Trust Board - Part A July 2023

Committee Rooms A and B, Trinity Building, Springfield Hospital

14 September 2023 01:30 PM - 04:00 PM London Standard Time

Agenda Topic

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

AGENDA

Meeting	**Board of Directors a**
Time of Meeting	**1.30pm to 4.00pm**
Date of Meeting	**Thursday 14th September 2023**
Location	**Conference Room B, Trinity Building, Springfield Hospital**

	PART A		**Format**	**Lead**	**Time**
1.	**PATIENT STORY**		**Paper**	**AB**	**13:30**
2.	**STANDING ITEMS**			**AB**	**14:00**
	2.1. Apologies	**FN**			
	2.2. Declarations of interests and register https://www.swlstg.nhs.uk/about-the-trust/trust-board/board	**FA**			
	2.3. Chair's action	**FE**			
	2.4. Minutes of the meeting held on 13th July 2023	**FA**	**Paper**	**AB**	
	2.5. Action tracker 2.5.1. Peer support workers update	**FE**	**Paper**	**AB**	
3.	**CHAIR'S and CHIEF EXECUTIVE'S REPORTS**				
	3.1. Chair's report	**FR**	**Paper**	**AB**	**14:05**
	3.2. Chief Executive's report	**FR**	**Paper**	**VF**	**14:10**
4.	**INCREASING QUALITY**				
	4.1. Quality and Safety Assurance Committee chair's report	**FR**	**Paper**	**DBo**	**14:20**
	4.2. Quality and Performance report	**FD**	**Paper**	**JeA**	**14:30**
	BREAK				**14:45**
5.	**MAKING THE TRUST A GREAT PLACE TO WORK**				
	5.1 People Committee chair's report	**FR**	**Paper**	**SA**	**14:55**
6.	**ENSURING SUSTAINABILITY**				
	6.1. Finance and Performance Committee chair's report	**FR**	**Paper**	**VS**	**15:05**
	6.2. Monthly finance and savings reports	**FD**	**Paper**	**PM**	**15:15**
	6.3. Estates Modernisation Committee chair's report	**FR**	**Paper**	**JuA**	**15:20**
	6.4. Audit Committee chair's report	**FR**	**Paper**	**RF**	**15:30**
	6.5 Corporate objectives quarterly report	**FR**	**Paper**	**AS**	**15:40**
7.	**NOTIFIED QUESTIONS FROM THE PUBLIC AND STAFF**	**FD**	**Verbal**	**AB**	**15:50**
8.	**MEETING REVIEW**	**FD**	**Verbal**	**AB**	**15:55**
9.	**Next Trust Board business meeting in public – 9th November 2023** – Conference Room B, Trinity Building, Springfield Hospital				

Attendees:

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

In attendance:

Emma Whitaker (EW)	Deputy Director of Corporate Governance

Apologies:

*=non voting

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

Trust Board

September 2023

Paper Reference:	
Report Title:	Service User Story
Executive Summary:	The Service User Story for September 2023 is being presented by Shaun and Anthea, the brother and sister of (the late service user) Michelle, who will share their experience as a family of the Trust's Adult Acute Female Inpatient Service, Rose Ward. This will give an insight from their perspective of the care and treatment provided to Michelle and their experience as her immediate family. Michelle died on 28th August 2021 in intensive care unit, following a ligature incident on Tuesday 24th August 2021. This story has been highlighted as there has been recent work completed around themes from complaints and patient experience, where several themes were identified. Two of the main themes identified were around: (i) Communication with families, and (ii) The confusion about Consent to Share and discuss information with families. The Carers Friends and Family Reference Group has asked the Trust to look at these themes, with learning and improvement across the Trust. Shaun and Anthea's experience highlights the care pathways, admission and the inpatient environment, patient engagement, and the importance of involving families in collaborative interventions, verbal and documentary communications about what to expect for their loved one's admission and treatment. This ensures a shared understanding of inpatient care assessments of needs and risks, and the treatment and safety plan. Family involvement remains a pivotal part of the care provided to patients/service users. This care must take into account views of the family by way of collateral information, as families hold valuable details about patients/service users that better inform treatment and safety plans. Trust policies remain clear about identifying Next of Kin and assessing the levels of consent to share information. This includes learning around informing patients/service users about considering emergency or complex situations where their consent to share information may be breached or withheld, depending on who has been listed by the patient/service user as Next of Kin. The story also highlights the value of gathering information from

family and acting promptly on the information; whilst providing updates on the clinical and management decisions related to the care of their loved one. The value to families of having access to relevant information about purpose of admission and the meaning of the status of admission (voluntary/formal) decided upon. Family involvement aims to ensure that there is a balance between information exchanged by services around care, risk management and treatment interventions, and the individual needs of the service user. This includes complexities identified which require referrals under safeguarding processes. Learning identified around inpatient care interventions such as engagement and observations has fed into an ongoing improvement programme around systems in place for observing and monitoring patient/service user wellbeing on the ward.

Rose Ward is a female acute mental health inpatient service that provides recovery-focused interventions to adults, presenting with mental health needs. The service is for adults aged between 18 and 75 years of age who require admission in crisis, relapse or further assessment. The ward team provides care needs and clinical risk assessment, care, risk and treatment planning by a multidisciplinary team. Care and treatment interventions are provided in a therapeutic inpatient setting, with individual ensuite facilities for privacy, dignity and recovery.

The Acute and Urgent Care Service Line has taken immediate actions in response to learning from patient experience, family/carers experiences and incidents. There are ongoing improvement plans with dedicated management oversight and monitoring. Inpatient environments have been part of the Estates and Modernisation Programme that was approved in 2015, to ensure patients/service user environments are based on central sites of the Trust and provide modern facilities. Family/carer views have provided welcome challenges to improvements related to care and service delivery, especially inpatient environments. The Trust has recently achieved 2-star membership of Triangle of Care demonstrating a commitment to family involvement and ensuring learning identified from family/carer views is evidenced through completed actions and sustained changes. This provides assurance to families and stakeholders that learning has been embedded.

There will be oral presentations from:

- Shaun and Anthea (Michelle's brother and sister)

Attending will also be:

- Acute and Urgent Care Service Line Management – Gina Mogan, Matron. Ramanah Venkiah, Deputy Head of Nursing and Quality Standards. Michael Hever, Head of Nursing and Quality Standards.

The presentations emphasise the importance of family involvement – identifying Next of Kin, information provision (both verbal and documentary) around inpatient admissions, purpose of admission, explanations to family of the clinical decisions made and the treatment plan, safeguarding concerns; and the Trust work on sharing learning from incidents through the Service Lines including

	the Suicide Prevention strategy. Consent – Please note that consent has been provided to refer to the family using first names in the written story and during the Board meeting: Shaun, Anthea and Michelle - which should be respected. -Should the meeting be recorded – Shaun and Anthea have consented. -Rights are reserved for Shaun and Anthea to make any changes to this consent at any time.
Action Required:	The Board is asked to note the Service User Story relating to Rose Ward – based at Queen Mary's Hospital at the time of the care episode – under the Acute and Urgent Care Service Line.
Link to Strategic Objectives:	The Trust launched its five year Trust Strategy in 2018. The strategy 2018 – 2023 includes four strategic ambitions: • **Increasing quality years -** Quality Improvement and Innovation • **Reducing inequalities -** Service users and carers co-production • **Making the Trust a great place to work -** Staff underpin all that we do • **Ensuring sustainability -** Transformation These ambitions move the Trust to focus on outcomes, not processes and are held together by the mission – Making Life Better Together – which is at the centre of the Trust's work. This story links to all our strategic ambitions as the Trust recognises that the views of our service users and carers/families/external agencies must not only be sought but evidenced to demonstrate that actions have been taken. The Trust promotes service review, learning and improvement, which is effective through collaboration with patients/service users, families, support networks/agencies and staff working in the services.
Risks:	Patient Safety is a domain of the Quality Strategy. Managed risks reduced with the move of Rose Ward to Springfield site.
Quality Impact:	Patient Experience is a domain of the Quality Strategy.
Resource Implications:	Shaun and Anthea's attendance in person has been facilitated through the Quality Governance Department.
Legal/Regulatory Implications:	None. Consent elements have been discussed with the family.
Equalities Impact:	The Board is asked to note of equality, diversity and inclusion – learning identified from QSAC feedback about how incident responses and reviews include an equality, diversity and inclusion statement as part of the Trust's commitment to Reducing Health Inequalities for those who use our services.
Groups Consulted:	Service Users' brother and sister – who were supported by their advocate. Service Line Management Service Leads and Clinicians Safeguarding Hub and Leads Family/Carers Involvement Leads
Author:	Brenda Ndiweni, Experience and Governance Lead
Owner:	Sharon Spain, Executive Director of Nursing and Quality Standards

Making life better together

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

Rose Ward
Acute and Urgent Care Service Line

14th September 2023

Background

This month's patient story to the Board is being presented by Shaun and Anthea, the brother and sister of Michelle, who will share their experience as a family of the Trust's Adult Acute Female Inpatient Service, Rose Ward. This will give an insight to the care and treatment they have received. Michelle died on 28th August 2021 in intensive care unit, following a ligature incident on Tuesday 24th August 2021.

Their story will highlight care pathways, patient engagement and the importance of involving families in collaborative interventions, verbal and documentary communications to ensure a shared understanding and take into account collateral information from the family.

Recovery Approach in the Acute Inpatient Services

The Recovery Model promotes inpatient care interventions that use a recovery-focused approach. Admission to hospital can add to the overwhelm during a crisis or relapse. A Recovery Approach with supportive and therapeutic engagement on the ward emphasises:

- Treatment and support directed towards fostering hope, enabling people to take back control over their lives, their problems, and the help they receive as far as possible and helping them to identify and access the opportunities they value.
- Collaboration and co-production of understanding and shared decision making.
- Promoting the needs of people with mental health problems and reducing the stigma associated with mental health care.
- Actively involving the patient and their family in the assessment and planning of care and treatment.

Rose Ward

Rose Ward is a female acute adult admissions ward for the treatment of patients presenting with depression, schizophrenia, first-presentation psychosis, schizo-affective disorder and manic depressive psychosis. The service is for adults aged between 18 and 75 years of age.

The service includes assessment, treatment and support for those diagnosed with complex and severe mental health difficulties and emotional disorders, including psychosis and mood disorders.

Access for in-patient admission is via a gate keeping role through the Coral Mental Health Crisis Hub and the Acute Care Coordination Centre.

The team is comprised of a range of professionals, including medical, nursing, healthcare assistants, occupational therapy, psychology, pharmacy, clinical leads and management, who assess, treat, monitor, evaluate and provide recommendations for the patient's inpatient stay.

Inpatient Care and Treatment

Patients admitted to the service receive an assessment of their mental health needs by the medical and nursing team. A plan of the care and support is formulated collaboratively for the care they will receive.

A named nurse is allocated who co-ordinates their care and support, through engagement, assessment of needs and risks, and support with recovery goals.

Information about rights and what to expect is provided through discussion, a welcome pack and orientation to the ward. An explanation is provided about the ward routine and therapeutic activities available.

Information is also provided to family which includes details such as the visiting times and ward contact phone numbers.

Shaun's Story

Experience of mental health services whilst Michelle was admitted to Rose Ward, Queen Mary's Hospital:

You may understand that as Michelle's family we are still coming to terms with the reality of her sudden and tragic loss. At the time of my experience of Rose Ward, I was in the dark about aspects of Michelle's hospital care since her attempted suicide at home early hours of Saturday morning 21st August 2021. I understood that this occurred while she was in her home with her sons and ex-partner and was taken by ambulance to C&W hospital.

My first visit to Rose Ward was on Sunday afternoon 22nd August 2021. Michelle had provided me with the number for Rose ward as she told me I had to call to book an appointment. When I went to the ward, I was told that Michelle was an informal patient and could go out. I was very surprised as she had just been admitted following a suicide attempt and that she had that much freedom. We had felt her admission would now allow time to have her looked after, to think about her care, whilst she was in a safe place and away from him. The ward environment was what I would expect of the psychiatric ward. The front door was locked and the entrance had a security camera. I was left in confusion about how she was able to walk in and out of the ward.

Shaun's Story: continued

During the visit on 22nd August, I brought her some toiletries in a sports bag. Her ex-partner also brought some items for her that day. After my visit, I met with a member of staff on Rose Ward to ensure that the staff had my contact details as Michelle's Next of Kin. I also expressed my concerns regarding Michelle's ex-partner, who was due to visit that evening, and requested that they 'keep an eye on her' when he is around. The member of staff made notes at the time.

My experience when I spoke to staff, is that I was surprised to learn that as her brother, I was not noted as her Next of Kin and neither were any of her family. In December 2020, Michelle attended Guys Hospital and had changed her next of kin from her ex-partner to me during that stay. As appointed Next of Kin, I was not informed of her attempted suicide, admission to Rose Ward or arrangements for her care, safety and support when she returned home. It became apparent to me that the staff were unaware of the circumstances with her relationship breakdown and the stress that followed. I spoke to a nurse who listened and told me that she would make a record and share this information with the team.

At the time, I was not sure whether this was followed. My only reliance was that I had previously been recorded then as Next of Kin. However, it seems that NHS systems are not connected. I can also appreciate that my sister had provided details of ex-partner to the staff but I felt there was no curiosity as on one hand a person is citing them as the cause of stress and on the other hand listing the person as their Next of Kin.

At 7pm on 22nd August I received a call from Michelle's ex-partner to say he was at the entrance to the hospital, struggling to restrain Michelle from running into the road and needed assistance to get her back to Rose Ward.

That same evening Michelle's ex-partner informed my sister that Michelle had left the hospital grounds, was attempting to cut herself with a branch and had removed her belt to strangle herself. The ex-partner informed my sister that he reported the incident with the belt to the ward staff.

On Monday afternoon, 23rd August 2021, Michelle informed me that she had spoken to a doctor and a referral would be made to Social Services and the Mental Health Team. I was however, not contacted on that day with updates of that meeting and the decisions made.

I was notified of the ligature incident on Tuesday 24th and when I went to the ward, had a meeting with several staff. I feel that Michelle was in a difficult situation with ex-partner and it would have been helpful to have a standard practice of asking patients about their Next of Kin from biological family. Learning should be shared about the impact of not just relationship difficulties with current partners, on mental health, but also difficulties from ex-partners – amongst many other complex relationships. A checklist or assessment should be completed to establish concerns and it is very important to involve family sooner rather than later.

Anthea's Story

My experience of Rose Ward was a telephone call I made after ex-partner visited. Michelle was texting with paranoia about the boys and ex-partner being on the ward and then saying they were not there.

When called the ward, the member of staff I spoke to said they could not speak to me as I was not the next of kin and, that they were going into staff change over. They said it was going to take a while and told me to call back in an hour.

I felt very frustrated at the time, really worried and concerned and the person who took the call did not provide a space for me to share my concerns and or at least take the information. I was very concerned about the call I had received from Michelle's ex-partner. It was a very abrupt call with the Rose Ward staff saying - [You are not next of kin, it is staff change over, call back in an hour]. I called my brother and told him. He rang the ward and there was no answer. He made further calls and they advised that she was sleeping, she was okay and nothing to worry about.

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

What Has Been Done

- The learning identified from the Carers and Family Reference Group will be incorporated into the new Learning Group in relation to the new Patient Safety Incident Response Framework (PSIRF). This triangulates other aspects of work and Involvement across the Trust.

- The learning identified around the support given to patients for psychological/emotional distress from a relationship or former relationship. Actions were completed around following safeguarding procedures and seeking guidance from the Domestic Abuse Advisor.
- The learning around involving families where consent to share information presents a conflict with a patients presenting needs. This was progressed into co-locating Independent Domestic Violence Advisors (IDVA) for the inpatient and psychological talking therapy services.
- The learning identified from Safe and Support Engagement and Observations, was incorporated into a Quality Innovation and Improvement (QII) Project with a focus on exploring and addressing the processes around observation checks.
- Suicide Prevention Conference was held on 17th May 2023 to share wider learning and continue to raise awareness of such cases. For 2023, the South West London Integrated Care Board suicide prevention programme and South West London and St George's Mental Health NHS Trust held a joint suicide prevention conference.

Next Steps and Way Forward

Dr Charlotte Harrison, Clinical Director for the Acute and Urgent Care Service Line comment:

"We are extremely thankful to Shaun and Anthea, for their time sharing their experience of our Trust inpatient services, despite the challenges with reflecting on Michelle's death.

Learning and improvement of our services is better informed by families. This way we are better able to deliver effective care in safe environments.

We continue in our commitment to ensure that effective systems are in place for families to voice their views and point out the areas that we can improve on.

The Acute and Urgent Care Service Line has been progressing improvements around Safe and Supportive Engagement and Observations, Safeguarding Adults procedures especially around Domestic Violence and Abuse reports.

The Service Line has a long standing Estates and Modernisation Programme since 2015, when consultations were held by South West London CCG (now the SWL Integrated Care Board) to determine the optimal configuration for inpatient facilities in South West London.

This recommended the centralisation of the Trust's inpatient services at Springfield and Tolworth, better modern environments as well as closer links between wards and supporting services.

We remain open to further feedback,, learning and to be able to evidence that we are embedding the learning identified through stronger partnerships with patients' families. At all times, maintaining our Trust values and the Triangle of Care involvement principles."

Presentations:

Brother of deceased: Shaun
Sister of deceased: Anthea

Service user: the late Michelle

Attending from Service Line:

Gina Mogan, Matron
Ramanah Venkiah, Deputy Head of Nursing and Quality
Michael Hever, Head of Nursing and Quality

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

Board of Directors (Part A)

Draft minutes of the meeting held on Thursday 13 July 2023, 1.30pm to 4.00pm, Conference Rooms A and B, Trinity Building, Springfield Hospital.

Present:

Ann Beasley (AB)	Chair
Professor Deborah Bowman (DBo)	Vice Chair, SID and Non-Executive Director
Vik Sagar (VS)	Non-Executive Director
Sola Afuape (SA)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Juliet Armstrong (JuA)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Dr Billy Boland (BB)	Medical Director
Philip Murray (PM)	Director of Finance and Performance
Sharon Spain (SS)	Director of Nursing and Quality
Jennifer Allan (JeA)	Chief Operating Officer
Ian Garlington (IG)	Integrated Programme Director
Jenna Khalfan (JK) – Non - voting	Director of Communications and Stakeholder Engagement
Amy Scammell (AS) – Non-voting	Director of Strategy, Transformation and Commercial Development
Katherine Robinson (KR) – Non-voting	Director of People

In attendance:

Izzy and Ellie	Patient story participants (item 23/37 only)
Dr Rachel Tucker	Head of Psychology and Psychotherapy, CAMHS and All Age Eating Disorders (item 23/37 only)
Dr Jennifer Walker	Principle Clinical Psychologist (item 23/37 only)
Jayne Evans	Experience and Governance Lead (item 23/37 only)
Suresh Desai (SD)	Staff side, Unison
Martin Haddon (MH)	Wandsworth Healthwatch
Giles Marcus	MadeTech
Emma Whitaker (minutes only)	Deputy Director of Corporate Governance

Apologies

Charlotte Clark	Non-Executive Director
David Lee	Director of Corporate Governance

Item		Action
23/37	**Patient story** The patient story was presented by Izzy and Ellie, who were part of the new MANTRA integrated group therapy offered by the All Age Eating Disorder Outpatient and Day hospital. Izzy described her experience in the group as brilliant, safe and supportive. Each time she attended group, she felt something click in her brain and felt that she understood her illness better. Ellie had a more negative experience in the group as she felt there was a lot of comparison and she was holding things back as she did not want to trigger people. Although the group had not worked as well for her, when it was offered to her she had felt she had to take it if she wanted NHS treatment.	

Item **Action**

Izzy and Ellie described the impact of the waiting list for them. Izzy had to wait for two years but had a supportive mum who helped her navigate the wait. Ellie described the wait as excruciating and felt lucky she had parents who could afford to fund private treatment for her. However, they did not know how they could best support her during her wait. She felt more information and support was needed for people while they were waiting.

Dr Walker explained that the MANTRA group was new, and the service tries to adjust to meet individual needs. Before every group session, clinicians would meet with each person individually to do a health monitoring session. People can then feed back anything they do not want to feed back in the group. At the end of the group sessions, they would be asked to fill in an anonymous questionnaire. The results were shared with senior managers, who use them to consider service development ideas.

The Board gave their thanks to Izzy and Ellie for bravely sharing their personal stories. The Board felt it was especially important to listen to the personal impact of wait times on patients.

23/38 Apologies and welcome
Apologies were received as listed above.

23/39 Declarations of Interest
JuA declared that she had stepped down as a trustee for the Makaton charity; and from August 2023, she would be starting as a trustee at Cruse Bereavement.

23/40 Chair's action
Noted that following consideration by Remuneration Committee it has been agreed that the Integrated Programme Director would sit as a non-voting member of the Board, with effect from the July 2023 Board.

23/41 Minutes of the last meeting
The minutes of the meeting held on 11 May 2023 were approved as a correct record with no amendments.

23/42 Action Tracker
The action tracker was noted and updated as below:
22/72 – **To establish an Executive Advisory Group to develop greater diversity in decision making** – completed. Action to be closed.

23/20 – **To report on peer support workers' recurrent funding** – A paper would come to the September Board. Action to be closed.

23/29 – **ADHD and ASD waiting lists** – this was on the agenda for the Board meeting today. Action to be closed.

23/32 – **BSL interpreters** – The collective grievance had been closed. SS and KR were meeting with the parties in a month's time. Agreed that this action be transferred to the People Committee's action tracker and be reported back to the Board in the Chair's report. Action to be closed.

23/6 – **Equality Engagement Champions to support the Staff Network chairs** – completed. Action to be closed.

Item **Action**

23/39 – **People plan** – it has been agreed that the People Plan will come to the May 2024 Board, having been reported to March 2024 People Committee.

23/40 – **Board and Committees to consider 2023/24 investment priorities** – The corporate objectives had set clear priorities for the organisation. The Executive will carry out further assessment of investment priorities.

23/43 – **Internal audit into clinical audit** – this action had been referred to QSAC. Action to be closed.

23/43 Chair's Report

Reported:
A clinical Non-Executive Director (NED), Jonathan Warren, and an Associate NED, Humaira Ashraf, had been successfully recruited to the Board. Both would be starting their roles formally from 1st September 2023.

Discussed:
SS raised that the NHS Equality, Diversity and Inclusion Improvement Plan (June 2023) had been discussed at People Committee. It has an action for all CEOs, Chairs and Board members to have specific and measurable EDI objectives. A fuller report on this will come to a future People Committee.

The Board noted the Chair's report.

23/44 Chief Executive's Report

Reported:
Referrals to the trust had increased by 25% compared to the pre-pandemic period. The average number of mental health patients waiting for beds pre-pandemic was eight and today it was around 15. The acuity and complexity of patients was also an issue.

Today was the first day of the longest industrial action by junior doctors in British history. Patients may stay away from services and we may not know the full impact until after the strike. It would be a challenging time but it continued to be well handled.

The Metropolitan Police proposals around the Right Care Right Person initiative were discussed. JeA was leading on work across London on the issue and it is now anticipated that implementation will no longer take place abruptly in September 2023.

Noted that the recommendations of the national Rapid Review into data on mental health inpatient settings had been published and the government response is awaited. An initial Trust self assessment will come to September QSAC. The government has also announced plans for an HSSIB investigation to examine mental health inpatient settings and the statutory Essex Mental Health Independent Inquiry.

Rose and Laurel inpatient wards had now moved onto the Springfield site.

Transformation work in Community and Acute services continued, supported by work around the Organisational Development (OD) framework. The OD framework was being developed with core leaders and the Executive Advisory Group (EAG).

Item **Action**

The Integrated Care Board (ICB) had approved a Mental Health Strategy. SW London ICB remained one of the most financially challenged in the country. The trust was currently working to embed the actions from the Strategy.

VF had led a call to action in terms of acute bed space. The Board had previously discussed risk appetite and had asked the Clinical Directors to bring a piece of work to a future Board as to what this meant in reality. This would be different to the clinical risk policy. Once this piece of work had taken place the risk appetite would be published and would make trust expectations explicit to patients.

Discussed:
BB gave assurance around the safety of services during industrial action. He thanked Dr Sean Whyte, Deputy Medical Director, and Pam Warren, Deputy Director of People, for helping negotiate arrangements with the LNC (Local Negotiating Committee). The Chair expressed her thanks for all involved in the planning and frontline staff for keeping us safe.

AS raised that this was the first year of delivery for the ICS Mental Health Strategy. There would be a wider strategy group established and stakeholder groups were planned.

The Board noted the Chief Executive's report.

23/45 Quality and Safety Assurance Committee (QSAC) chair's report

Reported:
The following points were highlighted by DBo:

- The Patient Safety Incident Response Framework (PSIRF)
- Patient and carer voice in Trust decision making.

- QSAC had discussed the waiting list for adult ADHD services. JeA advised that the waiting list was around 18 months for assessment. The solution was to design a more sustainable offer that included a shared care pathway for patients with medication monitoring done in Primary Care. The trust was working with GPs to communicate this to patients. Information had been shared with patients, the ICB and GPs. Information was available on the trust website. This would be followed up in September by QSAC.
- Industrial action – QSAC would continue to review learning from industrial action.
- QSAC received and discussed a 'break glass' policy which was included in the Chair's report as an appendix. The policy sets out arrangements for agency caps to be over ridden on patient safety grounds. QSAC recommended approval following a thorough discussion about process and context at the Committee.

Discussed:
In the trust's many forums there had been a strong range of lived experience (patient) members for a long time, and these fed into committees of the Board. Some Board Committees had Diversity in Decision Making (DiDM) representatives and not all had patient or carer representatives. DiDMs were being expanded into Service Lines to ensure they are feeding down through the organisation. The Executive Advisory Group has DiDMs as members. The EMC dashboard included a "ladder of co-production".

VS highlighted that observation costs last year were £5.6m compared to £2.3m the year before. DBo replied that QSAC had asked for a piece of work on observations to come back to a future meeting. SS added that staff were aware of the statistic and there was also work ongoing around quality of observations. Quality Matters reports had shown a

Item		Action

slight reduction in observations recently. JeA added that staff were aware of the significant costs. SS was leading on work on this and also on reducing restrictive practice.

There was a discussion about whether the number of KPIs could be reduced. JeA noted that the term KPI was used in different ways across the organisation and was sometimes misinterpreted as clinical data. There was a need to address this. There was a need to improve staff skills around documentation and to align clinical documentation processes and workflow to clinical processes. There is a need for development for staff, that emphasised that documentation was for timely appropriate streamlined clinical care; the purpose was not to measure KPIs. The Leadership OD programme would help staff in the middle layer translate KPIs in a meaningful way.

Agreed:
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**

The Board:

a. **Noted the QSAC Chair's report.**
b. **Received the approved Committee minutes.**
c. **Agreed that QSAC will lead on providing assurance to the Board on the PSIRF.**
d. **Agreed the patient and carer co-production piece of work.**
e. **Agreed the 'break glass' policy.**

23/46 Quality and Performance Report

Reported:
JeA highlighted the following:

- Performance remained stable in a challenging and complex operating situation.
- The trust is maintaining stable and safe services in the face of workforce challenges, high demands, acuity and industrial action.
- There were signs of progress in workforce but some significant challenges remained around agency use and the slow pace in improvement to Mandatory and Statutory Training (MAST). These continue to be areas of focus. There was a robust pipeline of recruitment coming in and a sprint piece of work on retention.
- Concerns remain about the Acute care pathway. Due to high demand the trust continues to use a large number of out of area placements. There was focus on supporting services across the organisation with the transformation programme. On conservative assumptions the trust should see improvements on out of area bed use this year.

The Board noted the Quality and Performance Report.

23/47 People Committee Chair's Report

Report:
The following points were highlighted by SA:

- MAST and industrial action were the key areas discussed.
- Recruitment, agency use and turnover remained focused areas of scrutiny. The Committee would be trying to review what was driving the number of leavers and if there were any cultural causes.

Item **Action**

- There had been a significant drop in Employee Relations (ER) cases, followed by an increase with the introduction of the HR Business Partner reviews.
- Turnover and temporary staffing – People Committee had a commitment to focus on plans and mitigations in place to address agency spend, and were assured by some of the work on this and that ELT were reviewing this on a weekly basis.
- The Committee had received assurance around a robust plan in place to improve MAST figures and that there should be some significant improvement by September.
- Industrial action issues continue to be monitored.

Discussed:
AB raised consultant recruitment and asked if the real issues were understood, including culture. BB responded that the medical staff vacancy rate across all Service Lines, is less than 15% so rag-rated "green". However, in Community Services the rate was 29.6% which requires attention. There was a targeted piece of work ongoing.

The Committee are seeking to triangulate data in order to review retention; e.g. staff survey, Freedom to Speak Up (FTSU) Guardian, and workforce metrics. A better picture was forming but more work was needed to get a granular understanding of the issues.

The People team were getting to grips with the hotspots for turnover, in order to understand root causes. Turnover was starting to level out but not for staff with the trust for under 12 months; 30% of these staff were under 30 years old. The expectation of work for the younger workforce and what we can offer them as a trust was something to consider. Career paths are a key issue.. News this week from the national work on retention showed that a number of pilot sites had seen a big dip in sickness and turnover with improved rostering; Pam Warren was looking at this and a plan would be going to ELT.

VF raised that, although retention was a current NHS-wide issue, the trust were at 17% against 11.3% nationally and the London average of 13.9%. There were clear plans in place to reduce this.

It was asked what was being done to give middle managers permission to take time to check-in with their staff. The trust was currently commissioning leadership development offers for bands 7, 8a and 8b, with the first placements from September onwards. The training package will make clear that Leaders are expected to go out and see their staff and to give their staff space.

BB would work with the Community Services Service Line to bring back some thoughts around how to recruit and retain consultants. The trust were investing in leadership development for consultants.

The Board:

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

23/48 Finance and Performance Committee (FPC) chair's report

Reported:
The following points were highlighted by VS:

- The current financial position was £0.2m deficit, which was in line with the plan. This would be revisited in September.

Item **Action**

- The KPI for external beds had not been met in May but there was a clear plan to reduce use. In May the Trust spent its highest amount yet on external beds.
- Delayed Transfers of Care (DTOCs) were increasing, as were observations.
- There had been a slight dip in agency use in May but this was likely to be Bank Holiday related.
- There had been lots of good activity in efficiencies around flow/ delivering value. The ask from the Committee was to review some of the plans to understand how activity will impact on outcome. This would be done for the September Committee.
- A good report came to FPC on suggested commercial income activities. Work was still ongoing and further analysis would come back to the September FPC. This would also be discussed further at a future Board seminar.

Discussed:
That relaunching the Cost Improvement Programme (CIP) as Delivering Value was a positive idea.

The Board:

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

23/49 Monthly Finance and Savings Reports

Reported:
The following points were highlighted by PM:

- With some fluctuation and notwithstanding extensive attention, agency spend had not reduced.
- The trust were expecting to onboard 331 new staff between now and the end of August, so the trust should expect to see a reduction in vacancies in September. The vacancy trajectory is 15% as long as the staff that join were retained.
- There had been a reduction in use of out of area acute adult beds in the period June to end July.

Discussed:
VF raised that with 331 new staff, there is a need to focus on the challenge of retaining staff.

AB suggested conducting "stay" interviews rather than exit interviews.

The Board noted the finance and savings reports.

23/50 Estates Modernisation Committee (EMC) Chair's report

Reported:
The following points were highlighted by JuA:

- The street party at Springfield was a great success.
- The Committee were coming to the end of phase one of the integrated programme and were refreshing the programme. The Committee had agreed the scope of the programme's next phase.
- There was still work to do to complete the refresh, and a lot of this work needed to be completed by the end of September.
- The Board seminar in October would take everyone through where the refresh was up to.

Item **Action**

- The Committee had approved the 2023 - 2028 Digital Strategy and this would be coming to Board in September. The Committee were pleased to see the patient and stakeholder feedback and how that had helped to shape elements of the strategy. JuA thanked JeA and IG for their work on the strategy.

Discussed:

The Board thanked the middle managers for the professional, impressive and safe way they had managed the recent moves.

IG suggested that the trust's ability to play a role as an Anchor Institution was accelerating, with the Street Parties and opening Springfield Park. The trust was starting to be seen as an NHS Mental Health innovator, in how we are pushing forward improvements and spreading learning into the rest of the country. IG and PM had been asked to go out and help other trusts around innovative moves. VF had been invited to a national event for Anchor Institutions, to discuss what the trust had done at Springfield. It was cheering to think that our work could help improve experiences for patients across the country.

The Board:

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

23/51 Audit Committee Chair's Report

Reported:
The following points were highlighted by RF:

- There had been two Internal Audits which were given "partial assurance". The actions were in hand on the Committee's action tracker and were flowing through to other committees.
- There had been a meeting of the Committee earlier this week, so this was not in this Board report. RF gave a verbal update: the Committee endorsed and confirmed the June audit opinions. The Trust accounts for 2022/23 had been filed with the positive opinions as reported to the Special Board in June.
- The Committee's annual report had been completed in draft and would come to the September Board.

The Board:

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

23/52 Charitable Funds Committee Chair's Report

Reported:
The following points were highlighted by JuA:

- The Committee were working towards a relaunch of the charity next year.
- The "nooks" in Trinity Building were funded by the charity, as was the new website.
- There would be a 5k fun run, raising funds to support the charity, taking place on 28th October in Wimbledon Park.
- The Committee recognised that there had been much work from PM and his team, in trying to contact owners of dormant funds. The Committee had agreed that

Item **Action**

sufficient attempts to contact owners had been made. If these funds remained unclaimed the Committee had agreed to amalgamate them into other funds.

- The charity had received a £30k grant to go towards a part-time fundraiser post to help generate funds for the charity. The Committee would like someone recruited with lived experience and fundraising skills if possible.
- The charity had been successful in winning a £55k bid which would be used to fund Mental Health First Aid (MHFA) training around the Springfield community.
- The Committee had agreed the re-appointment of the current independent examiner. This decision had also gone to Audit Committee for scrutiny.

Discussed:
JuA welcomed the grant for MHFA training. The CEO from MHFA training was at the Springfield Street Party.

The Board:

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

23/53 Questions from the public and staff

The Board had received two questions from the public and staff:

1) *The report from QSAC and the Quality and Performance Report for May both refer to the 6-month pause introduced from this month in the treatment pathway for Adult ADHD. This is clearly a matter of potential concern to the local communities affected. The Executive Summary of the QPR includes the statement: "we are liaising with ICS partners to issue communications and ensure safe processes to manage the pause". I would like to ask where such communications and information for the public about the processes in place are to be found and whether the Board is satisfied with the public information issued.*
From: Martin Haddon (on behalf of Healthwatch Wandsworth)

Mr Haddon was in attendance at the Board and confirmed to the Chair that his question had been answered within item 23/45 – QSAC Chair's Report. However he asked a follow up question, which was how would he have known about the adjustment to the position if he had not attended the Board today. VF responded that the GP communications are very clear, and there was a patient information leaflet and information on the trust's website (on the Adult ADHD pages). Mr Haddon raised that there had been no mention of the change in the recent stakeholder bulletin. It was confirmed that for the last bulletin the trust had still been working through how the adjustments would work, with ICS and GP colleagues, and so had not wanted to send out any incorrect information at that point. It was confirmed that information would be included in the next stakeholder bulletin.

2) *As the Trust is now progressing with working closely with SLP, ICS and ICB, can there be more openness and transparency with any pending changes? We are going through The Community Transformation Programme. What is the next imminent change that the staff should be aware of?*
From: Suresh Desai, Staff Side Chair/Unison Branch Secretary

The SWL Mental Health strategy had been approved by the Integrated Care Board in May. It did not define specific changes for services or staff, but was a clear direction of travel, and AS and the Strategy Team would be working through changes with partners this year. There were no other particular changes pending that would have an impact

Item	Action

on staff. If any arose these would be taken through the JCC and staff side would also be informed and involved. The trust were open and honest and had committed to include staff in any consultation.

23/54 Meeting review

The Board reflected that

- the patient story had been very moving and impactful.
- there had been limited discussion around anti-racism; although Health Inequalities were discussed. At the next Board the WRES and WDES data would have been published and received by People Committee and these reports may allow better exploration of anti-racism issues.
- that the Board had been better focused on the agreed priorities during today's meeting. It was valuable to remain focused on building stable foundations rather than iteratively adding new priorities.

23/55 Next public Board – 1.30pm, 14th September, Conference Room B, Trinity Building, Springfield.

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

ACTION TRACKER – for September 2023 Board

BOARD OF DIRECTORS (Part A)

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
DUE						
11/05/2023	23/40	**FPC chair's report**	Board Committees were encouraged to consider 2023/24 investment priorities, on advice from the executive, within the context of current financial performance.	**VK, DBo, RF, JuA, SA**	~~**13/07/2023**~~ **14/09/2023**	July update: The corporate objectives had set clear priorities for the organisation and the Executive would bring a report back to the Board in September with recommendations for investments. September update: Process and templates are in place. First cut suggestions have been reviewed and second cut proposals are expected mid-September, with the aim to take a paper through September FPC.
NOT 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**	September update: Government response to the recommendations of the Rapid review into data on inpatient mental health settings awaited. Report to follow after these recommendations are published.

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

ACTION TRACKER – for September 2023 Board

BOARD OF DIRECTORS (Part A)

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
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**	July update: 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			
14/07/2022	22/72	**Diversity in Decision Making**	To establish an Executive Advisory Group to develop greater diversity in decision making, to be led by the Chief Executive over the next six months.	**VF**	**11/05/2023**	Completed. Action to be closed.
09/03/2023	23/20	**Patient story**	Peer support workers – to report back on recurrent funding.	**SS**	~~**11/05/2023**~~ **13/07/2023**	An update would be going to ELT and would come to September Board. September update: we have managed to extend the current HEE funding for our 8 WTE Peer support posts (which are covered by 34 part-time trained people) until 2024. The Head of Therapy is working with the Service Lines through their workforce plans to embed peer support worker posts into the workforce. Action to be closed.

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

ACTION TRACKER – for September 2023 Board

BOARD OF DIRECTORS (Part A)

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
09/03/2023	23/29	**Quality and performance report**	ADHD and ASD waiting lists. Report to go to QSAC with further detail and proposals.	**JeA**	~~**11/05/2023**~~ **13/07/2023**	Considered by May QSAC. On agenda for July Board. Action to be closed.
09/03/2023	23/32	**EDC chair's report**	BSL interpreters – collective grievance. To be resolved by the end of March 2023. Report to go to People Committee.	**KR**	~~**11/05/2023**~~ **13/07/2023**	The collective grievance had been closed. SS and KR were meeting with the parties in a month's time to follow up and would report back through People Committee. The Board agreed this action could now be de-escalated to the People Committee's action plan and be reported back to the Board in the Chair's report. Action to be closed.
12/01/2023	23/6	**Action Tracker**	The new People Committee structure will support the Staff Network chairs going forward. It is anticipated that the Equality Engagement Champions will support the Staff Network chairs. People Committee to seek clarification on this and to report back to a future board.	**KR/People Committee**	**13/07/2023**	Completed.

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

ACTION TRACKER – for September 2023 Board

BOARD OF DIRECTORS (Part A)

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
11/05/2023	23/43	**Audit committee chair's report**	RF drew attention to the findings of the internal audits around clinical audit and location visits, which had both returned partial assurance. Action plans are in place and will be reported to QSAC.	**SS**	**13/07/2023**	This action had been referred to QSAC. Action to be closed.

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

3.1

Meeting:	Trust Board – Part A
Date of meeting:	2023
Report title:	Chair's Report
Author:	Ann Beasley, Trust Chair
Purpose:	For report

Murders and attempted murders at Countess of Chester Hospital

Details of the Trust's response are set out in the Chief Executive's report elsewhere on this agenda. In this report I want to acknowledge that many of the Trust's patients and staff will have been hugely affected by this. My heart goes out to the families - I cannot imagine their pain and anguish.

Mental health law reform

The Board will be aware of media reports that mental health law reform will not be progressed during this parliament. The most recent ministerial statement on the matter, in July 2023, indicated that an announcement would be made 'after the summer recess.' Further information is awaited.

New NED and Associate NED

I am delighted to welcome Jonathan Warren and Humaira Ashraf to their first Board meeting. Their terms of office formally commenced on 1st September 2023

Jonathan Warren has been appointed by NHS England as a non-executive director.

Jonathan is an experienced senior manager and nurse with over 40 years' experience in a variety of healthcare settings up to and including Chief Executive Officer. He is currently a member of the review team undertaking the inquiry into the Edenfield Unit in Manchester. Since retiring in 2021 he has continued as a faculty member for the IHI teaching on various Quality Improvement programmes in trusts . He has worked with both City University and Surrey University as an Honorary Professor both supporting their MH research teams, and direct teaching of undergraduate and post graduate students. He was Chief Executive at Norfolk and Suffolk NHS Foundation Trust from 2019 to 2021; Deputy Chief Executive/Chief Nurse at Surrey and Borders NHS Foundation Trust 2017 – 2019 and Deputy CEO/Chief Nurse/Head of Nursing at East London NHS Foundation Trust from 2007 to 2017.

NHS
South West London and St George's Mental Health

Humaira Ashraf has been appointed by the Trust as an associate non-executive director.

Humaira's track record includes the successful introduction and implementation of a range of strategic workforce development and culture change programmes for a variety of NHS organisations, including NHS England. She has recent experience of working at Board level at St George's University Hospital NHS Foundation Trust, where she was acting Chief People Officer and also Director of Education, Culture and Organisational Development. Her experience includes serving as Deputy Director of Organisational Development for NHS England and spells at South London CSU, NHS London, Alliance & Leicester, BT and the London Ambulance Service.

Board activity

The July Board part B discussions covered areas including the SW London mental health strategy, SLP, the BAF, risk appetite and committee chairs' reports. The monthly Board visits programme is proceeding with valuable opportunities for Directors to hear regularly and directly from the frontline.

Following the appointment of Jonathan and Humaira I am consulting on revised committee membership and will present recommendations at the meeting.

RECOMMENDATIONS

The Board is asked to

1) note this report
2) agree the tabled new committee membership list.

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

Chief Executive's Board report Part A

September 2023

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Making Life Better Together

Contents: Part A

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

Making Life Better Together

Our Trust

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

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

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

- Chief Executive Update - 1 September
- Chief Executive Update - 25 August 25 Aug 23
- Chief Executive Update - 11 August 11 Aug 23
- Chief Executive Update - 04 August 04 Aug 23
- Chief Executive Update - 28 July 28 Jul 23
- Chief Executive Update - 21 July 21 Jul 23
- Chief Executive Update - 14 July 14 Jul 23
- Chief Executive Update - 7 July 07 Jul 23

Making Life Better Together

Context

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

National/Regional

Local system

- Continued industrial action
- Countess of Chester response
- Heightened media
- SWL ICS restructure
- Financial recovery
- Right Care, Right Person

We must balance these elements

Integrated Programme / Better Communities

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Making Life Better Together

Responding to: Countess of Chester

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

- It's important to start by saying that our thoughts are with the families and friends of those who have been impacted by this tragic case.
- There is important learning for everyone in the NHS – the case highlights that while process actions and governance are important, relationships are essential. It also emphasizes the need to continue our focus on Psychological Safety and speaking out.
- Following the outcome of the trial of Lucy Letby, NHS England published a letter asking leaders and Boards to urgently ensure that:
  - All staff have easy access to information on how to speak up.
  - Relevant departments, such as Human Resources, and Freedom to Speak Up (FTSU) Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
  - Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
  - Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
  - Boards are regularly reporting, reviewing and acting upon available data.
- The letter also reminded organisations of their obligations under the Fit and Proper Person Test (FPPT) requirements.

- **The Executive Leadership Team has received a report detailing assurance currently in place in the Trust around FTSU and FPPT arrangements, which is appended alongside a letter from the FTSU guardian.**

Making Life Better Together

Responding to: Countess of Chester

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

- Subsequent to the initial government response there have been some further developments:
  - The status of the inquiry has been changed, to become a statutory inquiry, led by lady Justice Thirlwall, Senior Presiding Judge for England and Wales
  - Medical Examiners are to be moved onto a statutory basis from April 2024. This will ensure deaths not reviewed by a coroner are investigated in all medical settings.
  - Recommendation 5 of the Kark review of FPPT – on disbarring senior managers – are to be revisited by NHS England, alongside the actions recommended by the Messenger review of leadership
  - By January 2024 all trusts will have to adopt a strengthened Freedom to Speak up Policy. The forthcoming national model policy will bring consistency to freedom to speak up across organisations providing NHS services
  - NHS England will review the guidance that permits Board Members to be Freedom to Speak Up Guardians.
  - The government are exploring introducing Martha's Rule to the UK. This would be similar to Queensland's system, called Ryan's Rule. It is a three-step process that allows patients or their families to request a clinical review of their case from a doctor or nurse if their condition is deteriorating or not improving as expected.
  - The Secretary of State also announced that the statutory inquiry into NHS mental health inpatient facilities across Essex will be chaired by Baroness Lampard, who led the Department of Health's inquiry into the crimes of Jimmy Saville

Making Life Better Together

Responding to: Industrial action

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

- NHS industrial action continues amongst Junior Doctors and Consultants, and we will see the first joint industrial action by both groups together, in September
- Our response to the industrial action so far has been well managed. We have maintained services and have experienced no serious incidents thanks to the hard work and flexibility of our teams and their commitment to providing safe care to our patients, despite the current flow challenges. We recognize that people are having to wait longer for non-emergency care and understand the impact of that. We are working with our partners across South West London to develop a clear response.
- Our messaging has focused on the importance of multi disciplinary team working, patient physical health, and everyone's contribution to getting timely care to our patients in mental health crisis, while ensuring that patients who are ready for step down, don't experience delays leaving our wards.
- We understand that this is a challenging time for our staff, patients and community, and for some a time of strong emotions. Many of us are feeling the pressure on our local health and care system as well as that from other types of industrial action, against the backdrop of the cost of living crisis. We encourage members of staff to take advantage of the health and wellbeing support offered to all staff at the Trust

Making Life Better Together

Responding to: Right Care Right Person

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

- In July we received a communication from the Met Police which outlined their aim to reduce frontline policing hours spent looking after people who would be more appropriately supported by health or other professionals.
- In South West London we have existing strong relationship between mental health, local police, acute providers and social care.
- To support this, we coordinated a round table event at the end of July to discuss 'Right Care, Right Person' alongside the recently agreed London Crisis Concordat
- To ensure a coordinated and focussed response to support people in mental health crisis, we have supported the development of a South West London action plan, following the Round Table The action plan focussed on three workstreams:
  - **Workstream 1:** Partnership Working
  - **Workstream 2:** Supporting people in mental health crisis/reducing attendances at EDs (including prevention and early intervention and alternative to ED)
  - **Workstream 3:** Improving Flow Mental Health Inpatient Beds (including reducing delayed discharges, increasing inpatient capacity and implementing mental health transformation) (see further detail in slide 11).
- The delivery of these actions will be monitored through the South West London Mental Health Partnership Delivery Group (PDG).

Making Life Better Together

Two top priorities

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

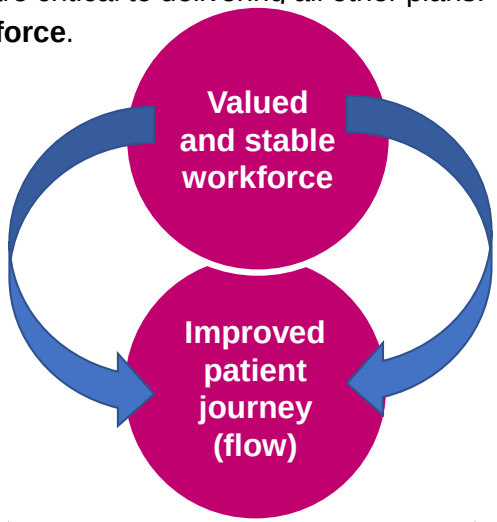
In 2023/24 we have identified two **'top priorities'** which are critical to delivering all other plans. These are: (1) **improved patient journey** through our services and (2) **creating a valued and stable workforce**.

Areas of work

Transformation
- Discharge challenge
- Complex emotional needs pathway
- Community enhanced response and interface teams
- Organisational development (MLBT)

Digital
- Clinical systems development

People
- Recruitment
- Retention
- Learning & development support



Measured by

Transformation
- Out of area placements
- Length of stay
- A&E presentations and admissions of known patients

Digital
- Productivity measure

People
- Vacancy rate
- Turnover rate (overall and within 12 months)
- Agency levels

Improved quality (and sustained CQC good)

Delivering improved journey and valuing and stabilising our workforce will deliver:

Financial sustainability and the EMP business case

Respectful Open Collaborative Compassionate Consistent

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Making Life Better Together

Two top priorities and annual delivery plans

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

Increasing Quality Years

To empower service users & carers to ensure their experience informs quality improvements in practice & services. We will do this by:

- Improving the patient journey through our services.
- Care planning.
- Safety planning.

Valued and stable workforce

To support our people to grow & develop our organisation to be the best we can be. We will do this by:

- Creating a valued & stable workforce
  Getting the HR basics right
  Focus on recruitment & retention
- Leadership, learning & development.

Great Place to Work

Reducing Inequalities

To increase inclusivity & improve equality and diversity becoming an organisation which values all contributions, voices & experiences. We will do this by:

- Reducing Health Inequalities
- Active Anti-Racism
- Implementing Patient & Carer Race Equality Framewor
- Supporting Ethnicity & Mental Health Improvement Project

Improved patient journey (flow)

To continue to work towards financial sustainability supporting best value & efficiency in health & care. We will do this by:

- Reducing agency & external bed use
  Improving clinical & corporate efficiency

Ensuring Sustainability

Better Communities: transforming our care and environments will help us to achieve our annual delivery plans and strategic ambitions. For example through: continuing our work to transform our environments (Shaftesbury, Barnes, Richmond Royal and Tolworth) and work on our discharge challenge, complex emotional needs pathway, community enhanced response and interface teams and organisational development

Partnerships: by working in partnership and acting as a system leader we will drive strategic improvements to mental health of our South West London communities. Our focus is on mental health provider collaborative development and the delivery of our South West London Mental Health Strategy

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Making Life Better Together

Valued and stable workforce

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

	Issue	Our aim	Organisational actions
Valued and stable workforce	We know that members of staff who are happy at work, provide better quality of care for our teams. Staff who feel valued and invested in, stay longer, reducing turnover, vacancies and our reliance on Bank and Agency staff. Our reliance on Agency staff impacts on our quality of care and is also very costly. **Vacancy rate:** 18.6% vs 15% end of year tolerance **Turnover rate:** 15.9 vs 15% end of year tolerance **Sickness rates**: 4% vs 3.5% for London MH trusts **Agency rate:** 5.6% vs 3.6% end of year tolerance	For our staff to have the resources they need to do a good job and recommend us as a place to work. For our organisation to be inclusive and actively anti-racist. For our leaders to have the confidence and ability to support and develop their teams and themselves. For everyone to be better supported to develop their career with us	• **New organisational development Framework:** will launch in October and will include an analysis of our culture, a diagnostic tool and associated interventions for leaders • **Development of a Leadership Development Offer:** which will launch in the autumn and will offer leaders the opportunity to feed in. Initial work on employment support for managers and a new middle leader development programme has already started. • **Recruitment:** our recruitment pipeline remains strong with over 330 new staff in our pipeline. Our turnover has started to slow, but turnover under 12 months has increased. Work is being done to respond to this, focussing on colleagues under 30 who have started in the last 12 months. • **New Bank recruitment campaign:** encouraging people from all backgrounds to join our Trust Bank • **New cohort of junior clinicians:** welcomed and inducted a new cohort of student nurses and junior doctors • **Health and wellbeing:** Further development of health and wellbeing support, including psychological safety in teams, speaking up, bereavement and grief support, ULEZ advice and post incident support • **Induction and anti racism** on slide 15

Respectful Open Collaborative Compassionate Consistent

Making Life Better Together

Improved patient journey (flow)

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

	Issue	Our aim	Organisational actions
Improved patient journey (flow)	Receiving mental health care in the wrong place can lead to poor quality outcomes and increase the risk of suicide or serious incidents. Unless someone needs to be in hospital, patients are more likely to recover, quicker in the community. Patients receiving care in the wrong place often report negative experiences and it is also very costly. **Length of stay:** 46 days vs 38 day end of year tolerance **Presenting in crisis:** 1.3% vs 1.1% end of year tolerance	To work collaboratively across services and teams to support people to receive the best care possible, in the right place. While improving access and addressing health inequalities. Wherever possible this means care at home, or in the community, not in restrictive mental health in-patient settings and not in in A&E or in out of area placements. To ensure best patient experience, safety and sustainability across our services.	• **Kingston & Richmond, and Sutton launched a new Enhanced Response Service (ESR).** The team of community Enhanced Response Practitioners and trainee advanced clinical mental health professionals provide telephone triage, assessment and brief domiciliary and walk-in interventions for patients experiencing acute mental distress in the community. • **New Protocol for working with clients who have Complex Emotional Needs (CEN) on our adult acute wards**. This will support focus on reducing crisis and empowering people to continue their recovery safely in the community. The new set of procedures combined with clinical skills training for all inpatient MDT staff will help us achieve our aim of dramatically reducing the length of time this group of service users spend on our wards to 5-7 days. • **New Perinatal Trauma and Loss Team (PTLT).** The team will support women, mothers and birthing people who are experiencing significant mental health difficulties brought on by birth or perinatal experience. This includes birth trauma, fear of childbirth (tokophobia) and all types and stages of perinatal loss. • **Right Care Right Person (Slide 8): Improving S136 and launching NHS 111:** Work with Psychiatric Liaison services and improving S136 pathways with London Ambulance and the Met Police, as well as developing NHS111, press 2 for mental health

Respectful Open Collaborative Compassionate Consistent 12

Making Life Better Together

Better communities

Transforming our care and environments

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

- **Better Communities** is our Transformation Programme (formerly the Integrated Programme or the Estates Modernisation Programme (EMP)
- Better Communities is about us transforming our care, our environments, reducing inequalities and stigma - to be the best we can be for our communities
- Following the opening of Trinity last year and Shaftesbury later this year, and the transformation of Sutton, Kingston and Richmond Community Services, Phase One of the Integrated Programme will have been completed
- Phase Two (Better Communities) will being in the autumn and will focus on the continued transformation of our Adult Community Services and Acute and Urgent Care Services alongside the redevelopment of Tolworth

Better Communities:
Transforming our care and environments

Better Care | **Better Environments**

Respectful Open Collaborative Compassionate Consistent

Making Life Better Together

Better communities

Transforming our care and environments

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

- **Shaftesbury**: Our three forensic wards are on track to move into Shaftesbury in October, and our new Intellectual Disabilities Ward (Oak Unit), will open at the same time. We have a months for training, induction and familiarization before we move in. Move packs and patient leaflets are with all of the teams to support their moves.
- **Trinity:** we have started to see early metrics, following our Trinity move. Early metrics show a reduction in serious incidents, incidents of violence and restrictive practice. While it is too early to say whether these improvements will be maintained, it is a really positive picture
- **Visits**: We continue to see visits to Trinity, over the last two months we have welcomed senior leadership from the CQC and Claire Murdoch, National Mental Health Lead
- **SWLSTG as an anchor:** We marked the opening of Springfield Village and the new park with a street party at Springfield in July. Work is continuing to make Trinity as accessible as possible to our community. As part of this we have welcomed Fircroft School, the local Bishop and Black Minds Matter Summer School into the building. We are planning to launch our first Mental Health First Aid training for our communities on World Mental Health Day in October
- **Tolworth:** We have received written confirmation from the Joint Investment Committee approving the Tolworth Business Case. The letter also confirmed that the Business Case received Ministerial approval. Early enabling works will begin soon
- **Outcomes:** We are currently compiling the evidence to support our self-assessment return at the end of October to NHS IMPACT, which support NHS organisations and systems to have the skills and techniques to deliver continuous improvement. This will be important in allowing us to make the most appropriate interventions that will have the most effective and sustainable improvements for patient outcomes and share best practice with others.

Making Life Better Together

Inclusion, EDI and anti racism

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

Executive Advisory Group: In September we are holding the third of our quarterly Executive Advisory Group to support diversity in our decision making. We have elected two Co-Chairs (Noel Brown and Ijeoma Ndubuisi pictured) the group is making a real difference to our decision making. Below you can see the topics discuss and impact.

Date	Agenda items	Impact
March	• Staff Survey results and response • Corporate Objectives	• Development of Line Managers as part of the Leadership Development Offer and the creation of an Organisational Development Framework • Simplification and renaming of the corporate objectives so they are aligned to delivery of Trust strategy
June	• Communicating Corporate Objectives • Organisational Development Framework	• Further simplification of the annual deliver plans, so that they make more sense and feel connected to front line • Inclusion of key themes in the Organisational Development Framework, including: Inclusion and anti-racism, importance of our leaders in change, silo working and getting the basics right.
Sept	• Trust and psychological safety in response to the Countess of Chester case • Organisational Development Framework	• Changing of the work 'flow' to patient journey • Promote 'Rewarding the Messenger" not "Shooting the Messenger"

- **Diversity in Decision Makers:** 10 people have signed up to be part of the new cohort of Diversity in Decision Making Representatives (largest cohort so far), and we are looking to extend these opportunities through our service lines
- **Action Learning Sets:** Over 40 people took part in the first Anti Racism Action Learning Sets. Over the coming months, the sets will offer more learning about our anti-racism work and priorities in a safe space and to support us to take forward this work

Making Life Better Together

Organisational Development

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

- The development of our Organisational Development Framework continues as part of a suite of interventions across our organisation
- The framework draws on data and intelligence and has had input from a number of groups across our organisation
- Next steps - ELT and board development session and leadership event in October
- The learning is already being used in our work on patient journey, with Community and AUC having specific OD interventions.

