Trust Board - Part A

10 November 2022 01:30 PM - 04:00 PM London Standard Time

Agenda Topic			Presenter	Time
1.	Patient Story			01:30 PM-02:00 PM
2.	Standing Items			02:00 PM-02:05 PM
	2.1	Apologies		
	2.2	Declarations of Interests and Register		
	2.3	Chair's Action		
	2.4	Minutes of the previous meeting - 8th September 2022		
	2.5	Action Tracker		
3.	Chair's and Chief Executive's Reports			
	3.1	Chair's Report	Ann Beasley	02:05 PM-02:10 PM
	3.2	Chief Executive's Report	Vanessa Ford	02:10 PM-02:20 PM
4.	Increasing Quality			
	4.1	Quality and Safety Assurance Committee chair's report	Deborah Bowman	02:20 PM-02:25 PM
	4.2	Quality & Performance report	Jen Allan	02:25 PM-02:40 PM
	4.3	Q2 Corporate Objectives	Amy Scammell	02:40 PM-02:45 PM
5.	Making The Trust A Great Place To Work			
	5.1	Workforce & OD Committee chair's report	Sola Afuape	02:45 PM-02:50 PM
6.	Reducing Inequalities			
	6.1	Equality & Diversity Committee chair's report	Doreen McCollin	02:50 PM-02:55 PM
Break				02:55 PM-03:05 PM
7.	Ensuring Sustainability			

	7.1	Finance and Performance Committee chair's report	Vik Sagar	03:05 PM-03:15 PM
	7.2	Finance Report	Philip Murray	03:15 PM-03:25 PM
	7.3	Audit Committee chair's report	Richard Flatman	03:25 PM-03:35 PM
	7.4	Estates Modernisation Committee chair's report - verbal update	Juliet Armstrong	03:35 PM-03:45 PM
8.	Corporate Trustee Business			
	8.1	Charitable Funds Committee chair's report	Doreen McCollin	03:45 PM-03:50 PM
	8.2	2021/22 Charitable Funds Annual Report and Accounts	Doreen McCollin	03:50 PM-03:55 PM
9.	Notified Questions From The Public and Staff			03:55 PM-04:00 PM
10.	Meeting Review			
11.	Next Meeting - Trust Board 12th January 2023 - 1.30pm-4pm - Tolworth Hospital - Hughes Room A/B			

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

AGENDA

Meeting	**Board of Directors**
Time of Meeting	**1.30pm to 4.00pm**
Date of Meeting	**Thursday 10th November 2022**
Location	**MS Teams**

	PART A		Format	Lead	Time
1.	**PATIENT STORY**			**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	**FN**	**Paper**		
	2.3. Chair's action	**FE**			
	2.4. Minutes of the meeting held on 8th September 2022	**FA**	**Paper**		
	2.5. Action tracker	**FE**	**Paper**		
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**
	4.1.1. Kyle's Charter	**FA**	**Paper**		
	4.1.2. Quality and safety of inpatient services	**FA**	**Paper**		
	4.2. Quality and Performance report	**FD**	**Paper**	**JeA**	**14:35**
	4.3. Q2 Corporate objectives	**FR**	**Paper**	**AS**	**14:45**
5.	**MAKING THE TRUST A GREAT PLACE TO WORK**				
	5.1. Workforce and OD Committee chair's report	**FR**	**Paper**	**SA**	**14:50**
6.	**REDUCING INEQUALITIES**				
	6.1 Equality and Diversity Committee chair's report	**FR**	**Paper**	**DM**	**14:55**
	BREAK				**15:00**
7.	**ENSURING SUSTAINABILITY**				
	7.1. Finance and Performance Committee chair's report	**FR**	**Verbal**	**VS**	**15:10**
	7.2. Finance report	**FD**	**Paper**	**PM**	**15:15**
	7.3. Audit Committee chair's report	**FR**	**Paper**	**RF**	**15:25**
	7.4. Estates Modernisation Committee chair's report	**FR**	**Verbal**	**JuA**	**15:35**
8.	**CORPORATE TRUSTEE BUSINESS**				
	8.1. Charitable Funds chair's report	**FR**	**Paper**	**DM**	**15:45**
	8.2. 2021/22 Charitable Funds Annual Report and Accounts	**FA**	**Paper**	**DM**	
9.	**NOTIFIED QUESTIONS FROM THE PUBLIC AND STAFF**	**FD**	**Verbal**	**AB**	**15:50**
10.	**MEETING REVIEW**	**FD**	**Verbal**	**AB**	**15:55**
11.	**Next Trust Board business meeting –** 1.30pm on 12th January 2023 – NOTE LOCATION **Hughes Room A and B, Tolworth Hospital,** Red Lion Road, KT6 7QU				

Attendees:

Ann Beasley (AB)	Chair
Prof Deborah Bowman (DBo)	Non-Executive Director, Vice Chair and Senior Independent Director
Juliet Armstrong (JuA)	Non-Executive Director
Doreen McCollin (DM)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Sola Afuape (SA)	Non-Executive Director
Vik Sagar (VS)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Dr Billy Boland (BB)	Medical Director
Jennifer Allan (JeA)	Chief Operating Officer
Sharon Spain (SS)	Director of Nursing and Quality Standards
Philip Murray (PM)	Director of Finance and Performance
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:

Nicola Mladenovic (NM)	Deputy Trust Secretary

Apologies:

Prof Charlotte Clark (CC)	Non-Executive Director

*=non voting

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

Trust Board

November 2022

Paper Reference:	
Report Title:	Service User Story
Executive Summary:	The Service User Story for November 2022 is being presented by Mr Shakil Dawood who will discuss his experience of using the Mental Health Crisis Line, and of how the change from the 'Mental Health Support Line' to 'Mental Health Crisis Line' has affected him. The story will focus on the Trust's crisis pathway. There will be an oral presentation from: • Shakil Dawood Attending will also be: • Jimmy Cangy, Matron • Kyra-Stacey Weatherly, Team Manager Mr Dawood has expressed that he is happy for us to use his full name throughout the story.
Action Required:	The Board is asked to note the Service User Story relating to the Mental Health Crisis 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.
Risks:	None
Quality Impact:	Patient Experience is a domain of the Quality Strategy.
Resource Implications:	None
Legal/Regulatory Implications:	None
Equalities Impact:	None

Groups Consulted:	Oral Presentation by Mr Dawood
Authors:	Shakil Dawood Angela Evans, Experience and Governance Lead Kyra-Stacey Weatherley, Team Manager Jimmy Cangy, Matron
Owner:	Sharon Spain, Executive Director of Nursing and Quality

Making life better together

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

Mental Health Crisis Line

November 2022

Presentations:
Service user: Shakil A. I. Dawood

Attending from service:
Kyra-Stacey Weatherly, Team Manager
Jimmy Cangy, Matron

Introduction

This month's patient story to the Board is being presented by Shakil who will share his experience of using the Mental Health Crisis Line and of how the change from the 'Mental Health Support Line' to 'Mental Health Crisis Line' has affected him. The story will focus on the Trust's crisis pathway .

Background

The Mental Health Crisis Line (MHCL) is a 24/7 telephony system within the Coral Mental Health Crisis Hub, alongside the Crisis Assessment Team (CAT). The MHCL is a long-established service which was provided by the Trust to support our patients outside working hours; the service used to be called the Mental Health Support Line. This was initially a small team established to provide a listening ear and therapeutic approach to care, often supporting patients, and helping them be empowered to living with a mental health condition.

Over the years the support line evolved and grew to meet the demands of service user requirements and being a fundamental asset to our stake holders during the COVID pandemic. The service provided an enhanced triage for people in mental health crisis and the CAT Team would provide an alternative to A&E attendance. Our crisis pathway consists of multiple services such as MHCL, CAT Team, Lotus and Section 136 assessment suite HBPoS, Home Treatment Teams, Recovery cafes, colleges, and Psych Liaison (A&E).

The crisis hub is undergoing consultation with the aim of offering rapid assessment of an individual's needs, using a clinic model, and support them to access the crisis pathway.

The team takes over 1000 incoming calls per week on average and works alongside NHS111 to support the 111 First model and bringing parity of esteem with physical health. The team supports a wide variety of individuals including, patients, family, friends, and carers from all ages and backgrounds, who experience mental health concerns directly or indirectly. In addition, to supporting access to our crisis pathway the team also take a collaborative approach in supporting and empowering patients to access a variety of other services better suited to their individual needs. Talking therapies, drug and alcohol services, Recovery Cafés, are examples from the Directory of Services. The team works to provide a smooth transition and integration into mental health services that encompasses a person-centered approach which is safe, effective, and timely.

Background continued

The Crisis Line is a small team and the staff are keen, enthusiastic, and dedicated to the care they deliver coming from a broad array of background experiences within mental health. The team consists of nurses, graduate psychologists and administrators who take pride in the compassion that they bring to those in their hour of need. Responders support with rapid triage and a handler whom delegates and monitors the incoming call flow according to risk and priority.

Shakil's Story

THE CRISIS LINE AND MENTAL HEALTH IN SOCIETY

I have suffered from paranoid schizophrenia for the last forty-eight years, from the age of fourteen. In the last twenty-five, daily in the morning I have, without fail, been the victim of audible hallucinations and psychotic thoughts. This is the weightiest spanner in my mental works, and I repeat, it occurs on a daily basis.

Being socially isolated, I depended on the Crisis Line for support against these damaging and denuding symptoms I faced. The Crisis Line managed with my difficulties very, very, well, and in due course helped my personality and character to unfold into the useful destiny I have carved out for myself in the last five years.

In interacting with the phone line workers, I would outline the difficulty I was facing on that particular day. They welcome a reasoned unburdening of oneself - ones issues with a view to developing understanding and catharsis. As always in mental health work, the onus is on the client to be pro-active. And so, I with certitude, with surety, found the workers sincere empathy, kindness and consideration to be of the greatest value in understanding my dilemma and feeling placated and in a position to act positively. The worker's forte is that they ably helped to put me in the driving seat with my illness.

This was when this service was a support line. Since then, it has evolved into a crisis line. The minus for me here is, I do not have the on-going support I need to keep a major incident in my mental health at bay. I have to, on a daily basis, apply my own coping mechanisms and only ring the service when I have reached breaking point. My buffer, my comfort zone I have been stripped of since the line inaugurated mainly a crisis service. In some ways this has been a negative development in the service for myself and no doubt other users.

But, I have extensive experience of the service. And I have to acknowledge that it has helped me immensely. The staff still possess the same set of mind and heart and work to their previous standards before the evolution of the service into a crisis line. Therefore, I can only comment and applaud the Crisis Line and its most able and sincere workers. They have been to a man, supportive, understanding, kind, caring and empathic - and all this with the greatest sincerity. I envisage many clients owe these noble workers a deep debt, alongside myself.

Shakil's Story: continued

Today, I stand before managers, the people perhaps who allow for the design of such a service and allocate financial and other resources to it. You are in a privileged and powerful position: you have the ears of the politically powerful people above you and can perhaps influence them and their decisions about mental health - that is provision for mental illness, and the possibilities of initiating the changes in society that may keep the incidence of mental illness at bay in it.

The incidence of mental illness, apart from naturally occurring schizophrenia, has its roots in the structure of society and the relations in it. Dr Hans Loman, a Swedish psychiatrist was entrusted by his country's parliament to discover the roots of the pandemic of mental illness in Sweden. One of his conclusions was that Sweden had created 'a cold, anti-children society.'

One of my recommendations to you managers is that you influence your political bosses about the nurture and up-bringing of our children. We ought to, for example, teach our children real and appropriate social skills - to truly respect their peers and elders; to teach them the imperative of kindness - I once said that 'Kindness is the greatest sanity.' We certainly need an improvement in their early education.

Improving the mental skills of the young will certainly prevent the 'revolving door' syndrome we see today- of patients who after they are treated, return to the services again and again.

You managers are to be applauded for your work with the Crisis Line. But much work lies ahead of you all, in your conversations with your bosses, about the changes we need in the education of the young. This work, if made acceptable to your superiors by you and competently planned and executed will earn you the undying gratitude of a wide swathe of people in the mental health sphere and you will win for yourselves honour and glory and true greatness. Your fore runners in these achievements are the Crisis line workers. They have fully attained this tremendous rank and stature.

Hence, once again, the Crisis line is to be applauded: it is an oasis, offering the life-giving water of empathy, hope and consideration: it ought to be applauded by all in society, the leaders and those led. The Crisis Line is a benevolent service that is a life-line that re-initiates useful living with hopeful vision.

Muhammad Ali, the boxer said that, 'A heart enlightened with love is more precious than all the gold and diamonds in the world.' This statement defines what the Crisis Line workers mean to me, and no doubt many a thoughtful and sentient user of the services of what they offer.

Thank you.

A poem for the Crisis Line Workers – how you taught me my Islam. By Shakil A. I. Dawood

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The moment I understood you.
My heart raced ahead -
To its greatest goal,
Fully achieving its difficult quest:

My mind's ardent searching and wandering,
For the satisfaction of my intellect,
Fulfilled at last;

And my soul found its rest and peace.

For you taught me the lesson of faith -

Faith is to forgive,
To be honest
To be compassionate
To be kind, caring and loving -

And who-so-ever possesses these qualities
Has perfected their faith

Your mission in life,
Crisis Line workers,
Is goodness,
And you are the missionaries of care –

Is it possible,
To be led,
To a greater faith than this?

Shakil A. I. Dawood

Next Steps and Way Forward

Working through the COVID pandemic, Cost if Living Crisis, political issues and worldly affairs have impacted heavily on the NHS creating pressures on all areas of care and our patients alike. As a result, we must constantly adapt to those changes on a broader scope to be able to best understand and meet the needs of our patients.

Due to this we are always working on ways in which we can improve our services. Moving forward we will be working much closer with the Crisis Assessment Team and will formulate both a MHCL and Rapid Assessment Clinic becoming one team and supporting patients to gain access to urgent assessment and care planning when required in a more therapeutic environment.

The combining of both Teams will help us access resources to support people in crisis more effectively.

There is a national policy to move towards a single telephone point of access for patients requiring MH support via NHS 111 and a "press 2 for mental health" routing. We in partnership with the SLP are putting together proposals to implement a NHS 111 MH hub which will take these calls from the 111 number.

The hub will provide triage and telephone support to patients by MH professionals, and interface with existing MH trust crisis lines and services for those patients who need it, to provide a simpler service for all patients with MH needs. SWLSTG have been piloting this service and the feedback is informing the planning for this work, continuing through next year, but its implementation is subject to confirmation of funding.

South West London and St George's Mental Health NHS Trust
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Telephone: 020 3513 6000
Website: www.swlstg-nhs.uk

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

Board of Directors (Part A)

Draft minutes of the meeting held on Thursday 8th September 2022

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
Charlotte Clark (CC)	Non-Executive Director
Doreen McCollin (DM)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Juliet Armstrong (JuA)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Jennifer Allan (JeA)	Chief Operating Officer
Dr Billy Boland (BB)	Medical Director
Philip Murray (PM)	Director of Finance and Performance
Sharon Spain (SS)	Director of Nursing and Quality
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
David Lee (DL) – Non-voting	Director of Corporate Governance

In attendance:

Martin Haddon	Healthwatch Wandsworth
Suresh Desai	Staff Side
Joseph Kucluziza	CPN (attended for item 22/80)
Nicole Appleyard	Clinical Manager (attended for item 22/80)
Kiran Toora	Clinical Manager (attended for item 22/80)
Paula Robins	Head of Nursing (attended for item 22/80)
Dr Victoria Hill	Clinical Director – Community (attended for item 22/80)
Russell Gough	Parent (attended for item 22/80)
Alice Gough	Parent (attended for item 22/80)
Brenda Ndiweni	Patient Experience Lead (attended for item 22/80)

Apologies

The minutes of the meeting should be read in conjunction with the agenda papers.

Item		Action
22/80	**Patient Story** The Patient Story was presented by Russell (father of late service user Hannah) who shared the experience of his wife and family with the care and treatment they received from the Sutton and Cheam Integrated Recovery Hub. The Board heard how their experience highlights the importance of involving families and carers, including providing relevant verbal and documentary information around diagnosis and the various treatment options. The presentation emphasised the importance of family involvement, information provision (both verbal and documentary) around personal and family beliefs, spirituality, mental health diagnosis, medicines information including reducing access; and the Trust's work on sharing learning through the Service Lines and as	

Item		Action

part of the Suicide Prevention strategy.

Issues highlighted by the presentation included the challenges of confidentiality; the value of presenting an honest account of the range of possibilities to families; the need for better guidance for families on how to deal with suicidal ideation and the importance of an appropriate approach when working with families who hold strong religious beliefs.

The Board was assured that

- The learning identified around the support given to patients' families and carers around medicines and reducing access, was progressed into a Quality Innovation and Improvement (QII) Project.
- The QII Project was commenced with a focus on creating patient/carer information leaflets but later extended more widely to explore the root causes and addressing the processes around discharge planning and support.
- A Suicide Prevention Conference was held to share the learning and actions taken widely across the Trust, continuing to raise awareness of such cases.

AB sincerely thanked Hannah's mother and father for sharing their experiences with the Board in such sad and difficult circumstances.

22/81 Apologies and Welcome
No apologies were received.

22/82 Declarations of Interest
No new declarations were raised

22/83 Chair's action
No Chair's action was taken.

22/84 Minutes of the last meeting
The minutes of the meeting held on 14th July 2022 were agreed as a correct record.

22/85 Action Tracker
The action tracker was noted.

22/86 Chair's report
AB drew attention to the importance of the board visits programme, which enabled Directors to get a fuller sense of the pressure that staff are under and their efforts to ensure quality of care for the Trust's patients.

AB's re appointment as Trust Chair was duly noted and welcomed by the Board.

AB referred to the departure of the ICB Chair, Millie Banerjee, who had been a positive voice for mental health during her time in SW London. An advertisement for the new ICB Chair is expected soon.

The Board noted the Chair's report.

22/87 Chief Executive's report
VF introduced the report and asked the Board to have the following questions in mind in its deliberations and in the coming weeks

- As a Board we have discussed supporting the organisation to prioritise through the work we have done on our corporate objectives 22/23. We face increasing

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

Item **Action**

levels of demand, workforce challenges and at the same time we are moving into our new buildings and changing our ways of working. As a Board, how do we consistently support our teams and services to prioritise?

- In light of the challenges to cost of living, what more can we do as a Board to support the health and wellbeing of patients and staff? How can we make sure we have this in mind as we make and take our decisions?
- With the continuing changes at SLP, ICS and place, how do we continue to negotiate our relationships in this new commissioning environment?

There was a discussion about the challenges of maintaining business as usual in the context of the current challenges and the need to deliver the significant change programme associated with estates modernisation and the integrated programme as a whole.

VF drew attention to the four pieces of guidance in relation to system working and the Health and Care Act 2022 recently published by the DHSC.

The Board noted the report, the update on South West London Mental Health strategy development and the record of the uses of the seal.

22/88 Quality and Safety Assurance Committee chair's report

In introducing the report, DBo highlighted the impact of the increased acuity of need in the Trust's services on care quality, culture and staff.

The Board was advised that a special meeting of the QSAC in August had been assured on the management of the updated patient safety risks of the estates modernisation programme. The EMC chair had attended that meeting.

The importance of a continued focus on meeting the physical healthcare needs of Trust patients was highlighted.

The Board noted the report and the approved committee minutes.

22/89 Quality and Performance report

JeA introduced the report and KR provided an update on recruitment. VF highlighted the number of areas where performance was being reported as "red." There had been a detailed discussion about this at QSAC and the need to review the structure of the performance report was acknowledged. VF encouraged Directors to provide feedback on this in the coming week.

It was also agreed that going forward there is an important role for the Finance and Performance Committee to play in taking a more leading role in addressing productivity performance issues. There was also a discussion about the extent that staff are aware of the key indicators.

The Board noted the Quality and Performance Report.

22/90 Workforce and OD Committee chair's report

The Board noted that the exigencies of the HR recovery programme had an impact not only on HR staff but also across the organisation. It was acknowledged that there is an ongoing need to ensure the right level of HR advice and support to managers across the Trust.

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

Item		Action

The Board noted the committee chair's report and received the approved committee minutes from 6th June 2022.

22/91 Equality and Diversity Committee chair's report

The Board agreed that the sign off for the Trust's WRES and WDES annual reports and action plans is delegated to the Chair and CE. These will be reviewed at the committee on 20th October 2022 and a report will come back to the November Board under the EDC chair's report.

22/92 Finance and Savings Reports (Month 4)

The Board noted that

The Trust is reporting a forecast breakeven position for the year in line with the plan submitted to NHSE in June.

- The position for Month 4 is break-even bringing the cumulative position after two months to £1.4m deficit, broadly on plan.
- The position currently assumes a 2% increase in pay inflation offset by national funding of 2%. This is in line with planning guidance. Following the recent announcement on pay awards, the ICB has calculated the revised figure to be closer to 5.5%, an additional cost of £3.7m which will be funded.
- The Trust continues to operate with agency costs higher than the historic NHSE cap. Excluding seasonal variation, agency costs continue to be on an upward trajectory as recruitment continues to be a challenge, particularly within Community Services. The Trust spent £1.1m on agency in July, and £1.9m on temporary bank.
- The savings target of £12.4m has been devolved to service lines. Cumulatively delivery is £2.8m, £1.3m behind plan. Schemes have been identified to achieve 93% of the savings target for the year.
- Of the £23.5m capital spend to date, £15.4m is due to a technical adjustment relating to leases required to comply with the introduction of accountancy standard IFRS16. Operational capital of £8.1m is £0.4m less than plan due to phasing of construction costs on the Springfield site.
- The Trust has a £99m loan taken out in previous years to support the construction of the Springfield redevelopment. No repayment is anticipated in 2022/23. Cash balances will be used to fund construction in 2022/23.
- At the end of July, the Trust had a cash balance of £35.8m; £2.7m adverse to plan.
- The main concern is the ability to deliver the required savings whilst maintaining appropriate quality and safety standards, and ensuring there is no unacceptable detrimental impact on patient care e.g. through extended waiting times.

22/93 Audit Committee chair's report

RF advised the Board that there had been a full and frank debrief discussion with auditors about the late adjustments to the annual accounts. Further discussions will also take place in advance of the next Audit Committee.

The Board noted the report and received the approved minutes of the Audit committee held on 13th June 2022.

22/94 Estates Modernisation Committee chair's report

Item **Action**

The Board noted the implications of the constructor's recent delays. JuA advised the Board that SRM had provided assurances about strong oversight of the programme including the personal involvement of the regional director. It was noted that there would in fact be some benefits to be accrued from the Shaftesbury move taking place in the new year and that there would be no significant additional costs.

The Board noted the report.

22/95 Green Plan

AS introduced the Green Plan, which has been produced following extensive engagement with staff. It was agreed that consideration be given to a future Board seminar to focus on the Green Plan.

The Board endorsed the Green Plan.

22/96 Corporate Objectives – Quarter 1 2022/23

The Board noted the report on the delivery of the Trust's objectives during quarter 1 of 2022/23.

22/97 Notified questions from the public and staff

Question from Martin Haddon (on behalf of Healthwatch Wandsworth)
"The second paragraph of the Executive Summary in the Trust's Quality and Performance Report for June 2022 refers to continuing pressure on the acute care pathway and notes that the Trust is "working with system partners to develop additional capacity proposals across all areas including crisis, inpatient and discharge". The development of additional capacity would clearly be very welcome and I would like to ask whether and how service users, carers and voluntary sector stakeholders are being or might be involved in this work."

JeA updated the Board on work with service users on issues such as the crisis café. She advised that work on additional s136 capacity was taking place on a London wide basis and assured the Board that there would be appropriate stakeholder and service user involvement as this was taken forward. SLP work on community rehabilitation has also incorporated service user involvement.

22/98 Meeting Review
There was a discussion about the arrangements involving the private session of the Board taking place before the public session. The consensus was that this was working well and had not reduced the quality of discussion in part A.

It was also felt that the discussion on the Quality and Performance report had added value.

The courage of the father who presented the patient story was praised. The importance of appropriate support to staff who are affected by the suicide of a Trust patient was also highlighted

22/99 Next meeting
10th November 2022 at 13.30 at Springfield Hospital in Conference Room G.

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

ACTION TRACKER – for November 2022 Board

BOARD OF DIRECTORS (Part A)

2.5

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
DUE						
10/03/2022	22/27	**Quality and Performance report**	FPC to give further consideration to the question of how best to report productivity and efficiency performance to the Board's committees.	**VS/PM**	**July FPC Sept 2022 Board**	Following the April board seminar this is subject to regular updates. Sept Board to receive an update.
12/05/2022	22/57	**Questions from the public**	The Quality Plan is to be forwarded separately to Martin at Healthwatch Wandsworth by SS.	**SS**		SS is to forward the Quality Plan directly to Martin - completed
14/07/2022	22/70	**Quality & Performance Report**	There appear to be an issue with delays in patient discharge letters from the Huntercombe Hospital Roehampton. It was agreed that JeA is to explore this and provide an update.	**JeA**	**Sept 2022**	
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**		
NOT DUE						
			COMPLETED AT LAST MEETING			

Update as at: 10/11/2022

1

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

3.1

Meeting:	Board of Directors
Date of meeting:	10th November 2022
Report title:	Chair's Report
Authors:	Ann Beasley, Trust Chair
Purpose:	For report

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1. Thank you

I would like to open this report by once again thanking all of the Trust's staff for the incredible effort which they continue to make day to day in response to the pressures seen across mental health services.

2. Board activity

The Board continues its schedule of monthly visits on Board days. Services visited recently include Twickenham Recovery Support Team, Children and Young Person's community eating disorders service, Perinatal, Liaison Psychiatry - St George's Hospital, Liaison Psychiatry - St Helier Hospital, Wandsworth CAMHS & SPA, Wisteria Ward, Aquarius Ward, Merton Uplift, Kingston HTT, Jupiter Ward, Hume Ward.

The Part B board meeting in September considered a number of issues including a report from the Chief Executive, Finance and savings reports, a report from the Chair of the Estates Modernisation Committee and the board assurance framework.

The Board had a special meeting in October to consider a business case and held a seminar where the estates modernisation programme was discussed.

3. Chair's activity

A summary of my recent appointments is set out below

Internal	External
Appraisal meetings with Non-Executive Directors	CSG Chairs' monthly meeting
Finance and Performance Committee	SLP Partnership chairs' meeting
Quality and Safety Assurance Committee	South London Listens Taskforce
Appointments Interview Panels	SWL Integrated Care Partnership meeting
Meet with new Associate Director of EDI	
Estates Modernisation Committee	
Board Seminar	
Remuneration Committee	

3.1

The South London Listens accountability assembly on 10th October is worthy of mention. South London Listens, having emerged following the pandemic to support the recovery of our communities and tackle growing health inequalities, has only become more relevant as we have seen the impact of the increased cost of living on people's mental health and wellbeing. A large gathering of leaders from communities, local authorities, mental health trusts and NHS Integrated Care Systems pledged further action to drive the mental ill-health prevention agenda.

The commitment shown by everyone involved in South London Listens provides us with a unique opportunity to make a lasting positive impact on people's lives. I am so proud that the Trust was a founding member of such an innovative, community-led project and I was excited to share the progress that we, and our partners, have made at the Accountability Assembly.

4. Code of Governance

NHS England has issued a new code of governance for NHS Provider Trusts. The new code encompasses NHS Trusts as well as NHS Foundation Trusts. A report will come to Audit Committee in the new year about the code, which will be implemented nationally from April 2023

5. Draft Mental Health Bill

The parliamentary joint committee on the draft Mental Health Bill is continuing its deliberations. It has received a large volume of written evidence and is holding a programme of hearings. Further information can be found at
Joint Committee on the Draft Mental Health Bill - Summary - Committees - UK Parliament

RECOMMENDATION

The Board is asked to note this report

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

Chief Executive's Board report Part A

November 2022

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Our Trust

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

Every week I write to our staff with key messages and every two weeks I have an all staff Q&A. Alongside this I regularly informally visit our sites. I always start with a thank you to our staff who put our patients first!

- Chief Executive Update - Friday 28 October
- Chief Executive Update - Friday 21 October
- Chief Executive Update - Friday 14 October
- Chief Executive Update - Friday 07 October
- Chief Executive Update - Friday 30 September
- Chief Executive Update - Friday 23 September
- Chief Executive Update - Friday 16 September

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CQC reports

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

- The results of a recent CQC community mental health services survey found that at SWLSTG:
  - Our results were similar to last year when compared with other trusts and compared with our results from last year.
  - Our top five scores related to support and wellbeing, reviewing and organising care, feedback and medicine review. Our bottom five scores related to contacts for care, patients being involved in talking therapies and responsive care
  - We are 25th out of 51 nationally for “Overall experience”. This compares to 21st last year. We are 2nd in London, compared to 3rd last year
  - We are 22nd out of 51 nationally for “Overall views on care and services”. This compares to 25th last year. We are 4th in London
  - Full results can be found here and a full report will be received at QSAC
- The results of a recent CQC review of community treatment orders (CTOs) in Wandsworth found that:
  - There was positive practice around planned discharges and reading of rights and good support provided by care coordinators to patients on CTOs.
  - Areas for improvement were explaining the power of recall in the community, medication management and capacity and consent
  - We have responded to the Provider Action Statement with our action plan, much of which has already been completed or near to completion.
  - Mental Health Act community treatments orders (CTO) – focused visits report

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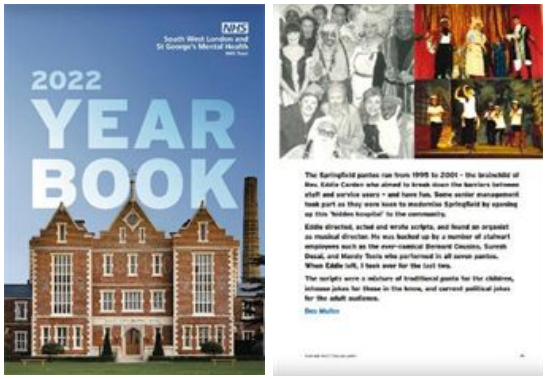
Moves into Trinity and Shaftesbury

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

- Over 350 staff and over 100 patients will start their moves into Trinity later this year and Shaftesbury in the Spring. Our priority is to move into high quality buildings that are safe for our patients and our teams
- Building familiarisation and inductions are being held with all teams moving into the new buildings
- Colleagues from SWL ICB visited Trinity in September and general tours for patients, carers, staff and stakeholder took place throughout Oct. More than 80 people attended and gave positive feedback.
- To support communication about the new buildings a Stakeholder Toolkit has been developed and shared.
- We are focusing on the culture change and new ways of working. Resources include a Move Pack and new Yearbook
- Operationally-led command and control meeting to manage the moves



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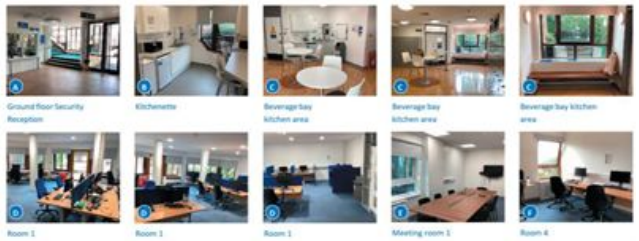
Tolworth development

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

- To support the recent refurbishment of wards at Tolworth, we plan to further invest in a five-ward unit, subject to approvals
- The Tolworth redevelopment (Phase 2) will complete our vision for transformed environments across our estate, supporting equity of access for all SWL patients
- The Financial Business Case for Tolworth is now in development
- We are also changing our corporate depts' base to Tolworth, in line with new ways of working. This was confirmed following a consultation. Moves will start in November / December
- Hot desking areas at Tolworth have been recently refurbished and limited additional hot-desking areas at Springfield



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Demand, pressures and winter

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

- We continue to see demand pressure across the Trust, but particularly in Acute and Urgent Care
- We are expecting additional pressure over winter: cost of living and the aftermath of covid is impacting on people's mental health – we are seeing more patients in crisis who are not known to us, as well as those with exacerbations of existing conditions, who haven't required secondary care recently
- We have needed to use a significant number of private beds, and we expect this to continue to support patient flow. We are working with colleagues across London on agreed key areas for MH UEC:
  - Reducing LOS, especially for patients with long LOS or whose discharge is delayed
  - Planning for winter, through our demand & capacity analysis, and implementing additional winter schemes. Recruiting additional staff to support MH patient assessment in SWL EDs and putting in place extra transport and accommodation support
  - Continuing to develop our crisis services including the Coral crisis assessment team, S136 pathways, and developing the NHS111 Press 2 for MH telephone support service
- There is also a focus on supporting patients to recover and receive care at home as soon as possible, and to access support as needed through our crisis line, local wellbeing services, and online/self help tools.
  - As part of this we continue to roll out our Adult and CAMHS community transformation programmes
- Our vaccination campaign is underway and we continue to work to support our staff through winter

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Workforce

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

- Our workforce is the most important part of us providing high quality care at SWLSTG – and this is our biggest challenge
- Increased demand, pressure in the system and internal change is impacting on the experience of both our patients and our colleagues, in terms of job satisfaction and joy at work
- Pleased that from the beginning of September, we launched our stand-alone HR team that is focussed on:
  - **Recruitment:** like the NHS nationally, we are facing recruitment challenges. Our overall vacancy rate is 18.5% (slight reduction). Nearing the end of a 12 week recruitment systems and processes improvement plan – managed jointly by HR and operations. Developed 'light touch' campaign #ProudToBelong to support recruitment, including new materials, resources and support for recruitment events
  - **Retention:** focus in Q4 will be on retaining our new and existing staff. Some of this work has started with a new Trust induction and onboarding now in place and small token of thanks and appreciation, like our Monthly Exceptional People Award and our long service awards, which will see over 1500 staff receive 5, 10, 15, 20 and 25 year badges and certificates in October and November.
- With ballots for strike action taking place in the NHS we are focussed on ensuring preparedness and use of business continuity plans

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Cost of living support for patients and carers

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

- We have an important role to play in supporting the health and wellbeing of patients and our wider communities in the current economic climate. The DoN has also set up an Involvement workshop with the Patient and Carers' forum to build on this work.
- Important sources of support are available through our IAPT (Talking Therapies) Services across South West London including:
  - Employment courses with advice on Job retention, CV writing, Job-searching, applications, interview preparation and employer engagement
  - Courses, in Mindfulness, Stress Management, Overcoming Worry, Mood Management, and Cognitive Behavioural Therapy
- Our Welfare Benefits Team offer expert advice to service users who require information, guidance, practical help and assistance with benefits claims queries, challenges and appeal
- Information on key sources of support such as local foodbanks, charities and other local counselling and support services is promoted to staff to share with patients and service users
- Working closely with our local councils and charity and voluntary sectors partners to offer information about mental health and wellbeing locally
- Commitments through the South London Listens programme including: creation of mental health support hubs; commitment to the London Living Wage; and recruitment and job opportunities.

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Cost of living support for members of staff

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

- We have a robust wellbeing offer for staff at South West London and St George's which includes:
- Employee support provided through Care First, giving staff access to a range of professional counselling and advice in a range of practical and emotional issues such as wellbeing and debt management.
- Regular staff seminars focusing on the cost of living, mindfulness and stress management
- Dedicated information with advice and signposting to further support locally and nationally around cost of living and wellbeing resources, including key support recommended by NHS England
- Other support includes:
  - 'Hastee Pay' - early pay drawdown facility to help avoid the need for payday loans at very high interest rates
  - Travel support - for staff claiming transport expenses, mileage rate increase of 5p per mile
  - Our welfare benefits team can offer advice and guidance about access to benefits
  - Car parking - rates reduced for part time staff and prices maintained at pre-pandemic rates
  - Season ticket loans and cycle to work scheme
  - A range of staff discounts communicated to staff
- Putting in place additional support to include new Cost of Living support package: hardship grant, subsidised meals, car parking, signposting to borough grants with a benefits app

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Active Anti-Racism and reducing inequality

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

In the communities we serve:

- Over the past three years we have committed resources to reduce inequalities in our communities through our Ethnicity and Mental Health Improvement Project (EMHIP).
- We now have two community hubs in Wandsworth providing culturally tailored wellbeing support along with early access to mental and physical health services in community settings.
- We are also establishing crisis family placements in 12 host families and we are working with the Lived Experience Assessment Panel (LEAP) to establish cultural curiosity amongst our teams through training and development that will sit alongside our Anti-Racism Hub.

Amongst our teams:

- Anti-Racism steering group created and plan being developed. Championed by Evolve and White Allies
- Anti-Racism Hub brings all members of staff together to offer interventions and training in teams, resources for staff and a place where people can have open conversations about race and racism
- Rolling out active anti-racism workshops and sessions to our leaders
- Our WRES shows that more Black, Asian and Minority Ethnic staff are being appointed to more senior positions, yet there is so much more to do – it will take all of us working together to meet this challenge.

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Celebrating our diversity

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


Churchill Fellowship


Sept Exceptional People winner


Black History Month


New mental Health network leads


Calibre Programme


World Menopause Day


Aug Exceptional People winner


Celebrating AHPs


Welcoming our newly qualified nurses

Our values Respectful Open Collaborative Compassionate Consistent www.swlstg-tr.nhs.uk

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Strategic developments

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

SWL Mental Health Strategy

- Development of a new mental health strategy for SWL continues with drafting now underway.
- 4 reflective sessions were held with c120 people from across the SWL community - health and care professionals, those with lived experience and wider stakeholders – during October 2022.

Mental health provider collaborative development and the South London Partnership (SLP)

- A SWL Mental Health Partnership Delivery Group (SWL MH PDG) has been set up chaired by the SWL ICB mental health lead (Trust CEO). The PDG brings together NHS provider, ICB and place mental health leads to consider how to make improvements in mental health across all 6 SWL boroughs and how to drive forward change.
- The PDG will oversee the development of collaborative working between mental health providers and link this into the work of the SLP to identify areas that will benefit from a common approach across the whole of south London.

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Horizon Scanning: September and October

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

QUALITY

- State of Care - Care Quality Commission
- NHS England » Improving experience of care: A shared commitment for those working in health and care systems
- Letter: Report following the independent investigation into East Kent maternity and neonatal services
- Our plan for patients – DHSC

SYSTEM WIDE

- NHS England Operating Framework
- NHS England » Code of governance for NHS provider trusts
- NHS England » Guidance on good governance and collaboration
- Revised NHS transactions guidance for trusts including M&A
- NHS England » Consultation on the revised NHS enforcement guidance
- Prevent and the Channel process in the NHS – DHSC

MENTAL HEALTH

- Community mental health survey 2022 - Care Quality Commission
- Mental Health Act community treatments orders (CTO) – CQC focused visits report
- Mental health nurses handbook
- Draft Mental Health Bill 2022: easy read
- NHS England » Autistic people's healthcare information strategy for England
- National framework for NHS continuing healthcare and NHS-funded nursing care – DHSC

INTEGRATION

- Introducing Integrated Care Systems: joining up local services to improve health outcomes - National Audit Office (NAO) report

WORKFORCE

- Health and Care LGBTQ+ Inclusion Framework | NHS Confederation
- Preparedness for potential industrial action in the NHS - November2022
- NHS England » National Quarterly Pulse Survey data

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Key questions to have in mind

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

- The Executives' key priorities for the next quarter are to: (1) Move safely into our new buildings, (2) Develop the Tolworth Business case to ensure sustainability; and (3) Continue business as usual - including essential elements of clinical transformation. How can the Board support the team to remained focussed on these priorities?
- Our workforce, and ensuring continued recruitment and retention, is the key to unlocking the challenges we have with quality and finance. What more can the Board do to support this work?
- Increase demand means pressures on our workforce. How does the Board continue to provide health and wellbeing support to our staff (and patients and their carers) in the face of internal pressure and external climate? And how can the Board balance increased demand with making sure that staff have 'doable jobs' that offer satisfaction and joy.

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Use of the Trust seal

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

Date	Type	Signatories
28.09.2022	Lease – Substation 5 at Springfield Hospital. Located on part of Plot G which is currently owned by the Trust, adjacent to the current Ronald Gibson House. The substation will power the new care home which has been constructed on Plot H and in the longer term the substation will power other buildings around the site in line with the approved master plan.	Chief Executive Officer and Director of Finance and Performance
27.10.2022	Agreement – Sect.278* Highways Act. Improvements on land at Springfield Hospital. Agreement between London Borough of Wandswsorth, SWLSTG, STEP Springfield Village Ltd and Springfield Village Estate Ltd **Section 278 Agreement is for the junction improvement works on Burntwood Lane which need to be completed by SRM as part of the wider Springfield Hospital development.*	Chief Executive Officer and Director of Nursing & Quality Standards

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

Kyle's Charter

Kyle's Charter provides details of the support, information and response that families, friends and carers can expect to receive from South West London and St George's Mental Health NHS Trust following the death of a loved one.

Kyle's Charter has been developed in collaboration with and at the request of the family of Kyle Maher to ensure that all families receive the most respectful, timely and individual support and information from the Trust. Kyle Maher, who tragically died in January 2017, was receiving care from the Trust's community services at the time of his death. The Charter acknowledges that every death is hard to bear, and that bereaved families need timely access to support, advice and information.

An unexpected bereavement causes immense shock, grief and emotional upset. There is often no opportunity to say goodbye and families have to immediately manage funeral, personal and financial arrangements whilst in shock from their sudden loss. A sudden bereavement requires a coordinated response providing a timely pathway for accessing help and support from day one. People need help and advice to cope with their reactions, which can be overwhelming, unfamiliar and difficult to talk about.

Supporting families following the death of a loved one

Relatives will always remember the way in which news of the death of a loved one was shared with them and the support that was made available immediately and in the longer term.

Following the unexpected death of a patient, Trust staff must provide open, sensitive and respectful information and communication. Bereaved families and carers should be offered as much information as possible in line with the Trust's Duty of Candour policy. Staff providing this support and information should be mindful that families will be experiencing a range of overwhelming emotions and may not be able to fully understand and retain the information provided. Every effort should be made to hold these discussions in a private, sympathetic environment without interruptions. The venue should be agreed with the bereaved family/carer.

The language, tone, and empathy provided will have a significant impact on the family and will directly affect the grieving process. The responses of family members, carers and friends will be individual in every situation and the circumstances will be different. It is essential that staff respect and are always sensitive and human to the grief responses and reactions of everyone concerned and remain caring and compassionate.

From the outset, the Trust will make every effort to openly engage with bereaved families and carers at their own pace whilst also being sensitive to the need for private space and time for grieving. This must be led by the family and supported by the Trust and may require a number of separate meetings over an extended period.

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

Kyle's Charter

Key principles

The key principles detailed below should guide all interactions by staff with those who have been affected by the death. This includes providing the time and opportunities to raise questions or share concerns in relation to the quality of care and interactions received.

Bereaved families and carers:

- must be treated as equal partners following a bereavement. This means that responses and explanations are sensitive and individual, and questions, concerns and emotional responses are supported with compassion, dignity, and respect;
- should be offered the highest standard of bereavement support and care which respects confidentiality, values, culture, and beliefs. This includes providing, offering, or signposting families to bereavement counselling, where appropriate, for all unexpected deaths;
- should be informed of their right to raise concerns about the quality of care provided to their loved one;
- should receive timely, responsive contact and support in all aspects of an investigation process, with a named single point of contact and liaison;
- should be offered support to contribute as partners in any investigation. This needs to be sensitively discussed and managed as families may not feel ready to engage in the process particularly in the early stages;
- who have experienced the investigation process should be offered the opportunity to work in partnership with the Trust in raising awareness and delivering training for staff in supporting family and carer involvement.

All communication by the Trust should be coordinated and as consistent as possible, with a named member of the Trust appointed to act as a single point of contact with support from their colleagues.

Staff training and knowledge

The Trust will ensure that staff, including family liaison officers, have the necessary skills, expertise, support and knowledge to engage with bereaved families and carers. This includes recognising and supporting the emotions, grief and questions about the death and the circumstances.

When reviewing or investigating possible problems with care, involvement of bereaved families and carers must begin with a genuine apology. Saying sorry and expressing condolences is the right thing to do in every circumstance.

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

Kyle's Charter

An appropriate senior staff member should be identified for each case, to explain what went wrong promptly, fully and compassionately (in line with the Trust's Duty of Candour policy). This may include clinicians involved in the case but this may not always be appropriate and should be considered on a case by case basis. This explanation should be given in person by the senior staff member accompanied by the Family Liaison Officer or another appropriate clinician/senior member of staff. If necessary, a member of the Governance team can attend to provide support.

Police involvement

In the case of an ongoing police investigation, the Trust should contact the Police Family Liaison Service at the earliest opportunity and share the contact details of the Trust Family Liaison Lead. The police will be the lead agency in the early period and it is important that the Police Family Liaison Officer (FLO) has the contact details for the Trust and that the Trust Family Liaison Lead is the point of contact for the police.

In these circumstances, it is recommended that initial meetings with the family and the Trust are held with and coordinated by the Police FLO to ensure the most timely and consistent support and information is made available.

Bereaved families and carers will:

- be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held (preferably at the Duty of Candour meeting);
- be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation;
- have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided;
- have a single point of contact (either the Police FLO, the Trust Family Liaison Lead or Engagement and Governance Lead) to provide timely updates, including any delays, the findings of the investigation and factual interim findings;
- have an opportunity to be involved in and contribute to any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date; this may not be possible for families in the initial stages as they will be grieving and may not feel able to contribute initially. The Trust should review and amend the Terms of Reference when the family feel able to contribute;

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

Kyle's Charter

- be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case;

- be offered an opportunity to respond to the findings and recommendations outlined in any final report in a way that is sensitive to their needs; and be informed not only of the outcome of the investigation, but what processes have changed and what other lessons the investigation has contributed for the future;

- be provided with the final version of the report. If an inquest is to be held, the family need to receive this prior to date of inquest.

Trust support following referral for a Hospital Treatment Order/secure hospital setting

The Trust will, in support of the bereaved family, initiate and maintain contact with the assigned Police Family Liaison Officer. On behalf of the family, the Trust should seek to confirm the locality of any health or secure hospital placement and treatment of a perpetrator and assess and discuss the possible impact on the bereaved family.

The Trust must be sensitive and responsive to any concerns raised by the victim's family with regards to the proximity of the care and treatment that may be provided to the perpetrator.

Where a possible placement in the local area to the victim's family leads to anxiety, distress or any negative impact, the Trust should urgently review with partner agencies and identify appropriate multi-agency support for the victim's family.

In addition to these captured principles, the Trust is committed to incorporating any additional measures and arrangements in response to new national guidance around engaging and involving families following an incident. This NHS guidance, called Engaging and involving patients, families and staff following a patient safety incident, was published in August 2022 and is part of the new NHS Patient Safety Incident Response Framework, which the Trust warmly welcomes.

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

QUALITY AND SAFETY OF INPATIENT SERVICES

Introduction
This paper sets out the Trust response to the circular issued by the National Mental Health Director following the recent BBC Panorama broadcast *"Undercover Hospital – Patients at risk."*

In headline terms, the letter expects Boards to "review the safeguarding of care in your organisation and identify any immediate issues requiring action now; including but not limited to:
a. freedom to speak up arrangements,
b. advocacy provision,
c. complaints,
d. CETRs and ICETRs, [Care (education) and treatment reviews / Independent Care (Education) and Treatment Reviews]
e. other feedback on services.

These five areas require a response from every Mental Health Trust. To provide additional assurance on how we set our culture and leadership at this Trust, six additional areas have been identified and included in the work summarised below on our assurance and gaps position. These additional areas demonstrate the ongoing work to improve patient safety and quality of care, the focus on developing and supporting our senior leaders and strengthening the assurance framework.

Sharon Spain
Director of Nursing and Quality

What the ask was	What do we have in place to provide assurance/reassurance	What are the gaps	How we are strengthening our current provision	By when	Lead

Freedom to speak up arrangements.	- We currently have 4-6 weeks of PALS sessions across our wards reported through the service lines. - Freedom to speak up Guardian is well established across the clinical services. - The Guardian reports into people Workforce & OD Committee on a quarterly basis.	Real time feedback needs better analysis by teams and learning actions to be shared. Improvement is needed with cross-referencing the feedback from Guardian with Feedback line, complaints and incidents.	We have increased our PALs sessions across all areas. Undertake a cross referencing exercise with other patient experience data (complaints / patient feedback) Freedom to speak up Guardian has increased visits to all wards and is closely linked with the Clinical leads. Guardian to report to people Matters meeting on a monthly basis, and triangulate themes with the governance department. Improved staff signposting / information on Insite	Oct 22 Oct 22	Guardian / Complaints Team Guardian DoNQ& DoP
Advocacy provision	- There is IMHA provision which is commissioned by the Local Authority but with inconsistencies across all areas. - Current fragmented system of each Borough providing advocacy for their resident inpatient.	Different local authority commissioning decisions have resulted in a	To continue to raise this directly with advocacy provider and local authority commissioners upon the concern that they are leaving gaps or delays in access to both IMHA and IMCA services for our patients.	Nov 22	Head of Social Work as Chair of MHLGG Director of Nursing & Quality

	- IMCA provision is available across all hospital sites, although inconsistent in the response. - Leaflets for all advocacy provision is provided to each ward for display and information about right to access IMHA is provided with s132 rights. - Engagement with providers who attend Mental Health Law Governance Group(MHLGG) by invite for any updates and have all made commitments to have greater presence back on the wards.	fragmented, poorly co-ordinated service Patients who are not local residents (including patients treated by our national and specialist services) often receive no advocacy provision from the commissioned services Informal patients have little access to advocacy Advocates do not always visit wards in person	Raise with Director of Quality for SW London ICB, in which local authorities are partners Review will continue to be on MHLGG action log and update to CQC MHA reviewer.		(in relation to ICB)
Complaints / Incidents	- Feedback live (patient feedback system) in place - Complaint themes are reviewed by a compassionate complaint learning group with service user representatives as part of group	Triangulation – improved triangulation is required to ensure that any indicators for further follow up are not missed	Review arrangements and measures in place to ensure effective triangulation Implementation of NHSE Patient Safety Incident Reporting Framework, which	Nov 22 2023 (PSIRF)	DoN&Q AD Quality Gov & Risk

	- New interactive Patient Experience information dashboards have been established - Robust incident management process and review at weekly meetings		includes enhanced thematic reviews and triangulation new SI/ incident dashboard and triangulation analysis with other patient experience data being done by informatics under the Improving patient outcomes group Increase clinical service leads involvement in compliant and incident and proactively embedding learning.	Oct 22	
CETRs and ICETRs I(Independent)Care Education Treatment Reviews(I)CETRs – these are panels set up for young people/children with Learning Disability/Autism who may be at risk of a Mental Health Hospital admission. Led by commissioners	- We engage and support the system when required.	Consistent recording and reporting all ICETR/CETRs across services.	To review the process for reporting, engaging and recording all CETRs and ICETRs involving our patients.	Oct 22	Head of Social Work.

Other feedback on services.	- Board visits and informal visits across the Trust – regular reports back to the Board and the clinical services. - CQRs, Care quality Reviews(CQC mock style inspections/visits) - Specific surveys carried out on in-patient wards by Peers / Lived Experience Members	No Gaps	Design a system of regular face to face surveys (completed by Peers / lived experience members) across in-patient wards Operational Review visits are being enhanced and consistent across the SLs.	Dec 22	DoN&Q AD Quality Gov & Risk DoN&Q Head of Therapies
Trust Actions					
Quality of Care	- Fundamental standards of care(FSOC) Quality Plan and updates reports to QSAC (Board quality and safety subcommittee) - Quality metrics added to the Trustwide Performance report, which is presented to Board monthly. - Carers and Service users members of all our Quality committees. - Patient Experience Facilitators are on all our wards. - Weekly Quality Matters meeting – reviewing every Serious Incident or concerns in relation to patient care. - National Patient Safety Incident Response Framework - work progressing well with a Implementation Group, chaired by Dir Nursing and Quality	Embedding it throughout as it is a new programme. Gaps in Lived Experience members in some local service line governance groups Not all wards have access to Peer workers / PEFs	Enhance the systemic quality approach using the FSOC as framework for MDT monthly quality meetings. New Lived Experience members recruited and trained to sit on local governance groups BC to establish funding to train cohort of Peer Engagement Facilitators . Skill mix reviewed as part of transformation Unannounced Out of Hours Senior team visits to clinical services	Nov 22 Nov 22 April 2023	HoN&Q Ho N &Q & Head of Therapies & Involvement Ho N &Q & Head of Therapies & Involvement

	- Triangle of care model embedded across the trust - Overall Good CQC rating - SIREN supports highlighting teams in need of support.	Upholding all Triangle of Care standards not consistent across all teams & services	Work with each service line to develop systems to review of T of C standards	Jan 2023	HoN&Q & Head of Therapies & Involvement
Closed Culture	- QII work on culture has been developed and successfully embarked - Closed culture self-assessments - A culture of openness and transparency- commended by CQC work on just culture and psychological safety - Evidence of swift response and intervention where signs of closed culture may be apparent - Risk registers are reflective of risks around cultures - Just Culture Framework implemented and now reflecting in key investigation and HR polices	Assurance on the nature of ward cultures on all Trust wards Still some reluctance to whistle blow and escalate incidents with fear of being punished.	To continue to roll our the QII framework to support clinical teams to identify and improve any areas to develop an open culture Training the methodology on how to lead on this work will be implemented across the service lines.	April 23	Associate Clinical Director for QII Supported by Medial Director and DoN&Q
Leadership	- Strong values led leadership- Clinical Directors, Heads Nursing & Quality, Heads of Service Delivery and psychology leads - Additional focus on middle managers leadership programme is underway, with future sessions planned. - Monthly Executive with Service Line Leadership members meetings to discuss areas of concern.	Our reporting systems could be more robust to capture the information that patients are treated with dignity and compassion in safe surroundings.	Further exploration around vital questions is needed and will shape responding plans in the weeks ahead. Resetting the clinical priorities for of the CSLs to ensure maximum benefit and consist of focus on quality and patient		

	- Delivery of the Quality plan which incudes the clarity of team members' roles, responsibilities and accountabilities, improved reporting systems, strengthened assurance and quality accountability framework. - Leadership team undertaking regular back to the floor and operational reviews. - Reflective practice space supported by MDT leads. - Masterclass in psychology safety master classes	Clinical Service Leads (CSLs) roles and how they are consistently used. Visibility at all levels of leadership with Time to prioritise meeting with teams and acting on the feedback.	experience in conjunction with the corporate quality functions More formal and planned back to the floor and operational reviews. Stronger focus on reflective space/groups for staff to allow expression and discussion. Continuing with the	Oct 22	DoN&Q & COO
Restrictive interventions	- Safety in motion programme (Reducing restrictive practices) - Regular audit on use of seclusion and seclusion reviews and seclusion care plans. - Audit that reviews all Rapid tranquilisation and the after care. - Monthly Reducing Restrictive practice Group monitor all incidents of restrictive practice and ensure they are clinically indicated and follow up care is provided. - EMHIP work - We have created a way to record observations electronically (eObs) which	Trust is thought to benchmark higher than peers for frequency of use of seclusion	Review of benchmarking data and of ward cultures relating to early interventions that might avoid the need for seclusion at a later date Further enhances work on medication management and prone restraint.	Monthly	Director of Nursing & Medical Director DoN&Q & COO

	allows for electronic daily reviews of obs levels for all patients documented and electronic record of obs done and significant focus on practice.				
Safeguarding	- Strong practice- and we have regular incidents raised which we manage and reported to the LA. - We hold extraordinary safeguarding meetings and invite external stakeholders, CCG, CQC, LA for transparency. - DoN&Q chairs a Bi – Monthly Executive Safeguarding Meeting with Service users, CCQ, LA and other external stakeholders.	No gaps identified by Trust or partner agencies. Feedback that we have a very open and transparent approach to Safeguarding.			DoN&Q & Head of Social Work

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 4th July 2022, 13:30-16:30**

Present:

Prof Deborah Bowman (DBo)	Non-Executive Director – Chair
Ann Beasley (AB)	Trust Board Chair - ex officio
Vanessa Ford (VF)	Chief Executive Officer
Sharon Spain (SS)	Director of Nursing and Quality
Richard Flatman (RF)	Non-Executive Director - observer
Prof Charlotte Clark (CC)	Non-Executive Director
Jennifer Allan (JeA)	Chief Operating Officer
Dr Billy Boland (BB)	Medical Director

Attendees:

Ryan Taylor (RT)	Associate Director of Clinical Governance & Risk
Frankie Campbell (FC)	Head of Safeguarding (Children) – for item 22/127
Tara Osbourne-Wallace (TOW)	Head of Safeguarding (Adults) – for item 22/127
Seema Shah (SSh)	Deputy Chief Pharmacist – for item 22/129
David Hobbs (DH)	Service User, Carer, Friends, and Family Representative
Carol Ann Brennan (CAB)	Service User, Carer, Friends, and Family Representative

Apologies:

David Lee	Director of Corporate Governance

Item

A22/120 Apologies
Apologies were noted

A22/121 Declarations of interest
No declarations of interest were raised

A22/122 Chair's action
No Chair's action was reported.

A22/123 Minutes of the previous Part A meeting
The minutes of the previous meeting were agreed.

A22/124 Action Tracker
The action tracker was agreed and noted
A22/30 – RT has received assurance from SLP regarding the work that IT is doing regarding cyber security. They are simulating attacks on the system, so they can learn lessons. As such, we have sufficient clarification to close the item.

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

A22/125 Risk Register

The Committee received the Risk Register, and the following key highlights were presented by RT

- The overarching Community Risk (2116) has been increased and amalgamated with risk 1830 (now closed).
- A risk for EDI has been added to the Executive Risk Register and is referenced to the EDI risk on BAF
- There is a new risk for Physiotherapy due to vacant posts and maternity leave. This risk tends to fluctuate and come on and off the register. RT plans to meet with the Head of Physiotherapy who is currently on leave.
- A risk was added in respect of licences for Big Hand (Pro dictation app) – this issue has now been resolved.
- RT informed the meeting that there are deep dives of certain areas each month to align with BAF.
- DH questioned the red risk in respect of safety in acute and urgent care following reports of a patient sleeping overnight on the floor.
- JeA advised this patient was at St Helier and from the Surrey area. She now has a suitable inpatient bed in Surrey.
- DH asked whether it is usual practice for patients to stay overnight before being assessed.
- JeA responded that patients are normally assessed within an hour.
- DBo requested thought was given to complexity, access and flow and how these affect the Trust both in terms of risk and other quality metrics.
- BB commented that these concerns and risk are reflected on the BAF with the root cause being a lack of inpatient beds
- DBo queried whether there is a plan to look at mitigation regarding the lack of beds.
- VF suggested that ELT debate this risk to ensure it is at the appropriate level.
- DBo questioned the risks in respect of the Integrated Programme and asked what happens next in terms of QSAC oversight given the forthcoming move? DBo sought assurance on this given there is no QSAC meeting during August.
- RT commented the top three risks on the ERR refer to the Integrated Programme and that these risks will be more granular as the move gets closer. The key is the relationship between the various teams as the move gets closer.
- VF commented that the Board will need assurance before patients start moving.
- It was agreed to convene a special meeting of QSAC in August to review patient safety and quality risks related to the estates modernisation programme. It was also agreed that the chair of EMC should be invited to the meeting. **Action SS/RT**

A22/126 Quality Matters

The Committee noted and accepted the Quality Matters Report. SS gave an overview of the April Report:

- There were 10 serious incidents, including three unexpected deaths and 2 suspected suicides.
- Suicide rates have significantly increased and are being monitored through QGG.
- Outstanding RCA actions have decreased.
- There have been no claims.
- Two inquests have been adjourned.
- There have been 10 emergencies and 46 planned interventions.

- DBo asked what positive steps have been taken to manage issues in respect of DNAs which is referred to in the report as an effective intervention for the second month in a row.

A22/127 Safeguarding (Children and Adults)

The Committee noted and accepted the Safeguarding Reports. FC gave an overview of the Safeguarding Children Report:

- A high level of Safeguarding Children incident reports has been maintained across all service lines, especially in Acute and Urgent Care and IAPT.
- The Safeguarding Children policy has been updated and a child friendly version has been produced
- Training levels have been maintained across the teams and DBS Compliance is at 87%.
- 4 children died this year, investigations are ongoing.
- There has been a significant increase in domestic abuse notification across the Trust.

TWO gave an overview of the Safeguarding Adult Report:

- A new safeguarding policy has been co-produced with Sutton.
- Bespoke level 3 training has been developed and it is currently being done jointly with SLAM.
- Reporting has increased in respect of violence and domestic abuse.
- One key challenge is the time it takes to hear back from Local Authorities and the demand for the Trust's resource to be part of various subgroups.
- TWO attends a range of meetings to ensure staff understand the minimum standard of care required to safeguard adults.
- The Trust's DVA Lead is currently working on a domestic abuse policy for staff.
- DBo thanked FC and TWO for their hard work in producing these repots
- DBo noted that the post of Domestic Violence and Abuse Lead is not substantive which may be significant in the context of progress relating to awareness of, and support for, domestic violence and abuse.

A22/128 Serious Incident and Incident Reporting Report, including inquests and claims (inc. learning) – Annual Report

The Committee noted and received the report. RT gave an overview:

- There has been a decrease in the number of SIs and the vast majority did not identify any material care or service delivery failures
- The vast majority of incidents are concerned with violence and aggression.
- There has been an increase in incidents concerning young people, including self-harm and attempted suicides in a context of growing numbers of referrals. QGG is concerned about the number of incidents in CAMHS.
- There have been key lessons learned in physical health care and zoning.
- Fundamental Standards of Care have been established and learning from incidents, complaints and patient experience will be used to inform the ongoing development and use in clinical practice of the standards
- Data capture for ethnicity has deteriorated – systems and process are being reviewed to improve response rates.
- Staff members' experiences of incidents and responses are being reviewed.
- DBo asked for clarification regarding the number of claims and how many are likely to succeed.
- RT advised that QSAC receives a quarterly report detailing claims, but he will ensure this is added to future reports.

