Trust Board - Part A

Room 31, Acacia Building, Tolworth Hospital

12 January 2023 01:30 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 - 10th November 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
5.	Making The Trust A Great Place To Work			
	5.1	Workforce & OD Committee chair's report	Sola Afuape	02:40 PM-02:45 PM
6.	Reducing Inequalities			
	6.1	Equality & Diversity Committee chair's report	Doreen McCollin	02:45 PM-02:50 PM
Break				02:50 PM-03:00 PM
7.	Ensuring Sustainability			

	7.1	Finance and Performance Committee chair's report - verbal report	Vik Sagar	03:00 PM-03:05 PM
	7.2	Finance Report	Philip Murray	03:05 PM-03:15 PM
	7.3	Estates Modernisation Committee chair's report - verbal update	Juliet Armstrong	03:15 PM-03:25 PM
8.		Notified Questions From The Public and Staff		03:25 PM-03:30 PM
9.		Meeting Review		
10.		Next Meeting - Trust Board 9th March 2023 - 1.30pm-4pm - Conference Room B - Trinity Building, Springfield Hospital		

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AGENDA

Meeting	**Board of Directors**
Time of Meeting	**1.30pm to 4.00pm**
Date of Meeting	**Thursday 12th January 2023**
Location	**Room 31, Acacia Building, Tolworth Hospital**

	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 10th November 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**
	4.2. Quality and Performance report	**FD**	**Paper**	**JeA**	**14:35**
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. Estates Modernisation Committee chair's report	**FR**	**Verbal**	**JuA**	**15:35**
8.	**NOTIFIED QUESTIONS FROM THE PUBLIC AND STAFF**	**FD**	**Verbal**	**AB**	**15:50**
9.	**MEETING REVIEW**	**FD**	**Verbal**	**AB**	**15:55**
10.	**Next Trust Board business meeting –** 1.30pm on 9th March 2023 – **Conference Room B, Trinity Building at Springfield Hospital, SW17**				

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
Prof Charlotte Clark (CC)	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 Director of Corporate Governance

Apologies:

*=non voting

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Board Visit Schedule – 12th January 2023

Time and Date	Team	Consultant Psychiatrist	Manager	Clinical Service Lead	Location	Non Exec Director	Executive Director
12/01/23 9:30 - 10:30	Ellis Ward	Dr Tom Verghese	Puja Matthews - Manager 020 3513 5777 07393 546584	Puja Matthews - Manager 020 3513 5777 07393 546584	Ellis Ward Tolworth Hospital Red Lion Road London KT6 7QU	Richard Flatman	Jenna Khalfan
12/01/23 9:30 - 10:30	Jasmines Ward	Dr Malarvizhy Baheerathan	Hannah Goodman (i) Manager 0203 513 5099 07970 458626	Adeshina Abdulsala 020 3513 5448	Red Lion Road Surbiton Surrey London KT6 7QU	Deborah Bowman	Sharon Spain
12/01/23 9:30 - 10:30	Lilacs	Dr Harshada Makena 07424 666135	Natalie Pegg - Manager 020 3513 5129	Puja Matthews - Manager 020 3513 5777 07393 546584	Red Lion Road, Surbiton KT6 7QU	Doreen McCollin	Vanessa Ford David Lee
12/01/23 9:30 - 10:30	Kingston CMHT OP and Memory Service	Dr David Somerfield, Dr Vanessa Loftus, Dr Anu Jha Locum	Neil Clemenson 020 3513 5096 07970 840804	Adeshina Abdulsala 020 3513 5448	Tolworth Hospital, Red Lion Road, Surbiton KT6 7QU	Sola Afuape	Philip Murray Amy Scammell
12/01/23 9:30 - 10:30	Kingston Clozapine Clinic		Diana Jenkins 020 3513 2556 / 07714 133809	Lucy Riddett 0203 513 6155	Tolworth Hospital, Red Lion Road, Surbiton KT6 7QU	Vik Sagar	Katherine Robinson
12/01/23 9:30 - 10:30	North Kingston CMHT	Dr Maura Killoughery	Jessica Wall 07821 638 177	Lucy Riddett 0203 513 6155	Tolworth Hospital, Red Lion Road, Surbiton KT6 7QU	Charlotte Clark	Dr Billy Boland Ian Garlington


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A patient's experience of Hume Ward

January 2023

Introduction

This month's patient story to the Board is being presented by Kieran who will share his experience of being a patient on Hume Ward, a low secure Forensic Unit at Springfield Hospital.

Background

Hume Ward provides a service for patients detained under the Mental Health Act who require care and treatment under conditions of low security due to the nature of the risk they pose to the general public. Therefore the primary function of Hume Ward is to deliver individually designed care and treatment whilst protecting the public.

Patients who use Forensic Services are often marginalised in society and may have become estranged from their families. Of the people who have mental illness, less than 1% require support from Forensic Services. Low secure services aim to reduce the risk individuals pose to others so they can return to the community in the least restrictive environment possible.

Hume Ward fits into a continuum of secure services for people detained under the mental health act and classified with a mental illness (and comorbid problems such as personality disorder and drug and alcohol problems) and who presents a significant risk to themselves or the public. The focus is on rehabilitation and recovery to achieve the best possible clinical and social outcomes for the individual.

The ward provides a wide range of therapeutic interventions in conjunction with the delivery of care and support through the Care Programme Approach (CPA). As well as ongoing appropriate risk assessment and risk reduction strategies the ward seeks to provide person centred holistic care within the least restrictive environment. The service operates a recovery model orientated approach that empowers patients to work in partnership with staff and provides meaningful opportunities for patients to progress and fosters hope through validation.

Patients are supported and encouraged to make links with the community as they progress through their pathway. The Hume MDT aims to work collaboratively with community agencies and resources in order to develop and maintain social integration and risk management during an inpatient stay. Such links are particularly important as a patient approaches discharge and will benefit from some continuity during transition.

All patients are encouraged to work in partnership with their MDT to develop a personalised care plan to address the issues required to facilitate recovery. Care planning involves active collaboration with the patient whenever possible, including on admission, and the act of formulating care plans is be a patient-centred process.

Background continued

Hume Ward also provides an activity programme which is facilitated collaboratively by nursing and Occupational Therapy staff and aims to provide opportunities for structured social engagement, simple vocational activities as well as enhancement of living skills. Patients on the ward also have access to the activity programme at the Shaftesbury Clinic as well as courses provided by the onsite Recovery College.

Kieran's story

Kieran is 32 and explained that he was admitted to Hume Ward in March 2022. He had previously spent around a month in prison before the transfer to Hume Ward. He explained that he has a likely diagnosis of Schizophrenia and noted that he had heard voices since around 2013. Prior to his admission to Hume Ward, Kieran had not had any contact with mental health services and had not told anyone about the symptoms he was experienced as he did not realise there was anything unusual about his symptoms.

Kieran was assessed in prison and spent some time in the medical unit before being transferred to Hume Ward. He said he did not know what to expect from Hume Ward as he had not been in a psychiatric hospital before. Kieran described prison as being loud and chaotic and stressful; he said there was a lot of shouting and noise and arguments between prisoners and has described how this contrasted with the more peaceful environment on Hume Ward.

Kieran explained that he was welcomed to the ward by staff when he first arrived; staff showed him round and explained how the ward operated and generally made him feel at ease. He described the ward as being like a 'brotherhood' and said that the staff are friendly, helpful and supportive and are available to talk and spend time with him and other patients. Kieran also described staff as being positive which fits in with the ward ethos of providing hope to patients.

Kieran noted that, although there are sometimes disagreements and arguments between patients on the ward, the overall environment is extremely different and much more positive and supportive than prison.
Kieran explained that there is a lot to do on the ward in terms of activities as well as therapeutic activities. He noted that he was able to play snooker and chess and board games and that there were various groups running on the ward for art and mentalisation among other things. He also described attending a meditation group for several weeks which he had found very calming.

The only negative Kieran shared about the ward is that it is sometimes not possible to have escorted community leave at the agreed time, due to other demands on the staff. He noted that this can be frustrating. Other than that, Kieran's experience on Hume Ward is a positive one and he hopes to be working towards discharge from the ward early in 2023.

Compliments and positive feedback

The ward shows high levels of patient satisfaction and positive feedback which is measured through the Trust Feedback Live! System. 425 individual questions were answered. The ward scored highly for safety (62.2%) and general satisfaction (69.5%). Relationships with staff had a positive rating of 78.9% and Help and Support rated 88.9% satisfaction.

The ward also received three compliments from student nurses praising the support and assistance they had received on the ward and reinforces the positive environment and ethos as experienced by Kieran has a patient on the ward.

'My placement on Hume Ward was both my first placement in a ward environment and my first forensic placement. This has meant that I have learnt so much in these last 6 weeks. Each member of staff has made me feel so welcome and as though I am part of the team. I have felt supported throughout my six weeks here by every member of staff I have had contact with.

Working here at Hume Ward has really helped me to build my confidence within my role. I was often given opportunities to carry out tasks that I have never done before and was given feedback when I needed to guide me. I aimed to build good therapeutic relationships with service users and feel I was able to do this with the support of the team. This experience has allowed me the opportunity to grow as a nurse. Furthermore, the feedback I have been given has all helped me to understand where I need to make improvements regarding my caregiving. There have rarely been moments that I have not enjoyed or felt too out of my 'depth.

Providing reflective practice that students could attend really helped me to reflect on my own emotions surrounding care that is restrictive and therefore allowed me to make sense of the situation'.

Next steps and way forward

Next steps and way forward continued

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It is an exciting time for patients and staff in Hume Ward as they prepare to move to new purpose built accommodation in the new Shaftesbury Building on the Springfield site. The move is due to take place within the first few months of 2023 and Martin McIntyre, Forensic Service Manager, noted that it is important to ensure that patients are fully supported and kept informed during the process.

As well as excitement there is some nervousness too; unlike other acute wards, some of which have already moved to new facilities, patients on Hume Ward may have been in hospital for some months and will have accumulated more possessions during that time. Packing to move for Forensic patients therefore needs more advance planning and preparations and staff are working with the patients to prepare them for the move. Patients have been able to look at photographs of the new ward and visits are also planned for nearer the time.

The new Hume Ward space will be lighter and more spacious and patients will be able to access green space which they are currently unable to do. The move will also provide patients with ensuite rooms which they do not have at present which is important for privacy and dignity.

Over 200 workshops were held with service users, carers, staff and stakeholders in the design of Shaftesbury and Trinity Buildings, as well as more than 120 workshops in the design of the art for the new buildings.

During the building and review process, we have had service user representatives from the South London Partnership visit the new Shaftesbury Building, as well as advocacy representatives. Finer details for the wards were picked with services users, including bedroom door colours and the images that are in the bedroom doors and windows.

Presentations:
Hume Ward Service user: Kieran

Attending from service: Martin McIntyre, Service Manager, Lawrenica Amoakoh, Deputy Ward Manager

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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 10th November 2022 via MS Teams.

Present:

Ann Beasley (AB)	Chair
Professor Deborah Bowman (DBo)	Vice Chair, SID and Non-Executive Director
Vik Sagar (VS)	Non-Executive Director
Sola Afuape (SA)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Juliet Armstrong (JuA)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
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

Observing

Judith Edwards	CQC Inspector
Alicja Wenderlich	CQC Inspector
Amy Barrett	Specialty Registrar ST4-6

In attendance:

Martin Haddon	Healthwatch Wandsworth
Nicola Mladenovic	Deputy Trust Secretary

For item 22/100

Angela Evans	Experience and Governance Lead
Shakil Dawood	Service User
Ian Higgins	Virtual Risk and Family Liaison Nurse
Jimmy Cangy	Matron (Urgent Care and Acute Care)
Kyra-Stacey Weatherley	Mental Health Line Co-Ordinator

For item 22/108

Teresa and Billie	Kyle's mother and sister

Apologies

Charlotte Clark (CC)	Non-Executive Director
Doreen McCollin (DM)	Non-Executive Director

Item		Action
22/100	**Patient Story** The Board heard a Service User's Story detailing his experience of having paranoid schizophrenia for the last 48 years. He spoke of using the Mental Health Crisis Line on a daily basis, and of how the change from the 'Mental Health Support Line' to 'Mental Health Crisis Line' has affected him. Initially the service provided an enhanced triage for people needing mental health support, providing an alternative to an A&E attendance. Shakil feels that the original service helped him immensely and the staff were well placed to support service users. However, the service has	

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now changed to being a crisis hub to offer rapid assessment using a clinical model, giving support to access the crisis pathway.

Now the service has changed he feels that he does not have the on-going support he previously accessed on a daily basis and now has had to apply his own coping mechanisms. Shakil stated he is now only able to ring the service when he has reached breaking point. He feels his buffer has been stripped since the line is now mainly a crisis service.

The Board was assured that the original service was held in high regard and noted that the service has changed. The Board considered Shakil's feedback.

It was noted that the Trust is currently working closely with different faith groups as part of the EMHIP. A well-being hub has also been opened including training provided to faith leaders to support members of the community. It is anticipated that this will support members of the community with serious mental health illness and help them to access services when needed.

The Board thanked Shakil for sharing his experience and noted that not everyone needs crisis support however support is needed to ensure service users remain well. VF invited Shakil to take part in future work that the Trust is considering to commence shortly around approaches to resource allocation.

22/101 Apologies and welcome
Apologies were received.

22/102 Declarations of Interest
SA reported that she has been nominated to chair the SW London ICS Anti-Racist Strategy and Implementation Group. .

22/103 Chair's action
No Chair's action was taken.

22/104 Minutes of the last meeting
The minutes of the meeting held on 8th September 2022 were agreed as a correct record.

22/105 Action Tracker
The action tracker was noted.
Action Item 22/27 – closed. Updates will come through Audit Committee to Board.
Action Item 22/70 –closed. Huntercombe use a different patient record system to the Trust. An adapted version of the KPI has been agreed to include length of stay, re-admissions and discharges.
Action Item 22/72 – work has progressed with the Making Life Better Together group and it is planned that an update will come back to Board through WODC in April 2023.

22/106 Chair's report
AB thanked all staff for their dedication and commitment to their work.

AB mentioned her recent visit to the Cricket Green School, a specialist school for children with severe learning disabilities, where she saw the dedication and commitment of the CAMHS staff who support the children.

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On World Mental Health Day, 10th October 2022, the South London Listens Accountability Assembly was held. There was a large gathering of leaders from communities, local authorities, mental health trusts and ICBs. Further pledges were given to drive the mental ill-health prevention agenda.

The Board noted the Chair's report.

22/107 Chief Executive's report

VF highlighted the following points:

- Teams will move into the new Trinity building in December, the culmination of work that has taken over 20 years to provide services from modern high quality buildings.
- A Cost of Living support package has been developed which will be available on a needs led basis. The package includes support with parking costs, travel costs, staff discounts and Hastee Pay.
- Industrial Action – VF assured the Board on the Trust's business continuity and contingency plans which also address industrial action on public transport networks
- The SWL Mental Health Strategy development is continuing with further discussions on provider collaborative and delegated budget arrangements.

The Board noted the report and the record of the uses of the Seal.

22/108 Quality and Safety Assurance Committee chair's report

The Board received the chair's report from DBo and the Board welcomed Teresa and Billie as they joined the discussion for Kyle's Charter.

Kyle's charter

The charter was developed following an NHS Resolution led mediation process between the Trust and the family of Kyle Maher. The process was in response to findings arising from the inquest and the independent review. During mediation, the Trust acknowledged and apologised that the contact and support provided to Kyle's family following his death was not to the standard expected. Following mediation discussions, it was agreed that the Trust and the family would jointly develop a charter to provide details of the support, information and response that families, friends and carers can expect from the Trust following the death of a loved one.

On behalf of the Trust, AB said how very sorry she was for the mistakes that occurred. She sincerely thanked Kyle's family for their bravery and commitment in working with the Trust to put this charter in place.

DBo thanked the family for their work, commitment and courage and asked for the Board's support in adopting the charter.

The Board formally adopted Kyle's charter.

Quality and Safety of Inpatient Services:

Following the BBC Panorama broadcast 'Undercover Hospital; patients at risk' on 28th October 2022, the November QSAC meeting had discussed the programme especially the distressing footage from the Edenfield Centre in Prestwich.

Following the broadcast, the National Director for Mental Health had written to all mental health providers. This was discussed by QSAC and also at the Board's

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October seminar. The response to the issues identified by the National Director for Mental Health was received by the Board.

Annual Mortality and Suicide Prevention Report
QSAC had received this report. The committee had discussed health inequalities and the way that ethnicity and learning disabilities intersect or could lead to over-representation. The Committee received assurance that there are effective mechanisms and governance for all types of mortality. DBo also highlighted the committee's discussion of gender identity especially in respect of children and young people.

The Board noted that there were no homicides reported in the year.

Mental Health Law Annual Report
This was received by the Committee. The Board noted the importance of detained and CTO patients having their legal rights read to them in line with Trust policy. There was also reference to the importance of clarity around the reasons for undertaking an assessment of someone's mental capacity. DBo drew attention to the committee's concern that changes in the commissioning of advocacy services might impede access for vulnerable patients.

November QSAC
DBO provided an initial verbal report and advised that the committee had received assurance on the delivery of the Quality Plan. It was noted that the Safety in Motion targets have to date only been partially achieved.

The Committee has also received the Medical and Nursing Revalidation and Safer Staffing Reports as well as a verbal update on the CQC visit to Burntwood Villas.

The Board also received the minutes of the QSAC meeting held on 4th July 2022.

22/109 **Quality and Performance Report**
JeA introduced the report and highlighted the following points:

- During September 2022 demand for mental health services and acuity has remained high across adults, community and CAMHS whilst there are constraints on workforce availability and finances.
- There is stable performance. Improvements are planned supported by a root cause analysis approach to identify areas where improvements can be made.
- Productivity and Financial grip & control KPIs have been enhanced and will be discussed at FPC each month moving forward to provide oversight and direction to work on financial sustainability. This will also look at the flow of patients including delayed transfers of care and community caseload issues.
- There is an intensified focus on recruitment to ensure this supports services, whilst reducing the use of temporary staffing.

The Board noted the Quality and Performance Report.

22/110 **2022/23 Corporate Objective Q2 delivery**
The Board received the Q2 report and AS highlighted the following:

- The report details delivery against the milestones as well as further data that was not available for the Q1 report.
- ELT had discussed the deliverability of the corporate objectives due to the volume of clinical service change, including team moves, in the forthcoming period. There

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is commitment to continue delivering all the elements that were set out at the beginning of the year through Q3 and Q4.

The Board noted the report. No additional risks were raised for noting.

22/111 Workforce and OD Committee chair's report

The Board received the report from SA. Points highlighted included:

- In terms of the effectiveness of the HR function, the committee had noted limited assurance in the capacity to deliver. However, there were initial signs that the return to a SWLSTG specific HR service could deliver improvements.
- Three priority areas have been agreed: recruitment and retention, employee relation cases and medical staffing.
- Within employee relations a focussed effort had seen a significant reduction in the number of outstanding cases in a recent eight-week period.
- ELT had agreed to declare a formal incident in relation to recruitment and retention. A 12 week implementation plan was put in place.
- A gap analysis has been undertaken in learning and development. The outcome of this will come to the next WODC meeting.
- At a recent HR Away Day, it was noted there is an improvement in morale and the team was more cohesive, supported by a values based, inclusive approach.

The Board noted the report and received the approved committee minutes held on 26th July 2022.

22/112 Equality and Diversity Committee chair's report

The Board received the chair's report and DBo updated on behalf of DM. The following were highlighted:

- The October meeting received the WRES and WDES Annual Reports.
- The staff networks presented their updates except for the Deaf Staff Network who will provide their update in December.
- A common theme from the presentations is the lack of time that the network chairs have as they are juggling their workload.

VF reflected on the work that is being undertaken with Emdad Haque, the new Associate Director of EDI and KR to support the staff network chairs being able to contribute in a meaningful way. (**Action**: KR to provide an update at a future EDC) **KR**

The Board noted the report and received the approved committee minutes held on 23rd June 2022.

22/113 Finance and Performance Committee chair's report and Finance and Savings Reports (Month 06)

VS provided a verbal update and confirmed that currently the external financial situation is very challenging and the Trust has been requested to submit a revised financial forecast. PM provided an update:

- Baseline surplus of £20k is being reported, £2k favourable to the plan. To maintain this going forward small surpluses will be required month on month.
- Agency in month is £295k above the 2021/22 average spend. Work continues to convert agency staff to substantive roles.
- External bed usage has reduced in September and there are further improvements indicated in the October data.
- Cash balance at end of September was £36.4m, £10.8m favourable to plan

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- Capital spend is £1.5m which is £0.4m below plan.
- Loan repayments are scheduled to commence in 2023/24

The Board noted the report.

22/114 Audit Committee chair's report

The Board received an update from RF. At the last meeting the Committee considered the following:

- External Audit – the lessons learnt have been considered from last year's audit and an action plan has been drafted. This will come back to the Committee in January.
- Internal Audit – two audits have been received. Data Security and Protection (DSP) received Limited Assurance and Capacity to Consent to Treatment received Reasonable Assurance. The DSP audit assurance focussed more on process rather than compliance and it is to be noted that the change in internal auditors has meant that some areas are audited in a different way. This will require further monitoring for the next audit to ensure the desired outcome is achieved.
- A benchmarking report on single tenders was received which indicates that the Trust uses this process relatively infrequently.
- There are no post balance sheet events that have arisen since the audit that need to be recorded.
- Chair's Action has been agreed to write off irrecoverable amounts, salaries have been adjusted going forward.

The Board noted the report and received the approved minutes of the Audit Committee held on 20th July 2022.

22/115 Estates Modernisation Committee chair's report

The Board received a verbal update from JuA. Items raised include:

- There is a delay in the construction, pre-handover and completion of the Trinity building. Several meetings have been held with the contractor and there is confidence that teams will be moving into their new locations soon.
- Teams are involved in the move plans and are part of the 'Move, No Move' process. All moves consider the quality of clinical services and where necessary a no go decision can be taken.
- Shaftesbury Building is also impacted by the construction delays and moves into this location will commence in the New Year.
- Updates have been received from the People Readiness and Culture Change group with assurance on progress items around leadership development. Further updates on this and other KPIs will come to the next EMC.
- Work is progressing on the refreshed Tolworth Business Case.
- The Barnes Disposal Business Case has been approved alongside the full business case to redevelop the health facilities on the Barnes site. Assurance has been received on the value for money that will be received on the land sale. It was noted that services will temporarily move to Teddington whilst work is carried out.
- Updates have been received from the clinical transformation programme and various workstreams are reporting a consistent approach for outcomes and measures.

The Board noted the report.

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22/116 Corporate Trustee business - Charitable Funds Committee chair's report

The Board received the chair's report and JuA updated on behalf of DM. The following was highlighted:

- The Annual Report and Accounts have been considered and are recommended for approval.
- £29k was received following the wind up of the Friends of Surbiton and Tolworth Health Community charity. This money will be ear-marked for work to improve the Kingston Memory Clinic.

The Board noted the report and approved the Charitable Fund Annual Report and Accounts.

22/117 Notified questions from the public and staff

The following question was received from Martin Haddon (on behalf of Healthwatch Wandsworth) - "The Minutes of the Board's Finance and Performance Committee meeting on 29 September 2022 refer (under Item 22/123) to the Improving Patient Outcomes Group working on bringing together recovery outcomes and reports on patients' experiences. Can a little more be said about the composition and workplan of this Group, in particular does it include members with Lived Experience and will its findings be made publicly available in due course?"

Sharon Spain, Director of Nursing and Quality Standards responded: The Improving Patient Outcome Group was set up to oversee the delivery of three key workstreams have been implemented:

1. *Embedding the use of dialogue as a patient outcome measure (Dialogue Plus will enable better patient centred care plans)*
2. *Improving the Health of the Nation Outcome Scale (HoNoS)*
3. *Improving the patients and carers feedback and experience*

The first two focus on the systems in order for staff to use the system in a more streamlined way. Members with Lived Experience will be involved in Feedback Live and they will support the development of questions including how the feedback is analysed. A new Compassionate Complaints Response Group has been set up. This group comprises carers and service users and look at how the complaint responses can be improved. This work will initially be brought to the Carers, Friends and Family Reference Group and the Patient Quality Forum.

22/118 Meeting review

There was a discussion focussing on Shakil's account and the courage of Kyle's mother and sister to come to the board meeting. Their powerful accounts informed the meeting's direction. Feedback from Ian Higgins on behalf of Kyle's relatives was that they felt positively about their attendance.

Judith Edwards from the CQC stated that she had found it to be an interesting meeting and looked forward to hearing more about the work described, especially the anti-racism initiative.

22/119 Next meeting – The next Trust Board meeting in public will be held on Thursday 12th January 2023 at 1.30pm at Tolworth Hospital

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

ACTION TRACKER – for January2023 Board

BOARD OF DIRECTORS (Part A)

2.5

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
DUE						
10/11/2022	22/112	**Equality and Diversity Committee chair's report**	Emdad Haque, the new Associate Director of EDI and KR to support the staff network chairs to manage pressures in undertaking their staff network chair role	**KR**	**Jan 2023**	
NOT DUE						
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**	**April 2023**	To be completed at the end of Q4 (April 2023)
			COMPLETED AT LAST MEETING			
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 has forwarded the Quality Plan directly to Martin Haddon.
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**	Regular updates will now come through the Audit Committee and to Board
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**	Huntercombe Hospital use a different patient record system to the Trust and has confirmed that discharge letters are forwarded post discharge and an adapted version of the key performance indicators has been agreed.

Update as at: 10/11/2022

1

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

ACTION TRACKER – for January2023 Board

BOARD OF DIRECTORS (Part A)

2.5

Update as at: 10/11/2022

2

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

3.1

Meeting:	Board of Directors
Date of meeting:	12th January 2023
Report title:	Chair's Report
Authors:	Ann Beasley, Trust Chair
Purpose:	For report

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.

The Part B board meeting in November 2022 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.

In December the board held an externally facilitated and powerful all day seminar focussed on the Trust's development as an anti-racist organisation.

3. Independent review of integrated care systems

Objectives and scope

The review will consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. It will cover ICSs in England and the NHS targets and priorities for which integrated care boards (ICBs) are accountable, including those set out in the government's mandate to NHS England.

In particular it will consider and make recommendations on:

- how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
- the scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities
- how the role of the CQC can be enhanced in system oversight

Engagement
The review will draw upon the expertise of ICSs, local government, the NHS, the voluntary sector, patient and service user representatives and other subject experts including in academia, government departments and relevant thinktanks.

Governance and timing
The review will be led by Rt Hon Patricia Hewitt and will be independent of government.
Secretariat support will be provided by the Department of Health and Social Care.
The review will report to the Secretary of State for Health and Social Care, with interim findings by 16 December 2022, a first draft by 31 January 2023 and a final report by no later than 15 March 2023.

4. Chair's activity

A summary of my recent appointments is set out below

Internal	External
Estates Modernisation Committee	NHS Providers Board meeting
Equality & Diversity Committee	NHS Providers Annual Conference
Quality & Safety Assurance Committee	SLP Partnership Committees in Common
Trinity Building visit	SWL Integrated Care Partnership seminar
Workforce & OD Committee	CSG Chairs – monthly meeting
Quality Awards	Interview panel – South West London ICS chair
Finance and Performance Committee	
Interview panel - Ward 2 consultant	
Board Seminar	
Interview panel – Deputy CEO	

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

January 2023

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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 - 25 December (newsweaver.com)
- Chief Executive Update - Friday 23 December (newsweaver.com)
- Chief Executive Update - Friday 16 December (newsweaver.com)
- Chief Executive Update - Friday 9 December (newsweaver.com)
- Chief Executive Update - Friday 2 December (newsweaver.com)
- Chief Executive Update - Friday 25 November (newsweaver.com)
- Chief Executive Update - Friday 18 November (newsweaver.com)
- Chief Executive Update - Friday 11 November (newsweaver.com)
- Chief Executive Update - Friday 04 November (newsweaver.com)

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Moves into Trinity

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

- Over 300 staff and nearly 100 patients successfully moved into Trinity in December, with more teams moving in in early January 2023.
- An operationally-led resilience group oversaw each move, each ‘go’ / ‘no go’ decision, and each post move review
- Patients, teams and stakeholders were communicated with before and after the moves.
- Patients and staff were welcomed into Trinity with welcome packs and information about the building. We are now focused on ensuring culture shift to ensure our teams get the most out of the new spaces

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Moves into Trinity

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

- Patient, staff and stakeholder feedback has been very positive and work is ongoing to meaningfully capture this feedback (which will be presented in the March Board)
- Ahead of the formal opening in summer 2023, we are arranging a series of stakeholder and staff visits, tours and meetings in Trinity
- We received positive media about the move in the Evening Standard, Financial Times, New York Times, BBC online and in local outlets
- Formal handover of Shaftesbury will be in the Spring. We will work with teams to develop move dates following this.

Our values: Respectful · Open · Collaborative · Compassionate · Consistent

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Changes at Tolworth, Barnes and Richmond

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

- In December we made important progress on a number of other redevelopment projects:
- **Barnes:** A final public consultation on the redevelopment of Barnes Hospital in Richmond was held ahead of formal submission to Richmond Borough Planning Committee, with construction works finishing in 2024.
- **Richmond Royal:** Works continue at Richmond Royal ahead of Richmond CAMHS moving in spring 2023.
- **Tolworth:** Our plans for Tolworth Hospital received approval from Kingston Council Planning Committee. 170 corporate services teams also successfully moved to our newly refurbished corporate base at Tolworth over Nov and Dec 2022.
- This redevelopment will complete our vision for transformed environments across our estate, supporting equity of access for all SWL patients

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Service change and transformation

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

- **Richmond Wellbeing Service:** In December we successfully welcomed Richmond Wellbeing Service, including 68 staff to the Trust. Richmond Wellbeing service is an Improving Access to Psychological Therapies (IAPT) and primary care liaison service. This change followed discussions with partners to bring together adult mental health services under the local lead provider.
- **Coral Crisis Hub:** Our Coral Mental Health Crisis Hub is changing how it works by seeing patients at our Springfield site at booked appointments, 10am-10pm, seven days a week. The hub provides a single 24/7 point of access for local people in mental health crisis. These changes aim to make our service work more efficiently for our patients. Access to the service remains the same.
- **Forensic Learning Disabilities ward:** The Trust is working with the South London Partnership to develop a specialist ward which will provide expert low secure care for forensic patients who have a mental health need and a learning disability, some with autism. Its aims will be to care for patients in a specialist hospital setting which is closer to home or their community, to improve length of stay, rehabilitate patients before leaving hospital, and reduce chance of readmission.
- **Corner House:** Working in partnership with families, carers and the wider national Deaf CAMHS community we are reviewing the service to continue to improve accessible, responsive, flexible and high quality care. While conducting the review, we are continuing to use our expert staff to support local mental health teams to care for young people. The outcome of the review is being worked through, ready to reopen.
- **Adult Community Service:** Work continues to embed changes with teams in Sutton, with lessons learned from the pilot being used for Kingston and Richmond. An initial dashboard to monitor the outcomes of transformation has been developed and Healthwatch Sutton have provided a report which baselines the service user experience in Sutton. Kingston and Richmond Assessment Team has been successfully split into two borough-based teams

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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. Cost of living and the aftermath of Covid is continuing to impact on people's mental health
- We are seeing more patients in crisis who are known to mental health services, including those with exacerbations of existing conditions, who may not have required secondary care recently
- We are continuing to use private beds, and we expect these to be needed throughout winter to support patient flow. We are working with colleagues across London on agreed key areas for mental health urgent care:
  - Winter demand & capacity analysis, and extra support to services, such as recruiting additional staff for mental health patient assessment in Emergency Depts and putting in place dedicated patient transport and accommodation support
  - Continuing to develop our crisis services, with the launch of the Coral rapid access clinic, improving S136 pathways, and developing the NHS111 Press 2 for mental health service
  - Reducing length of stay and delays to transfer of care by working with our Local Authority colleagues
- Linked to this we continue to roll out our Adult and CAMHS community transformation programmes. These aim to improve access and support crisis avoidance and recovery through more effective treatment pathways and additional new roles within our community teams.
- We are working with the ICS on a local campaign to promote access to support, via our mental health crisis line, specifically targeting Black, Asian and Minority Ethnic men within our communities

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Workforce

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

- Our workforce remains 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
- With ballots for strike action taking place in the NHS we are focussed on ensuring preparedness and use of business continuity plan
- **Recruitment:** like the NHS nationally, we are facing recruitment challenges. Following our focus on recruitment, our overall vacancy rate is 17.3% which is an small improvement. Our focus now is turning to retention.
- **Medical staffing:** Our support for Medical Staffing has been an ongoing concern. However recent changes to how recruitment and medical rotas are supported is showing early signs of improvement. A substantive Head of Medical Staffing has also been recruited and is due to commence employment in March 2023.
- **Staff survey:** closed at the end of November 2023, we had a response rate of 52% - a reduction on last year. The interim report has been made available and an initial review is being undertaken. The full NHS Staff Survey Report Findings will be published in March 2023.

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Recognising and thanking

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

Annual Quality Awards

- On 24th November, 160 staff, patients, senior leaders and Board members joined us at the Annual Quality Awards ceremony – this year hosted for the first time in our new Trinity Building
- From over 300 nominations (an increase on last year!), our judging panel – comprised of staff, and patient representatives – selected 16 winning teams and individuals, who were presented with a trophy and certificate on the night
- The celebration also saw five Special Achievement winners and recognition for our monthly Exceptional People and Long Service award winners.

Festive celebrations

- To help staff get in the festive spirit, a variety of activities went on across the Trust, including festive lunches at Springfield and Tolworth and festive food on our wards, as well as mince pie deliveries, parties in a box, presents for our patients and a carolling event
- An inclusive festive message was also issued to all staff using a design created by Rubbena Aurangzeb-Tariq, artist and member of staff in our Deaf services
- Within the festive message, substantive staff were also offered further support for their health and wellbeing, while our bank staff are being invited to a thank you lunch in February

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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 Director of Nursing and Head of Therapies and Involvement, recently held an Involvement workshop with Patients and Carers (Lived Experience Members) to develop ideas / support for those struggling with cost of living. Key points from the workshop included utilising the rich knowledge of local resources and sharing current resources and help within each borough
- Actions following the workshop included:
  - Ensuring that all current resources are accessible to all / put in one place – this is currently being shared with attendees before being publicised
  - Involvement service to be the central point for continuing to add / update resources
  - Highlighting new resources to staff so that they can signpost service users and carers, families and friends to these - with special emphasis on community staff
  - Director of Nursing is also investigating the creation of a “swap shop” – a free and local exchange where members of the public can pass on things they no longer want, in exchange for something they need
  - The Recovery College developing “tips and hints” course re online safety to avoid scams and sharing money saving tips .

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Cost of living support for members of staff

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

- In November 2022, as part of Making Life Better Together, we launched a new Cost of Living support package which includes individualised advice and support, alongside financial support such as hardship grants, subsidised meals, car parking
- Nearly 20 people have approached the service so far. The vast majority have been clinical staff
- Some of the requests were for general cost of living information and most of those who contacted the service received a 1:1 conversation identifying specific cost of living support including:
  - relocation expenses support,
  - housing support,
  - support for addressing unpaid sick leave,
  - support around car parking charges,
  - support following theft, and
  - subsidised lunches
- Further promotion of the service is ongoing with more cost-of-living workshops and lunches planned for the New Year.

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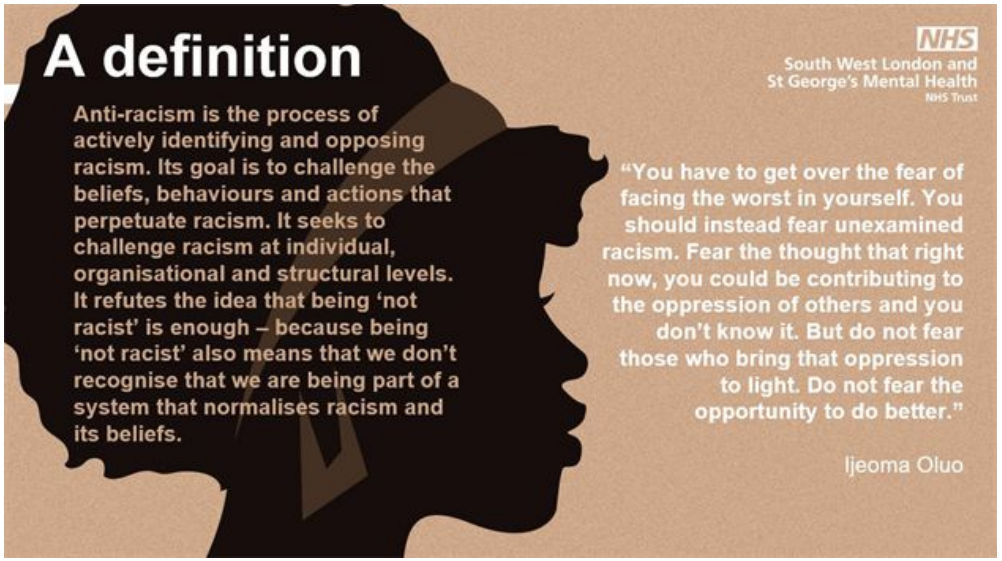
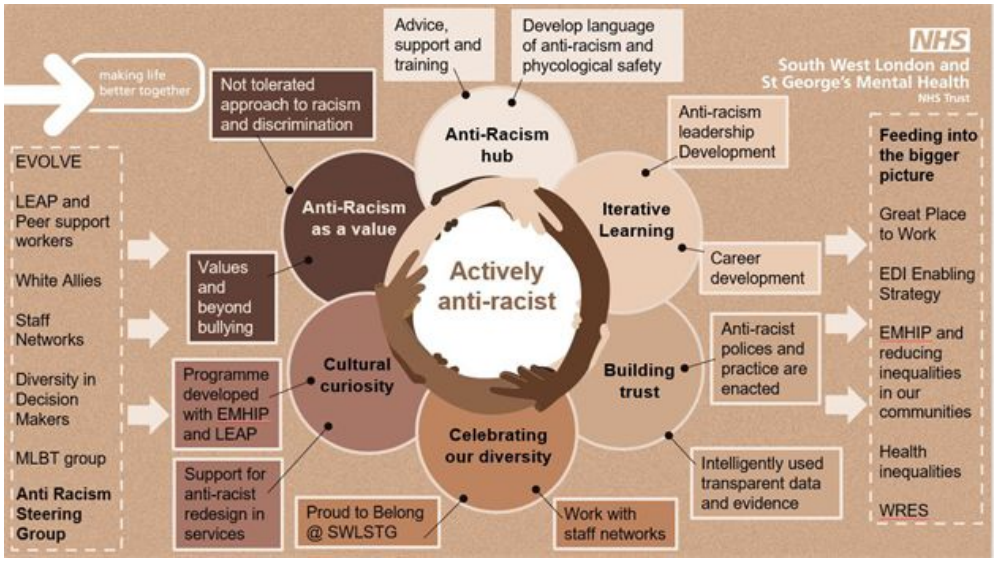
Active Anti-Racism and reducing inequality

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

- Our new Anti-Racism steering group has developed a new active anti racism approach for the organisation, being championed by Evolve and White Allies
- We are rolling out active anti-racism workshops and sessions to our leaders





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Partnership working

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

- We continue to work on strengthening partnerships with key stakeholders and organisations.
- Our work with the South London Partnership (SLP) has seen us develop initial proposals for a full pathway perinatal provider collaborative and to re-energise our collective work on acute and urgent care. We are planning a leadership event in February 2023 to bring clinical and operational leads together to consider wider areas such as population health management and workforce.
- Within SWL we have set up a monthly SWL Mental Health Partnership Delivery Group (SWL MH PDG) chaired by the Trust CEO as the SWL ICB Partner Member for Mental Health. This group brings together place, ICB and provider representatives to develop the strategic mental health agenda in our system.
- The SWL Mental Health Strategy is emerging with draft content being reviewed by the SWL MH PDG.

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SWL Mental Health strategy vision and aims

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

Vision: "In SWL we want everyone to have access to early support for their emotional wellbeing and mental health, recognising many influences on health and wellbeing come from outside health care, including factors such as education, employment, housing, and community. We want services to work effectively together to meet people's needs and ensure everyone receives the support they need in the most appropriate setting."

Aims

1. Increase equity of access, experience and outcomes for all SW Londoners – reducing unwarranted variation and ensuring a fair and sustainable allocation of resources.
2. Prioritise prevention and early support as we know this promotes good recovery and reduces burden of Ill-health.
3. Better support and equip our CYP to manage their mental health in future given 75% of MH diagnosed by age 24.
4. Design a new model for mental health workforce including voluntary and community sector and peer support to tackle mental health recruitment and retention issues.
5. Expand bio-psycho-social care to address the mortality gap and the opportunity to increase years of quality life.
6. Co-produce this strategy and delivery with service users/ residents in SWL, putting partnership with those who use services and those in our communities at the heart of everything we do.

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SWL Mental Health strategy themes

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

The Strategy has 4 themes:

1. Prevention and early support inc (a) Children and Young People and family support, (b) healthy environments and (c) mental health literacy and reducing stigma
2. Bio-psycho-social model inc (a) physical healthcare for people with serious mental illness, (b) neighbourhood teams & integration and (c) complex needs & co-occurring issues
3. Inequalities inc. (a) unwarranted variation and (b) at risk communities
4. Timely access inc. (a) least restrictive care & recovery, (b) waiting times. (c) transitions and (d) discharge

The outcomes (at 3, 5 and 10 years) are being developed at present along with a delivery approach for year 1. This is linked to the SWL mental health planning work which is managed as a sub-group of the SWL MH PDG.

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Horizon Scanning

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

SUPPORT FOR VULNERABLE ADOLESCENTS - National Audit Office report

- 50% of mental health problems are established by 14 and 75% by 24.
- 142% increase in referrals of children to secondary mental health services between 2016-17 and 2021-22
- 72% of children sentenced in 2019-20 had mental health concerns
- 21.3% of 16-24 year-old NEETs had a mental health condition
- 17.4% of 6-16 year-olds had a probable mental health disorder in 2021, an increase from 11.6% in 2017. Almost 40% had experienced a deterioration in mental health since 2017

NHS PROVIDERS STATE OF THE PROVIDER SECTOR 2022

- 85% of leaders are more concerned about this winter than any previous winter
- 86% are worried about having the capacity to meet demand
- 77% are worried about the numbers, quality and mix of staff
- 93% are concerned about 'burnout' and 80% worried about morale.
- 84% say it is unlikely that their trust will end the financial year in a better financial position than it ended 2021/22.
- 94% are worried that not enough investment is being made in social care.

CQC MONITORING THE MENTAL HEALTH ACT IN 2021-22

- Workforce and staff shortages mean that people are not getting level or quality of care. Safety of patients and staff is being put at risk.
- Gaps in community mental health care are compounding rising inpatient demand
- Urgent action needed to tackle the over-representation of people from some ethnic minority groups
- The quality of ward environments is an ongoing concern,
- Examples of good practice around advance planning and applying the principle of least restriction.

'UNDERSTANDING ETHNIC INEQUALITIES IN MENTAL HEALTH'

- Need a model of mental health that is responsive to the lived experiences of people in ethnic minority groups
- Better alignment needed of mental health services with social and anti-racist models of care
- Intersections related to racism, migration, religion, and complex trauma might be more relevant than ethnic group classifications.
- Strategies to tackle ethnic inequalities in mental healthcare require an evaluation of individual, systemic, and structural obstacles to authentic and meaningful coproduction and implementation of existing community recommendations in services.

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Horizon Scanning

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

PAY REVIEW BODY REMIT

- DHSC SSRB remit letter: 2023 to 2024 pay round
- Review Body on Doctors' and Dentists' Remuneration remit letter: 2023 to 2024 pay round
- NHS Pay Review Body remit letter: 2023 to 2024 pay round
- *"As described during last year's pay round, the NHS budget has already been set until 2024 to 2025. Pay awards must strike a careful balance – recognising the vital importance of public sector workers while delivering value for the taxpayer… not increasing the country's debt further. In the current economic context, it is particularly important that you also have regard to the government's inflation target."*

AUTUMN STATEMENT 2022

- £6.6bn funding for the NHS over the next two years and maintaining departmental settlements as set out in the Oct 2021
- The government will continue with the New Hospital Programme and will introduce measures to support workforce and improve performance
- ensure the NHS has the workforce it needs for the future, including publishing a comprehensive workforce plan next year
- further measures to support greater local decision making and freedom for healthcare professionals.

2023/24 priorities and operational planning guidance

- Improve access to mental health support for children and young people in line with the national ambition
- Increase the number of adults accessing IAPT treatment
- Achieve a 5% year on year increase in the number of adults supported by community mental health services
- Work toward eliminating adult acute out of are a placements
- Recover dementia diagnosis to 66.7%
- Improve access to perinatal mental health services

Also:

- Continue to achieve the Mental Health Investment Standard by increasing expenditure by more than allocations growth
- Develop a workforce plan that supports delivery of the system's mental health delivery ambition, working closely with ICS and the VCSE sector
- Improve mental health data to evidence the expansion and transformation
- Set out how the wider commitments in the Implementation Plan will be taken forward to improve the quality of local mental healthcare

NHS England will:

- continue to support the growth in IAPT workforce by providing 60% salary support for new trainees in 2023/24
- Support ICBs to co-produce a plan by 31 March 2024 to localise and realign mental health and learning disability inpatient services over a three year period as part of a new quality transformation programme

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Key questions to have in mind

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

1. We are proud of how we have remained focused on the delivery of our 22/23 Corporate Objectives. How can the Board support our teams to continue this focus and not become overwhelmed with other priorities?
2. Our workforce, and ensuring continued recruitment and retention, is the key to unlocking the challenges we have with quality and finance. However workforce remains our biggest challenge, especially in the context of continued strike action and cost of living increases. How can the Board support this work?
3. We have successfully moved into Trinity and our corporate staff into Tolworth. Moves into Shaftesbury, Teddington and Morrison will take place in the New Year. How do we ensure that we use these moves, and the opportunities of our new buildings , to shift our culture?

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Use of the Trust seal

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

Date	Type	Signatories
08.11.2022	License to Alter Works to Livingstone House must be started within two months of the date of the license and completed within six months. The Trust is to provide the head landlord with a copy of any EPC and recommendation report following works	Chief Executive Officer and Director of Finance and Performance
16.11.2022	Section 106 Agreement Change CAMHS school room windows	Chief Executive Officer and Director of Finance and Performance
17.11.2022	Deed of Surrender Agreement and Part Variation Lavender Ward move from QMH to Springfield Hospital	Director of Finance and Performance and Chief Operating Officer
07.12.2022	ET Settlement Agreement	Chief Executive Officer and Director of Finance and Performance
07.12.2022	Barnes Hospital - Contract for Sale Freehold Land for vacant possession for Barnes Hospital between SWLSTG and Secretary of State for Levelling Up, Housing and Communities	Chief Executive Officer and Chief Operating Officer
07.12.2022	Engrossment Contract/Lease Birches House between SWLSTG and NHS Property Services Ltd	Chief Executive Officer and Director of Finance and Performance
15.12.2022	8th Deed of Variation on the Section 106 as part of the planning permission at Springfield between SWLSTG, Wandsworth Borough Council and Transport for London (intended bus route for G1 bus route).	Chief Executive Officer and Director of Finance and Performance

Meeting	Trust Board
Date of meeting:	12th January 2023
Report title:	**Quality and Safety Assurance Committee Chair's Report**
Author:	Deborah Bowman, Non-Executive Director, Committee Chair
Executive sponsor:	N/A
Purpose:	For report

1. INTRODUCTION

This report covers the November and December meetings of QSAC. At Board, I will provide verbal report on the January QSAC, with a written report to follow at our next meeting.

The reports received and items discussed by QSAC are described in the minutes. The November Board received a report further to the committee's consideration of the *Quality and Safety in Inpatient Services* circular from the National Director of Mental Health. See also section 11 *post*.

In addition to the committee's regular detailed consideration of the executive risk register, Quality Matters and Quality and Performance reports, I would like to draw the Board's attention to the following key areas of the committee's assurance, discussion and scrutiny.

2. PATIENT SURVEY

QSAC received a detailed report on the outcome of the recently published CQC survey of community mental health patients. The full report is appended. An action plan is due for consideration at February QSAC. Highlights included:

- "Overall experience"– nationally we are 25th out of 51, compared to 21st last year. We are 2nd in London, compared to 3rd last year;
- "Overall views on care and services" – nationally SWLSTG is 22nd out of 51 (up from 25th last year), and 4th in London;
- "Total" column – we are 22nd nationally, down from 13th last year. SWLSTG is 5th in London compared to 3rd last year.

- Our best section score was again in “feedback” (7th in England);
- Our weakest was in the new section on “responsive care” (37th nationally); and
- Our overall ranking compared to the other 50 mental health trusts declined in 8 out of 11 comparable sections. Our largest falls were in crisis care and talking therapies. The committee agreed that crisis care should be a priority focus based on the survey results.

QSAC noted the results and discussed the implications, particularly in relation to those areas in which performance was below the mean and/or had declined. The committee welcomed information regarding the ways in which these data will be used to inform and develop the existing action plan that had been developed following the last survey to ensure that a coherent and efficient approach is taken to developing the plan to come to February QSAC.

3. SAFER STAFFING

The committee was assured that an annual comprehensive review was completed in September and October 2022.

To ensure that all wards are staffed safely the Trust has put in place comprehensive temporary staffing arrangements involving the Trust Bank and support from nursing Agencies (all on framework) as a secondary resource. These arrangements ensure that shifts are covered when staff take sick leave but particularly when extra staff are required for support with increased therapeutic observations. Increased observations accounted for 68% of all the additional shifts created.

The review indicated that the current staffing arrangements across the Trust are safe and adequately monitored. There was no request for additional posts or a change in skill mix. The daily safer staffing meetings ensure that gaps in staffing are picked up and remedial action is taken to ensure that all clinical areas are safely staffed.

There are no recommendations to increase our minimum safer staffing inpatient establishment. The report provided assurance that the Trust fulfils its nursing inpatient safer staffing requirements on shift-by-shift and reporting and monitoring bases.

The committee noted significant challenge in terms of recruiting and retaining our permanent nursing workforce. Vacancy rates have remained above the 19.2% average since September 2021. Vacancy rates for inpatient services for September 2022 were 20%. This is down from the previous month where permanent nursing post vacancies were 21.3%. The direct employment programme continues to influence recruitment the trend downwards for vacancies. A new cohort of 87 newly qualified graduate nursing staff are available in September and October which has a positive impact on the vacancy rate. The Director of Nursing and Quality has completed an inpatient nursing sustainability review which will be incorporated into the annual business planning cycle. A separate report will be commissioned to review nursing workforce sustainability for the next five years, also beginning the process to grow our own nursing workforce to support safe staffing at the new Tolworth Hospital. It will include increasing our Nursing Associate workforce, along with developing Advanced Clinical Practitioner (ACP) roles to support new ways of working, e.g. non-medical prescribing and supporting nurses to assume roles such as responsible clinicians

(RC). There will be cost implications and those will be considered as part of the annual business planning cycle and subject to governance via the appropriate committees.

QSAC also noted that bed occupancy data illustrated the acuity of our inpatient services: it has remained high particularly for the adult acute wards and PICU. The full Safer Staffing report is available for Directors on Diligent in the November QSAC papers. The committee noted that there is a national requirement for the safer staffing review to include staffing levels in community services and was advised that a report will follow in 2023. Board will, of course, be advised of the assurance position and discussion following receipt of that community services Safer Staffing report.

4. REVIEW OF QUALITY AND PERFORMANCE REPORT PRIORITY METRIC STANDARDS

Further to discussions around performance improvement and its evaluation at previous QSAC meetings, we received a report on the review of Q&P report priority metric standards. The review considered standards against national requirements, as well as exploring the rationale behind local targets within the Q&P priority metric set.

Proposals for amendments to the current standards reflected the current context within which the Trust is working to support more realistic ambitions for improving performance. The proposals excluded those metrics where the Trust is subject to a national standard (all of which remain priority metrics). The principle being that national standards should be monitored at Board level, with more detailed and/or locally-agreed stretch targets monitored as supporting metrics within the Trust's Q&P framework.