Organisational Development Framework (including change management)	Leadership Development Offer	Leadership Seminars	Transformation OD interventions	Core Leadership	Exec and Board Development
A whole Trust approach – to allow consistent use of OD interventions moving the Trust forward	Targeted development at Band 7 and above including assessment and commissioned projects	Quarterly development days for our top 100 influential, diverse leaders to discuss 'wicked issues' to learn, develop direction and network together	Focused OD interventions for those teams central to FBC delivery ie Community and AUC	Deputies and Clinical Directors to develop relationships that enable problem solving and cross department working around shared challenges	Coaching to support the most senior team to empower actions at the right level
October 2023	October 2023	18 July 2023 17 Oct 2023 30 Jan 2024 30 April 2024	Small test of change 2024	First challenge: creating space to do the work	23 June 2023 24 Nov 2023

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Making Life Better Together

Celebrating our people

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

- **Street parties:** Almost 2,000 members of staff, patients, carers and members of the local community came together to celebrate at our Making Life Better Together Summer Street Parties in July. The Making Life Better Together Programme is a Trust initiative aiming to increase engagement with and improve the experience of mental health care for patients, staff and the community.
- **Pride:** Following our presence at London Pride, we followed up with a stall at Black Pride in August and attendance at Trans Pride
- **We have seen a number of teams and individuals recognised locally and nationally:**
  - Congratulations to Shalini Ramguttee and our preceptorship programme who were each nominated for Nursing Times awards!
  - Congratulations to Dr Gary Wannan, a consultant in our Deaf inpatient unit for children and young people, who has won the British Medical Association's 2023 Fellowship Award
  - Congratulations to Hannah Pearce, Highly Specialist MBT Therapist and Supervisor in the Richmond Personality Disorder Intensive Treatment Team, who won Carer of the Year for Day and Community Services in the annual Dignity in Care Awards.
  - Congratulations to Heidi Phillips, Mira Lemke and Jayed Alom being selected as our latest winners of the Exceptional People Award

Suggested questions / points to have in mind

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

1. Do we have the right balance of focus on access, finance and quality, and understand the impact for our people?
2. How, as leaders, do we best ensure that we keep our messaging as clear and simple as possible (in a complex landscape). How do we hold firm on our two top priorities for 2023/24 and not allow mission creep?
3. Given the Board's responsibilities around culture leadership, are we clear that we are focussing our work in the right areas when addressing the critical themes of psychological safety, inclusion, patient safety and a speaking up culture.
4. Can we take further action to ensure that when concerns are raised, we engage and empower patients and staff more clearly – especially when communicating the reasons for our responses

Integrated Programme / Better Communities

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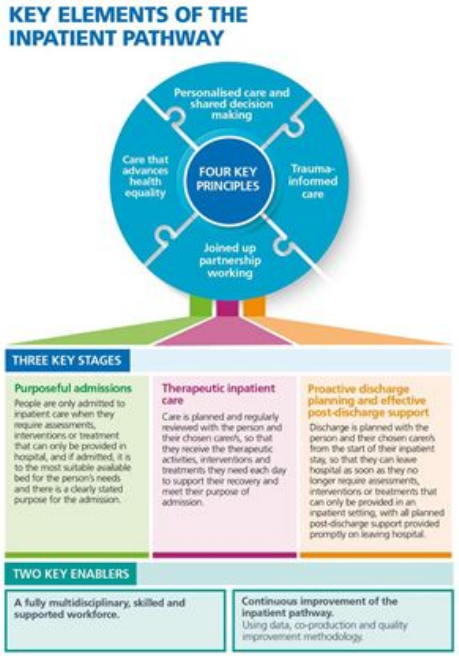
Making Life Better Together

Appendix 1: Horizon Scanning

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

- Progress in improving NHS mental health services – Public Accounts Committee
- NHS England » Acute inpatient mental health care for adults and older adults
- National Partnership Agreement: Right Care, Right Person (RCRP)
- NHS England Fit and Proper Person Test Framework for board members
- NHS enforcement guidance
- Major conditions strategy: case for change and government strategic framework
- Workforce Disability Equality Standard 2022 data analysis report for NHS trusts
- NHS sexual safety charter: **We are recommending to the Board that we sign up to this charter**



Making Life Better Together

Appendix 2: Use of Trust seal

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

Date	Type	Signatories
13/07/2023	Deed of Surrender Deed of Surrender of Substation Lease Harewood House Between SWLSTG and London Power Networks	Director of Finance and Director of Strategy and Transformation
13/07/2023	Land Transfer Land Transfer of land outside Trinity Building. Between SWLSTG and Springfield Village Estate Ltd.	Director of Finance and Director of Strategy and Transformation
13/07/2023	Tolworth Hospital Section 106 Agreement Tolworth Hospital Section 106 Agreement Between SWLSTG and Kingston Council	Director of Finance and Director of Strategy and Transformation

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

Trust Board – Part A 14 September 2023

Report Title:	Trust Strategy Review – Final report
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	ELT 7 September 2023

Purpose:	☒	Approval	☒	Discussion	☒	Information	☒	Assurance
Additional information:								

What?	The Trust Strategy was published following extensive engagement and development work in September 2018 and covers the period 2018-2023. Stretching strategic objectives were developed for the first two years of the Strategy to support implementation and achievement of outcomes. During Covid, Strategy delivery was effectively paused as the approach changed to focus on safe clinical delivery and staff health and wellbeing. Due to this, and a challenging external environment post-Covid, delivery of the Strategy is not yet complete. Recognising this, the Trust Board has agreed to extend the life of the Strategy. To support our work going forward, we have reviewed delivery of the Strategy to date, focusing on progress towards achieving key outcomes and delivery of core programmes defined in 2018. The Trust Board received a midpoint paper – a progress update – on this work in July 2023 which outlined data against a subset of key metrics and stakeholder reflections. Over the summer period the review work has been completed. This paper provides completed data analysis across five years on all key metrics, a summary of stakeholder reflections and a summary of delivery against programmes. Much has been delivered since 2018, including the opening of our new Trinity building and Springfield Village and strengthening our co-production and involvement work, while key service improvements have been delivered through our Clinical Transformation and QII programmes. We have also seen notable improvements in support for physical health assessments, in our workforce diversity (ethnicity and disability), including those from a BAME background in leadership and medical roles and an increased financial turnover. However, on reflection across the entirety of our ambitions, most areas are still 'in progress,' and some challenges exist, including those that are outside the Trust's control. Overall, delivery appears consistent with mid-way through a five-year strategy, in line with the hypothesis that between two and two-and-a-half

	years of delivery were lost to the pandemic and the challenging post-Covid environment. The paper outlines recommendations for the Board in terms of strengthening focus on Strategy delivery. ELT received and discussed this paper on 7 September 2023 and agreed onward submission to Board. They: • Requested additional external context, • Amended and agreed the assessment of delivery, and • Debated the length of time for extension, requesting a decision be made by Board
So What?	The Trust Strategy is a key document for the organisation – defining our ambitions, setting direction of travel and outlining key programmes and approaches to delivery. Post-Covid the health and care landscape is much altered and we needed to ensure that the ambitions and core areas of work defined before the pandemic are still relevant. The Trust has had significant challenges post-pandemic, including its HR recovery programme, and external factors, such as the national NHS workforce challenges, rising demand and cost-of-living crisis that have clearly impacted on our delivery. This work provides assurance that our four strategic ambitions, outcomes and enabling programmes remain appropriate to drive forward our delivery through our aligned annual delivery plans and top priorities. The changes to the external landscape present opportunities for us to work with partners more closely to deliver positive change.
What Next?	Board is asked to: • Note the work completed on the Strategy review and consider the information within this paper, • Advise on the length of time for extension, between two-four years, and • Support the recommendation in section 5
Any specific issues to note and/or for escalation:	N/A

Strategic ambitions this paper supports			
	☒	Increasing quality years	This paper supports all of our strategic ambitions as it describes work to review and refresh our Strategy and those ambitions.
	☒	Reducing inequalities	
	☒	Making the Trust a great place to work	
	☒	Ensuring sustainability	

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

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.
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
Reputation:	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 Eg. 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):	N/A
Appendices/ Attachments:	None

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

Trust Strategy Review – Final Report

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

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.

1.2. 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.

1.3. To consider where best to focus our efforts and how long to extend the Strategy for, the Trust Board commissioned a review of delivery of the Strategy, which began in March 2023. Our review has 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

1.4. In July 2023, the Board received a midpoint update that set out the initial data analysis, carried out in May and June 2023, and qualitative stakeholder feedback obtained through a series of reflective sessions in June 2023.

1.5. The report highlighted the impact of Covid and that we had seen notable improvements, primarily related to quality, but that performance against many of our operational KPIs had deteriorated. It also set out a summary of discussions with stakeholders who, mostly, view the Trust very positively. They feel we are improving in the way we deliver care, but they also highlighted ideas and areas they would wish us to focus on in the future. The Board noted the work to date and confirmed the direction of travel for the remainder of the work.

1.6. This paper acts as the final report and includes recommendations for Board.

2. Expected outcomes, structures and processes and core programmes

2.1. In order to measure delivery of the Trust Strategy, expected outcomes, structures and processes were defined for each of the four strategic ambitions were defined in the first year of delivery of the Trust Strategy. The aim was for these to all be achieved by the end of 2023/4. 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

2.2. 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

3. Delivery to date

3.1. The delivery of the Trust Strategy to date has been considered using quantitative data (standardised metrics related to the outcomes outlined above), feedback from stakeholders and an assessment of the five core enabling programmes of work. The findings are presented below.

3.2. Data analysis

Two phases of data analysis have been completed with the July 2023 Board paper setting out most of our clinical indicators and some of our workforce indicators. Over the summer, further analysis has been completed on:

a. Baseline 2018/19 data
b. CYP self-harm
c. Impact of delivery on BAME/protected characteristics – reducing inpatient admissions and increasing referrals to Talking Therapies
d. Impact on staff: Staff Survey results, Friends & Family Test – Staff element and National Pulse Quarterly Survey, gender pay gap, diversity of our workforce
e. Financial analysis

The final data set presented below comprises all available data.

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

KPI Description[1]	2018/19	2019/20	2020/21	2021/22	2022/23
Increasing Quality Years					
Death - Suspected suicide[2]	22	25	22	44	44
Significant Incidents (STEIS) formally known as Serious Incidents	74	88	103	121	80
CYP self-harm (% of all referrals) [3]	1.21	6.29	12.53	14.53	8.94
CYP self-harm (% of referrals that accessed a service)	4.41	13.22	24.39	26.23	13.89
Adult Acute monthly average LoS (excl. other ward types)	33.12	37.6	37.25	40.96	47.71
Delayed transfers of care (%)	2.31	1.88	3.34	4.64	8.11
Discharges From the Trust	77753	75651	37617	48109	72426
Cardiometabolic Assessments (%) [4]	-	75.83	83.76	84.45	85.14
Inappropriate out of area placement bed days - Adult Acute & PICU	1486	2850	157	2318	2566
Physical Health Assessment attempted within 48 hours of admission (%)	91.97	92.84	92.77	96.51	94.59
Physical Health Assessment completed within 7 days of admission (%)	79.38	79.53	75.15	78.6	82.95
Patient Friends and Family Test (%)	69.83	81.74	81.83	81.74	82.9
Reducing Inequalities					
Talking Therapies recovery rate (%)	-	51.52	55.11	52.92	51.59
Talking Therapies: The proportion of BAME people who are moving to recovery (%)	45.19	47.87	51.88	48.26	47.82
Settled Accommodation (On CPA 18-69 yrs only) (%)	80.62	83.01	81.42	82.37	75.95
Employed (On CPA 18-69 yrs only) (%)	11.71	12.33	11.57	10.42	11.48
Inpatient admissions, adult acute (% BAME) [5]	37.9	41.4	39.4	40.6	39.9

[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 BAME population in the five boroughs served by the Trust is 31.3%. The data provided is the % of admissions from people from BAME backgrounds and can be compared to the overall population percentage.

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

KPI Description[1]	2018/19	2019/20	2020/21	2021/22	2022/23
Talking Therapies referrals accepted (% BAME) [6]	23.8	27.9	27.6	31.6	32.2
Making the Trust a great place to work					
Turnover Rate (%)	16.01	16.1	14.12	15.42	18.03
Vacancy Rate (%)	15.79	16.63	16.56	20.09	18.99
Sickness rate (%) (reported month in arrears)	3.84	4.26	4.08	4.8	4.89
Workforce diversity - BAME (%)	47.8	48.5	50	50.2	50.3
Workforce diversity - disability (%)	8.4	8.4	8.6	8.9	8.8
BAME staff - Band 8+ and Medical (%)	25.39	25.58	26.6	27.19	30.7
Agency spend as % to NHI target	88.36	104.63	113.88	128	124.84
Staff Survey - Care of patients / service users is my organisation's top priority (%) [7]	72.2	76.5	79.9	77.8	77
Staff Survey - My organisation acts on concerns raised by patients/service users (%)	71.6	71.7	76.2	73.8	73.7
Staff Survey - I would recommend my organisation as a place to work (%)	56.7	58.1	63.9	60	58.2
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
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
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

[6] The 2021 census indicates that the BAME population in the five boroughs served by the Trust is 31.3%. The data provided is the % of referrals accepted from people from BAME 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 2018-2023 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.

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

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

[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 2022/23 is not yet available.

As can be seen from the data above delivery is mixed. Notable improvements include around cardiometabolic assessments physical health assessments, the patient Friends and Family Test (FFT), workforce diversity (ethnicity and disability), workforce from non-white ethnic backgrounds in leadership and medical roles, staff experiencing discrimination and financial turnover. Areas where performance has declined include suspected suicides, acute adult length of stay, delayed transfers of care and out of area placements. Many indicators present a mixed picture without a clear trajectory, which probably reflects as much around the impact of the Covid-19 pandemic as the work still yet to do.

3.3. Stakeholder reflections

As outlined in the midpoint report, we held five Strategy Reflective Sessions in June 2023 – both face-to-face and virtual. From the responses, most people felt the Trust had improved since 2018. There was a general acceptance, or understanding, that demand had gone up due to the pandemic and that some issues and challenges such as long waiting times were linked to this, rather than to the Trust's delivery of the strategy or general performance. There was also consensus that our ambitions were still the right ones and created a clear vision.

Participants highlighted areas which require continued improvement including support for children and young people and working more collaboratively with communities, as well as support for people with neurodiversity, especially children and young people.

Our work on inequalities, specifically anti-racism, and our adoption of digital support during the pandemic, and the prospect of going further, were both welcomed. In continuing this work, we were encouraged to look at wider inequalities, such as gender, sexuality and age and reminded that not everyone has technical skills or access to the internet or devices to access support in this way.

Finally, with the changes to the NHS and external environment, people were as interested in 'how' we were going to deliver as much as 'what' we were going to deliver. People want to know how different elements will fit together with the new integrated care system (ICS) and Place structures. This is especially of interest in light of the new SWL Mental Health Strategy and its focus on early intervention and prevention, which was also highlighted as an important focus area. It was clear from the session that there is an opportunity to work in partnership with the system to deliver our strategic ambitions and people will welcome clarity on how we will do this without duplicating work.

3.4. Programme delivery

We have considered 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. The QI approach continues to be valued and promoted within the NHS and our QII team link to external partners and aim to continuously improve on how we develop and embed a QII culture within the Trust. 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 ICB groups – People and Communities Engagement Group. Through our transformation programmes we have increased peer support roles most notably in our community adult services.
c. **Collaboration and partnership working** is now critical. The NHS has a duty to collaborate under the Health and Care Act 2022 and the implementation of ICSs. The Trust has proactively stepped forward into a leadership role locally in setting up, with wider partners, the SWL Mental Health Partnership Delivery Group and the development of the SWL Mental Health Strategy. We participate in Place structures for all the boroughs we serve. We have extended our work with VCSE partners and continue to support the EMHIP programme which is extending outside of Wandsworth. We continue to collaboratively lead the South London Mental Health and Community Partnership (SLP) with colleagues from South London and the Maudsley NHS Foundation Trust and Oxleas Foundation Trust.
d. The **Estate Modernisation Programme (EMP)** Phase 1 has almost completed with the momentous development of brand-new hospital buildings: a successful move into Trinity in 2022, as well as Springfield Village and a new public park. Our move to Shaftesbury is scheduled for autumn 2023 and work continues to progress around community estates developments at, for example, Barnes and Richmond Royal. Planning and preparation for Phase 2, involving the development of Tolworth, continues to move forward and a revised structure for this work and critical elements of transformation has been agreed.
e. **Transformation** programme activities have had a high profile since the inception of the Integrated Programme in autumn 2019. Significant transformation plans are in place for all clinical service lines, including the substantial multi-year community transformation programme for adults with serious mental illness, and a major digital transformation agenda. Transformational work is also supported via business planning processes, cost improvement programme (CIP) and efficiency work – looking at activity delivered and operational processes and workflows. Workforce developments have also moved forward in terms of the development of new roles, most notably within our community transformation programme with an extensively expanded peer support offer.

These enabling five enabling programmes remain relevant and central to supporting the Trust to deliver against its ambitions and outcomes.

4. Assessment of achievement and work still to do

4.1. Reflecting back to the outcomes, structures and processes outlined in section 2, our assessment is that many elements are underway with progress being made as can be seen from the table below:

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

	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	• 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	• Reduction in inpatient admissions for people from BAME groups • 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	• 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 • 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	• 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

		• Co-production and involvement strategy, plan and processes • Expert panels in place	• 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 serious incidents occur ○ Fewer children and young people self harm • Increase in positive feedback from service users and carers • 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	• Improvement in staff retention • Increase in vacant posts filled • Reduction in sickness absence • Improvement in staff element of Friends and family Test results • Succession planning underway	• Standardisation of clinical delivery across services • Outstanding rated organisation

4.2. For **Increasing Quality Years**, we have seen some improvement around measures to provide care in the least restrictive setting, including the reduced use of restraint. We have also improved how we support the physical health of our service users and, generally, our feedback from service users and carers has remained relatively steady. Areas for continued focus under this ambition include reducing deaths by suicide and self-harm in children and young people, though it is noted that the pandemic and cost of living crisis have impacted adversely on people's wellbeing and, thus, also the rise in such incidents. The Trust has strong mortality governance reporting overseen through appropriate structures. Our rate of serious incidents went up during the pandemic but has now settled back to pre-pandemic levels, but this represents an overall increase rather than the intended decrease, so further work is needed here.

4.3. For **Reducing Inequalities**, the Trust has made strides to embed anti-racism and address health inequalities into its culture significantly since 2018/19 but we continue to see more people from non-white backgrounds in our inpatient beds than we would expect based on our population. We have seen improvements in people from non-white backgrounds accessing support for mild to moderate conditions through our Talking Therapies services which is positive, but for those that do access these services, they do not experience the same level of recovery as those from a white ethnicity. We have positive work in our Health Inequalities and Equality, Diversity and Inclusion programme that needs embedding. We have also not seen an improvement in the numbers of individuals in settled accommodation and employment. The move away from the Care Programme Approach to more holistic care planning, and the move away from these metrics, offers an opportunity to assess how we measure these patient outcomes through the introduction of DIALOG+.

4.4. For **Making the Trust a Great Place to Work**, improvements to the organisation as an employer remain a high priority. We have not yet seen improvement in key areas such as retention, sickness absence and vacancies but, of course, this must be viewed in the context of the NHS's workforce challenges and the Trust's HR recovery, which is an ongoing programme of work and where we are seeing green shoots of improvement. Where we have seen improvements is in our workforce diversity and an increase in the numbers of colleagues from non-white backgrounds in leadership positions, but we still do not fully represent some of the populations we serve and there are still reports of discrimination based on ethnicity being reported. We need to do more work to ensure that our people are satisfied in all areas.

4.5. For **Ensuring Sustainability**, the Trust has grown substantially since 2018/19 and has delivered financial annual commitments over the five-year period. Maintaining this position is critical and also highly challenging in 2023/24 with expected levels of cost improvement and efficiency. We achieved a momentous milestone in 2022/23 when we opened the new Trinity building on the Springfield site and work is ongoing to deliver the full Estate Modernisation Programme. We have delivered transformation in our community services for almost three of our five boroughs, through a major national investment and we have transformation and improvement work in place across all our service lines and around areas of corporate process. We are rated 'Good' by the CQC and are still striving to be 'Outstanding'.

4.6. Our focus for the next 2 years should be to continue to work to deliver the key outcomes defined – all of which remain relevant to our mission of 'Making Life Better Together'.

5. Conclusions and recommendations

5.1. This review has allowed us to reflect on the delivery of our Trust Strategy, elements of success and challenge and how we have been impacted by the Covid pandemic. We have made progress in all areas but there remains more work to do.

5.2. Our strategic ambitions remain relevant as do the outcomes, structures and processes defined to measure success. Progress has been made in all areas and we now need to continue to build delivery of the Strategy into our annual planning and setting priorities. We also need to recognise that with the launch of the new SWL Mental Health Strategy, we have greater opportunities to deliver change collaboratively with system partners.

5.3. We recommend that:

- The Board advise on the length of time the Trust Strategy is extended: between two-four additional years for delivery.
- No formal refresh is undertaken but a focus is given to raising the visibility of the Strategy across the Trust (including though communications with Teams and Services) and ensuring the Strategy clearly links to existing areas of work.
- Annual planning and the development of annual delivery plans for 2024/25 during Q3 2023/24 will take renewed account of the outcomes, structures and processes defined as measures of success.
- We assess delivery approaches for key indicators and step up collaborative working with system partners to affect change in areas related to Reducing Inequalities and Increasing Quality Years.
- Annual monitoring of outcomes, structure and processes is implemented with an annual report to the Trust Board July session.

Meeting:	Trust Board
Date of meeting:	14th September 2023
Transparency:	Public
Committee Name	Quality and Safety Assurance Committee (QSAC)
Committee Chair and Executive Report	Deborah Bowman and Sharon Spain

BAF and Corporate Objective for which the Committee is accountable:

QSAC has responsibility for the following BAF risks:

- A failure to effectively respond to equality and diversity issues facing the Trust; and
- 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; and
- Objective 3: To increase our inclusivity and improve equality and diversity, becoming an organisation which values all contributions, voices and experiences.

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

1.1. The challenge of providing quality care in a context of demand, pressure (including financial, productivity and efficiency expectations) and constrained resource inevitably raises questions for QSAC and Board. QSAC takes as its starting point, that SWLSTG does not tolerate risks to patient safety. Beyond that foundational premise, there are judgements and choices to be made about clinical care. QSAC and Board are charged with providing strategic direction and, if appropriate, support for the Trust as it considers how to make those judgements and choices in a context of challenge.

1.2. At the September QSAC meeting (which is not covered formally by this report but will be included in the November Board report), the committee had early sight of some clinically-led work on expectations and the provision of care. QSAC continues to encourage patient involvement and co-production, as well as systemic and stakeholder engagement as these proposals develop.

1.3. QSAC seeks to work effectively with other committees, mostly via the Chairs, to ensure that there is a holistic view on our challenges, interdependencies and the intersections of responsibilities. For example, Board will recall that QSAC was review observation practice with attention to patient safety, following a discussion about agency spend at FPC. A report was scheduled for the September QSAC but it has been deferred until October. Following the recent People committee discussion of the appreciative inquiry, QSAC has amended the new quality and safetly BAF risk (see below) to acknowledge the importance of leadership and culture for quality care. Board may wish to consider whether there are other areas in which it wishes to encourage cross-committee attention. .

2. Areas of Risk Escalation to the Board:

2.1. After reviewing the Quality and Performance (Q&P) report, QSAC wishes to highlight issues of timeliness in relation to delivering the AUC transformation plan. The latter is ambitious and has to be managed alongside day-to-day workloads and pressures. The report suggests difficulties: there is limited evidence of progress in some areas and slow or delayed progress in others. Sustained improvement also seems challenging notiwtstanding the best efforts of staff. QSAC also heard important feedback from patient and service user attendees about their perception of the limited impact oftransformation thus far, questions about transparency and the apparent pace of meaningful change.

2.2 QSAC has been concerned about the extent and severity of violence and aggression experienced by staff. The committee heard about the establishment of a post-incident support task and finish group. At the meeting the Chair of the People Committee asked that she receive the terms of reference for the task and finish group. QSAC invites Board to consider violence and aggression which has implications for our culture, staff recruitment and retention and potential inequalities i.e. strategically important areas that are “wicked” problems.

2.3. From an assurance and compliance perspective, Board should note that QSAC received and discussed an internal audit of clinical audit at SWLSTG which contained a number of important recommendations. The committee will review the actions arising from the audit as they are progressed, reporting via the Chair’s report to Board as appropriate. The Chair has written to the Chair of Audit Committee to inform him of the same.

3. Committee Agenda Items

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

3.1. 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.

So What:

QSAC approved the wording of a new overarching Quality and Safety risk.

The committee noted, *inter alia*:

- Two new risks and mitigations relating to NHS Wandsworth Talking Therapies access and waiting times.
- The resolution of IT difficulties that allowed for the closure of risks relating to Safeguarding Training Compliance andRecording Medical Emergency Response data (Sharepoint).

What next?

QSAC continues to make suggestions regarding the analysis of the risk register, both as a standalone document and in relation to other sources of data and information. QSAC has requested consideration of how BAF risks align with the ERR. The committee proposed framing discussion of the risk register with reference to the current risk appetite statement. QSAC discussed potential deep dives focusing on accountability, governance and strategic priorities whilst resisting operational management.

3.2. Annual Reports

What:

The Committee noted and accepted the following reports:

- CQUIN / Quality Account / Quality Priorities Annual Report;
- Complaints and Patient Experience Annual Report;
- Safeguarding Adults Annual Report - including Sexual Safety and Domestic Violence and Abuse;
- Infection Prevention and Control, Tissue Viability Annual Reports; and

- Physical Healthcare, Medical Emergency and Medical Devices Group Annual Report.

So what:

The Committee noted and discussed the following, inter alia, from the above reports:

- The Trust had achieved two CQUINs and had partially-achieved one. The Trust did not achieve the CQUIN for staff flu vaccinations.
- QGG will review all complaints made by patients from racialised minorities QSAC considers this to be important work that reflects our commitment to being an anti-racist organisation..
- Poor compliance relating to Safeguarding Adults Level 3 training had been due to a categorisation error that is now resolved.
- The Physical Healthcare team has, in its work, included a focus on health inequalities which QSAC welcomed.

What next?

QSAC would welcome greater attention to health inequalities in relation to adult safeguarding. QSAC noted the reflections of the adult safeguarding lead who presented the report and will continue to take an interest in safeguarding and priorities for its development e.g. within the wider system and building confidence within service lines.

3.3. Quality and Performance (Q&P) Report

What:

QSAC received the report and discussed priorities arising, noting the focus flow, operations and workforce. QSAC noted that these three areas underpin performance across the range of metrics.

So What:

The Committee noted that:

- Ongoing challenges with flow, length of stay, delayed discharge and high use of out-of-area beds.
- The AUC and Community transformation programme is fundamental to improving flow and meeting demand; see note above regarding progress with this programme.
- The adult ADHD pathway remains difficult and SWLSTG is in communication with ICB colleagues about next steps.

What next?

QSAC had a detailed discussion on the presentation of data in the Q&P report. Considerable work has been led by the COO to develop the report and the revised version will be available at the September meeting of the Committee.

QSAC discussed the data within the report that suggest difficulties with improvement and / or slow progress e.g. with the transformation programme. The executive members consider that the plan remains on track but that there will be a delay before impact is evident in the data, noting the programme runs until March 2024. QSAC will continue to monitor and consider progress, noting the significance of transformation to the Trust's ambitions.

QSAC identified other specific areas for ongoing attention from the committee, including MAST and staff retention, each of which has significant patient safety and quality implications. QSAC will continue to review performance and, where appropriate, work with other committees and their Chairs to facilitate a comprehensive oversight.

3.4. 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 'Ward to Board' understanding of quality, safety and the patient experience.

So What:

The Committee noted that:

- The complaints team is still not meeting their target of 85% of responses sent within 25 working days. There was a plan in place within the team to address capacity within the team.
- There were 20 DNAs in month for psychiatric emergencies (not medical emergencies). All 20 had been reviewed in Quality Matters.
- There were five SIs and they would be considered via the PSIRF59 patient safety reviews are ongoing.
- There had been no statutory notifications from the CQC but there had been some CQC enquiries.
- There had been an increase in unannounced Mental Health Act inspections.

What next? QSAC will continue to review the performance of the complaints team, acknowledging the pressures on the service.

The Committee discussed the assaults on staff described in the report and was advised by executive members of the process for responding to incidents of staff harm The task and finish group for post-incident support following violence and aggression is intended to ensure consistent support, reporting and oversight of staff incidents across the Trust.

3.5. Internal Audit (RSM) Clinical Audit Report

What:

The Committee noted and accepted the audit report. This report had come to QSAC rather than Audit Committee as it related to clinical audit and therefore practice.

So What:

QSAC noted the findings of the audit and the recommendations regarding the clinical audit programme, acknowledging progress with many of the actions..

What next: QSAC were made aware that Audit Committee sought assurance that the clinical audit programme was being monitored effectively. The QSAC Chair agreed to write to the Chair of Audit Committee to confirm receipt and review of the report and the committee's responsibility for ongoing review of actions.

3.6. Item by correspondence

The Committee also reviewed the Patient Safety Incident and Management Policy and approved it by correspondence.

4. Appendices

- Ratified minutes of the meeting of July 2023.

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

Quality and Safety Assurance Committee (Part A)

Minutes of the MS Teams meeting held on Monday 3 July 2023, 13:30 – 16:30

Present:

Professor Deborah Bowman (DBo)	Committee Chair – Non-Executive Director
Sola Afuape (SA)	Non-Executive Director
Prof. Charlotte Clarke (CC)	Non-Executive Director (from 14:00)
Richard Flatman (RF)	Non-Executive Director
Sharon Spain (SS)	Director of Nursing and Quality
Billy Boland (BB)	Medical Director
David Lee (DL)	Director of Corporate Governance

Attendees:

Carol Anne Brennan (CAB)	Lived Experience Representative
David Hobbs (DH)	Lived Experience Representative
Ryan Taylor (RT)	Associate Director of Clinical Governance and Risk
Emdad Haque (EHa)	Associate Director of Health Inequalities
Ijeoma Ndubuisi (IN)	Lead Nurse, Learning Disability and Autism, Diversity in Decision Making (DiDM) representative
Claire Reid (CR)	CQUIN, Quality Account and Compliance Manager (item A23/110 only)
Theresa Pardey (TP)	Head of Quality Governance and Patient Experience (item A23/113 only)
Tara Osbourne-Wallace (TOW)	Safeguarding Adults and Prevent Lead (item A23/114 only)

Minutes:

Emma Whitaker (EW)	Deputy Director of Corporate Governance

Apologies:

Jennifer Allan	Chief Operating Officer
Jaydene Campbell	Lived Experience Representative
Sofia Husain	Lived Experience Representative

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A23/103	**Apologies** Apologies were noted as listed above.	
A23/104	**Declarations of Interest** No new declarations of interest were reported.	
A23/105	**Chair's action** No Chair's actions had been taken since the last meeting. The Chair updated the Committee that the Board members recently had Board-level training on the Patient Safety Incident Reporting Framework (PSIRF). **Discussed:** The Committee's Lived Experience Representatives would like to be booked on to the training. RT advised that he was in talks with the ICB about holding a specific	

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	training course on the PSIRF with patient safety partners and Lived Experience Representatives. There was a specific training aspect in relation to engagement with families. The first round of that training had been offered to Suzie Galvin as part of the implementation group.	
A23/106	**Minutes of the previous meeting** The minutes from the meeting of 5 June 2023 were agreed as a true and accurate record with no amendments.	
A23/107	**Action Tracker** The action tracker was reviewed and amended as follows: <u>A23/6-2, 23/22-2 and A23/96 – increased use of observations</u> QSAC was to have oversight on agency overspend due to enhanced observations, with the lens of patient safety, and with FPC with the lens of financial savings. A report would be coming back to the September QSAC. SA asked if KR and SS could also consider this action with the lens of the workforce implications and whether anything should go to People Committee for oversight. SS and EW would review these three actions and combine into a new one that considers workforce, finance and patient safety. <u>A23/74 - liaison psychiatry</u> BB reviewed the original minutes from May 2023 and would discuss this with Charlotte Clark outside of the meeting. Action to be closed. <u>A23/78 - Thematic review</u> This case was being reviewed and would then be going through QGG. Due to this, it was agreed that the thematic review was not needed. RT would email AB to update her, outside of the meeting. Action to be closed. <u>A23/85 – Aligning the BAF, ERR and risk appetite</u> It was clarified that this action was about how the Committee were not good at regularly reviewing the current risk exposure vs. the risk appetite; and about supporting clinicians to make risky decisions. Action to be closed and re-drafted to make it clearer.	
A23/108	**Risk Register** The Committee noted and accepted the Executive Risk Register (ERR). **Reported:** RT reported the following: • New Risks Added: Risk 2417: NHS Wandsworth Talking Therapies access - NHS - Mitigating actions around working with GPs and others to increase awareness and referrals into the service; and risk 2418: Talk Wandsworth Waiting times - Mitigations around recruitment, care pathway cleanse and capacity monitoring. • Risks updated: ○ Risk 2427: NHS Sutton Talking Therapies (IAPT) service: mitigations were in place around regular reviews and encouraging clients to continue treatment until the full course was completed.	

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	○ Risk 2416: Aquarius ward medical cover: mitigating actions included on-going liaison with medical staffing to recruit into a 0.5WTE fixed-term consultant post for the ward. ○ Risk 2420: Trinity Lifts: mitigations were in place including technical fix and ensuring a good emergency response, plus reviewing protocols. ○ Risk 2421: Car parking, Springfield site: mitigations included better use of existing spaces, securing additional spaces and a review of polices around encouragement of site users to use public transport. • No risk levels were increased or reduced in this period. • Closed executive risks: ○ Risk 2397: Safeguarding Adults Level 3 Training Compliance: training had not been mapped correctly to the staff dashboard and was not showing as MAST. This had now been resolved. Routine monitoring of compliance would be via normal routes and via the Safeguarding Group. ○ Risk 2419: Recording of Medical Emergency Response data (Sharepoint). The technical issue within IT / App development had been resolved. • Other closed risks: ○ Risk 1146: Water safety: this was a duplicate risk covered by risk 1636 on the ERR. ○ Risk 1354: Asbestos management: all mitigating actions were now complete. ○ Risk 2365: Burntwood Villas Medical Cover: the risk was now resolved, with a new, clearer operational policy in place. • BAF Quality and Safety risk: this new risk has been developed and agreed at ELT (22 June) and was presented to QSAC today, in advance of Audit Committee and Trust Board. • BAF move to Ulysses - Considerable doubts in relation to the success of this proposal, largely linked to limitations of the system and the ability of the company to provide the necessary support. • Estates and Facilities risks had been transferred into the facilities risk register as business as usual items. Car Parking (risk 2421) and Trinity Lifts (2420) had been added to the ERR. • Risk 2410: Display Screen Arrangements (DSE): the system was now fully functional and ready to be launched. It would be piloted within corporate services in July, following which a large campaign would be launched to ensure managers and staff undertake their DSE assessments. **Discussed:** Whether Merton had better access rates for their talking therapies than Sutton; and if yes, were they doing anything different that could be rolled out within Sutton. DH raised that around three years ago the same scenario had occurred and the CCG had rolled out an awareness campaign; he suggested that the ICB could be approached to do a similar campaign again. Whether it was imperative to move the BAF onto Ulysses. RT advised that the ERR is on Ulysses so adding the BAF would help avoid duplication and would allow those responsible for BAF risks to update them at the same time in the same way. Whether a deep dive into one or two of the risks that the Committee was responsible for, to review controls and mitigations, would be useful. That at the last meeting, SA commented on the burden of risk held by QSAC and that she was not sure she was completely sighted on shared risks at People Committee.	

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	She would like some more consideration about how best to ensure cross committee working. The Chair of the Board had fed back that she felt that some risks – such as violence and aggression, industrial action - which have huge quality impacts, did not quite land. The Committee Chair had heard from all Board members that they do not feel they have assurance from the papers provided to Committees, and the QSAC would need to think about how to get to a point of receiving appropriate assurance around its BAF risks, whilst resisting operational management.	
A23/109	**BAF risk for Quality and Safety** The Committee noted and accepted the BAF risk. **Reported:** That this risk had been created following a conversation at the Board a few months' ago, around supporting frontline staff and balancing that with finances and other issues in the organisation. It covered Quality in the round including safety and patient experience. The target risk score is nine, reflecting the complexity of risks around Quality and Safety; but the introductory score of 12 was suggested. **Discussed:** Whether the risk score was correct, as other BAF risks score highly, and these other risks would have an impact on quality also. SS clarified that some of these risks were in the trust's control, and some were not. The elements of the quality risks were mitigated them well, despite high demand, system pressures, observations, workforce issues etc. SS and ELT felt the quality risk was a balanced risk hence the score. RT had just relaunched the Friends and Family test to make it easier for patients and carers to use. **Agreed:** The Committee approved the BAF risk for Quality and Safety and recommended it to the Board.	
A23/110	**CQUIN / Quality Account / Quality Priorities Annual Report** The Committee noted and accepted the CQUIN / Quality Account / Quality Priorities Annual Report. **Reported:** CR reported the following • The trust had achieved two CQUINs and had partially achieved one. The trust did not achieve the CQUIN for staff flu vaccinations. Compared to other Mental Health trusts nationally we had achieved highly and were not an outlier. • Three CQUINs will go into the 23/24 year, including staff flu vaccinations and routine outcome monitoring. • There was a new CQUIN for intervention for inpatient older adult and adult services.	

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	• IAPT paired scores were similar to outcome measures for community Mental Health services. • The trust would be carrying on with the same quality priorities for Q3 – Q4. **Discussed:** Whether payment would have been received for the CQUINs that were not achieved. RT confirmed that the trust did get payment of £160k. The trust performance on the CQUINs had improved significantly since the Q1 position. There were a couple of targets through the year that were not achieved, and there would be an additional audit undertaken and monitored via the Complaints Review Group. As the report says some CQUINs were not achieved, but money was received, this made a confusing message. RT explained that the trust get paid in advance through contractual means. If something was not achieved, Commissioners could take money away from the trust, but if the trust shows willing and can evidence that good progress had been made, they usually do not take back any money. CR would make this clearer in the next report. SA highlighted the CYP Mental Health needs formulations CQUIN. In the trust submission were the vacancy issues and workforce risk impacts fully. CR responded that at Q1 the trust gave an update to potential risks to achieving the CQUIN including workforce risks.	
A23/111	**Quality and Performance Report** The committee noted and accepted the report. **Reported:** SS and BB reported the following: • There were no significant differences from last month's report and things were overall RAG rated 'amber' and were stable. • There were still struggles with flow, length of stay and DTOCs, and high use of out of area beds. • The AUC and Community transformation programme was being heavily relied upon to improve flow and support demand. • There remains a challenge with the Adult ADHD pathway. The trust were in communication with ICB colleagues about next steps. • Fundamental standards of care was continuing with QI support. There was focus on therapeutic observations as restrictive intervention, quality of interventions, finances and workforce. • The vacancy rate and turnover rate were above target. **Discussed:** The Chair raised that the Chair of the Board had said that evidence in the report seemed to suggest improvement was not happening and / or not happening quickly. SS agreed and added that JeA had highlighted that there was a significantly high risk around trying to sustain some of the work the teams were trying to do; as although we want things to happen quickly, teams need time to systematically work through pieces of work and embed change. There was also significant reputational and clinical risk.	

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	BB added that the AUC transformation plan runs until March of next year. The modelling explains that if the plan was delivered on time and on plan the trust should make the efficiencies it wants to, such as reducing use of out of area placements. His understanding was that the plan was currently on track and moving ahead, but the modelling shows there would be a lag before the delivery wanted was seen. This would be reflected in the Q&P reporting data. The Chair would escalate this to the Board by including it in her Chair's report. That the BAF risk of 12 may need reflection when reviewing the overall picture of Q&P. SA raised that at People Committee there was a critical focus on workforce and flow. Flow in the report was presented as 'green' but the narrative suggested different. SS clarified that the flow was the flow of patients across all services, and for the most part patient flow was very good through services. There was localised pressure in AUC and crisis pathways, and these were individually rated 'amber'. CC raised concern that the 'doughnut' diagram score had not changed since December 2022, when the pressures on the system had. As it does not show what people felt was going on with the trust, it may be too blunt an instrument to use to guide the Board. BB clarified that the score of the doughnut was determined by a sustained improvement in metrics. The Committee should not be expecting the doughnut to change too quickly between QSACs unless there was six months' sustainability in improvement in performance. SA added that there was a feeling of disconnect between the presentation of data and the triangulation of various papers that did not necessarily correlate with the picture/context, and for assurance there may need to be clarity about what is underneath some of that disconnect. It was discussed that there was a conversation at Board recently regarding the PSIRF, as to work as reported vs work that was done, and that some of the high-level statements may be masking some of the underlying context. SS added that the Executive Team were constantly revamping this report so that it gave robust assurance. They sit with the Service Lines monthly to discuss their Q&P reports and each one looks different to this one, but mirror this one. JeA had done a huge amount of work on the new version of this report which would be attached to the trust dashboard, so more of the detail should be in the report next month. The Chair discussed that the Committee may wish to identify priority metrics and these could be reviewed in a sustained way. She would discuss this up with JeA. She was also meeting with DL to discuss what QSAC might need in order to be more effective. CAB raised that the transformations due to be in place by next March would take time to embed. From a patient's view this was worrying and people did not feel confident going to A&E or in being discharged. She was concerned about relying so heavily on these transformations. Anecdotally these were not yet making a difference in Sutton. It was important that the trust continued to inform the community of what transformation work it was doing and what they could expect. DH asked what the trust's response was to the Met Police letter, saying they would not be attending all mental health emergency calls. The Chair responded that this came to the Board first due to timings. All mental health trusts across London were	

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	concerned. The essence of the 'right care right person' model was correct, as the trust would prefer its patients to not be with police, but time to prepare for moving away from police colleagues attending was needed, especially when there were significant safety risks. JeA was currently working with COOs across SWL, including acute colleagues, to ensure a joined up system approach was adopted.	
A23/112	**Quality Matters (May data)** The Committee noted and accepted the Quality Matters report. **Reported:** SS reported the following: • There had been 11 MP enquiries, 59 compliments and 49 complaints. • The complaints team were still not meeting their target of 85% of responses sent within 25 working days. There was a clear plan in place within the team. • The KPI of acknowledging complaints within 3 working days (100%) would not be met this month as a complaint did not come into the team until the deadline had passed. • There were 20 DNAs in month for psychological emergencies (not medical emergencies). All 20 had been reviewed in Quality Matters on a weekly basis and all were managed well. • There were five SIs on STIES; one was an unexpected death and one a suspected suicide. All five would be going through the PSIRF. • There were 59 patient safety reviews ongoing whilst the team were moving to the PSIRF. • There were 18 outstanding investigations on STIES. These were making good progress. • There were 12 outstanding RCAs, these were being worked through. • There had been no statutory notifications from the CQC but there had been some CQC enquiries. • There had been an increase in unannounced Mental Health Act inspections to wards recently. **Discussed:** The Chair raised that the Chair of the Board had been alarmed to note one of the psychiatric consultants had been knocked unconscious. She asked if QSAC should have been informed about the incident. BB updated the Committee that the doctor had been properly supported by the Service Line, and had reported feeling well and was looking forward to returning to work. SS raised that the trust had previous reports of harm to staff and that this was being taken forward within the task and finish group for post-incident support for staff. The Executive Team were on top of responding to incidents of staff harm and to individual incidents where needed. They discussed incidents in ELT weekly and received assurance around what actions were taking place. It was felt that QSAC should review governance and ensure actions were appropriate. The task and finish group would ensure consistent support, reporting and oversight of staff incidents. SA raised that, as a Board member, she wanted to be sighted on the environment and culture in which staff were working, not just about governance. SA and BB had recently visited Shaftsbury and saw the aftermath of an attack on a nurse. Whilst they were pleased there was a caring approach the Board had a responsibility to prevent this being the working environment for our staff. SS suggested that once the task and	

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	finish group have reviewed incidents they could be reported through People Committee, to assure them on what has been done to support staff and what was being done to prevent and reduce incidents in the first place. EH raised that the 2021 NHS staff survey results showed 46% of staff experience violence and aggression and suffer long-term ill health as a result. 30+% think of leaving the NHS because of an incident. If this was triangulated with other data in the organisation, this would give better insight into what was happening for staff turnover and sickness.	
A23/113	**Complaints and Patient Experience Report** The Committee noted and accepted the report. **Reported:** TP reported the following: • In 22/23 the trust received 1040 compliments and 472 complaints. • A consistent theme was communication – patients feel not listened to, there were delays in receiving information from services, calls were not returned and letters were not being sent in good time. • The number of complaints from BAME patients not being upheld reduced to 14% (from 38%). • The Complaint Review Group were reviewing a sample of complaints to reflect on decisions, in all outcomes the group agreed with the team's findings. • The team audited compliance against the NHS complaints standards. • There had been a rise in reopened complaints. The team want to improve on this. The rise may be due to the PHSO requirement that the trust must review complaints at least twice before the PHSO open a case. There had been 12 PHSO cases in 22/23. **Discussed:** That QGG would be reviewing all complaints from BAME patients, to see what their feedback was telling us about our services; whether or not they were upheld; and a thematic review. The Chair asked for her thanks to be shared with the team and the patient and service user group. The Chair of the Board was pleased to see the reporting data by ethnicity and noting differentials.	
A23/114	**Safeguarding Adults - including Sexual Safety and Domestic Violence and Abuse** The Committee noted and accepted the annual report. **Reported:** TOW reported the following: • Safeguarding Adults L3 training had poor compliance in September 2022 (5% when should be at 95%). This was found to be due to a new training package launched in May 2022 that had been incorrectly categorised as non-MAST. It therefore did not appear on staff dashboards so people were not completing it. This issue was now resolved, alongside a campaign focused on operational staff	

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	and managers. Training compliance was now at 47.6%. To support improving compliance further TOW created a two page FAQ guide. • The team had limited resources which impacted on the work they could do to provide assurance. They also provided operational support to staff which took up a large part of their time. They would like to carry out audits and deep dives, and had started reviewing ethnicity data. TOW was leaving the trust also. **Discussed:** Where safeguarding adults and ethnicity data was reviewed with the lens of health inequalities; e.g. was there a disparity and why. TOW advised this had only recently been reviewed and the team were trying to unpick it currently. CC would like to know the timing of that work if it takes place. What the level of confidence was in staff managing safeguarding issues as business as usual. TOW advised that during training the team feel confident in staff ability and competency to deal with issues. Queries received by the team suggested staff were not confident with decision making. How the trust benchmarks against other organisations. This was difficult to do, as the trust were in an ICB with five boroughs, and work in service alignment; whereas most other mental health organisations work in borough alignment. The team therefore had to go to lots of ICB meetings. People are sympathetic with our position. SS advised that there were two new leads starting with the trust and there would be a meeting to discuss best use of the limited resources. NHSE and the ICB have confidence in the trust's safeguarding adults service and have said that it was managed really well and in an open, transparent and proactive way. There were also no patient safety concerns.	
A23/115	**Internal Audit (RSM) Clinical Audit Report** The Committee noted and accepted the audit report**.** **Reported:** RT reported the following: • The clinical audit programme had been produced and the clinical audit policy had been approved by QGG. • Most actions had now been completed. • A number of groups were overseeing the detail of the programme of actions. **Discussed:** Which Committee of the Board was best to review the audit actions when completed; QSAC for clinical governance or Audit Committee as the Committee that reviews internal audit reports. The Board had agreed that everything should go to one Committee of the Board who would then report to the Board. DL advised the Committee that Audit Committee were keen to receive regular assurance that the clinical audit programme was being monitored effectively. If not then they would request to receive direct reports on this issue.	

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	Agreed: The Chair to write to RF that QSAC has reviewed the clinical audit internal audit thoroughly and would review the actions with ongoing interest. It would be reported to the Board in the QSAC Chair's report to the Board.	**DB**
A23/116	**Infection Prevention and Control, Tissue Viability Annual Reports** The Committee noted and accepted the annual report. **Reported:** • That the IPC team had completed an yearly self-assessment framework since the beginning of Covid. They were compliant against this framework. • The trust was continuing to assess itself against IPC standards in all services. • The centralised PPE supply was no longer in place so the organisation would need to order its own supplies going forwards. • Covid vaccination rates for the trust were low but this was a consistent picture for all Mental Health trusts across London. **Discussed:** The Chair wanted to acknowledge that IPC was an area of huge development and she was pleased to see the significant positive change in reporting. She asked SS to pass on the Committee's thanks to the IPC team. SS thanked the IPC lead and his team, and informed the Committee that the team had been doing many ward inspections and were seeing good improvement.	
A23/117	**Physical Healthcare, Medical Emergency and Medical Devices Group Annual Report** The Committee noted and accepted the annual report**.** **Reported:** • That a framework on obesity and diabetes had been implemented from last year and teams had received training on how to use this. • The Physical Healthcare team were looking to see a reduction in inequalities and an increase in care plans and physical healthcare provided to those from BAME backgrounds. • The team wanted to improve escalations on wound care and a new wound care nurse would be soon starting with the trust. • Really robust training programmes were in place that the clinical Service Lines were leading on. • Clinical skills.net had been launched. This was a training database that all staff could access. **Discussed:** How nutrition factored into food on wards, especially for diabetic patients. SS responded that there had been a huge increase in referrals to dieticians from adult acute wards to work with patients and teams to implement nutrition care plans. Some concerns had been raised about the food supplier, and SS was the SRO for the new contract for food and cleaning services, which was going out to tender now. She would be ensuring that current inpatient service users feedback was being considered in the tender process.	

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

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A23/118	**Patient Safety Incident and Management Policy** The Committee noted and accepted the Policy**.** **Reported:** Due to this paper arriving late, the Chair invited Committee members to review by correspondence and return their comments, if any, to the clerk by COP Wednesday 5 July.	
A23/119	**Quality Governance Group minutes** The Committee noted and accepted the Quality Governance Group minutes**.**	
A23/120	**Agenda for the next meeting – September 2023** The Committee noted the agenda for the September meeting. **Reported:** That a copy of the next meeting's agenda would come for note to each Committee, so that members were more clearly aware of upcoming items in advance. That there had been a lot of annual reports coming through QGG all at one time that also needed to be reviewed by QSAC. SS would work with EW and the QGG on this so that the same situation does not happen next year. September's agenda therefore had many Annual Reports on it, but this would be reviewed by SS and EW and spaced out where possible. That an updated version of the Committee forward plan would come to the next meeting, once the report schedule had been reviewed. This would also be circulated by email before the next meeting. **Discussed:** That some members would give some offline feedback on the Committee forward plan. That it was helpful to be realistic about timings and to consider which items needed time to be thoroughly reviewed.	
A23/121	**Meeting Review** The Committee reflected that there had been robust conversations about the reports presented today with a good level of challenge. There was a constant tension between providing the right level of detail for this Committee in order to properly hold the governance to account versus focusing on individual cases. In reviewing the Q&P report, it would be useful to reflect on what the purpose of this group's review is and what level of detail should be given. They also reflected on the concerning reports of incidents of violence and aggression, especially the assault on a consultant. The Chair and others had pointed out how important the environment can be in terms of whether it, and how it, impacts on behaviour; and whether some positive behaviour principles could be bought into working and/or clinical environments.	

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	A final reflection was that members were not clear on the idea of deep dives and would like some more detail around these.	
A23/122	**Matters for Escalation for the Board** The following matters would be reported to the Board via the QSAC Chair's report: • That the AUC transformation plan was currently on track to deliver the required efficiencies and transformation, but there would be a lag before the delivery wanted was seen, which would be reflected in the Q&P reporting data. • The work of the post-incident support task and finish group, the wider implications at Board level for a strategic look at culture and violence and aggression, and wicked issues around staff recruitment, retention and inequalities. • QSAC had reviewed the clinical audit internal audit thoroughly and would review the actions with ongoing interest. Updates would be reported to the Board in the QSAC Chair's report. The Chair would write formally to the Chair of Audit Committee to inform him of the same.	
A23/123	**Next meeting:** Monday 5 September 2023, 13:30, MS Teams **Report deadline: 9am, Tuesday 29 August 2023.** **Late papers will not be accepted. Please also note that Monday 28 August is a Bank Holiday.**	

Trust

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

Quality and Performance Report

June 2023

Glossary

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

Contents

Part A: Executive Summary

What

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

Exec time is being focused on Observations, with additional reporting and quality improvement work to be taken through ELT. Similarly Exec attention will continue to be given to MAST and Agency with a short life exec subgroup to oversee Agency reduction plans. These actions support the need to reduce costs in these areas.

The organisation's performance remains stable, overall Amber, but we continue to face significant challenges in supporting our workforce and patient flow priorities in the context of the demand on our services, acuity of our patients, and ongoing industrial action. During June, we successfully moved two acute wards from Queen Mary's Hospital Roehampton to new settings in Morrison Building at Springfield as part of our Estates Modernisation programme. Work also continued on our acute, community and CAMHS transformation and through the South London Partnership on acute, CAMHS and complex care pathways, with a view to supporting timely and sustainable care.

We continue to see underperformance on crisis metrics including the number of people seen within 1hr in ED and the number of 12hr breaches in ED. Liaison and crisis services have drawn up an improvement plan which is being aligned with the acute transformation programme to address this. There are also active discussions with NHSE and the Metropolitan Police about the "Right Care Right Person" programme which will supplement regional work in progress to improve section 136 pathways for patients in mental health crisis; the Trust is actively participating in this work. Acute flow challenges with LOS and DTOC days remaining high (although this is a London wide issue) drive high use out of area placements and extend waits for patients. Focus on this area continues and some improvement is seen more recently in July, which we aim to sustain through embedding our transformation work.

Following discussion with the ICS and Primary care colleagues, GPs are being encouraged to consider alternative referral or support routes for patients requiring ADHD assessment, while a clinical working group designs a more sustainable model for this service. High levels of 52 week breaches are seen in Adult ADHD and will continue in future months as service capacity is constrained, but the group aims to address this, as well as in future considering further shared care pathways between mental health and primary care. Long waits of over 30 weeks, as well as some 52 week waits, are increasing due to high demand for community psychological therapies and capacity and workforce constraints within Talking Therapies (formerly IAPT) services, as well as some temporary service gaps in Eating Disorders. Service line teams have action plans to address all these areas.

It is encouraging that the patient safety domain of performance remains stable and we are working to implement the Patient Safety Incident Response Framework as well as design a more holistic care and safety planning framework which will replace CPA in due course. There is a significant focus on these quality improvement priorities in line with our corporate objectives.

Our vacancy rate continues on a downward trend but remains above the minimum target of 15%. The current recruitment pipeline suggests that if turnover held at a similar level, then we would meet the 15% target in September 2023. Agency use remains high and a reduction in agency use if proving difficult to achieve. An action plan has been in place, but this is being revisited and further scrutiny applied to see what more can be done to ensure greater assurance can be provided as to how the target of 3.7% or less will be achieved by the end of the financial year.

Overall turnover remains above target but has started to reduce and it is hoped that the detailed retention action plans will start to impact the turnover data – however it is unlikely that this will be immediately realised as it takes several months for the impact of any work to be demonstrated in the overall turnover figures. Improved MAST compliance remains challenging however the root causes have now been finalised and options are being recommended to resolve the technical issues which are causing some of the process issues. It is therefore expected that this should start to be reflected in compliance rates towards the end of September 2023.

The Trust submitted a revised financial plan in May which showed a position of a £0.2m surplus for the year. To achieve this, the Trust needs to deliver a savings target of £13.0m. Cumulative savings delivery to Month 3 contribute £3.5m towards this target. The overall financial position was on track at Month 3.

So What

There has been ongoing focus on acute transformation and flow to address the significant sustainability issues with the quality and cost of out of area placements as well as high levels of observations being used on the wards. We are committed to supporting transformational changes to embed and be maintained and therefore we are mindful of how to balance immediate actions to support flow especially during industrial action, with making time and space for transformation leadership. This work has started to take effect looking into Q2 and it is critical that we maintain this and extend to new areas such as Liaison and Crisis services. Work to optimise complex care pathways will also be important and continues through active partnership with Local Authority colleagues both directly through the monthly interface meeting and via the SLP complex care programme.

In partnership with ICS and Primary care colleagues, ADHD patients are being redirected where possible, but if preferred patients may wait for assessment within the Trust, with clear communication about the length of wait being well over 52 weeks, and appropriate risk assessment and management. This will provide patients with a realistic expectation about the assessment service wait while urgent work is being undertaken through the clinical working group to design a new shared care pathway over the next 3 months.

The Trust's Access Meeting oversees waiting times and will be refreshed to ensure a focus on hotspots and those areas where waits may be extending and to cascade analysis and action plans through from Service Line level discussions. Caseload LOS in CAMHS and Specialist services will be a focus for service lines in coming months as well as reviewing our team configuration within Adult Community to make caseloads and skill mix more consistent in all boroughs.

The HR function are building a detailed retention action plan, similar to that being developed for agency highlighted the key actions and interventions being taken to support improved retention. This includes learning from national vanguard Trusts who have provided a series of recommendations around how they have managed to reduce turnover. This includes self-rostering, mentoring support for new joiners etc. Our SIREN reporting is being enhanced with additional triangulation information on agency use and caseload flow, and work is in train through the Service Lines to make more proactive use of the SIREN reporting, flowing through SLR and to QSAC.

Our Leadership offer will launch towards the end of July/early August with learning commencing in September 2023. Trends being identified within our ER caseload are being factored into this learning opportunity ensuring that they are targeted to manage risks associated with the level of Employment Tribunals we are seeing. This focusses on recruitment and selection, and access to work/reasonable adjustments.

The Trust is in a relatively stable financial position in the context of significant challenges across SWL ICS. Our Delivering Value programme is being refreshed with a clinical leadership focus around processes that reduce wasted clinical time and improve quality and continuity of care, a project plan for community clinical efficiency is in place and a trajectory has been set for the rest of the year.

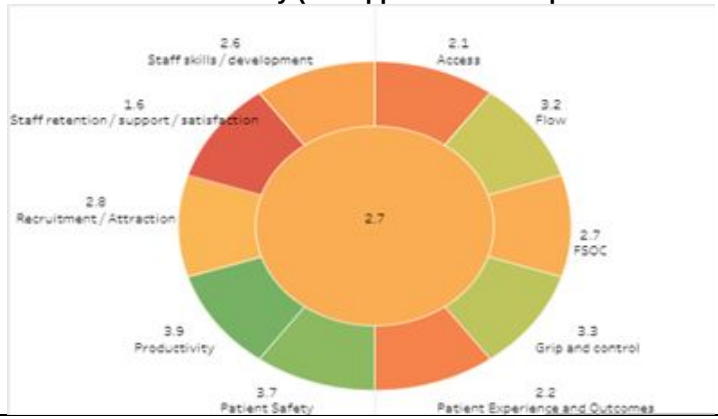
What Next

We are seeing indicators moving in the right direction in a number of areas, but the challenges of meeting significant increased demand and acuity in all services with a constrained workforce mean that improvement is slow. A range of transformation work supports our key priorities of workforce and patient flow, and we are focusing on embedding and sustaining changes through clinical and operational leadership and our digital programme where the Clinical Systems workstream aims to design more intuitive and streamlined clinical workflows.

Ongoing focus on recruitment and more importantly retention is required as vacancy levels, agency use and staff satisfaction remain challenging. This will be supported by the development of the Leadership framework and organisational development work.

Refreshed Board committee Q&P reports will be launched in the next cycle of meetings, including key points for the committee discussion, aligned to our priority areas. Transformation metric report is also in development and anticipated to be launched in the coming months. The streamlined Q&P reporting enables us to free up Performance Analyst time to support service line work on Access and Flow, which is designed to improve performance in these areas.

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

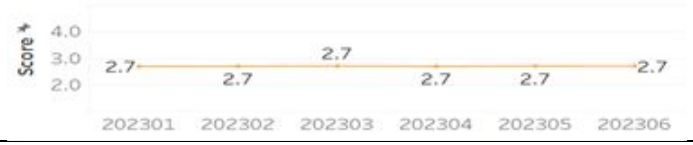


Summary Domain Performance:

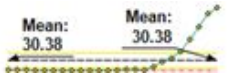
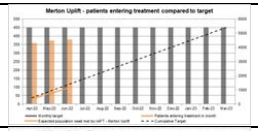
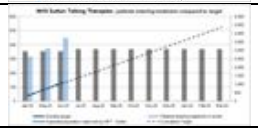
Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	5	14	16	54.3%
Quality	9	12	10	67.7%
Workforce	1	3	8	33.3%
Finance	0	3	0	100.0%
Total	**15**	**32**	**34**	**58.0%**

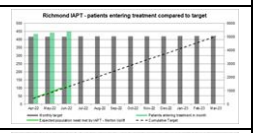
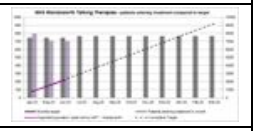
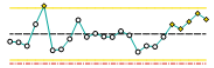
A table showing how many KPIs have full assurance, some assurance and no assurance, split by domain.

