided at next meeting. Action to be updated as part of agenda item. **24/79 – Quality Performance and Reporting Framework:** Ascertain content of item and include in January Audit Committee. NHSE oversight framework 2023-24 is still not published; it is not known whether this will happen before publication of the 2024-25 planning guidance. DL to update the March Committee if possible, and/or communicate any updates from the intervening period with RF.	

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

Item	Action

24/8(iv) - IA progress report, including tracker: Clinical audit programme: CM to set up a peer-to-peer conversation between BB and another Trust. CM has approached another Trust in Berkshire, and will pick this up internally to establish next steps.

EXTERNAL AUDIT

24/96 Early Reflections on Audit Risks

The Committee received and noted the review paper.

Reported:

- The paper sets out current thinking on the planning and risk assessment aspects of the audit.
- Initial work commenced in December 2023, with the next tranche anticipated in February 2024.
- A full audit plan is not yet available, as some risk opinions are not finalised; this paper details the early thinking on these risks.
- Many of the risks outlined are similar to those from previous years.
- The Fraudulent Revenue risk was rebutted in previous years. It is thought that this will also be the case this year, but this will not be finalised until there is certainty around funding arrangements.
- The Value for Money (VFM) risk assessment is underway. This will be brought to the next Committee to establish what further work may be needed.
- An initial calculation of materiality has been included. The methodology is consistent with prior years; the changes that are observed reflect revenue movement within the Trust.
- The high level audit cycle and timetable is driven by the national timetable.

Discussed:

The Committee welcomed ES, who will be conducting the audit this year.

The VFM Framework is the same as the previous year, having been amended two years ago, so the nature of the reporting will not fundamentally change this year.

The Quality Accounts will not be audited this year, in line with previous years. It is not known whether this will change in future years.

The Interim Audit will commence on 12th February 2024.

Agreed:

Action – KPMG will bring the full audit plan and VFM risk assessment to the March Committee. **JL**

INTERNAL AUDIT

24/97 Internal Auditor's Plan

The Committee received and noted the internal auditor's plan for 2024-25.

Reported:

- The internal audit plan for 2024-25 is ahead of schedule.
- The plan has been created with input from the Executive Team.
- Audit Committee were asked about two issues:

Item	Action

- Whether the plan covered the areas they expected it to cover
- Whether there were any areas missing, and how these should be tackled.

- The Committee's approval was sought for the plan.

Discussed:

That the Finance and Transformation work is picking up the Cost Improvement Plans (CIPs) and productivity workstreams; there was potential for duplication with the transformation programmes, project management quality improvement and sustainability work. However, as the audit will focus on deep dives rather than broad brush assessments, RSM will ensure these work streams aren't covering the same things. PM will guide RSM on which CIPs will be included.

The HR focus areas are employee relations and Freedom to Speak Up (FTSU) – a question was raised on whether the findings of the staff survey could have an impact on the pertinence of the areas and whether this had been considered as part of the plan. It was noted that the meeting to finalise the audit plan had taken place after the high level staff survey results were received, but that many areas highlighted in the survey were unsuitable for audit review e.g., bullying and harassment. A separate action plan would be needed to work on the findings of the staff survey. (Whilst the plan does include bullying and harassment in future years, as well as race equality and fair recruitment, these will be audited more from a process point of view, whereas the staff survey action plan will focus more on underlying cultural issues.) It was noted that there were some areas of the plan, such as violence and aggression and fair recruitment, that had been included in future years because work was on-going in these areas and it was felt that the Trust was not yet in the right position to audit these things.

Bed management and out of area placements will be audited in 2025-26, as these have been looked at in a recent year.

Use of force was last audited when the law on this changed, so work in the coming year will be a follow up to this.

Cyber security has been audited in the current year, so it will be picked up again in 2025-26, in order to establish progress on the relevant actions.

The assurance map is under review and has been refreshed recently, enabling triangulation with the internal audit plan.

The three-year rolling strategy envisaged in the plan includes a greater number of reviews in 2026-27 than in 2024-25. RSM will review and consider a five-year strategy instead.

Agreed:

The internal audit plan was approved, subject to the actions below.

RSM will ensure that the Finance and Transformation work is picking up the Cost Improvement Plans (CIPs) and productivity workstreams are not duplicating each other.	**CM**
RSM will review the internal audit plan and add in the dates when work areas were last reviewed.	**CM**

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

Item		Action

24/98 Internal Audit Progress Report inc. tracker assurance map/outstanding internal audit actions

The Committee received and noted the Internal Audit Progress Report.

Reported:

- 80% of the current audit plan is now either finished or reported in draft.
- There is one remaining review on risk management, timetabled to start on 29th January 2024.
- CM thanked PM and the wider team for engaging with RSM on the completion of the plan.
- The pack includes a report on Key financial controls; this has a reasonable assurance rating. Meta data have been included to give a more thorough assessment compared with previous audit. Areas for improvement include supplier set up and supplier amendments, in particular around bank accounts. The policy on Purchase Order (PO) usage is to be clarified.
- An update on the action plan in the pack will follow in due course.
- The assurance map has been refreshed through the planning process – additional areas have been identified which are to be included in the next iteration of the audit plan.
- The pack includes a paper on management actions. These fall into five categories: patient safety, workforce, finance, digital and partnerships. The Trust is not an outlier in any of these areas.
- There is also a paper on Integrated Care Systems (ICS); key learning has been taken from this, as well as a sector briefing paper.

Discussed:

An indication of the likely annual audit opinion will be brought to the March committee.

There was a discussion on the change of approach to auditing financial controls. The use of the whole range of data instead of separate risk areas, as in previous audits, meant that there were a lot of validations. Assurance was not as strong as in other years, partly because of challenges in recruiting to finance posts, and there are several recommendations to follow up on.

Some audit actions are overdue, and need to be followed up. There are revised dates for these in the report, as the initial dates were missed. RSM's process is more robust than previous auditors. The requirement for external evidence where self-certification by directors may have previously been accepted has meant that the assurance process can take longer. The Executive team are to push for resolution of these actions.

Reporting on the HR transformation risk noted that the people strategy will be published before the end of Q4 2024, but the revised date is 31st March 2024. This is thought to in fact refer to Q4 of 2023-24. PM will confirm this is the case.

There are actions not yet due relating to Data Security and Protection (DSP) – these are under control following a data security meeting. The individual formerly responsible for these actions has retired, but has left a detailed handover note and a successor will be appointed soon.

Item		Action
	When RSM complete the outstanding risk management report they will consider how risk appetite is currently being used. In the assurance map, first- and second-line assurance is only complete for the Governance section. The focus hitherto has been primarily on the third line of defence; now a lot of this work is complete, it will be possible to concentrate on more detailed assurance. There were five areas where greater assurance was needed. Medical Revalidation was noted as an example where there may be forms of external evidence that could give increased assurance. CM noted that, for revalidation, extra assurance was anticipated soon, whereas for other areas, such as duty of candour, standard assurance was available, but the timing needed to be agreed as part of the plan. RSM will ask their other clients to share details of third line assurance with the Trust. The conclusion paragraph did not note that the Trust is satisfied that reasonable assurance is in place – PM/CM will consider this again following receipt of the additional evidence in relation to the five areas where more assurance is sought. It is thought the reasonable assurance is in place in areas of greatest risk. A question was raised on whether any of the work RSM have done around population health could yield any information on health inequalities that might further the Trust's work in this area. RSM will share some of this information. **Agreed:**	
	The Executive team will ensure that outstanding actions from the internal audit report are resolved.	**Execs**
	When RSM complete the outstanding risk management report they will include information on how risk appetite should be considered.	**CM**
	RSM will ask their other clients to share with the Trust details of third line assurance they have obtained on the areas where the Trust requires additional assurance.	**PM**
	PM/CM will consider the conclusion in the assurance map again following receipt the additional evidence in relation to the five areas where more assurance is sought. This will be updated to clarify whether sufficient assurance is available for the March Committee update.	**PM/CM**
	RSM to share information on population health with the Trust to inform its work on health inequalities.	**CM**
Counter Fraud		
24/99	**Review Counter Fraud and Security Progress Reports** The Committee received and noted the Counter Fraud Update Report. **Reported:** • Fraud awareness week took place during the reporting period. There were 13 training sessions, including bespoke sessions for HR, budget holders, procurement and finance, as well as cyber awareness sessions. • Trust attendance was low, with only 24 Trust staff having had face to face training; targeted sessions with relevant departments and collaboration on HR around inductions are planned to boost attendance within Trust.	

Item **Action**

- Pro-active reviews are underway. A pharmaceutical theft case is due to be closed. Another case on favouring an agency is being looked at to understand whether this is an outlier. Controls are in place regarding this, and the agency is on the framework.
- Other outstanding cases been closed; there have been six awareness alerts.