The Q&P metric set, including standards, are reviewed on an annual basis and therefore may be amended via the usual processes. QSAC accepted the proposals made in the review and will monitor the impact closely, reporting to Board regularly.

5. CLINICAL RISK DEMAND AND CAPACITY

As Board colleagues are aware, the Trust faces challenges in both performance and quality given the extraordinary context in which services are being provided. Specifically:

- Intense demand for mental health services since the pandemic;
- A national workforce crisis; and
- Local HR issues that affect our workforce.

Our challenges can be categorised as follows (nothing that these categories intersect):

i. Productivity;
ii. Performance improvement; and
iii. Quality of services, especially our approach to a) managing clinical risk where demand exceeds capacity; and b) best practice standardisation of processes.

Each of these categories require a focused and innovative response that attends to them individually and collectively. In November, QSAC had a focused discussion on the Trust's approach to managing clinical risk and service quality in the context of high demand and constrained capacity.

Extensive work has been undertaken by the Clinical Directors supported by the members of the ELT to identify, consider and evaluate approaches to these challenges. A range of proposals were discussed with the group and more widely with service line leadership teams falling within three main headings, namely:

- Our clinical offer;
- Our thresholds; and
- Enhancing acute discharge decision-making

QSAC heard the following was planned :

- further data analysis;
- ongoing monitoring of the Psychology & Psychotherapies clinical offer linked to the P&P strategy under development;
- a refreshed community patient discharge policy for adults and CAMHS services, accompanied by an implementation plan;
- proposals for new medication pathways in primary care; and
- the development of purposeful admission and integrated discharge teams by the A&UC team as part of their transformation and improvement programme.

The committee will continue to review and consider the progress and effectiveness of this work.

6. ROOT CAUSE ANALYSIS APPROACH TO PERFORMANCE IMPROVEMENT

The Board and its subcommittees have discussed the ongoing challenges in improving performance across the Trust, with the Q&P report showing multiple areas of 'red' performance for some time.

Acknowledging the challenging context of demand, acuity, and shortages in resource and workforce, QSAC welcomed executive director recognition of, and commitment to, the imperative to improve performance. The committee was advised that, in partnership with Service Lines, a Root Cause Analysis session considered the most "stuck" KPIs, aiming to identify actions. That session resulted in a focused action plan across several performance domains building on business plans and SLR reviews with an emphasis on outcome measurement. QSAC particularly welcomed the attention to recovery outcomes and use of crisis services (noting the findings of the patient survey, discussed at section 2 *ante*).

QSAC noted the pace and limited impact of improvement plans to date and was advised that a QI-focused Service Line Review improvement session will focus on RCA action plans. In addition, there will be greater executive oversight and support e.g. QI check ins, quarterly review and escalation meetings.

7. HEALTH AND SAFETY ANNUAL REPORT

QSAC noted improvements in the reporting of incidents of violence and aggression. The total number of reports has doubled compared to the previous year which may indicate a more accurate and effective reporting regime. Board colleagues will recall from previous Chair's report that QSAC received and discussed the Restrictive Practice annual report in September 2022 which included consideration of the Safety in Motion programme which is key in reducing violence and aggression.

24 RIDDOR reportable incidents were submitted to the Health and Safety Executive; an increase of 42% compared to the previous year. 90% were injuries related to violence and aggression.

QSAC welcomed progress in manual handling training compliance. However, the committee noted that improvement is required in relation to Physical Interventions and Conflict Resolution and Breakaway training.

17 of the 25 Ligature Anchor Points Risk Assessments have been completed and associated action plans are being monitored. The remaining are scheduled to be completed by the end of the financial year. QSAC was pleased to note that all ligature risk assessments have taken place within their agreed review periods.

8. COMPLIANCE

The committee received formal reports providing assurance on compliance in important areas of quality and safety, namely:

- Guardian of safe working hours
- Nurse revalidation
- Medical revalidation
- Duty of candour
- Same sex accommodation

QSAC had no concerns regarding the above. The full reports are available for Directors on Diligent.

9. ETHNICITY AND MENTAL HEALTH IMPROVEMENT PROJECT (EMHIP)

The committee received a report about EMHIP, specifically work by the cross-system delivery group on a 3-year phased approach to interventions in Wandsworth (beginning in 2021/22). Two of the five initiatives are running concurrently, with the two initiatives to begin shortly. Although there have been some changes and delays, the strategic goals and objectives remain the same. SWLSTG aligns delivery with Trust priorities, especially our transformation agenda.

QSAC heard that the inclusion of a broader range of stakeholder groups has enhanced collaboration, coproduction and the alignment of expectations with project goals. Executive colleagues reflected that these developments have supported the Trust's involvement and suggested that fostered stronger relationships and mitigated potential reputational risks.

QSAC welcomed news of a framework and commission of an independent agency to evaluate the programme from April 2023.

10. LEARNING DISABILITIES AND AUTISM

The December committee received a report on Learning Disabilities and Autism.

Benchmarking: the implementation of the action plan from the previous Green Light Tool Kit audit facilitated improvements. However, over three years have passed since the last survey. As such, a new survey will follow and QSAC will receive more current information about benchmarking.

NHS Learning Disabilities Improvement Standard: The action plan from the 2019/2020 NHS Learning Disabilities Improvement Standard audit remains in progress and subject to monitoring. The report of the latest data submission is being reviewed and the 2022 data collection project is ongoing.

Positive Behaviour Support Training: QSAC was disappointed to hear that uptake of this training continues to be an area where improvement is required. The committee will take a particular interest in participation rates in the coming year.

Autism Strategy: SWLSTG continues to implement the autism strategy and respond to future initiatives arising from the review of the NICE standards.

Flagging system: QSAC heard that developing a flagging system for service users with learning disabilities and/or autism remains challenging. The committee welcomes the ongoing work with the information management and IT teams to improve our capacity to identify service users with additional needs.

A lead nurse for learning disabilities and autism has been recruited. QSAC heard that a framework document will be developed to ensure ongoing monitoring and implementation of action plans.

11. SAFETY CULTURE

The committee received a report on the Trust's response to the recent NHS England publication "*Safety culture, learning from best practice.'* A self-assessment is underway; see B1760-safety-culture-learning-from-best-practice.pdf (england.nhs.uk)

12. RECOMMENDATIONS

The Board is asked to:

1) Endorse the Safer Staffing report;
2) Note and receive this Chair's report; and
3) Note and receive the appended approved QSAC minutes.

ATTACHMENTS

Patient survey

NHS Community Mental Health Survey Benchmark Report 2022

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

NHS
Care Quality Commission
Survey Coordination Centre

Contents

This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the Community Mental Health Survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Community Mental Health Survey has been conducted almost every year since 2004. The CQC use the results from the survey in its assessment of mental health trusts in England.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

Community Mental Health Survey

The survey was administered by the Survey Coordination Centre for Existing Methods (SCCEM) at Picker Institute.

The 2022 survey of people who use community mental health services involved 53 providers of NHS community mental health services in England. We received responses from 13,418 people, a response rate of 20.9%.

People aged 18 and over were eligible for the survey if they were receiving care or treatment for a mental health condition and were seen face-to-face at the trust, via video conference or telephone between 1 September 2021 and 30 November 2021. For more information on the sampling criteria for the survey, please refer to the sampling instructions detailed in the 'Further information' section. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between February and June 2022.

Trend data

The Community Mental Health Survey is comparable back to the 2014 survey. Trend data is presented in this report for questions that have been asked in previous survey years.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about the CQC's survey programme, please visit the CQC website.

Key terms used in this report

The 'expected range' technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age and sex, can influence service users' experience of care and the way they report it. For example, research shows that older people report more positive experiences of care than younger people. Since trusts have differing profiles of service users, this could make fair trust comparisons difficult. To account for this, we 'standardise' the results, which means we apply a weight to individual service user responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by the age and sex of respondents to reflect the 'national' age-sex type distribution (based on all respondents to the survey).

This helps ensure that no trust will appear better or worse than another because of its profile, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example Q1) and others are 'routing questions', which are designed to filter out respondents to whom the following questions do not apply (for example Q23). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

National average

The 'national average' mentioned in this report is the arithmetic mean of all trusts' scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the service users who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve.
- **Change over time** – displays your trust score for each survey year. Where available, trend data will be shown from 2014 to 2022. Questions are displayed in a line chart with the trust mean plotted alongside the national average. Statistical significance testing is also shown between survey years 2022 vs 2021. This section highlights areas your trust has improved on or declined in over time.
- **Appendix** – includes additional data for your trust; further information on the survey methodology; and interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey. Additionally, line charts show your trust's trend data over time.

The two chart types used in the section 'Benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; technical document: http://www.cqc.org.uk/cmhsurvey
- National and trust-level data for all trusts who took part in the Community Mental Health Survey 2022 https://nhssurveys.org/surveys/survey/05-community-mental-health/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors hospitals: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the best and worst scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of service users who took part in the survey.

1250 invited to take part

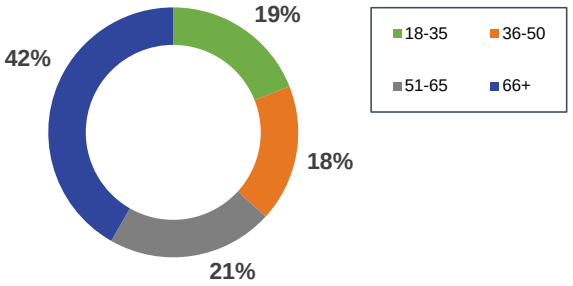
242 completed

20% response rate

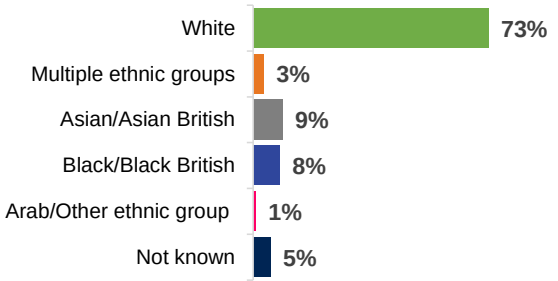
21% average response rate for all trusts

27% response rate for your trust last year

AGE



ETHNICITY



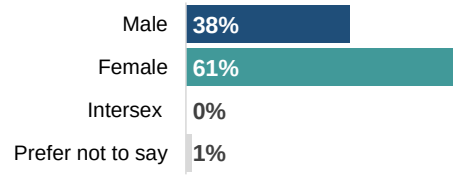
LONG-TERM CONDITIONS

93% of service users have a **physical or mental health condition or illness that has lasted or is expected to last for 12 months or more.**

Number of long-term conditions reported:

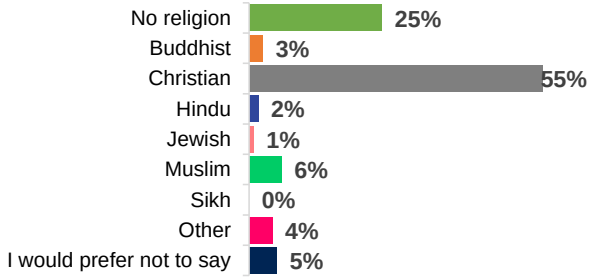
SEX

At birth were you registered as…



2% of service users said their **gender is different from the sex they were registered with at birth**.

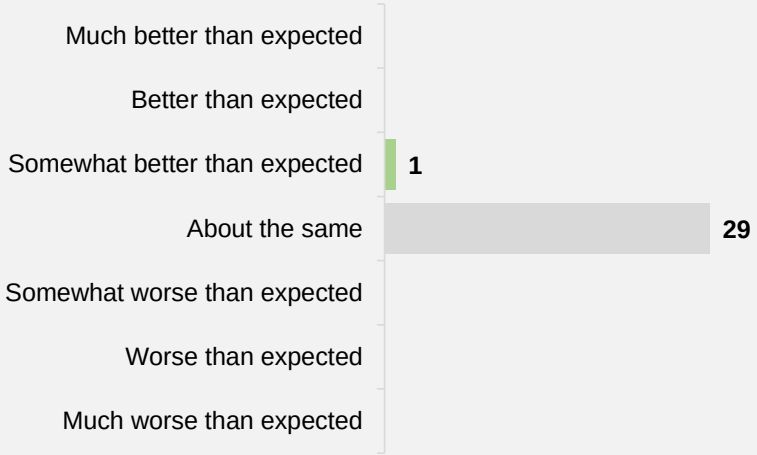
RELIGION



Summary of findings for your trust

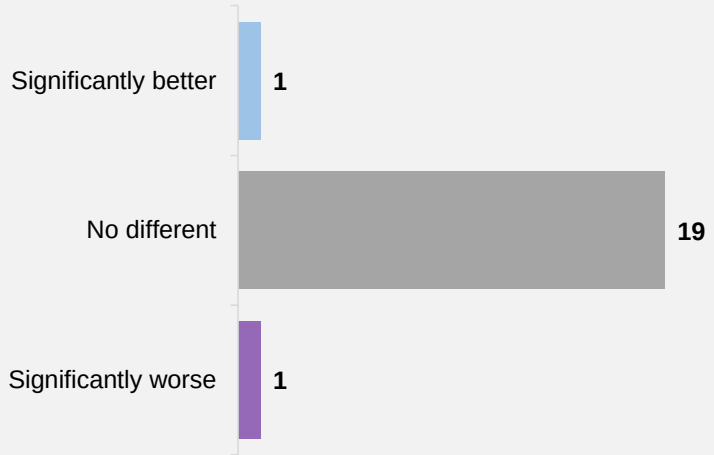
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2022 vs 2021.

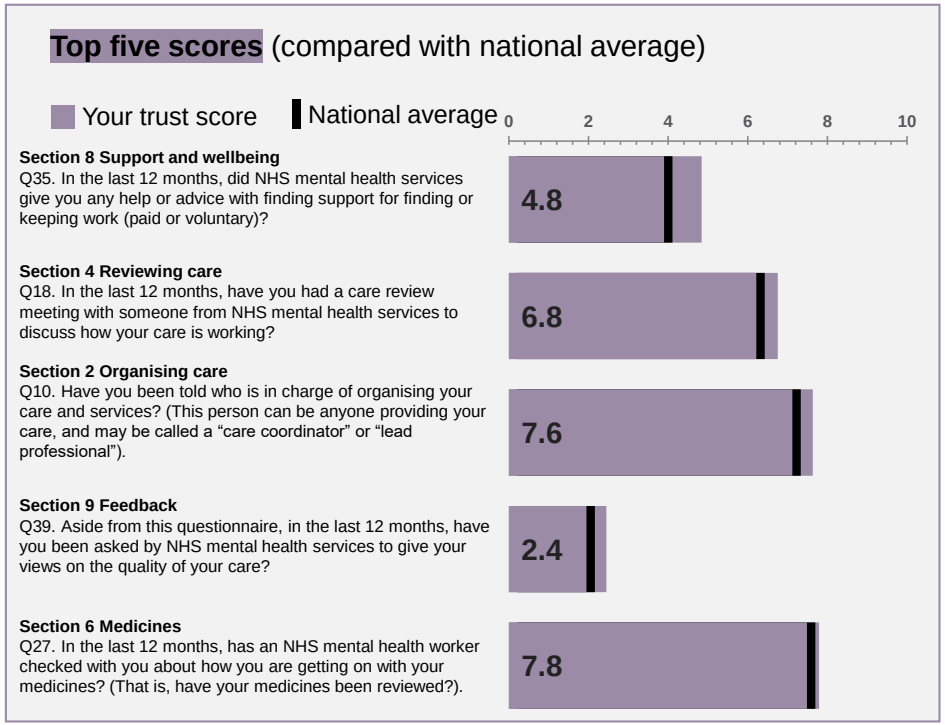


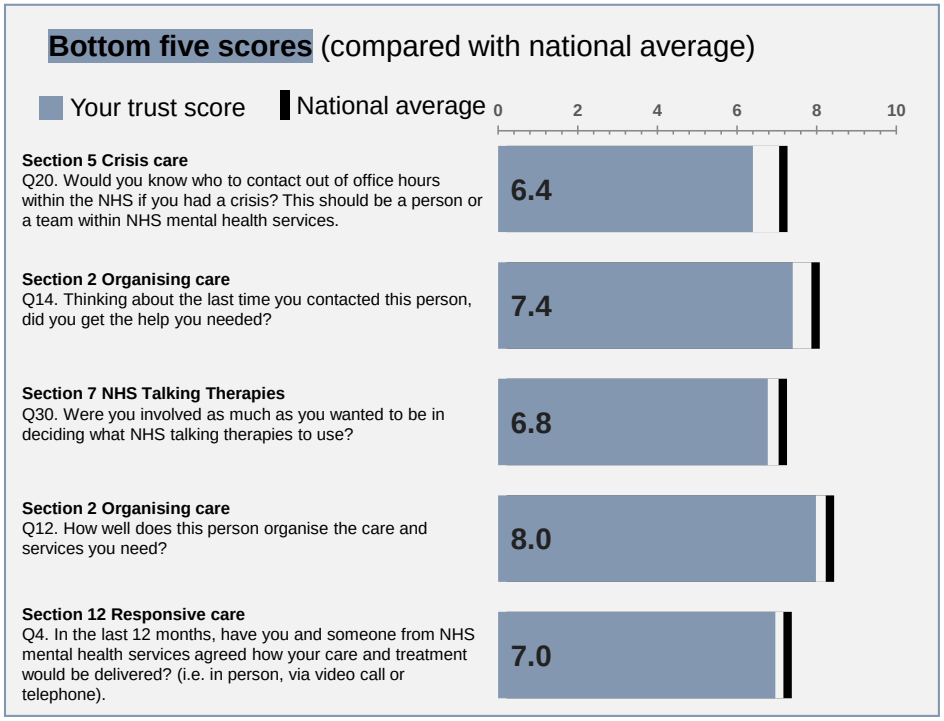
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "your trust has performed much worse" , "your trust has performed worse" , "your trust has performed somewhat worse", "your trust has performed somewhat better", "your trust has performed better", "your trust has performed much better" .

Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the national average.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.





Benchmarking

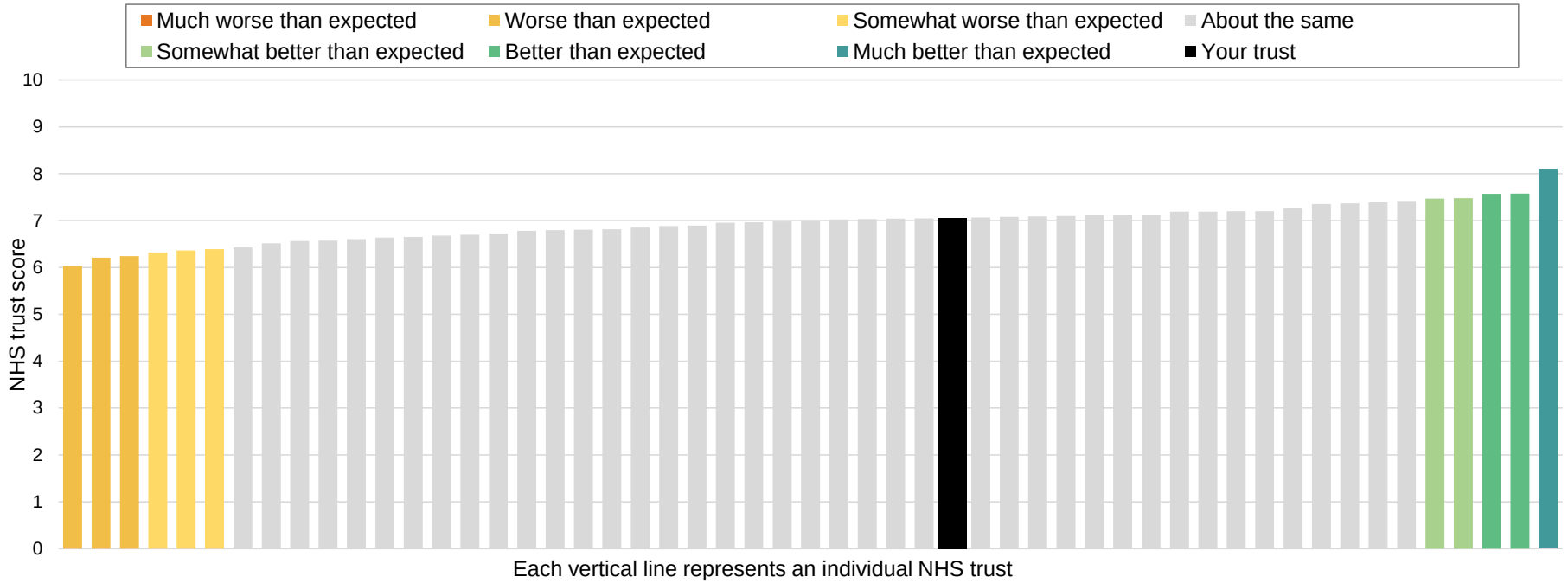
This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part.
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts.

Section 1. Health and social care workers

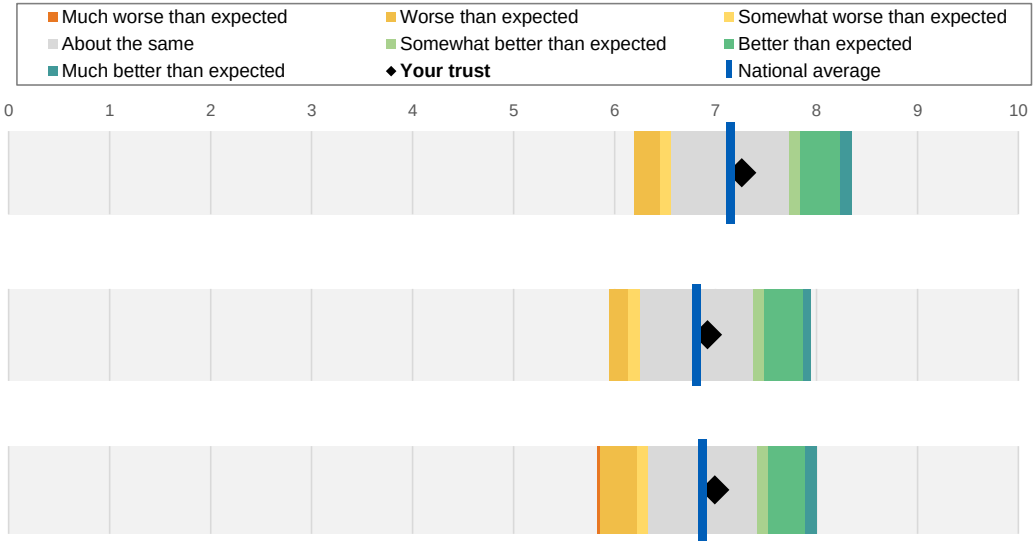
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.1 About the same



Section 1. Health and social care workers (continued)

Question scores

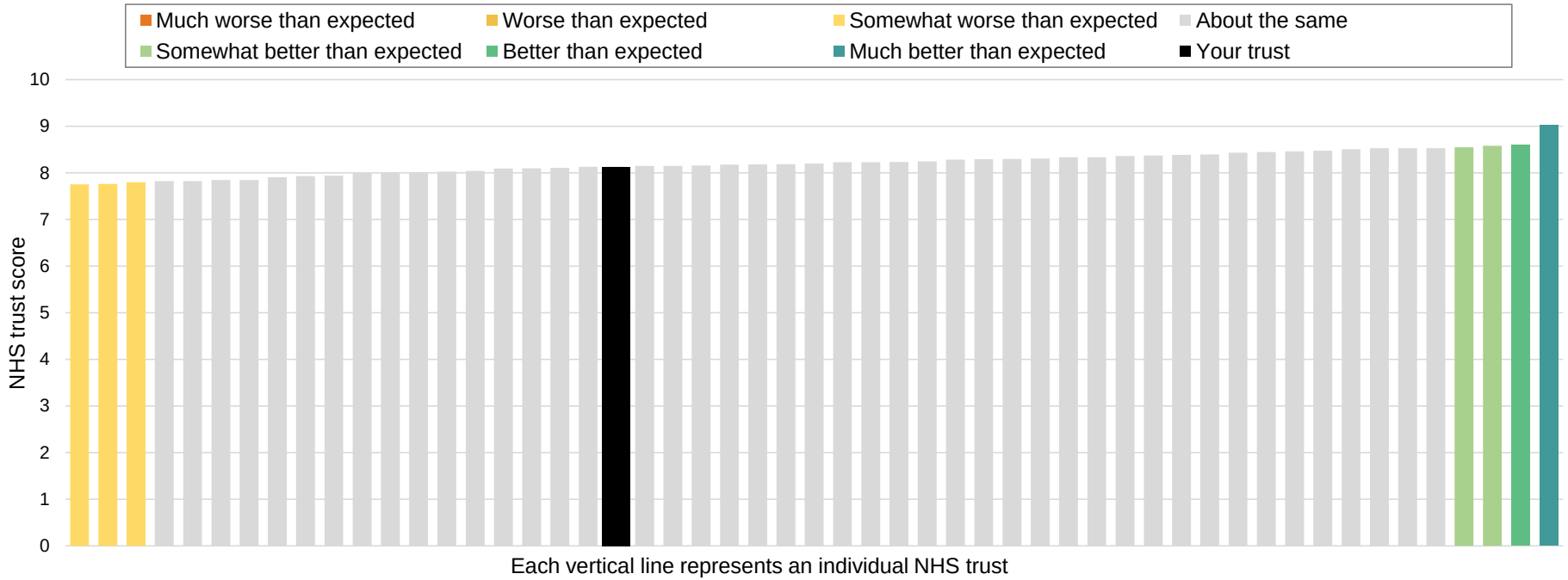


		All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score	
Q7. Were you given enough time to discuss your needs and treatment?	226	7.3	7.1	6.2	8.4	About the same
Q8. Did the person or people you saw understand how your mental health needs affect other areas of your life? (This includes contact in person, via video call and telephone).	216	6.9	6.8	5.9	7.9	About the same
Q9. Did the person or people you saw appear to be aware of your treatment history? (This includes contact in person, via video call and telephone).	209	7.0	6.9	5.8	8.0	About the same

Section 2. Organising care

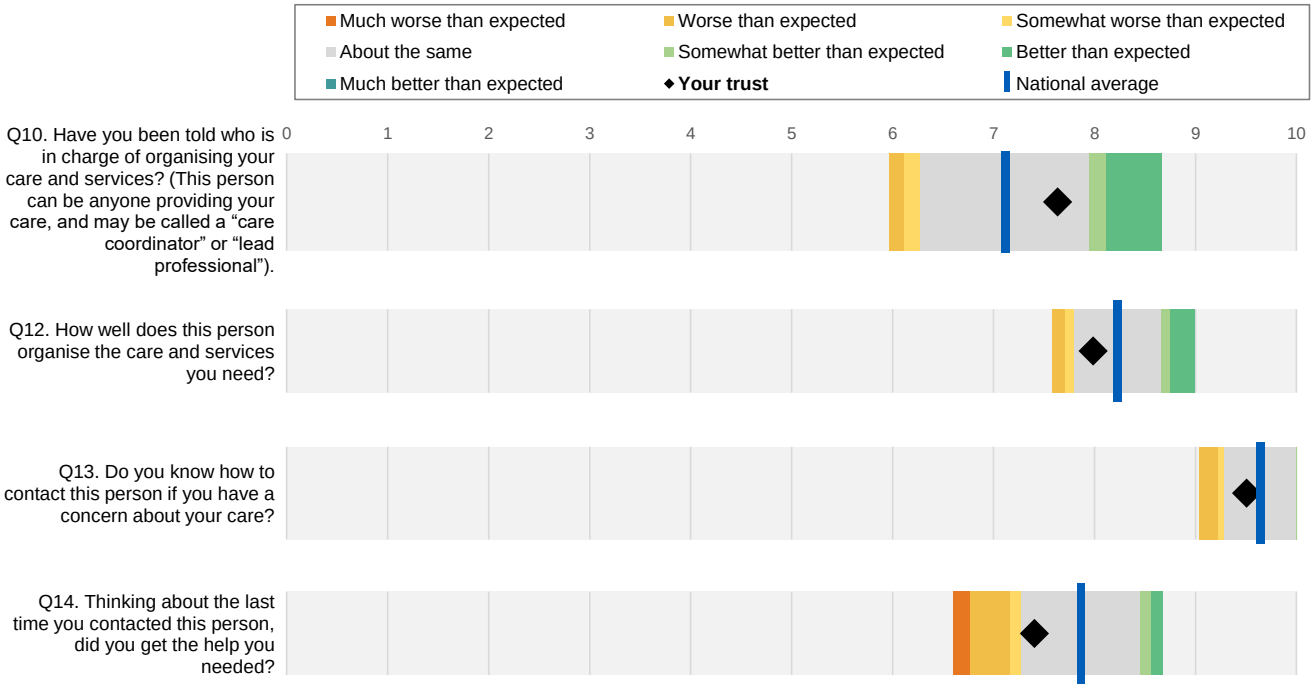
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.1 About the same



Section 2. Organising care (continued)

Question scores

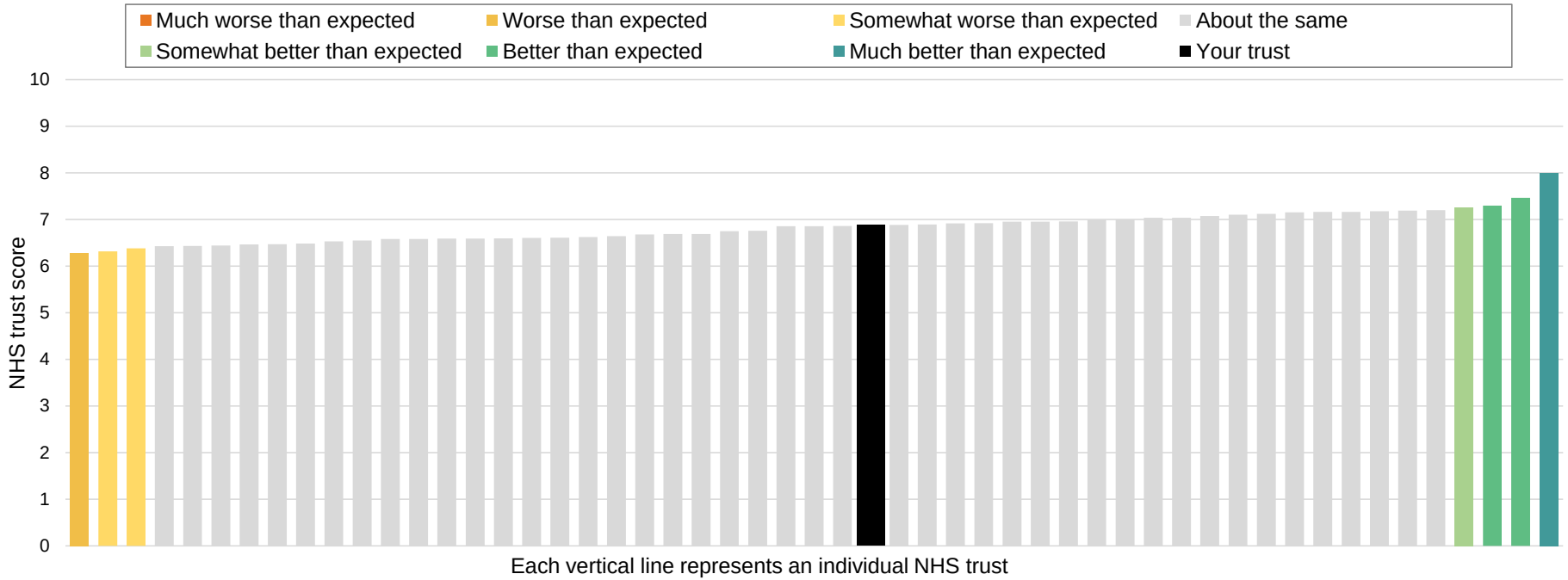


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same: 194	7.6	7.1	6.0	8.7
About the same: 109	8.0	8.2	7.6	9.0
About the same: 109	9.5	9.6	9.0	10.0
About the same: 100	7.4	7.9	6.6	8.7

Section 3. Planning care

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.9 About the same



Section 3. Planning care (continued)

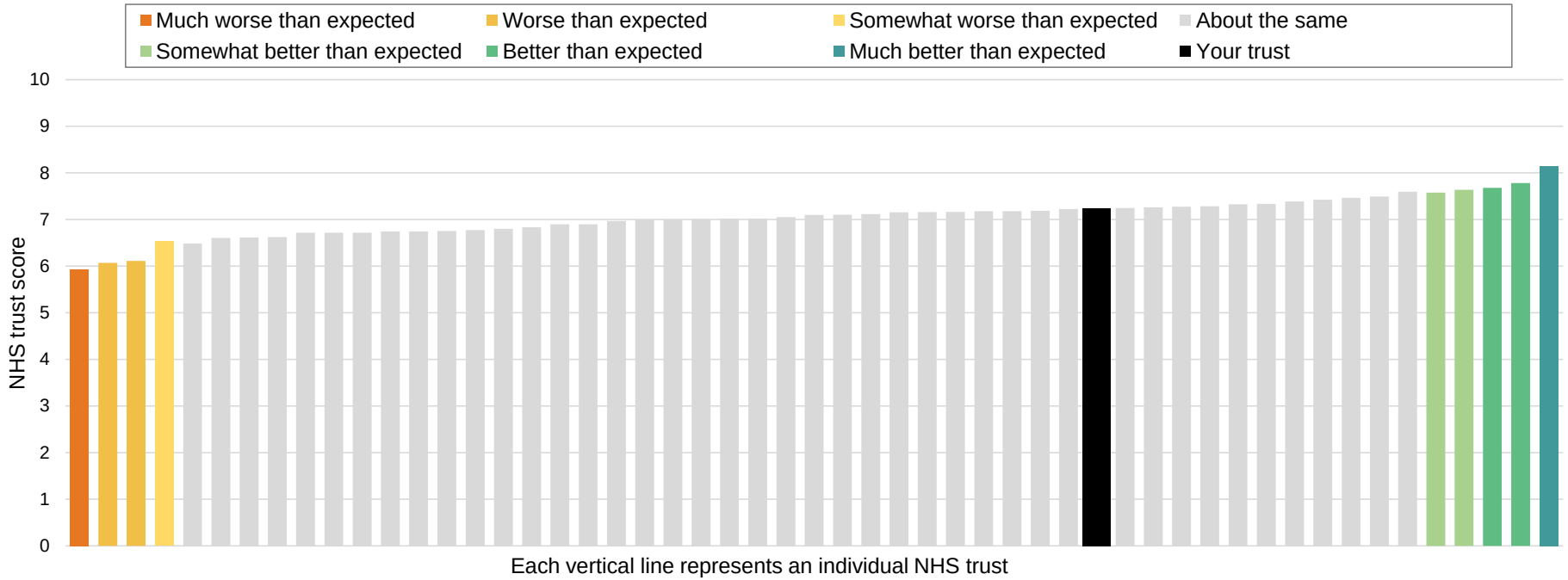
Question scores

		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same				
202	6.2	6.1	5.0	7.6
About the same				
151	7.5	7.4	6.7	8.3
About the same				
147	7.0	7.0	6.3	8.0

Section 4. Reviewing care

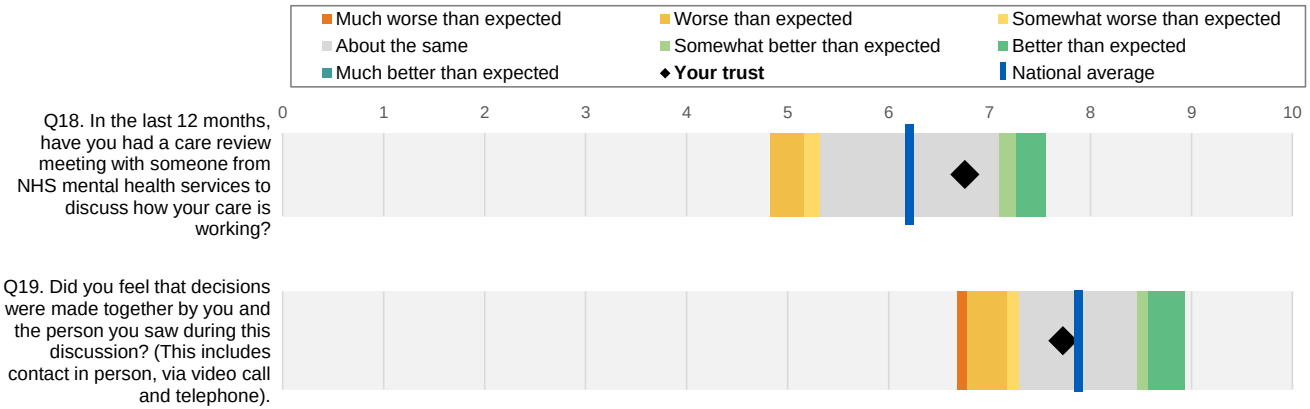
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.2 About the same



Section 4. Reviewing care (continued)

Question scores

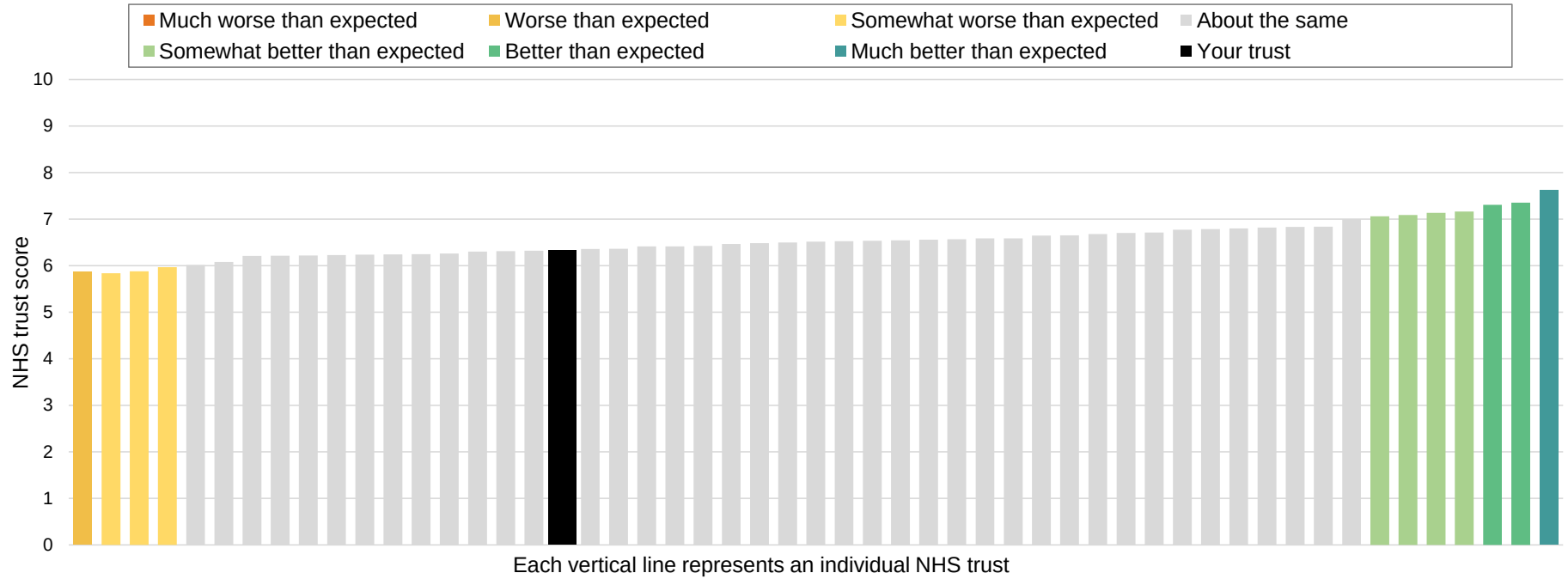


			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	166	6.8	6.2	4.8	7.6
About the same	105	7.7	7.9	6.7	8.9

Section 5. Crisis care

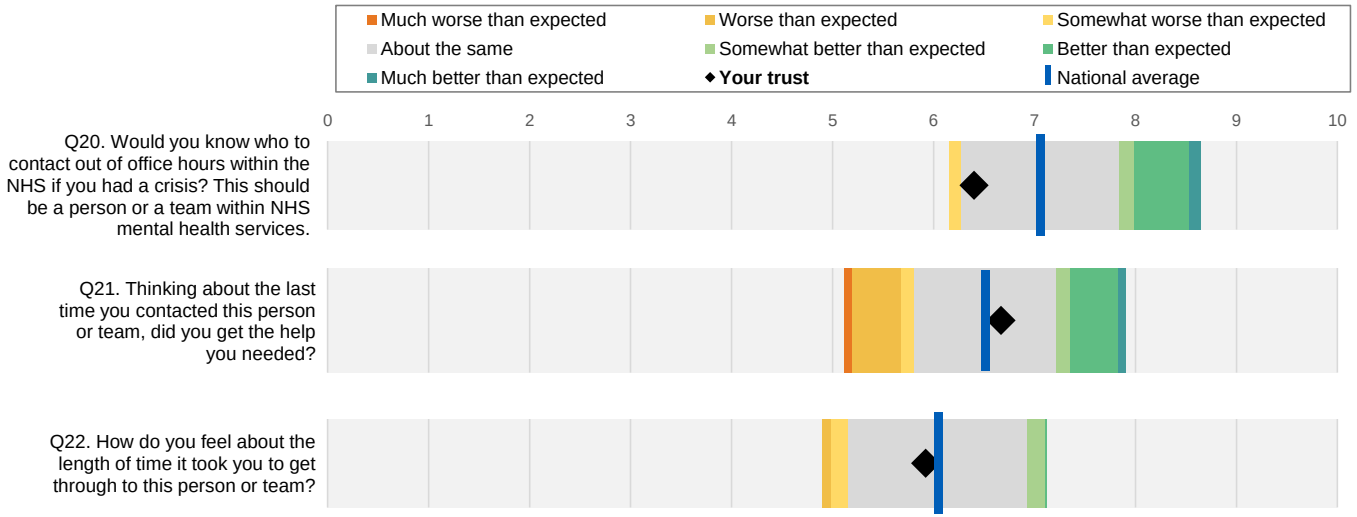
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.3 About the same



Section 5. Crisis care (continued)

Question scores

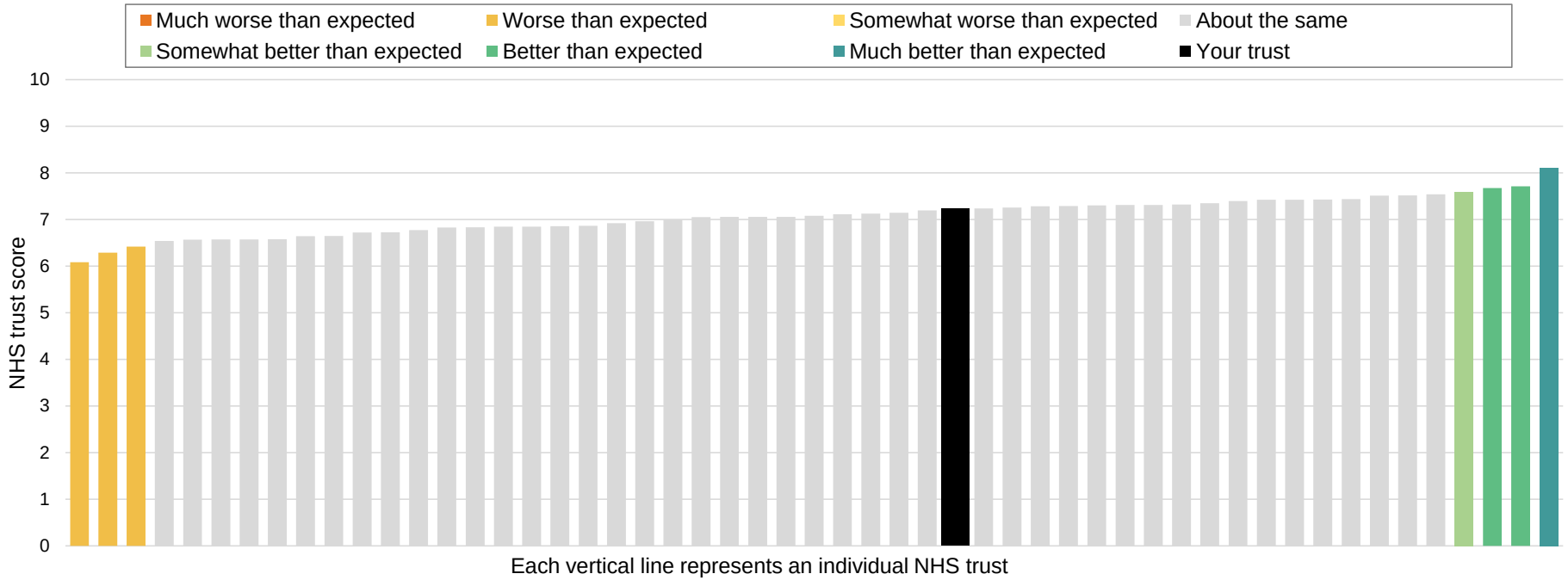


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Q20. Would you know who to contact out of office hours within the NHS if you had a crisis? This should be a person or a team within NHS mental health services.				
189	6.4	7.1	6.2	8.6
About the same				
Q21. Thinking about the last time you contacted this person or team, did you get the help you needed?				
93	6.7	6.5	5.1	7.9
About the same				
Q22. How do you feel about the length of time it took you to get through to this person or team?				
81	5.9	6.0	4.9	7.1
About the same				

Section 6. Medicines

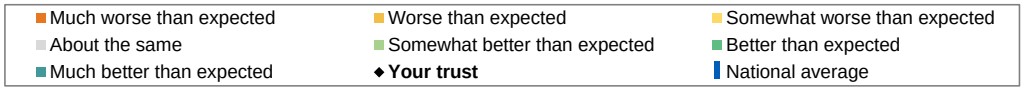
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

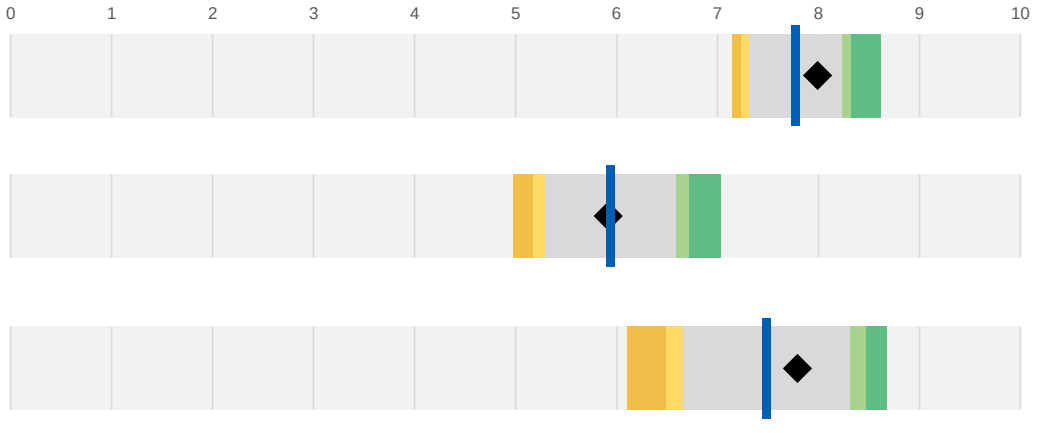
Your trust section score = 7.2 About the same



Section 6. Medicines (continued)

Question scores





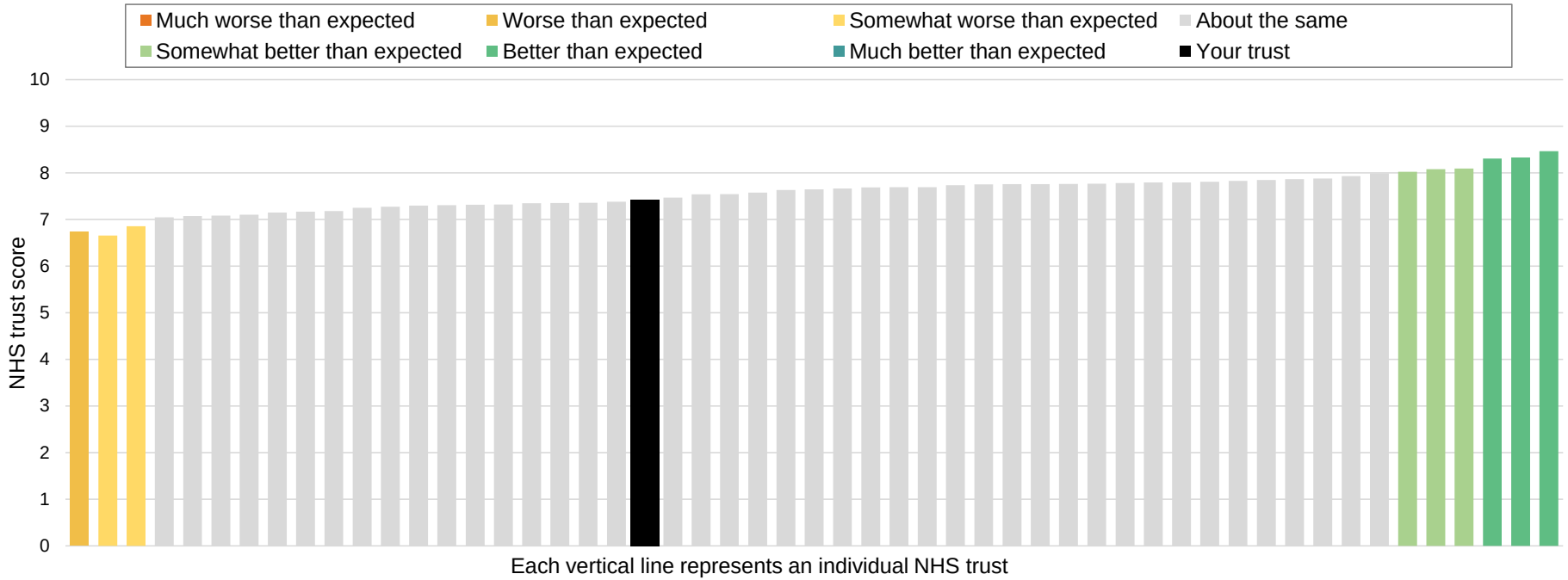
			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
Q24. Has the purpose of your medicines ever been discussed with you?	177	8.0	7.8	7.2	8.6
Q25. Have the possible side effects of your medicines ever been discussed with you?	172	5.9	5.9	5.0	7.0
Q27. In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines? (That is, have your medicines been reviewed?).	136	7.8	7.5	6.1	8.7

Q24. Has the purpose of your medicines ever been discussed with you?	About the same
Q25. Have the possible side effects of your medicines ever been discussed with you?	About the same
Q27. In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines? (That is, have your medicines been reviewed?).	About the same

Section 7. NHS Talking Therapies

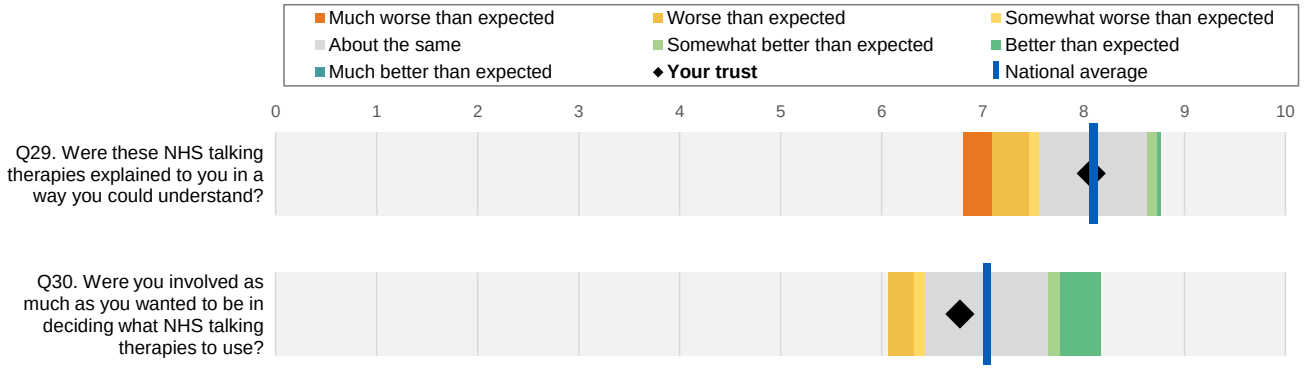
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.4 About the same