A22/129 Medicines Management and Optimisation – Annual report

The Committee noted and received the report. SSh gave an overview:

- There are a few risks on the risk register including the use of Valproate with women of childbearing age, and non-adherence to alerts, the Prevent Programme and effective contraception.
- There is lack of assurance about completion of the annual risk acknowledgment forms. There is an ICS project to ensure a systematic approach.
- There are delays to some in-year medical optimisation strategy deliverables which are due to external inter-dependences, internal issues and the demands of the Covid vaccination programme.
- There is a Workforce risk, specifically the national shortage of pharmacists and pharmacy technicians.
- Funding has been received from Community Transformation for new posts.
- Clozapine Community prescriptions are not being renewed in a timely manner – a project has been developed to address this with the Lead Community Pharmacist.
- Most Year 3 deliverables have been achieved and there is a good safety culture.
- AB questioned the lack of pharmacy posts in Community Services where the report states this can lead to insufficient capacity to ensure safe medicines administration.
- SSh explained that pharmacy is stretched and would like to have more assurance about capacity, although she did not consider that safety was currently compromised.
- DBo asked why there is no change in respect of Valproate.
- SSh advised that there is an improvement in respect of recording the number of women on Valproate. The problem is that Primary Care colleagues do not report back to the Trust once a patient has been discharged so it is hard to follow up. SSh informed QSAC that Pharmacy now approves all Valproate prescriptions.
- DBo thanked Pharmacy for the attention to, and consideration of, health inequalities included in the report.

A22/130 Physical Healthcare Framework

DD gave an overview:

- There have been meetings with service users and carers to identify gaps and priorities.
- One key focus is to have conversations with acute care before the patients start to deteriorate. BB and DD have worked with Kinesis for advice and guidance on how to treat patients without sending them to St George's as this creates a transfer risk.
- Staff education is a priority.
- The Framework aligns with Corporate Objectives.
- Mandatory checks and compliance are key.
- SS wanted to thank DD for the work on the Framework.
- VF wanted to sure medical engagement was at the right level to ensure success.
- DD informed QSAC that BB and Sean Whyte have been involved in the QI, Digital and Transformation aspects of the Framework.

A22/131 Quality and Performance Report

The committee noted and received the report:

- BB informed QSAC that there is an interim Medical Staffing manager in place who is helping to build confidence in HR provision in this area.
- Fundamental Standards of Care are making good progress.
- JeA informed the meeting that there is high demand on Acute, Community Services and CAMHS which has been the constant picture over several months.

- Patient safety indicators have improved.
- Less urgent /elective work is unlikely to improve in the near future, bearing in mind the increased demand for acute care and services.
- A further review is being undertaken to look at long-term challenges.
- RF questioned why the Rag ratings (doughnuts) are changed to red if the figure falls below 98% and asked if this could be adjusted as it is difficult to understand which areas are actually failing
- DH asked how long the Crisis Care pathway review will take. JeA advised that this is currently being finalised and should be available soon.
- SS informed QSAC that there are 100 newly-qualified nurses, of whom fourteen are working in the Community.

A22/132 Matters for the Board:

- DBo advised that her report would address issues of complexity, pressure and acuity and the implications for risk, quality, safety and experience
-

A22/133 Meeting review

- CAB thinks the meetings are more open
- DH feels the meetings are patient focused and not rushed

A22/134 Next Meeting

Monday 5th September, 13:30-16:30 via MS Teams.

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

Quality and Safety Assurance Committee (Part A)

Draft Minutes of the MS Teams meeting held on Monday 5th September 2022

Present:

Professor Deborah Bowman (DBo)	Committee Chair – Non-Executive Director
Ann Beasley (AB)	Trust Chair
Jennifer Allan (JeA)	Chief Operating Officer
Dr Billy Boland (BB)	Medical Director
Prof. Charlotte Clark (CC)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Observer
David Lee (DL)	Corporate Governance Director
Doreen McCollin (DM)	Non-Executive Director
Sharon Spain (SS)	Director of Nursing & Quality

Attendees:

Carol Anne Brennan (CAB)	Service User, Carer, Friends and Family Representative
David Hobbs (DH)	Service User, Carer, Friends and Family Representative
Fergus Keegan (FK) – (22/141)	Lead Quality Manager – NHS SW London CCG
Chris Lambourne (CL) - (22/144)	Director of Quality
Zoe Mears (ZM - (22/142)	Head of Social Work
Ijeoma Ndubuisi (IN)	Clinical Team Manager, DIDMR
Claire Louise Reed (CLR)– (22/143)	
Ryan Taylor (RT) (22/140)	Associate Director of Clinical Governance & Risk
Clair Hartley (CH)	Committee Governance Manager (Minutes)

Apologies:

Vanessa Ford (VF)	Chief Executive

Item

A22/135 **Apologies**

Apologies were noted.

A22/136 **Declarations of Interest**

No new declarations of interest were reported by the members.

A22/137 **Chair's Action**

There were none.

A22/138 **Minutes of the previous Part A meeting**

The minutes of the meeting of 4 July 2022 were approved as an accurate record.

DL reported that the August meeting wasn't minuted as it wasn't a standard meeting but he would distribute a record of the meeting to committee members, who could comment on them. They would be formally approved at the next meeting. **Action DL**

DH informed the Committee about the progress the Patient Quality Forum (PQF) had made. They had sent a letter to Tfl and received a prompt response. The PQF was to meet Tfl on 9

Item

September and he would report back at the next meeting. The Chair congratulated DH and the PQF on their achievement.

A22/139 **Action Tracker**

There were no outstanding actions.

A22/140 **Risk Report**

RT presented the Risk Report. He highlighted the following issues.

- Use of force – ELT felt that the risk could be reduced to 16 based on current assurances.
- Cultural issues with Forensic Liaison and Diversion team – agreed that it would go back to the service line for work on the improvement plan.
- EDI risk - Comprehensively captured and managed via the BAF. The risk level matches the BAF.
- A number of financial risks had increased. The AUC teams had failed to operate within agreed budgets ; caused partly by overspend on private beds.
- The risk around failure to maintain F2F contact in the community service line, and safe management of clients on community caseloads was reduced.
- A number of risks were closed. The Avalon Board Culture risk was closed, there was significant improvement; Fask mask risk was closed
- Adult Acute pathway – reconciliation between Exec Branch register and BAF done to be more effective.
- In Main risk register, Risk 2335 related to a high vacancy rate within Liaison and Diversion service, caused by backlog in metropolitan police clearance.
- Risk 2347 – Failure to comply with trust standards of physical health monitoring and documentation. Crocus ward was currently non-compliant. A recovery plan has been developed.
- Risk 2351 - Access to young people early warning signs in RIO from RoMEO tablets was an amber risk, level 9.
- MHA rights – An improvement plan was being established to support Clinical Managers.
- Liaison & Diversion workers use of NSPIS Custody and the supply of data containing protected characteristics – L & D workers would no longer have access to NSPIS Custody App.
- A&UC KPIs - Failure to effectively improve on main Key Performance Indicators such as Supervision and 1-hour Referral to Assessment.
- Shaftesbury Unit - Failure to lock clinic doors - presented a safety and security risk.
- Risk 2356 – Burntwood Villa's medical cover during out of hours – Problem that out of hours staff did not understand out of hours requirements. The risk was more a reputational risk rather than a risk of clinical practice. Operation of Burntwood was agreed. Team don't agree with operational agreement so they complained to CQC.
- ELT formally agreed that the Workforce risk (2328) level within the BAF (and reflected in the ERR) be increased to level 20.
- Work would be done around the clinical service transformation risks as it was felt that it was higher than it needed to be.
- There would be reconciliation around some of the workforce related risks particularly in regard to the medical workforce.
- ELT had asked whether a risk in terms of the cost-of-living crisis could be introduced.
- ELT asked whether the cross- referencing to other risks could be improved.

RT informed the Committee that they had recruited a new risk manager and health and safety manager who started work in the previous week.

The Committee discussed the following issues:

- That introduction of a risk in terms of the cost of living crisis was supported as QSAC was interested in health inequalities which affected the cost of living in relation to patients, service users, families and staff.

Item

- The link to EDI was welcomed. The audit Committee had looked at the BAF and thought EDI was probably one of the areas that needed work in terms of the detail underpinning it. The question was asked whether work was being done on EDI. BB replied that a new Associate Director had been appointed for EDI. The post had been created to help transform leadership in the area. A comprehensive action plan had been developed.
- Concern was raised about the incident in Ward 1, question asked whether the risk was anticipated. SS replied that there were no pre-warning signs. They had conducted a deep dive and found no patient complaints or incidents of inappropriate use of force. They had found that a culture had developed in the ward and people were very afraid. Incidents were not managed as expected. The incident opened a conversation and the investigation into the wider issues around Ward 1.
- Risk 2016 - Failure to fit test FFP3 masks for staff resulting in an infection control risk was queried. RT replied that the risk remained in place because the fit test needed to be updated every two years.

The Committee **noted** the risk report.

A22/141 **Quality Matters**

SS presented the Quality Matters report from July 22. She highlighted the following:

- There were eight serious incidents; five met the criteria to be externally reported. They included one unexpected death and two suspected suicides in the community which were investigated.
- There were two serious incidents. Patients money went missing on Lavender ward on two occasions. Investigation had led to a review of the management of patient property. They hadn't been able to identify the perpetrator, but the patients had been reimbursed.
- A report of violence and aggression on Ward One led to a patient raising concerns with the CQC and a review of the culture and behaviours on the ward was conducted. It is much more significant than how it is documented in the Quality Matters report. This has triggered a significant safeguarding investigation and trust investigation, which have been overseen by the safeguarding external and internal CQC and CCGs, all of our relevant stakeholder quarters, which **SS** chaired, which allows the Trust to be transparent and have external scrutiny on it.
- Outstanding RCA actions increased from 12 to 18 across the Service Lines and in Estates and Facilities.
- The number of Post Incident Investigation Reviews (PIRs) awaiting sign off/approval has increased again from 141 in June to 166. Training has been provided to service lines on how to sign-off PIRs. New reports have been set up to further support this process.
- There were 6 Investigation Reports submitted (including RCA & PIR). All have been through the Executive lead SI panel and were accepted by the service line and clinical teams. Of the 6 reports, 2 identified care and service delivery problems, however they were not contributory to the incident and recommendations were made to prevent reoccurrence.
- Areas of learning were identified from this month's RCAs and will be shared with the appropriate Committees or subgroups to note the actions and support their completion include Searches; Risk Assessment; Care Planning; Fire Evacuation; Restraint; Documentation; Medication.
- One LTPS claim was reported to NHSR in the month of July. During this period one claim was concluded. This claim highlighted the need for ward staff to ensure patients did not bring valuable items onto wards.
- There were 3 inquests concluded in July 2022.
- There were 10 emergencies called and 46 planned interventions. There were 7 DNAs reported. The CQC asked the Trust to investigate 5 complaints that patients and/or staff make directly to them.

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

Item

- There was one CQC MHA reviewer visit identifying the issue of poor IMHA advocacy provision to Specialist Services patients.
- The repetition of 132 Rights. Every patient is informed of their rights at the beginning of their section or CTO and this indicator shows where they have been regularly reminded of their rights thereafter. In August, 75% of all formal patients were reminded of their rights in accordance with trust policy, down 4% from July.
- Complaint response times have continued to improve, there was a increase for the month of July with 90.9% of responses sent within 25 days compared to 85.2% in June (target 85%).
- There was a slight decrease in the activity of Feedback Live! for inpatient wards with 2,446 responses to 378 questions which is a drop from the 448 responses and 2,639 questions answered in the previous month.
- General Satisfaction in the Trust averaged at 79.6%, down from 91.3% in the previous month, and FFT remained very high with 97.4% up from 95.9%.

The Committee discussed the following issues:

- **DH** asked how Feedback Live was working, whether there were still problems experienced with tablets. **SS** replied that the team had done a reset of the questions which would make it easier for patients to answer. IT were checking the tablets regularly for technical errors. They had a good response from inpatients but wanted to make it easier for community to respond. They hoped to see an increase in the number of responses soon.
- **CAB** referred to a number of statements which she found concerning, being
  - Families raising concerns with regards to accessing services in a crisis.
  - Families asking why a crisis team could not come to the home in these circumstances.
  - Several recent cases where families have requested that the Trust should discipline or suspend staff from duty following an incident.
  - Seven complaints about physical abuse or assaults by staff.
- **SS** replied that complaints were investigated thoroughly and in some cases it was found that suspension was not justified. She would be meeting with the family involved. **CAB** asked that **SS** report back on the outcome in order to satisfy the Committee that the matter had been dealt with. **SS would provide feedback on the meeting**. **ACTION SS.**
- **DBo** asked whether these incidents where early indicators that a Deep Dive should be held.
- **AB** referred to the incident where 507 letters were sent to patients containing a patient's personal details. **AB** asked whether the incident had been treated correctly, whether it should have been reported to the ICO. **DBo** felt that this was sensitive information under the Act and the beach should have been reported to the ICO. **SS** responded that they had taken legal advice and the matter was dealt with in terms of that advice. **SS would report back on the action taken ACTION**
- **DM** asked that **SS** find out how this mistake happened and take steps to ensure that it did not happen again. Staff needed to be aware of the law and receive training on Information Law. **RF** said that training and awareness of Information Governance was very important and the training stats should be monitored. He asked that this incident be reported to the next Audit Committee meeting. **SS to report incident to next Audit Committee meeting ACTION**
- **SS would investigate and report back about the cause and steps taken to prevent this happening in the future – ACTION**
- **DM** queried the breach of the KPI requiring acknowledgment of complaints within 3 days. **SS would look into the reasons for the breach and report back – ACTION**

Item

The Committee **NOTED** the report.

A22/142 **Mental Health Act (including Advocacy Services and regulatory compliance relating to MHAct)**

ZM reported on the Mental Health Act, including Advocacy Services and regulatory compliance relating to MHAct. The report gave reasonable assurance as to how the Trust implemented mental health law in 2021/2022. However, improvement was required in two areas:

(1) Detained and CTO patient must have their legal rights explained to them more frequently, as per Trust policy (This was improving. QGG was reviewing quarterly); and

(2) Assessments of mental capacity assessments should be better worded, indicating how the assessor reached their conclusions, as required by the MHA Code of Practice and the CQC. CQC reviewers have found that mental capacity assessments are not adequate as they don't contain sufficient detail. (A Deputy head of Social Work had been appointed and she was working on a plan to improve the quality of the assessments. She was planning webinars and further training).

- The Independent Mental Health Advocacy support had become fragmented across the Trust as more agencies were being commissioned in different areas, making the referral process less straightforward. Confusion over the commissioning arrangements meant that some patients were missing out on IMHA support. **ZM** reported that she was meeting with Commissioners to try to solve the problem.

The Committee discussed the following issues:

- **JA** had sent a note, asking why there was no mention in the report about the Trusts participation in the consultation on the amendments to the Mental Health Act. **ZM** mentioned that they had included this information in the last annual report.
- There was concern about the lack of Independent Mental Health Advocates. A review conducted by Hertfordshire Partnership University NHS Foundation Trust concluded that governance was not fully adequate in relation to MCA. It was recommended that some specific resources be recruited. The recruitment campaign was unsuccessful, and it was assumed that the existing workforce would do the necessary work. However, **AB** questioned whether staff would be able to do any extra work in addition to their existing workloads.
- **ZM** replied that the newly appointed Deputy would do some of the work. They had tried to recruit a MCA Lead into a six-months' full-time Band 7 post but there were no candidates. Other Trusts were advertising permanent positions for MCA leads and the Trust wasn't competitive in the market. They were devising a plan to fill the vacancy. **AB** replied that the Committee would like to ensure that it was a thorough plan because it seemed that not enough resources were committed to the recruitment. [**ACTION] Plan for recruitment of a MCA lead to be submitted to the Committee - ZM**
- **CAB** asked how they could ensure that people were getting advocacy support while the plan was being drawn up. She said that advocacy support was very important, and people often did know that they were entitled to advocacy.
- The Committee discussed methods that could be used to inform patients of their rights to advocacy support. **ZM** said that they were putting up posters in wards. Groups in the community could also provide information to patients as posters could be ineffective for people when they were admitted. **ZM** said that they were considering other methods of making people aware of their rights and they invited groups to their meetings to discuss this. **DBo** said that they had to think of more effective ways of bringing the message to people's attention. **DH** recommended that the Crisis Cafes be used to inform people about their advocacy rights**.**
- **DM** asked whether as there were challenges around patients' rights being read to them, data was kept about attempts to inform patients of their rights when they were not reciprocal and unable to have their rights read to them**. ZM** replied that the failure to

Item

record attempts to read patients their rights was due to an IT issue which was being dealt with.

- **IN** asked whether people could be informed of their right to advocacy at their first appointment and whether a checklist could be put in place so that it could be recorded that they were informed. **ZM** replied that the right to advocacy was part of the Section 132 rights that every patient had to be informed of on admission.
- **CAB a**sked whether the advocacy groups could be informed when a person from their area was in hospital. **ZM** replied that they did inform them without disclosing the patient's private details. They asked them to be more visible.
- **ZM** reported that **JA** asked how they might use the data, particularly the national data. **ZM** informed the Committee that this was on the Mental Health Law agenda for next month. They wanted to review the annual report and find out what data was helpful and how it was actually being used because they were not sure whether what they were delivering actually translated into service responding.

The Committee **noted** the report and thanked **ZM.**

A22/143 **Care Quality Review (CQR)**

CR presented the review. The review was taken as read but she highlighted a few matters:

- South Kingston RST was rated inadequate in the well-led domain again due to Team leader and Consultant vacancy. There were significant risks identified in South Kingston RST and CWWB related to vacancies in management and staffing, which were escalated and acknowledged by senior management, providing an immediate assurance with a plan of action.
- There were similar workforce problems in Central Wandsworth and West Battersea where there had been no senior management previously, although the team presently did have more managerial representation.
- Overall ratings were reviewed, and ratings of two teams were revised following the review by Service Line senior leaders. It was found that the outstanding rating given to AOT was not appropriate given concerns raised across CAMHS services in general regarding waiting times and pressure to services. The ratings will be downgraded from outstanding to good overall. Corner house was downgraded from good to 'requires improvement' given the quality and safety concerns raised for the service.

The Committee discussed the following issues:

- The importance of giving honest reviews and pointing out difficulties in order to avoid complacency.
- BB commented that he was pleased with how the CQR process was developing.

The Committee **noted** the review.

A22/144 **Quality Priorities / CQUINs**

CR presented a report on Quality priorities which showed that targets had been achieved in the following categories:

Safety In Motion, Physical Health, Experience Challenge, Patient Choice in Medication; and Suicide Prevention.

The Committee **noted** the report.

A22/145 **Homicide Report**

BB presented the annual homicide report and highlighted the following issues:

- No homicides had been reported in the last year.
- The data showed homicides that happened over the past 10 years because of the length of the court process and the Trust's approach to reviewing internally within organisations. There were 4 homicides in 2020/21 which was an increase from previous years and above the average for the Trust.

Item

- The learning process was ongoing. A couple of investigations were closed and considered through the through the mortality Committee.
- A deep dive was commissioned due to the four homicides within the period of a year.
- The mortality Committee learned from homicides, both internally and externally to the Trust.

The Committee **noted** the report.

A22/146 **Mortality and Suicide Prevention – Annual Report**

BB presented the report which provided an annual summary on the number of deaths reported in the Trust and the key learning from these deaths for 2021/22, highlighting any key concerns or learning.

He highlighted the following:

- A high number of deaths were reported previously in the context of the COVID 19 pandemic. The numbers of deaths had returned to pre pandemic levels. This was an endorsement of the Trust's approach to IPC. SS and her team and colleagues had been working under difficult circumstances and had adapted their practice in difficult circumstances.
- The pandemic had affected lives negatively and there had been a large rise in suspected suicides. The cost- of-living crisis might also impact people's mental health.
- The Trust was not reporting any concerning themes around care and service delivery issues, so it was felt that the suicide prevention strategy that the Trust committed to last year was working. They would continue to monitor the implementation of the strategy through the mortality governance group.

The Committee discussed the following issues:

- **DM** asked whether causes of death for people who were younger than 65 and people with learning disabilities who were dying from natural causes had been analysed so that ailments could be diagnosed by physical health screening to provide treatments that could mitigate death. **BB** replied that no themes had been identified for the causes of death for those groups of people, but it was taken very seriously. A new physical healthcare strategy had been introduced and would be developed further. Changes to access of specialist advice for people with serious mental illness and learning disability had been introduced. A new electronic advice and guidance system had been launched.
- **DM** noted that the report highlighted that a number of suspected suicides were from patients that were new to secondary mental health services or those that had been re-referred after a long period of time. DM asked whether it had been determined whether they had been unwell for some time before they were referred. She asked whether this was linked to the fact that GP's weren't seeing many people anymore. BB replied that they had not looked at these issues specifically. However, the report indicated that more patients were being referred than ever before. GPs were very active and they were seeing patients and referring people on so he was not particularly concerned about that.
- **DH** commented that in the crisis cafes, a significant proportion of people accessing crisis service were not known to the trust, and yet they were in mental health crisis.
- **BB** said that more people were accessing mental health services than ever before. Within any community, there are often significant numbers of people that died by suicide that never had contact with mental health services.
- **CAB** said that another reason people didn't access mental health services was the stigma involved. A mental health diagnosis could affect your work, your career and your standing in the community. Certain communities found it harder to accept help because of the stigma in the community eg. Ukranians. It was necessary to address the reasons people did not seek help when they were in crisis because many resorted to suicide, instead of getting help.

Item

- **DBo** emphasised the importance of co-production from the beginning. She said that the context within which services were provided was shifting and the Trust had to remain attuned to that because public health saved lives.

The Committee **noted** the report.

A22/147 **Quality and Performance Report**

SS presented the July quality and performance report. She highlighted the following:

- The report had been developed through the monthly service line reviews where quality performance and the metrics were discussed within the service lines and submitted to ELT.
- There continued to be very high demand for mental health services, alongside challenges in recruiting and supporting the workforce to meet this.
- Pressures in the community for adults and children and young people around waiting times, significantly around ADHD /ASD services were continuing.
- The HR recovery plan had agreed it's priority areas, Medical staffing and Employee Relations with project plans now in place, There had been continuing concerns around the pace of some of the work in the HR function, particularly around recruitment and appointments, especially in medical staffing.
- ELT had decided to place the HR process around recruitment into an internal critical incident, for a 12 week period. This would enable the organisation to improve processes to ensure the functions are effective and efficient in bringing new candidates into the organisation.
- The Trust recognised that it needed to improve upon its performance in a number of areas. Only 50.6% of the metrics had full or limited assurance meaning some 49.4% had no assurance (in accordance with the Trust's own internal assurance measures). Whilst that position improves slightly when considering just the priority metrics it remains unacceptable. In some cases, the Trust is setting itself higher standards than those set nationally.
- The Trust has been subject to externalities largely outside of its control such as Covid linked sickness. The Trust had been struggling with gaining traction in a number of these areas through the pandemic and was undertaking a root cause analysis approach to understanding the key drivers behind the performance and the actions taken and their impacts. The Trust was determining which areas were attainable and which areas it should prioritise in order to improve the safety and the quality of the patient care.
- While the Trust recognised the need for improvement, it benchmarked well against other NHS Trusts in terms of actual performance attained.
- Employee Relations had been transferred from Capsticks. The Trust was dealing with Employee Relations cases within its HR function.
- A new Disciplinary policy had been developed and was out for discussion.
- The consultation for Corporate and Clinical Staff impacted by the Integrated Care Programme had closed and final decisions had been published.
- The work on Fundamental standards of care continued to be led through the Service line Leadership team with great engagement from frontline staff. Risk assessments were a priority focus for clinical services, as part of the Fundamental Standards of Care.
- The Trust had incurred two 52-week breaches in July 2022. The first was linked to the Neuropsychiatry Service and the second linked to Merton ASD service. Both cases had subsequently been discharged.
- IAPT recovery rates remained above target YTD in 3 out of 4 services.
- Work to address internal waits over 30 weeks was on-going. Reporting now incorporated treatment waits in CAMHS Tier 3 and Adult ED treatment waits.

Item

- Crisis and acute inpatient services remained in a challenging position, with the need to balance demand, waiting times in crisis, and bed capacity.
- Performance on clients seen for assessment by liaison services within an hour was concerning with delays in St George's due to lack of cubicle space as well as very high demand.

The Committee discussed the following issues:

- Setting higher standards – The Trust set a target to follow up within 48 hours of discharge even though the national target was 72 hours because the greatest risk of suicide was in that first 48-hour period after discharge. However, this led to a poor reflection in the report. The report should reflect that the Trust is meeting national standards.
- **AB** reported on her visit to the neuro- psychiatry team at St George's hospital. The staff made the point that the waiting time until the first appointment was not as significant as the waiting time for an intervention, which might be a much longer period of time. There should be more focus on the outcome.
- **AB** also reported on the discussion she had with the liaison psychiatry team. Patients in crisis were taken to five different A & E departments in South- West London which did not have the right staff to deal with them. It would be better if the London Ambulance Service were told to take them to a hospital where they could receive specialized care.
- **AB** commented that the medical staffing crisis was discussed as an HR risk, but it should also be considered from the perspective of the potential harm it could cause to patients and the effect on the quality of care.
- **BB** replied that the Executive team was mindful of the link between medical vacancies and the risk to patient safety and the quality of care. However, although there were significant medical vacancies, there were not many services without any doctors at all. The Trust was paying large amounts of money to agency doctors which potentially might have an impact on the Trusts financial stability in the future. The workforce crisis was a national crisis. Solutions had been canvassed. Training more doctors would only take effect in 13 years. International recruitment was one solution. They could encourage agency doctors to work for the Trust. NHS England might impose agency caps which might encourage agency staff to join the Trust.
- **DH** said that he had seen the IAPT results from all 32 London Boroughs and he confirmed that the Trust compared well to other organisations. He said that NHS England and the London Mental Health Transformation board were doing very valuable work, but it was not communicated to the Trusts. He said that the ICS and the ICB were consulting with service users about a new strategy but were not collaborating with the Trusts. DH also said that there was no communication on several other important issues, like digital providers.
- **AB** replied that the Trust was leading on the work to develop a mental health strategy for South West London, although it seemed like an ICS strategy.
- **DH** said that people were not properly triaged in A & E. It was essential that they were identified as having a mental health problem so that appropriate medical staff could treat them. There was also insufficient cubicle space.
- **BB** agreed that the treatment of people in crisis in A & E was not working as intended. He would consider how they could make a difference.
- **SS** replied that she would consider the treatment of people in crisis in A & E and bring the matter back to the Committee. – **ACTION.**
- **CAB** said that they were asked to fill in many surveys about the proposed strategy and they did not know what the outcome would be.
- **DBo** thanked DH and CAB for the valuable information they had provided.
- **DBo** said that it would be helpful for the Committee to understand the principles and criteria that the Executive Team was using to make judgments about what to prioritise within the metrics, accepting that it could not be perfect in an overstretched system.

Item

- **SS** replied that the Executive Team hadn't decided on priorities yet. They needed to understand the framework they were going to use. They would decide where they should focus their efforts.
- **DBo** replied that she hoped that the committee's discussion would help the discussion.

***JeA** joined the meeting.*

The Committee **noted** the report.

A22/148 **Bed management process & assurance**

JeA presented a paper and highlighted the following issues:

- She reported that there were challenges within the acute urgent care pathway. ELT wanted to have a dive into the processes by which these demands were managed. There was a need for good oversight of the demand and the capacity and to find a process to manage the demand against the capacity in a very clinically driven way. They were trying to optimise flow throughout inpatient services.
- They had achieved a lot in the time she had been in the Trust. She complimented her team, especially Charlotte Harrison, Lou Hellard, Jimmy???, Kenny ??? and the whole team within the Acute Coordination Centre for the huge amount of effort and time they had devoted to the process.
- The paper described the framework for managing acute demand capacity and showed excerpts of the various processes and policies and reports. JeA said that she felt assured that they had a robust process in place. They had shared their Smart Capacity Management system and prioritisation matrix with other mental Health Trusts and received positive feedback.
- The challenges were that patients in crisis could not be accommodated because there were no available beds. Mental Health Assessments could not be conducted. When patients were ready for discharge, they could not be discharged because of lack of suitable supported settings. Liaison with local authorities and other colleagues was necessary to find space to accommodate patients on discharge. This highlighted the need for transformation work and the right investment in both preventive and crisis services as demand increased.

The Committee discussed the following:

- Whether patients could be discharged to spare care home capacity? JeA explained that there was no space in care homes.
- ELT would discuss this issue at their next meeting
- The difficulty in managing the demand and capacity on a day to day basis and also finding the time and the headspace to perform the transformation as well.
- That it was difficult to make the system work but they were trying hard to address the situation and to try to improve it.
- Whether there was a better way of holding patients in crisis in A & E? Whether they should focus on holding patients in one of the 3 A&E's in the area and provide better facilities there?
- Alternatives to patients being held in A & E. A rapid access route rather than waiting in A & E was one solution that was being canvassed. Other solutions without patients going into the pathway were also being discussed.
- The possibility of using crisis houses to hold people before they were admitted to hospital and after discharge. JeA explained that there were presently two crisis houses in the area and they would look at opening others.

The Committee thanked JeA for the paper and asked her to convey its thanks and appreciation to her colleagues for the work they had done.

The Committee **noted** the paper.

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

Item

A22/149 **Corporate Objectives Q1 Report**

The Committee **noted** the report.

A22/150 **COMMITTEE GOVERNANCE and REPORTING**

A22/151 **Quality Governance Group minutes**

The Committee noted the minutes.

A22/152 **Mortality and Prevention Group Minutes**

The Committee noted the minutes.

A22/153 **Matters for Escalation to the Board**

- Menta Health Report
- Annual Homicide Report
- Mortality and Suicide Prevention Annual Report
- HR recruitment – Internal Critical Incident
- Information Governance Risk
- Perception in the Community regarding Strategy Development.

A22/154 **Committee Workplan**

The Committee noted the Committee workplan.

A22/155 **Meeting Review**

(a) Patient focus

Bed management discussion brought home the harm that could be done to patients who were held in A & E for some time because there were no beds in the hospital. Secondly, the risk of the patients becoming institutionalised when they could not be discharged because of lack of space in the community.

(b) Quality of challenge

Challenge of working hard to address the lack of beds and to try to improve the situation at the same time. The difficulty of balancing the demand for services and waiting times against staff capacity.

- The next meeting would be held on Monday, 3rd October at 13:30 via MS Teams.

Trust

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

Quality and Performance Report

September 2022

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

Introduction

The South West London and St George's Mental Health NHS Trust Quality and Performance report aims to supply information, describe action being taken and provide assurance to the sub committees and the Board.

During September, mental health service demand and acuity has remained high, while we continue to experience constraints on workforce availability. The impact is seen in continued pressure on our acute pathway (including waits for assessment and admission, length of stay and use of additional private beds, albeit supported by a robust framework to manage this safely) and extending waiting lists for community services for both adults and children (again, which we carefully oversee and track). As we work through our HR recovery plan, we have initiated a specific focus on recruitment to ensure we address these challenges and reduce our use of temporary staffing as a priority; alongside this our Fundamental Standards of Care work is being embedded in both inpatient and community settings. These programmes support the sustainable delivery of good care while we progress our Clinical Transformation programmes and plan for the exciting moves of our services into the new EMP buildings later this year.

The focus of this report is September 2022 and our priority metrics to ensure patient safety and effective care, along with our integrated approach to quality, workforce and overall productivity and sustainability. This is supported by detailed executive review and discussion at the bi-monthly Service Line Review (SLR) meetings, which focus on key issues, actions and accountability to address these. The SLR QI focussed cross-Service Line session has been re-launched to drive delivery of our priority KPI action plan created from the Root Cause Analysis of performance undertaken in September, and the Clinical Directors are considering further approaches to demand and capacity optimisation within services in line with discussions at QSAC. Productivity and Financial Grip & Control KPIs have been enhanced in this report and will be discussed at FPC each month moving forward to provide oversight and direction to our work on financial sustainability.

The HR Recovery Programme has agreed its key projects and deliverables across priority areas of, Medical Staffing, and Employee Relations, with project plans now in place between HR and the operational teams. There is now a more SWLSTG-focussed service in a number of HR functions, and it has been agreed to progress work to split services more fully as of September, with an over-hang of the OD function that will formally split at the end of March 2023. The executive team and HR and operational leads continue to monitor key workforce metrics as we work together to change the experience and outcomes for our teams. ELT have also agreed to place Recruitment (both general and Medical HR) into an internal critical incident, for a 12 week period. This will enable the organisation to improve processes to ensure the functions are as effective and efficient in bringing in new candidates into the organisation.

The following areas of challenge and improvement in relation to priority performance metrics are noted in September 2022.

Clinical Quality Update:

- The work on Fundamental standards of care continues to be led through the service line leadership team with great engagement from frontline staff. We have agreed a process for teams of concern to be escalated through the Service Line Reviews, triangulated with the Siren and the quality metrics. The FSOC are also embedded into the new building inductions to support it being part of the new culture.
- The Trust has agreed to add the Care Quality Review (CQR) outcomes alongside CQC actions and will be reviewed at service line reviews and through the CQC #always ready group
- Covid Booster and Flu vaccination centre commenced this month with continued drive to support uptake of the vaccine for all frontline staff.
- Concerns recognised in the MAST 1; there have been focused conversations in each SLR. Senior leadership have committed to daily dedicated focus. DoN has set up a meeting with the new Head of L&D to review the process around MAST (including DNAs). There is also consideration for an improvement plan for this area in Learning & Development.

Workforce Update:

- We are in the remaining three weeks of the recruitment incident and making good progress. Highlights are, improvements to the recruitment process maps and processes, the establishment is being cleansed to ensure live vacancy levels are more accurate in order to plan mass recruitment campaigns for this year, Service Lines review of establishments and agency usage is near to completion with Finance, HR and Ops working together to ensure this work is maintained when the project ends. Focus is now on the remaining actions targeting the remaining Medical Staffing processes, and temporary staffing processes and controls.
- Work on supporting colleagues with the cost-of-living issues are in place and further options were discussed w/c 17th October 2022 to enhance this further.
- The staff survey launched on 3rd October and the response rates are being closely monitored. Responses were lower in the first two weeks in comparison to last year's survey, but this is starting to increase. 'ComplEAT' lunches and site walks will take place over the remaining weeks of the survey which should also encourage increased response rates.

Access Update:

- Adult ADHD/ASD services face significant demand and capacity pressures and the impact is seen across this pathway. There is also an increased risk of the Trust incurring 52 week breaches due to the long waits. Waiting list initiative was implemented in order to address wait list backlog and additional staff are in place. An improvement plan has now been implemented led by Clinical Manager to improve processes around referrals, cancellations and contact options I.e. encourage e-consultation in long waiters who cannot attend face to face.
- The Trust has incurred a 52 week breach in Merton Adult ADHD service following cancellation of appointment and is now due to be seen in November 2022.
- All four IAPT services are below their cumulative access requirements. The volume of waits over 30 weeks continues to rise as Step 3 vacancies continue; this is a challenge for IAPT services nationally. Internal modelling, benchmarking and national modelling tools all indicate services are under-established for the current IAPT access rates. The Trust is working with the ICB to agree renegotiated targets for access to enable the services to stabilise the growth in long waiting patients. The revised targets include assumptions around internal efficiencies being delivered. The

Community service line will integrate the Richmond Wellbeing Service to the Trust in Dec 2022/23 which performs well on key measures. It should be noted that the South West London sector benchmarks above national averages for both access and recovery rates in latest publication of Royal Psychiatric Mental Health Watch.

- RTT performance is impacted by high demand and long waits. Reporting is being enhanced to use new clinician-designated treatment points in both Adult and CAMHS services. Work to address internal waits over 30 weeks is on-going. Focus is now on ensuring a robust referral and waiting list management process for psychology and to optimise capacity and review clinical treatment pathways. Reporting now incorporates treatment waits in CAMHS Tier 3 and Adult ED treatment waits.

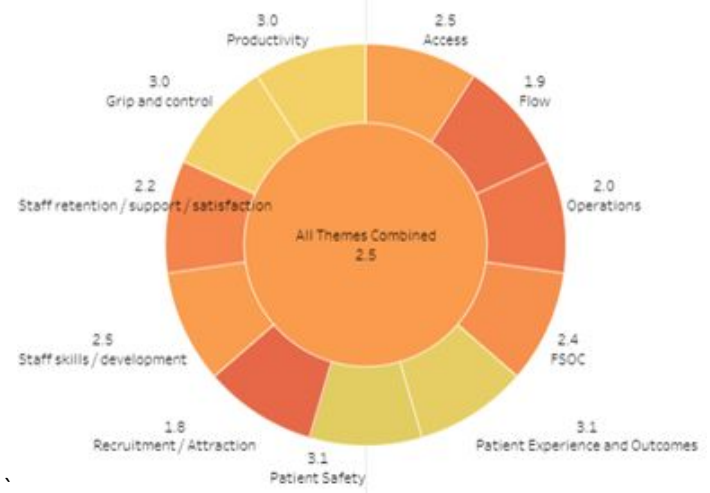
Flow & Productivity Update:

- Crisis and acute inpatient services remain in a challenging position, with the need to balance demand, waiting times in crisis, and bed capacity. All mental health trusts across London are facing similar issues and many have adopted block purchase of private beds. We are utilising a range of additional capacity, keeping patients in SWL wherever possible through block contracts for private acute and step-down hostel beds. Improving LOS is a key priority for the acute service transformation programme, with both clinical pathway and process work ongoing, using the EMP moves as a catalyst to standardise practice.
- The New Working Discharge Summary process was launched across the Trust on 1st August 2022. The new process allows GP letters to be automatically submitted via Docman Connect within RiO. Training on the new process and a new SOP has been disseminated across service lines. Performance in September 2022 further deteriorated as underlying operational process issues were exposed and these are being actively addressed to embed the new way of working and ensure timely communication. Intermittent IT glitches have also impacted on a small number of cases and the Trust's Application Development Team are working on resolution.
- Liaison services seeing patients in Emergency Departments within 1hr remains a concern; with delays in St George's due to lack of cubicle space as well as very high demand, whilst there have been staffing difficulties in Kingston. Services are looking at creatively utilising existing establishment (e.g. creation of new twilight shift in order to meet demand at peak times) and winter funding has been allocated to additional Triage resources for the liaison teams.
- There are significant concerns in Community Service Line on medical vacancy rate in Wandsworth & Richmond with mixed success from recovery efforts to date.
- New productivity measures have been introduced to reporting in September 2022, underlying issues and actions to address will be reported from October 2022. Reports to support service lines with this process will need development.

We continue to support front line staff and service line leadership teams to deliver improvements to our key priority areas in the context of ongoing demand and wider workforce pressure. 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 mean that improvement is slow. While progressing our transformation work in HR, Quality and Clinical services, we are also mindful of how to use digital workflows and best practice processes to support delivering sustainably excellent services in the future. Overall the Trust position is amber (see summary below) and the executive and Service Line leadership teams continue to work together to address our quality and performance challenges.

The Trust submitted a revised financial plan in June which showed a position of break-even for the year. To achieve this, the Trust needs to deliver a savings target of £12.4m. At Month 6, the Trust remains on its target trajectory and has delivered £5.0m of cumulative savings which is £1.2m behind plan, although remains on plan trading at a deficit to date of £1.4m. The underlying issue is one of identifying and delivery recurrent efficiencies to ensure financial sustainability moving forward (only c6% of savings are recurrent or c£1m)

Quality & Performance Summary (see appendix 9 for explanation on scoring)

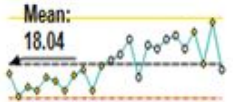
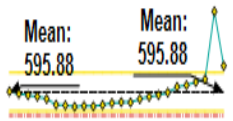
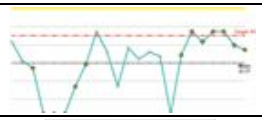
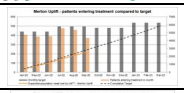
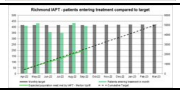
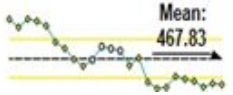
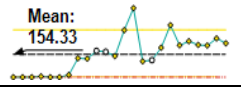
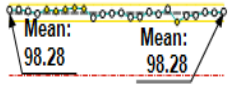


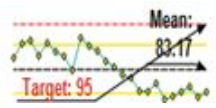
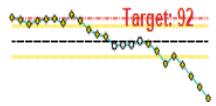
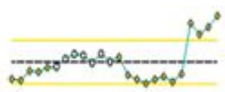
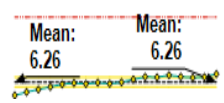
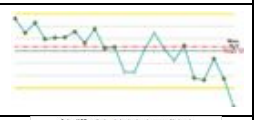
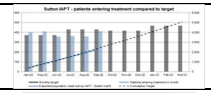
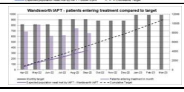
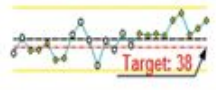
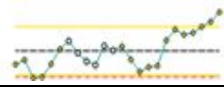
Summary Domain Performance:

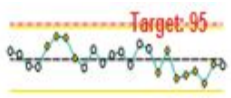
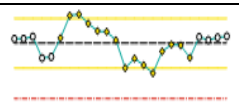
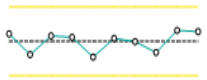
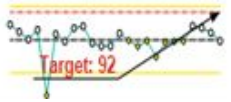
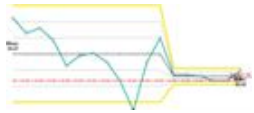
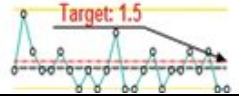
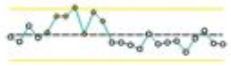
Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	5	10	20	42.9%
Quality	5	17	7	75.9%
Workforce	3	1	8	33.3%
Finance	0	3	0	100.0%
Total	**13**	**31**	**35**	**55.7%**

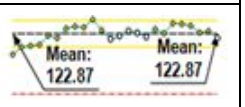
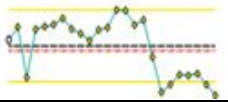
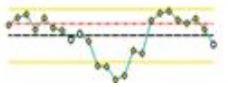
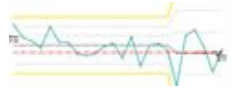
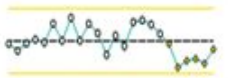
A table showing how many KPIs have full assurance, some assurance and no assurance, split by domain.

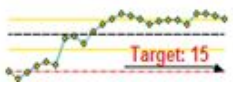
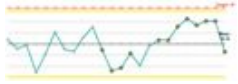
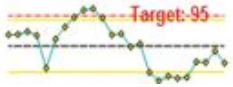
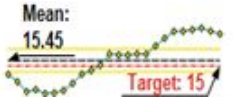
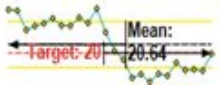
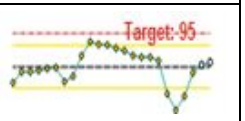
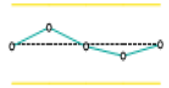
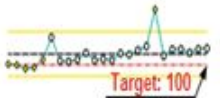
Priority Metrics

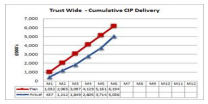
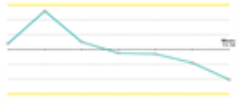
	Priority Metrics	Sep-22	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 10)	69.6	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 11)	15	= 0	↗	X	
	Access					
	No one is waiting more than 30 weeks for treatment - Number of breaches (including CAMHS Neuro, IAPT & Non-RTT teams) (see page 12)	1267	0	↗	X	
	Access					
	Adult and Older People's CMHTs - Non-Urgent Referrals assessed within 28 days (%) (see page 13)	72.1	≥ 80.0	→	?	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 15)	77.8	≥ 95.0	↗	?	
	Access					
	Expected population need IAPT – Merton Uplift (see page 14)	2814	2491	-	-	
	Access					
	Expected population need IAPT – Richmond (page 14)	2392	2505.9	-	-	
	Access					
	Time on caseload (days) (see page 17)	445.3	-	↘	-	
	Flow					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 18)	229	= 0	↗	X	
	Flow					
	Data quality maturity index (DQMI) (%) (see page 19)	98.3	≥ 95.0	→	✓	
	Operations					

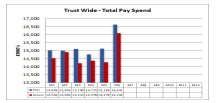
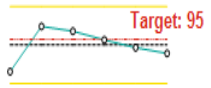
	Priority Metrics	Sep-22	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (see page 10)	77.3	≥ 95.0	↘	X	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 11)	76.4	≥ 92.0	↘	X	
	Access					
	Internal waits for treatment of over 30 weeks (see page 13)	381	-	→	-	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 14)	6.7	≥ 10.0	↗	X	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 15)	53.5	≥ 80.0	↘	?	
	Access					
	Expected population need IAPT Sutton Uplift (see page 14)	2302	2409	-	-	
	Access					
	Expected population need IAPT – Talk Wandsworth (see page14)	4145	5187	-	-	
	Access					
	Adult acute average length of stay (Excluding PICU) (see page 17)	50.9	≤ 38	↗	X	
	Flow					
	Delayed transfers of care (%) (see page18)	9	≤ 2.5	↗	X	
	Flow					

	Priority Metrics	Sep-22	Target	Trend	Assurance*	SPC Chart
Quality	Community risk assessments reviewed within the last 12 months (%) (see page 20)	92.6	≥ 95.0	↘	✗	
	Fundamental Standards of Care					
	Physical Health Assessment attempted within 48 hours of admission (%) (see page 21)	91.5	≥ 95.0	→	?	
	Fundamental Standards of Care					
	Cardiometabolic Assessments - Community and EIS (%) (see page 22)	85.6	≥ 75.0	↘	✓	
	Fundamental Standards of Care					
	Safe Staffing: requirements inc obs levels (see page 23)	87.2	-	→	-	
	Fundamental Standards of Care					
	Always Ready Audits Completed (%) (see page 23)	76.6	≥ 90.0	↗	✗	
	Fundamental Standards of Care					
	Patient Friends and Family Test (%) (see page 25)	81.2	≥ 92.0	↘	✗	
	Patient Experience and Outcomes					
	IAPT recovery rate - Merton Uplift (%) (see page 26)	51.9	≥ 52.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate – Richmond IAPT (%) (see page 26)	51.6	≥ 50.0	↘	?	
	Patient Experience and Outcomes					
	Patient Safety Incidents – Severe Harm (see page 27)	0	≤ 1.5	→	?	
	Patient Safety					
	Reducing restrictive practices – Prone Restraint (see page 28)	23	-	→	-	
	Patient Safety					
	Inpatient discharge letters sent within 24 hours (%) (see page 29)	77.3	≥ 90.0	↘	?	
	Patient Safety					

	Priority Metrics	Sep-22	Target	Trend	Assurance*	SPC Chart
Quality	Inpatient Risk assessments completed within 48 hours of admission (%) (see page 20)	90.2	≥ 95.0	↘	✗	
	Fundamental Standards of Care					
	Physical Health Assessment completed within 7 days of admission (%) (see page 21)	84.4	≥ 90.0	→	✗	
	Fundamental Standards of Care					
	Safe Staffing: National Compliance - Inpatients (%) (see page 22)	121	≥ 95.0	↗	✓	
	Fundamental Standards of Care					
	Always Ready Audit Compliance (%) (see page 24)	84.7	≥ 90.0	↘	✗	
	Fundamental Standards of Care					
	Complaints Answered Within 25 Days (%) (see page 24)	59.4	≥ 85.0	↗	?	
	Patient Experience and Outcomes					
	Emergency readmission within 30 days - Adult Acute & PICU (%) (see page 25)	3.4	≤ 8.5	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate - Sutton Uplift (%) (see page 26)	50.7	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate - Talk Wandsworth (%) (see page 26)	51	≥ 50.0	→	✓	
	Patient Experience and Outcomes					
	Total number of restraints (physical restraints and rapid tranquilisation) (see page 28)	110	-	↘	-	
	Patient Safety					
	Death - Suspected suicide (see page 29)	0	≤ 4	→	-	
	Patient Safety					
	Follow up within 48 hours of discharge from inpatient services (%) (see page 30)	83	≥ 95.0	→	✗	
	Patient Safety					

	Priority Metrics	Sep-22	Target	Trend	Assurance*	SPC Chart		Priority Metrics	Sep-22	Target	Trend	Assurance*	SPC Chart
Workforce	Vacancy Rate (%) (see page 31) **Recruitment/ Attraction**	19.9	≤ 15	↗	✗		Workforce	Vacancies in active recruitment (%) (see page 32) **Recruitment/ Attraction**	58	≥ 90.0	→	✗	
	Time to Recruit (days) (see page 32) **Recruitment/ Attraction**	60.5	≤ 49	↗	✗			Percentage of BAME staff - Band 8+ and Medical (see page 33) **Recruitment/ Attraction**	30.4	≥ 50.0	↗	✗	
	Temporary staffing - Acute and Urgent Care Service Line (%) (see page 33) **Recruitment/ Attraction**	30.2	≤ 22	↗	✗			Temporary staffing - Community Service Line (%) (see page 34) **Recruitment/ Attraction**	18.1	≤ 22	↗	✓	
	Statutory and Mandatory Training: 1 (%) (see page 35) **Staff Skills/Development**	92.2	≥ 95.0	↘	✗			Statutory and Mandatory Training: 2 (%) (see page 35) **Staff Skills/ Development**	88.3	≥ 85.0	↘	✓	
	Turnover (%) (see page 36) **Staff Retention/ Support / Satisfaction**	17.6	≤ 15	↗	✗			Staff Leaving within 12 months of appointment (%) (see page 36) **Staff Retention/ Support / Satisfaction**	20	≤ 20	↘	✓	
	Supervision (%) (see page 37) **Staff Retention/ Support / Satisfaction**	82.1	≥ 85.0	→	?			PADR (%) (see page 37) **Staff Retention/ Support / Satisfaction**	87	≥ 95.0	↘	✗	
	Active ER cases (see page 38) **Staff Retention/ Support / Satisfaction**	51	TBA	→	-			ER cases exceeding 90 days (see page 38) **Staff Retention/ Support / Satisfaction**	23	TBA	→	-	
	Staff FFT (recommend treatment) (%) (see page 39) **Staff Retention/ Support / Satisfaction**	-	≥ 75.0	-	-	Metric to be developed	Finance	Agency as a % to NHSI Target (%) (see page 40) **Grip & Control**	138.3	≤ 100	→	?	

	Priority Metrics	Sep-22	Target	Trend	Assurance*	SPC Chart
Finance	% Forecast budget overspend (see page 40 (see)	**0**	≤ 0	→	?	Mean: .00 Mean: .00
	Grip & Control					
	Cumulative CIP Delivery £000 (see page 41)	5036	6194	-	-	
	Grip & Control					
	Activity Vs WTE (see page 42)	12.5	-	→	-	
	Productivity					

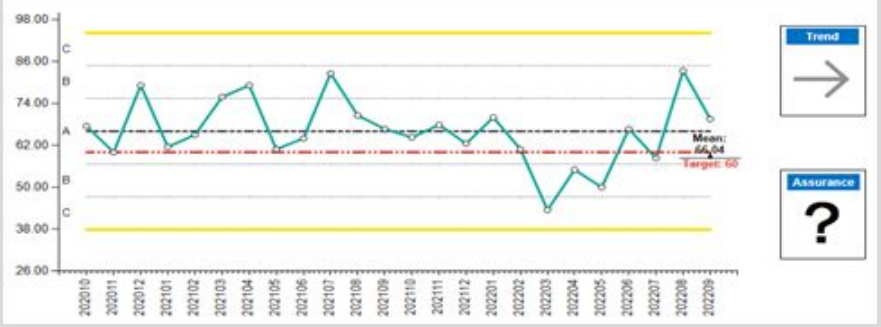
	Priority Metrics	Sep-22	Target	Trend	Assurance*	SPC Chart
Finance	Pay Cost Vs Budget £000 (see page 41)	16,102	16,631	-	-	
	Grip & Control					
	Activity vs Caseload (see Page 42)	1.4	-	→	-	
	Productivity					
	Contract Activity – Local CCG Contract (%) (See page 43)	93	≥ 95.0	→	?	
	Productivity					

* 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 – September 2022

EI Team	Treatment <= 14 days	Referrals	% Treatment <= 14 days
Kingston Early Intervention Service	1	5	20.0%
Merton Early Intervention	5	5	100.0%
Richmond Early Intervention Team	2	3	66.7%
Sutton Early Intervention	1	2	50.0%
Wandsworth Early Intervention	7	8	87.5%
Total	16	23	69.6%

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
While there is significant variation, the Trust can be expected to usually exceed the target which is below average performance.

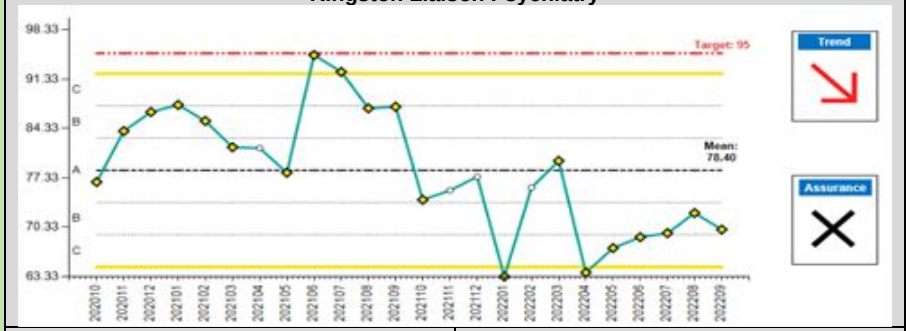
Underlying issues
- Inconsistent clinical oversight of waiting list and validation is not always completed promptly.
- Occasional insufficient awareness of processes for new staff.
- Some inpatient wards and community teams are slow to refer patients on to EI services once psychosis is identified making 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.
- There has been an unplanned gap in team leadership in Kingston & Richmond EIS contributing to insufficient oversight of recent performance.
- There were some administration issues which led to duplicate referrals being added to clinical record – such cases need to be removed.

Actions:
- Trust to explore digital solution to initiate a prompt in Rio upon entry of diagnosis of psychosis. This issue will be discussed at the RiO Governance Group in August 2022.
- Targeted training for SPA teams to continue in order to reinforce the importance of timely referrals to EIS.
- 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.

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

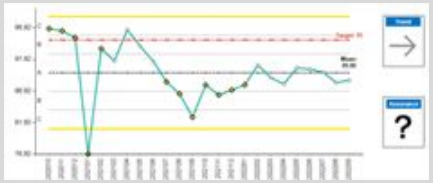
Access

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.

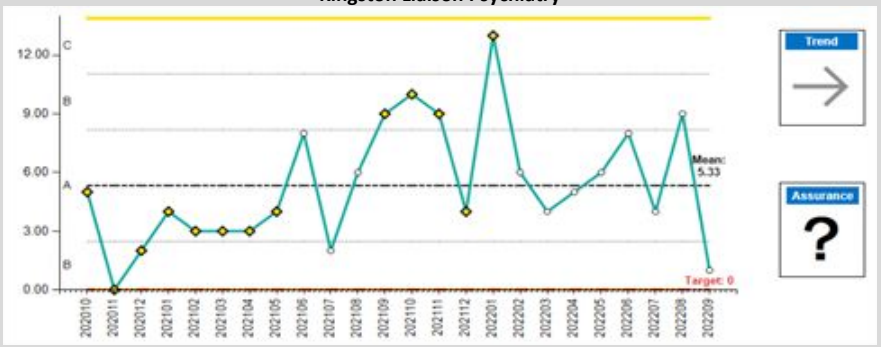
Underlying issue:
- High numbers of referrals in Kingston and St Georges in comparison to staff levels; unfilled posts; referrals during handovers or out of hours meaning the services are not always able to meet demand.
- Service users delayed at A&E are causing an increased workload for clinicians and a drain on the resources as these patients require additional review.
- Liaison services also see patients on acute hospital wards which also diminishes capacity.
- Delays in St Georges continue to be caused by a lack of cubicle space to assess patients and the team do hold a larger caseload with some clients required to be seen on the acute hospital wards.

Actions:
- Recruitment of new Clinical Service Leads and Team Managers as part of the work of creating an MDT Leadership Culture and ownership of key liaison KPIs.
- In St George's costing of new establishment to include an additional night staff has been completed. The aim is to provide floating support across all 3 Liaison and help improve performance related to capacity of staff in peak times.
- Additional resource at night-time has been made available to all three services.
- Consultant and Team Managers are working together using QI methodology for improvement in 1- hour response time by also understanding efficiency/productivity by accurate use of RiO, task prioritisation.
- Recruitment of new Clinical Service Leads and Team Managers as part of the work of creating an MDT leadership culture and ownership of key liaison KPIs.

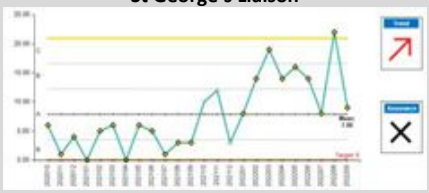
Access

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

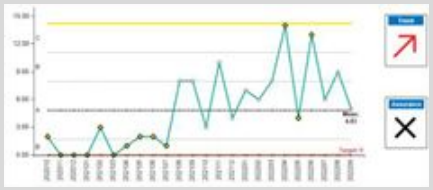
Kingston Liaison Psychiatry



St George's Liaison



St Helier Liaison



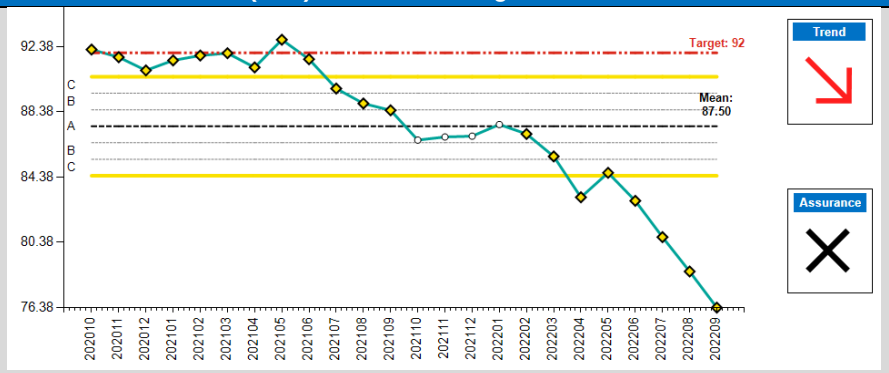
Background
Patients assessed at A&E by Liaison Psychiatry should not experience long waiting times if access to a bed is required.

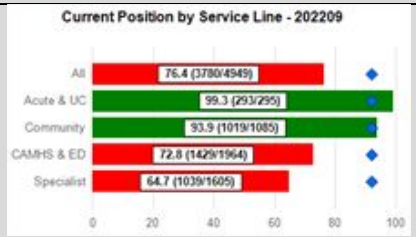
What the charts tells us
The level of 12-hour breaches is relatively consistent across the three services with occasional variation.

Underlying issue
- A lack of available adult acute beds will lead to an increase in waits over 12 hours.
- Increased levels of delayed transfer of care can affect patient flow.

Actions
- Breaches are discussed and escalated in a daily pathway meeting where patient clinical needs and risks are rated using a bed prioritisation scoring.
- The new Acute & Urgent Care Service Line management are to have discussions with liaison services in November 2021 as part of a review and update of action plans related to consistently underperforming metrics.
- The Trust has extended its contract for use of 12 beds at Huntercombe in Roehampton until the end of the financial year.
- Meeting took place to review use of trusted assessor framework to minimise need for admission.
- Recruitment of Consultant Psychiatrist to Kingston Liaison Psychiatry on short term contract; there is also ongoing recruitment process for substantive Consultant posts within the service.
- 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%





% Waiting less than 18 weeks including / excluding ADHD/ASD teams – September 2022

Including ADHD/ASD teams	76.4%
Excluding ADHD/ASD teams	85.7%

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.

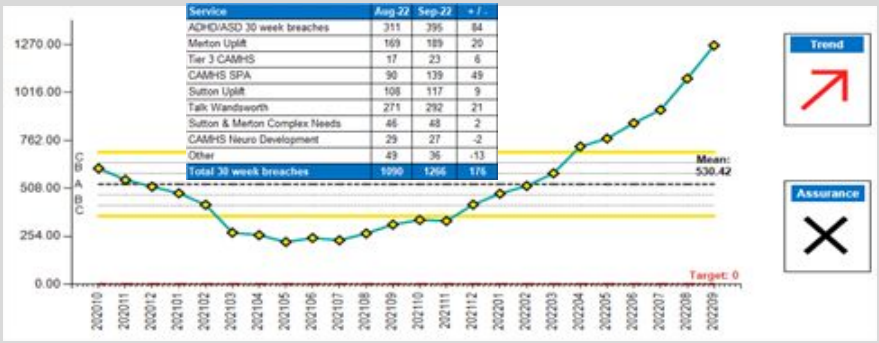
What the chart tells us
Mean performance is below target and there has been a significant downturn trend in performance since April 2021. A change in process is required in order to improve performance.

Underlying issue
- **Adult ADHD:** There are known demand and capacity issues within the service; in September 2022, 44.0% (536/1217) of the 18-week breaches relate to this service (see below for further information).
- **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.
- **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 the Tier 3 CAMHS service. Additional staff are being recruited to a number of Tier 3 services following further investment. Nurse prescriber in Merton (for ADHD medication) commenced in post on 7th July 2022.
- **CAMHS SPA:** NDT backlog clearance resource deployed in Kingston & Richmond SPA in August 2022.
- Therapy waiting cases are reviewed through 8 weekly review calls and all waiting patients are provided with a While you Wait support pack. In addition, therapy waiters are asked to call the T3 duty line if they feel their issues are deteriorating.
- **Adult ADHD:** See below.