Discussed:
RF noted that it was disappointing that Trust attendance of the fraud awareness training was low; it was noted that pre-recorded sessions and other measures were being looked at to improve this.

There was a question on the case of favouring an agency, and whether this had been flagged through a declaration of a Conflict of Interest (COI). It was noted that there is no formal requirement to declare a friendship, and so this case may not have been covered by COI procedures, but the review will consider this alongside wider questions about agency usage. In spite of the ethical issues, there is probably no financial loss to the Trust in this case as it involves an on-framework agency, which would have nationally-agreed rates.

24/100 **National Fraud Initiative updates**
The National Fraud Initiative review has been completed.

Reported:
- 113 matches were identified. Only one requires further investigation (i.e., it is a match with another organisation)
- This involves checking with the other organisation what dates the individual has worked, and also checking dates with HR to ensure that they're not working while on sick leave.
- There are many justifications for matches within the NHS, so these matters, whilst the require investigation, are not always a cause for concern.

Internal Governance

24/101 **Board Assurance Framework (BAF) and Executive Risk Register (ERR)**
The Committee received and noted the papers.

Reported:
- There were no changed scores in the BAF report.
- ELT have reviewed the scores, as have individual committees where appropriate.
- The ERR is also included for information.
- On the Acute Pathway risk, non-trust bed use is still very high, reaching 55; the risk score is 16.
- On the workforce Risk, progress has been made across workforce KPIs, but the current score was retained due to the scale of challenges involved.
- A risk appetite commentary is included. Conversations on improving presentation of this are ongoing; Board is due to discuss risk appetite more widely in their seminar session on 8th February.

Discussed:
BAF used to be presented to board after it had been approved by Audit Committee, but now it is presented regardless of such approval. This meant that some

Item		Action

committee members were already familiar with the BAF (The board were content with the BAF).

It was suggested that the target risk score could be added to the BAF, as well as the actual risk score.

The BAF identifies a number of risk appetite domains i.e., levels of organisational risk appetite relating to particular types of activity. An individual risk may sit across numerous domains, each with a different level of appetite e.g., patient safety has the lowest level, whereas innovation has a higher level of appetite. It was noted that there ought to be a discussion at Executive regarding calibration of the risk appetite boundaries and whether these should be changed.

On the ERR, RT and PM regularly look at this and consider whether the risks are at a tolerable level.

It was noted that target risks have previously been challenged on achievability, and that some thought should be given to whether current levels of risk are within the Trust's tolerance.

Other committees are starting to take full responsibility for own BAF risks. It was suggested that this be reflected in the terms of the risk management review.

Agreed:
RSM to reflect on individual committees' ownership of the relevant BAF risks in the terms of the risk management review. **CM**

Executive to reflect on calibration of risk appetite boundaries. **DL**

24/102 Code of Governance
The Committee received and noted the code.

Reported:
- Of the 58 provisions in the code, there are 6 the Trust should report as explain rather than comply.
- There are 6 other provisions where the Trust can take action to report compliance later in the year. The biggest piece of work required in order to do this is a minor update to the Remuneration Committee Terms Of Reference (TOR).
- The Code of Governance previously only applied to foundation trusts, and some of the provisions reflect this.
- The Code of Governance is an opportunity for the Trust to focus on good governance.

Discussed:
It was noted as encouraging that there are few areas of non-compliance. RF has fed some comments back to DL, which he will review. Others will also comment.

Agreed:
DL will bring the Code of Governance compliance actions to March Committee. **DL**

24/103 Annual Accounts update
The Committee received and noted the Annual Accounts update.

Item **Action**

Reported:

- The Events Outside the Reporting Period (EARP) official letter, signed and submitted by VF, is included in the report.
- Most of guidance around planning and year end is not yet published – the Trust will undertake an exercise at the appropriate time to delete policies that no longer apply and make changes to those where a discretionary adjustment is needed before bring these to March committee. There is currently no indication that there will be any major changes to policies.
- There is a national requirement to include in the annual report a statement confirming that the Trust is a going concern. The Finance Team propose to submit a more detailed paper in March for consideration of the going concern principle.
- Formal agreement of the Valuation approach for Trinity and Shaftesbury is required. This will require a ratification of the management judgement linking the two buildings into an asset go live date of October 2023. This will impact how Public Dividend Capital (PDC) and depreciation are calculated. The District Valuer (DV) has been instructed to give a valuation for the two buildings.
- Committee to note that, based on last year's valuation (undertaken before Shaftesbury was fully operational) an impairment of c.£50m is anticipated; this will lead to a loss of around £49.5m in the Profit and Loss accounts. This reflects the fact that the project has been running for 15 years. As the loss is outside the Trust's control, being derived from the DV valuation, it will not affect the statutory break-even requirements.
- Changes to the Scheme of Delegations need to be agreed. Most of these changes are just rebadging committee terms, so they should be straightforward.
- There is an outstanding action on ICB controls, with an update sought on how the Trust is ensuring they are applied. This year, there has been a peer review between the Trust, Royal Marsden and the ICB, with DH representing the Trust. Evidence was provided for why our scores were as they were, and compared this with the other organisations in the review. The other participants increased the Trust's scores slightly. The Trust overall score has moved from 3.2 in June to 3.7. The Trust has no scores below 3, which is an important cut-off point.
- The Charitable Funds (CF) letter of representation is included for information. The annual report and accounts have been approved by board.
- The CF admin charge must be agreed each year. In the past two years, the Trust has discounted the recharge so that it is no greater than the Charity's income. This would give an estimated charge £3k for accounting and audit services.

Discussed:

It was discussed that a more detailed paper on the reasons to support the going concern basis would be of value, although this is not a mandatory requirement.

Audit Committee has previously discussed and agreed the valuation basis, and this approach was supported by KPMG. Nothing is thought to have changed since then, and confirmation has subsequently been received that KPMG continue to support the approach. The Trust is yet to receive the valuation. A paper confirming that there are no other impairments is scheduled for March Committee, but this may be a late submission due to the scheduled receipt date of the valuation.

Item		Action

The committee has previously agreed to "fair value" the Barnes asset. The valuation is currently awaited from the DV. The transaction creates an internal capital budget that can't be carried forward, and so the timing of the sale is crucial. The sale can't be carried out until the bids from the latest tender have been assessed and the contractor appointed. There is therefore a plan to try to formally delay the sale until the new financial year as the capital resources can't be carried forward. If the transaction follows the rules in the General Accounting Manual (GAM), then this should be acceptable. The asset will be fair valued as at 1st January 2024, but this fair value can be used at 31st March 2024; the same will apply to 2b parcel 1. The Fair Value paper is still with KPMG for sign-off.

The Scheme of Delegations relating to Estates Modernisation has not been updated for four years, although other elements of the scheme of delegation have been to committee more recently than that.

Agreed:
The Committee noted the chair's action regarding submission of the EARP letter.

Action: Finance team will bring the following papers to the March committee: Account Update, Accounts Policy Update, Going Concern paper, Impairments paper. **PM**

The Committee noted the proposed valuations and the projected impairment of c£50m.

The valuation approach for Trinity and Shaftesbury is approved by committee, subject to revised valuations and impairment.

The Committee approved the changes to Scheme of Delegations.

The Committee noted the positive position on the NHS ICB controls.

The Committee noted the submission of the Charitable Funds Annual Report and Accounts.

The Committee approved the CF charge of £3k or up to the maximum funding raising level.

24/104 Losses Report
The Committee received and noted the report.

Reported:
- There are low levels of losses.
- Losses appear to have increased, but this is mainly due to a payment for dental work for an assaulted member of staff.
- Without this transaction, average losses had reduced from c.£220 to c.£160.

24/105 Debtors Report
The Committee received and noted the report.

Reported:
- A relatively stable position was noted.
- Over £20K debts were included, and the debt age profile has improved.

Item		Action

- A sense check on debts under £20K has been carried out, to ensure the position is not deteriorating. Although the value of these debts has increased, the percentage that are over 30 days old have reduced from 69% to 50%.

Discussed:
Most older debt is held by London Boroughs; the Committee discussed taking a tougher line on POs not being set up in time in order to reduce this.

ICB debts from the previous report have largely been cleared.

Agreed:
PM to review aged Local Authority debts to determine if a harder line can be taken on local authorities not setting up POs. **PM**

24/106 Waivers Report
The Committee received and noted the report.

Reported:
- All waivers over £25k are subject to NHSE controls, if they relate to revenue spending, but not if they relate to capital spending. They must be reported retrospectively, but don't require prior approval.
- The DocMan Interface waiver was necessary because this is the standard system for transferring discharge letters to GPs. The waiver originated as a quote waiver and later changed to a tender waiver, due to a change in the price.
- The run rates in this area are relatively flat and continue to benchmark well.