Section 7. NHS Talking Therapies (continued)

Question scores

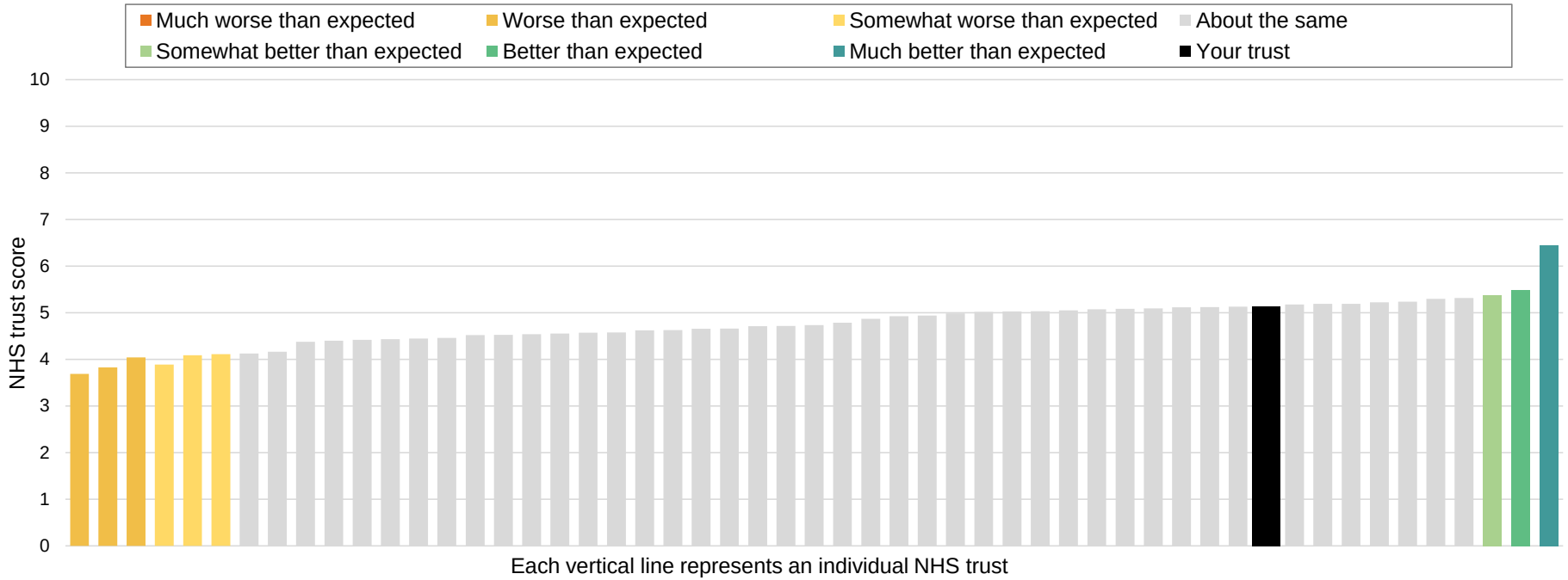


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Q29. Were these NHS talking therapies explained to you in a way you could understand?				
85	8.1	8.1	6.8	8.8
About the same				
Q30. Were you involved as much as you wanted to be in deciding what NHS talking therapies to use?				
85	6.8	7.0	6.1	8.2
About the same				

Section 8. Support and wellbeing

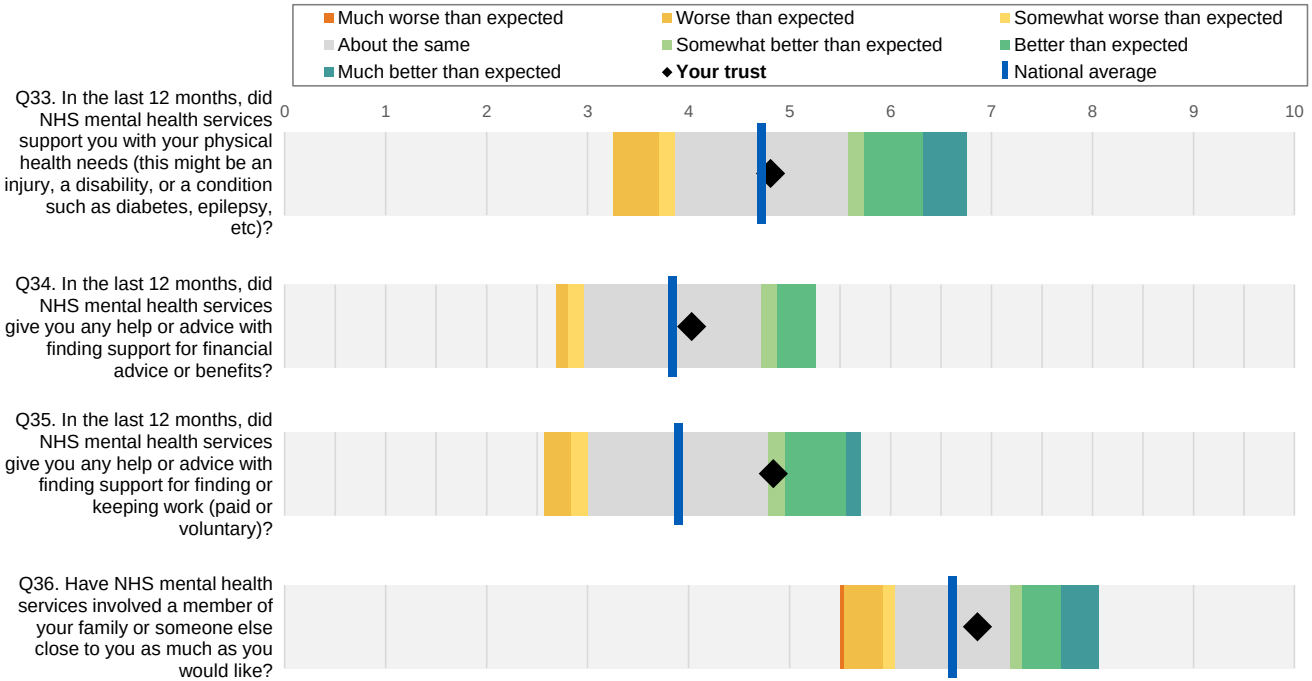
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 5.1 About the same



Section 8. Support and wellbeing (continued)

Question scores

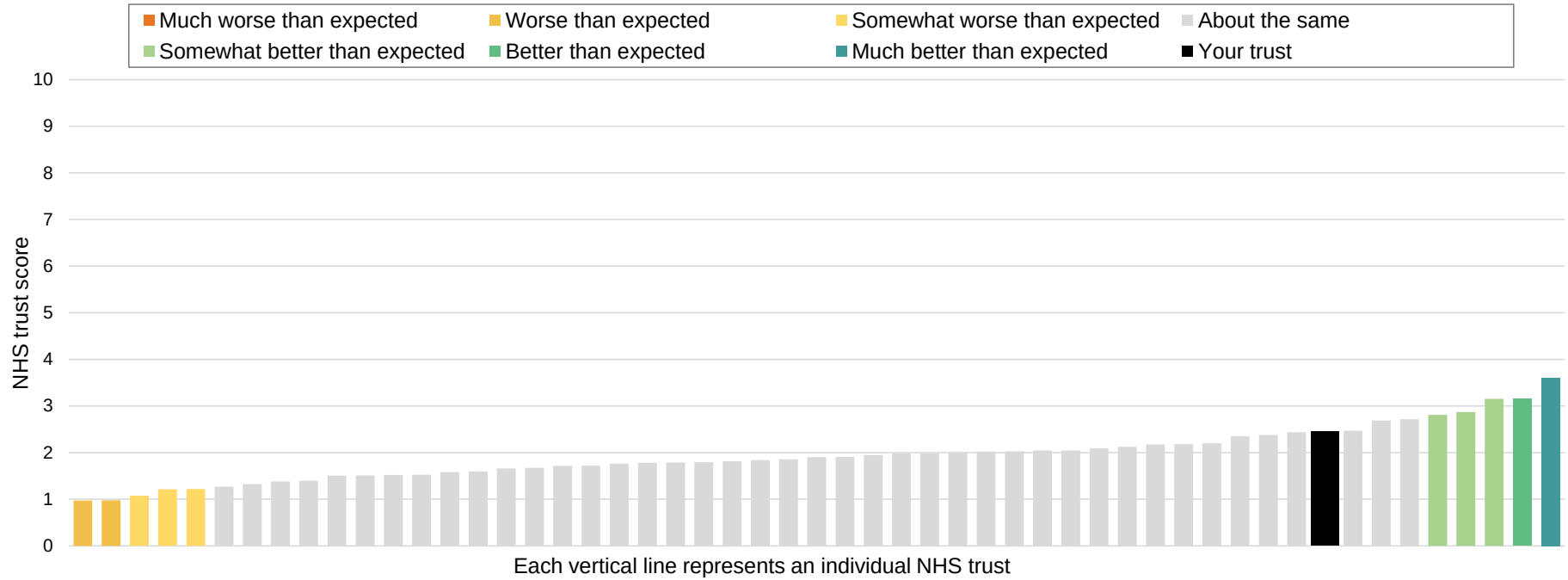


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
About the same				
114	4.8	4.7	3.3	6.8
About the same				
132	4.0	3.8	2.7	5.3
Somewhat better than expected				
82	4.8	3.9	2.6	5.7
About the same				
147	6.9	6.6	5.5	8.1

Section 9. Feedback

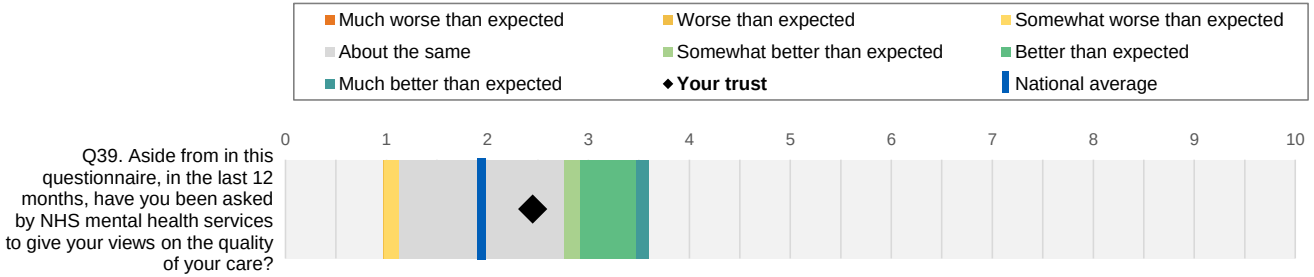
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 2.4 About the same



Section 9. Feedback (continued)

Question scores



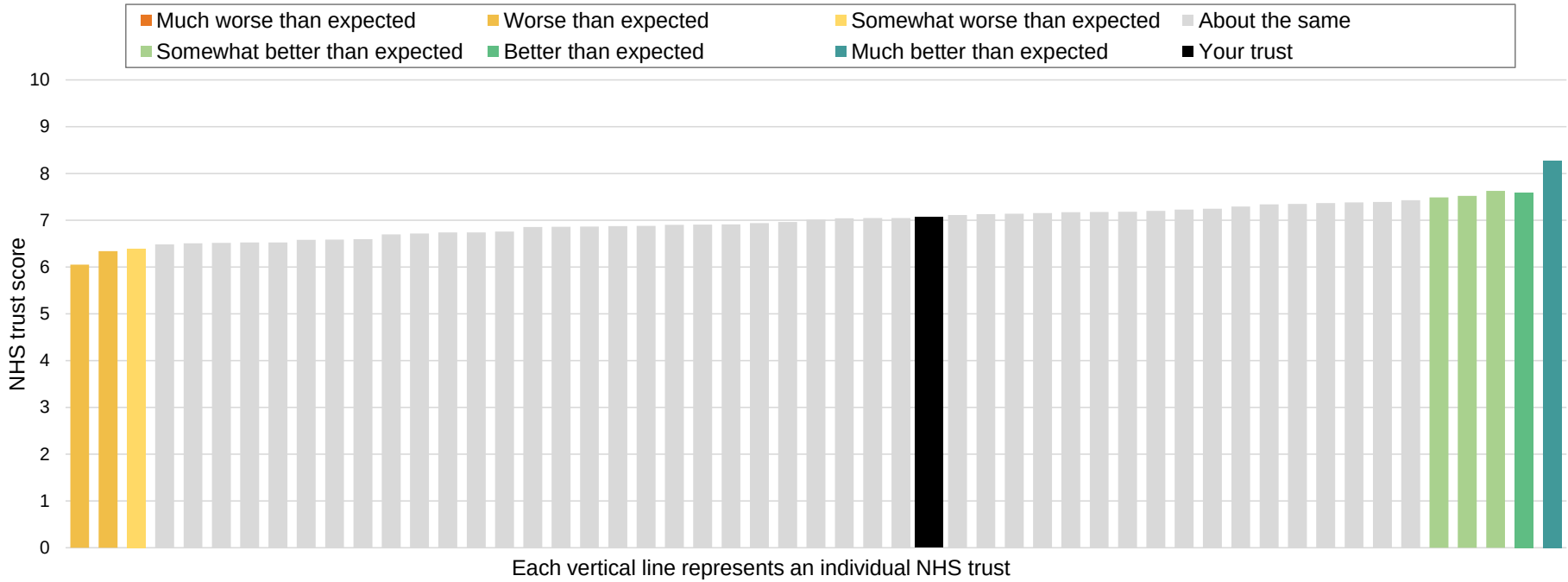
About the same

		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
189	2.4	1.9	1.0	3.6

Section 10. Overall views of care and services

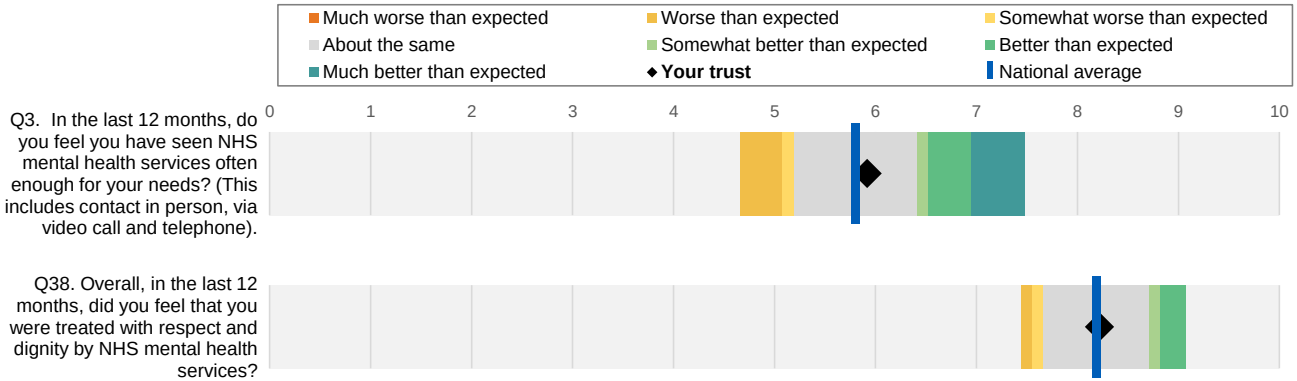
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.1 About the same



Section 10. Overall views of care and services (continued)

Question scores

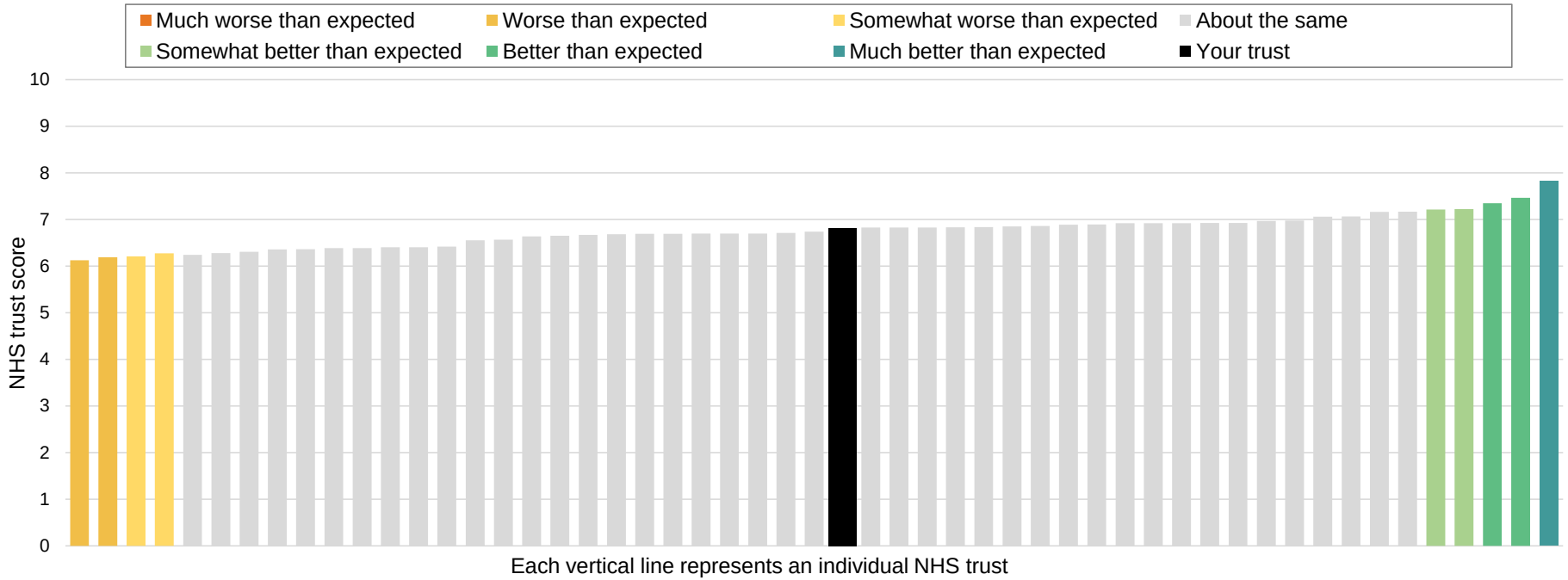


		All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score	
Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? (This includes contact in person, via video call and telephone).	223	5.9	5.8	4.7	7.5	About the same
Q38. Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	223	8.2	8.2	7.4	9.1	About the same

Section 11. Overall experience

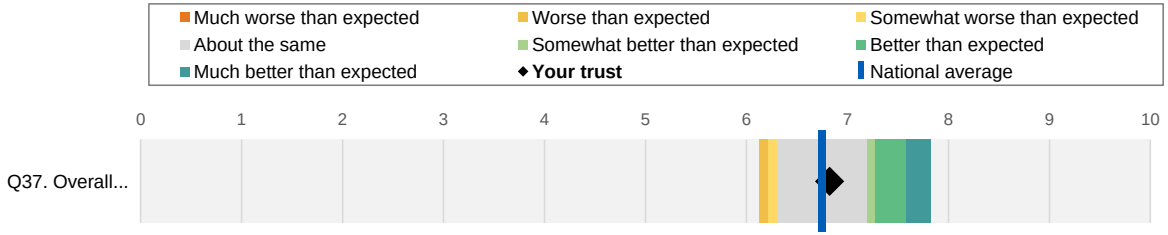
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.8 About the same



Section 11. Overall experience (continued)

Question scores



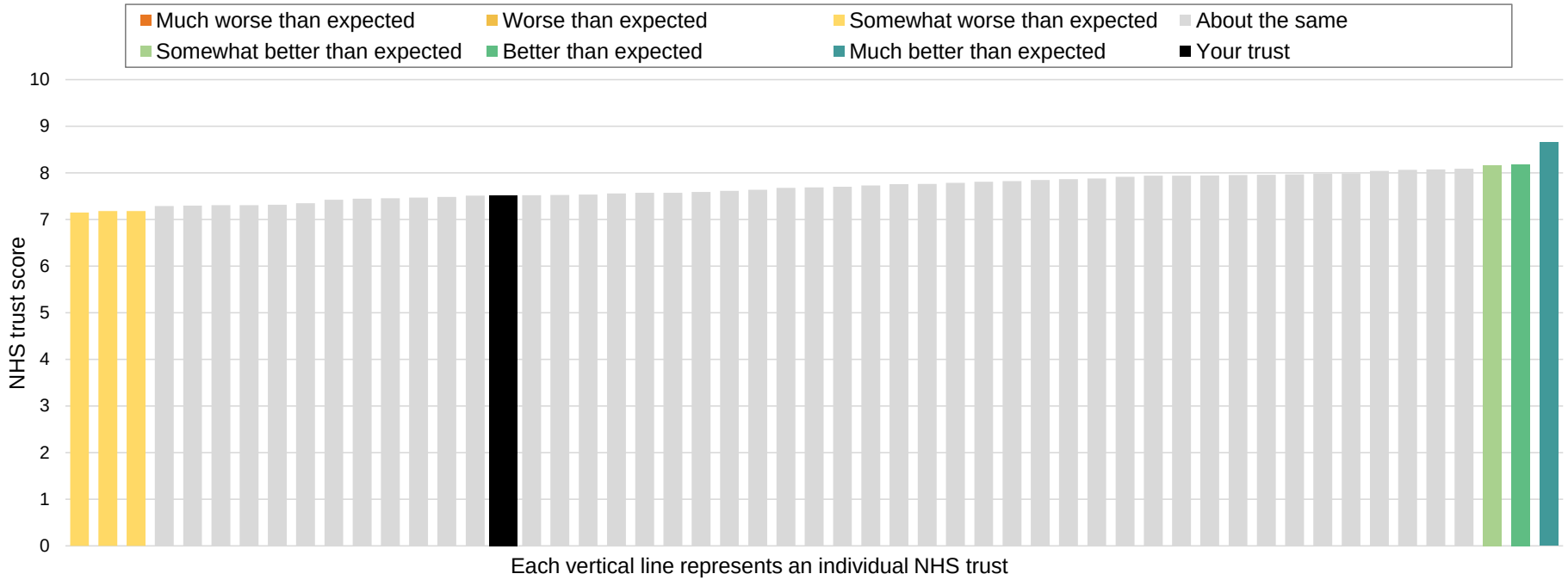
About the same

		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
212	6.8	6.7	6.1	7.8

Section 12. Responsive care

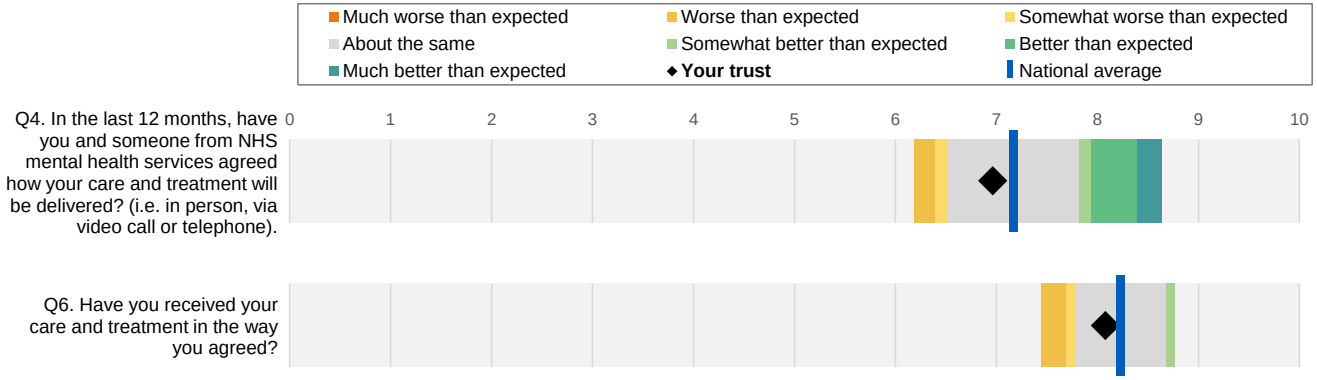
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.5 About the same



Section 12. Responsive care

Question scores



			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	230	7.0	7.2	6.2	8.6
About the same	161	8.1	8.2	7.4	8.8

Change over time

This section includes:

- a comparison to previous survey years scores for your trust for each question, including:
  - your trust's 2022 score compared with its scores from 2014 to 2021.

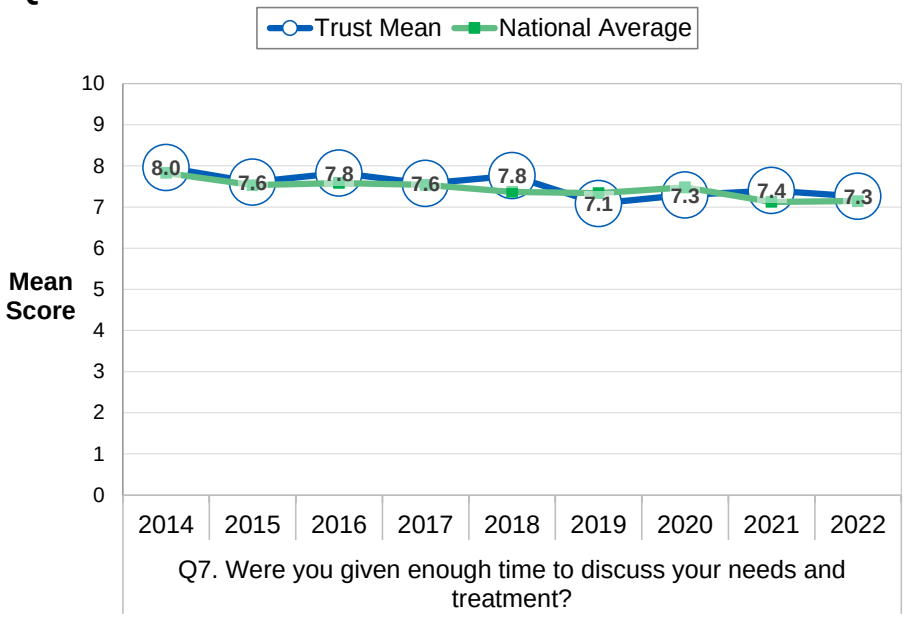
Please note;

- Section 3 planning care, appears missing from the change over time section as the questions that comprise the section score are non comparable to previous survey years and therefore do not display trends.
- If data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.

NHS Care Quality Commission Survey Coordination Centre

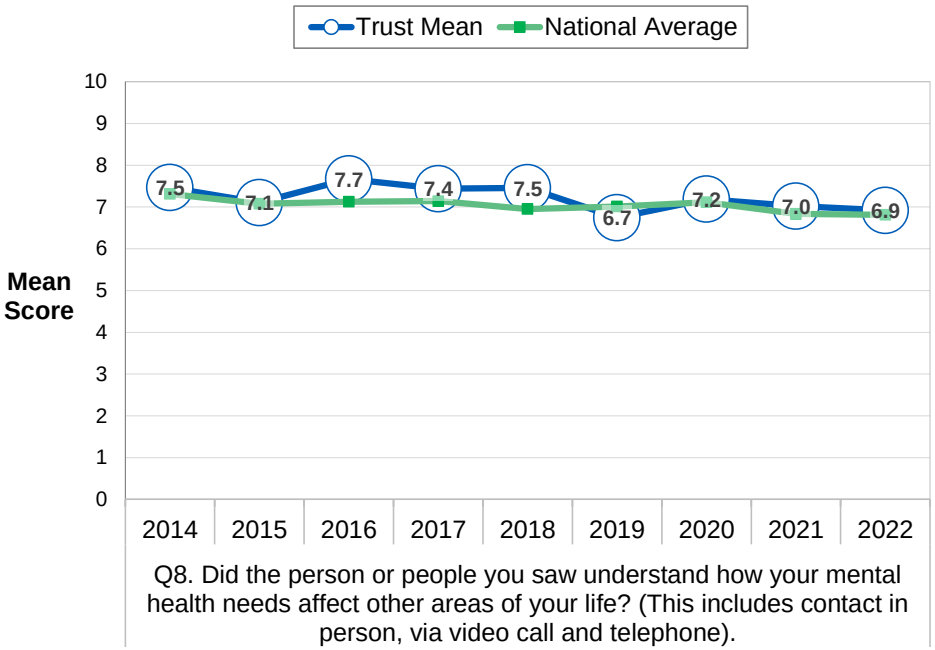
Section 1. Health and social care workers

Question scores



Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2014: 192; 2015: 197; 2016: 182; 2017: 169; 2018: 193; 2019: 216; 2020: 280; 2021: 310; 2022: 226

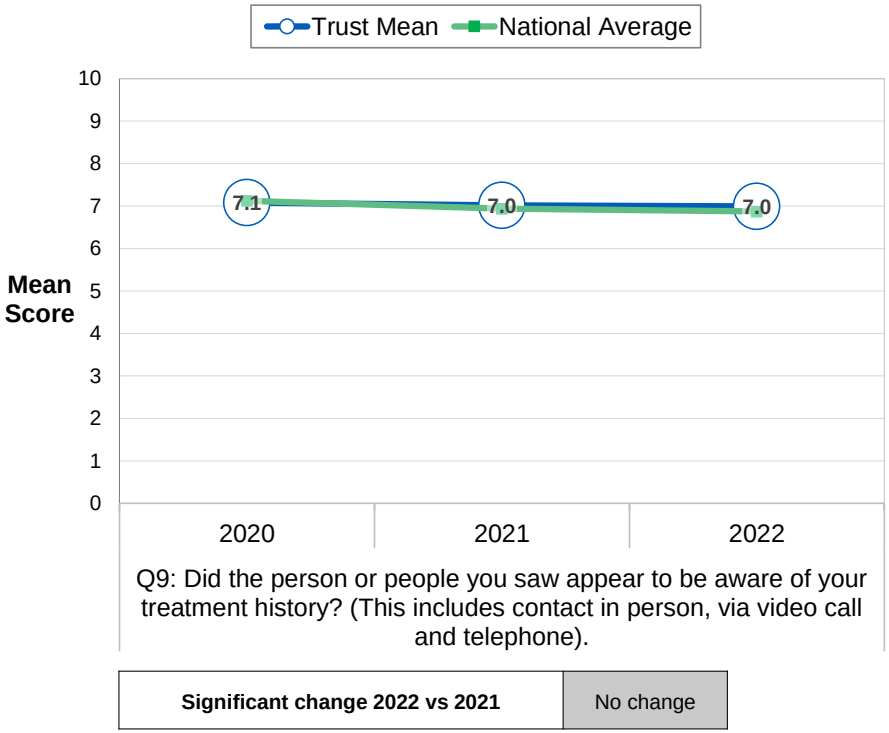


Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2014: 193; 2015: 196; 2016: 181; 2017: 166; 2018: 189; 2019: 210; 2020: 276; 2021: 314; 2022: 216

Section 1. Health and social care workers

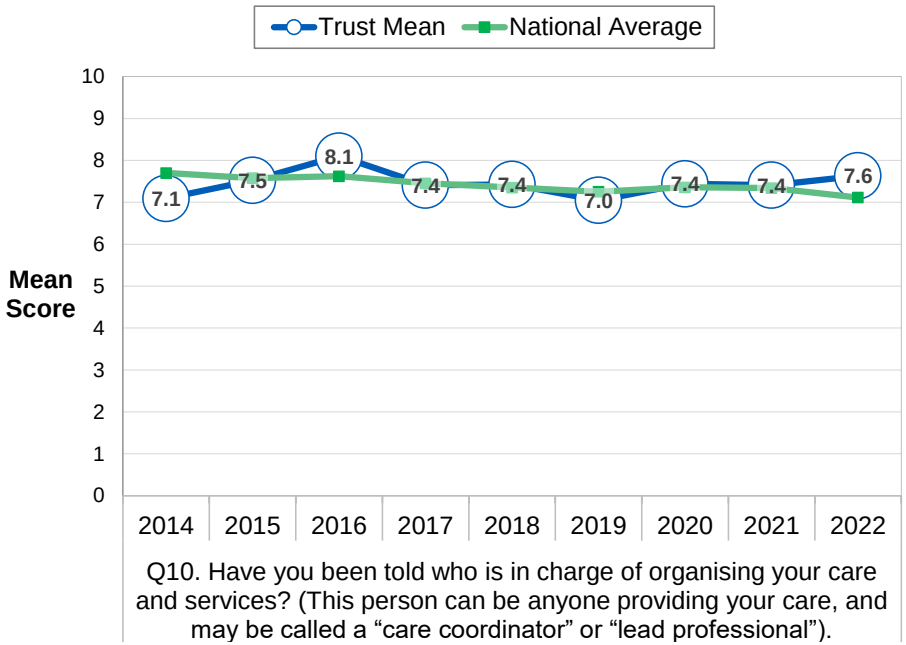
Question scores



Answered by all. Respondents who stated that they didn't know / couldn't remember or that they had no treatment prior to this have been excluded.
Number of respondents: 2020: 265; 2021: 304; 2022: 209

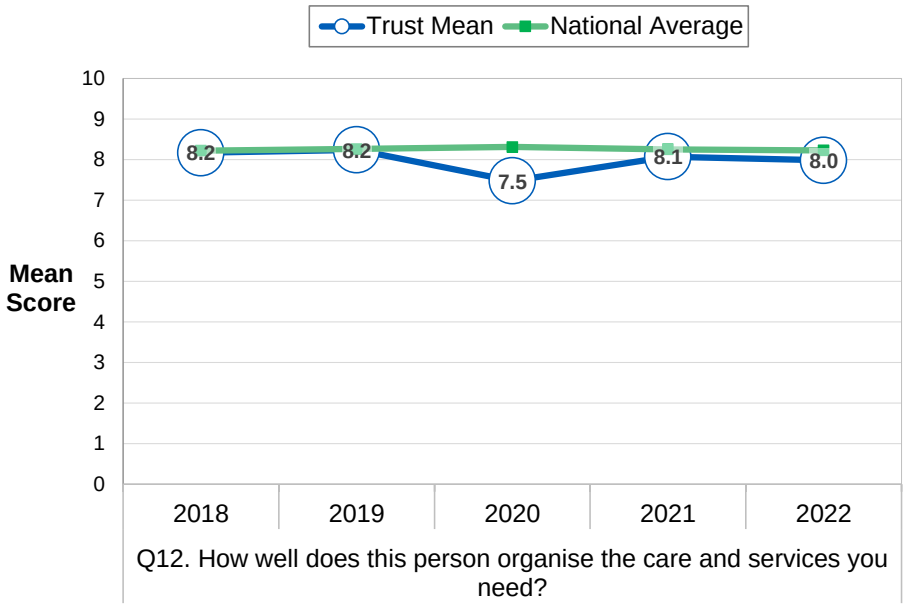
Section 2. Organising care

Question scores



Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they weren’t sure have been excluded.
Number of respondents: 2014: 165; 2015: 171; 2016: 165; 2017: 145; 2018: 167; 2019: 179; 2020: 235; 2021: 275; 2022: 194

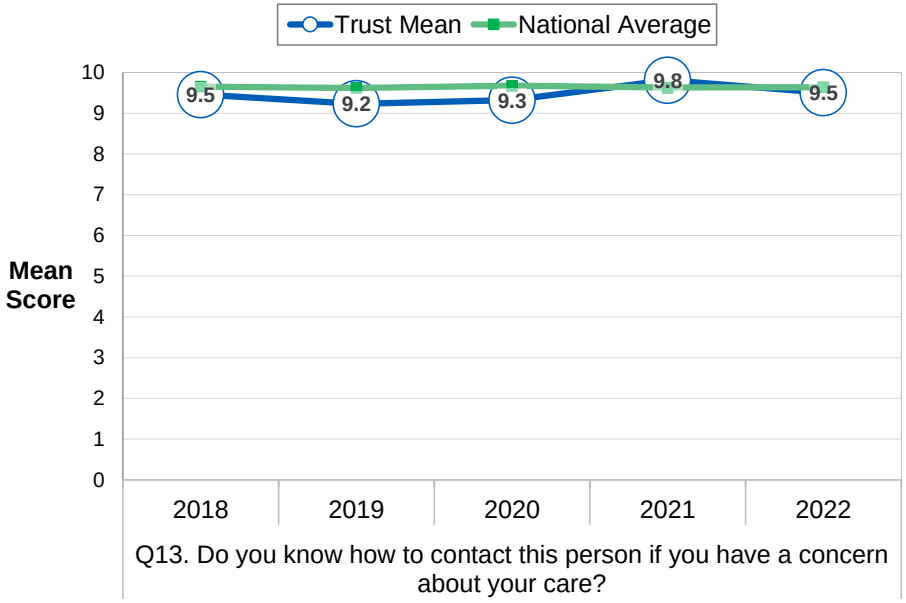


Significant change 2022 vs 2021	No change

Answered by those who have been told who is in charge of organising their care and services, and the person in charge is not a GP.
Number of respondents: 2018: 94; 2019: 101; 2020: 123; 2021: 137; 2022: 109

Section 2. Organising care

Question scores

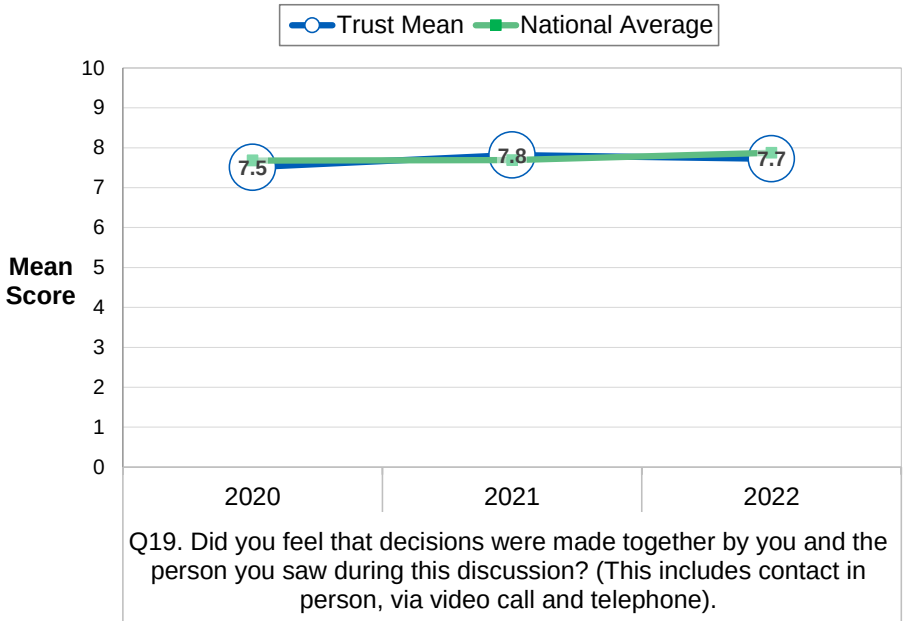


Significant change 2022 vs 2021	No change

Answered by those who have been told who is in charge of organising their care and services, and the person in charge is not a GP. Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2018: 89; 2019: 98; 2020: 118; 2021: 133; 2022: 109

Section 4. Reviewing care

Question scores

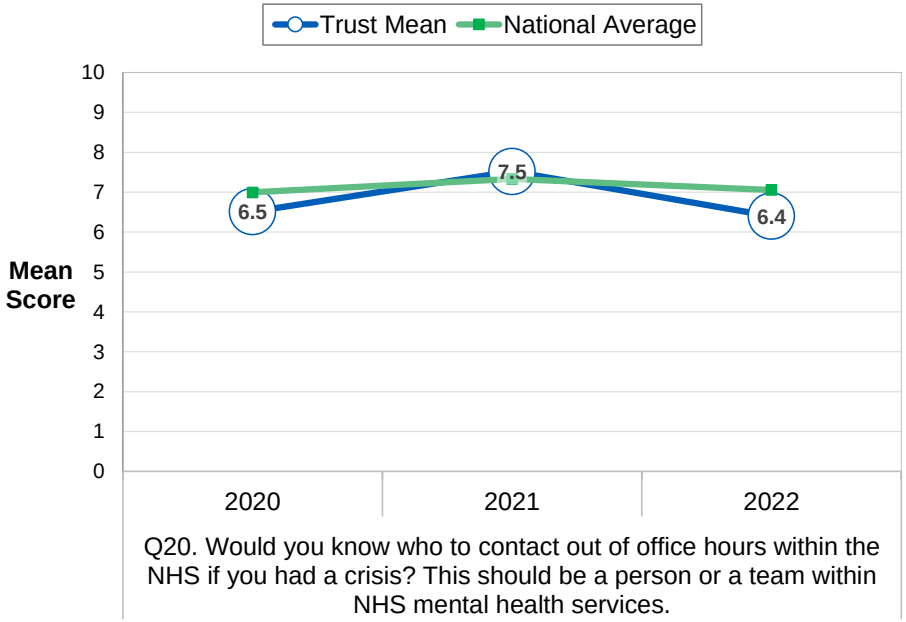


Significant change 2022 vs 2021	No change

Answered by those who felt that decisions were made together with the person they saw during this discussion. Respondents who stated that they didn't know / couldn't remember or did not want to be involved in making decisions have been excluded.
Number of respondents: 2020: 149; 2021: 165; 2022: 105

Section 5. Crisis Care

Question scores

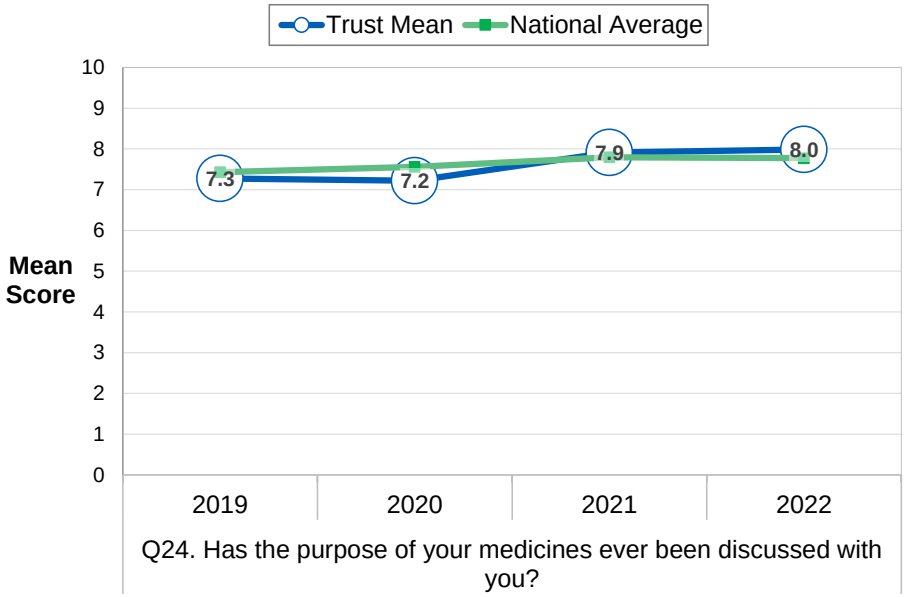


Significant change 2022 vs 2021	Decrease

Answered by all. Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2020: 236; 2021: 278; 2022: 189

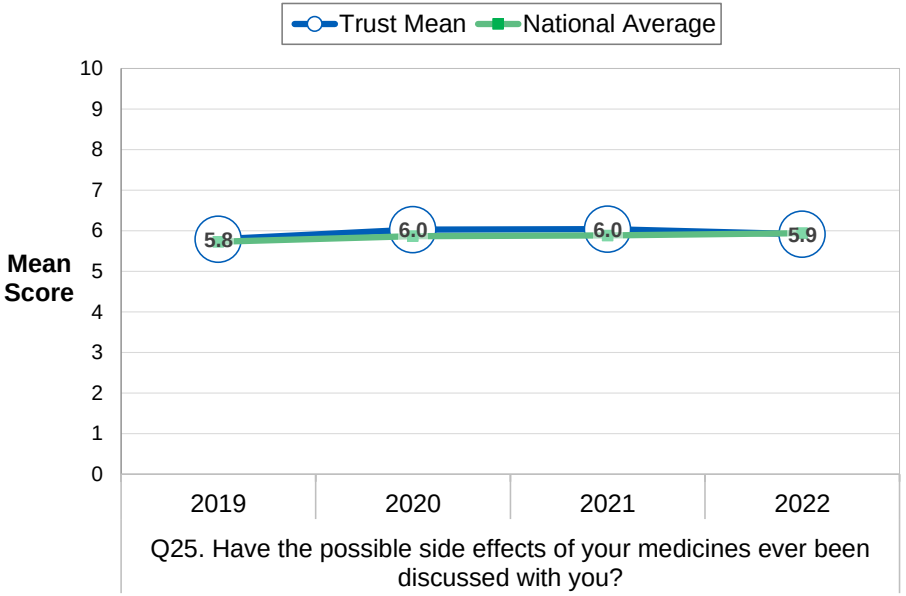
Section 6. Medicines

Question scores



Significant change 2022 vs 2021	No change

Answered by those who have been receiving any medicines in the last 12 months for their mental health needs. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 159; 2020: 216; 2021: 253; 2022: 177

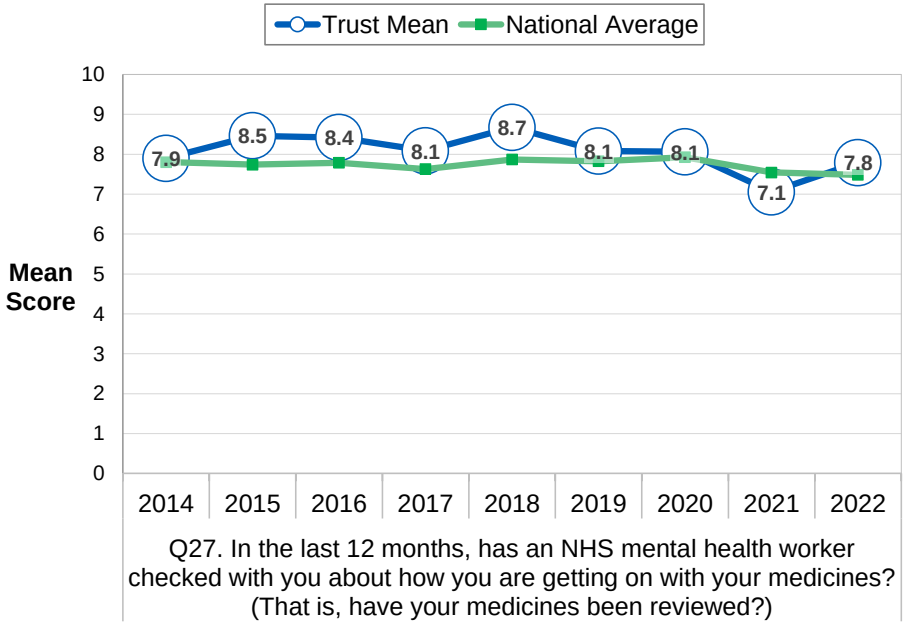


Significant change 2022 vs 2021	No change

Answered by those who have been receiving any medicines in the last 12 months for their mental health needs. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 156; 2020: 212; 2021: 248; 2022: 172

Section 6. Medicines

Question scores

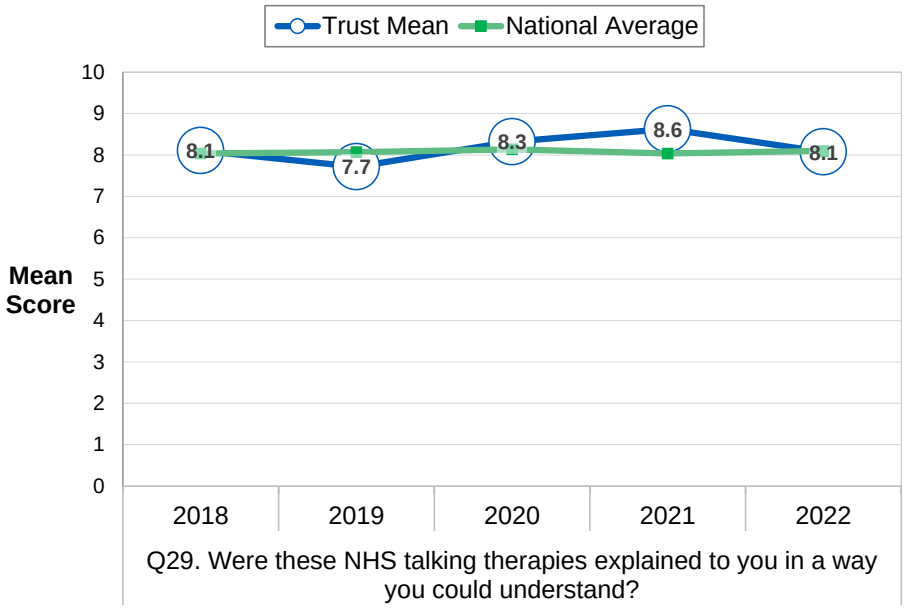


Significant change 2022 vs 2021	No change

Answered by those who have been receiving any medicines for 12 months or longer for their mental health needs. Respondents who stated that they didn't know / couldn't remember have been excluded. Number of respondents: 2014: 139; 2015: 123; 2016: 133; 2017: 119; 2018: 123; 2019: 132; 2020: 165; 2021: 190; 2022: 136

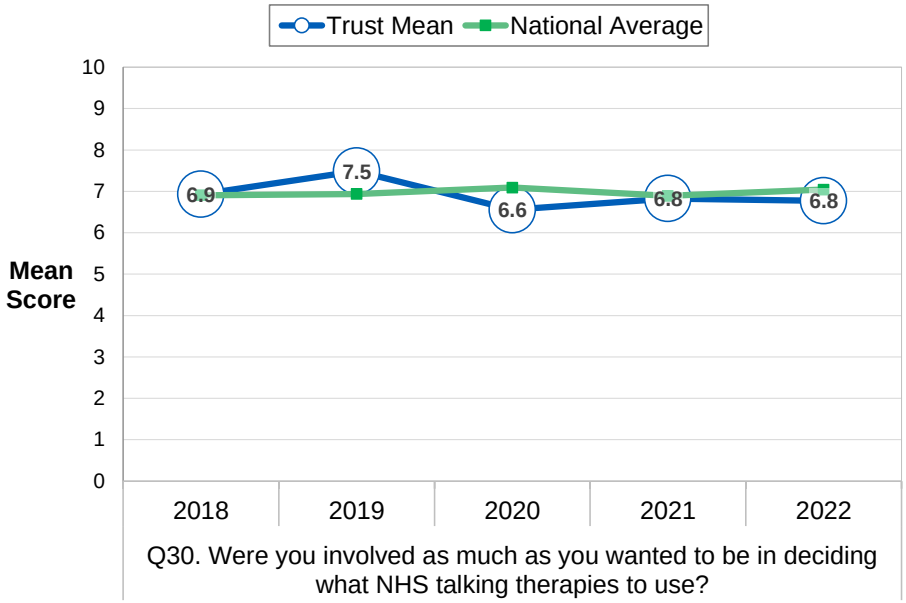
Section 7. NHS Talking Therapies

Question scores



Significant change 2022 vs 2021	No change

Answered by those who have received any NHS talking therapies in the last 12 months for their mental health needs. Respondents who stated that no explanation was needed have been excluded.
Number of respondents: 2018: 77; 2019: 73; 2020: 98; 2021: 109; 2022: 85

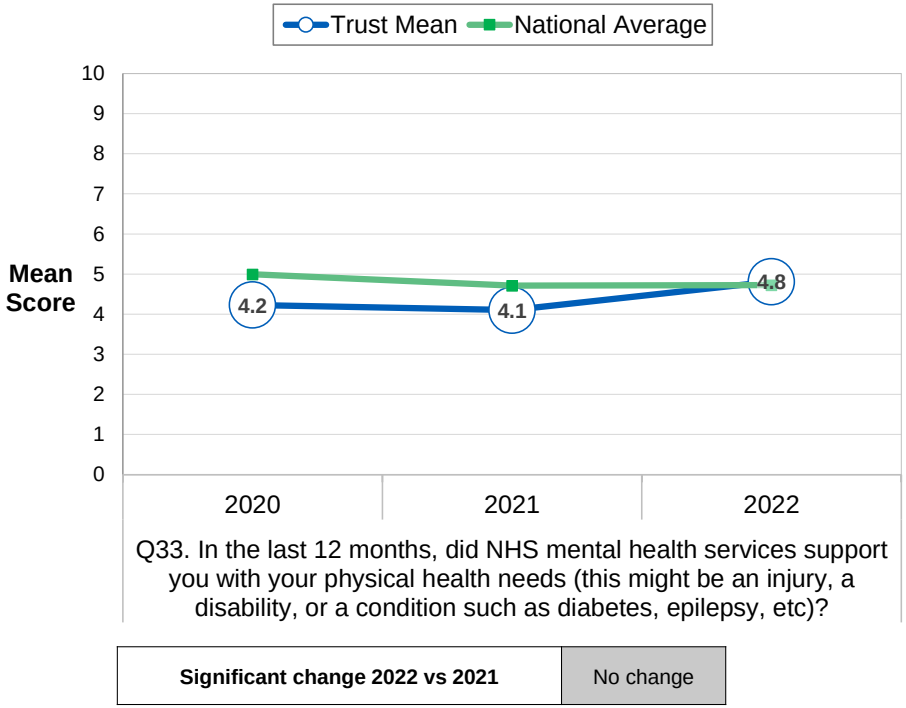


Significant change 2022 vs 2021	No change

Answered by those who have received any NHS talking therapies in the last 12 months for their mental health needs. Respondents who stated that they didn't know / couldn't remember or did not want to be involved have been excluded.
Number of respondents: 2018: 73; 2019: 71; 2020: 98; 2021: 100; 2022: 85

Section 8. Support and wellbeing

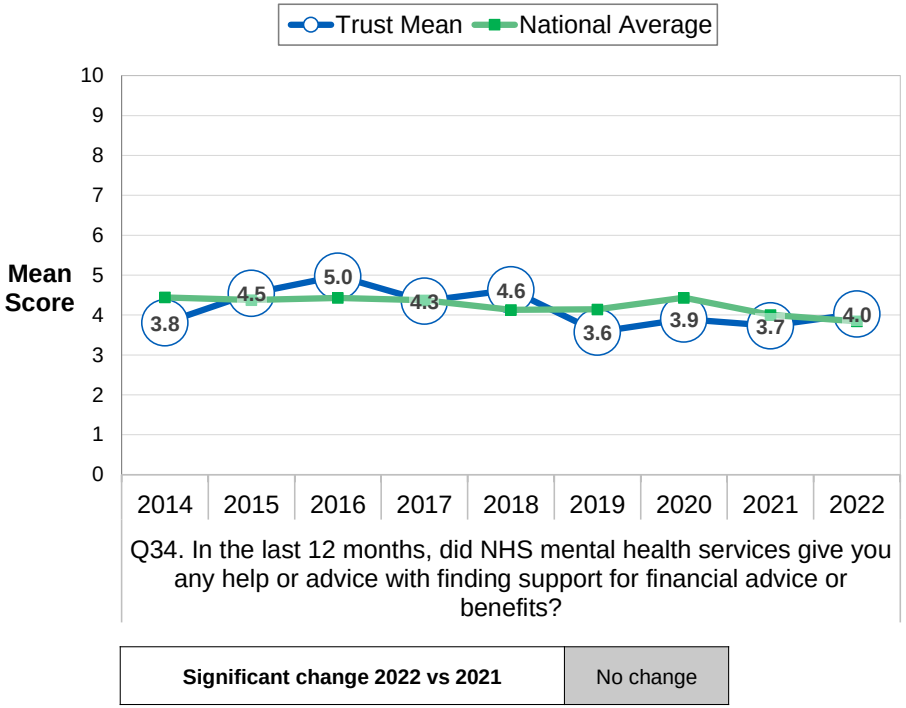
Question scores



Q33. In the last 12 months, did NHS mental health services support you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc)?