Access

No one is waiting more than 30 weeks for treatment - Number of breaches (including IAPT & Non-RTT teams) Target = 0



Background
The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment by a consultant led service. This metric includes other non-consultant led teams.

What the chart tells us
Following long-term poor performance, the trust was able to consistently improve but there has been further deterioration over recent months.

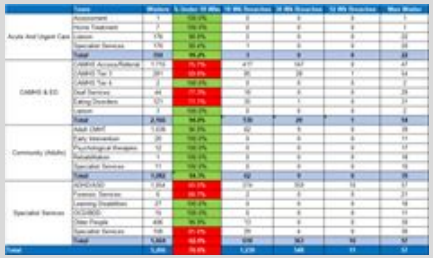
Underlying issues

- Relates to a small number of services with longstanding demand and capacity issues (see table opposite).
- **Adult ADHD:** Significant increase in referrals and insufficient capacity. Additional monies have been received but recruitment has been challenging and will not resolve the issue. Productivity issues in assessment reports and assessment tools have been identified. A significant risk of 52-week breaches without intervention.
- **CAMHS Neurodevelopment Team:** Insufficient capacity to clear those already waiting; the service was able to only manage to address the current flow of patients. Onward referrals to Tier 3 for ADHD medication commencement contributed to the increasing wait times.
- **Sutton & Merton Complex Needs:** Demand and capacity issues and lack of stepped care pathway for patents with personality disorder; 24 people waiting more than 52 weeks for treatment while under support of the RST.
- **IAPT:** The volume of waits over 30 weeks continues to rise as Step 3 vacancies continue; this is a challenge for IAPT services nationally. Internal modelling, benchmarking and national modelling tools all indicate services are under-established for the current IAPT access rates.
- Long waiters have been outsourced to 3rd party provider and there are concerns about capacity and performance and longer waits. The Trust believes this is common among many third party providers. Administration resources stretched and unable to get cover via Trust Bank.

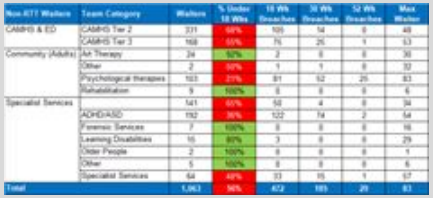
Actions:

- The reporting of RTT by appointment type commenced on 1st July 2022 this will provide more accurate waiting times and enable teams to have more control in determining when treatment has commenced. Dashboards are currently being realigned to support local monitoring.
- **Adult ASD/ADHD**: **Waitlist initiative**: ADHD long waiters will be seen by a third-party using waiting list initiative monies. Thus far 176 clients have been transferred to Clinical Partners. **Annual Medication Review**: To undertake annual medication reviews and support caseload management two non-medical prescribers have been recruited, these staff are now in post and completing their scope of practice. A further post is currently out for recruitment.
- Improvement plan led by Clinical Manager to improve processes around referrals, cancellations and contact options I.e. encourage e-consultation in long waiters who cannot attend face to face.
- **CAMHS SPA:** NDT backlog clearance resource deployed in Kingston & Richmond SPA in August 2022. **Sutton**
- **Merton Complex Needs (non-RTT):** Short & medium term action plan in place to recruit to new posts and address variation between borough CNS teams – reporting through to Trust-wide work on PD. Improved stepped care through community transformation. Recruitment and training of new Structured Clinical Management workers (x13 new posts into Community SL in Jan 2022, adding 6 more in 22/23).
- **IAPT:** Agreement to return to ICB to renegotiate targets for access to enable the services to stabilise the growing long waiters. Meeting with ICB set for mid-September and revised access trajectory will be provided.
- Continued focus to drive down vacancies for Step 3.
- A performance review with COO for IAPT services was held on 22nd August 2022.

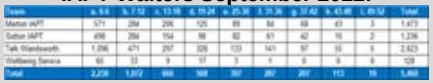
RTT Waiting September 2022:



Non RTT Waiting September 2022:

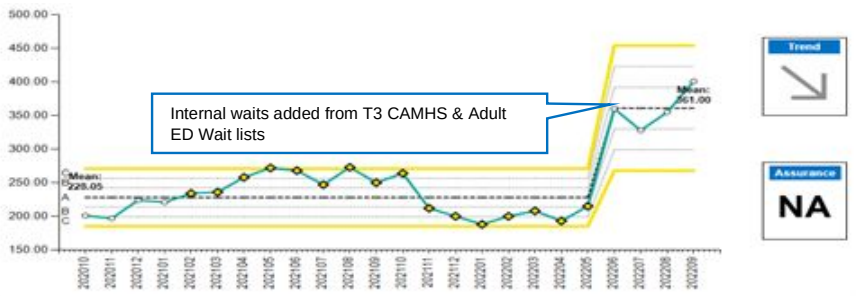


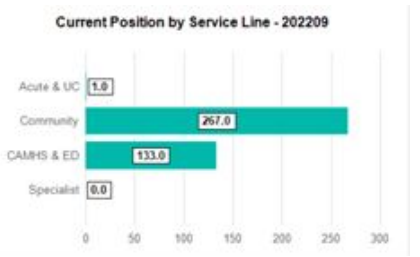
IAPT Waiters September 2022:

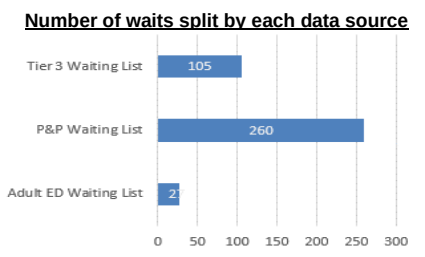


Access

Internal waits for treatment of over 30 weeks — Target = 0







Background
Psychological interventions, such as the use of Cognitive Behavioural Therapy (CBT) are an important part of patient treatment and lead to improved outcomes. Delays or barriers to treatment are likely to adversely affect patient outcomes. This is a new priority metric for the Trust Board introduced in July 2021.

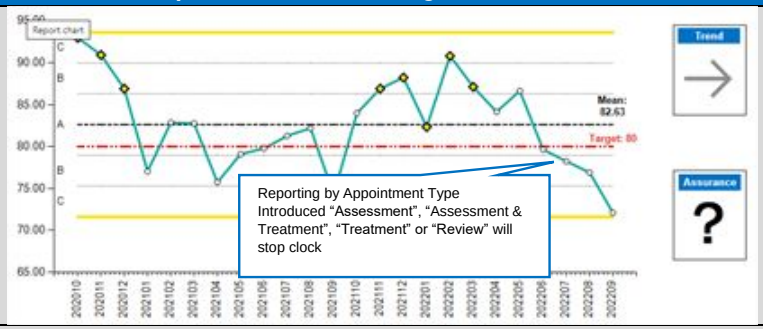
What the chart tells us
Period of significant increase has been followed by a decrease in long waiters in recent months. Recent spike linked to changes in reporting definition.

Underlying issues
- CAHMS Tier 3 & Adult Eating Disorders are now incorporated in internal wait reporting.
- CAMHS waiting data for Tier 3 is now in place; Richmond Tier 3 historically has had a back log waiting for therapy
- Historically services have not been reviewing existing dashboards resulting in data quality issues.
- An ever-increasing demand for psychological input with demand exceeding capacity.
- Staff issues: early career posts remaining vacant for extended periods; preceptorship posts reducing in-service capacity; staff training (HEE community transformation programme) reducing capacity.

Actions
- Community: Improvement plan in place and discussed at April's Access Meeting. A recruitment drive is ongoing and a review of staff productivity is to be undertaken over the summer period. The service line is also Training non-P&P staff to deliver CBT which will increase capacity, this is a long-term measure with staff taking 2 years to complete training.
- Comprehensive action plan for Complex Needs services in place.
- There a number of Trainee Clinical Psychologists placements due to commence in November 2022 and this led to reduction in wait list.
- Employment of 10 Trainee Mental Health & Wellbeing Practitioners will increase capacity to deliver psychologically informed interventions. Trainees started 9/5/22 but there will be a lag before they are trained sufficiently – likely Sept 2022.

Access

Adult and Older People's CMHTs - Non-Urgent Referrals assessed within 28 days (%) — Target ≥ 80%



Underperforming Teams

Assessment Team	Assessed within 28 days	Assessments	% Assessed within 28 days
Kingston & Richmond Assessment Centre	75	95	78.9%
Wandsworth Older People's CMHT	7	9	77.8%
Carshalton & Wallington IRH	9	12	75.0%
South Kingston CMHT	3	4	75.0%
Richmond OP Recovery & Support Team	16	23	69.6%
Richmond RST	3	5	60.0%
Wimbledon Recovery and Support Team	4	7	57.1%
Sutton PLRS - Single Point of Access	36	69	52.2%
Mitcham Recovery and Support Team	2	4	50.0%
North East Wandsworth CMHT	3	6	50.0%
Wandsworth SPA	58	119	48.7%
Sutton and Cheam IRH	3	7	42.9%
Sutton PLRS - Recovery Team	0	1	0.0%

Background
The Trust is committed to ensure our service users have rapid access to Trust services as evidence suggests that this can lead to improved outcomes.

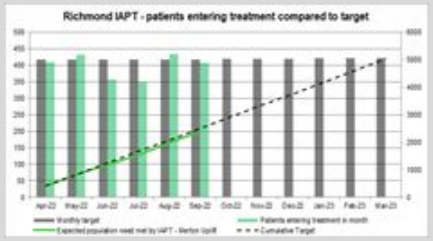
What the chart tells us
Mean performance is above target but there is some variation over the period. Last three months there has been deterioration.

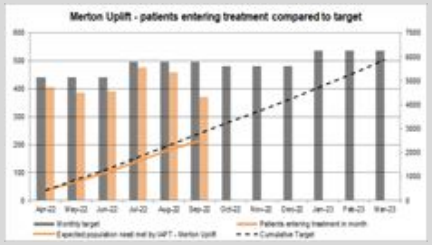
Underlying Issue
- Trust: Increased demand has placed significant capacity pressure on some assessment teams/CMHTs.
- Managerial gaps (Team Manager level) affecting coordination of service delivery and staffing team manager level.
- Limited clinical capacity due to sickness and difficulty filling locum positions has reduced assessment slots from consultants.
- Audit undertaken in September 2022 has shown Assessment Teams were seeing people within 28 days however have been recording 1st appointment type as "Triage". Under new rules (implemented in July 2022) only "assessment", assessment & treatment", "treatment" or "review" stop the 1st appointment clock.

Actions
- The reporting of RTT & Access KPI's by appointment type commenced on 1st July 2022 this will provide more accurate waiting times and enable teams to have more control in determining when treatment has commenced.
- Additional communication on appointment type recording has been issued to assessment teams in Community Service Line. Teams have also been asked to progress amendments to appointments accordingly.
- Substantive team managers in place in both North Kingston and South Kingston and Advanced Clinical Practitioner to assist in coordinating non urgent assessment.
- Sutton: Sutton Primary Liaison and Recovery Service Single Point of Access team has a recovery plan in place and is currently working through their wait list backlog which is reducing.
- Additional management support is being provided to the team via the Service and Clinical Manager

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.

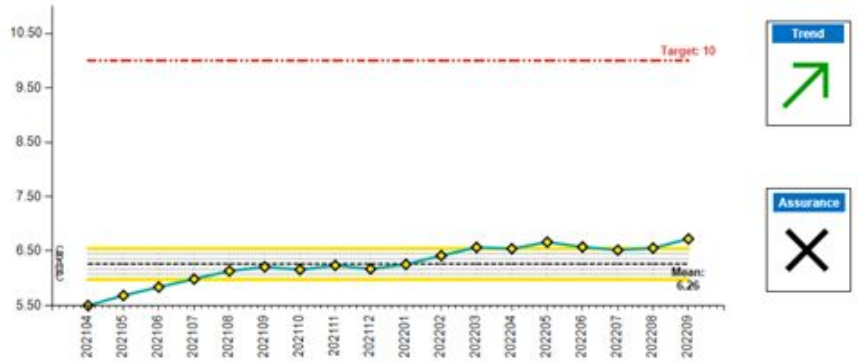
What the chart tells us
All four IAPT services are below their cumulative access requirements.

Underlying issues
- The volume of waits over 30 weeks continues to rise as Step 3 vacancies continue; this is a challenge for IAPT services nationally. Internal modelling, benchmarking and national modelling tools all indicate services are under-established for the current IAPT access rates.).
- Staff absences due to long term sickness/unplanned leave can lead to lost triage slots.
- National lack of available of PWP trained clinicians contributing to high vacancy rates.
- Issue with self-referral referral link on website for Merton Uplift which is impacting on incoming numbers and referral rates. Issue picked up in June 2022.

Actions
- The Trust is working with the ICB to agree nationally renegotiated targets for access to enable the services to stabilise the growth in long waiting patients.
- Internal modelling, benchmarking and national modelling tools all indicate services are under-established for the current IAPT access rates
- The Trust has met with the third-party provider that is underperforming and an action plan is in place to address known issues including people who disengage with the service.
- Services continually review marketing plans; initiatives include face to face engagement, health and social care meetings and use of social media platforms.
- On-going recruitment across all services; increased marketing including working with partners, local authorities and community hub partners are in place in order to promote services and increase referrals; calls to all users in Sutton to support digital offer from online partner agencies.
- Continued close oversight of sub-contracted providers to ensure appropriate level of activity is being undertaken, and housekeeping (discharge management) is routinely performed in service
- IAPT performance meeting with COO held on 22nd August 2022, marketing plans subject to scrutiny at this meeting.

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

Access



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.

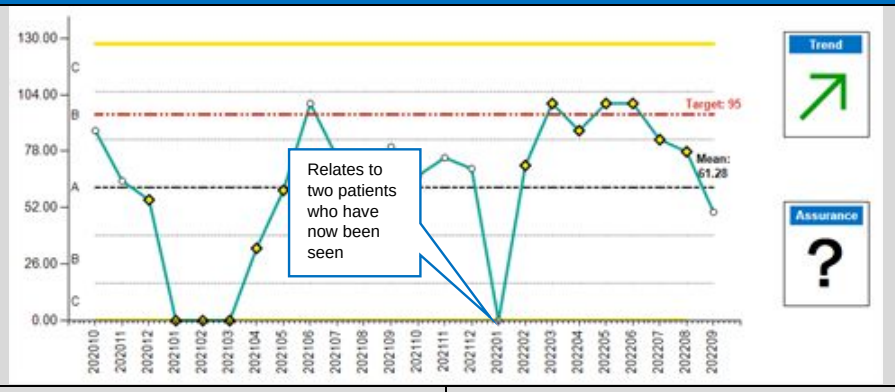
What the chart tells us
Although positive upward trend mean performance is considerably below national requirement (target).

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.
- Data quality in recording is impeding performance.
- Limited financial investment will prevent expansion of team –lack of capacity to increase access rates to required levels and reduce ability to reduce inequalities.

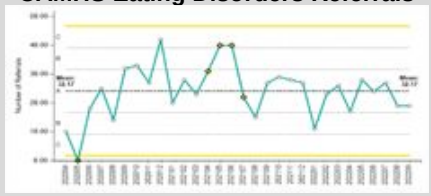
Actions
- Bank shifts added to capacity in order to increase new patient assessments and reduce waiting time, especially in Sutton& Merton.
- Health visitors and midwives attend some huddle meetings this will help increase referrals. This practice to be more standardised across all huddle meetings where possible.
- Ongoing development of maternal mental health service with review of additional capacity and impact on access
- Management Team have continued focus correct coding of activity.

Access

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



CAMHS Eating Disorders Referrals



Waiting for Treatment Summary September 2022

		00 - 01	01 - 02	02 - 03	03 - 04	04 - 05	06 - 07	07 - 08	09 - 10	11 - 12	12+	Total
Waited	Standard	0	0	0	0	0	1	0	0	0	0	1
	Urgent (7days)	0	2	0	0	0	1	0	0	0	0	3
Waiting	Standard	2	3	3	5	2	2	1	1	2	5	26
	Urgent (7days)	0	0	1	1	0	0	0	1	0	0	3

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

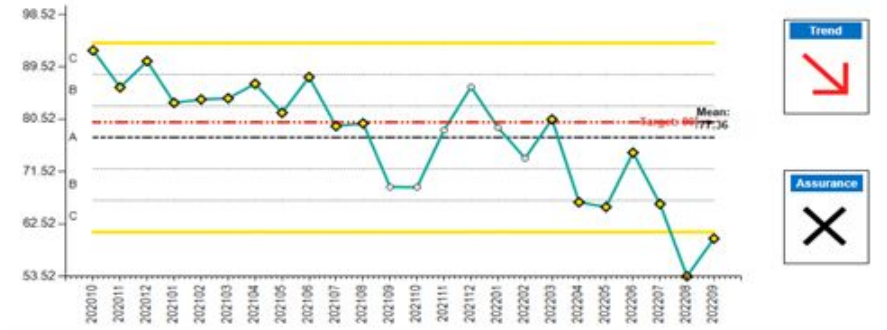
What the chart tells us
Mean performance is below target. Recent performance has shown improvement with targe being met on occasion.

Underlying issue
- Long term demand capacity issues within the team lead to children waiting over 30 weeks for treatment
- Over-reliance on part time staff to maintain administrative systems.
- There was one breach in September 2022, caused by a delayed referral transfer to the CAMHS Eating Disorders team and demand and capacity issues within the team. The denominator is low (n=2 in September 2022), so any case seen outside 28 days is likely to lead to target being missed.
- Recruitment into the service has been challenging with certain posts difficult to recruit to.

Actions
- Additional training and intensive supervision have been provided to nurses in fixed term / seconded posts in the team to provide first line family focused eating disorder therapy.
- There is ongoing recruitment within the service with all vacant posts either out for advert or about to be advertised. A new Consultant commenced in post in July 2022.
- Improved recording process and dashboards have been introduced to support more accurate reporting.
- New Service Manager is now in post and improving waiting times has been identified as a priority.

Access

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



Team Breakdown

Access Team	Accessed 8 Weeks	Assessed	%
Wandsworth CAMHS Tier 3	13	15	86.7%
Sutton CAMHS Tier 3	16	19	84.2%
Merton CAMHS Tier 3	10	14	71.4%
Richmond CAMHS Tier 3	3	9	33.3%
Kingston CAMHS Tier 3	6	23	26.1%
Total	**48**	**80**	**60.0%**

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 just above target indicating target will frequently be met but there will be variation. Recent months there has been deterioration.

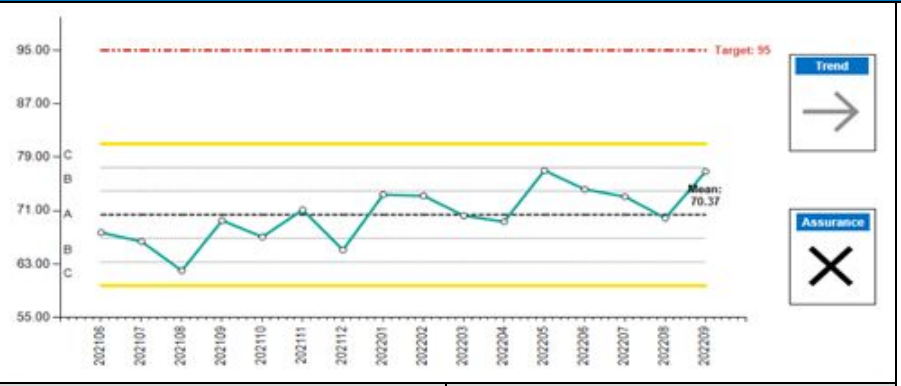
Underlying issue
- Most breaches relate to waits for ADHD medication and Psychiatry. As T3 CAMHS continues to assess more of the backlog of ADHD waiters this KPI will continue to deteriorate of until the backlogs are cleared.
- There are delays in ADHD medication due to the prioritisation of urgent referrals, screening forms being returned late, patients cancelling appointments and a small number of errors in recording.
- Increased urgent referrals and inpatient reviews have impacted on psychiatry time.
- As T3 CAMHS continues to assess more of the backlog ADHD waiters this KPI may also continue to deteriorate in terms of the % of assessments completed within the 8-week KPI in month until the backlogs are cleared.

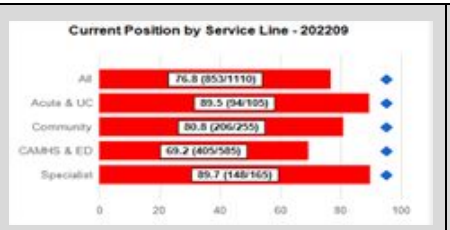
Actions
- Psychiatry continues to prioritise higher risk referrals for appointments, meaning ADHD medication waiters (who are less risk) will continue to be reason for most 8-week breaches.
- Non-medical Prescriber commenced in post in March 2022 with focus on clearing ADHD backlog. Currently working in Kingston Tier 3 after reducing backlog in Wandsworth Tier 3.
- Ongoing recruitment into Tier 3 CAMHS services which will increase assessment capacity.
- Additional Non-Medical Prescriber for Merton Tier 3 commenced in post in July 2022.

Zoning caseload seen as required (%) - Amber

Target ≥ 95%

Flow





Background
Following the COVID pandemic in March 2020 there was a significant reduction in the numbers of face to face contacts as these were replaced with telephone and video calls. Services have developed procedures and standards to ensure that patients receive appropriate care and levels of face to face contacts. Patients are categorised into 'zones' according to clinical need and risk and how often they should be seen.

What the chart tells us
Significant under-performance the target will not be met without a change in process.

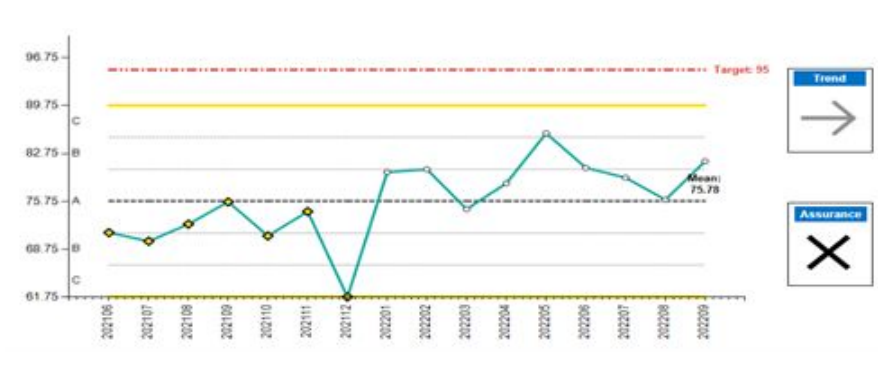
Underlying issue
- Slow adoption of some teams of standard operating procedures relating to recording the correct zone and the prompt recording of contacts.
- Poor administration of diary in RiO/IAPTus; where seen appointments are not recorded/outcomed in timely manner or are missed completely
- CAMHS: Audit has highlighted that there are cases where the client's zone needs to be downgraded to i.e. red to amber or amber to green. So there are cases where young person remain on higher risk zone for too long.
- Significant and unresolved variation in clinical practice, relating to risk-management and the categorisation of 'amber zone' patients.
- Significant numbers of patients are either shielding or do not feel it is safe and so are unwilling to agree to a face to face contact, preferring a telephone or video call. Ration of diary in RIO
- Improvement noted in Specialist Service Line where there has been a focus on embedding zoning in teams led by Deputy Head of Service Delivery.

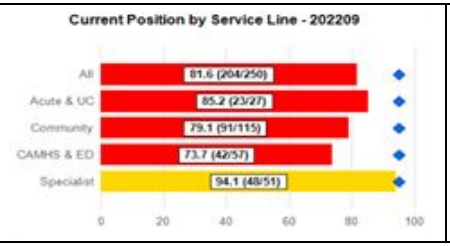
Actions
- A decision support tool has been introduced across all service lines to support staff to deliver care in the appropriate setting and at the right frequency
- This metric is subject to Root Cause Analysis review led by COO which commenced in August 2022.
- The CAMHS Service Line has developed and issued revised guidance (developed by the Advanced Clinical Practitioner) in order to support Tier 3 services.
- Zoning audits are being across service lines to inform on learning and local practice
- This metric is subject to Root Cause Analysis review led by COO which commenced in August 2022.
- Specialist Services are also undertaking regular audit on zoning breaches to inform on learning and Clinical Managers/Modern Matrons are ensuring teams are using dashboards in meetings and reviewing breaches when there is no contact.

Zoning caseload seen as required (%) – Red

Target ≥ 95%

Flow





Background
Following the COVID pandemic in March 2020 there was a significant reduction in the numbers of face to face contacts as these were replaced with telephone and video calls. Services have developed procedures and standards to ensure that patients receive appropriate care and levels of face to face contacts. Patients are categorised into 'zones' according to clinical need and risk and how often they should be seen.

What the chart tells us
Significant underperformance, the target will not be met without a change in process.

Underlying issue
- Slow adoption of some teams of standard operating procedures relating to recording the correct zone and the prompt recording of contacts.
- Significant numbers of patients are either shielding or do not feel it is safe and so are unwilling to agree to a face to face contact, preferring a telephone or video call.
- Poor administration of diary in RiO/IAPTus; where seen appointments are not recorded/outcomed in timely manner or are missed completely.
- Improvement noted in Specialist Service Line where there has been a focus on embedding zoning in teams led by Deputy Head of Service Delivery.

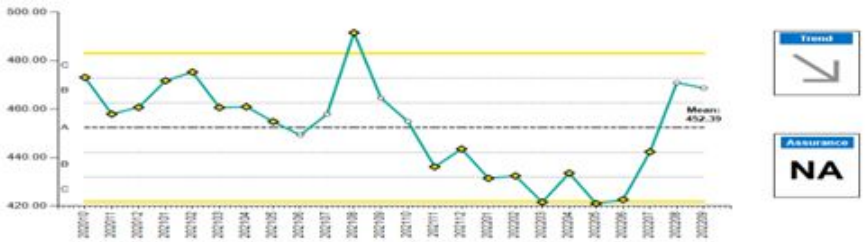
Actions
- A decision support tool has been introduced across all service lines to support staff to deliver care in the appropriate setting and at the right frequency
- This metric is subject to Root Cause Analysis review led by COO which commenced in August 2022.
- The Community Service Line in conjunction with AUC are developing a more aligned approach to patients who are showing signs of deterioration into crisis or disengagement.
- The CAMHS Service Line has developed and issued revised guidance (developed by the Advanced Clinical Practitioner) in order to support Tier 3 services.
- Zoning audits are being conducted across service lines to inform on learning and local practice

Flow

Time on caseload (Community & CAMHS & ED Service Lines Only) — No Target

Adult Community:

CAMHS & ED:

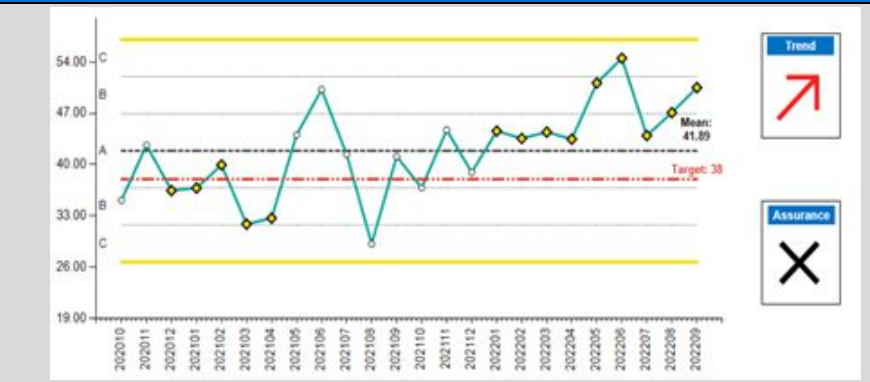


Background
To monitor caseloads and review duration on caseload between clinical services.
What the chart tells us
Community: Consistent downward trend on average time on caseload.
CAMHS & Eating Disorders: Consistent downward trend on average time on caseload.
Underlying issue
- Community: Some patients remain for long periods on caseload due to being prescribed Clozapine.
- Staff in the RSTs/CMHTs often focus on those patients presenting with significant risk (Amber/Red zoned) patients, and patients zoned as Green are not discussed regularly. This affects capacity and focus on discharge.
- GPs in some areas are still reluctant to accept patients on depot and therefore these patients remain on the RST/CMHT caseloads.
- CAMHS: In Kingston & Richmond there are cases having to be kept open in T3 due to long waits to be seen in Tier 2 Achieving for Children (a non Trust service).
- In Richmond Tier 3 the Psychiatry caseload has young people above 18 years of age that remain open until the Adult services have taken on the case (this is due to long waiting times in the Richmond Adult services for psychiatry).

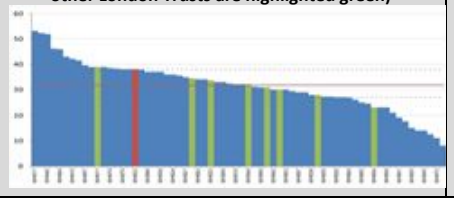
Actions
Community:
- As part of transformation of community services and the introduction of new roles and processes, the service line is reviewing the process of stepdown/discharge following recovery.
- Analysis undertaken in May 2022 to look at the teams with the longest average waiting times. This was reviewed in the June Flow Meting.

CAMHS:
- A review of Tier 3 caseloads has been undertaken.
- The service is currently recruiting a transition coordinator position to assist with transition cases in Kingston & Richmond.
- KPI definition document to be worked up in order to provide greater clarity for time on caseload

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



2020/21 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 exceeds the national average in 2020/21 (denoted as the target).

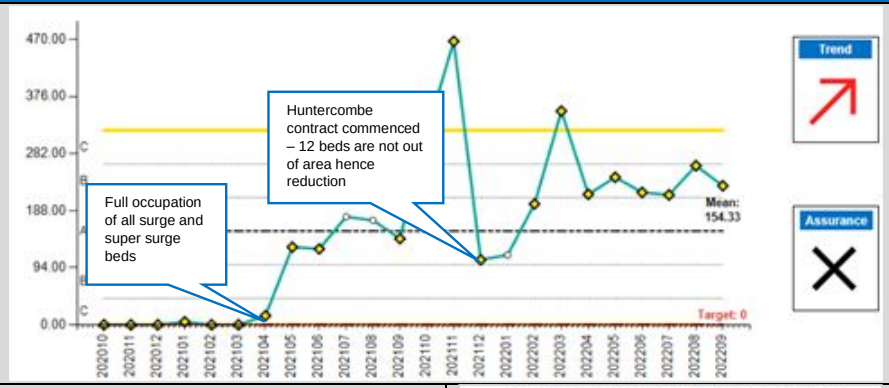
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds as the overall bed stock is reduced with less complex cases now being treated in the community.
- Increased demand can lead to increased acuity on admission and longer time to recover.

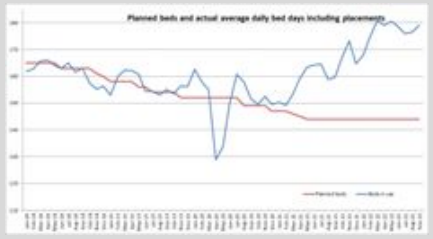
Action
- Consistent use of estimated discharge dates (EDD); reviews of patients with stays of over 90 days.
- More assertive use of the improved delayed transfer of care (DTOC) process
- A revised draft choice/discharge policy for use by the discharge co-ordinators has been issued to partners for comment.
- 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.
- The Trust held a MADE event held on 25th May and follow up actions in place.
- Further development of EUPD pathway for inpatients.
- In-reach worker now working across all 8 adult acute wards.

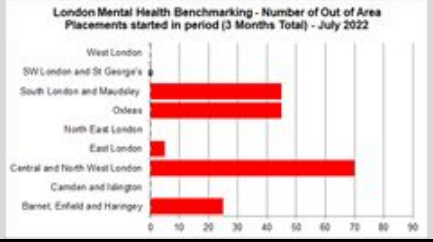
Inappropriate Out of area placement bed days - Adult Acute & PICU

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.
- Increase demand after May 2021 a result of fully occupied surge and super surge beds, related to acuity, demand and available staffing issues. On occasion super surge beds are not available to ensure the safe staffing of patients.

Actions

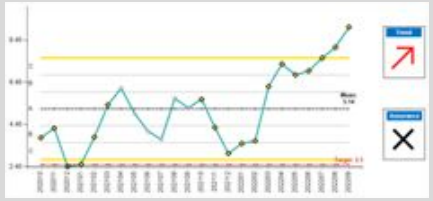
- The Trust has extended its contract for use of 12 beds at Huntercombe in Roehampton until the end of the financial year.
- Due to continuing demand pressure on beds, the Trust is evaluating options for use of further Huntercombe beds (preferred) against potential use of an internal option.
- The Cygnet Discharge to Assess arrangement ended in May 2022 and patients are being moved on to appropriate settings in a phased way.
- 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).
- Community service line has joined pathways meeting to support with discharge, care co-ordinator allocation and flow.

Delayed transfers of care (%)

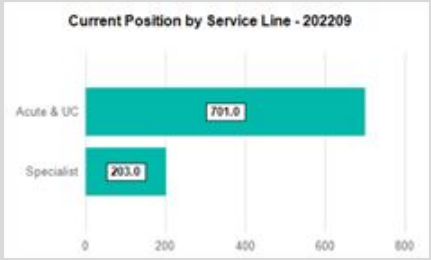
Target ≤ 2.5%

Flow

Trust DToC Rate



Trust DToC Days



Background

A delayed transfer of care (DTOC) occurs when an adult inpatient (children are excluded) is ready to go home or move to a less acute stage of care but is prevented from doing so for non-medical reasons such as unsuitable accommodation. This reduces the number of beds available, as well as causing unnecessarily stays in hospital. In many cases Trusts must work with local authorities and local CCGs to resolve issues.

What the chart tells us

A sustained deterioration in performance, routinely above the target and significantly higher than historic levels.

Underlying issue

- Improved identification of delays for non-medical reasons through use of an estimated discharge date.
- An increase in the proportion of more complex cases as bed numbers are reduced.
- Delays are often beyond the control of the Trust and reliant on LA engagement and resources.
- A reduction in care home places due to COVID has led to increase in delays for some older people.
- Staffing issues in social services (although improved) have continued.

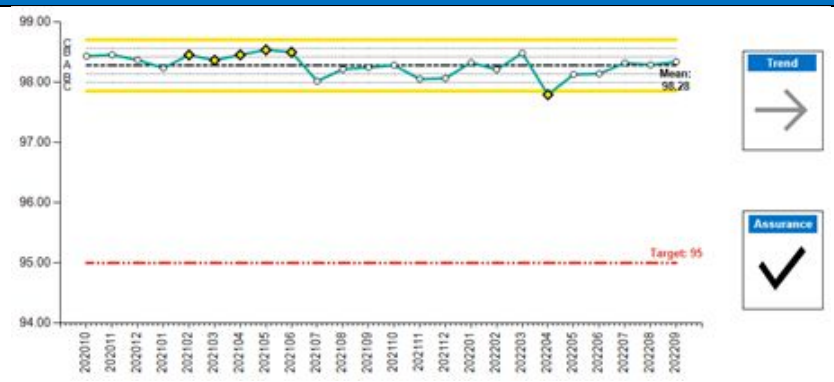
Actions

- Escalation processes involving local authorities & CCG's is in place.
- The Creating Inpatient Capacity project is working to ensure use of estimated discharge dates, barriers to discharge and delayed patient processes work effectively. Standard operating procedure should improve flow through the system. Discharge and Choice policy has been circulated for review. Part of transformation programme is to reduce stay of complex cases and reduce stays on wards
- Plan to develop pan borough DToC call and escalation framework (will need local authority engagement).
- Discharge and choice policy for review with stakeholders and discharge event planned for October 2022.
- The Trust held a MADE event held on 25th May for South West London sector to explore and address issues which effect patient flow; follow up sessions are also scheduled.

Operations

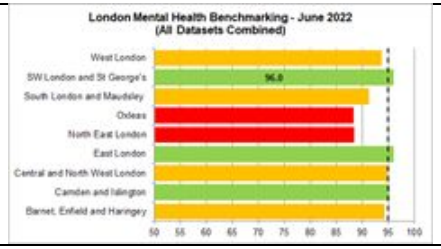
Data quality maturity index (DQMI) (%)

Target ≥ 95%



DQMI Areas for Improvement – September 2022

DQMI Item	% Compliance
Ethnicity Category Code	94.6%
Care Contact Time (hour)	93.1%
Primary reason for Referral	92.3%
Referral Closure Reason	91.6%
Ex British Armed Forces	88.3%



Background

The Data Quality Maturity Index (DQMI) is a monthly publication (via NHS Digital) intended to highlight the importance of data quality in the NHS. It provides data submitters with timely and transparent information about their data quality.

What the chart tells us

Mean performance is comfortably above target which is below lower control limit (not on chart) indicating target will consistently be met.

Underlying issues

- Trust consistently benchmarks well on this indicator when compared to other mental health Trusts.
- A small number of measures on the DQMI need improvement – these are listed in the summary table i.e. Ethnicity Category Code and Ex British Armed Forces.
- Lack of oversight at service line and team level.

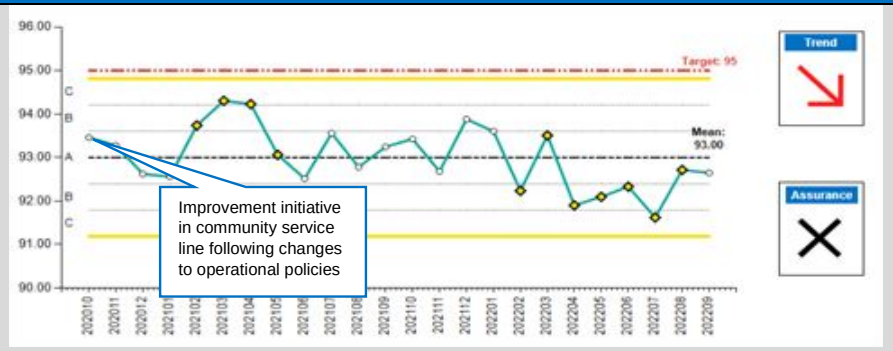
Actions

- No major concerns as Trust performance is consistently above target.
- Information Management to configure reporting at service line/team level in order for closer scrutiny on data.

Quality Domain

Fundamental Standards of Care

Community patients with an up to date risk assessments (%) — Target ≥ 95%



CPA Breakdown – September 2022

CPA	93.8%
Non-CPA	92.3%

Background
The assessment and management of the risk of a person with a mental illness causing harm to themselves or another is an important part of psychiatric practice. It is integral to providing safe and effective care and making decisions on transition between services.

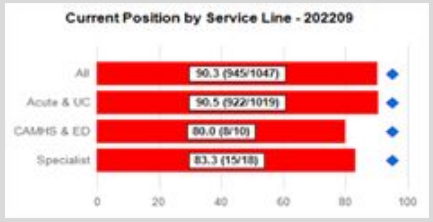
What the chart tells us
Target is in line with upper control limit suggesting it is unlikely that the target will be met without a change in process.

Underlying issue
- Risk assessments are reviewed following a meaningful clinical contact and so this target is harder to achieve for the non-CPA cohort of patients who are seen infrequently and mainly by medical staff.
- In Community service there a number of medical posts not filed by substantive staff. High staff turnover resulting in some new staff being unaware of risk recording processes.
- Deterioration in CPA position following introduction of revised rules, aligned to Trust policy in May 2020.
- There is significant variation between teams with a number of outlying under performers such as adult ADHD/ASD services where people are seen only once per year and where there are capacity issues. In addition, assessment teams in community service lines are under performing due to clinical practice.

Actions
- The Fundamental Standards of Care community campaign and dashboard was launched in July 2022 across Community Services.
- CAMHS Risk Assessment recording via IAPTus is now available via the FSoC Dashboard and will be reported in Quality and Performance as a separate risk metric in the coming months.
- Deputy Medical Director is currently undertaking a review of clinical risk assessment policy/recording.
- The Trust has shared with the CCG a proposal to increase service capacity by transferring the care of some stable adult ADHD patients (who require an annual specialist review) to primary care to create more capacity within the service.
- Dashboard report has been enhanced and provides greater detail on risk assessments that are out of date or invalid and these will support operational processes such as daily team meetings and 'huddles.
- Community Service Line: New Quality Delivery Group to support good practice and monitor progress implemented.

Fundamental Standards of Care

Inpatient/Community Risk assessments completed within 48 hours of admission (%) — Target ≥ 95%



Compliance by Service Type – September 2022

Event Type	Risk Assessed 48 hours	Admission / Community Assessment	% Risk Assessed 48hrs
Admission	110	121	90.9%
HTT Assessment	247	269	91.8%
Liaison Assessment	497	564	88.1%
Lotus assessment	93	96	96.9%
Grand Total	947	1,050	90.2%

Background
The assessment and management of the risk of a person with a mental illness causing harm to themselves or another is an important part of psychiatric practice. It is integral to providing safe and effective care and making decisions on transition between services.

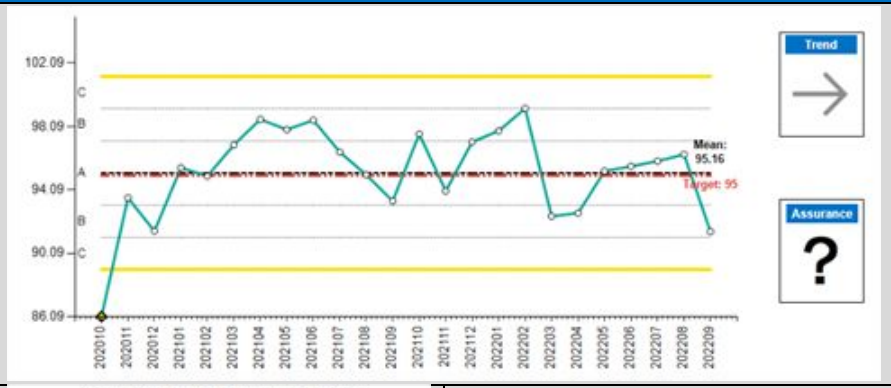
What the chart tells us
Downward (negative) trend in performance; target (which is above upper control limit) will not be met under current process.

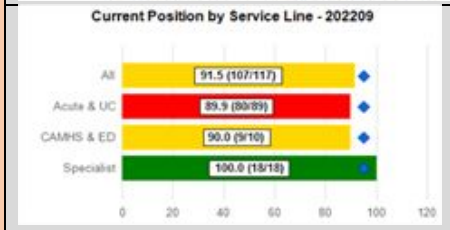
Underlying Issues
- Risk assessments have been a priority focus for our clinical services, as part of the Fundamental Standards of Care, which is being monitored through the quality plan, there has been an improvement in the quality of the risk assessment, but the quantity has not improved. This is due to the 3rd wave in Omicron which resulted in significant challenges in our workforce due to sickness and isolation. The Service line leadership team are prioritising these standards.
- Audits of clinical practice show that whilst assessments are completed, home treatment and liaison teams were not recording information in the appropriate place and within the agreed timescales. Some improvement noted in HTT however there remains variation between teams.

Actions
- Historic audits indicate that assessments are carried out but recorded in clinical notes rather than within the appropriate form. Given the number of recent breaches further audits will be undertaken in November 2021 and guidance to staff is to be reviewed given there has been no recent improvement.
- Dashboards have been amended to provide teams with more information on breaches; underperforming teams in the community service line are being given additional support to ensure that data is recorded and processes are being followed.
- Amendment to reporting made following review with HTT, AUC Management and Performance & Information at end May in order to capture community risk assessments recorded in the 12 hours prior to assessment event. The change was implemented in order to align with actual clinical practice.

Fundamental Standards of Care

Physical Health Assessment attempted within 48 hours of admission (%) — Target ≥ 95%





September 2022 (Underperforming wards)

Admission Ward	Attempted 48 Hrs	Admissions	% Attempted 48 Hrs
Lavender	14	15	93.3%
Rose	13	14	92.9%
Ward Three	12	14	85.7%
Elm	5	6	83.3%
Aquarius	3	4	75.0%
Jupiter Ward	6	8	75.0%
Laurel	6	8	75.0%
Ward One PICU	1	2	50.0%

Background
Clients with mental health problems (especially psychosis) are at a higher risk of developing serious physical health problems and have a shorter life expectancy. It is important therefore, that the Trust is aware of the physical heath of its clients and has effective monitoring systems in place.

What the chart tells us
Historic under performance followed by recent sustained improvement above target.

Underlying issue
- Consistent under performance linked to an inadequate configuration of the clinical IT system to support workflows and a need to improve daily ward processes to ensure assessments are consistently completed.
- There are times where some wards have limited medical cover, and this can impact on performance.
- Some medical staff are poor at recording measurable information, preferring to only update clinical notes. In September 2022 a number of PHA forms were not completed by Junior Doctors this follows audit investigation from Clinical Director from Acute and Urgent Care.

Actions
- The Clinical Director for Acute and Urgent Care has communicated with all doctors who complete admission clerking, clarifying the correct process for completing and recording PHA on admission as well as handing over outstanding tasks. This will also be discussed at the medical out of hours group.
- The Clinical Director for Acute and Urgent Care has requested that Ward Consultants ensure that the Junior Doctors in their teams know how to use the dashboards and ensure that they are viewed daily to pick up when PHA forms have not been completed.
- It should be noted that whilst performance in some ward areas is poor, there has been no reported harm for clients who did not meet the physical health assessment target. All patients will have their physical health considered and may well have had some parts recorded in the assessment.
- The roll out of the "Romeo" eObs project (mobile tablet-based capture of patient observations) has Inpatient caseload dashboard is used daily in safe staffing meetings.

Fundamental Standards of Care

Physical Health Assessment completed within 7 days of admission (%) — Target ≥ 90%

September 2022 (Underperforming wards)

Admission Ward	Completed 7 Days	Admissions	% Completed 7 Days
Crocus	5.0	6.0	83.3%
Rose	9.0	14.0	81.8%
Lavender	12.0	15.0	80.0%
Aquarius	3.0	4.0	75.0%
Bluebell Old Church	2.0	3.0	66.7%
Ward Three	7.0	14.0	63.6%
Jupiter Ward	4.0	8.0	57.1%

Background
Clients with mental health problems (especially psychosis) are at a higher risk of developing serious physical health problems and have a shorter life expectancy. It is important therefore, that the Trust is aware of the physical heath of its clients and has effective monitoring systems in place.

What the chart tells us
There is significant variation and mean performance is below target indicating that compliance will not be achieved unless there is a change in process.

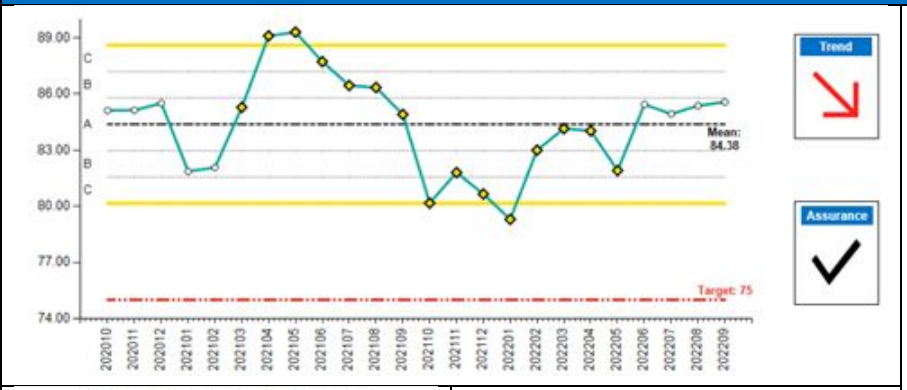
Underlying issue
- Consistent under performance linked to an inadequate configuration of the clinical IT system to support workflows and a need to improve daily ward processes such as handover to ensure assessments are consistently completed.
- A high number of patients initially refusing to undertake physical health checks (related to acuity) within the acute service line; medical staff are then reattempting the assessments and not recording the results in the appropriate measurable form, preferring to record in patient notes.
- In September 2022 a number of PHA forms were not completed by Junior Doctors this follows audit investigation from Clinical Director from Acute and Urgent Care.

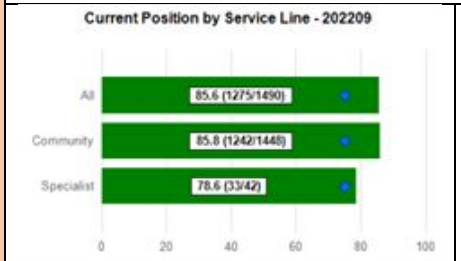
Actions
- The Clinical Director for Acute and Urgent Care has communicated with all doctors who complete admission clerking, clarifying the correct process for completing and recording PHA on admission as well as handing over outstanding tasks. This will also be discussed at the medical out of hours group.
- The Clinical Director for Acute and Urgent Care has requested that Ward Consultants ensure that the Junior Doctors in their teams know how to use the dashboards and ensure that they are viewed daily to pick up when PHA forms have not been completed.
- Inpatient caseload dashboard are used daily in safe staffing meetings.

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
Community: It is highly likely that the target will always be exceeded

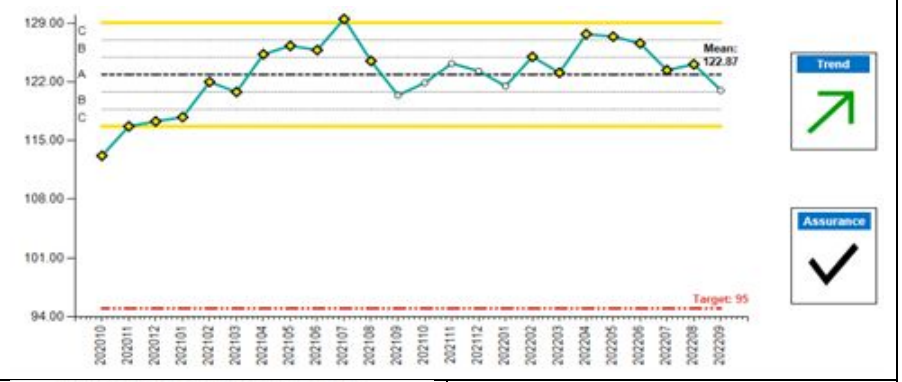
Underlying issue
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised. Trust clinical systems do not support workflow and performance is expected to dip in Q3 when annual re-reviews are required. Some medical staff do not follow processes and there is more focus required on supporting/training junior doctors to complete; difficulty accessing service users during Covid-19 due less face to face contacts meaning more reliance on GP and Clozapine clinics to obtain missing data.
- 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.

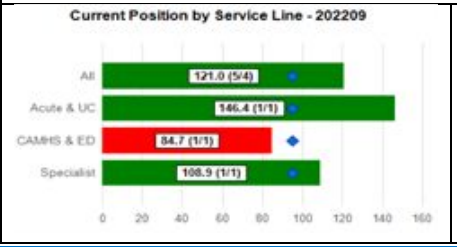
Actions
- A task and finish group led by the Deputy Head of Service Delivery for Community Services has reviewed the process for capturing physical health information on clinical systems. Clinical data collection forms have been simplified and were implemented across the Trust in Sept 20 and guidance issued to staff.
- 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.
- QI project being developed, led by Junior Doctors and enabled by QI team. Focus will be on improving physical health for inpatients, effective use of dashboards and streamlining admission process.
- Community: Assertive outreach approach for patients who have refused CMA over the last 12 months, including the offer of home visits.

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.

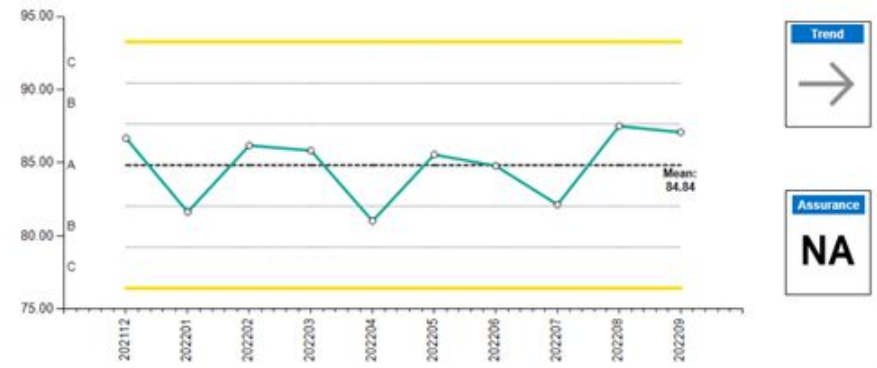
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.
- All wards were safely staffed in Specialist services.

Actions
- 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.

Fundamental Standards of Care

Safe Staffing: baseline includes requirements related to observation levels

Target TBC



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

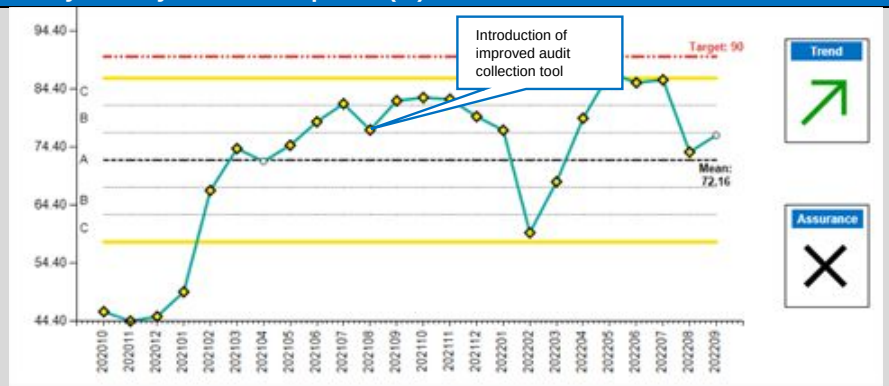
What the chart tells us
Common cause variation around the mean.

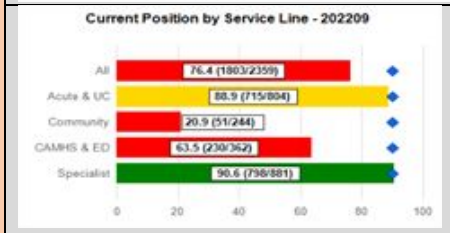
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.

Actions
- 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.
- 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.

Always Ready Audits Completed (%)

Target ≥ 90%





Audit Volumes by Service Line:

Service Line	Always Ready Audits Completed	Always Ready Audits Required	% Completed Capped
Acute & Urgent Care	724	804	88.9%
CAMHS & ED	234	362	63.5%
Community	52	244	20.9%
Specialist	889	811	90.1%
Other (i.e. inc Pharmacy)	9	68	13.2%
Trust	1830	2367	76.3%

Please note: % audits capped ignores audits completed above requirement.

Background:
The Trust has implemented an electronic system called 'Always Ready' to collect and measure the quality of audits in key areas linked to quality and safety. This is to evidence that the Trust is delivering the required standards of care.
This metric measures quantity by comparing the number of audits undertaken against total number of required audits. It gives no indication of the quality of the audit results which is provided by the metric below.

What the chart tells us:
Whilst performance continues to improve, mean performance is significantly below target indicating that the target will not be met unless there is a change in process.

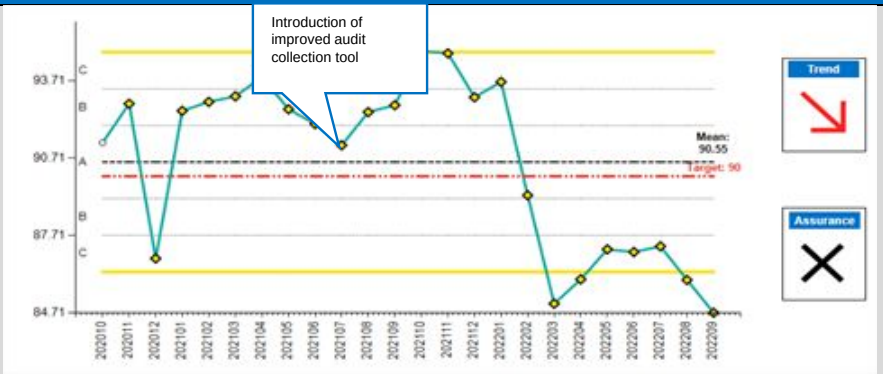
Underlying issue
- The Always Ready application improved and implemented in June 2021 before some staff had received training and a period of familiarisation.
- Some teams have required support and training with understanding and using the Always Ready Audit application and dashboard,

Action
- Service lines to agree the audit cycle (action plan template) in order to provide a standard feedback process for teams to review actions.
- In Acute & Urgent care Service Line dashboard training has been provided via Performance & Information Team.
- Community Service Line are undertaking a reset on recording so all Clozapine Clinics will be required to report via the Application. Some improvement noted in June 2022 but there are still some technical issues to address which are being worked through by Applications Development.
- The acute service line carryout formal weekly meetings to review compliance and actions. Additional training for staff has been provided by Applications Development and Information Management.
- Updated training video on dashboard has been developed and deployed in order to support staff.

Fundamental Standards of Care

Always Ready Audit Compliance (%)

Target ≥ 90%



Audits of Concern:

Audits	Compliance
Case Note Audit - Community	79.5%
Flushing Audit	62.2%
Safety in Motion Audit	81.0%
TMP Inpatient Audit	89.3%
Ward IT Equipment Audit	50.0%

Background:
The Trust has implemented an electronic system called 'Always Ready' to collect and measure the quantity and quality of audits in key areas linked to quality and safety. This is to evidence that the Trust is delivering the required standards of care. This metric measures quality by comparing the number of audit responses that indicated good practice compared against total number of required responses. This metric excludes audits that were not undertaken (see the metric below).

What the chart tells us:
Mean performance is above target indicating that the target will be frequently met

Underlying issue

- The Always Ready application improved and implemented in June 2021 before some staff had received training and a period of familiarisation.
- Risk that pressures on the ward related to patient acuity, demand for beds and staff issues may affect the ability of wards to carry out routine audits.
- Some services are not operational every day and so are unable to carry out daily audits.

Action:

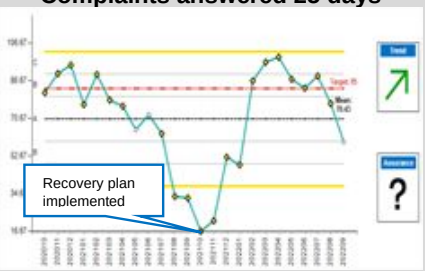
- Additional information of the quality of audits, themes and risks and any outlying areas will be provided next month
- Always Ready dashboard has been developed to assist completion and improve performance. A Training video for use of new Always Ready Dashboard is also available on My Dashboards.
- The acute service line undertakes formal weekly meetings to review compliance and actions. Additional training for staff was undertaken in April 2022 supported by Applications Development and Information Management.
- Community: Audit action plan is in place there are some residual IT issues with the application which are being progressed.
- Service line performance is monitored via local governance structures.

Patient Experience and Outcomes

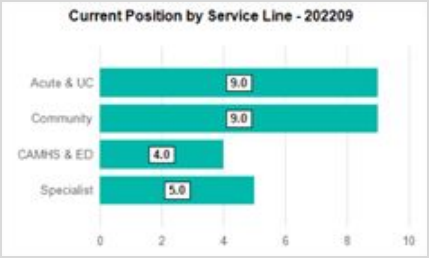
Complaints answered within 25 days (%)

Target ≥ 85%

Complaints answered 25 days



Number of Complaints



Background
It is important that the Trust promptly responds to complaints or concerns raised by clients or carers. The Patient Experience Team expects to respond to any concerns raised within 25 days.

What the chart tells us
Since February 2022, performance has routinely been above the target, in line with an agreed improvement plan. There remains some variation, but typically the target is achieved.

Underlying issue

- The Patient Experience Team are managing increased workload due to an increase in the number of complaints. However, this is now starting to stabilise.
- In September the response rate fell below the 85% target and this is due to a combination of factors including the knock on effect of annual leave taken during August. However the current performance at 21/10/22 is 84%.

Actions:

- Service Line learning events continue to increase and evolve, helping focus on learning from incidents, complaints, and good practice.
- The Community Service Line has made successful changes to their sign-off process.
- Further work is on-going to build on the quality of responses, which has largely been successful.

Themes and Learning:

- In September there were 31 complaints received this is less than that in the previous month but below current average of 39 complaints a month.
- The AUC service line continues to investigate the safeguarding related allegations from patients. And the wider investigation through the on-going RCA / Safeguarding investigation is in progress.
- The review in the CAMHS service Line is ongoing following the theme on Access to Services
- The new integrated dashboard bringing together the themes from a range Patient Experience information is now completed and was launched during September 2022.

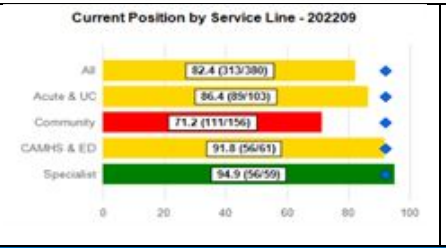
Patient Experience and Outcomes

Patient Friends and Family Test (%)

Target ≥ 92%

Trend

Assurance



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

Underlying issues:
- Challenges with engaging patients to complete at appropriate points in their pathway.
- An analysis task required by the Patient Outcomes Group to further understand the survey feedback and ensure feedback is representative of the Trust as a whole.