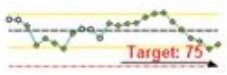
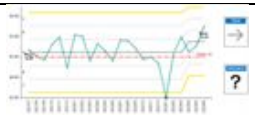
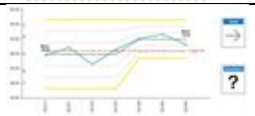
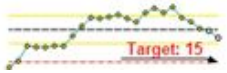
Donut Performance over-time (all themes combined):

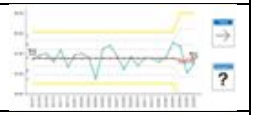
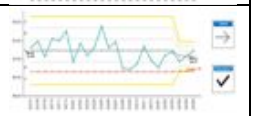
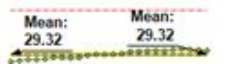
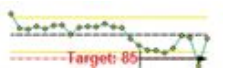
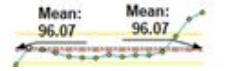


Priority Metrics

	Priority Metrics	Jun-23	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 8)	69.2	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 9)	54	= 0	↗	✗	
	Access					
	Referral to treatment (RTT): 52 week breaches (see page 11)	211	= 0	↗	✗	
	Access					
	Expected population need IAPT – Merton Uplift (see page 11)	1114	1344	-	-	
	Access					
	Expected population need IAPT Sutton Uplift (see page 11)	1137	1059	-	-	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 12)	100.0	≥ 95.0	→	?	
	Access					
	Dementia diagnosis within 6 weeks of referral to a memory assessment service (%) (see page 13)	95.1	≥ 85	→	?	
	Access					
	Adult Acute Bed Occupancy (see page 14)	98.0	≥ 90	→	✗	
	Flow					
	Number of adults and older adults receiving 2+ contacts in new integrated model across the core and dedicated service provision (see page 15)	1554	-	↗	-	
	Flow					

	Priority Metrics	Jun-23	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (see page 8)	71.6	≥ 95.0	↘	✗	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 10)	73.6	≥ 92.0	→	✗	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 12)	6.9	≥ 10.0	↗	✗	
	Access					
	Expected population need IAPT – Richmond (page 11)	1326	**1257**	-	-	
	Access					
	Expected population need IAPT – Talk Wandsworth (see page 11)	2205	2310	-	-	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 13)	62.9	≥ 80.0	→	?	
	Access					
	Adult acute average length of stay (Excluding PICU) (see page 14)	61.2	≤ 38	→	?	
	Flow					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 15)	357	= 0	↗	✗	
	Flow					

	Priority Metrics	Jun-23	Target	Trend	Assurance*	SPC Chart
Quality	Cardiometabolic Assessments - Community and EIS (%) (see page 16)	80.4	≥ 75.0	↘	✓	
	Fundamental Standards of Care					
	Patient Friends and Family Test (%) (see page 17)	82.3	≥ 92.0	→	✗	
	Patient Experience and Outcomes					
	IAPT recovery rate - Merton Uplift (%) (see page 17)	55.9	≥ 52.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate – Richmond IAPT (%) (see page 17)	52.1	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	Death - Suspected suicide (see page 19)	**4**	-	→	-	
	Patient Safety					
Workforce	Vacancy Rate (%) (see page 20)	18.4	≤ 15	↘	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 1 (%) (see page 22)	92.9	≥ 95.0	↘	✗	
	Staff Skills/Development					
	Turnover (%) (see page 23)	16.6	≤ 15	↗	✗	
	Staff Retention/ Support / Satisfaction					
Finance	% Forecast Overspend (See Page 24)	0	≤ 0	→	?	
	Grip & Control					

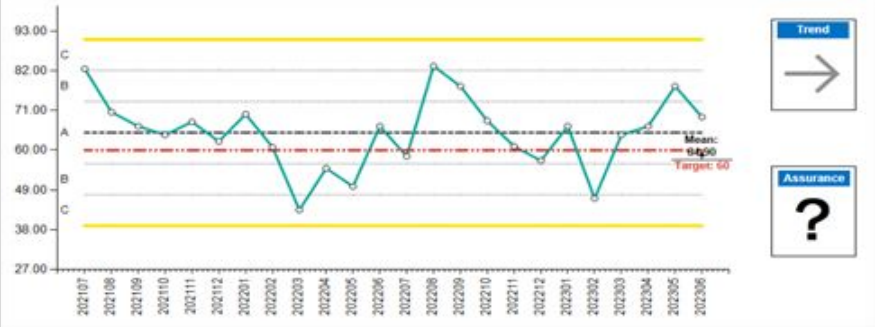
	Priority Metrics	Jun-23	Target	Trend	Assurance*	SPC Chart
Qualityy	Safe Staffing: National Compliance - Inpatients (%) (see page 16)	140.1	≥ 95.0	↗	✓	
	Fundamental Standards of Care					
	IAPT recovery rate - Sutton Uplift (%) (see page 17)	48.2	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate - Talk Wandsworth (%) (see page 17)	53.4	≥ 50.0	→	✓	
	Patient Experience and Outcomes					
	Paired Dialog Completed % (see 18)	10.5	≥ 40.0	→	✗	
	Patient Experience and Outcomes					
Workforce	Percentage of BAME staff - Band 8+ and Medical (see page 21)	31.2	≥ 50.0	↗	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 2 (%) (see page 22)	88.3	≥ 85.0	↘	?	
	Staff Skills/ Development					
Finance	Activity vs Plan (Local Contract) (See Page 24)	111	≥ 95.0	↗	?	
	Productivity					

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

Operations Domain

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

Access



Team Breakdown – June 2023

Team	Treatment Within 14 Days	Referrals	% Treatment Within 14 Days
Kingston Early Intervention Service	1	1	100.0%
Richmond Early Intervention Team	1	1	100.0%
Merton Early Intervention	3	3	100.0%
Sutton Early Intervention	2	2	100.0%
Wandsworth Early Intervention	1	5	20.0%
Trust Total	8	12	66.7%

Background
There is good evidence that early intervention, when delivered in accordance with NICE standards, helps people to recover from a first episode of psychosis and to gain a better quality of life.

What the chart tells us
The Trust can be expected to frequently exceed the target which is below average performance.

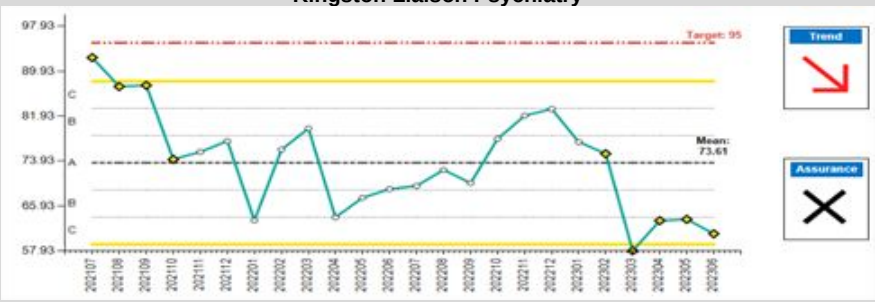
Underlying issues
- Inconsistent clinical oversight of waiting list and validation is not always completed promptly.
- Some inpatient wards and adult assessment teams are slow to refer patients on to EI services once psychosis is identified making it much harder for them to meet the waiting time targets.
- RiO is not configured to allow the accurate recording of first episode of psychosis and provide a workflow; as a result, there is an administrative burden on teams to manually validate all waiters.
- Wandsworth EIS outlier in June2023 (where 4/5 referrals breached) vacancies in team have impacted. Team have been using agency who required further local induction.

Actions:
- Targeted training for SPA teams to continue in order to reinforce the importance of timely referrals.
- Alert system is now available in RiO which will support workflow for recording first episode psychosis.
- To maintain performance over 60% for all teams through core structures of daily huddles and use of dashboards by each EIS team.
- EIS teams to ensure robust referral checking systems are in place.
- Community Service line to engage with acute services to improve processes for timely referrals to EIS.
- Wandsworth EIS to ensure agency staff are thoroughly inducted in local systems to avoid referral breaches.

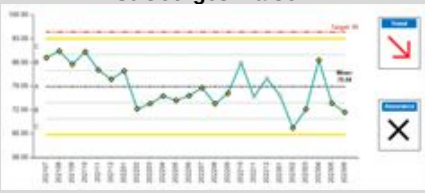
Liaison psychiatry - Seen within 1 hour in A&E (%) Target ≥ 95%

Access

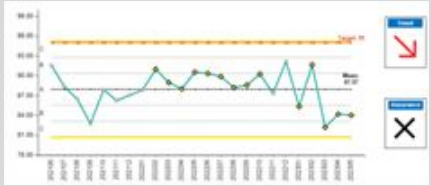
Kingston Liaison Psychiatry



St Georges Liaison



St Helier Liaison



Background
Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care' published by NICE in 2015 states that an emergency liaison mental health service should respond within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment.

What the charts tells us
All three liaison services are consistently below target (which is above upper control in Kingston & St George's). A change of process is required.

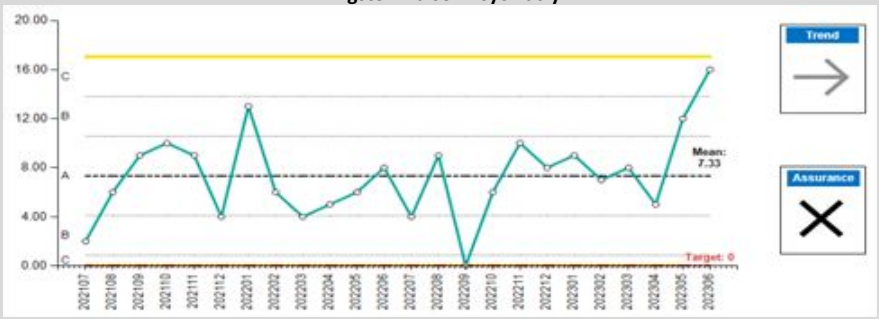
Underlying issue:
- The process of managing Emergency Referrals is impacted by many factors such as staffing shortages (including sickness and vacancy rate, cubicle space (St George's), other activities such as handover and multiple referrals from both ED and wards.
- Impact of extended number of patients waiting for MH beds in general hospital requiring further reviews.
- Acute hospitals have been experiencing a high level of acuity and this has had an impact on referrals into liaison services.
- High numbers of referrals in Kingston and St George's in comparison to staff levels; unfilled posts; referrals during handovers or out of hours meaning the services are not always able to meet demand.
- Liaison services also see patients on acute hospital wards which also diminishes capacity.
- Liaison services have started to see an increase in patients presenting with complex social issues, not always linked to acute deterioration in MH. This has impacted on clinical capacity.

Actions:
- Action plan for liaison services formalised including improving access and induction for bank staff working across sites. Agreed requirements and competencies of bank staff are in place. Improvement plan is to align with overall Liaison Psychiatry Business Plan with focus on demand and capacity.
- Shift patterns has been reviewed as part of Pilot evaluation and Core24 compliance and proposals sent to Finance to cost before engagement/consultation work to begin with Teams.
- Clinical Service Lead and Matron undertaking staffing review in regard to demand and capacity and CORE24 compliance. This is a longer term piece of work and will be trialled in Kingston Liaison initially.

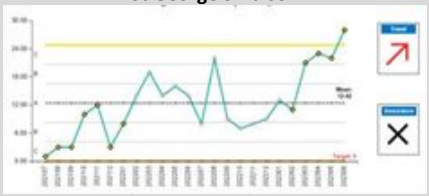
Access

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

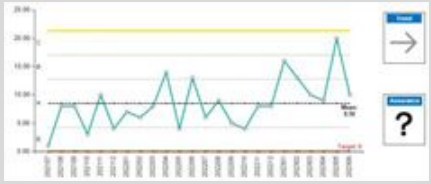
Kingston Liaison Psychiatry



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.

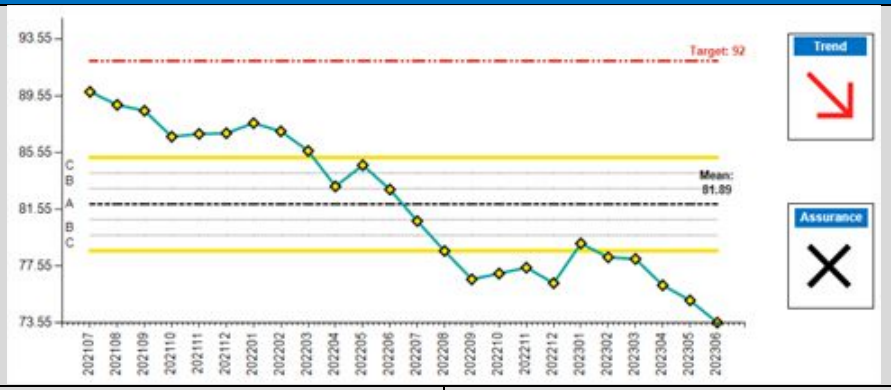
What the charts tells us
The level of 12-hour breaches is increasing across the three services with occasional variation.

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 and use of surge beds.

Actions
- Matron and CSL meeting with Associate Director of Transformation to discuss review method of providing assurance that patients are being reviewed at least once a day. Diary contact assurance is not reliable.
- Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds.
- Substantive recruitment of Consultant Psychiatrist to Kingston Liaison Psychiatry and also successful recruitment across services.
- The Trust has contract for use of 18 beds at Holybourne in Roehampton until the end of the financial year.
- Matron working with Inpatient MDT to develop a new process of using Southcroft Lodge for step downs of those awaiting accommodation, hence improving flow of DTOC patients out of MH Inpatient services into a more suitable setting.
- Trust recently reviewed the Trusted Assessors Framework which will prevent duplicate assessments pre-admission i.e. once assessed by liaison or HTT there should be no need for further assessment as long as all points of framework are covered.

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

Access



% Waiting less than 18 weeks including / excluding ADHD/ASD teams – June 2023

Including ADHD/ASD teams	73.6%
Excluding ADHD/ASD teams	86.4%

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 since April 2021. A change in process is required.

Underlying issue

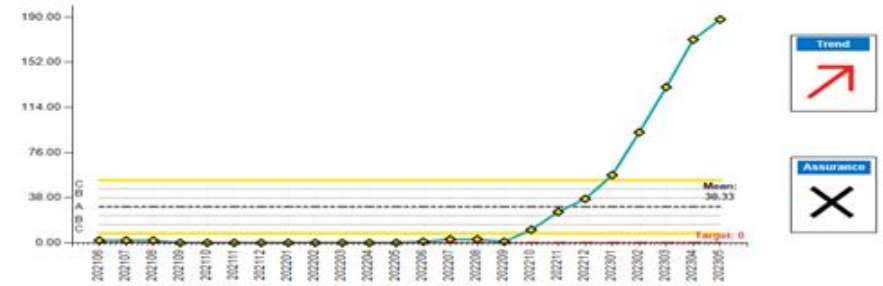
- **Adult ADHD:** There are known demand and capacity issues within the service; in June 2023, 61.7% (1077/1743) of the 18-week breaches relate to this service (see below for further information). Continued increase in caseload (for annual medication review) will impact on service assessment capacity.
- **CAMHS Tier 3:** Underinvestment in the Kingston & Richmond SPA. Onward referrals from the CAMHS Neurodevelopment team to Tier 3 for ADHD medication titration has led to increased wait times. These waits are linked to lower risk patients.
- **CAMHS SPA:** Tightening of the CAMHS Neurodevelopmental acceptance criteria has caused a backlog in the NDT screening within the SPA's (especially Kingston & Richmond SPA).

Actions

- **Trust:** The reporting of RTT by appointment type commenced on 1st July 2022 which provides more accurate waiting times and enables teams to have more control in determining when treatment has commenced.
- **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 July 23 to progress the development of a discharge pathway. Meetings are held fortnightly. The Trust is also working with primary care on wider shared care pathways for ADHD patients.
- Improvement plan led by Clinical Manager to improve processes around referrals, cancellations and recording. The service is also undertaking work to optimise clinical capacity, which will involve a review of ADHD admin and clinical processes.
- **CAMHS Tier 3:** The Trust has secured further investment to increase the capacity of the Kingston and Richmond CAMHS SPA and reduce the number of inappropriate referrals reaching CAMHS Tier 3 service. Additional staff are being recruited to a number of Tier 3 services following further investment. Non-Medical Prescriber commenced in post on 15th May and will work across Kingston and Richmond.
- CAMHS Management to review processes in SPA & NDT in order to streamline. SPA teams need to tighten administration on case closure (where forms sent to families are not returned).
- 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): New CBT group set to commence in September 2023 which will increase capacity. AED has recently had 5 new starters once training is complete this should see reduction in waitlist.

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

Access



52 Week Breaches – June 2023

Team	Number of Breaches
Sutton Adult ADHD	149
Merton Adult ADHD	60
Adult Eating Disorders Outpatients	2
Richmond ADHD	2
Richmond CAMHS Tier 3	2
Kingston CAMHS Tier 3	2
CAMHS Complex Care	1
Total	**218**

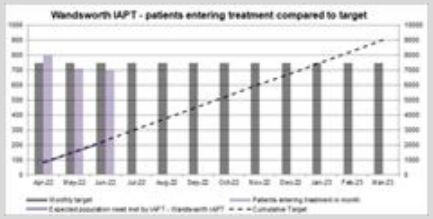
What the chart tells us:
Historic performance consistently met target; however recent months have seen significant increase in 52 week breaches with performance above upper control limit in last 4 months; a change in process is required.

Underlying issues that prevent us from consistently reaching the target:
- Adult ADHD: There are known demand and capacity issues within adult ADHD services and there is a continued risk of further increase in 52 week breaches. The levels of 52 breaches will continue to rise as diagnosed cases remain on the adult caseload for annual medication review.
- CAMHS Tier 3: Breaches were linked to waits for ADHD medication commencement.
- Sutton SPA Breaches: 1 case should have been excluded as already in treatment in Tier 2 and the other case had long wait in Neuro pre-screening.
- Adult Eating Disorders service incurred two breaches linked to wait for CBT Group due to lack of appropriate patients and team unable to provide 1:1 CBT due to capacity.

Actions:
- Adult ADHD: In addition to actions outlined in 18 week commentary, daily administration meetings are held to ensure cancellations are managed promptly and 52 weeks breach lists are cleansed routinely and prioritised. Management support being provided to ensure clinicians are outcoming all appointments (and specifically 52 week breach appts) on the same day.
- An ICB led Task and Finish Group with SWLSTG and Primary Care representation commenced July 23 to progress the development of a discharge pathway. Meetings are held fortnightly.
- CAMHS: Non-medical prescriber continues to work on ADHD backlog in Kingston & Richmond.
- AED: New CBT group set to commence in June 2023 which will increase capacity. AED has recently had 5 new starters once training is complete this should see reduction in waitlist. AED working on clinical efficiency to reduce DNA's and cancellations.

Expected population need met by IAPT (numbers entering treatment)

Access



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

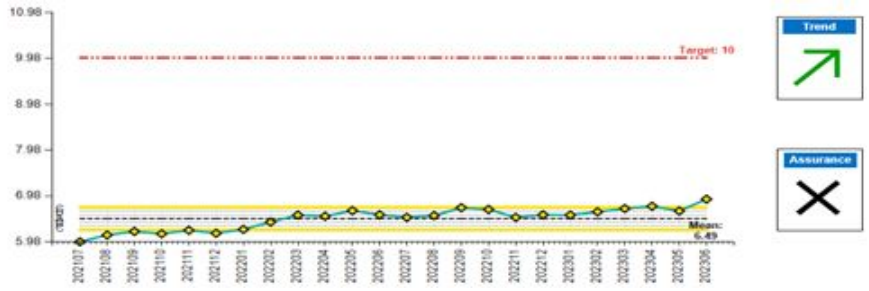
What the chart tells us
Two (Sutton IAPT & Richmond Wellbeing Service) of the four IAPT services are below their cumulative access requirements for 23/24. Merton Uplift is considerably below its requirement whilst Talk Wandsworth performance is just below target.

Underlying issues
- Access targets have now been agreed for FY23-24. Due to a delay there is an increase for this financial year which will be amortised across Q2-Q4.
- There is insufficient resource in Wandsworth, Merton, and Sutton and therefore meeting access requirements will continue to be an ongoing challenge.

Actions
- iPlato (3rd party provider) has been commissioned across all 4 boroughs to help us achieve our access targets. Service managers will be closely monitoring referral numbers on a weekly basis, ensuring there is sufficient slots to meet these access target.
- The Trust is proposing to invest an additional £200k for 3rd party provider IESO to undertake further activity; this has been agreed by ICB as part of the "triple lock" approval process.
- Service Managers will raise any concerns which bears any risk to target or wait lists to IAPT/Community Service Line senior management who will raise with ICB as appropriate.
- Talking Therapy services that accumulated a deficit for Q1 will look to claw back any shortfall where possible coming into Q2. IAPT management are working closely with Merton on a recovery plan to close the deficit. Capacity issues will be resolved by Aug 2023 (new starters joining) and concerted efforts are underway to encourage Merton GPs to sign up to iPlato so that adequate referrals are received.

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	202208	202209	202210	202211	202212	202301	202302	202303	202304	202305	202306
Women accessing PMH services *	1,022	1,049	1,043	1,016	1,025	1,024	1,035	1,046	1,054	1,038	1,079
Estimated births	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595
Nationally Published Figures: Service use per birth (ONS)	6.6	6.7	6.7	6.5	6.6	6.6	6.6	6.7	6.8	6.7	6.9
Service use per birth (For Context Only)	*7.7*	*7.9*	*7.9*	*7.7*	*7.7*	*7.7*	*7.8*	*7.9*	*8*	*7.8*	*8.1*

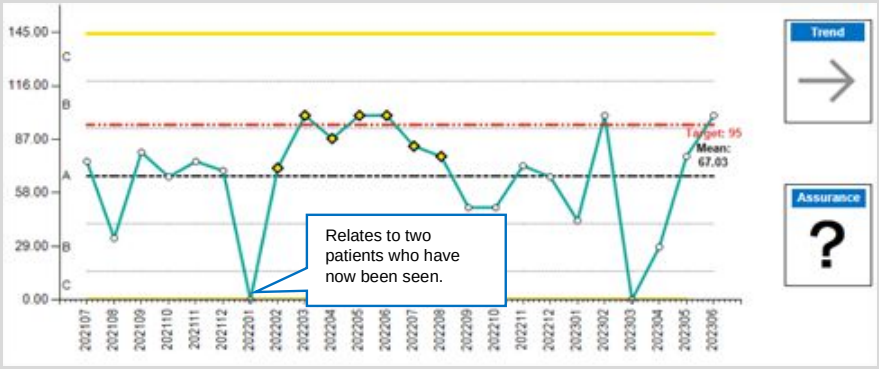
Background
Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of new and expectant mums and covers a wide range of conditions. The NHS Long Term Plan is for improved access to perinatal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

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

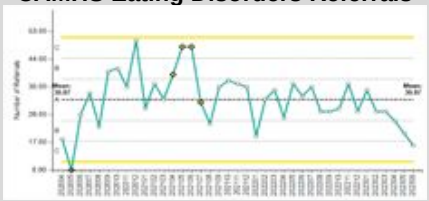
Underlying issue
- National target is based on predicted birth rate which is higher than the actual local birth rate.
- Number of referrals received progressing to assessment is too low in order to reach access requirements of 10% of PMH population.
- Following recent investment there are now new posts that require recruitment.
- High DNA rate for new patient assessments.

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.
- Bank shifts added to capacity in order to increase new patient assessments and reduce waiting time, especially in Sutton & Merton.
- Standardised practice of Health Visitors and midwives attend some huddle meetings this will help increase referrals.
- The service line is currently reviewing impact of recently completed reduction of dna pilot.

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



CAMHS Eating Disorders Referrals



Waiting for Treatment Summary June 2023

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

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

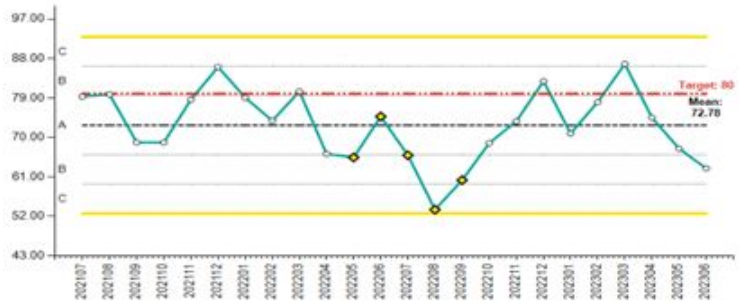
What the chart tells us
Mean performance is below target. Recent months performance have shown improvement with target being met in June 2023.

Underlying issue
- Long term demand and capacity issues within the team.
- Over-reliance on part time staff to maintain administrative systems.
- The denominator for this KPI is low (n=3) in June 2023, so any case seen outside 28 days is likely to lead to target being missed. Full compliance noted for June 2023.
- Recruitment into the service has been challenging with certain posts difficult to recruit to.

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

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

Access



Team Breakdown – June 2023

Team	Assessed Within 8 Weeks	Assessments	% Assessed Within 8 Weeks
Wandsworth CAMHS Tier 3	11	13	84.6%
Merton CAMHS Tier 3	10	14	71.4%
Sutton CAMHS Tier 3	17	25	68.0%
Kingston CAMHS Tier 3	8	16	50.0%
Richmond CAMHS Tier 3	10	21	47.6%
Trust Total	**56**	**89**	**62.9%**

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 target will be met on occasion but there will be variation.

Underlying issue
- Most breaches relate to waits for ADHD medication and Psychiatry. As T3 CAMHS continues to assess more of the backlog of ADHD waiters this KPI will continue to deteriorate of until the backlogs are cleared.
- There are delays in ADHD medication due to the prioritisation of urgent referrals, screening forms being returned late, cancelling appointments and a small number of errors in recording.
- Kingston & Richmond Tier 3 services continue to struggle with assessment slot availability within the team, as resources are being focused on offering therapy slots for waiting patients.
- There will be a further shortfall in non-medical prescriber resource due to expected vacancy.

Actions
- 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.
- Non-medical Prescriber post being advertised for Kingston and Richmond CAMHS to support the ADHD medication demand across both teams.
- Psychiatry recruitment drive across all community teams.
- CAMHS Non Medical Prescriber commenced in post on 15th May and will across Kingston and Richmond.

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

Access

Team Breakdown

Team	Diagnosed Within 8 weeks	Required	%
Kingston Memory Service	11	12	91.7%
Memory Assessment Service Wandsworth	28	29	96.6%
Merton Memory Assessment Service	9	9	100.0%
Richmond Memory Assessment Service	18	20	90.0%
Sutton Memory Assessment Service	31	31	100.0%
Total	**97**	**101**	**96.0%**

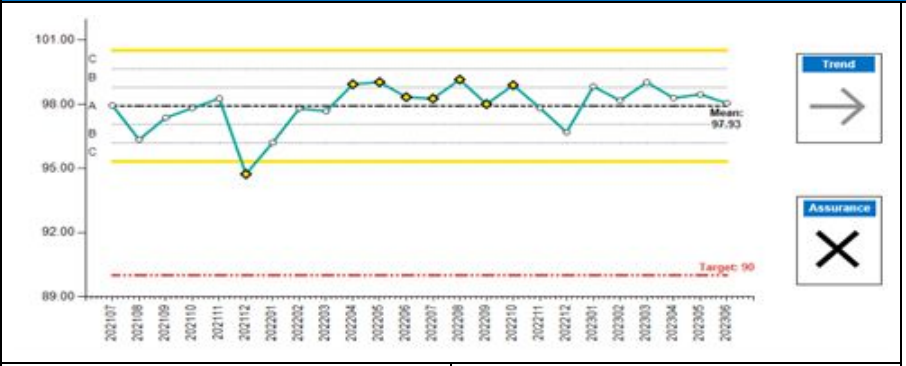
What the chart tells us
Mean performance is comfortably above target indicating frequent compliance with occasional variation.

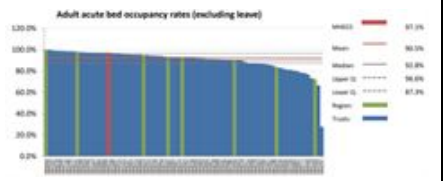
Underlying issue
- 4 breaches reported in June 2023 with all 5 teams above target.

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

Flow

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





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

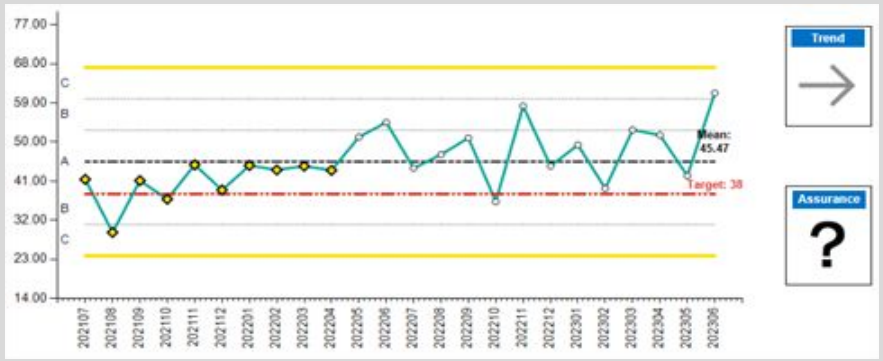
What the chart tells us
Low level variation with mean performance considerably above target.

Underlying issue
- Demand for inpatient services remains high, with over performance on occupancy rates resulting in use of out of area placements and surge beds.

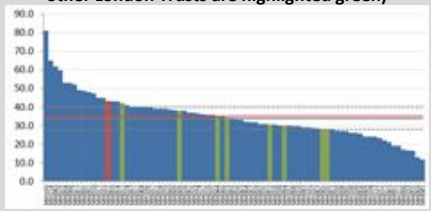
Actions
- The Trust has extended its contract for use of 18 beds at Holybourne in Roehampton until the end of 23/24.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- Work to address occupancy rates is outlined within the 100 day challenge work within inpatient transformation.
- Trust is currently undertaking a review of KPI definition.

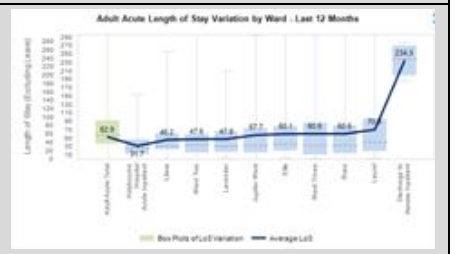
Flow

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



2021/22 Benchmarking (Trust is highlighted red, other London Trusts are highlighted green)





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.

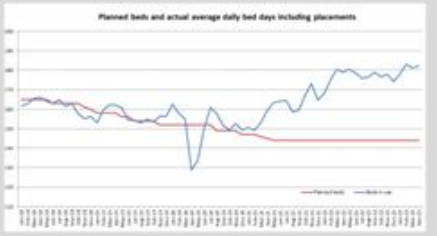
What the chart tells us:
Trust average performance consistently exceeds target.

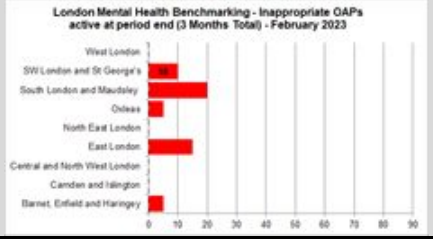
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds 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 and use of Winter surge beds.
- Increased demand can lead to increased acuity on admission and longer time to recover.
- There is variation on LOS between adult acute ward.

Action
- Consistent use of estimated discharge dates (EDD); reviews of patients with stays of over 90 days.
- More assertive use of the improved delayed transfer of care (DTOC) process
- A revised draft choice/discharge policy for use by the discharge co-ordinators has been issued to partners for comment.
- The 100 day challenge action plan to be implemented in July 2023.
- Monthly variability will continue as complex patients are discharged as part of transformation programme, which aims to improve the efficiency of all ward processes. The core & complex and inpatient processes workstream should gradually reduce stays towards the 33-day target during the next 6-12 months.
- As part of data assurance process the Trust is undertaking a review of the definition of length of stay.
- Design Implementation of EUPD/CEN pathway for inpatients.
- In-reach worker now working across all 8 adult acute ward.

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.

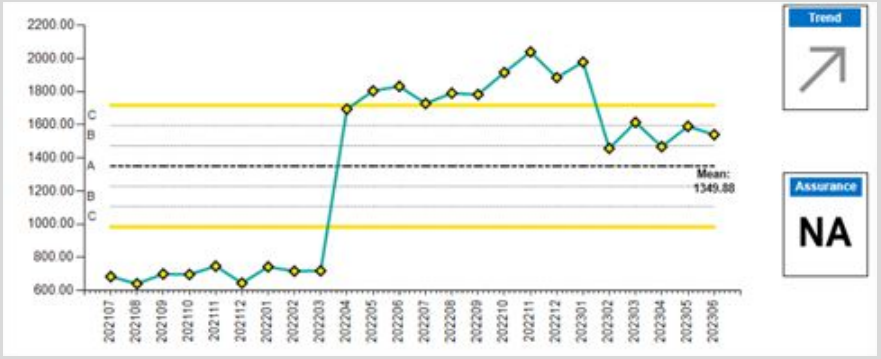
What the chart tells us
- Statistically significant and sustained increase (deterioration) in recent months following a long period of good performance.

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 and use of Winter surge beds. The apparent correlation between external occupied bed days used and increased DToC days is being explored.

Actions
- The Trust has extended its contract for use of 18 beds at Holybourne in Roehampton until the end of 23/24.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- Focus on discharge of patients in private out of area beds where possible (community follow up for those patients with care co-ordinators, otherwise HTT Follow up).
- 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.

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
Low level of variation with performance consistently above mean since April 2022.

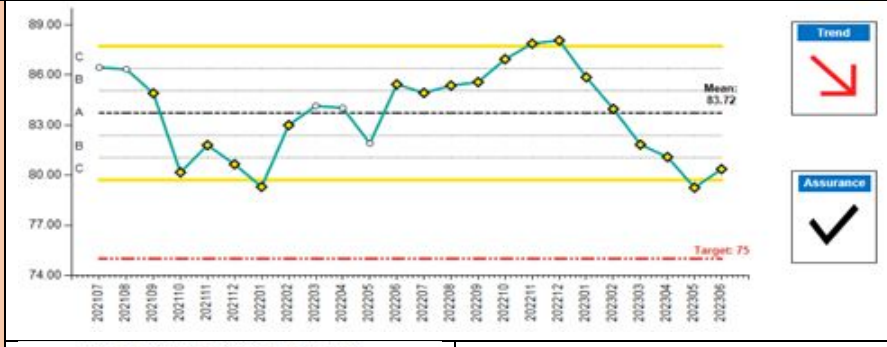
Underlying issue
- There is a lack of understanding across the Trust on tis metric and clarification is required in order for clinical services to address.

Actions
- DHOSD to work with the performance to understand this metric further.
- Ensuring appointments are booked and outcomed in timely fashion will aid improvement.
- A KPI definition is required to aid clinical service understanding of metric.

Quality Domain

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

Fundamental Standards of Care



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

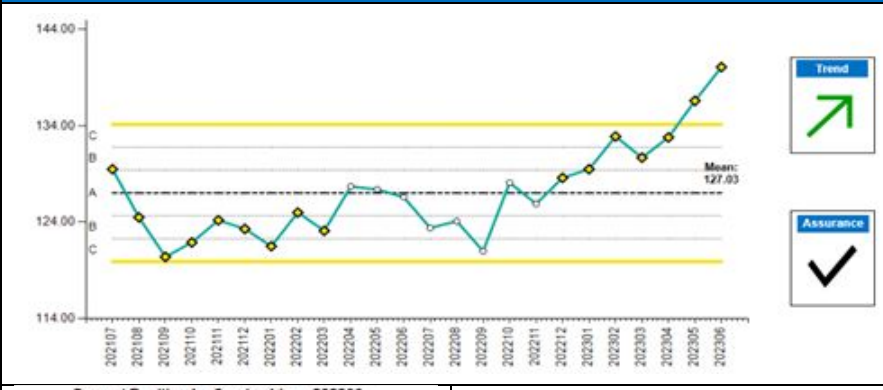
What the chart tells us
It is likely that the target will consistently be exceeded however there is a negative downward trend in performance.

Underlying issue
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised. Trust clinical systems do not support workflow and performance is expected to dip in Q3 when annual re-reviews are required. Some medical staff do not follow processes and there is more focus required on supporting/training junior doctors to complete.
- Number of community patients have declined assessments i.e. due to covid or personal choice. Community Service line have focus on improving the number of clients who receive a full CMA check.

Actions
- Teams have access to shared care records that contain supporting information to simplify the data collection process.
- Acute: All wards using the inpatient caseload dashboard in handover.
- Community: Assertive outreach approach for patients who have refused CMA over the last 12 months, including the offer of home visits.
- Head of Nursing working with ICS in regard to Health and Wellbeing Practitioner providing support across community services with GPs to support improvement in CMA recording.

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

Fundamental Standards of Care



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

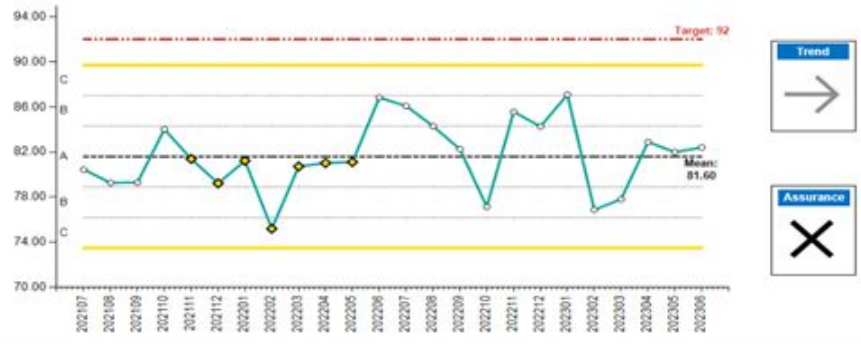
What the chart tells us
Trust performance is consistently above target which is below lower control limit.

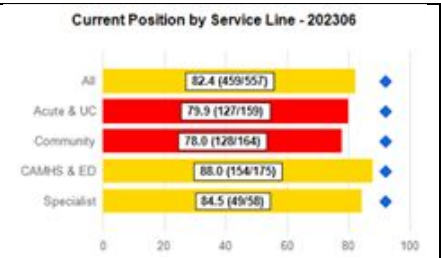
Underlying issue
- In Acute & Urgent care services and Specialist all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.
- CAMHS & ED: All ward areas were safely staffed; Corner House is minimally staffed due to very low occupancy and some team members are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

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

Patient Experience and Outcomes

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





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

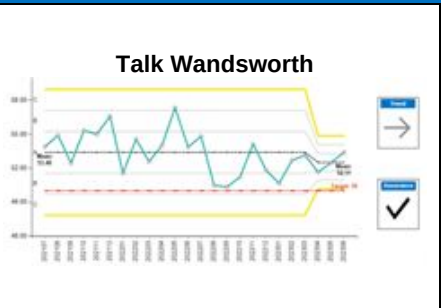
What the chart tells us:
Mean performance is consistently below target a change of process required.

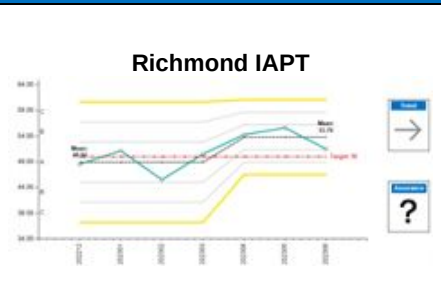
Underlying issues:
- Information Management team are undertaking a review on the target thresholds.
- Challenges with engaging patients to complete at appropriate points in their pathway and staff not actively seeking feedback.
- Using the results in a meaningful way to identify and make improvements within the clinical services.
- Acute and Urgent Care: In inpatient areas kiosks are no longer available; QR codes are displayed and patients and families are encouraged to use them.

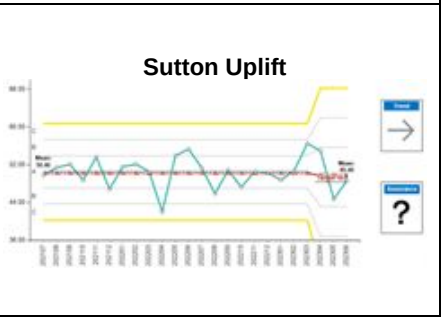
Actions:
- Feedback live has recently been relaunched as a platform for completing Friends and Family Test. First question on system is linked to the Friends and Family Test.
- Staff encouraged to promote use of the FBL QR code for service users and carers (FBL first question is the FFT).
- Community Service Line: Promoting use of the FBL QR code for service users and carers (FBL first question is the FFT).
- Governance Leads attending Community QGG to relaunch FFT.
- Head of Service Delivery met with Associate Director of Quality and Governance and agreed plan to help support with increasing feedback. There is now specific focus on certain teams within each borough.

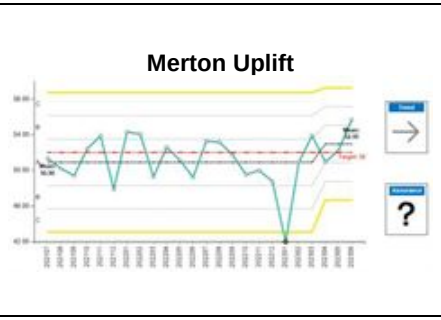
Patient Experience and Outcomes

IAPT recovery rate (%) — Target ≥ 50%









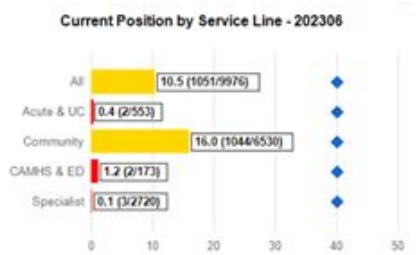
Background
Improving Access to Psychological Therapies (IAPT) is an NHS programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety.
What the chart tells us
Sutton Uplift is below target whilst all other services are likely to exceed the target which is below the average performance; Merton Uplift is also exceeding locally agreed stretch target of 52%. Monthly variation is expected.
Underlying issues
- Clients who 'drop-out' and fail to attend appointments (DNA) may be discharged before they have 'recovered'. This can be more apparent with sub-contracted services.
- Routine audits have shown that some processes around discharging clients (who were unrecovered) are not always being followed.
- Drop off in recovery rate in Sutton to be reviewed.
- Poor timeliness on discharge led to inconsistency /fluctuation in recovery.

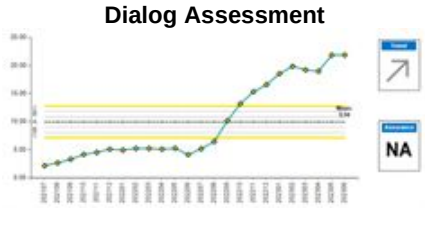
Actions:
- Data cleansing for historic months has now been completed in all boroughs.
- Engagement with service users to ensure they complete treatment course or offer further sessions if close to recovery.
- Clinical leads implementing a programme of work this year intended to improve diagnostic assessment and treatment planning decisions. This is being launched in May 2023 in Sutton, Merton and Wandsworth.
- Deep dive on Sutton Uplift quarter 1 recovery rate to be undertaken in July 2023.
- Individual recovery rates for clinicians are monitored in all services and shared with staff to support improvements.
- Project for 2023 to be undertaken to draw comparison between 1:1 & Groups at step 3 for quality improvement with trainees.
- Cross-borough recovery working group has now been established to identify interventions to support improved recovery across all services.

Patient Experience and Outcomes

Paired Dialog Completed

Target ≥ 40%



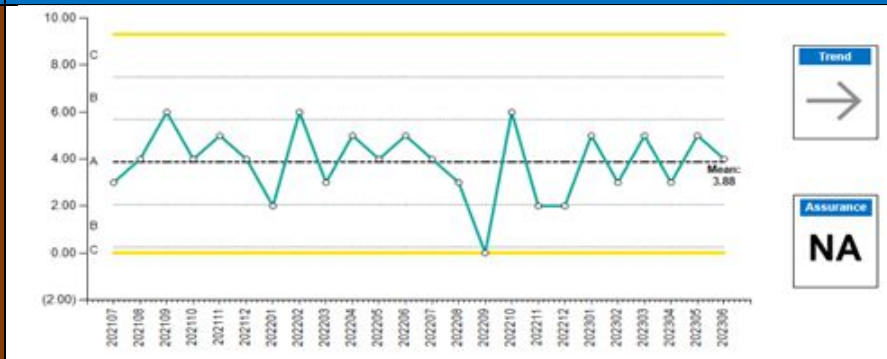
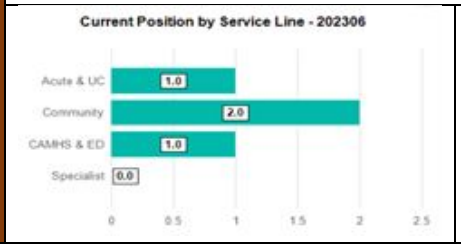
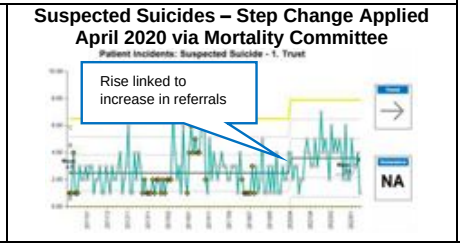


Background
DIALOG is an 11-question survey whereby people with a mental health illness are asked to rate their satisfaction and needs for care on 8 life domains and 3 treatment aspects. It is a tool that is completed by the service user and its content helps to highlight areas they may want support with.

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

Underlying issue
- Reporting on paired dialog is a new priority metric for 23/24; local practice is being embedded.
- Review of team inclusions for DIALOG is ongoing and is discussed at the Patient Experience & Outcomes Group.
- 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.
- Patients remaining on community caseloads for long periods are not completing more than one DIALOG currently i.e. no discharge DIALOG.

Actions
- SOP for dialog use has been developed and issued to across the Trust.
- Specialist Service Line to raise exclusions queries with Patient Outcomes Group.
- Baseline DIALOG completeness to be discussed at Improving Patient Outcomes Group (IPO) and further strategy for improvement to be recommended,
- Community: DIALOG refresher training held in June 2023.

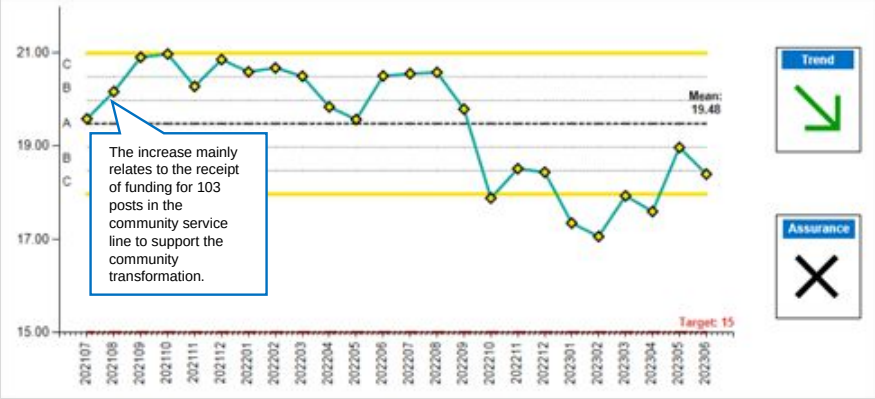
	Death - Suspected suicide	No Target
Patient Safety		**What the chart tells us** The number of suicides each month is subject to variation. Numbers reported are low. **Underlying Issue:** - There were four suspected suicides reported in June 2023. - The number of suicides being reported month to month continues to vary. This data was reviewed in the bi-monthly Mortality & Suicide Prevention Committee. The mean monthly average has increased from 2.9 (pre-April 2020) to 3.5 (post April 2020). **Actions:** - All such incidents will be subject to a review in line with the Patient Safety Incident Response Framework (PSIRF). - The milestones from the Trust's Suicide Prevention Strategy continue to be monitored via the Mortality & Suicide Prevention Group. - Suicide Prevention Conference took place in May 2023.
		

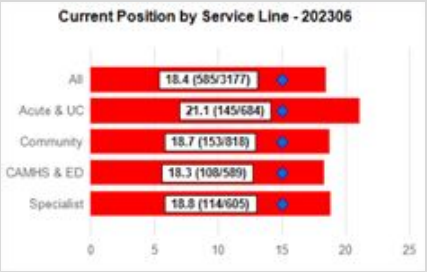
Workforce Domain

Recruitment / Attraction

Vacancy Rate (%)

Target ≤ 15%





Benchmarking – NHS Digital Q4 22/23

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

Vacancies by Staff Group

Staff Group	Post Fte	Assign Fte	Vacant FTE	Vacancy Rate FTE
Allied Health Professionals	168.5	126.3	42.2	25.0%
Nursing and Midwifery Registered	884.8	676.1	208.7	23.6%
Additional Clinical Services	722.2	584.5	137.7	19.1%
Add Prof Scientific and Technic	486.4	395.1	91.3	18.8%
Medical and Dental	240.8	210.2	30.7	12.7%
Administrative and Clerical	637.2	566.6	70.6	11.1%
Estates and Ancillary	35.0	31.9	3.0	8.6%
Healthcare Scientists	2.0	2.0	0.0	0.0%
Total	**3,176.9**	**2,592.7**	**584.1**	**18.4%**

Background

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

What the chart tells us

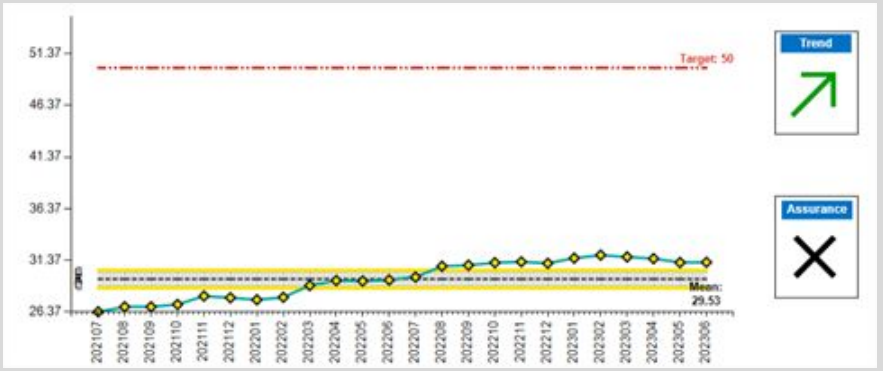
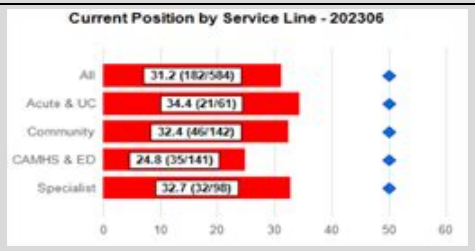
There has been variation in the Trust vacancy rate with mean performance above target. Recent months have seen a decrease (positive downward trend).

Underlying issue:

- Each Service Line has created a workforce plan, and they will be working in partnership with the Head of Resourcing and the People Delivery Partner to ensure there is a continued focus on recruitment, including bank and agency conversions into vacant positions.
- The Trust turnover has increased steadily over the last 2 years, which impacts on the vacancy rates, in addition to the newly created roles as in some months there are more staff leaving than being recruited.
- There is a national shortage of various professions and so even with robust recruitment initiatives, for some posts successful recruitment will still continue to prove challenging.
- To meet the skills shortage in some areas new roles will need to be considered and developed at pace to enable areas to continue to provide high quality patient care.

Actions:

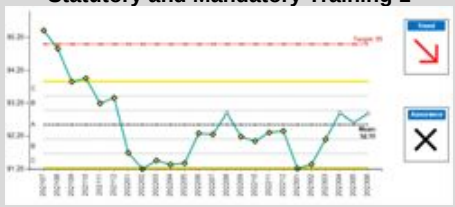
- **Recruitment Annual Timetable** – detailed recruitment timetable for the year compiled by the Recruitment Team which is being developed to continue to build recruitment opportunities and ensure mass recruitment campaigns are scheduled effectively to meet the organisational need.
- **Recruitment Delivery Group** – the first of these meetings has taken place with key stakeholders in the organisation 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.
- **Career pathways** – Two workshops are being scheduled to understand key skills gaps and possible new career paths and new roles. These will be held in September 2023.
- **Workforce Plans** – These have been established in each service line and are now being monitored through the Service Line Reviews. This also contains details about the recruitment hotspots and other key people issues.
- **Increased support within Temporary staffing** – additional support has been moved to the Temporary Staffing team to provide professional nursing support to the recruitment and management of bank staff and further to support conversion to substantive roles and conversation of staff with qualifications in other countries.
- **Vacancy Rate** – During September and October a drop in vacancy rate to at or below 15% is expected owing to numbers currently within our recruitment pipeline.

	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:** - More work needs to be undertaken to understand where the blocks are in terms of our black, Asian and ethnic minority staff progressing in the organisation. It is likely that this is at grades below 8a and the lack of career progression opportunities between bands 6-8a within certain clinical areas, which has been flagged as part of the workforce planning process. - Our anti racism programme has a workstream focussed on career development and has identified that a small pilot is required to understand what more can be done to enable greater career conversations and progression for colleagues keen to progress. - Specialist: Diversity and Inequalities forum is now in the early stages of introduction with a first meeting having taken place in June. As part of this initiative further EDI champions will be appointed to assist in promoting Equality and Diversity within the service line. - One-day workshop entitled 'Managing racism in the workplace' has been commissioned and will be delivered on 9th and 23rd May 2023. - Community: New borough based band 7 inequalities leads to be recruited as part of transformation. - Ensure all recruitments have a DIR rep on the panel. (Diversity in recruitment), especially for 8+ posts. - CAMHS & ED: Service line has staff members on the HEE Ethnic Minority Psychological Professions Leadership Mentoring Scheme - The EDI committee has committed to running focus group discussions with Black Asian and Minority Ethnic colleagues based on the NHSE Scope for Growth model. These workshops are being supported by a HR Consultant with expertise in this area of career development dialogue.

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

Current Position by Service Line - 202306

Current Position by Service Line - 202306

Training Compliance Projection – MAST 1

Certificate Name	Actual				Projection			
	May-23	Jun-23	Jul-23		Aug-23	Sep-23	Oct-23	
	%	%	%	Breaches	%	%	%	Breaches
Adult Basic Life Support (1 year)	85.4%	89.5%	91.1%	37	86.4%	81.8%	74.4%	107
FFP3 Mask Testing (2 Year)	64.5%	68.6%	68.7%	86	68.0%	66.5%	65.8%	94
Fire Safety Awareness (Community) (2	94.7%	95.2%	94.2%	77	91.8%	89.3%	86.8%	187
Fire Safety Awareness (Inpatient) (1	87.2%	88.8%	87.9%	74	82.5%	78.4%	68.4%	194
Fire Safety Awareness (Non-Clinical) (2	95.8%	95.7%	95.6%	33	91.9%	89.0%	86.8%	104
Infection Prevention and Control L1 (3	90.3%	88.8%	89.2%	56	89.2%	89.0%	88.6%	59
Infection Prevention and Control L2 (1	93.2%	93.6%	93.5%	145	84.4%	76.9%	67.5%	720
Information Governance (1 Year)	95.1%	95.9%	95.6%	120	87.3%	80.2%	71.0%	790
Medical Emergency Training (1 Year)	66.2%	66.0%	65.4%	81	71.8%	73.1%	67.9%	75
Medicines Management (Community) (2	89.4%	88.7%	87.2%	56	82.4%	79.2%	76.0%	105
Medicines Management (Inpatient) (2	92.9%	94.6%	95.8%	10	91.6%	87.0%	81.9%	43
Naso-gastric Intubation & Entral Feeding	85.2%	80.8%	80.0%	5	80.0%	80.0%	80.0%	5
Proactive Physical Interventions (3	85.8%	87.5%	87.0%	65	89.2%	86.2%	84.0%	80
Safeguarding Adults Basic Awareness -	95.4%	95.9%	95.7%	118	94.6%	93.6%	91.9%	221
Safeguarding Adults Level 2 (3 Years)	92.4%	93.2%	93.0%	136	91.5%	90.8%	89.8%	215
Safeguarding Children and Young People	91.4%	93.0%	93.6%	37	91.7%	89.4%	87.6%	75
Safeguarding Children and Young People	84.5%	86.5%	86.7%	112	85.6%	84.6%	83.6%	138
Safeguarding Children and Young People	87.3%	80.1%	80.9%	250	72.2%	67.5%	65.0%	386
Safeguarding Children and Young People	82.2%	86.3%	85.7%	41	85.0%	85.0%	83.9%	46
All Certificates (95% Target)	91.2%	91.7%	91.6%	1499	87.5%	83.9%	79.5%	3644

Training Compliance Projection – MAST 2

Certificate Name	Actual				Projection			
	May-23	Jun-23	Jul-23		Aug-23	Sep-23	Oct-23	
	%	%	%	Breaches	%	%	%	Breaches
ABLS eLearning for Community and	11.1%	73.8%	73.7%	123	68.3%	55.1%	48.5%	241
Advanced Patient Handling (2 Years)	81.4%	82.8%	84.2%	75	84.2%	82.5%	78.3%	103
Care Certificate	75.3%	79.5%	79.3%	67	80.8%	80.8%	80.8%	62
Conflict Resolution and Breakaway (3	81.4%	83.5%	83.7%	265	85.7%	84.8%	83.7%	265
Equality and Diversity (3 Years)	97.1%	97.9%	97.8%	60	96.8%	95.7%	93.9%	165
Food Hygiene Level 1 (3 Year)	99.1%	98.5%	98.5%	3	96.0%	95.0%	93.5%	13
Food Hygiene Level 2 (3 Year)	83.6%	83.8%	85.8%	20	84.4%	83.7%	81.6%	26
Food Hygiene Level 3 (3 Year)	33.3%	33.3%	50.0%	1	50.0%	50.0%	50.0%	1
Health and Safety General Awareness (3	96.8%	97.2%	97.2%	77	95.5%	94.0%	91.8%	223
Load Handling (2 Years)	85.4%	85.0%	85.0%	6	85.0%	87.5%	87.5%	13
Mental Health Law Training (3 Year)	77.3%	82.7%	82.7%	283	83.6%	83.9%	82.5%	286
National Early Warning Score (3 Years)	97.8%	97.9%	97.9%	11	97.1%	96.7%	95.7%	22
Observation and Intensive Engagement	97.3%	97.4%	98.0%	9	97.6%	97.6%	96.7%	15
Prescribers Medicines (2 Years)	53.4%	63.7%	64.9%	85	68.3%	58.7%	55.4%	108
PREVENT Basic Awareness - Level 1-2	93.6%	94.3%	94.8%	40	94.8%	94.8%	94.8%	40
PREVENT Raising Awareness - Level 3-	93.1%	93.4%	93.4%	129	92.3%	91.5%	90.2%	192
Rapid Tranquilisation (3 Years)	97.0%	92.4%	92.5%	40	91.4%	89.9%	88.2%	63
RATE Training (3 Year)	62.7%	64.8%	68.8%	411	68.9%	69.3%	68.7%	413
Safeguarding Adults Level 3 (3 Years)	29.0%	39.8%	40.6%	563	40.6%	40.6%	40.6%	563
Safety in Motion - (Discontinued)	51.7%							
Security Awareness (Forensic) (1 Year)	92.5%	92.4%	91.6%	12	81.8%	69.9%	61.5%	55
All Certificates (85% Target)	81.9%	86.3%	86.8%	2280	85.9%	85.0%	83.3%	2865

Background

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

What the chart tells us

MAST 1: There has been a significant downward trend in performance more recent months have improved but remain below mean which is below target.

MAST 2: Despite reduction in performance the Trust remains well above target. Significant downturn in May 2023 (special cause variation) had been followed by immediate improvement.

Underlying issue

A detailed piece of work by the Head of Learning & Development has established some historical underlying reasons for % Compliance not being at the required level - some quick solutions have been put in place:

- The application used to record MAST (COMPASS) required a system upgrade on the operating platform (Totara) to enable training activity to be registered correctly. This was successfully completed on 14 June 2023.
- Management of cancelling existing Bookings / managing DNAs (no shows on the day) - cancellations can now be made up to 24 hrs before the start of the course, therefore reducing the no show rates. DNAs therefore are only recorded if a colleague does not attend on the day. This required the system to be updated to delivery this improved process.
- Technical issues associated with dashboard, COMPASS and e-LFH possibly related to firewall issues are impacting the ability for recording of completed training – mitigation in place is for people to share the fact they have completed with the L & D Team.
- Review of MAST requirements as this has grown over time with further requirements to be added.
-

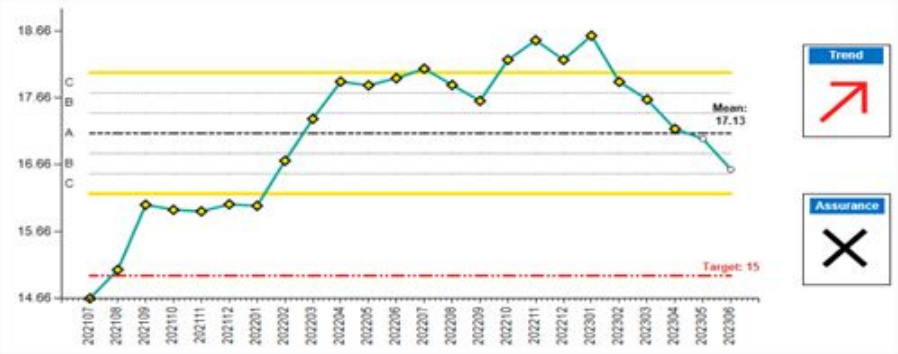
Actions:

- The Director of People and Director of Nursing & Quality have met with the Head of Learning & Development to review the MAST 1&2 list. This is now being checked with each SME to confirm changes.
- Service Lines asked to adopt a proactive and focused approach to increasing their compliance rates, and to work with their dedicated LDT administrator for solutions to access or availability issues.
- Recommendations will be shared in respect of the next steps for the technical elements of the project i.e. confirm where our server is hosted, the establishment build on Compass and ways to resolve the firewall issues.
- Continues focus on DNA rates, and improved process in place on Compass to define cancellation v DNA.
- Understand underlying issues related to the DNA rates for bank staff which are high.
- Refine the audiences for revised MAST 1 and 2 list and ensure this is reflected within COMPASS system.
- New MAST 1 and 2 list to be reflected into dashboard reports.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%



Annual Turnover FTE – March 2022 – March 2023

Trust	Leavers	%
Tavistock and Portman NHS Foundation Trust	145.3	22.2%
Camden & Islington NHS Foundation Trust	424.0	19.3%
South West London and St George's Mental Health NHS Trust	422.1	17.6%
Central and North West London NHS Foundation Trust	1251.4	17.3%
Barnet, Enfield and Haringey Mental Health NHS Trust	549.4	17.2%
East London NHS Foundation Trust	1063.0	17.0%
North East London NHS Foundation Trust	1022.1	16.5%
West London NHS Trust	631.1	16.1%
South London and Maudsley NHS Foundation Trust	787.6	15.2%
Oxleas NHS Foundation Trust	548.6	14.5%
London Average	684.0	17.3

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

Turnover has been on negative upward trend more recent have seen turnover rate decline but position remains above target.