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they have support and did not need NHS mental health services to provide it, do not need support for this, or do not have physical health needs have been excluded. Number of respondents: 2020: 131; 2021: 155; 2022: 114



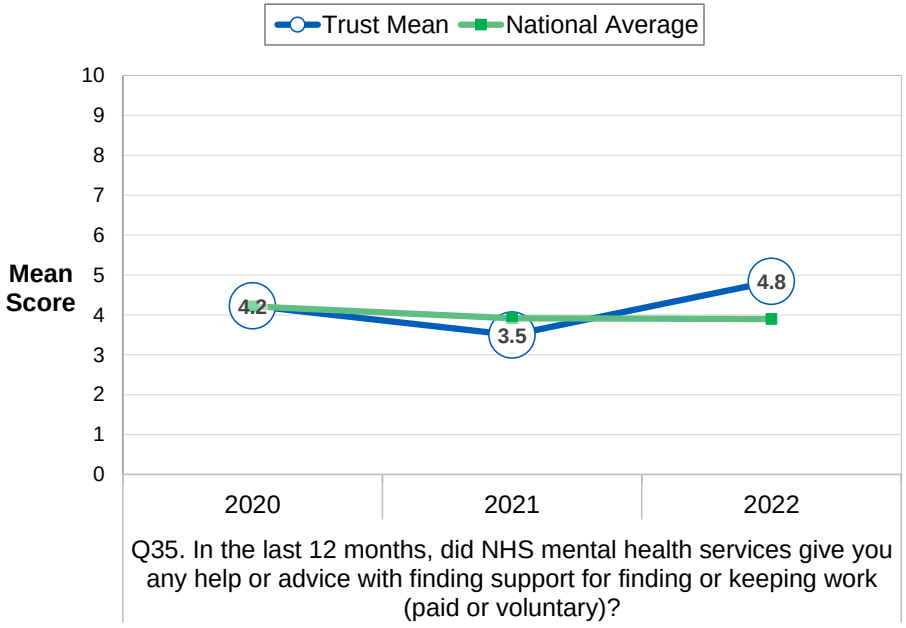
Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they have support and did not need help / advice to find it, or do not need support for this have been excluded.
Number of respondents: 2014: 105; 2015: 102; 2016: 95; 2017: 92; 2018: 106; 2019: 118; 2020: 150; 2021: 176; 2022: 132

Section 8. Support and wellbeing

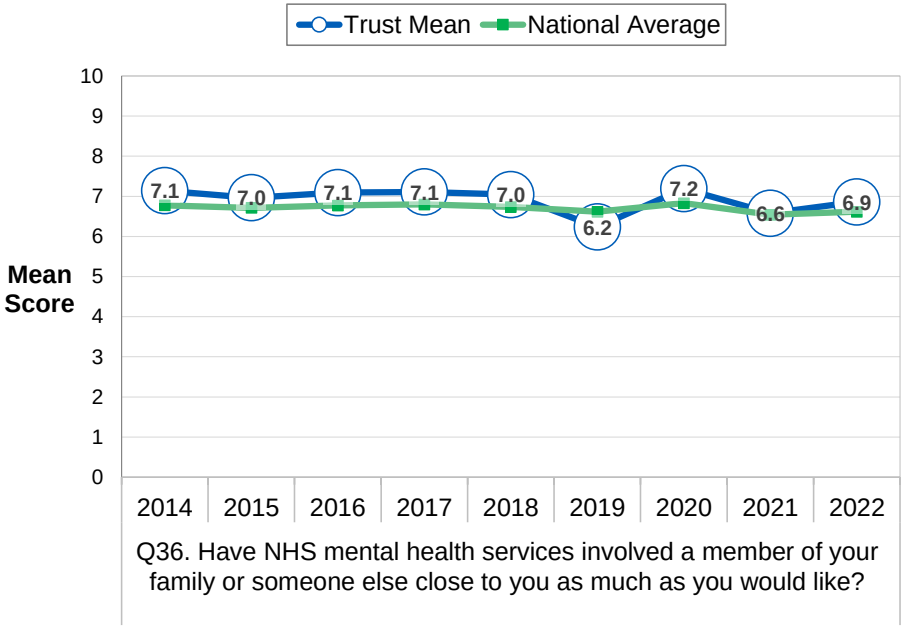
Question scores



Q35. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?

Significant change 2022 vs 2021	Increase

Answered by all. Respondents who stated that they have support and did not need help / advice to find it, do not need support for this, or are not currently in or seeking work have been excluded. Number of respondents: 2020: 78; 2021: 90; 2022: 82



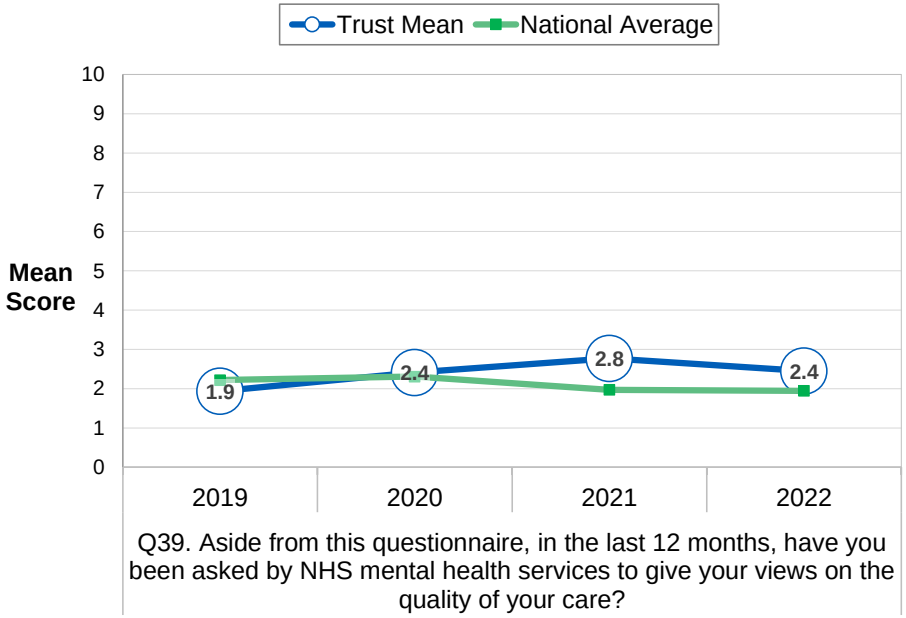
Q36. Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that their friends or family did not want to be involved, did not want their friends or family to be involved, or that this does not apply to them have been excluded. Number of respondents: 2014: 128; 2015: 126; 2016: 132; 2017: 123; 2018: 132; 2019: 149; 2020: 188; 2021: 215; 2022: 147

Section 9. Feedback

Question scores

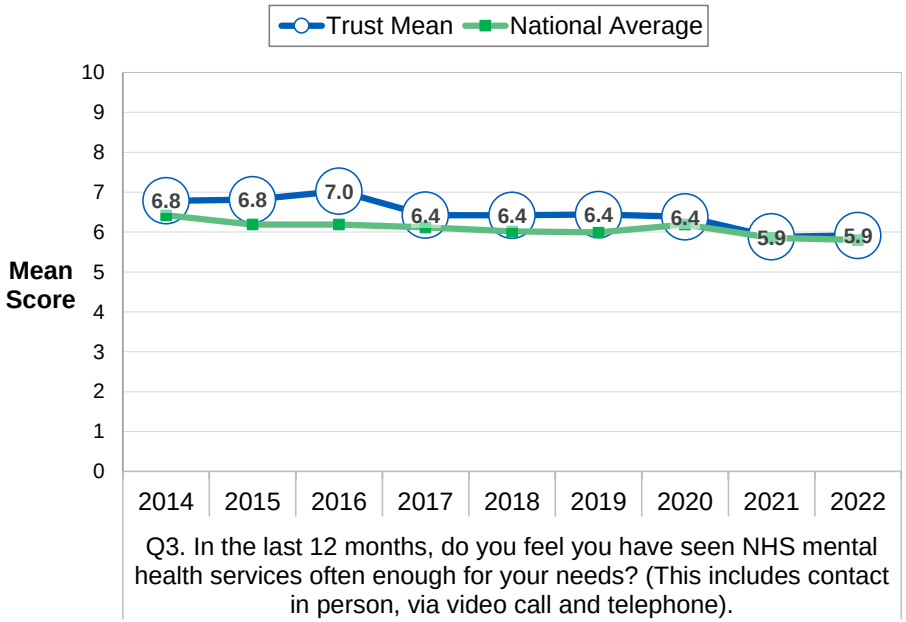


Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2019: 189; 2020: 242; 2021: 277; 2022: 189

Section 10. Overall views of care and services

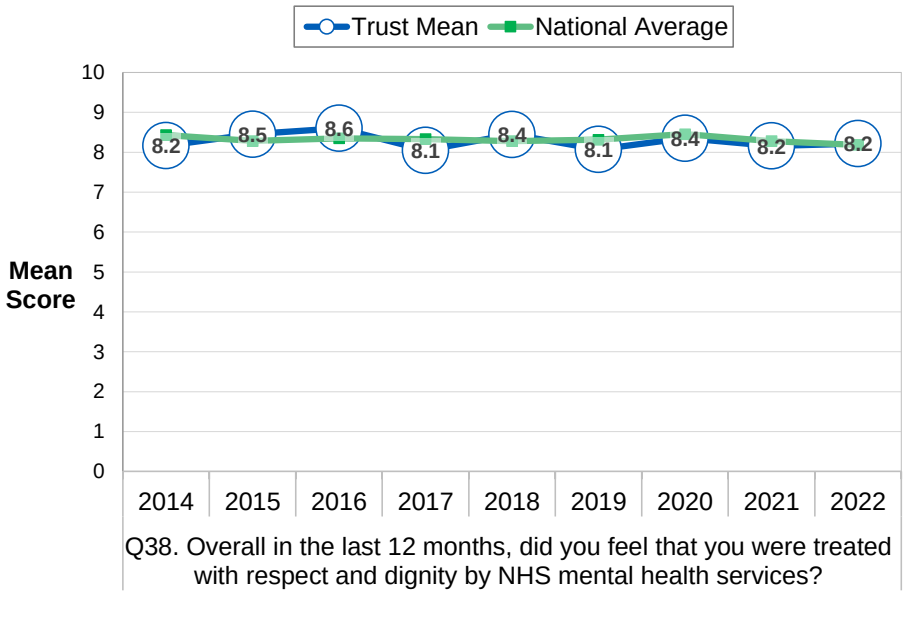
Question scores



Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs? (This includes contact in person, via video call and telephone).

Significant change 2022 vs 2021	No change

Answered by all. Respondents who stated that they didn't know have been excluded.
Number of respondents: 2014: 200; 2015: 204; 2016: 181; 2017: 175; 2018: 198; 2019: 209; 2020: 280; 2021: 318; 2022: 223



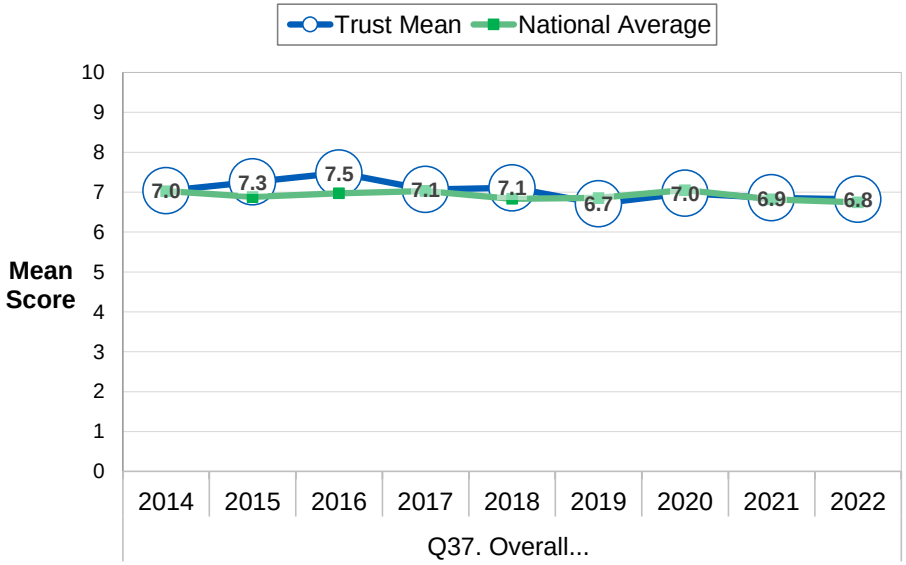
Q38. Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

Significant change 2022 vs 2021	No change

Answered by all.
Number of respondents: 2014: 196; 2015: 205; 2016: 191; 2017: 172; 2018: 196; 2019: 221; 2020: 283; 2021: 320; 2022: 223

Section 11. Overall…

Question scores



Significant change 2022 vs 2021	No change

Answered by all. Number of respondents: 2014: 188; 2015: 189; 2016: 183; 2017: 165; 2018: 184; 2019: 210; 2020: 269; 2021: 303; 2022: 212


Appendix
NHS
Care Quality Commission
Survey Coordination Centre

Comparison to other trusts: where your trust has performed much better

The questions at which your trust has performed much better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed better

The questions at which your trust has performed better than compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed somewhat better

The questions at which your trust has performed somewhat better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- Q35. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?

Comparison to other trusts: where your trust has performed somewhat worse

The questions at which your trust has performed somewhat worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed worse

The questions at which your trust has performed worse compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed much worse

The questions at which your trust has performed much worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

NHS Community Mental Health Survey

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

Where service user experience is best

- ✓ **Support and well-being (Work):** service users being given help or advice with finding support for finding or keeping work
- ✓ **Care review:** service users had care review meeting in last 12 months
- ✓ **Organisation of care:** service users being told who is in charge of organising their care and services
- ✓ **Views on quality of care:** NHS mental health services asking service users for their views on the quality of their care
- ✓ **Medicines review:** NHS mental health services checking how service users are getting on with their medicines

Where service user experience could improve

- ○ **Crisis care (access):** service users knowing who to contact out of hours in the NHS if they have a crisis
- ○ **Getting help needed:** staff delivered help needed at last contact
- ○ **NHS Talking Therapies:** service users being involved in deciding what NHS talking therapies to use
- ○ **Organisation of care:** service users feeling their care is organised well
- ○ **Care Delivery:** staff and service users agreeing how care and treatment will be delivered

These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for your trust that are lowest compared with the national average.

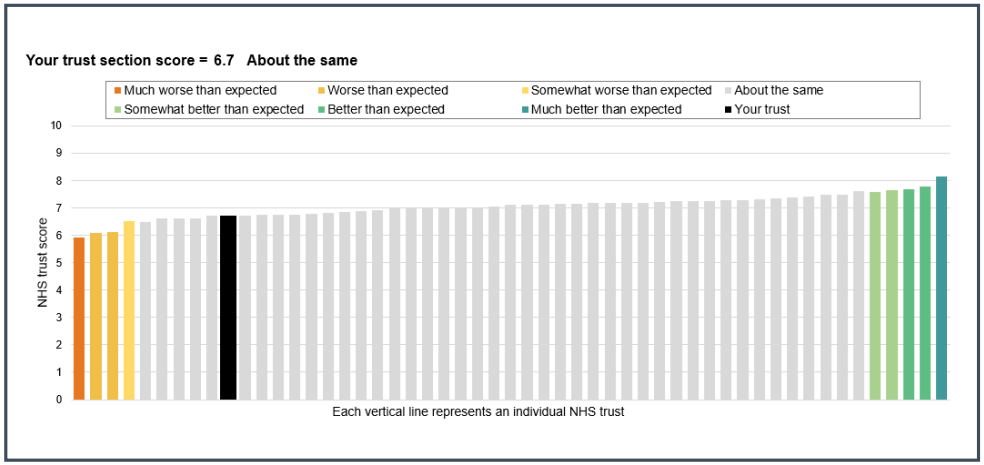
This survey looked at the experiences of people who were receiving care or treatment for a mental health condition and had been treated by the trust between 1 September 2021 and 30 November 2021. Between February and June 2022, a questionnaire was sent to 1250 recent service users. Responses were received from 242 service users at this trust. If you have any questions about the survey and our results, please contact [INSERT TRUST CONTACT DETAILS].

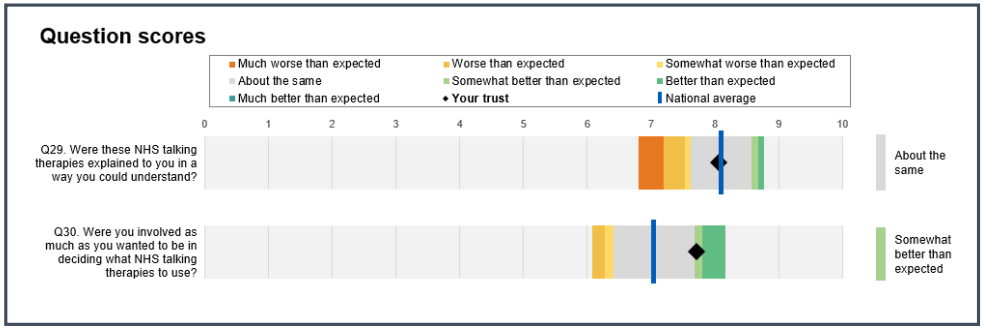
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

In some cases, there will be no shades of orange and/or green area in the graph. This happens when the expected range for your trust is so broad that it encompasses either the highest possible score for all trusts (no green section) or the lowest possible score for all trusts (no orange section). This could be because there were few respondents and/or a lot of variation in their answers.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

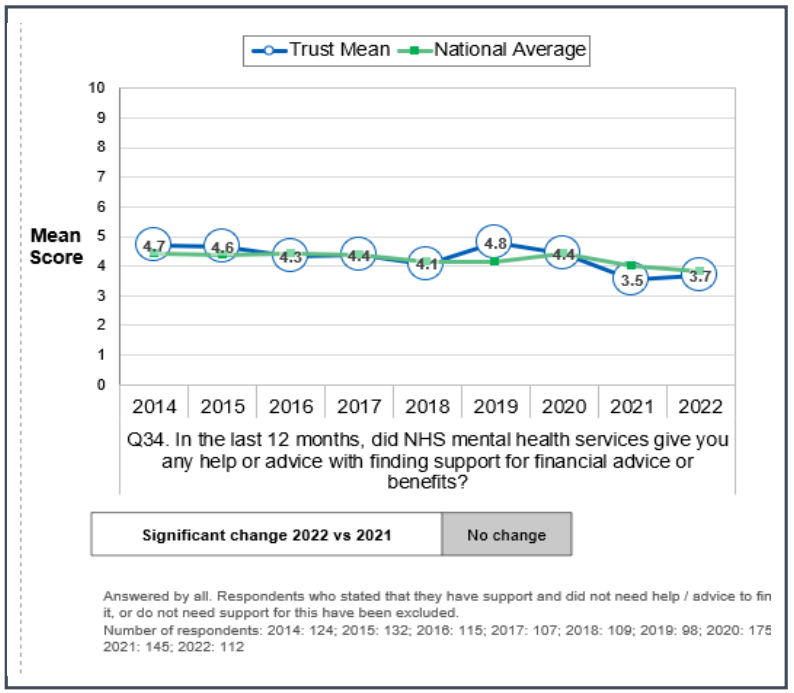
Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

How to interpret change over time in this report

The charts in the 'change over time' section show how your trust scored in each Community Mental Health survey iteration. Where available, trend data from 2014 to 2022 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable, are also not shown.

Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years, this is the average score for that question across all community mental health trusts in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this is may be due to either a low number of responses, because the trust was not included in the survey that year, sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2022) and the previous year (2021). Z-tests set to 95% significance were used to compare data between the two years (2022 vs 2021). A statistically significant difference means it is unlikely we would have obtained this result if there was no real difference.



An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the service user's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive service user experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of service user experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 7 "Were you given enough time to discuss your needs and treatment?":

- The answer code "Yes, definitely" would be given a score of 10, as this refers to the most positive service user experience possible.
- The answer code "Yes, to some extent" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer code "Don't know / can't remember" would not be scored, as they do not have a clear bearing on the trust's performance in terms of service user's experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.


Thank you.
For further information please contact the Survey Coordination Centre for Existing Methods:
mentalhealth@surveycoordination.com
NHS
Care Quality Commission
Survey Coordination Centre
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Community Mental Health Survey | 2022 | RQY | South West London and St George's Mental Health NHS Trust

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 3rd October 2022

Present:

Professor Deborah Bowman (DBo)	Committee Chair – Non-Executive Director
Ann Beasley (AB)	Trust Chair
Vanessa Ford (VF)	Chief Executive Officer
Jennifer Allan (JeA)	Chief Operating Officer
Prof. Charlotte Clark (CC)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
David Lee (DL)	Corporate Governance Director
Doreen McCollin (DM)	Non-Executive Director
Sharon Spain (SS)	Director of Nursing & Quality
Emdad Haque (EHa)	Associate Director of EDI & Health Inequalities

Attendees:

Carol Anne Brennan (CAB)	Service User, Carer, Friends and Family Representative
David Hobbs (DH)	Service User, Carer, Friends and Family Representative
Ryan Taylor (RT)	Associate Director of Clinical Governance & Risk
Elaine Holder (EH)	Committee Governance Manager (Minutes)
Ijeoma Ndubuisi (IN)	Clinical Team Manager, DIDMR
Jaydene Campbell - Clemons (JC)	Lived Experience Representative
Sofia Husain (SH)	Lived Experience Representative
Ian Petch (IP)	Trust Head of Psychology & Psychotherapies (in attendance for
Ian Higgins (IH)	item A22/164)
Mike Hever (MH)	Family Liaison Lead/Patient Safety Team
Farai Addy (FA)	Deputy Nursing Director (in attendance for item A22/168)
	Experience & Governance Lead (Serious Incidents)
	(in attendance for item A22/169)

Apologies:

Billy Boland	Medical Director

Item

A22/156 **Apologies**

Apologies were noted.

A22/157 **Declarations of Interest**

No new declarations of interest were reported.

A22/158 **Chair's Action**

DBo highlighted the letter from Claire Murdoch in respect of the experience of patients following the recent Panorama programme

A discussion took place and SS highlighted the following:

- SS described a discussion that took place at the last Executive Leadership Team meeting on what the programme means for the Trust, noting that the Panorama documentary had focused on front line staff. SS informed the meeting that the ELT Team discussed the impact and implications for the Trust's teams and management.

Item

- SS informed the Committee that there are a number of measures in place at the Trust to mitigate the risk of harms shown in the Panorama. Some of the key elements of mitigation are set out below.
- SS & JeA have met with the Senior Leadership Team to find out if they need any support. More visibility of Senior Nurses and Managers was highlighted to enable issues to be easily escalated if necessary.
- The Quality Plan was put in place after CQC concerns in respect of some of the Trust's Clinical practices and is core to setting out and monitoring expectations of care.
- Fundamental Standards of Care have also been put in place describing 11 basic practices to improve quality and care for patients.
- Closed cultures in the Trust have been reviewed and there has been a QI approach towards managing teams where there is a risk of a closed culture developing.
- Care Quality Reviews are undertaken 3 times a year which are mock CQC inspections via peer review.
- Board and Senior Leadership visits take place on a regular basis and are key to triangulation of assurance and other data.
- Safeguarding across the Trust is strong and the CQC and CGG feel the Trust are transparent and have open conversations regarding incidents.
- AB felt SS gave some assurance especially in respect of the Continuous Quality Improvements but also expressed concern about the situation in Ward 1 and that these incidents were brought to the Trust's attention by external sources, noting the wider context of perceived under-reporting in that clinical setting.
- DH suggested that patients who have been restrained or secluded have the opportunity to talk to peer workers in order to include a more open and balanced view of their experience.
- CAB was concerned that no progress has been made in respect of the policy for 'Making Safeguarding Personal' and that the safeguarding categorisation has been revised. She also noted that the temporary post for Domestic Violence and Abuse is not being made permanent. CAB also felt patients need more support to enable them to report incidents and does not feel assured as a patient and service user that things in the Panorama Programme may not be happening at the Trust.
- VF felt the Trust should not become desensitised to these concerns and that the Trust needs to carry on with work that is currently being undertaken, including co-production with Involvement and Peer support workers
- CH wanted to ensure the Board knows exactly what assurance is and that it is important to look at the evidence in a balanced way.
- DM wanted to ensure there are mechanisms in place so that patients do not have a bad outcome when raising a concern.
- SH felt there should be separate wards and more funding available for patients with autism
- SS informed the meeting that PALs staff go into the wards on a regular basis.

A22/159 **Minutes of the previous of meeting for August IP meeting and September QSAC Meetings.**

- AB suggested an amendment to the sentence regarding the discussion about liaison psychiatry at St George's and the London Ambulance service. The meeting agreed to make that amendment.
- DH pointed asked if the slides can be inserted for the IP presentation – EH informed the meeting this has now been put in. DH also pointed out a spelling mistake 'feminisation'

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

Item

should read 'familiarization'. DH also pointed out that general results on Page 9 should read IAPT results.

- DH also pointed out on page 9 the sentence should read patients are 'not properly triaged 'rather than 'not triaged'.

Minutes were agreed subject to these amendments.

A22/160 **Action Tracker**

There were no outstanding actions and actions were updated as attached tracker.

A22/161 **Risk Register**

The committee noted and accepted the report.

RT highlighted the following:

- Risk 2328 has been increased from level 16 to 20
- There are no reduced risks
- Risk 2115 has been closed Failure to maintain Face to Face contact in the community service line, and safe management of clients on community caseloads.
- Risk 1998: Domestic violence: Failure to comply with NICE Guidelines for identification and response to disclosures of domestic violence & abuse has been closed but will remain on the nursing risk register
- One new risk has been added to the main Risk Register since the last report. This risk (2361) relates to a routine annual Ligature Risk Assessments/audits (LRA) and does not require specific inclusion.
- ELT asked for assurance regarding restrictive practices therefore this risk will be reviewed
- VF informed the meeting that there are 3 key priorities (listed below) which will be reframed and put at the beginning of the risk register to save reviewing these on a regular basis, namely:
    - Safely move into the new hospitals;
    - Deliver the Tolworth Business case; and
    - Business As Usual

A22/162 **Quality Matters**

The committee accepted and noted the report

SS gave an overview:

- During August there were 11 serious incidents meeting the national SI criteria that were reported externally to Commissioners (via STEIS). This includes 3 unexpected deaths and 3 suspected suicides within the Community service line which are under investigation.
- Outstanding RCA actions have increased this month to 20 across the service lines, with 2 overdue by more than one year.
- There has been a decrease in respect of low harm incidents in the Community Team – this may be a reporting issue which is being investigated.
- PIRs and IRs have decreased.
- There are 3 investigation reports which refer to policies not being followed/enacted.
- NHS England published its Patient Safety Incident Response Framework (PSIRF) on 16th August 2022, which replaces the Serious Incidents Framework (SIF). The new Framework aims to provide guidance to local healthcare systems on how to conduct "*strategic, preventative, collaborative, fair and just, credible and people focused*" investigations into any safety breaches.
- AB asked why there are 2 actions that have been outstanding for over a year.

Item

- SS informed the meeting that these actions refer to searches and that the quality of searches is hard to maintain with patients going in and out – there is ongoing training and things are improving
- RT informed the meeting that the 2 actions that are outstanding are complex, and RT will follow up.

A22/163 **Always Ready (CQC and regulatory compliance)**

The committee accepted and noted the report.

CR highlighted the following:

- Specialist Eating Disorder Services – New should do actions received. Most are already providing reasonable assurance, one limitation is Wisteria moving to their new ward, subject to lighting contractors finishing their work.
- QC Inspections - The Specialist Eating Disorder services improved in the 4 domains, previously rated as 'requires improvement' and are now rated as 'good'. This has also affected the overall rating which is also now rated as 'good'. No new requirement notices were issued to the service, though there were 5 new 'should do' actions issued
- CQC enquiries - There were 6 informal enquiries which were responded to fully and on time (full details are within Appendix 4). There were also 8 CQC Complaints received within the quarter which are investigated in the formal complaint process.
- RT informed the meeting that there is an increase in patient complaints going direct to CQC.

A22/164 **An Integrated Programme to improve the care and treatment of people with complex needs**

IP highlighted the following:

There are 5 projects addressing resources in providing treatment for adult service users with complex emotional needs (CEN). The projects are:

- a standardised stepped care model in the community service line
- a training programme for inpatient staff
- the development of crisis management clinics
- the provision of a transitions role to support young people with CEN moving from CAMHS services to adult services
- the development of a transition support role to facilitate discharge form acute admission wards to community services

- IP informed the meeting that the projects are due to be completed by 31st March 2022 and these projects will be treated as a priority
- DB stated that she is looking forward to seeing the co-production work for these projects
- SH asked if the Community MH for Adults will be included
- IP confirmed this will be included as part of Community Transformation

A22/165 **Quality Strategy/Plan**

Committee noted and accepted the report.

SS highlighted the following:

Item

- There are 10 workstreams
- Launches were attended by 500 staff
- There have been challenges with Bank and Agency staff participating which are being addressed.
- A strategic approach to QII skills development has been agreed, with service line leads nominating staff to join the Quality, Service Improvement and Redesign (QSIR) Practitioner Programme and building staff capabilities so they can embed QI as business as usual with a focus on key priority areas and strategies (including FSOC).
- Clarity and progress on clinical systems alignment workstream, with three distinct projects (Romeo Reset, Clinical Systems Project and Ward Workflow Project) all underway to support the alignment of clinical systems to the delivery of the Fundamental Standards of Care.
- The move in the new building is an opportunity to set new expectations.
- The quality plan workstreams are all part of improving the quality of care provided to our patients which we can monitor through the Fundamental Standards of Care (FSOC) dashboard which is presented at each Service Line Review and the monthly Quality and Performance report.
- DH asked if sub-contractors are being briefed on the Fundamental Standards of Care.
- SS will follow check and follow up.

A22/166 **Kyle's Charter**

The committee noted and accepted the review.

IH highlighted the following:

- The Mediation process was in response to the death of Kyle Maher in January 2017 whilst under the Trust's community services. Learning for the Trust was identified in the externally chaired Trust Investigation report, NHS England Independent Review, and the Inquest by the Coroner.
- The Trust acknowledged and apologised during the mediation process that the contact and support provided to the family of Kyle following his death was not to the standard expected. Following discussions at the mediation it was agreed that the Trust and the family would jointly develop a charter to provide details of the support, information and response that families, friends and carers can expect to receive following the death of a loved one.
- CH asked how the paper will be disseminated across the Trust.
- IH informed the meeting that the paper will be available through the Trust Insight and via the monthly Learning Bulletins.
- CAB requested the paper is also sent to the Family and Carers Reference Group.

A22/167 **Q&P Report**

The Committee noted and accepted the report.

JeA highlighted the following:

- The RCA Approach to Performance Improvement report will be circulated after the meeting and put on the agenda for the QSAC meeting in November.
- There is a stable but challenging position.
- There are challenges within HR and Finance as well as flow of services.
- Demand and acuity are still high.
- HR relaunch and transformation work is progressing although it is early days.

Item

- There has been a root cause analysis of challenging KPIs, and an action plan has been delivered which has resulted in refocusing action plans.
- Q&P KPIs will be aligned with Commissioners' KPIs.

- DH asked for an update on the Coral Hub Review.
- JeA will follow up as the review is ongoing and not complete.
- DH also asked re the digital framework launch and whether the Trust's suppliers have accreditation.
- JeA will review re accreditation for the Trust Digital Suppliers

A22/168 **Safety in Motion (Violence and Aggression & Restrictive Practice Report)**

The Committee accepted and noted the report**.**

MH gave an overview:

- Instances of violence and aggression are reducing.
- Handcuffs are used for forensic patients when they are being moved in/out of the Trust. Data show Ruby Ward uses handcuffs on a regular basis which has been attributed to a patient with self-harm issues.
- EMHIP meetings have restarted.
- The Restrictive Practice Dashboard has rapidly improved.
- The Patient Safety team are undertaking a Quarter 1 review which will audit Safety in Motion.
- Following the Panorama programme, SS and MH will complete a review to include a stronger patient voice.
- DM asked if there is a breakdown of ethnicity data in respect of restrictions.
- MH informed there is no analysis in respect of the proportion of ethnic patients.
- MH and Ward 1 staff plan to visit Oxleas for learning as they currently have a low figure of restrictions.
- VF felt there needs to be a debate with staff and people with lived experience to set targets in respect of prone and seclusions in the new hospital.
- MH informed the meeting that prone positioning is used to administer medication and that there are most likely more people being restrained than is being recorded.
- AB felt the report contained lots of data but is wanted to know if the reporting is accurate and actually provides assurance.
- MH informed the meeting that Acute Service lines are undertaking QII in regard to observations and seclusions and that Safety in Motion ensures debriefs occur.
- CAB felt Service Users should always be involved in reviews.
- JC felt staff may be desensitised to restraint and asked if there is opportunity for Service users to talk to staff after the event to let them know how they feel.

A22/169 **Mortality & Suicide Prevention**

The Committee accepted and noted the report**.**

FA highlighted the following:

- There were 68 deaths in Q2 – although there were no service delivery or care issues identified that could be considered to be causative of the patient's death
- Ethnicity data is being collated.
- In respect of suspected suicides there is work to look at what point patients were at in their referral pathway and if they were receiving the right treatment.

- Learning is being looked at in respect of the prevention strategy for suspected suicides for those under 18.
- SH asked when the ethnicity data will be available.
- FA informed the meeting that IMT are working on this report and should hopefully be in the Q2 report
- VF acknowledged the work FA has undertaken at the Trust and wished her well in her new job.
- The meeting recorded its formal thanks to FA for all her work and contribution to QSAC.

A22/170 **Quality Governance Group minutes**

The Committee received and noted the minutes.

A22/171 **Mortality and Prevention Group Minutes**

The Committee received and noted the minutes.

A22/172 **Matters for Escalation to the Board**

- Discussion on the Panorama programme and linking this to reports
- The IP Programme
- Kyle's Charter
- Safety In Motion
- Patient Experience which is an overriding theme in reports and work

A22/173 **Committee Workplan**

The Committee noted the Committee work plan and DB commented that she would like to see the inclusion of Health Inequalities in reports and QSAC discussions.

A22/174 **Next Meeting**

The next meeting is on Monday, 7th October 2022 at 13:30 via MS Teams.

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 November 2022

Present:

Professor Deborah Bowman (DBo)	Committee Chair – Non-Executive Director
Ann Beasley (AB)	Trust Chair
Vanessa Ford (VF)	Chief Executive Officer
Billy Boland (BB)	Medical Director
Jennifer Allan (JeA)	Chief Operating Officer
Richard Flatman (RF)	Non-Executive Director
David Lee (DL)	Corporate Governance 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
Ryan Taylor (RT)	Associate Director of Clinical Governance & Risk
Elaine Holder (EH)	Committee Governance Manager (Minutes)
Ijeoma Ndubuisi (IN)	Clinical Team Manager, DIDMR
Jaydene Campbell – Clemons (JC)	Lived Experience Representative
Sofia Husain (SH)	Lived Experience Representative
Ben Nereli (BN)	Medical Consultant (joined for item A22/191)

Apologies:

Prof Charlotte Clarke	Non-Executive Director
Doreen McCollin (DM)	Non-Executive Director

Item

A22/175 Apologies

Apologies were noted.

A22/176 Declarations of Interest

No new declarations of interest were reported.

A22/177 Chair's Action – None

A22/178 Minutes of the previous Part A meeting

Minutes of the previous meeting were agreed

A22/179 Action Tracker

There were no outstanding actions and actions were updated as attached tracker.

Risk Register

The Committee accepted and noted the report
RT highlighted the following:

- A new risk was added in respect of Information Governance which was put on because of Corporate Induction not being face-to-face. However, this is hand and was discussed with the Executive Team and HR and will be closed soon.
- The Lone Working Risk was added back to the register for assurance as the Management Tool that captures compliance needs updating.
- RF asked if the new risk stems from the workstream that RSM (Internal Auditors) are working on
- RT informed the meeting that this is not connected to RSM and that it is in response to the Corporate Induction. There have been several IG breaches that could be avoided if the Corporate Induction were developed.
- VF informed the meeting that this risk will be reviewed in totality
- AB commented there has been limited movement on the Risk Register, and specifically questioned the water risk in Hume Ward which has been on the register for some time
- RT informed the meeting that that no movement is not uncommon and explained there has recently been an internal audit by RSM.
- RT explained the water risk for Hume Ward is ongoing and this ward will be moving into the new building. Mitigations have been put in place and there is assurance this is not a patient safety risk
- BB is working on the Medical Workforce Risk which impacts waiting times. VF has commissioned a waiting time review.
- Industrial action has been added to the workforce risk.
- CAB raised the issue of Section 17 leave and asked about its implications e.g patient experience and pressures on staff time/capacity.
- BB informed the meeting that that Section 17 refers to patients detained under the MH Act and applies as the new Hospital will not have any grounds. BB assured CAB that this will not be a barrier for unescorted leave.
- SS informed the meeting that Section 17 is currently used for all patient leave and that patients find this very helpful and this will not take up any extra staff time.
- VF informed the meeting that there will be a post-move evaluation to review questions such as these as well as the wider patient experience and quality implications, including risks such as those discussed.

A22/180 Quality and safety of inpatient services

The Committee accepted and noted the report.

SS highlighted the following:

- SS informed the meeting that that The Trust has added 6 additional key areas as part of its assurance of patient safety and the ability to escalate.

A22/181 CQC Community Survey

The Committee accepted and noted the report.

RT highlighted the following:

- This is an interim report and a detailed action plan was put together after last year's publication.
- The focus will be looking at the action plan from last year and reconciling this year's results against it.
- The results are low in respect of Crisis Care with people not knowing who to contact in times of crisis. This was discussed by ELT who were clear that signposting and making sure people know what services can be accessed will be reviewed.
- JC informed the meeting that there is ongoing work regarding patient experience within crisis care by the Involvement and Home Treatment Team which could be reported back to QSAC.

A22/182 Quality Matters

The Committee accepted and noted the report.

SS highlighted the following:

- There has been work in respect of the Patient Incident Framework during September.
- The Trust has been working closely with the ICB regarding incident reports.
- There was 1 serious incident and no unexpected deaths or suicides.
- 19 cases have been closed or deescalated by the ICB.
- No care or service delivery problems have been identified this month.
- The second meeting for the Implementation Group has taken place which will be reported through QGG.
- 5 investigation reports have been reviewed at the Serious Incident Panel meeting where key areas or learning have been discussed with individuals.
- There has been 1 claim where the coroner was critical of the Trust's completion of an assessment.
- There have been no MH Act reviews by CQC.
- The timeliness target for complaint responses has fallen by 50% which has been partially caused by sickness in the team.
- RF asked if the Trust should be concerned in respect of the 5 RCAs that were submitted late.
- SS informed the meeting that the delay was caused by questions that were sent back to the Teams for clarification.
- RF questioned the use of the term 'cumulative' in respect of unmanaged incidents when the actual figures are appear to be reducing
- RT informed the meeting that this is a running total. RF and RT agreed to clarify outside the meeting.
- DBo asked SS what she considered the current priorities are in respect of clinical services.
- SS informed the meeting that there are safeguarding concerns that are highlighted in the Q&P report.

A22/183 Safer staffing - in-patient services

The Committee accepted and noted the report.

SS highlighted the following:

- There is assurance that services have been safely staffed throughout the year.
- MH will lead a review in respect of sustainability of staff over the next 5 years.
- There are different workstreams including a skills mix review for Burntwood Villas and the new LDA ward.
- VF informed the meeting that The Trust is regularly working over 100% staffing and supports SS in respect of sustainability of staff for the future.

A22/184 Corporate Objectives

The Committee accepted and noted the report.

- BB informed the meeting that that where will be changes for the milestones for EMHIP which may in turn affect the EMHIP Corporate Objectives.

A22/185 Health and safety - inc Ligature Risk Assessment and Management

The Committee accepted and noted the report.

A22/186 Guardian of safe working hours

The Committee accepted and noted the report.

A22/187 Nurse revalidation

The Committee accepted and noted the report, welcoming the way in which it had developed since previous reports were presented to QSAC.

A22/188 Quality and Performance Report

The Committee accepted and noted the report.

JeA highlighted the following:

- Demand and acuity remain high during September although there has been a bit of leveling off during October and September.
- There has been a focus on recruitment, transformation and EMP.
- The challenges reflect previous months in respect of training.
- There are significant challenges in outpatients and community services in respect of Community, ADHD and IAPT with high levels of wait – a review of wait times has been commissioned by VF
- The same challenges apply in respect of acute flow, crisis assessment and private bed usage.
- DH asked about the recording problems because of the rollout of Silver Cloud 2.0.
- JeA has not heard of any issues and will let DH know if there are any problems.
- DH also asked if the Trust is aware of rebranding of IAPT.
- JeA informed The Trust are aware and she will forward information on to the Involvement Team.

A22/189 RCA approach to performance and delivery

The Committee accepted and noted the report.

JeA highlighted the following:

- The paper focuses on Performance improvement and where changes can be made to KPIs that are not progressing. The aim is to produce an action plan via the QI Focus Group which will be overseen by Executive Leadership Team.
- These areas require a focused and innovative response, and ELT considered proposals for each domain. Whilst they are in many ways interlinked, the proposed new approach is being considered by Board subcommittees for further discussion, alongside further work with the Service Line teams as required.
- Both QSAC and FPC have a responsibility to oversee performance improvement in relevant areas, and the paper proposes a Root Cause Analysis review and approach. A separate paper addressing Productivity has been submitted to FPC. A further discussion of our approach to sustainably improving quality of services will be brought n due course.
- A potential approach to focus our attention on the most critical areas is the use of “starred items” for specific consideration at QSAC, which may be based on either those KPIs or performance themes felt to be most critical to service quality and performance, or those which require the most improvement. It would be helpful for QSAC to discuss

how "starred items" might best be identified to focus the discussion at future committee meetings, or to identify an alternative approach.

The proposals were discussed and Committee agreed to receive updates on thematically-focused areas which may involve service lines where necessary.

A22/190 Medical revalidation and appraisal

The Committee received and noted the minutes.
BN highlighted the following:

- Peer reviews with neighbouring Trusts have been completed.
- The internal Quality Audit and The Professional Governance Group have both now underway

A22/191 Clinical Risk Approach

The Committee received and noted the minutes. JeA highlighted the following:

- This paper summarises the work completed in respect of clinical risk during high demand with the accompanying constraints on workforce and finance.
- Several workshops have been held and it was discussed whether any services can be stopped. ELT decided not to proceed with closures.
- The challenges include:
  Productivity;
  Performance improvement; and
  Quality of services, in particular our approach to:-
  a) managing clinical risk where demand exceeds capacity; and
  b) best practice standardisation of processes.
- Actions have been set out for QSAC's consideration and assurance;
- These require a focused and innovative response, and ELT considered proposals for all areas. Items 1and 2 were discussed at the September / October QSAC and FPC meetings.
- BB was keen that the Trust supports clinicians when making difficult decisions.
- VF Informed the meeting that stopping un-commissioned services was considered, but this would be the subject of considerable challenge from patients and clinicians.
- All workstreams will be led by Clinical Directors.
- CAB was keen to collaborate with, and seek the input of, the Involvement Team for co-production

QSAC agreed the proposed actions, leads and ongoing oversight to include co-production.

A22/192 EMHIP Update

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

- BB welcomed the arrival of Emdad Haque as Associate Director of EDI
- Maxine Christian will start at the Trust full time during December. Maxine will run the EMHIP Project and will oversee the delivery of the EMHIP Programme, including engagement with the Black Community in Wandsworth.
- There were challenges last year in respect of delivery and its co-ordination. The new direction of travel will include a broader range of stakeholder groups which has already yielded better collaboration and coproduction. Stakeholder expectations are clearer and better aligned with the project goals. These recent developments enable SWLSTG to be more involved in the project, thereby mitigating potential reputational risks. Our partner organisations are positive about the future, and the Trust intends to sustain these relationships throughout the programme.

- VF stated the importance of developing a robust infrastructure to support EMHIP.
- DH asked is keen for the evaluation data about the project to be shared.
- BB informed the meeting that the evaluation and data collection are included in the report; the ICS will fund evaluation.
- CAB was keen for similar work to be rolled out in Sutton.

A22/193 Quality Governance Group minutes

The Committee received and noted the minutes.

A22/194 Mortality and Prevention Group Minutes

The Committee received and noted the minutes.

A22/195 Matters for Escalation to the Board

- Compliance
- Safer Staffing
- Medical revalidation
- CQC Survey and feedback
- Broader reflections in respect of BAU, transformation and the EMP Programme
- Q&P report changes

A22/196 Committee Workplan

The Committee noted the Committee work plan.

A22/197 AOB –

Bus routes through Springfield - DH Highlighted the following:

- DH informed the meeting that there have been discussions with TFL and the Patient Quality Forum in respect of transportation to Trust Sites.
- Any issues raised cannot progress until the Trust conducts a travel survey/plan to include patients, staff, and visitors.
- All information has been sent to the EMP Team.
- DH would like to request commitment and a timescale for the survey/plan to include interviews with visitors to the Hospital.
- VF informed the meeting that that she has recently met with the CE of Wandsworth Council and will report back to QSAC with a timetable for the work after the hospital move

- SS informed the meeting that the improvement work for Burntwood Villas has been acknowledged by the CQC.
- On the point about quality priorities, SS will report back in respect of clinical areas that have concerns and triangulate this information in the Quality Matters report.

A22/198 Next Meeting

The next meeting is on Monday, 7th December 2022 at 13:30 via MS Teams.

Trust

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

Quality and Performance Report

November 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 November, pressure on mental health services has continued, with an ongoing need to address demand within our adult and CAMHS crisis, acute and urgent care pathways, while we have high acuity and waiting lists for our community services. Our transformation and improvement programmes aim to enhance access, recovery, and crisis avoidance across our services to enable us to support people in a sustainable way, and work is progressing across all service lines in partnership with the wider SWL Integrated Care System. However, the context for our teams remains challenging, in common with all NHS and care services, with the impact of flu, covid, the cost of living, industrial action and workforce shortages being significant. In delivering our services we prioritise the safety of our patients and staff and acknowledge that we cannot fully meet all ongoing mental health demand with the resources available.

The focus of this report is November 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 now oversees the priority KPI action plan addressing our Root Cause Analysis of performance. We continue also to work on standardising pathways for psychological intervention, optimising the efficiency of our clinicians including through digital skills and tools, and considering how to develop and flex our workforce most effectively. These programmes of work to reduce variation and improve productivity are aligned with our transformation programmes to ensure a joined up approach, though there remain constraints to delivery due to the demand and resource challenges outlined above.

The HR function split from SLaM in September as planned with the exception of Staff Survey, Job evaluation, Health and Wellbeing and OD which is planned to split at the end of March, although planning has commenced to try to move to splitting these functions earlier. Vacancies across the HR teams are being recruited to and Interims are being released wherever possible, although there are still secondees that are not due to return until early 2023. Although the HR Recovery has been subsumed into business as usual, The Trust took the decision to place recruitment into an internal incident on the 22nd August, with this incident running until the 14th November 2022. This has meant that HR and Operation's joint focus over this period has been on improving processes in 5 key areas, with more details below.

The following areas of challenge and improvement in relation to priority performance metrics are noted in November 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. Changes to be made to the dashboard to help easily identify outstanding actions from Incidents and Root Cause Analysis (RCAs), and Post Incident Reviews (PIR's). Action plan for each Service line on improving outstanding or unmanaged incidents.
- Successful and safe moves of four inpatient wards, Community teams and some corporate services into Trinity.
- CQC inspection of Rehab services, Burntwood Villas and Phoenix ward in October. Formal Report received December for factual Accuracy, Rehab Service re-rated to Good in all domains.
- Covid Booster and Flu vaccination centre due to end in November, with low uptake, which is in line with the London data for Mental Health Trusts. We continue to provide drop in clinics on site, with a range of peer vaccinators across all service lines to drive to 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.

Workforce Update:

- The Trust is in the remaining final weeks of the recruitment incident which concluded on the 14th November. 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. This year's staff Survey has also included Bank Workers who have recently worked in the Trust.