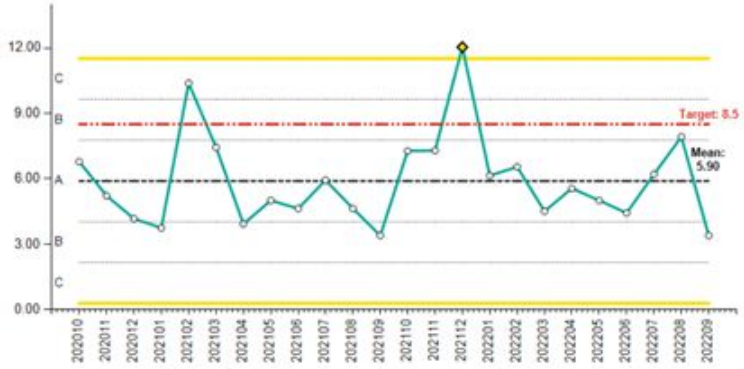
This and next months actions and timescales:

- The Improving Patient Outcomes group is to take a lead on FFT collection and analysis.
- This includes a review of all patient feedback systems including Feedback Live! in order to improve the data collected.
- Community Service Line are promoting use of the QR code for service users and carers.
- IPO group is to review and amend the SMS algorithm for requesting FFT from patients to ensure it is fully representative.

Patient Experience and Outcomes

Emergency readmission within 30 days - Adult Acute & PICU (%)

Target ≤ 8.5%



Trend

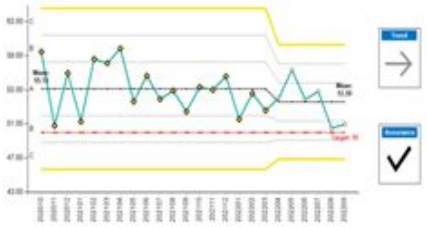
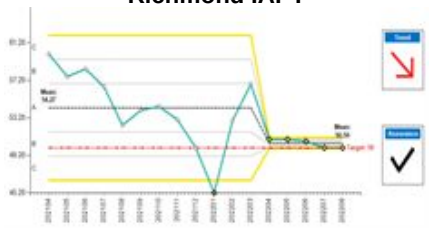
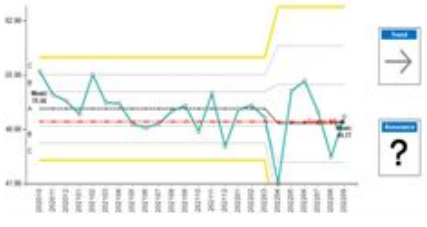
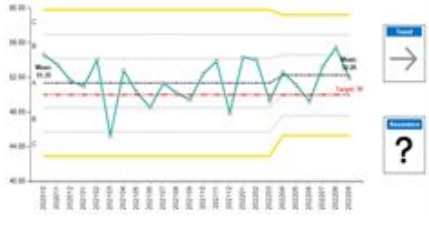
Assurance

Background
This indicator aims to measure the success of the NHS in helping people to recover effectively from illnesses. If a person is not at the correct point in their recovery journey for discharge it is more likely that they will require hospital treatment again within the 30 days following their previous admission. Thus, readmissions are widely used as an indicator of the success of healthcare effective discharge and recovery.

What the chart tells us
Mean position is considerably below target indicating target will consistently be met but there will be occasional variation.

Underlying issue
- 4 emergency re-admissions reported in September 2022.

Actions
- Acute & Urgent Care Service Line continue to review re-admissions to identify any underlying themes.

	IAPT recovery rate (%)		Target ≥ 50%
Patient Experience and Outcomes	**Talk Wandsworth** 	**Richmond IAPT** 	**Background** Improving Access to Psychological Therapies (IAPT) is an NHS programme in England 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** Merton is below stretch target in 2021/22 but mean position is above national target. All other services are likely to exceed the target which is below the average performance. 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. - In Sutton Uplift there has been an increase in dropouts (before last session) and premature discharging of clients close to recovery. - Richmond: Changes in recording processes following Silvercloud 2.0 roll out led to decline in recovery rate (clients who had not engaged were incorrectly being shown as completed). **Actions** - Clinical leads hold workshops for managers on recovery and best practice and the results of audits; includes analysis of recovery by diagnosis to address any psychological conditions where the service could improve treatment delivery or extend sessions. - Individual recovery rates for clinicians are monitored in all services and shared with staff to support improvements. - Richmond Wellbeing service have applied correction to completed cases and position improved. - The Trust holds monthly performance meetings with Richmond IAPT which is a subcontracted service. - Mid-month audit to be undertaken in Sutton Uplift to check for unplanned discharges and management have emphasised the need for clinicians to document reason for discharge.
	Sutton Uplift 	**Merton Uplift** 	

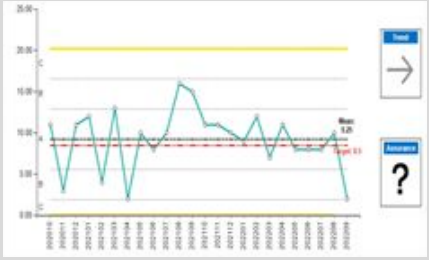
Patient safety incidents - Severe harm | **Target ≤ 1.5%**

Patient Safety

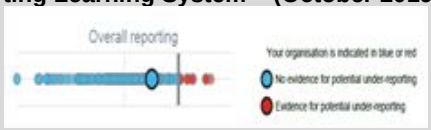
Patient Safety Incidents – Severe Harm

Patient Safety Incidents Reported

STEIS



National Reporting Learning System – (October 2019 – March 2020)



Background
Patient safety incidents are reported nationally across the NHS via the National Reporting Learning System (NLRS). Increases in the number of reported incidents generally reflects an improved safety reporting culture, particularly low level and near-miss incidents and should not be interpreted as a decrease in the safety of the Trust.

What the chart tells us
PSI: The Trust is likely to consistently exceed the threshold.
PSI Severe: The Trust is likely to consistently be below the threshold which indicates good performance; there will be variation due to low numbers recorded in each month.

Underlying Issue:
- In September there was 1 serious incident reported to STEIS, which relates to an allegation against a healthcare professional.
- Following the new Patient Safety Incident Response Framework (PSIRF) published in August, the Trust is required to consider new approaches to investigations and therefore, what is added to STEIS going forward; ensuring a proportionate and meaningful response to what is currently deemed a 'serious incident'. This will lead to a reduction in cases added to STEIS as alternative methods of investigation are review and established.

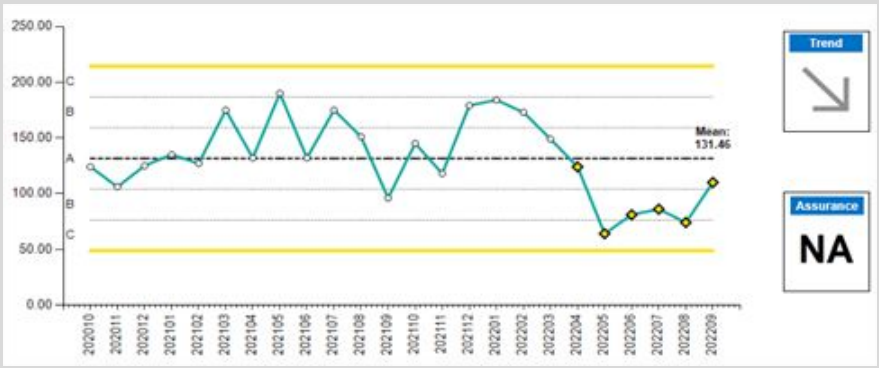
Actions:
- A number of teams are not routinely reporting Incidents on the Ulysses system, Heads of Nursing are following this up with their teams to improve incident reporting.
- As overall numbers of incidents reported has decreased a reminder of importance of recording patient safety incidents on Ulysses has been issued to service lines. This impacts the PSIs being reported to the NRLS.

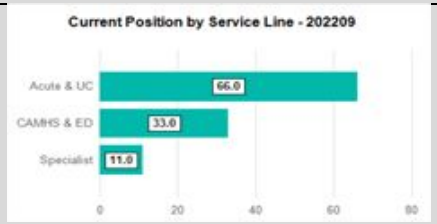
Themes & Learning:
- In September a theme around observations was noted, including how staff respond to their observations. This links in with the theme around physical health monitoring.

Patient Safety

Total number of restraints (physical restraints and rapid tranquilisation)

No Target





This metric measures the total number of episodes of physical restraint and rapid tranquilisations. An episode of physical restraint may include the use of more than one restraint and will be reported as part of a single incident on Trust systems e.g. a person placed in a prone and then in a sitting position will count as a single episode.

Background
A restraint is a planned or reactive act that restricts an individual's movement, liberty and/or freedom to act independently in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken. It is important that restraint is used appropriately and in a safe manner.

What the chart tells us
There are occasional periods of outlying values that require explanation. There can be significant variation between months.

Underlying Issue:
- A single patient can be subject to multiple restraints in a reporting month depending on acuity/presentation therefore monthly variation is to be expected. These patients all have clear care plans in place and MDT reviews occur
- The requirement to self-isolate in relation to the management of Covid-19 can sometimes lead to an increase in the incidents of restrictive practice.
- The restrictive practise and seclusion policy need to be reviewed as it is not providing a clear message as to when the RiO Restrictive practise form and the Ulysses form should be completed and this could lead to some under reporting.

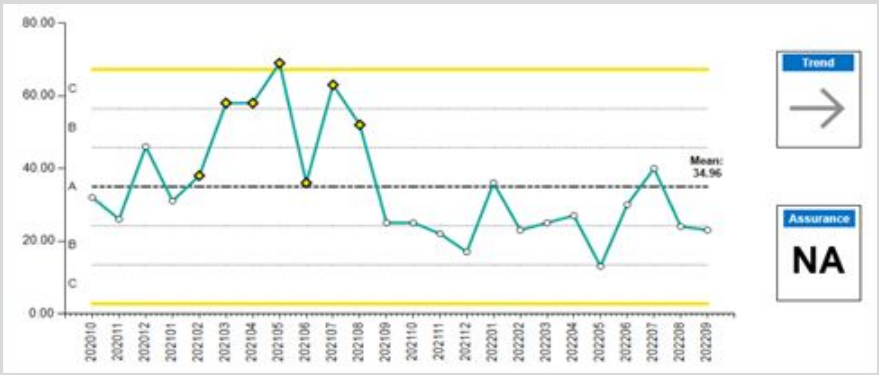
Actions
- Restrictive Practice Policy is to be reviewed in the Restrictive Practice Group.
- Restrictive Practice Groups review data to understand issues and inform learning.
- Following the publication of revised guidance wards have recorded all missing data since April 2021
- Acute: Safety in Motion Interventions have been reintroduced and discussed with teams.

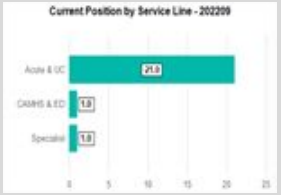
Themes and Learning:
- **Acute and Urgent Care:** The main for physical restraint continue to be administration of medication followed by harm to others and self.

Patient Safety

Reducing restrictive practices - Prone restraint

No Target

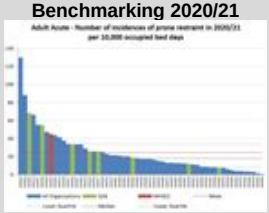




Number of Clients Prone Restrained – September 2022

Measure	Total
Number of Prone Restraints	23
Number of patients restrained more than once	4
Highest number of prone restraints	2

Adult Acute - Prone Restraint Benchmarking 2020/21



Background
It is important that restraint is used appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. The Trust reports all incidents of prone restraint in line with the new draft NHS guidance.

What the chart tells us
Numbers of prone restraint are subject to variation; at the beginning if 21/22 levels did increase significantly but last four months have seen a drop to below the mean.

Underlying Issue:
- A small number of clients can have more than one restraint in a reporting period and this is often due to the use of seclusion on entry and exit or to administer medication.
- Increases in use of prone restraint have been driven by increases in clinical acuity.
- Concern of use of supine restraint (face up positioned restraint) in older people wards; staff do not feel confident to use on vulnerable client group.

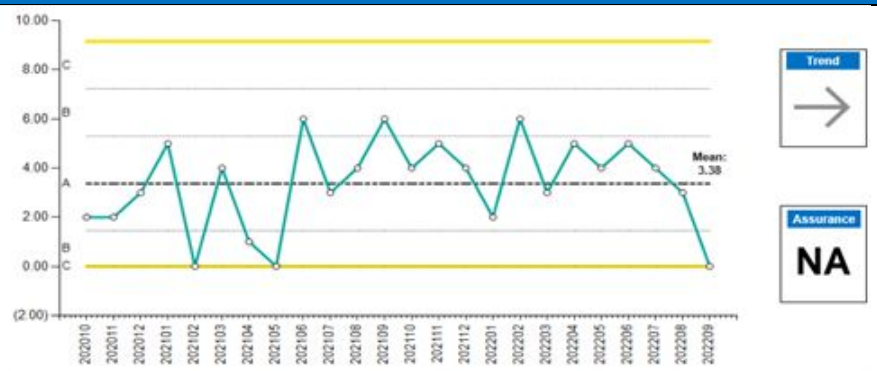
Actions:
- The deltoid technique is used where possible and prone restraint is used as a last resort.
- Staff are debriefed following an incident to review how the incident was managed and any alternative practices that should/could have been considered
- The use of prone restraints is monitored monthly through the service lines local restrictive practice groups led by the Matron. A report is published monthly detailing all uses of restrictive practices for that month with clinical narratives attained from the clinical managers
- Following an audit in April 2021 it has been reported that there has been under reporting by 30% within acute services. Revised guidance has been issued and since issued there has been an increase in restraint recording.

Themes and Learning:
- **Acute:** The use of restraint and rapid tranquilisation fluctuates month on month, the service line to continue the appropriate monitoring of the understanding of the reporting processed with respect to the RiO Restrictive Practice monitoring form and the Ulysses incident form.

Patient Safety

Death - Suspected suicide

No Target



Background

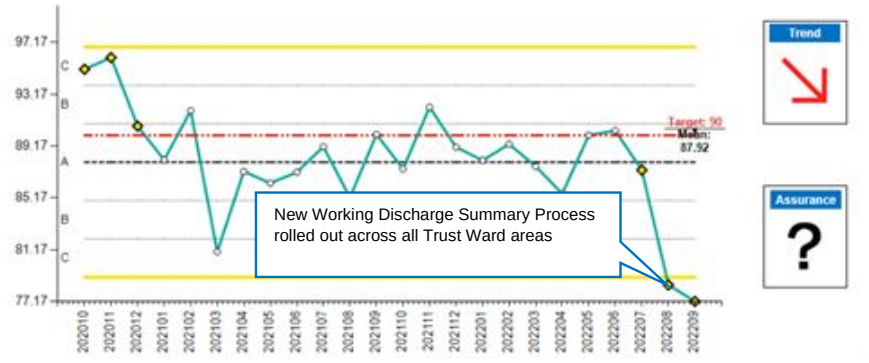
What the chart tells us
The number of suicides each month is subject to variation. Numbers reported are low.

Underlying Issue:
- There were 0 suspected suicides reported in September 2022.
- The number of suicides being reported month to month continues to be variable. This data was reviewed in the bi-monthly Mortality & Suicide Prevention Committee. With the data points for the last two years highlighting an increasing trend in deaths by suspected suicides. 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 an investigation and are signed off by a Serious Incident panel chaired by Director of Nursing and Quality.
- The milestones from the Trust's Suicide Prevention Strategy will be monitored via the Mortality & Suicide Prevention Group.
- Mortality Committee have commissioned thematic reviews of the last two years of community suicides, inpatient deaths, unexpected deaths with a focus on zoning and physical health, homicides involving trust patients and serious incidents that have occurred in the community assessment teams.
- The Mortality Committee requested a deep dive on the deaths by suicide (Railway), following the presentation of the desktop review. This will look at social factors, drug & alcohol usage and where in the treatment pathway the patient was at the time of the incident.

Inpatient discharge letters sent within 24 hours (%)

Target ≥ 90%



Letters sent within 24 hours – September

Compliant	Total Letters	%
98	127	77.2%

9 / 20 wards were 100% compliant

Letters sent within 7 days – September

Compliant	Total Letters	%
121	127	95.3%

15 / 20 wards were 100% compliant

Background
Discharge summaries are an important part of patient care and medical communication. It is an NHS requirement that GPs receive an electronic discharge letter within 24 hours to ensure the discharge plan is communicated in a safe and timely fashion.

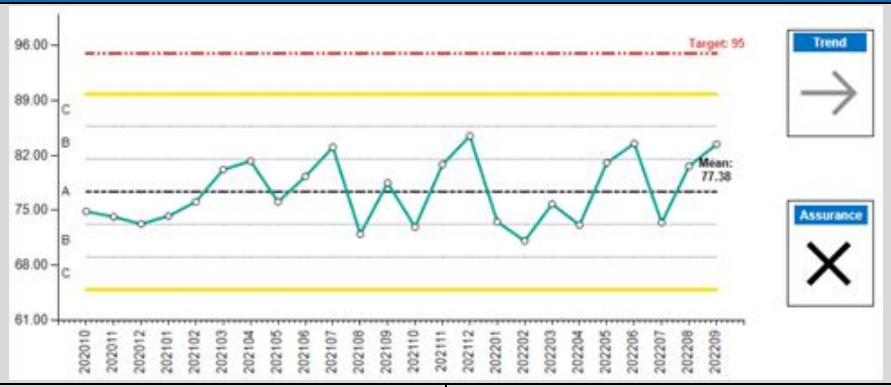
What the chart tells us
Significant variation the Trust is sometimes able to meet the target which is just above the average performance. Significant deterioration in recent months with performance below lower control limit.

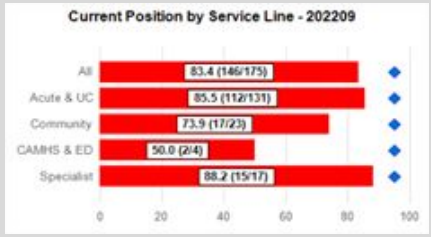
Underlying issue
- There will be a period of embedding new practice within ward areas post introduction of new Working Discharge Summary process.
- Main issue remains 24 hour completion not being adhered to.
- A small number of adult acute wards do not have a robust process due to insufficient and unresolved medical cover and administrative staff continuity.
- Intermittent IT glitches in relation to Pharmacy validation and also a small number of cases that were completed but did not progress through to DocMan.

Action
- The new process for Working Discharge Summary Completion was launched across all inpatient wards on the 1st August 2022. The new process includes the automatic submission of the Discharge Summary to the GP via DocMan Connect in RiO.
- Clinical and Administration staff have been trained on new Working Discharge Summary process and a new SOP has been issued across inpatient services and Trust Admin Lead has reissued guidance. Further training has also been provided for staff in September and October.
- Work is in progress to embed the use of a dashboards report for daily checking of physical health assessment compliance, post-discharge follow-up and discharge letters, with the aim being for inpatient teams to be able to access and act on key standards of care in one place.
- Application Developments are looking into IT issues incurred in recent weeks.
- Training Induction for Junior Dr's needs review to in order to incorporate recent changes to RiO.

Patient Safety

Follow up within 48 hours of discharge from inpatient services (%) — Target ≥ 95%



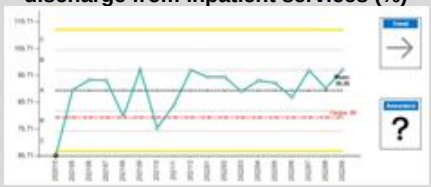


Performance by service – September 2022

Team Type	Seen Within 48 Hours	Discharges	%
Community	24	33	72.7%
HTT	63	67	94.0%
Lotus	23	30	76.7%
Ward	36	45	80.0%
Grand Total	146	175	83.4%

Follow-up summary including attempts – September 2022

Discharge follow up within 72 hours of discharge from inpatient services (%)



The Trust remains a high performer against the national 72 hour target of 80%.

Background

The 2017 report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness reports that people are at the greatest risk of suicide during the first 48 hours following discharge from m an inpatient ward. From November 2020 it is Trust policy that all people discharged from an inpatient service should receive an appropriate contact within 48 hours.

What the chart tells

Variation in performance, it is extremely unlikely that the Trust will exceed the target which is above the upper control limit without a change in process.

Underlying issues

- Previous process mapping highlighted inadequacies in the referral system for follow up; responsibilities are not always clear, inadequate communication between wards and community teams and systems are overly reliant on individuals rather than process.
- High sickness and vacancy rate has meant reliance at times on agency staff who are less familiar with follow up processes
- Inconsistent documentation of clinical record; appointments not recorded in diary or discharge planning form.
- Lotus Assessment Suite has highest number of breaches and relates to patients who are more difficult to engage (i.e. patients not answering phone calls) and where processes have not been amended to resolve this issue. Lotus have also identified staffing issues (vacancies) as a contributing factor in follow up processes not always being implemented. In September 2022 all Lotus breaches had attempts to contact recorded.
- Whilst patients may not be seen, the Trust has assurance that attempts were made (see table) to contact most people.
- Attempts to contact in September 2022 remained at 94%; the Trust needs performance at 100%.
- **7 day follow Up:** The Trust incurred 9 breaches in September 2022 with 5 clients subsequently seen. Of the 4 not seen cases two cases the wards were able contact family who provided update on well-being (in once case ward provided additional guidance to family. The two other cases have been escalated to Acute Service Line for additional information in regard welfare checks.

Actions

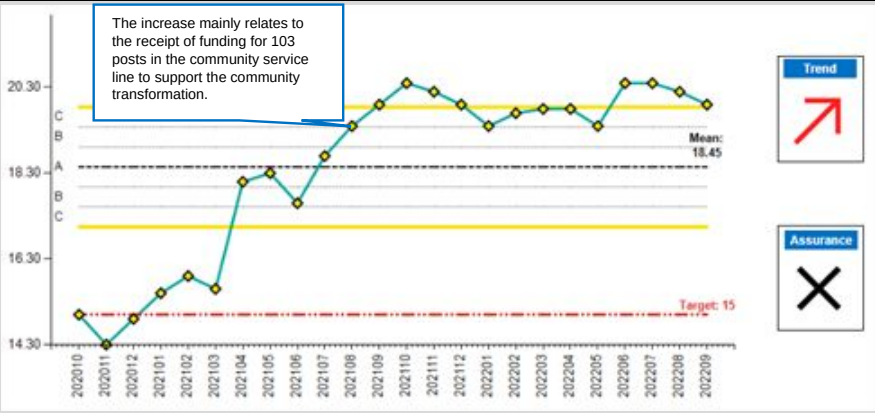
- Introduction of near 'live' dashboards including information on when attempts were made and revised operational processes such as daily team "huddles" have been implemented.
- Continued actions to adopt a consistent rationale for staff highlighting importance of documenting recording accurately and in the correct place on RiO.
- Community Service Line to reinvigorate use of daily huddles across all teams and ensure discharge plans include arrangements for 48 hour follow up.
- Contact recoding focus in Productivity Programme for Community Service line led by Service Improvement Lead with Team Managers to ensure Zoning Dashboard is utilised.
- Acute: Learning across the service line on the SOP has been undertaken with focus on incident reporting and ensuring cases of no contact post are reported as missing person.

Workforce Domain

Recruitment / Attraction

Vacancy Rate (%)

Target ≤ 15%



Vacancies by Staff Group

Staff Group	Sum of Position FTE	Sum of Actual FTE	Sum of Vacant FTE	%
Registered Nurse	882.3	681.2	221.1	25.1%
Allied Health Professional Assistant	58.6	45.5	13.1	22.4%
Allied Health Professional	141.5	111.0	30.5	21.6%
HCA/Support	472.3	370.5	101.8	21.5%
Pharmacy	44.6	35.2	9.4	21.1%
Psychology / Psychotherapy	517.5	409.5	108.0	20.9%
Manager	143.8	122.0	21.9	15.2%
Administrative & Clerical	489.1	418.3	70.8	14.5%
Social Care	46.6	40.5	6.2	13.2%
Medical & Dental	233.7	208.5	25.2	10.8%
Estates	35.2	34.0	1.2	3.4%
Total	3065.1	2456.0	609.0	19.9%

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, increases demands on existing staff and results in increased use of more expensive agency staff.

What the chart tells us

There has been significant variation in vacancy rate followed by a long-term reduction with recent increase above target and the upper control limit (special cause variation).

Underlying issue

- Service leads are not proactively reviewing their vacancies and end those which are no longer existing in their establishments, which results in an artificial higher vacancy rate. This despite monthly meetings set up with the services, with the HRBP's and the recruitment lead.
- The Trust has in the past created a significant number of new roles resulting in an increase to the vacancy rate, however we are starting to see this slowing down slightly.
- **Community**: There has been difficulty in the recruitment of medical staff particularly in Richmond and Wandsworth.
- The Trust turnover have increased steadily in 2021 into 2022, which impacts on the vacancy rates, in addition to the newly created roles.
- Year 2 of the community transformation project has 64 newly created role, which has increased the vacancy rate slightly. Recruitment for these roles is already underway and we are starting to see vacancies being filled.

Actions

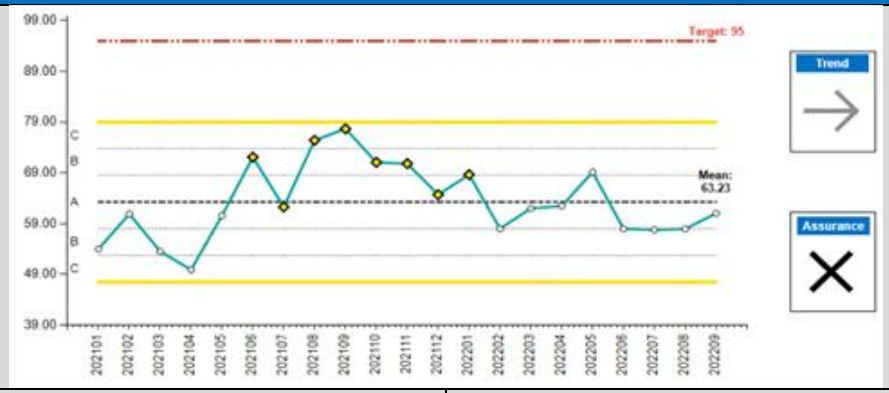
Vacancy rate is linked to turnover; retention strategies need to be developed.

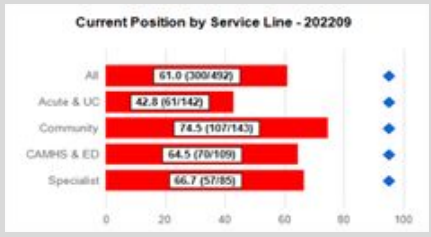
- Due to increasing concerns at the levels of vacancies in the Trust a Recruitment Incident Framework has been implemented led by COO and Director of People. An initial 12 week recruitment plan will be implemented in order to expediate the current process fixes i.e. cleansing establishment.
- An establishment review of all divisions and services areas are underway, which is identifying old roles no longer active. Additionally, for all vacant roles left on the establishment a date for these roles to be progressed to recruitment are being set.
- **Community:** Review of core skill mix within the RSTs/CMHTs from band 5-7 as part of transformation of community services year 2 programme.
- Medical workforce strategy has range of actions in progress. Medical posts in Wandsworth and Richmond are back out to advert and BMS Agency (framework agency) have been approached to support with attracting international Doctors already in the pipeline to the Trust. Cv's have been obtained and sent to the Clinal Director. Medical recruitment weekly meetings with HR.
- Review hard to recruit posts to developmental role in order to attract suitable candidates as career pathways to fill the vacancies.
- Communication Team is supporting with advertising via Social media on Facebook, Twitter, LinkedIn for targeted adverts and currently developing YouTube content.
- Mass recruitment across the Trust for HCAS and band 5 nurse roles is underway on monthly (rolling) basis and includes bank recruitment on mass on a monthly basis. This has now been expanded and includes recruitment for Nursing Associates, band 4 and Band 5 OT's.
- The bank / agency to permanent conversion is still happening across the Trust to help fill our vacancies. Managers will need to continue to review and convert bank and/or agency staff to help close the vacancy rate and reduce spend.
- HRBPS, Recruitment and Service Leads are working together to identifying suitable strategies to assist recruitment within areas with high vacancy rates. This is resulting in proactive recruitment and more candidates in the pipeline.
-

Recruitment / Attraction

Vacancies in active recruitment (%)

Target ≥ 95%





Background:
Ensuring the Trust is maximising its recruitment capacity by scrutinising vacant posts not being recruited.
What Chart Tells Us:
The target is above the upper control limit meaning that a change in process is required to improve performance.
Underlying issue

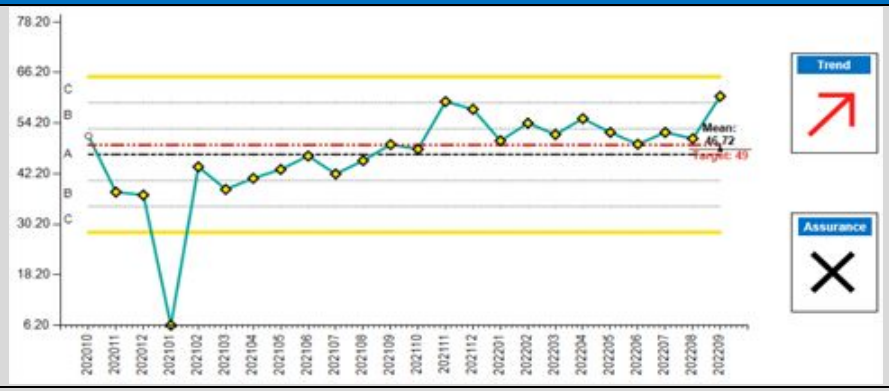
- Service leads are not proactively progressing their vacancies into recruitment, despite a very proactive and support approach from recruitment, which includes creation of recruitment drop in sessions and support workshops.
- More in-depth conversations with services on future requirements is needed in order to progress recruitment at the point of new role creation.
- Some posts are 'frozen' and so there are no plans to recruit. For example, vacancies within HTT and Liaison teams were used for suitable alternative employment in the Crisis Hub. The HRBP's and the recruitment lead are asking all managers to freeze / end any roles that are no longer active on their establishment. Monthly meeting with services are still showing that services are not proactively doing this, artificially inflating the vacancy rate and negatively impacts on the vacancies in active recruitment.
- Residual data quality issues relating to staff not following prescribed recording processes. For example, recruiting to multiple posts but recorded against one position on IT systems.
- Community: There have been some manager capacity issues (due to vacancies) particularly in Richmond which has resulted in some delay in recruitment process.

Action:

- Some service lines are now holding their managers account for their recruitment activities, ensuring that they progress their vacancies as soon as they arise. This has also resulted in an increase in roles being progressed to recruitment.
- Service lines and HR staff have access to detailed automated dashboards to identify data quality issues and performance. Data is now refreshed on as weekly basis.
- The recruitment pipeline reports are shared with HRBP's and service leads on a monthly basis, which will assist in identifying recruitment successes/issues. This will continue to help in identifying areas where a more strategic approach may be required to bring about the required outcome.
- Acute Urgent & Care: 14 posts through Direct Engagement (DE) have been confirmed with start date in October where data will be refreshed and logged into vacant posts for next month.

Time to recruit

Target ≤ 49 days



Directorate	Total Staff Recruited	T19 - Advertising start date to starting letter sent (Target 49) Denom	T19 - Advertising start date to starting letter sent (Target 49) Avg Wait (work days)	T01 - Duration of advertising (Target 14) Denom	T01 - Duration of advertising (Target 14) Avg Wait (work days)	T04a - Time to shortlist (Target 4) Denom	T04a - Time to shortlist (Target 4) Avg Wait (work days)	T04b - Time to update interview outcomes (Target 2) Denom	T04b - Time to update interview outcomes (Target 2) Avg Wait (work days)	T06 - Time to send conditional offer (Target 1) Denom	T06 - Time to send conditional offer (Target 1) Avg Wait (work days)	T11 - Conditional offer to Checks OK (Target 10) Denom	T11 - Conditional offer to Checks OK (Target 10) Avg Wait (work days)	T12 - Checks OK to starting letter sent (Target 2) Denom	T12 - Checks OK to starting letter sent (Target 2) Avg Wait (work days)	T26 - Starting letter sent to recruitment start date (No Target) Denom	T26 - Starting letter sent to recruitment start date (No Target) Avg Wait (work days)
Acute And Urgent Care	57	12	55.1	15	8.8	16	8.2	12	2.3	12	4.6	12	16.5	12	0.8	16	24.5
CAMHS & ED	54	13	49.5	14	7.5	14	6.5	13	2.1	14	0.7	14	21.5	13	0.5	13	24.3
Community (Adults)	59	15	48.5	13	8.0	14	11.3	13	0.7	13	1.3	13	16.2	15	1.2	14	28.9
Corporate	33	20	85.8	24	6.5	25	81.5	20	3.7	32	1.1	32	32.0	18	0.7	18	23.2
Specialist Services	54	14	61.9	13	8.2	14	8.8	14	4.8	14	1.1	14	25.5	14	0.4	13	34.7
Trust Total	97	79	60.5	79	7.8	83	31.3	79	3.9	96	1.7	96	24.0	77	1.0	74	28.8

Background
The metrics is defined as the average number weeks from the advert goes live through to the unconditional offer is sent. The monthly time to hire is measuring this period (advert live to unconditional offer sent) for candidates starting during a specific month.
What Chart Tells Us:
Mean position is just below target indicating target will be met fairly frequently but there will variation.
Underlying issues:

- Recruiting managers do not always pre-plan the recruitment activity, meaning there are delays in shortlisting, interview invites and offer completions following interviews. Start dates may have been agreed by the HR teams are not always notified.
- Recruitment is reliant on external factors which are beyond the Trust's control such as response times of candidates.
- The time to shortlist and confirming interview outcome by hiring managers are outside of agreed KPI's and the time to send an offer by the recruitment team is outside KPI. There have been significant delays with our Occupational Health provider in terms of receiving clearances, which has now been worked through.

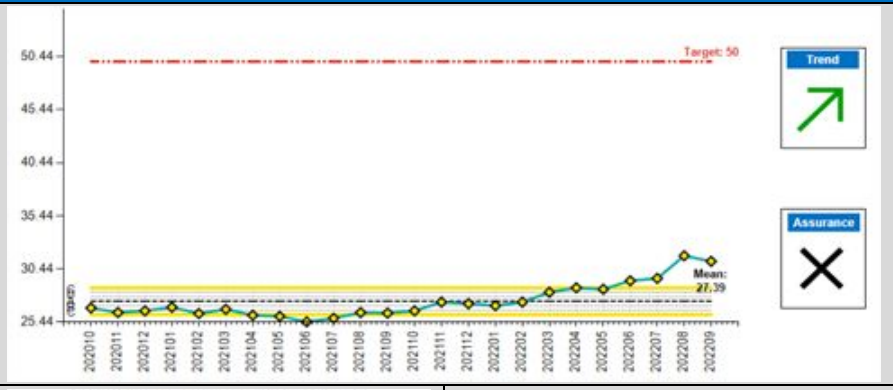
Actions:

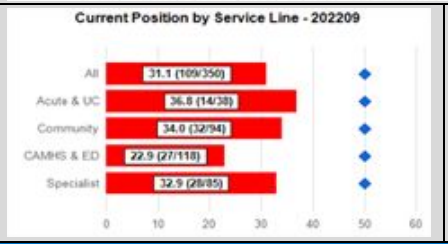
- There are some delays in hiring managers confirming agreed start dates to recruitment and HR have put in place a process to regularly chase these up to confirm start dates to prevent delay.
- The candidate pipeline has been reviewed in detail and new ways of working implemented. This has resulted in some checks coming through quicker than in past few months and where appropriate HR will work with the relevant Managers to start applicants at risk to accelerate the process.
- Recommendations remain for managers to pre-plan (proactive approach) their recruitment activity and flag up any challenges at the earliest possible to the recruitment team.
- Reconciliation exercise required on figures from Dashboard and TRAC as currently not fully aligned. This however will need input from TRAC in order to complete exercise.
- Recruitment issue weekly extract of all ongoing recruitment to provide oversight of where vacancies sit in the process.

Recruitment / Attraction

Percentage of BAME staff - Band 8+ and Medical

Target ≥ 50%





Background:

What Chart Tells Us:
Mean position is below target indicating target will not be met unless there is a change in process.

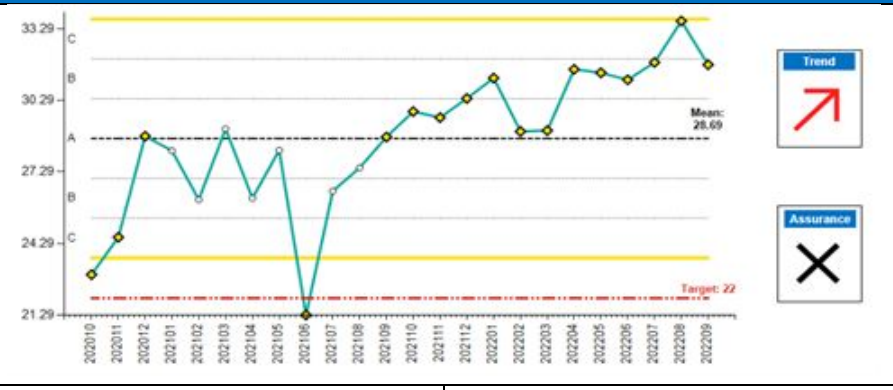
Underlying Issues:
- We are currently undertaking a Leadership Gap Analysis. The first draft was presented to the ELT in July 2022. It highlights the good offer we have as an organisation in respect of leadership development, but we need to improve visibility, access and evaluation of outcomes. We also need to agree our talent approach.

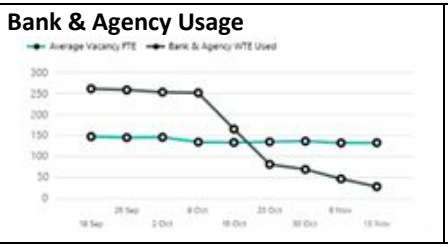
Actions:
- Diversity in Recruitment representatives are on interview panels for band 7 and above roles across the Trust.
- Specialist: Diversity and Inequalities forum is now in the early stages of introduction with a first meeting having taken place in June. As part of this initiative further EDI champions will be appointed to assist in promoting Equality and Diversity within the service line.

Recruitment / Attraction

Temporary staffing - Acute and Urgent Care Service Line (%)

Target ≤ 22%



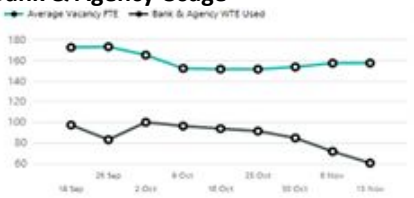


Background:
Trust analysis shows that agency staff often cost 25% more than those temporary staff source through the Trust bank. Based on its 2021/22 annual agency spend, the Trust could free up to £2.0m to reinvest in front line services or utilise to meet efficiency requirements by reducing reliance on expensive external agencies.

What Chart Tells Us:
There is a negative upward trend with mean performance above target (which is in line with lower control limit). A change of process is required.

Underlying Issues:
- Agency spend is for mainly nursing with some medical and psychology expenditure.
- This % spending trend always happens during periods of reported high levels of unplanned absence and high levels of additional therapeutic observations for nursing due to the demand this activity places on Trust Bank.

Actions:
- Service line is working with medical staffing to address vacancies and temporary fill rates.
- Human Resources Business Partners' (HRBP) are now meeting Service Lines regularly to review vacancies, sickness and agency usage in order to address areas with high agency usage.
- There is now improved processes within Dashboard to prompt and support Managers with sickness absence processes.
- Continued monitoring of temporary staffing costs in line with vacancies and requirements for additional staffing on the wards.
- Focus on recording, reviewing and following policy for observations at a ward level.

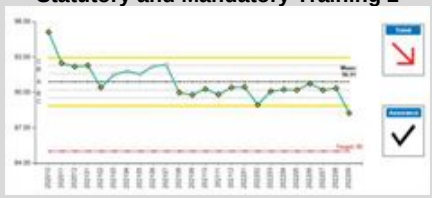
	Temporary staffing - Community Service Line (%)	Target ≤ 22%
Recruitment / Attraction		**Background:** Trust analysis shows that agency staff often cost 25% more than those temporary staff source through the Trust bank. Based on its 2021/22 annual agency spend, the Trust could free up to £2.0m to reinvest in front line services or utilise to meet efficiency requirements by reducing reliance on expensive external agencies. **What Chart Tells Us:** There is a positive downward with mean performance consistently below target. **Underlying issues:** - Difficulties in filling substantive posts across core community roles, including band 6 CPNs, consultant psychiatry and qualified P&P. **Actions:** - Continued focus on BAU recruitment actions and capitalizing on Community Transformation recruitment campaign - Follow up with Recruitment to address transaction process issues to expedite and streamline recruitment. - Borough level vacancy reviews with head of recruitment and HRBP to confirm actions against all posts are completed
	Bank & Agency Usage 	

Staff Skills / Development

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

Statutory and Mandatory Training 1

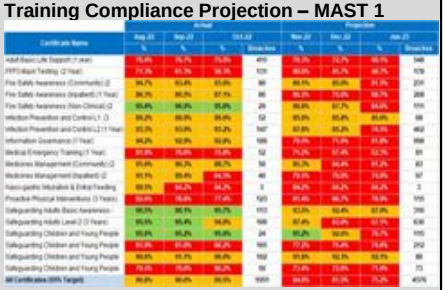
Statutory and Mandatory Training 2



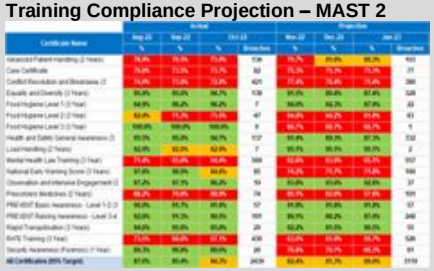
Current Position by Service Line - 202209

Current Position by Service Line - 202209

Training Compliance Projection – MAST 1



Training Compliance Projection – MAST 2



Course DNA Rate

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: Following period of improvement performance there is now a significant downward trend in performance.

MAST 2: Despite a recent reduction in performance the Trust remains well above target.

Underlying issue

- Evidence shows that in higher performing areas managers proactively book staff onto courses and staff are able to cancel any MAST course within reason if their direct line manager is copied in the email sent to E&D.
- The training budget has not been adjusted to reflect the change in audiences for Advanced Patient Handling, Food Hygiene, or British Sign Language Training.
- Advanced Patient Handling is a new course that has replaced Patient Handling with Hoist and shown here for transparency, services will be given 3 months to complete before further scrutiny is applied. However, we will not be able to fund the full demand within the existing budget as the target audience is now 560 staff from the original 136 staff.
- In September DNAs remained around 20% impacting on the training budget and ability to provide sufficient places.
- Significant amounts of staff sickness across the Trust resulted in cancelations and DNAs; high vacancy rates may prevent staff from being released for training.

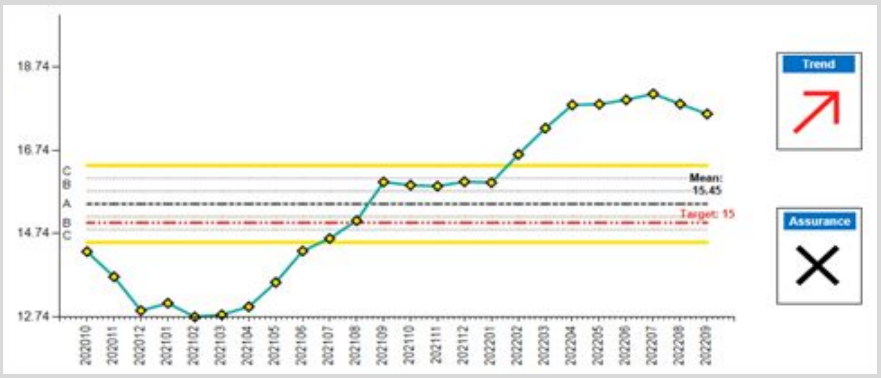
Actions

- Focused conversations in each SLR in regard to MAST 1 performance. Senior leadership have committed to daily dedicated focus. DoN to link with the new Head of L&D to review the process around MAST. There is also consideration for an improvement plan for this area in L&D.
- Classroom training is available for staff; trajectories of performance are reviewed at the monthly Service Line Reviews with executives.
- Managers receive regular reports on DNAs; staff receive booking reminders to attend courses. Non-attendance to be raised in staff supervision.
- Health Education England have released one-off funding for the rest of this financial year for Health Care Support Worker development. A post has been put in place for 6 months to reduce the backlog in Care Certificate – now sitting in Nurse Education Team.
- In 2022/23 a MAST Steering Group is to be set up in order to formalise decision making with respect to MAST and training delivery.
- There are currently sufficient ABLS training courses following an increase in capacity to 4 days per week and courses are now planned up to 6 months in advance. Cancellations and No Shows at these courses are high and work needs to be done to ensure that where possible, those booked on the courses do attend.
- Education to work with EMP about room availability and priority bookings from September 2022.
- There is a London-wide shortage of BLS interpreters and it has been difficult to book sufficient for all MAST training. We are trialling pre-booking well in advance to ensure availability.
- Review of classroom and e-learning performance to be undertaken in October 2022. This review will also incorporate a review of DNA's by MAST course.
- Further reviews recommended to compare DNAs for F2F versus Webinar / Online training to establish causality and propose change.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%



London Benchmark - January 2022

Trust	Leavers	Turnover
North East London NHS Foundation Trust	901	13.6%
South London and Maudsley NHS Foundation Trust	759	14.6%
East London NHS Foundation Trust	970	15.5%
West London NHS Trust	614	15.8%
Central and North West London NHS Foundation Trust	1,219	16.0%
Barnet, Enfield and Haringey Mental Health NHS Trust	541	16.2%
South West London and St George's Mental Health NHS Trust	414	16.6%
Oxleas NHS Foundation Trust	649	16.6%
Camden and Islington NHS Foundation Trust	403	18.4%
Tavistock and Portman NHS Foundation Trust	155	19.8%
London Mental Health Average	6,625	15.7%

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
Historic sustained improvement followed by consistent increase in staff turnover; recent performance is above both target and upper control and change in process is required.

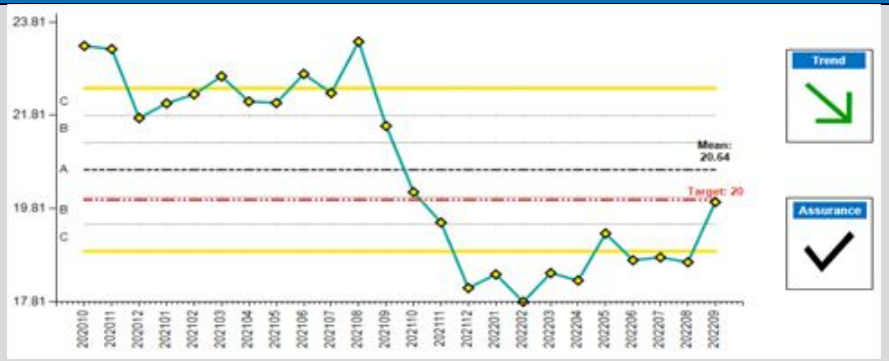
Underlying issue
- Over the past few years, Community Service Line teams have experienced significant workforce challenges with workload and capacity frequently cited as a factor behind staff leaving the Trust.
- An ineffective, inconsistent process to collect meaningful exit interview data means that the Trust has imperfect information on why staff leave the Trust

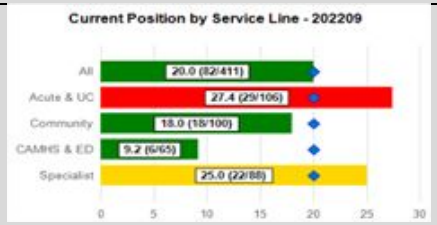
Actions:
- Trust is currently reviewing the exit interview process as uptake is low. This review includes a consideration as to how the Trust embeds new joiner/stay interview questions for new joiners.
- There are ongoing discussions with HR and Service lines regarding staff leaver discussions and interventions where possible to request staff to reconsider potential resignation decisions.
- Community and Acute and Urgent Care service lines to develop plan on retention where exit interview data notes a primary reason for leaving being lack of L&D and promotion.
- **Acute and Urgent Care:** Implementation of retention actions identified in workforce plan with focus on stay interviews for new starters, promotion of agile working and implementing staff survey action plans.
- HRBP's to remind managers with staff leaving SWLSTG to arrange exit interview meetings / OR arrange via HR so it takes place.
- Staff attitude action plans have been completed by all service lines
- The Trust will be adding 1, 3 and 6 months stay interviews to dashboards in the new year.

Staff Retention/ Support / Satisfaction

Staff leaving within 12 months of appointment (%)

Target ≤ 20%





Background
'Staff Leaving within 12 months of appointment %' is defined as the number of staff who left within 12 months of their appointment during the previous 12 months, divided by the total number of staff who left in the previous 12 months.

What the chart tells us
Historical performance is consistently above the target (poor performance) suggesting that the target will; not be met without a change in process. Recent performance has shown improvement with last four months below target.

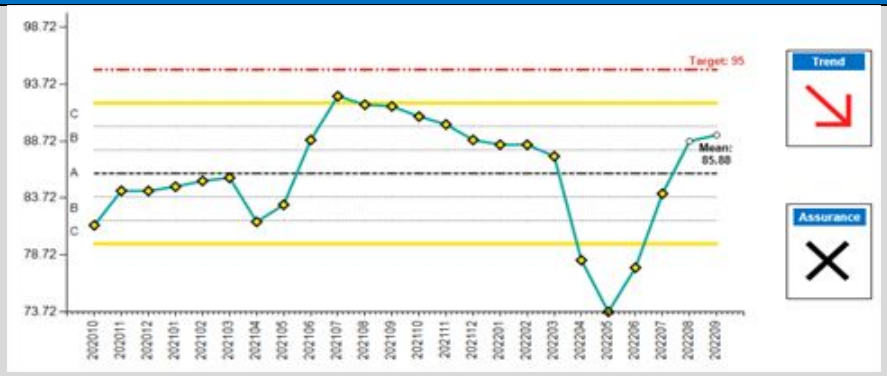
Underlying issue
- Whilst the Community service line have experienced significant workforce challenges, over 50% of the 'leavers within 1 year of starting' were Psychological Well Practitioners working for IAPT teams left to progress their career.
- Historically the Acute service line has had high turnover as a number of band 5 nurses seek out other opportunities including promotion, usually within a year of appointment.
- In CAMHS & ED a small number of exit interviews have cited lack of training/career progression as reasons for leaving.

Actions:
- Onboarding / stay questions are being launched for managers to ask their new starters on their experience during the first, third and sixth month in post.
- **IAPT:** plan to offer some PWP staff band 5 high intensity roles
- **Acute & Urgent Care:** Implementation of retention actions identified in workforce plan with focus on stay interviews for new starters, promotion of agile working and implementing staff survey action plans. HR to issue new starters a survey within 6 months of starting to help identify and resolve issues,
- **Specialist Services:** Continued use of mentor and buddy system for new starters
- **Community:** Managers to plan to fill any potential vacancies from leavers by retain staff who are on one year training placements
- The CAMHS& ED Service Line is undertaking a deep dive on staff turnover and developing a workforce plan.
- The Trust will be adding 1, 3 and 6 months stay interviews to dashboards in 22/23.

Staff Retention/ Support / Satisfaction

Supervision (%)

Target ≥ 85%



Supervision by staff group / Corporate – September 2022

Clinical Staff	83.6%
Non-Clinical Staff (inclusive of Corporate)	71.7%
Corporate Services	72.8%

Background
Regular, formal supervision for all staff ensures that everyone within the organisation has an opportunity to discuss their role, workload, performance and the support they may need to do their job. The frequency of supervision should be at least every 6 weeks.

What the chart tells us
Whilst there has been an overall improvement, it is unlikely that the Trust will consistently exceed the target.

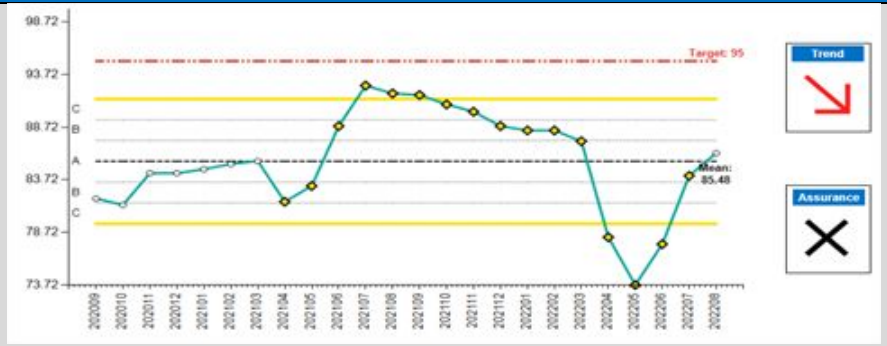
Underlying issue
- Trust is unable to consistently maintain performance on this metric.
- Supervision is below target overall for both clinical and non-clinical staff.
- Workload pressures, cancellations of meetings due to incidents on wards, high sickness levels in some areas (AUC) and high numbers of staff allocated to individual managers are often cited as reasons for supervision not taking place, as it is not always incorporated as 'business as usual'.

Actions
- Chief Executive Officer has reiterated to staff that supervision remains a priority for the Trust. Senior team to work with all consistently underperforming areas
- Community Service Line have instructed supervision to be carried out every 4 weeks as routine. Community to spot check this is in place and is working.
- In Community Service Line revision of SOP to embed performance coaching as key conversation in supervision of all staff.
- Responsibility for improvement in supervision is with all line managers. Senior leads to ensure protected time is given to staff to update records after a supervision has taken place.

Staff Retention/ Support / Satisfaction

Appraisal (PADR) (%)

Target ≥ 95%



PADR by staff group / Corporate – September 2022

Clinical Staff	87.9%
Non-Clinical Staff (inclusive of Corporate)	81.4%
Corporate Services	81.5%

Background
Performance appraisal development reviews (PADRs) are an effective way of motivating staff by recognising achievements, setting roles and addressing problems which prevent performance to the best of ability. Meaningful PADR's recognise good practice and areas for development.

What the chart tells us
It is unlikely that the Trust will meet the target (which is outside of the expected range) without a change in the process; performance had a period of improvement but has now started to decline.

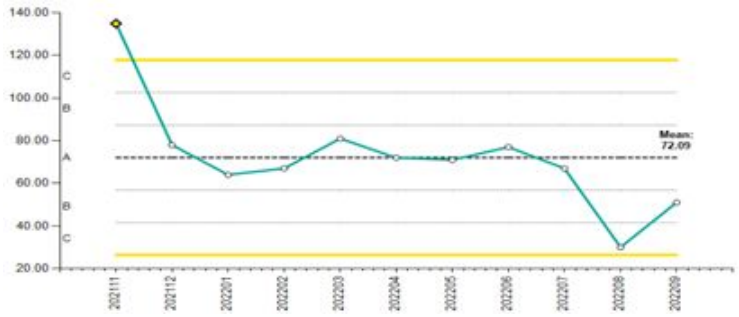
Underlying issue
- Processes are not routine; performance tends to improve only when it is prioritised over other indicators.
- Expected deterioration in April 2022 as PADR's become out of date due to push for PADR completion by Q1 2021/22. Improvement expected by Q1end 22/23.
- Incomplete paperwork on PADR can lead to delay in submission.

Actions
- Beginning April 2021, it is a requirement for staff to have been appraised before the award of any pay increment.
- PADR process and documentation has been refreshed to support a new appraisal format to be completed for all staff between April and June 2021. The PADR window closed in September, after an extension; the new annual window will open in April 2022.
- Acute and Urgent Care have agreed to set standard objectives for staff
- Managers have been advised to allocate protected time write up appraisals for staff.
- There is an email weekly reminder about the requirement for the completion of PADRs.
- PADR rates to improve in quarter 1 2022/23 as Trust managers are expected to complete in this period.

Staff Retention/ Support / Satisfaction

Active ER cases

Target TBA



What Chart Tells Us:
Since peak in November 2021 levels of active ER have frequently below the mean.

Factors Affecting Employee Relations Cases:

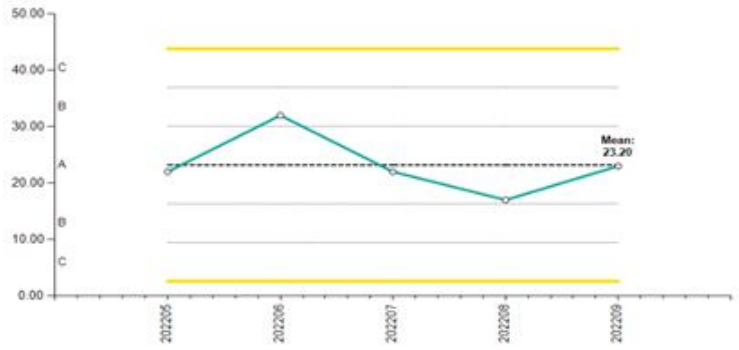
- At the end of September 22, the ER team had 51 Open cases.
- There are 13 Employment Tribunal cases.

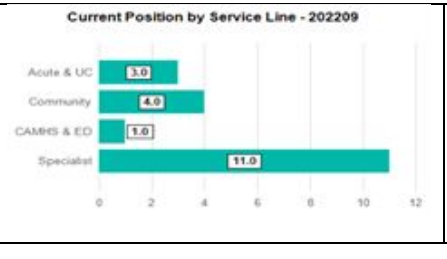
Actions:

- Current ER cases over 90 days are 6 which are being proactively managed. with exception of 2, are being managed within a 3-month period. There are no cases that have exceeded a 6-month period
- Active health and wellbeing cases make up over half of the overall caseload. Absence cases over 90 days has reduced to 12. New sickness reporting system is scheduled for implementation in November 2022, which will enable managers to manage sickness absence better with ongoing support from Employee Relations Team. Absence % for August is the lowest in 8 months at 3.95% and 4% for September.
- Informal resolution (mediation and facilitation pilot) is due to end with the service going live in November 2022.

ER Cases exceeding 90 days

Target TBA





What Chart Tells Us:
Low level variation with numbers over 90 days aligned to mean of 23 per month.

Underlying Issues:

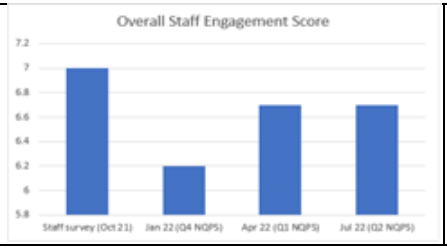
- Current ER cases over 90 days are 6 which are being proactively managed. with exception of 2, are being managed within a 3-month period. There are no cases that have exceeded a 6-month period

Actions:

- As above.

Staff Retention/ Support / Satisfaction

Staff Friends and Family Test (recommend treatment) (reported quarter in arrears) (%) **Target ≥ 75%**



Background

With the change of the old metric this will be the first time that we will be able to report on this from the National Quarterly Pulse Survey which we complete every quarter except for October when the NHS Staff Survey takes place. The NQPS can be completed by any member of staff that has a Trust email address whether they are contract, substantive or Bank. The figures you see are the number of people that completed the NQPS

Underlying Issues:

- We are in the early stages of collecting data through NQPS and with a low response rate it looks like we are in a healthy position. Trend analysis will be built in as more data becomes available.

Actions:

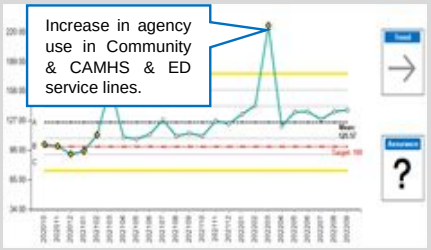
- The Trust will soon to launch the 2022 NHS Staff Survey which is scheduled to commence on 3rd October and end on 25th November 2022.
- As part of the promotion plan for the 2022 Staff Survey we will also do more face-to-face events which will include visits to wards and in person workshops.
- Our Retention Programme will allow us to use that data to further understand how we can encourage staff to become advocates of the services they provide to service users.
- The Trust will be looking at sharing data with managers at selected training sessions to increase the response rate of the NQPS which will provide a more representative picture of staff this measure.

Finance Domain

Grip & Control

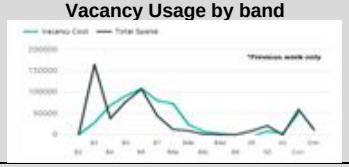
Agency spend as % to NHI target

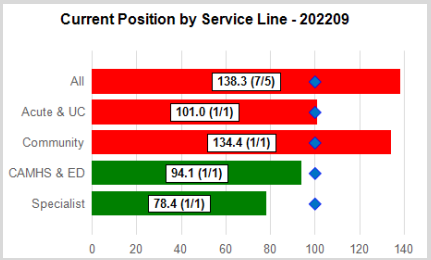
Target TBA



Vacancy Usage by Week

Vacancy Usage by band





Vacancy Spend – Indicative Numbers only

Background
The Trust is assigned an agency cap by NHSI. Aside from being good practice to minimise agency expenditure, breaching this cap produces adverse impacts on the Trust's overall financial risk rating.

What Chart Tells Us:
Performance has mainly been above target; target unlikely to be met unless there is a change in process.