24/107 Salary Overpayments
The Committee received and noted the report.

Reported
- There are no significant changes in the run rate, with the position not improving a great deal despite increased focus.
- Most individual divisions have improved, except the medical division.
- EDI statistics show white staff have fewer overpayments than black staff, but this is not broken down by staff group.
- It is proposed to share the report with the People Committee to ensure they have oversight.
- The number of instances is stable, but value has increased by more than the annual pay rise.
- Other Trusts have taken a firmer line, with repeat offender managers having to explain the situation to finance; Royal Marsden is an example.
- The overpayment rate is slightly higher than overall NHS rate. It is proposed to inform People Committee and tweak the process on holding people to account.
- Hastee usage is growing in the current climate, offering protection to staff.

Agreed:
The Chair was supportive of the more robust approach to managers whose staff have overpayments, and bringing the reports to People Committee.

Item		Action
	Action – PM to ask the Director of People to produce a paper for committee on amending the salary overpayment process to better hold to account managers with frequent salary overpayments.	PM

24/108 Procurement Policy

The Committee received and noted the policy.

Reported:

- The policy has come to committee because it is due for renewal.
- The policy was reviewed, and found to be still fit for purpose.
- ELT asked for anchor institution information to be more prominent.
- The Trusts "No PO, no pay" policy will now be enforced.
- Benchmarking with other organisations e.g., Royal Marsden and Southwest London Procurement was used to derive the No PO, no pay policy.

Discussion:

Track changes would be helpful in future policy reviews, to clarify what has changed.

There was a question over whether forthcoming procurement legislation will result in further changes. It was suggested that the policy will remain in place, but that the new act will change what things have to be tendered. When these changes happen, a new policy will be taken to FPC and Audit Committee.

CM was supportive of the policy, as it resolves one of the audit points.

Agreed:

The Committee approved the revised Procurement policy.

24/109 Better Communities Programme Assurance – risk and controls

The Committee received and noted the report.

Discussed:

That is important for Audit Committee to have oversight of the Better Communities programme, in terms of controls, risk and governance.

External assurance that is obtained in respect of Better Communities should be shared via Audit Committee to feed into the overall assurance programme.

The mandatory "Gate Reviews" for the project include key learning which should be incorporated into the assurance map.

Agreed:

Action – as external assurance is obtained in respect of the Better Communities Programme, this should be brought to committee. **IG**

24/110 Gifts and Hospitality Registers

The Committee received and noted the registers.

Discussed:

Communications regarding the registers were sent out on 15th January 2023. An update will be brought to the March committee.

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

Item		Action
	Agreed: An initial report regarding the Gifts and Hospitality and Conflicts of Interest should be sent to Committee in the next 1-2 months, with further reporting to committee on an annual basis thereafter.	
Committee Governance and Reporting		
24/111	**Matters to report to the Board** The Committee agreed that the following should be reported to the Board: • External audit planning process and progress on assessing risks and that this will feed into a more detailed plan for the March Committee. • Key audit requirements on VFM and Quality Accounts will not change • Committee has approved the Internal Audit plan for 2024-25 • The Key Financial Controls – Accounts Payable review demonstrated Reasonable Assurance • The progress made on the assurance map • The reporting on EARP • That Committee confirmed the management judgement on the Trinity and Shaftesbury valuations • Committee's approval of the changes to the Scheme of Delegations • Committee's approval of the changes to the CF administration charge • BAF reporting to Board • The update on the NHS Code of Governance • The Committee's approval of the Procurement policy.	
24/112	**Review of Committee forward plan** The Committee noted the forward plan.	
24/113	**Agenda for next committee** Counter fraud self-assessment will be done in May, but the draft version will be brought to March Committee. **Agreed:** AG to amend agenda to reflect some of the papers Finance Team will bring: • Account Update • Accounts Policy Update • Going Concern paper • Impairments paper. RSM to bring draft Counter fraud self-assessment to March Committee.	**AG** **HG**
24/114	**Information items** These items were noted with no comments: • Quality and Safety Assurance Committee minutes. • Modernisation Committee minutes. • NHS England (NHSE) Cyber Security Conference.	
24/115	**Date of Next Meeting** Thursday **21st March** 2024, 14:00 -16:30, MS Teams.	

Meeting:	Trust Board
Date of meeting:	9 May 2024
Transparency:	Public
Committee Name	Finance and Performance Committee
Committee Chair and Executive Report	Vik Sagar (Committee Chair) Philip Murray (Chief Finance and Performance Officer)

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 April and May meetings of Finance and Performance Committee:

1. We are on track to achieve the 23/24 plan. This is a good achievement given the challenging environment.
2. We submitted a forecast for 24/25 with surplus of a quarter of a million pounds, and the Committee has approved a further quarter of a million pounds to help the system in 24/25 i.e. total £0.5m surplus. The final submission will be in May.
3. We recognised the impact for the Trust of the system potentially going into System Oversight Framework SOF4 (even though we are currently in SOF1 (best level) as a Trust, it is likely all Trusts will be downgraded if the system moves to SOF 4 (requiring intensive support)).
4. We acknowledged the significant amount of work already done to improve flow, although to date we have not seen the planned outcomes or savings. We agreed the progression of some further 'grip and control' options.

Areas of Risk Escalation to the Board:
None.

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. About 50% of the DTOC for the Trust is mainly due to housing and social care delays. We discussed the Trust target length of stay.

What next:
Whilst the community caseload is decreasing the numbers of patients in crisis have gone up. This will be reviewed.

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 to deliver £1m surplus as previously agreed.

What Next: The Committee will continue to monitor the finances via the monthly report. Balance sheet strength and provisions were discussed to ensure we are adhering to the model; we continue to deliver to plan.

Submission of the plan for 24/25 will be early May.

FPC also noted the in-month position and that there will be a refocus of our efforts in the area of agency spend, following the significant improvement in 23/24, as we move into 2024/25.

Strategy, transformation and commercial draft 24/25 priorities.
What: the Committee reviews the annual strategy, transformation and commercial draft priorities for assurance.

So What: Some of the objectives could be SMARTer (Specific, Measurable, Achievable, Relevant, Time-Bound) and there could be more detail around productivity to include metrics once they are agreed.

What Next:
The priorities would come back to May FPC.

Flow Savings Workstream
What:
The report details that despite an immense amount of work, length of stay and bed usage have not reduced in the context of a challenging environment.

So What:
The following three grip and controls to release further efficiency have been considered:

- Hold and maintain the current position of number of additional external beds.
- Identify the volume of DTOCs due to social reasons (B&B, food vouchers, home environment) and take action to mitigate these; e.g. consider a gain share agreement with Local Authorities to support the discharge process.
- Introduce a step-down facility "Hostel plus" in-between inpatient services and current hostel beds to support flow of patients from inpatient beds.

What Next: the Committee agreed to the suggested pause to the monitoring against the existing OBD trajectory for six months, and the three Grip and Control options to release further efficiency. An update report would come to a future Committee.

Items for note
None.

Appendices
March Confirmed Minutes
Month 11 Finance and Savings Report

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

Finance and Performance Committee (FPC)

Minutes of the meeting held on Thursday 28 March 14:00 -16:30 by Microsoft Teams

Present:

Juliet Armstrong (JuA)	Non-Executive Director (Chair)
Philip Murray (PM)	Chief Finance and Performance Officer
David Lee (DL)	Director of Corporate Governance

In attendance:

Ann Beasley (AB)	Board Chair
Vanessa Ford (VF)	Chief Executive Officer
Billy Boland (BB)	Chief Medical Officer
Charlotte Harrison (CH)	Clinical Director, AUC (in attendance for item 24/38)
Ashley Painter (AP)	DiDM Representative (from 14:20)
Indie Kaur (IK)	Head of Cost Improvement Programme (in attendance for item 24/38)
Leah O'Donovan (LOD)	Deputy Director of Strategy and Transformation (in attendance for item 24/35)
Emma Whitaker (EW)	Deputy Director of Corporate Governance
Nick Worner (NW)	Associate Director of Commercial and Business Development (in attendance for item 24/34)

Apologies:

Vik Sagar (VS)	Non-Executive Director
Jen Allan (JeA)	Chief Operating Officer
Debbie Hollinghurst (DH)	Deputy Director of Finance
Elaine Holder (EH)	Corporate Governance Manager (Minutes via recording)
Amy Scammel (AS)	Chief Strategy, Transformation and Commercial Officer