Access Update:

- Adult ADHD/ASD services face significant demand and capacity pressures; the waiting list initiative completed earlier in 2022 mitigated this position temporarily but the impact is now being seen across this pathway in the form of growing 52 week breach numbers. An improvement plan is in place and there is weekly scrutiny on wait list via performance meetings. The Trust is also to engage with local GPs on ADHD medication review pathway through the Integrated Care Board (ICB), with the aim of freeing up capacity for ADHD diagnosis work

- The Trust incurred (26) 52 week breaches in November 2022 - (21) in the Adult ADHD service and (5) in Wandsworth Complex Needs (CNS). Following review of Wandsworth CNS internal processes some new long waiters were identified and these cases are being processed as a priority. Longest waits are subject to weekly scrutiny and are also reviewed at monthly Access Meeting.
- 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, with the transfer process going smoothly to date. Significant leadership effort has been invested into welcoming the RWS teams and experience from each area will be shared between IAPT teams.
- Work to address internal waits over 30 weeks is on-going. Focus is now on ensuring a robust referral and waiting list management process across SPAs and receiving teams, and to ensure correct recording of assessment and treatment. Work to optimise capacity in psychology services is ongoing and a clinical workshop on psychology treatment pathways took place with Heads of P&P and CDs in November. Reporting now incorporates treatment waits in CAMHS Tier 3 and Adult ED treatment waits.

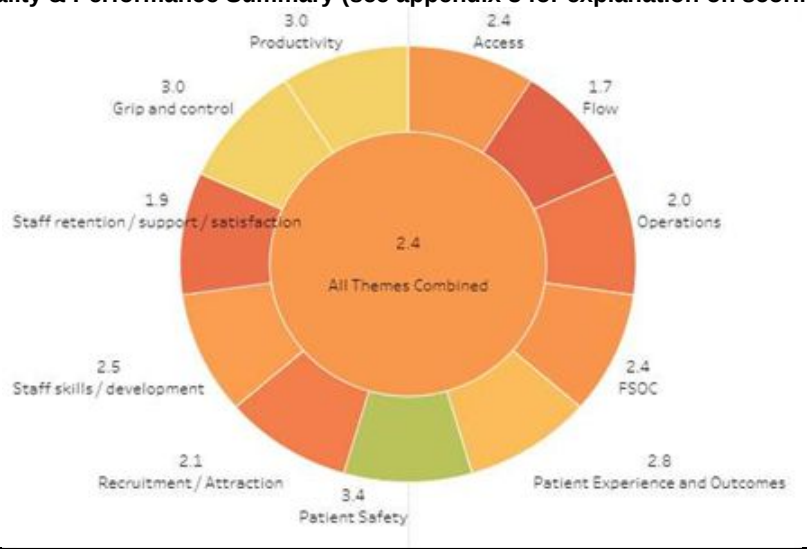
Flow, Patient Safety & Productivity Update:

- Crisis and acute inpatient services remain in a challenging position, with the need to balance demand, waiting times in crisis, and bed capacity. The Trust keeps patients in SWL wherever possible through block contracts for private acute and step-down hostel beds, the latter of which are being expanded in partnership with adult social care as a short term measure for winter.
- Improving LOS is a key priority for the acute service transformation programme, with both clinical pathway and process work ongoing, and plans to standardise ward workflows in progress. The transformation work is being refreshed in line with the national MH discharge challenge for 2023. There are high levels of delayed transfers of care, reflecting in part constraints in the wider system, with active exec escalation weekly. Performance on the Discharge summary KPI is not yet meeting the standard. Technical glitches have been largely resolved but the underlying discharge process is fragmented and is not undertaken contemporaneously; work to map and improve this is in train.
- Length of stay is also under review in community services, with review and action planning to address patient recovery and step down under way in CAMHS and adult community teams.
- Liaison services seeing patients in Emergency Departments within 1hr remains a concern; as do 12hr breaches in Emergency Depts, which attract significant system-wide attention. 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 with additional shifts now in place in all three EDs.

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 8, the Trust remains on its target trajectory and has delivered £8.6m of cumulative savings; savings plans are in place to fully deliver, and work continues to identify recurrent savings. Year to date 30% of savings are recurrent and this remains the area of concern as we move to year-end and plan for 2023/24

Quality & Performance Summary (see appendix 8 for explanation on scoring)



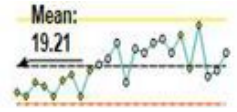
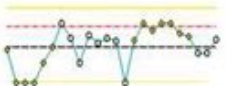
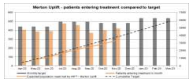
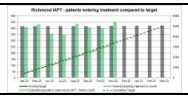
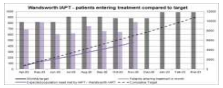
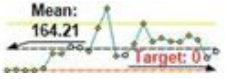
Summary Domain Performance:

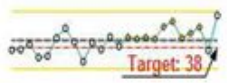
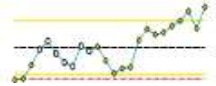
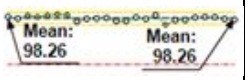
Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	4	10	20	41.2%
Quality	5	14	8	70.4%
Workforce	2	3	7	41.7%
Finance	0	3	0	100.0%
Total	**11**	**30**	**35**	**53.9%**

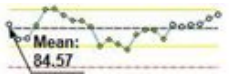
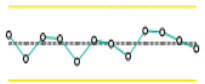
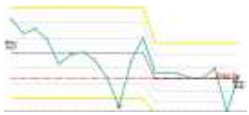
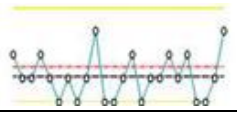
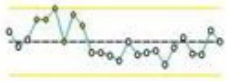
A table showing how many KPIs have full assurance, some assurance and no assurance, split by domain.

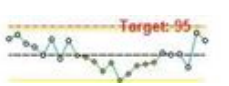
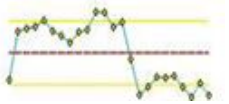
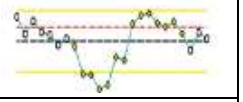
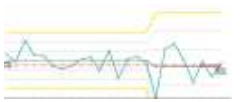
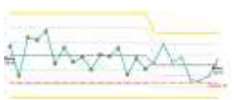
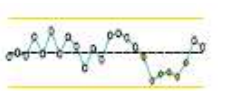
Donut Performance over-time (all themes combined):

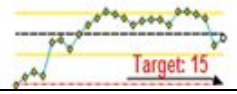
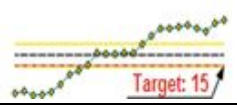
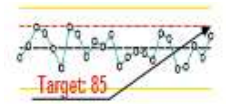
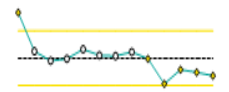
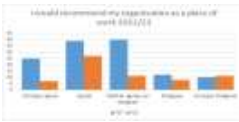
Priority Metrics

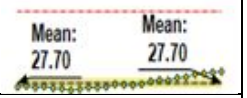
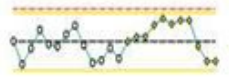
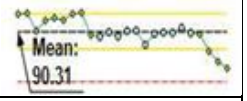
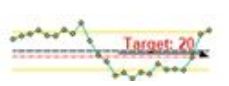
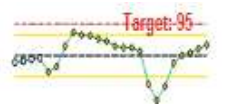
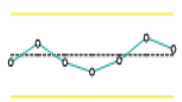
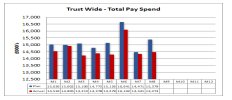
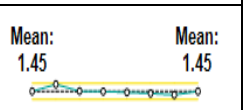
	Priority Metrics	Nov-22	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 9)	55.6	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 10)	26	= 0	↗	X	
	Access					
	No one is waiting more than 30 weeks for treatment - Number of breaches (including CAMHS Neuro, IAPT & Non-RTT teams) (see page 11)	1356	0	↗	X	
	Access					
	Adult and Older People's CMHTs - Non-Urgent Referrals assessed within 28 days (%) (see page 13)	82.4	≥ 80.0	→	?	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 14)	72.7	≥ 95.0	↗	?	
	Access					
	Expected population need IAPT – Merton Uplift (see page 13)	3310	3776	-	-	
	Access					
	Expected population need IAPT – Richmond (page 13)	3245	3345.3	-	-	
	Access					
	Expected population need IAPT – Talk Wandsworth (see page13)	5612	6955	-	-	
	Access					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 16)	143	= 0	↗	X	
	Flow					
	Time on caseload (days) (see page 15)	438.1	-	↘	-	
	Flow					

	Priority Metrics	Nov-22	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (see page 9)	80.3	≥ 95.0	↘	X	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 10)	76.9	≥ 92.0	↘	X	
	Access					
	Referral to treatment (RTT): 52 week breaches	26	= 0	↗	X	
	Access					
	Internal waits for treatment of over 30 weeks (see page 12)	441	-	→	-	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 14)	6.5	≥ 10.0	↗	X	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 15)	73.7	≥ 80.0	↘	X	
	Access					
	Expected population need IAPT Sutton Uplift (see page 13)	3039	3245	-	-	
	Access					
	Adult acute average length of stay (Excluding PICU) (see page 16)	58.3	≤ 38	↗	?	
	Flow					
	Delayed transfers of care (%) (see page17)	9.4	≤ 2.5	↗	X	
	Flow					
	Data quality maturity index (DQMI) (%) (see page 17)	98.2	≥ 95.0	→	✓	
	Operations					

	Priority Metrics	Nov-22	Target	Trend	Assurance*	SPC Chart
Quality	Community risk assessments reviewed within the last 12 months (%) (see page 18)	91.8	≥ 95.0	↘	✗	
	Fundamental Standards of Care					
	Physical Health Assessment attempted within 48 hours of admission (%) (see page 19)	95.3	≥ 95.0	→	?	
	Fundamental Standards of Care					
	Cardiometabolic Assessments - Community and EIS (%) (see page 20)	87.9	≥ 75.0	→	✓	
	Fundamental Standards of Care					
	Safe Staffing: requirements inc obs levels (see page 21)	83.8	-	→	-	
	Fundamental Standards of Care					
	Always Ready Audits Completed (%) (see page 21)	78.9	≥ 90.0	↗	✗	
	Fundamental Standards of Care					
	Patient Friends and Family Test (%) (see page 23)	85.6	≥ 92.0	→	✗	
	Patient Experience and Outcomes					
	IAPT recovery rate - Merton Uplift (%) (see page 24)	50.5	≥ 52.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate – Richmond IAPT (%) (see page 24)	50.5	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	Patient Safety Incidents – Severe Harm (see page 25)	**3**	≤ 1.5	→	?	
	Patient Safety					
	Reducing restrictive practices – Prone Restraint (see page 26)	36	-	→	-	
	Patient Safety					
	Inpatient discharge letters sent within 24 hours (%) (see page 27)	79.2	≥ 90.0	↘	?	
	Patient Safety					

	Priority Metrics	Nov-22	Target	Trend	Assurance*	SPC Chart
Quality	Inpatient Risk assessments completed within 48 hours of admission (%) (see page 18)	93.4	≥ 95.0	→	✗	
	Fundamental Standards of Care					
	Physical Health Assessment completed within 7 days of admission (%) (see page 19)	84.3	≥ 90.0	↗	✗	
	Fundamental Standards of Care					
	Safe Staffing: National Compliance - Inpatients (%) (see page 20)	125.9	≥ 95.0	→	✓	
	Fundamental Standards of Care					
	Always Ready Audit Compliance (%) (see page 22)	**85**	≥ 90.0	↘	✗	
	Fundamental Standards of Care					
	Complaints Answered Within 25 Days (%) (see page 22)	**72.4**	≥ 85.0	↗	?	
	Patient Experience and Outcomes					
	Emergency readmission within 30 days - Adult Acute & PICU (%) (see page 23)	**2.9**	≤ 8.5	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate - Sutton Uplift (%) (see page 24)	**50.5**	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate - Talk Wandsworth (%) (see page 24)	54.4	≥ 50.0	→	✓	
	Patient Experience and Outcomes					
	Total number of restraints (physical restraints and rapid tranquilisation) (see page 26)	149	-	↘	-	
	Patient Safety					
	Death - Suspected suicide (see page 27)	**1**	≤ 4	→	-	
	Patient Safety					
	Follow up within 72 hours of discharge from inpatient services (%) (see page 28)	**96.5**	≥ 95.0	→	✗	
	Patient Safety					

	Priority Metrics	Nov-22	Target	Trend	Assurance*	SPC Chart
Workforce	Vacancy Rate (%) (see page 29)	18.4	≤ 15	↗	✗	
	Recruitment/ Attraction					
	Time to Recruit (days) (see page 30)	**49.7**	≤ 49	↗	✗	
	Recruitment/ Attraction					
	Temporary staffing - Acute and Urgent Care Service Line (%) (see page 31)	30.2	≤ 22	↗	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 1 (%) (see page 33)	92.3	≥ 95.0	↘	✗	
	Staff Skills/Development					
	Turnover (%) (see page 34)	18.5	≤ 15	↗	✗	
	Staff Retention/ Support / Satisfaction					
	Supervision (%) (see page 35)	83.6	≥ 85.0	→	?	
	Staff Retention/ Support / Satisfaction					
	Active ER cases (see page 36)	42	TBA	→	-	
	Staff Retention/ Support / Satisfaction					
	Staff FFT (recommend treatment) (%) (see page 37)	-	≥ 75.0	-	-	
	Staff Retention/ Support / Satisfaction					
Finance	% Forecast budget overspend (see page 38 (see)	**0**	≤ 0	→	?	
	Grip & Control					
	Cumulative CIP Delivery £000 (see page 39)	8,551	8258	-	-	
	Grip & Control					
	Activity Vs WTE (see page 40)	12.9	-	→	-	
	Productivity					

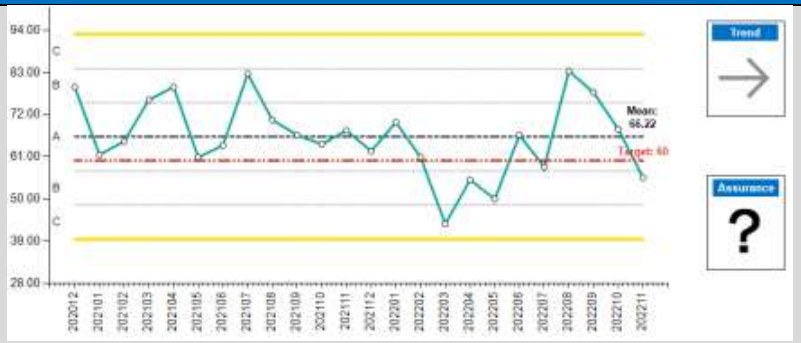
	Priority Metrics	Nov-22	Target	Trend	Assurance*	SPC Chart
Workforce	Vacancies in active recruitment (%) (see page 30)	**55.2**	≥ 90.0	→	✗	
	Recruitment/ Attraction					
	Percentage of BAME staff - Band 8+ and Medical (see page 31)	31.3	≥ 50.0	↗	✗	
	Recruitment/ Attraction					
	Temporary staffing - Community Service Line (%) (see page 32)	16.5	≤ 22	↘	✓	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 2 (%) (see page 33)	86.4	≥ 85.0	↘	✓	
	Staff Skills/ Development					
	Staff Leaving within 12 months of appointment (%) (see page 34)	22.6	≤ 20	↘	?	
	Staff Retention/ Support / Satisfaction					
	PADR (%) (see page 35)	89.2	≥ 95.0	↗	✗	
	Staff Retention/ Support / Satisfaction					
	ER cases exceeding 90 days (see page 36)	**29**	TBA	→	-	
	Staff Retention/ Support / Satisfaction					
Finance	Agency as a % to NHSI Target (%) (see page 38)	**133.3**	≤ 100	→	?	
	Grip & Control					
	Pay Cost Vs Budget £000 (see page 39)	14,473	**15,379**	-	-	
	Grip & Control					
	Activity vs Caseload (see Page 40)	1.4	-	→	-	
	Productivity					
	Contract Activity – Local CCG Contract (%) (See page 41)	95	≥ 95.0	→	?	
	Productivity					

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

Operations Domain

Access

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



Team Breakdown – November 2022

Team	Treatment Within 14 Days	Referrals	% Treatment 14 Days
Kingston EIS	0	3	0%
Merton EIS	1	1	100.0%
Richmond EIS	0	0	0%
Sutton EIS	3	4	75.0%
Wandsworth EIS	6	9	66.7%
Total	10	18	55.6%

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.

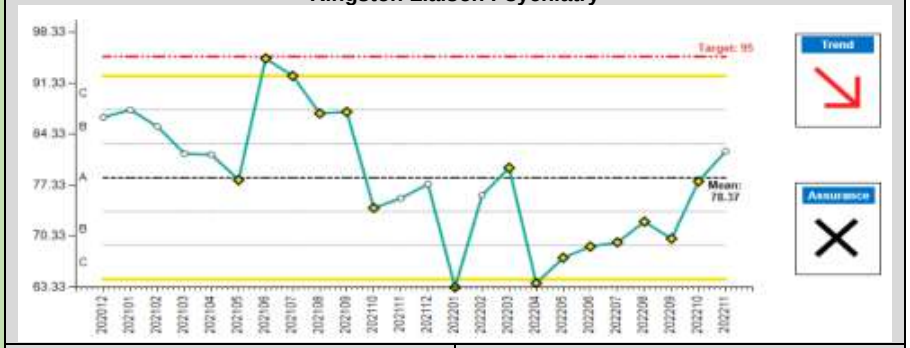
What the chart tells us
While there is significant variation, the Trust can be expected to usually exceed the target which is below average performance.

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.

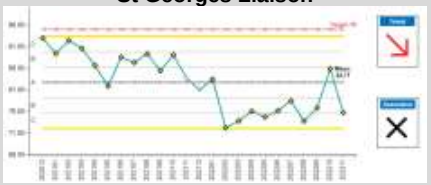
Actions:
- Trust to explore digital solution to initiate a prompt in Rio upon entry of diagnosis of psychosis. This issue will be discussed at the RiO Governance Group in August 2022.
- Targeted training for SPA teams to continue in order to reinforce the importance of timely referrals to EIS.
- To maintain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

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.

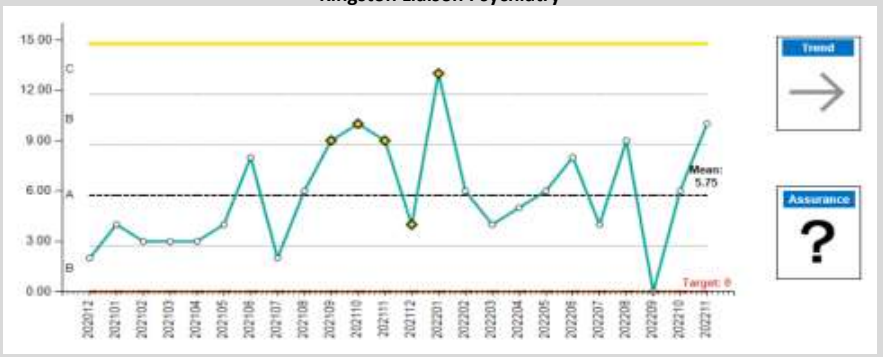
Underlying issue:
- High numbers of referrals in Kingston and St Georges in comparison to staff levels; unfilled posts; referrals during handovers or out of hours meaning the services are not always able to meet demand.
- Service users delayed at A&E are causing an increased workload for clinicians and 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.
- Establishment variation completed for additional Band 7 nurses (across all three A&E Departments) to work late shift for 6 months. Funder via winter scheme monies and will support with mental health triage and divert from Emergency Department when clinically appropriate.
- 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.

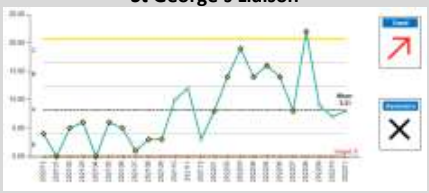
Liaison psychiatry - People waiting over 12 hours in A&E for a bed — Target = 0

Access

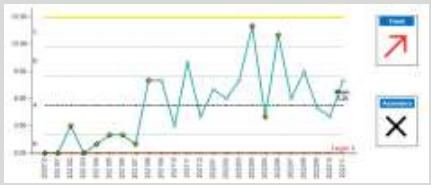
Kingston Liaison Psychiatry



St George's Liaison



St Helier Liaison



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

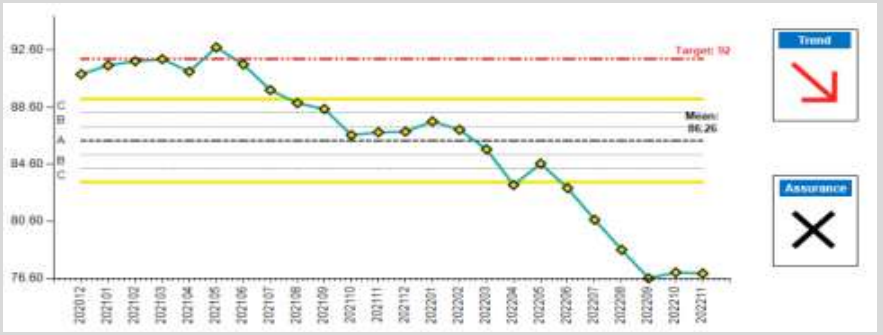
What the charts tells us
The level of 12-hour breaches is relatively consistent across the three services with occasional variation.

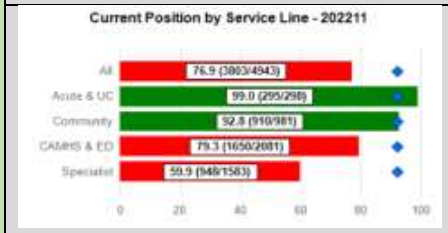
Underlying issue
- A lack of available adult acute beds will lead to an increase in waits over 12 hours.
- Increased levels of delayed transfer of care can affect patient flow.

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 contract for use of 18 beds at Holyborne 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%

Access





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

Including ADHD/ASD teams	76.9%
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.

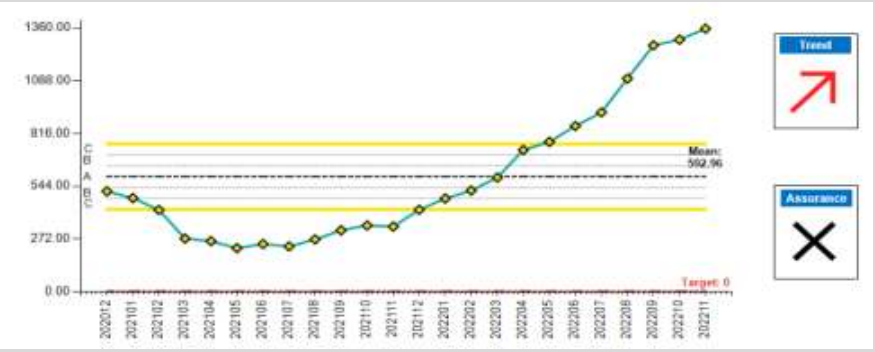
What the chart tells us
Mean performance is below target and there has been a significant downturn trend in performance since April 2021. A change in process is required in order to improve performance.

Underlying issue
- **Adult ADHD:** There are known demand and capacity issues within the service; in November 2022, 47.9% (557/1162) 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



Service	Oct-22	Nov-22	+ / -
Adult Eating Disorders	1	10	9
ADHD/ASD 30 week breaches	432	452	20
CAMHS SPA	90	123	33
CAMHS Tier 3	11	19	8
CAMHS Tier 2	60	30	-30
CAMHS Neuro Development	53	54	1
Cognitive Stimulation Therapy	11	16	5
Merton Uplift	180	163	-17
Sutton Uplift	109	103	-6
Talk Wandsworth	253	283	30
Sutton & Merton Complex Needs	46	45	-1
Wandsworth Complex Needs	16	18	2
Other	37	40	3
Total 30 week breaches	**1299**	**1356**	**57**

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.

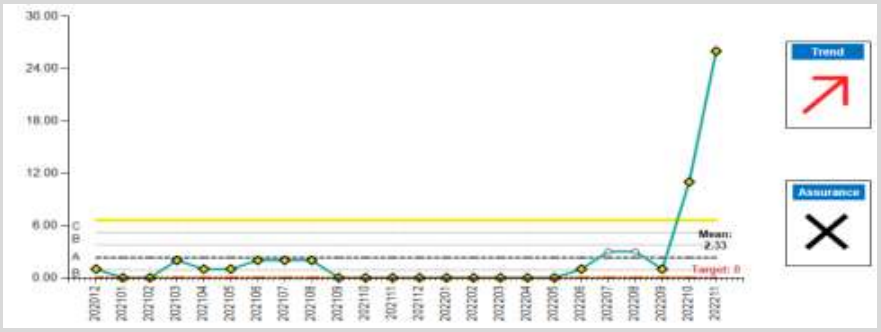
What the chart tells us
Following long-term poor performance, the trust was able to consistently improve but there has been further deterioration over recent months.

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:
- **Adult ASD/ADHD**: **Waitlist initiative**: ADHD long waiters will be seen by a third-party using waiting list initiative monies with 176 clients having been transferred to Clinical Partners who will need annual medication review to be booked once returned to service and will further impact on capacity. **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. The Trust is also to engage with local GPs on ADHD medication review pathway through the Integrated Care Board (ICB) in the near future, with the aim of freeing up capacity for ADHD diagnosis work.
- Improvement plan led by Clinical Manager to improve processes around referrals, cancellations and recording. The service is also undertaking work to optimise clinical capacity, which will involve a review of ADHD admin and clinical processes.
- IAPT: Recruitment to next round of trainees in March 2023 which aid planning and support for clinical capacity in service
- **CAMHS SPA:** NDT backlog clearance resource deployed in Kingston & Richmond SPA in August 2022.
- **CAMHS Tier 3:** Psychiatry recruitment drive across community CAMHS T3.
- **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. (final conversation expected to be had mid-Nov).

Access

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



Team	Number of Breaches
Merton Adult ADHD	10
Sutton Adult ADHD	11
Wandsworth Complex Needs Service	5
Total	**26**

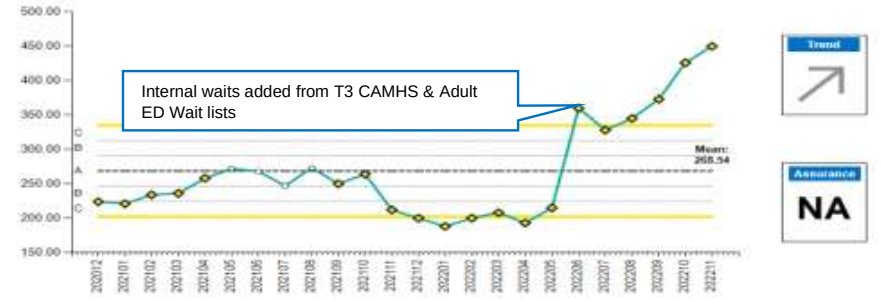
What the chart tells us:
Target is met frequently but there are periods of variation.

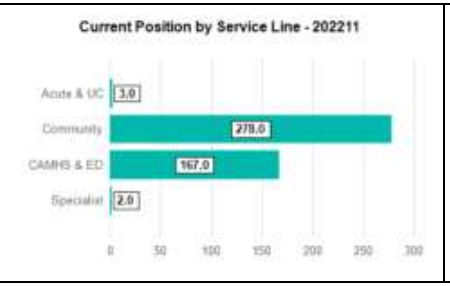
Underlying issues that prevent us from consistently reaching the target:
- There are known demand and capacity issues within adult ADHD services and there is a continued risk of further 52 week breaches.
- Wait list is increasing making it difficult to offer appointments within the timeframe.
- Staff sickness within service has impacted on offer of appointments and resulted in some cancellations leading to appointments being re-booked after 52 weeks.
- Further service cancellations due to limited trainee availability and Consultants having to cover the wards at St Georges Hospital.
- Appointment cancellations (by patient/or clinician) can lead increased waiting times within service due to lack of appointment availability.
- Following review of Wandsworth CNS internal process some new long waiters have been identified and are being processed as a priority.

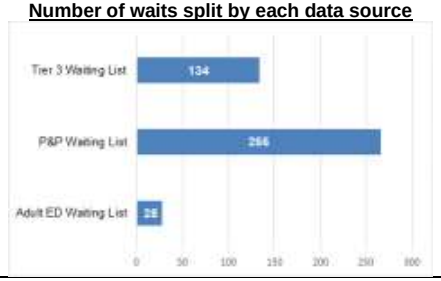
Actions:
- **ADHD:** Improvement plan led by Clinical Manager to improve processes around referrals, cancellations and contact options (i.e. use of e-consultation).
- The Trust is to engage with local GPs on ADHD medication review pathway through the Integrated Care Board (ICB) in the near future, with the aim of freeing up capacity for ADHD diagnosis work.
- Adult ADHD service and Performance Analyst are having weekly meetings to review 50 plus week waiters. The service waiting times are subject to scrutiny via the Internal Access meeting and 52 weeks breaches are now reported as a priority metric.
- 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 CNS Team undertook data cleanse on longest waits to ensure cases added to RiO were valid waiters. Longest waiters are subject to scrutiny on weekly basis via Community Service Line and Performance Team.

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.

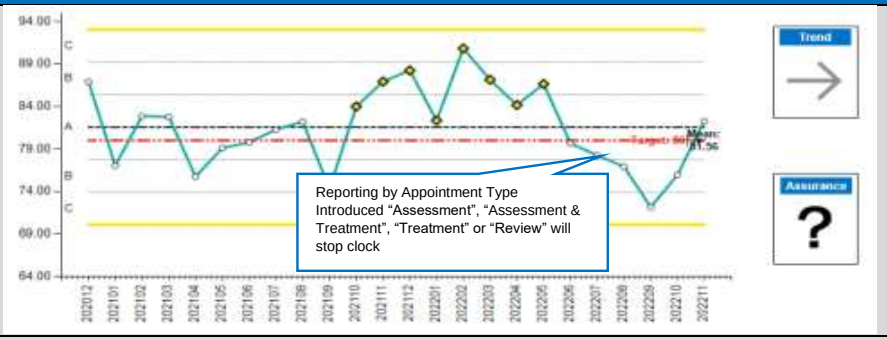
What the chart tells us
Period of significant increase has been followed by a decrease in long waiters in recent months. Recent spike linked to changes in reporting definition.

Underlying issues
- 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.
- Record number of trainee clinical psychologist placements starting in Nov 2022 will lead to reduction in waits.

Access

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



Underperforming Teams

Team	Assessed Within 28 Days	Assessments	% Assessed Within 28 Days
Sutton PLRS - Single Point of Access	61	80	76.3%
North East Wandsworth CMHT	5	7	71.4%
Merton Uplift PCRS	14	21	66.7%
North Kingston CMHT	9	14	64.3%
Morden Recovery and Support Team	5	8	62.5%
Central Wandsworth & West Battersea CMHT	4	8	50.0%
Putney & Roehampton CMHT	1	2	50.0%
Wimbledon Recovery and Support Team	2	5	40.0%
Carshalton & Wallington IRH	4	14	28.6%
Sutton and Cheam IRH	3	11	27.3%

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.

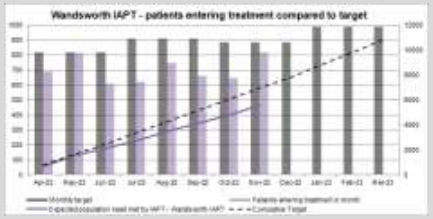
What the chart tells us
Mean performance is above target but there is some variation over the period. Last three months there has been deterioration.

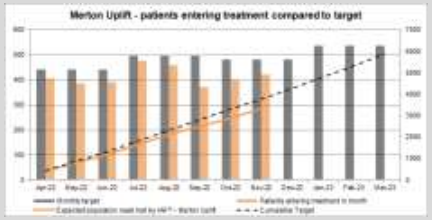
Underlying Issue
- Managerial gaps (Team Manager level) affecting coordination of service delivery and staffing team manager level.
- Limited clinical capacity due to sickness and difficulty filling locum positions has reduced assessment slots from consultants.
- IRH in Sutton have lack of medical cover in November. Shortage in workforce means current waits to assessment is 3months.

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.
- Locum consultant for IRH beginning in December to improve IRH Assessment waits.
- COO in conjunction with Community Service Line Management to lead review of appointment recording within SPA's.

Access

Expected population need met by IAPT (numbers entering treatment)





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

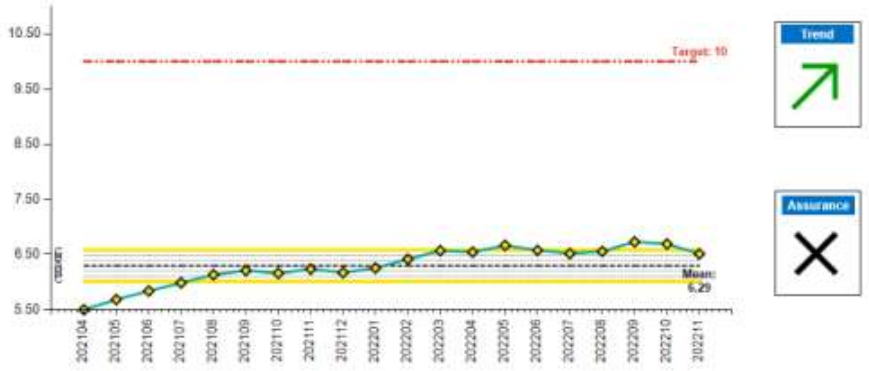
What the chart tells us
All four IAPT services are below their cumulative access requirements.

Underlying issues
- Insufficient referrals across all services.,
- 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.

Actions
- 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
- Services continually review marketing plans; initiatives include face to face engagement, health and social care meetings and use of social media platforms.
- 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.

Access

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



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.

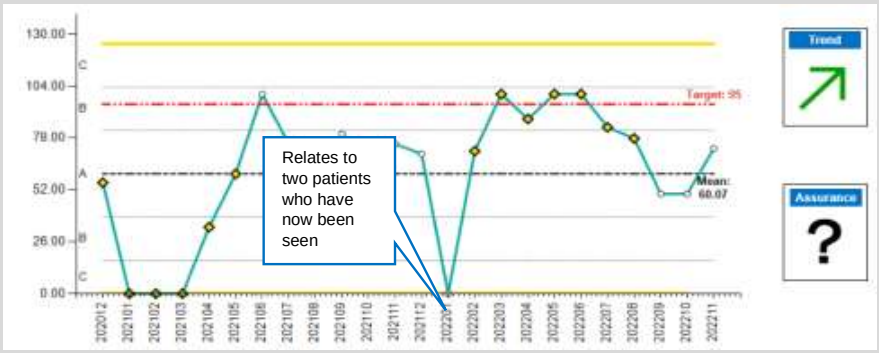
What the chart tells us
Although positive upward trend mean performance is considerably below national requirement (target).

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.
- 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, expectation for access rate of one percentage point increase from this service once live. Soft launch scheduled for January 2023.
- New Maternal Mental Health Service is in the process of being mobilised and this service will also contribute to access requirements.

Access

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



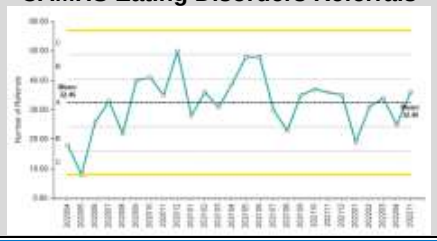
Background
To ensure that young people in urgent need of care have prompt access to CAMHS services when there are concerns for welfare.

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

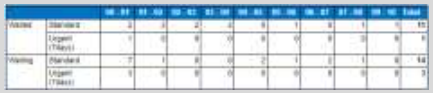
Underlying issue
- Long term demand capacity issues within the team lead to children waiting over 30 weeks for treatment
- Over-reliance on part time staff to maintain administrative systems.
- The denominator for this KPI is low, so any case seen outside 28 days is likely to lead to target being missed.
- Recruitment into the service has been challenging with certain posts difficult to recruit to.

Actions
- New Service Manager is now in post and improving waiting times has been identified as a priority.

CAMHS Eating Disorders Referrals



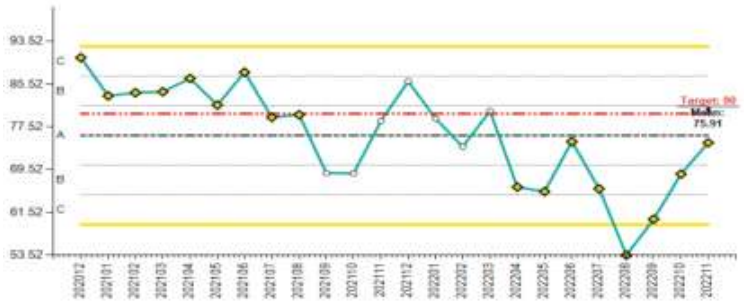
Waiting for Treatment Summary November 2022



Access

CAMHS - Non-Urgent referrals assessed within 8 weeks (%)

Target ≥ 80%



Team Breakdown

Team	Assessed Within 8 Weeks	Assessments	% Assessed Within 8 Weeks
Sutton CAMHS Tier 3	32	35	91.4%
Wandsworth CAMHS Tier 3	13	17	76.5%
Merton CAMHS Tier 3	14	20	70.0%
Richmond CAMHS Tier 3	7	11	63.6%
Kingston CAMHS Tier 3	16	27	59.3%
Trust Total	**82**	**110**	**74.5%**

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

What the chart tells us
Mean performance is below target indicating target will be met on occasion but there will be variation. Recent months there has been some improvement but performance remains below mean and target.

Underlying issue

- Most breaches relate to waits for ADHD medication and Psychiatry. As T3 CAMHS continues to assess more of the backlog of ADHD waiters this KPI will continue to deteriorate of until the backlogs are cleared.
- There are delays in ADHD medication due to the prioritisation of urgent referrals, screening forms being returned late, cancelling appointments and a small number of errors in recording.
- Kingston & Richmond Tier 3 services continue to struggle with assessment slot availability within the team, as resources are being focused on offering therapy slots for waiting patients.
- 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 post being advertised for Kingston and Richmond CAMHS to support the ADHD medication demand across both teams.
- Psychiatry recruitment drive across all community teams.

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:

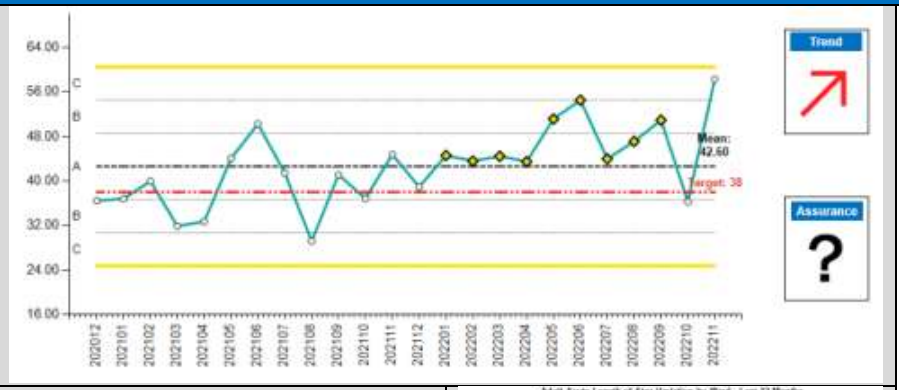
- As part of transformation of community services and the introduction of new roles and processes, the service line is reviewing the process of stepdown/discharge following recovery.
- Analysis undertaken in May 2022 to look at the teams with the longest average waiting times. This was reviewed in the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

CAMHS:

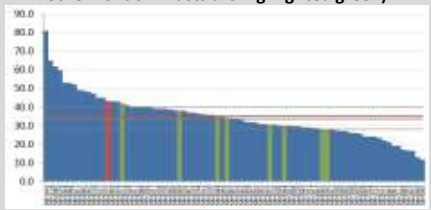
- A review of Tier 3 caseloads has been undertaken.
- The service is currently recruiting a transition coordinator position to assist with transition cases in Kingston & Richmond.
- KPI definition document to be worked up in order to provide greater clarity for time on caseload

Flow

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



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



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

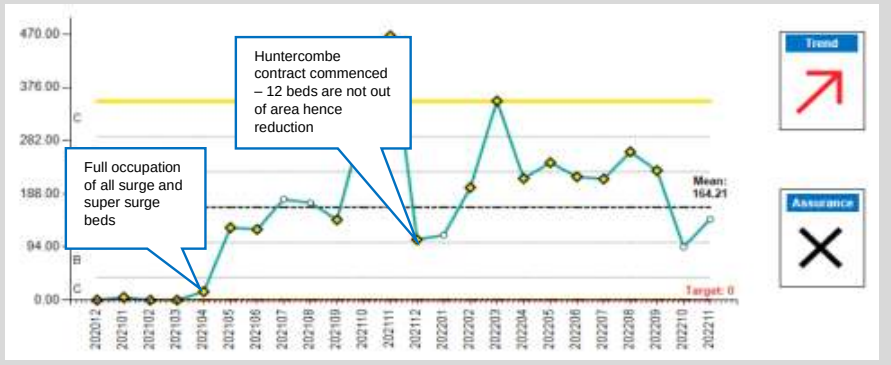
What the chart tells us
Trust average performance exceeds the national average in 2020/21 (denoted as the target).

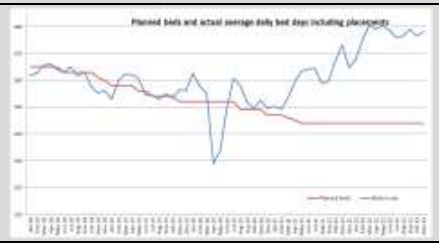
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds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

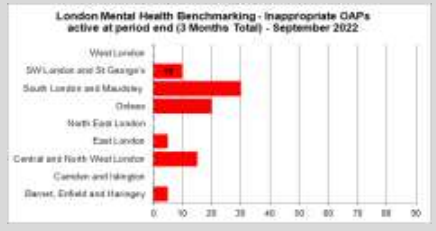
Action
- Consistent use of estimated discharge dates (EDD); reviews of patients with stays of over 90 days.
- More assertive use of the improved delayed transfer of care (DTOC) process
- A revised draft choice/discharge policy for use by the discharge co-ordinators has been issued to partners for comment.
- Acute & Urgent Care service line are undertaking a 100 day challenge which will have an in depth focus on adult acute length of stay.
- 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.
- Further development of EUPD pathway for inpatients.
- In-reach worker now working across all 8 adult acute wards.

Flow

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







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.

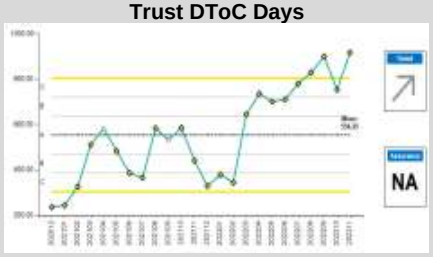
Underlying issue
- Performance is related to the demand for adult acute and PICU beds. High and continual occupancy rates that exceed 95% inevitably lead to the use of out of area beds at times of peak demand.

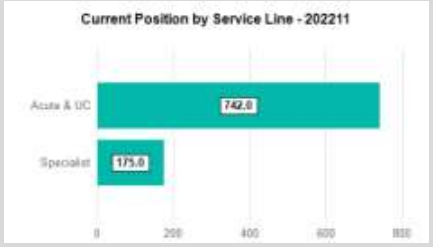
Actions
- The Trust has extended its contract for use of 18 beds at Holyborne in Roehampton until the end of the financial year.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- Focus on discharge of patients in private out of area beds where possible (community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

Flow

Delayed transfers of care (%)

Target ≤ 2.5%





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.

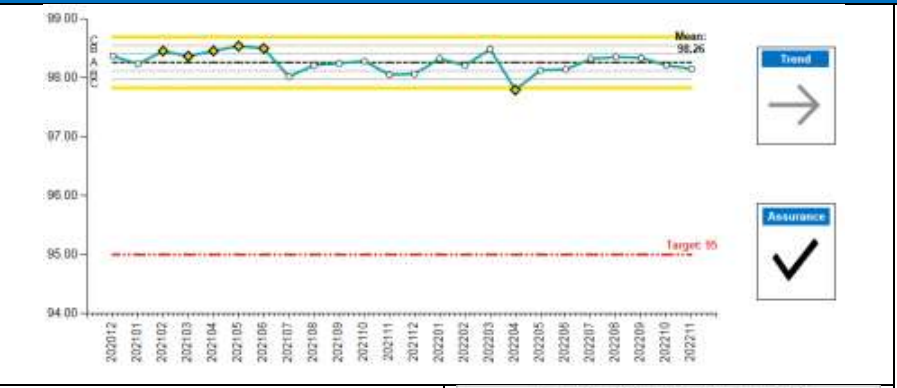
Underlying issue
- Improved identification of delays for non-medical reasons through use of an estimated discharge date.
- An increase in the proportion of more complex cases as bed numbers are reduced.
- Delays are often beyond the control of the Trust and reliant on LA engagement and resources.
- A 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 has been extended for 6 month period and a task and finish group (with representation from LA's) commenced in November 2022.

Operations

Data quality maturity index (DQMI) (%)

Target ≥ 95%



DQMI Areas for Improvement – November 2022

DQMI Item	% Compliance
Ethnicity Category Code	93.8%
Primary reason for Referral	92.3%
Referral Closure Reason	90.7%
Indirect Contact time (hour)	90%
Ex British Armed Forces	88.1%

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.

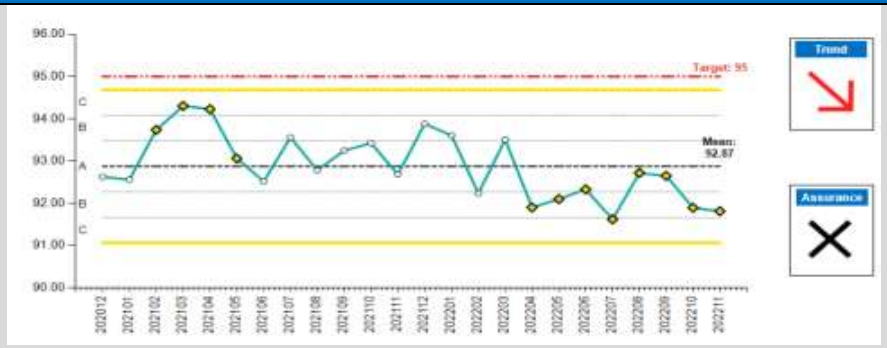
Underlying issues
- Trust consistently benchmarks well on this indicator when compared to other mental health Trusts.
- A small number of measures on the DQMI need improvement – these are listed in the summary table i.e. Ethnicity Category Code and Ex British Armed Forces.
- Lack of oversight at service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

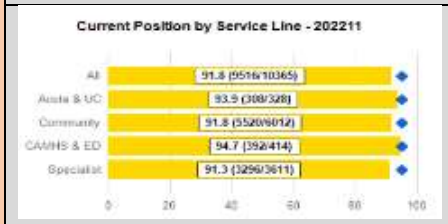
Actions
- No major concerns as Trust performance is consistently above target.
- Information Management to configure reporting at service line/team level in order for closer scrutiny on data.

Quality Domain

Fundamental Standards of Care

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





CPA Breakdown – November 2022

CPA	93.3%
Non-CPA	90.5%

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.

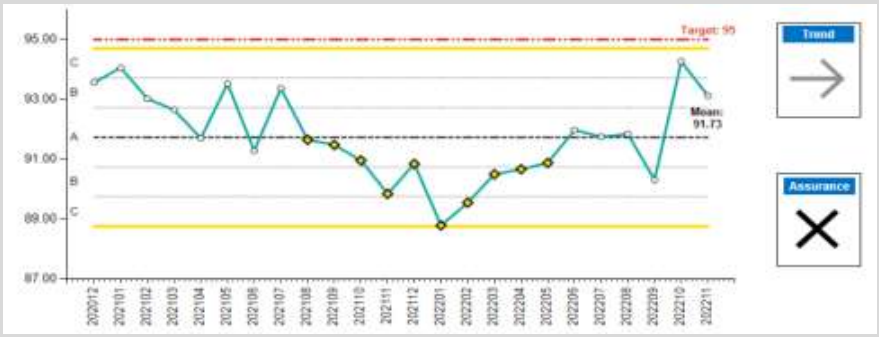
What the chart tells us
Target is in line with upper control limit suggesting it is unlikely that the target will be met without a change in process.

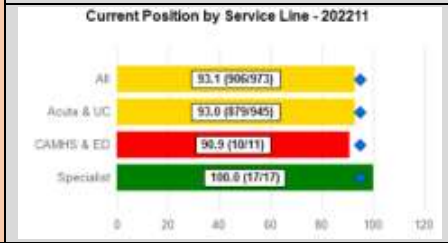
Underlying issue
- Risk assessments are reviewed following a meaningful clinical contact and so this target is harder to achieve for the non-CPA cohort of patients who are seen infrequently and mainly by medical staff.
- In Community service there a number of medical posts not filed by substantive staff. High staff turnover resulting in some new staff being unaware of risk recording processes.
- There is significant variation between teams with a number of outlying under performers i.e such as adult ADHD service where team capacity can lead to delay in undertaking the annual medication/risk review.

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. Proposed changes include the use of new safety formulation forms which are currently subject to a pilot scheme for six month period across three community based teams.
- 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 – November 2022

Event Type	Risk Assessed within 48 hours	Admission / Community Assessments	% Risk Assessed within 48 hours
Admission	111	127	87.4%
HTT Assessment	242	256	94.5%
Liaison Assessment	527	678	91.2%
Lotus assessment	84	84	100.0%
Total	964	1045	92.2%

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.

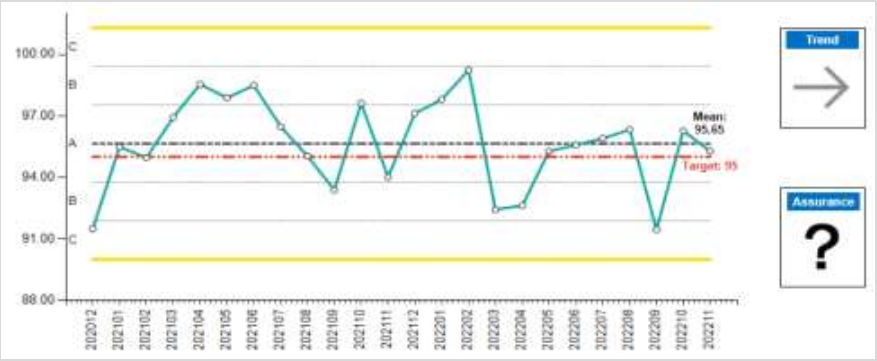
What the chart tells us
Downward (negative) trend in performance; target (which is above upper control limit) will not be met under current process.

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.

Actions
- 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.
- Acute & Urgent Care: Improvement plans for Inpatient wards and Richmond Home Treatment Team are addressing the issues of recording.

Fundamental Standards of Care

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



November 2022 (Underperforming wards)

Team	PHA Attempted Within 48 Hours	Admissions	% PHA Attempted Within 48 Hours
Ward Two	14	15	93.3%
Ellis	6	7	85.7%
Rose	6	7	85.7%
Jupiter Ward	4	5	80.0%
Bluebell Old Church	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.

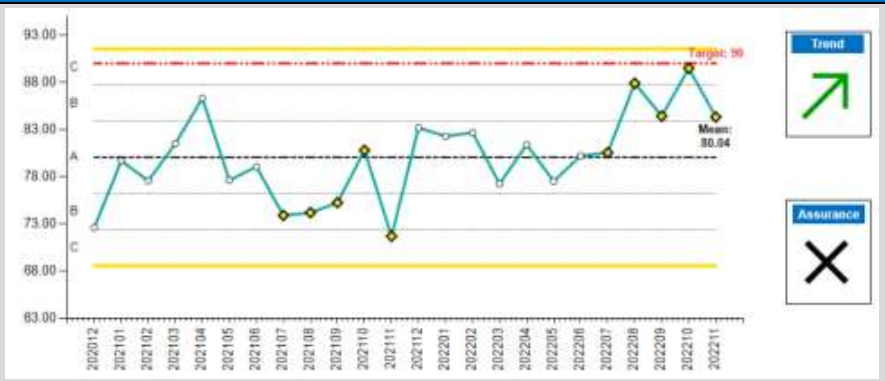
What the chart tells us
Historic under performance followed by recent sustained improvement above target.