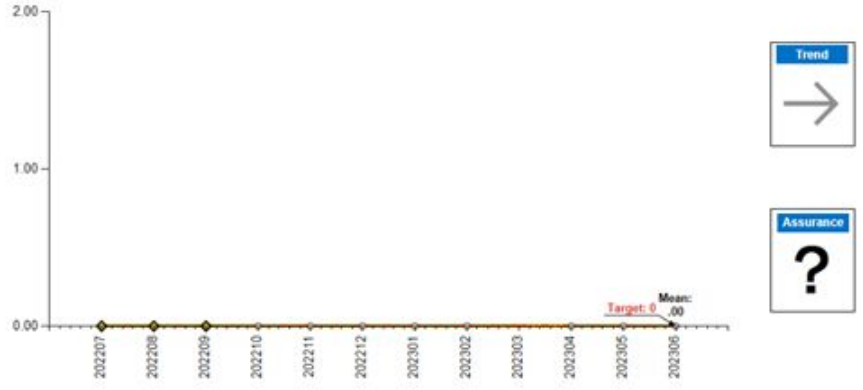
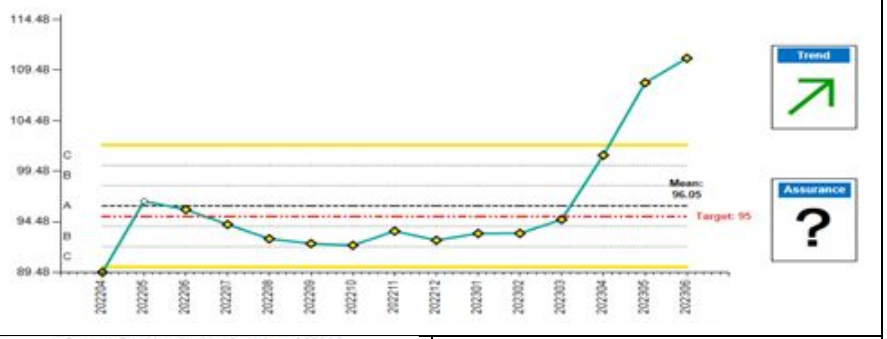
Underlying issue

- Turnover is starting to slowly decrease, however we are still above the 15% target. The high turnover rates are likely impacted by the high vacancies in some teams and lack of career progression and cost of living within SWL.
- Turnover under 12 months is increasing and over 30% of this is from staff who are aged 30 or below.

Actions:

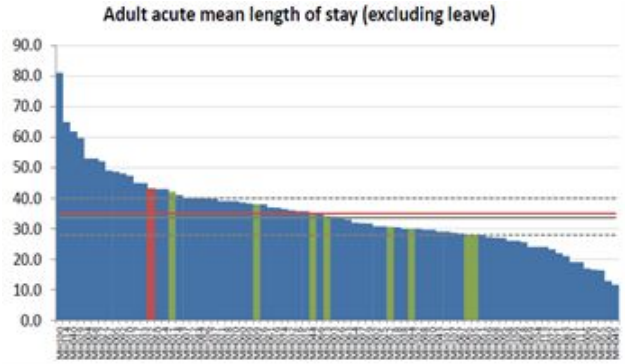
- A revised detailed retention plan is being developed to be managed through People Matters.
- Actions will include, stay interviews, consideration of external exit provision, revised exit process, review of bespoke actions needed by SL as the reasons for leaving will be different.

Finance Domain

	% Forecast budget overspend	Target TBC
Grip & Control		**What Chart Tell us:** The chart indicates that Trust forecast is currently at break-even position. **Underlying Issues:** - Trust is forecast break even after month 3. **Actions:** - Acute and Urgent Care: Pay overspends on wards due to observation levels; being addressed through FSOC and review of observations and engagement- fidelity to the trust policy and recruitment to vacancies. Out of area bed placements which are unfunded aside from the acute bed contract with Holybourne and a Trust wide approach being adopted to reduce demand for beds. - Workforce plans being finalised to address agency, along with increased control mechanism. - CIP plans being finalised for all services.
	Contracted activity - Local CCG contract (%)	**Target ≥ 95%**
Productivity	 	**What Chart Tells Us:** Mean performance is above target indicating frequent compliance. 23/24 compliance is comfortably above target and has exceeded upper control limits in recent months. **Underlying Issue:** - Activity plans for 23/24 have been finalised with activity post April 23 based. - Community: Poor compliance with activity recording in some teams - Clinicians may review patients from different teams, but they do not have access to this teams diary on RIO e.g. Depot, CMA and Clozapine Clinics. **Actions:** - Community: Activity recording training currently been delivered to all outlying teams, to be completed by the June - Clinics staff to be given access to all RIO team diaries of patients that they review.

Appendix 1: Benchmarking

The NHS Benchmarking Network's 2021/22 Inpatient and Community Mental Health Benchmarking Report was issued in October 2022 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.

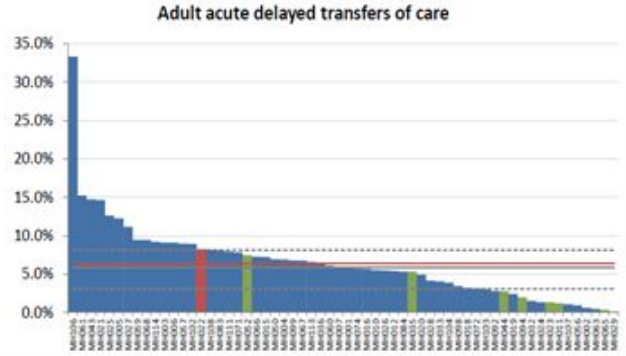


- **Adult acute average length of stay (days):**

2021/22		2023/24	
Trust	England	Jun-23	YTD
43.0	34.9	65.0	55.8

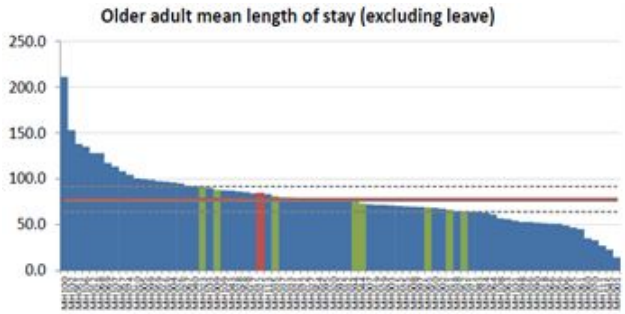
- **Adult acute bed occupancy rate (%):**

2021/22		2023/24	
Trust	England	Jun-23	YTD
97.1%	90.5%	98.5%	98.3%



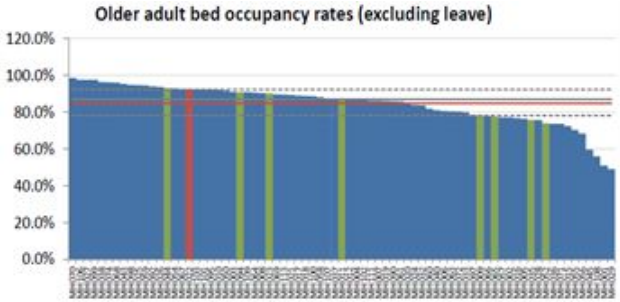
- **Adult acute delayed transfers of care (%):**

2021/22	
Trust	England
8.1%	6.4%



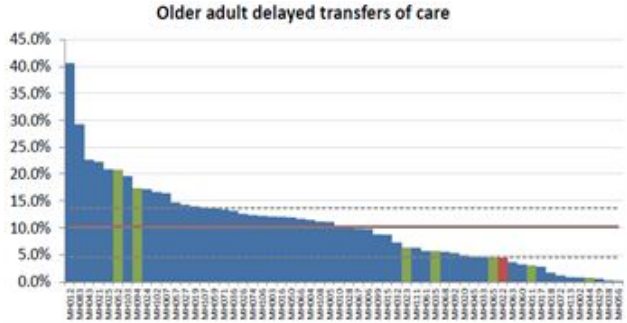
- **Older people's average length of stay (days):**

2021/22		2023/24	
Trust	England	Jun-23	YTD
84.0	78.5	96.1	96.1



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

2021/22		2023/24	
Trust	England	Jun-23	YTD
92.6%	84.8%	97.6%	97.6%



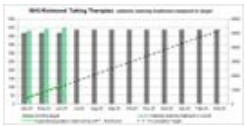
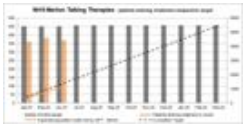
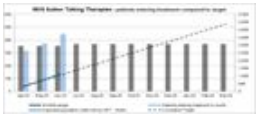
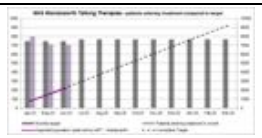
- **Older people's delayed transfers of care (%):**

2021/22	
Trust	England
4.4%	10.3%

Appendix 2: NHS England Oversight Metrics

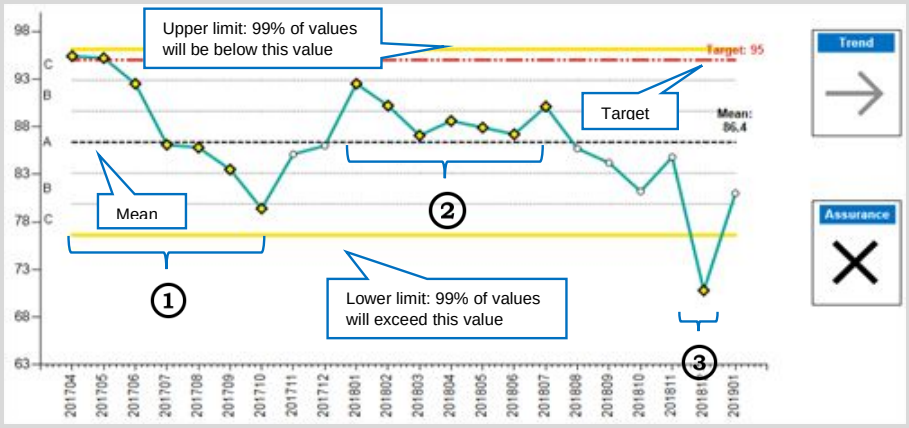
To provide an overview of the level and nature of support required across systems and target support capacity as effectively as possible, NHS England and NHS Improvement have allocated trusts and ICB's to one of four segments. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

It should be noted that the Trust remains at segment 1 of 4 on the NHS Improvement (NHSI) Single Oversight Framework (SOF) which means that no potential support needs are currently identified.

NHSI SOF Operational Performance Metrics	Jun-23	Target	SPC Chart	Comments
Number of children and young people accessing mental health services as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people with severe mental illness receiving a full annual health check and follow up intervention as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people accessing IAPT services (Richmond).	1326	1257		Richmond Wellbeing service is on track to achieve access requirements for 2023/24.
Number of people accessing IAPT services (Merton).	1114	1344		Merton Uplift is below its cumulative access requirements for 2023/24.
Number of people accessing IAPT services (Sutton).	1137	1059		Sutton Uplift is above its cumulative access requirements for 2023/24.
Number of people accessing IAPT services (Wandsworth).	2205	2310		Talk Wandsworth is below its cumulative access requirements for 2023/24.

Number of adults and older adults with severe mental health accessing community mental health services	-	-	-	Metric to be incorporated in future reports.
	357	= 0		Trust continues to require use of out of area beds due to high demand. Trust has renegotiated use of 18 beds at Holybourne until end of 23/24 and continues to open surge beds at times of peak demand.

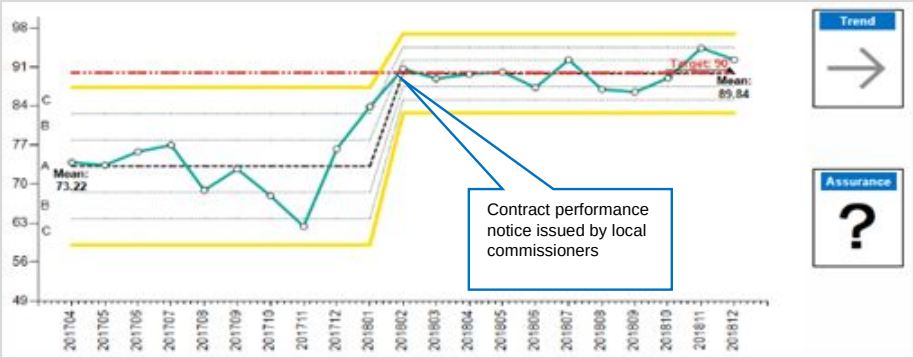
Appendix 3: Statistical Process Control (SPC) Charts & Performance Donut



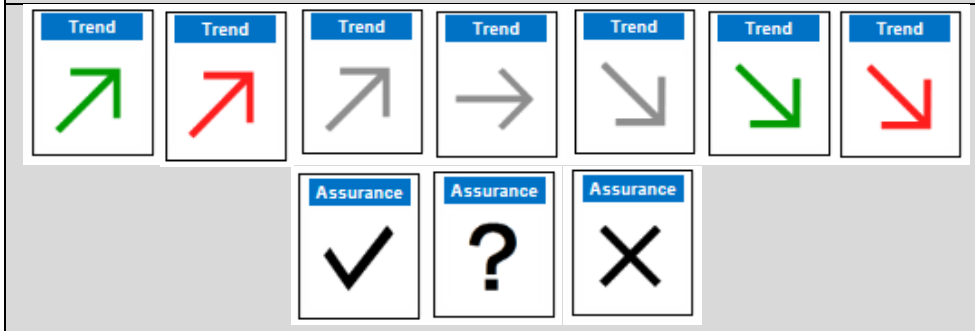
What is an SPC chart?
A Statistical Process Control (SPC) chart is a time series graph (we try to use 2 years) with three reference lines – the mean, upper and lower control limits. The limits help you understand the variability of the data. The variance of the data determines the process limits and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

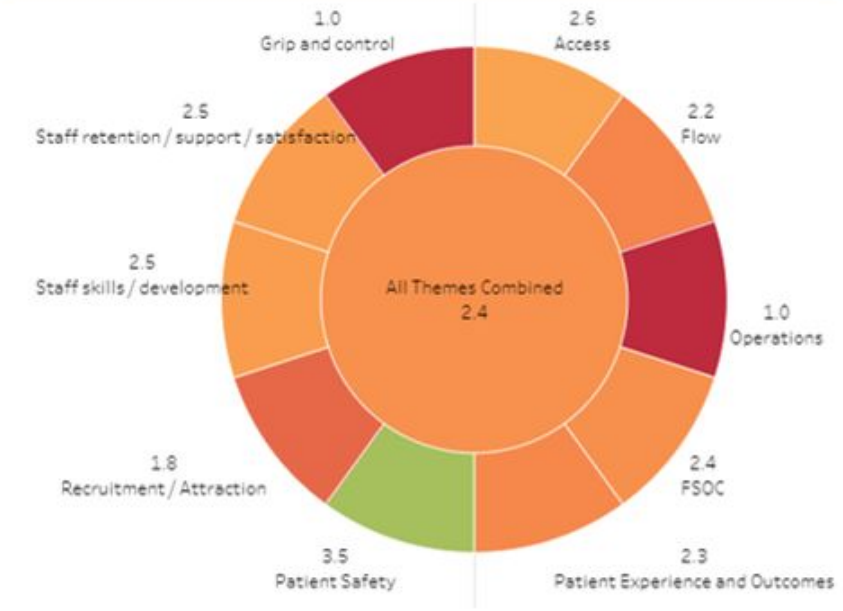


Use of icons to interpret charts
The Trend icon is shown as one of seven upward, horizontal or downward arrows depending on which direction the data is heading, coloured green, grey or red to indicate whether this is an improvement or deterioration in performance (or neutral where there is no target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

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

July 2023

Glossary

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

Contents

Part A: Executive Summary

What

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

Execs continue to oversee work on improving practice around observations and reducing agency usage, with a further focus on advancing our use of the SIREN tool to support service lines in working with challenged teams and ensuring robust engagement with teams around operational and clinical concerns. The SIREN output will be reviewing in upcoming SLR meetings and service lines will be developing how they use the tool through, for example, safer staffing discussions and team meetings.

The organisation's performance remains stable, overall amber, with ongoing challenges to further improvement presented by patient acuity and demand, as well as ongoing industrial action. We continue to prepare for the move of the Shaftesbury wards in the coming months and embed clinical transformation work and track through the benefits of the EMP phase 1 programme.

An area of ongoing challenge is our crisis pathway where we continue not to meet standards for timely assessment and waits within ED, driven in part by extended LOS and delayed transfers of care meaning a lack of ability to move patients to acute MH beds. The psychiatric liaison services have put together an improvement plan with transformation support which is now in progress, and there are positive signs that the inpatient and discharge improvement work is starting to take effect, with slight reduction in use of out of area beds in July and August, though industrial action continues to contribute to slow patient flow. Senior discussions and project work at London level continue about the "Right Care Right Person" programme, contributing to work in progress to improve section 136 pathways for patients in mental health crisis.

As flagged last month, the Trust continues to work to address 52 week and 30 week breaches, in particular high demand service areas such as ADHD diagnosis, complex emotional needs services, and talking therapies. A range of solutions including recruitment and workforce review, standardising our offer for psychological therapies, and working on shared care pathways with GPs, are in progress.

It is encouraging that the patient safety domain of performance remains green and we are working to implement the Patient Safety Incident Response Framework as well as design a more holistic care and safety planning framework which will replace CPA in due course, a project manager is being recruited for this work.

As is expected at this time of year our vacancies remain higher than the minimum target of 15% but as previously reported this is expected to improve in Sept/Oct as onboarding commences with a number of newly qualified colleagues. Overall turnover is reducing from its highest of 19% in Jan 2023 to 17.1% for July 2023 which is promising however the turnover for those with less than 12 months is seeing an upward trend.

MAST compliance is steadily increasing – key points to note since the last board report are the firewall issue has been resolved so records are automatically updating. MAST 1 and MAST 2 requirements have been reviewed with professional leads and final approach agreed at ELT. SMEs are refreshing their audiences to reflect this and the compass and dashboard are being updated. The L&D Team have a new Head of Learning & Development in post (on secondment), with a dedicated lead working on MAST compliance. We remain confident that our compliance rate will be met in Q3.

The Trust plan is a £0.2m surplus for the year. To achieve this, the Trust needs to deliver savings of £13m. Cumulative savings delivery to Month 4 contributes £4.7m towards this target and the Trust has a 93% confidence of being able to deliver the full £13m during the year.

So What

There has been ongoing focus on acute transformation and flow to address the significant sustainability issues with the quality and cost of out of area placements as well as high levels of observations being used on the wards. We are committed to supporting transformational changes to embed and be maintained and therefore we are mindful of how to balance immediate actions to support flow especially during industrial action, with making time and space for transformation leadership. Early signs are positive that time taken to engage staff has resulted in more effective change, and a similar approach is being taken with psychiatric liaison improvement. Alignment to SWL system MH in ED plans is also a consideration, with active discussions with acute, Local Authority and UEC colleagues.

Continued focus on waiting times is led through the Trust Access Group and the new Access policy and SOPs will also be embedded, as well as improved referral and waiting list management processes. We anticipate improvement in visibility and management of waiting lists in future months and improvement will also be supported through the Clinical Efficiency sustainability programme.

Action plans have been completed to ensure an improvement in the current levels of agency use. Working with the Director of Nursing and their team, revised process are in place to reduce the amount of time that wards can request agency, scrutiny of some of the areas that are in the top three agency users, this is starting to see an improvement but this will be tracked to ensure it can be sustained.

A detailed plan focussing on quick wins to tackle retention under 12 months has been developed and in addition our priority is on the c330 new starters to joining the Trust in Sept/Oct to ensure that there is a concentrate focus on those who are joining us in the next quarter.

With regard to MAST key points to note since the last board report are the firewall issue has been resolved so records are automatically updating. MAST 1 and MAST 2 requirements have been reviewed with professional leads and final approach agreed at ELT. SMEs are now refreshing their audiences to reflect this and the dashboard is being updated. The L&D Team have a new Head of Learning & Development in post (on secondment), with a dedicated lead working on MAST compliance. We remain confident that our compliance rate will be met in Q3.

Our Leadership Development Programme will launch in September 2023, with the first offering focussed on our Team and Clinical Leaders. We are ensuring that the leadership development reflects key priorities focussed on leading through change and transformation, embed the principles of our OD Framework and ensure leaders recognise the impact they have in senior positions.

The Trust is in a relatively stable financial position in the context of significant challenges across SWL ICS.

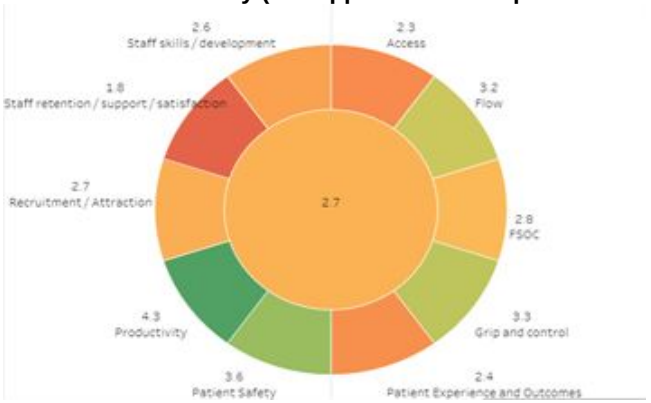
What Next

We are seeing indicators moving in the right direction in a number of areas, but the challenges of meeting significant increased demand and acuity in all services with a constrained workforce mean that improvement is slow. A range of transformation work supports our key priorities of workforce and patient flow, and we are focusing on embedding and sustaining changes and improving our tracking, realisation and communication of benefits within our transformation programmes.

Ongoing focus on recruitment and more importantly retention is required as vacancy levels, agency use and staff satisfaction remain challenging. This will be supported by the development of the Leadership framework and organisational development work.

Refreshed Board committee Q&P reports are in place for September meetings, with KPIs relevant to the committees' respective priority areas, and additional focus as applicable. This will include SIREN reporting for QSAC and People Committee, and transformation programme specific overviews for EMC. Triangulation of committee discussions takes place through the Board Q&P report and discussion.

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

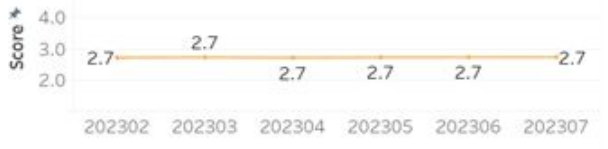


Summary Domain Performance:

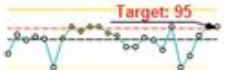
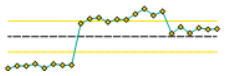
Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	6	17	16	59.0%
Quality	7	16	8	74.2%
Workforce	1	3	8	33.3%
Finance	0	3	0	100.0%
Total	**14**	**39**	**32**	**62.4%**

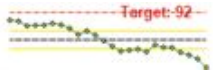
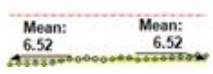
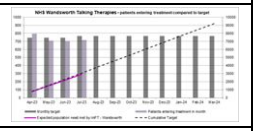
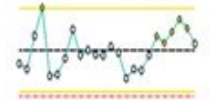
A table showing how many KPIs have full assurance, some assurance and no assurance, split by domain.

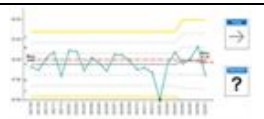
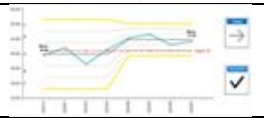
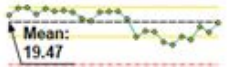
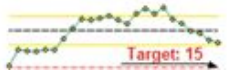
Donut Performance over-time (all themes combined):

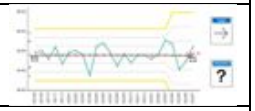
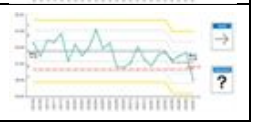


Priority Metrics

	Priority Metrics	Jul-23	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 8)	41.7	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 9)	24	= 0	↗	X	
	Access					
	Referral to treatment (RTT): 52 week breaches (see page 11)	269	= 0	↗	X	
	Access					
	Expected population need IAPT – Merton Uplift (see page 11)	1474	1801	-	-	
	Access					
	Expected population need IAPT Sutton Uplift (see page 11)	1559	1428	-	-	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 12)	100.0	≥ 95.0	→	?	
	Access					
	Dementia diagnosis within 6 weeks of referral to a memory assessment service (%) (see page 13)	92.8	≥ 85	→	?	
	Access					
	Adult Acute Bed Occupancy (see page 14)	98.5	≥ 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 15)	1567	-	↗	-	
	Flow					

	Priority Metrics	Jul-23	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (see page 8)	76.3	≥ 95.0	↘	X	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 10)	70.1	≥ 92.0	↘	X	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 12)	6.8	≥ 10.0	↗	X	
	Access					
	Expected population need IAPT – Richmond (page 11)	1739	**1695**	-	-	
	Access					
	Expected population need IAPT – Talk Wandsworth (see page 11)	1923	3078	-	-	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 13)	58.1	≥ 80.0	→	?	
	Access					
	Adult acute average length of stay (Excluding PICU) (see page 14)	53	≤ 38	→	?	
	Flow					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 15)	276	= 0	↗	X	
	Flow					

	Priority Metrics	Jul-23	Target	Trend	Assurance*	SPC Chart
Quality	Cardiometabolic Assessments - Community and EIS (%) (see page 16)	83.3	≥ 75.0	↘	✓	
	Fundamental Standards of Care					
	Patient Friends and Family Test (%) (see page 17)	87.9	≥ 92.0	→	✗	
	Patient Experience and Outcomes					
	IAPT recovery rate - Merton Uplift (%) (see page 17)	48.1	≥ 52.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate – Richmond IAPT (%) (see page 17)	53.3	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	Death - Suspected suicide (see page 19)	**2**	-	→	-	
	Patient Safety					
Workforce	Vacancy Rate (%) (see page 20)	19.4	≤ 15	↘	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 1 (%) (see page 22)	93.0	≥ 95.0	↘	✗	
	Staff Skills/Development					
	Turnover (%) (see page 23)	16.5	≤ 15	↘	✗	
	Staff Retention/ Support / Satisfaction					
Finance	% Forecast Overspend (See Page 24)	0	≤ 0	→	?	
	Grip & Control					

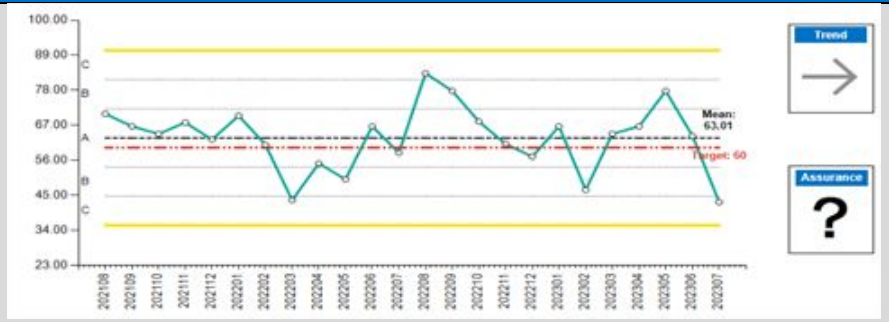
	Priority Metrics	Jul-23	Target	Trend	Assurance*	SPC Chart
Qualityy	Safe Staffing: National Compliance - Inpatients (%) (see page 16)	129.8	≥ 95.0	↗	✓	
	Fundamental Standards of Care					
	IAPT recovery rate - Sutton Uplift (%) (see page 17)	53.7	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate - Talk Wandsworth (%) (see page 17)	48	≥ 50.0	→	✓	
	Patient Experience and Outcomes					
	Paired Dialog Completed % (see page 18)	11.2	≥ 40.0	→	✗	
	Patient Experience and Outcomes					
Workforce	Percentage of BAME staff - Band 8+ and Medical (see page 21)	31.4	≥ 50.0	↗	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 2 (%) (see page 22)	89.3	≥ 85.0	↘	?	
	Staff Skills/ Development					
Finance	Activity vs Plan (Local Contract) (See Page 24)	110.8	≥ 95.0	↗	?	
	Productivity					

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

Operations Domain

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

Access



Team Breakdown – July 2023

Team	Treatment Within 14 Days	Referrals	%
Kingston Early Intervention Service	1	1	100.0%
Merton Early Intervention	3	4	75.0%
Richmond Early Intervention Team	1	1	100.0%
Sutton Early Intervention	0	2	0.0%
Wandsworth Early Intervention	1	6	16.7%
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.

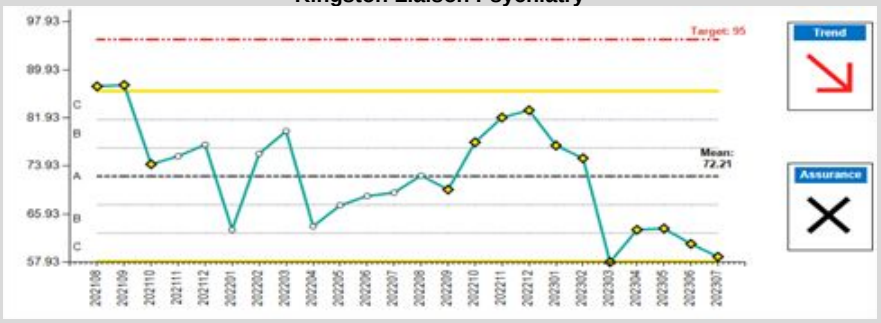
Underlying issues
- Inconsistent clinical oversight of waiting list and validation is not always completed promptly.
- Some inpatient wards and adult assessment teams are slow to refer patients on to EI services once psychosis is identified making it much harder for them to meet the waiting time targets.
- RiO is not configured to allow the accurate recording of first episode of psychosis and provide a workflow; as a result, there is an administrative burden on teams to manually validate all waiters.
- Wandsworth EIS outlier in July 2023 (where 5/6 referrals breached) vacancies in team have impacted. Team have been using agency who required further local induction.

Actions:
- Targeted training for SPA teams to continue in order to reinforce the importance of timely referrals.
- Alert system is now available in RiO which will support workflow for recording first episode psychosis.
- To maintain performance over 60% for all teams through core structures of daily huddles and use of dashboards by each EIS team.
- EIS teams to ensure robust referral checking systems are in place.
- Community Service line to engage with acute services to improve processes for timely referrals to EIS.
- Wandsworth EIS to ensure agency staff are thoroughly inducted in local systems to avoid referral breaches.

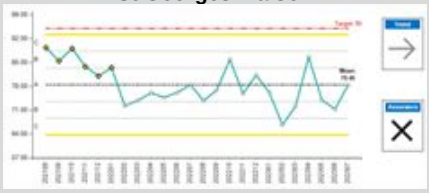
Liaison psychiatry - Seen within 1 hour in A&E (%) Target ≥ 95%

Access

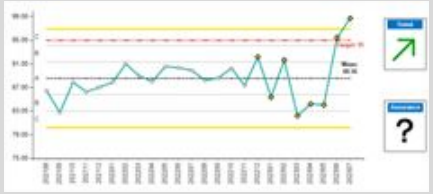
Kingston Liaison Psychiatry



St Georges Liaison



St Helier Liaison

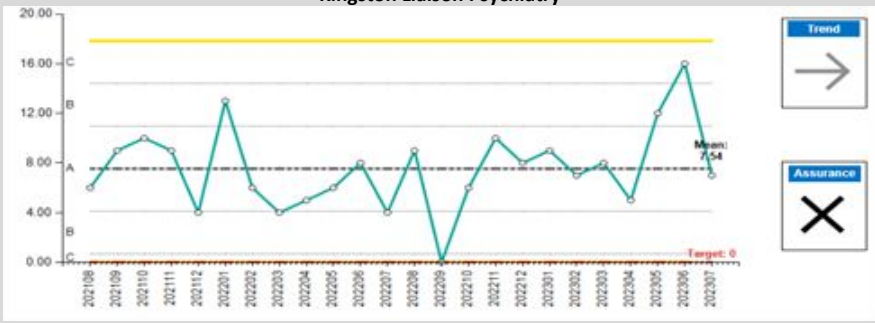
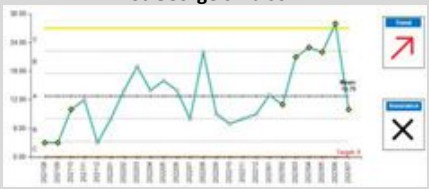
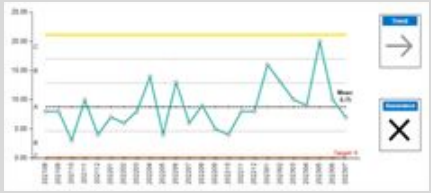


Background
Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care' published by NICE in 2015 states that an emergency liaison mental health service should respond within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment.

What the charts tells us
All three liaison services are consistently below target (which is above upper control in Kingston & St George's). A change of process is required.

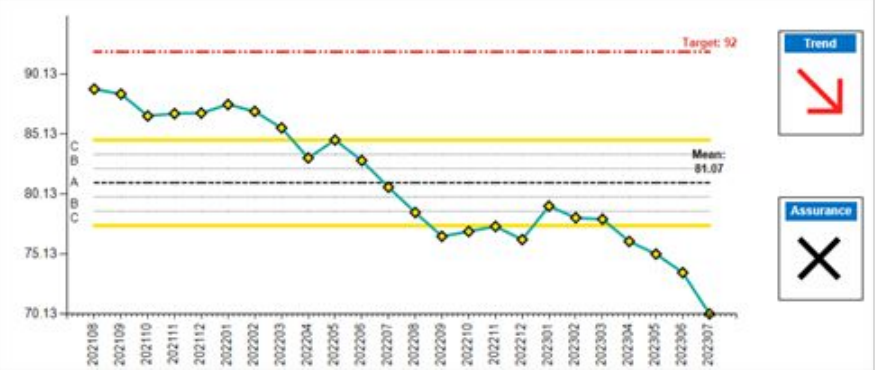
Underlying issue:
- The process of managing Emergency Referrals is impacted by many factors such as staffing shortages (including sickness and vacancy rate, cubicle space (St George's), other activities such as handover and multiple referrals from both ED and wards.
- Impact of extended number of patients waiting for MH beds in general hospital requiring further reviews.
- Acute hospitals have been experiencing a high level of acuity and this has had an impact on referrals into liaison services.
- High numbers of referrals in Kingston and St George's in comparison to staff levels; unfilled posts; referrals during handovers or out of hours meaning the services are not always able to meet demand.
- Variation in performance between services Kingston Liaison is an outlier service. St Helier met target in July.
- Liaison services have started to see an increase in patients presenting with complex social issues, not always linked to acute deterioration in MH. This has impacted on clinical capacity.

Actions:
- Action plan for liaison services formalised including improving access and induction for bank staff working across sites. Agreed requirements and competencies of bank staff are in place. Improvement plan is to align with overall Liaison Psychiatry Business Plan with focus on demand and capacity. Action plan scheduled to go to EMMG in August 2023.
- Shift patterns has been reviewed as part of Pilot evaluation and Core24 compliance and proposals sent to Finance to cost before engagement/consultation work to begin with Teams.
- Clinical Service Lead and Matron undertaking staffing review in regard to demand and capacity and CORE24 compliance. This is a longer term piece of work and will be trialled in Kingston Liaison initially.

	Liaison psychiatry - People waiting over 12 hours in A&E for a bed	Target = 0
Access	**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 and use of surge beds. **Actions** - Matron and CSL meeting with Associate Director of Transformation to discuss review method of providing assurance that patients are being reviewed at least once a day. Diary contact assurance is not reliable. - Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds. - Substantive recruitment of Consultant Psychiatrist to Kingston Liaison Psychiatry and also successful recruitment across services. - The Trust has contract for use of 18 beds at Holybourne in Roehampton until the end of the financial year. - Matron working with Inpatient MDT to develop a new process of using Southcroft Lodge for step downs of those awaiting accommodation, hence improving flow of DTOC patients out of MH Inpatient services into a more suitable setting. - Trust recently reviewed the Trusted Assessors Framework which will prevent duplicate assessments pre-admission i.e. once assessed by liaison or HTT there should be no need for further assessment as long as all points of framework are covered.

Access

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



% Waiting less than 18 weeks including / excluding ADHD/ASD teams – July 2023

Including ADHD/ASD teams	70.1%
Excluding ADHD/ASD teams	83.4%

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 since April 2021. A change in process is required.

Underlying issue

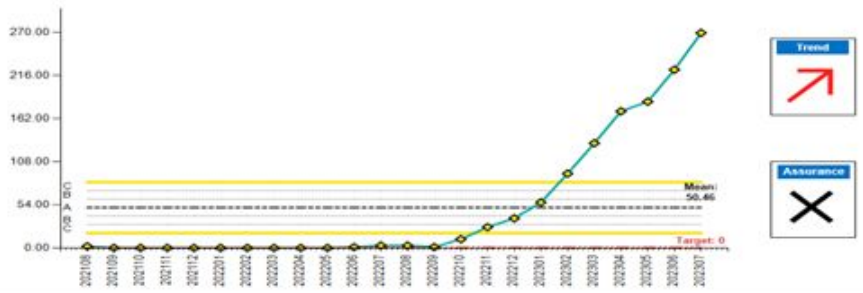
- **Adult ADHD:** There are known demand and capacity issues within the service; in July 2023, 59.1% (1198/2026) of the 18-week breaches relate to this service (see below for further information). Continued increase in caseload (for annual medication review) will impact on service assessment capacity.
- **CAMHS Tier 3:** ADHD medication titration waiters due to on-going psychiatry staffing shortages and Psychiatry case managing increase for psychology waiters.
- Individual therapy waiters due to on-going staffing shortages in Clinical Psychology positions (especially in Richmond and Wandsworth Tier 3).
- **CAMHS SPA:** Longest waits are linked to cases awaiting of completion of Neurodevelopment screening.
- **Adult Eating Disorders (AED):** Service only outcome an appointment as "treatment" when its meets NICE evidence based guidance. Therefore some clients who are being seen for i.e. dietetics outreach or step for changes group will remain as waiters as their appointment don't meet threshold for evidence based NICE treatment.

Actions

- **Adult ADHD:** Trust working with ICS to develop a sustainable solution for Adult ADHD pathway management.
- An ICB led Task and Finish Group with SWLSTG and Primary Care representation commenced in July 23 to progress the development of a discharge pathway, meetings are held fortnightly. The Trust is also working with primary care on wider shared care pathways for ADHD patients.
- Improvement plan led by Clinical Manager to improve processes around referrals, cancellations and recording. The service is also undertaking work to optimise clinical capacity, which will involve a review of ADHD admin and clinical processes.
- **CAMHS Tier 3:** Non-medical Prescriber newly recruited for Kingston and Richmond CAMHS Tier 3 to address the ADHD medication backlog across both teams.
- New psychiatry locum in post for Merton CAMHS Tier 3 who is addressing ADHD backlog.
- Continue to recruit to T3 investment across the five teams to increase choice assessment resource.
- 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): New CBT group set to commence in September 2023 which will increase capacity. AED has recently had 5 new starters once training is complete this should see reduction in waitlist.

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

Access



52 Week Breaches – July 2023

Team	Jul
Sutton Adult ADHD Service	168
Merton Adult ADHD Service	76
Richmond Adult ADHD Service	16
Adult Eating Disorders Outpatients	3
Richmond CAMHS Tier 3	2
CAMHS Complex Learning	1
Kingston CAMHS Tier 3	1
Merton CAMHS Tier 3	1
Wandsworth CAMHS Referral	1
Total	269

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

Underlying issues that prevent us from consistently reaching the target:
- Adult ADHD: There are known demand and capacity issues within adult ADHD services and there is a continued risk of further increase in 52 week breaches. The levels of 52 breaches will continue to rise as diagnosed cases remain on the adult caseload for annual medication review.
- CAMHS Tier 3: Breaches were linked to waits for ADHD medication commencement.
- Sutton SPA Breaches: 1 case should have been excluded as already in treatment in Tier 2 and the other case had long wait in Neuro pre-screening.
- Adult Eating Disorders service incurred two breaches linked to wait for CBT Group due to lack of appropriate patients and team unable to provide 1:1 CBT due to capacity.

Actions:
- Adult ADHD: In addition to actions outlined in 18 week commentary, daily administration meetings are held to ensure cancellations are managed promptly and 52 weeks breach lists are cleansed routinely and prioritised. Management support being provided to ensure clinicians are outcoming all appointments (and specifically 52 week breach appts) on the same day.
- An ICB led Task and Finish Group with SWLSTG and Primary Care representation commenced July 23 to progress the development of a discharge pathway. Meetings are held fortnightly.
- CAMHS: Non-medical prescriber continues to work on ADHD backlog in Kingston & Richmond.
- AED: New CBT group set to commence in June 2023 which will increase capacity. AED has recently had 5 new starters once training is complete this should see reduction in waitlist. AED working on clinical efficiency to reduce DNA's and cancellations.

Expected population need met by IAPT (numbers entering treatment)

Access

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

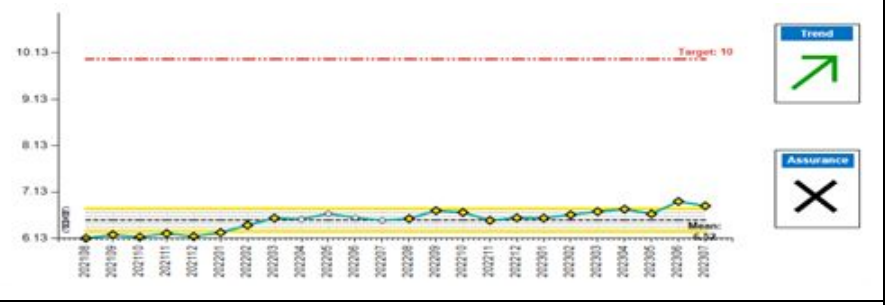
What the chart tells us
Two (Sutton IAPT & Richmond Wellbeing Service) of the four IAPT services are above their cumulative access requirements for 23/24. Merton Uplift is considerably below its requirement whilst Talk Wandsworth performance is just below target.

Underlying issues
- Access targets have now been agreed for FY23-24. Due to a delay there is an increase for this financial year which will be amortised across Q2-Q4.
- There is insufficient resource in Wandsworth, Merton, and Sutton and therefore meeting access requirements will continue to be an ongoing challenge.

Actions
- iPlato (3rd party provider) has been commissioned across all 4 boroughs to help us achieve our access targets. Service managers will be closely monitoring referral numbers on a weekly basis, ensuring there is sufficient slots to meet these access target.
- The Trust is proposing to invest an additional £200k for 3rd party provider IESO to undertake further activity; this has been agreed by ICB as part of the "triple lock" approval process.
- Service Managers will raise any concerns which bears any risk to target or wait lists to IAPT/Community Service Line senior management who will raise with ICB as appropriate.
- Talking Therapy services that accumulated a deficit for Q1 will look to claw back any shortfall where possible coming into Q2. IAPT management are working closely with Merton on a recovery plan to close the deficit. Capacity issues will be resolved by Aug 2023 (new starters joining) and concerted efforts are underway to encourage Merton GPs to sign up to iPlato so that adequate referrals are received.

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	202209	202210	202211	202212	202301	202302	202303	202304	202305	202306	202307
Women accessing PMH services *	1,049	1,043	1,016	1,025	1,024	1,035	1,046	1,054	1,038	1,080	1,065
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)	6.7	6.7	6.5	6.6	6.6	6.6	6.7	6.8	6.7	6.9	6.8
Service use per birth (For Context Only)	7.9	7.9	7.7	7.7	7.7	7.8	7.9	8	7.8	8.2	8

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

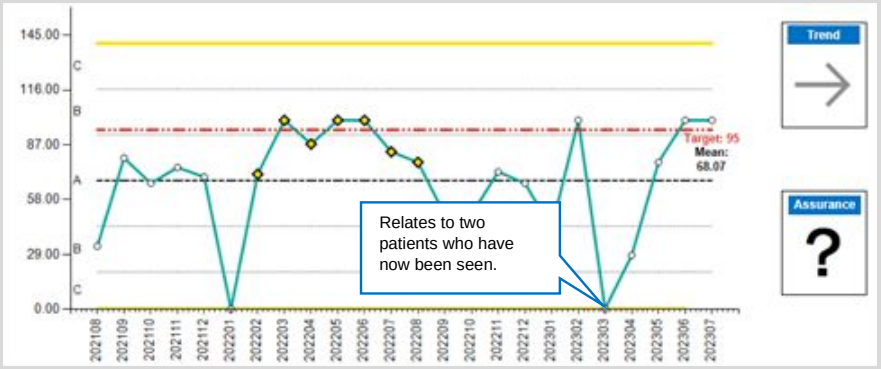
What the chart tells us
Although a slight upward trend is observed mean performance is below national requirement (target).

Underlying issue
- National target is based on predicted birth rate (2016 census data) which is higher than the actual local birth rate in 2022.
- Number of referrals received progressing to assessment is too low in order to reach access requirements of 10% of PMH population.
- Following recent investment there are now new posts that require recruitment.
- High DNA rate for new patient assessments.

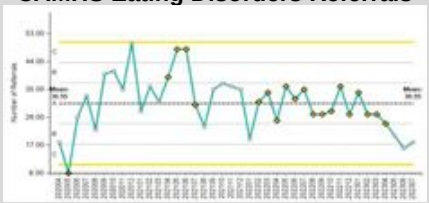
Actions
- Ongoing development of Perinatal Trauma and Loss Service with review of additional capacity and impact on access. Service has now been rolled out across the three South West London.
- Bank shifts added to capacity in order to increase new patient assessments and reduce waiting time, especially in Sutton & Merton.
- Standardised practice of Health Visitors and midwives attend some huddle meetings this will help increase referrals.
- The service is currently reviewing impact of recently completed reduction of dna pilot.
- Service establishment has increased and recruitment has commenced.

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

Access



CAMHS Eating Disorders Referrals



Waiting for Treatment Summary July 2023

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

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

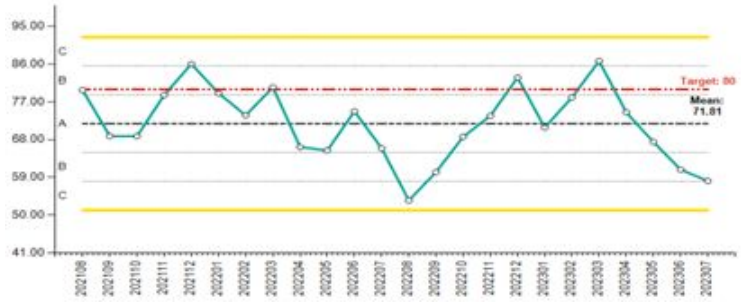
What the chart tells us
Mean performance is below target. Recent months performance have shown improvement with full compliance in June and July 2023.

Underlying issue
- Long term demand and capacity issues within the team.
- Over-reliance on part time staff to maintain administrative systems.
- The denominator for this KPI is low (n=7) in July 2023, so any case seen outside 28 days is likely to lead to target being missed. Full compliance noted for June & July 2023.
- Recruitment into the service has been challenging with certain posts difficult to recruit to.

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

Access

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



Team Breakdown – July 2023

Team	Assessed Within 8 Weeks	Assessments	% Assessed Within 8 Weeks
Sutton CAMHS Tier 3	18	24	75.0%
Wandsworth CAMHS Tier 3	6	9	66.7%
Merton CAMHS Tier 3	12	22	54.5%
Richmond CAMHS Tier 3	8	16	50.0%
Kingston CAMHS Tier 3	6	15	40.0%
Trust Total	**50**	**86**	**58.1%**

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 target will be met on occasion but there will be variation.

Underlying issue
- Most breaches relate to waits for ADHD medication and Psychiatry. As T3 CAMHS continues to assess more of the backlog of ADHD waiters this KPI will continue to deteriorate of until the backlogs are cleared.
- There are delays in ADHD medication due to the prioritisation of urgent referrals, screening forms being returned late, cancelling appointments and a small number of errors in recording.
- Kingston & Richmond Tier 3 services continue to struggle with assessment slot availability within the team, as resources are being focused on offering therapy slots for waiting patients.
- There will be a further shortfall in non-medical prescriber resource due to expected vacancy.

Actions
- 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.
- Non-medical Prescriber newly recruited for Kingston and Richmond CAMHS to address the ADHD medication backlog across both teams.
- New psychiatry locum in post for Merton CAMHS Tier 3 who is addressing ADHD backlog.
- Continue to recruit to T3 investment across T3 teams to increase Choice assessment resource.

Access

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

Team Breakdown – July 2023

Team	Dementia Diagnosis Within 6 Weeks	Required	%
Kingston Memory Service	15	16	93.8%
Memory Assessment Service Wandsworth	26	28	92.9%
Merton Memory Assessment Service	18	20	90.0%
Richmond Memory Assessment Service	15	16	93.8%
Sutton Memory Assessment Service	16	17	94.1%
Total	**90**	**97**	**92.8%**

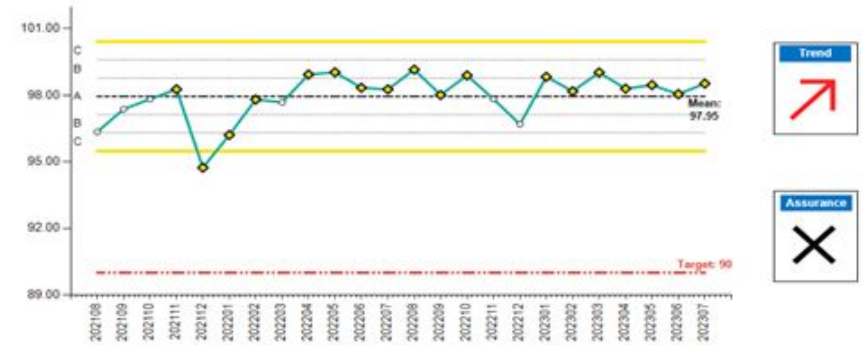
What the chart tells us
Mean performance is comfortably above target indicating frequent compliance with occasional variation.

Underlying issue
- 7 breaches reported in July 2023 with all 5 teams above target.

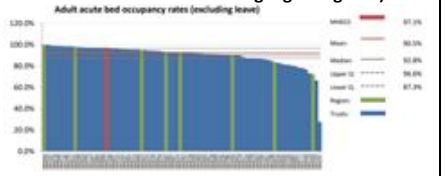
Actions
- **Trust:** Work with CCG to increase referral activity where DDR rate is low- e.g. Kingston.
- Continued monitoring and additional support for teams where needed.

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

Flow



2021/22 Benchmarking (Trust is highlighted red, other London Trusts are highlighted green)



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

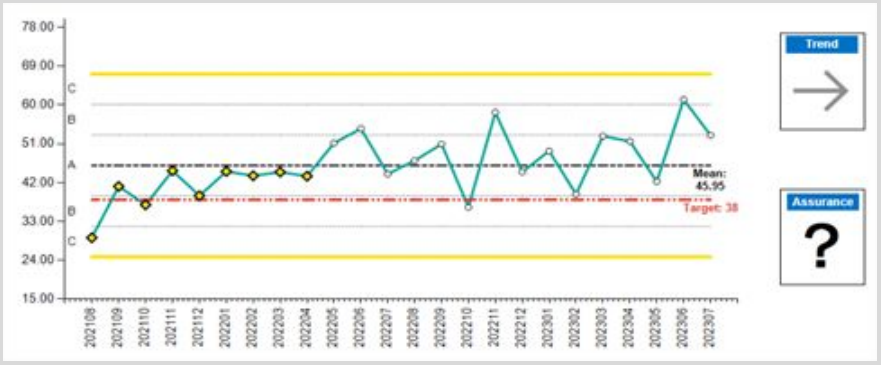
What the chart tells us
Low level variation with mean performance considerably above target.

Underlying issue
- Demand for inpatient services remains high, with over performance on occupancy rates resulting in use of out of area placements and surge beds.
- Out of area placements for acute beds have reduced through July and no new demand for female PICU.

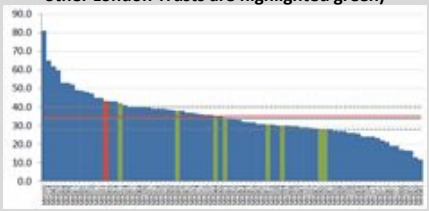
Actions
- The Trust has extended its contract for use of 18 beds at Holybourne in Roehampton until the end of 23/24.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- Work to address occupancy rates is outlined within the 100 day challenge work within inpatient transformation.
- Trust is currently undertaking a review of KPI definition as the Trust estate has changed considerably over last 24 months.

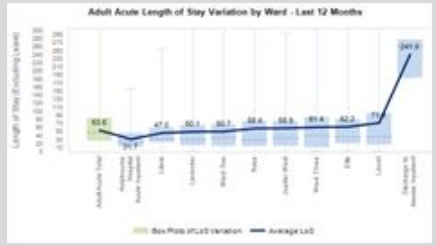
Adult Acute monthly average length of stay (excluding PICU) — Target ≤ 38

Flow



2021/22 Benchmarking (Trust is highlighted red, other London Trusts are highlighted green)





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.

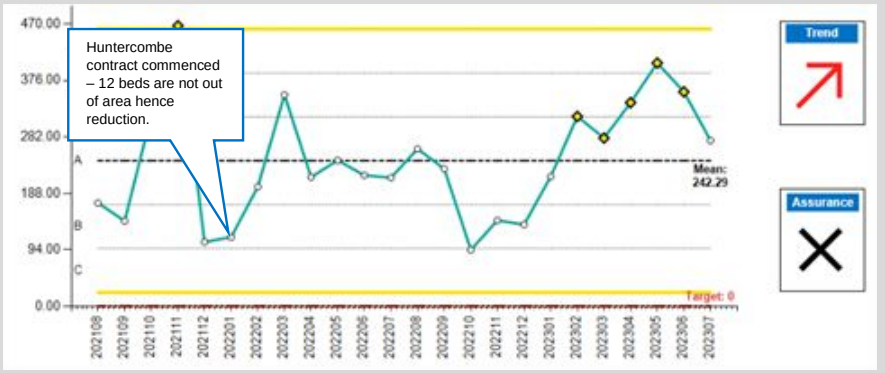
What the chart tells us:
Trust average performance consistently exceeds target.

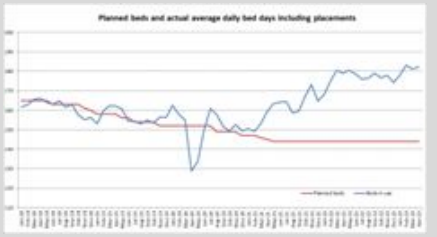
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds 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 and use of Winter surge beds.
- Increased demand can lead to increased acuity on admission and longer time to recover.
- There is variation on LOS between adult acute ward.

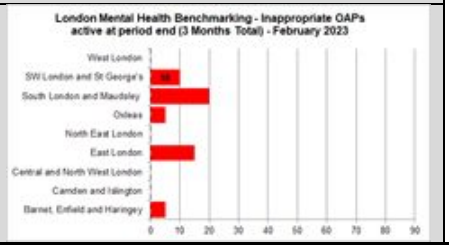
Action
- Consistent use of estimated discharge dates (EDD); reviews of patients with stays of over 90 days.
- More assertive use of the improved delayed transfer of care (DTOC) process
- A revised draft choice/discharge policy for use by the discharge co-ordinators has been issued to partners for comment.
- The 100 day challenge action plan to be implemented in July 2023.
- Monthly variability will continue as complex patients are discharged as part of transformation programme, which aims to improve the efficiency of all ward processes. The core & complex and inpatient processes workstream should gradually reduce stays towards the 33-day target during the next 6-12 months.
- As part of data assurance process the Trust is undertaking a review of the definition of length of stay.
- Design Implementation of EUPD/CEN pathway for inpatients.
- Contract meeting being booked for ELFT to review pathways and LOS alongside other quality metrics.

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.

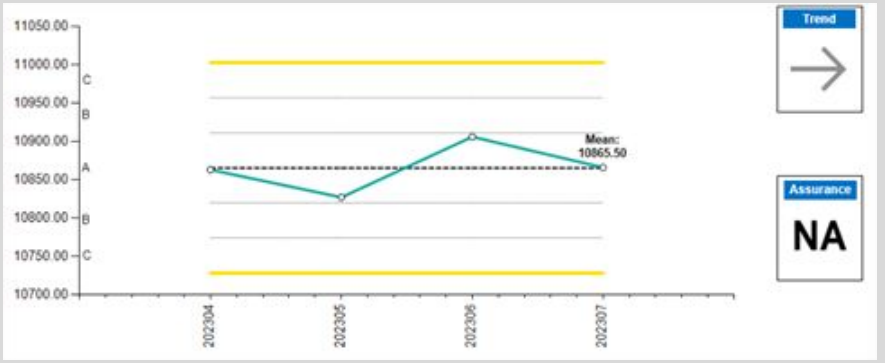
What the chart tells us
- Statistically significant and sustained increase (deterioration) in recent months following a long period of good performance.

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 and use of Winter surge beds. The apparent correlation between external occupied bed days used and increased DToC days is being explored.

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

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

Flow



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

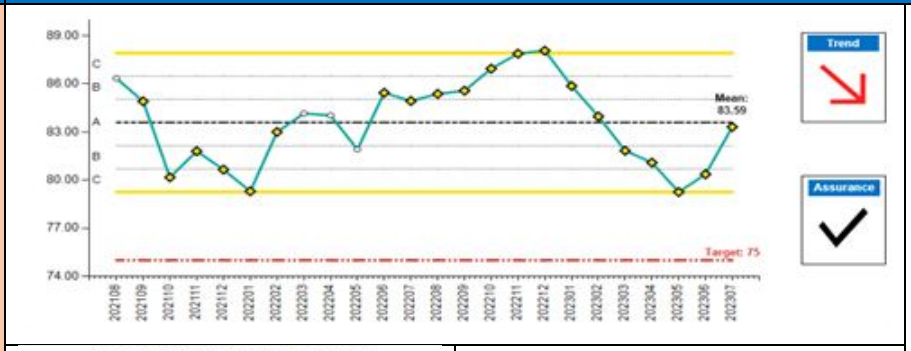
Underlying issue
- There is a lack of understanding across the Trust on this metric and clarification is required in order for clinical services to address.
- Metric requires review to ensure correct cohorts are reflected.

Actions
- DHOSD to work with the performance to understand this metric further.
- Ensuring appointments are booked and outcomed in timely fashion will aid improvement.
- A KPI definition is required to aid clinical services.
- The Information Management Team Metric have reviewed metric definition and issued guidance of team category inclusion.

Quality Domain

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

Fundamental Standards of Care



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

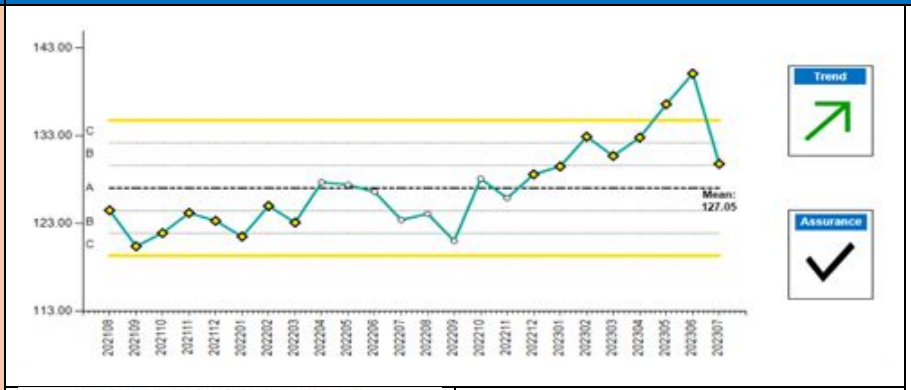
What the chart tells us
It is likely that the target will consistently be exceeded however there is a negative downward trend in performance.

Underlying issue
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised. Trust clinical systems do not support workflow and performance is expected to dip in Q3 when annual re-reviews are required. Some medical staff do not follow processes and there is more focus required on supporting/training junior doctors to complete.
- Number of community patients have declined assessments i.e. due to covid or personal choice. Community Service line have focus on improving the number of clients who receive a full CMA check.