24/29	**Apologies** Apologies were as listed above.	
24/30	**Declarations of Interest** No new declarations were reported.	
24/31	**Chair's Action** The Trust had submitted a 24/25 plan at break-even following agreement from the Board in March 2024.	
24/32	**Minutes of the previous meeting and Matters Arising** Minutes of the previous meeting on 29 February 2024 were taken as an accurate record of the meeting, with no material corrections; subject to a final review by VS.	
24/33	**Action Tracker** • Update to existing action 24/23 - Agreed: PM to speak to JeA and Jonny Comfort to do some DTOC modelling and bring back next steps to the May FPC meeting. PM to also speak with Mike Jackson (LA link on the ICB). **Agreed:** • Ensure all actions have due dates on them before they come to the meeting. • BAF review to come to the next meeting.	
STRATEGY		
24/34	**Strategy, transformation and commercial draft 24/25 priorities** The Committee noted the Strategy, transformation and commercial draft 24/25 priorities. **Discussed:** The Committee felt these were a sensible set of priorities. JuA raised that Health Inequalities was missing and that the priorities needed to feed into the QI discussion. LOD responded that ELT had agreed this morning to split the	

	priorities metrics by ethnicity and Health Inequalities where possible to allow a deeper conversation around these areas. The priorities would come back to May FPC.	
REPORTING AND PLANNING		
24/35	**Finance and Savings Report M11** The Committee noted the Finance and Savings Report for M11. **Agreed:** • FPC was happy for PM to submit a statement on Tuesday to the system that the Trust could go up to another quarter of a million pounds surplus in 24/25 in order to support the system. • The split between Part A and Part B FPC meetings. **Action:** PM to update the April Committee on the strategic investments.	**PM**
PERFORMANCE REPORTING		
24/36	**Flow Savings Workstream** The Committee noted the Flow Savings Workstream update and the actions taken to date. **Agreed:** • The pause to the monitoring against the existing OBD trajectory for six months. • The three Grip and Control options to release further efficiency: 1. Hold and maintain the current position of number of additional external beds. 2. Identify the volume of DTOCs due to social reasons (B&B, food vouchers, home environment) and take action to mitigate these e.g. consider a gain share agreement with Local Authorities to support the discharge process. 3. Introduce a step-down facility "Hostel plus" inbetween inpatient services and current hostel beds to support flow of patients from inpatient beds; discussions to take place.	
COMMITTEE GOVERNANCE AND REPORTING		
24/37	**Committee Workplan** The Committee noted the workplan. **Agreed:** • To review the Finance BAF in the April meeting.	
24/38	**Matters for the Board** 1. We are on track to achieve the 23/24 plan. This is a good achievement given the challenging environment. 2. We submitted a forecast for 24/25 with surplus of a quarter of a million pounds, and the Committee has approved a further quarter of a million pounds to help the system in 24/25 i.e. total £0.5m surplus. The final submission will be in May. 3. We recognised the impact for the Trust of the system potentially going into System Oversight Framework SOF4 (even though we are currently in SOF1 (best level) as a Trust, it is likely all Trusts will be downgraded if the system moves to SOF 4 (requiring intensive support)). 4. We acknowledged the significant amount of work already done to improve flow, although to date we have not seen the planned outcomes or savings. We agreed the progression of 3 further 'grip and control' options, noting the feedback from the ELT and the particular interest around the hostel plus option.	
24/39	**Meeting Review** • It was good that the Committee talked about quality of care and patients. • The dynamics of having hybrid meetings was discussed.	
24/40	**Next meeting –** Thursday 25th April 2024 14:00-16:30 via MS Teams	

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Report Title:	**Finance report 2023/24 Month 11**
Name of Meeting:	Trust Board
Date of Meeting:	May 2024
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Chief Finance & Performance Officer
Transparency:	Public
Scrutiny Pathway:	Direct review / ELT / FPC (28 March) / Trust Board (9 May)

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** – The Trust is reporting a £41.5m deficit, £8.3m better than plan. The deficit position is driven by a £42.5m impairment on the new Springfield buildings. Impairments are technical in nature and the Trust is performance monitored on its position before impairments. The forecast before impairments is now £1.0m surplus, £0.2m better than last month, and consistent with the H2 reforecast position agreed with ICB and NHSE. ➢ **In Month / cumulative position** - £0.1m deficit in month, resulting in cumulative £0.5m surplus to date, on track to achieve the £1.0m forecast surplus, before impairments, above. ➢ **Agency** – February costs increased and were marginally adverse to plan. Cumulatively there is a decrease in spend compared to 2022/23 and £0.75m below plan for 2023/24. NHSE target is not being achieved, ytd at 5.0% of pay bill, 4.5% in month. ➢ **External Beds** – Costs reduced in month though in part due to the fewer working days. Year to date costs £4m more than budget. ➢ **Savings** – identified schemes forecast more than delivers the £13.0m target. Recurrent Delivery increased to the required planned 62% (£8.1m) due to reduced PDC following the impairment. ➢ **Capital** – underspend of £11.2m ytd due mainly to slippage on Tolworth, Barnes and Richmond Royal schemes. Increased spend in month due to early works at Tolworth and costs of sales incurred for 2024/25 asset sales. ➢ **Cash** – the cash balance is £62m

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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 supported the items FPC were 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 has been given to increasing block contracts to reduce the cost and additional actions and approaches are being considered within the AUC service line. ➢ **Agency** – Further improved oversight arrangements are being introduced as the Trust is not achieving the national requirement of agency spend not exceeding 3.6% of pay bill and recognising the target reduces to 2.9% for 2024/25. ELT discussed the need to refocus and reflect on approach to agency.
What Next?	Actions have been identified as follows: ➢ Focus is needed on 2024/25 CIP delivery, schemes to be identified for the full savings target, and PIDS written up. ➢ Refocus on approach to agency ➢ Finance Department primary focus will now be on ensuring a successful annual accounts submission, draft submission 24 April.
Any specific issues to note and/or for escalation:	1. All committees are asked to ensure that focus is maintained on improving the underlying deficit through reducing external beds, reducing agency and delivering recurrent savings.
Appendices/Attachments:	One Power Point accompanies this cover sheet.

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	*Outline below the key implications which may result from the proposals or information contained within this report.*
Equality analysis *[linking to EDI strategy]*	Positive impact – The Trust spends money to improve equality and diversity for patients and staff

Health Inequalities	Positive impact – Trust Funds are spent to reduce health inequalities within the population we serve
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
Reputational:	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. The report provides updates on the financial sustainability ambition and achievement of the financial plan.
Workforce:	Positive impact – The Trust provides information on temporary worker spend and achievement of NHSE targets in this area.
Sustainability e.g. Green Plan:	Positive impact – The Trust knows its cost drivers and is taking positive action to ensure financial sustainability.
Other (specify):	This report relates to the Finance risk on the BAF and risks 1027/1770/993 in the risk register.

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Finance Report 2023/24
11 Months to February 2024

Meeting	Trust Board
Date of Meeting	May 2024
Report Title	Finance Report 2023/24 – 11 Months to February 2024 – Part A
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Chief Finance & Performance Officer
Purpose	For Information
Scrutiny Path	Director review/ELT/FPC/Trust Board
Transparency	Private
Recommendation	None
The Board is asked to	Discuss and Note

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Overall – I & E Position

- In February, the Trust delivered a £0.1m surplus, which was marginally favourable to plan.
- The cumulative position is now a £0.5m surplus which is £0.6m favourable to plan despite incurring additional costs (with no additional funding) covering the industrial action in December and January (Months 9 and 10)
- The Trust has agreed a revised surplus with the ICB of £1.0m for the year. This is a £0.2m increase on that presented last month and will help the overall system position. This position is before impairments and profit on asset sales.
- Performance in-month was consistent with enabling the £1.0m surplus to be realised
- The valuation of the two new hospital buildings completed in 2023/24 has now been received and as planned generates a significant impairment. The impairment is c £42.5m, £7.5m less than the indicative £50m included in the plan. The Trust is performance managed before impairments. After inclusion of the impairment the Trust is forecasting a £41.5m deficit.
- Asset sales in 2023/24 may generate a small immaterial unplanned profit. Actual figures are still being finalized.
- The costs associated with external bed pressures remain significant, and continued diligence and continued strong financial control is required during M12 to ensure that the Trust remains on track and delivers its year-end forecast