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 in order to address missing/incomplete PHA forms.
- 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%



November 2022 (Underperforming wards)

Team	PHA Completed Within 7 Days	Admissions	% PHA Completed Within 7 Days
Aquarius	6	7	85.7%
Ellis	6	7	85.7%
Ward One PICU	6	7	85.7%
Laurel	3	6	50.0%
Lilacs	7	11	63.6%
Ward Three	5	8	62.5%
Rose	3	6	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
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

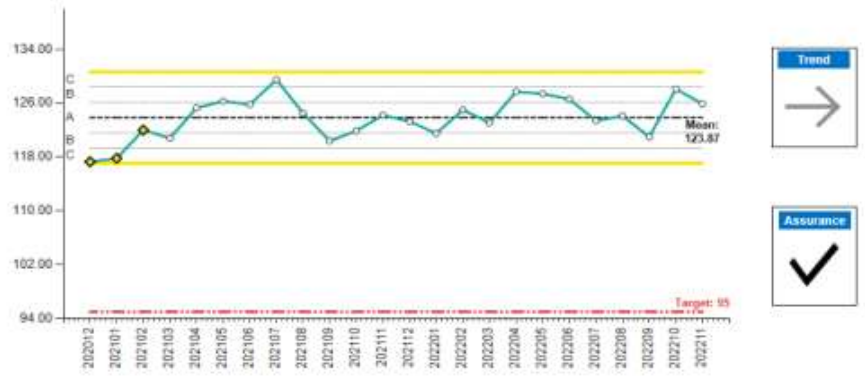
Underlying issue
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised. Trust clinical systems do not support workflow and performance is expected to dip in Q3 when annual re-reviews are required. Some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

Actions
- Teams have access to shared care records that contain supporting information to simplify the data collection process.
- Acute: All wards using the inpatient caseload dashboard in handover.
- 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.

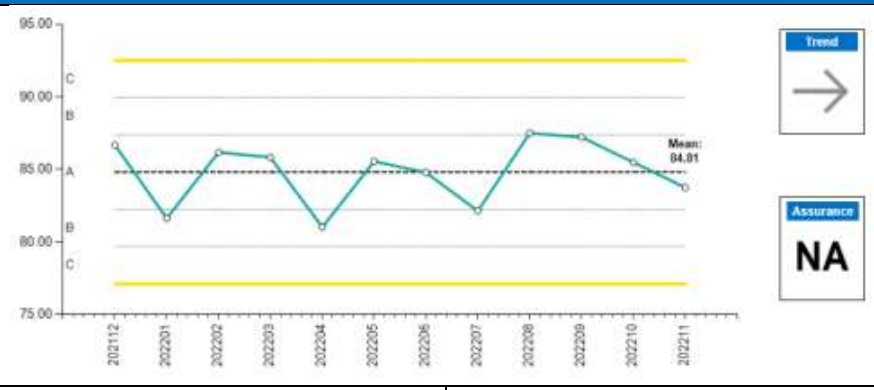
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.
- All wards were safely staffed in Specialist services.
- Downturn for CAMHS & ED service line linked to closure of Corner House there were no staffing issues perse.
- CAMHS & ED: Wisteria (74%) reduced staffing numbers due to bed closures, staff redeployed to other areas

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.

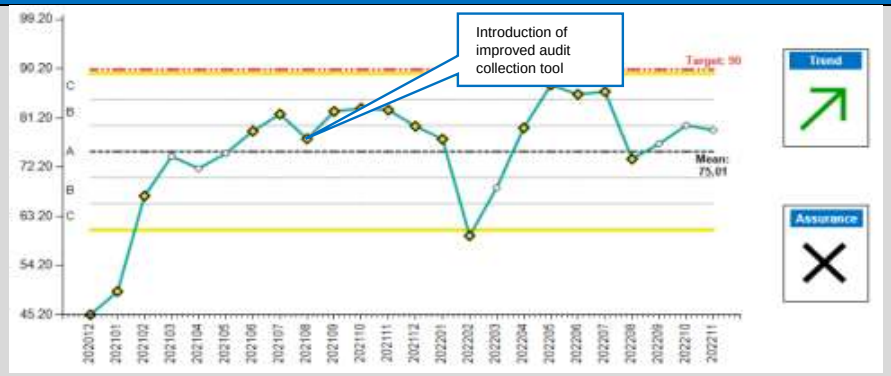
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.

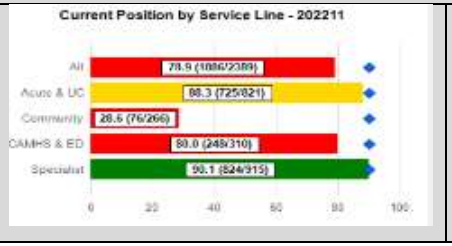
Actions
- Acute & Urgent Care: Focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.
- Training has been provided for Ward Managers & Team Leaders on the Fundamental Standards of Care Dashboard.
- Daily 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.

Fundamental Standards of Care

Always Ready Audits Completed (%)

Target ≥ 90%





Audit Volumes by Service Line:

Service Line	Audits Completed	Audits Required	% Audits Completed
Not Set	9	9	100.0%
Specialist Services	824	915	90.1%
Acute And Urgent Care	725	821	88.3%
CAMHS & ED	248	310	80.0%
Pharmacy	3	4	75.0%
Community (Adults)	76	266	28.6%
Unknown Service Line	1	64	1.6%
Trust Total	1886	2389	78.9%

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.

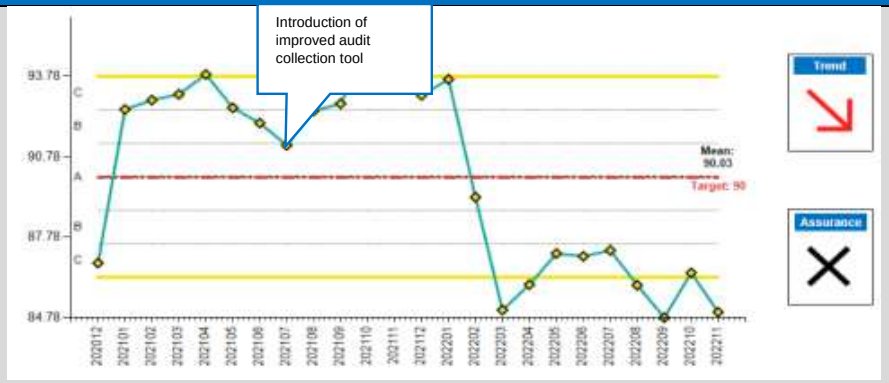
Underlying issue
- The Always Ready application improved and implemented in June 2021 before some staff had received training and a period of familiarisation.
- Some teams have required support and training with understanding and using the Always Ready Audit application and dashboard.

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.
- 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
TMP Inpatient Audit	89.9%
Safety in Motion Audit	84.6%
Case Note Audit - Community	77.5%
Ward IT Equipment Audit	74.8%
Flushing Audit	65.2%

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.
- Compliance on Flushing Audit has been poor across service lines,

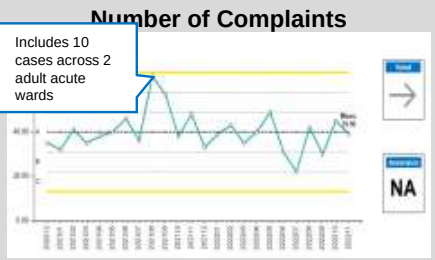
Action:

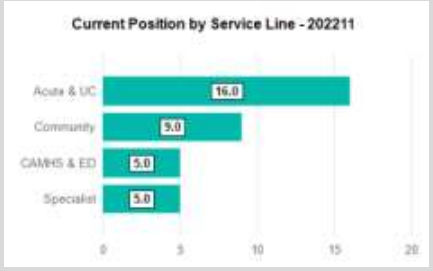
- Additional information of the quality of audits, themes and risks and any outlying areas will be provided next month
- Always Ready dashboard has been developed to assist completion and improve performance. A Training video for use of new Always Ready Dashboard is also available on My Dashboards.
- 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%





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
From February 2022 to July 2022, performance has routinely been above the target, in line with an agreed improvement plan. The KPI of responding to complaints within 25 working days has been variable since August, but not achieved the target. The actual numbers are fairly low, so this can have a more notable impact on the percentage.

Underlying issue

- In October the response rate had improved to 78.9% and in November this reduced again slightly.
- One reason for this includes long tern sickness within the Experience and Governance Team; although this has now been resolved. This meant that the Leads who investigate complaints had to cover PALS and complaints admin, leaving less time to investigate and mange complaints.

Actions:

- Service Line learning events continue to increase and evolve, helping focus on learning from incidents, complaints, and good practice.
- Further work is on-going to build on the quality of responses, which has largely been successful.
- The Complaints Review Group (Lived experience driven) met in November and their case audits were positive in regard to the quality of the complaints

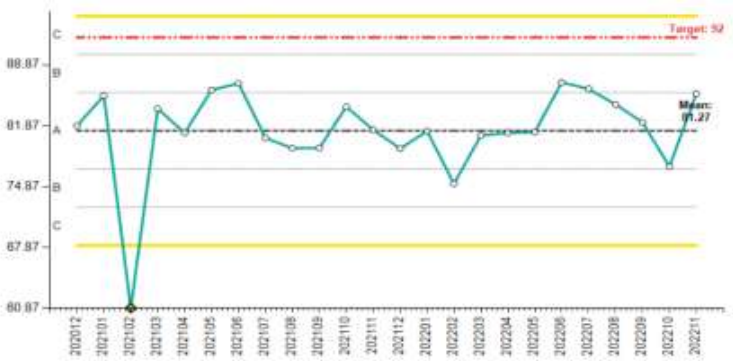
Themes and Learning:

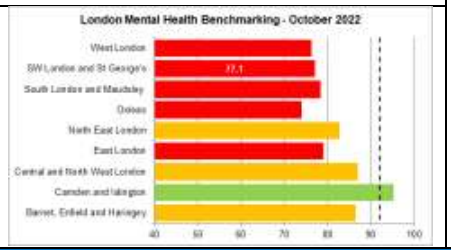
- In November there were 40 complaints received; this is less than those received in the previous month and just above the average of 39 complaints a month.
- The review in the CAMHS service Line continues to be ongoing following the theme on Access to Services

Patient Friends and Family Test (%)

Target ≥ 92%

Patient Experience and Outcomes





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

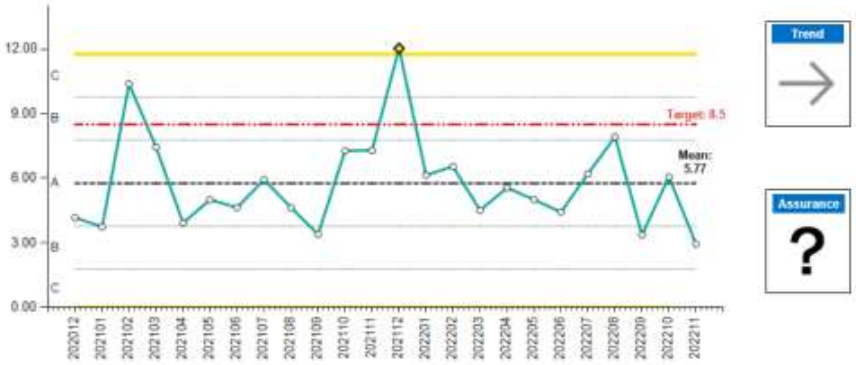
Underlying issues:
- Information Management team are undertaking a review on the target thresholds
- Challenges with engaging patients to complete at appropriate points in their pathway.
- Using the results in a meaningful way to identify and make improvements within the clinical services.

Actions:
- The Improving Patient Outcomes group has taken a lead on FFT collection and analysis. A specific task and finish group to look at all Patient-reported experience measures (PREMs), which includes FFT has agree to commence in January. It will also include greater review around the wider patient experience information, including FBL.
- Community Service Line are promoting use of the FBLQR code for service users and carers (FBL first question is the FFT)
- IPO group has now amended the SMS algorithm for requesting FFT from patients to ensure it is fully representative and not disproportionately weighted to assessment teams, over treatment teams, but this will take time to stabilise in the results
- Satisfaction levels within Specialist Services remain very high.

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

Target ≤ 8.5%

Patient Experience and Outcomes

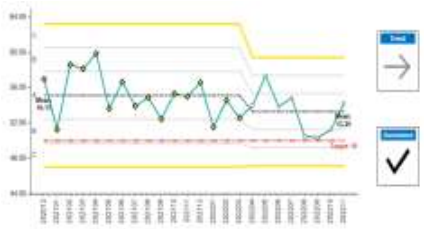
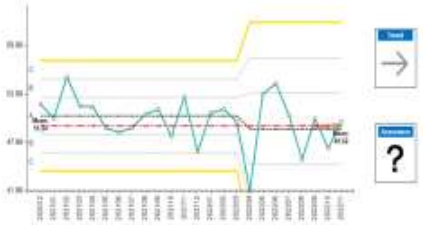
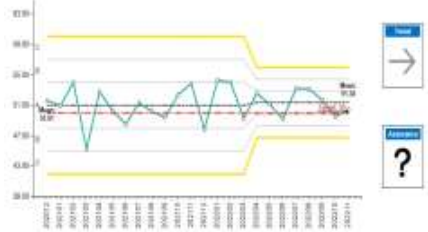


Background
This indicator aims to measure the success of the NHS in helping people to recover effectively from illnesses. If a person is not at the correct point in their recovery journey for discharge it is more likely that they will require hospital treatment again within the 30 days following their 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
- 3 emergency re-admissions reported in November 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** 	

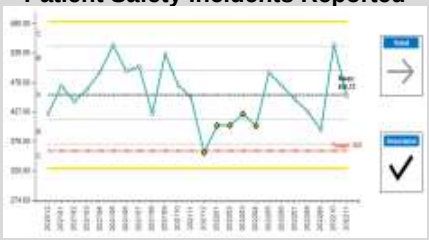
Patient Safety

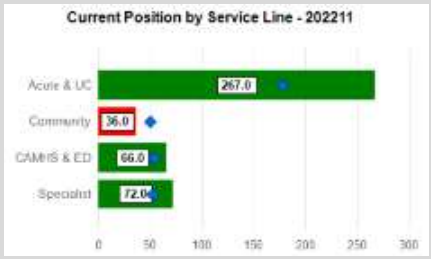
Patient safety incidents - Severe harm

Target ≤ 1.5%

Patient Safety Incidents – Severe Harm

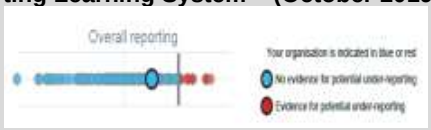
Patient Safety Incidents Reported





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 November there were nine serious incidents reported to STEIS; 4 suspected suicides, 3 unexpected deaths, 1 attempted suicide and 1 road traffic accident.
- 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 reviewed and established.
- The number of incidents reported in October did increase and is more in line with the average reported in 2021/22.

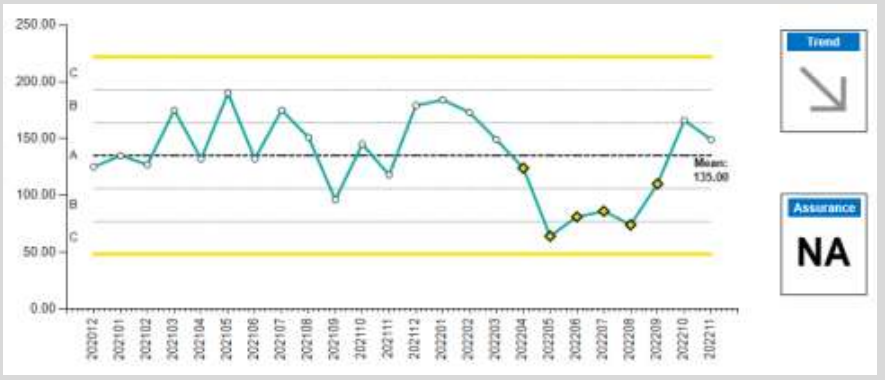
Actions:
- A number of teams are not routinely reporting Incidents on the Ulysses system, Heads of Nursing are following this up with their teams to improve incident reporting.
- Despite the increase of incidents reported in October, overall numbers of incidents reported has decreased. Standard NG feed equated to, on average, 90 incidents per month and this would provide some rationale for the drop in incident reporting, as this is now captured on RiO.
- 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.

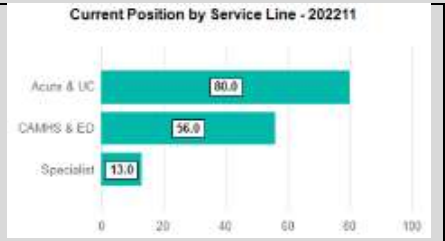
Themes & Learning:
- In October learning around documentation was reported, including documenting leave arrangements and destination within the RiO record.

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.

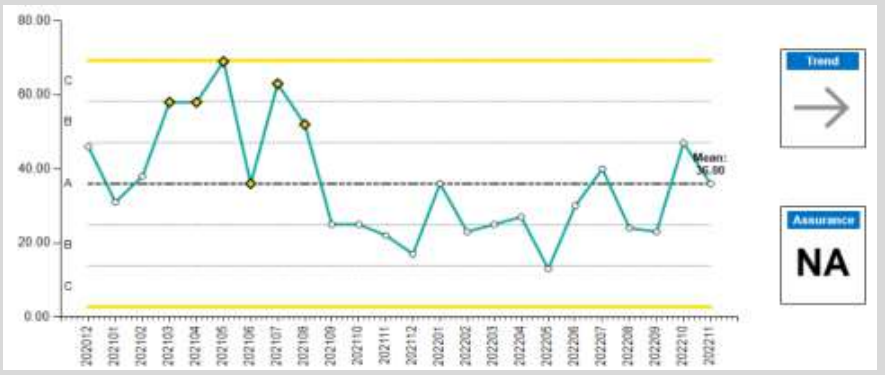
Underlying Issue:
- A single patient can be subject to multiple restraints in a reporting month depending on acuity/presentation therefore monthly variation is to be expected. These patients all have clear care plans in place and MDT reviews occur
- The requirement to self-isolate in relation to the 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.
- Acute: Safety in Motion Interventions have been reintroduced and discussed with teams. Updated Rapid Tranquilisation Policy has been circulated 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

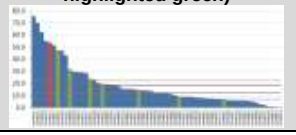
Reducing restrictive practices - Prone restraint

No Target



Number of Clients Prone Restrained – November 2022

Adult Acute - Prone Restraint Benchmarking 2021/22 (Trust is highlighted red, other London Trusts are highlighted green)



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.

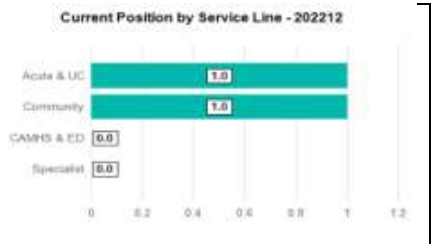
Actions:
- The deltoid technique is used where possible and prone restraint is used as a last resort.
- Staff are debriefed following an incident to review how the incident was managed and any alternative practices that should/could have been considered
- The use of prone restraints is monitored monthly 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

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



Suspected Suicides – Step Change Applied April 2020 via Mortality Committee

What the chart tells us

The number of suicides each month is subject to variation. Numbers reported are low.

Underlying Issue:

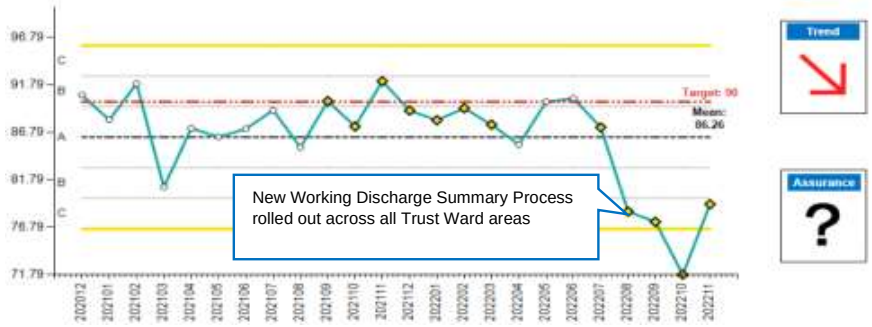
- There was two suspected suicides reported in November 2022.
- The number of suicides being reported month to month continues to vary. This data was reviewed in the bi-monthly Mortality & Suicide Prevention Committee. The mean monthly average has increased from 2.9 (pre-April 2020) to 3.5 (post April 2020).

Actions:

- All such incidents will be subject to 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 received the thematic review of the last two years of community suicides. The presentation/report will be presented more widely highlighting the learning and recommendations from the review.
- 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 will be presented at future meetings.

Inpatient discharge letters sent within 24 hours (%)

Target ≥ 90%



Letters sent within 24 hours – November

Compliant	Total Letters	%
80	101	79.2%

8 / 18 wards were 100% compliant

Letters sent within 7 days – November

Compliant	Total Letters	%
96	101	95.0%

13 / 18 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.
- Need for a more streamlined discharge process this will be reviewed by Ward Flow Working Group.
- 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.

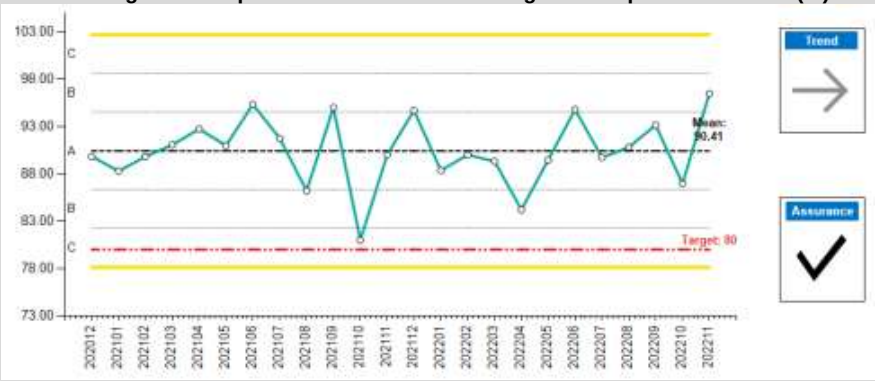
Action

- 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.
- COO, Lead Consultant & Trust Admin Lead to undertake site visit to discuss and review local practice.
- Ward Flow Group to review discharge practice.
- Application Developments are investigating the IT glitches incurred in recent weeks and feedback will be provided to COO.
- Training Induction for Junior Dr's has been reviewed and incorporates recent changes to discharge process in RiO.

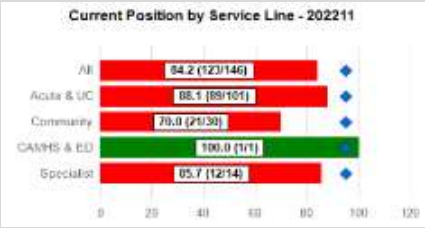
Patient Safety

Follow up within 72 hours of discharge from inpatient services (%) — Target ≥ 80%

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

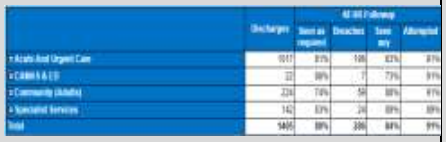


The Trust remains a high performer against the national 72 hour target of 80%.



Follow up within 48 Hours of discharge from inpatient services

Follow-up summary including attempts – November 2022



48 hour follow up performance by service – November 2022

Responsible Team Type	48Hr Seen	Discharges	% 48Hr Seen
Community	55.0	71.0	77.5%
Crisis Assessment Team	0.0	1.0	0.0%
HTT	104.0	110.0	94.5%
Lotus	37.0	54.0	68.5%
Ward	61.0	76.0	80.3%
Total	257.0	312.0	82.4%

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, which is a higher demand than national requirements.

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

72 Hour follow Up:

- The Trust consistently achieves the national 72 hour target from November 2022 this is the priority metric for follow up following discharge from inpatient services.

48 Hour Follow Up:

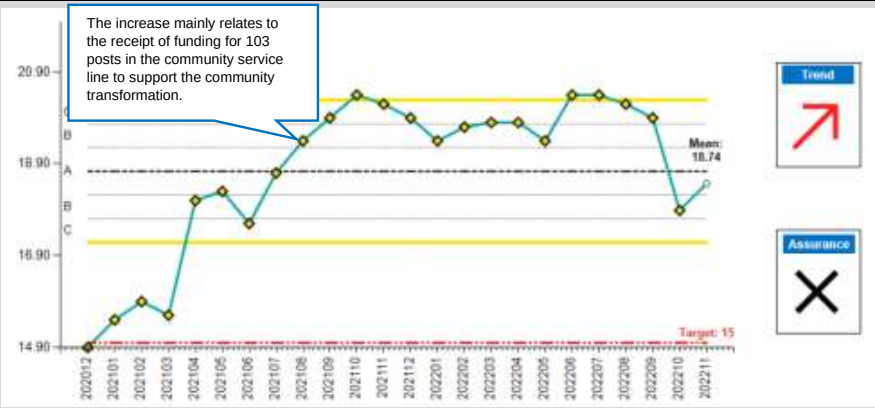
- High sickness and vacancy rate has meant reliance at times on agency staff who are less familiar with follow up processes
- Inconsistent documentation of clinical record; appointments not recorded in diary or discharge planning form.
- Lotus Assessment Suite has highest number of breaches and relates 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 November 2022 (95%) 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 in November 2022 attempts to contact was at 95%.
- Attempts to contact in November 2022 slightly decreased to 95%; the Trust needs performance at 100%.
- 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.
- **7 day follow Up:** The Trust incurred 3 breaches in November 2022 where one case was not a genuine breach; contact was made via telephone within the 7 days after discharge. Of the remaining 2 cases, one client left the UK and is receiving mental health support and treatment at their current destination, and the other client is reported to be doing well via a staff member at their housing placement.

Workforce Domain

Recruitment / Attraction

Vacancy Rate (%)

Target ≤ 15%



Vacancies by Staff Group

Staff Group	Post Fte	Assign Fte	Vacant FTE	Vacancy Rate FTE
Add Prof Scientific and Technic	464.5	356.7	107.8	23.2%
Additional Clinical Services	678.3	549.5	128.8	19.0%
Administrative and Clerical	634.0	541.7	92.3	14.6%
Allied Health Professionals	159.1	126.3	32.8	20.6%
Estates and Ancillary	35.0	32.9	2.0	5.7%
Healthcare Scientists	1.0	-	-	-
Medical and Dental	231.8	206.4	25.3	10.9%
Nursing and Midwifery Registered	871.2	693.3	177.8	20.4%
Total	**3,074.8**	**2,506.9**	**567.9**	**18.5%**

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

- The vacancy rate artificially gone back up in November due to TUPE'd in of the Richmond Wellbeing Service in communities. A number of posts were created on the establishment to accommodate the TUPE staff, who did not start until 5th December. Without the TUPE roles being created on the establishment, the vacancy rate would have been at 17.31% in November.
- Some service leads have not proactively reviewed their vacancies and/or are not confirming all the position numbers where multiple roles can be included in a recruitment campaign, 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. Processes such as commissioning meetings being introduced at the beginning of a Recruitment campaign have been introduced as part of the incident, however it is clear that only certain departmental leads have oversight over posts to be included in bulk recruitment. Meetings with these leads have been set up, which will hopefully start to remedy this issue.
- Historic creation of a significant number of new roles resulting in an increase to the vacancy rate, however we are starting to see this slowing down slightly and regular meetings with HRBP's and the Head of Resourcing should ensure a more planned approach in the future.
- The Trust turnover have increased steadily in 2021 into 2022, which impacts on the vacancy rates, in addition to the newly created roles. Work needs to be carried out to ensure that the number of new starters exceeds the number of leavers, as part of reviewing retention.

Actions

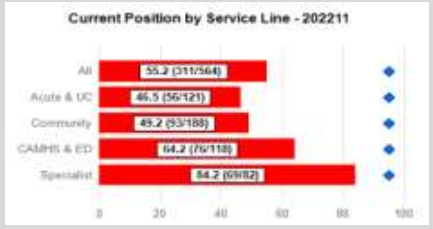
Vacancy rate is linked to turnover; retention strategies need to be developed.

- Establishment review of all divisions and services areas identifying old roles no longer active is now complete, resulting in some "incorrect" vacancies being removed. For all vacant roles left on the establishment a date for progression to recruitment are being set.
- **Community: Transformation:** continued recruitment campaign for remaining 21/22 posts (90% roles filled) and launch of 22/23 campaign. Review of core skill mix within the RSTs/CMHTs from band 5-7 as part of transformation of community services y2 programme.
- **Medical workforce strategy:** A number of roles across all divisions now have a recruitment plan in place against them with 14 adverts going live after the Christmas and New Years break.
- Work is being carried out with Remedium looking to bring in Specialist (SAS) posts to the Trust.
- 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.
- HRBPS, Recruitment and Service Leads are working together to identifying suitable strategies to assist recruitment within areas with high vacancy rates. HR will be supporting the organisation with a Workforce Planning programme of work that will focus on addressing the vacancy gap and growth of our future workforce to meet the future staff-shortages and patient acuity demands. This piece of work will be scoped once the Recruitment Incident has been concluded in December/ January.

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

- At present, not all positions numbers are included in recruitment campaigns where there is more than one post, resulting in an inaccurate view of roles progressed to recruitment. As mentioned above, more work has been carried out to meet with the Nursing Leads in each Service line to link post numbers to adverts when bulk recruitment activity takes place.
- More in-depth conversations with services on future requirements will take place as part of the Commissioning meeting in order to progress recruitment at the point of new role creation.
- 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.

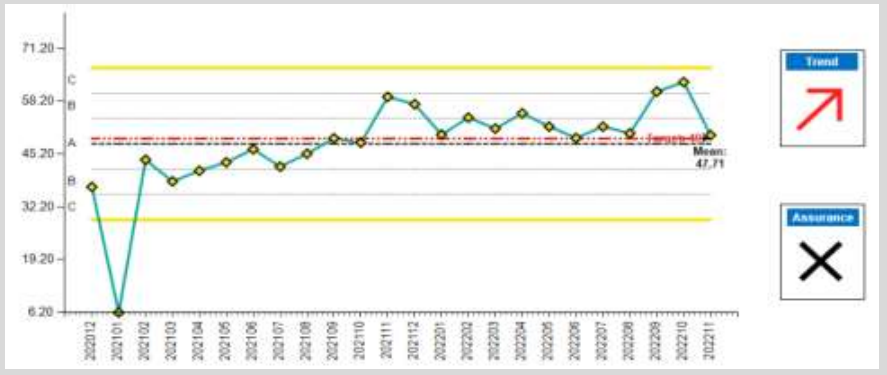
Action:

- Service lines are now holding their managers account for their recruitment activities, ensuring progression 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.
- 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.
- 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) were confirmed with start dates in October where data will be refreshed and logged into vacant posts for November.

Recruitment / Attraction

Time to recruit

Target ≤ 49 days



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. This issue should now be resolved as a result of the Commissioning meetings.
- Recruitment is reliant on external factors which are beyond the Trust's control such as response times of candidates, or newly qualified Nurses awaiting their pins.
- 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 due to the cessation of the contract, which is closely being monitored and worked through.

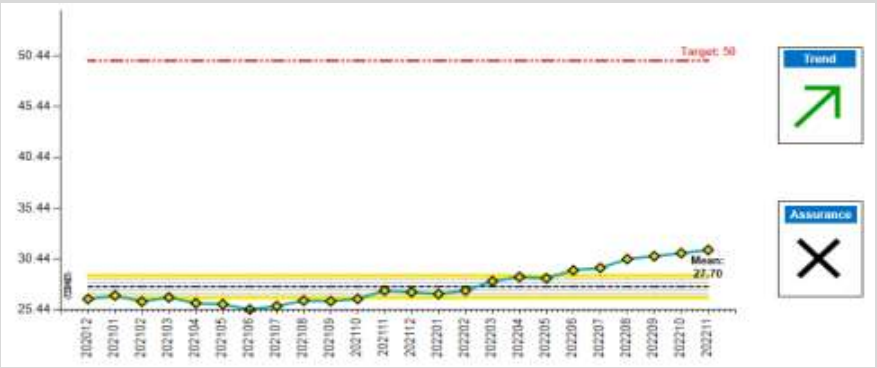
Actions:

- 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, however, this is in its final stages so we should see the data aligned shortly.
- 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.

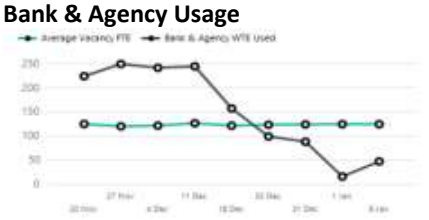
Underlying Issues:
- We are currently undertaking a Leadership Gap Analysis. The first draft was presented to the ELT in July 2022. It highlights the good offer we have as an organisation in respect of leadership development, but we need to improve visibility, access and evaluation of outcomes. We also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

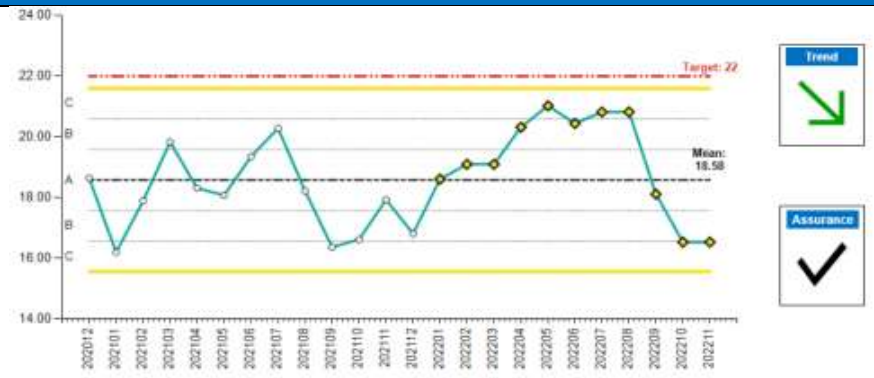
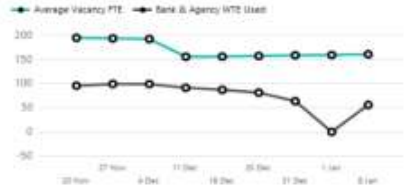


Background:
Trust analysis shows that agency staff often cost 25% more than those temporary staff source through the Trust bank. Based on its 2021/22 annual agency spend, the Trust could free up to £2.0m to reinvest in front line services or utilise to meet efficiency requirements by reducing reliance 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:
- As part of the Recruitment Incident, long-term agency usage has been triangulated with vacancies with the aim of services releasing agency temps once the vacancy is filled. Stronger governance by way of TWR and TWE forms required for each long-term agency worker will be put in place as part of the Recruitment Incident.
- 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 will be 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

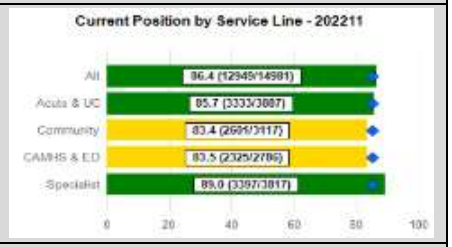
Statutory and Mandatory training 1 (%), Statutory and Mandatory training 2 (%) — Target ≥ 95%, Target ≥ 85%

Statutory and Mandatory Training 1

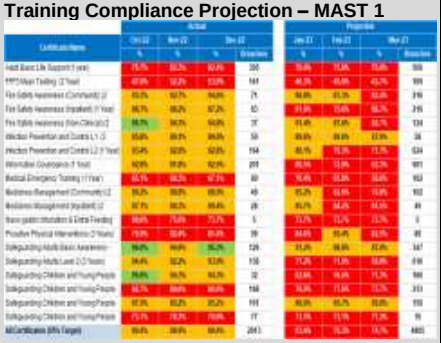
Statutory and Mandatory Training 2

Current Position by Service Line - 202211

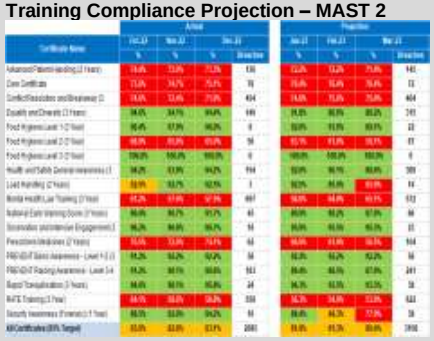
Current Position by Service Line - 202211



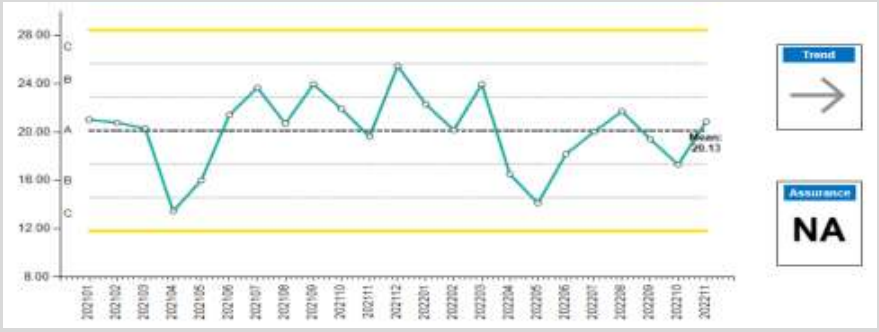
Training Compliance Projection – MAST 1



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.
- Levels of DNA's are too high and impact 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.

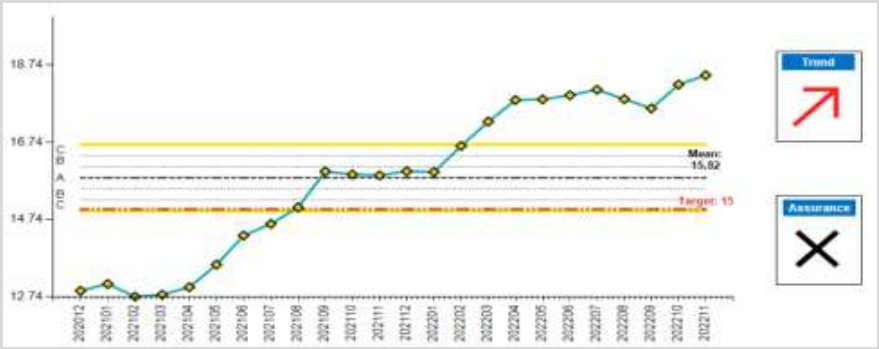
Actions

- 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. The review for the L&D Provision, which will create a "MAST Grid" – that will reflect the training requirements for each job group, also start the conversations for a deeper Training Needs Analysis for individual service provisions and inform changes for any specific job roles which are not captured.
- Non-attendance is to be raised in staff supervision by the line managers.
- 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
- Learning and Development Team (LDT) 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 new year. 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 - June 2022

Trust	Leavers	Turnover Rate
Tavistock and Portman NHS Foundation Trust	174	22.5%
South West London and St George's Mental Health NHS Trust	458	18.2%
Central and North West London NHS Foundation Trust	1342	17.8%
South London and Maudsley NHS Foundation Trust	813	17.4%
West London NHS Trust	686	17.3%
Barnet, Enfield and Haringey Mental Health NHS Trust	573	17.0%
North East London NHS Foundation Trust	1398	16.3%
East London NHS Foundation Trust	1333	16.1%
Oxleas NHS Foundation Trust	684	15.4%

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.

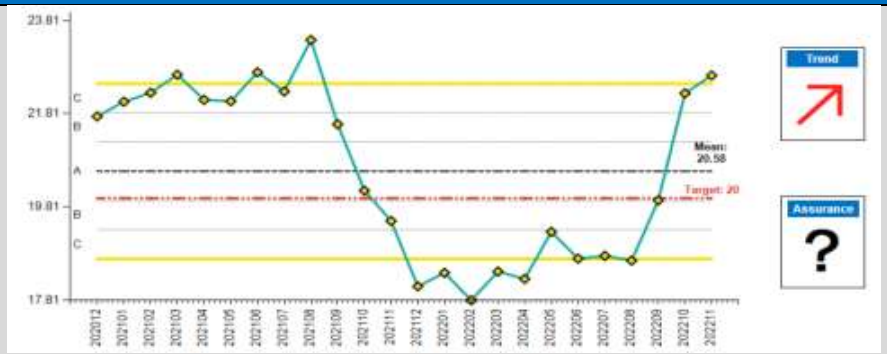
Underlying issue
- Over the past few years, Community Service Line teams have experienced significant workforce challenges with workload and capacity frequently cited as a factor behind staff leaving the Trust.
- An ineffective, inconsistent process to collect meaningful exit interview data means that the Trust has imperfect information on why staff leave the Trust.
- There has been an increase in leavers within Additional Clinical Services, Allied Health Professionals (mostly in Community Service Line) and Nursing (mostly in Acute & Urgent Care) within last rolling 12 month period.

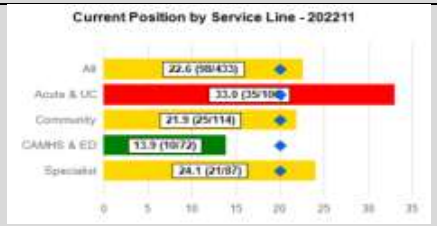
Actions:
- People Directorate are reviewing retention, attraction and work force planning as part of a follow up task and finish project following the recruitment incident. The onboarding workstream, which forms part of the Recruitment incident has also focussed on the candidate experience as part of the onboarding process ensuring new starters receive their kit and id badge on their first day and attend a Trust welcome and induction within their first few weeks of joining.
- 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.
- Staff attitude action plans have been completed by all service lines.

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.

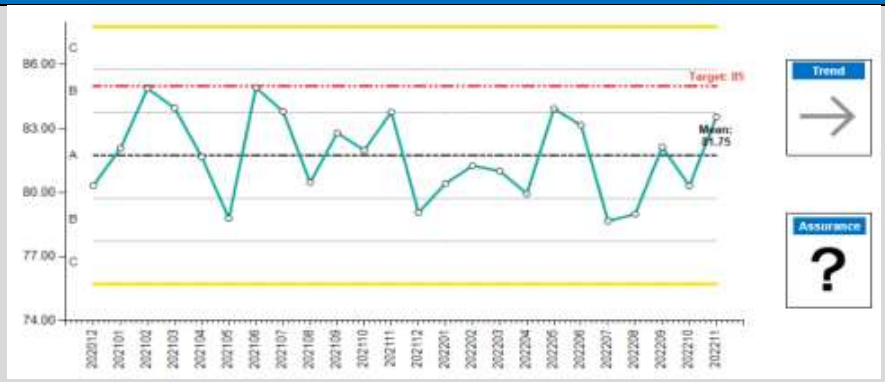
Underlying issue
- Whilst the Community service line have experienced significant workforce challenges, over 50% of the 'leavers within 1 year of starting' were Psychological Well Practitioners working for IAPT teams left to progress their career.
- Historically the Acute service line has had high turnover 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 – November 2022

Clinical Staff	83.6%
Non-Clinical Staff (inclusive of Corporate)	83.5%
Corporate Services	86.7%

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.

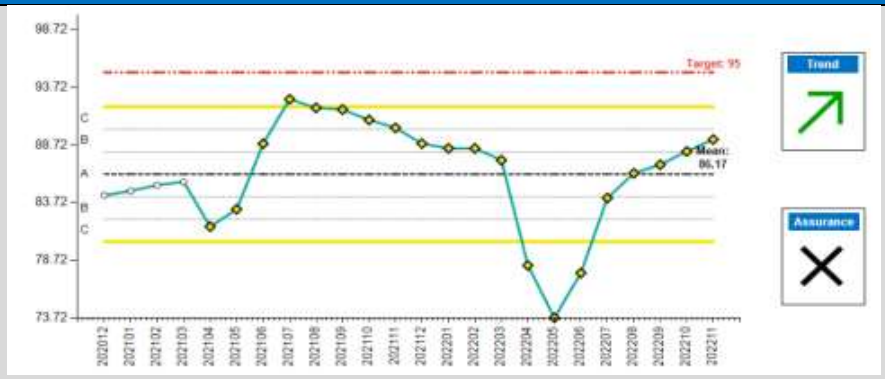
Underlying issue
- Trust is unable to consistently maintain performance on this metric.
- Supervision is below target overall for both clinical and non-clinical staff.
- Workload pressures, cancellations of meetings due to incidents on wards, high sickness levels in some areas (AUC) and high numbers 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 – November 2022

Clinical Staff	89.7%
Non-Clinical Staff (inclusive of Corporate)	84.8%
Corporate Services	88.2%

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.

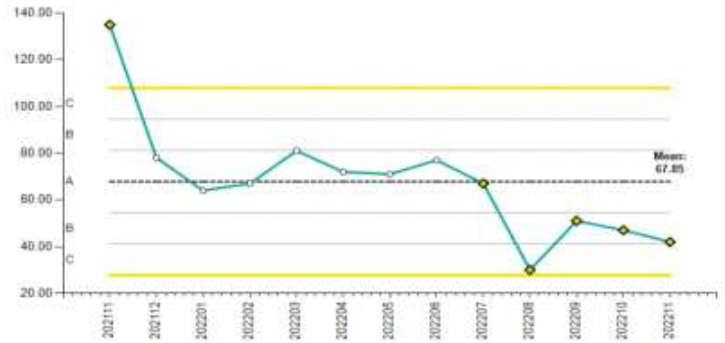
Underlying issue
- Processes are not routine; performance tends to improve only when it is prioritised over other indicators.
- Expected deterioration in April 2022 as PADR's become out of date due to push for PADR completion by Q1 2021/22. Improvement expected by Q1end 22/23.
- Incomplete paperwork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

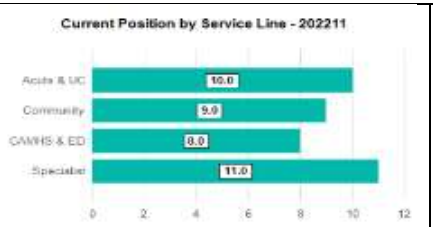
Actions
- Beginning April 2021, it is a requirement for staff to have been appraised before the award of any pay increment.
- PADR process and documentation has been refreshed to support a new appraisal format to be completed for all staff between April and June 2021. The PADR window closed in September, 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





Case Type Breakdown

Case Type	Employee Relation Cases	%
Appeal only	0	0.0%
Disciplinary	12	28.6%
Grievance	5	11.9%
Bullying & Harassment	1	2.4%
Performance	0	0.0%
Sickness Absence	24	57.1%
Total	42	
Employment Tribunal	14	

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 November 22, the ER team had 42 Open cases.
- There are 14 Employment Tribunal cases.

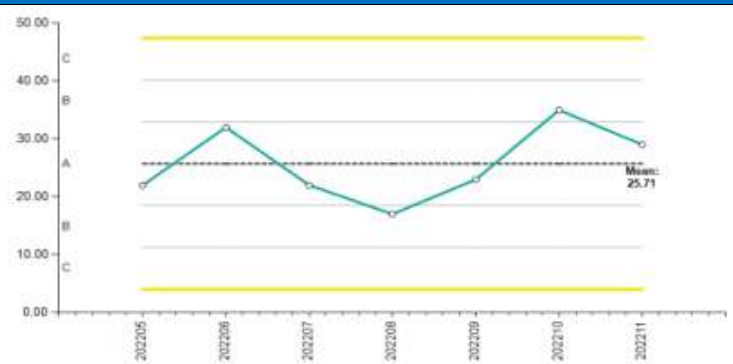
Actions:

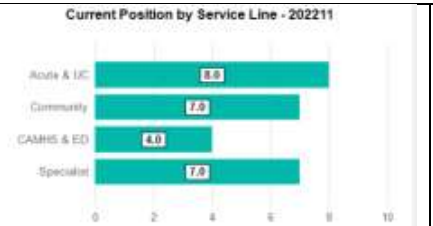
- Active health and wellbeing cases make up over half of the overall caseload. Absence cases over 90 days has reduced to 12. New sickness reporting system is scheduled for implementation in December 2022, which will enable managers to manage sickness absence better with ongoing support from Employee Relations Team.
- Informal resolution (mediation and facilitation pilot) is due to end with the service going live in December 2022.
- Acute & Urgent Care: Development of regular meetings with ER to discuss cases and progress to work as 'action learning sets' (ALS).

Staff Retention/ Support / Satisfaction

ER Cases exceeding 90 days

Target TBA





What Chart Tells Us:
Low level variation with numbers over 90 days aligned to mean of 25 per month.

Underlying Issues:

- Current ER cases over 90 days are 26 which are being proactively managed.
- Of the 26, by the end of December 2022, 6 sickness cases and 3 ER cases will be closed. Of the 6 sickness cases which will be closed, 3 cases date back to 2021 and 1 case dates back to 2020. With the above case closures, the present open case number will reduce from 26 to 17 and there will be no ER cases open more than one year.

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:

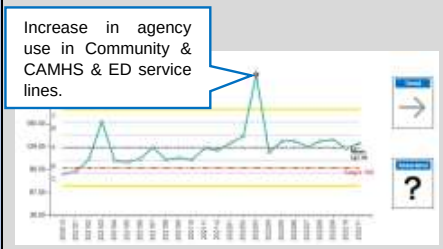
- The Trust will soon to launch the 2022 NHS Staff Survey which is scheduled to commence on 3rd October and end on 25th November 2022.
- As part of the promotion plan for the 2022 Staff Survey we will also do more face-to-face events which will include visits to wards and in person workshops.
- Our Retention 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.

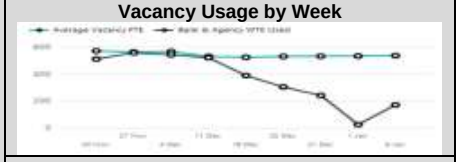
Finance Domain

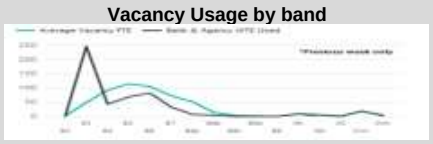
Grip & Control

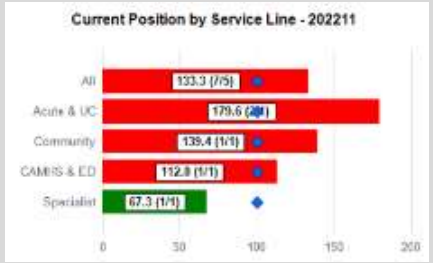
Agency spend as % to NHI target

Target TBA









Vacancy Spend – Indicative Numbers only

Organisation Name	Vacancy Cost (£k)	B&A Spend (£k)
Acute And Urgent Care	958.5	1142.2
Balance Sheet	35.6	49.9
CAMHS & ED	1088.8	311.7
Chief Executives Office	0.0	4.6
Community (Adults)	1580.6	1239.5
Estates & Facilities	21.4	12.3
Finance & Information	179.5	119.6
HR / OD & Workforce	135.9	67.5
Medical	(24.6)	0.0
Nursing & Quality	83.8	29.8
Pharmacy	6.5	12.5
Psychology	3.9	0.0
Research & Development	(2.9)	1.7
Senior Operations Management	18.3	16.3
Specialist Services	540.1	499.9
Strategy & Planning	93.2	0.0
Total	4826.5	3507.1

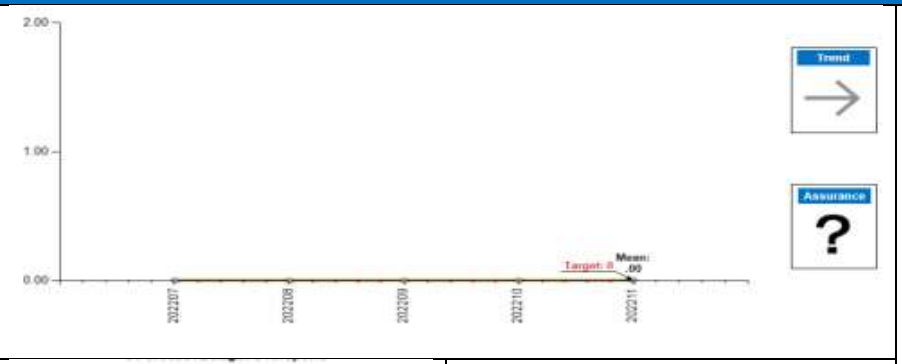
Background
The Trust is assigned an agency cap by NHSI. Aside from being good practice to minimise agency expenditure, breaching this cap produces adverse impacts on the Trust's overall financial risk rating.
What Chart Tells Us:
Performance has mainly been above target; target unlikely to be met unless 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 difficulties in recruiting to nursing and high-cost medical posts.
- £1.3m behind plan YTD. The average cost of an agency worker has increased due to the increase in costly medical staff.
- 82% of agency expenditure to date has been incurred within the Trust's 4 clinical service lines, with 12% relating to corporate areas, and 6% relating to agreed strategic investments
- Run rate reductions are being monitored at monthly OFMG meetings against trajectories agreed through the line-by-line reviews, including exit strategies for all agency staff.