Actions
- Teams have access to shared care records that contain supporting information to simplify the data collection process.
- Acute: All wards using the inpatient caseload dashboard in handover.
- Community: Weekly/twice weekly physical health clinics in all boroughs continue.
- Head of Nursing working with ICS in regard to Health and Wellbeing Practitioner providing support across community services with GPs to support improvement in CMA recording.
- Training in physical health being set up and will be offered across teams by PH ACP.
- Kingston QII will be looking at how to increase full compliance with CMA checks.

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

Fundamental Standards of Care



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

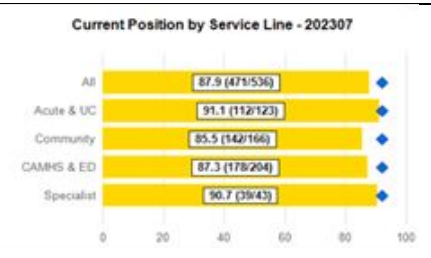
What the chart tells us
Trust performance is consistently above target which is below lower control limit.

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

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

Patient Experience and Outcomes

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



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

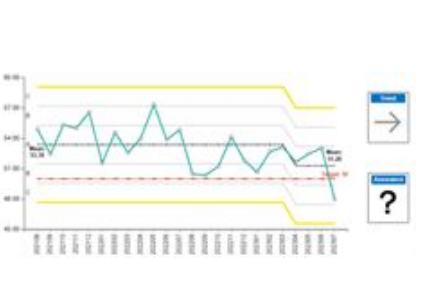
What the chart tells us:
Mean performance is consistently below target a change of process required.

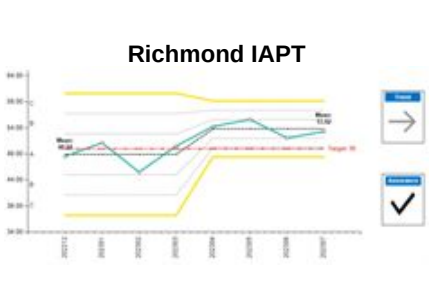
Underlying issues:
- Information Management team are undertaking a review on the target thresholds.
- Challenges with engaging patients to complete at appropriate points in their pathway and staff not actively seeking feedback.
- Using the results in a meaningful way to identify and make improvements within the clinical services.
- Acute and Urgent Care: In inpatient areas kiosks are no longer available; QR codes are displayed and patients and families are encouraged to use them.

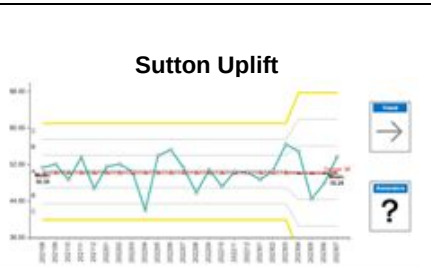
Actions:
- Feedback live has recently been relaunched as a platform for completing Friends and Family Test. First question on system is linked to the Friends and Family Test.
- Staff encouraged to promote use of the FBL QR code for service users and carers (FBL first question is the FFT).
- Community Service Line: Promoting use of the FBL QR code for service users and carers (FBL first question is the FFT).
- Governance Leads attending Community QGG to relaunch FFT.
- AUC – FBL will be an agenda item within Community Meetings to promote service user engagement.
- Head of Service Delivery met with Associate Director of Quality and Governance and agreed plan to help support with increasing feedback. There is now specific focus on certain teams within each borough.

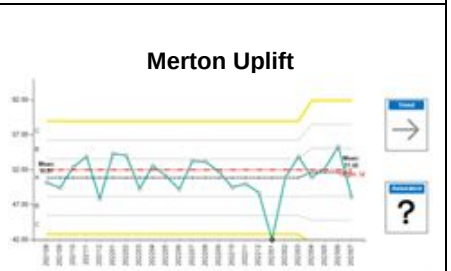
Patient Experience and Outcomes

IAPT recovery rate (%) — Target ≥ 50%







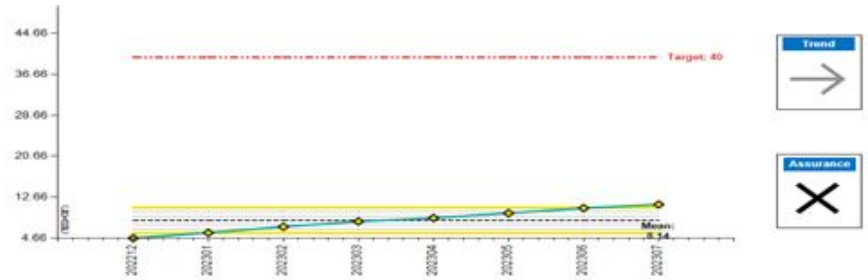


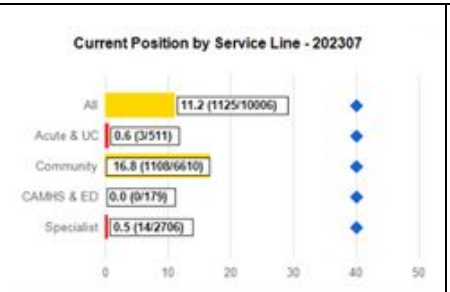
Background
Improving Access to Psychological Therapies (IAPT) is an NHS programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety.
What the chart tells us
Sutton Uplift is below target whilst all other services are likely to exceed the target which is below the average performance; Merton Uplift is also exceeding locally agreed stretch target of 52%. Monthly variation is expected.
Underlying issues
- Clients who 'drop-out' and fail to attend appointments (DNA) may be discharged before they have 'recovered'. This can be more apparent with sub-contracted services.
- Routine audits have shown that some processes around discharging clients (who were unrecovered) are not always being followed.
- Better data quality has revealed a deterioration in recovery rates across all services, especially in Sutton where increased access is placing a particular pressure on waiting times.
- Poor timeliness on discharge led to inconsistency /fluctuation in recovery.

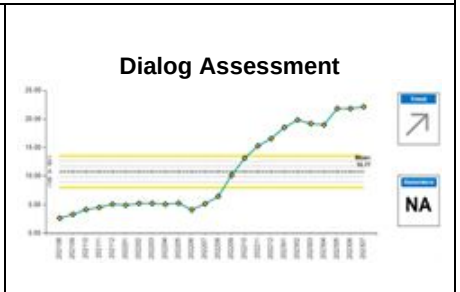
Actions:
- Data cleansing for historic months has now been completed in all boroughs except Merton.
- Ensuring service clinical leads complete data quality checks in advance of the monthly recovery audits which then take place each month by 9th. Investigate audit outcomes and follow through on their action plan.
- Data and clinical leads analyse recovery by diagnosis to address any psychological conditions where the service could improve treatment delivery or existence of any skills/training needs.
- Individual recovery rates for clinicians are monitored in all services and shared with staff to support improvements.
- Project for 2023 to be undertaken to draw comparison between 1:1 & Groups at step 3 for quality improvement with trainees.
- Cross-borough recovery working group has now been established to identify interventions to support improved recovery across all services.

Patient Experience and Outcomes

Paired Dialog Completed — Target ≥ 40%





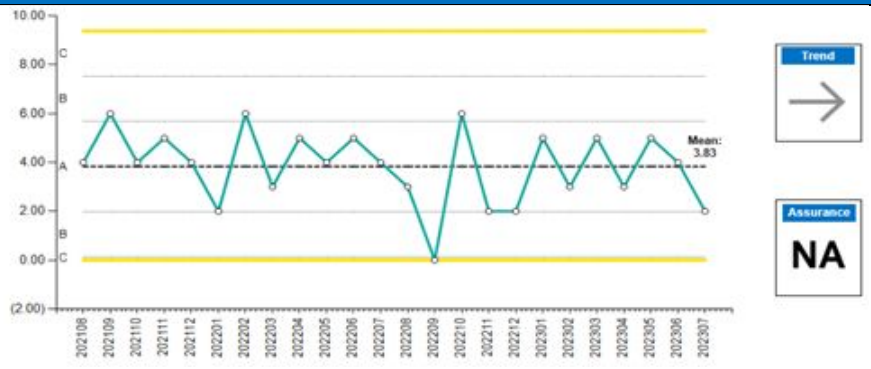
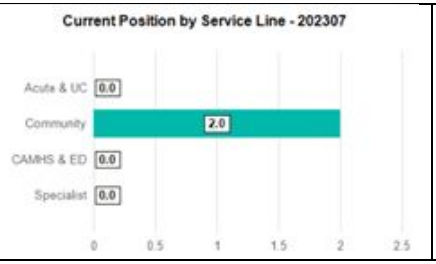
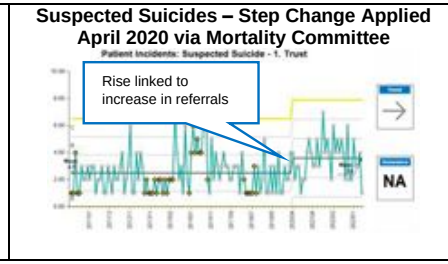


Background
DIALOG is an 11-question survey whereby people with a mental health illness are asked to rate their satisfaction and needs for care on 8 life domains and 3 treatment aspects. It is a tool that is completed by the service user and its content helps to highlight areas they may want support with.

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

Underlying issue
- Reporting on paired dialog is a new priority metric for 23/24; local practice is being embedded.
- Review of team inclusions for DIALOG is ongoing across service lines.
- 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.
- Patients remaining on community caseloads for long periods are not completing more than one DIALOG currently i.e. no discharge DIALOG.

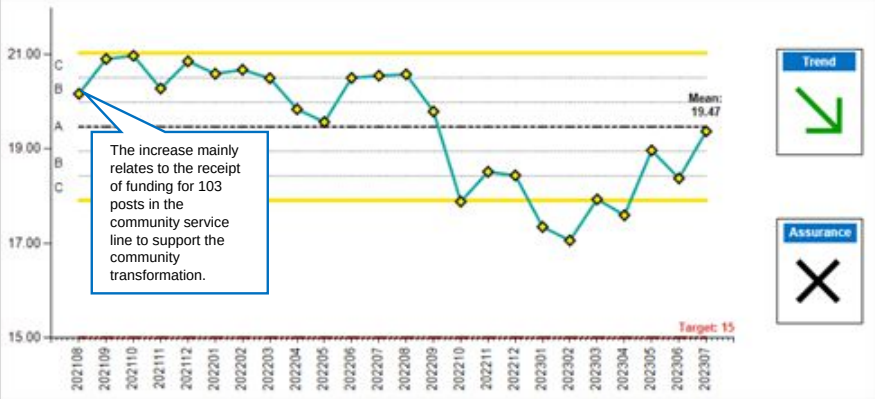
Actions
- SOP for dialog use has been developed and issued to across the Trust.
- Specialist Service Line to raise exclusions queries with Patient Outcomes Group.
- Baseline DIALOG completeness to be discussed at Improving Patient Outcomes Group (IPO) and further strategy for improvement to be recommended,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

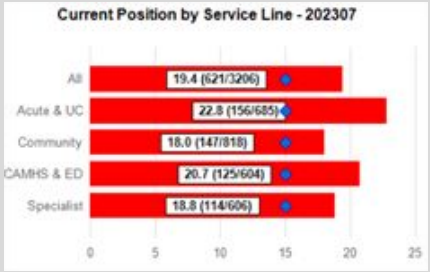
	Death - Suspected suicide	No Target
Patient Safety		**What the chart tells us** The number of suicides each month is subject to variation. Numbers reported are low. Underlying Issue: - There were two suspected suicides reported in July 2023. - The number of suicides being reported month to month continues to vary. This data is reviewed in the bi-monthly Mortality & Suicide Prevention Committee. The mean monthly average has increased from 2.9 (pre-April 2020) to 3.9 (post April 2020). Actions: - All such incidents will be subject to a review in line with the Patient Safety Incident Response Framework (PSIRF). - The milestones from the Trusts Suicide Prevention Strategy continue to be monitored via the Mortality & Suicide Prevention Group. - Suicide Prevention Conference took place in May 2023. - Community: Learning events now in place and action plan against thematic review of patient deaths being progressed.
		

Workforce Domain

Recruitment / Attraction

Vacancy Rate (%) — **Target ≤ 15%**





Benchmarking – NHS Digital Q4 22/23

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

Vacancies by Staff Group

Staff Group	Post Fte	Assign Fte	Vacant FTE	Vacancy Rate FTE
Add Prof Scientific and Technic	493.9	399.9	94.1	19.0%
Additional Clinical Services	727.3	575.3	152.0	20.9%
Administrative and Clerical	646.9	568.7	78.1	12.1%
Allied Health Professionals	170.4	126.5	43.9	25.8%
Estates and Ancillary	35.0	31.9	3.0	8.6%
Healthcare Scientists	2.0	2.0	0.0	0.0%
Medical and Dental	240.8	208.6	32.2	13.4%
Nursing and Midwifery Registered	890.7	670.7	220.0	24.7%
Total	**3,207.0**	**2,583.6**	**623.4**	**19.4%**

Background

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

What the chart tells us

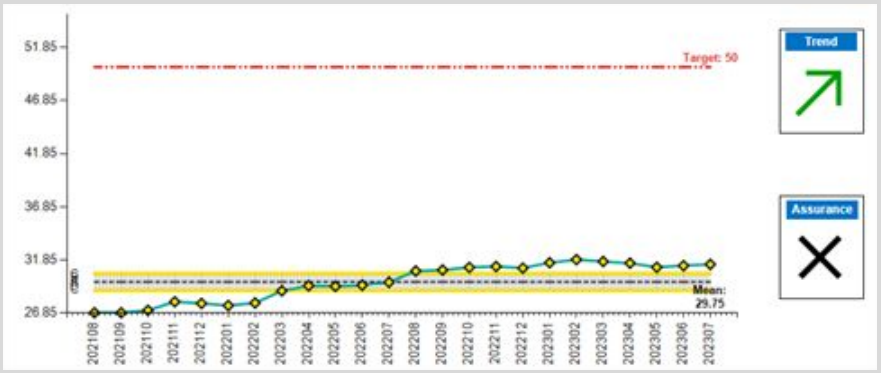
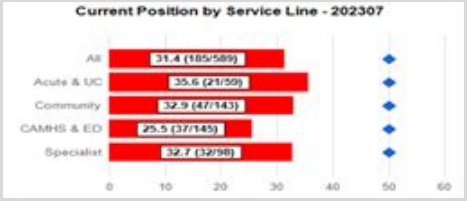
There has been variation in the Trust vacancy rate with mean performance above target. Recent months have seen a decrease (positive downward trend) with performance below the mean.

Underlying issue:

- Each Service Line has created a workforce plan, and they will be working in partnership with the Head of Resourcing and the People Delivery Partner to ensure there is a continued focus on recruitment, including bank and agency conversions into vacant positions.
- The Trust turnover has increased steadily over the last 2 years, which impacts on the vacancy rates, in addition to the newly created roles as in some months there are more staff leaving than being recruited.
- There is a national shortage of various professions and so even with robust recruitment initiatives, for some posts successful recruitment will still continue to prove challenging.
- To meet the skills shortage in some areas new roles will need to be considered and developed at pace to enable areas to continue to provide high quality patient care.

Actions:

- **Recruitment Annual Timetable** – detailed recruitment timetable for the year compiled by the Recruitment Team which is being developed to continue to build recruitment opportunities and ensure mass recruitment campaigns are scheduled effectively to meet the organisational need.
- **Recruitment Delivery Group** – the first of these meetings has taken place with key stakeholders in the organisation 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.
- **Career pathways** – Two workshops are being scheduled to understand key skills gaps and possible new career paths and new roles. These will be held in September 2023.
- **Workforce Plans** – These have been established in each service line and are now being monitored through the Service Line Reviews. This also contains details about the recruitment hotspots and other key people issues.
- **Increased support within Temporary staffing** – additional support has been moved to the Temporary Staffing team to provide professional nursing support to the recruitment and management of bank staff and further to support conversion to substantive roles and conversation of staff with qualifications in other countries.
- **Vacancy Rate** – During September and October a drop in vacancy rate to at or below 15% is expected owing to numbers currently within our recruitment pipeline.

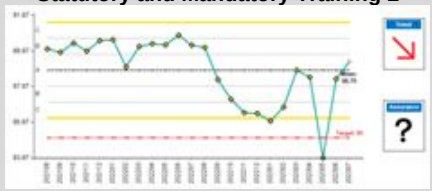
	Percentage of BAME staff - Band 8+ and Medical	Target ≥ 50%
Recruitment / Attraction	 	**What Chart Tells Us:** Mean position is below target indicating target position seems to have plateaued in recent months following period of improvement. **Underlying issues:** - The number of black, Asian and minority ethnic colleagues being appointed at Band 8a is steadily increasing. - The pace of change is slower than needed in order to meet target. **Actions:** - More work needs to be undertaken to understand where the blocks are in terms of our black, Asian and ethnic minority staff progressing in the organisation. It is likely that this is at grades below 8a and the lack of career progression opportunities between bands 6-8a within certain clinical areas, which has been flagged as part of the workforce planning process. - Our anti racism programme has a workstream focussed on career development and has identified that a small pilot is required to understand what more can be done to enable greater career conversations and progression for colleagues keen to progress. - Specialist: Diversity and Inequalities forum is now in the early stages of introduction with a first meeting having taken place in June. As part of this initiative further EDI champions will be appointed to assist in promoting Equality and Diversity within the service line. - One-day workshop entitled 'Managing racism in the workplace' has been commissioned and will be delivered on 9th and 23rd May 2023. - Community: New borough based band 7 inequalities leads to be recruited as part of transformation. - Ensure all recruitments have a DIR rep on the panel. (Diversity in recruitment), especially for 8+ posts. - CAMHS & ED: Service line has staff members on the HEE Ethnic Minority Psychological Professions Leadership Mentoring Scheme - The EDI committee has committed to running focus group discussions with Black Asian and Minority Ethnic colleagues based on the NHSE Scope for Growth model. These workshops are being supported by a HR Consultant with expertise in this area of career development dialogue.

Staff Skills / Development

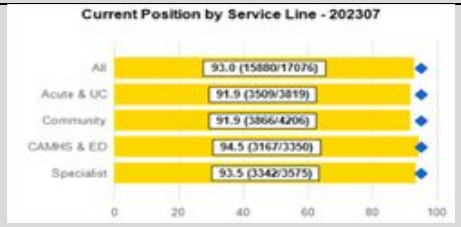
Statutory and Mandatory training 1 (%), Statutory and Mandatory training 2 (%) — Target ≥ 95%, Target ≥ 85%

Statutory and Mandatory Training 1

Statutory and Mandatory Training 2



Current Position by Service Line - 202307



Current Position by Service Line - 202307

Training Compliance Projection – MAST 1

Certificate Name	Actual				Projection			
	Jun-23	Jul-23	Aug-23		Sep-23	Oct-23	Nov-23	
	%	%	%	Breaches	%	%	%	Breaches
Adult Basic Life Support (1 year)	89.5%	89.6%	88.7%	48	87.5%	84.0%	74.8%	107
FFP3 Mask Testing (2 Year)	68.6%	47.0%						
Fire Safety Awareness (Community) (2	95.2%	93.8%	93.9%	81	92.0%	89.4%	86.2%	184
Fire Safety Awareness (Inpatient) (1	88.8%	84.5%	82.3%	109	76.3%	70.9%	66.7%	205
Fire Safety Awareness (Non-Clinical) (2	95.7%	95.6%	94.7%	39	92.3%	89.6%	85.8%	105
Infection Prevention and Control L1 (3	88.6%	90.3%	91.1%	46	91.1%	90.7%	90.7%	48
Infection Prevention and Control L2 (1	93.6%	92.1%	92.2%	174	84.4%	76.0%	67.6%	724
Information Governance (1 Year)	95.9%	94.8%	94.6%	147	87.3%	78.9%	70.3%	813
Medical Emergency Training (1 Year)	66.0%	67.9%	70.0%	70	75.1%	75.5%	67.0%	77
Medicines Management (Community) (2	88.7%	88.5%	89.5%	47	84.4%	81.3%	79.0%	94
Medicines Management (Inpatient) (2	94.6%	92.5%	92.2%	19	86.8%	81.9%	79.8%	49
Naso-gastric Intubation & Entral Feeding	80.8%	80.0%						
Proactive Physical Interventions (3	87.5%	87.2%	86.9%	66	84.5%	84.1%	83.9%	81
Safeguarding Adults Basic Awareness -	95.9%	95.0%	95.6%	121	94.8%	93.2%	90.3%	266
Safeguarding Adults Level 2 (3 Years)	93.2%	92.3%	93.0%	137	92.3%	90.6%	88.8%	221
Safeguarding Children and Young People	93.0%	93.8%	93.6%	37	91.3%	88.9%	85.8%	82
Safeguarding Children and Young People	86.5%	85.4%	87.4%	106	86.5%	85.6%	84.0%	134
Safeguarding Children and Young People	80.1%	77.6%	77.4%	249	70.9%	68.5%	63.7%	401
Safeguarding Children and Young People	86.3%	85.1%	85.2%	42	85.2%	83.8%	81.7%	52
All Certificates (95% Target)	91.7%	90.9%	91.2%	1538	87.7%	83.8%	79.2%	3643

Training Compliance Projection – MAST 2

Certificate Name	Jun-23	Jul-23	Aug-23		Sep-23	Oct-23	Nov-23	
	%	%	%	Breaches	%	%	%	Breaches
ABLS eLearning for Community and	73.8%	71.1%	64.7%	164	62.3%	55.8%	47.0%	246
Advanced Patient Handling (2 Years)	82.8%	82.1%	82.4%	84	86.1%	85.5%	81.1%	90
Care Certificate	79.5%	79.2%	79.6%	66	82.4%	82.4%	82.4%	57
Collaborative Clinical Safety Training	64.8%	68.6%	67.2%	442	68.2%	67.6%	66.6%	451
Conflict Resolution and Breakaway (3	83.5%	83.5%	84.3%	257	86.1%	86.5%	85.5%	237
Equality and Diversity (3 Years)	97.9%	97.4%	97.4%	70	96.4%	94.8%	92.3%	209
Food Hygiene Level 1 (3 Year)	98.5%	97.5%	98.5%	3	97.9%	96.4%	93.8%	12
Food Hygiene Level 2 (3 Year)	83.8%	86.4%	87.2%	18	87.2%	85.8%	85.1%	21
Food Hygiene Level 3 (3 Year)	33.3%	50.0%	50.0%	1	50.0%	50.0%	50.0%	1
Health and Safety General Awareness (3	97.2%	96.3%	96.3%	102	94.9%	93.0%	90.4%	262
Load Handling (2 Years)	85.0%	85.0%	82.9%	7	55.5%	55.5%	55.5%	14
Mental Health Law Training (3 Year)	82.7%	82.4%	81.1%	313	85.0%	84.2%	82.5%	283
National Early Warning Score (3 Years)	97.9%	97.7%	97.3%	14	96.7%	95.8%	94.8%	27
Observation and Intensive Engagement	97.4%	97.2%	97.2%	13	97.2%	96.3%	96.1%	18
Prescribers Medicines (2 Years)	63.8%	60.9%	63.7%	90	60.9%	57.7%	56.0%	109
PREVENT Basic Awareness - Level 1-2	94.3%	95.7%	96.2%	29	96.2%	96.2%	96.2%	29
PREVENT Raising Awareness - Level 3-	93.4%	93.0%	94.0%	119	93.2%	92.1%	89.9%	199
Rapid Tranquilisation (3 Years)	92.4%	93.0%	93.0%	37	91.5%	90.0%	88.4%	61
Safeguarding Adults Level 3 (3 Years)	39.8%	45.5%	49.0%	492	49.0%	49.0%	49.0%	492
Security Awareness (Forensic) (1 Year)	92.4%	91.7%	89.4%	15	80.1%	72.3%	65.2%	49
All Certificates (85% Target)	86.3%	86.5%	86.5%	2336	86.6%	85.4%	83.5%	2867

Background

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

What the chart tells us

MAST 1: There has been a significant downward trend in performance more recent months have improved but remain below mean which is below target.

MAST 2: Despite reduction in performance the Trust remains well above target. Significant downturn in May 2023 (special cause variation) had been followed by immediate improvement.

Underlying issue

A detailed piece of work by the Head of Learning & Development has established some historical underlying reasons for % Compliance not being at the required level - some quick solutions have been put in place:

- The application used to record MAST (COMPASS) required a system upgrade on the operating platform (Totara) to enable training activity to be registered correctly. This was successfully completed on 14 June 2023.
- Management of cancelling existing Bookings / managing DNAs (no shows on the day) - cancellations can now be made up to 24 hrs before the start of the course, therefore reducing the no show rates. DNAs therefore are only recorded if a colleague does not attend on the day. This required the system to be updated to delivery this improved process.
- Technical issues associated with dashboard, COMPASS and e-LFH possibly related to firewall issues are impacting the ability for recording of completed training – mitigation in place is for people to share the fact they have completed with the L & D Team.
- Review of MAST requirements as this has grown over time with further requirements to be added.

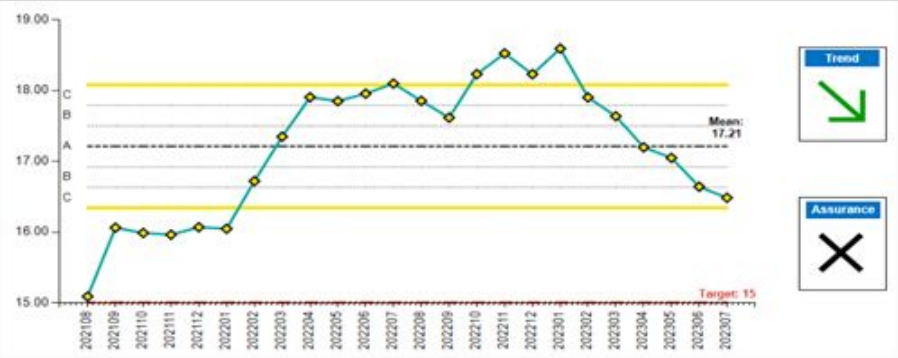
Actions:

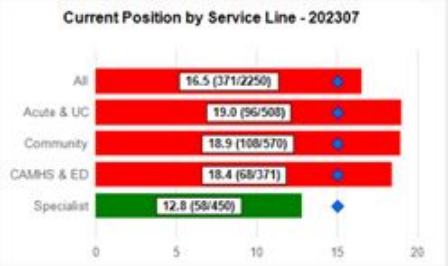
- The Director of People and Director of Nursing & Quality have met with the Head of Learning & Development to review the MAST 1&2 list. This is now being checked with each SME to confirm changes.
- Service Lines asked to adopt a proactive and focused approach to increasing their compliance rates, and to work with their dedicated LDT administrator for solutions to access or availability issues.
- Recommendations will be shared in respect of the next steps for the technical elements of the project i.e. confirm where our server is hosted, the establishment build on Compass and ways to resolve the firewall issues.
- Continues focus on DNA rates, and improved process in place on Compass to define cancellation v DNA.
- Understand underlying issues related to the DNA rates for bank staff which are high.
- Refine the audiences for revised MAST 1 and 2 list and ensure this is reflected within COMPASS system.
- New MAST 1 and 2 list to be reflected into dashboard reports.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%





Annual Turnover FTE – March 2022 – March 2023

Trust	Leavers	%
Tavistock and Portman NHS Foundation Trust	145.3	22.2%
Camden & Islington NHS Foundation Trust	424.0	19.3%
South West London and St George's Mental Health NHS Trust	422.1	17.6%
Central and North West London NHS Foundation Trust	1251.4	17.3%
Barnet, Enfield and Haringey Mental Health NHS Trust	549.4	17.2%
East London NHS Foundation Trust	1063.0	17.0%
North East London NHS Foundation Trust	1022.1	16.5%
West London NHS Trust	631.1	16.1%
South London and Maudsley NHS Foundation Trust	787.6	15.2%
Oxleas NHS Foundation Trust	548.6	14.5%
London Average	684.0	17.3

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

Turnover has been on negative upward trend more recent have seen turnover rate decline but position remains above target.

Underlying issue

- Turnover is starting to slowly decrease, however we are still above the 15% target. The high turnover rates are likely impacted by the high vacancies in some teams and lack of career progression and cost of living within SWL.
- Turnover under 12 months is increasing and over 30% of this is from staff who are aged 30 or below.

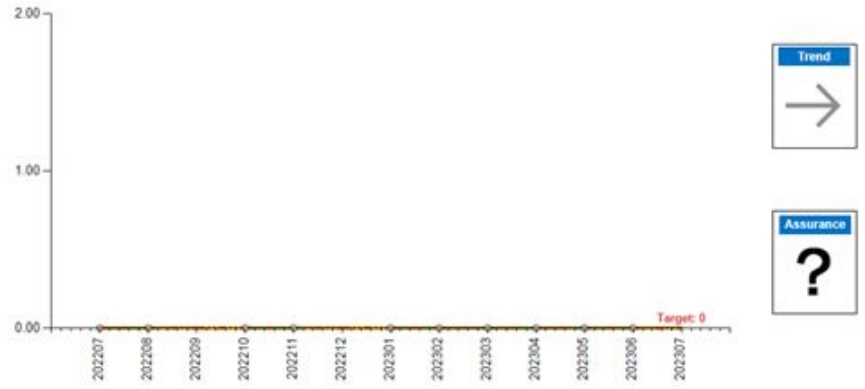
Actions:

- A revised detailed retention plan is being developed to be managed through People Matters. Actions will include, stay interviews, consideration of external exit provision, revised exit process, review of bespoke actions needed by SL as the reasons for leaving will be different.
- CAMHS & ED: Service line to review staff survey results. Staff survey engagement sessions have been run and themes are to be reviewed.
- Human Resources Business Partners liaising with On-boarding working group lead by Chief Operating Officer to improve the current exit interview process.

Finance Domain

Grip & Control

% Forecast budget overspend — **Target TBC**



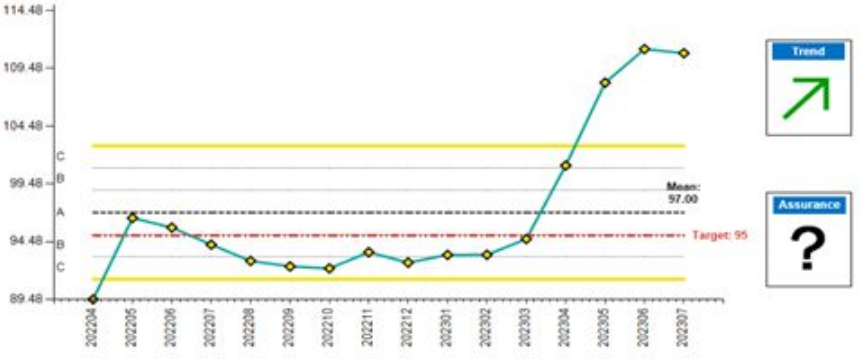
What Chart Tell us:
The chart indicates that Trust forecast is currently at break-even position.

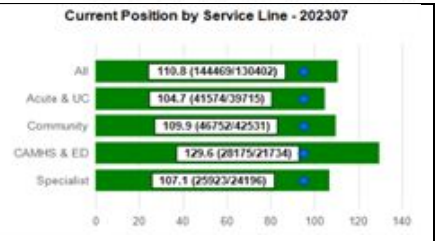
Underlying Issues:
- Trust is breaking even after month 4 compared to plan and forecasting to achieve the planned £0.2m surplus at year end.
- Agency whilst below plan remains above the national requirement of 3.6% of total pay bill.
- The Trust needs to increase recurrent savings delivery; delivery to date is underpinned by non recurrent vacancy factor and other non-recurrent means impacting on longer term financial sustainability. Trajectory is needed on productivity savings.
- External beds pressures continue creating a financial risk.

Actions:
- Work with ICB to identify and remaining Agency control gaps or collaborative actions to reduce agency spend.
- Finalise costed agency trajectories to identify potential shortfall against agency targets and further mitigations.
- Ensure plans are in place and being monitored to deliver 100% of the £13m target i.e. move all schemes out of 'red'.

Productivity

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





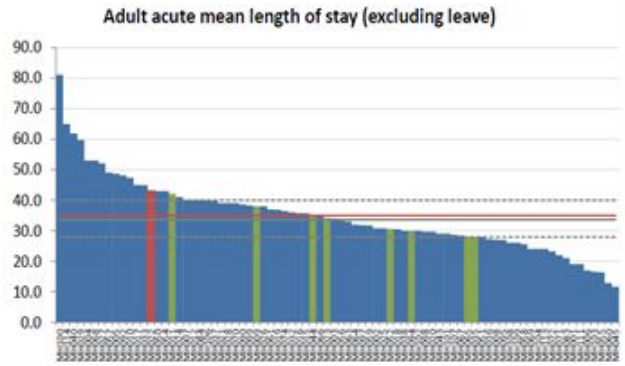
What Chart Tells Us:
Mean performance is above target indicating frequent compliance. 23/24 compliance is comfortably above target and has exceeded upper control limits in recent months.

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

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

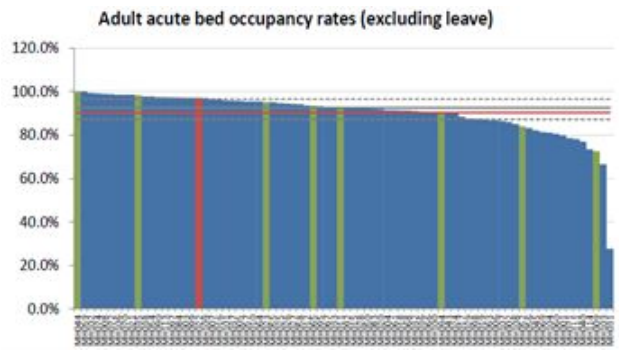
Appendix 1: Benchmarking

The NHS Benchmarking Network's 2021/22 Inpatient and Community Mental Health Benchmarking Report was issued in October 2022 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.



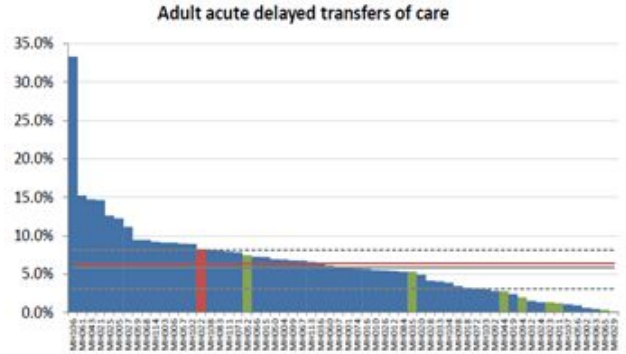
- **Adult acute average length of stay (days):**

2021/22		2023/24	
Trust	England	Jul-23	YTD
43.0	53.0	58.2	56.0



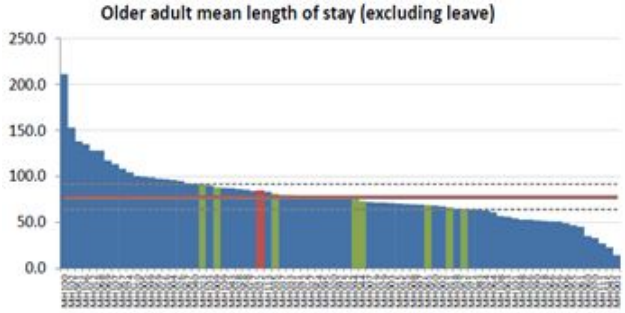
- **Adult acute bed occupancy rate (%):**

2021/22		2023/24	
Trust	England	Jul-23	YTD
97.1%	90.5%	98.5%	98.3%



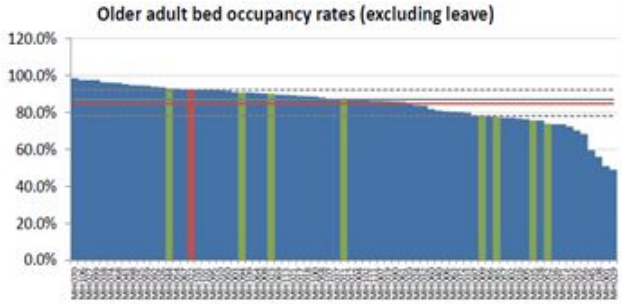
- **Adult acute delayed transfers of care (%):**

2021/22	
Trust	England
8.1%	6.4%



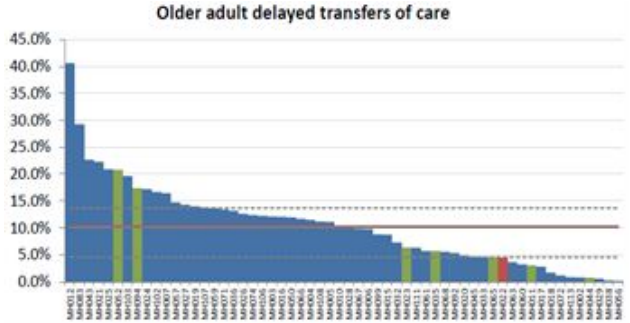
- **Older people's average length of stay (days):**

2021/22		2023/24	
Trust	England	Jul-23	YTD
84.0	78.5	115.8	101.0



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

2021/22		2023/24	
Trust	England	Jul-23	YTD
92.6%	84.8%	94.1%	96.7%



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

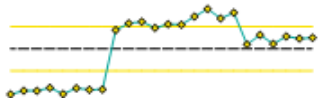
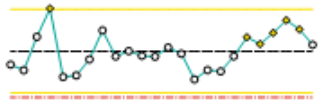
2021/22	
Trust	England
4.4%	10.3%

Appendix 2: NHS England Oversight Metrics

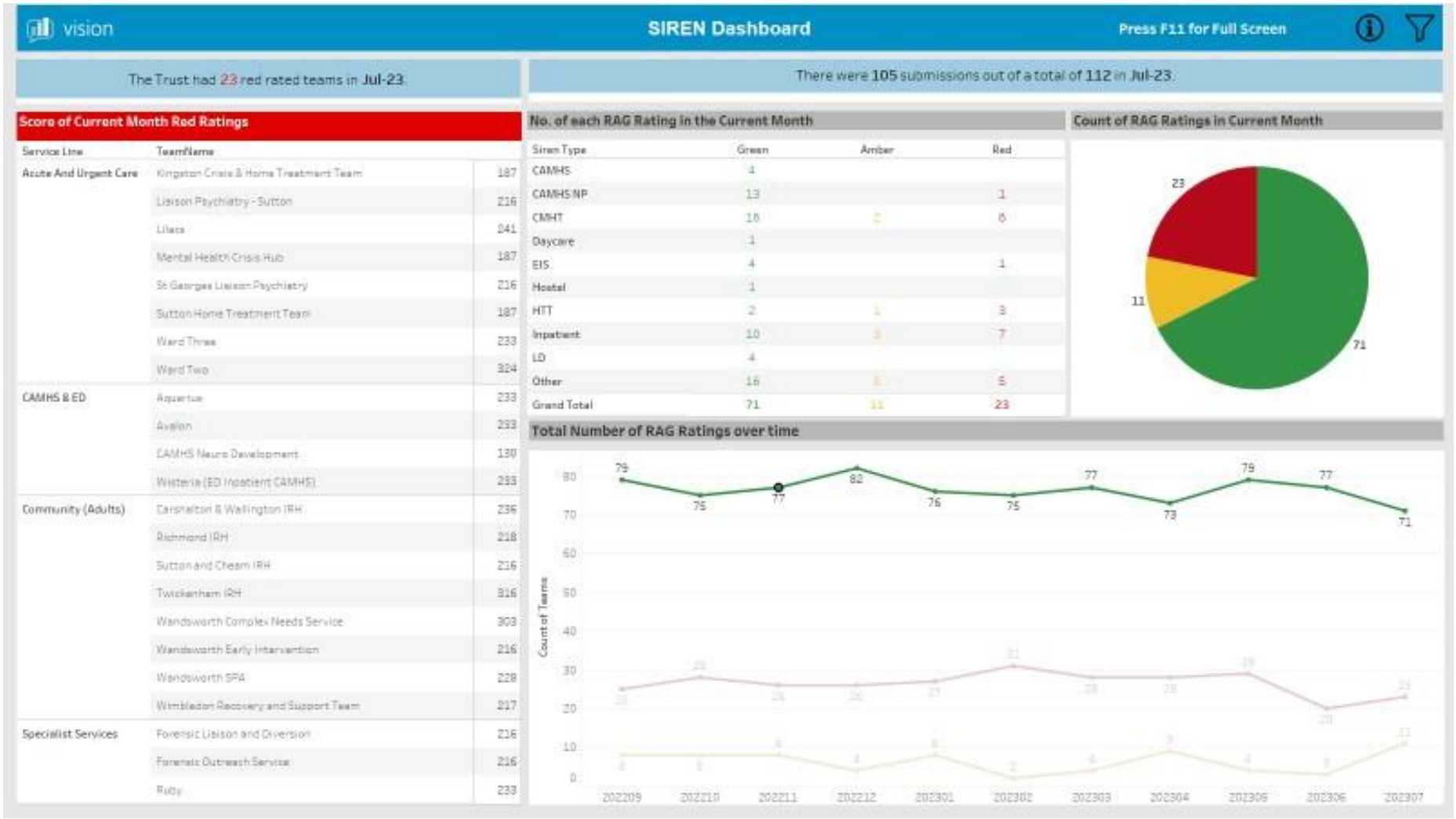
To provide an overview of the level and nature of support required across systems and target support capacity as effectively as possible, NHS England and NHS Improvement have allocated trusts and ICB's to one of four segments. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

It should be noted that the Trust remains at segment 1 of 4 on the NHS Improvement (NHSI) Single Oversight Framework (SOF) which means that no potential support needs are currently identified.

NHSI SOF Operational Performance Metrics	Jul-23	Target	SPC Chart	Comments
Number of children and young people accessing mental health services as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people with severe mental illness receiving a full annual health check and follow up intervention as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people accessing IAPT services (Richmond).	1739	1695		Richmond Wellbeing service is on track to achieve access requirements for 2023/24.
Number of people accessing IAPT services (Merton).	1474	1801		Merton Uplift is below its cumulative access requirements for 2023/24.
Number of people accessing IAPT services (Sutton).	1559	11428		Sutton Uplift is above its cumulative access requirements for 2023/24.
Number of people accessing IAPT services (Wandsworth).	2923	3078		Talk Wandsworth is just below its cumulative access requirements for 2023/24.

Number of adults and older adults with severe mental health accessing community mental health services	1567	-		Trust is developing definition for this metric – target to be confirmed.
Inappropriate out of area placement bed days - Adult Acute & PICU	276	= 0		Trust continues to require use of out of area beds due to high demand. Trust has renegotiated use of 18 beds at Holybourne until end of 23/24 and continues to open surge beds at times of peak demand.

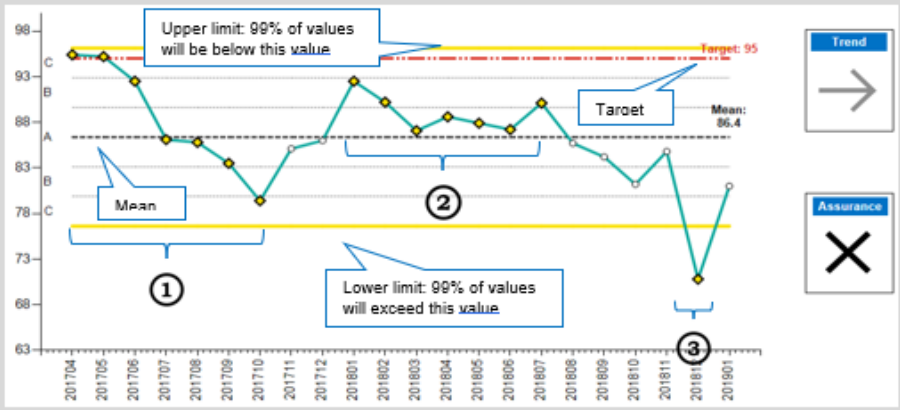
Appendix 3: SIREN



SIREN - summary commentary

- **A&UC:**
  - Lilacs, Ward 2 and Ward 3 are challenged due to recent managerial / medical changes but early signs indicate greater stability. The SL are also aware of pressure on Rose and Laurel wards where there are medical staffing and leadership challenges being actively addressed. The SL will explore why SIREN does not reflect this concern
  - Within crisis teams, there are significant leadership issues in all HTTs particularly Sutton and Kingston, which are being addressed with the Matron and CSL. Liaison teams remain in a difficult position given demand and flow issues but transformation is designed to engage the teams to resolve these and includes cultural work with the teams.
- **CAMHS & AED:**
  - Avalon, Aquarius and Wisteria wards are all managing extremely complex service users with frequent incidents and high acuity. The SL team are managing this closely with support from the HON as impact on sickness rates and burnout of the nursing teams is a concern. There has also been SLP-wide instability in the Eating Disorder and CAMHS wards that has increased pressure on SWLSTG wards but this has been managed and is now improving.
- **Community:**
  - There are significant recruitment, retention and leadership issues across the community service line which the SL leadership are working to resolve. The use of agency staff impacts on continuity of care and team functioning, and work is in progress to enhance staff experience and engagement.
  - The teams showing red SIREN align with the known areas of vacancy and leadership challenges and have improvement plans in place, however concerns about workforce resilience remain. Further OD work is in progress and the transformation programme is showing early signs of impact with new Enhanced Response and Interface Teams likely to support our challenged community teams.
- **Specialist:**
  - Specific challenges within Forensic outreach and L&D are being addressed by the SL team. Ruby staffing is a concern but the recruitment pipeline will address this by September.

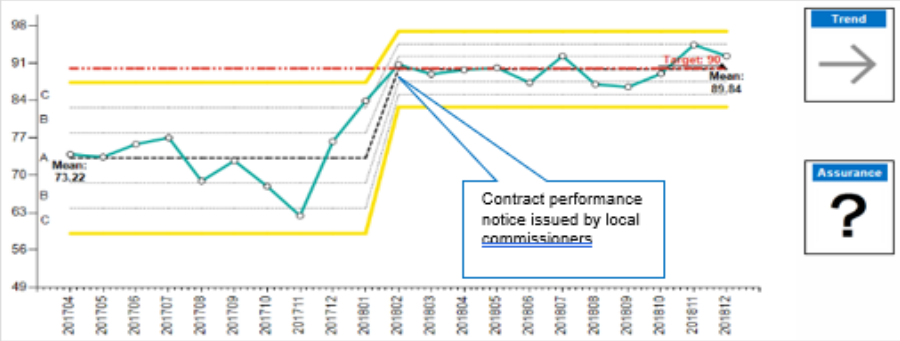
Appendix 4: Statistical Process Control (SPC) Charts & Performance Donut



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

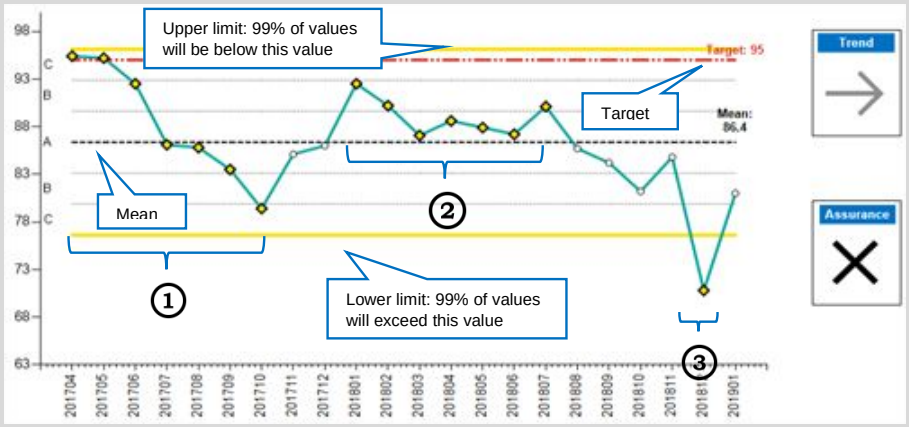


Special-cause variation
These are statistically significant patterns in data which may require investigation and includes the following (as illustrated in the chart above):
Trend: 7 consecutive points trending up or trending down (a 0.8% chance of this happening naturally).
Zone A: 7 or more consecutive 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*").



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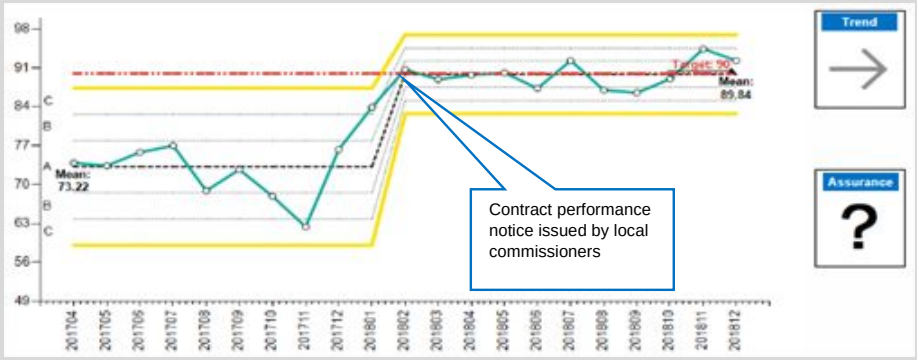

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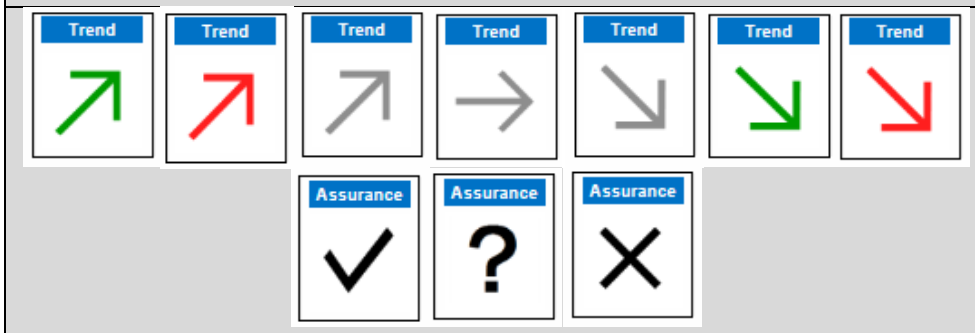

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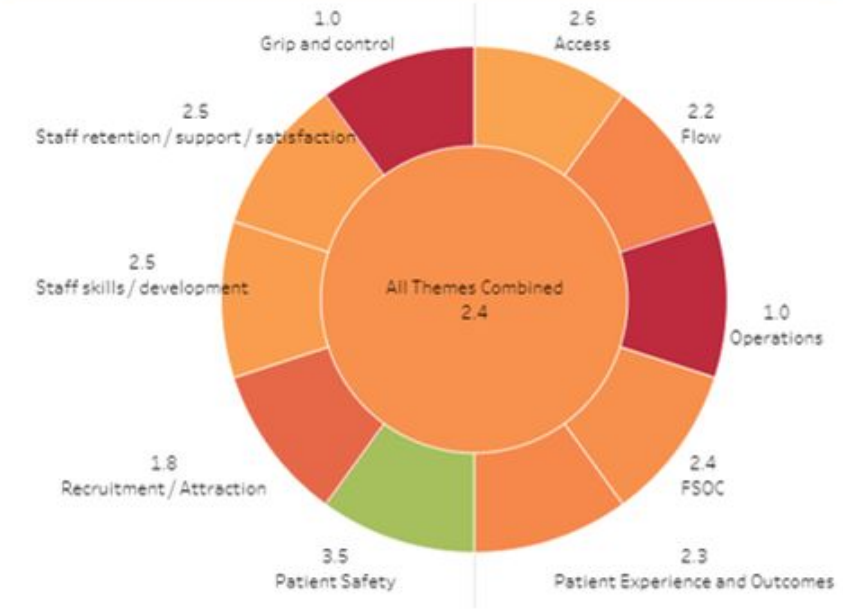
If "*Questionable Assurance*", however target has been hit for last 6 months and positive trend identified then set to "*Assurance Given*" (and vice versa for "*Assurance not given*").

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

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

RAG Rating:

Score 1.0 — 5.0

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

Meeting:	Trust Board
Date of meeting:	14th September 2023
Transparency:	Public
Committee Name	People Committee
Committee Chair and Executive Report	Sola Afuape (Chair) Katherine Robinson (Executive)

BAF and Corporate Objective for which the committee is accountable:
People Committee has responsibility for the following BAF risks:

- Failure to have the right staff with the right skills at the right time.
- Failure to effectively respond to EDI issues facing the Trust.

People Committee is responsible for the following corporate objectives:

- To support our people to develop and grow and develop our organisation to be the best that we can be
- To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences

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

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

1. MAST
2. Ongoing industrial action
3. EDI BAF
4. ER cases
5. Retention.

Areas of Risk Escalation to the Board:

- Agency use – the Committee only have partial assurance that the trust can reduce agency use to the required levels.
- Further Industrial Action.
- Employee Relations (ER) cases continue to be a concern, despite a manageable level of cases, more grip and control and better data which was more closely monitored; e.g. cases over 90 days. A case management system is needed which the team are working with Jen Allen to try to utilise a system that the trust has already in place.
- Retention and the different needs of service lines.

- The automatic uplift for Bank staff which was unfunded.

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

Board Assurance Framework (BAF)
What: The Committee reviewed the EDI BAF.

So What: The Committee EDI risks remain at the same score at present. The EMHIP had five key interventions where the EDI team were working with ICB colleagues and the voluntary sector to fast track some of the delivery. However, it may be the case that the original timeline may not be achieved in some of the intervention areas; e.g. restricted practice and crisis family intervention.

What next: A plan is in place to bring all of the outcomes for EDI (NHSE EDI Improvement Action Plan, WRES, WDES, pay gap, etc.) into an integrated Health Inequalities and EDI action plan, to easily compare implementation of actions and outcomes. This would include clear indication of statutory compliance requirements and assurance.

It was noted that some of the elements in the EDI BAF were historical and / or had ended, such as the disciplinary deep dive. The Committee requested that the BAF be presented in a different way or for these items to be removed.

The Committee requested that the EDI BAF include specific intelligence to help the Committee think about key workforce metrics broken down by ethnicity; so that the Committee can be assured that controls were in place.

A progress indicator was requested, to help the Committee see how actions have moved along/shifted.

The importance of using comparative data with other trusts and including best practice was also noted.

WDES and WRES reports
What: The Committee receives these reports annually prior to submission being made to NHSE. The WDES had been submitted to NHSE on 31 May 2023.

So What: Concerns were raised about zero disclosures of disabilities in some staff bands, when we have the highest number of disabled staff across Mental Health trusts. The Committee were assured that there is an ongoing piece of work on how to encourage staff to feel comfortable disclosing disabilities, alongside access to work and reasonable adjustments. The Committee should see that work coming through within the next month or so and would report this up to the Board through the Chair's report.

Further concerns were raised around career progression for band 7 staff especially in Deaf services. Assurance was given that there was a piece of work taking place with St George's, University of London, to help Deaf student nurses be able to work in hearing wards so that they had the same experience and were developed in the same way as hearing student nurses. The Committee acknowledged that there was further work to do, especially with promotions for people in band 7 roles and above.

The Committee asked that the WDES and WRES reports be given a RAG rating to show if changes to the data were positive or negative; and to better reflect progress of actions.

What next: The WDES should be published in October 2023. The ongoing work around zero disclosures of disabilities in some staff bands, alongside access to work and reasonable adjustments, would be monitored by People Committee.

Corporate Objectives Q1 update report

What: The Committee received an update report on the progress of Q1 for its Corporate Objectives. The Objectives were mostly on track with slight slippage. A lot of work needed to be done this year and a lot of good progress had been made, especially around retention data and the leadership development offer. The Committee noted that across the trust it was a positive picture overall at Q1, so the Committee is not an outlier; but that some things were slipping due to the required volume of work and the capacity of some teams to deliver.

So What: The Committee were assured that the slippage for workforce objectives was not a cause for concern. The Committee understand that the People function are trying to navigate many workstreams alongside stabilising the department. The leadership development work may be a barrier to achieving the objectives on time. It was reported to Committee that it had been difficult to create, commission and deliver one offer that suited all of the different needs. An approach would go to ELT for agreement and implementation should happen in Q2. It had been hoped to deliver the Training Needs Analysis by now, but the Learning and Development team were struggling with capacity around Mandatory and Statutory Training. The team now had additional support in place. The paper on retention had slipped due to capacity and staff absence; this would now go to the August People Matters meeting. All of the other pieces of work were on target to be achieved on time.

What Next: The Director of People would be aligning the corporate objectives with the actions that were within the People BAF, in time for the September People Committee.

Director of People (DoP) Report

What: The Committee regularly receives this fulsome report as it provides timely updates and useful context for the Quality and Performance (Q&P) report, which currently provides intelligence that is two months behind.

So What: Assurance was provided that progress was being made with the recruitment pipeline with clear tracking and a timetable for recruitment across the year now in place. The Committee were informed that further industrial action from junior doctors and consultants had recently taken place and the trust had been notified of further planned action from consultants over the August bank holiday weekend. The Committee were assured that industrial action continued to be well-managed through the Operational Resilience Assurance Forum (ORAF) and Local Negotiating Committee (LNC).

ER cases and Employment Tribunals continued to be a concern. The HR Business Partners were helping with ET cases, but this moved them from work that they needed to be doing. The ET tracker had been improved. • The People team were trying to resolve a number of things all at once, including ER and Leadership Development. In order for managers to operate well they need development available and policies in place. In turn the People team needed managers to support ER cases. This may feel like challenge as it was all coming together at once.

What next: The Committee has suggested the People team make a business case for the investment priorities budget to help with the capacity challenges.

The Committee has requested a benchmarking paper which shows the current People team structure against other trust and private sector HR structures.

Quality and Performance Report
What: The main areas of concern arising from the July Report were agency use and retention (especially those leaving under 12 months).

So What: There was positive assurance regarding recruitment, which was at the highest levels it had been since the HR separation from SLaM. Time to hire remained in target and the People team were getting more positive comments regarding the support teams had received from the recruitment team. Mia Kruber would follow up any outliers in terms of time to hire.

The Committee were informed that ELT had had a discussion around assurance, actions and delivery times in relation to agency use. A paper would go to ELT in August to provide assurance on what else needs to be done, the traction on current actions and what actions were needed to hit target by the end of this year. A trajectory for each Service Line had been produced. The People team were working closely with the Operations team to consider when would be a right time to say the trust would no longer be able to use clinical agency and HCA agency, with patient safety at the forefront of that discussion and decision. This was a continued area of scrutiny for the Executive and the teams were in a position to provide better assurance. Even with all of that, it was still hard to reduce agency use, and it was not a guarantee that it could be reduced completely. This was being flagged as partial assurance at this stage.

Assurance was given that the Director of People was having ongoing discussions with her Executive colleagues on the sequencing of pieces of work and how best to use the limited People team resources available.

What Next: Turnover of staff leaving after 12 months was being explored further, including the fact that 30% of this group were under 30 years old.

The Committee would like the report to include Corporate departments as well.

FTSU Guardian Report
What: The FTSU guardian had just began his promotional work in the Corporate departments that were not using the service. He reported that he had consistently heard that one reason why staff in these areas did not speak up, or that when they did they wished to keep anonymous, was a fear of their career being affected.

So What: The Committee were concerned to hear this. It was suggested that the FTSU guardian triangulate his data with the recent Corporate Services review actions and/or findings.

What Next: The Committee noted the different elements of information around Corporate Services teams that may need to be triangulated (e.g. low disability declarations; staff survey results) and were seeking assurance that there were active controls in place to address issues around fear to report for Corporate Services teams. The FTSU guardian would continue the promotional work and delve deeper into what may be the root cause/s of Corporate staffs' fears.

The Committee asked to see the Corporate Services review to understand the findings and actions that came out of the review.

Mandatory and Statutory Training (MAST) Progress Report
What: The Committee heard that the Compass update had now taken place and so data should be more accurate going forwards. Inesa Sinkeviciute had been seconded to the Learning and Development team, in order to release capacity to focus on getting traction and delivery with MAST.

The Committee members asked about what the Executive were doing to set a strong culture and leadership expectations around the importance of MAST; and how to support staff to embed training so it was not seen as a tick box exercise. The Committee heard that MAST

was required to keep staff and their patients safe. The ELT were using the Service Line meetings to shift the culture and conversations around this. It was reported that ELT were confident that there was a robust plan in place and that root causes had been identified and mitigated, including resolving the system issues.

So What: The Committee were assured that the Learning and Development team and Subject Matter Experts had proactively pushed training and had a better grasp on the amount of Did Not Attends (DNAs). Improvements should soon be seen month on month.