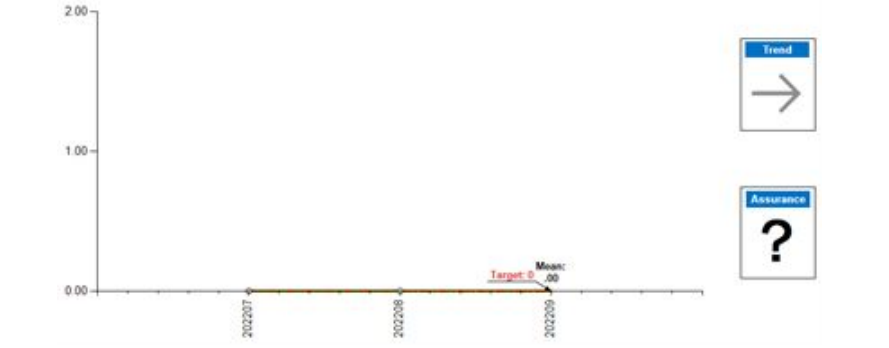
Underlying issues:
- Financial incentives and flexibility afforded by agency working remain key barriers to transitioning staff to bank or permanent contracts.
- There are particular difficulties in recruiting to CPN and high cost medical posts.
- Trust processes to record future agency costs are not followed and are not sufficiently enforced.
- Managers sometimes fail to pre-plan or carry out recruitment activity, leading to avoidable delays and the need for short-term agency staffing.
- **Community:** Vacancies and difficulties recruiting in particular nurses and doctors, operational pressures including cover for long-term covid are factors in agency spend.

Actions:
- All Services are meeting with HR and Finance Business Partners to carry out a line-by-line review of agency staff against agreed criteria; this includes difficult decisions i.e., risk impact on safety and quality if the post is removed and not replaced. Services will confirm action to be taken and by when to inform the year end forecast. The review will be completed by the end of October 22.
- Trust guidance is for managers to pre-plan (proactive approach) their recruitment activity and to raise and resolve issues with the recruitment team. Guidance is also available on converting agency staff into bank or permanent roles.
- Monthly recruitment meetings between services and HR leads try to resolve long term agency contracts
- Community services are implementing an improvement plan to recruit medical staff with reductions in agency spend expected within the coming months.
- Trust has signed contract with recruitment consultancy Remedium to assist with medical recruitment and the Trust has reviewed locum rates and the CAMHS middle grade rota with Junior doctors.
- **Community Service Line:** Skills mix review of core CMHT/RST band 4-6 roles as part of transformation. (POD Model). Direct employment of 13 new band 5 nurses who will commence in post in September 2022.

Grip & Control

% Forecast budget overspend

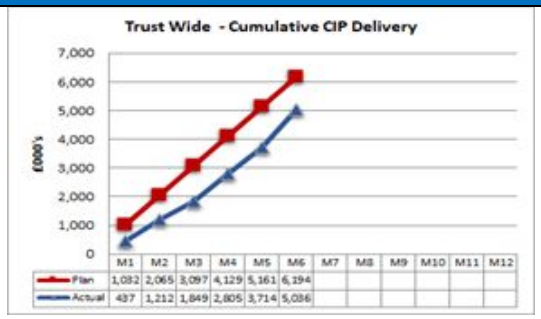
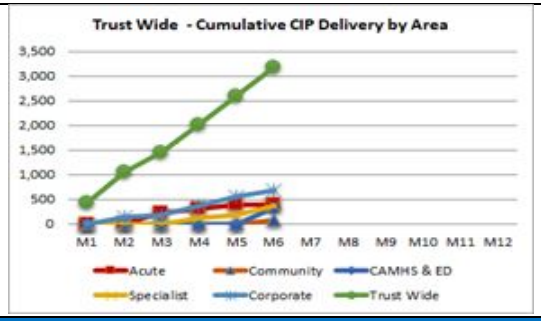
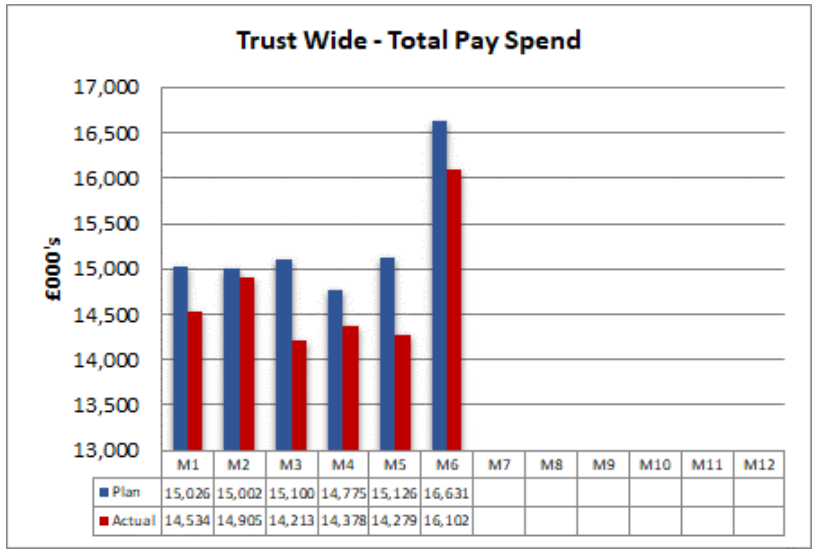
Target TBC

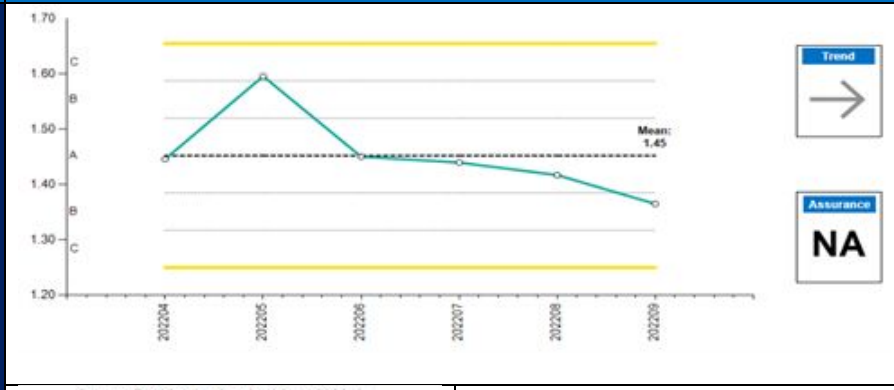
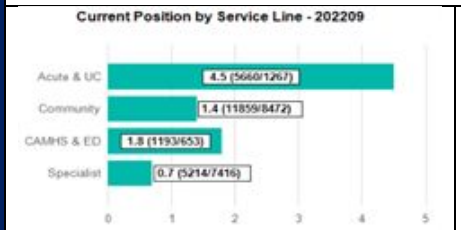


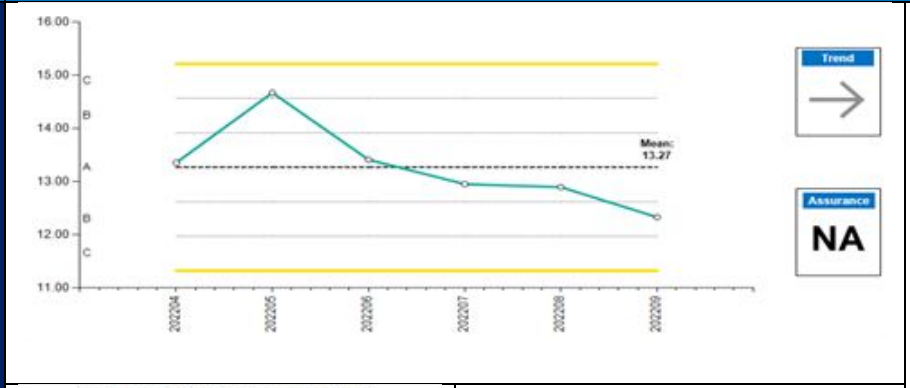
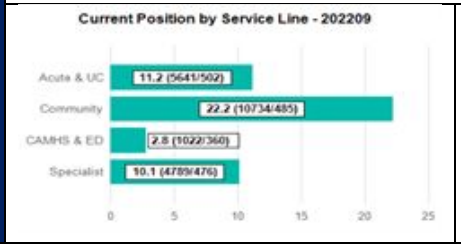
What Chart Tell us:
The chart indicates that Trust forecast is currently at break-even position.

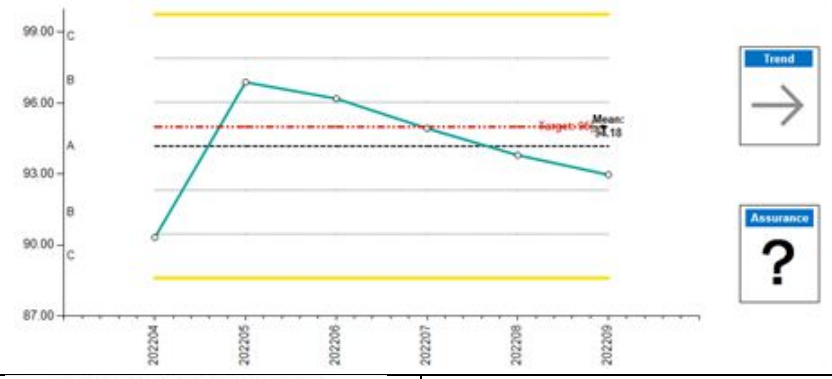
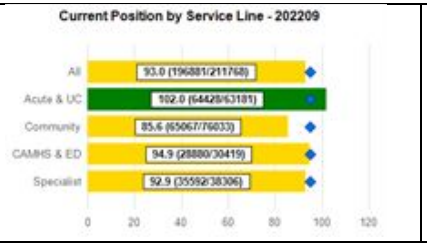
Underlying Issues:
- Trust: The Trust is forecasting break-even overall currently.
- Acute: Overspend is mainly due to staffing for observations and specialling, plus out of area bed placements which is unfunded aside from the acute bed contract with Holybourne.
- CAMHS & Specialist: Underspend linked to vacances in service lines.

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.
- Overspends due to agency – addressed through review of agency and conversion to bank or FTC where possible. Line by line reviews with each service line in train
- OOA beds addressed through LOS stay work and DTOC work programs.
- CAMHS & ED: 62% of posts are out to advert. Service line continue to recruit to substantive positions, liaising with recruitment to drive forward offers in timely way.
- Specialist: Service line reviewing stretched target to include additional non-recurrent savings and NPSA activity on Seacole Ward & potentially develop NPSA income from Ruby ward, when it moves to the new Shaftesbury.

	Cumulative CIP Delivery	No Target
Grip & Control	 	**What Chart Tells Us:** CIP Delivery position is currently below plan. **Underlying Issues:** - Recurrent savings are challenging to release (currently 6%) creating a risk to the Trust's future financial stability. Increased focus required to ensure the Trust exits 2022/23 with a breakeven run rate. - The increasing agency spend has now triggered the Trust as an outlier in the region; agency spend as a proportion of total pay bill. - Clinical Efficiency –risk that time released could be immediately reinvested in new activity/ indirect task - Delivery of the Facilities savings target remains challenging due to operational pressures of the move and cost pressures within the team. **.Actions**: - Service Lines have been tasked to review all pay and non-pay underspends and where possible, release them against their unachieved CIP targets e.g. Community is reporting a net £0.6m underspend YTD and £0.6m CIP non-achievement. - All Services are meeting with HR and Finance Business Partners to carry out a line-by-line review of all agency staff against agreed criteria; this includes difficult decisions i.e., risk impact on safety and quality if the post is removed and not replaced. Services will confirm action to be taken and by when to inform the year end forecast. The review will be completed by the end of Oct 22. - Existing Establishment Vacancies - line by line review of long-term vacancies has been proposed and will be supported by HR. - Meetings continue with Corporate budget holders and Executive to help close the gap in delivery.
	Pay Cost Vs Budget	
Grip & Control		**What the chart tells us:** Total Pay Spend in the Trust is currently below plan. **Underlying Issues:** - An underspend is due to vacancies across the service line. - CAMHS & Eating Disorders: Vacancies in Nursing Q £368k, Psychologists £1,166k and Medical Consultants £174k. £656k relates to Trailblazer teams. - Specialist: Vacancies in Nursing Q £530k underspend offsetting a Nursing UQ £589k overspend, Psychologists £225k and AHPs £175k. - Community: Pay position increased in Month 6 to £3,860k showing a continuing upward trend from the start of the financial year. The increase on month is the impact of the pay award. The service remains favourable overall due to widespread vacancies. **Actions:** - CAMHS & ED: 62% of posts are out to advert. Review of vacancies, agency is being reviewed between the service line, HR and Finance. Additionally as above t he establishment is being reviewed and validated

	Activity vs Caseload (%)	No Target
Productivity	 	New productivity measures have been introduced to reporting in September 2022, underlying issues and actions to address will be reported from October 2022. Reports to support service lines with this process will need development.

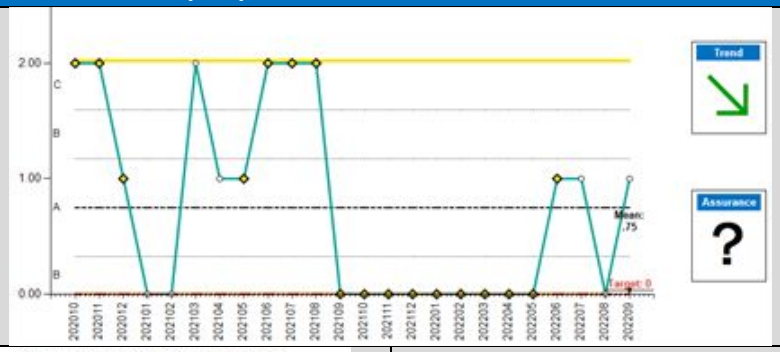
	Activity vs WTE	No Target
Productivity	 	New productivity measures have been introduced to reporting in September 2022, underlying issues and actions to address will be reported from October 2022. Reports to support service lines with this process will need development.

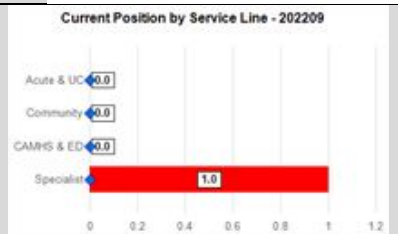
	Contracted activity - Local CCG contract (%)	Target ≥ 95%
Productivity	 	New productivity measures have been introduced to reporting in September 2022, underlying issues and actions to address will be reported from October 2022. Reports to support service lines with this process will need development.

Non-Priority Metrics: reported by exception

Access

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





52 Week Breach - September 2022

Team	Breaches	Weeks Wait
Merton Adult ADHD Service	1	56

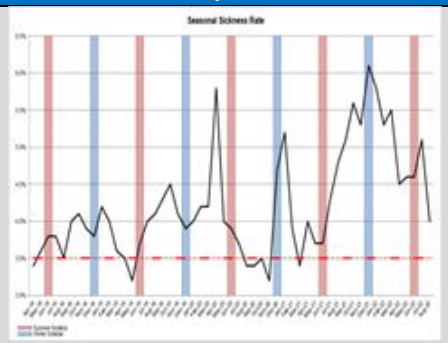
What the chart tells us:
Target is met frequently but there are periods of variation.

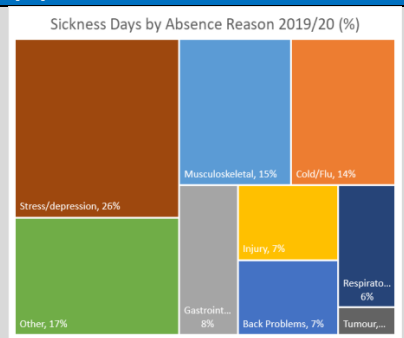
Underlying issues that prevent us from consistently reaching the target:
- There are known demand and capacity issues within adult ADHD services and there is a continued risk of further 52 week breaches.
- One 52 week waiting breach was incurred in September 2022 linked to the Merton ADHD Service linked to lack of appointment availability and subsequent cancellation of appointment due to staff sickness. Client is now due to be seen at end of November 2022.

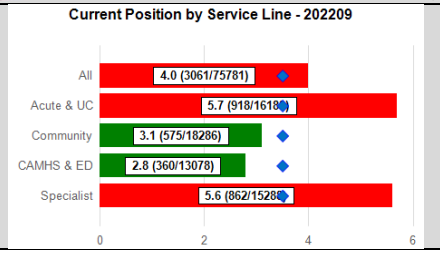
Actions:
- Improvement plan led by Clinical Manager to improve processes around referrals, cancellations and contact options I.e. encourage e-consultation use in long waiters who cannot attend face to face.
- Adult ADHD service and Performance Analyst are having weekly meetings to review 50 plus week waiters – previous breaches which were showing for ADHD services were incorrect (they had been seen but booked as 'Assessments' – admin and IT are retrospectively fixing these so they should come off and not be included.
- To undertake annual medication reviews and support caseload management two non-medical prescribers have been recruited, these staff are now in post and completing their scope of practice. A further post is currently out for recruitment.
- The service will continue to have its waiting times monitored via the Internal Access meeting and will continue to be reported in Board reporting via i.e. 30 week breaches KPI.

Staff Retention/ Support / Satisfaction

Sickness Rate - reported month in arrears (%) — Target ≤ 3.5%







Background
Looking after the health and wellbeing of staff directly contributes to the delivery of quality patient care. Poor employee health has high and far-reaching costs and ultimately patients. The Trust is concerned about the well-being of Trust employees and wishes to support staff in improving their attendance.

What the chart tells us
Performance follows seasonal trends, but the Trust is consistently above target. There was a significant increase in sickness in March 2020 linked to COVID-19 pandemic.

Underlying issue
- The spike in January 2021 relates to COVID and the effects on staff of the vaccine. For example, in Acute and Urgent Care there were 180 episodes of short term sickness, an increase of 16 from the previous month. Of this 180, 99 were related to COVID.
- A complex method of reporting of sickness cases whilst managed by Capsticks (till mid-July 22) not fully understood by managers.

Actions
- New sickness reporting system which is scheduled for implementation in September 2022. New system will enable managers to better manage sickness absence with ongoing support from Employee Relations Team.
- The Trust is now overseeing all stage 2 sickness cases following handover from Capsticks in July 2022.
- HR FAQs aligned to COVID concerns/questions have all been circulated to staff and risk assessment and guidance documents have been updated.
- E-roster has updated reasons for absence to include absence due to COVID vaccinations to enable more robust reporting.

Fundamental Standards of Care Dashboard – Inpatients

vision

Fundamental Standards of Care - Inpatients

Press F11 for Full Screen

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

Summary Table

Group	KPI	Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
FSOC 1	Annual care plan review (%)	95%	97.2	100	97.5	93.6	90.1	94.2	87.8	89.1	90.6	87		87.5
	Care planning audit compliance (%)	90%								93.1	94.2	94.8	94.7	95.4
	Care planning audits completed (%)	90%								73.4	83.1	87	93.9	92.4
FSOC 2	Cardiometabolic Assessments - Inpatients (%)	90%	89.2	85.9	83.4	88.6	88.4	82.4	90	86.6	79.8	86	83.7	76.1
	Physical Health Assessment attempted within 4...	95%	94	97.1	97.8	99.2	92.4	92.6	95.3	95.6	95.9	96.3	91.5	89.9
	Physical Health Assessment completed within 7...	90%	71.7	83.2	82.3	82.6	77.2	81.4	77.5	80.2	80.5	87.9	84.4	89.7
FSOC 3	Risk Assessments within 48 hours of admission...	95%	92.9	97.1	94.7	97.8	96.1	94.1	94.7	98.2	99.5	96.1	93.5	94
FSOC 4	Observation reviews completed against standar...	Null				35.8	34.8	39	45.4	37.7	41.6	40.1	42.1	39.3
	Observations required vs completed (%)	Null				80.6	79.8	74.7	69.1	70	70.8	73.6	79.8	82.5
FSOC 5	Number of safeguarding adults alerts	Null	16	15	15	21	13	16	13	29	14	19	25	6
	Number of safeguarding children incidents repo...	Null	4	3	5	6	2	1	0	2	7	2	4	1
	Safeguarding adults training (%)	95%	98.3	98.2	98.5	98.9	98.7	98.7	98.9	99.1	99.1	99	97.9	98
	Safeguarding children training (%)	95%	92.8	92.9	93.2	88.4	90.4	90.5	90.5	91.1	90.9	90.9	88.9	89.2
FSOC 6	Infection Prevention and Control Training (%)	95%	96.5	96.8	95.9	96.8	95.7	96	96.7	96.3	96.9	96.5	95.9	95.7
	Infection prevention control audit compliance (...	90%	99.3	99.8	99.5	96.3	96	97.7	98.5	98.7	98.4	98.7	98.6	99.2
	Infection prevention control audits completed (...	90%	80	80	80	52.2	65.4	79.4	90.4	89.6	88.2	83.1	90.2	92.7
FSOC 7	Pharmacy audit compliance (%)	90%	87.8	89.1	87.1	87.5	89.7	89	90.9	92.5	91.4	88.5	88.5	
	Pharmacy audits completed (%)	90%	95.8	53.7	87	95.7	73.9	100	95.7	91.3	100	82.6	90.9	
FSOC 8	Mental health act audit compliance (%)	90%	86.9	88.4	89.3	90.8	93.3	92.3	92	92.1	89.6	91.8	91.9	95.1
	Mental health act audits completed (%)	90%	72.8	65.3	66	64.8	68	74.4	81.3	84.8	86.4	88.2	93.8	100
	Mental Health Law Training (3 Year)	85%	89.4	89.7	89.9	88.7	88.3	89.8	83.7	84.1	79.8	83.2	74.3	71.4
	Section 132 Patient Rights Repetition	100%	80.2	82.1	83.4	87.6	92.4	87.2	86.4	90.8	86.4	89.9	87.9	87
FSOC 9	Duration of physical restraint (average minutes)	Null	7.3	6.7	10.6	4.9	8.7	9.1	4.9	7.7	12.2	7.6	12.6	13.3
	Duration of prone restraint (average minutes)	Null	8	4.5	2.1	1.8	2.9	3	1.6	3.3	16.1	3.5	2.3	5.1
	Reducing restrictive practices - Prone restraint	Null	22	17	36	23	25	27	13	30	40	24	23	21
	Total number of restraints (physical restraints...	Null	118	179	184	173	149	124	64	81	86	74	110	82
FSOC 10	Patient Safety incidents	Null	328	259	259	249	275	286	336	329	324	294	278	238
	Root Cause Analysis (RCA) actions that are over...	0	8	11	9	8	7	7	5	3	2	5	5	7
	Serious incidents	Null	15	25	22	18	11	13	14	26	19	14	21	20
FSOC 11	Safe Staffing: Shift Assurance, inc Obs Require...	Null		86.7	81.6	86.2	85.8	81	85.6	84.8	82.1	87.5	87.2	85.2
	Supervision (%)	85%	83.4	80.6	81.2	79.3	86	88.9	84.7	84.5	79.9	79.2	82.7	78.1

Comments

- The work on Fundamental standards of care continues to be led through the service line leadership team with great engagement from frontline staff. We have agreed a process for teams of concern to be escalated through the Service Line Reviews, triangulated with the SIREN and the quality metrics. The FSOC are also embedded into the new building inductions to support it being part of the new culture.
- Dashboards for monitoring inpatient Fundamental Standards of Care were deployed in April 2022.
- Care planning physical health are areas for further focus in coming months, the training and quality in these areas have improved, further focus to improve staff appropriately updating the systems. In addition MHA training & section 132 reading of rights compliance are of concern. These areas are reviewed in the service line quality governance meetings and through the service line reviews.
- In Specialist Service Line FSOC inpatient exception report meetings have been in place since Dec 2021 and reporting monitored monthly and weekly in our regular Monday meetings

Fundamental Standards of Care Dashboard – Community

vision — Fundamental Standards of Care - Community — Press F11 for Full Screen

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

Summary Table

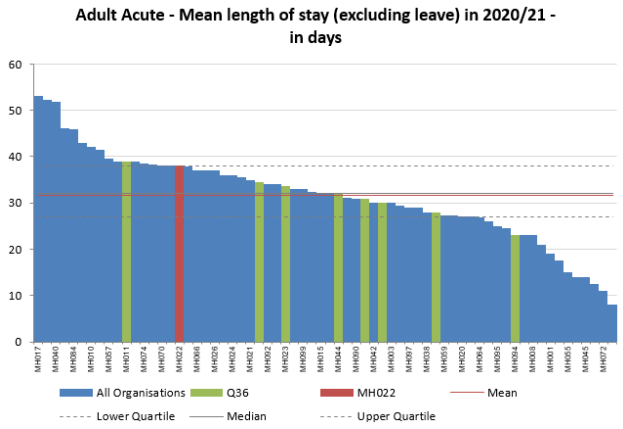
Group	KPI	Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
FSOC 1	Annual care plan review (%)	95%	97	98.3	97.4	97	96.2	95.2	94.6	94.4	94.8	94.3		94.8
	Care planning audit compliance (%)	90%										88.5	79.5	77.2
	Care planning audits completed (%)	90%										18.6	28.5	31.3
	Carers of Clients on CPA who have been offered ...	85%	91.7	94.4	94.4	93.6	88.2	94.8	93.5	83.7	87.6	96.7	95.3	97.8
	Cluster accuracy and quality (%)	90%	87.2	88.2	87.8	87.1	85.7	85.4	85.2	85.1	85	86	84.7	83.9
	Cluster in-date (%)	90%	89.9	90.6	90.5	89.9	88.5	87.9	88.3	88	87.3	88.2	87	86.3
	Cluster Recorded (%)	90%	85.2	86.1	86.1	85.8	85	85.2	85.2	85.1	85	86	84.7	83.9
	Dialog assessment recorded in the last 6 month...	Null	4.5	5.1	4.9	5.2	5.2	5.1	5.2	4.1	5.1	6.4	10.2	12.2
	Employment, education and training informatio...	90%	86.2	89.6	82.4	84	94.4	87.5	87.5	87.1	87.2	79.3	77.2	80.3
	Feedback Offered (%)	90%	87.4	81.1	90	93.2	89.5	90.9	85.2	89.9	91.5	88.2	83.9	94.7
	Goals Set (%)	90%	93.7	94.9	91	88.3	92.8	87.9	87.7	89.9	78.9	84.5	82.2	70.5
	Paired Measures (%)	80%	65.7	42.3	68.9	64.1	71.7	75	64.1	85.4	71.4	80.5	68.3	81.5
FSOC 2	Cardiometabolic Assessments - Community & EI...	75%	81.8	80.7	79.3	83	84.1	84	81.9	85.4	84.9	85.4	85.6	85
	Cardiometabolic Assessments - EIS (%)	90%	87.3	87.4	82.3	86	84.4	81.2	80.1	91.6	92.1	90.4	88.7	88.5
FSOC 3	CAMHS IAPTUS patients with an up to date risk ...	95%										60.6	59.4	59.4
	Community patients with an up to date risk ass...	95%	92.7	93.9	93.6	92.2	93.5	91.9	92.1	92.3	91.6	92.7	92.6	92.5
	Risk Assessments within 48 hours of admission ...	95%	89	89.3	87.3	87.5	89.1	89.8	90	90.5	89.8	90.8	89.3	93.7
FSOC 5	Number of safeguarding adults alerts	Null	76	48	53	76	77	80	71	61	72	73	40	25
	Number of safeguarding children incidents repo...	Null	35	50	43	43	44	61	64	47	44	35	41	19
	Safeguarding adults training (%)	95%	97.9	98.2	98	97.9	98.3	98.5	98.4	98.9	98.9	98.1	98.1	97.8
	Safeguarding children training (%)	95%	95.2	95.7	95.6	93.3	94.5	94.2	94.1	94.8	94.6	93.3	91.6	91.1
FSOC 6	Infection Prevention and Control Training (%)	95%	95.2	94.7	94.2	93.8	94.6	95.1	95.6	95.9	95.7	95.8	95.2	96
	Infection prevention control audit compliance (...	90%							100	100	96.3	97.2	96.1	94.3
	Infection prevention control audits completed (...	90%						0	8.3	25	19.2	46.4	50	38.9
FSOC 7	Pharmacy audit compliance (%)	90%		87.6							76.4			
	Pharmacy audits completed (%)	90%		100							100			
FSOC 8	Mental Health Law Training (3 Year)	85%	89.7	89.4	89	86	83.6	86.6	84	84	79.4	82.2	69.8	69.1
	Section 132 Patient Rights Repetition	100%	57.6	70.3	77.8	76.7	69.1	79.7	76.1	68.5	50.5	74.2	80.3	82.5
FSOC 10	Patient Safety incidents	Null	116	88	136	146	139	114	149	138	118	124	111	67
	Root Cause Analysis (RCA) actions that are over...	0	9	8	15	2	6	6	7	6	5	6	9	7
	Serious incidents	Null	23	12	20	28	14	16	23	14	27	16	22	16
FSOC 11	Supervision (%)	85%	86	81.4	84.4	84.1	83	79.2	86.4	85.4	82	85.8	86.3	84.9

Comments

- The work on Fundamental standards of care continues to be led through the service line leadership team with great engagement from frontline staff. We have agreed a process for teams of concern to be escalated through the Service Line Reviews, triangulated with the SIREN and the quality metrics. The FSOC are also embedded into the new building inductions to support it being part of the new culture.
- New Community Dashboard for Community Fundamental Standards of Care was launched on the 4th July 2022.
- CAMHS Risk Assessment recording via IAPTus is now available via the FSoC Dashboard and will be reported in Quality and Performance as a separate risk metric from August 2022.

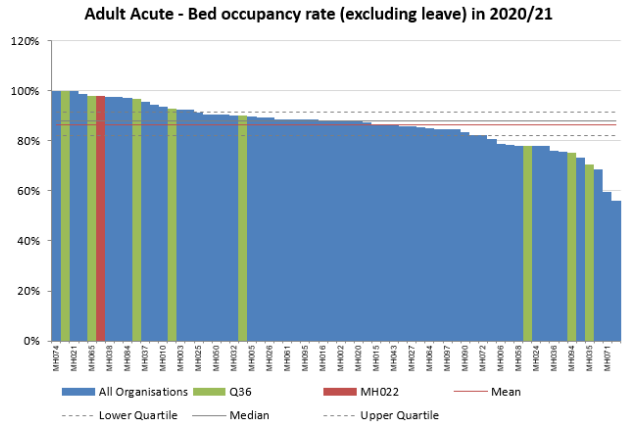
Appendix 1: Benchmarking

The NHS Benchmarking Network's 2020/21 Inpatient and Community Mental Health Benchmarking Report was issued in October 2021 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.



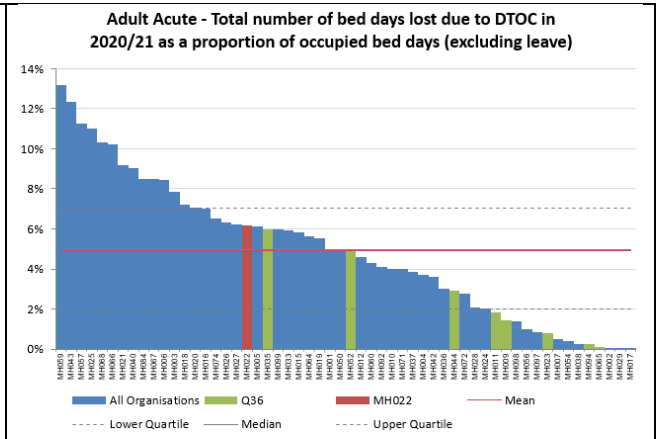
- **Adult acute average length of stay (days):**

2020/21			2022/23	
Trust	London	England	Sep-22	YTD
38.0	32.0	32.0	49.4	48.1



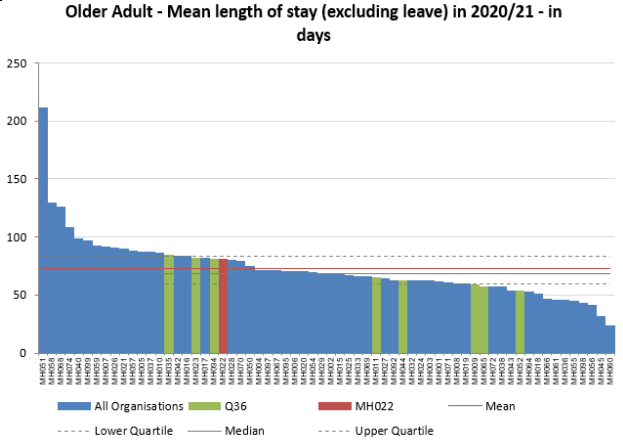
- **Adult acute bed occupancy rate (%):**

2020/21			2022/23	
Trust	London	England	Sep-22	YTD
98.0%	89.0%	86.0%	98.0%	98.6%



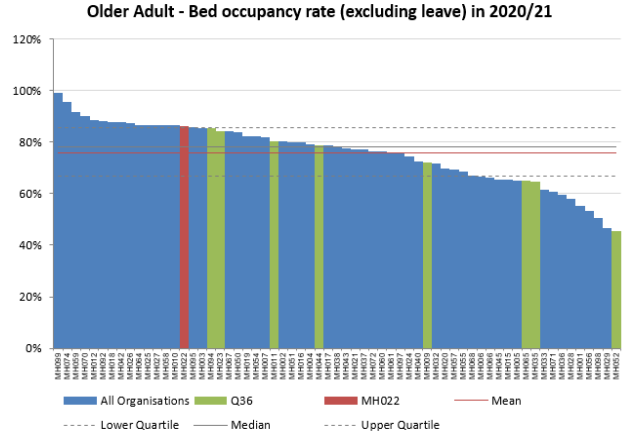
- **Adult acute delayed transfers of care (%):**

2020/21		
Trust	London	England
6.0%	3.0%	5.0%



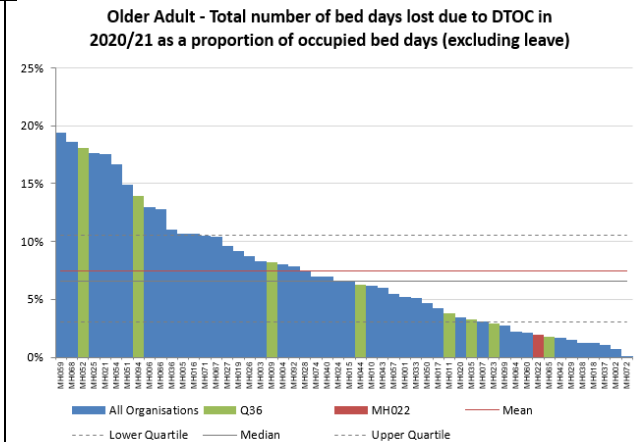
- **Older people's average length of stay (days):**

2020/21			2022/23	
Trust	London	England	Sep-22	YTD
81.0	70.0	73.0	100.4	95.6



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

2020/21			2022/23	
Trust	London	England	Sep-22	YTD
86.0%	74.0%	76.0%	87.3%	89.3%



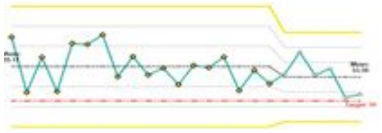
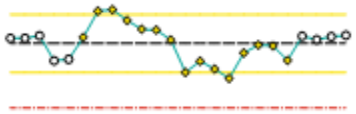
- **Older people's delayed transfers of care (%):**

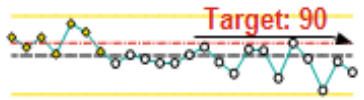
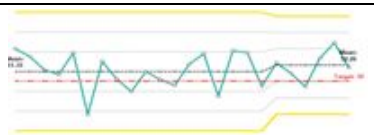
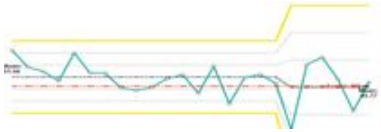
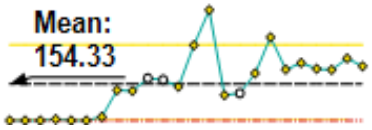
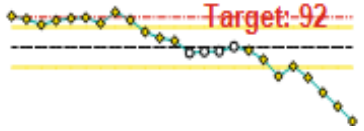
2020/21		
Trust	London	England
2.0%	7.0%	7.0%

Appendix 2: NHSI Compliance Overview

Following best practice guidance from NHSI the summary of performance against SOF NHSI metrics replaces RAG (red, amber, green) ratings with statistical process control (SPC) charts to provide assurance and trend analysis. An explanation of the use of icons and charts is provided in Appendix 8 of this report.

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	Sep-22	Target	Trend	Assurance on consistently meeting the target	SPC Chart	Comments
Data quality maturity index (DQMI) (%) see page 19	98.3	≥ 95.0	→	✓		Performance remains stable and consistently exceeds the target following the introduction revised administrative processes to collect missing data. The Trust is reported by NHS Digital as being one of the highest performers in England.
IAPT recovery rate - Talk Wandsworth (%) see page **Error! Bookmark not defined.**	51	≥ 50.0	→	✓		Performance is consistently above target for Talk Wandsworth.
IAPT/talking therapies - Waiting time to begin treatment within 18 weeks (%)	100	≥ 95.0	→	✓		Performance is consistently above target.
IAPT/talking therapies - Waiting time to begin treatment within 6 weeks (%)	98.1	≥ 75.0	→	✓		Performance is consistently above target.
Cardiometabolic Assessments - Community & EIS (%) see page 22	85.6	≥ 75.0	↘	✓		Sustained improvement following the implementation of a recovery plan in January 2020. Data forms have been simplified and were introduced across the Trust in September 2020. Staff continue to be trained on the use of the new forms and guidance has been issued.
1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) see page 10	69.6	≥ 60.0	→	?		There was a period of deterioration in performance, mainly due to referrals from wards and assessment teams.

Cardiometabolic Assessments - Inpatients (%)	83.7	≥ 90.0	→	?		A task and finish group has reviewed the process for capturing physical health information on clinical systems. Clinical data collection forms have been simplified and were implemented across the Trust in Sept 20. Guidance has been issued to all staff.
IAPT recovery rate - Merton Uplift (%) see page **Error! Bookmark not defined.**	51.9	≥ 50.0	→	?		Average performance for 2022/23 is currently above target.
IAPT recovery rate - Sutton Uplift (%) see page **Error! Bookmark not defined.**	50.7	≥ 50.0	→	?		Average performance for 2022/23 is currently below target.
Inappropriate out of area placement bed days - Adult Acute & PICU Ⓟ see page 18	229	= 0	↗	X		The Trust has opened surge beds to help manage peak demand and keep out of area usage to minimum and has negotiated a six month contract for use of 12 beds at Huntercombe unit which commenced on the 29th November 2021.
Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) see page 11	76.4	≥ 92.0	↘	X		There have been demand and capacity issues within adult ADHD services. A wait list initiative targeted at longest waiters ran between March 2022 – July 2022 where 176 of longest waiters were transferred and seen by a third party provider. Additional resources for non-medical prescribing have also been out in place.

Appendix 3: Effective: CQUIN key measures

Overall Dashboard					
The Mental Health CQUIN team are currently developing schemes for 2022/2023					
Effective: CQUIN Key Measures	**Target**	**Sep-22**	**YTD**	**Information**	**Outcome**
Flu vaccinations for frontline healthcare workers (%)	≥ 90.0			Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	The reporting for this CQUIN does not start until Q3.
Cirrhosis and fibrosis tests for alcohol dependent patients (%)	≥ 35.0	N/A		Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	The Trust have partially achieved the CQUIN and achieved 30%, this was an improvement on Q1's performance, but still off the 40% target
Routine outcome monitoring in CYP and perinatal mental health services (%)	≥ 40.0	30		Achieving 40% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measured at least twice	The Trusts did not achieve the target for Q2, achieving 6%, which again was an improvement of 1% from Q1. There is further work promoting PROMIS and DIALOG in the community teams and there has been an improvement in single outcome being completed at beginning, though there is not an improvement in paired scores.
Routine outcome monitoring in community mental health services (%)	≥ 40.0	6.1		Achieving 40% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice. In order to meet the requirements of this indicator, Patient Reported Outcome Measures (PROMs) data will need to be submitted (either in combination with Clinician Reported Outcome Measures (CROMs), or only PROMs) as part of the numerator for this CQUIN during the financial year.	Achieved Q2 targets, achieved 66%.
Use of anxiety disorder specific measures in IAPT (%)	≥ 65.0	66.4		Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).	Audits have been completed for Q2 and the achievement is currently being assessed.
Biopsychosocial assessments by MH liaison services (%)	≥ 80.0	N/A		Achieving 80% of self-harm [1] referrals receiving a biopsychosocial assessment concordant with NICE guidelines	Currently on track, though there is a concern with auditing as staff are leaving who are the current auditors.
CAMHS Formulation (%)	≥ 80.0	N/A		Delivery of formulation or review within 6 weeks of admission, as part of a dynamic assessment process for admissions within Tier 4 CYPMH settings	Partially Achievement for Q2, achieving 72.1, which was an improvement on Q1 achievement.
CAMHS: Restrictive Practice (%)	≥ 80.0	72.1		Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings	The Trust have partially achieved the CQUIN and achieved 30%, this was an improvement on Q1's performance, but still off the 40% target

Appendix 4: CQC regulation and quality improvement plan (QIP)

Key points and underlying issues	Action taken
The CQC undertook an inspection of our services in September 2019, with the Well-Led element in October 2019. The subsequent report concluded an overall rating of 'good' across all five domains. It was clear that the Trust had really strengthen its good rating, but not to the extent to achieve 'outstanding' at this time (see matrix below) The only areas that were deemed as 'requires improvement' were from the Specialist eating disorders service, which also resulted in requirement notices in respect of five regulates that were assessed as being breeched in this service As expected, the CQC focused heavily on physical health care plans; ligature audits, risk assessments, incident reporting and learning from incidents; staff morale, records of staff training and meetings, the quality of staff supervision, and are asking to see to see a number of types of documentation such as audits and records. The CQC noted many outstanding features, such as; In our wards for older people with mental health problems, staff provided excellent support to families and carers, considered their needs and were proactive in involving them in their relative's care Staff provided a very high standard of physical health care and treatment to patients. The Trust's 'safety in motion programme' which works to reduce restrictive interventions shows that staff are committed to using the least restrictive practice and this was evident in the low usage of restraint, seclusion and rapid tranquilisation. On Avalon Ward, the occupational therapist developed a 'Your Group, Your Say' workshop where patients could make suggestions for new ward groups and then vote on what activities they wanted. The Trust had set up an expert panel to look at the experience of black, Asian and minority ethnic (BAME) patients who were over-represented in mental health services and less likely to use talking therapies. The panel was chaired by an academic expert in the field. The expert panel was committed to developing a work programme to make Trust services appropriate to BAME needs and ensure equitable, safe and effective mental health care. The pharmacy team had written a successful business case for a project on medicines optimisation in care homes for people living with learning disabilities. This has received praise from GPs and other stakeholders across the five boroughs. CQC also found our staff to be caring, compassionate and kind and the leadership of our wards and services is strong and is having a positive impact on patient care. Patients were positive about the care and treatment that they are receiving from us and Physical health care had improved - in particular NEWs escalation and Rapid Tranquillisation monitoring. They commended the model of care provided in Lotus Psychiatric Decision Unit - which is important as we are leading the way nationally in this area They found strong evidence of good risk management, learning from incidents and teamwork	During the inspection a number of immediate actions were taken to address the verbal feedback provided each day. Action plans were devised after receiving formal verbal feedback in September 2019 at the end of the inspection Upon receipt of the draft report in November 2019 the actions were initially reviewed with the Service Lines, through the CQC Actions Group, that also established actions that link with the supporting information pack provided by the CQC. The actions were formally agreed at QGG in January 2020 and presented to QSAC for assurance also in January 2020. The September Always Ready meeting discussed the CQC's single assessment framework. There are no significant changes that will be affecting the Trust, as yet. **Ratings on how Trust Scored for each core service:** 

Appendix A – Current regulation notices

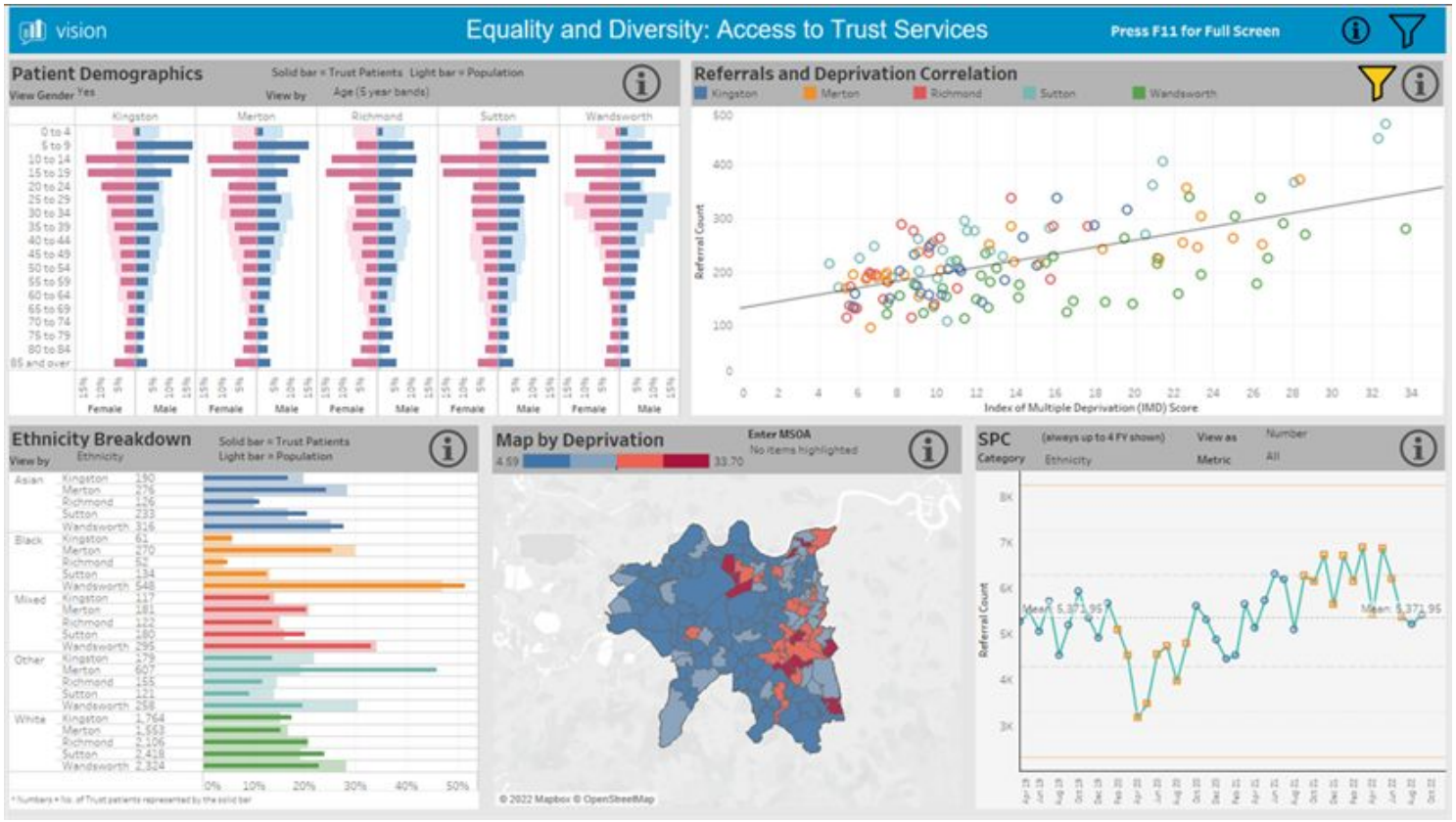
Regulation	Service	Issue
Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Long stay or rehabilitation mental health wards for working age adults	The trust must ensure that staff at Burntwood villas have access to adrenaline and know where it is stored and that risk assessments are undertaken where needed for patients with specific medication requirements. Regulation 12 (2)(f)
		The trust must ensure that staff always follow infection prevention and control policies. Regulation 12 (1)(2)(h)
Regulation 17 HSCA (RA) Regulations 2014 **Good governance** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Long stay or rehabilitation mental health wards for working age adults	The trust must ensure there is a robust model of care, that patients are admitted in accordance with the defined admission and exclusion criteria and that where a patient no longer meets the criteria, they are transferred promptly to a more suitable service. Regulation 17(2)(a)
		The trust must ensure that operational risks relating to the service are documented, monitored and managed. Regulation 17(2)(a)(b)
		The trust must ensure fire safety arrangements are adequate so that risks are mitigated to safeguard patients and staff and that issues identified through risk assessments and fire drills are acted on promptly. Regulation 17(2)(b)
Regulation 18 HSCA (RA) Regulations 2014 **Staffing** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Long stay or rehabilitation mental health wards for working age adults	The trust must ensure that the service is suitably staffed, with the right skill mix, to provide the level of care required to meet patients' needs and that this is aligned to the model of care on offer. Regulation 18(1)
Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Acute wards for adults of working age and psychiatric intensive care units	The trust must ensure that there are appropriate and detailed plans in place to manage patients' physical health risks and that specialist advice is followed after a review of patients' needs. Regulation 12 (1)(b)
		The trust must ensure that staff do not complete intermittent observations at regular, predictable intervals. Regulation 12 (1)(b)

CQC MHA monitoring visits

Date of CQC Visit	Service/ Ward Visited	Service Line	Visit Ref	Date Summary received	Response Due to CQC	Date Sent to CQC
January – March 2021						
13/01/2021	Lilacs	Acute & U	ENQ1-10272797692	25/01/2021	01/03/2021	26/02/2021
11/03/2021	Wisteria	Forensic & Specialist	ENQ1-10604136327	24/03/2021	21/05/2021	13/05/2021
18/03/2021	Lavender	Acute & U	ENQ1-10682947938	07/04/2021	13/05/2021	11/05/2021
16/03/2021	Ellis	Acute & U	ENQ1-10604817975	24/03/2021	21/05/2021	29/04/2021
April – June 2021						
27/05/2021	Burntwood Villas	Forensic & Specialist	ENQ1-11017079528	03/06/2021	08/07/2021	08/07/2021
July – September 2021						
20/07/2021	Wandsworth CTOs	Community (Adults)	MHV1-11271771291	02/09/2021	23/09/2021	22/09/2021
02/09/2021	Hume Ward	Forensic & Specialist	MHV1-11477034581	13/09/2021	n/a, no issues	n/a, no issues identified
02/09/2021	Phoenix Ward	Forensic & Specialist	MHV1-11498451091	13/09/2021	30/09/2021	24/09/2021
April – June 2022						
05/04/2022	Ward 1/PICU	Acute & U	MHV1-12897891721	14/04/2022	09/05/2022	09/05/2022
13/06/2022	Avalon Ward	CAMHS & ED		05/07/2022	22/07/2022	
July – September 2022						
08/08/2022	Halswell	Specialist S	MHV1-13369484111	16/08/2022	06/09/2022	

Appendix 5: Equality Diversity Dashboard

The information below is taken from the Trust Equality and Diversity dashboard and provides an overview of referrals to Trust services comparing the gender, age and ethnicity of our patients against those of the local population. Information on relative deprivation is also provided. The dashboard has been designed to be interactive by providing 'hover over' and pop up information (not shown below) to give detailed insight.



Note: the information relates to referrals (access) to Trust secondary MH community services (all ages). Further iterations will include inpatient admissions and IAPT services.

Selected key themes by dashboard heading:

- Ethnicity breakdown: the following groups are significantly over-represented: black people in Wandsworth and the ethnic group 'other' in Merton.
- SPC (statistical process control): the number of black people referred to the Trust appears to have increased over the past year.
- Patient demographics: White people are underrepresented among people referred to Trust in Merton and Wandsworth.
- Referrals and Deprivation Correlation: There appears to be a correlation and the many of the most deprived areas are in Sutton.

Appendix 6: Methodology for choosing the domains, metrics and calculating the RAG ratings

Domains: The domains & themes used in this report have been reviewed by the Executive and approved at the Executive Leadership Team Meeting.

Metrics: They have been selected for use in the domain tables, are based on the key operational performance and organisational health indicators reported nationally; key contractual indicators used locally; metrics that have been prioritised by the Trust to identify high risk areas and external benchmarking where available.

Quality and performance Board Report definitions and tolerances have been reviewed and approved by Executives.

Operation Domain:
Access Metrics
- RTT
- Access to Adult /OP CMHT within 28 days
Flow
- Zoning caseload seen as required
- Adult Acute Average LOS
Operations
- Cluster accuracy and quality
Quality Domain:
Fundamental Standards of Care
- Inpatient Risk Assessment Completed within 48 Hours of admission/event
- Physical Health Assessment Attempted within 48 Hours of Admission
Patient Experience & Outcomes
- Patient Friends & Family Test
- Complaints Answered within 25 Days
Patient Safety
- Patient Safety Incidents
- Total Number of Restraints
Workforce Domain
Recruitment / Attraction
- Vacancy Rate
- Time to Recruit
Staff Skills / Development
- Mandatory & Staff training
Staff Retention / Support / Satisfaction
- Turnover Rate
- Staff leaving within 12 months of appointment
Finance Domain
Grip & Control
- Agency Spend as a % to NHI target
- % Forecast budget overspend
Productivity
- Overall SL community productivity % vs expectation

Priority & Supporting metrics: The priority & supporting metrics have been discussed and approved by the relevant Executive Team members.

SPC Charts: This report uses the methodology of statistical process control (SPC) charts to provide better information on trends and to evidence the sustained effect of changes in process to improve performance.

'Donut' Charts: The production of the performance summary donut uses a methodology based on the metrics' assurance on consistently meeting target, as approved by the Trust executives.

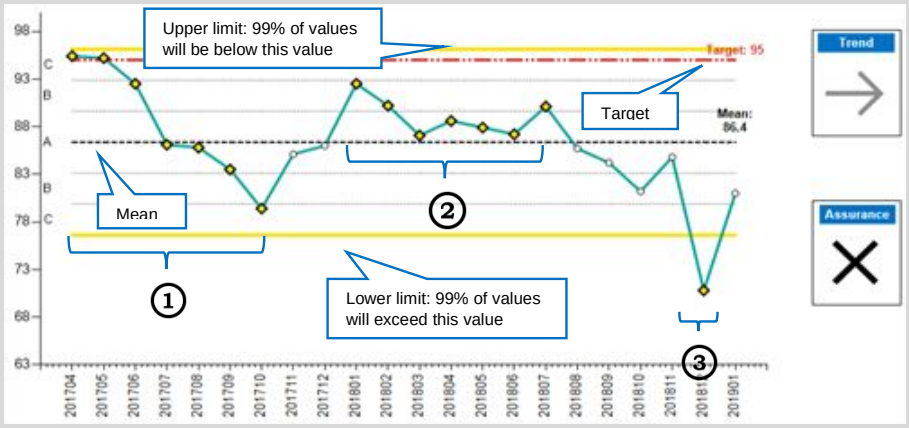
Appendix 7: Data quality assurance

The Trust assesses the quality of the data it uses for performance or decision making. The assessment is undertaken against 6 kite mark criteria, as set out in the board quality and performance report, metric definitions and tolerances manual. A colour coding rating, see below, is given to each metric on the domain dashboards.

The Trust maintains a programme of data quality assessments, with any new metric assessed within 3 months and action plan to address metrics where there is insufficient data quality assurance.

Green	Rated 6 or above against the 6 kite mark criteria, 'positive'.
Red	Rated 5 or less against the 6 kite mark criteria.
White	Data quality not fully assessed. Plan to complete assessment within 3 months.

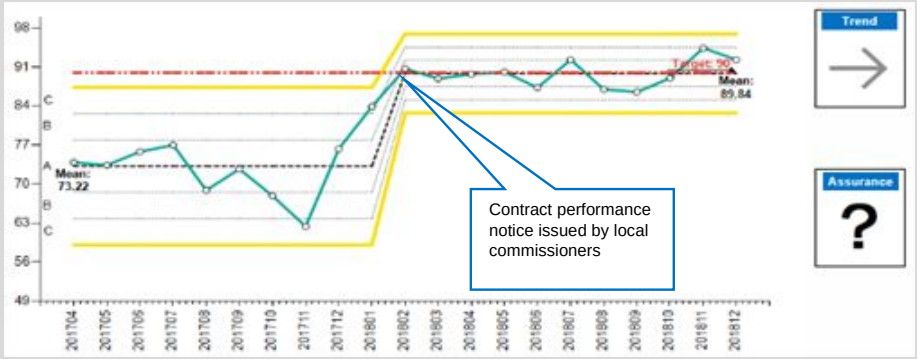
Appendix 8: Statistical Process Control (SPC) Charts & Performance Donut



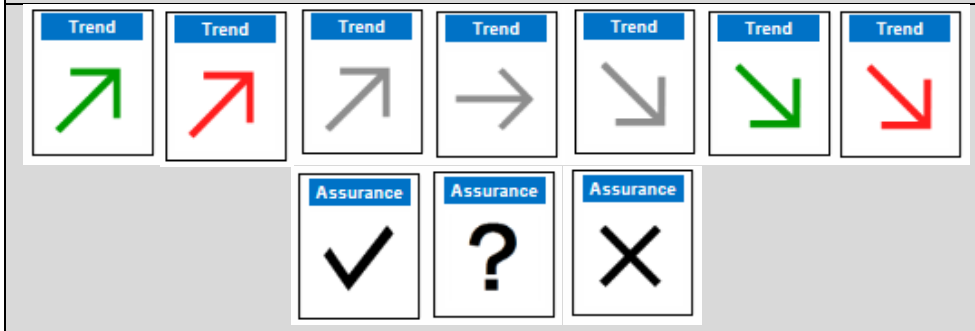
What is an SPC chart?
A Statistical Process Control (SPC) chart is a time series graph (we try to use 2 years) with three reference lines – the mean, upper and lower control limits. The limits help you understand the variability of the data. The variance of the data determines the process limits and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

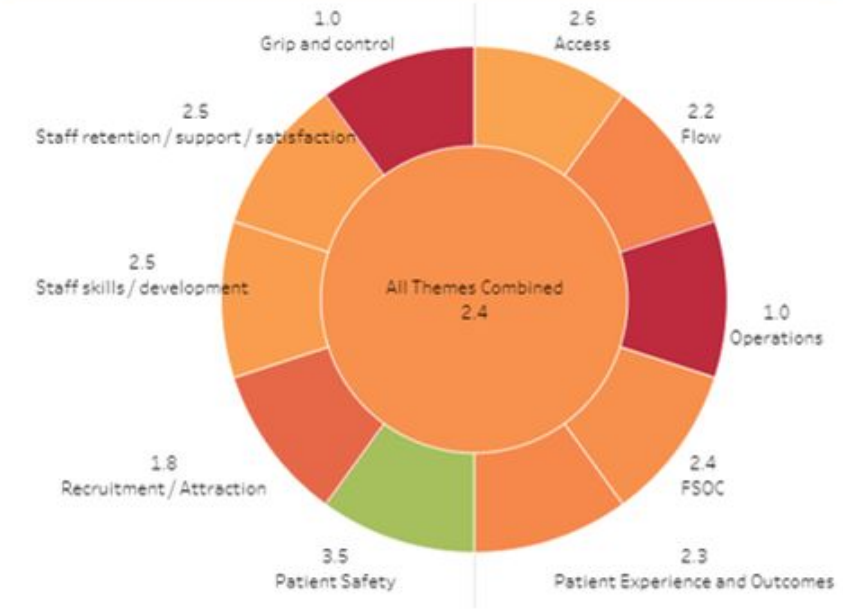


Use of icons to interpret charts
The Trend icon is shown as one of seven upward, horizontal or downward arrows depending on which direction the data is heading, coloured green, grey or red to indicate whether this is an improvement or deterioration in performance (or neutral where there is no target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

Meeting:	Trust Board – Part A
Date of Meeting:	10th November 2022
Report Title:	2022/23 Corporate Objectives – Q2 delivery
Author(s):	Amy Scammell, Director of Strategy, Transformation and Commercial Development
Executive Sponsor(s):	Amy Scammell, Director of Strategy, Transformation and Commercial Development
Purpose:	For approval
Scrutiny Pathway:	Executive Leadership Team 27.10.22; Finance and Performance Committee 27.10.22; Estate Modernisation Committee 01.11.22; Quality and Safety Committee 07.11.22.
Transparency:	Public

Executive Summary

1.1. Each year, a set of organisational corporate objectives are developed to support delivery of the Trust Strategy. The Trust Board in May 2022 approved the proposed set of corporate objectives for 2022/23 following discussions at the Executive Leadership Team and Trust Board sub-committees between February and April 2022.

1.2. 2022/23 is a year of significant change for the Trust with the delivery of the integrated transformation programme, changes to the health and care landscape, ongoing demand pressures for mental health services and workforce and financial challenges across the NHS.

1.3. The 2022/23 corporate objectives were developed through an iterative process including Board discussions which recognised a need to pause some areas of delivery to create 4-6 months of space between July and December 2022 for the organisation to focus on moving into the new Springfield buildings. Areas being paused in 2022/23 include commercial income development, R&D, extension of QII, strategic development of work related to learning disability and autism, formal well-led review preparation, further development of charitable funds agenda and development of the Trust as an anchor institution.

1.4. In this context, the 2022/23 corporate objectives are:

- (1) To improve the quality of our services through delivering a stepped change in fundamental standards of care and empowering service users and carers;
- (2) To deliver our integrated transformation programme providing state of the art mental health facilities, improving access and outcomes and reinvigorating working practices for staff and service users alike;
- (3) To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences;
- (4) To support our people to grow and develop our organisation to be the best we can be;
- (5) To proactively develop partnerships and act as a system leader driving strategic improvements to mental health of the SWL population;

- (6) To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL.

1.5. For each objective, key delivery items have been outlined with the intended timescale for delivery. Key outcomes or metrics have also been included that will enable monitoring of delivery of the objective. Baseline measures were agreed where these were available. Finally, each corporate objective has been mapped supports delivery of the Trust's four strategic ambitions.

1.6. Quarterly reports on progress will be made to ELT, sub-committees and the Trust Board. Revised RAG ratings will be included for 2022/23 with reporting 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.

In the Q1 report a progress RAG system only was used. For the Q2 report outcome data has been included for objectives 1 and 4 to illustrate the position at M6 2022/23.