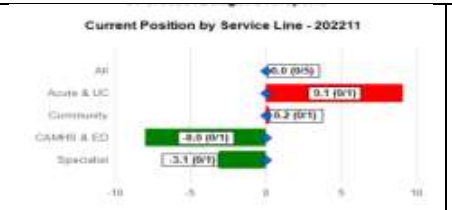
Actions:
- Financial incentives and flexibility afforded by agency working remain key barriers to transitioning staff to bank or permanent contracts.
- There are difficulties in recruiting to nursing and high-cost medical posts.
- £1.3m behind plan YTD. The average cost of an agency worker has increased due to the increase in costly medical staff.
- 82% of agency expenditure to date has been incurred within the Trust's 4 clinical service lines, with 12% relating to corporate areas, and 6% relating to agreed strategic investments
- Run rate reductions are being monitored at monthly OFMG meetings against trajectories agreed through the line-by-line reviews, including exit strategies for all agency staff.

Grip & Control

% Forecast budget overspend

Target TBC





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

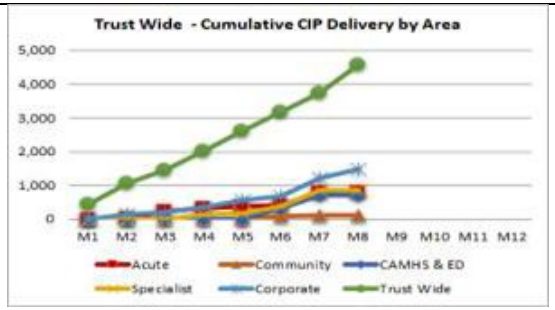
Underlying Issues:
- Trust: The Trust is forecasting break-even overall currently.
- Acute: Overspend is mainly due to staffing for observations and specialling, plus out of area bed placements which is unfunded aside from the acute bed contract with Holybourne.
- CAMHS & Specialist: Underspend linked 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: 91.2% 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.

Grip & Control

Cumulative CIP Delivery

No Target



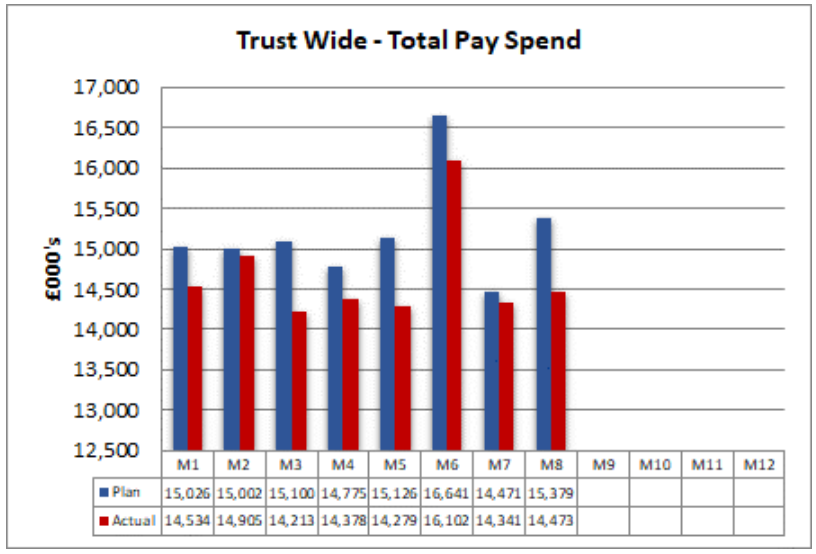
What Chart Tells Us:
CIP Delivery position is slightly ahead of plan, £0.3m favourable YTD.

Underlying Issues:
- Year to date - £7.6m delivered primarily from central and technical schemes (62%)
- Recurrent Green savings represent 30% of the total CIP target, an in month increase of 22% (£2.7m). The improvement is through the alignment of pay savings to planning assumptions moving £2.2m of vacancy factor savings from non-recurrent to recurrent savings. This change also reflects practice in other Trusts.
- Focus continues on CIP delivery this year and efforts continue to convert non-recurrent savings to recurrent and to progress existing schemes to a lower rated RAG status.

Actions:
- Operational efficiency workstreams are ongoing but slow delivery in releasing cash. Risk: unmet demand and growth in services could absorb any savings identified.
- Delivering Value / CIP workshop focused event held on 14 December. Ideas and feedback from the group discussions will be summarised for consideration by ELT. A Workforce Redesign workshop will be held early in the new year, to identify tasks of critical job roles with the aim to redesign future services.
- Internal review of existing leases and activity by site in progress; 5 leases have been targeted for potential savings. Release of four rooms over two sites has been identified.
- Service lines presented to OFMGs expected agency forecasts by month. Community Adults will revisit their line-by-line review and re-present their final information at OFMG on 11 January 23. All services lines are being monitored against these expected trajectories. These trajectories were based on agency usage at the end of September and did not incorporate an allowance for new agency resulting from staff turnover or other demands.

Grip & Control

Pay Cost Vs Budget



What the chart tells us:
Total Pay Spend in the Trust is currently below plan.

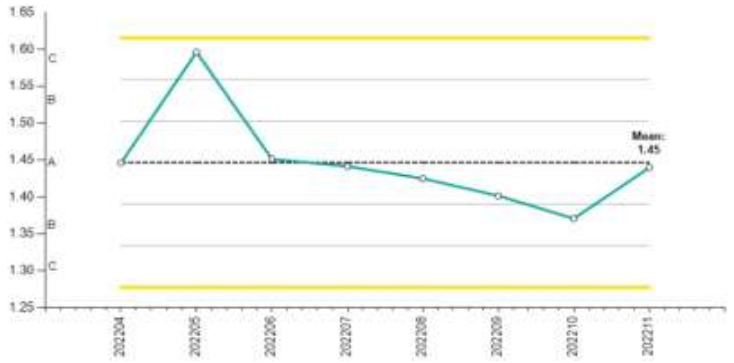
Underlying Issues:
- An underspend is due to vacancies across the service line.
- Acute and Urgent Care: Overspend is mainly due to staffing and out of area bed placements which is unfunded aside from the acute bed contract with Holybourne
- CAMHS & Eating Disorders: Vacancies in (qualified) Nursing (£373k), Psychologist (£1,238k), Medical Consultants (£208k) and Psychotherapists (£153k). £788k underspend in pay is due to Trailblazer teams.
- Specialist: Vacancies in Nursing (Qualified) £480k underspend offsetting a Nursing (Unqualified) £561k overspend, Psychologists £172k, AHPs £173k and Consultants £125k.
- Community: The Pay position decreased by £497k in Month 7 to a normalised figure of £3,363k. The month 6 pay position contained the impact of the pay award, which was back paid from 1st April 2022, and therefore the position was inflated.

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.
- CAMHS & ED: 91.2% of posts are out to advert. Review of vacancies, agency is being reviewed between the service line, HR and Finance. Additionally as above the establishment is being reviewed and validated

Productivity

Activity vs Caseload (%)

No Target



Trend

Assurance: NA

What Chart Tells Us
Ratio of activity vs caseload has been below mean since July 2022.

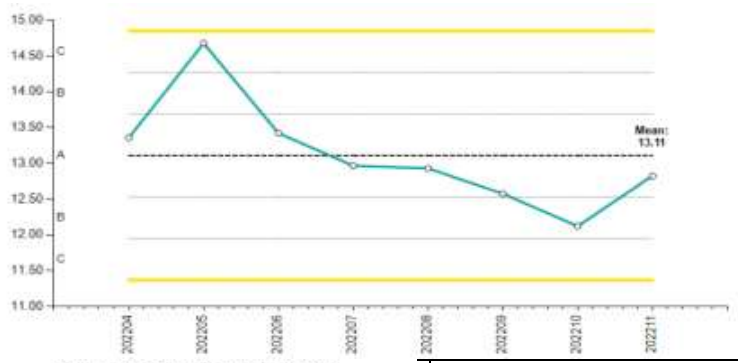
Underlying Issue
- New productivity measures have been introduced to reporting in September 2022.
- Variation in performance within services and poor administration leading to appointments not being booked or outcomed.
- Community: Complex clinical work requiring significant non patient facing care planning and care co-ordination not recorded as clinical activity.
- CAMHS Community Teams on IAPTus are not currently included in reporting.

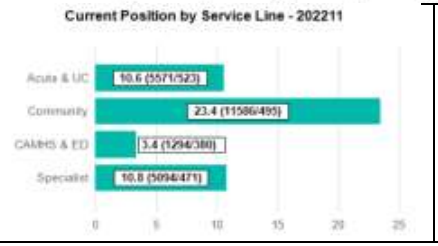
Actions
- Reports to support service lines with monitoring are being development.
- Community Service Line to target services with high levels of unoutcomed appointments in order to improve activity reporting.
- KPI document to be developed to assist with metric understanding.
- Specialist: Service variation is to be reviewed via the Clinical Efficient and Job Planning Pilots.
- CAMHS services on IAPTus to be added to reporting in the coming months

Productivity

Activity vs WTE

No Target





Trend

Assurance: NA

What Chart Tells:
Ratio of activity vs WTE has been below mean since July 2022.

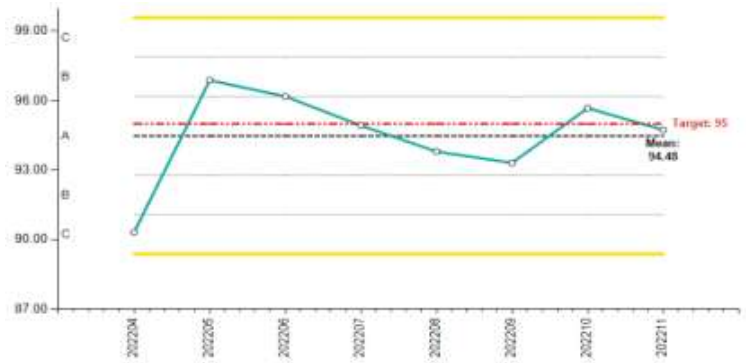
Underlying Issue
- New productivity measures have been introduced to reporting in September 2022.
- Variation in performance within services and in some area poor administration leading to appointments not being outcomed
- New metric for service lines, there will be a period of adjustment as services adapt to the KPI requirements.
- CAMHS Community Teams on IAPTus are not currently included in reporting.
-

Actions
- Reports to support service lines with monitoring are being development.
- Community Service Line to target services with high levels of unoutcomed appointments in order to improve activity reporting.
- KPI document to be developed to assist with metric understanding.
- Specialist: Service variation is to be reviewed via the Clinical Efficient and Job Planning Pilots.
- CAMHS services on IAPTus to be added to reporting in the coming months

Productivity

Contracted activity - Local CCG contract (%)

Target ≥ 95%



What Chart Tells Us

Mean performance is just below target indicating target will be met on occasion but there will be variation.

Underlying Issue

- New productivity measures have been introduced to reporting in September 2022.
- The Trust needs to have more focus on activity reporting and this will reviewed at service line meetings. Current oversight is not routine.
- In local Specialist Services recruitment and long term sickness impacting.

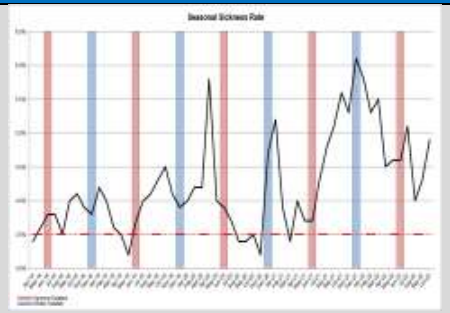
Actions

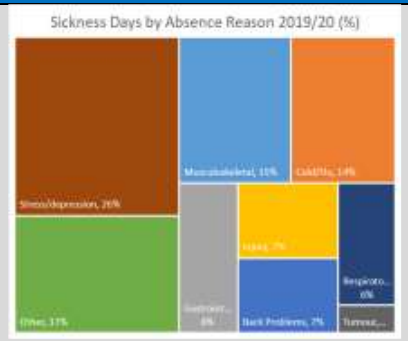
- Contracted activity reports to be issued to services pre submission to commissioner in order enable greater oversight on reporting.
- Reports to support service lines with this process need development.
- Contract schedule to commissioners is currently shared with service line management and Performance Analysts.
- Community Service Line to target services with high levels of unoutcomed appointments in order to improve activity reporting.
- Dashboard report to support contracted activity reporting has been developed by Information Management and deployed.

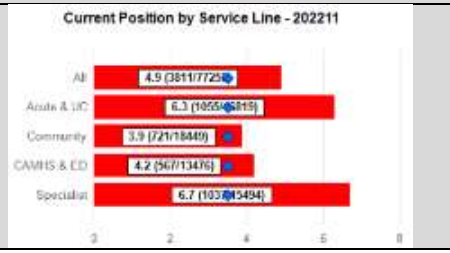
Non-Priority Metrics: reported by exception

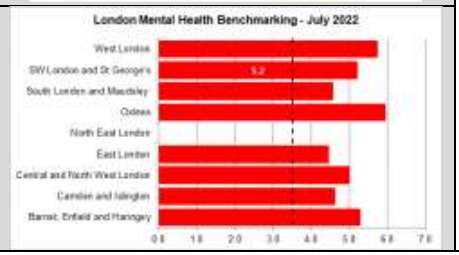
Staff Retention/ Support / Satisfaction

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.

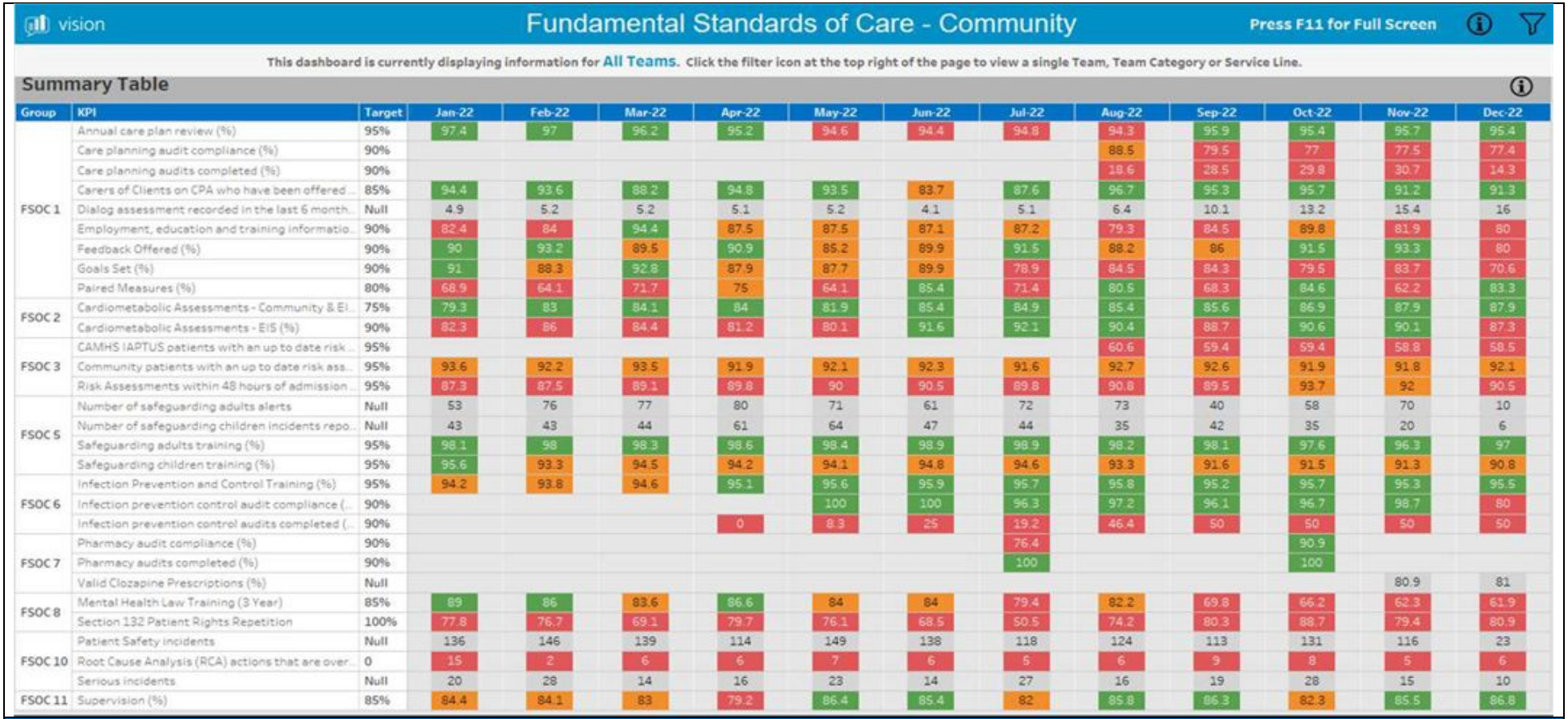
Summary Table

Group	KPI	Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
FSOC 1	Annual care plan review (%)	95%	97.5	93.6	90.1	94.2	87.8	89.1	90.6	87	94.4	84.8	92.9	93.9
	Care planning audit compliance (%)	90%						93.1	94.2	94.8	94.7	93.9	94.6	93.7
	Care planning audits completed (%)	90%						73.4	83.1	87	93.9	93.9	87.9	77.3
FSOC 2	Cardiometabolic Assessments - Inpatients (%)	90%	83.4	88.6	88.4	82.4	90	86.6	79.8	86	83.7	79.6	79.3	76.6
	Physical Health Assessment attempted within 4...	95%	97.8	99.2	92.4	92.6	95.3	95.6	95.9	96.3	91.5	96.3	95.3	95.2
	Physical Health Assessment completed within 7...	90%	82.3	82.6	77.2	81.4	77.5	80.2	80.5	87.9	84.4	89.5	84.3	
FSOC 3	Risk Assessments within 48 hours of admission ...	95%	94.7	97.8	96.1	94.1	94.7	98.2	99.5	96.1	93.5	96.4	98.4	97.1
FSOC 4	Observation reviews completed against standar...	Null		35.8	34.8	39	45.4	37.7	41.6	40.1	43	41.5	37.9	27.1
	Observations required vs completed (%)	Null		80.6	79.8	74.7	69.1	70	70.8	73.6	80.3	83.2	24.7	7.9
FSOC 5	Number of safeguarding adults alerts	Null	15	21	13	16	13	29	14	19	26	11	15	5
	Number of safeguarding children incidents repo...	Null	5	6	2	1	0	2	7	2	4	1	5	0
	Safeguarding adults training (%)	95%	98.5	98.9	98.7	98.7	98.9	99.1	99.1	99	97.9	97.3	97.4	97.5
	Safeguarding children training (%)	95%	93.2	88.4	90.4	90.5	90.5	91.1	90.9	90.9	88.9	90.7	90.8	91.2
FSOC 6	Infection Prevention and Control Training (%)	95%	95.9	96.8	95.7	96	96.7	96.3	96.9	96.5	95.9	95.3	96.1	96.4
	Infection prevention control audit compliance (...	90%	99.5	96.3	96	97.7	98.5	98.7	98.4	98.7	98.6	98.9	98.7	99.1
	Infection prevention control audits completed (...	90%	80	52.2	65.4	79.4	90.4	89.6	88.2	83.1	90.2	93.3	93.8	90.2
FSOC 7	Pharmacy audit compliance (%)	90%	87.1	87.5	89.7	89	90.9	92.5	91.4	88.5	88.5	90.3	89.6	
	Pharmacy audits completed (%)	90%	87	95.7	73.9	100	95.7	91.3	100	82.6	90.9	97.1	100	
FSOC 8	Mental health act audit compliance (%)	90%	89.3	90.8	93.3	92.3	92	92.1	89.6	91.8	91.9	93.1	93.9	95.3
	Mental health act audits completed (%)	90%	66	64.8	68	74.4	81.3	84.8	86.4	88.2	93.8	97.7	94.6	100
	Mental Health Law Training (3 Year)	85%	89.9	88.7	88.3	89.8	83.7	84.1	79.8	83.2	74.3	69.9	63.6	63.1
	Section 132 Patient Rights Repetition	100%	83.4	87.6	92.4	87.2	86.4	90.8	86.4	89.9	87.9	87	80	82.4
FSOC 9	Duration of physical restraint (average minutes)	Null	10.6	4.9	8.7	9.1	4.9	7.7	12.2	7.6	12.6	17.1	17.5	8
	Duration of prone restraint (average minutes)	Null	2.1	1.8	2.9	3	1.6	3.3	16.1	3.5	2.3	5.9	4.5	1.8
	Reducing restrictive practices - Prone restraint	Null	36	23	25	27	13	30	40	24	23	47	36	3
	Seclusions	Null	16	26	27	23	9	14	20	21	9	31	19	3
	Total number of restraints (physical restraints ...	Null	184	173	149	124	64	81	86	74	110	166	149	20
FSOC 10	Patient Safety incidents	Null	259	249	275	286	336	329	324	294	279	406	330	48
	Root Cause Analysis (RCA) actions that are over...	0	9	8	7	7	5	3	2	4	5	7	7	7
	Serious incidents	Null	22	18	11	13	14	26	19	14	19	28	16	7
FSOC 11	Safe Staffing: Shift Assurance, inc Obs Require...	Null	81.6	86.2	85.8	81	85.6	84.8	82.1	87.5	87.2	85.5	83.8	73.6
	Supervision (%)	85%	81.2	79.3	86	88.9	84.7	84.5	79.9	79.2	82.7	82.4	82.9	82.6

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.
- Changes to be made to the dashboard to help easily identify outstanding actions from Incidents and Root Cause Analysis (RCAs), and Post Incident Reviews (PIR's).
- Action plan for each Service line on improving outstanding or unmanaged incidents.

Fundamental Standards of Care Dashboard – Community



Summary Table

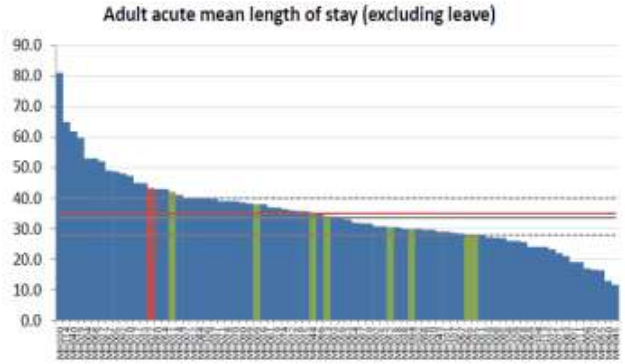
Group	KPI	Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
FSOC 1	Annual care plan review (%)	95%	97.4	97	96.2	95.2	94.6	94.4	94.8	94.3	95.9	95.4	95.7	95.4
	Care planning audit compliance (%)	90%								88.5	79.5	77	77.5	77.4
	Care planning audits completed (%)	90%								18.6	28.5	29.8	30.7	14.3
	Carers of Clients on CPA who have been offered ...	85%	94.4	93.6	88.2	94.8	93.5	83.7	87.6	96.7	95.3	95.7	91.2	91.3
	Dialog assessment recorded in the last 6 month...	Null	4.9	5.2	5.2	5.1	5.2	4.1	5.1	6.4	10.1	13.2	15.4	16
	Employment, education and training informatio...	90%	82.4	84	94.4	87.5	87.5	87.1	87.2	79.3	84.5	89.8	81.9	80
	Feedback Offered (%)	90%	90	93.2	89.5	90.9	85.2	89.9	91.5	88.2	86	91.5	93.3	80
	Goals Set (%)	90%	91	88.3	92.8	87.9	87.7	89.9	78.9	84.5	84.3	79.5	83.7	70.6
	Paired Measures (%)	80%	68.9	64.1	71.7	75	64.1	85.4	71.4	80.5	68.3	84.6	62.2	83.3
FSOC 2	Cardiometabolic Assessments - Community & El...	75%	79.3	83	84.1	84	81.9	85.4	84.9	85.4	85.6	86.9	87.9	87.9
	Cardiometabolic Assessments - EIS (%)	90%	82.3	86	84.4	81.2	80.1	91.6	92.1	90.4	88.7	90.6	90.1	87.3
FSOC 3	CAMHS IAPTUS patients with an up to date risk...	95%								60.6	59.4	59.4	58.8	58.5
	Community patients with an up to date risk ass...	95%	93.6	92.2	93.5	91.9	92.1	92.3	91.6	92.7	92.6	91.9	91.8	92.1
	Risk Assessments within 48 hours of admission ...	95%	87.3	87.5	89.1	89.8	90	90.5	89.8	90.8	89.5	93.7	92	90.5
FSOC 5	Number of safeguarding adults alerts	Null	53	76	77	80	71	61	72	73	40	58	70	10
	Number of safeguarding children incidents repo...	Null	43	43	44	61	64	47	44	35	42	35	20	6
	Safeguarding adults training (%)	95%	98.1	98	98.3	98.6	98.4	98.9	98.9	98.2	98.1	97.6	96.3	97
	Safeguarding children training (%)	95%	95.6	93.3	94.5	94.2	94.1	94.8	94.6	93.3	91.6	91.5	91.3	90.8
FSOC 6	Infection Prevention and Control Training (%)	95%	94.2	93.8	94.6	95.1	95.6	95.9	95.7	95.8	95.2	95.7	95.3	95.5
	Infection prevention control audit compliance (...	90%					100	100	96.3	97.2	96.1	96.7	98.7	80
	Infection prevention control audits completed (...	90%				0	8.3	25	19.2	46.4	50	50	50	50
FSOC 7	Pharmacy audit compliance (%)	90%							76.4			90.9		
	Pharmacy audits completed (%)	90%							100			100		
	Valid Clozapine Prescriptions (%)	Null											80.9	81
FSOC 8	Mental Health Law Training (3 Year)	85%	89	86	83.6	86.6	84	84	79.4	82.2	69.8	66.2	62.3	61.9
	Section 132 Patient Rights Repetition	100%	77.8	76.7	69.1	79.7	76.1	68.5	50.5	74.2	80.3	88.7	79.4	80.9
FSOC 10	Patient Safety incidents	Null	136	146	139	114	149	138	118	124	113	131	116	23
	Root Cause Analysis (RCA) actions that are over...	0	15	2	6	6	7	6	5	6	9	8	5	6
FSOC 11	Serious incidents	Null	20	28	14	16	23	14	27	16	19	28	15	10
	Supervision (%)	85%	84.4	84.1	83	79.2	86.4	85.4	82	85.8	86.3	82.3	85.5	86.8

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.
- Changes to be made to the dashboard to help easily identify outstanding actions from Incidents and Root Cause Analysis (RCAs), and Post Incident Reviews (PIR's).
- Action plan for each Service line on improving outstanding or unmanaged incidents.

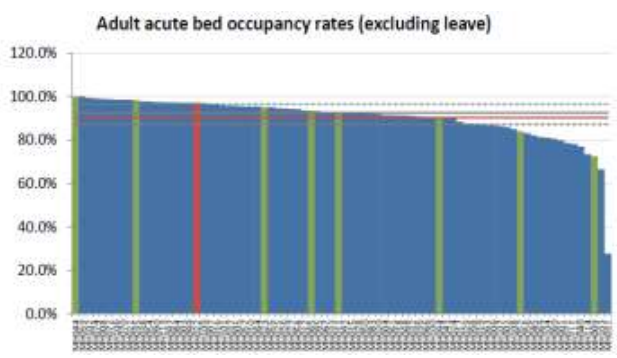
Appendix 1: Benchmarking

The NHS Benchmarking Network's 2021/22 Inpatient and Community Mental Health Benchmarking Report was issued in October 2022 and allows Trusts to benchmark their performance against other participating Trusts throughout England and within their local region. Our Trust is highlighted red in the graphs below, London Trusts are highlighted green and all other Trusts are highlighted blue.



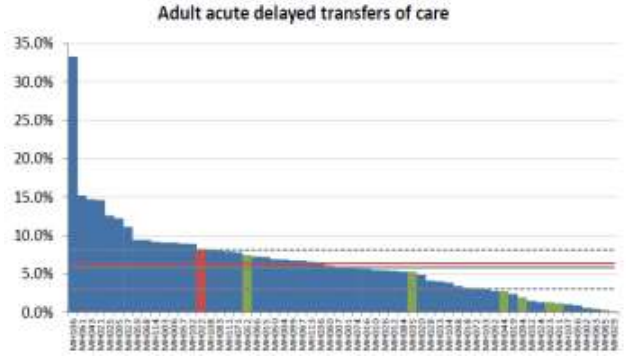
- **Adult acute average length of stay (days):**

2021/22		2022/23	
Trust	England	Nov-22	YTD
43.0	34.9	50.2	48.5



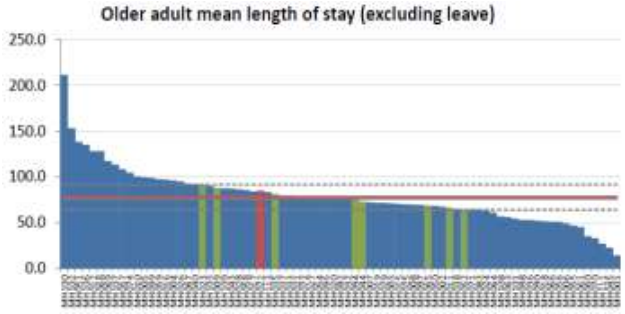
- **Adult acute bed occupancy rate (%):**

2021/22		2022/23	
Trust	England	Nov-22	YTD
97.1%	90.5%	97.8%	98.6%



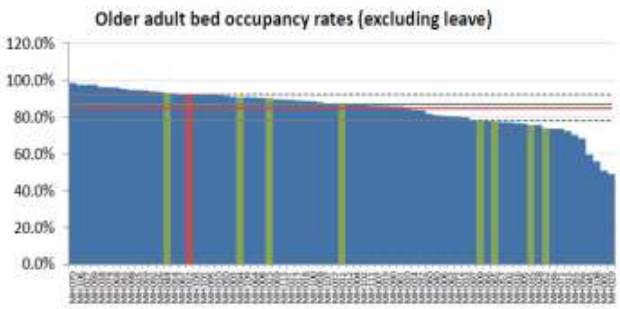
- **Adult acute delayed transfers of care (%):**

2021/22	
Trust	England
8.1%	6.4%



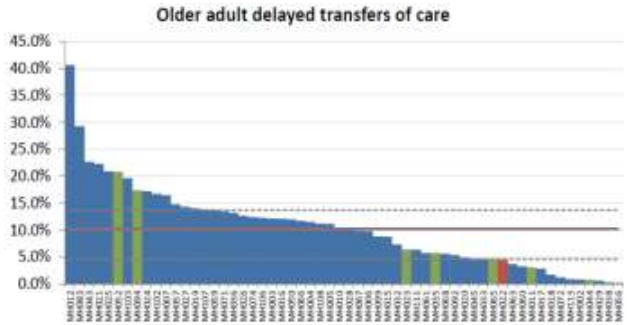
- **Older people's average length of stay (days):**

2021/22		2022/23	
Trust	England	Nov-22	YTD
84.0	78.5	97.9	97.0



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

2021/22		2022/23	
Trust	England	Nov-22	YTD
92.6%	84.8%	93.8%	89.9%



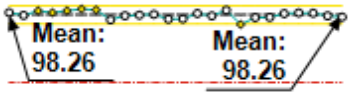
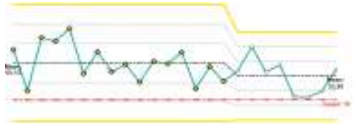
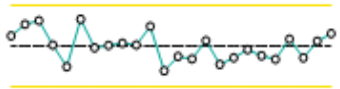
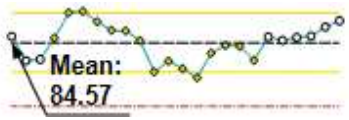
- **Older people's delayed transfers of care (%):**

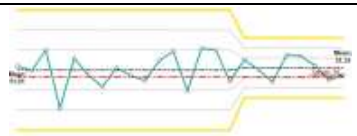
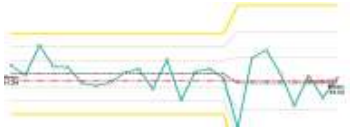
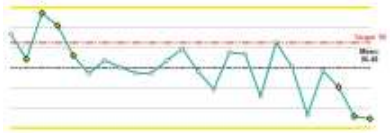
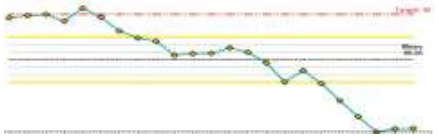
2021/22	
Trust	England
4.4%	10.3%

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	Nov-22	Target	Trend	Assurance on consistently meeting the target	SPC Chart	Comments
Data quality maturity index (DQMI) (%) see page 17	98.2	≥ 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.**	54.2	≥ 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 (%)	98.9	≥ 75.0	→	✓		Performance is consistently above target.
Cardiometabolic Assessments - Community & EIS (%) see page 20	87.9	≥ 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 9	55.6	≥ 60.0	→	?		There was a period of deterioration in performance, mainly due to referrals from wards and assessment teams.

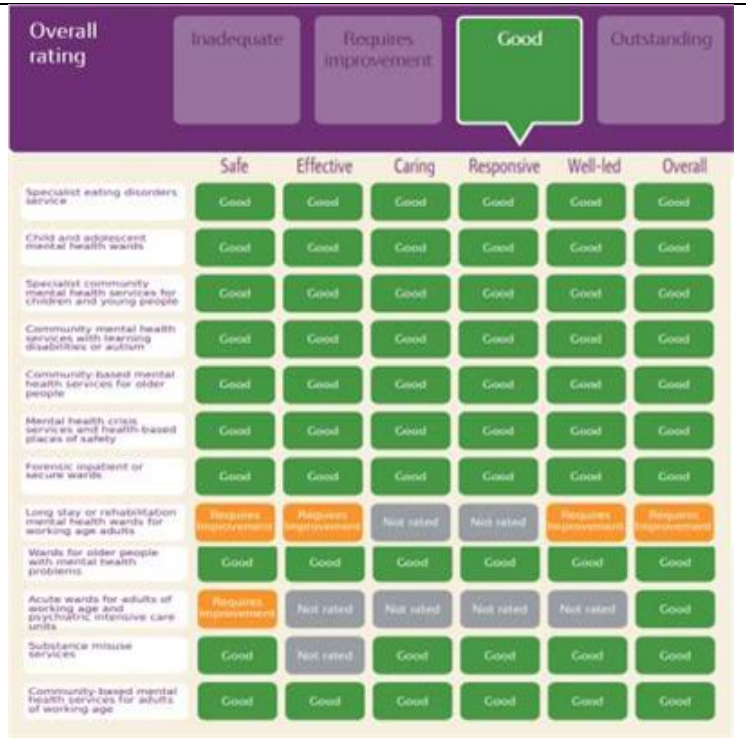
IAPT recovery rate - Merton Uplift (%) see page **Error! Bookmark not defined.**	50.2	≥ 50.0	→	?		Average performance for 2022/23 is currently above target.
IAPT recovery rate - Sutton Uplift (%) see page **Error! Bookmark not defined.**	50.5	≥ 50.0	→	?		Average performance for 2022/23 is currently below target.
Inappropriate out of area placement bed days - Adult Acute & PICU Ⓟ see page 16	143	= 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.
Cardiometabolic Assessments - Inpatients (%)	79.3	≥ 90.0	↘	X		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.
Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) see page 10	76.9	≥ 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**	**Nov-22**	**YTD**	**Information**	**Outcome**
Flu vaccinations for frontline healthcare workers (%)	≥ 90.0	33		Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	Currently the Trust is at 33%, which is far below the minimum threshold of 70%. The reporting for the CQUIN will be at the end of Q4, but there will be a monthly update to IMMFORM.
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 is currently achieving this CQUIN and achieved targets for Q3
Routine outcome monitoring in CYP and perinatal mental health services (%)	≥ 40.0	26.2		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 achievement is still above the partial payment threshold of 10%, but there has been a downward trajectory in October and November.
Routine outcome monitoring in community mental health services (%)	≥ 40.0	7.4		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.	The achievement in steadily improving, though still below the lowest achievement threshold.
Use of anxiety disorder specific measures in IAPT (%)	≥ 65.0	68.7		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).	Currently achieving above the target and achievement looks set to continue until the end of Q3.
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	Audits are being completed for Q3, the teams will be chased for any outstanding audits to be completed.
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	So far 21 admissions have taken place in Aquarius and Wisteria wards, which require auditing for Q3.
CAMHS: Restrictive Practice (%)	≥ 80.0	69.3		Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings	Currently will have a partial achievement for this CQUIN.

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; o 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 o Staff provided a very high standard of physical health care and treatment to patients. o 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. o 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. o 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. o 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. o 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 o 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 long stay or rehabilitation mental health wards for working age adults were inspected on 13th and 14th October, which was an unannounced inspection. The CQC attended both Burntwood Villas and Phoenix Ward. ▪ The CQC relayed the formal verbal feedback to the Trust on 18th November 2022. The draft report should be with the Trust in the next few weeks. ▪ It was reported that the CQC recognised the work Burntwood Villas had undertaken, saw an impact and said it felt like a different place. The CQC would not comment on whether the 6 'must do' actions from 2021 were rescinded, the Trust is hopeful these will be. Both units were praised for being 'rehab' wards. There were areas to improve noted around: ▪ Cleanliness ▪ Medical sundries opened and not dated ▪ Best interest decisions not documented ▪ Potential use of leave as an incentive to complete 'tasks' ▪ Risk Assessments not always update ▪ NEWS2 scores escalation not always in line with policy. ▪ Once the draft report is received the Trust will do a factual accuracy assessment on the report, and send findings back to the CQC. This is usually within 10 working days. **Ratings on how Trust Scored for each core service:**


Overall rating
Inadequate
Requires improvement
Good
Outstanding
Safe
Effective
Caring
Responsive
Well-led
Overall
Specialist eating disorders service
Child and adolescent mental health wards
Specialist community mental health services for children and young people
Community mental health services with learning disabilities or autism
Community-based mental health services for older people
Mental health crisis services and health-based places of safety
Forensic inpatient or secure wards
Long stay or rehabilitation mental health wards for working age adults
Wards for older people with mental health problems
Acute wards for adults of working age and psychiatric intensive care units
Substance misuse services
Community-based mental health services for adults of working age
Good
Requires improvement
Not rated

Appendix A – Current regulation notices

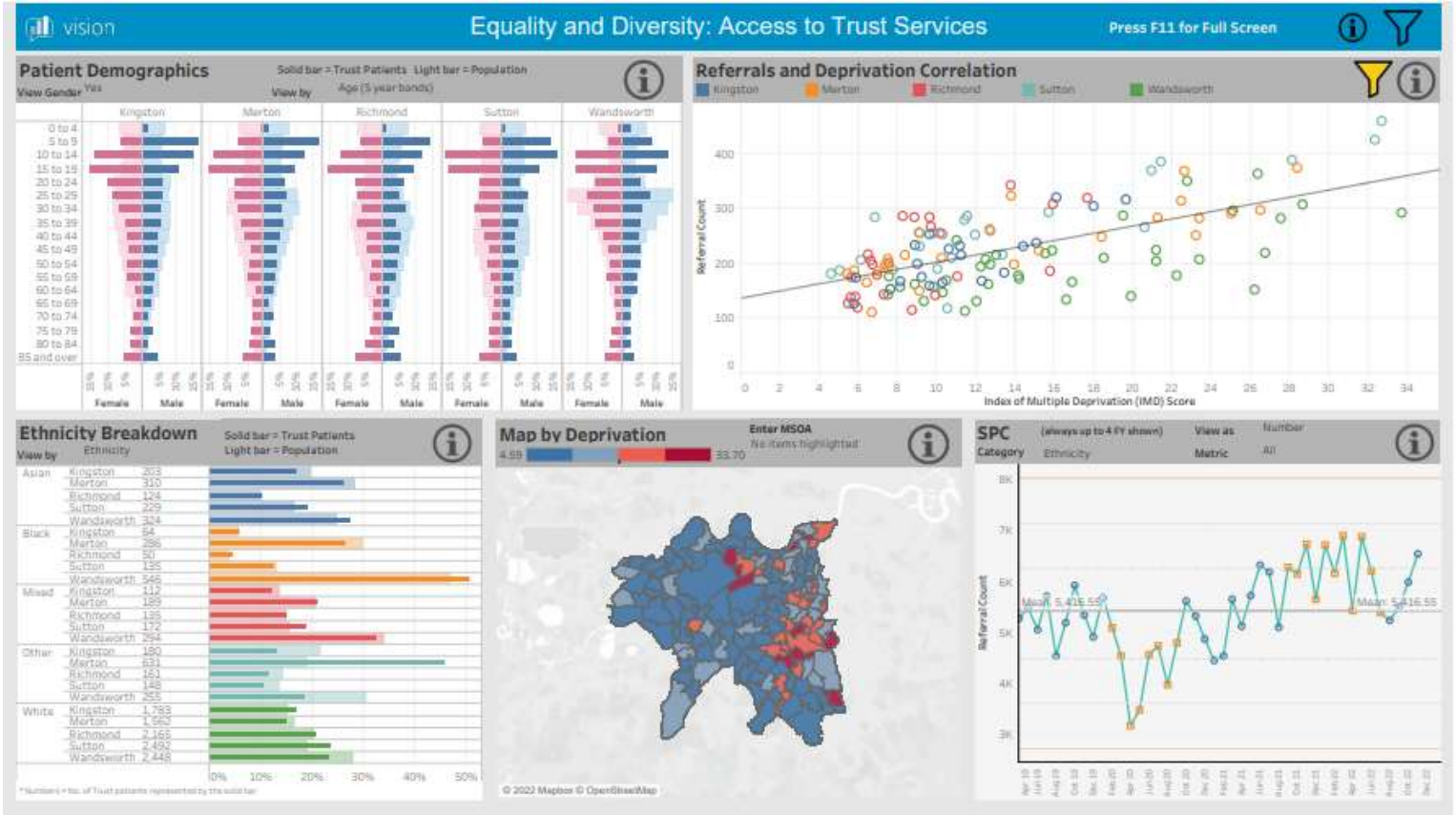
Regulation	Service	Issue
Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Long stay or rehabilitation mental health wards for working age adults	The trust 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.

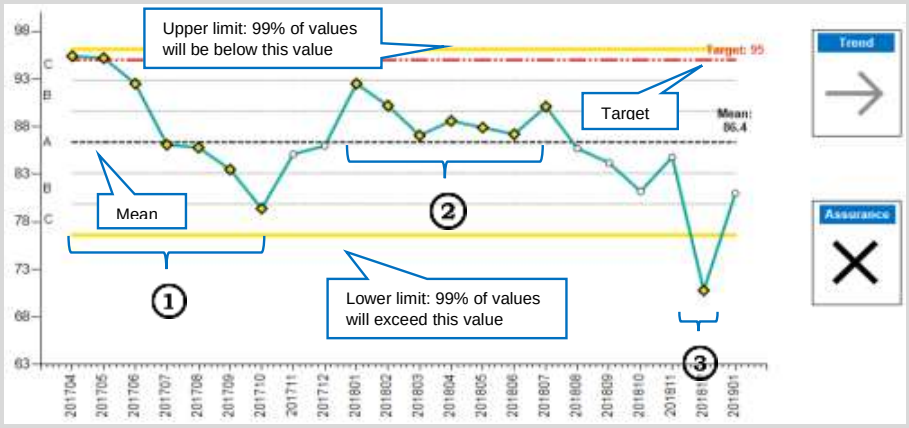
Appendix 7: Data quality assurance

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.

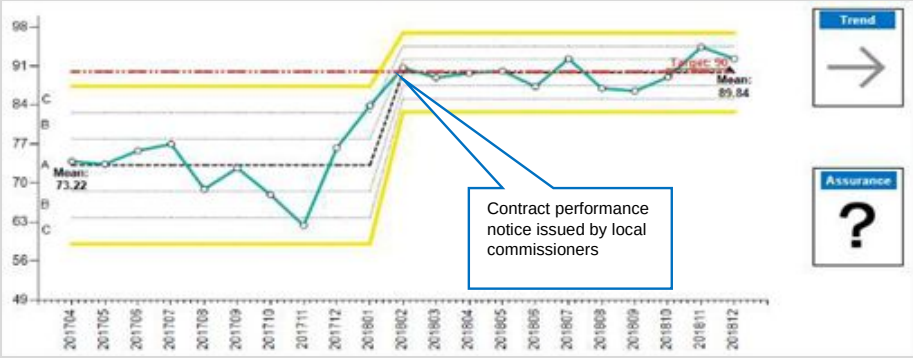
Appendix 8: Statistical Process Control (SPC) Charts & Performance Donut



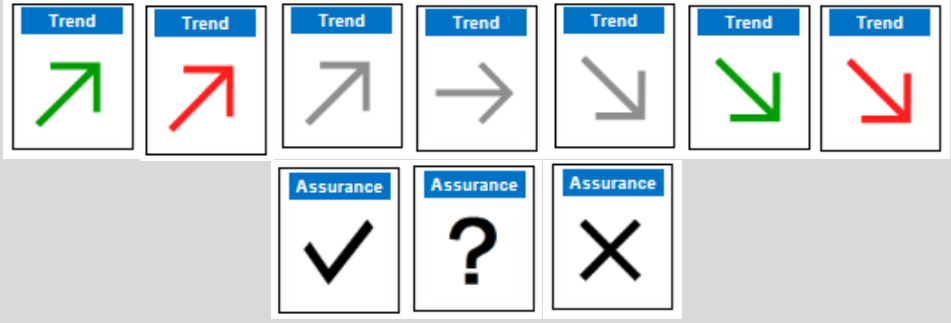
What is an SPC chart?
A Statistical Process Control (SPC) chart is a time series graph (we try to use 2 years) with three reference lines – the mean, upper and lower control limits. The limits help you understand the variability of the data. The variance of the data determines the process limits and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

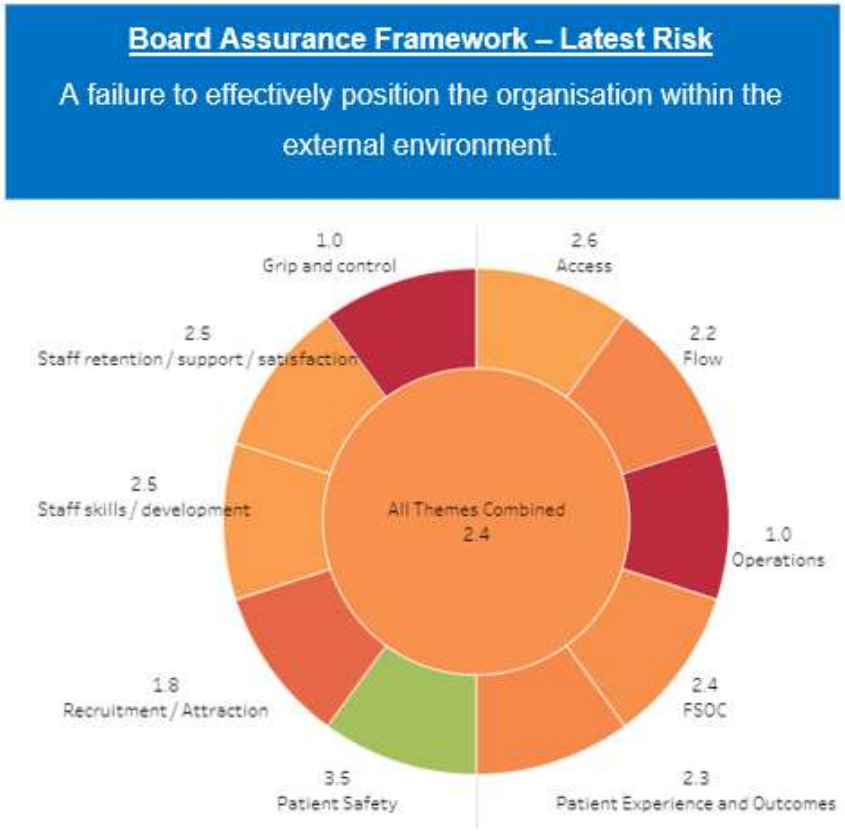


Special-cause variation
These are statistically significant patterns in data which may require investigation and includes the following (as illustrated in the chart above):
Trend: 7 consecutive points trending up or trending down (a 0.8% chance of this happening naturally).
Zone A: 7 or more consecutive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



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

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

RAG Rating:
Score
1.0 — 5.0

Meeting	Board of Directors
Date of meeting:	12th January 2023
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 22nd November 2022.

Matters discussed were as follows:

- HR Budget Update
- Recruitment and Retention Progress Report
- Medical Staffing and Employee Relations Progress Update
- Leadership & Development Report
- People Scorecard
- Quality & Performance Report
- Workforce Board Assurance Framework
- People Matters
- Policy Development Timetable
- Staff Survey Report and Progress Report
- Guardian Report
- Making Lives Better Together Report
- Corporate Objectives Q2 Update
- Committee Forward Plan

The following items are for reporting to the Trust Board:

Nurse Validation – Full Assurance
Committee assured that workforce requirements relating to Nurse Validation had been met. This was following on from presentation and assurance received at QSAC noting that there was a clear functioning process between the Nursing and HR team. Additional assurance was sought to ensure that mechanisms in place could effectively identify and proactively address any revalidation matters. It was also noted that to date only one person was not revalidated due to long term sickness. An annual report is to be received going forward.

Picker Staff Survey – Full Assurance regarding engagement approach
Committee noted that current indications suggested that the Trust's response rate would be lower than previous years and this was aligned with the national picture. The team have undertaken comprehensive engagement across the Trust which has built on the activities and learning from previous years.

Committee was assured that HR colleagues were working effectively with the Comms and Engagement Team in a manner that reflect where and how staff were working and therefore could be accessed. Committee sought assurance in future updates that staff/teams who do not traditionally engage are proactively engaged; e.g. night shift. The Committee thanked colleagues for their hard work.

Guardian's Report – Limited Assurance
The report is presented at every 2nd Committee. The Committee heard that key areas raised relate to bullying and harassment and concern with managers. It was noted. Committee noted a consistent absence of some staff groups not engaging with the service. The Committee sought assurance that this was not an issue for those staff and an update at the next report following engaging with those teams e.g. Estates. It was noted that a coversheet would have helped the Committee navigate the report more effectively.

MLBT (Full Assurance)
Progress is on target and reflects actions required to address risks identified in BAF.

Committee agreed to receive regular updates due to the Trust holding this as a known unmanaged risk. A 12-week review of the Trust's requirement is underway. Existing activities on offer were set out. It was noted that there needs to be greater clarify and publicity of the Leadership offer and assurance it is accessible, inclusive and responds to matters raised in WRES/WDES.

People Scorecard
The Committee received a verbal account setting out a number of approaches included use of dashboards. This is still in development.

Q&P report (Limited Assurance)
Key priorities remain R&R (now serious incident)
ER (significant decline in numbers – improvement – Risk being reviewed)

The Committee heard that vacancy rate continues to fall but still remains above the 15% target. The recruitment critical incident work took a forensic look at vacancies and the establishment undertaking a cleansing exercise which ensures that future oversight will be sighted on more accurate information.

A number of workforce related metrics remain off target with temporary staffing and time to recruit remaining significantly off target. It was noted that tackling agency spend was a high impact area for improvement and one of the critical priority areas for the Finance & Performance Committee. The Committee were advised that progress would need to be incremental and take time as both the HR function, Trust processes and procedures come on board, some time will be required to reboot these operationally and thereafter some time required before the Trust will see the impact. The Committee was minded to acknowledge and support this view as this had been the case with ER and more recently the recruitment work.

Recruitment and Retention progress report (Limited Assurance
Progress made with Recruitment; Retention remains a significant issue)

Committee was advised that the 12-week Recruitment incident work had completed requiring a significant number of actions and workstreams across operations, HR and the services. Just under 200 posts in train for recruitment before the end of the year. Performance indicators identified and tracked operationally at People Matters Committee.
The Committee were assured that HR support to the managers in the service lines would ensure that the activity to achieve the agreed recruitment numbers could be sustained.