Financial Reports 2023/24	Current Month			YTD month 11			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	25.7	0.8	271.1	277.6	6.5	297.0	303.1	6.1
Pay	(16.5)	(16.6)	(0.0)	(177.2)	(178.2)	(1.0)	(194.0)	(194.2)	(0.3)
Non Pay	(7.0)	(8.1)	(1.1)	(77.2)	(88.3)	(11.1)	(84.7)	(96.4)	(11.8)
EBITDA	**1.4**	**1.1**	**(0.4)**	**16.7**	**11.0**	**(5.6)**	**18.3**	**12.5**	**(5.9)**
Cap Charges - Depreciation	(0.9)	(0.7)	0.2	(10.4)	(10.1)	0.3	(11.2)	(10.6)	0.6
Cap Charges - Interest & Div	(0.6)	(0.5)	0.1	(7.0)	(1.5)	5.5	(7.6)	(2.0)	5.6
Interest	0.1	0.2	0.1	0.6	1.1	0.5	0.7	1.2	0.5
Post EBITDA	(1.4)	(1.0)	0.4	(16.8)	(10.5)	6.2	(18.1)	(11.4)	6.7
Underlying Surplus / (Deficit)	**0.0**	**0.1**	**0.0**	**(0.1)**	**0.5**	**0.6**	**0.2**	**1.0**	**0.8**
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)	(42.5)	7.5
Net Surplus / (Deficit)	**0.0**	**0.1**	**0.0**	**(0.1)**	**0.5**	**0.6**	**(49.8)**	**(41.5)**	**8.3**

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 surplus of £0.5m
- Both in-month and cumulative positions in line with revised forecast of £1.0m agreed with the ICB
- In month external bed pressures partially offset by investment slippage

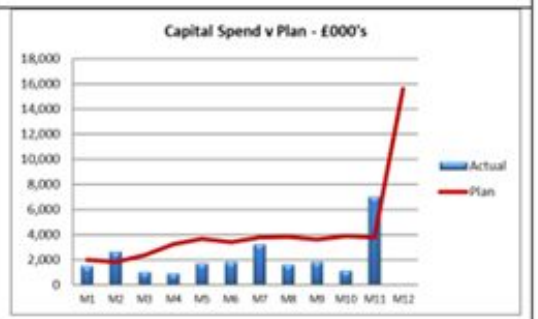
- Income received in month, £25.7m, £0.8m above plan
- Includes, £0.2m extra packages of care, £0.1m hostels and £0.1m Education income
- No additional funding received for M9,M10, or M11 industrial action

- Spend of £24.7m, £1.2m adverse to plan
- Incorporates industrial action costs
- External bed expenditure of £1.1m in month, £0.4m above 2022/23 average
- Cumulative overspend on external beds of £4.0m, funded from slippage and reserve issues
- Reduced external bed usage currently shown in M12

- Agency spend in month £0.7m, £0.3m below 2022/23 average spend
- £0.15m above plan
- £0.02m increase on M10
- Equates to 4.5% of pay bill, 0.9% above NHSE target of 3.6%
- 32% of monthly spend on Medical, 40% on Nursing
- Community Service Line spend amounts to 61% of cumulative spend

- Cash balance at end of February £62.0m
- £11.0m positive to plan
- Result of capital underspend +loan repayment deferral
- Loan repayments of £99m now to commence in 2024/25
- Spike in Month 9, the result of asset sales

- Cumulative capital spend of £17.2m.
- £11.2m behind plan
- £11.1m relates to slippage on significant site developments – Richmond Royal, Barnes & Tolworth
- Forecast spend of £27.7m, £23.2m less than original plan



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

Income Position

- Cumulatively, income is £6.4m favourable to plan
- Local contract income is £2.0m ahead of plan. This positive position is caused by additional funding awarded for Winter Pressures (Hostels), SDF, and to cover industrial action costs up to and including November (M8)
- NPSA income is £0.2m behind plan as external referrals are below planned levels
- Provider Collaborative income is £1.0m above plan due to additional funding being made available for a complex patient on Wisteria Ward as well as additional packages of care on Ruby and Hume wards
- Other NHS Clinical income is over-recovered by £1.3m due to additional investments in CAMHS and Complex Care
- Other Non-Clinical Income is £1.3m ahead of plan, primarily due to additional SLP allocations and several smaller areas such as rates rebates
- Non-NHS Clinical income is showing a £0.7m favourable variance due to Local Authority grants, additional Local Authority contributions to Complex Care Wave 2, and reimbursement for above plan deaf interpreter costs
- Education income is now £0.4m ahead of plan due to additional allocations received

Financial Reports 2023/24	Current Month			YTD month 11			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	19.4	19.5	0.2	209.3	211.3	2.0	229.6	231.5	2.0
Nhs England	1.8	1.8	0.0	20.1	20.1	(0.0)	21.9	21.9	(0.0)
Npsa Income	0.0	0.0	(0.0)	0.5	0.3	(0.2)	0.6	0.3	(0.2)
Provider Collaborative Income	2.3	2.4	0.1	24.7	25.7	1.0	27.0	28.0	1.0
Other Nhs Clinical Income	0.2	0.4	0.2	2.1	3.4	1.3	2.2	3.5	1.3
Nhs Clinical Income	**23.7**	**24.1**	**0.5**	**256.7**	**260.9**	**4.1**	**281.3**	**285.3**	**4.0**
Education & Training	0.7	0.8	0.1	7.5	7.9	0.4	8.1	8.5	0.4
Other Non Clinical Income	0.2	0.3	0.1	2.3	3.6	1.3	2.5	3.7	1.2
Merit Award Income	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.1	0.0
Non Clinical Income	**0.8**	**1.1**	**0.2**	**9.9**	**11.5**	**1.7**	**10.7**	**12.3**	**1.6**
Non NHS Clinical Income	0.4	0.5	0.1	4.5	5.2	0.7	4.9	5.5	0.6
Non Nhs Clinical Income	**0.4**	**0.5**	**0.1**	**4.5**	**5.2**	**0.7**	**4.9**	**5.5**	**0.6**
Income	**25.0**	**25.7**	**0.8**	**271.1**	**277.6**	**6.4**	**297.0**	**303.1**	**6.1**

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

Pay Position

- Pay amounted to £16.6m in-month, a marginal overspend. Cumulatively, pay is now £1.0m overspent
- Medical Staff are £0.2m overspent, the result of agency premia and industrial action costs
- Nursing budgets are overspent by £4.8m. Of this, approximately £1.6m relates to extra packages of care funded by the SLP with a further £0.5m 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 £4.5m on Other Clinical staff primarily consists of Psychologist vacancies and continues the trend seen both in this and previous years
- Non-clinical staff are overspent by £0.5m. The key drivers of the overspend are redundancy costs and staff transferred from capital

Financial Reports 2023/24	Current Month			YTD month 11			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.6)	(2.6)	(0.1)	(28.6)	(28.8)	(0.2)	(31.2)	(31.4)	(0.2)
Nursing	(6.7)	(7.1)	(0.5)	(71.9)	(76.7)	(4.8)	(78.8)	(83.6)	(4.8)
Other Clinical	(4.4)	(3.8)	0.6	(45.3)	(40.8)	4.5	(49.6)	(44.3)	5.3
Non Clinical	(2.9)	(3.0)	(0.1)	(31.4)	(31.9)	(0.5)	(34.3)	(34.9)	(0.6)
Total Pay	**(16.5)**	**(16.6)**	**(0.0)**	**(177.2)**	**(178.2)**	**(1.0)**	**(194.0)**	**(194.2)**	**(0.3)**

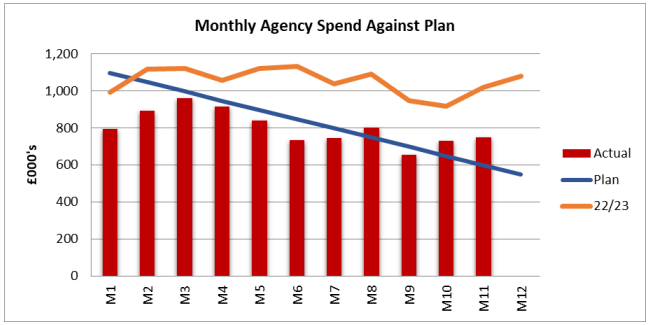
- Spend on agency staffing is cumulatively £0.5m favourable to plan but reported a £0.2m overspend against plan during the month. This is detailed on the next slide
- Bank is £2.6m adverse to plan with the overspend being driven by the Nursing overspends detailed above
- Permanent staffing is now showing a £1.1m underspend