1.7. This paper provides the Q2 2022/23 corporate objectives delivery update highlighting a summary of work completed and any outstanding elements. Notes on future milestone risk have been included. The key points to note are:

- Objective 1: Restrictive practises are unlikely to reduce as per originally anticipated trajectory due to delays in moving into the new Springfield buildings.
- Objective 2: Some elements of clinical transformation will slow due to demand pressures within clinical services and changing move timetables; a re-timetabling for Barnes and Tolworth business case development has been agreed – these are being managed by the Executive Team.
- Objective 4: Leadership programme development will move back in Q4 2022/23 and Q12023/24 as will organisational development work. This is in recognition of the need to focus on foundational elements in HR including recruitment and retention.

1.8. Given the operating context, the Executive Team has reviewed the deliverability of the corporate objectives overall – we remain committed to driving towards these ambitions for this year. Capacity remains a key issue and the Executive Team continue to consider if suitable additional support can or should be acquired.

1.9. This paper has been received by the ELT, the Finance and Performance Committee, the Estate Modernisation Committee and the Quality and Safety Assurance Committee. This paper has not been received by the Workforce and Organisational Development Committee or the Equality and Diversity Committee prior to Board due to meeting schedules. The report will be discussed with WODC and EDC chairs prior to Board.

1.10. **The Trust Board is asked to:**

- Note the Q2 2022/23 delivery and identify any key risks or issues to future delivery.

Corporate Risk	**N/A**	**Board Assurance Risk**	**N/A**

KEY IMPLICATIONS
Outlined below are the key implications that may result from the proposals or information contained within this report.

Assurance/ Governance:	Positive impact – Corporate objectives support organisational governance and assurance, as well as ongoing planning work in the Trust for 2022/23 and beyond.
Clinical:	Positive impact – Delivery of corporate objectives for 2022/23 ensured continued safe delivery clinical services, and wider delivery of strategic ambitions' outcomes.
Equality & Diversity:	Positive impact – Delivery of equality, diversity and inclusivity is everyone's business. There is a specific corporate objective in 2022/23 to continue progress around reduction of inequalities, and a clear focus on delivering the vision of the Trust's Equality, Diversity and Inclusion Enabling Strategy. Some delivery around EDI work is slower than anticipated but momentum exists and progress is being made.
Estates:	Positive impact – Delivery of the Estate Modernisation Programme (EMP) is a key organisational priority in 2022/23.
Financial:	Positive impact – Financial delivery is a key focus of 2022/23 in recognition of the exceptionally challenging landscape that the Trust is working in. Delivery is likely to be pressured throughout the year.
Legal:	N/A
Quality:	Positive impact – Quality, safety and experience were key considerations of the 2022/23 corporate objectives, particularly given the new Quality Plan and focus on Fundamental Standards of Care. At Q2 good progress has been made with a couple of areas taking longer to complete that anticipated.
Reputation:	Positive impact – Delivery of corporate objectives in 2022/23 will continue to support the Trust's reputation with stakeholders.
Strategy:	Positive impact – Corporate objectives continue to support delivery of the four strategic ambitions of the Trust Strategy.
Workforce:	Mixed impact – The Trust workforce remains impacted by the ongoing impacts of Covid-19 including coping with additional pressure and demand for services. In addition, the Trust has experienced significant issues with delivery of the HR function. Due to this situation the 2022/23 people objective is moderate in ambition recognising the need to support our workforce and build a HR service that can support the Trust.
Other (specify)	None.

Appendices/Attachments: ***None***

Q2 2022/23 corporate objectives delivery

Objective 1: To improve the quality of services through delivering a stepped change in fundamental standards of care and empowering service users and carers.
Outcomes/ Metrics:

- Increase in % Alwaysready care planning and risk assessment audits completed (2021/22 average 85%; 2022/23 M6 87%; target 95%)
- Increase in % risk assessments reviewed within 48 hours (2021/22 average – 91%; 2022/23 M6 95%; target 95%)
- Increase in % risk assessments reviewed within last 12 months (2021/22 average – 93%; 2022/23 M6 93%; target 95%)
- Increase in % physical health assessments completed within 7 days of admission (2021/22 average 78.6%; 2022/23 M6 79.3%; target 95%)
- Increase in % of cardiometabolic assessments completed for community service users (2021/22 average 84.41%; 2022/23 M6 84%; target 95%)
- Reduction in Restrictive Practices (Total # Prone Restraints 2021/22 – 450; 2022/23 M6 290; Total # Restraints – Physical & Rapid Tranquilisation 2021/22 – 1,824; 2022/23 M6 1.313; Total # Seclusions 2021/22 – 374; 2022/23 M6 208)
- Medicines optimisation guidance for service users and staff

Delivery priorities	Q2 2022/23 delivery summary	Q2 delivery rating	Plans for any outstanding Q2 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
Care planning and risk assessment • Revised standard operating procedures (SOPs) published and monitoring framework agreed (Q1) • Interventions identified to support improvements using a QI methodology, communications delivered for all staff and training cascaded around processes and standards (Q2) • Clinical audit governance developed and completion audits underway quarterly (Q2-Q4) • Patient experience outcomes triangulated with care planning and risk assessment initiatives (Q2-Q4) **Physical health assessment** • Revised standard operating procedures (SOPs) published and monitoring framework agreed (Q1) • Interventions identified to support improvements using a QI methodology,	**Care planning and risk assessment** • QI methodology has supported (1) the redesign of the care planning audit in the Always ready App and this has led to an increase in audit completion and (2) real time updates in care plan review meetings. • Training and comms have been completed via various routes including ward manager development days. • Audits are underway. **Physical health assessment** • The work around this area has been delayed due to a lack of clinical lead; this has now been resolved and scoping of change ideas will now commence. • Audits are underway. **Restrictive practices**		• The triangulation of patient experience data for all areas has not yet commenced; this is being planned in Dec 2022 and will be in place by end of Q4. • The Restrictive Practice Policy Use of Force Policy has not yet been completed and will be by end Q3. • Medicines optimization framework is being co-produced with service users and this is work will be completed by end of Q3.	N/A		Unlikely to meet restrictive practises reductions due to delays in moves.

communications delivered for all staff and training cascaded around processes and standards (Q2) • Clinical audit governance developed and completion audits underway quarterly (Q2-Q4) • Patient experience outcomes triangulated with physical health initiatives (Q2-Q4) **Restrictive practices** • Current safety in motion work reviewed, training delivered for Clinical Service Leads, safety in motion work relaunched, SOP for restrictive practices published and terms of reference for Restrictive Practice Group refreshed (Q1) • Restrictive Practice and Use of Force Policy updated and Restrictive Practice Monitoring Framework developed (Q1) • Quality monitoring of restrictive practises commenced (including oversight group) and support delivered for operational teams to implement safety in motion programme (Q2) • Use of Force Policy compliance audit completed (Q2) • Quarterly reporting on restrictive practices commenced (Q2-Q4) Patient experience outcomes triangulated with restrictive practice initiatives (Q2-Q4) **Medicines optimisation** • Tools available to support adherence scoped and options paper on this discussed at Quality Governance Group (Q1)	• Quality monitoring of restrictive practices in underway via Restrictive Practice monthly meeting. Support is in place via the Safety in Motion (SIM) work. • Audits are underway. **Medicines optimisation** • A QI group has been initiated. 17 Lived Experience members (LEMs) have been recruited to be involved in the co-production of resources to support patients in medicines shared decision making. Following a meeting with LEMs on 19.07.22 a survey was issued and completed to identify issues and areas for support. A session on medicines safety was held on 22.09.22 as part of National Patient Safety Day. Focused groups have been diarised for 05/19/26.10.22. Following these sessions the resource will be written and launched.					

5

• Framework developed with service users to embed shared decision making around medicines (Q2) • Advice around positive messaging around medications developed for staff with training provided (Q3) • Guidance developed and training delivered for interventions when screening identified adverse effects of medication (Q3)						

6

Objective 2: To deliver our integrated transformation programme providing state of the art mental health facilities, improving access and outcomes and reinvigorating working practices for staff and service users alike.

Outcomes/ Metrics:

- Services, staff and service users safely moved into new buildings.
- Waiting times in Sutton community SMI services reduced.
- Inpatient beddays used by Sutton residents reduced.
- Longest lengths of stay reduced impacting positively on overall LoS
- Corporate and other staff safely relocated
- Positive feedback received on moves from staff
- Tolworth business case approved
- Estates Strategy approved.

Digital delivery plan completed and digital strategy approved.

Delivery priorities	Q2 2022/23 delivery summary	Q2 delivery rating	Plans for any outstanding Q2 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
Overall • Peer review recommendations implemented (Q1) and Gateway 4 review completed (Q2) • Initial post-project evaluation on Phase 1 completed (Q4) **EMP** • Clinical and operational sign off completed for service moved (Q2) • Shaftesbury and Trinity soft landings completed (Q2) and services successfully operating from new buildings (Q3) • Retail units opened (Q2) • Remaining Springfield site elements closed – Fairways (Q2), Conference Centre and Car Park B (Q3), Restaurant, Main Building, Harewood House and Diamond Estate (Q4) • Phase 2a planning applications submitted by partners (Q1)	**Overall** • Brand refresh (part of the gateway 4 review) will be completed during Q3/Q4 reflecting some reprogramming that is necessary due to delays to some individual areas (as outlined below). **EMP** • Delays to the completion of Trinity and Shaftesbury mean that clinical and operational sign off, soft landings and moves are all delayed. • The retail unit approach offer and provision has been reviewed as unviable and work to reconsider this is now underway. • Fairways has been closed. • Estates Strategy was approved by the Trust Board on 14.07.22. • As flagged in the Q1 report there are delays with Barnes redevelopment		**Overall** • Brand refresh will be completed in Q3/4. **EMP** • Clinical and operational sign off, soft landings and moves have all been reprogrammed due to delays. • Retail unit offers and provisions options are being worked through at present with a proposal being produced as soon as possible. • Barnes delivery has been reprogrammed as per Q1 report update and this will	**Overall** • Delays mean that he phase 1 post-project evaluation (planned for Q4) will be completed in early 2023/24. **EMP** • Trinity and Shaftesbury moves remain the key priority for 2022/23. • Barnes delivery reprogrammed as noted. • Retail unit provision and availability of food offer/s are under discussion at present. **Clinical transformation**		

• Estates Strategy approved (Q2) • Barnes plans progressed with planning application submitted and Barnes business case approved (Q1), planning application approved (Q2), business case confirmed (Q3) and services decanted from Barnes accommodation (Q3). **Clinical transformation** • Sutton community adult mental health model fully implemented (Q1) and evaluated using agreed metrics (Q2) • Kingston and Richmond community adult mental health models fully implemented (Q3) • Year 3 community mental health adult transformation funding bid submitted (Q4) • Redesigned rehabilitation, personality disorder and adult eating disorder models fully implemented (Q4) • Children and Young People's mental health transformation defined and planned (Q1) and underway with external stakeholder support (Q3) **People Readiness and Culture Change** • Relocation consultation outcome published for corporate and clinical support staff currently based at Springfield (Q1) and staff moved to new location (Q3) • Agile and change training for staff completed (Q1) • Staff moved from Acacia, Woodroffe (Q1), Building 30, Phoenix and Morrison (Q3) and Newton (Q4)	work with a planning application now being submitted in Q3 and the business case being approved in Q4. **Clinical transformation** • The Sutton model remains a core focus with a performance dashboard under development at present; evaluation has not yet taken place. **People Readiness and Culture Change** • No milestones due in Q2. **Digital** • All EMP digital elements are in place.		be managed towards a year end approvals. • Data on the effectiveness of the Sutton community transformation a model will be available in Q3.	• Delivery of K&R models is being realigned to Q4 to fit with service changes and a phased approach to delivery. • Some elements of rehabilitation redesign may move slower than planned due to capacity pressures; timescales are being reviewed at present. **Digital** • As flagged in the Q1 report, capacity pressures in Applications Development are impacting on the wider (non-EMP) digital delivery. In addition, a focused approach around benefits realisation and change management/ user adoption is needed. Additional support has been sourced and a capacity review is taking place in November 2022.		

• Effective consultation and engagement for all areas impacted by the transformation (Q4) **Digital** • Digital delivery plan, leadership and governance structure signed off (Q1) • EMP digital elements in place to support building moves (Q2) • Digital 22/23 plan fully delivered (Q4)						

Objective 3: To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences.
Outcomes/ Metrics:

- Standardised dataset embedded and in use
- Improvement in scores in Staff Survey EDI sections (diversity and equality and inclusion people promise elements[1])
- Improvement in Workforce Race Equality Standard (WRES) indicators[2]
- Medical Race Equality Action Standard (MRES) plan developed
- Improvement in Workforce Disability Equality Standard indicators (WDES)[3]
- Sustained improvement in Stonewall Index Score **(Total score for 2021: 70.5)**
- EMHIP evaluation completed

Improvement in staff confidence in talking about race and ethnicity

Delivery priorities	Q2 2022/23 delivery summary	Q2 delivery rating	Plans for any outstanding Q2 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
• EDI leadership roles recruited to and supporting structure agreed to drive delivery of EDI Strategy (Q1) • Standardised reporting and data capture agreed and embedded across all protected characteristics within the Trust for services and staff (Q4)	• Anti-racism leadership programme has been rescoped. 2/3 anti-racism pilot will go live in Q3. • As flagged in the Q1 report the cultural capability will begin in Q3. • Work on EMHIP continues with discussions ongoing around timescales and deliverables.		• The anti-racism final pilot will not be progressed in 2022/23but rather focus will be on setting up supporting infrastructure including a steering	• Anti-racism pilot evaluations may need to take place in 2023/24. • Cultural capability work will not all be delivered in 2022/23.		TBC – most data will not be available until Q4.

[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), Q18 (I think that my organization respects individual differences (eg cultures, working styles, background, ideas, etc) Baseline of 67.1% in 2021) and Q7c (I receive the respect I deserve from my colleagues at work. Baseline of 75.6% in 2021).

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

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

• Refreshed action plan for workforce EDI actions agreed with Equality and Diversity Committee (Q1) and actions delivered (Q4) • Anti-racism leadership programme in place (Q1) and three small anti-racism pilots delivered and evaluated to support learning (Q2-4) • Cultural capability training development group, approach and action plan to leadership and supervision agreed, including organisational practice and service delivery level changes (Q1) • Manualised dialogical cultural capability training programme co-produced with BAME stakeholders, service users and EVOLVE (Q2), leadership and supervision action plan implemented (Q2), training piloted in Wandsworth (Q3) and evaluation of all elements completed (Q4) • EMHIP delivery agreed and underway and evaluation approach agreed (Q1) and evaluation of EMHIP hub and family placement scheme supported (Q3); EMHIP 2023/4 plan agreed (taking account of evaluation findings) (Q4) • Ethnicity audit approach agreed (Q1) and audit completed (Q3) • Medical Race Equality Standard (MRES) action plan developed (Q3) • EDI Strategy reviewed and full implementation plan agreed for 2023/24 (Q4)			group, hub and Equality Matters meeting. • Cultural capability work will move forward in Q3 as noted in the Q1 report.	• EMHIP work is being reprogrammed at the request of the wider health and care system.		

Objective 4: To support our people to develop and grow and develop our organisation to be the best we can be.

- Reduction in staff turnover (2020/21 average 14.17%; 2021/22 average 18.4%; 2022/23 M6 17.85%)
- Reduction in staff turnover for those with less than 12 months service (2022/23 M6 19.95%)
- Reduction in sickness absence rate (2020/21 average 4.03%; 2021/22 average 4.97%; 2022/23 M6 5.09%)
- Reduction in vacancy rate (2021/22 19.78%; 2022/23 M6 19.87%)
- Improvement in feedback around medical staffing, recruitment (both candidate and managers) and employee relations
- Monthly reduction in employee relations cases
- HR Recovery Plan delivered
- Leaders reporting improved skills
- Improved HR & OD team staff survey results
- Substantive HR & OD team in place

Improvement in staff survey results related to health and wellbeing (health and safety climate, negative experiences and support for work-life balance people promise elements[4]) and learning development (development people promise element)[5]

Delivery priorities	Q2 2022/23 delivery summary	Q2 delivery rating	Plans for any outstanding Q2 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast

• Leadership and development 2022/23 offering developed, agreed and communicated (Q1), underway (Q2) and evaluated (Q4)
• HR recovery governance reviewed and updated (Q2)
• HR recovery plan elements delivered:
  ○ Recruitment and retentions plans in place for each service line (Q2) and reduction in medical and clinical vacancies plus reduction in agency spend achieved (Q4)
  ○ Recruitment and onboarding process reviewed and
	• Leadership offers are in place for the organisation and will be reviewed at year end.
	• The formal HR recovery governance has closed; a review meeting will be held.
	• In terms of HR recovery plan elements:
	  ○ An organisation wide 'recruitment incident' approach has been taken involving detailed service line reviews being held in Sept and Oct 2022. Following these, specific
			• Too early to say whether HR and OD team pulse surveys have been improved.	• Leadership offer will be developed in Q3/ 4 as we focus on retention. The delivery of the leadership offer will begin in 2023/24 and so impact on metrics will mainly be in 2023/24.
				• Organisational development work will be reviewed by the end of Q4 and developed for 2023/24.
						Data is now available and included; improvements in recruitment mean that somenpositive changes will be seen from M7.

[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). 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). 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).

[5] For PP element on development specifically Q20c (I have opportunities to improve my knowledge and skills. Baseline 70.3% in 2021) and Q20d (I feel supported to develop my potential. Baseline 54.3% in 2021).

improvements implemented (Q2) with new onboarding and induction introduced (Q3) ○ Effective and high quality medical staffing, employee relations and recruitment service in place and able to support all Services Lines and corporate teams (Q4) ○ Policy development framework in place (Q1) with core policies agreed and implemented (Q3) and rolling policy review and update programme in place (Q4) • HR & OD disaggregation completed (first phase Q2 and second phase Q3) and substantive HR & OD function in place (Q4) • HR & OD team engagement scores increased in Pulse staff survey (Q2) and further increased in main staff survey (Q4) • People plan developed and agreed for 2023/24 (Q4) • Cultural practice and organisational development work delivered in key service areas and embedded as an approach across the Trust (Q4)	recruitment action plans will be defined. ○ New onboarding and induction processes (inc F2F welcome day and technical skills training sessions) have been implemented and will be reviewed mid Nov 2022. A further review will take place at the end of Q4 to make 2023/24 plans. ○ Anecdotal feedback suggests that recruitment support is improving. • Disaggregation has been achieved in the main with some smaller elements remaining as joint functions until March 2023.Final recruitment to existing posts will occur in Q3.					

13

Objective 5: To proactively develop partnerships and act as a system leader to drive strategic improvements to mental health of the SWL population.

- SWL MH Strategy in place
- SWL MH provider collaborative, and team, in place
- Agreed MH budgets delegated
- SLP structures and delivery updated
- Place MH programmes developed

SLL commitments delivered

Delivery priorities	Q2 2022/23 delivery summary	Q2 delivery rating	Plans for any outstanding Q2 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
SWL ICS and SLP • Analytical and engagement work for SWL MH Strategy completed (Q1) and new SWL MH Strategy produced, approved and launched (Q2) • SWL MH provider collaborative (SWL MHPC) action plan and timetable and wider SLP plan developed; engagement work on MH PC development completed across SWL and across SLP (Q1) • Scope of SWL MH PC elements and potential clinical workstreams identified (and flagged for SLP connections) (Q2) and then confirmed (Q3) • Due diligence framework and approach confirmed for SWL MHPC areas defined as in scope for budget delegation (Q2) and due diligence review completed (Q3) • SWL MHPC resourcing requirements defined (Q2) and SWL MHPC team implemented (Q4) • SWL MH PC structure and governance drafted (Q3) and then set up and in place (Q4)	**SWL ICS and SLP** • SWL MH Strategy analytical work completed and engagement work completed; strategy being drafted but not yet completed. • SWL MHPC work underway with areas outlined; clinical and wider engagement underway on a case by case basis. Specific work on complex care, CAMHS, acute and urgent care and perinatal progressing. • Due diligence approach confirmed with SLP colleagues and now for enactment. • SWL MH Partnership Delivery Group (PDG) in place (chaired by SWL MH lead – Trust CEO). PDG will support the drive for system working on mental health and joint 2023/24 planning and financial review work. • Programme Director appointed to lead the SWL MHPC. **Places**		• SWL MH strategy writing will be completed in Q3 – Trust and system capacity has delayed this. • Resourcing requirements for the SWL MHPC will require ongoing discussion.	• All MHPC actions are complex and are likely to take longer time with a key deliverable of being in place for April 2023; the team is managing pragmatically to ensure this happens. • The SWL MH Strategy approval routes awaited from the SWL ICB.		

• Budget delegation (following negotiation) for 2023/24 signed off within the Trust, SLP and SWL ICS (Q4) • Existing SLP programmes continued with all required governance and decision making undertaken and SLP ongoing development supported (Q4) • Delivery of South London Listens commitments completed (Q4) **Places** • Sutton place MH programme developed and implemented (Q1) and Kingston and Richmond places MH programmes (Q3) developed • Initial work to define Wandsworth and Merton place MH programmes undertaken (Q4) • Standardised communications across places developed and resourcing for place input confirmed (Q1)	• Sutton MH place programme confirmed and new borough level mental health partnership boards for adult and children and young people in place.					

Objective 6: To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL. • Planned outturn met • CIP 2022/23 plans in place and delivering on four priority areas						
Delivery priorities	**Q2 2022/23 delivery summary**	**Q2 delivery rating**	**Plans for any outstanding Q2 delivery**	**Future quarters delivery at risk/ revised**	**Future quarters progress rating**	**Year end outcome forecast**
Internal delivery • Initial CIP plans in place, investment levels reviewed and non-recurrent CIP mitigation schemes agreed and enacted (Q1) • CIP plans implemented and CIP delivery underway (Q1-4) • CIP development for 2023/24 underway (Q3) and 2023/23 plan in place (Q4) **Strategic financial developments** • Structural deficit analysis completed identifying opening, changes and forecast outturn for 22/23 (Q1) • Undertake all cash flow and CDEL/ capital planning taking account of asset sales, loan and revenue requirements and stress test this (Q2) • Approve Tolworth business case and submit to NHSEI (Q3) • Support ICS colleagues to form financial governance structures for the SWL ICB and assess impact of IBC financial structures on Trust financial operations (Q1) • Implement strategic financial resourcing (Q1) and lead and complete SWL MH provider collaborative financial due diligence (Q3) • Implement budget planning module to support strategic financial planning (Q3)	**Internal delivery** • CIP delivery in M6 £300k above plan leaving cumulative position £1.2m less than target delivery (£5m vs £6.1m target). £12.1m schemes now identified and RAG rated giving us a 74% confidence (compares well to a 61% confidence at M6 in 2021/22). Issue remains that whilst £7.3m of the savings are rated green currently only c£1m is recurrent (6% of those identified). **Strategic financial developments** • Revised JD for strategic financial support completed with recruitment ot be completed in Q3. ICB and Trust finance group in place with financial review work underway to support SWL MHPC development and 2023/24 planning. • Initial cashflow work undertaken; liquidity rated green at M6 and forecast to end of financial year secure – more detailed work underway as part of the Tolworth case refresh to be completed in Q3. First cut base case and cash flow now complete.		Cashflow work to be completed alongside work on refreshed Tolworth business case in Q3.	No actions flagged for progress risk but delivery risk will remain all year around the ability to meet our financial targets.		

Meeting	Board of Directors
Date of meeting:	10th November 2022
Report title:	**Workforce and Organisational Development Committee Chair's Report**
Author:	Sola Afuape, Non-Executive Director, Committee Chair
Executive sponsor:	N/A
Purpose:	For Information

Executive Summary
The Workforce and Organisational Development Committee met on 27th September 2022.

Matters discussed in June Committee were as follows:

- HR & OD Structure Transition and Budget Review
- Recruitment and Retention Progress Report
- Leadership & Development Gap Analysis
- Employee Relations Report
- People Scorecard
- Quality & Performance Report
- Workforce Board Assurance Framework
- HR Service Transition Group Report
- People Matters
- Policy Development Framework Update
- Committee Annual Report
- Cost of Living Support Update
- Staff Survey Report and Progress Report
- Quarterly Pulse Survey Report Update
- Committee Forward Plan

The following items are for reporting to the Trust Board:

HR & OD Structure Transition and Budget Review

- The Committee noted **limited assurance** in relation to the effectiveness of the HR function and its capacity to deliver. Whilst the progress through recovery remains positive and purposeful this has not yet made the required impact on operations and quality.
- The establishment of a SWLSTG specific HR function following the formal split from SLAM is rapidly underway and contributing to pockets of encouraging improvements. In the main the majority of posts are in place and the team were brought together to strengthen team working and cohesion in a recent HR staff team day. The CEO and I, who attended part of the day, were able to hear from and witness positive engagement of the HR team, an improvement in staff morale and shared purpose.

- Work has been commissioned to reimagine the workforce development function across a number of existing functions QI, Nursing Development and Learning and Development. A report setting out the proposed plan will come to Committee this financial year.
- Further work is required to reduce the notable number of interim HR staff, resolve IT issues that have hampered effective working and work towards buy-in from the service lines and staff.
- The HR budget has been agreed at ELT and this is for £3.6M (with a pay budget of £2.1M). Savings of £134,469 identified towards an agreed 6% CIP of £146,123 was discussed including seeking assurance that this was achievable, given the current HR challenges,. Assurances given it wouldn't compromise ongoing improvements. Monies are being found primarily through underlying vacancy factors.
- As NED with remit for Well-being, a request has been made to meet with the Well Being lead and HR lead to gain insight into how the Trust is fulfilling its responsibilities. It is noted that the Trust only has a half time resource whilst the operational role currently works across both Trusts. It is a similar position for the engagement leads.

Recruitment and Retention Progress Report

The Committee noted with concern that the ELT had raised the Trust's first ever recruitment Critical Incident, given the escalating impact of the lack of recruitment into key operational areas. The Committee reflected on whether there was sufficient early sighting of the escalating seriousness of the issue. A comprehensive and granular set of focused mitigations across a 12-week implementation period was presented, in partnership between HR and Operations, with assurance that there was immediate ELT level action and oversight. Notable areas of actions have sought to determine accurate establishment and vacancy figures and revise a number of HR processes. It was noted that the plan would be progressed and monitored at the highest operational level, ELT. The Committee was assured as to the action taken and implementation plan presented. The Committee requested that the high-level risk be reflected in the BAF with an update position reported to the next Committee. It is noted that a new People Scorecard with high level risks will be introduced at the next Committee and must include strengthened oversight of this area.

Leadership and Development Gap Analysis

The Committee received a paper which set out the commissioned review of the current Learning and Development function. The Committee was provided with a limited assurance position as the limited HR capacity to deliver the Learning and Development function remains a known risk to the organisation. L&D is not one of the agreed three HR priorities and is currently on hold whilst there are plans to develop a proposal to develop the function more broadly for greater efficiency. The sequencing of the recommendations for next steps and alignment of the issues and mitigations were queried along with how the recommendations would address development and career progression concerns flagged in the WRES and likely applicable to the WDES. These will be reported in the next L&D report to the Committee.

Employee Relations

The Committee was pleased with progress reported in Employee Relations cases and especially noted the marked improvement over a short period of time (8 wks). It was reported that the ER team's work was well received by both the Service lines and JCC. Questions were raised about maintaining progress and wider application of lessons learnt to other parts of HR. The Committee was assured that current efforts could be sustained and the learning would be extracted and embedded in future practice.

The need to provide coaching for managers was highlighted as a critical enabler for better management of staff and to prevent future cases. The Committee drew attention to how this would be affected by the impact of the L&D unmanaged risk and HR capacity issue. This was noted. A query was raised about the number of ER cases for the size of the Trust and whether there should be more. It was also noted that it was important to strike the right balance between identifying and addressing capability and being assured the right environment is in place that gives staff the right tools and environment to effectively do their job. The ER risk is to be reviewed to account for the increasing improvements and to determine whether it remains one of the three HR priorities. The review is to include an account of how the improved ER position will be sustained and embedded into practice. The Committee thanked the ER team for their hard work and recorded an assured position.

Quality & Performance Report

The Committee received a mixed picture of assurance across the priority metrics with assurance in some aspects of statutory training, temporary staffing in Community lines and staff leaving the organisation within 12 months however across the key priorities areas; Recruitment and Retention (as indicated earlier was reported as a serious incident), Medical staffing (highlighted as a growing issue in particular in Community in Wandsworth and Richmond) and ER (reported a significant reduction in cases) there was an overall limited assurance position. Operations and quality whilst gaining increasing confidence in plans to tackling HR improvements report the required impact has not yet hit at an operational level. Recruitment to key posts remains the most significant area for improvement with interdependencies that impact a number of other workforce indicators e.g. the recruiting pipeline, DNAs training programmes etc. It is to be noted that the vacancy rate remains high with 57% of vacancies currently not converted into the recruitment pipeline. The agency rate is above the NHIE target and is reported at 136%. Further work is planned to support agency staff to be able to take up bank posts as the agency rate and cost cannot be sustained.

The Committee heard that improvements in on-boarding is having a positive impact in reducing staff leaving within the first 18 months.

Cost of Living
The COL was discussed and ELT will consider a paper setting out our Trust's response. Joint MLBT/HR Workshops engaging staff on the issue have already begun.

Board Assurance Framework
The Committee noted there was agreement that the granular detail in the BAF remain in place. A full review of the workforce elements of the BAF will be part of the December BAF review. The **Forward plan** was also noted.

Management Information
Overall, the content in the management information and transparency of issues are largely coming through and provides background and a narrative of the workforce and OD internal landscape. There is also greater representation of presenters coming from the different HR departments, speaking directly to their function providing greater insight to how the HR function is developing. Further work to strengthen the presentation of data and analysis to balance the narrative provided in the reports for more effective oversight is required and will be met in part through the development of the people score card.

Recommendation
The Board is asked to note the report and receive the minutes from 26th July 2022.

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

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the meeting held on **Tuesday 26th July 2022**, 15:00-17:00 via MS Teams

Attendance list

Present:

Sola Afuape (SA)	Non–Executive Director (Chair)
Katherine Robinson (KR)	Director of People
Sharon Spain (SS)	Director of Nursing (attended until 22/47)
Jenna Khalfan (JK)	Director of Communications and Stakeholder Engagement

Attendees:

Nicola Mladenovic (NM)	Deputy Trust Secretary – Minutes
Richard Morton (RM)	Dep Director of Operations for Community and is attending in Jen's absence (attended until 22/47)
Pam Warren (PW)	Interim Human Resources Deputy Director
Sarah James (SJ)	Assoc Director – Education and Learning

Observer with speaking rights:

Shikainah Champion (SC)	Diversity in Decision Making Representative and Specialist Clinical Psychologist for Sutton Uplift

Apologies:

Vanessa Ford (VF)	Chief Executive Officer
Jen Allan (JeA)	Chief Operating Officer
David Lee (DL)	Director of Corporate Governance
Deborah Bowman (DBo)	Non-Executive Director
Doreen McCollin (DM)	Non–Executive Director
Vik Sagar (VS)	Non–Executive Director

Item		Action
22/38	**Welcome and Apologies** Apologies for absence were received and noted.	
22/39	**Declarations of Interest** No new declarations were reported.	
22/40	**Chair's Action** The Chair took no action on behalf of the Committee outside of the meeting.	
22/41	**Minutes of the previous meeting** The minutes of the meeting held on 6th June 2022 were approved as an accurate record following the amendment to 22/26 Workforce Update, of the action owner initials to be amended to read: *'SA and KR to take a discussion off line to finesse this.'*	
22/42	**Action Tracker and Matters Arising** The Committee received and noted the action tracker. The following updates were received on the following:	

Item 21/62 – Disciplinary Deep Dive Outcome Report – this is on the agenda.
Item 22/11 - Recovery Advisory Board Assurance Report – this action has been amended and a report on the Recovery Programme Board (now renamed as the HR Transition Group) will come to the September committee. An update on the service split will be discussed on the agenda.
Item 22/14 Committee Terms of Reference – this is outstanding. A meeting is to take place with the newly appointed EDI Lead and chairs of EDC and WODC to discuss the overlap across the Committees. The meeting is to be scheduled in Sept. Close action
Item 22/27 – Corporate Objectives. This is on the agenda
Item 22/28 – Committee Annual Report – Nicola is to receive updates from KR and SA and the finished version will be included in the September board papers. **SA/ KR**

22/43 HR Proposal

The Committee received and noted the HR Proposal to separate the HR model from SLaM. The following points were reported:

- The report has been received at the Executive Leadership Team twice and suggested changes have been incorporated and identified in the executive summary.
- The timeline for full separation is scheduled for September 2022.
- The costings are still to be tweaked as this is coming in over budget.
- Members of the HR Team in senior joint roles are confirming their preferred locations and this detail will highlight the roles where further recruitment is required.
- A project group has been set up to manage the general routine queries to enable quicker and consistent responses to queries.

The Committee heard that work towards full recovery remains complex and has focussed on the following areas:

a. Reducing the number of Employee Relation cases. ER cases have reduced significantly and currently total 71 and are now managed in-house. New ER cases are triaged with the support of the COO and DoN to deliver more detailed interventions.

b. Education and Learning. This team is small and therefore skills gaps in skills and capacity issues to be addressed. SLaM have the benefit of SaM Partners (an OD function) and Maudsley Learning. It is currently unclear where the changes will be made to facilitate a dedicated function as the service will need to continue until these issues are resolved.

c. Recruitment is similarly impacted by the joint arrangements. Filing a vacancy in SlaM has to be resolved before full separation and strengthening of the dedicated SWLSTG recruitment team.

KR confirmed that now the senior team have been informed of their posts at SWLSTG this has now freed up support for KR to ensure work continues with the SLP, London HRDs and also working with the ICS.

The Committee heard that outputs from the separation will not begin to be seen until 6-8 months after. Work has commenced between KR and the Director of Finance to ensure the new model is within budget and also a 6% CIP will need to be identified. SA asked for the Forward Plan to be updated to include an agenda item and report setting out the workforce, quality and operational implications and risk mitigation to which the chair of the Finance and Performance Committee is to be invited. **(Action: KR)** **KR**

SJ was invited to report on learning and development, noting that the SLaM learning and education function is to move to Maudsley Learning, pending the split of the joint posts. Recruitment to the resultant vacant posts is a priority to enable the split to happen. KR confirmed that the disruption to COMPASS training has been identified as a risk and is detailed in the Risk Register and the HR service changes are linked in the BAF. The Committee sought views to better understand the impact on quality and operations. SS noted whilst Learning and OD is an important area it was agreed by ELT that the three HR and priority areas should continue to be the primary areas of focus. Revisiting how this provision may be provided in the future offered an opportunity to develop a more creative service in conjunction with nursing development. RM confirmed that the operational services are optimistic that changes in the HR provision will improve support and provide a cohesive focused approach rather than being split with different priorities.

The Committee noted the report.

22/44 Workforce BAF Update

The Committee received and noted the BAF. KR reported that the timelines and progress reports have now been added in. The following key points were highlighted:

- Recruitment and retention are areas of significant concern. The recruitment process remains very lengthy. To attract candidates action is underway to strengthen the branding of the organisation and promote the new working environment.
- The ER advice service provided by Capsticks for the last six months has now ended and is now in-house.
- Separation of the joint HR &OD function comes with a number of

The Committee noted that the BAF risk has been identified as 16 however the target is 9. KR feels the current rating is correct and should be reviewed in December 2022/Jan 2023. The detail should also be reduced as part of the review. **(Action: KR)** **KR**

The Committee noted the report.

22/45 Corporate Objectives Q1 Report

The Committee received the corporate objectives report. The following points were highlighted:

- A new EDI Lead has been recruited and is starting in August.
- An Anti Racism Workshop has been held and work is commencing with an external consultant to further develop this work.
- The EDI programme of work has been refreshed and this will be reported to the next Equality & Diversity Committee.
- The Leadership Gap analysis has recently been discussed with the Executive Directors. This will be brought to the September committee **(Action: KR)** **KR**
- Objective 2 is rated as AMBER however with newly recruited staff members it is planned that the reports for Q2 will be shown as GREEN.

SA asked if based on the recent risks highlighted whether the current and proposed future ratings were still valid and was assured by KR that they were and that despite a number of actions being completed a cautionary approach (remaining AMBER and nt going to GREEN) was being taken as the impact of those actions were not yet realised.

The Committee noted the report.

22/46 Workforce Update

The Committee received and noted the Workforce Update. The following points were highlighted:

- PADR 77.60% and Supervision 83.16% - figures are across both organisations and KR indicated that not all teams have imputed their records due to lack of access to the system from SLaM.
- Training is currently at 91.59%
- Vacancy rates will fluctuate and will settle as posts are filled.
- Sickness rates have improved outside of those from Covid-19, with a view this will continue to be improved and monitored.
- Stability Index – this remains red whilst there is a reliance on interim posts which will cease in Sept 2022.
- Agency rates are high but it is planned this will reduce as permanent appointments are made
- Staff Survey results report that the HR and OD/Workforce teams engagement scores being the lowest. This has been attributed to the need for an organisation split.
- An additional £600k has been invested by both SLaM and SWLSTG whilst the department is in recovery. However changes in the support provided by Capsticks will support the funding queries.

The Committee requested that an updated report be presented and aligned to the BAF review. This will come back in Jan 2023. **(Action KR)** **KR**

The table showing establishment rates is to be checked as this is different from RM's understanding of the operational teams. KR to check this. **(Action KR)** **KR**

RM raised a query as to whether these were the right indicators and if, in retrospect, it was considered that they could have been used be to anticipate these challenges. It was agreed this would be explored along to provide the Committee of assurance of effective performance oversight. KR to provide an update at the September meeting as a case study. **(Action KR)** **#** **KR**

The Committee agreed that this report had a performance focus and future reports would be renamed and presented in the Performance section of the agenda.

22/47 MLBT Update

The Committee received the Making Life Better Together Update. The following points were highlighted:

- The MLBT programme is the Trust's culture change initiative to support achieving the Trust's mission, ambitions and values by engaging with staff and stakeholders.
- The programme has been launched in waves and worked alongside the induction process. Wave One – new starter surveys, tea/break/chat, Wave Two – shadowing programme, monthly social, Rising Star Award, Wave Three – FYFU newsletter, social network for staff and welfare checks.
- The Long Service Awards is to be re-started to commemorate staff having achieved 5,10, 15, 20 and 25 years service and retirees to the Trust.
- There are plans to improve the MLBT current governance arrangements and would include membership from the current and past years Diversity in Decision Making representatives from committees. A proposal was presented at the July Board and is being further developed.

Priorities – these have been developed over the years and is based on feedback:

The next update is to include an induction refresh, staff's first 12 months of being in the Trust and the Long Service Awards. The Committee requested a future review of the impact of the programme on meeting the Trust's priorities and action to address poor engagement hotspot areas,

The Committee noted and accepted the priorities and plans.

22/48 Local Clinical Excellence Awards Scheme

The Committee received a verbal update from KR. A paper will come to the September meeting but as an early update it was reported that the previous scheme arrangements followed by the Trusts reflected the national approach; whereby central funding is used. This will continue to be the process followed this year.

22/49 Guardian Service Report

The Committee received the April Guardian Service Report.

It was agreed that future meetings will be received on a quarterly basis and the Guardian invited to present.

The Committee noted the report.

22/50 Ways of Working Policy

The Committee received the Ways of Working Policy. The paper has been received at ELT, JCC and Estates Modernisation Management Group and supports the hybrid model of working across the Trust.

The Committee noted the new policy and asked for an update when this was reviewed.

22/51 Disciplinary Deep Dive

The Committee received and noted the Disciplinary Deep Dive Update.

22/52 Draft Disciplinary Policy

The Committee received the Draft Disciplinary Policy. Comments are to be forwarded to Hazel Carson and Pam Warren by ……..

22/53 People Matters minutes

This meeting has been renamed from the previous Workforce Matters meeting. The Committee received the minutes from the 20th May 2022 and 17th June 2022 meetings. The Committee heard that the meeting receives updates through Dashboard updates and indicators are robustly tracked.

PW updated the Committee to confirm that the Business Partners attend the service line review meetings to support clinical operational manager in their HR concerns and also to support managing agency usage, sickness and training aspects.

22/54 Committee Forward Plan

The Committee received the updated forward plan and asked for the deep dives to be included. Consideration is to added to decide whether Gender Pay Gap, WRES and WDES is to be added on. An update meeting is to be set up to include the New EDI Lead SA and DM. **(Action KR)** **KR**

It was agreed that MLBT should be a quarterly update and the interceding months a verbal update would be included.

It was agreed that VS is to be invited to the finance discussion regarding the CIP and budget item. This item is to be added to the forward plan.

22/55 Matters to Report to the Board

The Committee is to report a summary of items discussed to the Trust Board.

- HR Proposal – this has been well received.
- Risks – there is some vulnerability in OD but the committee is sighted on this.
- Recruitment remains an area of high concern, as too separation of services and capacity to undertake the required work.
- HR Dashboard – noting that September is a critical transition time and it is hoped that future months will demonstrate an improved position.
- BAF to be reviewed.
- 6% CIP saving is required however there is a lot of work to be undertaken to achieve this which will be carefully monitored through the Committee
- MLBT is a strong enabler within the organisation, however expectations need to be managed as the team is small and the Committee is seeking to have oversight of MLBT activity on organisational challenges.

22/56 Meeting Review

The Committee reflected on the meeting and acknowledged the sheer amount of work that has gone into preparing the papers.

22/57 Date of Next Meeting

The next meeting will be held on 27th September 2022.

Meeting:	Trust Board
Date of Meeting:	10th November 2022
Report Title:	**Equality and Diversity Committee chair's report**
Author:	Doreen McCollin, Non-Executive Director, Committee Chair
Purpose:	For assurance
Transparency:	Public

September Meeting
The Committee was originally scheduled to receive Staff Network presentations at the meeting in September however due to the period of formal mourning following the death of Her Majesty The Queen the meeting was cancelled and presentations deferred to October. Unfortunately due to time constraints the Deaf network was unable to do their presentation, as a result of which the Board will receive feedback from that network following the December EDC meeting.

The requirement to publish the WRES and WDES annual reports was met and these were discussed in October at the Committee.

October Meeting
The Committee's annual special meeting took place on 20th October 2022. This is the third year whereby the Staff Networks deliver presentations, in partnership with their executive champions, which outline staff directed activities that support the Trust fulfill its equality, diversity and inclusion ambitions. These contribute to the assurance received by the Committee that the Trust is tackling inequality.

Set out below are some of the key activities that are shaping our journey towards a more inclusive and equitable organisation as well as the challenges that are being faced;

Diverseability Network (formerly the Disabled staff network)
During the year the following took place:

- Disability Confident Employer – Level 2 achieved in December 2021
- Disability Leave guidance - March 2022
- Mandatory Vaccination advocacy – December to March 2022
- Monthly Network meetings
- Increased membership of the network
- Calibre Leadership Programme - May 2022

Aspirations

- Workplace Health and Welling passport for all staff – this is still in progress
- To increase in disability declaration rate to about 13%

Challenges

- Time to undertake work as part of the staff network

- Stigma raised by staff as they are [1]being treated differently
- Reasonable adjustments are an ongoing requirement to support staff

Mental Health Staff Network
During the year the chair of the network changed and Stephen and Nisha were welcomed to their first committee meeting. The following took place during the year:

- The network has been refreshed with the support of psycho-educational workshops.
- Increase the membership as numbers were previously low. Contacting managers to ask for support to enable staff to attend the network by being given protected time.
- Reaching out to key colleagues to support the network to include the Involvement Team, Evolve staff network.
- A safe space has been provided for staff to be provided with support to be supported with their lived experience of MH conditions.

Challenges:

- Provide a safe space due to stigma/discrimination.
- Making the network accessible in order for a wider attendance at meetings.
- Support to make the meetings part of protected time.

Christian Staff Network
The network has now grown to 140 members. There is positive feedback from members and good collaboration with the Chaplain Team. The staff network is well connected to the national NHS Christian Staff Network and this has brought about recruitment benefits.

Challenges:

- Having capacity to attend the meetings as well as juggling a full time role.
- Accessibility for deaf members, MS Teams captions are assisting but are not great.

Women's Staff Network
During the year the chair of the network changed and it has been noted that the membership is currently at 150 members. The following took place in the year:

- **18th November 2021** – "Equal Pay Day" session to introduce new leadership team, agree priorities for the network and have open discussion
- **20th January 2022** – Site safety discussion (Springfield) and network meeting
- **8th March 2022** – International Women's Day "Break the Bias" with guest speaker, interactive quiz and Q&A panel
- **27th June 2022** – Network meeting focused on women's health with speakers from the Trust's Health & Wellbeing team and Carefirst
- **6th & 13th July 2022** – stalls at the Springfield and Tolworth street parties signing up new members and promoting the network
- Key speakers were invited focusing on Women's Safety, Gender Pay Gap, Women's Health and Leadership & Development.

Challenges:

- Capacity of co-chairs to further develop network e.g. more frequent meetings
- Despite a large number of members we would like to encourage a more active model of participation e.g. using network meetings to get input on policies, face to face events.
- Difficulty in recruiting members to create a formal committee structure.

[1]

LGBTQIA+ Staff Network
During the year the following took place:

- Holocaust Memorial Day.
- LGBTQ+ History Month.
- Staff Network Day Conference was held in March 2022.
- London Pride – 50+ staff attended jointly with Sutton Uplift.
- UK Black Pride, jointly with Evolve.
- In the Stonewall Workforce Equality Index the Trust came 160th (in previous years the Trust was ranked 307th and 384th) and was ranked 15th in the sector. Awarded a silver award.

Challenges

- To identify a new chair/co-chairs for the network.
- The process of booking /arranging BSL interpreters is still complex and time consuming. This would benefit from being streamlined.

EVOLVE
During the year the following took place:

- A conference has been held on “Anti Racism is Everyone’s Business”.
- There has been a increase in membership and Evolve Lanyards have been distributed.
- Staff Network Meeting discussions with expert presenters have included White Allies, Communications, Staff Survey results, WRES, Guardian Service, EMHIP.
- Workshops have been held on –“If You Don’t Know, Get to Know Series: HR Policy & Process Awareness”.
- Worked with clinical teams to resolve issues around Racism.
- Supported the Anti-Racism Hub and the Trust Anti-Racism initiatives.
- Windrush Celebrations -Screening of Soon Gone: Windrush Chronicle Monologues.
- South Asian History Month -18th July to 17th August. Evolve promoted British South Asian heritage and history.
- Attendance at UK wide Black Pride and local Black Pride.
- Staff have shared their experiences of the challenges of their intersectional identity as LGBTQIA+ and BAME.
- Quarterly and lunchtime Quizzes –with prizes for winners.

Challenges:

- Lack of involvement in the design and decision making on key Trust initiatives, e.g., WRES development, Talent Management Scheme, Staff Survey response development.
- Lack of understanding at senior levels of the urgency and support required to move the dial, e.g., WRES actions noted in action plan and not delivered in 2021-2022.
- Ongoing process issues, e.g., 4 years of no direct access to budgets to support Evolve initiatives leaving staff having to ask various members of HR staff on numerous occasions for reimbursements.

Recommendations

The Board is asked to note the key points of this report and receive the minutes of the 23rd June 2022 meeting.

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

Equality & Diversity Committee

Minutes of the MS Teams meeting held on **Thursday 23rd June 2022, 14:30-17:00**

Present:

Sola Afuape (SA)	Non-Executive Director (meeting chair)
Deborah Bowman (DBo)	Non-Executive Director

Attendees:

Jenna Khalfan (JK)	Director of Communications and Stakeholder Engagement
Billy Boland (BB)	Medical Director (to attend from 3.30pm)
Vanessa Ford (VF	Chief Executive
Katherine Robinson (KR)	Director of People
Ranti Lawuni (RL)	Evolve Staff Network
Jacqueline Ewers (JE)	Evolve Staff Network
Andrew Francalanza (AF)	Equality & Diversity Inclusion HR Lead
Lenka Novakova (LN)	Deaf Staff Network
Ashley Painter (AP)	DiverseAbility Staff Network
Andy Cohen (AC)	LGBTQIA+ Staff Network
Sarah Burrell (SB)	Service User and Carer representative
Emily Downey (ED)	Women's Staff Network (interim co-chair)
Johnny Steyn (JS)	Employee Engagement Manager
Nicola Mladenovic (NM)	Deputy Trust Secretary (minutes)
Jacqui Beckford	Interpreter
Ryan Eldridge	Interpreter

Apologies

Doreen McCollin (DMc)	Non-Executive Director (Committee Chair)
Melissa Heath (MH)	Women's Staff Network (interim co-chair)
David Lee (DL)	Director of Corporate Governance
David Heasman (DH)	Christian Staff Network
Shikainah Champion (SC)	Diversity in Decision Making Representative (WODC)
Sarah James (SJ)	Associate Director, Training & Development (WODC)
Bernadette McManus (BM)	DiverseAbility Staff Network
Sharon Spain (SS)	Director of Nursing and Quality Standards

Item		Action
22/38	**Introduction and Apologies** Apologies were noted. VF reported that the Mental Health Network are currently recruiting for their co-chairs and as Executive Lead is here to represent the network. The Committee thanked Miles Rinaldi for his contribution to the Mental Health Network and wished him well in his next role.	
22/39	**Chairs Action** No Chair's Action has been taken.	
22/40	**Minutes from the last meeting**	

	The minutes from the 21st April 2022 were agreed to be an accurate reflection of the meeting. **Item 22/28 – Staff Demographics Annual Report.** It was noted that data on the updated characteristics is to be added to future reports. This will be brought the next meeting.	**KR**
22/41	**Action Tracker** **Item 22/14 – Deaf Community Team Space.** JK provided an update and confirmed that a meeting had been set up to go through the concerns raised by Lenka and the deaf staff brought about through the Estate Transformation. Through discussion it was agreed that the previous plan to join DACT with the junior doctors was not appropriate for deaf staff or the junior doctors. The suggestion made by Deaf Services to utilise additional space within DACT will be taken forward and Ian Garlington, Integrated Programme Director and Mike Tart, Team Manager will continue to progress this further.	
22/42	**EDI Dashboard Update** The Committee received the paper on equality reporting. • The work on the Q&P Dashboard is on-going and the work links to the EDI Strategy and links with health inequalities and the request to have better data. This improved reporting will better understand the need and to be able to make improved changes to address the inequalities. • Ethnicity and gender are the domains that are more reported on however the report details the drill downs currently reported on are for age, BAME, ethnic group and gender. However further reporting should include health and disability characteristics under the Equality Act. • Future reports will come through the Quality and Performance Report.	
22/43	**EMHIP Report** The Committee received the EMHIP update. BB provided an update on the following: • Currently the programme is in Year 2 in a 3-Year Programme approach to introducing a suite of interventions to include the Health and Wellbeing Hub in the New Testament Assembly in Tooting. • The programme remains on track with the revised milestones. • Key Intervention 3 – reducing restraint and coercion. Observers will come to the ward to help comment on restrictive practice and they will work with patients to bring about a change in the use of these interventions. The timelines have been amended for this intervention to ensure the work in this area is as effective as it can be. • There has been good progress being made and the partnership arrangements are working well. Previously it was reported the risks of organisations working together to deliver the programme. These risks have now been closed or revised. BB explained that the team structure is made up of Associate Director of EDI, Health Inequalities Lead and the EMHIP Project Manager. Delivering the interventions will be managed with the service lines, for example, the interventions in the community will be delivered by the Community Service Line. It is envisaged that the overall	

	governance of EMHIP will be undertaken by the Wandsworth Place structure, however the finer details are still being worked through. VF confirmed that not all EMHIP aspects identified in the original business case will be delivered but the interventions would be and further work is needed to move this programme of work into business as usual. Key Interventions 4 (Enhance inpatient care) is yet to be progressed and Key Intervention 5 (Ensuring a culturally capable workforce through training and development) is at greatest risk of failing to deliver. Key Intervention 5 has undergone further iterations and currently this is being worked through to ensure it is able to deliver the agreed and deliverable outcomes. BB reported that the previous EMHIP assumptions have been reconsidered for capacity and demand. In terms of the Family Placement Scheme this would require a lot of input from the Home Treatment Team and currently this activity has not been factored in. This is being considered by the CCG as being able to effectively resource this changed scheme would bring about a reduction in bed usage but the finer points in service delivery still need to be worked through. The Committee acknowledged the work that has been undertaken to date and that future reports will come through the Quality and Safety Assurance Committee.	
22/44	**Committee Forward Plan** The Committee received and noted the committee workplan. The workplan is to be updated as there are some sections where some dates are to be updated. KR proposed that some deep dives should be planned in a priority topic and that this will be discussed with DMc and views from the Staff Network chairs will be considered if there are areas that should be prioritised for deep dives. Sarah Burrell offered to be involved in a working group to support in an external function.	**KR**
22/45	**Staff Network Updates** AF provided an over-view of the highlights: - Staff Network Day was celebrated in May and on this day all the staff networks gave a presentation to outline the work that they undertake - Since the last committee, Ashley and Lenka graduated from their Calibre Leadership Academy programme - Windrush Day has been celebrated this month - The first ever South Asian History month will be celebrated in July/August - London Pride will be celebrated on 2nd July and the network has been successful in obtaining 50 places for the Pride in London march - Christian Network has received increasing invites to attend meetings and to comment on policies and this is having an impact in being able to effectively manage time accordingly to prioritise demands - DiverseAbility has mentioned changing the culture and thought patterns of staff including management about disabilities and support to staff in their roles - Evolve Staff Network have requested that Black and Minority Ethnic staff data is to be added to the dashboard for greater transparency	

	- Womens Staff Network have not been able to recruit a chair and so interim co-chairs have stepped in as co-chairs. However the network is looking for someone to take over as chair or for the Information & Media Officer or Events Officer roles to be filled. **Deaf Staff Network** Three areas were reported: Training Trust Induction Centralised interpreter budget • Issues associated with booking interpreters. KR confirmed that a new administrator will be recruited to support this going forward. A central cost centre is to be set up to support the booking of interpreters and the finance arrangements will be managed internally to move budgets around to manage the costs associated. **(Action: LN to provide an update in a few months on the progress that has been made)** • The Deaf Awareness session will be brought back to be included to the induction session. This is planned to take place from September. **DiverseAbility Staff Network** – more work is needed across all levels to obtain a change in culture. The change in Ways of Working does not support all staff and more education is needed in this regard to see whether this is appropriate to the staff member and if there is any flexibility in this. As network chair protected time is needed to be able to undertake the role of being a network chair. Through reflection it was agreed that KR would consider how the staff network chairs could have some protected time to be able to solve these issues. **Evolve Staff Network** - the network would like a team site created so that this can be used as a depository for information and meeting recordings to be collated in one place. A request was made for the BAME data to be added to the dashboard in order for the staff network chair and deputy chair to access. A core group was previously successful in managing the activity of the network and this is something that will be re-implemented. JK confirmed that Jack Moss in IT will be able to support in creating a teams site. **Women's Staff Network** – having co-chairs to lead the network has been a good model and has supported the network overall. This will also support staff network members in taking on roles within the network. **Christian Staff Network** – there appears to be an increase in urgent requests and this means that there is no time for suitable feedback. Recently there was a request to support policy changes, adequate timelines are needed as urgent feedback within two weeks means that this falls to the network chair rather than receiving wider feedback through consultation. KR acknowledged that the requests to support policy reviews had no lead in time as this is due to the requirement to have the Disciplinary Policy reviewed. A programme of policy review will be implemented going forward. KR reflected on the comments raised and would like to consider with the new Associate Director for Equality Diversity and Inclusion about the implementation of an EDI Working Group as this will keep the discussions progressing as the committee	**LN** **KR**

	meets on a quarterly basis. (**Action: KR to consider options to include the Staff Network chairs and to feedback at the next committee**)	
22/46	**Committee Annual Report** The Committee received the Annual Report. Comments are to be included from both chairs as during mid year there was a change in chair. BB asked for a balance on work that is done in EDI rather than work that is being undertaken in health inequalities. It was reported that during the period being reported there was more of a focus on EDI but it was agreed that health inequalities, EMHIP and the new well-being hub is to be included. **(Action: It was agreed that SA and DMc would link together to expand section 3)** Going forward BB reported that the future EMHIP updates will come through QSAC to the Trust Board as this has a quality aspect and so going forward the change in reporting to committees will take place. **(Action: QSAC and EDC forward plans are to be updated)**	**SA/ DMc** **NM**
22/47	**WRES update inc Medical WRES** The Committee received the WRES update and it is to be noted that work has commenced on achieving these actions over the coming year and to carry forward other indicators and actions in the coming years. The action plan has 24 actions however the completion of these will be delayed due to the work taking place on HR Recovery however work has progressed on six actions. Training has commenced to support the next cohort of staff enrolling as Diversity in Decision Making representatives. Work for Medical WRES has commenced and the Medical Director is considering the progress that has been made. A further update will be included in the report to the next meeting. The Committee considered the deadline extensions and noted that KR expressed a need for the deadlines to be balanced and achievable.	
22/48	**WDES update** The Committee received the WDES update and AF reported there have been updates on the actions in particular Ashley and Lenka graduated from the Calibre Leadership Academy programme. The action plan has 20 actions in total; 4 actions have been complete. 6 actions are on track. 6 actions have been delayed. 4 actions haven't started. Since the last meeting the EDI Team has carried out an EDI health check report and the EDI priorities and actions are being refreshed. KR updated the Committee that the Associate Director of EDI has been recruited and will take up his post from August 2022 and will be key in supporting the equality and diversity work. The Committee noted that extensions to deadlines have been included in the report however work is progressing but not at the speed initially planned due to resources.	

22/49	**EDI enabling strategy update** KR provided an update on the EDI Strategy: • There are numerous actions plans for EDI and it is planned to bring these into three pillars to ensure appropriate focus is given before moving onto other aspects. • There are some areas of overlap and so this will be consider to ensure the framework encompasses the networks effectively. • The EDI Project Plan detailed the milestones, task descriptions, the progress and dates will also be included on the plan. The full document was not received by the Committee for full approval. • The project plan is to be discussed further with the Staff Networks and union colleagues and it is proposed that this will be the central focus for all communication including the prioritisation of actions. • The project plan will come to each committee meeting in order for action progress to be tracked. It is to be noted that BAME is the only acceptable term if shortening this to initials instead of BME and this is supported by the Anti-Racism hub (Anti-racism virtual hub (sharepoint.com) The Committee agreed that the EDI Project Plan is to be circulated by KR and a date for comments to be agreed with Doreen and this will be detailed in the supporting email.	**KR**
22/50	**Board Assurance Framework – Equality and Diversity incl HR and OD EDI Risk Register** The Committee received the BAF for noting and KR reported that all items had been refreshed. The report includes reference to greater connections with the staff networks, WRES action plans and WDES action plans and the staff survey action plans. SA commented that the implementation date for Reverse Mentoring needs to be updated. The Committee noted the BAF.	

22/51	**Staff Survey Action Plans**
	
	The Committee received a presentation on the Staff Survey and reported on the following:
	
	• The data of the staff survey is being shared with senior managers and also the Senior Management Team. Hot spots are being highlighted. Individual teams are being invited to workshops in order for changes to be identified and to be actioned going forward.
	• The EDI action plans are linked to the staff survey themes.
	• Six workshops and hotspot checks have been completed and one service line is yet to be set up. The Pharmacy Team have been involved in a workshop and their feedback has been included in the action plans.
	• Themed feedback features:
	  ○ More team building
	  ○ More QI Projects	

	○ More time for staff development and away days ○ EDI training needs to improve ○ More staff ○ Better office environments ○ Improve recruitment processes ○ Better communication ○ More opportunities for ethnic minority staff to be involved in leadership roles ○ More training opportunities ○ Bette support for staff who rise concerns about bad practice ○ HR training for trams ○ More trainee development training ○ Prioritise career progression in teams • Staff engagement scores have been received to look at data for Q4 2021/22 and Q1 2022/23 and this can be viewed in response to the staff survey The feedback and reflections from staff about the last Staff Survey are to be shared with staff as the next Staff Survey will be taking place in Sept/October. Through discussion it has been noted that staff have raised their concerns to the Chief Executive in relation to the cost of living queries. JK stated that a response will be made to staff and this will also include the staff wellbeing support that is available. Clarification was asked about how the teams are identified for feedback and Jonny confirmed that to protect the anonymity of small teams who have less than 11 members then teams will need to be joined with another small team. The outcomes of the survey will be brought to WODC as the next survey is taking place in Sept/Oct.	
22/52	**Matters for the Board** The following points are to be reported to the Board: • Acknowledge the EDI refresh on the strategy and that people need to be more sighted on the plans that underpin this. KR and DMc are to work on this more so the committee can be assured further. • EMHIP has given its final presentation to the committee and this moves to QSAC as this lends itself more to quality. This is to be updated in the Committee annual report.	
22/53	**Meeting Review** The Committee reflected on the meeting and the following points were discussed: • The time at the meeting needs to be used more strategically. • DBo thanked SA for standing in to chair the meeting in Doreen's absence. • DBo reflected on those not in attendance and how their updates are received/ feedback • Thanks were given to the teams working with BB and KR. • LN does not feel that all groups are captured in the reporting and going forward more needs to be done to reflect this more as Wandsworth is the biggest borough.	
22/54	**Date of Next Meeting** The next meeting will be held on 14th September 2022 at 14:30-17:00 via Teams meeting and this will be for Staff Network presentations	

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

Finance & Performance Committee

Minutes of the Meeting held on Thursday 28th July 2022 at 14.00 by Microsoft Teams

Present:	
Vik Sagar (VS)	Non-Executive Director (Chair)
Ann Beasley (AB)	Trust Board Chair
Vanessa Ford (VF)	Chief Executive
Philip Murray (PM)	Director of Finance and Performance
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial
Juliet Armstrong (JuA)	Non-Executive Director
Billy Boland (BB)	Medical Director
Doreen McCollin	Non-Executive Director
Attendees:	
Nick Worner (NW)	Associate Director: Commercial and Business Development
Clair Hartley (CH)	Committee Governance Manager
Apologies:	
Jen Allan (JeA)	Chief Operating Officer
Debbie Hollinghurst (DH)	Deputy Director of Finance
Ian Garlington (IGa)	Programme Director – Estates Modernisation Programme (EMP)

Item		Action
22/93	**Apologies** Noted as above	
22/94	**Declarations of Interest** No new declarations were noted.	
22/95	**Chairs Action** No Chairs Action have been taken.	
22/96	**Minutes of the previous meeting and Matters Arising** The minutes of the meeting held on 30 June 2022 were agreed as a true and accurate record.	
22/97	**Action Tracker and Matters Arising** The action tracker was received and discussed. **21/53, Business Integrated Dashboards -** The Committee discussed this action. It was to be combined with 22/014 and 22/048. The Chair questioned whether the tracker had been updated since the last meeting as the three actions had not been combined as he requested. PM apologised the work had been undertaken and the actions would be combined for next month.	