What Next: The Committee asked to have an update at the October meeting on the following items, including assurance: agreement of what training courses were classed as MAST 1, 2 and 3 and what the staff audience was for each level; the number of DNAs and if Compass was fulfilling its IT functionality.

HR Internal Audit Recommendations
What: The trust's internal auditors, RSM, had undertaken a review of the new People service and had produced some recommendations.

So What: The Committee discussed that some of these recommendations were relevant some months ago but there had been great improvement since: the management information had provided increasing levels of analysis which had allowed the Committee to focus even further into items of assurance, and the recent addition of the Director of People report and new Q&P report had strengthened this further.

What Next: RSM had suggested a cultural shift was needed but had not gone into any detail about what that meant. The Director of People would follow up with them about this and report back to the Committee.

Items for note

- That the WRES final draft would be reviewed at the September meeting as the Committee had requested a change in the RAG to better reflect progress.
- The forward plan was reviewed briefly. The Director of People was asked to bring a paper to the Committee on agile working (passed to People Committee from EMC) as to how agile and flexible working would be included in the retention plan, what monitoring and assurance might look like, when the retention plan can come to Committee and how to feed back to EMC to close the loop.

Appendices

Ratified minutes of the June 2023 meeting.

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

PEOPLE COMMITTEE
Draft Minutes of the meeting held on **Monday 26 June 2023**, 13:30-16:00 via MS Teams.

Present:

Sola Afuape (SA)	Non–Executive Director (Chair)
Juliet Armstrong (JuA)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive Officer (until 14:30)
Jenna Khalfan (JK)	Director of Communications and Engagement
David Lee (DL)	Director of Corporate Governance
Katherine Robinson (KR)	Director of People
Sharon Spain (SS)	Director of Nursing and Quality

Attendees:

Jeremy Coutinho (JC)	Diversity in Decision Making Representative and Recovery College Manager
Emdad Haque (EH)	Associate Director of Health Inequalities and EDI (from 15:00)
Mia Kruber (MK)	Head of Resourcing
Jan Lonsdale (JL)	Head of Education and Development
Nisha Proietti (NP)	Diversity in Decision Making Representative and Deputy Senior Employment Advisor, Sutton Uplift
Pam Warren (PW)	Deputy Director of People

Apologies:

Jen Allan	Chief Operating Officer
Vik Sagar	Non-Executive Director

Minutes:

Emma Whitaker (EW)	Deputy Director of Corporate Governance

	Item	Action
1	**Standing Items**	
26/19	**Welcome and Apologies**	

The Chair welcomed attendees to the meeting and introduced and welcomed JuA, one of the trust NEDs who had formally joined the Committee.

Apologies for absence were received and noted as recorded above.

The Chair asked for Committee members to keep Patient Flow and Workforce in their minds throughout the meeting, as these were the Committee priority areas.

The Chair highlighted the importance of being as informed as we can be as a Committee. At the end of each agenda going forwards would be links to key workforce and organisational development (OD) papers, to help provide the right background/context for agenda items.

The Chair highlighted a couple of critical awareness months and weeks the Committee should be aware of – Pride month and gypsy and traveller community awareness week.

26/20 Declarations of Interest

No new declarations were reported.

26/21 Chair's Actions

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

26/22 Minutes of the meeting held on 23 May 2023

The minutes of the meeting held on 23 May 2023 were approved as an accurate record of the meeting, with the following amendments:

- Pg. 6 – MAST – JC had mentioned that the Recovery College used a system of overbooking people on courses as they know roughly how many no shows they get. Alternatively, a wait list could be used for cancellations in the days before a course. This would push up the MAST percentages.
- JC had asked the Committee if it would help to see patterns of ER cases that had been 'lost' by the Trust; e.g. poor management or lack of clear procedures. Additionally, the department could be noted. This would help HR to identify problem areas.
- Pg.4 – Guardian Report – JC had asked if the table giving theme and location in the Guardian Report could cover the whole year so that trends could be spotted.
- Pg.5 – "In the Guardian report, DL made references to the trust's performance in freedom to speak up issues in staff survey as "weak" – the Chair sought clarification from DL on the meaning of 'weak' and asked what does the Trust need to do to get to an improved position" to be changed to: "In the Guardian report, DL made references to the trust's performance in freedom to speak up issues in staff survey as "weak" – *the Chair sought clarification from DL on the meaning of 'weak' and asked what does the Trust need to do to get to an improved position*".

26/23 Action Tracker

The Committee received and noted the action tracker. The following updates were received:

22/28 Staff Demographics Report – This was on the agenda for today's meeting. Action to be closed.

25/9 New Quality and Performance Reporting – EDI and workforce metrics – EH to discuss this with colleagues to assure themselves that the new Q&P reporting has the right EDI elements. EH would circulate a response before the July meeting. Action to be closed.

25/9(i) New Quality and Performance Reporting – QSAC and People Committee review of EDI impact on Quality and Workforce

This action was a Chair's discussion about where the Q&P integrated position on EDI would be presented. Deborah Bowman, Chair of QSAC, and SA were having these conversations, but it was also important for EH to discuss what was going to be agreed in the assurance position. EH added that he would be considering how to bring EDI reports to the other Board Committees. When the report comes

to People Committee it would have an EDI and Health Inequalities focus. Action to be closed.

New Action: SA to confirm with Deborah Bowman how best to report QSAC and People Committee review of EDI impact on Quality and Workforce to the Board going forwards. **SA**

25/9(ii) New Quality and Performance Reporting – demonstration on dashboards
Diaries were being co-ordinated to put this in as quickly as possible. Action to be closed.

25/10 – Agency Use Progress Report
KR and SA had discussed this directly following June's Committee meeting. Action to be closed.

26/1 – Apologies
KR confirmed that she had passed on to ELT colleagues the message about formal apologies to the Committee. Action to be closed.

26/6 – Director of People Report – more granular detail
KR had provided greater detail in the report around areas of concern. She would be happy to take continuous feedback as the report is evolving. Action to be closed.

26/7 – Guardian Report – Guardian to engage with corporate areas and feed back to the Committee
Lincoln Murray (LM) had been in contact with some corporate areas since the last meeting; he was arranging visits and he had the relevant organisational charts. He would feedback any findings at the July meeting then the action could be closed. Action to stay open.

26/7 (i) – Guardian Report – To provide some commentary on the possibility of utilising data, or commentary on data, from union cases
This action to be merged with action 26/7 above. DL assured that, for the next report, LM should be able to do some of the triangulation in terms of themes, using union data and staff survey data. Action to stay open.

26/8 – Q&P Report – when the MAST report would come back to the Committee.
This was on the agenda for the June meeting and the new report format should come to July meeting. Action to be closed.

26/9 – Agency use – monthly agency use position with short narrative to come to the Committee.
This was on the agenda for the June meeting. Agency was being reviewed at every ELT and was also reported through FPC. This month it had been captured in the Q&P and Director of People reports. Action to be closed and KR was asked to bring a separate report to the Committee based on this data, including "board to ward and back" internal controls.

26/10 – Occupational Health (OH) Report – A quarterly report on the OH service to be presented to the Committee for assurance.
This had been factored into the forward plan and would be bought to Committee quarterly. Action to be closed.

26/10 (i) – OH Report – The guidance on the role of the Health and Wellbeing Board member to be revisited and built into the first Health and Wellbeing paper coming to the Committee.
There would be a Health and Wellbeing paper bought to the July Committee. SA and KR would meet beforehand to discuss the paper. Action to be closed.

26/11 – BAF – the forward plan will reflect when the BAF paper with the statutory compliance cover sheet and Executive Risk Register (ERR) that sits underneath the BAF will come to Committee.
The ERR would come to the July Committee and workforce and People risks would be highlighted on the cover paper. Action to be closed.

26/12 – Q4 Objectives – KR to provide headlines in terms of how the objectives had been achieved versus last year's performance, and any gaps.
This action had been completed. Action to be closed.

26/14 – Terms of Reference (TOR) – KR and SA to discuss where internal audits could add value, and the timing for the/an HR internal audit.
This action had been completed. Action to be closed.

2 Culture

26/24 Director of People Report
The Committee received the Director of People Report.

Reported:
KR highlighted the following points:

- MAST – The Compass upgrade had now taken place. It had gone well, and the system had been tested and was working. It was expected that MAST compliance would begin to rise as a result. Conversations around MAST remain live and ELT were continuing to review MAST weekly.
- Industrial action – There was further junior doctor industrial action planned, as well as potential consultant and nursing action. A desktop exercise for contingency planning for industrial action was taking place today.
- ER Caseload – The caseload was in a good position and was being managed robustly. Themes from cases were emerging. There had also been an increase in tribunal cases within the last few weeks.
- Recruitment was working well, with over 300 people now in the pipeline. Quite a number were newly qualified nurses, staff for the new LDA unit, and HCAs following the recent successful mass recruitment. The vacancy number should reduce when these staff were in post.
- Time to hire was still within target thanks to the People team. A slight dip over the peak period may occur.
- The additional measure "from conditional offer to start date" was being monitored and it had been identified that shortlisting was where the biggest

delay was in the recruitment process. This should start to reduce as commissioning meetings with recruiting managers were now in place to ensure that, at the beginning of the recruitment campaign, time is put into manager's diaries to shortlist.

- Medical staffing – Antoinette Bob-Manuel continued to do a great job managing general queries and working with Clinical Directors. She had talked to the royal colleges about MTI and speciality doctors and was working on reducing locum spend and job planning. The trust still had a number of consultant vacancies which were not attracting applications.
- LNC – There had been improvements to this Committee, in terms of management and responsiveness. The LNC members had fed back that they felt the Committee had improved.
- There had been an appreciative inquiry carried out by an external Director of Nursing. The inquiry produced a number of recommendations that had now been fed back to the relevant quartet. Recommendations were made around openness of dialogue within community services, and that vision around change was needed in the Service Line. No discrimination was found by the inquiry but there had been some ER cases in community services that involved possible indirect discrimination. Engagement with the Freedom to Speak Up (FTSU) Guardian was lower in community services. The Service Line had been asking for some OD report before this inquiry. Within the OD Framework that was being built the community services Service Line had been identified as a priority area. The Framework would provide support to leaders about affecting change.

Discussed:
The Chair raised that she had reviewed Q&P reports from prior years and they had also had recruitment as an area of challenge and had tried to mitigate it with commissioning meetings. She asked what would be different about the current commissioning meetings that would bring shift. She would also like assurance on hotpots. MK reported that feedback from current commissioning meetings had been positive. KR stated that she would need to give some thought about how best to answer this query in a way that would provide assurance on hotspots. She would discuss this with the Chair outside of the meeting.

There were recognised areas where more work was needed; e.g. recruitment. However, it was positive that there was more joined up working with recruitment and the Service Lines. ER cases continued to improve. MAST was not deteriorating and there was active work ongoing in the Service Lines to tightly manage it. SS, JeA and KR were actively working on this too. Policy and procedure sprint work was ongoing which should help reduce tribunals/ER cases.

There was a table of numbers of ER cases that involve BAME staff included in the report. JC asked if the percentage of BAME staff that work for the trust could also be included, to enable the Committee to put this data into context. PW had been asked to collate this information going forwards; KR would ask her to include the percentage of BAME staff working for the trust. She would also triangulate the ER data with the FTSU Guardian's report.

That an update on the work planning process would be helpful for the Committee.

That the Committee would like to know where medical locums were situated, maybe in a separate report.

That it was great to see the recruitment pipeline growing.

That the table in report that showed "time to hire" was very helpful for the Committee.

Whether consideration had been given for the career development of the hybrid roles in the LDA. MK responded that there had been a specific piece of work on career pathways for these LDA roles, as they were specialist, and the pathways were advertised in the job role adverts. This may be why the trust saw a high number of applications for these roles. KR added that as LDA was a specialist area there was a definite need to consider career pathways and retention; and this would be captured in the workforce plan.

The Chair raised whether it would be helpful for the Committee to receive a stand-alone paper around retention whilst it remained an area of concern, with data and hotspots included. She would discuss this with KR outside of the meeting.

That the People team had started to collect metrics on recruitment experience and the team were starting to see good feedback coming through.

The Committee discussed the appreciative inquiry report, which showed that internal controls, such as managers adhering to policies and procedures, were not being followed appropriately. The Chair would like assurance around this issue and would like the Terms of Reference (TOR), findings and recommendations to come to the Committee. She requested that this information be shared with members by email and that going forwards this was picked up in the Director of People report. KR responded that she would be happy to share the TOR and recommendations; with the Chair and that the recommendations would come to the Committee. She added that there was a need to be thoughtful of sharing the full report and she would discuss this with the Chair outside of the meeting.

The Chair queried what the mechanisms/internal controls were to give the Committee assurance around how people were correctly using policies and procedures. She asked that KR consider this and report to the next Committee.

The Committee reflected that a few years' ago, bullying and harassment was a trust focus and the staff survey highlighted this was an issue. There was a "Beyond Bullying" campaign. It was decided to park this piece of work at the time. The Committee discussed being sighted on bullying and harassment work that was going on now. The Chair stated that she was not confident that the Committee was getting assurance of, and a real sense of, the trust culture. There was a need to consider how to have this coming through the Committee. KR updated the Committee that there had been recent thought around the next iteration of "Beyond Bullying" and a paper would be going to ELT and would then be bought to People Committee, as to what that concept would look like. Currently there was a piece of work ongoing around engaging with stakeholders for their input into what the concept would look like.

Agreed: **KR**

KR to share the TOR and recommendations from the Appreciative Inquiry with members of the Committee by email. **KR / SA / EW**

KR, SA and EW to discuss retention being a stand-alone, regular agenda item outside of meeting.

KR

KR to consider the mechanisms/internal controls in place to give the Committee assurance. around how people were correctly using policies and procedures, and report to the next Committee.

26/25 Quality and Performance Report (April data) and Highlight Report

The Committee noted the Quality and Performance Report and Highlight Report.

Reported:

KR highlighted the following:

- Recruitment – in July there would be the first meeting of the Recruitment Delivery Group, who would have oversight of mass recruitment campaigns. They would consider how the trust were publicising the organisation to the wider community, how people were bought into the trust, and how to go out to the local community. Where there are events locally these would be bought to the group to ensure resource with the right people involved.
- Agency spend – the People Delivery Partners had met with each Service Line and had checked all longstanding agency staff. These all now had an individual action plan attached. The team were continuously looking at data in terms of HCAs/observations.
- Turnover had slowed but it was recognised that there was a need for focused attention on retention.

Discussed:

The Chair reflected that, in relation to the assurance position, it is broadly where things had been before. She was mindful of the need to report to the Board how things would be going to shift; and where improvement activities have shown impact, and outcomes. KR responded that, for some metrics, the team would be able to give assurance as to when changes should be happening; e.g. recruitment, vacancy rate, MAST, ER cases (stabilisation rather than improvement); but a few metrics would be tricky; e.g. temporary staffing, turnover. The Chair said that it would be helpful in the next iteration of the Q&P report, to show any evidence that can quantify improvement, as this would be helpful in terms of assurance to the Board.

The Chair reflected that the mitigations in the Q&P report were similar to previous years' mitigations. She asked what was going to be different this time . SS updated the Committee of two pieces of work she was leading on. The first was violence and aggression support and wellbeing for staff, which was being taken forward with a task and finish group. This piece of work would link in with Making Life Better Together and zero tolerance. The second piece of work was a task and finish group set up after review of some ER cases where learning had highlighted the lack of flexible and agile working, and lack of reasonable

adjustments for staff with disabilities, including hidden and 'low level' disabilities. These two groups would come up with clear ways of working. There would be a verbal update on progress to the Committee in two months' time.

KR added that although some mitigations were similar, it was because this was foundational work, and that there should be a difference seen now the People team were in place and the HR function had changed.

That under turnover, and staff leaving within 12 months, there seemed to be activities going on to address the issues, but it felt like each Service Line was doing something different. It was asked where this work was being coordinated. A theme seemed to be lack of career progression and training. PW responded that there was a workshop this morning on reducing agency spend and triangulating with vacancies and retention issues. On a recent webinar three key themes arose: flexible working, self-rostering, and Preceptorships. These points would be included in an overarching plan that sits alongside the trust workforce plan. The actions from the agency spend workshop will be pulled into the over-arching plan. PW would be happy to bring this plan back to the Committee.

26/26 Pulse Survey Report (April)

The Committee noted the report.

Reported:

JK highlighted the following:

- These were the results from the National Quarterly Pulse Survey (NQPS), which was used as a temperature check of how staff were feeling, in-between the annual staff surveys.
- The trust benchmarked poorly in Q4, with 1.4% of staff completing the survey.
- There was a poor experience rate, especially in the advocacy questions (staff recommending the trust as a great place to work or to receive care).
- Q1 was launched with a light touch digital campaign supported by HR colleagues. It had been reasonably successful, with an increase of staff completing the survey to 7.5%.
- Results have improved in some areas; e.g. around Health and Wellbeing.
- It was not possible to collect demographic data for these surveys.

Discussed:

The Committee asked what the plan was to increase the percentage of response rates and to maintain this. JK responded that as these surveys are quarterly the communications and engagement team were being proportionate to marketing them, by focusing on digital campaigns. The aim was to increase the response rate to 9%, which was the national average response rate to the NQPS from Mental Health trusts. This would also be a valid statistical number and it was hoped to be able to use this data more robustly at that point.

It was suggested that in next survey report, the conversation be expanded about if the communications team's limited resources could be best used elsewhere, due to the low response rates to the quarterly surveys.

26/27 Making Lives Better Together (MLBT) Report

The Committee noted the verbal update of the Making Lives Better Together (MLBT) Report.

Reported:

JK highlighted the following:

- The Employee Advisory Group (EAG) met for the second time recently. The group discussed specific parts of future areas of work. Mostly the meeting has been positive. It was hoped that the group would influence the future direction of the organisation and would support the Committee with assurance.
- Diversity in Decision Making (DiDM) Champions – the evaluation of cohort two was being considered currently. The Champions scheme might be expanded through the Service Lines if there was a role for them there, and in Corporate Services. The cohort two evaluation would have recommendations that would come to People Committee.
- Anti-racism – a call went out for members of staff to come to action learning sets, and JK was overwhelmed by the response. She hoped to get 10-15 people and got 60. There was a reasonably proportionate response from many areas, including clinical.
- The trust was successful at bidding for £55k to fund Mental Health First Aid training at Springfield Hospital. It will fund 400 places. This would be an important part of place building and sustainable community at Springfield.

Discussed:

The Committee would value a paper on MLBT in future, to give people time to digest and mull over the activity prior to the meeting. The Committee would like better understanding of the impact of this work; how this work has an impact on hot spot issues e.g. recruitment; and insight; e.g. from EAG, to help the Committee understand the organisational culture.

That it might be worthwhile considering the best way to communicate this work and its impact to middle management and the front line. JK would think about how to do this best.

The Committee looked forward to hearing about how the DiDM representatives would go into Service Lines and also how they could be empowered to speak truth to power.

26/28 People Demographic Profile Report

The Committee noted the People Demographic Profile Report.

Reported:

EH presented the key points:

- This was the first version of this report. Previously the Committee only received WRES, WDES and the gender pay gap report.
- This report was a snapshot of the profile of the workforce as of 31 March 2023.
- The trust workforce was very diverse and the trust had the highest disability declarations (8.5%) across Mental Health and Learning Disabilities organisations across the country. The national average was just over 4%.

- The workforce was very young, and the highest new recruits last year were in the 26 – 30 year old age group.
- Ethnicity had not changed much since the last WRES report. However, the percentage of BAME staff who left the organisation (21%) was slightly higher than the percentage of white staff who had left (19%).

Discussed:
Whether civil partnerships data could be captured in any way to be fully inclusive.

Whether the sequencing of the report can be changed so that it would come to Committee before the annual reports.

Whether the ICB/system position could be included.

Whether this was a report required by the NHSE or was it the trust's report, and if the former if there were any benchmarking to see if the trust was a statistical outlier, and also to see how the organisation benchmarks against other Mental Health trusts. EH clarified that this report is a part one report of the trust's workforce equality information. Part two would be the WRES/WDES reports, which would be coming to the Committee in July. Later in the year there would be a report on Medical Staffing WRES and bank staff WRES, which were two new areas of data collection. EH would think about how to share with the staff networks and triangulate the data with lived experience to make it richer.

Whether the Disability disclosure could be a recruitment advantage for the trust. KR responded that the trust should absolutely use anything that attracts people to the trust, but there was a need to be careful that people get the experience promised when they arrive.

Whether there was any data to show if people found the trust more open to share their disabilities or if the trust hires more disabled staff. SS responded that the trust had not done enough analysis around this, but anecdotally the Diversability staff network had become strong and influential across the organisation, so people feel they can be more open.

JK suggested that her team could create some personas that represent the majority of trust staff, to show how diverse and inclusive the trust's staff groups were.

It was highlighted that protected characteristics were underreported in corporate areas, and it was discussed as to if there an issue; and if so what was being done to address this. LM would be asked to provide assurance around underrepresentation in the July FTSU Guardian report. VF added that there was a Corporate Departmental Review this week which would review the deep dive of staff survey results. LM had been asked to raise his profile on team visits to Corporate Services departments.

JC asked if this data could be shown in bandings. EH confirmed that banding and medical/non-medical information would be included within the WRES report coming to Committee in July.

Agreed:
JK and EH to look at whether some infographics could be included when presenting this data especially if it goes out to staff. **JK / EH**

26/29 Health Inequalities and EDI Action Plan Update
The Committee noted the report.

Reported:
EH highlighted the following:

- The action plan was part of the Public Sector Equality Duty (PSED) which required the trust to produce EDI objectives once every four years, that would give assurance that the trust was meeting its objectives and delivering outcomes.
- The updated action plan included some other outcomes in appendix 1 to provide assurance that the trust were delivering objectives to achieve patient and workforce outcomes.

Discussed:
That the action plan was RAG rated "green" throughout, which was queried by the Committee, who felt that this showed a disconnect to today's discussions. EH clarified that the RAG rating was for when activities had been achieved, and he would look at having a more reflective RAG rating, or a separate rating for outcomes; and at making the presentation more outcomes focussed.

Whether the action plan could be shorter, with five to 10 key actions that could really turn the dial on some of the desired outcomes; and that some of the actions seemed to be operational or business as usual items. EH responded that the action plan had been downsized from approximately eleven action plans that were in place when EH had first joined the trust. There was an opportunity to refresh the plan as the new Health Inequalities and EDI strategy was being designed this year. This could reduce the amount of actions and would look to split the EDI and equality objectives from what should be business as usual / operational. He added that EDI objectives were supposed to be developmental not business as usual items.

Whether there was enough focus on the transformation programmes and how they were going to improve workforce EDI metrics. JuA discussed that an action from the last Estates Modernisation Committee (EMC) was to review the EMC's BAF actions to ensure there was enough reference to EDI within them. EH responded that there were actions included around Health Inequalities and transformation. The trust had wanted a high-level plan that would allow Service Lines to work on their own action plans in a co-productive way, which was happening and working very well. EH had oversight of EDI aspects of all of the transformation programmes.

Agreed:
EH to consider the presentation of the Health Inequalities and EDI Action Plan Update as to adding in an element of impact and RAG rating the impact.

4 Accountability

26/30 People and EDI BAF

The Committee noted the People BAF and that the EDI BAF would come to the July Committee.

Discussed:

The Chair asked if the Committee felt there were any additional areas of risk that should be noted based on today's conversations. She suggested that culture and retention seemed to be growing areas of risk; as was internal controls, alongside recognition of the position the HR team were in six months' ago. JuA suggested agency spend, as a key area of focus for the Committee and the impact it had on the trust as a whole.

KR stated that the organisational development (OD) part of the BAF was covered by the OD piece of work. There was also need to consider ambition as an organisation versus the resources available.

5 Strategy

26/31 Q1 23/24 Objectives Report

The Committee noted the Q1 23/24 Objectives Report.

Reported:

This item would be rolled over to the July meeting and the Director of Strategy would be asked to attend.

6 Committee Governance

26/32 People Committee Forward Workplan 2023/24

The Workplan was bought to Committee for note.

26/33 People Matters Minutes – 21 April 2023

The Committee noted the People Matters Minutes for the meeting held on the 21 April 2023.

26/34 Key Matters to Report to the Board or other Committees

The Committee agreed to report a summary of items discussed to the Board:

- That Workforce and workflow would be the Committee's two main drivers for assurance.
- Improvement in vacancy / recruitment and MAST was expected towards September – and a note that the Committee would be expecting a clear articulation of this each month.
- That two areas of continual concern for the Committee are turnover and temporary staffing.
- Retention – comes up in Q&P, staff survey and other areas and is an area of Committee focus for assurance. The July meeting had a helpful discussion about how the Committee are starting to synthesise lots of areas of data and will continue to do so; and would request additional sources of data such as the Pulse report.

- Until the Committee receives the statutory compliance report this cannot be reported to Board – this would be coming in July in the wellbeing paper and EDI/HI action plan.
- That the Chair felt more assured around consistency and around triangulation of different sources of data – and gives appreciation to KR and her team for this.

26/35 Meeting Review

JuA reflected that this had been a good meeting. She had been impressed with the papers, liked and appreciated the focus on trying to get more immediate data, and the good conversations around triangulation of data. It was clear that lots of work was going on and she thanked KR and her team.

NP reflected that as part of a staff network and the Diversity in Decision Making (DiDM) programme, and having access to the Employee Advisory Group (EAG), you gained good insight and your voice was heard. Some of the feedback for objectives for the trust had been taken into account. She was excited to be part of the action learning set for Anti-Racism and was grateful for the acronym list now provided on the agenda and minutes.

DL reflected that it would be valuable to build on ensuring that the Committee has input into the BAF. The BAF was there to address the progress to attaining the objectives of the trust and how to realistically mitigate the risks and challenges.

KR reflected that work was starting to get under some of the detail and enabled the Committee to look at the root cause rather than quick fixes. Going forward the Director of People report would be balanced with some deep dives into specific problem areas; e.g. retention.

26/36 AOB

<u>Pay Award</u>

KR highlighted that there had been conversations about a Trust in the North of England paying the pay award lump sum to bank staff, which was not included in the final agreement. If that momentum swells it could present a financial risk to the organisation. KR would also flag to FPC.

26/37 Date of Next Meeting

It was noted that the next Committee meeting would be held on Tuesday 25 July 2023, 14:30 to 17:00, via MS Teams.

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

People Committee Acronyms List

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

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

Meeting:	Trust Board
Date of meeting:	14 September 2023
Transparency:	Public
Committee Name	Finance and Performance Committee
Committee Chair and Executive Report	Vik Sagar Philip Murray

BAF and Corporate Objective the committee is accountable for:

BAF Risk Description
A failure to achieve financial targets

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

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

The following are themes that informed and reflect the discussion at the July meeting of Finance and Performance Committee:

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

Areas of Risk Escalation to the Board:
None.

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

<u>Productivity Report</u>
What: The Committee regularly receives and reviews this report for assurance.

So What: The Committee noted the revised format; overall position is stable and improvements are needed in flow and agency usage. In June it was reported that there had been some good work on caseload review and DNA rate reductions in the Community through the clinical efficiency workstream. The positive improvement could be seen on the dashboard. Challenges remain with focus on incremental sustainable improvements.

What next: The Committee acknowledged the improvements and noted that further focussed work on community flow is planned for August and September. The Committee would keep monitoring the KPIs and noted that there would be concerns if improvement was not seen by September/October.

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

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

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

Digital update
What: The Committee received an update from the Digital team including local benchmarking, use of Digital as an enabler and importance of customer focus.

So What: The Committee received assurance that the team benchmark well compared to other teams in London against the backdrop of a growing Trust and recruitment difficulties.

What next: Action plans with trajectories against the internal audit action plan to be developed.

Strategy, Transformation, Corporate objectives and Commercial Priorities report Q1
What: The Committee received a paper on the delivery of strategy, transformation and commercial priorities in Q1.

So what: Committee noted and accepted the report.

What next: n/a

Items for note
None

Appendices
Appendix 1 - 2023/24 M3 Finance Report Part A – Cover
Appendix 2 - 2023/24 M3 Finance Report Part A - Powerpoint
Appendix 3 - 2023/24 M4 Finance Report Part A – Cover
Appendix 4 - 2023/24 M4 Finance Report Part A - Powerpoint

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

Report Title:	**Finance Report 2023/24 Month 3**
Meeting:	Trust Board
Date of Meeting:	14 Sept 2023
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Transparency:	Public
Scrutiny Pathway	Director review / ELT / FPC / Trust Board

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

What?	Key items to note are: ➢ **Plan / Year End Forecast** – year end forecast in line with plan at £250k surplus before impairments, impairments estimated at £50m. ➢ **Plan adjustments –** approval is sought for adjustments to plan c£16m increase in income and costs, net zero overall ➢ **In Month / cumulative position** - £0.5m deficit in line with plan. ➢ **Agency** – a decrease in spend compared to 2022/23 and £0.5m below plan. Above NHSE targets. Upward trajectory in 2023/24. CIP targets are red. ➢ **Observation costs** – Expenditure on observations continues on steady upward trajectory. Costs in 2023/24 being 20% higher than in 2022/23. ➢ **External Beds** – Expenditure on external beds continues on a steady upward trajectory with year to date costs being £0.8m more than budget. ➢ **Savings** – identified schemes more than achieve the £13.0m target, with £1.6m over programming. Recurrent Delivery is currently 46% and planned to be 62%, £8.1m at year end. Nationally recurrent savings delivery for 22/23 was 50%. ➢ **Capital** – underspend of £1.1m ytd due to cost of sales incurred ahead of plan, offsetting slippage on Tolworth and Richmond Royal schemes. ➢ **Cash** – the cash balance is £22.7m.
So What?	The report provides partial assurance that the Trust is on track to achieve the plan for the year and progress is required against major actions including agency spend, external beds and recurrent savings delivery. The Executive Team and FPC have reviewed the report and assurance levels are provided as follows:

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	➢ **External Beds** – A plan is in place and ELT are confident this will deliver. Bed usage has started to reduce in July providing assurance. ➢ **Observations** – An action plan is in place however there is a lack of confidence that this will reduce the associated costs and therefore an ELT deep dive is planned in coming weeks. ➢ **Agency** – Improved Oversight is in place however there is a lack in confidence and a rapid review is planned for August. ➢ **Savings** – Delivery to date is improved compared to prior years and schemes are in place to deliver. There is improved internal support and traction. Other Key items to note are: ➢ The Trust is not achieving the national requirement of agency spend not exceeding 3.6% of the paybill but is currently not an outlier compared to other London Providers. ➢ Through overprogramming we have eradicated unidentified efficiency targets. Progress is now needed on red rated schemes to improve the financial position and ahead of any external scrutiny in this area. ➢ The Trust has sufficient cash to manage its business and must not lose sight of the requirement to start repaying the loan in 2023/24.
What Next?	Actions have been identified as follows: ➢ Financial position to be communicated to budget holders through the 'Managers Matters' briefing from July/August.
Any specific issues to note and/or for escalation:	1. Committee are asked to ensure that focus is maintained on reducing external beds, reducing agency and delivering recurrent savings

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

Implications	Outlined below are the key implications which may result from the proposals or information contained within this report
Equality analysis *[linking to EDI strategy]*	Positive impact – The Trust spends money to improve equality and diversity for patients and staff
Service users/ carers	Positive impact – Trust Funds are spent to get the best

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

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

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1. I&E Position

Cumulatively to end of May we remain in line with plan; a deficit of £0.5m. In month additional funding and the payment of the national AfC pay award results in £0.8m favourable variance on income offsetting overspends in pay. Underlying underspends on pay continue driven primarily by vacancies and slippage on investment. The non pay overspend is driven by continued high external bed usage.

As all Trusts will have significant income and expenditure variances resulting from the pay award being agreed after plans were set, there is an opportunity to re-align the plan with no impact on the overall surplus position. It is recommended that the Trust realigns the plan for the Complex Care Wave 2 which was agreed after plan submission (£12m increase in costs and funding) and the Pay award (£4m increase in costs and funding).

Whilst the net position is on plan it is important to recognise that it is underpinned by investment slippage and vacancies. High levels of vacancies and high agency usage do not support quality, nor does this underlying workforce position support operational sustainability. Further, it is important to recognise that agency spend, covering vacancies, has increased year on year and is not sustainable.

Without intervention there is currently significant risk to achieving the Trust's plan of £0.2m surplus for the year. Net Trust risk is reported at c£8.3m and a major action tracker has been created to ensure financial risks to the I&E position are mitigated. The c£8.3m is consistent with the underlying position at the start of the year.

Workforce/agency/WTE – There is continued national and system focus on agency with the expectation that agency will not exceed 3.6% of the paybill for the system. The Trust plan has been set based on 2022/23 levels (7.1%) reducing to 3.6% of the paybill at year-end.

Agency expenditure in June was £1.0m (5.7%) in line with plan. As predicted costs increased in June and if expenditure does not reduce in July the Trust will breach its plan.

Observation Costs – over the last two years there has been a rise in the number of observations and their associated costs rising from £2.6m (c111,000 hours) per annum in 2020/21 to £5.6m (c232,000 hours) per annum in 2022/23. Based on current spend trajectories projected expenditure for 2023/24 is c£7.0m if mitigating action is not taken. Progress on the fundamental standards of care QI project to address the upward trajectory and delivery of a £0.5m savings target is reported through QSAC.

External beds – updated analysis of external bed usage is provided with costs decreasing slightly in June, £0.7m, £0.1m more than the 2022/23 monthly average. Use of beds is being managed at the EMC and trajectories for reduction produced. To date the pressures have continued into July again at slightly reduced levels. It is not possible to say whether the reduction is natural variation or due to the impact of management action. Whilst the overspend to date has been covered by investment slippage, this is at reduced levels to 2022/23 and therefore cannot be relied upon to cover external bed costs should the current high usage continue.

Savings – The Trust savings plan for the year is £13m and £14.6m of schemes have been identified providing over programming of 13%. Delivery after three months is £0.2m above target with £3.5m of savings being delivered. Risk adjusted forecast delivery for the year is £10.3m (£2.1m improvement in the month). With £5.9m (46%) already being delivered recurrently (an improvement on 35% last month). Planned delivery for the year is 62%

recurrent. Only schemes being delivered are given a recurrent status in the forecast. The risk adjusted forecast and recurrent delivery will therefore improve as schemes progress through implementation stages and confidence is achieved.

2. Capital, Cash and Balance Sheet Update

Capital is reporting a £1.1m underspend at quarter one due to slippage against EMP schemes including Tolworth and Richmond Royal. The forecast position is £58.5m in line with plan.

Cash is currently £22.7m, £3.7m more than plan.

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Finance Report 2023/24
3 Months to June 2023

Meeting	Trust Board
Date of Meeting	July 2023
Report Title	Finance Report 2023/24 – 3 Months to June 2023
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Director of Finance & Performance
Purpose	For Information
Scrutiny Path	Director review/ELT/FPC/Trust Board
Transparency	Public
Recommendation	None
The Board is asked to	Discuss and Note

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Overall – I & E Position

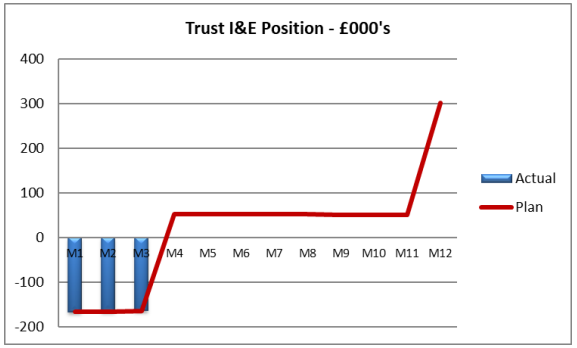
- In June, the Trust recorded a £0.2m deficit, in line with plan
- This brings the cumulative deficit to £0.5m, also in line with plan. The planned and actual deficit to date are due to costs associated with new buildings being incurred before associated savings from moving out of old buildings are delivered
- The forecast remains a baseline surplus of £0.2m for the year (before impairments)
- Completion of two new hospital buildings in 2023/24 will generate significant impairments (approx. £50m). The Trust is performance managed before impairments
- The Month 3 position reflects additional income and expenditure associated with the agreed 5% NHS pay award (excluding Medical staff).
- The baseline surplus forecast is subject to material risks including full funding of the pay award, external beds usage, patient acuity, inflationary pressures, energy, and CIP delivery

Financial Reports 2022/23	Current Month			YTD month 3			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	24.0	24.7	0.6	69.8	70.6	0.8	277.6	277.6	0.0
Pay	(15.5)	(16.6)	(1.1)	(46.9)	(47.3)	(0.4)	(191.9)	(191.9)	0.0
Non Pay	(6.9)	(6.6)	0.4	(18.2)	(18.8)	(0.6)	(67.4)	(67.4)	0.0
EBITDA	**1.6**	**1.5**	**(0.1)**	**4.7**	**4.5**	**(0.2)**	**18.3**	**18.3**	**0.0**
Cap Charges - Depreciation	(1.1)	(1.1)	0.0	(3.3)	(3.3)	0.0	(11.2)	(11.2)	0.0
Cap Charges - Interest & Div	(0.6)	(0.6)	0.0	(1.9)	(1.9)	0.0	(7.6)	(7.6)	0.0
Interest	(0.0)	0.1	0.1	(0.0)	0.1	0.2	0.7	0.7	0.0
Post EBITDA	(1.7)	(1.7)	0.1	(5.2)	(5.0)	0.2	(18.1)	(18.1)	0.0
Underlying Surplus / (Deficit)	**(0.2)**	**(0.2)**	**0.0**	**(0.5)**	**(0.5)**	**0.0**	**0.2**	**0.2**	**0.0**
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	(50.0)	(50.0)	0.0
Net Surplus / (Deficit)	**(0.2)**	**(0.2)**	**0.0**	**(0.5)**	**(0.5)**	**0.0**	**(49.8)**	**(49.8)**	**0.0**

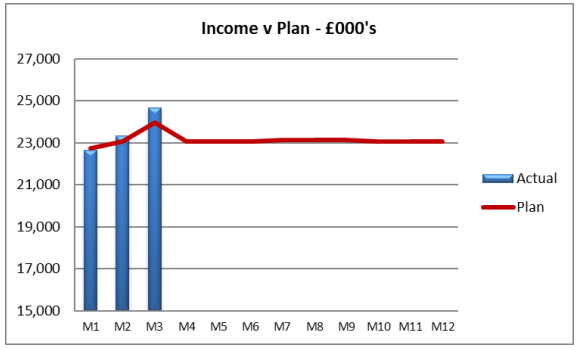
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

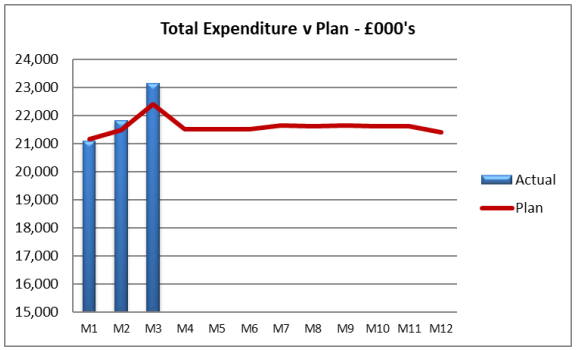
- Baseline deficit of £0.2m reported in month, in line with plan
- Cumulative deficit of £0.5m, also in line with plan
- Deficit driven by EMP phasing
- In month external bed pressures offset by investment slippage
- Significant risks to planned surplus



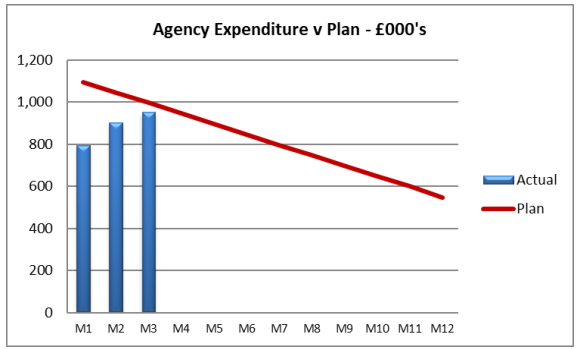
- Income received in month, £24.7m, £0.6m above plan
- Reflects additional funding agreed as part of the contracting process (£1.5m per month)
- Month 3 positions reflects additional funding associated with the backdated pay award (approx. £1.0m)
- Additional £1.1m awarded for Hostel usage



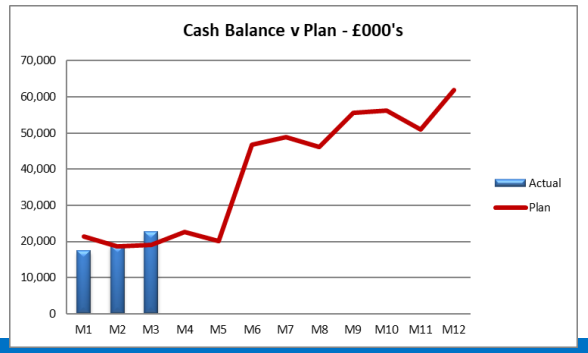
- Spend of £23.2m, £0.7m adverse to plan
- Reflects backdated pay award costs (£1.2m)
- External bed expenditure of £0.7m in month, £0.1m above 2022/23 average
- Cumulative overspend on external beds of £0.8m funded from slippage
- Early indications are that this pressure is starting to ease in M4



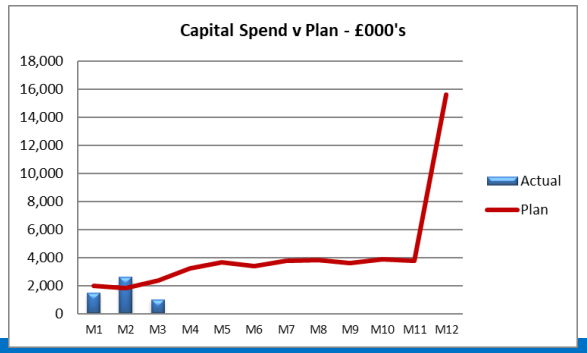
- Agency spend in month £1.0m, £0.1m below 2022/23 average spend
- £0.1m below plan
- Equates to 5.7% of pay bill, 2.1% above NHSE target of 3.6%
- April and May costs depressed by bank holidays
- Community Service Line spend amounts to 56% of total



- Cash balance at end of June £22.7m
- £3.7m favourable to plan
- Caused by capital underspend and favourable working capital balances
- Loan repayments of £99m to commence in 2023/24
- Movement in cash during the year due to asset sales, deferred receipts, and loan repayments



- Cumulative capital spend of £5.1m
- £1.1m behind plan
- Underspend on EMP, other areas broadly on plan
- Forecast spend of £51m
- Spike in M12 the result of current uncertainties around the timings in spend on the Tolworth redevelopment



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Income Position

- Cumulatively, income is £0.8m favourable to plan
- Local contract income is £0.3m ahead of plan due to additional funding after the initial contracting round on which the plan was set
- NPSA income is £0.1m behind plan as external referrals are below planned levels
- Provider Collaborative income is £0.4m below plan due to reduced Adult Eating Disorders inflow income
- Other NHS Clinical income is over-recovered by £0.6m due to the release of deferred income to cover the AED shortfall alongside additional investments in CAMHS and Complex Care
- Education income is £0.1m behind plan as salary replacement income does not yet reflect full inflationary allowances
- Other Non Clinical Income is £0.5m ahead of plan, primarily due to additional SLP allocations
- All other income flows are approximately break-even

Financial Reports 2022/23	Current Month			YTD month 3			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	18.3	18.6	0.3	53.4	53.6	0.3	213.4	213.4	0.0
Nhs England	1.8	1.8	0.0	5.3	5.3	(0.0)	21.0	21.0	0.0
Npsa Income	0.0	0.0	(0.0)	0.1	0.1	(0.1)	0.6	0.6	0.0
Provider Collaborative Income	2.8	2.4	(0.4)	6.5	6.0	(0.4)	26.0	26.0	0.0
Other Nhs Clinical Income	(0.1)	0.2	0.3	0.7	1.3	0.6	1.9	1.9	0.0
Nhs Clinical Income	**22.8**	**23.1**	**0.2**	**65.9**	**66.3**	**0.4**	**262.9**	**262.9**	**0.0**
Education & Training	0.7	0.7	0.0	2.2	2.1	(0.1)	8.5	8.5	0.0
Other Non Clinical Income	0.2	0.5	0.4	0.8	1.3	0.5	2.4	2.4	0.0
Merit Award Income	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0
Non Clinical Income	**0.9**	**1.3**	**0.4**	**3.0**	**3.4**	**0.4**	**11.0**	**11.0**	**0.0**
Non NHS Clinical Income	0.3	0.3	0.0	0.9	0.9	0.0	3.7	3.7	0.0
Non Nhs Clinical Income	**0.3**	**0.3**	**0.0**	**0.9**	**0.9**	**0.0**	**3.7**	**3.7**	**0.0**
Income	**24.0**	**24.6**	**0.6**	**69.8**	**70.6**	**0.8**	**277.6**	**277.6**	**0.0**

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Pay Position

- The pay position has been skewed by two factors in Month 3: firstly, the backdated payment of the 5% pay award for non-Medical staff and, secondly, a significant in month clearance of pay CIPs. These gives the appearance of a £1.1m overspend. Cumulatively pay is a £0.4m overspent
- Medical staffing are now overspent by £0.4m. The largest single driver of this is the premium paid for agency Medical staff
- Nursing budgets are now overspent by £1.4m. Of this, approximately £0.3m relates to extra packages of care funded by the SLP with a further £0.2m relating to specialling for off-site patients. The balance encompasses acuity pressures and the costs of the additional bank holiday
- The underspend of £1.3m on Other Clinical staff primarily consists of Psychologist vacancies and continues the trend seen in recent years
- Non-clinical staff are underspent by £0.2m

Financial Reports 2022/23	Current Month			YTD month 3			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.3)	(2.6)	(0.3)	(7.2)	(7.6)	(0.4)	(29.9)	(29.9)	0.0
Nursing	(6.4)	(7.2)	(0.8)	(19.1)	(20.5)	(1.4)	(77.8)	(77.8)	0.0
Other Clinical	(3.8)	(3.8)	0.0	(12.1)	(10.8)	1.3	(50.0)	(50.0)	0.0
Non Clinical	(3.0)	(3.0)	(0.0)	(8.5)	(8.3)	0.2	(34.2)	(34.2)	0.0
Total Pay	**(15.5)**	**(16.6)**	**(1.1)**	**(46.9)**	**(47.3)**	**(0.4)**	**(191.9)**	**(191.9)**	**0.0**

- Spend on agency staffing is £0.5m favourable to plan. This is positive but health warnings regarding an increasing trajectory and being above the NHSE target should be applied
- Bank is now £0.6m adverse to plan with the overspend being driven by the Nursing overspends detailed above
- Permanent staffing is now £0.3m adverse to plan caused by central provisions for expected costs, funded project work with substantive budgets yet to be established, and the impact of the extra bank holiday

Financial Reports 2022/23	Current Month			YTD month 3			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(12.5)	(13.3)	(0.8)	(38.0)	(38.3)	(0.3)	(158.8)	(158.8)	0.0
Bank	(2.0)	(2.4)	(0.3)	(5.8)	(6.4)	(0.6)	(23.2)	(23.2)	0.0
Agency	(1.0)	(1.0)	0.0	(3.1)	(2.6)	0.5	(9.9)	(9.9)	0.0
Total Pay	**(15.5)**	**(16.6)**	**(1.1)**	**(46.9)**	**(47.3)**	**(0.4)**	**(191.9)**	**(191.9)**	**0.0**

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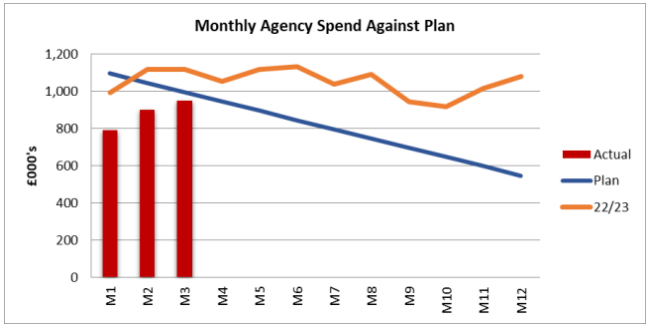
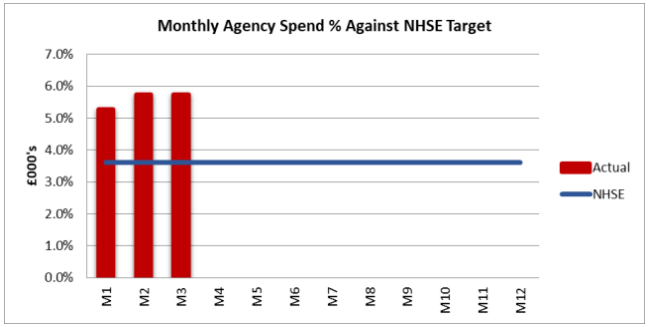
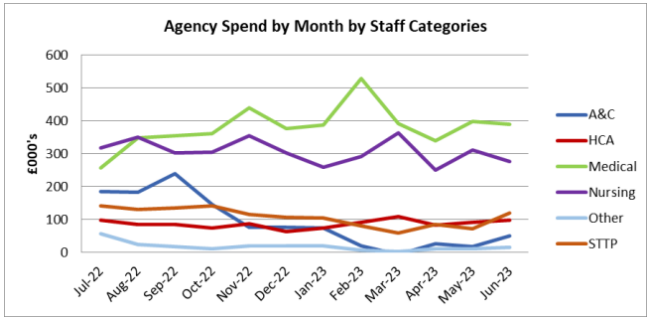
Agency - in month and cumulative position

- NHSE have set a cap on agency spend being a maximum of 3.6% of total pay costs across ICBs
- Actual Trust agency expenditure in 2022/23 amounted to 7.1% of total pay costs; the Trust needed to halve its agency expenditure to meet the NHSE target
- Through system wide agreement the Trust set agency targets which start at 2022/23 actuals and exit the year at the required 3.6%
- Month 3 performance was better than plan: expenditure of £951k was £45k favourable to plan and amounted to 5.7% of the total pay bill. It was also £169k less than expenditure this time last year (June 2022)
- Cumulative expenditure is £493k below plan (5.6% of pay bill) but £941k above the NHSE target.
- Expenditure in June was £50k above May levels.
- Whilst the headline positive variance is encouraging it should be noted that
  - Spend in April and May was depressed by bank holidays and additional leave taken
  - Spend is on an upward trajectory
  - If spend remains at June levels in July, the July trajectory target will not be achieved
- Of June expenditure, Medical staffing remained the largest element, amounting to £391k. Nursing was £276k with the next highest being STTPs (scientific staff) at £120k
- As shown on the next page, the Community Service Line remains the highest user of agency staffing. Cumulative expenditure of £1,475k equates to 56% of the Trust total
- The Trust is being asked to provide a forecast for NHSE in terms of agency spend for the year. For Month 3 the planned position has been assumed. It is also recommended that this approach is adopted for M4, to allow time for agency reduction initiatives to become embedded



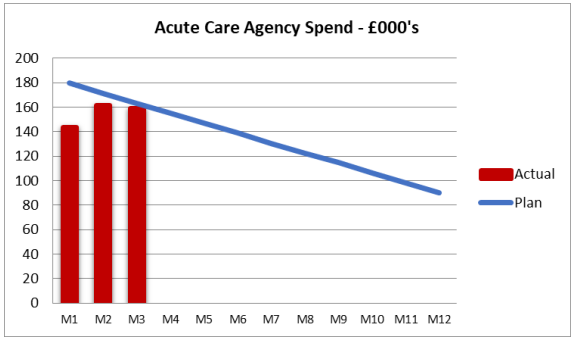




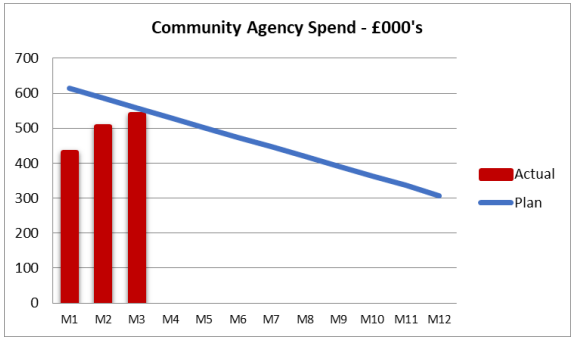
South West London and St George's Mental Health NHS Trust

Agency – Service Line and Corporate Analysis

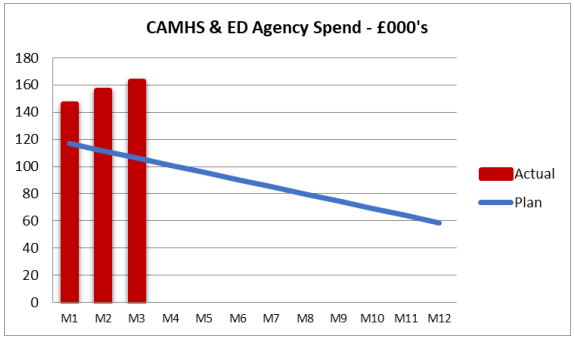
- In month spend of £159k
- £4k below plan
- £2k below M2 spend
- Cumulative spend of £465k, £50k below target
- Largest type of spend: HCA (£186k) followed by Medical (£179k), Nursing (£88k) and STTP (£11k)
- £382k of total spend on wards, with £45k in Liaison Services and £38k in HTTs
- Highest area of spend: Ellis Ward (£114k)



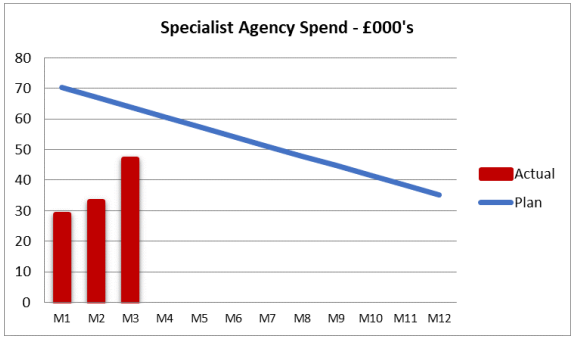
- In month spend of £541k
- £18k below plan
- £37k above M2 spend, growth in Medical and STTP spend
- Cumulative spend £1,475k
- Largest type of spend: Medical (£735k), followed by Nursing (£654k), and STTP (£62k), HCAs (£7k), Other (£16k)
- Highest areas of spend: Carshalton IRH (£158k) and Twickenham RST (£134k)



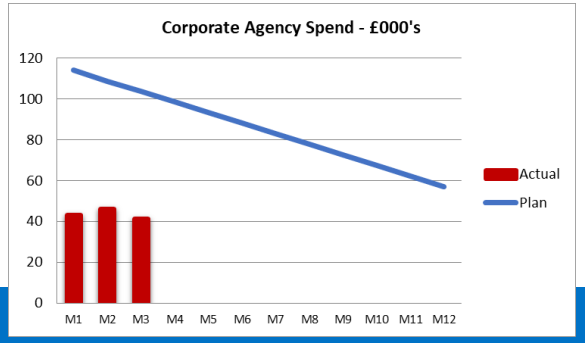
- In month spend of £163k
- £57k above plan
- £7k above M2 spend
- Cumulative spend of £466k
- Largest spends: Medical (£212k), STTP (£155k), Nursing (£55k), HCAs (£23k), Others (£20k)
- £368k of spend in community, £98k on wards
- Highest area of spend: Wandsworth Assessment Service (£70k)



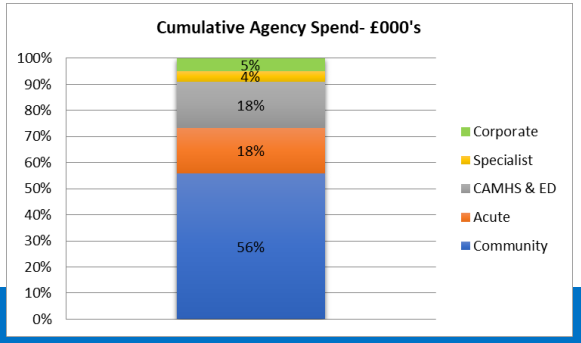
- In month spend of £47k
- £17k below plan
- £14k above M2 spend
- Cumulative spend of £109k
- Spend: HCA (£54k), Nursing (£42k), STTP (£12k)
- £59k of spend in wards, £50k in community settings
- Highest single area of spend: Jasmine Ward (£25k)



- Spend of £41k in month
- £63k below target
- £5k below M2 spend
- Cumulative spend of £130k
- Largest area of spend: Digital Services (£44k)



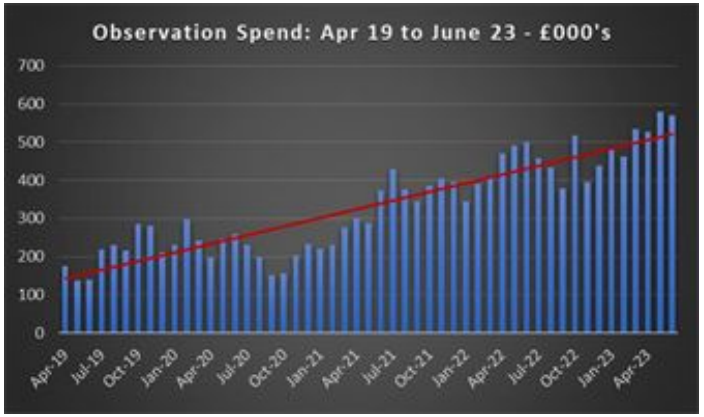
- Largest area of cumulative spend = Community (56%)
- CAMHS ED and Acute both account for 18% of spend
- Specialist = 4%, Corporate = 5%
- Service line and Corporate split = 95/5. Last year amounted to 89/11

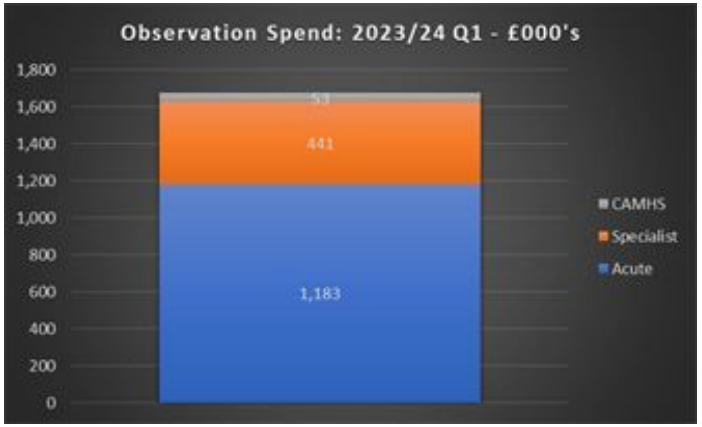


South West London and St George's Mental Health NHS Trust

Observation Costs

- The Month 2 report detailed the increases in Observations from April 2019 to March 2023
- This analysis has now been expanded to cover the period to June
- This shows that the upward trajectory has continued into 2023/24 with average monthly observation hours increasing from 19,309 in 2022/23 to 23,303 in 2023/24 Q1
- This increase of 3,994 hours equates to a further pressure of £96k per month, over and above the significant pressures experienced in 2022/23. In particular, this is manifesting as overspends within the Acute Service Line
- If Q1 Observation hours are replicated during the rest of the year, annual expenditure will amount to £6.7m – a 20% increase on 2022/23 expenditure of £5.6m
- This could increase to over £7.0m, if the in-year increase trends of the past two years continue
- Total expenditure in Q1 amounted to £1.7m, with the majority falling within Acute Care (71%). Specialist accounts for 26% and CAMHS equates to 3%
- A CIP target of £0.5m has been assigned to Observations and a QI project is underway to improve processes
- The challenge is twofold: not only to reduce expenditure by £0.5m but also to reverse the increasing trend seen in Q1





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

Non-Pay & Post EBITDA

- Non-Pay performance has also been skewed in-month by the pay award and CIP clearance. Cumulatively, non-pay budgets are now £0.6m overspent
- The major pressure area continues to be external beds, accounting for £0.8m of the £0.9m Secondary Commissioning costs overspend
- Other costs are now £0.4m underspent due to releasing investment reserves to cover external bed overspends. This is then partially offset by overspends on Estates and IT budgets alongside the deficit reserve created by the pay award shortfall

Financial Reports 2022/23	Current Month			YTD month 3			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Drug Costs	(0.2)	(0.2)	0.0	(0.6)	(0.6)	(0.0)	(2.3)	(2.3)	0.0
Clinical Supplies & Servs Cost	(0.1)	(0.1)	(0.0)	(0.2)	(0.2)	(0.0)	(0.6)	(0.6)	0.0
Secondary Commisioning Costs	(3.0)	(3.3)	(0.3)	(8.8)	(9.7)	(0.9)	(35.1)	(35.1)	0.0
Other Costs	(3.7)	(3.0)	0.7	(8.7)	(8.3)	0.4	(29.4)	(29.4)	0.0
Contingency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Pay	**(6.9)**	**(6.6)**	**0.4**	**(18.2)**	**(18.8)**	**(0.6)**	**(67.4)**	**(67.4)**	**0.0**

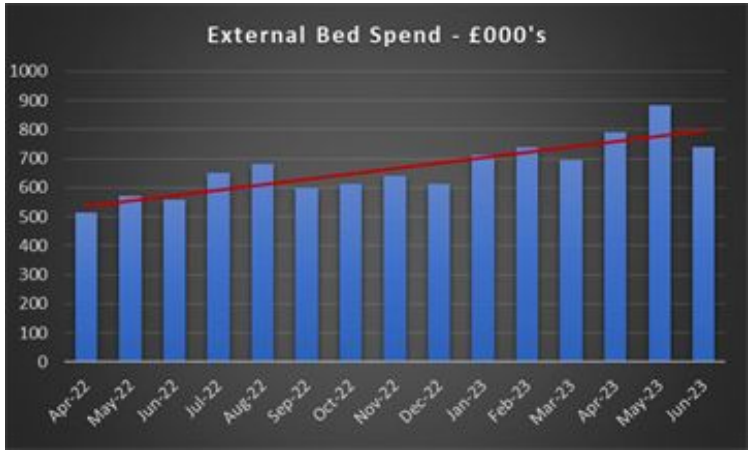
- Post EBITDA costs are now £0.2m favourable to plan. This is as a result of capitalising interest payable in relation to the £99m loan for hospital construction, alongside a favourable performance on Interest Receivable
- Depreciation and interest budgets were increased in 2023/24 to reflect the impact of IFRS16, approx. £0.5m per month
- A significant impairment of approximately £50m is expected to be occurred due to market valuation when the two new hospitals on the Springfield site complete in 2023/24.