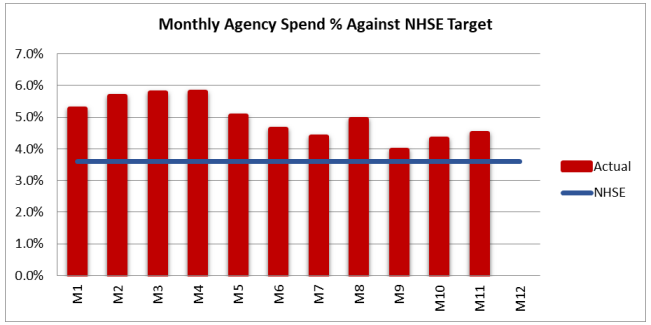
Financial Reports 2023/24	Current Month			YTD month 11			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(14.0)	(13.6)	0.4	(146.6)	(145.5)	1.1	(160.8)	(158.2)	2.6
Bank	(1.9)	(2.2)	(0.2)	(21.3)	(23.9)	(2.6)	(23.3)	(26.4)	(3.1)
Agency	(0.6)	(0.7)	(0.2)	(9.3)	(8.8)	0.5	(9.9)	(9.6)	0.2
Total Pay	**(16.5)**	**(16.6)**	**(0.0)**	**(177.2)**	**(178.2)**	**(1.0)**	**(194.0)**	**(194.2)**	**(0.3)**

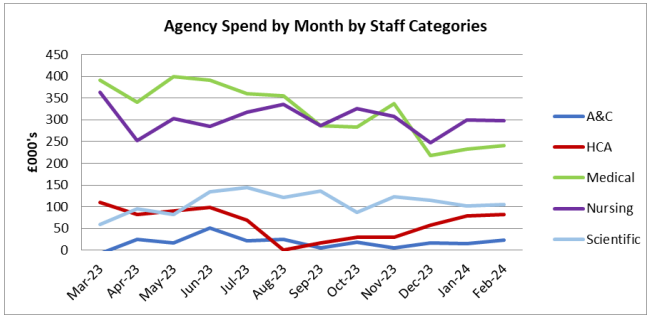
South West London and St George's Mental Health NHS Trust

Agency - in month and cumulative position

- Cumulative expenditure is £8.8m and amounts to 5.0% of the pay bill. It is £0.5m below plan but £2.4m above the NHSE target of being 3.6% of pay expenditure
- 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%
- If the Trust is to exit the year with expenditure at 3.6% of the pay bill for March then expenditure must fall by £0.2m to £0.5m
- Month 11 performance was adverse to plan: expenditure of £0.7m was £0.2m higher than plan and amounted to 4.5% of the total pay bill. It was, however, £0.3m less than expenditure this time last year (February 2023)
- Expenditure in February was marginally above January levels
- Of February expenditure, Nursing was the highest at £0.3m. Medical spend amounted to £0.2m with the next highest being Scientific at £0.1m
- As shown on the next page, the Community Service Line remains the highest user of agency staffing. Cumulative expenditure of £5.4m equates to 61% of the Trust total
- At current expenditure levels, the annual underspend against plan will fall to approximately £0.3m.
- Planning guidance for 2024/25 indicates that agency spend must reduce further to no more than 3.2% of the paybill (2.9% for deficit systems). This will mean reducing expenditure to approximately £0.5m per month on an ongoing basis



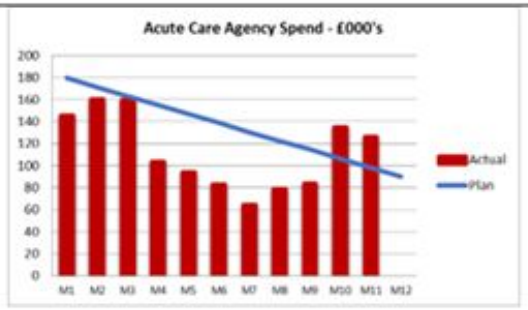




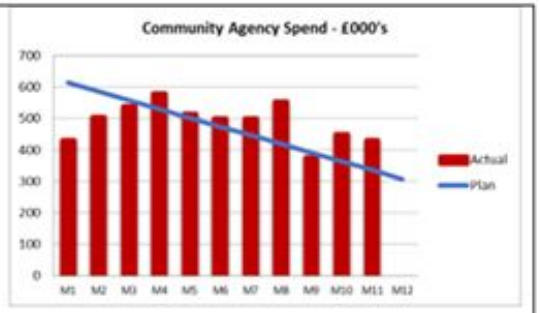
South West London and St George's Mental Health NHS Trust

Agency – Service Line and Corporate Analysis

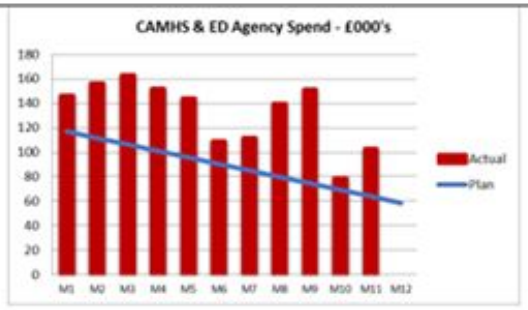
- In month spend of £126k
- £28k above plan
- £9k below M10 spend
- Cumulative spend of £1,234k, £294k below target
- Largest type of spend: Medical (£584k) followed by HCA (£435k), Nursing (£201k) and Scientific (£14k)
- £1,003k of total spend on wards, with £157k in Liaison Services and £73k in HTTs
- Highest area of spend: Ellis Ward (£249k)



- In month spend of £431k
- £105k above plan
- £21k below M10 spend
- Cumulative spend £5,386k. £162k above plan
- Largest type of spend: Nursing (£2,539k), followed by Medical (£2,301k), and Scientific (£546k)
- Highest areas of spend: Carshalton IRH (£538k) and Central Wandsworth CMHT (£450k)



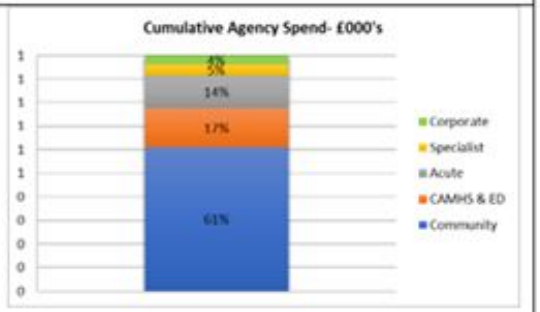
- In month spend of £103k
- £39k above plan
- £24k above M10 spend
- Cumulative spend of £1,455k, £459k above plan
- Largest spends: Medical (£559k), Scientific (£552k), Nursing (£283k), HCAs (£61k)
- £1,232k of spend in community, £223k on wards
- Highest area of spend: Tier 3 Wandsworth (£324k)



- In month spend of £59k
- £21k above plan
- £17k above M10 spend
- Cumulative spend of £410k
- Spend: HCA (£139k), Nursing (£232k), Scientific (£39k)
- £156k of spend in wards, £254k in community settings
- Highest single area of spend: Sutton & Merton MHLD (£58k)

- Spend of £30k in month
- £32k below target
- £10k above M10 spend
- Cumulative spend of £324k
- Largest area of spend: Digital Services (£141k)

- Largest area of cumulative spend = Community (61%)
- CAMHS ED – 17%, Acute = 14%
- Specialist = 5%, Corporate = 4%
- Service line and Corporate split = 96/4. Last year amounted to 89/11



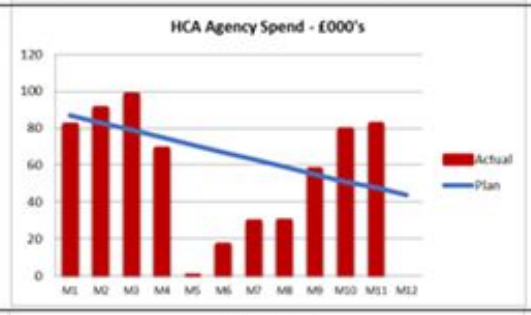
South West London and St George's Mental Health NHS Trust

Agency – Analysis by Pay Type

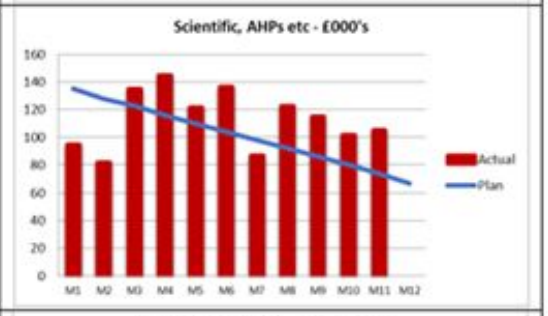
- In month spend of £240k
- £28k below plan
- £8k above M10 spend
- Cumulative spend of £3,343k, £727k below target
- £576k of total spend on wards, with £2,749k in Community settings and £118k in HTTs/Liaison
- Highest area of spend: Carshalton IHR (£347k)

- In month spend of £298k
- £121k above plan
- £2k below M10 spend
- Cumulative spend £3,258k. £500k above plan
- £2,019k of spend in in Community settings, £127k on wards, and £112k within HTTs/Liaison
- Highest area of spend: Central Wandsworth CHMT (£180k)