Item		Action
	PM reported that they he and JA had met with Jonathan Comfort (JC) to discuss the Dashboard. They asked JC to go through all the metrics of their monitoring reporting over the last three years to try and build a picture and identify those that have been entrenched for some time. They intended to do an RCA, showing what the issues were, the actions that had been taken and their impact. The key metrics would be analysed and key reasons for non-performance would be identified. They would decide on methods of improving. They hoped to use data from the NHS England Mental Health Minimum Data to benchmark against national statistics. It was hoped that the stats would provide a context against which the Trust could scale itself and consider action commensurate with the relative position and relative risk of the dashboard metric.	**PM**
	PM said that he hoped to provide the committee with an update at the September meeting. **[Action]**	
	VF commented that their performance position was significantly challenged and that they were not seeing an improvement in a number of key metrics. It was necessary to identify the most serious problem areas and conduct RCA's around the stuck metrics. She reported that the Executive Team had discussed this issue and considered whether the KPI's were appropriate.	
	VS reminded the Committee that the Board had asked the Committee to address this issue. This action was also on the Board's action plan. It was a complex area and was taking some time but there had been progress as PM had reported. VS asked AB whether she was comfortable with the timelines and the progress that had been made and whether she understood why the Committee had not reported back to the Board yet.	
	AB replied that the process was intractable and would take some time to complete. She emphasized that they had to make progress on the existing KPI's. Statutory targets had to be met. They knew that they would miss the targets. The question was whether to admit this or do it by default.	
	PM expressed the opinion that it might be preferable to admit that they did not foresee being able to meet the targets due to certain factors.	
	JuA asked whether the key root causes had been identified. She suggested that some people be brought in to assist for a short period of time to have an in-depth look at the issues. PM said that bringing in extra staff to complete the tasks would not solve the problems. PM said that it might help to get someone in to re-imagine the process or help with mapping the processes.	
	The Committee discussed the following issues: • That people often did not follow processes that they thought were not correct. • That some people often did not record the tasks that they had performed leading to the appearance that targets had not been met. • Problems with Rio and the ongoing work to re-design it; it was a complex process which had been discussed for years. Whether to consider getting external help to rectify RIO or migrate to another system.	**JA**
	It was decided that JA should report on her thoughts on digital transformation with particular emphasis on RIO. **[ACTION]**	
	21/149, Estates Strategy – Had been discussed at meeting of 30 June 2022. - Closed	

Item		Action
	22/155, Inspire Sutton Contract on agenda as item 3.5. - Closed	
	22/042, Commercial Priorities and Update on agenda as item 3.1. - Closed	
	22/046, Contracts Update had been discussed at meeting of 30 June 2022. - Closed	
	22/074, Complex Care Programme - on agenda as item 3.4. - Closed	
22/98	**Commercial Priorities and Update**	
	AS and NW presented the paper and highlighted the following issues:	
	The paper closed off last year's programme. Most of the effort now focused on mental health provider collaborative development and associated SLP links and the strategic development of mental health in Southwest London (SWL). There was considerable focus internally on clinical transformation, most notably around community and looking at outcomes and impacts and the embedding of the Sutton models.	
	The Committee complimented AS and NW on the clear reports they had submitted.	
	JuA asked how much of PLACE the Trust drove and how much was driven through the ICB, particularly from a performance and efficiency perspective. She asked who was driving any standardisation type or unwarranted variation agenda across PLACE and the extent to which lessons have been learned.	
	AS said that from her work in Sutton she could say that there were conversations around productivity and efficiency. All parties were driving them but that had not translated into anything yet. The ICB did have a role and that had translated into a structure in the places where efficiency, productivity and value for money was considered but she was not seeing that consistently at present where she was working or in any other places. VF confirmed that they were nowhere near that place of efficiencies.	
	PM said that Wandsworth had not advanced as far as the other areas in that they had only had two meetings and those had been around setting up governance.	
	JuA asked about the 21/22 activities, the closeout summary. She said that she thought that the SLP back office intrinsically felt like an area of opportunities and asked whether progress had been made. She thought that it could yield some efficiencies and cost savings.	
	AS replied that the SLP corporate programme, the back office programme, was set up with good intentions and best endeavours, but it had become apparent that where you don't have a strong case for change, it becomes very difficult to drive through transformational progress and release efficiencies or savings. It was unlikely that the programme would release significant commercial opportunities and it was not seen as a focus within SLP at present. It started with real energy and ambition, but the opportunities and the savings were smaller and more complex than originally scoped but it might be revisited in the future.	
	VS asked about relationships with the SLP. AS replied that her experience of working with SLP colleagues, trust colleagues and hub colleagues was very good. They were aligning around local mental health provider collaborative development. They were thinking about how they could do things differently. They were trying to seek alignment in their organisations and working with the ICS's. There were positive, enriching, and interesting conversations to have but it took up an enormous amount of capacity and time. She found the relationships to be positive and useful.	
	VF agreed that the relationships were satisfactory. However, she felt that the SLP was not realizing its full potential. Partners were not putting equal amounts of energy into it. They did not have true collaborative working with transparent shared goals, but they were making a good enough job of a complex partnership. St George's was pulling its weight	

Item		Action

within that, but the Trust might be over pulling its weight. The endgame was to get the collaborative off the floor and the only way they could do that was to drive the SLP.

VS asked about the decision around the investment as he believed that £4m of surplus for prior years would come back to the Trust. He asked whether the investment would be pulled at some time. In regard to investment, AS said that they had to help people strategically plan investments through the year for the programmes. PM and finance colleagues were supporting that work within the SLP hub. PM said that the surplus could only be used non-recurrently. It could not be used to open a new ward or something that would be running in perpetuity, it could only be used for pilots and with the pressure in the systems and on the finance directors, it was incumbent upon them to ensure that one of the options they considered was to use it to support the longevity of the organisation.

JuA asked whether removal of unwanted variation or standardisation would be a key organising principle as she felt that this was a real opportunity to remove some of the unwarranted variations as this would support efficiencies. AS replied that each of the six PLACES across SW London regarded tackling inequalities and driving out variation to be an absolute priority.

The members discussed problems encountered in doing away with unwanted variation. Different Places charged varying amounts for treatment. The ICB needed to intervene to do some cross-cutting standardisation work to ensure collaboration between Places so that wider benchmarking could be done. This could not easily be done at Places, although Richmond and Kingston might be an exception because they were starting to work closer together.

Changes were taking place to align approaches across various areas, starting with finance. Finance departments were working on underlying assumptions in plans and had made the same assumptions regarding inflation. The HRD network was also taking a similar approach.

The Committee noted the 2022/23 priorities and progress made during July 2022.

22/99 Corporate Objectives Delivery Update Q1, 2022/23

AS presented a report on Corporate Objectives, showing delivery against Quarter one milestones, flagging where things were delayed or off track and a future progress RAG. She reported on all six objectives. The report would go to the subcommittees, be updated, and then submitted to the Board in September.

The Committee noted the Q1 2022/23 delivery and approved onwards submission to the Trust Board.

22/100 Adult Eating Disorders Provider Collaborative 2021/22 close and 2022/23 plans

AS presented a progress update on the Adult Eating Disorder Provider Collaborative (AED PC). She reported that the AED PC closed last year with an £0.801m surplus. Following confirmation from all three SLP trust audit committees this was carried forward to 2022/23. The new investment would be used to fund an Enhanced Treatment Team; the business case was recently approved, and it had now been mobilised.

She reported that there had been really good work by the core executive teams consisting of Suzanne Roche, AED Programme Director (SLP), John Reeves, Finance Director (SLP) and Al Saunders who was one of the consultants and also the Clinical Director. They were finalising papers for the next programme partnership group which would be held on Tuesday, 2nd August. They had responded well to challenges, and they continued to deliver a solid Provider Collaborative function. Over the last three months, they had increased the level of inflow activity and income that had come through both the Tyson West ward at SLAM and the Avalon Ward.

Item **Action**

The Committee discussed the following issues:

- JuA said that she was pleased to hear about the increase in inflow activity and income and asked whether there was a short-term window to exploit this or whether this was a long-term opportunity?
- AS replied that she felt that there was a relatively short window to capitalise on inflow income because other sites offering the service were being developed. It was important to increase open and available beds. There was significant demand and very complex cases. They were in a pilot situation for the next few months to see how this developed in the future.
- JuA asked whether qualitative feedback would be sent on the patient services, experiences and outcomes. AS replied that she had been in discussion with the Director of Nursing around reporting on the quality elements related to the AED PC and the need to flow that into QSAC. Three service users and carers who are experts by experience join the AED PC partnership group on a monthly basis, and they feed into elements of service development and design. Their feedback would flow into the trust.

The Committee noted the progress on the AED PC to date, the 2021/22 outturn and plans for 2022/23.

22/101 Complex Care Programme 2021/22 close and 2022/23 plans

AS provided the Committee with a summary of the Complex Care programme report. She apologised that the report had been submitted late due to delays in acquiring all the information. She reported the following:

1.1. Since April 2021 when Phase 1 of the Complex Care Programme (CCP) moved to BAU, significant work had been completed. Delivery continued to be strong, however there were some declining/ intractable areas of KPI delivery – trusted assessment within 7 days and LoS on inpatient wards. Net savings for 2021/22 were £7.25m and at M3 2022/23 were £1.6m. There were, however, delays with the implementation of some material transformational activities and around contract signature to support market management. In addition, the compilation of this paper was complex with deadlines for agreed, standardised processes around financial triangulation being missed.

1.2. Phase 2 of the CCP involved shadowing the CCG element of shared care spend during 2021/22. Pilot site work had progressed slowly and despite an agreed plan for staged budget delegation this had not progressed with CCG (now ICB) leads. ICB structures now required different sign off mechanisms in SEL which may create variation in approvals between the ICSs. It was possible that this could have been avoided with up front discussion and planning. In addition, a risk/ benefit share proposal had been developed to incentivise ICB involvement. However, the ICBs have not approved this so timescales and approaches for Phase 2 need resetting.

1.3. There was a need for renewed rigour and programme grip to deliver against Phase 1 and Phase 2 requirements and avoid further delay and associated costs. The Trust needed to consider how to ensure senior leadership was used to support the CCP delivery. This would be picked up by the DoF and DoTSCD. The internal programme group met monthly, and accountability would be strengthened here. The COO remained the Trust representative into the CCP Board.

VF informed the Committee that AS had to rewrite complex care papers which were badly written by the SLP colleagues and asked the Committee for proposals for dealing with

Item		Action
	this. It was decided that committee members would consider solutions and discuss the issue at a later meeting. **ACTION -**	**ALL**
	As committee members did not have sufficient time to read the paper, it would be discussed at the next meeting. **ACTION**	**ALL**

22/102 Inspire Sutton lessons learned review

AS presented a paper on Lessons learned from the Inspire Sutton project. Towards the end of 2021, the Trust decided not to bid for the Inspire Sutton project. It was agreed that a lessons-learned exercise would be completed as it was important to identify areas for improvement in the future. The lessons are set out in para 3.3 on page 7 of the paper. AS summarized the elements to be considered.

The Committee noted the lessons learned review and complimented AS on a very good reflective paper.

22/103 Financial Report 2022/23 (Month 3 update) Part A

Part A, produced for the public part of the Board meeting, was taken as read. In the light of Trusts being asked to be increasingly open and transparent and to share Finance Committee reports with the ICB, PM shared the month 2 page of Part B which showed the £16 million risk.

The Committee noted the Part A Finance Report.

22/104 Financial Report 2022/23 (Month 3 update) Part B

PM highlighted the following elements of the paper:

- Finances were in line with plan at £1.3m deficit year to date. At the end of May £1.6 million slippage had been built into accruals that had increased to £1.9 million.
- Calculation of the risks had been reconsidered after discussion at the Board meeting. They had been RAG rated and left a potential £12.9m shortfall, inclusive of savings shortfalls. PM explained how and why the risks had been reduced.
- The balance sheet had been updated and PM referred members to the changes. Accruals and provisions totaling £16.6m were made that sat outside normal BAU year-end adjustments. £4.8m was potentially available after applications. A balance of £1.1m was available to further support 2022/23 or be carried into future periods
- The underlying Run Rate showed deficits of approximately £1m per month for the first quarter. The Trust had a significantly improved Month 3, reducing the deficit by over £0.5m from that reported in Month 2. However, financial performance for the first 3 months had been underpinned by balance sheet releases and non-recurring benefits. To achieve the improved break-even plan, the Trust had to release contingency into the Month 3 position.
- Ten people had been on agency staff for more than four years. It was intended that agency staff be used on a short-term basis while recruitment was underway, but agency staff were being used on a longer-term basis to fill vacancies. Workforce and OD groups were looking at the process of moving agency staff onto payroll.
- Spend on external beds had increased over the past 15 months, increasing from £9k in April 2021 to £446k in June 2022. The shortage of beds had necessitated the use of external beds. Discussions had been held on ways of reducing reliance on external beds in the medium to long term, but there was no alternative in the short term.

The Committee discussed the following points:

- That the issue around agency spend was very significant. The Workforce and OD Committee was working on agency controls and restrictions. The Trust needed to aim to save about £400 to £500k into contingencies. The transition of the ELFT services to the Trust had been discussed at the ELT meeting and it needed to be handled well.
- Whether discussions were happening at regional level or within the ICB to work together centrally to rationalize the numbers of agencies to make deals with some of these agencies to achieve savings.
- PM replied that the majority of agency doctors and nurses came from very few agencies. Agency staff were procured via approved framework agreements. The Trust was mainly paying nationally negotiated rates. HR directors were working together at both ICB level and London level and having discussions about bank and agency rates. Changes would need to be done nationally to influence agencies.
- Whether the Trust had made provision for inflationary risks. - PM replied that they had made provision for the increase in energy bills at an early stage. The Trust had also considered the risk that suppliers would increase prices. If the Trust was not flexible in negotiating increases, there was a danger that suppliers might declare bankruptcy. PM reported that the Trust would be able to pay the increased wage bill with additional funding expected.
- KR was considering recruiting doctors internationally via agencies, but agencies did not have many doctors and were competing for the few candidates.
- The Committee decided that three or four things for example agency spend, external beds and a few other issues should be selected to focus on. Robust action plans and realistic timelines should be set with the objective of achieving a break even run rate by March 2023. **ACTION**
- The increased demand on Trust services was discussed. There was a need to inform ICS colleagues about the limitation on what the Trust could do The Trust's capacity was also dependent on developments in the estate's modernization programme and movement into the new buildings because much of the Trust's savings were predicated on dates and moving in. **ALL**
- The impact of quality and safety was discussed. There was underspend of £2.4m within community services. Although the Trust might make savings, staff were needed to provide safe services within the community to prevent an influx of people being admitted to hospital. The vacancies the Trust was holding had an impact on the community.
- It was proposed that ELT should inform the Non- Executive Directors of the problem. A collective discussion would be held so that each of the Committee chairs was aware in advance of the multiple challenges the Trust faced in order that the problems could be discussed at September's Board meeting. **ACTION**

The Committee noted the financial position provided in Part B and complimented the Finance team on the well-prepared papers. **ELT**

As there would be no FPC in August, PM suggested the following reporting approach:

- The normal suite of reports (Part A, Part B, and Savings) would be presented to ELT on 25th August
- Due to leave commitments, these would not be reviewed by the Director of Finance prior to publication
- Following review at ELT, the Director of Finance and ELT would make any necessary changes to the reports by close of play Tuesday 30th August
- The normal suite of reports (Part A, Part B, and Savings) would then be circulated to FPC on 31st August

- The normal suite of reports (Part A, Part B, and Savings) would then be circulated to the Trust Board on 1st September, with Trust Board scheduled for 8th September.

The Committee approved the revised reporting arrangements for month 4.

22/105 Savings Report 2022/23 (Month 3 update)

PM delivered a presentation on savings and highlighted the following factors:

- The Trust was not delivering savings at the level needed. Total savings schemes identified amounted to £11.5m against a target of £12.4m, £0.9m less than required.
- There were increasing amounts of non-recurrent saving. £1.8m of the savings were rated recurrent (14%). Non-recurring schemes totalled £6.4m.
- All schemes were currently behind plan; In month, £0.6m CIPs were delivered, £0.4m shortfall against a plan of £1.0m. Cumulative savings totalled £1.8m, £1.2m shortfall against plan.
- Service Lines were analysing savings to determine which savings were in reality recurrent.
- The challenge for the Trust was fourfold:
    - To close the remaining gap.
    - To turn Red and Amber schemes to Green.
    - To ensure that as many schemes as possible generated recurrent savings.
    - To ensure that recurring schemes had a full year impact that mitigated the non-recurring schemes and therefore the opening deficit for 2022/23

The proposed action plan to focus on improvement in three big key items would hopefully reduce the deficit at year end.

The Committee noted the delivery to date, the work required for future delivery and run rate reductions and the requirement to improve the 2022/23 position.

22/106 Committee Workplan 2022-2023

The Committee discussed the workplan and decided that the following matters would be on the agenda in September. Performance Dashboard, Cash Flow, Analysis of 3 areas,

Contracting, National costs (PM would follow up to see if paper would be ready)

The Digital 18- month Plan would be on the agenda In October.

The estates, 6-month update would be on the agenda in December.

22/107 Business Case, Investment and Costing Policy

The policy was presented for approval. It was taken as read.

JuA asked to what extent it included aspects of the conversation around the Inspire Sutton tender and whether other partnership type agreements were considered in the policy.

PM replied that he did not think the policy would have made any difference to the outcome of the Inspire Sutton Bid. There was rigorous scrutiny of all business cases by BCAG and they would reject any problematic aspects of the contracts.

The Committee ratified the policy.

22/108 Any Other Business

No items were discussed.

22/109 Date of Next Meeting

The next meeting would be held on Thursday 29th September 2022 by Microsoft Teams.

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

Finance & Performance Committee

Minutes of the Meeting held on Thursday 29th September 2022 at 14.00 by Microsoft Teams

Present:

Vik Sagar (VS)	Non-Executive Director (Chair)
Ann Beasley (AB)	Trust Board Chair
Juliet Armstrong (JuA)	Non-Executive Director
Sola Afuape (SA)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Philip Murray (PM)	Director of Finance and Performance (part)
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial Development
Jen Allan (JeA)	Chief Operating Officer (remote attendance for part)

Attendees:

Debbie Hollinghurst (DH)	Deputy Director of Finance
Nick Worner (NW)	Associate Director: Commercial and Business Development
Dominique Zakkour (DZ)	Clinical Team Manager, CAMHS, NDT, DiDMR.
Clair Hartley (CH)	Committee Governance Manager

Apologies:

Billy Boland (BB)	Medical Director
Charlotte Clark (CC)	Non-Executive Director

Item		Action
22/110	**Apologies** Noted as above	
22/111	**Welcome** VS welcomed DZ to the Committee as the Diversity in Decision Making Representative. (DiDMR). DZ is Team manager in the CAMHS Neuro Development Team. She looked forward to learning more about finance.	
22/112	**Declarations of Interest** No new declarations were noted.	
22/113	**Chairs Action** No Chairs Action have been taken.	
22/114	**Minutes of the previous meeting and Matters Arising** The minutes of the meeting held on 28 July 2022 were agreed as a true and accurate record.	
22/115	**Action Tracker and Matters Arising** The action tracker was received and discussed. • 21/53 – on agenda • 22/01 – papers to be monitored • 22/97 – on agenda	
22/116	**Financial Report 2022/23 (Month 05 update) Part A** PM highlighted the following issues: • In August, the Trust recorded a £0.01m surplus, marginally favourable to plan. The cumulative position to Month 5 is £1.4m deficit, broadly on plan.	

Item		Action

- At the end of August, the Trust had a cash balance of £34.8m; £1.3m adverse to plan.
- The continued high demand for beds and acuity of patients resulted in high external bed costs and additional nursing costs
- Agency costs increased by £65k in August compared to July. The Trust spent £1.1m on agency in August, and £1.9m on temporary bank. Agency costs continued to rise as recruitment continued to be a challenge, particularly within Community Services.

The Committee **noted** the Part A Finance Report.

22/117 Financial Report 2022/23 (Month 05 update) Part B

PM and DH highlighted the following from the Part B report:

- The 2022/23 financial position and progress against mitigating actions to ensure financial targets were met.
- The Trust has been asked by the ICB and the London Region to complete a piece of work detailing upside, most likely, and worst-case forecasts for 2022/23 out-turn.
- NHSE accepted that they had supported the waiver in the Ronald Gibson House Capital Grant Release originally and were prepared to release the grant to Brendon Care. However, the write-off had to be approved by Treasury. NHSE/DHSC were presently considering options to allow the transaction to proceed while waiting for Treasury approval.
- The key drivers of Agency costs and External bed costs were not changing so the run rate remained unchanged. The overall position was not sustainable as the Trust continued to spend above its means. Based on this underlying rate of overspend it was unlikely that the Trust would be able to meet its financial targets this year. Increases in gas and electricity bills were expected.
- The Trust would reimburse VAT costs incurred by lease car holders pre 2021 to staff

The Committee discussed the following:

- The legal costs incurred in the Gibson House matter - **PM would report back.** **PM**
- The Trust was able to claim money back due to changes in pension rules relating to high employer contributions following pay rises to staff in the year prior to them taking retirement.
- An update on the Cavendish Group was requested. VF reported that there have been numerous conversations at regional level about whether the individual agency CAP could be managed differently. Negotiations were continuing.
- There was a concerted effort on recruitment which also involved JeA and SS. VS asked what the next step would be. There was an active recruitment process and yet vacancies were at 57%. He asked for information on the next step to reduce agency costs, an update on progress made and information as to who owned the process. VF replied that PM was the executive lead on the agency spend and owned and reported on the spend through the finance reports with the support of KR. On an operational basis agency spend was reported to ELT and then onwards through this report to workforce and OD and to FPC. **PM would provide the Committee with a progress report and information on the next steps.** **PM**
- VS asked what the next step was re external beds, where it was reported and what the next step was? VF replied that the report around external bed

Item		Action
	used was put in place across multiple committees. The work around ward workflows came in through the transformation papers into ELT. QSAC provided the quality assurance that people were in the safe and right place and reported to WODC. FPC oversees the financial spend. The oversight of the actions taken to address the use of private beds sits with EMC but was quality assured through QSAC. **The Committee asked that an update on ward workflows be submitted to EMC**.	
	• Cash flow would be quite constrained in the following year, given an assumption of a £10 million deficit. What was the timeline and work plan for the cash flow? DH was working on the cash flow modelling. A**n updated cashflow model would be submitted to the November meeting.**	**AS**
	• The EMP team would submit a long-term financial model, including the cash flow for Tolworth to the October Board seminar. The Finance team would report on the impact of the CIP not being recurrent.	**PM**
	• The new building would be more energy efficient. Staff would also be asked to conserve energy, where possible. **More information on energy savings would be submitted to the Committee.**	
	• The SLP surplus was discussed at the Committees in Common meeting and proposals were moved forward. A clear picture of the spending would be submitted to the Portfolio Board. Some of the money would come back and some would be reinvested or be used to tackle cost pressures. They were working to reduce the SLP surplus and there needed to be some investment in the SLP areas.	**PM**
	• VS reminded the Committee that it had agreed at the last meeting that it would focus on two or three key problems areas with the object of addressing the £10 million underlying deficit. Two of the areas, agency spend and external beds had been discussed. Energy spend was also discussed and VS asked that PM consider if a 3rd area was appropriate.	
	The Committee • **Noted** the 2022/23 financial position and progress against mitigating actions to ensure financial targets were met. • **Noted** the key drivers of the underlying position and 2022/23 position forecast. • **Noted** the ICB challenge to improve the position (both forecast and agency spend) and the consequences of not doing so. • **Noted** the improved cash modelling and recognised that this cash was needed to pay off the loan and could not be used to improve the underlying financial position. • **Noted** the proposed reimbursement to staff of VAT savings relating to lease cars. • **Discussed** what further action could be taken to improve CIP delivery, agency spend and reduce bed pressure demand and what assurance could be given to FPC that improvements would be made.	
22/118	**Savings Report 2022/23 (Month 05 Update)** DH presented the savings report. AB asked whether the Trust was behind plan due to the unidentified savings. DH replied that the profiling of the savings plan allowed for this and therefore it doesn't impact on the year-to-date position. VF reported that ELT had a detailed conversation about the paper. They were pushing on corporate savings which were in the black. Each of the execs would be coming up with clear plans about how they could make those savings and what the risks and mitigations were.	

Item **Action**

AS said that they had considered income generation opportunities, but some required enormous amounts of effort to mobilise and would create problems in the long term.

The Committee discussed several opportunities. Non-contracted additional patient activity and government grants for the green and sustainability agenda would be explored. However, it was doubtful whether the Trust would take this forward until the new year as all resources were concentrated on the move into the new buildings and a Heat Decarbonisation Plan would probably need to be developed. Income opportunities utilised by other organisations would also be explored.

Private patient income had been considered but it was very challenging to acquire and required very significant corporate structures and protocols and processes. Income from overseas patients and patients from devolved nations could be considered, however these remained under block arrangements following Covid rules.

The Committee **noted** the delivery to date, the work required for future delivery and run rate reductions and the requirement to improve the position.

22/119 HFMA Getting the Basics Right Review

DH introduced the report highlighting the need for balanced scoring and appropriate actions. DH confirmed that the assessment was a national requirement and would be audited, the aim being to ensure organisations had the appropriate reporting, governance and culture to enable sound financial decisions to be made. The Trust had adopted a thorough approach to the assessment scoring all 72 questions with 19 requiring mitigating actions as outlined in the report. The initial scoring by the Finance team had been reviewed by the Finance Director and subsequently the ELT who supported the scores and the proposed mitigating actions. It was noted that some of the actions were not new and were already in train. The area of culture, training and development scored weakest, reflecting the HR turnaround and recovery. Committee discussed the need to ensure training for staff was adequate and useful to staff and asked if the review of training could also review communication of financial positions as highlighted in the grip and control assessment. DH confirmed this would be possible. Committee noted that some of the detail in the full return would need to be updated before submission to the auditors but that this would not impact on scoring or actions.

Committee **approved** the scoring and actions as outlined in the report and asked for the outcome of the audit to be reported back to this committee, as well as the Audit Committee, so that completion of actions could be monitored.

22/120 NHSE Grip and Control Review

DH presented the report to the Committee. She informed the Committee that this was a self-assessment that would not be audited. The review highlighted the results of a review of the national financial grip and control toolkit to ensure that the Trust had considered all appropriate actions to improve its financial position. The Trust usually conducted the review informally at least once a year. The ICB asked the Trust to conduct the review formally.

A number of recommendations were to be considered. One of them was whether the Trust had enough focus on communication of the financial position. Another was whether people managing contracts had the appropriate skill set to ensure the contracts were managed in such a way as to get best value for money and to challenge poor performance. It was also unclear whether there was a named representative for each contract.

Item		Action
	The Committee discussed the action to be taken. DH informed the Committee that they would review the training offered to staff and communication regarding the financial position. The report would be submitted to the October meeting. The Committee **noted** the review.	**JeA**
22/121	**Commercial Priorities and Update** AS and NW presented a paper outlining the 2022/23 strategic, transformation and commercial priorities and providing an update of progress against these. The 2022/23 priorities and key elements were: • To lead the strategic development of mental health in South West London (SWL). • To improve partnership working. • To transform services; and • To support the productivity and CIP agenda. During September 2022, the key area of focus had been: • Development of the proposals for a provider collaborative for mental health for SWL and development of a SWL MH Strategy. • Ongoing delivery of transformation programmes most significantly around community mental health year 2, revised funding for transformation in Kingston and Richmond and dedicated focus areas. The CYP transformation work continued, including work to identify solutions to improve flow. The Committee discussed the following issues: • NW informed the Committee that no services have been lost in recent times. He would make that clear in the next report. • Whether diversification of the income stream meant dependence on public sector funding which was vulnerable at present. NW replied that they would look at opportunities for income outside the public sector closely and prioritise them given the current environment. • The Virtual waiting room was an initiative of South London Listens which had been extremely well received. AS invited members to attend the South London listens Accountability Assembly on 10th of October. • The Trust's business case criteria - AS reported that business cases were very thoroughly reviewed and went through a stringent governance process. NW informed the Committee that some of the business cases that went through BCAG recently were funded through SLP savings. A couple of Complex Care business cases were funded from Complex Care savings. The proposals were projected to generate savings and would replenish the savings pot. • DH assured the committee that inflation was factored in to costing, particularly where there was reliance on 3rd party or external costs. National rates were used to calculate inflation on pay awards. Inflation on rental and utilities was also built in. • It was pointed out that the report usually contained more information on the status of work and the due date. The Committee required assurance that the projects were on track. AS replied that they had prioritised service review and efficiency, but the work was complex and had to be done in collaboration with external stakeholders. • VF reported that the Trust had hosted the first ICB Board seminar session at Springfield. VF provided a report on discussions at the meeting and interaction with the ICB.	

Item		Action
	The Committee **noted** the 2022/23 priorities and progress made during September 2022.	
22/122	**Defining the Performance in Finance & Performance** JeA presented a background to the paper. She informed the Committee of the work that that been conducted to address challenges through productivity, performance and quality improvement. The approach outlined was described in an appendix showing the metrics that were suggested although some of them were still in development. The Committee discussed • whether it was possible to obtain more up-to-date benchmark data; whether they could see the next level down in terms of clinical performance measures; whether any new performance metrics were being considered in other areas, such as workforce and the extent to which the Trust could take a process view. • JeA informed the Committee that they were addressing the performance issues that belonged to each committee step by step. They intended to triangulate indicators of productivity of services. • Timescales and the attaching of a money value to proposals were discussed. **JeA confirmed that the Productivity Performance Review would be submitted to the next meeting.**	**JeA**
22/123	**Essential RCA Approach to Performance** JeA provided a summary of the actions that were taken over the last month or two to endeavour to have a fresh approach to the ongoing performance challenges around a large portion of the performance portfolio. A root cause analysis session which was run in August was well supported by informatics and came up with a refreshed action plan which was contained in Appendix A of the report. The specific proposals were • Focused action plans from the RCA session were to be taken forward through the refreshed service line improvement session. • Review of Q&P metrics against national standards and benchmarking to be undertaken by performance and informatics. Proposals on changes to standards and/or Q&P report were to be brought back to QSAC in Q3. • Discussion of use of ‘‘starred items’’ or alternative ways of prioritising discussions at QSAC were to be held in October meeting. • Further work on shifting culture and ways of working towards standardised best practice frameworks and digital workflows were to be brought to subcommittees/ Board in due course. The Committee thanked JeA for an illuminating presentation and the greater emphasis on outcomes rather than just processes. JeA reported that the Improving Patient Outcomes Group was working on bringing together recovery outcomes and reports on patients’ experiences. The Committee **approved** the proposed actions.	
22/124	**Committee Workplan 2022-2023** JeA pointed out that the Workplan was not accurate. **The Workplan was to be amended to reflect decisions made at July Meeting**.	**CH**
22/125	**Matters for the Board of Directors** None	

Item		Action
22/126	**Meeting Review** VF commended DH for stepping in after PM had to leave. SA commented that the Committee did live its values. She appreciated how they responded to PM's needs. She reiterated the value of NEDs attending meetings of other committees. She had found it valuable to attend the meeting as some of the papers on the agenda gave her a different insight on matters. **ANY OTHER BUSINESS** None.	
22/127	**Date of Next Meeting** The next meeting would be held on Thursday 27th October 2022 by Microsoft Teams.	

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

Meeting:	Trust Board
Date of Meeting:	10 November 2022
Report Title:	Part A - Finance Update 2022/23 Month 6
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Purpose:	For discussion and note
Scrutiny Pathway:	Director review / ELT/ FPC / Trust Board
Transparency:	Public

1. Executive Summary

- The Trust is reporting a forecast breakeven position for the year in line with plan.
- The position for Month 6 is break-even meaning the cumulative position remains at £1.4m deficit, broadly on plan.
- Underspends against Pay are offsetting overspends in non-pay driven by the unidentified savings target and external bed usage.
- This position incorporates the national pay award and associated funding. The award, back dated to April, was paid to staff in September.
- The Trust continues to operate with agency costs higher than the plan; from September Trusts are performance managed on their ability to keep agency costs below plan and the Trust has been identified as an outlier for the level of agency costs as a percentage of total pay. The Trust spent £1.1m on agency in September, and £2.2m on temporary bank. The Trust must reduce agency costs.
- The savings target of £12.4m has been devolved to service lines. Cumulatively delivery is £5.0m, £1.2m behind plan. Schemes have been identified to achieve 97.5% of the savings target for the year.
- All clinical service lines are reporting break even or better except for Acute Services and Corporate. Acute Services is reporting a cumulative £1.8m adverse position reflective of high levels of acuity on inpatient wards and the higher than planned usage of external beds. Corporate is reporting a cumulative £1.2m adverse position due to central provisions against known trust wide liabilities including the September additional bank holiday and overspends in HR and Estates.
- Of the £25.5m capital spend to date, £15.4m is due to a technical adjustment relating to leases required to comply with the introduction of accountancy standard IFRS16. Operational capital of £10m is £2.3m less than plan due to phasing of construction costs on the Springfield site. The annual forecast is £0.6m more than plan due to the lease transfer from ELFT associated with the Trust taking on the service provision of the Richmond Well Being service later in the year. The Trust will be seeking a budget uplift to offset this.
- The Trust has a £99m loan taken out in previous years to support the construction of the Springfield redevelopment. No repayment is anticipated in 2022/23. Cash balances will be used to fund construction in 2022/23.

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

- At the end of September, the Trust had a cash balance of £36.4m. High cash balances are being accumulated in preparation for loan repayments.
- There are two major concerns. Firstly, the ability to deliver the required savings, including reduction of agency costs, whilst maintaining appropriate quality and safety standards and ensuring there is no unacceptable detrimental impact on patient care e.g. through extended waiting times. Secondly, the continued high demand for beds and acuity of patients resulting in high external bed costs and additional nursing costs.

Recommendation:

Committee is asked to: **note** the content of this cover sheet to be read in conjunction with the part A Finance Report. More details of the position can be found in part B cover sheet/report and the savings update.

Appendices/Attachments:
One Power Point report accompanies this report.

Corporate Risk	**1025/27**	**Board Assurance Risk**	**1025/27**

KEY IMPLICATIONS
Outlined below is the key implications which may result from the proposals or information contained within this report

Assurance/Governance:	Positive impact – This paper provides update to the financial targets against which the Trust is performance monitored against
Clinical:	Positive impact – Trust Funds are spent to get the best value to support our clinical services and patients
Equality & Diversity:	Positive impact – The Trust spends money to improve equality and diversity for patients and staff.
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
Quality:	Positive impact – Trust funds are spent providing good quality services to our patients whilst achieving financial targets
QII:*	n/a
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Involvement (SUCFF):*	n/a
Strategy:	Positive impact – Underlying financial sustainability is a key part of the Trust's strategy

Workforce:	Positive impact – Trust funds supports the employment of a secure permanent and stable workforce, the report provides information on the cost of agency
Other (specify):	n/a

QII = Quality Improvement & Innovation; Involvement (SUCFF)= Service User, Carers' Friends & Family Engagement and Involvement

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

Finance Report 2022/23
6 Months to September 2022 – part A

Meeting	FPC
Date of Meeting	October 2022
Report Title	Finance Report 2022/23 – 6 Months to September 2022 – part A
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

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

Executive Summary

This report provides an update on :

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

Overall – I & E Position

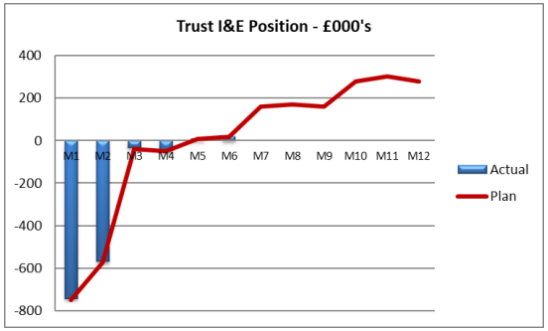
- In September, the Trust recorded a £0.02m surplus, marginally favourable to plan
- The cumulative deficit remains at £1.4m, also marginally favourable to plan
- The position fully reflects income flows agreed with South West London and other ICBs as part of 2022/23 contracting
- The expenditure position includes new year investments relating to MHIS and SDF. Unfunded pressures such as external bed usage and observation costs contribute to the current deficit
- Income and expenditure budgets have now been realigned to reflect the costs of (and additional funding associated with) the inflationary pay increase paid in September
- A further downward realignment will be made in November to reflect the reversal of the National Insurance increase
- The forecast outturn is break-even in line with plan and requires an improvement in run rate during the remainder of the year. There are a number of significant risks associated with this.

Financial Reports 2022/23	Current Month			YTD month 6			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	23.7	23.3	(0.4)	129.5	128.8	(0.7)	258.3	257.9	(0.3)
Pay	(16.6)	(16.1)	0.5	(91.7)	(88.4)	3.3	(185.1)	(178.7)	6.4
Non Pay	(5.6)	(5.8)	(0.2)	(30.5)	(33.2)	(2.7)	(55.9)	(62.1)	(6.2)
EBITDA	**1.5**	**1.4**	**(0.0)**	**7.3**	**7.1**	**(0.2)**	**17.4**	**17.2**	**(0.1)**
Cap Charges - Depreciation	(1.0)	(1.0)	(0.0)	(5.7)	(5.7)	(0.0)	(11.5)	(11.7)	(0.2)
Cap Charges - Interest & Div	(0.4)	(0.4)	(0.0)	(2.6)	(2.6)	(0.0)	(5.1)	(5.1)	0.0
Interest	(0.1)	(0.0)	0.1	(0.4)	(0.2)	0.2	(0.8)	(0.4)	0.3
Post EBITDA	(1.5)	(1.4)	0.1	(8.7)	(8.5)	0.2	(17.4)	(17.3)	0.1
Underlying Surplus / (Deficit)	**0.0**	**0.0**	**0.0**	**(1.4)**	**(1.4)**	**0.0**	**(0.0)**	**(0.0)**	**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	0.0	0.0	0.0
Net Surplus / (Deficit)	**0.0**	**0.0**	**0.0**	**(1.4)**	**(1.4)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**

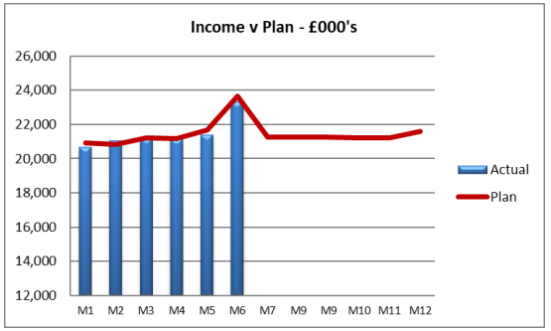
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

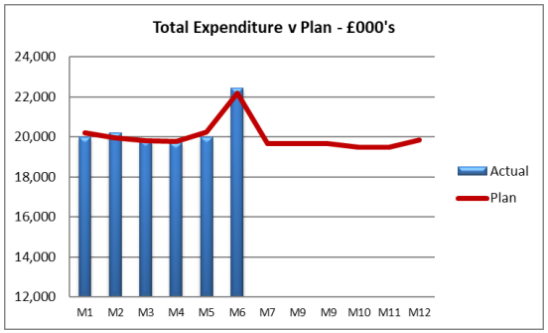
- Baseline surplus of £20k reported in month, £2k favourable to plan
- Cumulative deficit of £1,367k, £17k favourable to plan
- Deficit driven by external beds, Coral and Observation costs
- Profile reflects revised plan break-even submission to NHSE/I
- Significant risks to break-even position



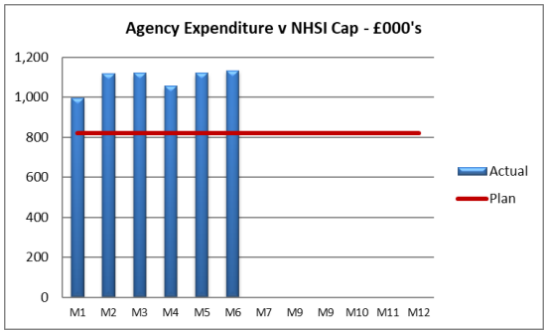
- Income received in month, £23.3m, £0.3m behind plan
- Month 6 increase reflects additional funding (approx. £2m) for pay award
- Confirmation of £0.6m Employment Advisor and £0.2m SDF funding received in-month
- NHS income expected to reduce by 0.5% in November in line with National Insurance reversal



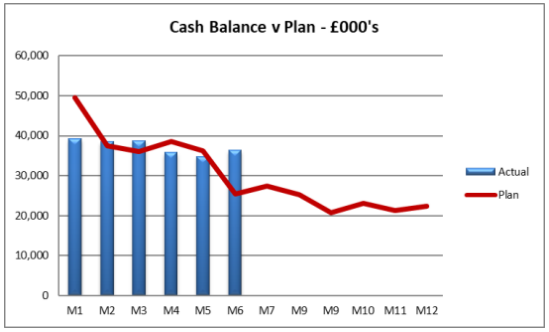
- Spend of £22.2m in month, £0.2m favourable to plan
- In month spike (approx. £2m) reflects back-dated pay award
- September position also incorporates additional bank holiday spend
- External bed expenditure of £588k in month
- External Bed pressure continues into M7



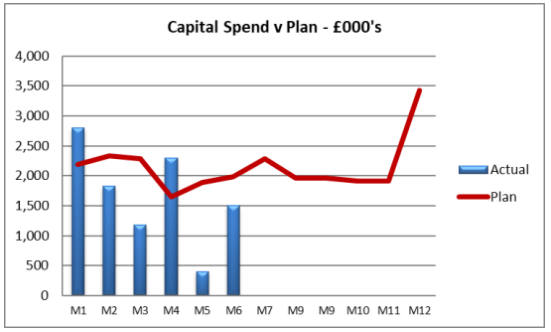
- Agency spend in month £1,133k, £295k above 2021/22 average spend
- £313k above plan
- M5 London wide analysis reveals Trust to be an outlier in terms of agency use
- Community spend in M6 of £601k (53% of total)
- Corporate spend £255k including £102k of Strategic Investment expenditure



- Cash balance at end of September £36.4m
- £10.8m favourable to plan
- Key reasons are capital underspends and receipts
- Expected to equalize over the remainder of the year
- Cash balances required for loan repayment
- Loan of £99.3m; repayments scheduled to commence in 2023/24



- In month capital spend of £1.5m, £0.4m below plan
- Cumulative spend of £10.0m, £2.3m below plan
- Underspend found in EMP, relating to construction costs
- Forecast spend of £25.8m in line with plan
- Position excludes leases, £15.4m, capitalised under IFRS 16



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

Income Position

- For Month 6 the Trust reported £23.3m of income, £0.3m behind plan and cumulatively £0.7m adverse to plan
- All income budgets and actuals are fully reflective of the additional pay award funding received
- Local Contracts are showing a £0.4m adverse variance. This is a phasing issue and will correct from Month 7 onwards
- NHSE income is, following the resolution of the £2.8m funding error, showing a balanced position
- Other NHS Clinical income is showing a £0.1m positive variance due to additional staffing recharges being made to the SLP
- Education income is £0.2m favourable to plan due to additional salary replacement funding being received
- Other non-clinical income is £0.6m behind plan as expected income flows from the SLP have yet to crystallise
- Non-NHS Clinical Income is £0.1m adverse to plan as a result of reduced salary recharges. This, however, is balanced by reduced pay expenditure
- NPSA, Provider Collaborative and Merit Award income are all in line with plan

Financial Reports 2022/23	Current Month			YTD month 6			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	18.0	17.9	(0.1)	97.9	97.5	(0.4)	196.1	196.1	0.0
Nhs England	1.8	1.8	(0.0)	10.0	10.0	(0.0)	20.0	19.9	(0.1)
Npsa Income	0.0	0.1	0.0	0.2	0.3	0.0	0.5	0.6	0.1
Provider Collaborative Income	1.9	1.9	0.0	10.0	10.0	0.0	20.0	20.0	0.0
Other Nhs Clinical Income	0.3	0.3	0.0	1.8	2.0	0.1	3.1	3.1	0.0
Nhs Clinical Income	**22.0**	**21.9**	**(0.0)**	**120.0**	**119.7**	**(0.2)**	**239.8**	**239.8**	**0.0**
Education & Training	0.7	0.7	0.0	4.0	4.1	0.2	7.9	8.9	1.1
Other Non Clinical Income	0.6	0.3	(0.3)	2.8	2.2	(0.6)	5.2	4.0	(1.2)
Merit Award Income	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0
Non Clinical Income	**1.3**	**1.0**	**(0.3)**	**6.8**	**6.4**	**(0.4)**	**13.2**	**13.0**	**(0.1)**
Non NHS Clinical Income	0.5	0.4	(0.1)	2.7	2.6	(0.1)	5.3	5.1	(0.2)
Non Nhs Clinical Income	**0.5**	**0.4**	**(0.1)**	**2.7**	**2.6**	**(0.1)**	**5.3**	**5.1**	**(0.2)**
Income	**23.7**	**23.3**	**(0.4)**	**129.5**	**128.8**	**(0.7)**	**258.3**	**257.9**	**(0.3)**

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

Pay Position

- Pay amounted to £16.1m in September, £0.5m favourable to plan
- This includes the backdated element of the pay award above the 2% provision required by NHS and which amounted to approximately £1.7m
- The in-month pay position is again suppressed by the release of provisions
- Medical Staff are now overspent by £0.4m due to continued high agency and bank usage
- Despite continued acuity pressures, Nursing budgets are now showing a £0.2m underspend cumulatively
- Other Clinical Staff (principally Psychologists) have continued the trend reported in previous years and have returned a £3.7m cumulative underspend to date
- Non-Clinical staff are showing a £0.2m adverse variance due to agency usage

Financial Reports 2022/23	Current Month			YTD month 6			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.5)	(2.7)	(0.1)	(14.5)	(14.9)	(0.4)	(29.4)	(29.9)	(0.5)
Nursing	(7.3)	(7.1)	0.1	(39.1)	(38.9)	0.2	(78.4)	(78.5)	(0.1)
Other Clinical	(3.9)	(3.3)	0.7	(22.2)	(18.5)	3.7	(45.3)	(38.1)	7.2
Non Clinical	(2.9)	(3.0)	(0.1)	(15.9)	(16.1)	(0.2)	(31.9)	(32.1)	(0.3)
Total Pay	**(16.6)**	**(16.1)**	**0.5**	**(91.7)**	**(88.4)**	**3.3**	**(185.1)**	**(178.7)**	**6.4**

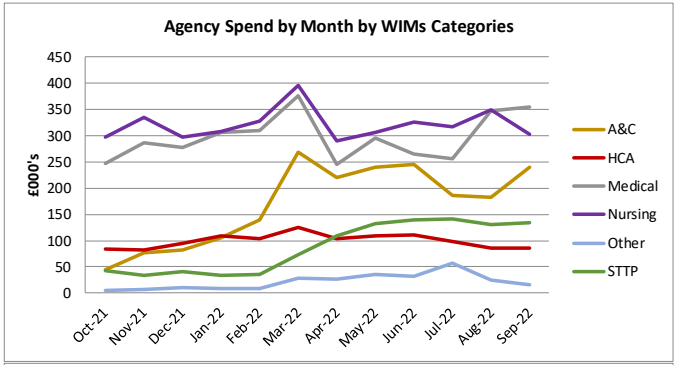
- Agency expenditure of £1.1m was £0.3m above the Trust's plan. This was the highest monthly expenditure of the year to date and £0.3m more than the 2021/22 average
- Bank expenditure was £2.2m, £0.5m above plan (£0.8m above cumulatively). The in-month and cumulative variances have been increased by the backdated pay award
- Permanent pay amounted to £12.8m in month. This was £1.3m favourable to plan due to continued vacancies and provision releases. Permanent pay is now £5.7m favourable to plan cumulatively

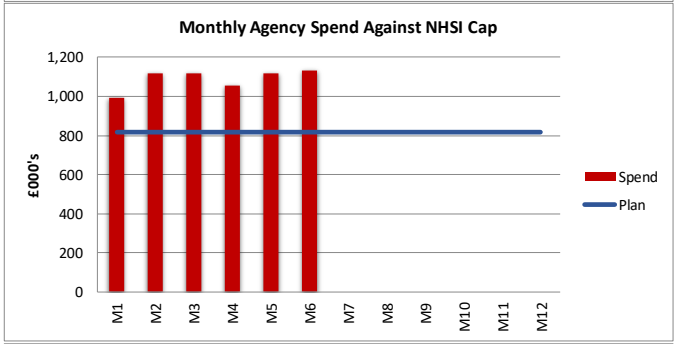
Financial Reports 2022/23	Current Month			YTD month 6			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(14.1)	(12.8)	1.3	(76.4)	(70.7)	5.7	(154.5)	(144.8)	9.7
Bank	(1.7)	(2.2)	(0.5)	(10.4)	(11.2)	(0.8)	(20.7)	(22.3)	(1.5)
Agency	(0.8)	(1.1)	(0.3)	(4.9)	(6.5)	(1.6)	(9.8)	(11.6)	(1.8)
Total Pay	**(16.6)**	**(16.1)**	**0.5**	**(91.7)**	**(88.4)**	**3.3**	**(185.1)**	**(178.7)**	**6.4**

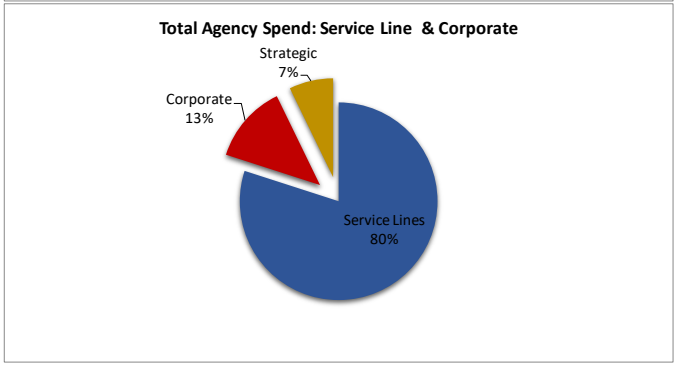
South West London and St George's Mental Health NHS Trust

Agency - in month and cumulative position

- Month 6 agency expenditure was £1,133k
- Increase of £13k on Month 5 expenditure
- Equates to 7.0% of pay costs (7.4% cumulatively, 6.1% in 2021/22, London average 4.4%)
- Highest areas of monthly spend: Medical £354k, Nursing £303k, and A&C £239k. Medical expenditure outstripped Nursing for the first time
- Above the current plan by £313k in month
- It is unclear the ramifications of additional central scrutiny. The Trust has been identified as an outlier across the London Region and must drive down agency costs
- The key pressure area remains the Community Service Line; of the £1,133k total spend, £601k (53%) was incurred in Community. This represented an increase of £80k on M5 expenditure with virtually all of this in Medical staffing
- 80% of agency expenditure to date has been incurred within the Trust's 4 clinical service lines, with 13% relating to corporate areas, and 7% relating to agreed strategic investments
- Including strategic investments, Corporate expenditure has increased from £25k in M1 2021/22 to £255k in M6 2022/23







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

Non-Pay & Post EBITDA

- Non-Pay expenditure amounted to £5.8m in month, a £0.2m overspend (cumulatively £2.7m)
- External bed expenditure amounted to £0.6m in September, £0.3m above plan. This position will further deteriorate in future months as budgets were predicated on reduced usage whereas current utilisation remains above that
- The non-pay budget and expenditure have increased by approximately £0.3m year to date, reflecting the additional pay award funding that is payable on some (mainly NHS) contracts
- Other costs are now cumulatively £1.7m overspent, with £1.2m of this relating to CIP non-achievement and the balance relating to areas such as estates, soft FM and central provisions
- Lease budgets have been moved to depreciation and interest payable (below the line) to reflect the impact of IFRS 16. This amounts to approximately £0.5m in-month (£3.1m) cumulatively

Financial Reports 2022/23	Current Month			YTD month 6			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Drug Costs	(0.1)	(0.2)	(0.1)	(1.1)	(1.1)	(0.0)	(2.2)	(2.2)	(0.0)
Clinical Supplies & Servs Cost	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0	(0.5)	(0.5)	0.0
Secondary Commisioning Costs	(2.9)	(3.2)	(0.3)	(17.2)	(18.2)	(1.0)	(33.5)	(35.8)	(2.3)
Other Costs	(2.5)	(2.2)	0.2	(11.5)	(13.2)	(1.7)	(19.7)	(23.6)	(3.9)
Contingency	(0.1)	(0.1)	0.0	(0.5)	(0.5)	(0.0)	0.0	0.0	0.0
Total Non Pay	**(5.6)**	**(5.8)**	**(0.2)**	**(30.5)**	**(33.2)**	**(2.7)**	**(55.9)**	**(62.1)**	**(6.2)**

- Post EBITDA costs are now cumulatively £0.1m favourable to plan due to higher than planned interest receipts
- The increase in depreciation and interest budgets reflect the impact of IFRS 16 (detailed above)
- There are currently no asset sales included in the plan due to their uncertain nature. There are no planned impairments

Financial Reports 2022/23	Current Month			YTD month 6			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Cap Charges - Depreciation	(1.0)	(1.0)	(0.0)	(5.7)	(5.7)	(0.0)	(11.5)	(11.7)	(0.2)
Cap Charges - Pdc Dividend	(0.4)	(0.4)	(0.0)	(2.6)	(2.6)	(0.0)	(5.1)	(5.1)	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest	(0.1)	(0.0)	0.1	(0.4)	(0.2)	0.2	(0.8)	(0.4)	0.3
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)**	**(1.4)**	**0.1**	**(8.7)**	**(8.5)**	**0.2**	**(17.4)**	**(17.3)**	**0.1**

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

Service Line Positions

- Whilst the overall position remains currently on track, there is significant variance in terms of Service Line financial performance
- Acute Care is now £1.8m overspent cumulatively as a result of acuity and external bed pressures. These are likely to be recurring pressures that require central actions to mitigate.
- CAMHS & ED is £1.6m underspent as continued recruitment slippages are greater than the CIP target
- Community is cumulatively £0.6m underspent. This is primarily the result of non-recurring vacancies partially offset by unachieved CIP targets
- Specialist Services is £0.7m underspent as vacancies continue to outweigh CIP non-achievement
- The Corporate deficit is largely caused by adverse positions within the Estates and HR functions. The in month position includes a Trust wide provision for the additional September bank holiday which will be paid in October.
- Following the revised plan submission in June, the forecast for the year remains one of break-even. There is significant risk in achieving this position as an improved profile is required during the remainder of the year to offset H1 deficits alongside the emergence of additional pressures

Financial Reports 2022/23	Current Month			YTD month 6			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Acute And Urgent Care	(4.6)	(5.0)	(0.3)	(24.0)	(25.8)	(1.8)	(47.1)	(51.1)	(4.0)
Camhs & Ed	(3.1)	(2.6)	0.5	(14.8)	(13.2)	1.6	(29.7)	(27.7)	2.0
Community (Adults)	(4.6)	(4.4)	0.2	(23.2)	(22.5)	0.6	(46.4)	(45.3)	1.0
Specialist Services	(3.3)	(3.0)	0.2	(15.9)	(15.3)	0.7	(31.7)	(31.0)	0.7
Corporate	17.1	16.4	(0.6)	85.2	84.0	(1.2)	172.2	172.3	0.1
Capital Costs	(1.5)	(1.4)	0.1	(8.7)	(8.5)	0.2	(17.4)	(17.3)	0.1
Total	**0.0**	**0.0**	**0.0**	**(1.4)**	**(1.4)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**

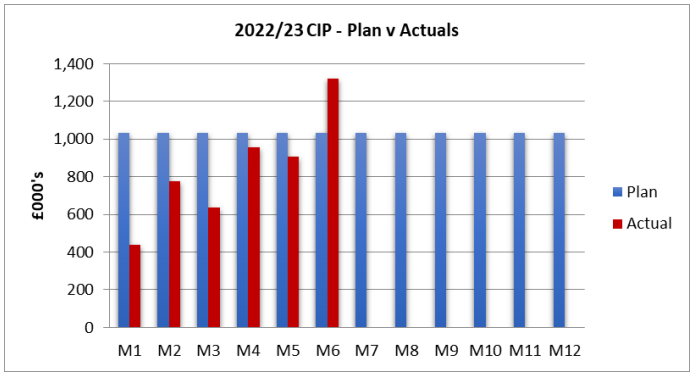
South West London and St George's Mental Health NHS Trust

Savings

- The Trust has a recurrent savings target of £12.4m (4.5%) to achieve the planned break-even position for 2022/23
- The savings target is phased equally across the year with a greater proportion of non-recurring schemes being achieved earlier in the year
- To date, £12.1m of the target has been identified (£11.7m last month). Of this, £7.3m is rated green
- Once risk adjusted values have been applied, expected delivery falls to £9.1m, leaving a £3.3m shortfall (£5.2m last month)
- This gives a 74% confidence level in delivery – the equivalent value for M6 last year was 61%
- In month delivery amounted to £1.3m against a target of £1.0m – a £0.3m positive movement in month
- Cumulative delivery now stands at £5.0m against a plan of £6.2m - £1.2m adverse
- A high proportion of savings delivered to date are non-recurrent
- The challenge facing the Trust remains to
  - Identify new schemes to close the £0.3m gap
  - Turn red and amber schemes to green, and,
  - To significantly reduce the reliance on non-recurrent schemes

Status	2022/23 £000's	Risk Level %	Expected £000's
Green - Rec	789	0%	789
Green - Non-Rec	6,540	0%	6,540
Amber	2,368	50%	1,184
Red	2,385	75%	596
Unidentified	304	100%	0
Total	**12,387**	**74%**	**9,110**

Gap	**-3,277**



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	1.7	1.1	0.5	10.4	8.1	2.3	21.9	21.9	0.0
Estates Maintenance	0.2	0.2	(0.1)	0.9	0.9	0.1	1.9	1.9	0.0
IT/Digital	0.2	0.2	(0.0)	1.0	1.0	(0.1)	2.0	2.0	0.0
Operational Total	2.0	1.5	0.4	12.3	10.0	2.3	25.8	25.8	0.0
Leases	0.0	0.0	0.0	15.4	15.4	0.0	15.4	16.0	(0.6)
Total Capital Expenditure	**2.0**	**1.5**	**0.4**	**27.7**	**25.5**	**2.3**	**41.2**	**41.7**	**(0.6)**

- The Trust is forecasting to spend £41.7m, including £16.0m on leases which are now shown on the balance sheet in line with the new IFRS 16 requirements. The forecast includes £0.6m for the lease transfer from ELFT associated with the Trust taking on the service provision of the Richmond Well Being service later in the year. Once this value has been confirmed the Trust will be seeking a CRL budget uplift to offset.