Financial Reports 2022/23	Current Month			YTD month 3			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	(1.1)	(1.1)	0.0	(3.3)	(3.3)	0.0	(11.2)	(11.2)	0.0
Cap Charges - Pdc Dividend	(0.6)	(0.6)	0.0	(1.9)	(1.9)	0.0	(7.6)	(7.6)	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	(50.0)	(50.0)	0.0
Interest	(0.0)	0.1	0.1	(0.0)	0.1	0.2	0.7	0.7	0.0
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Post EBITDA	**(1.7)**	**(1.7)**	**0.1**	**(5.2)**	**(5.0)**	**0.2**	**(68.1)**	**(68.1)**	**0.0**

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

External Beds

- This analysis of external beds has now been expanded to include contracted beds at ELFT (both Female PICU and Acute)
- Significant external bed costs were incurred in 2022/23 and this has continued into 2023/24
- June expenditure amounted to £741k which was a reduction of £143k on that incurred in May. This level of spend, albeit reduced, was £108k above the monthly average for 2022/23
- The current budgetary base covers 18 Huntercombe Beds, 3 additional Acute beds, and 3 Female PICU beds. However, June usage remained significantly above these levels, resulting in a £334k overspend in month
- Cumulatively, external beds are now overspent by £767k
- The budgetary base for June covered 720 days, actual utilisation amounted to 999 days, 279 days above plan
- The £767k overspend has been covered by slippage against 2023/24 new investments. It should be noted that available slippage is at reduced levels from that available during 2022/23 impacting on the ability to cover external bed costs should the current high usage continue
- Of the cumulative expenditure to Month 3: £1,368k was at Hollybourne, £540k was spent on other acute beds, £430k was spent on Female PICU, with £80k spent on Male PICU beds
- The daily bed occupancy report produce by Information Management indicates that external acute bed usage is starting to fall in July but that Female PICU usage remains at high levels



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Service Line Positions

- Whilst the overall position remains on plan, there is significant variation in Service Line performance
- All positions reflect the devolvement of CIP targets which was enacted in Month 1
- Acute Care is £1.7m overspent as a result of acuity and external bed pressures, alongside additional nursing pressures outlined earlier in the report
- CAMHS & ED is £0.2m underspent due to continued recruitment slippages
- Community is £0.7m underspent as a result of recruitment slippages
- Specialist Services is £0.1m underspent primarily due to temporary capacity reductions
- Both CAMHS and Specialist overspent during the month as CIP targets for future periods were cleared. This is a budgetary technicality rather than a run rate issue and will correct itself in future months
- The Corporate underspend of £0.5m is caused by an amalgam of items: Income over-recoveries, and reserve and balance sheets releases to cover the cost of external beds and the pay award excess
- Capital costs are £0.1m underspent in relation to interest income
- The forecast for the year is (before impairments) for a £0.2m surplus. This is subject to material risks in terms of: adequate pay award funding, capacity, acuity, inflation, energy, and CIP delivery

Financial Reports 2022/23	Current Month			YTD month 3			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	(4.3)	(4.9)	(0.6)	(12.3)	(14.0)	(1.7)	(48.4)	(48.4)	0.0
Camhs & Ed	(2.5)	(2.8)	(0.3)	(7.7)	(7.5)	0.2	(32.3)	(32.3)	0.0
Community (Adults)	(5.0)	(4.8)	0.2	(13.7)	(13.0)	0.7	(54.1)	(54.1)	0.0
Specialist Services	(2.8)	(3.0)	(0.2)	(8.0)	(7.9)	0.1	(33.1)	(33.1)	0.0
Corporate	16.2	17.0	0.8	46.4	47.0	0.5	186.2	186.2	0.0
Capital Costs	(1.7)	(1.7)	0.1	(5.2)	(5.0)	0.2	(68.1)	(68.1)	0.0
Total	**(0.2)**	**(0.2)**	**0.0**	**(0.5)**	**(0.5)**	**0.0**	**(49.8)**	**(49.8)**	**0.0**

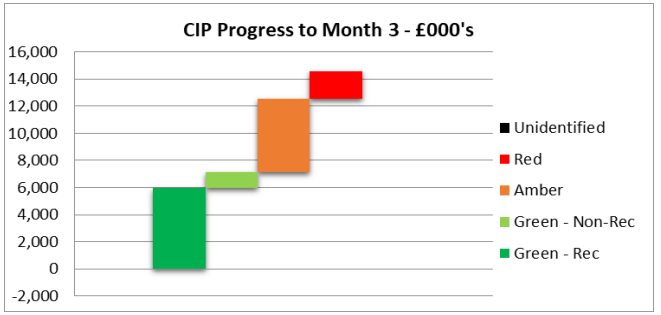
South West London and St George's Mental Health NHS Trust

Savings – YTD Position

- **Target £13m** - £14.6m schemes identified; £1.6m (13%) overprogramming; £7.1m Green (55%), £5.4m Amber (42%), £2.1m Red (16%).
- **In month Delivery** - £1.5m delivered, £0.4m ahead of plan
- **YTD Delivery** - £3.5m delivered, £0.2m ahead of plan
- **Delivery Confidence** – Risk assessed delivery £10.3m, 80% compared to 44% at Month 3 last year.
- **Recurrent Target £8m (62%)** - forecast delivery of green schemes £6.0m (46%)
- **Key movements in month:**
  - Community delivered £0.4m; £0.26m recurrent (R/A→GNR/GR)
  - Specialist reported £0.5m mostly non-recurrent sources (R/A → GNR)
  - CAMHS reported £0.95m mostly non-recurrent sources (R/A → GNR)
  - Technical savings balance £2.8m RAG improvement (R → A)
  - Reclassification of £1.1m non-recurrent service line pay underspends classified as recurrent. The Trust recurrently underspends by c£2.1m due to vacancies. (GNR → GR)

Status	2023/24 £000's	2023/24 %	Risk Level %	Expected £000's
Green - Rec	5,993	46%	0%	5,993
Green - Non-Rec	1,123	9%	0%	1,123
Amber	5,401	42%	50%	2,701
Red	2,081	16%	75%	520
Overprogramming	-1,624	-13%	100%	0
Unidentified	0	0%	100%	0
Total	**12,974**	**100%**	**80%**	**10,337**

Gap	**-2,637**



		In Month			YTD		
Service Line £k	Total Target	Plan	Actuals Total	Variance	YTD Plan	YTD Actuals	YTD Variance
Acute And Urgent Care	1,439	120	81	39	360	320	-39
Camhs & ED	1,042	87	673	-586	261	673	412
Community (Adults)	2,228	186	371	-185	557	371	-186
Specialist Services	1,056	88	532	-444	264	544	280
Operations total	5,765	480	1,656	-1,175	1,441	1,908	467
Corporate total	1,833	153	107	46	458	460	2
Technical Savings	7,000	580	394	186	1,740	1,095	-645
Adjustment for YTD position	0	0	-650	650	0	0	0
Overprogramming	-1,624	-135	0	-135	-406	0	406
Total	12,974	1,078	1,507	-429	3,234	3,463	229

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	2.1	0.8	1.3	5.5	4.5	1.0	48.1	48.1	0.0
Estates Maintenance	0.1	0.0	0.1	0.4	0.2	0.2	1.4	1.4	0.0
IT/Digital	0.1	0.1	(0.0)	0.4	0.5	(0.1)	1.4	1.4	0.0
Operational Total	2.4	1.0	1.4	6.2	5.1	1.1	51.0	51.0	0.0
Leases	0.0	0.0	0.0	0.0	0.0	0.0	7.5	7.5	0.0
Total Capital Expenditure	**2.4**	**1.0**	**1.4**	**6.2**	**5.1**	**1.1**	**58.5**	**58.5**	**0.0**

- The final capital plan was submitted at the beginning of May 2023, with a value of £58.5m, predominantly Phase 2 EMP £33.5m, Barnes £11.1m and £3.5m for other EMP schemes.
- The plan includes £0.5m relating to new leases that are expected to materialise in 2023/24 and £7.0m of leases due for renewal during the year.
- Capital expenditure for the month is £1.0m (£1.4m below plan), predominantly in EMP due to cost of sales of Phase 2, offset by underspends due to delays in the Richmond Royal Scheme. Estates and IT are broadly on plan.
- The Trust has not received formal confirmation of its CRL target and EFL target for the financial year. The Trust is forecasting to achieve both targets

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Statement of Financial Position

Statement of Financial Position (£m)	Plan as at end 30 June 2023	Actuals as at end 30 June 2023	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	6.2	7.0	0.7
Plant, Property and Equipment	338.6	341.0	2.4
Receivables	16.0	15.9	(0.2)
Right of Use Asset	10.2	10.2	0.0
Total Non-Current Assets	**371.1**	**374.1**	**3.0**
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	18.1	13.7	(4.4)
Other Financial Assets	2.4	7.5	5.1
Prepayments	0.0	0.0	0.0
Cash and Cash Equivalents	19.0	22.7	3.7
Total Current Assets	**39.7**	**44.1**	**4.5**
CURRENT LIABILITIES:			
Trade Payables	(7.0)	(14.7)	(7.8)
PDC Dividend Payable	(0.0)	(1.9)	(1.9)
Capital Payables	(12.6)	(9.9)	2.7
Provisions	(4.2)	(4.3)	(0.1)
Other Financial Liabilities (Accruals)	(32.0)	(29.9)	2.1
Deferred Revenue	(8.0)	(3.8)	4.3
Borrowings	(11.6)	(11.8)	(0.2)
Total amounts falling due within one year	**(75.3)**	**(76.2)**	**(0.9)**
NET CURRENT ASSETS/(LIABILITIES)	**(35.7)**	**(32.1)**	**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	(8.7)	(8.7)	0.0
Total amounts falling due after one year	**(104.9)**	**(106.2)**	**(1.3)**
TOTAL ASSETS EMPLOYED	**230.5**	**235.7**	**5.2**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	146.2	145.9	(0.3)
Retained Earnings (accumulated losses)	30.6	28.6	(2.0)
Retained Surplus(Deficit) in year	(0.5)	(0.5)	(0.0)
Revaluation Reserve	54.3	61.8	7.5
TOTAL TAXPAYERS EQUITY	**230.5**	**235.7**	**5.2**

- Current Receivables stand at £13.7m, £4.4m lower than plan, of which prior year is £1.8m. This value includes deferred receipt from plot sales in 2019/20 due during 2022/23.
- Cash is £22.7m, £3.7m higher than plan, see next slide.
- There have been no loan repayments with the loan remaining at £99.4m. There are two scheduled principal repayments of £10m due in 2023/24, one in Sept and one in March.

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Cash

All figures £k

	Plan as at end Jun 2023	Actuals as at end Jun 2023	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	1,595	1,154	(441)
Non Cash Adjustments			
Depreciation and Amortisation	3,294	3,282	(12)
Interest Received	(180)	(247)	(67)
Increase/(Decrease) in Working Capital	(6,209)	4,447	10,656
Net Cash Inflow/(Outflow) from Operating Activities	**(1,500)**	**8,636**	**10,136**
Cash Flows from Investing Activities			
Interest Received	180	247	67
(Payments) for Property, Plant and Equipment	(7,859)	(10,589)	(2,730)
Net Cash Inflow/(Outflow) from Investing Activities	**(7,679)**	**(10,342)**	**(2,663)**
Net Cash Inflow/(Outflow) before financing	**(9,179)**	**(1,706)**	**7,473**
Cash Flows from Financing Activities			
Public dividend capital received	2,206	1,837	(369)
Interest paid	(90)	0	90
Interest element of finance lease	(108)	(108)	0
PDC dividend (paid)/refunded	0	0	0
Net Cash Inflow/(Outflow) from Financing Activities	**2,008**	**1,729**	**(279)**
Net Increase/(Decrease) In Cash And Cash Equivalents	**(7,171)**	**23**	**7,194**
Cash / Cash Equivalents at beginning of month	**26,148**	**22,680**	**(3,468)**
Cash / Cash Equivalents at end of month	**18,977**	**22,703**	**3,726**

- The cash balance at the end of the month was £22.7m compared with the plan of £19.0m.
- Funds held in escrow accounts continue to be monitored.
- The Trust drew down the £1.8m PDC relating to Barnes up to June with further draw downs happening monthly in line with spend.
- The main variances in the month are an increase in working capital due to capital slippage.
- This resulted in an increase in cash in the month

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Report Title:	**Finance Report 2023/24 Month 4**
Meeting:	Trust Board
Date of Meeting:	14 September 2023
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Transparency:	Public
Scrutiny Pathway	Director review / ELT / FPC / Trust Board

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

What?	Key items to note are: ➢ **Plan / Year End Forecast** – year end forecast in line with plan at £250k surplus before impairments, impairments estimated at £50m. ➢ **In Month / cumulative position** - £0.1m surplus in month, £0.4m deficit cumulatively in line with plan. ➢ **Agency** – a decrease in spend compared to 2022/23 and £0.5m below plan for 2023/24. In month reduction following upward Q1 trajectory. CIP targets are red. NHSE target not being achieved. ➢ **External Beds** – Reduction in costs for second month following an upward trajectory for preceding 12 months. Year to date costs £0.9m more than budget. ➢ **Savings** – identified schemes more than achieve the £13.0m target, with £1.6m over programming. Recurrent Delivery is currently 47% and planned to be 62%, £8.1m at year end. Nationally recurrent savings delivery for 22/23 was 50%. ➢ **Capital** – underspend of £3.5m ytd due to cost of sales incurred ahead of plan, offsetting slippage on Tolworth and Richmond Royal schemes. ➢ **Cash** – the cash balance is £23.8m
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 major actions including agency spend, external beds and recurrent savings delivery. The Executive Team have reviewed and support the items FPC are asked to approve below. FPC noted that no change has been made to the financial plan following approval in M3.

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	Assurance levels are provided as follows: ➢ **External Beds** – A plan is in place and based on recent usage ELT are relatively confident the plan will deliver. Bed usage reduced in July, and indications are this is continuing into August, providing assurance. ➢ **Agency** – Improved Oversight is in place however the Trust is not achieving the national requirement of agency spend not exceeding 3.6% of paybill, and costed forecast trajectories are not yet in place to give assurance that the required position can be achieved for the year. Emerging data on agency and bank usage in acute would indicate lower level of observations but it is too early to say whether this is a real statistical change. ➢ **Savings** – Delivery to date is improved compared to prior years and schemes are in place to deliver. There is significant improvement in RAG ratings in month. Forecast recurrent delivery remains below plan. Through overprogramming we have eradicated unidentified efficiency targets. Progress is now needed on red rated schemes to improve the financial position Other Key items to note are: ➢ The Trust has sufficient cash to manage its business and must not lose sight of the requirement to start repaying the loan in 2023/24.
What Next?	Actions have been identified as follows: ➢ Financial position to be communicated to budget holders through the 'Managers Matters' briefing from July/August ➢ Agency delivery trajectories to be finalised
Any specific issues to note and/or for escalation:	1. Focus must be maintained on reducing external beds, reducing agency and delivering recurrent savings

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

Implications	Outlined below are the key implications which may result from the proposals or information contained within this report
Equality analysis *[linking to EDI strategy]*	Positive impact – The Trust spends money to improve equality and diversity for patients and staff

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

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

1. I&E Position

Cumulatively to end of July we remain in line with plan; a deficit of £0.4m. A surplus of £0.1m was reported in month as savings associated with the move out of QMH are realised. Underlying underspends on pay continue driven primarily by vacancies and slippage on investment. The non pay overspend is driven by continued high external bed usage.

As all Trusts will have significant income and expenditure variances resulting from the pay award being agreed after plans were set, there is an opportunity to re-align the plan with no impact on the overall surplus position. It is recommended that the Trust realigns the plan for the Complex Care Wave 2 which was agreed after plan submission (£12m increase in costs and funding) and the Pay award (£4m increase in costs and funding).

Whilst the net position is on plan it is important to recognise that it is underpinned by investment slippage and vacancies. High levels of vacancies and high agency usage do not support quality, nor does this underlying workforce position support operational sustainability. Further, it is important to recognise that agency spend, covering vacancies, has increased year on year and is not sustainable.

Without intervention there is currently significant risk to achieving the Trust's plan of £0.2m surplus for the year. Net Trust risk has improved and is now c£4.0m.

Workforce/agency/WTE – The Trust plan has been set based on 2022/23 levels (7.1%) reducing to 3.6% (as nationally required) of the paybill at year-end.

Agency expenditure in July was £0.9m (5.8%) marginally below plan. If costs do not reduce further in August the Trust will breach its plan for the month.

External beds – updated analysis of external bed usage is provided with costs decreasing for the second month in July. Costs were £0.7m and were £67k more than the 2022/23 monthly average. Cumulatively costs are £0.9m more than budget. Use of beds is being managed at the EMC and trajectories for reduction produced. Indications are that usage has continued to fall in August. It is not possible to say whether the reduction is natural variation or due to the impact of management action. Whilst the overspend to date has been covered by investment slippage, this is at reduced levels to 2022/23 and therefore cannot be relied upon to cover external bed costs should the current high usage continue.

Savings – The Trust savings plan for the year is £13m and £14.6m of schemes have been identified providing over programming of 13%. Delivery after four months is £0.4m above target with £4.7m of savings being delivered. Risk adjusted forecast delivery for the year is £12.0m (£1.7m improvement in the month). Recurrent delivery is £6.0m (47%) a 1% improvement on last month. Planned delivery for the year is 62% recurrent. Only schemes being delivered are given a recurrent status in the forecast. The risk adjusted forecast and recurrent delivery will therefore improve as schemes progress through implementation stages and confidence is achieved.

2. Capital, Cash and Balance Sheet Update

Capital is reporting a £3.5m underspend after four months due to slippage against EMP schemes including Tolworth and Richmond Royal. The forecast position is £58.5m in line with plan.

Cash is currently £23.8m, £1.2m more than plan and includes the £1.8m in an escrow account. Now the RGH grant has been waived action will be taken to transfer the funds from escrow. The Trust is due to start repayments in 2023/24 on the £99m loan.

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

Finance Report 2023/24
4 Months to July 2023

Meeting	Trust Board
Date of Meeting	September 2023
Report Title	Finance Report 2023/24 – 4 Months to July 2023
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Director of Finance & Performance
Purpose	For Information
Scrutiny Path	Director review/ELT/FPC/Trust Board
Transparency	Public
Recommendation	None
The Board is asked to	Discuss and Note

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

Contents

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

Overall – I & E Position

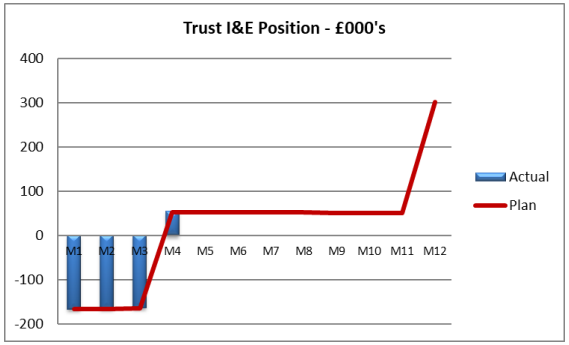
- In July, the Trust recorded a £0.1m surplus, in line with plan
- This brings the cumulative deficit to £0.4m, also in line with plan. The planned and actual deficit to date are due to costs associated with new buildings being incurred before associated savings from moving out of old buildings are delivered. The improvement in-month is caused by rental savings after vacating more of the QMH site in June
- The forecast remains a baseline surplus of £0.2m for the year (before impairments)
- Completion of two new hospital buildings in 2023/24 will generate significant impairments (approx. £50m). The Trust is performance managed before impairments
- The Month 4 position reflects additional income and expenditure associated with Wave 2 of the Complex Care initiative which started in July
- The baseline surplus forecast is subject to material risks including full funding of the pay award, external beds usage, patient acuity, inflationary pressures, energy, and CIP delivery

Financial Reports 2023/24	Current Month			YTD month 4			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	24.7	25.2	0.5	94.6	95.8	1.3	291.2	293.6	2.5
Pay	(15.9)	(15.7)	0.2	(62.9)	(63.0)	(0.1)	(192.2)	(189.2)	2.9
Non Pay	(7.2)	(7.9)	(0.7)	(25.4)	(26.7)	(1.3)	(80.7)	(86.2)	(5.6)
EBITDA	**1.6**	**1.6**	**0.0**	**6.3**	**6.1**	**(0.1)**	**18.3**	**18.2**	**(0.2)**
Cap Charges - Depreciation	(0.9)	(0.9)	(0.0)	(4.2)	(4.2)	(0.0)	(11.2)	(11.2)	0.0
Cap Charges - Interest & Div	(0.6)	(0.6)	0.0	(2.5)	(2.5)	0.0	(7.6)	(7.6)	0.0
Interest	0.0	0.1	0.0	0.0	0.2	0.2	0.7	0.9	0.2
Post EBITDA	(1.5)	(1.5)	0.0	(6.7)	(6.5)	0.2	(18.1)	(17.9)	0.2
Underlying Surplus / (Deficit)	**0.1**	**0.1**	**0.0**	**(0.4)**	**(0.4)**	**0.0**	**0.2**	**0.2**	**0.0**
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	(50.0)	(50.0)	0.0
Net Surplus / (Deficit)	**0.1**	**0.1**	**0.0**	**(0.4)**	**(0.4)**	**0.0**	**(49.8)**	**(49.8)**	**0.0**

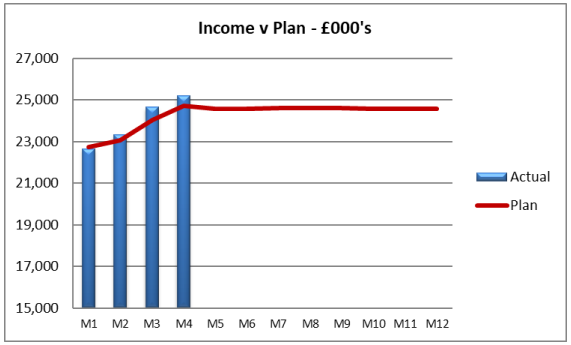
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

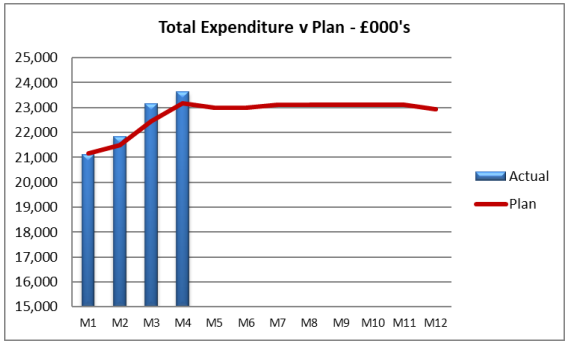
- Baseline surplus of £0.1m reported in month, in line with plan
- Cumulative deficit of £0.4m, also in line with plan
- Deficit driven by EMP phasing
- In month external bed pressures offset by investment slippage
- Significant risks to planned surplus



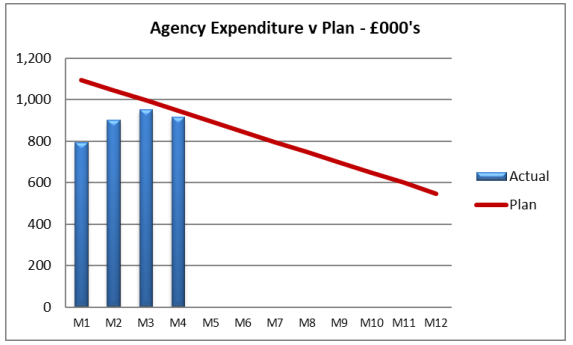
- Income received in month, £25.2m, £0.5m above plan
- Month 4 reflects an additional £1.3m funding in relation to Complex Care Wave 2
- Also shown, £0.3m in relation to Hostels funding
- Additional funding expected when Medical pay award is agreed



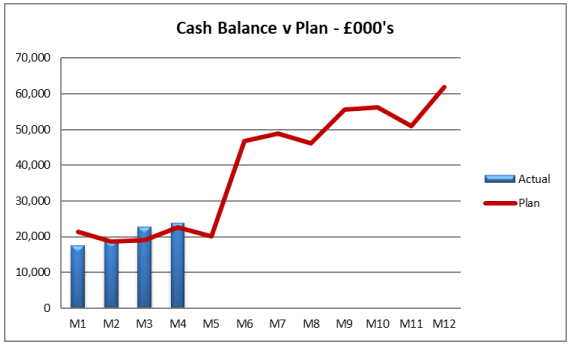
- Spend of £23.6m, £0.4m adverse to plan
- Reflects Complex Care Wave 2 expenditure (£1.3m)
- External bed expenditure of £0.7m in month, £0.1m above 2022/23 average
- Cumulative overspend on external beds of £0.8m funded from slippage
- Bed expenditure reduced in M4 which continues into M5



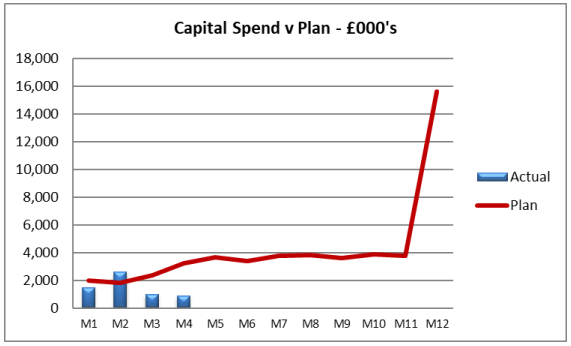
- Agency spend in month £0.9m, £0.1m below 2022/23 average spend
- Marginally below plan and below M3 expenditure
- Equates to 5.8% of pay bill, 2.2% above NHSE target of 3.6%
- Community Service Line spend amounts to 58% of total and on an increased trajectory



- Cash balance at end of July £23.8m
- £1.2 favourable to plan
- Predominately caused by capital underspend
- Loan repayments of £99m to commence in 2023/24
- Movement in cash during the year due to asset sales, deferred receipts, and loan repayments



- Cumulative capital spend of £6.0m
- £3.5m behind plan
- Underspend on EMP, other combined areas broadly on plan
- Forecast spend of £51m
- Spike in M12 the result of current uncertainties around the timings in spend on the Tolworth redevelopment



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

Income Position

- Cumulatively, income is £1.3m favourable to plan
- Local contract income is £0.4m ahead of plan due to additional funding after the initial contracting round on which the plan was set, primarily hostel income
- NPSA income is £0.1m behind plan as external referrals are below planned levels
- Provider Collaborative income is £0.5m below plan due to reduced Adult Eating Disorders inflow income
- Other NHS Clinical income is over-recovered by £1.0m due to the release of deferred income to cover the AED shortfall alongside additional investments in CAMHS and Complex Care
- Education income is £0.1m behind plan as income does not yet reflect full expected inflationary allowances
- Other Non Clinical Income is £0.6m ahead of plan, primarily due to additional SLP allocations
- Other income flows are approximately break-even

Financial Reports 2023/24	Current Month			YTD month 4			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	19.3	19.4	0.1	72.6	73.0	0.4	225.7	227.0	1.3
Nhs England	1.8	1.8	(0.0)	7.0	7.0	(0.0)	21.0	21.0	0.0
Npsa Income	0.0	0.0	(0.0)	0.2	0.1	(0.1)	0.6	0.3	(0.3)
Provider Collaborative Income	2.2	2.0	(0.1)	8.6	8.1	(0.5)	26.1	24.6	(1.5)
Other Nhs Clinical Income	0.2	0.5	0.4	0.8	1.8	1.0	2.0	4.5	2.5
Nhs Clinical Income	**23.4**	**23.7**	**0.3**	**89.3**	**90.0**	**0.7**	**275.3**	**277.3**	**2.0**
Education & Training	0.7	0.7	0.0	2.9	2.8	(0.1)	8.5	8.4	(0.1)
Other Non Clinical Income	0.2	0.3	0.1	1.0	1.6	0.6	2.4	3.0	0.5
Merit Award Income	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0
Non Clinical Income	**0.9**	**1.0**	**0.1**	**3.9**	**4.5**	**0.5**	**11.0**	**11.4**	**0.4**
Non NHS Clinical Income	0.4	0.5	0.0	1.4	1.4	0.0	4.9	4.9	(0.0)
Non Nhs Clinical Income	**0.4**	**0.5**	**0.0**	**1.4**	**1.4**	**0.0**	**4.9**	**4.9**	**(0.0)**
Income	**24.7**	**25.2**	**0.5**	**94.6**	**95.8**	**1.3**	**291.2**	**293.6**	**2.5**

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

Pay Position

- Pay amounted to £15.7m in-month, a £0.2m underspend. Cumulatively, pay is £0.1m overspent.
- Medical staffing are cumulatively overspent by £0.4m. The largest single driver of this is the premium paid for agency Medical staff to cover vacancies
- Nursing budgets are now overspent by £1.5m. Of this, approximately £0.4m relates to extra packages of care funded by the SLP with a further £0.2m relating to specialling for off-site patients. The balance encompasses acuity pressures and the costs of the additional bank holiday in May. Acuity and off-site pressures eased slightly in July. July Nursing spend was £0.1m below the Q1 average monthly spend
- Other Clinical staff underspend, £1.6m, primarily consists of Psychologist vacancies continuing the trend seen in recent years
- Non-clinical staff are underspent by £0.1m

Financial Reports 2023/24	Current Month			YTD month 4			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.5)	(2.5)	(0.0)	(9.7)	(10.1)	(0.4)	(29.8)	(30.6)	(0.8)
Nursing	(6.7)	(6.7)	(0.1)	(25.7)	(27.2)	(1.5)	(78.4)	(82.4)	(4.0)
Other Clinical	(4.0)	(3.7)	0.3	(16.1)	(14.5)	1.6	(49.9)	(42.6)	7.3
Non Clinical	(2.8)	(2.8)	(0.0)	(11.3)	(11.2)	0.1	(34.1)	(33.6)	0.4
Total Pay	**(15.9)**	**(15.7)**	**0.2**	**(62.9)**	**(63.0)**	**(0.1)**	**(192.2)**	**(189.2)**	**2.9**

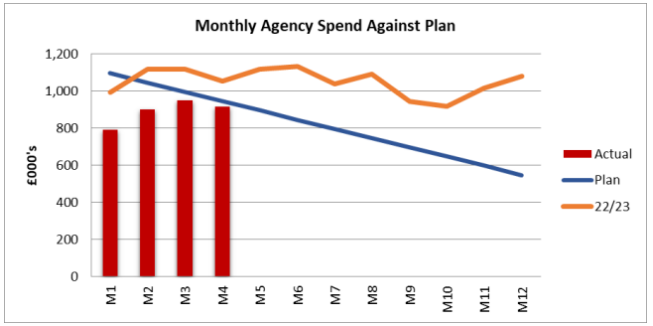
- Spend on agency staffing is £0.5m favourable to plan. This is positive but health warnings should be applied as the plan assumes improvement each month until NHSE target achieved in March. There is an increasing trajectory cost within Community the highest user of agency
- Bank is now £0.8m adverse to plan with the overspend being driven by the Nursing overspends detailed above
- Permanent staffing is now £0.2m favourable to plan and the result of continued vacancies. The budget is suppressed as savings generated by vacancies get allocated CIP targets retrospectively

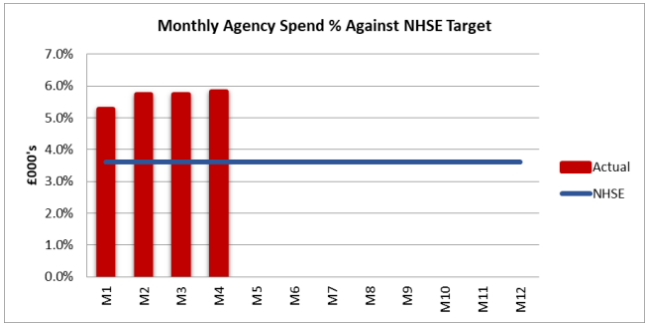
Financial Reports 2023/24	Current Month			YTD month 4			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(13.0)	(12.6)	0.4	(51.1)	(50.9)	0.2	(159.1)	(153.5)	5.6
Bank	(2.0)	(2.2)	(0.2)	(7.7)	(8.6)	(0.8)	(23.2)	(25.8)	(2.6)
Agency	(0.9)	(0.9)	0.0	(4.1)	(3.6)	0.5	(9.9)	(9.9)	0.0
Total Pay	**(15.9)**	**(15.7)**	**0.2**	**(62.9)**	**(63.0)**	**(0.1)**	**(192.2)**	**(189.2)**	**2.9**

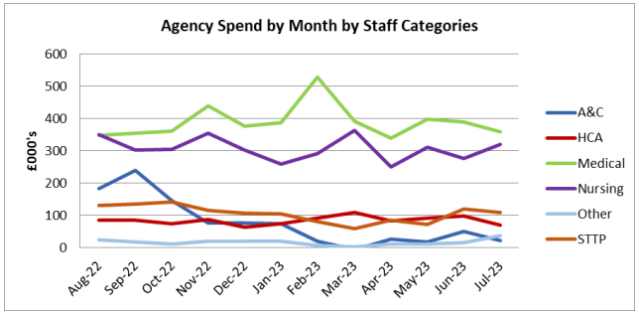
South West London and St George's Mental Health NHS Trust

Agency - in month and cumulative position

- Actual Trust agency expenditure in 2022/23 amounted to 7.1% of total pay costs; the Trust needs 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 start at 2022/23 actuals and exit the year at the required 3.6%
- Month 4 performance was better than plan: expenditure of £915k was £31k favourable to plan and amounted to 5.8% of the total pay bill. It was also £140k less than expenditure this time last year (July 2022)
- Cumulative expenditure amounts to 5.6% of the pay bill and is £524k below plan but £1,291k above the NHSE target.
- Expenditure in July was £36k below June levels.
- Whilst the headline positive variance is encouraging it should be noted that
  - Spend in April and May was depressed by bank holidays and additional leave taken
  - Spend in the Community Service Line is on an upward trajectory
  - If spend remains at July levels in August, the August trajectory target will not be achieved
- Of July expenditure, Medical staffing remained the largest element, amounting to £360k. Nursing was £320k with the next highest being STTPs (scientific staff) at £108k
- As shown on the next page, the Community Service Line remains the highest user of agency staffing. Cumulative expenditure of £2,056k equates to 58% of the Trust total
- The Trust is required to produce an agency forecast for NHSE. Despite currently being below plan, the forecast will be maintained at planned levels until further assurance is gained to enable the forecast to be varied



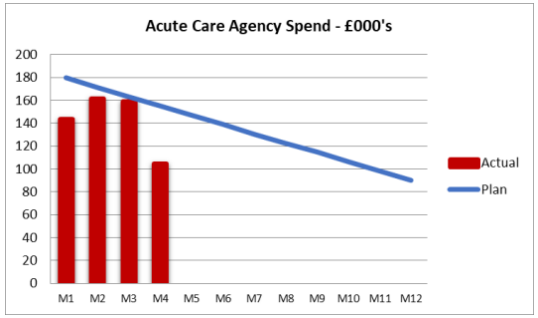




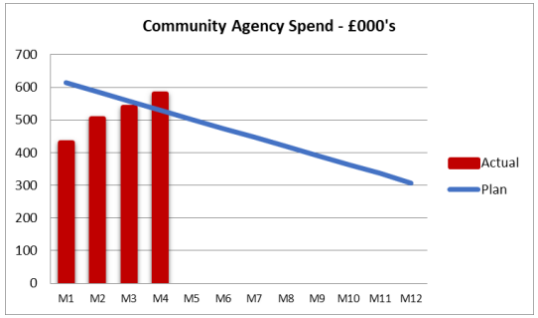
South West London and St George's Mental Health NHS Trust

Agency – Service Line and Corporate Analysis

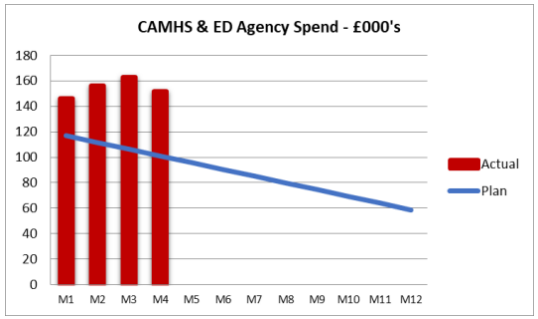
- In month spend of £105k
- £50k below plan
- £54k below M3 spend
- Cumulative spend of £570k, £100k below target
- Largest type of spend: Medical (£229k) followed by HCA (£219k), Nursing (107k) and STTP (£14k)
- £382k of total spend on wards, with £45k in Liaison Services and £38k in HTTs
- Highest area of spend: Ellis Ward (£155k)



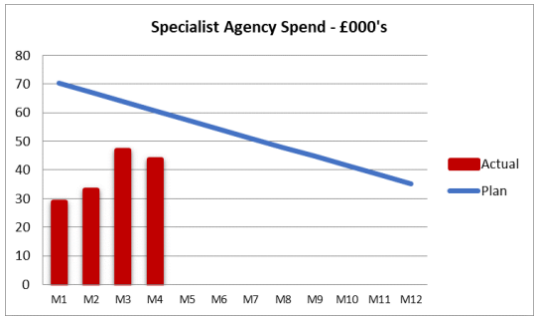
- In month spend of £581k
- £50k above plan
- £40k above M3 spend, growth in Medical and STTP spend
- Cumulative spend £2,056k
- Largest type of spend: Medical (£1,003k), followed by Nursing (£900k), and STTP (£94k), HCAs (£11k), Other (£47k)
- Highest areas of spend: Carshalton IRH (£227k) and Twickenham IRH (£176k)



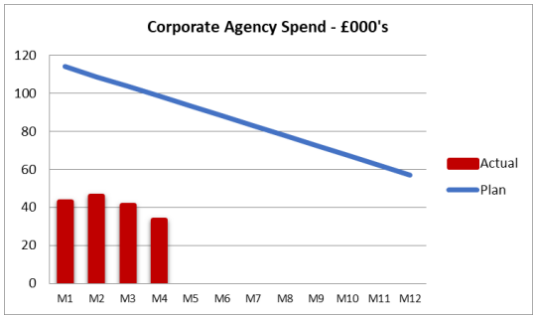
- In month spend of £152k
- £51k above plan
- £9k below M3 spend
- Cumulative spend of £617k
- Largest spends: Medical (£255k), STTP (£215k), Nursing (£87k), HCAs (£34k), Others (£25k)
- £490k of spend in community, £127k on wards
- Highest area of spend: Tier 3 Wandsworth (£95k)



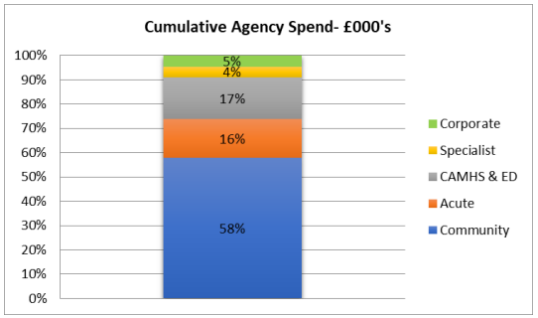
- In month spend of £44k
- £17k below plan
- £3k below M3 spend
- Cumulative spend of £152k
- Spend: HCA (£75k), Nursing (£64k), STTP (£13k)
- £81k of spend in wards, £71k in community settings
- Highest single area of spend: Jasmine Ward (£33k)



- Spend of £33k in month
- £65k below target
- £8k below M3 spend
- Cumulative spend of £164k
- Largest area of spend: Digital Services (£63k)



- Largest area of cumulative spend = Community (58%)
- CAMHS ED – 18%, Acute = 17%
- Specialist = 4%, Corporate = 5%
- Service line and Corporate split = 95/5. Last year amounted to 89/11



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

Non-Pay & Post EBITDA

- Non-Pay budgets overspent by £0.7m in the month to take the cumulative overspend to £1.3m
- The major pressure area continues to be external beds, accounting for £0.9m of the £1.4m Secondary Commissioning costs overspend. The balance relates to hostels and Complex Care investment, both of which are covered by additional income
- Other costs overspent by £0.2m in the month. This was the result of several factors including estates, domestic and IT costs. Other costs are underspent cumulatively as the release of reserves to cover external bed costs outweighs other pressures

Financial Reports 2023/24	Current Month			YTD month 4			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Drug Costs	(0.2)	(0.2)	(0.0)	(0.8)	(0.8)	(0.1)	(2.3)	(2.5)	(0.2)
Clinical Supplies & Servs Cost	(0.1)	(0.1)	(0.0)	(0.2)	(0.2)	(0.0)	(0.6)	(0.6)	(0.0)
Secondary Commisioning Costs	(4.4)	(4.9)	(0.5)	(13.4)	(14.9)	(1.4)	(47.9)	(51.7)	(3.8)
Other Costs	(2.6)	(2.8)	(0.2)	(11.0)	(10.8)	0.2	(29.9)	(31.4)	(1.5)
Contingency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Pay	**(7.2)**	**(7.9)**	**(0.7)**	**(25.4)**	**(26.7)**	**(1.3)**	**(80.7)**	**(86.2)**	**(5.6)**

- Post EBITDA costs are now £0.2m favourable to plan. This is as a result of capitalising interest payable in relation to the £99m loan for hospital construction, alongside a favourable performance on Interest Receivable
- A significant impairment of approximately £50m is expected to be occurred due to market valuation when the two new hospitals on the Springfield site complete in 2023/24.

Financial Reports 2023/24	Current Month			YTD month 4			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Cap Charges - Depreciation	(0.9)	(0.9)	(0.0)	(4.2)	(4.2)	(0.0)	(11.2)	(11.2)	0.0
Cap Charges - Pdc Dividend	(0.6)	(0.6)	0.0	(2.5)	(2.5)	0.0	(7.6)	(7.6)	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	(50.0)	(50.0)	0.0
Interest	0.0	0.1	0.0	0.0	0.2	0.2	0.7	0.9	0.2
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	**(1.5)**	**(1.5)**	**0.0**	**(6.7)**	**(6.5)**	**0.2**	**(68.1)**	**(67.9)**	**0.2**

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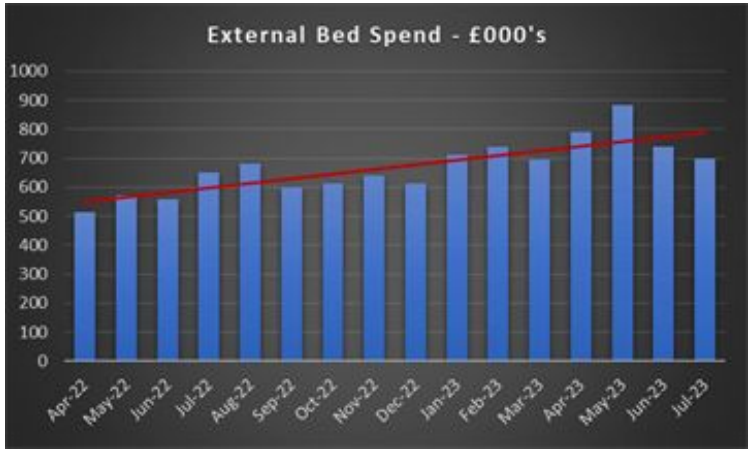
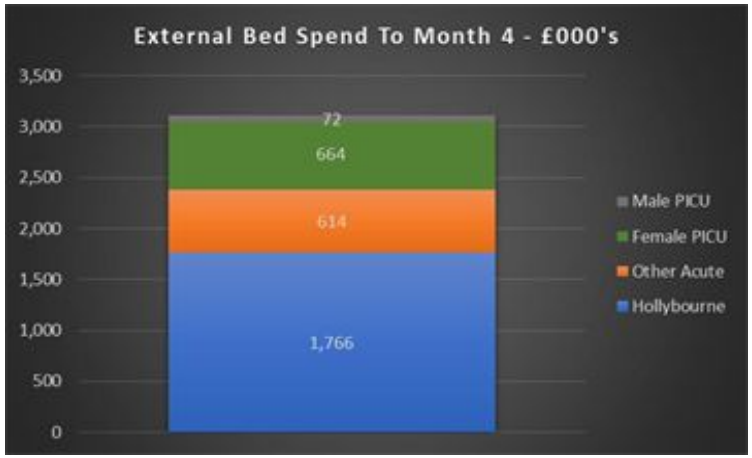
External Beds

- This analysis of external beds has now been expanded to include contracted beds at ELFT (both Female PICU and Acute)
- Significant external bed costs were incurred in 2022/23 and this has continued into 2023/24
- July expenditure amounted to £699k which was a reduction of £42k on that incurred in June
- This was the lowest monthly spend of the year to date but remained £67k above the monthly average for 2022/23
- July saw a significant fall in Acute external bed usage, and a rise in the more expensive Female PICU bed usage
- The current budgetary base covers 18 Huntercombe Beds, 3 additional Acute beds, and 3 Female PICU beds. However, July usage remained above these levels, resulting in a £150k overspend in month
- Cumulatively, external beds are now overspent by £916k
- The budgetary base for July covered 744 days, actual utilisation amounted to 915 days, 171 days above plan. External bed usage in June amounted to 999 days
- The £916k overspend has been covered by slippage against 2023/24 new investments. It should be noted that available slippage is at reduced levels from that available during 2022/23 impacting on the ability to cover external bed costs should the current high usage continue
- Of the cumulative expenditure to Month 4: £1,766k was at Hollybourne, £664k was spent on Female PICU, £614k was spent on other acute bed with £72k spent on Male PICU beds
- The daily bed occupancy report produced by Information Management indicates that external acute bed remains at a lower level in August and that Female PICU usage is also starting to fall





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Service Line Positions

- Whilst the overall position remains on plan, there is significant variation in Service Line performance
- All positions reflect the devolvement of CIP targets which was enacted in Month 1. Full detailed forecasts for each Service Line have now been completed
- Acute Care is £1.9m overspent as a result of acuity and external bed pressures, alongside additional nursing pressures outlined earlier in the report
- CAMHS & ED is £0.4m underspent due to continued recruitment slippages
- Community is £0.6m underspent as a result of recruitment slippages
- The Corporate underspend of £0.3m is caused by an amalgam of items: Income over-recoveries, and reserve and balance sheets releases to cover the cost of external beds and the pay award excess
- To enable a balanced position, Corporate costs will have to underspend by £2.6m. This is likely to be achieved by non-recurrent means
- Capital costs are £0.2m underspent in relation to interest income
- The forecast for the year is (before impairments of £50m) for a £0.2m surplus. This is subject to material risks in terms of: adequate pay award funding, capacity, acuity, inflation, energy, and CIP delivery

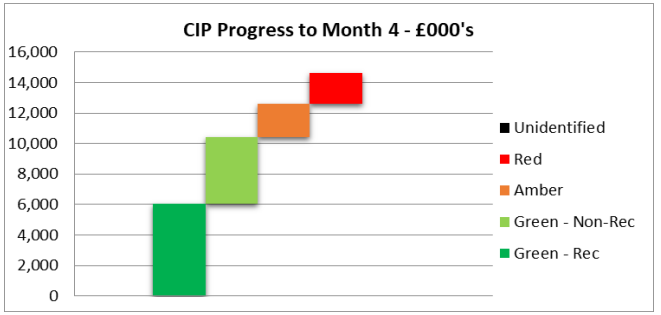
Financial Reports 2023/24	Current Month			YTD month 4			12 Mths to 31 March 2024		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Acute And Urgent Care	(4.1)	(4.3)	(0.2)	(16.4)	(18.3)	(1.9)	(48.6)	(54.5)	(5.9)
Camhs & Ed	(2.8)	(2.5)	0.2	(10.4)	(10.0)	0.4	(32.4)	(31.2)	1.2
Community (Adults)	(4.5)	(4.5)	(0.1)	(18.2)	(17.6)	0.6	(54.1)	(53.1)	1.1
Specialist Services	(2.9)	(2.7)	0.2	(10.9)	(10.5)	0.3	(33.1)	(32.1)	0.9
Corporate	15.7	15.5	(0.2)	62.1	62.5	0.3	186.5	189.1	2.6
Capital Costs	(1.5)	(1.5)	0.0	(6.7)	(6.5)	0.2	(68.1)	(67.9)	0.2
Total	**0.1**	**0.1**	**0.0**	**(0.4)**	**(0.4)**	**0.0**	**(49.8)**	**(49.8)**	**0.0**

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

Savings – YTD Position

- **Target £13m** - £14.6m schemes identified; -£1.6m overprogramming (-13%); £10.4m Green (80%), £2.2m Amber (17%), £2.0m Red (15%).
- **In month Delivery** - £1.3m delivered, £0.2m ahead of plan
- **YTD Delivery** - £4.7m delivered, £0.4m ahead of plan
- **Delivery Confidence** – Risk assessed delivery £12.0m, 93% compared to 53% at Month 4 last year. This is a significant improvement from last month (80%)
- **Recurrent Target £8m (62%)** - forecast delivery of green schemes £6.0m (47%)
- **Key movements reported in month:**
  - Technical savings achieved £3.0m non-recurrent (A → GNR)
  - Community £0.2m from non-recurrent sources (R/A → GNR)
  - Pharmacy £0.1m from non-recurrent sources (R/A → GNR)
  - Reclassification of £0.1m non-recurrent service line pay underspends noted above classified as recurrent. (GNR → GR)

Status	2023/24 £000's	2023/24 %	Risk Level %	Expected £000's
Green - Rec	6,056	47%	0%	6,056
Green - Non-Rec	4,359	34%	0%	4,359
Amber	2,187	17%	50%	1,093
Red	1,996	15%	75%	499
Overprogramming	-1,624	-13%	100%	0
Unidentified	0	0%	100%	0
Total	**12,974**	**100%**	**93%**	**12,008**
Gap				**-966**



		In Month			YTD		
Service Line £k	Total Target	Plan	Actuals Total	Variance	YTD Plan	YTD Actuals	YTD Variance
Acute And Urgent Care	1,439	120	0	120	480	320	-159
Camhs & ED	1,042	87	41	46	347	713	366
Community (Adults)	2,228	186	206	-21	743	577	-166
Specialist Services	1,056	88	8	80	352	552	200
Operations total	5,765	480	255	226	1,922	2,163	241
Corporate total	1,833	153	117	36	611	577	-34
Technical Savings	7,000	582	878	-296	2,323	1,973	-349
Overprogramming	-1,624	-135	0	-135	-541	0	541
Total	12,974	1,080	1,250	-170	4,314	4,713	399

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	3.0	0.6	2.5	8.5	5.0	3.5	48.1	48.1	0.0
Estates Maintenance	0.1	0.2	(0.1)	0.5	0.4	0.1	1.4	1.4	0.0
IT/Digital	0.1	0.1	(0.0)	0.5	0.6	(0.1)	1.4	1.4	0.0
Operational Total	3.2	0.9	2.4	9.5	6.0	3.5	51.0	51.0	0.0
Leases	0.0	0.0	0.0	0.0	0.0	0.0	7.5	7.5	0.0
Total Capital Expenditure	**3.2**	**0.9**	**2.4**	**9.5**	**6.0**	**3.5**	**58.5**	**58.5**	**0.0**

- The capital plan has a value of £58.5m, predominantly Phase 2 EMP £33.5m, Barnes £11.1m and £3.5m for other EMP schemes.
- The plan includes £0.5m relating to new leases that are expected to materialise in 2023/24 and £7.0m of leases due for renewal during the year.
- Capital expenditure for the month is £0.9m (£2.4m below plan). The underspend is 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 not received formal confirmation of its CRL target and EFL target for the financial year. 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 31 July 2023	Actuals as at end 31 July 2023	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	6.2	6.8	0.6
Plant, Property and Equipment	340.9	341.5	0.6
Receivables	16.0	15.9	(0.2)
Right of Use Asset	0.0	10.2	10.2
Total Non-Current Assets	**363.2**	**374.5**	**11.3**
Total Non-Current Assets Held for sale	**0.0**	**0.0**	**0.0**
CURRENT ASSETS:			
Inventories	0.2	0.2	0.0
Receivables due in less than 1 year	16.5	12.8	(3.7)
Other Financial Assets	0.9	6.6	5.7
Prepayments	0.0	0.0	0.0
Cash and Cash Equivalents	22.6	23.8	1.2
Total Current Assets	**40.2**	**43.4**	**3.2**
CURRENT LIABILITIES:			
Trade Payables	(6.7)	(12.0)	(5.2)
PDC Dividend Payable	(0.0)	(2.5)	(2.5)
Capital Payables	(13.5)	(9.7)	3.7
Provisions	(4.2)	(4.3)	(0.1)
Other Financial Liabilities (Accruals)	(33.6)	(30.5)	3.1
Deferred Revenue	(8.0)	(5.1)	3.0
Borrowings	(10.0)	(11.8)	(1.8)
Total amounts falling due within one year	**(76.0)**	**(75.8)**	**0.2**
NET CURRENT ASSETS/(LIABILITIES)	**(35.9)**	**(32.4)**	**3.4**
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		(8.7)	(8.7)
Total amounts falling due after one year	**(96.2)**	**(106.2)**	**(1.3)**
TOTAL ASSETS EMPLOYED	**231.1**	**235.8**	**4.7**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	146.7	145.9	(0.8)
Retained Earnings (accumulated losses)	30.6	28.6	(2.0)
Retained Surplus(Deficit) in year	(0.4)	(0.4)	(0.0)
Revaluation Reserve	54.3	61.8	7.5
TOTAL TAXPAYERS EQUITY	**231.1**	**235.8**	**4.7**

- Current Receivables stand at £12.8m, £3.7m lower than plan, of which prior year is £1.8m. This value includes the deferred receipt from plot sales in 2019/20 due during 2023/24.
- Cash is £23.8m, £1.2m higher than plan, see next slide.
- There have been no loan repayments with the loan remaining at £99.4m. There are two scheduled principal repayments of £10m due in 2023/24, one in Sept and one in March.

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

Cash

All figures £k

	Plan as at end Jul 2023	Actuals as at end Jul 2023	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	2,341	2,228	(113)
Non Cash Adjustments			
Depreciation and Amortisation	4,177	4,220	43
Interest Received	(260)	(340)	(80)
Increase/(Decrease) in Working Capital	(1,478)	5,049	6,527
Net Cash Inflow/(Outflow) from Operating Activities	**4,780**	**11,157**	**6,377**
Cash Flows from Investing Activities			
Interest Received	260	340	80
(Payments) for Property, Plant and Equipment	(11,108)	(12,090)	(982)
Net Cash Inflow/(Outflow) from Investing Activities	**(10,848)**	**(11,750)**	**(902)**
Net Cash Inflow/(Outflow) before financing	**(6,068)**	**(593)**	**5,475**
Cash Flows from Financing Activities			
Public dividend capital received	2,747	1,837	(910)
Interest paid	(120)	0	120
Interest element of finance lease	(140)	(140)	0
PDC dividend (paid)/refunded	0	0	0
Net Cash Inflow/(Outflow) from Financing Activities	**2,487**	**1,697**	**(790)**
Net Increase/(Decrease) In Cash And Cash Equivalents	**(3,581)**	**1,104**	**4,685**
Cash / Cash Equivalents at beginning of month	**26,148**	**22,680**	**(3,468)**
Cash / Cash Equivalents at end of month	**22,567**	**23,784**	**1,217**

- The cash balance at the end of the month was £23.8m compared with the plan of £22.6m.
- Funds held in escrow accounts continue to be monitored.
- There have been no further PDC draw downs relating to the Barnes scheme in July, the balance remains £1.8m
- The main variances to the plan are an increase in working capital +£6.5m partially offset by escrow monies, less capital creditors and less PDC than planned.
- This resulted in a slight increase in cash in the month

NHS
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Meeting:	Trust Board
Date of meeting:	4 July 2023
Transparency:	Public
Committee Name	Estates Modernisation Committee (EMC)
Committee Chair and Executive Report	Juliet Armstrong (Chair) Ian Garlington (Executive)

BAF and Corporate Objective the committee is accountable for:

BAF Risk Description
A failure to deliver transformed models of care, working practices and environments

Corporate Objective:

- **Objective 5:** To deliver our integrated transformation programme improving access and outcomes, reinvigorating working practices for staff and service users alike and providing state-of-the-art mental health facilities. Our focus is on delivering clinical transformation elements and supporting change within the Trust

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

The Board to note:

- EMC approved the principles, scope and governance as part of the Integrated Programme refresh, recognising that more work is required to complete the refresh by the end of September. The Board seminar in October will take the whole Board through the changes.

- EMC approved the 2023-28 digital strategy, which will now come for Board approval. EMC discussed it would be helpful to ensure a common simple understanding of 'digital' and 'digital culture' as well as have a more granular understanding of the priorities and delivery timetable.

- EMC noted the work undertaken to date to transfer from transformation teams to BAU teams, and had a helpful discussion to recognise that BAU will need to embed, develop and sustain changes to e.g. working practices and also new roles. BAU governance will also be re-emphasised so all understand the escalation route up through leadership teams and then up to committees, as needed; EMC will not oversee BAU issues.

Areas of Risk Escalation to the Board:

Item discussed- Integrated Programme Refresh

Assurance Position

- Good assurance on the overall direction of travel of the refresh, including de-scoping of elements to be overseen by the committee (EMMG will continue to oversee all the key Trust Transformation programmes). It will be important to ensure there are still effective mechanisms for overall transformation prioritisation and control e.g. quarterly objectives
- Recognition this is still a 'work in progress' with more to do by September to complete the refresh, including the new Quality and Performance metrics, a clear, streamlined view of benefits reporting/tracking and a new programme name!

Evidenced by

Papers presented to EMC.

What next?

- Review of full refresh at September EMC
- Board to review at Trust Board seminar in October

Item discussed- Risk and Transfer Process to BAU

Assurance Position

- Good assurance on the process and progress for Estates and Facilities departments but limited assurance currently on wider implications of transition to BAU such as HR implications to embed and develop new roles. There will be more focus on this during Q3/Q4
- More to do to confirm committee governance routes for BAU issues, as they will not come to this committee e.g. if required to be escalated issues for Wi-Fi and car parking.

Evidenced by

Papers presented to EMC.

What next?

- Map out governance routes including respective Board committee for BAU issues e.g. wi-fi, car parking.

Item discussed- Digital Strategy refresh

Assurance Position

- Good assurance that the vision, themes and outcomes have been developed through collaboration, and have brought in external NHS themes and horizon scanning, including learnings from a national Digital Maturity self-assessment
- Recognition that digital literacy is a key risk to transformational change and that we need to mitigate against digital exclusion in pathway re-design
- More work is needed to develop a clear more granular prioritised implementation plan

Evidenced by
Digital strategy paper, including input from external consultancy used to support stakeholder engagement and external NHS themes (ATOS)

What next?