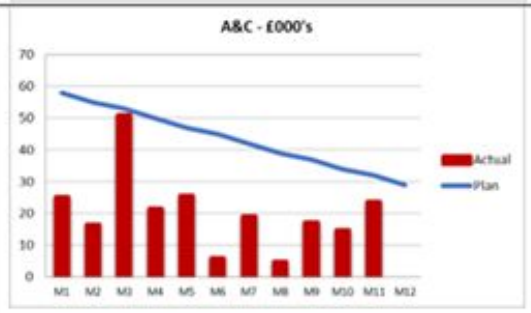
- In month spend of £82k
- £34k above plan
- £3k increase on M10 spend
- Cumulative spend of £635k, £103k below plan
- Increases in from M9 the result of reduced availability of bank staff
- Totality of spend on wards
- Highest area of spend: Lilacs Ward (£85k)



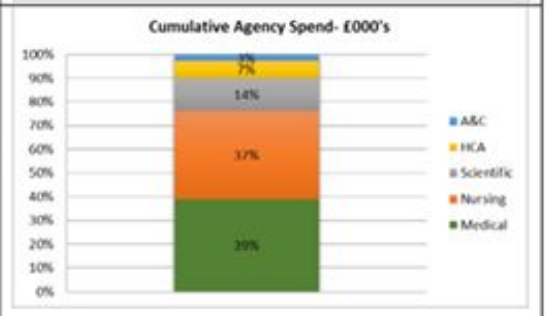
- In month spend of £105k
- £31k above plan
- £3k above M10 spend
- Cumulative spend of £1,246k, £100k above plan
- £1,138k of spend in Community, £63k in Pharmacy, and £45k in wards
- Highest single area of spend: Talk Wandsworth (£106k)



- Spend of £24k in month
- £8k below target
- £9k above M10 spend
- Cumulative spend of £225k, £267k below target
- Largest area of spend: Digital Services (£141k)



- Largest area of cumulative spend = Medical (40%)
- Nursing = 37%
- Scientific = 14%, HCA = 7%, A&C = 3%
- Clinical/Non-Clinical split = 97/3, last year amounted to 84/16



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Non-Pay & Post EBITDA

- Non-Pay budgets overspent by £1.1m in the month to take the cumulative overspend to £11.1m. This position incorporates the inclusion of £4.1m of risk contingency
- The area causing major financial pressure continues to be external beds, accounting for £4.0m of the £6.2m Secondary Commissioning costs overspend. The remaining balance incorporates externally funded Hostels and Complex Care (£1.2m), waiting list initiative expenditure (£0.6m) and £1.6m of risk contingency
- Other costs are now £3.9m overspent and includes: Energy (£0.9m), Soft FM (£0.4m), IT (£0.3m), and £2.5m of risk contingency

Financial Reports 2023/24	Current Month			YTD month 11			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)	0.1	(2.1)	(2.1)	(0.0)	(2.3)	(2.4)	(0.0)
Clinical Supplies & Servs Cost	(0.1)	(0.0)	0.0	(0.6)	(0.6)	(0.1)	(0.6)	(0.7)	(0.0)
Secondary Commisioning Costs	(4.6)	(5.5)	(0.9)	(46.4)	(53.5)	(7.0)	(51.0)	(58.9)	(7.9)
Other Costs	(2.1)	(2.5)	(0.3)	(28.1)	(32.0)	(3.9)	(30.7)	(34.5)	(3.8)
Contingency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Pay	**(7.0)**	**(8.1)**	**(1.1)**	**(77.2)**	**(88.3)**	**(11.1)**	**(84.7)**	**(96.4)**	**(11.8)**

- Post EBITDA costs are now £6.2m favourable to plan.
- The majority of this (£5.2m) relates to a PDC reduction resulting from delays to the go live date of the new hospitals.
- An impairment of approximately £42.5m (26%) will be incurred reflecting the valuation of the two new buildings, that went live in year, versus what it cost to build them. The impairment is 26% and typical for new builds of this size.
- The final position on the asset sale is still being calculated and may result in a small immaterial profit in M12.

Financial Reports 2023/24	Current Month			YTD month 11			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)	(0.7)	0.2	(10.4)	(10.1)	0.3	(11.2)	(10.6)	0.6
Cap Charges - Pdc Dividend	(0.6)	(0.5)	0.1	(7.0)	(1.5)	5.5	(7.6)	(2.0)	5.6
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	(50.0)	(42.5)	7.5
Interest	0.1	0.2	0.1	0.6	1.1	0.5	0.7	1.2	0.5
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)**	**(1.0)**	**0.4**	**(16.8)**	**(10.5)**	**6.2**	**(68.1)**	**(53.9)**	**14.2**

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External Beds

- Cumulatively, external beds have cost £10.0m, are overspent by £4.0m and forecast spend for the year is £11.1m
- This analysis of external beds incorporates unplanned external bed usage as well as contracted beds at Holybourne and ELFT (both Female PICU and Acute)
- Significant external bed costs incurred in 2022/23 continued into 2023/24
- February expenditure amounted to £1.1m, £0.1m below January, but largely a function of fewer days in the month
- This was £0.4m above the monthly average for 2022/23
- This was the third highest monthly spend in the period under review and was £0.3m higher than February 2023 expenditure
- The budgetary base for February covered 696 days, actual utilisation amounted to 1,322 days, 626 days above plan and 79 days below January actuals
  - The cumulative overspend has been primarily 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
  - Available slippage ran out in December, and to date it has been necessary to release an additional £1.1m of reserves to cover costs
  - Of the cumulative expenditure: £6.2m was at Holybourne, £1.8m was spent on Female PICU, £1.6m has been spent on other acute beds, and £0.4m spent on Male PICU beds
  - The daily bed occupancy report produced by Information Management indicates that there has been a small reduction in usage in March

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Service Line Positions

- Whilst the overall position remains on plan, there is significant variation in Service Line performance
- Acute Care is now £6.6m overspent. The largest element of this is external bed pressures of £4.0m. The remainder is primarily comprised of acuity and other Nursing pressures outlined earlier in the report.
- CAMHS & ED is £1.8m underspent due to continued recruitment slippages
- Community is £0.8m underspent due to recruitment slippages
- Specialist is £0.8m underspent, again predominantly non-recurring recruitment slippages
- The Corporate overspend of £2.3m primarily caused by the incorporation of risk contingency into the position.
- Capital costs are £6.2mm underspent in relation to: reduced PDC, interest income and reduced interest payable on the EMP loan. This position is expected to further improve to a £14.2m underspend. The main driver of this increase is the final impairment figure materialising at 42.5m, some £7.5m below plan
- The forecast for the year is (before impairments/profit on sale of assets of c£42.5m) for a £1.0m surplus. As detailed previously, the Trust is managed on the pre-impairment/profit on sale position

Financial Reports 2023/24	Current Month			YTD month 11			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	(4.2)	(5.0)	(0.8)	(45.1)	(51.7)	(6.6)	(49.3)	(56.1)	(6.8)
Camhs & Ed	(2.9)	(2.9)	0.1	(30.8)	(29.0)	1.8	(33.8)	(31.9)	1.9
Community (Adults)	(4.9)	(4.5)	0.3	(50.4)	(49.7)	0.8	(55.2)	(54.2)	1.0
Specialist Services	(2.9)	(2.8)	0.1	(31.2)	(30.4)	0.8	(34.1)	(33.1)	1.0
Corporate	16.4	16.3	(0.1)	174.2	171.9	(2.3)	190.8	187.9	(2.9)
Capital Costs	(1.4)	(1.0)	0.4	(16.8)	(10.6)	6.2	(68.1)	(54.0)	14.2
Total	**0.0**	**0.1**	**0.0**	**(0.1)**	**0.5**	**0.6**	**(49.8)**	**(41.5)**	**8.3**

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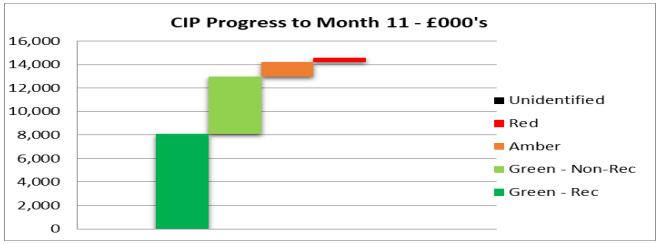
Savings – YTD Position