- Capital expenditure for the month is £1.5m; £25.5m YTD which is £2.3m below plan

- The Estates Modernisation Programme (EMP) is underspent by £2.3m year to date (£0.5m in the month) due to a delay in construction costs relating to the handover of one of the buildings at Springfield. 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 2022/23 plan for CRL is £45.8m and EFL is £34.4m, 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 September 2022	Actuals as at end September 2022	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	7.3	6.7	(0.7)
Plant, Property and Equipment	342.6	344.3	1.6
Receivables	26.7	26.7	0.0
Total Non-Current Assets	**376.7**	**377.7**	**1.0**
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	6.8	2.7	(4.1)
Other Financial Assets (Accrued Income)	2.4	2.6	0.2
Prepayments	0.0	1.6	1.6
Cash and Cash Equivalents	25.5	36.4	10.8
Total Current Assets	**34.9**	**43.4**	**8.5**
CURRENT LIABILITIES:			
Trade Payables	(33.2)	(9.8)	23.4
PDC Dividend Payable	(0.0)	(0.0)	0.0
Capital Payables	(29.1)	(27.4)	1.7
Provisions	(4.4)	(4.2)	0.2
Other Financial Liabilities (Accruals)	0.0	(31.3)	(31.3)
Deferred Revenue	(2.6)	(6.0)	(3.4)
Total amounts falling due within one year	**(69.3)**	**(78.7)**	**(9.4)**
NET CURRENT ASSETS/(LIABILITIES)	**(34.4)**	**(35.3)**	**(0.8)**
NON CURRENT LIABILITIES:			
Provision for Liabilities and Charges	(1.5)	(1.7)	(0.1)
Capital Payables	(5.2)	(5.2)	0.0
Borrowings	(99.4)	(99.4)	0.0
Total amounts falling due within after one year	**(106.1)**	**(106.2)**	**(0.1)**
TOTAL ASSETS EMPLOYED	**236.2**	**236.2**	**0.0**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	142.3	142.3	(0.0)
Retained Earnings (accumulated losses)	30.6	30.6	0.0
Retained Surplus(Deficit) in year	(1.4)	(1.4)	(0.0)
Revaluation Reserve	64.6	64.6	(0.0)
TOTAL TAXPAYERS EQUITY	**236.2**	**236.2**	**0.0**

- Receivables stand at £2.7m, which is £4.1m favourable to plan, and relates to more receipts owed to the Trust having been collected than expected in the plan. Prior year debtors account for £0.7m of the £2.7m.
- Cash is £36.4m, £10.8m more than plan, see next slide.
- Late receipt of invoices is resulting in a £23.4m favourable variance on Trade Payables offset by a £31.3m adverse variance on accruals.
- There are no further loan drawdowns due, with the loan remaining at £99.4m. There are no plans to repay any of the principal in 2022/23

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

Cash

All figures £k	Plan as at end September 2022	Actuals as at end September 2022	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	4,146	2,707	(1,438)
Non Cash Adjustments			
Depreciation and Amortisation	5,843	6,645	802
PDC Dividend	(2,571)	(1,135)	1,436
Interest Received	(6)	(206)	(200)
Interest Paid	0	(185)	(185)
(Increase)/Decrease in Inventories	0	0	0
Increase/(Decrease) in Working Capital	(616)	23	639
Net Cash Inflow/(Outflow) from Operating Activities	**6,796**	**7,849**	**1,053**
Cash Flows from Investing Activities			
Interest Received	6	206	200
(Payments) for Property, Plant and Equipment	(27,733)	(19,780)	7,953
Proceeds from sales of property, plant and equipment	0	0	0
Net Cash Inflow/(Outflow) from Investing Activities	**(27,727)**	**(19,574)**	**8,153**
Net Cash Inflow/(Outflow) before financing	**(20,931)**	**(11,725)**	**9,207**
Cash Flows from Financing Activities			
Interest element of finance lease	(390)	(185)	205
PDC dividend (paid)/refunded	(2,571)	(1,135)	1,436
Net Cash Inflow/(Outflow) from Financing Activities	**(2,961)**	**(1,320)**	**1,641**
Net Increase/(Decrease) In Cash And Cash Equivalents	**(23,892)**	**(13,045)**	**10,848**
Cash / Cash Equivalents at beginning of month	**49,403**	**49,403**	**0**
Cash / Cash Equivalents at end of month	**25,511**	**36,358**	**10,848**

- The cash balance at the end of the month was £36.4m compared with the plan of £25.5m.
- The increase of £10.8m relates to:
  - Capital spend, +£8.0m (of which £3.4m relates to the Care Home purchase provided for in 21/22)
  - Movements in working capital, +£1.1m
  - PDC Receivable,+£1.4m
  - Other £0.3m
- There are no further loan drawn downs due, with the full loan now drawn down to the value of £99.4m. There are no plans to repay any of the principal in 2022/23.

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

Monthly Cashflow

	April Actual £'000	May Actual £'000	June Actual £'000	July Actual £'000	August Actual £'000	September Actual £'000	October Forecast £'000	November Forecast £'000	December Forecast £'000	January Forecast £'000	February Forecast £'000	March Forecast £'000
Bank Balance b/f	47,403	39,183	38,463	38,827	35,842	34,822	36,358	36,807	36,344	32,455	28,429	26,116
Receipts												
SLA Income	18,230	18,615	19,986	20,901	17,659	20,058	20,057	20,035	20,035	20,035	20,035	20,369
Other NHS Income	2,111	1,035	2,816	861	609	6,864	1,622	778	778	778	778	824
Other income	584	337	327	455	2,469	86	566	250	250	250	250	260
Loans	-	-	-	-	-	-	-	-	-	-	-	-
PDC Income	-	-	-	-	-	-	-	-	-	-	-	250
Asset Sales	-	-	-	-	-	-	-	-	-	-	-	4,500
Total Receipts	**20,926**	**19,987**	**23,128**	**22,216**	**20,737**	**27,008**	**22,246**	**21,064**	**21,064**	**21,064**	**21,064**	**26,203**
Payments												
Payroll costs	(12,936)	(13,189)	(13,536)	(13,070)	(13,198)	(14,546)	(14,757)	(14,615)	(14,615)	(14,615)	(14,615)	(14,629)
Suppliers (Revenue)	(8,280)	(4,111)	(6,293)	(10,319)	(4,913)	(8,843)	(4,677)	(4,947)	(4,947)	(6,363)	(6,363)	(6,244)
Suppliers (Capital)	(1,254)	(562)	(1,572)	(557)	(2,719)	(621)	(399)	(324)	(325)	(325)	(326)	(326)
Suppliers (EMP)	(6,565)	(2,783)	(1,296)	(1,165)	(835)	(63)	(1,963)	(1,640)	(1,641)	(3,786)	(2,073)	(3,333)
Asset Purchases	-	-	-	-	-	-	-	-	(3,425)	-	-	-
Other Non Pay Costs	(110)	(63)	(67)	(89)	(93)	(78)	(0)	-	-	-	-	-
PDC Dividend	-	-	-	-	-	(1,135)	-	-	-	-	-	(4,007)
Loans & interest	-	-	-	-	-	(185)	-	-	-	-	-	(178)
Total Payments	**(29,145)**	**(20,707)**	**(22,764)**	**(25,201)**	**(21,757)**	**(25,471)**	**(21,797)**	**(21,526)**	**(24,953)**	**(25,089)**	**(23,377)**	**(28,716)**
Net Receipts/ (Payments)	**(8,220)**	**(721)**	**364**	**(2,985)**	**(1,020)**	**1,536**	**449**	**(463)**	**(3,890)**	**(4,026)**	**(2,313)**	**(2,512)**
Bank Balance c/f	**39,183**	**38,463**	**38,827**	**35,842**	**34,822**	**36,358**	**36,807**	**36,344**	**32,455**	**28,429**	**26,116**	**23,603**
10 Days Operating Expenses	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000
Difference	32,183	31,463	31,827	28,842	27,822	29,358	29,807	29,344	25,455	21,429	19,116	16,603

- A weekly cash flow for the next 13 weeks has been produced; this shows no weeks when the cash balance falls below the £7m threshold of 10 days operating expenses
- Cash balances are expected to be utilised to pay back the loan required for the hospital construction.

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

Solvency Dashboard

Solvency Tests	RAG	Comments	Criteria
Trading Position	G	The Trust delivered a deficit of £1.4m in the year to date compared to a planned deficit of £1.4m.	G : Forecast surplus in line with plan A : Forecast breakeven R : Trading at a loss
Net Current assets	R	The Trust has net current liabilities of £35.3m, with current assets of £43.4m and current liabilities of £78.7m. The plan was for net current liabilities of £34.4m.	G : Greater than £7m A : Positive net current assets R : Negative net current assets
Liquidity Ratio	G	Based on the forecast phasing of cash flow for the next 13 weeks , the Trust has no weeks below the 10 day operating expenses amount of £7m.	G : 13 week forecast always above 10 days operating expenses A : 13 week forecast always positive R : 13 week forecast is not always positive
Debtors Ageing	G	The level of non-current aged receivables was £1.6m at the end of September. It consists of £0.8m NHS and £0.8m of Non NHS organisations. The total current trade receivables not due is £1.1m making a total debtors position of £2.7m. Prior Year debt which was £6.0m was £0.7m up to the end of September, a reduction in the financial year of £5.3m.	Excluding (current) G : Less than £2m debts A : Greater than £2m debts but less than £4m debts R : Greater than £4m debts
Creditors Ageing	G	The Trust has £0m outstanding greater than 30 days, the less than 30 days balance is £0.6m, the majority of of which relates to non-NHS organisations, of which £0.2m relates to agencies, £0.1m relates to interpreting services and £0.1m capital.	Excluding less than 30 days (current) G : Less than £200k creditors A : Greater than £200k and less than £500k R : Greater than £500k
Legal claims against Trust (not covered by NHS Resolution)	G	The Trust has no outstanding legal claims not covered by NHS Resolution	G : Less than £100k A : Less than £500k R : Greater than £500k

Meeting	Trust Board
Date of Meeting:	10th November 2022
Report Title:	**Audit Committee Chair's Report**
Author:	Richard Flatman, Audit Committee Chair, Non-Executive Director
Purpose:	For report
Transparency	Public

The Audit Committee met on 25th October 2022. The Board is asked to note the following key points addressed at the meeting.

- **External audit**

The Committee received an update that the audit planning would commence in November and the bulk of the audit will be undertaken in the January to April period. The audit plan will be presented to the January audit committee.

- **Lessons Learnt Report**

The Committee heard that both KPMG and the Finance Team have met to thoroughly de-brief on last years audit and steps have been put in place to ensure the next audit is managed seamlessly.

- **Internal audit**

The Committee received and noted the progress report from RSM. Since the last meeting, 6 management actions (two high, two medium and two low) have been implemented and there are no overdue actions currently. The Committee received updates on two reports as follows:

- Capacity to Consent to Treatment, where reasonable assurance was received, and
- Data Security and Protection (DSP) where limited assurance was received.

The DSP assurance rating is disappointing. However, it is noted that the review process carried out by RSM is substantially different from TIAA. The difference in reporting outcome was only known in June at the time of report submission. In addition the Committee heard that multiple assertions hadn't been uploaded in all the different sections to confirm compliance as previous submissions allowed for duplication of section confirmations. Going forward the self assessment audit will be started earlier (in April) to allow for more in-depth cross-checking. The IA Lead agreed with the Director of Finance's explanation of the impact that the change in process and tight submission had on the outcome. The Committee heard that there is no underlying issue of compliance in this regard.

The Committee heard that the IA audit plan has been amended mid-year to allow for auditing of workforce aspects in recruitment, medical staffing and employee relations due to the ongoing changes within Workforce. These reviews have replaced planned work on EDI which will be conducted later than originally planned.

- **Counter Fraud**

The Committee received updates in regard to counter fraud, bribery training and changes to the induction training for new staff. In particular that three new referrals have been received and relate to allegations of working whilst sick and payroll mandate frauds. Four investigations have been closed and five investigations remain ongoing.

A single tender benchmarking audit has been completed and of the 55 companies that took part the Trust has been rated 5th overall and did well compared with other organisations in size and budget.

A query was raised concerning an invoicing mandate for fraud. The Trusts bank intercepted the payment as this had been subject to a sophisticated phishing scam. This has been resolved and the correct supplier has been paid. The learning from this has been embedded with training undertaken within the Finance, Procurement and EMP Teams.

- **Financial Accounts update**

The Committee received an update and the following was discussed:

EARP - To date the post-balance sheet event requirements have not identified anything necessary of report. There is no published date for final submissions as national guidance is awaited.
Car parking leasing income– This was approved and the Trust intends to receive the lease income in 2022/23.
Capitalised loan interest – This was approved for the EMP scheme. The accounting rules allow the capitalisation of borrowing costs that are directly attributable to the acquisition, construction, or production of a qualifying asset as they form part of the cost of the asset.
HCAS Overpayments – it has been identified that some staff have been incorrectly paid HCAS. A process has been agreed to rectify this and the outcome and value will be reported to Board when complete. In the meantime Chairs action from the Board chair will be sought to write off irrecoverable amounts and adjust salaries where necessary.

Other matters to report:

Committee:

- **Approved** the Detailed Scheme of Delegation, subject to the approval levels being amended.
- **Approved** the Charitable Funds Accounts.
- **Approved** the Board Assurance Framework and noted that a reduced version will be reviewed at the Board
- **Agreed** to write-offs the HCAS overpayments.
- Received the **QSAC minutes.**
- Received the **EMC minutes.**

RECOMMENDATIONS

The Board is asked to:

a. Note the contents of this report
b. Receive the approved minutes of the committee held on 20th July 2022

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

Audit Committee
Minutes of the meeting held via video-conference on Wednesday 20th July 2022, 14:00-16:30

Present:

Richard Flatman (RF)	Non-Executive Director (Chair)
Vik Sagar (VS)	Non-Executive Director, Chair of FPC

Attendees:

Vanessa Ford (VF)	Chief Executive
Philip Murray (PM)	Director of Finance & Performance
David Lee (DL)	Director of Corporate Governance
Debbie Hollinghurst (DH)	Deputy Director of Finance
Joanne Lees (JL)	External Audit – KPMG
Clive Makombera (CM)	Internal Audit – RSM (attended until 22/82)
Matt Wilson (MW)	Internal Audit - RSM
Ruth Goddard	Internal Audit – RSM
Nicola Mladenovic (NM)	Deputy Trust Secretary (Minutes)

Apologies

Doreen McCollin (DMc)	Non-Executive Director, representative from QSAC

Item		Action
22/72	**Welcome and Apologies** Apologies for absence were received and noted as above.	
22/73	**Declarations of Interest** No additional declarations of interest were reported for noting.	
22/74	**Chair's Action** No Chair's Action has been taken. However some additional days have been agreed for some counter fraud audits and Richard had discussed with Philip regarding the late submission of the annual accounts.	
22/75	**Minutes of the previous meeting** The minutes of the previous meeting held on 13th June 2022 were approved as a correct record subject to the following amendment to the Counter Fraud Workplan (22/63). 'Work will be carried out in regard to *detection* activity and the team will work jointly with internal audit team.'	
22/76	**Action Tracker/Matters Arising** The Committee received the action tracker and noted the following: **22/60 Internal Audit Recommendations** – updates have been received and this is on track **22/62 Counter Fraud** – updates are being received and an update will be available for the October meeting **22/64 – Board Assurance Framework**. DL confirmed that an update will come to the September Board. A draft of the revised BAF and risk appetite will be circulated on-line so that Audit Committee members will be able to input ahead of this coming to Board. Following the update from Board the risk targets are to be reviewed and updated.	
22/77	**External Audit**	

The Committee received a verbal update from JL and confirmed that a de-brief is scheduled to take place to learn from the recent audit and to confirm actions for subsequent years.

PM confirmed that although the reporting deadline was not met a key data return had been made by the deadline as required by NHSE. PM noted that the Value For Money opinion has been submitted at the same time as the main audit opinion and accounts 2 days after the deadline (many trusts had still not yet submitted the VFM opinion).

A Lessons Learnt review has been undertaken within the Finance Team and other contributors and this will support learning and actions going forward.

RF reported that the Board expressed disappointment that the reporting deadline was not met in full. RF requested that PM draft an update so the Board are briefed on the auditing background that led to the delays and the context (**Action PM)** **PM**

22/78 Internal Audit

The Committee received the Progress Report and highlighted the following:

- The Audit Plan 2022/23 was approved at the last meeting, since then the Data Security and Protection Toolkit draft report has been issued. This will be finalised and brought back to a future meeting.
- A change to the plan has been requested by NHS E/I whereby the Trust is required to undertake an audit into Improving NHS Financial Sustainability. This will take the form of a self-assessment that RSM will then review. This will be added to the Audit Plan and will replace the scheduled Payroll and Accounts Payable review.
- Follow Up – since the last meeting 13 actions (6 medium and 7 low) have been implemented, 5 actions (2 high and 3 medium) are overdue and in progress. Since the report has been published the physical health monitoring action has been received so this leaves 4 actions still outstanding none of which are overdue.
- The assurance map has been started and the development is on-going with NM. When complete this will be reported to a future Committee meeting.

Through discussion the Committee asked if there were any early concerns for the Data Security and Protection Toolkit. CM confirmed that some areas had different weighting applied; this can cause issues that have had been flagged to NHS Digital. RSM can apply discretion where there is sufficient evidence and it was agreed that a meeting between RSM and John Hughes would take place.

The additional audit into Financial Sustainability is a national requirement and will cover 8 areas incl CIPs, financial planning and budgetary requirements. This will be broad ranging and evidence to meet the requirements will be required. CM confirmed that RSM will link with KPMG as there is some over lap.

The report details a new data strategy to drive innovation and improve efficiency. CM confirmed this is planned to be included in the work with IT.

A report was received on Cyber Security. This is an increasing pressure and NHS organisations are requested to consider this in terms of best practice, to look at vulnerable areas and implement plans to ameliorate this. It was reported that some organisations have taken out their own cyber insurance however NHS

organisations are actively discouraged in taking out separate independent cyber insurance. PM confirmed that NHS Resolutions offer Business Continuity insurance but further confirmation is required to see if this would be suitable in maintaining a service provision in the event of a cyber attack. With the implementation of increased homeworking further awareness is required. PM re-assured the Committee that daily back-up and reports are provided to the Trust by the third providers of IAPTus and RiO, the patient record system and this would support in the eventuality of there being a cyber attack. The Trust manages the electronic prescribing management (EPMA) system only however extracts of EPMA are added to the patient record system. It was also noted that a RSM audit in this area is planned for later in the year.

The Committee received two papers for noting; the NHS News Briefing and the Health Matters virtual workshop for ICS collaboration at place.

The following were noted:

- Noted the Progress Report.
- Requested the rolling three-year Audit Plan is appended to future reports.
- The Committee approved the changes to the Internal Audit Plan.

22/79 Counter Fraud Report

The Committee received the update on the Counter Fraud progress report and the following points were highlighted:

- Five referrals have now been received and relate to mandate fraud and NHS attacks on email accounts/making changes to account domains. Training is provided in this area however staff require refreshers to remain alert to these types of attacks.
- Three induction sessions have taken place since the last report.
- Through a proactive exercise an analysis of pharmaceutical companies by the Association of the British Pharmaceutical Industry (ABPI) has been undertaken. According to the register there are eight payments/benefits in kind (£4,950.36) against healthcare professionals and six payments/benefits in kind (£7,565.48) against the healthcare organisation that have not been declared in line with the Conflicts of Interest Policy. The non-declaration is in line with other organisations and the Committee Chair asked how further communication and learning can be shared. It was agreed that this could form part of the induction learning. It was confirmed that eight staff members received funds. In addition it was considered if the payments to the organisation were equipment donations, training places or donations of food to a certain value.

<u>Reactive Benchmarking</u>

- The report details the number of referrals from mental health trusts since 2020/21 to 2021/22. The report shows two referrals received each year, by source and includes some case studies.
- Year to date five referrals have been received and this is indicative of a greater awareness across the organisation.

The Committee noted the reports.

22/80 Annual Accounts Progress Update

The Committee received the final versions of the reports; ISA 260, Auditors Annual Report and the signed Letter of Representation. The following points were highlighted:

- The final accounts were submitted slightly later however NHS E/I have not imposed any penalties for the late submission.
- The Value for Money assessment was concluded and was rated GREEN. This has been uploaded.
- The Annual Report and Accounts are not usually uploaded on the Trust website until September however as the Annual Public Meeting is being held on 21st July 202 they have been uploaded to the website.
- The post balance sheet (EARP) event requirements have not been received yet. Should there be any updates received these will be brought to the attention of the Committee Chair.
- The IFRS 16 accounts note was amended; the change relates to start dates on leases and the transition arrangements.
- The Scheme of Delegation has not been amended. It was agreed that this would be extended to September and this will be reviewed at the October Committee meeting. **DL**
- Financial Sustainability Assessment will be added to the Internal Audit Plan as this is a request from NHS E/I.
- Charitable Funds Independent Assessment – as the charity is below the £250,000 threshold that would require a statement audit, there is only a requirement for an independent examination process to be followed. It was agreed that GSM would remain as the independent examiner for the Charitable Fund.

The Committee agreed the:

1. **Extension to the Audit Plan to include the Financial Sustainability assessment.**
2. **Extension to the Scheme of Delegation and SFIs as this will come to the October meeting.**
3. **Re-appoint GSM as the independent examiners.**

22/81 Debtors Report

The Committee received the Debtors Report and the following point was highlighted:

- £3,064 is to be written off, this is in relation to the Bank Holiday unsocial hours enhancements for the period January 2022 to 30 June 2022.

The Committee agreed to this debt being written off; £3,064 works out at £17 per affected employee and staff are not to be pursued to repay this amount as it was due to a software glitch. This error has now been corrected.

The Committee noted the report and approved the write-off whilst pursuing the staff contributions.

22/82 Waivers Report

The Committee received the Waivers Report and the following points were highlighted:

- Since the last report there has been one tender waiver for £110,000 and this relates to the MICAD tender waiver, this system is a computer aided facilities management system.
- Since the last report there have been 17 quotation waivers with a total value of £342,032. These waivers cover a period of four months and straddle two financial years with nine in March 2021/22 and eight in 2022/23.

The Committee noted the report.

22/83 Losses and Special Payments

The Committee received the Losses and Special Payments report. The following points were highlighted:

- In this period there have been 19 losses totalling £6,998. Within this there were five pieces of lost equipment from the HR Team. Steps have been taken to change the pin codes for the department and main door.
- There are no new losses above the £2,000 threshold requiring approval.

The Committee raised a previous item regarding a fallen tree at the Barnes site as this damaged the property of a neighbour during the storm. The costs for insurance purposes comes to £2,400. The Committee agreed to the costs for the damage to the neighbours property.

The Committee noted the report.

22/84 Salary Overpayments

The Committee received the Salary Overpayments report. The following points were highlighted:

- In 2022/23 there have been 26 instances of overpayments totalling £20k, compared to overpayments in previous years for £120k. More prompt/force functions have been put in place whereby managers need to confirm they have read the required statement.

VF confirmed that the processes will be put in place following further breaches. This will take the form that the line manager will be subject to formal discussions to make them aware of their financial responsibilities.

The Committee noted the report.

22/85 Policy Update - Anti-Fraud, Bribery and Corruption Policy

The Committee received the Anti-Fraud, Bribery and Corruption Policy.

The main changes are:

- Removal of specific names and contact numbers for LCF specialists in the main body of the policy (they remain in appendix 2) and replaced with where this information can be found, thus ensuring it is always up to date (page 6)
- Inclusion of the role of the Trust, the Trust Board, and the Audit Committee and amendments to the role of the Chief Executive and Director of Finance (pages 8-9)
- Inclusion of the responsibilities of external parties (page 12)
- Statement that individuals must not communicate with a third party about a suspected fraud (page 12)
- Clarification of section 7 of the Bribery Act 2010 and how the Trust can defend itself through having adequate procedures in place and regularly undertake risk assessments (page 12-13)
- Section 11 – Monitoring Compliance and Effectiveness (page 15) has been revised

The Committee approved the policy.

22/86 Committee Workplan

The Committee received the workplan, however some columns were missed off due to a formatting error. This is to be brought back to the next committee.

Self Certification is to be moved from the External Auditors section and included in the self-review against the NHS Counter Fraud Authority. (NHS CFA). Where there is a reference to TIAA this is to be amended to RSM. (**Action: NM** to re-format, update and add to diligent). **NM**

22/87 QSAC minutes

The Committee received and noted the meeting notes from QSAC for May and June 2022.

22/88 EMC Minutes

The Committee received and noted the meeting notes from EMC for May 2022.

22/89 Matters to Report to the Board

The following items are to be reported to the Board:

- Key matters from the financial accounts update
- Internal Audit progress report
- Changes to the IA Annua Plan – review sustainability
- Anti-Fraud, Bribery and Corruption Policy - approved
- Re-appoint GSM as Charitable Fund internal assessors
- Extend the Scheme of Delegation and Standing Financial Orders
- To report the agreement of the none pursuance of the £3k salary overpayment

22/90 AOB

VF raised a question if there are any audits that are required to ensure the Estates Integrated programme has assured the Committee. It was agreed that the Lessons Learnt update should be highlighted and this should come through a post-project review and should be received at the other committees.

22/91 Date of Next Meeting

The next meeting is scheduled to take place on 25th October 2022

Meeting	Trust Board as Corporate Trustee
Date of meeting:	10th November 2022
Report title:	**Charitable Funds Committee Chair's Report**
Author:	Doreen McCollin, Committee Chair
Executive sponsor:	N/A
Purpose:	For decision and for report

The committee met on 31st October. The main items considered were as follows

CHARITABLE FUNDS ANNUAL REPORT AND ACCOUNTS
These had already been scrutinised by the Audit Committee. The committee agreed to recommend the approval of the annual report and accounts by the corporate trustee.

The committee also received

- **Charitable Funds Finance Report year to date**

The committee noted that there is a balance of £67,109 as at 30 September 2022. The majority, £48,490, of this relates to unrestricted funds. Since April 2022, the Charity has received £3,648 of which £500 related to investment income and £3,148 came from direct donations. This was offset by expenditure of £9,456. The majority, £5,452, was on patients' comforts, £2,252 on staff other, £1,056 on patients' furniture, £492 on patients' social groups/functions and of £204 bank charges. This results in a net outflow of £5,808.

Since September, the Charitable Funds have received £29,021 from the wind up of the Friends of Surbiton and Tolworth Health Community. Ann Beasley has formally written to the Friends to sincerely thank them for this. . These funds will be put into a separate restricted fund and reported as part of the next financial update to the committee. Some of this funding will be used for a project to improve the Kingston Memory Clinic at Tolworth.

The committee also noted a report on the expenditure of the £32,000 from NHS Charities Together, originally received in 2020.

- **Charity implementation plan working group update**

It was noted that the Charity Working Group had paused to allow focus on the moves to the new buildings. The pause will now need to be extended until the end of the calendar year due to the building delays. However, activity has not stopped completely. CAF Donate is now the online fundraising platform for the Trust Charity,

although the Trust's page is due to be upgraded to reflect a conventional donation page, but people can make donations here.

The team will continue to work on the following priorities:

- Monitoring and closing out projects already allocated NHS Charities Together funding by March 2023.
- Streamlining unrestricted charity accounts, identifying budget holders and ensuring budget holders are aware of their charity balances.
- Submit a bid for £30,000 funding via the NHS Charities Together Development Grant Programme by 30th December 2022.
- Develop a bid for £55,000 funding via the NHS Charities Together Stage 3 Covid Recovery Grant.

Information items

In addition, the committee received for information

- the annual report and accounts of Momark (formerly the Friends of Springfield Hospital)
- a legal briefing note on the Charities Act 2022 and the recent high court judgement on responsible investment

RECOMMENDATIONS

The Board, as corporate trustee, is asked to

1) formally adopt the appended annual report and accounts of the Trust's Charitable Funds, including the Independent Examiner's Report.
2) note this report

KEY IMPLICATIONS

Outlined below is the key implications which may result from the proposals or information contained within this report

Assurance/Governance:	Positive - Need for the Audit Committee to formally meet to discuss and recommend the submission of the Charity's 2021/22 accounts, including the independent examiners report.
Clinical:	n/a
Equality and Diversity:	n/a
Estates:	n/a
Financial:	Positive - To report to the Committee the financial reserves available to the Charity.
Legal:	Positive - To ensure compliance with the relevant statutory final accounts' duties, in line with the Charities Act 2011, the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.
Quality:	n/a
Reputation:	n/a
Strategy:	n/a
Workforce:	n/a

NOVEMBER 2022 BOARD

APPENDIX TO EQUALITY AND DIVERSITY COMMITTEE CHAIR'S REPORT

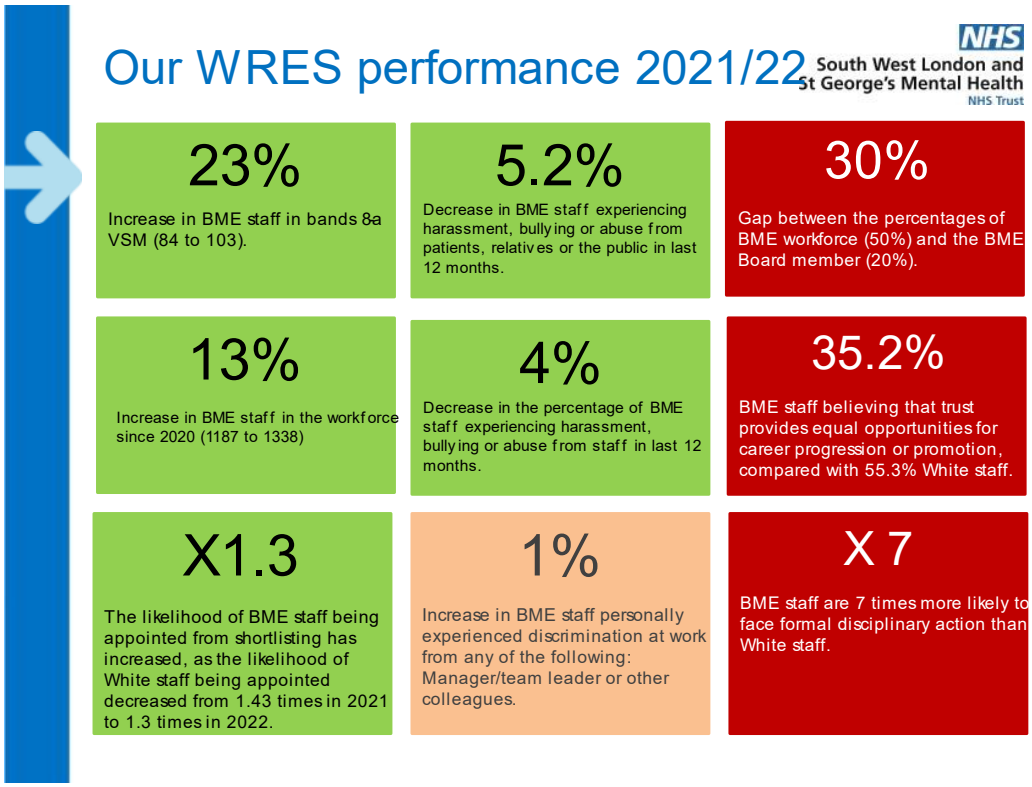
ANNUAL REPORTS AND ACTION PLANS :

a) **WORKFORCE RACE EQUALITY STANDARD (WRES)**
b) **WORKFORCE DISABILITY EQUALITY STANDARD (WDES)**

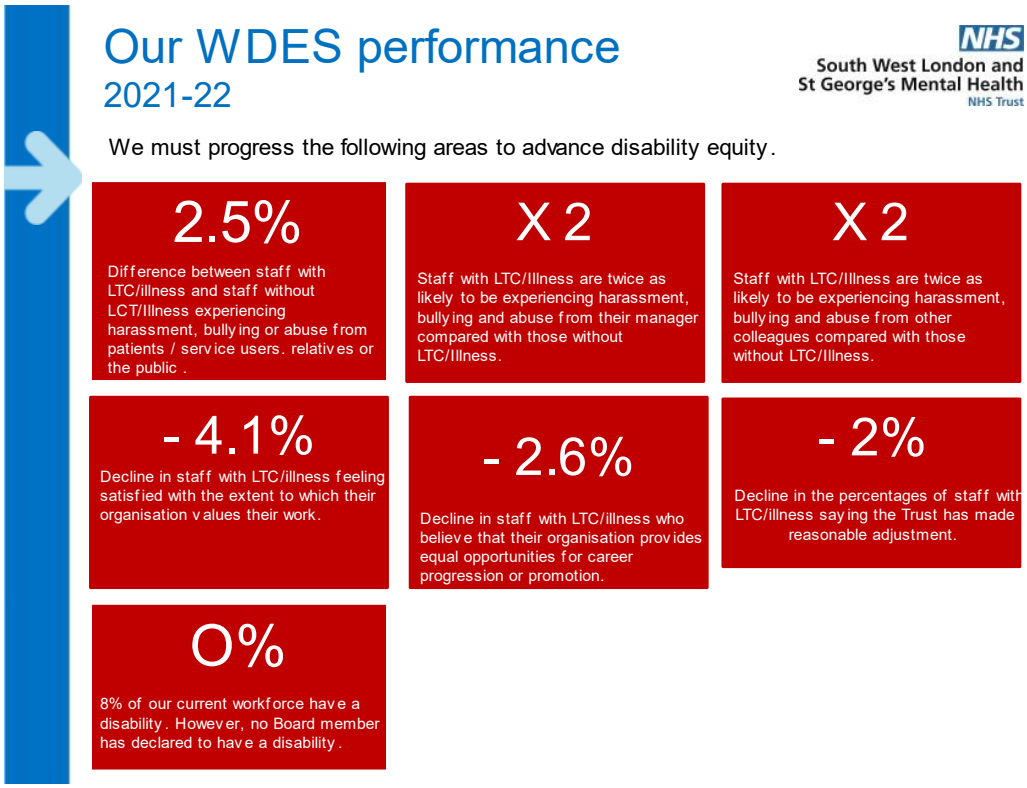
The September Board agreed that sign off for the Trust's WRES and WDES reports would be delegated. These reports were considered and approved by the October EDC meeting, links to the full reports, including comprehensive action plans, as published on the Trust website are provided below
WRES Report 2021 22 final141022EDC (swlstg.nhs.uk)
WDES Report 2021 22 Final 141022EDC (swlstg.nhs.uk)

Workforce race equality standard (WRES)
Becoming a genuinely anti-racist organisation by advancing race equity is an unwavering commitment of the Trust. The WRES is crucial as part of our "towards anti-racism" initiative.

The report highlights the fact that the majority of Trust staff (51%) are now from black and minority ethnic communities. This compares with the population of our five boroughs which has 29% from black and minority ethnic communities.



Workforce disability equality standard



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

Annual Report and Financial Statements

31 March 2022

Registered Charity No. 1060944

Legal and Administrative Information

South West London and St George's Mental Health NHS Trust Charitable Fund (The Charity) is a registered Charity (registered number 1060944) with the Charity Commission, the Board of South West London and St George's Mental Health NHS Trust (the Trust) being the Corporate Trustee.

The Charity was registered in the name of South West London and St George's Mental Health NHS Trust Charitable Fund on 25 February 1997. Prior to this, the declaration of trust as a Special Purposes Charity was made on 1st August 1996 to Pathfinder NHS Trust Endowment Fund.

The Charity is managed under delegated authority by a Charitable Funds Committee (The Committee), which provide detailed scrutiny of the Charity. The Committee also make appropriate recommendations to the Trust Board in their position as Corporate Trustees. The Committee has formal contacts with our external auditors/independent examiners.

The Charity produces its Trustees' annual report as a dual purpose document so that the annual report can be distributed with the accounts or as a freestanding document. Therefore, the Charity includes summary financial statements in its annual report.

Our Trustees

The Trustees are responsible for deciding policy and ensuring that it is implemented. There is a scheme of delegation to fund managers or senior managers in the Trust.

The Trustees give of their time freely and do not receive any pay, emoluments or other financial benefit. Whilst the Trustees are not paid for their time, they can claim expenses, details of which are disclosed in the accounts (note 12). For 2021/22 no expenses were claimed.

During the year, the following Trustees held office:

Trustee name	**Office (if any)**	**Dates acted if not for whole year**
Ann Beasley	Chair	
Vanessa Ford	Chief Executive	
Philip Murray	Director of Finance and Performance	
Sharon Spain	Director of Nursing and Quality Standards	
Dr Billy Boland	Medical Director	
Jennifer Allan	Chief Operating Officer	
Amy Scammell	Director of Strategy and Commercial Development	
Richard Flatman	Non-Executive Director	
Jean Daintith	Non-Executive Director	1 April to 19 November 2021
Sola Afuape	Non-Executive Director	
Juliet Armstrong	Non-Executive Director	
Vikas Sagar	Non-Executive Director	
Doreen McCollin	Non-Executive Director	
Deborah Bowman	Non-Executive Director	

Trustees are required to disclose all relevant interests and register them with the trust fund director and withdraw from decisions where a conflict of interest arises. All related party transactions are disclosed in the accounts (note 3).

Our staff

The Charity does not have any employees of its own. The Charity's administration and finances are managed by the employees of the Trust, the cost of which is recharged to the Charity, on the basis of the estimated time spent administering the Charity's finance. For 2021/22 accounts the Charity was charged £10,000 (2020/21 £10,000).

Our advisors

Investment Managers
CCLA Fund Managers Limited
Senator House
85 Queen Victoria Street
London
EC4V 4ET

Independent Examiners
Griffin Stone Moscrop & Co
21-27 Lamb's Conduit Street
London
WC1N 3GS

Internal Auditors
TIAA Ltd
53-55 Gosport Business Centre
Aerodrome Road
Gosport
PO13 0FQ

Legal Advisors
Capsticks Solicitors
1 St.George's Road
Wimbledon
London
SW19 4DR

Bankers
Lloyds Bank
125 Balham High Road
London
SW12 9AT

The Charity office and principal address of South West London and St George's Mental Health NHS Trust Charitable Fund is:

South West London and St George's Mental Health NHS Trust Charitable Fund
Trinity Building
Springfield University Hospital
15 Springfield Drive
Tooting
London
SW17 0YF

Tel: 020 3513 5000

Trustees' Annual Report

Foreword by the Chair of Trustees of the South West London and St George's Mental Health NHS Trust Charitable Fund.

Welcome to our annual report for 2021/22. We are the corporate Trustees of South West London and St George's Mental Health NHS Trust Charitable Fund.

1. We exist to provide resources and facilities to meet the needs of patients and staff of South West London and St George's Mental Health NHS Trust. I am delighted to be reviewing another year where we raised additional funds and provided grants to support patients in order to accelerate their recovery and to integrate them to the wider community. We will continue to have as our aim, to raise more funds in order to support the needs of our patients and staff and in order to fulfil our charitable objectives through our close partnership with South West London and St George's Mental Health NHS Trust. This partnership is the key to our success and continues to go from strength to strength.

2. Funds raised by the Charity itself in 2021/22 helped fund £3,017 on new blinds for patient areas, £6,577 on patients' social activities, £1,179 on patient Christmas parties and decorations, £1,000 on staff survey prizes and £422 on sports and entertainment equipment for patients.

3. I would like to thank the volunteers who fundraise and help us, my fellow trustees, and the volunteers who work alongside the professional staff of the South West London and St George's Mental Health NHS Trust.

4. I hope that like me you will be inspired by our plans to help patients and staff and want to continue to be a part of our story. If you would like to donate, you may do so via the Charity's webpage or as an employee through the Trust's Give As You Earn (GAYE). Please support us, every generous gift makes a difference.

Ann Beasley

Date:

What we aim to do: our objectives and activities

Our Objectives

The Charity's objectives are to improve the welfare of patients and staff at South West London and St George's Mental Health NHS Trust both in hospital and community services.

Our mission

Our key aim is to serve the NHS patients of the Trust for the public benefit. By working with the NHS, we assist patients from every walk of life, irrespective of race, creed, ethnicity or personal or family financial circumstances. We put this aim into practice in a variety of ways which help the patients, such as:

- Funding for away day activities
- Funding for basic new furniture and equipment when they move into a new accommodation
- Investing in people and creating a caring environment for the patients receiving care
- Providing direct support to patients by way of information and networking support
- Improving facilities and providing small grants

What we have achieved: highlights from the activities undertaken in the year

By raising new funds and through careful management of our existing funds, the Charity was able to make small grants to various activities initiated by both staff and patients. These activities included, away days, Christmas lunches and small Christmas gifts for patients. For staff, expenditure concentrated on areas that supported health and wellbeing and improving the work environment.

Grants and expenditures are made in accordance with charity law, our constitution and the wishes and directions of donors. In making grants and expenditures, we endeavour to reflect the wishes of patients and staff by directing funds towards areas they tell us are most in need.

During the year 2021/22, grants and expenditure on patients totalling £6,988 were made and £2,790 was spent on staff welfare. In addition, there was a £5,000 contribution to Hospital Rooms (a registered charity specialising in site specific artwork for hospitals). Hospital Rooms is engaging artists to lead more than 80 art workshops with patients and staff which will inform the artworks for the new buildings at Springfield. Our future plans are to raise our level of income through fundraising by organising different events to achieve higher levels of income so that we can support more activities our patients and staff enjoy doing.

How we funded our work, our achievements and performance

The following figures are taken from the full accounts which have been approved by an independent examination report.

The Charity can only continue to support future activities if more donations or funds are raised. Almost all of our income comes from direct donations and dividend/interest income from fixed investments.

Money received: where we got our money from

Total income received was £8,190 (2020/21: £120,568). The main sources of income were donations from individuals amounting to £4,500 and corporate donations of £2,750. A further £940 was earned from investment in the form of dividends and interest. The main movement between 2020/21 and 2021/22 was the £100k received from NHS Charities Together in 2020/21. Further tranches of funding from this source will be available in 2022/23, which the charity will bid for.

Money spent: what we spent the money on

Our charitable work was mainly concentrated on the following areas:

- **Patients' comfort, recreation, functions, training and other activities.** We spent £6,988

in supporting our patients on various items and activities which contributes to their wellbeing and comfort and future development.

- **Staff welfare.** We spent £2,790 on initiatives to support the staff that care for patients, providing wellbeing opportunities paid for by the Charity.

The Trustees continue to explore initiatives for funding that will benefit both patients and staff, whilst also progressing alternative sources of income.

Performance against objectives

The Trustees are now looking at a more structured way of raising funds which includes various fundraising activities initiated both by staff and the Trust's Board members. The expenditure will also increase in line with the income generated for good causes. The Trustees will devise measures to monitor the progress of the new initiatives and objectives and performance criteria in months to come. During 2021/22 there has been limited opportunity to develop the charity with Trust focus being on the construction of new hospital buildings at Springfield which will transform the wider Trust site into a mixed-use community area including brand new housing, public park and investment in local transport links as well as providing world class care facilities for our patients. Following the move into the new buildings in 2022/23 there will be renewed impetus put into both fund raising and spending existing funds for the benefit of patients and staff to capitalize on these excellent facilities.

Our reserves policy

The policy is that the funds must be spent for the purposes for which they were received. Funds should not be accumulated, unless for a specific purpose, and should be spent promptly.

- **General funds** – these funds are received by the Charity with no preference on how they are spent expressed by donors. Grants or funding to various small projects are made as and when it is needed. Representatives from the clinical or corporate services make applications to the Trustees expressing a clear aim for the application and how the funding will benefit patients and how much is required. The bid is then considered by the Committee for a decision. Funding is particularly targeted on projects in areas of the hospital that do not have available designated funds to assist them.

- **Designated non restricted funds** – these funds are for a specific part of the hospital or activity nominated for support by the donor. They are overseen by fund holders who can make decisions on how to spend the money within their delegated responsibility and within the designated conditions of the fund. Fund holders are actively encouraged to draw on the fund for the benefit of patients and staff.

- **Restricted funds** – these are funds which are restricted by the donors as to where it can be spent. These funds were transferred from Epsom and St Helier NHS Trust which previously managed the Sutton Mental Health Services. Many of these funds have been dormant but recently there has been active encouragement for fund holders to use the funds.

Our financial health: a strong balance sheet

The net assets and fund balances are stated below and show a decreased level of funds compared to last year due to the donations from NHS Charities Together being spent on activities that benefited both patients and staff

	2022 £'000	**2021 £'000**
Fixed Asset Investments	37	39
Net Current Assets	36	55
Total Net Assets	**73**	**94**
Restricted Income Funds	18	18
Unrestricted Income Funds	55	76
Total Funds	**73**	**94**

About our investments

Investment is managed by CCLA Fund Managers Ltd. The investments are in the form of COIF Charities Investment fund, the Fixed Interest fund and the Deposit fund. Dividends are paid to the Charity's separate bank account on a quarterly basis. Investment reports are provided by CCLA on a quarterly basis, when it is reviewed to determine any change needed. Investments are sold whenever it is needed in order to meet the expenditure requirements.

During the year, the total return, including dividends and interest was £940. During the year, the Trustees reviewed the investment policy to support the intention to invest ethically and to ensure that funds were not used to support businesses that conflict with the aims of the Charity or its supporters.

Risk management

As part of their business planning exercise carried out during the year, the Trustees have considered the major risks to which the Charity is exposed. They have reviewed systems and identified steps to mitigate those risks. Two major risks have been identified and arrangements have been put in place to mitigate those risks.

- **Future levels of income –** The Charity is reliant on donations to allow it to make grants/expenditure to patients or staff. If income falls, then the Charity would not be able to make as many grants/expenditure or enter into longer term commitments to support the patients. The Trustees have put in place plans to mitigate the risk that income will fall by engaging with various organisations including the League of Friends and NHS Charities Together, by engaging with fresh bidding rounds for funds and working with departments within the hospital in order to raise the profile of the Charity and to increase fundraising activities.

- **Fall in investment returns –** The Charity generates additional income from investing its cash balances. The Trustees consider the loss of investment income to be a financial risk. The risk is mitigated by retaining expert investment managers, having a diversified investment portfolio, and regularly reviewing that portfolio. The Trustees make use of benchmarking information when reviewing the portfolio.

Related parties

The Charity works closely with and provides the majority of its grants and expenditure on patients and staff at the Trust.

Our relationship with the wider community

The ability of the Charity to continue its vital support for patients is dependent on its ability to maintain and increase donations from the general public. We continue to forge strong relationships with members of staff of the Trust, without their co-operation, the ability to make an effective contribution would be much diminished.

Acknowledgements

The Trustees would like to pay tribute to:

- Our volunteers for their time, support, and commitment

- The members of staff who give their time out of hours in support of the work on the committees, in developing ideas and working with us to identify how we can help our patients

- Our fundraisers who do so much to encourage others to enrich the lives of others through donations and fundraising activities.

Signed on behalf of the Trustees:

Ann Beasley Date:

Statement of Trustees' responsibilities in respect of the Trustees' annual report and accounts

Under charity law, the Trustees are responsible for preparing the Trustees' annual report and accounts for each financial year which show a true and fair view of the state of affairs of the Charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice requires that the Trustees:

- Select suitable accounting policies and then apply them consistently
- Make judgments and estimates that are reasonable and prudent
- State whether the recommendations of the Statement of Recommended Practice (SORP) have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue its activities.

The Trustees are required to act in accordance with the trust deed and the rules of the Charity, within the framework of trust law. The Trustees are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the Charity at that time, and to enable the Trustees to ensure that, where any statements of accounts are prepared by the Trustees under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. The Trustees have general responsibility for taking such steps as are reasonably open to the Trustees to safeguard the assets of the Charity and to prevent and detect fraud and other irregularities.

Signed on behalf of the Trustees:

Ann Beasley

Date:

Statement of Financial Activities for the year ending 31 March 2022

	Note	Unrestricted Funds	Restricted Funds	Total Funds 2022	Total Funds 2021
		£'000	£'000	£'000	£'000
Income and endowments from:					
Donations and legacies	4	7		7	119
Charitable activities		-	-	-	-
Other trading activities	5	-	-	-	-
Investments	6	1	-	1	2
Total incoming resources		**8**	**-**	**8**	**121**
Expenditure on:					
Charitable activities	8				
· Admin and Audit fees		(12)	-	(12)	(12)
· Patients comfort & other		(12)	-	(12)	(35)
· Staff welfare		(3)	-	(3)	(34)
		(27)	-	(27)	(81)
Total expenditure		**(22)**	**-**	**(22)**	**(81)**
Net gains/(losses) on investments	15	(2)	-	**(2)**	
Net income/(expenditure)		**(21)**	**-**	**(21)**	**40**
Transfers between funds					
Net Movement in funds		**(21)**	**-**	**(21)**	**40**
Reconciliation of Funds					
Total Funds brought forward	20	76	18	94	54
Total Funds carried forward	20	**55**	**18**	**73**	**94**

Balance Sheet as at 31 March 2022

	Note	Unrestricted Funds	Restricted Funds	Total Funds 2022	Total Funds 2021
		£'000	£'000	£'000	£'000
Fixed assets:					
Investments	15	21	16	37	39
Total Fixed Assets		**23**	**16**	**39**	**39**
Current assets:					
Debtors	16	0	-	0	0
Cash and cash equivalents	17	44	2	46	179
Total Current Assets		**44**	**2**	**46**	**179**
Liabilities:					
Creditors falling due within one year	18	(10)	-	(10)	(124)
Net Current assets/(liabilities)		**34**	**2**	**36**	**55**
Total assets less current liabilities		55	18	73	94
Creditors falling due after more than one year	18	0	0	0	
Total net assets or liabilities		**55**	**18**	**73**	**94**
The funds of the charity:	20				
Restricted income funds		-	18	18	18
Unrestricted income funds		55	-	55	76
Total charity funds		**55**	**18**	**73**	**94**

The Trustees have not required the Charity to obtain an audit of its accounts for the year in question. The Trustees acknowledge their responsibilities for complying with the requirements of the Act with respect to accounting records and the preparation of accounts. These accounts have been prepared in accordance with the provisions subject to the small entities' regime.

The notes at pages 11 to 19 form part of these accounts

Signed:

Ann Beasley

Date:

Statement of Cash Flows for the year ending 31 March 2022

	Note	Total funds 2022 £'000	Total funds 2021 £'000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	19	(134)	143
Cash flows from investing activities:			
Dividends, interest and rents from investments	6	1	2
Proceeds from the sale of investments	19	-	-
Purchase of investments	19	-	-
Net cash provided by (used in) investing activities		1	2
Change in cash and cash equivalents in the reporting period		(133)	145
Cash and cash equivalents at the beginning of the reporting period	17	179	34
Cash and cash equivalents at the end of the reporting period	**17**	**46**	**179**

Notes on the accounts

1. Accounting Policies

(a) Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

(b) Reconciliation with previous generally accepted accounting practice

In preparing these accounts, the Trustees have considered whether any restatement of comparatives was required to comply with FRS 102 and the Charities SORP FRS 102.

(c) Cash and cash equivalents

These are cash held in hand and in the current bank account.

(d) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- A restricted fund or
- An endowment fund

The Charity does not have an endowment fund.

Those funds which are neither endowment nor restricted income funds, are unrestricted income funds. These are sub-analysed between earmarked funds, where the Trustee has set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and those that are at the Trustee's discretion, including the general fund which represents the Charity's reserves. The major funds held in each of these categories are disclosed in note 20.

(e) Incoming resources

All incoming resources are recognised once the Charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point.

Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

(f) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the

legacy and
- All conditions attached to the legacy have been fulfilled or are within the Charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

(g) Incoming resources from endowment funds

The Charity does not have any endowment funds.

(h) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(i) Recognition of expenditure and associated liabilities as a result of grant

Grants payable are payments made to patients of the Trust in accordance with the charitable objectives of the funds held on trust, primarily relief of those who are mentally not well.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant
- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant
- There is an established pattern of practice which indicates to the recipient that we will honour our commitment.

The Trustees have control over the amount and timing of grant payments and consequently where approval has been given by the Trustees and any of the above criteria have been met then a liability is recognised. Grants are not usually awarded with conditions attached. However, when they are then those conditions have to be met before the liability is recognised.

Where an intention has not been communicated, then no expenditure is recognised, but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met, then no liability is recognised, but a contingent liability is disclosed.

(j) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, internal and external audit costs and IT support. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 11.

(k) Fundraising costs

There were no fundraising costs incurred in 2021/22.

(l) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objectives

of the Charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 8.

(m) Fixed asset investments

Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair value (market value) as at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the Balance Sheet at the current market value quoted by the investment analyst, excluding dividend. Other investments are included at the Trustees' best estimate of market value.

The main form of financial risk faced by the Charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk, and changes in sentiment concerning equities and within particular sectors or sub sectors. Further information on the Charities fund investments can be found in note 15.

(n) Debtors

Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

(o) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due.

(p) Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long-term creditors. The Charity does not have long term creditors.

(q) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

(r) Pensions

The Charity does not have directly employed staff. The staff who run the Charity are employees of the Trust.

(s) Going concern

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the Charity are a fall in income from donations or investment income but the Trustees have arrangements in place to mitigate those risks (see the risk analysis sections of the annual report for more information).

2. Prior year comparatives by type of fund

	Unrestricted Funds	Restricted Funds	Total Funds 2021
	£	£	£
Income and endowments from:			
Donations and legacies	119		119
Investments	1	1	2
Total incoming resources	**120**	**1**	**121**
Expenditure on:			
Charitable activities			
• Admin and Audit fees	(13)	-	(13)
• Patients comfort & other	(34)	-	(34)
Other			
• Staff welfare	(34)	-	(34)
Total expenditure	**(81)**	**0**	**(81)**

3. Related party transactions

One of the charity's Trustees is also the Chair of Hospital Rooms, which has provided painting workshops as part of the Trust's integrated programme. Hospital Rooms is engaging artists to lead more than 80 art workshops with patients and staff which will inform the artworks for the new buildings at Springfield.

None of the Trustees or members of the Trust board or parties related to them has received any benefit from the Charity in payment or in kind. The Trustees received no honoraria or emoluments in the year and no expenses were paid.

The Trust makes a number of clerical and transaction services available to the Charity, by agreement with the Trustees. These include:

- Administrative services at a cost of £10,000 (£10,000 in 2020/21) in running the Charity accounts which includes preparing the Charity's final accounts.

The charges made by the Trust constitute the costs of the Charity's day to day activity. The amounts paid for administrative services are based on time spent by the Trust in the running the Charity accounts.

Income from donations and legacies

	Unrestricted funds £'000	Restricted Funds £'000	Total 2022 £'000	Total 2021 £'000
NHS Charities Together	0		0	100
Donations from individuals	4		4	3
Corporate donations	3		3	9
Legacies	0		0	2
Grants	0		0	5
	7	**0**	**7**	**119**

5. Analysis of income from other trading activities

The Charity was not involved in any trading activities during 2020/21.

Gross investment income

	Unrestricted funds £'000	Restricted funds £'000	Total 2022 £'000	Total 2021 £'000
Fixed Asset Equity and similar investments	-	-	-	-
Short term Investments & deposits & cash on deposit	1	-	1	2
	1	**0**	**1**	**2**

7. Analysis of expenditure on raising funds

The charity did not incur any expense in raising funds in 2021/22 (£0 in 2020/21).

Analysis of charitable expenditure

The Charity did not undertake any direct charitable activities on its own account during the year.

The expenditure is shown below in summary:

	Grant funded Activity £'000	Support Costs £'000	Total 2022 £'000	Total 2021 £'000
Patients comfort, functions & other	12	6	18	41
Staff education and welfare	3	6	9	40
Total	**15**	**12**	**27**	**81**

9. Analysis of grants

The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and the actual funds spent on each category of charitable activity, is disclosed in note 8.

The Trustees operate a scheme of delegation for the majority of the charitable funds, under which fund advisors manage the day to day disbursements on their projects in accordance with the directions set

out by the Trustees in the Charity's procedures. Funds managed under the scheme of delegation represent ongoing activities and it is not possible to segment these activities into discrete individual grant awards.

10. Movements in funding commitments

	Note	Current liabilities	Non-current liabilities	Total 2022	Total 2021
		£'000	£'000	£'000	£'000
Opening balance at 1 April	18	124	-	124	61
Additional commitments made during the year		0	-	0	128
Movement from current to non-current		-	-	-	-
Amounts paid during the year		(124)	-	(124)	(65)
Closing balance at 1 April	18	**0**	**0**	**0**	**124**

Expenditures are approved and paid out in the same financial year. As the charity has control over the award and timing of grants there is little uncertainty around these payments.

Allocation of support costs and overheads

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic and day to day management of a charity.

The basis of allocation used are as follows:

- Time: based on the estimated time spent by the staff members who work for the Charity.
- Expenditure: this is a proportion based on the fund balance at the end of the year before governance cost. This is used where the Trustees consider this is a more equitable treatment to avoid disadvantaging funds with high volume, low value transactions.
- Salaries: The Charity did not pay any money for salaries directly but a percentage of staff costs who were involved in the running of the Charity accounts was recharged.

	Raising funds	Charitable activities	2022 Total	2021 Total	Basis
	£'000	£'000	£'000	£'000	
Independent Examination	-	2	2	2	Expenditure
Accountancy Costs	-	-	-	0	Expenditure
Staff salary recharges	-	10	10	10	Expenditure
Governance costs	**-**	**12**	**12**	**12**	
Office Admin Charge	-	-	-	0	
Total	**-**	**12**	**12**	**12**	

	Unrestricted funds	Restricted funds	Endowment funds	2022 Total	2021 Total
	£'000	£'000	£'000	£'000	£'000
Charitable Activities	12	-	-	12	12
	12	**-**	**-**	**12**	**12**

12. Trustees' remuneration, benefits and expenses

The Charity's Trustees give their time freely and receive no remuneration for the work that they undertake as Trustees.

13. Analysis of staff costs and remuneration of key management personnel

There were no staff directly employed by the Charity.

14. Independent Examiner's remuneration

The independent examiner's remuneration of £2,280 (2020/21: £2,280) relates to the independent examination fee.

15. Fixed asset investments

Movement in fixed asset investments	2022	2021
	£'000	£'000
Market value brought forward	39	81
Add: additions to investments at cost	-	-
Less disposals at carrying value	0	(42)
Add net gain (loss) on revaluation	(2)	0
Market value as at 31st March	**37**	**39**

Fixed asset investments by type	2022	2021
	£'000	£'000
COIF Charities Fixed Interest Fund	23	25
COIF Charities Investment Fund	10	10
Total listed investments	**33**	**35**
Deposit Fund interest bearing	4	4
Total	**37**	**39**

All investments are carried at their fair value.

The Charity's investments are mainly traded in markets with good liquidity and high trading volumes. The charity has no material investment holdings in markets subject to exchange controls or trading restrictions.

The Charity manages these investment risks by retaining expert advisors and operating an investment policy that provides for a high degree of diversification of holdings within investment asset classes. All investments were made in companies listed on a UK stock exchange or incorporated in the UK and therefore all investments are treated as investment assets in the UK. Restricted appeals to fund specific equipment or assets are held on notice deposit or overnight on the money markets in accordance with the Trustees' investment policy.

The Charity does not make use of derivatives and similar complex financial instruments as it takes the view that investments are held for their longer term yield total return and historic studies of quoted financial instruments have shown that volatility in any particular 5 year period will normally be corrected.

16. Analysis of current debtors

Debtors under 1 year	2021	2020
	£000	£000
Accrued income	-	-
Total	**-**	**-**

17. Analysis of cash and cash equivalents

	2022	2021
	£'000	£'000
Cash in hand	1	1
Current Account	45	178
Total cash and cash equivalents	**46**	**179**

No cash or cash equivalents or current asset investments were held in non-cash investments or outside of the UK. All of the amounts held in the current account are available to spend on charitable activities.

18. Analysis of liabilities

	2022 £'000	2021 £'000
Creditors under 1 year		
Trade creditors	8	10
Other accruals	2	114
	10	**124**
Creditors falling due after more than 1 year	-	-
Total	**10**	**124**

19. Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2022 £'000	2021 £'000
Net income/(expenditure) (as per theStatement of Financial Activities)	**(21)**	**40**
Adjustments for:		
(Gains)/losses on investments	2	0
(Purchase)/Sale of Investments	0	42
Dividends, interest and rents from investments	(1)	(2)
(Increase)/decrease in debtors	0	0
Increase/(decrease) in creditors	(114)	63
Net cash provided by (used in) operating activities	**(134)**	**143**

20. Analysis of charitable funds

a) Analysis of endowment fund movements

The Charity does not have any endowment funds.

b) Analysis of restricted fund movements

	Balance b/ f £'000	Income £'000	Expenditure £'000	Transfers Gains £'000	Balance c/f £'000
Child Psychiatry	2	-	-	-	2
Henderson Staff Training	2	-	-	-	2
Sutton Community Older People fund	2	-	-	-	2
Crocus ward	9	-	-	-	9
Others (below £1k)	3	-	-	-	3
Total	**18**	**0**	**0**	**0**	**18**

All the remaining restricted funds were transferred from Sutton and St Helier Hospitals and the main purpose was to improve welfare of patients and staff.

c) Analysis of unrestricted and material designated fund movements

	Balance b/f	Income	Expenditure	Transfers	Gains & Losses	Balance c/f
	£'000	£'000	£'000	£'000	£'000	£'000
Aquarius	9	-	-	-	-	9
Deaf & Family contingency	8	-	-	-	-	8
Pharmacy MHU	2	-	(1)	-	-	1
Richmond Comm. MH team	5	-	-	-	-	5
Other designated funds	12	-	-	-	-	12
General fund	40	8	(26)	-	(2)	20
Total	**76**	**8**	**(27)**	**-**	**(2)**	**55**

The Trustees reported all the unrestricted funds in the above table without limiting to a threshold. In the interests of accountability and transparency a complete breakdown of all such funds is available upon written request.

The objects of each of the designated unrestricted funds are as follows:

The **Aquarius Ward fund** is designated to support the children on the ward with their activities and improving the ward environment.

The **Deaf & Family Contingency Centre** is a fund designated for the welfare and benefit of staff and patients on the relevant wards.

The **Pharmacy MHU fund** is designated for the welfare and benefit of staff in the Pharmacy department.

The **Richmond Community MH team** is a fund designated for the welfare and benefit of staff and patients on the relevant wards. It was donated by a family of a former patient of the Trust.

Other designated funds relate to assisting patients on other wards and clinical departments within the Trust for which donors have indicated their non-binding wishes when making their generous gifts.

The **general fund** includes all donations for which a donor has not expressed any preference as to how the funds shall be spent and the unrestricted income accruing to the charity. These funds are applied for any charitable purpose to the benefit of the patients of the Trust at the absolute discretion of the Trustees.

Independent examiner's report to the Trustees of South West London and St George's Mental Health NHS Trust Charitable Fund (the 'charity')

I report to the charity Trustees on my examination of the accounts of the charity for the year ended 31 March 2022.

This report is made solely to the charity's Trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008. My work has been undertaken so that I might state to the charity's Trustees those matters I am required to state to them in an Independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's Trustees as a body, for my work or for this report.

Responsibilities and basis of report

As the Trustees of the charity you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the 2011 Act').

I report in respect of my examination of the charity's accounts carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act.

Independent examiner's statement

Your attention is drawn to the fact that the charity has prepared the accounts in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) in preference to the Accounting and Reporting by Charities: Statement of Recommended Practice issued on 1 April 2005 which is referred to in the extant regulations but has been withdrawn.

I understand that this has been done in order for the accounts to provide a true and fair view in accordance with the Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

I have completed my examination. I can confirm that no matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the charity as required by section 130 of the 2011 Act; or
2. the accounts do not accord with those records; or
3. the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Signed: Dated:

Robert Smith ACA

Griffin Stone Moscrop & Co
Chartered Accountants
21-27 Lamb's Conduit Street
London
WC1N 3GS