- Further work to develop a more granular implementation plan
- Board to approve Digital 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 of the 4th July 2023 EMC (Part A)

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

ESTATES MODERNISATION COMMITTEE – BUSINESS MEETING PART A (PUBLIC)

Minutes of the meeting held on Tuesday 4th July 2023 at 3.00pm, via MS Teams

Present:

Juliet Armstrong (JuA)	Non-Executive Director (Chair)
Ann Beasley (AB)	Trust Chair
Jenna Khalfan (JK)	Director of Communications & Stakeholder Engagement
Philip Murray (PM)	Director of Finance and Performance
Vik Sagar (VS)	Non-Executive Director (NED member)
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial Development

Attendees:

Anna Barnes (ABa)	Associate Director Integrated Programme
Emily Downey (ED)	Integrated Programme Delivery Manager (minutes)
Bruce Duncan (BD)	Estate Modernisation Programme Director
David Lee (DL)	Director of Corporate Governance
Stephen Reid (SR) *until 4pm*	Diversity in Decision Making Representative
Katherine Robinson (KR)	Director of People

Apologies:

Sola Afuape (SA)	Non-Executive Director (NED observer)
Jennifer Allan (JA)	Chief Operating Officer
Billy Boland (BB)	Medical Director
Deborah Bowman (DB)	Non-Executive Director
Charlotte Clark (CC)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Ian Garlington (IG)	Integrated Programme Director
Sharon Spain (SS)	Director of Nursing and Quality Standards

Item		Action
23/130	**Apologies** The apologies for absence were noted.	
23/131	**Declarations of Interest** There were no formal declarations of interest reported.	
23/132	**Chair's Actions** The Chair took no action on behalf of EMC outside of the meeting.	
23/133	**Minutes of the meeting held 6th June 2023 Part A** The minutes of the meeting held on 6th June 2023 (Part A) were approved as an accurate record.	
23/134	**Action Tracker and Matters Arising (Part A)** *Updates to the action tracker are minuted in Part B.*	

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Item		Action

23/135 EMC Workplan

The Committee noted the EMC workplan for 2023/24.

JuA noted the park has not been adopted by Wandsworth Council and she requested an update to the Committee to explore the social enterprise vehicle for managing the park and its role in reducing stigma.

The Committee agreed the following action:

1) **Add an update on the park to the workplan** — **ED/IG**

23/136 IPD: Integrated Programme Refresh

The Committee received and noted the Integrated Programme Refresh. AS gave the following summary:

- Paper 2-1B builds on the conversation from the Board Development session in February to refresh and update the Integrated Programme for Phase 2 with the key principles and approach to transformation. The scope of the Integrated Programme at EMC and Trust Board will be focused on the areas which are most critical for delivering the FBC and the 23/24 priorities to improve flow and maintain a stable workforce. No decision has been made as yet on the new name for the programme. AS noted the refresh is a work in progress and reporting and governance changes need to be finalised.

The following key points were raised in discussion:

- VS noted the focus on outcomes is good as a key principle. VS asked where the prioritisation of all transformation takes place as EMC will not be sighted on all projects and possibly should review every 6 months. AS suggested using the quarterly corporate objectives as discussion of top priorities. EMMG will still be chaired by the CEO and oversee transformation including quarterly updates on lower priority projects. AS noted it would be sensible to review the programme refresh in February 2024 to reflect on the new arrangements in line with priority setting for next year.

- SR queried if the lessons from phase 1 are being taken into phase 2 to ensure changes are sustained and addressed from an EDI perspective. AS confirmed that reviews have been conducted but is an iterative process. AS noted the refresh should be carefully communicated because "out of scope" projects for EMC are still important and complex.

- JuA noted the refresh is the right direction of travel and the reduced scope will be helpful to focus on outcomes and delivery of benefits. The Committee would like a clear streamlined view of the key outcomes, including the FBC benefits being tracked and how these are being achieved, noting the new Quality & Performance (Q&P) report will help. JuA also suggested the approach now being taken to track Q&P KPIs (smaller number at committee-level with full dashboard at operational level) might be a good model to track the programme benefits.

Item **Action**

- JuA noted the Trust Board seminar in October will cover the Integrated Programme so all NEDs will get an update.

The Committee approved the Integrated Programme Refresh.

23/137 IPD: Risk and Transfer Process to BAU

The Committee received and noted the Risk and Transfer Process to "Business as Usual" (BAU). BD and PM updated on the following key points:

- Paper 2-2 shows the reflections of a workshop with Estates & Facilities (E&F) colleagues, in readiness for other moves. It is acknowledged the handover to BAU for Trinity could have been smoother with better communications. Specific actions have been implemented for future moves.

- Shaftesbury: The E&F team have been located there since February 2023, and the systems are the same as Trinity so there is less training required. Broadly similar teams will be moving across to Shaftesbury so there will be less "meshing" of different teams compared to Trinity. There is more confidence from both EMP and E&F because extra resources are in place and there is good working relationship with Sir Robert McAlpine (SRM) to resolve issues.

- Barnes: teams moving back to Barnes in 2024 are currently located together in Teddington. The new building at Barnes will be a similar design to Trinity using the same systems so more familiarity for E&F. Potentially the Putney & Roehampton community team will move from QMH into Barnes so there may be some work required with integration.

- Tolworth: as wards will be moving from Springfield, site familiarisation is important, not just building familiarisation.

- Work has also taken place supported by the Trust's risk team to transfer appropriate EMP risks into the BAU E&F risk register. This has resulted in two new BAU risks regarding car parking and lifts in Trinity.

- The responsibilities between BAU, EMP and SRM have been clarified.

The following key points were raised in discussion:

- AB noted that transformation has an impact on existing infrastructure but BAU is not always ready e.g. 13 new roles in Sutton will need HR support to develop career pathways. KR agreed and noted the HR focus has been getting the foundations right and the next step is to develop a people plan in Q3/Q4 to be more strategic.

- AB noted that there are also wi-fi issues in Trinity and queried where new issues from the moves get escalated to. BD noted a Trinity leaders' forum has been set up to discuss and escalate issues to BAU. BD reflected that

Item		Action

both Digital and E&F may have underestimated the scale of dealing with issues in the new building which is taking time to get resolved as there are multiple factors involved.

- PM noted that various options are being worked through regarding car parking (led by BAU), but it must be recognised that early decisions made by the Trust are now impacting service users and staff and that the Trust is restricted by planning regulations. KR noted the impact on staff retention which has been raised through JCC.

- JuA noted the need to think through implications of changes earlier for existing departments. This should be part of the refresh and then communicated to BAU and benefit owners.

- JuA noted that once handed over to BAU, issues need to go through BAU governance and not EMC, however they can reflect on the reputation of the programme. It was noted the first step is to raise issues at the Trinity leaders' forum and should only be escalated further if not resolved. It was agreed to map out the governance routes for BAU issues.

The Committee agreed the following actions:

2) **Map out governance routes including respective Board committee for BAU issues e.g. wi-fi, car parking.** **ELT/DL**

23/138 Digital Strategy Refresh

The Committee received and noted the Digital Strategy Refresh. PM and AS updated on the following key points:

- The refreshed Digital Strategy for the next five years builds on stakeholder engagement conducted by AToS and brings in the customer and supplier perspectives. Lessons have been learnt from the Global Digital Exemplar (GDE) projects and the strategy interfaces with the ICS and SLP.

- Work planned comes under four themes: Digital First (digitally enabled employees), Digitally Enabled Patients, Interoperable & Intelligent Systems (digitised pathways) and Infrastructure (digital inclusion and cybersecurity).

- The Trust completed a national Digital Maturity self-assessment tool (results on slide 16 of paper 2-3B) and will produce an action plan in response which links in with the short, medium and long term aims of the strategy encompassing deliverability and working with external partners.

The following key points were raised in discussion:

- AB noted there is a design principle "digital readiness & culture" and advised to be clear what is in and out of scope. KR responded that digital is an enabler for transformation and should be part of the Organisational Development (OD) framework to support a change of mindset. JuA has been assured there is a team working on a plan to increase staff digital

Item		Action

literacy and confidence. PM confirmed that digital responsibilities will be built into clinical leader roles and change champions in teams to widen digital leadership across the Trust.

- KR suggested clarifying what we mean by "digital" potentially using examples of different roles e.g. community nurse, psychologist on a ward. **JuA suggested having a Board seminar would be helpful, noting one by NHS Providers would be suitable.**

- AB noted the discussion showed that everyone has different expectations of "culture"; the word is overused and has become meaningless. It could be replaced with "digital literacy and confidence" in this context. **PM/AS/JA to consider more carefully and provide a better term for "digital culture".**

- PM noted the biggest risk for transformational change is digital literacy and people finding workarounds to avoid change. However, there is a need to recognise difference by using a flexible approach to minimise digital exclusion.

- VS wanted to hear more about the next steps and which areas can get moving. JuA noted there should be a clearer prioritised implementation plan which is more granular leading up to 2028.

- AS confirmed the strategy will go to Trust Board in September 2023. The Digital Oversight Group holds delivery of the strategy, however it needs to be agreed which Board Committee will have oversight.

EMC approved the Digital Strategy Refresh 2023-2028

The Committee agreed the following actions:

3) **Request for a Trust Board seminar on Digital to get a common understanding at Board level.** — **DL**

4) **Use an alternative word for "culture" with reference to Digital as this is overused and poorly understood.** — **PM/JA/AS**

23/139 Green Plan Implementation Quarterly Review

The Committee received and noted the quarterly review of the Green Plan Implementation. AS updated on the following key points:

- A green sustainability lead is currently being recruited. Communications are being agreed for the summer period to increase engagement and the aim is to set up governance from September 2023 including an inclusive Green Plan group and associated small delivery team. A recent bid for sustainability funding was not successful noting it was extremely competitive. Collaborative work is taking place with teams to build on interests that will contribute to the programme.

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

Item **Action**

- It was noted that the proposal is that refreshed EMC will not oversee the Green Plan. DL agreed to clarify which Board Committee will do this.

The Committee agreed the following actions:

5) Specify the Board Committee to oversee updates on the Green Plan.

DL

23/140 COMMS: Springfield Stakeholder Visits Update

The Committee received and noted the Springfield Stakeholder Visits Update. JuA thanked everyone involved, noting the volume of people and work to ensure the visits are successful. AB reflected that the messages being portrayed could inspire the new name for the refreshed programme e.g. "Creating Healing Spaces", "Reducing Stigma".

23/141 Messages to Trust Board (Part A)

JuA confirmed the key messages for the Trust Board (Part A) from EMC are:

- EMC approved the principles, scope and governance as part of the Integrated Programme refresh, recognising that more work is required to complete the refresh by the end of September. The Board seminar in October will take the whole Board through the changes.

- EMC approved the 2023-28 digital strategy, which will now come for Board approval. EMC discussed it would be helpful to ensure a common simple understanding of 'digital' and 'digital culture' as well as have a more granular understanding of the priorities and delivery timetable.

- EMC noted the work undertaken to date to transfer from transformation teams to BAU teams, and had a helpful discussion to recognise that BAU will need to embed, develop and sustain changes to e.g. working practices and also new roles. BAU governance will also be re-emphasised so all understand the escalation route up through leadership teams and then up to committees, as needed; EMC will not oversee BAU issues.

23/142 Meeting Review (Part A)

This item is minuted in Part B.

23/143 Next meeting

The next meeting (Business) will be held at 3.00pm on Tuesday 5th September 2023 via MS Teams.

Meeting:	Trust Board
Date of meeting:	14th September 2023
Transparency:	Public
Committee Name	Audit Committee
Committee Chair and Executive Report	Richard Flatman and Philip Murray

BAF and Corporate Objective for which the Committee is accountable:

Audit Committee is not responsible for the delivery of the Corporate Objectives or managing BAF risks. Its work supports them all through ensuring appropriate controls and oversight are in place in the Trust and that they are operating effectively. The internal audit review of risk management (undertaken in 2022-23) found there to be a sound governance structure around the BAF and risk management and confirmed that the structure is operating as intended.

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

1. The July Audit Committee meeting noted the final submission of the trust Annual Report and Accounts, which were submitted on 30 June 2023 in line with the national deadline, and all the prior recommendations had been closed. The Committee also noted the final audit opinion including ISA260.
2. The Committee was asked to discuss what information from the BAF should be shared with the Board going forwards, taking into account that the sub-Committees had greater ownership of their BAF risks, and these were reported to Board within the Committee Chair's reports. The Committee agreed that the Board should see the BAF summaries so that they would still see the oversight of the total risks, but they would leave the sub-Committees responsible for the delivery of the action plans that sit underneath these risks.
3. The Committee again requested the risk appetite commentary be added to the BAF.
4. The System plan and associated controls, oversight, governance; and ensuring that all works effectively on an ongoing basis.

Areas of Risk Escalation to the Board:

1. An HCAS error which had been ongoing was now resolved. The trust would not be pursuing individual staff members for the debt, which totalled £145,000. This had been approved previously at the Committee on the understanding that the staff involved agreed to the accept the corrected values going forward.
2. A write-off of a loss was agreed in respect of some equipment damaged by a patient, at the value of £4,000.

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?

Internal audit actions
What: The Committee continues to monitor internal audit action plan progress, noting that good progress was being made against the internal audit action plan. The DSPT and HR transformation reports had been finalised. The DSPT audit had been assigned a 'moderate assurance' rating but it was recognised this had moved along since last year (when it was rated 'limited assurance') and the toolkit was submitted on time.

The HR Transformation was issued as an advisory piece and had been signed off by the Director of People. The 10 original recommendations were only relevant to the trust if they had kept the joint HR function with SLaM. These had therefore been taken through the Workforce and OD Committee (now known as the People Committee) and it was recognised that many of them were no longer relevant after the decision to separate. There was then a more general HR governance and process audit.

So What: An action plan from the HR transformation audit was being monitored in the People Committee with some actions having moved on since the audit report. The next internal audit reviews will look at the theme 'brilliant at the basics' to ensure that these have robust assurance; this has been the trust aspiration for the past year. Alongside this RSM report, given where the trust were two years' ago, the Board Chair and trust CEO have commissioned Ann MacIntyre to undertake an HR "MOT", to ascertain whether the trust is now where it needs to be. Concerns remain but there was assurance around some grip and control being in place. The Q&P report showed that progress was being made in terms of the KPIs, such as recruitment and vacancy rates.

What next: It was agreed to triangulate the findings from Ann MacIntyre's MOT report with the internal audit report, and to drill down into the separate People areas, as the different departments were at different stages along the process.

Internal Audit Assurance Map
What: The trust's internal auditors, RSM, had produced a draft Assurance Map which maps out key areas of assurance across the trust, links them to their relevant BAF risks and shows how the trust will know it has increasing assurance in these areas, alongside if and when an internal audit had taken place.

So What: This piece of work would help the Committee and the Board to gain further assurance in one place which is easy to review.

What Next: RSM would be arranging meetings with all of the Executive Leads and some Assistant Directors to get their input into the first and second lines of defence on the map. There would then be a cleansing exercise on the third line, after which the map would be bought back to Audit Committee with a summary page highlighting any gaps and the next steps needed. When this work had been completed and reviewed it would be shared with the Board and would feed into future internal audit planning.

Counter Fraud Update Report and Reactive Benchmarking Report
What: The Committee receives regular update reports from the Counter Fraud team, benchmarked against RSM's wider client base and other similar trusts, to provide

assurance that the trust is reviewing fraud regularly and not becoming an outlier in any area.

So What: This month's report showed that two emerging areas of risks were secondary working (i.e. staff working a second job whilst working for the trust) and exploitation of salary sacrifice schemes, as vouchers could not be traced once issued. There had been a sharp increase in fraud referrals from the trust but the rate was still below the number seen in the sector. There were currently low referral numbers from recruitment which usually would be an area where a lot of referrals were made.

What next: The finance team had been made aware of both emerging areas of risk. RSM would work to increase referrals, to ensure staff were confident to report to them; referrals from the trust were not too low.

Audit Committee Annual Report 2022-23
What: The Committee receives a report annually on its performance and effectiveness over the prior year.

So What: The report is an opportunity for the Committee to consider its effectiveness and how it has performed against its Terms of Reference.

What next: The 2022-23 report includes an assurance and position statement that provides an opinion to the Board in terms of the adequacy and effectiveness of systems of control, governance, risk management and Value for Money. There is a positive assurance statement and the evidence for the Committee being able to make that opinion is set out. This report is appended to the Chair's report.

Board Assurance Framework (BAF) and Executive Risk Register (ERR)
What: The Committee regularly reviews the BAF and ERR.

So What: The Committee heard that there was a new Quality and Safety risk that had been approved at QSAC and would be recommended to the Board. The Chair of the Committee had also attended the QSAC where the Quality risk had been discussed in detail and he was satisfied with the process it had gone through and that it was comprehensive.

The Committee were assured by ELT having discussed the BAF at a meeting where Clinical Directors and Deputies were in attendance.

What next: The Committee was asked to discuss what information from the BAF should be shared with the Board going forwards, taking into account that the sub-Committees had greater ownership of their BAF risks, and these were reported to Board within the Committee Chair's reports. The Committee agreed that the Board should see the BAF summaries so that they would still see the oversight of the total risks, but they would leave the sub-Committees responsible for the delivery of the action plans that sit underneath these risks.

The Committee again requested the risk appetite commentary.

Gifts and Hospitality (G&H) Register Update
What: The Committee had previously requested that the G&H register be separated from the conflict of interest (COI) register and for it to come biannually to the Committee for review. This was due to concerns about the nil return on G&H in the trust.

So What: The registers and the policies were separated and bought to Committee in draft. The COI was not approved due to some minor amendments needed that had been suggested by RSM. The Committee asked for some further amendments and information around the communications on relaunching both policies and registers.

What next: The Committee asked for some further amendments and information around the communications on relaunching both policies and registers.

Annual Accounts update, including Earnings After the Reporting Period (EARP)
What: The reports had been submitted as planned by 30 June 2023. This paper confirmed there were no EARPs for note. Reflections on the process – what worked well and what could work better next time – were included in the paper.

So What: A reflection on communications was raised as the finance team felt that KPMG slowed their approach and process after the June Audit Committee. KPMG explained the delay had been due to internal work needed that the trust would not have been sighted on.

GSM were approved to continue as auditors for the Charitable Funds accounts as their rates had remained the same as last year.

It was confirmed that an HCAS error which had been ongoing was now resolved. Any individual who had been overpaid had been spoken to by HR colleagues. HR had fed back that these individuals had recognised that their HCAS would be adjusted to a lower rate following an appropriate notice period. The trust would not be pursuing individuals for the debt, which totalled £145,000. This had been approved previously at the Committee on the understanding that the staff involved agreed to their lower salary.

What next: The finance team would alert the Committee Chair of any EARPs between the July meeting and the submission date of December 2023.

Losses report July 2023
What: The losses report is a regular item on the Audit Committee agenda to ensure significant financial losses to the trust are scrutinised and assurance gained where needed.

So What: The Committee were assured by the report; the finance team had done a lot of work over the last few years to make sure that loss information was being captured, but that even with that extra work, reported losses remained low.

A loss was agreed in respect of some equipment damaged by a patient, at the value of £4,000. The trust were not pursuing the patient for the £4,000 so this was not technically a write-off or loss, but came to the Committee for agreement as a matter of good practice. The Chair was assured that the incident itself would have been considered and robustly reviewed by the Director of Nursing, the Quality Matters Committee and QSAC.

What next: The Committee would continue to monitor the losses report.

Debtor's report July 2023
What: The debtor's report is a regular item on the Audit Committee agenda to ensure significant debts to the trust are scrutinised and assurance gained where needed.

So what: The Committee were assured by the fact that the overall debt over £20,000 had come down by £2.3m.

The trust had not collected any debt that was older than nine months due to year end and onboarding of a new post holder.

What next: Now the new post holder was embedded in the team and year end was over, it was expected that the new person would begin working with debtors and contract team to bring debt down further.

Waivers Report
What: The waivers report is a regular item on the Audit Committee agenda to ensure waivers are scrutinised and assurance gained where needed.

So what: There had been no quote or tender waivers to report. The Director of Finance and Performance had rejected a quote waiver request on the basis that there was reasonable time to get quotes in. He felt this had given assurance that the process was working and was robust.

What next: The RSM work on benchmarking tender waivers would come to the October Committee.

Salary Overpayments Report
What: The Committee regularly receives the Salary Overpayments report as it is a source of lost revenue to the trust, and they seek assurance that any issues or lessons learned are reviewed to ensure processes are robust and overpayments are mitigated. Salary underpayments were included for note. This report is also regularly reviewed by FPC.

So what: Incidents of overpayment remain flat, allowing for small, non-material fluctuations, such as the values for pay awards and inflation. The Committee were assured to hear that the trust was not an outlier for overpayments – it benchmarked marginally under the national median for errors (.07% versus the national median of .08%). There were not any significant concerns.

What next: Despite the extra scrutiny of the payroll and HR processes, it was disappointing that the incidents were not coming down. This was largely due to late notification from managers of people being sick or having left the organisation. The Committee discussed at length whether there was anything that could be done to reduce late notifications. The Committee were assured that the finance team were looking at corporate systems and processes to see if these could be digitised and made leaner, to prevent overpayments. There was not felt to be a standout part of the process that was causing any issue but that late notifications were genuinely because people were very busy and forgot to do the paperwork on time.

System Plan sign off letter and associated controls
What: This report would also be shared with the FPC and People Committee.

Any payment over £25k non-pay has to go through extra system controls – to the ICB and NHSE for sign-off - as do any administrative agency requests.

All trusts were required to create a waterfall diagram that explained how they got from the head count and whole time equivalent at March 2020 (from the start of the pandemic)

to now. As a mental health trust there had been underlying investment because of the Mental Health Investment Standard and the System Development Fund; so the diagram showed legitimate increases linked to national investment.

So What: As the report spans a number of Committees, Audit Committee asked how it would gain assurance that these controls were operating effectively. The Director of Finance and Performance confirmed that ELT and People Committee, plus the Board, had reviewed it as the 'break glass' agency use process had needed to be signed off at Board level. Technically, it should then come back to Audit Committee, to say it had been signed off with the various Committees (including FPC) and then up to the Board. 'Break glass' use would be reported into FPC.

What Next: There were some conflicts between the content of the main letter and what was included within the appendix. The ICB was working through those disparities and were going back to region to clarify.

It was agreed that a short report would be presented to the October Committee on how the Executive think the trust had complied with the system plan and controls; and this report would come back to Committee on an ongoing basis for assurance.

Items for note:
The July minutes will not be ratified until the October meeting (there are no Audit Committee meetings in August or September).

Appendices
Annual Committee Report 2022-23.

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Annual Committee Report

Audit Committee

1. Introduction

1.1. Committee Establishment

The Audit Committee (the Committee) is an established Committee of the Board of Directors (the Board).

1.2. Committee Purpose and Duties

The Committee is charged with ensuring that there are effective governance processes including risk management, internal control and protection of the Trust's assets in place.

Areas overseen include:

- The relationship with the external and internal auditors;
- Reviewing the audit-related aspects of the annual financial statements;
- Reviewing reports of External and Internal Audit and Counter Fraud auditors;
- Monitoring progress in terms of implementing agreed management action to redress identified control weaknesses;
- The Board Assurance Framework and risk management process; and
- All disclosures relevant to its Terms of Reference.

The Committee has overall responsibility for providing the Board with a means of independent professional advice and to secure the attendance of outsiders with relevant experience and expertise as it considers necessary.

The Committee is authorised by the Board in the following areas:

- To investigate any activity within its Terms of Reference;
- To seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee; and
- To appoint/reappoint internal and external auditors of the Trust.

1.3. Terms of Reference

The full details of the Committee's duties are outlined in the Terms of Reference. A full review of the Committee's workplan and the meetings that report into the Audit Committee has been undertaken in order to support good governance.

As a matter of good practice, and in line with its duties, the Committee regularly reviews the Board Assurance Framework and Executive Risk Register.

2. Membership and Meeting Attendance

The Committee is independent and accordingly only non-executive directors are members. In addition to the Chair, the Committee members include a member of the Finance and Performance Committee, the Quality, Safety and Assurance Committee and the Estates Modernisation Committee. Other regular attendees include representatives from the internal auditors and the external auditors (RSM and KPMG respectively for 2022/23), the Chief Executive, the Director of Corporate Governance, the Director of Finance and Performance and the Deputy Director of Finance.

During the period the Committee met five times and the attendance is set out below in Table 1.

The Committee commissions and reviews many detailed reports and therefore a number of different presenters have attended the various meetings during the period.

2.1. Table 1: Members and Meeting Attendance - 1 April 2022 to 31 March 2023.

Members	Role	Attendance (Actual/Eligible)
Richard Flatman	Non-Executive Director, Committee Chair	4/5
Vik Sagar	Non-Executive Director (Finance and Performance Committee and Estates Management Committee representative)	5/5
Doreen McCollin	Non-Executive Director (Quality and Safety Assurance Committee representative)	3/5

2.2. Table 2: Attendees and Meeting Attendance - 1 April 2022 to 31 March 2023.

Attendees	Role	Attendance (Actual/Eligible)
Vanessa Ford	Chief Executive Officer	3/5
Philip Murray	Director of Finance and Performance	4/5
Debbie Hollinghurst	Deputy Director of Finance	5/5
David Lee	Director of Corporate Governance	2/5

The Trust's internal and external auditors, RSM and KPMG respectively, send representatives as appropriate to the agenda items at each meeting.

3. Committee Work and Activities

3.1. Annual Review - 1 April 2022 to 31 March 2023

The Committee has conducted work in accordance with its purpose of reviewing the effective system of integrated governance, risk management and internal control across the Trust's activities in both clinical and non-clinical areas during the period, as stated in its agreed Terms of Reference and workplan.

The reports commissioned and reviewed by the Committee are broad and could be themed in five broad categories:

- Governance including BAF and risk management
- Financial
- Internal audit
- External audit
- Counter fraud.

The items featured on the Committee's agenda during the period are included in Table 3 below.

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Table 3: Committee Activity - 1 April 2022 to 31 March 2023

Governance	Financial	Internal Audit	External Audit	Counter Fraud
Review Assurance Framework incl. Executive Risk Register and Board Assurance Framework	Tender Waivers report	Internal Audit Programme Progress Report	Audit Progress Reports	Progress Reports
Review Annual Governance Statement	Review of Annual Report and Accounts Progress	Internal Audit Report and HOIA Opinions	Audit Plan	Workplan
Accounting Policies updates	Annual Accounts	Internal Audit Workplan: *Location Visits *IT Project Management *Risk Management *Clinical Audit *Cyber Security *Use of Force *Workforce Review *Data Protection Toolkit (DPST) *Consent and capacity to treatment *Financial governance	External Audit Report and Opinions	Annual Counter Fraud Assessment
Annual Committee Report	Going Concern	Internal Audits and action plan updates	Annual Report	
Integrated Programme Assurance	Losses and Special Payments	Client Briefing notes	Annual Governance Statement	
Quality and Safety Assurance Committee minutes	Debtors Report	Appointment of Internal Auditors	Appointment of External Auditors	
Estates Modernisation Committee minutes	Procurement policy			
Committee work plan	Valuation of assets being sold			
Terms of Reference	Cyber security			
COI and register of Gifts and Hospitality	Salary Overpayments			
Data Protection Information Governance Group Terms of Reference	Value for Money (VfM)			
Charitable Funds Accounts				
Quality Accounts				
Tender arrangements for new auditors				
Corporate Objectives				
Risk Management Framework				
Health and Safety				

3.2. Forward Planning - April 2023 to March 2024

The Committee has developed a forward workplan for the period April 2023 to March 2024 which will include continued monitoring of internal control and risk management, internal audit, external audit and annual accounts review. It will address key risks, especially those on the corporate registers and the Board Assurance Framework, and any key emerging financial challenges.

The forward workplan for 2023-24 is detailed in **Table 4** on page 8.

4. Assurance and Position Statement

During the year, the Committee has conducted a detailed review of key governance, financial, internal audit, external audit, risk and assurance matters.

For the period 2022-23, the Committee's opinion on the Trust's framework for risk management, control and governance is that the arrangements are adequate and effective. Further enhancements have been identified to ensure that the framework remains adequate and effective.

The Committee's opinion on the arrangements in place to deliver value for money through promoting economy, efficiency and effectiveness in the use of its resources is that these arrangements are also adequate and effective.

These opinions are based on:

- The Head of Internal Audit's annual opinion that the Trust has reasonable and effective risk management, control and governance processes in place, which are meeting the Trust's objectives and mitigating against key risks.
- The annual external auditors issued an unqualified opinion on the financial statements and a positive opinion on value for money – no significant changes or weaknesses have been identified.
- The Auditors Annual Report has reported no significant risks or weaknesses or noted any material misstatements within the key risk areas.
- Other internal assurance processes as appropriate.

It should be noted that assurance can never be absolute. Whilst the Trust's arrangements for risk management, control and governance are considered effective, reviews undertaken by Internal Audit during the year have highlighted areas where further improvements are required. The Committee will continue to focus closely on the implementation of those improvement actions.

The table on page 13 (**Table 5**) shows those reports considered by the Committee during the financial year.

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Table 4:

AUDIT COMMITTEE				2023 / 2024					
ITEMS	***Frequency***	***Executive Lead***	***Authors***	**14/03/2023**	**13/06/2023**	**11/07/2023**	**31/10/2023**	**18/01/2024**	**21/05/2024**
GOVERNANCE									
Review the assurance framework, including BAF				√	√	√	√	√	√
Board Assurance and Executive Risk Register				√	√	√	√	√	√
Review the Risk Management Strategy		DONQ	ADQG	√					√
Review draft annual governance statement	A		DCG		√				
Value for Money		DFP		√	√	√	√	√	√
Review whistleblowing arrangements		HRD	HRD						√
Review other reports and policies as appropriate						√	√		
Corporate Risk Register		Chair		√	√	√	√	√	√
Gifts and Hospitality Updates	each	DCG	DTS	√	√	√	√	√	√
Quality & Performance Reporting Framework		DCG	DCG	√		√	√		√
Review annual report progress		DCG	DCSE		√				
Review accounts progress		DFP	DDF		√				

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AUDIT COMMITTEE				2023 / 2024					
ITEMS	***Frequency***	***Executive Lead***	***Authors***	**14/03/2023**	**13/06/2023**	**11/07/2023**	**31/10/2023**	**18/01/2024**	**21/05/2024**
Approve Quality Accounts	A	DoNQ	DASDQG		√				
Approve Annual Report	A	DCG	DCG		√				
FINANCIAL									
Approve Audited Annual Accounts	A	DFP	DDF		√				
Approve Annual Report	A	DCG	DCG		√				
Approve the Charitable Funds Annual Accounts	A	DFP	DDF						
Annual Accounts progress including:-	Q	DFP	DDF	√	√			√	√
- Accounting Policies approval	A	DFP	DDF					√	
- Consideration of Going Concern	A	DFP	DDF	√					√
- IFRS update	6m	DFP	DDF			√	√	√	
- EARP	A	DFP	DDF			√	√		
- Valuation update	6m	DFP	DDF			√	√	√	
Losses and Special Payments & Write Offs	6m	DFP	DDF		√	√	√	√	
Debtors Report	Q	DFP	DDF		√	√	√	√	√
Waivers Report	Q	DFP	DDF			√	√	√	

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AUDIT COMMITTEE				2023 / 2024					
ITEMS	***Frequency***	***Executive Lead***	***Authors***	**14/03/2023**	**13/06/2023**	**11/07/2023**	**31/10/2023**	**18/01/2024**	**21/05/2024**
Salary Over Payments Report	6m	DFP	DDF			√			
INTERNAL AUDIT									
Annual review of the effectiveness of internal audit	A	DFP	RSM		√				
Internal Audit Programme progress reports		DFP	RSM	√	√	√	√	√	√
Receive the internal auditor's plan	A	DFP	RSM					√	
Head of Internal Audit internal audit opinion	A	DFP	RSM	√	√				√
Data Security and Protection Toolkit	A	DFP	RSM					√	√
Various Audits to be reported at each Committee		DFP	RSM	√	√	√	√	√	√
EXTERNAL AUDIT									
Agree external audit plans	A	DFP	KPMG					√	
Review external audit progress reports		DFP	KPMG	√	√	√	√	√	√
Receive the external auditor's report		DFP	KPMG	√	√	√	√	√	√
Quality Account	A	DFP	KPMG		√				
Receive / consider the external auditor's annual audit letter	A	DFP	KPMG		√				

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AUDIT COMMITTEE				2023 / 2024					
ITEMS	***Frequency***	***Executive Lead***	***Authors***	**14/03/2023**	**13/06/2023**	**11/07/2023**	**31/10/2023**	**18/01/2024**	**21/05/2024**
Going Concern	A	DFP	KPMG		√				
Letter of Representation	A	DFP	KPMG		√				
COUNTERFRAUD									
Review and approve the annual work plan for counter fraud activity	A	DFP	RSM		√				
Review counter fraud and security progress reports		DFP	RSM	√	√	√	√	√	√
Review the organisation's annual self-review against NHS Protect's standards	A	DFP	RSM		√				
Review the effectiveness of those carrying out counter fraud activity	A	DFP	RSM		√				
Receive the annual report on counter fraud activity	A	DFP	RSM		√				
National Fraud Initiative updates		DFP	RSM	√	√	√	√	√	√
Self Certification	A	DFP	RSM		√				
Committee Governance & Reporting									
Committee's Annual Report	A	DCG	DTS		√				
Review of Terms of Reference	A	DCG	DTS		√				

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AUDIT COMMITTEE				2023 / 2024					
ITEMS	***Frequency***	***Executive Lead***	***Authors***	**14/03/2023**	**13/06/2023**	**11/07/2023**	**31/10/2023**	**18/01/2024**	**21/05/2024**
Review Workplan	A	DCG	DTS	√	√	√	√	√	√
Minutes of Quality & Safety Assurance Committee (QSAC)	M	DONQ	DONQ	√	√	√	√	√	√
Minutes of Estates Management Committee (EMC)	M	CEO	NED Lead	√	√	√	√	√	√
Matters for the Board	M	Chair	DTS	√	√	√	√	√	√

Table 5:

Review:	Assurance:
Consent and Capacity to Treatment	Reasonable assurance
Data Security and Protection Toolkit	Limited assurance
Financial Sustainability HFMA	Advisory
IT Project Management	Reasonable assurance
Risk Management	Reasonable assurance
Use of Force	Reasonable assurance
Location Visits	Partial Assurance.
Clinical Audit	Partial Assurance.
Cyber Risk Assessment	Partial Assurance.

The Committee was pleased to note the relatively stable control environment as evidenced by:

- the fact once again that there were no audits where *No Assurance* had been provided; and
- the work on Data Security and Protection has since been audited again in May 2023 and is now reported as *moderate assurance*.

It was disappointing to have had some Partial assurance reports in 2022/23; however, the Committee noted that these areas had been chosen due to concerns, the need to seek assurance and support the delivery of any required action plan.

The table below summarises the relative ratings over the past five financial years (for note 21/22 excludes In Patient Ward Visits and Data Protection Toolkit):

Year/Assurance	Substantial	Reasonable	Partial / Limited	No Assurance
2022/23	0	4	4	0
2021/22	4	4	3	0
2020/21	4	6	0	0
2019/20	3	7	0	0
2018/19	6	5	3	0

The Committee reviewed the Quality Accounts and Annual Board Report in detail and these have been submitted in accordance with the relevant deadline.

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

Appendix 1:Terms of Reference

Committee	AUDIT COMMITTEE
Key Strategic Ambitions	**All four of the Trust's strategic ambitions fit within the scope of this Committee:** • ***Increasing quality years*** • ***Reducing inequalities*** • ***Making the Trust a great place to work*** • ***Ensuring sustainability***
Chair	Non-Executive Director
Executive Lead	Director of Finance and Performance
Secretary	Trust Secretariat
Members	The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members as follows: • one of whom has recent and relevant finance experience; • one of whom is a member of the Finance and Performance Committee, normally the chair • one of whom is a member of the Quality and Safety Assurance Committee • one of whom is a member of the Estates Modernisation Committee A member may fulfil more than one of the above criteria, however the Chairman of the Trust shall not be a member of the Audit Committee. The Board shall appoint one of the Non-Executive members of the Audit Committee to be its Chair.
Attendees	The Chief Executive, the Director of Finance and Performance and the Trust Secretary shall regular be in attendance at the Committee. Representatives of Internal Audit, the local counter fraud service and External Audit shall also normally attend all meetings. Other executive directors and senior staff should attend by invitation, and particularly where the Committee is discussing significant issues related to their area of operation. At least once a year the Committee shall meet the External and Internal Auditors separately and without any Trust staff present.

Frequency	Meetings shall be held at least quarterly and at such other times as the Chairman of the Committee deems necessary. The Chair of the Committee, External Auditor or Head of Internal Audit may request meetings if they consider it necessary. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, shall be forwarded to each member of the Committee no later than ten working days before the date of the meeting.
Quorum	A quorum shall be two Non-Executive Director members of the Committee. A duly convened meeting of the Committee at which a quorum is met shall be competent to exercise all authority and power vested in the Committee by the Trust Board. Where the Chairman is absent, one of the other members of the Committee shall chair the meeting. Members of the Audit Committee shall not appoint deputies to attend meetings in their place.

Purpose

The Audit Committee has overall responsibility for providing the Trust Board with a means of independent and objective review of financial and corporate governance assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical).

The Committee shall take cognisance of the work of the Board's committees in providing assurance to the Board, and work with them as necessary to ensure an effective overall risk management and assurance system.

Duties

The duties of the Committee can be categorised as follows:

Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that support the achievement of the Trust's objectives.

In particular, the Committee shall review the adequacy of:

- All control related disclosure statements, particularly the Annual Governance Statement together with any accompanying Head of Internal Audit opinion, external audit opinion and other appropriate independent assurances prior to endorsement by the Board;
- The structures and assurance processes for identifying and managing key risks facing the organisation, taking cognisance of the work of the Board's committees
- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in relevant guidance;
- The operational effectiveness of relevant policies and procedures.

Internal Audit

- To consider the appointment and performance of the Internal Audit service, their terms of reference, the audit fee and any questions of resignation and dismissal.
- To review the Internal Audit strategy and annual plan, ensuring consistency with the needs of the Trust.
- To consider the major findings of internal audit investigations (and management's response) and monitor the implementation of recommendations thereof.
- To ensure co-ordination between the Internal and External Auditors.
- To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- The committee shall undertake an annual review of the Internal Audit function and in doing so shall take into account the management review of the function.

External Audit

- To consider the appointment and performance of the External Auditor, as far as the rules permit and agree the External Audit fee.
- To discuss the external audit plan with the External Auditor before the audit commences, the nature and scope of the audit as set out in the Annual Plan, and ensure coordination as appropriate, with other External Auditors in the local health economy.

- To review External Audit reports, including value for money (VFM) reports and annual audit letters, together with the management response.

- To receive and review all opinions to be issued by the external auditors prior to their public release and issue.

- To make recommendations to the Board in respect of the letter or representation and Annual Audit letter.

Counter fraud

- The Committee shall review the adequacy of the policies and procedures for all work related to fraud and corruption as set out in relevant Directions issued by the Secretary of State and as required by the Director of Counter Fraud Services, including being notified of any action taken under that policy.

Annual accounts review

The Audit Committee shall review the annual financial statements before submission to the Board for approval, focusing particularly on:

- The wording in the Audit findings report and other disclosures relevant to the terms of reference.

- Changes in, and compliance with, accounting policies practices and disclosures relevant to the terms of reference of the annual audit.

- Assurances about financial systems.

- The quality of control arrangements over the preparation of the accounts.

- Major judgmental areas.

- Significant adjustments resulting from the audit.

- The Annual Governance Report.

To review on behalf of the Board, the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, scheme of delegation, and standards of business conduct including maintenance of relevant policies and registers.

To examine the circumstances of any significant departure from the requirements of any of the

foregoing, whether those departures relate to a failing, overruling or suspension.

Other assurance functions

- To satisfy itself that suitable arrangements are in place to deliver value for money through promoting economy, efficiency and effectiveness.
- To review the Board Assurance Framework at least quarterly, prior to approval by the Board, conducting detailed consideration of individual high risks on a cycle as appropriate.
- To be assured on the process for the approval of Health and Safety policies and monitor compliance with relevant regulations and best practice.
- To review the findings of other significant assurance functions, both internal and external and consider the implications to the governance of the organisation. These will include reviews by the Department of Health and Social Care and its arm's length bodies, regulators, inspectors, and professional bodies.
- To ensure the work of the Integrated Programme is subject to appropriate internal and external audit and to receive OGC Gateway review reports (gates 4 and 5). To support this the Committee will also regularly receive the minutes of the Estates Modernisation Committee
- To regularly receive the minutes of the Quality and Safety Assurance Committee
- To review performance indicators relevant to the remit of the Audit Committee.
- To examine any matter referred to the Audit Committee by the Board and initiate any necessary investigation.

Authority

The Audit Committee is constituted as a standing committee of the Trust Board.

Its constitution and terms of reference shall be as set out below, subject to amendment by the Board as necessary.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and

expertise if it considers this necessary.
Monitoring compliance The Terms of Reference of the Committee shall be reviewed by the Audit Committee and Trust Board at least annually. The Audit Committee shall undertake an annual review of its performance and effectiveness, which shall form part of the annual report to the Board.
Reporting Meetings of the Audit Committee shall be formally recorded and minutes submitted to the Board at the next opportunity. The chair of the Committee shall also provide a written report to the Board at each meeting where minutes are presented and draw to its attention any issues that require disclosure to the full Board. The Audit Committee shall make an annual report to the Board in respect of the fulfilment of its function in line with these terms of reference.

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

Trust Board Part A 14 September 2023

Report Title:	2023/24 Corporate Objectives – Q1 delivery
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	ELT – 13 July 2023 People Committee – 25 July 2023 Finance & Performance Committee – 27 July 2023 QSAC – 5 September 2023 EMC – 5 September 2023

Purpose:	☐	Approval	☒	Discussion	☐	Information	☒	Assurance
Additional information:	N/A							

What?	Each year, a set of organisational corporate objectives are developed to support delivery of the Trust Strategy. The Trust Board in May 2023 approved the proposed set of corporate objectives for 2023/24 following discussions at the Executive Leadership Team, within the Executive Advisory Group and at Trust Board development sessions. We have considered our greatest challenges and 'must do' work for 2023/24 and agreed that the most important priorities are to (1) improve flow through our services (most specifically our adult acute pathway) and (2) value and stabilise our workforce. In this context, we are continuing to progress strategic delivery through our existing corporate objective structure while we have also identified and elevated a smaller set of work areas, which will see us successfully address our challenges and deliver against those 'top priorities.' The 2023/24 corporate objectives are: 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.

Within the corporate objectives there are 8 critical areas of work that will support the delivery of our two top priorities of improved flow and a valued and stable workforce. These pieces of work are:

1. Complex Emotional Needs (CEN) pathway.
2. Discharge challenge work.
3. Community enhanced response service and interface team.
4. Organisational development framework.
5. Clinical systems development.
6. Recruitment.
7. Retention.
8. Leadership, learning and development.

For each corporate objective, key delivery items have been outlined with the intended timescale for delivery. Key outcomes or metrics have been developed to enable monitoring of delivery of the objective. Baselines for metrics have been calculated where available. Finally, our first four corporate objective are 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 – are enablers for all strategic ambitions.

Following initial agreement of the milestones for the Digital part of the Transformation objective, further refinement has been necessary to ensure they accurately reflect the Digital programme and its link to transformation. Milestones have thus been minimally revised in this paper.

As per previous years, quarterly reports on progress will be made 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 has been agreed to focus on delivery against target with patient and staff experience as balancing measures. This reporting will have greater oversight on a monthly or bi-monthly basis via ELT or the Estate Modernisation Management Group (EMMG) and relevant Board committees.

This paper provides the Q1 2023/24 corporate objectives delivery update highlighting a summary of work completed and any outstanding elements.

	Notes on future milestone risk have been included. Delivery is variable at this point with some elements off track. Recovery work is underway. A version of this paper has been received by ELT and relevant Board committees as detailed in the scrutiny pathway section above.
So What?	Corporate objectives 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 will support the Board and Board committees to focus directly on a small number of work programmes with specific metrics. Progress and delivery should be more clearly measurable. This also takes account of previously flagged issues around ensuring activities undertaken will genuinely deliver the desired outcome/ impact. Despite corporate objectives and top priorities being agreed only very recently, work is slipping in some areas. There are also issues with baseline and progress data being available which is a focus for resolution over the next month. Executives are working with their senior leaders to drive progress forward. Some areas of work have significant targets and some have high volumes of work to deliver – this all presents risk for the year end.
What Next?	The Trust Board is asked to: • Note the Q1 2023/24 delivery and key risks or issues to future delivery.
Any specific issues to note and/or for escalation:	None

Strategic ambitions this paper supports	*(please check box including brief statement)*		
	☒	Increasing quality years	This paper supports all four strategic ambitions as it details delivery against our 2023/24 corporate objectives, which are directly linked to delivery of our strategic ambitions.
	☒	Reducing inequalities	
	☒	Making the Trust a great place to work	
	☒	Ensuring sustainability	

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

Implications	
Equality analysis *[linking to EDI strategy]*	Positive – Delivery of equality, diversity and inclusivity is everyone's business. EDI work begun in previous years will continue and develop in 2023/24 within a specific corporate objective aligned to the 'Reducing Inequalities' strategic ambition within the Trust Strategy.
Service users/ carers	Positive – Delivery of our corporate objectives and top priorities supports improving care for our service users and their carers. Impact of our work will be 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) remains a key organisational priority in 2023/24.
Financial:	Positive – Financial delivery will be a key focus in 2023/24 with a specific corporate objective aligned to the 'Ensuring Sustainability' strategic ambition within the Trust Strategy. Work described under the 'top priorities' element all contributes to improving efficiency and reducing financial pressure.
Legal:	N/A
Reputation:	Positive – Delivery of corporate objectives in 2023/24 will continue to support the Trust's reputation with stakeholders.
Strategy:	Positive – Corporate objectives 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 adds 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. Workforce has a specific corporate objective linked to the 'Making the Trust a Great Place to Work' strategic ambition within the Trust Strategy. The corporate objective focuses 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 Eg. 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):	
Appendices/ Attachments:	N/A

Q1 2023/24 corporate objectives delivery

Objective 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 outturn: Dialog assessment recorded in the last 6 months (%) – 19.2%) Q1 – 20.8%**
- 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 outturn: Community patients with an up to date risk assessment (%) – 91.6%) Q1 – 91.3%**
- Increase in % Always Ready care planning audits completed **(22/23 outturn – 78.4%) Q1 – 75.8%**
- Friends and Family Test (FFT) net positive score target 81% - **(22/23 outturn – 70.66%) Q1 – 72.8%**
- Patient experience of changes monitored through Feedback Live! and through Service User and Carer Group feedback (to be reported quarterly through narrative). **TBC – not yet available**

Delivery priorities	Q1 2023/24 delivery summary	Q1 delivery rating	Plans for any outstanding Q1 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
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) • OD support for key worker culture changes identified and case management and key worker SOP signed off (Q3)	**Embedding use of DIALOG/ holistic care planning, through co-production with service users and carers** • Set-up work was completed in Q1, except for service user/carer representation. Service users were recruited in Q2 and are ready to join the steering group when it is started again. The Delivery group has been established and agreed its ToR and project plan with good representation from service lines and support services. It is currently on pause until project support is secured. • DIALOG+ Care Planning SOP has been drafted, including job role of keyworker and is currently out for comment with all service lines. Full sign-off is now likely in Q3 as it is		• Involvement request for service user/carer representation live • DIALOG+ Care Planning SOP to be signed off in Q3	A need for a Project Lead resource has been identified to support the Delivery Group and prepare and deliver the project plan. Recruitment is underway for this role but, until it is in place, future quarters are at risk of delay.		

• 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)	continuing to be circulated for comment. • The RiO DIALOG+ Care plan has been developed and is in test stage. • Service Lines and Community Borough Leads have been tasked with identifying suitably-engaged teams for the pilot due to begin in Q3. **Implementation of safety planning in alignment with a change in risk assessment** • Safety planning pilots have completed with the outcome report presented to Trust QGG on 28.06.23 and next steps agreed. • Safety planning will now be brought under the moving away from CPA workstream as a key principle.					

Objective 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
- Increase in numbers of BAME staff at Band 8A and above **(22/23 outturn 1,110) Q1 – 1,092**
- Numbers of racism complaints reported **TBC once trajectory confirmed**
  - By patients
  - By staff
- Maintenance of improved staff survey results on EDI sections[1]
- Improved MWRES, WRES[2] and WDES scores[3]

Delivery priorities	Q1 2023/24 delivery summary	Q1 delivery rating	Plans for any outstanding Q1 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
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)	**Delivery of the integrated EDI Action Plan, including producing resources, tools and capability to support delivery and refresh of the EDI strategy** • Collaborative programmes with system partners partially achieved in Q1.		• Remaining collaborative programmes have been developed in Q2 with roles being advertised through voluntary sector partners.	• There are delays to the delivery of the SWL ethnicity dashboard, but this is being led by the ICS and is now outside the gift of the Trust to meaningfully impact timelines.		

[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) (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).

[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). 2022 data will be reviewed and included as a baseline when available. MWRES baselining will take place when 2022 data is available.

[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). 2022 data will be reviewed and included as a baseline when available.

• 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) **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) • EMHIP interventions around reducing restrictive practice and cultural capability developed and delivered (Q1) • Patient and Carers Race Equality Framework (PCREF) work programme developed (Q1)	• Inclusion Matters Group on pause, following agreement through People Committee based on an assessment of existing groups aligned to support HR and EDI programmes; the Committee has agreed to review again in six months. • Resource Portal is now live on Insite. **Embedding EDI and health inequalities in service lines** • EQIA template and guidance have been revised with QGG approval and testing with service lines on track for end of Q2. **Deliver EMHIP and support the implementation of the Patient and Carers Race Equality Framework (PCREF)** • EMHIP project plans have been agreed with Service Implementation Groups and EMHIP Delivery Group. • The Trust ethnicity metrics dashboard is operational but the SWL EMHIP ethnicity dashboard is still to be developed by colleagues in SWL ICS. This is likely to be delayed until Q4. The Trust dashboard is being used for baseline analysis in support of the EMHIP projects, specifically the restrictive practice intervention. • Implementation project planning for EMHIP key intervention 3 (reducing restrictive practice) and 5 (cultural		• Inclusion Matters Group being reviewed in six months (Q3). • EQIA template and guidance is on track for roll-out by end of Q2 with a paper going to QGG in September. • Implementation of EMHIP Key Intervention 3 (reducing restrictive practice) has continued into Q2. • PCREF action plan is in development for end of Q2.	Delivery now likely to be Q4.		

• Patient diversity data including impact of services on access, experience and outcomes published (Q2) • EMHIP evaluation commissioned and completed (Q3-Q4)	capability) has completed but full delivery is delayed with delivery now planned for end of the financial year. Key intervention 3 implementation has started while scoping has been completed for key intervention 5, with procurement underway for a provider. • PCREF work programme has been developed including a project plan, Task and Finish group, self-assessment tool and learning from national pilots and early adopters. The action plan for Part 1 of the PCREF is in development.					

Objective 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 **TBC once launched**
- Attendance rate of leadership offer sessions **TBC once launched**
- Reduction in overall staff turnover and turnover of those with less than 12 months service with the Trust (tolerance of 15%) – **(22/23 outturn – 17.6% and 24.3% respectively) Q1 – 16.9% and 24.3% respectively**
- Reduction in sickness absence rate **(22/23 outturn 4.9%) Q1 – 4.3%**
- Reduction in vacancy rate (target of 15%) **– (22/23 outturn – 17.8%) Q1 – 16.9%**
- Improvement in staff advocacy score in quarterly pulse staff survey and annual staff survey (targets 6.4 and 6.9 respectively) – **(22/23 outturn – 5.2 and 6.7 respectively) Q1 – TBC following Q1 report results**
- 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]) **TBC once survey results returned**
- Qualitative feedback on leadership approach and offer gathered via feedback forms and reported quarterly via narrative update **TBC once launched**

Delivery priorities	Q1 2023/24 delivery summary	Q1 delivery rating	Plans for any outstanding Q1 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
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.)	**Implement the Leadership Framework and associated Leadership Development offer** • The Leadership approach is now set to launch in Q3 as more work is required to establish the correct offer, combined with the technical skills piece. Clinical and Team Leaders are being launched in September with dates agreed to end of December. The senior leaders programme is due to		• Leadership external support being commissioned • Detailed programme outlines being refined • The training needs analysis will be completed in Q3 to incorporate PADR discussions. Heads of Profession meeting has been	There is a significant programme of work to deliver and any delays risk future quarters and year end achievement. A better understanding of elements at risk will be available by end of September 2023.		

[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).

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) • 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)	launch in October once a delivery partner is finalised. • Training needs analysis has not been completed and will shift to Q3 to capture discussions at PADR • Lunch & Learn sessions on track for delivery by the end of Q2. A first session was held with Capsticks at the end of August with a further date booked in September. HR Surgeries on track to commence by end of September. **Produce and deliver clear workforce plan for each service line aligning to overarching corporate priorities** • Workforce plans are in place. Action plans are in place and being monitored through Service Line Reviews. • Workforce plans for Corporate services are also being finalised. **Produce focused programme of work to attract and retain our people** • Data analysis has not been completed. A Paper on retention will be shared at People Matters and ELT in July with onward scrutiny to the People Committee. **Development work to support future People Plan** • It was agreed that this would be postponed until Q3 enabling the HR function to stabilise.		set up and the training needs analysis process is being defined through them. • Retention data analysis has been completed in Q2 with a paper due in September. • Plan on a Page will shift to Q3			

Objective 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 outturn – 7.1%); Q1 – 5.6%**
- Increase in activity per WTE (productivity metric) to wards 15 units per month – **(22/23 outturn – 12.45); Q1 – TBC; methodology still being agreed**

Delivery priorities	Q1 2023/24 delivery summary	Q1 delivery rating	Plans for any outstanding Q1 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
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) **Introduce workflows to improve corporate productivity (e.g. HR)** • As-is scoped and opportunities for change identified (Q1)	**Implement the agency reduction plan** • Agency reduction plan is in place and being monitored weekly by ELT and the OFMG **Implement Clinical Efficiency programme** • The programme has identified four focus areas for which it has developed improvement plans: ○ Activity variation: aligning job plans to expected contacts per week; developing a short guide on supervision for managers ○ Reducing unused appointment slots: focusing on outliers and improving use of cancelled slots ○ Digital advancement: aligned to staff skills improvement workstream in Digital programme ○ Reducing staff travel time: optimising clinic and e-consultations and increasing site occupancy.		N/A – all required elements in place.	No areas of risk have been specifically identified but the targets are significant and challenging hence the amber rating.		

• Workflows amenable to change analysed and plans developed to implement (Q2) • Plans implemented (Q3-Q4)	• Implementation is due to be monitored through Delivering Value meeting from Q2. **Align transformation to deliver productivity to reduce the bed base** • Trajectory signed off through EMMG and EMC in June 2023. **Introduce workflows to improve corporate productivity (e.g. HR)** • Meetings are in place to review aspects amenable to introducing workflows, including the clinical onboarding process and access to clinical systems. • A schedule of existing digital processes is being developed to review other areas that have multiple touchpoints that might benefit from review, as many processes are now many years' old.					

Objective 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 and, then to 12 – **(22/23 outturn – 14 beds) Q1 – TBC; trajectory being finalised**
- Zero inappropriate out of area placements **(22/23 outturn – 17,962) Q1 – 7,707**
- Reduction in average Length of Stay (target 38 days) – **(22/23 outturn – 44 days); Q1 – 52.2**
- Reduction in % of patients on caseload presenting to crisis services (target 1.1%) – **(22/23 outturn – 1.4%) Q1 – 1.5%**
- Reduced DToCs **(22/23 outturn – 8.1%); Q1 – 11.1%**
- Waiting times in key areas reduced (community, CAMHS) **TBC; trajectory being confirmed**
- Number of patients waiting over 30 weeks for complex emotional needs or psychology and psychotherapy support reduced (targets of 20 and 400 respectively) **(22/23 outturn – 271) Q1 – 292**
- Reported positive staff engagement in transformation work **TBC; not yet measured**

Delivery priorities	Q1 2023/24 delivery summary	Q1 delivery rating	Plans for any outstanding Q1 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
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) • Discharge challenge workstreams mobilised (Q2) and impact being delivered (Q4)	**Integrated programme overall** • Principles and scope of future integrated programme agreed by EMMG and EMC. • Governance and structure changes have been agreed and will flow through in the November reporting cycle. **Clinical transformation** • Implementation plan for CEN inpatient protocols finalised. Full implementation is now delayed to Q3. Training has been delivered and embedding daily ward round tasks is in place but the larger cultural change in skills is ongoing and focus is on specific aspects. Continual progress will be made and support from Assistant		• Implementation of the CEN protocol continues into Q3 with training in place and wider culture change support being scoped. • Ward workflows for forensic services will continue to be implemented during Q3. • OD framework will continue to be implemented.	• Change support menu of options aligned to OD framework and likely to be delayed in line with framework delivery delay. • Barnes construction is likely to be delayed owing to the need to commission enabling works ahead of main construction. • The construction partner for Richmond Royal has gone into liquidation. The Master Developer has re-		

• 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 (Q2) • Digital skills programme rolled-out (Q2-Q3) • Clinical workflows programme on RiO (Q3-4) • SLP patient health record programme scoped (Q4) **Organisational development and change support** • OD framework in place (Q1) • 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)	Psychologists to embed change is being scoped for investment. • Community enhanced response service pilot commenced in July 2023 in Sutton, Kingston and Richmond. **Digital** • Clinical systems and RiO work programme completed for Q1, facilitating ongoing improvements over the life of the project. • Ward workflows is mostly complete with handover to BAU as of the first week of September, with the exception of Shaftesbury forensic wards as they will move in to the new buildings and test from October. **Organisational development and change support** • Discovery phase is complete and implementation of the framework has begun with direct support for AUC and Community in place in Q1. **EMP** • All QMH patients and colleagues safely moved using the move-in-a-box protocol.			procured members of the same team and instructed a new contractor but this is likely to lead to further delays with completion now expected in February 2024, facilitating a move in March 2024.		

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• 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						

Objective 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
- SWL MH strategic financial and delivery review completed
- Complex Care phase 2 year 1 delivered
- Perinatal provider collaborative in place
- CAMHS and Adult Eating Disorder cases for change agreed
- SLP business support revised and processes amended

Delivery priorities	Q1 2023/24 delivery summary	Q1 delivery rating	Plans for any outstanding Q1 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
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** • SWL MHPC Partnership Delivery Agreement finalised with the SWL ICB – will go to SWL ICB Board in September 2023 at ICB request. **SLP** • Complex care phase 2 governance in place with dashboard and monitoring; workshops held to support co-design. Funding and responsibility transfer outstanding but discussion progressing between the trusts and SWL ICB. Formal reporting not yet in place but under development.		Trust DoFP is in liaison with SWL ICB finance leads to finalise complex care phase 2 financial transfer and approach.	There are likely to be capacity pressures in strategy delivery through the year and the Trust is working with partners to mitigate these.		

QUESTION FOR BOARD 14TH SEPTEMBER 2023

From the mother of an ex-seafarer, a mental health campaigner and a LE member of SWLSTG Involvement.

QUESTION

In the addendum to the final minutes of the Trust Board Meeting of 9th March 2023, ref item 23/36/0, the Trust stated:

…it was confirmed that the Trust will be adding specific information to its website to guide merchant navy personnel and their families to relevant specialist services…

It is great to see that the Trust has signed the Armed Forces Corporate Covenant and has a dedicated web page. However, the link on that page to the Veterans' Gateway shows that only tri-service veterans and their families are supported, as does the Armed Forces Corporate Covenant, and a search for 'merchant' on those websites returns no results.

However, the link to veteranaware.nhs.uk, does lead to the following information:

> ***6. Are F&C and Merchant Navy veterans included in the Armed Forces Covenant?***
>
> *Yes, Foreign and Commonwealth veterans who ordinarily reside in the UK, and their families, as well as Merchant Navy veterans who served on Named Operations, are covered by the Covenant.*

On the SWLSTG website there is no mention of specific guidance to specialist services for merchant navy personnel and their families, as agreed in the abovementioned minutes (23/36/0).

Would the Board consider adding the words *Merchant Navy* to the point *training relevant staff on veteran-specific culture or needs* in your excellent 'Support for veterans' poster, and to the Veteran Aware headers on your website?

RESPONSE

Yes we can and will add a specific reference around merchant navy personnel.

We are adding the following wording about Veterans to our website and poster

*** Veterans are defined as anyone who has served for at least one day in His Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.**