- **Target £13m** – total of £14m schemes identified; Green £13m (100%), Amber £1.3m (10%), Red £0.4m (3%)
- **Overprogramming** of £1.6m offsets outstanding Red and Amber schemes in full and part of green balances.
- **In month Delivery** - £ 0.4m delivered, £0.7m behind plan
- **YTD Delivery** - £12.6m delivered, £0.7m ahead of plan
- **Delivery Confidence** – Risk assessed delivery continues to exceed target at £13.7m (106%)
- **Recurrent Target £8.1m (62%)** - forecast delivery increased by 4%, resulting in the 62% target being met. Increase in month due to the technical saving associated with the impairment. Recurrent CIP delivery has increased by 32% when compared to the 2022/23 delivered position (30%)

Status	2023/24 £000's	2023/24 %	Risk Level %	Expected £000's
Green - Rec	8,071	62%	0%	8,071
Green - Non-Rec	4,903	38%	0%	4,903
Amber	1,256	10%	50%	628
Red	368	3%	75%	92
Overprogramming	-1,624	-13%	100%	0
Unidentified	0	0%	100%	0
Total	**12,974**	**100%**	**106%**	**13,694**
Over delivery				**720**



Service Line £k	Total Target	In Month Plan	In Month Actuals Total	In Month Variance	YTD Plan	YTD Actuals	YTD Variance
Acute And Urgent Care	1,439	120	0	-120	1,319	1,439	120
Camhs & ED	1,042	87	30	-57	955	1,012	57
Community (Adults)	2,228	186	1	-184	2,042	2,242	199
Specialist Services	1,056	88	10	-78	968	1,057	89
Operations total	5,765	480	41	-440	5,285	5,750	465
Corporate total	1,833	153	36	-116	1,680	1,357	-323
Technical Savings	7,000	586	327	-259	6,413	5,450	-963
Overprogramming	-1,624	-135	0	135	-1,489	0	1,489
Total	12,974	1,084	404	-680	11,889	12,557	668

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	6.7	(3.1)	32.8	21.7	11.1	48.1	24.6	23.5
Estates Maintenance	0.1	0.2	(0.0)	1.3	1.0	0.3	1.4	1.4	0.0
IT/Digital	0.1	0.1	(0.0)	1.3	1.6	(0.2)	1.4	1.7	(0.3)
Operational Total	3.8	7.0	(3.2)	35.3	24.2	11.2	51.0	27.7	23.2
Leases	0.0	0.0	0.0	0.0	0.0	0.0	7.5	3.3	4.2
Total Capital Expenditure	**3.8**	**7.0**	**(3.2)**	**35.3**	**24.2**	**11.2**	**58.5**	**31.0**	**27.4**

- The capital plan is £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 £31.0m due to asset sale delays matched by underspends on the Tolworth scheme, and to reflect slippage on the Barnes scheme.

- 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. The IFRS 16 leases forecast reduction of £4.1m to £3.3m, reflects the Kingston leases moving to 2024/25.

- Capital expenditure for the month is £7.0m (£3.2m above plan) due to enabling works at Tolworth and costs being incurred for future asset sales. Cumulatively, 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 £28.1m and an EFL target of £33.8m. The Trust is forecasting to achieve both targets

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

Statement of Financial Position

Statement of Financial Position (£m)	Plan as at end February 2024	Actuals as at end February 2024	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	6.2	5.9	(0.3)
Plant, Property and Equipment	355.8	357.0	1.2
Receivables	16.0	15.9	(0.2)
Right of Use Asset	0.0	10.2	10.2
Total Non-Current Assets	**378.1**	**389.1**	**11.0**
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	5.8	9.2	3.5
Other Financial Assets	1.5	9.0	7.5
Prepayments	0.0	0.0	0.0
Cash and Cash Equivalents	51.0	62.0	11.0
Total Current Assets	**58.5**	**80.5**	**22.0**
CURRENT LIABILITIES:			
Trade Payables	(6.9)	(10.6)	(3.7)
PDC Dividend Payable	(0.0)	(4.5)	(4.5)
Capital Payables	(10.0)	(13.8)	(3.8)
Provisions	(4.2)	(4.3)	(0.1)
Other Financial Liabilities (Accruals)	(27.6)	(39.2)	(11.7)
Deferred Revenue	(11.3)	(6.3)	5.0
Borrowings	(5.0)	(11.8)	(6.8)
Total amounts falling due within one year	**(64.9)**	**(90.5)**	**(25.6)**
NET CURRENT ASSETS/(LIABILITIES)	**(6.4)**	**(10.0)**	**(3.6)**
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	**275.5**	**272.9**	**(2.6)**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	154.6	147.0	(7.6)
Retained Earnings (accumulated losses)	30.6	63.5	33.0
Retained Surplus(Deficit) in year	36.0	0.6	(35.5)
Revaluation Reserve	54.3	61.8	7.5
TOTAL TAXPAYERS EQUITY	**275.5**	**272.9**	**(2.6)**

- Current Receivables stand at £9.2m, £3.5m higher than plan, of which prior year is £0.7m.
- Cash at the end of February was £62.0m, £11.0m higher 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 February 2024	Actuals as at end February 2024	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	7,559	996	(6,563)
Non Cash Adjustments			
Depreciation and Amortisation	10,358	10,078	(280)
Interest Received	(1,250)	0	1,250
Increase/(Decrease) in Working Capital	1,912	20,193	18,281
Net Cash Inflow/(Outflow) from Operating Activities	**18,579**	**31,267**	**12,688**
Cash Flows from Investing Activities			
Interest Received	1,250	1,488	238
(Payments) for Property, Plant and Equipment	(36,998)	(28,516)	8,482
Proceeds from sales of property, plant and equipment	40,872	35,054	(5,818)
Net Cash Inflow/(Outflow) from Investing Activities	**5,124**	**8,026**	**2,902**
Net Cash Inflow/(Outflow) before financing	**23,703**	**39,293**	**15,590**
Cash Flows from Financing Activities			
Public dividend capital received	10,653	2,946	(7,707)
Loans from Department of Health and Social Care - repaid	(5,000)	0	5,000
Interest paid	(330)	(364)	(34)
Interest element of finance lease	(364)	(66)	298
PDC dividend (paid)/refunded	(3,792)	(2,476)	1,316
Net Cash Inflow/(Outflow) from Financing Activities	**1,167**	**40**	**(1,127)**
Net Increase/(Decrease) In Cash And Cash Equivalents	**24,870**	**39,333**	**14,463**
Cash / Cash Equivalents at beginning of month	**26,148**	**22,680**	**(3,468)**
Cash / Cash Equivalents at end of month	**51,018**	**62,013**	**10,995**

- The cash balance at the end of the month was £62.0m compared with the plan of £51.1m.
- There are £1.3m of funds held in escrow accounts not accounted for in the Trust position.
- There have been two PDC drawdowns relating to Tolworth and IT (£1.1m) in the month. These are the final draw downs in 2023/24.
- Both loan repayments, a total of £10m due in 2023/24 have been deferred to March 2024/25.

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Meeting:	Charitable Funds Committee meeting
Date of meeting:	19 March 2024
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. ***Finance update***: £18k of unrestricted dormant funds have now been transferred into the General Fund. The Approval Matrix has been updated as well as financial controls, the latter to ensure fundholders remain in budget
2. ***Fundraising***; the Committee was pleased that further fundraising initiatives are taking place. Unfortunately recent recruitment for a charity fundraising post was not successful and so an interim fundraising consultant will be appointed soon to progress with the overall fundraising strategy.

Areas of Risk Escalation to the Board:

- None

Item discussed- Charitable Funds finance report:

Assurance Position

The balance of the charity funds as at December 23 is c. £123k and £18k of unrestricted dormant funds have now been transferred into the general fund, as agreed at the previous meeting.

Controls around expenditure have been tightened and no fund is overdrawn.

An update on the performance of the Ethical fund was not received and the committee asked for this at the next meeting.

The committee discussed it would be good to ensure the Memorandum and Articles of the charity and all associated policies are up-to-date, partly to be ready for submitting fundraising bids in the future.

Evidenced by
- Good assurance provided by the Finance report

What next?
- Update on performance of Ethical Fund
- Review of key charity documentation and policies

Item discussed- Charity working group update

Assurance Position
Unfortunately the charity was not successful in recruiting a part-time fundraiser so is reviewing proposals from interim fundraising consultants to help develop a fundraising strategy.

The committee was pleased to hear that the number of fundraising events available has already increased, and that the Mental Health First Aid Training funded by the NHS Charities Together stage 3 Covid Recovery Grant grant is going well for local residents and also some Trust staff.

An agreement has now been signed with Pennies from Heaven which will allow new staff to make small donations from their salary to the charity on an entirely voluntary basis if wished. This will be rolled out to all staff after the first phase has been assessed.

Evidenced by
- Good assurance provided by the Report

What next?
- Progress with fundraising strategy.

Appendices
All annual reports and other items that require to be in the full Board papers will be appended to the Committee Report
- Minutes