Medical staffing (Very Limited Assurance
Growing set of challenges – offset somewhat by early mitigation activity in place)

The Committee was informed that in medical staffing there are increasing numbers of challenges both in resource and operationally and therefore increased risk and concern. Plans are in place to bolster the function by bringing it with the general recruitment function which is reported to being to improve the way it operates. The Committee were assured that bringing these two together would not compromise the recruitment area where there are still significant gains to be made to hit operational targets.

Policy Review Timetable (Limited Assurance – timetable of reviews in place)
Committee noted that a review of all relevant policies had taken place and set out in a category determining the priority by which they would be reviewed. The Committee were in support of the rationale for prioritising whilst also noting the risk held whilst there were outstanding policies for review.

Workforce BAF
The fall in number and management of ER cases has been sustained and the revised risk will be included in a revised BAF presented to the January Committee and will set out the status of the current 3 Committee priorities and identify a revised set.

Recommendation
The Board is asked to note the report and receive the minutes from 27th September 2022.

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

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the meeting held on Tues**day 27th September** , 15:00-17:00 via MS Teams

Attendance list

Present:

Sola Afuape (SA)	Non–Executive Director (Chair)
Sharon Spain (SS)	Director of Nursing
Jenna Khalfan (JK)	Director of Communications and Stakeholder Engagement
Vik Sagar (VS)	Non–Executive Director

Attendees:

Elaine Holder (EH)	Corporate Governance Manager
Pam Warren (PW)	Interim Human Resources Deputy Director
Saffron Pineger (SP)	Head of Communications and Campaigns
Trevor Procter (TP)	Management Accountant
Rob White (RW)	HR Transformation Lead
Johnny Steyn (JS)	Employee Engagement Manager

Observer with speaking rights:

Jeremy Coutinho (JC)	Diversity in Decision Making Representative and Recovery College Manager

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
Nicola Mladenovic (NM)	Deputy Trust Secretary
Katherine Robinson (KR)	Director of People

Item		Action
22/58	**Welcome and Apologies** Apologies for absence were received and noted.	
22/59	**Declarations of Interest** No new declarations were reported.	
22/60	**Chair's Action** Chair reviewed the Board action on the matter of Workforce Equality. SA/EH/DM held a meeting to discuss this which will be presented at EDC and any actions will be brought back to WDOC. MLBT will be deferred.	
22/61	**Minutes of the previous meeting** The minutes of the meeting held on 26th July 2022 were approved as an accurate record.	
22/62	**Action Tracker and Matters Arising**	

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

22/467 KR to look at Workforce numbers – on agenda

22/46 Case study metrics action – DL/KR to meet to discuss.

22/63 HR & OD Structure Transition & Budget Review

The Committee noted the report.

PW highlighted the following:

- There are 2 recommendations for Committee to make
  1- Note progress made in respect of separation of HR and OD functions
  2- Agree budget for HR and OD

- ELT have agreed the structure and allocated pay budget of £2.1m (within total budget of £3.67m also a CIP of £134k has been agreed)
- A Recruitment Management post has been added in the structure
- The Trust's structure/needs are different to where they were 3 years ago, and this will need to be continually reviewed
- Education and Learning Dept is still in the process of separation with a new interim head
- Engagement Health and Wellbeing functions are due to split - date to be confirmed
- VS asked how the figure of £2.1m for Business Partnering, Recruitment Education and workforce is split across the categories. VS also asked how the figure of £4.196m of actual spend for 22/23 was calculated.
- VS asked for the job description for Business Partner. **Action PW to circulate** **PW**
- VS questioned the figure of £1m premium paid to external agency providers and whether this could be linked to savings costs for the next 12 months.
- TP informed that he is working on the figures with KR and will provide figures/changes for month 6 at the next WDOC meeting in November. **Action TP/KR** **TP/KR**
- SA asked if these figures have been benchmarked and how they compare against other organisations and National Guidelines
- TP informed that Agency Spend is reviewed at the Corporate Finance Savings Board and areas being looked at include Direct Employment to avoid agency premiums.
- PW informed agency spend is being triangulated via the Q&P report and Recruitment Incident.

22/64 Recruitment and Retention Progress

The Committee noted the presentation.

- RW informed due to the Trust's high vacancy rate a recruitment incident (lasting 12 weeks) has been put in place and is led by JeA to address the concerns of operations and quality
- Action tracking and project planning are taking place in real time
- The incident is reported to ELT on a weekly basis
- VS asked if the onboarding project outcomes have been finalised and RW informed the work for onboarding has been extended until end October.
- SA asked if there is sustainability for the current high level of effort as well lessons learnt

- PW informed that ELT asked for HR processes to be the focus to bring the vacancy rate target in line with national figures
- JeA reviewed process mapping which has been the main focus
- PW informed the focus after the incident will be retention
- PW informed data from various sources need to be cleansed and checked for accuracy
- SA stated there are clear risks in respect of HR Capacity progress should be clearly articulated in the BAF review in December

22/65 Leadership & Development Gap Analysis

The Committee noted the report. RW gave an overview:

- This has been affected by the Recruitment Incident work
- Task and finish groups have been introduced
- The Trust's need to enhance its Leadership programme as it is not widely known and there is no overall framework
- Evaluation needs to be undertaken so HR are clear about the gaps
- There are plans to run a talent Management workshop with ELT which has been deferred to 2023 due to the Recruitment Incident. This is not one of the three immediate priorities, but it has been acknowledged that this needs to be addressed. There are plans to look at having someone in place to review and bring together, LOD,QI and Nurse development.
- SA asked if career opportunities for WRES and WDES in respect of Leadership could be included in the next report **Action PW** Chair queried sequencing and alignment of Recommendation to Actions agreed and how it will link to addressing career development matters raised in WRES and likely applicable to WDES **PW**
- EH informed that ICS is starting a Leadership programme where 60/70 % of places will be offered to BAME staff.
- SA informed there is limited assurance in respect of the HR & OD Structure & Budget Review, and this will be reviewed at the January 2023 WODC meeting. Further analytics required to the narrative re budget timeline, RAG of sorts to assess progress **Action: Chair requests next iteration to also include context in relation to National guidance, benchmarking, best practice** **PW**

22/66 Employee Relations Report

The Committee noted the report. MB gave an overview of the presentation:

- This work is being done due to the Trust splitting ahead the release of Capsticks who previously managed.
- A new ER structure has been put in place and it has been recognised there is marked improvement over a short period of time (8 weeks)
- There are currently 54 active cases
- The Trust sickness rate has gone from red to amber
- PW informed that the tribunal numbers are high due to Covid and tribunal staff shortage although most of the cases are historic
- VF commended the ER work.
- VF commented there are only 7 people on capability and questioned what the target range is.
- PM informed that as the Trust ais now more responsive things can be nipped in the bud and can be dealt with informally. In the terms of lessons learned finance have put things in place in respect of overpayments. The Trust's new occupational health provider is holding workshops to support staff more effectively especially those staff with disabilities and sickness.

- SP & PW to work together to incorporate MLBT. **Action SP & PW** **SP/PW**
- It has been reported that ER work has been well received by service lines and JCC
- Chair questioned re sustainability and lessons learnt – how this will be extracted and embedded in future practice. What are we doing now that we need to sustain and highlighted the need to provide coaching for managers and link to L&OD unmanaged risk holding and HR capacity issue
- Chair flagged the need to strike the right balance with a more professional focus on identifying and addressing capability and being assured the Trust is meeting its responsibility creating the right environment that builds the right culture and gives staff the right tools and environment to do their job.

22/67 People Scorecard

The Committee noted the report.

- PW informed that the scorecard looks at retrospective data
- KR/PW will review at KPIs
- SA asked if members could email any questions on the People Scorecard to PW/KR within 2 weeks

22/68 Quality & Performance Report

The Committee noted the report. PW highlighted the following:

- The vacancy rate is 54.87
- There are currently move leavers than joiners
- VP stated that 57% of vacancies held have not been converted into the recruitment pipeline
- Agency figures are currently 136% over NHIE target – notice will be given so staff can be moved over to Bank
- Staff leaving in the first 18 months has reduced – onboarding work has helped
- Percentage of BAME staff in band 8a-c has increased (23% in the last 2 years)
- MH feels there should be a focus on recruitment of BAME staff band 8c and above
- KR is reviewing how long current BAME staff have remained in their current band
- There is work to cleanse workforce data to clarify the establishment 88 band 5, 28 HCA in pipeline and where they sit operationally to understand the risk (which will start by end of September) as well as the process for getting feedback on the recruitment process

22/69 Workforce BAF

The Committee noted the report. PW highlighted the following:

- There will be a deep dive review having allowed some of the interventions to bed in e.g., HR Recovery improving situation, SLT recruited to split in place, HRBP in place
- The Recovery Risk Register will also be reviewed
- Updated BAF will go to Audit Committee in October
- Chair noted granular detail in BAF to remain in place whilst close scrutiny in place was supported in Audit chair's report to Board– will be revised as part of the BAF December review

22/70 HR Service Transition Group Report

The Committee noted the report.
It was agreed this will be disbanded in September

22/71 People Matters
The Committee noted the report.
JeA informed the People Matters Committee will be shortly disbanded.

22/72 Policy Development Framework Update
The Committee noted the report

- PW informed the Trust's disciplinary meeting has been signed off at the last JCC meeting and good feedback was received
- PW informed that a third Company will be helping with policy sign off
- SA asked if this would satisfy the Trust's statutory requirements
- PW informed there are currently 25 polices that are out of date
- SA requested PW let committee know when the Board can have assurance in respect

22/73 WODC Annual Report
SA and KR to confirm the committee annual report.

22/74 Cost of Living Support Update
The Committee note the report. JS highlighted the following

- A series of workshops have been set up – 3 have taken place so far
- Early morning and late shift events were not well attended
- There have been some good suggestions that have been taken on board
- New drop-in sessions will be set up to include staff survey, wellbeing, vaccinations etc
- VF informed mileage rate has been increased and meals for in-patient staff will be offered
- VF has asked KR to bring a paper to ELT for MLBT/HR workshops asking staff their COL impact and what they would like /need for support

22/75 Staff Survey Report and Progress Report
The Committee noted the report and JS Informed the 2022 Staff survey will be launched on 3rd October.

22/76 Quarterly Pulse Survey Report Update
The Committee noted the report.

- JS informed the response rate is exceptionally low at 5% -(10% being last years rate)
- Comms will be ramped up to try and increase numbers
- SA will put future survey agenda items at the beginning of the agenda to allow plenty of time for discussion

22/77 Committee Forward Plan
The Committee noted the report.

HR and OD – 24th January 2023
BAF review needs to be added to the workplan 2022

22/78 Matters to Report to the Board
The Committee is to report a summary of items discussed to the Trust Board.

- Limited assurance for HR Structure and Budget review – KR/DL will look at lessons learnt and case study against metrics to include threshold of recruitment and retention
- Significant process has been made on Employment Tribunals and there is strong level of assurance for this
- Learning and Development is a risk area
- Q&P – Vacancy and agency are critical areas as well as medical recruitment
- HR Capacity is a risk considering the Recruitment Incident
- BAF to be updated for the Board

22/79 Date of Next Meeting

The next meeting will be held on 22nd November 2022

Meeting:	WODC
Date of Meeting:	24 May 2022
Report Title:	**Workforce & Organisation Development Committee Annual Report**
Author:	Nicola Mladenovic, Deputy Director of Corporate Governance
Purpose:	For Approval
Transparency:	Public

Executive Summary

All Committees of the Board are required to complete a self-assessment of its work during the year. This report contains the outline of the activity discussed at the Workforce & OD Committee during 2021 / 2022. The report provides both an annual review of the committee's work in the prior year and details of the forward plan for the Committee in addition to terms of reference. It is also good practice for the Committee to provide an assurance position statement to the Board. A draft statement is included for the Committee's consideration.

Recommendations

The Board is asked to:

1) Receive the committee annual report

Corporate Risk		**Board Assurance Risk**	

KEY IMPLICATIONS

Outlined below are the key implications which may result from the proposals or information contained within this report

Assurance/Governance:	As a matter of good practice it is important that the Committee reviews its work. This ensures that there is robust coverage of matters which are important to the Board. This practice is a key element of the well-led framework
Clinical:	The sufficiency and quality of the Trust's clinical workforce is a direct concern of this Committee.
Equality & Diversity:	The equality and diversity considerations for this committee are intrinsic to the agendas at all times.
Estates:	Whilst there were no direct implications in 2021/22, the People Readiness and Culture Change changed to report to the Estates Modernisation Committee due to the close working it has with the committee.
Financial:	There are no direct implications from this report.
Legal:	There are no direct implications.
Quality:	The Committee's agendas consider the quality issues for workforce and organisation development at each meeting and this report highlights those areas of main concern.
Reputation:	If the Trust cannot demonstrate that it has a robust governance system and the organisation is not well-led it can lead to reputational damage.
Strategy:	The workforce and organisation development strategy is not affected by this report; but it underpins the work under the committee's consideration.
Workforce:	The workforce implication is that the Trust has a committee dedicated to reporting on its key asset – the workforce.

ANNUAL COMMITTEE REPORT
WORKFORCE & ORGANISATION DEVELOPMENT COMMITTEE

1. Introduction

1.1. Committee Establishment

The Workforce & OD Committee (the Committee) is a long established committee of the Board of Directors and operated during the reporting 01 April 2021 to 31 March 2022 (the period).

1.2. Committee Purpose

The Committee is charged with ensuring that there are effective mechanisms and systems in place to deliver the workforce and educational investment objectives of the Trust whilst keeping abreast of the pertinent system-wide strategic issues and the implications.

The Committee also has a duty to support the Board in fostering an organisational culture and environment where staff are engaged, feel valued and developed to support an innovative recovery focused service which is co-produced with services users.

The broad themes of the Committee's work are below:

- Workforce Planning and Equality & Diversity
- Retention & Recruitment
- Leadership & Culture
- Governance & Reporting

Through its work the Committee drove the development and delivery of the workforce and organisational development strategy and monitored key workforce metrics which underpin the delivery of the strategic objectives.

1.3. Terms of Reference

The full details of the Committee's duties are outlined in the terms of reference.

The internal audit report on corporate risk management flagged the importance of ensuring that all board committees have oversight of the relevant key risks. As a matter of good practice the committee does review key risks and will continue to so in relation to the board assurance framework risk related to workforce and organisation development

The terms of reference are reviewed annually and these were presented to the Committee's meeting in March 2022.

2. Membership and Meeting Attendance

The Committee comprises a mixture of non-executive directors, executive directors and other representatives and attendees. In addition, report writers attended to present

reports, including the Freedom to Speak Up Guardian. During the period the Committee met on five occasions. Since the covid pandemic the committee has continued to meet virtually rather than as a face-to-face meeting. The number of meetings attended by members and contributing attendees is detailed in the table below.

Table 1: Committee members' attendance - April 2021 to March 2022

Members	05/05/2021	07/07/2021	01/09/2021	03/11/2021	22/03/2022
Jean Daintith (Chair)	x	x	apols	x	
Sola Afuape (Chair)	x	x	x	x	x
Mary Foulkes	x	x	x	x	
Jenna Khalfan	x	x	x	x	apols
Sharon Spain	x	x	x	apols	x
Jen Allan	x	x	x	x	x
David Lee	x	x	x	x	x
Nicola Mladenovic	x	x	x	x	x
Ann Beasley				x	x
Namdi Ngoka	x	x	x	apols	
Katherine Robinson			x		x
Vanessa Ford	x	x	x	x	x
Shikainah Champion - Diversity in Decision Making rep	x	x	x	x	x

3. Committee Work and Activities

3.1. Annual Review - April 2021 to March 2022

The Committee has conducted work in line with its purpose reviewing key workforce related matters and during the period developed and agreed its terms of reference and a workplan.

The items featured on the Committee's agenda during the period are included:

Date	Key topics
May 2021	Workforce Q&P Report HR Risk Register Joint Workforce & OD Strategy HR Risk Register Occupational Health six month update People Readiness and Culture Change update Covid Updates Corporate Objectives Q4 Committee Annual Report Workforce Matters minutes
July 2021	Workforce Q&P Report HR Risk Register Stress Assessment – planning update Covid Updates Workforce Transformation Disciplinary Deep Dive update Supervision Update MBLT Update Apprenticeship Levy Corporate Objectives Freedom to Speak Up Report Committee Workplan Committee Annual Report

	Workforce Matters minutes
September 2021	Workforce Planning Priorities – Q&P Report and Workforce Risk Register Covid Updates MLBT Update Stress Assessment update People Readiness and Culture Change update Preparing for the Staff Survey Employee Relations Update Committee Workplan Workforce Matters minutes
November 2021	Recommendations, risk, mitigation and recovery planning Q2 Corporate Objectives 2021/22 Workforce Q&P Report
December 2021	Recommendations, risk, mitigation and recovery planning Virtual Visits – workforce themes
March 2022	Q3 Corporate Objectives People Priorities Plan 2022/23 Workforce Q&P Report BAF Update Q&P Metrics for 2022/23 Freedom to Speak Up Guardian report Recovery Advisory Board Assurance report Nurse Validation Report Estates Modernisation Programme consultation briefing and update Committee Terms of Reference Committee Workplan 2022/23

3.2. Forward Plan

The Committee's forward plan is presented to each Committee for review and includes robust monitoring of key elements of the Workforce & Organisational Development Strategy, Board Assurance Framework and Corporate Risks and key workforce challenges.

The forward workplan in draft is detailed in **Table 2: Forward Workplan – 01 April 2022 to 31 March 2023,** however this will be driven by the Risk Register and in consultation with the Joint Executive Director of HR & OD and the Chair.

Table 2: Forward Workplan – 01 April 2022 to 31 March 2023

				2022/2023						
AGENDA ITEMS	**Executive Lead**	**Purpose**	APRIL SEMINAR	24/05/2022 (Board 12/05/2022)	26/07/2022 (Board 14/07/2022)	27/09/2022 (Board 08/09/2022)	22/11/2022 (Board 10/11/2022)	DECEMBER SEMINAR	24/01/2023 (Board 12/01/2023)	28/03/2023 (Board 09/03/2023)
Workforce Planning										
Inclusion Report:	**DHR**	**FR**		√	√	√	√		√	√
Workforce Scorecard and Q&P Dashboard										
Training Update to include MAST / PADR and Supervision										
Employee of the Month										
Temporary Staffing and Agency use										
Workforce Profile Report										
Red Flag Employee Relations Cases including any MHPS cases										
Vacancies / Turnover / Recruitment/Retention, Compliance & Governance Report KPI's										
Sickness Absence & Health & Wellbeing										
Staff Friends, Family Test and National Staff Survey Report										
HR Recovery and Risk Register Update	**DHR**	**FR**		√	√	√	√		√	√
People Priorites Plan (Attraction, Retention and Development)	**DHR**	**FR**			√		√			√
Board Assurance Framework Review (HR Risks Only)	**DHR**	**FR**		√	√	√	√		√	√
Leadership & Culture										
PADR - Revisions	**DHR**	**FR**			√					
Supervision	**DHR**	**FR**			√					
Recruitment and Retention (every other meeting) to inc workforce planning	**DHR**	**FR**		√		√			√	
MLBT - Update (alternate meetings, each meeting from Sept)	**DCE**	**FI**		√	√	√	√		√	√
Quality Leadership Programme (Leadership Update)	**DHR**	**FR**				√				
Guardian Service Report (every 6 months)	**DHR**	**FI**			√					
Occupational Health	**DHR**	**FR**			√					
Staff Survey - update	**DHR**	**FR**	√							
Mandatory & Statutory Training - Update	**DHR**	**FR**		√			√			
Nurse Development Programme	**DON**	**FR**			√					
Nurse Validation Report (noting only)	**DON**	**FN**								√
Corporate Objectives	**DHR**	**FR**			Q1		Q2		Q3	
Estate Modernisation Programme updates	**DHR**	**FR**		√		√			√	
Governance & Reporting										
People Matters - sub group (minutes for noting)	**DHR**	**FI**		√	√	√	√		√	√
Employee Relation updates (alternate meetings)	**DHR**	**FI**		√		√			√	
Terms of Reference	**DHR**	**FI**								√
Committee Workplan	**DHR**	**FI**		√	√	√	√		√	√
Committee Annual Report	**TS**	**FA**			√					

4. Draft assurance and position statement

The Committee's work has supported the Board in achieving the strategic objective to improve leadership and talent. The Committee has given and will continue to focus on those areas that might prevent the realisation of the Trust's objectives, especially where they could impact on the quality of care, high agency usage, staff health and safety, Trust reputation, financial controls and CQC requirements/regulations. All areas of recruitment and retention, including turnover and time to recruit, have been scrutinised. Supervision, Performance and Development Reviews (PADRs) and Mandatory and Statutory Training (MAST) have also been considered regularly. Employee relations, the staff survey, communications plan and occupational health reports were also considered. The 'Speak Up Guardian' has presented reports to the Committee every six months. The Committee has routinely received updates from the Workforce Matters Group and received a number of updates including recruitment of staff and medical staff; apprenticeships; Quality Leadership Programme, SLP and nurse development, staff development and organisational development.

Appendix: Workforce & Organisational Development Committee terms of reference

Committee	Workforce & Organisational Development
Key Strategic Ambitions	3. Making the Trust a Great Place to Work
Chair	Non-Executive Director
Executive Lead	Chief People Officer
Secretary	Trust Secretariat
Members	x2 Non-Executive Director, one of whom is the Chair Chief People Officer Chief Operating Officer Director of Nursing & Quality Standards
Attendees	Deputy of Director of Human Resources Director of Corporate Governance (from time to time) The Committee may invite any other Trust representative and/or external professional advisors as it deems necessary from time to time.
Frequency	Presently the work plan can be accommodated with quarterly meetings. Two seminars will also be held in the year and will include members from the Equality & Diversity Committee
Quorum	The quorum of the Committee shall be one Non-Executive Director, Chief People Officer (or a deputy agreed with the Chair) and either the Director of Nursing & Quality Standards or Chief Operating Officer. Where an executive director is not able to attend the meeting they must send a deputy who is authorised to make decisions on their behalf.

Purpose

This Committee has been established to ensure, on behalf of the Board, that there are effective mechanisms and systems in place to deliver the objectives approved by the Board in relation to the Trust's workforce and educational investment.

Through its work the Committee will support the Board in creating a culture and environment where staff are engaged, feel valued and developed to support an innovative recovery focused service which is co-produced with services users.

The Committee will also keep abreast of the strategic context the Trust operates in and the workforce consequences and implications of this.

Duties

The Committee will drive the development and delivery of the Trust's workforce and organisational development strategy and regularly monitor key workforce metrics which underpin the delivery of the Trust's workforce strategic objectives.

With the view of providing relevant assurance to the Board the core Committee duties include:

Workforce Planning & Equality & Diversity

- Regular review the Trust's workforce performance metrics and data (e.g. sickness, absences, staff survey, diversity etc) to ensure that there are effective systems in place and provide exception reports to the Board as necessary.

- To support development of the Trust's workforce strategies in line with the overarching Trust vision including, but not limited to:
    - workforce and organisational development strategy;
    - staff wellbeing strategy; and
    - education and training strategy

- Ensure there are effective workforce and organisational development policies, procedures and practice standards in place to deliver the Board's strategy for workforce.

- Through regular review and scrutiny ensure there are robust systems and controls in place to ensure the Trust's continues to comply with all statutory and regulatory requirements including, but not limited, to Care Quality Commission Standards and NHS Improvement.

- Review and contribute to the production of the annual workforce report included in the Trust's annual report and accounts.

Retention & Recruitment

- Ensure that there are effective governance systems and mechanisms in place to delivery compliant recruitment in the Trust.

Leadership & Culture

- Regularly review the Trust's quality development programme.

- To review the Trust's Workforce and OD Strategy to include professional education, training and re-validation (where relevant) for all frontline staff including students and apprentices, and employee wellbeing strategies prior to approval by the Board, to ensure that they support the Trust's vision.

- Oversight of the People Readiness and Culture Change Programme. However during the Estates Modernisation Programme this oversight will be managed by the Estates Management Committee.

Governance

- Ensuring compliance with statutory elements of workforce governance.

- Considering internal audit reports in respect of areas which directly impact on workforce, HR and organisational development.

- Reporting to the Audit Committee its findings in regard to the system of control in place to manage workforce risks.

- Receiving updates from the Clinical Transformation Programme, People Readiness & Culture Change Programme and Estates Modernisation Programme via the Estates Modernisation Management Group, where key areas from these programmes fall within the Committee remit

- Agreeing work plans and monitoring the work of People Matters Group.

Risk & Board Assurance Review

The Committee will also review key risks related to its work and escalate to the Board as appropriate. Where key risks exist, the Committee will support the executive team in developing action plans and monitoring delivery.

As and when required the Committee will flag key risks which give rise to wider issues to the Audit Committee.

For the avoidance of doubt, the work of the Committee is underpinned by the requirement to provide assurance to the Board, and as such, will scrutinise key documents such as strategies and annual reports before they are presented to the Board for approval.

Authority

The Committee has been established to make relevant recommendations to the Board and must act within its delegated authority. It may make decisions which give effect to the agreed strategic objectives and workforce plans.

Operation

The Secretary to the Committee shall produce minutes of each meeting which will be presented at the subsequent meeting for approval, subject to the Chair's prior review.

The Committee will develop a robust work plan each year which outlines the business it will consider. The plan must include relevant operational and strategic workforce priorities for the Trust.

Reporting

Reports to the Board

Following each meeting the Chair with support from the Secretary, will produce a report to the Board which highlights key matters considered, provide relevant assurances or exception reports. The approved Committee minutes will also be submitted to Board for information.

The Committee must also conduct an annual self-assessment and review of its terms of reference and present to the Board for endorsement and approval. Once the Board has approved the Committee's terms of reference any future material change must be presented to the Board for approval.

Reporting Groups

- The Committee will receive the minutes and regular reports from the following groups; People Matters Group and the Service Transformation Group.

  The Service Transformation Group was established in April 2022 for a fixed term period of six months. Its purpose is to oversee the HR Recovery and Transformation process and report back to the Committee to provide assurance in respect of an improvement in the service.

4-2_SIRG ToR FINAL DRAFT {clean}.pdf

Updated TORs agreed by the Committee on 6 June 2022.

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

Meeting:	Trust Board
Date of Meeting:	12th January 2023
Report Title:	**Equality and Diversity Committee chair's report**
Author:	Ann Beasley, Trust Chair and Non-Executive Director
Purpose:	For assurance
Transparency:	Public

The Committee met on 1st December 2022 and received the presentation by the Deaf Staff Network and also discussed the following items:

- Integrated Programme – equality impact assessment/approach
- EMHIP Update
- Corporate Objective Q2 report
- Board Assurance Framework

Deaf Staff Network
During the year the following took place:

- Great progress has been made especially around interpreting.
- Guidance has been published to support working with interpreting staff and this has been received especially within service line teams.
- Progress has been made in interpreting the two weekly all staff meeting that is led by the Chief Executive.
- Artwork has been co-produced and this will be displayed in the new buildings as well as signage to support deaf staff and service users accessing all Trust locations.
- The Trust values and mission have now been BSL interpreted and this will be included in all materials.
- Further work is progressing with the Learning and Development Team to make sure that a BSL interpreter is available for all training and not just mandatory training. This will also include progressing talks to have a centralised budget that would allow teams to access BSL.

Challenges:

- There is difficulty in booking interpreters especially as more face-to-face work is taking place and there are not enough interpreters to manage the ward even though Corner House is not open.

<u>Integrated Programme – equality impact assessment/approach</u>
The Committee heard an update in the integrated programme and was assured that equality and diversity is a continual process of quality improvement.

Since the completion of work at Springfield Hospital there have been changes in learning and these will be implemented in the Tolworth Hospital design and will focus on quality improvements for protected characteristics. The Committee heard that further development will continue in respect to support staff and patients with hidden disabilities as week as visible disabilities.
As part of the Phase 2 Tolworth work an EQIA has been undertaken to determine the impact of the proposal on patients and staff. The impact on clinical care has been assessed as improved. However the staffing impact is scored as red and considers the turnover due to the loss of income for staff going to Tolworth and this is being picked up as part of the consultation. This affects approx. 200 staff and this is being worked through with the support of Human Resources.

EMHIP Update
Significant progress is being made in the programme in particular the work of the wellbeing hubs and in developing the lived experience approach to some of the interventions.

Work is progressing in designing how the interventions will be delivered however there has been a delay in co-producing the approach around the crisis family placement service. The delays have been supported by the partnership.

The Committee noted the **Board Assurance Framework.**

Recommendations

The Board is asked to note the key points of this report and receive the minutes of the 20th October 2022 meeting.

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

Equality & Diversity Committee

Minutes of the MS Teams meeting held on **Thursday 20th October 2022, 14:30-17:00**

Present:

Doreen McCollin (DMc)	Non-Executive Director (Committee Chair)
Deborah Bowman (DBo)	Non-Executive Director

Attendees:

Jenna Khalfan (JK)	Director of Communications and Stakeholder Engagement
Vanessa Ford (VF	Chief Executive
Billy Boland (BB)	Medical Director
Katherine Robinson (KR)	Director of People
Sharon Spain (SS)	Director of Nursing and Quality Standards (attended until 4pm)
Philip Murray (PM)	Director of Finance and Performance
Ian Garlington (IG)	Integrated Programme Director
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial Development
David Heasman (DH)	Christian Staff Network - chair
Victor Nathan (VN)	Christian Staff Network - deputy
Andrew Francalanza (AF)	Equality & Diversity Inclusion HR Lead
Emdad Haque (EH)	Associate Director – Equality, Diversity and Involvement
Lenka Novakova (LN)	Deaf Staff Network - chair
Ashley Painter (AP)	DiverseAbility Staff Network
Andy Cohen (AC)	LGBTQIA+ Staff Network - chair
Eduard Margarit	LGBTQIA+ Staff Network – interim chair
Jacqueline Ewers (JE)	Evolve Staff Network - deputy
Stephen Charlery (SC)	Mental Health Staff Network - chair
Nisha Proietti (NP)	Mental Health Staff Network – deputy and Diversity in Decision Making representative
Emily Downey (ED)	Women's Staff Network (interim co-chair)
Melissa Heath (MH)	Women's Staff Network (interim co-chair)
Sarah Burrell (SB)	Service User and Carer representative
Nicola Mladenovic (NM)	Deputy Trust Secretary (minutes)

Apologies

Juliet Armstrong (JuA)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Charlotte Clark (CC)	Non-Executive Director
David Lee (DL)	Director of Corporate Governance
Sola Afuape (SA)	Non-Executive Director

Item		Action
22/55	**Introduction and Apologies** Apologies were noted. Doreen welcomed Emdad Haque who has recently joined the Trust as Associate Director of EDI and Health Inequalities. Emdad shared that he has previously worked at the ICB, CSU and the local authority before joining the NHS. He is a trained counsellor and management consultant.	
22/56	**Chairs Action** No Chair's Action has been taken.	

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

22/57	**Minutes from the last meeting** The minutes from the 23rd June 2022 were agreed to be an accurate reflection of the meeting.	
22/58	**Action Tracker** **Item 22/8 Staff demographics annual report –** this item will come to the next meeting **Item 22/44 Committee Forward Plan** – this is to be discussed as the committees are changing and then this will come back to the next committee. **Item 22/45 Staff Network** – KR introduced Emdad Haque who has started in his role as Associate Director for EDI. It was confirmed that this will come to the next meeting. An Equality Matters meeting is being started and this will support the work of the organisation going forward. **Item 22/49 EDI enabling update** - Emdad spoke about combining the WRES and WDES actions into the Integrated EDI Strategy action plan and he confirmed that updates will come through and will detail the stream that they are coming through. The update will focus on actions and outcomes whereby progress updates will be reported to give assurance to the committees and the board. An update will come to the February meeting. **Item 22/45 Deaf Staff Network** – KR provided an update on the progress being made regarding the interpreter booking process. Jan Lonsdale, Head of Learning and Development has joined the team and will be in touch with Lenka regarding the progress being made.	
22/59	**Staff Network and Champions Updates** <u>DiverseAbility Network</u> Ashley Painter presented an update. 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 • Workplace Health and Welling passport for all staff – this is still in progress • To increase in disability declaration rate to about 13% **Plans for the next year:** • Disability Awareness Month – Nov/Dec • World Disability Day – 3 December • Complete Work Health and Wellbeing Passport • Target acute wards for staff network-equity of access • Introduce sunflower lanyard – raise hidden disability awareness **Challenges** • Time to undertake work in the staff network • Stigma raised by staff as they are being treated differently • Reasonable adjustments are an ongoing requirement to support staff	

22/60	Mental Health Staff Network Stephen Charlery was welcomed as he has taken over as the Chair of the staff network since Miles Rinaldi left and this is his first meeting since taking over in July 2022. Nisha Proietti also joined as she is the Deputy Chair of the staff network. Nisha is also attending as a Diversity in Decision Making representative. During the year the following took place: • 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. **Plans for the next year:** • To support staff by providing cost of living and well-being workshops. • Provide better network understanding of what other services staff have access to such as the Recovery College, IAPT Services. • Be a point of contact for staff who might need employment support to be able to Survive and Thrive at Work and also be a source of support to those who are signed off on long term sickness. • To be involved in the staff Induction process encouraging new staff to declare protected characteristics. **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.	
22/61	Christian Staff Network David Heasman presented an update. During the year meetings have taken place during the year and feedback has been received in the following areas: *What aspects of your job do you find stressful?* • Workload: Impossible deadlines. • Admin / paperwork. • Lack of real engagement. • Disrespect for my professionalism. • Recruitment & Retention: constant staff changes. • Upheaval caused by EMP – moving team base. *What aspects of your job energise you?* • Supportive colleagues and line manager – pulling together during a crisis. • Informal connection with colleagues eg social occasions. • Supervision – adds to battery life.	

	• Being thanked. • CSN prayer times are refreshing – create time to reflect *What do you find challenging regarding living out your faith at work?* • Speaking about faith at work – feel afraid to mention it – fear of being misunderstood / being accused of not being politically correct; don't want to be seen to be imposing faith on others • Modelling Christ-like character can be challenging when feeling resentful, irritated or encountering 'difficult' people *What has been your experience of the CSN?* • Supportive, de-stressing; helps me recharge • I look forward to it – I always try and prioritise attending • Comforting to know its there even when I'm unable to make it • Encouraging, welcoming • Helps live out the Trust' values The membership is growing with increasing engagement (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. Philip Murray thanked David and Victor for their presentation and welcomed the next steps in welcoming new members to the staff network that will ensure the network is accessible to all.	
22/62	Women's Staff Network Emily Downey and Melissa Heath presented an update. During the year the following took place: • **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 are invited focusing on Women's Safety, Gender Pay Gap, Women's Health and Leadership & Development. • Membership is at approx. 150. **Plans for the next year:** • **28th September 2022** – network meeting focusing on Leadership & Development • **18th October 2022** – World Menopause Day, aiming to support launch of the Trust's first Menopause Policy	

	Challenges: • Capacity of co-chairs to further develop network e.g. more frequent meetings • Despite a large number of members (approx. 150) 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. Amy Scammell thanked Emily and Melissa as they have taken on being co-chairs. JK reflected on the importance of the Menopause Day as this is important as the Trust has a population that would benefit from more information on this subject. BB reflected that this is also being considered by the Medical Staffing workforce. The Committee heard that Men in Menopause is a topic for further exploration and information sharing.	
22/63	<u>LGBTQIA+ Staff Network</u> Andy Cohen presented an update and said this was his last meeting. Eduard Margarit will be taking over as the interim lead for this 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. **Plans for the next year:** • Increase growing the network as have over 60 members so far. • Improve on the Pride and Black Pride engagement. • Staff training to promote more inclusive language across the Trust and to include this in the Trust induction. • To develop the key areas for improvement and development of a Trust action plan. **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 stream lined. Jen Allan thanked Andy Cohen for his support he has given to the staff network and wished him well in his retirement. Eduard queried if the membership to the staff network is closed to only LGBTQIA+ staff however this was confirmed that anyone is able to be a member or ally.	
22/64	<u>Evolve Staff Network</u> Jacqueline Ewers presented an update and thanked Billy Boland for being the Executive Lead of the network.	

	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 Black Pride and 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. **Plans for the next year:** • Annual Staff Conference October 2022 **"I am not my hair"** • Black History Month Book Club - reading **Small Great Things** by Jodi Picoult with weekly discussion groups throughout October 2022. • Contribute to and support the Trust Anti-Racism Strategy. • Continue to support the Trust's Anti-Racism hub. • Monthly Staff Network Meetings & Weekly Core Group meetings. • Support the Trust Associate Director for EDI with the formulation and review of the WRES action plan and the Staff Survey action plan. • Continued Development of safe spaces to talk and reflect. • Keep our members informed on and engaged with Trust initiatives. • Run quarterly social events e.g., quiz nights. • Inaugural celebration of Africa Unity Day in May 2023. • Celebrate Windrush Day, South Asian Heritage Month and Black Pride. **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. VF thanked Jacqueline for her work to the Trust and for the involvement of Evolve working in a collaborative manner.	
22/65	Deaf Staff Network This presentation will be deferred to the December meeting.	

22/66	**WDES and WRES Annual Reports 2021** The Committee received the WRES and WDES Annual Reports for 2021. The following points were raised: *Workforce Race Equality Standard:* • 23% increase in BME staff in bands 8a-Very Senior Manager level. • 5.2% decrease in BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. • 4% decrease in BME staff experiencing harassment, bullying or abuse from staff in the last 12 months. • 13% in BME staff in the workforce since 2020s. • The likelihood of BME staff being appointed from shortlisting has increased as has the likelihood of white staff being appointed has decreased from 1.43 times in 2021 to 1.3 times in 2022. • There is a 30% gap between the percentages of the BME workforce and the BME board members. This gap needs to change and should be closer to 50%. • 35.2% of BME staff believe that the Trust provides equal opportunities for career progression/promotion compared with 55.3% of white staff. • BME staff are 7 times more likely to face formal disciplinary action than white staff. The Committee heard that the report has been received at the Executive Leadership Team and Evolve core group and comments have been incorporated in the updated version reported at the meeting. EH confirmed that the outputs from the action plan will support updates on the progress being made and will be reported through subsequent updates. The Committee was assured that EDI has an agreed set of actions already in place and these are being re-formatted to allow for greater accountability and assurance going forward. An update will be reported at the February meeting (**Action** (EH) *Workforce Disability Equality Standard:* • 8.3% of Trust staff have declared to having a disability compared to 3.7% nationally across all NHS Trusts. • 90% of staff have a declared disability, compared with 78.7% nationally. It is felt that this is attributed to staff involvement in the Diverseability Network. • There has been an increase of 2.9% of staff with a long term condition (LTC)/illness having experienced harassment, bullying or abuse at work. • There has been an improvement in staff (6.9%) with a LTC/Illness experiencing harassment , bullying or abuse from patients, service users, relatives or the public. • There has been an improvement (5.6%) in staff with LTC/Illness experiencing harassment, bullying or abuse from managers. • There has been a decrease in staff (8.9%) who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. • There has been a decline of 2% of staff with LTC/Illness saying reasonable adjustments have been made for them at work. The Committee heard that some staff with a sensory disabilities do not share the same opinion that there have been improvements in reporting and also not everyone has	**EH**

	made a declaration. It is acknowledged that more work is needed to support in managing the implementation process of reasonable adjustments. A query was raised concerning the WDES data over a three year period and staff involved in disciplinary proceedings as the combined percentage appears wrong. A request was made to ask for further work to be carried out to look at BAME staff involved in disciplinaries. In addition BAME staff in bands 1-5 is showing a decrease in staff in this metric. This metric would benefit from further exploring to determine if this is due to staff being promoted or leaving the organisation. There appears to be a difference in terminology as sometimes BME or BAME is used. It was confirmed that BAME is the Trust's agreed terminology. EH confirmed that a glossary of words will explain the terminology of using BME or BAME. The Committee **approved** the WRES and WDES and agreed for this to be reported to the Trust Board and added to the main website.	
22/67	**Committee Workplan** The workplans for both Workforce and Organisation Committee and Equality & Diversity Committees are being combined to ensure there is greater synergy. This will come to the December meeting **(Action**: KR)	**KR**
22/68	**Matters for the Board** A summary of the staff network presentations will be shared with the Board and confirmation of the approval of the WDES and WRES Annual Reports.	
22/69	**Meeting Review** The Committee reflected on the meeting and the following points were discussed: Doreen thanked all the networks for their tremendously informative presentations and apologies for the over-running of the meeting that did not make it possible for all the presentations to be received. It was agreed that the Deaf Staff Network presentation will take place in December.	
22/70	**Date of Next Meeting** The next meeting will be held on 1st December 2022 at 14:30-17:00 via Teams meeting	

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

Finance & Performance Committee

Minutes of the Meeting held on Thursday 27th October 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
Charlotte Clark (CC)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive (part)
Philip Murray (PM)	Director of Finance and Performance
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial Development

Attendees:

Debbie Hollinghurst (DH)	Deputy Director of Finance
Nick Worner (NW)	Associate Director: Commercial and Business Development
Clair Hartley (CH)	Committee Governance Manager (minutes)

Apologies:

Billy Boland (BB)	Medical Director
Jen Allan (JeA)	Chief Operating Officer
Dominique Zakkour (DZ)	Clinical Team Manager, CAMHS, NDT, DiDMR.

Item		Action
22/128	**Apologies** Noted as above	
22/129	**Declarations of Interest** No new declarations were noted.	
22/130	**Chairs Action** No Chairs Action have been taken.	
22/131	**Minutes of the previous meeting and Matters Arising** The minutes of the meeting held on 29 September 2022 were agreed as a true and accurate record.	
22/132	**Action Tracker and Matters Arising** The following items were discussed.	
22/132.1	22/117 - Cash flow A long-term base case financial model (LTFM) was being prepared over which the Tolworth business case options such as the 'do nothing' option, the 'four ward' option and the 'five ward' option would be overlaid. The LTFM includes a cashflow forecast incorporating the key cash drivers. The cash flow would be presented to FPC in November. No cash flow problems were expected, despite the £16 million shortage, caused by the delayed sale of Edward Wilson House, due to a slowing of expenditure on the Tolworth case and also Richmond Royal refurbishment. Problems might be experienced at the principal repayment date stage of the loan, but a clause negotiated in the loan agreement allows renegotiation of the repayment profile, particularly where linked to the EWH sale.	

Item		Action
22/132.2	2/117 – Energy savings Committee had asked for a report on any short- term energy measures introduced or planned to be more energy efficient to reduce the Trust's energy consumption. PM reported that an Estates update would be presented to the December meeting by Robin Bruce (RB), who had worked with AS on the Trust's Green Plan which was signed off recently. They were working on a heat decarbonization plan. RB would report on energy measures that had been Introduced and were planned in the future.	
22/131.3	22/120 - NHSE Grip and Control Review - Communication of financials to staff The self- assurance questionnaire asked how financials were communicated to staff. This was part of the grip and control action. It was decided at the last meeting that DZ's experience as a member of staff could be leveraged to canvass methods of communicating the Trust's financial metrics and financial position to staff. PM had scheduled a meeting with DZ. VS and DH would meet DZ thereafter. **Action**	**PM, VS, DH**
22/132.4	Update on performance was expected but PM reported that the paper had not been to QSAC yet. Once the paper was signed off by QSAC, the process would be broken down and narratives would be added to the dashboard which would be on the agenda for discussion at the November meeting.	
22/132.5	**PM** and **JA** were working together on the people scorecard / dashboard that was being developed for WODC so that there was some congruence. They were working to ensure that each section of the Q&P report read across to its subcommittee and was much more streamlined. This would make it easier to see where challenges and strengths lay through an EDI lens. They were working on bringing all information into the Master database, specifically in terms of the Workforce and OD subset so that the informatics and data analysis team could obtain all the information from the same place. Information for the HR recovery and particularly the recruitment and retention Incident action plan would also be incorporated.	
22/133	**Financial Report 2022/23 (Month 06 update) Part A** **PM** highlighted the following: In September, the Trust recorded a £0.02m surplus, marginally favourable to plan. The cumulative deficit remained at £1.4m, also marginally favourable to plan. In year to date, efficiency target underachieved by £1.2 million.	
22/133.1	Agency expenditure of £1.1m was £0.3m above plan. This was the highest monthly expenditure of the year to date and £0.3m more than the 2021/22 average.	
22/133.2	An increasing number of savings are moving into green, but unfortunately are non-recurrent. The cash balance at the end of the month was £36.4m compared with the plan of £25.5m.	
22/133.3	The Committee **noted** the Part A Finance Report.	
22/137	**Q2 Corporate Objectives**	
22/137.1	**AS** presented the Quarter 2 report on Corporate Objectives. She reported that delivery was good across most areas. There were some milestones which weren't entirely complete, but most things were progressing well. The Quarter 1 report was primarily focused on delivery of milestones. Quarter 2 onward would include data as it became available.	
22/137.2	ELT had discussed progress achieved against objectives set in April. Although the Executive team was committed to delivering the objectives, it was necessary to	

Item		Action
	consider extending some objectives to Q4 or to 2023. They considered accelerating progress by employing additional capacity. Executives needed to manage the scope of work and delivery of outputs tightly.	
22/137.3	The Committee • **Noted** the Q2 2022/23 delivery and identified key risks or issues to future delivery. • **Approved** onwards submission to sub-committees and the Trust Board.	
22/140	**CPB Terms of Reference**	
22/140.1	The Committee discussed the Terms of Reference.	
22/140.2	**JuA** asked whether the Head of Estates shouldn't be a member of the Board. **PM** explained that **DH** chaired the capital program Sub Board. Robin Bruce and Ben Fry, senior Capital Projects manager were members of the Sub Board. The detailed, granular discussions about individual capital programs happened in the subgroup. **DH** brought the analysis to the CPB. If they had real concerns about a particular project, they would invite the project manager or the overseer of the project manager into the CPB to account for that risk.	
22/140.3	**JuA** questioned the role of the Board in regard to assuring quality, both in terms of the learnings and sharing of good practice for capital programs, but also in the actual process, whether there was a stage gating type approach for Capital Programs. **PM** explained that the CPB's role was to oversee the capital program and ensure through its oversight that the right areas were targeted. **PM** said that the CPB had not been reviewing the quality of any individual program but expected rather that that would be part of the lessons learned of any significant capital program. Most of the Capital programs were relatively small.	
22/140.4	PM welcomed the challenge on Quality and said it would be considered at the next CPB. The Committee approved the terms of reference.	
22/141	**Committee Workplan**	
22/141.1	The following papers would be brought to the December meeting • National costs - would depend on receipt of information from NHSE • Estates update • Contracting. • Digital update The following particulars should be presented in each paper.	
22/141.2	• <u>Estates</u> ❖ Green agenda ❖ Energy efficiency.	
22/141.3	• <u>Contracting</u> ❖ Sodexo contract - have an independent person reflect on their experiences and provide feedback. ❖ Provide update on Sodexo's performance.	
22/141.4	• <u>Digital update</u> ❖ basic update on load that normally goes through arena. ❖ Signpost productivity opportunities or some significant digitisation opportunity where work is still done manually. ❖ Process and workflow in onboarding process to ensure that new joiners had access to laptops and software like Rio to ensure that that they are able to start work as soon as possible.	

Item		Action

- Help- desk performance.
- Opportunities to improve the process in terms of productivity and efficiency, workflow to speed the process up.
- General comment on broader BAU digital KPIs.
- People skills and capability perspective within the digital team - how Trust's IT staff's skill sets compared against staff in modern digital organisations, particularly around innovation and productivity and efficiency.

22/142 ANY OTHER BUSINESS

None.

22/143 Date of Next Meeting

The next meeting would be held on Monday 28 November 2022 by Microsoft Teams.

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

Finance & Performance Committee

Draft Minutes of the Meeting held on Monday 28th November 2022 at 13.00 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
Charlotte Clark (CC)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive (part)
Philip Murray (PM)	Director of Finance and Performance
Jen Allan (JeA)	Chief Operating Officer
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial Development
David Lee	Director of Corporate Governance
Attendees:	
Dominique Zakkour (DZ)	Clinical Team Manager, CAMHS, NDT, DiDMR.
Nick Worner (NW)	Associate Director: Commercial and Business Development
Clair Hartley (CH)	Committee Governance Manager (minutes)
Apologies:	
Billy Boland (BB)	Medical Director
Debbie Hollinghurst (DH)	Deputy Director of Finance

Item		Action
22/144	**Apologies** Noted as above	
22/145	**Declarations of Interest** No new declarations were noted.	
22/146	**Chairs Action** No Chairs Action have been taken.	
22/147	**Minutes of the previous meeting and Matters Arising** The minutes of the meeting held on 27 October 2022 were agreed as a true and accurate record.	
22/148	**Action Tracker and Matters Arising** The actions were discussed and updated.	
22/149	**Financial Report 2022/23 (Month 07 update) Part A** **PM** highlighted the following: • The Trust was reporting a forecast breakeven position for the year in line with plan. • The position for Month 7 was a £0.2m surplus improving the cumulative position to £.1.2m deficit, broadly on plan.	

Item		Action

- Underspends against Pay were offsetting overspends in non-pay driven by the unidentified savings target and external bed usage.
- The Trust continued to operate with agency costs higher than the plan and additional controls were in place to reduce agency costs. In October the Trust spent £1.0m on agency, a £0.1m reduction compared to September costs. Temporary bank costs also reduced and were £1.7m in October. The Trust must continue to reduce agency costs in line with national focus to improve quality and reduce premium agency costs.
- The Trust continued to attempt to reduce agency costs and deliver the required savings whilst maintaining appropriate quality and safety standards and ensuring there was no unacceptable detrimental impact on patient care.
- There were continual requests for increased hourly rates, but they had been able to negotiate reductions in some hourly rates or premiums charged by agencies.
- The high demand for beds and acuity of patients was continuing to result in high external bed costs and additional nursing costs.

22/149/1 The Committee discussed the following:

- Agency costs – Negotiating with some agencies for particular deals – There were not many agencies, it might not be the right time. With strike action pending, there might be a greater need for agencies. Discussions were being held with other Trusts around agency controls and negotiating points
- The Integrated Care Partnership Board (ICPB) had decided that workforce was its biggest priority. This would give some strategic oversight to the ICS over coming months.
- Progress with the three savings areas (agency, external beds and productivity) the Committee had chosen to focus on –whether any of these areas needed more support or effort or weren't moving quick enough. **PM** said that he didn't think that bringing in extra support would materially change the pace. The Community service line was behind plan due to a combination of conflicting priorities and annual leave. The finance business partner left, and a new person had started work. The community service line had the largest number of agency staff and were struggling to recruit permanent staff. It would take time for them to deliver on their action plan. They had persuaded a few agency workers to join permanent staff.
- Recruitment - There was a need to be more innovative. A large amount of effort had been put into recruitment and retention and would be supported by the Leadership Development plan. Turnover had been high in the middle management layer of Community Services which needed security and solidity.
- **JA** and others had been tasked with drawing up a plan for transformation of the Community Service and the Care Programme Approach (CPA) which would lead to a different type of workforce role. A report on progress on the plan would be submitted to the next meeting. **Action** **JA**

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

Item		Action
22/149/2	• The Committee discussed the solvency dashboard and questioned the reflection of the trading position, debtors, current liabilities, and forecast. • The Committee said that the dashboard was not helpful. • PM said that they were using the Monitor criteria to compile the dashboard. He would reflect on the dashboard and report back to the Committee. **Action**	**PM**
22/149/3	The Committee **noted** the part A Finance Report.	

22/153 Performance Report

JeA presented the report and highlighted the following:

They had established this overview of productivity performance to think about the target areas to enhance productivity to address those through the CIP program. A CIP workshop was planned next month to consider key areas of productivity improvement, being

- workforce productivity in the sense of skill mix redesign.
- operational productivity and I think that's where a number of these metrics will come in.
- Grip and control, particularly around agency spending.

VK proposed that the Committee look through the metrics in preparation for the workshop. The Committee discussed their response to a challenge that the Trust had extra staff compared with pre Covid but were less productive. Although the overall staff had increased that was connected to Community transformation, there hadn't been an increase in staff numbers in inpatient wards. Management costs had also escalated.

PM said that he had asked his team to break down how the situation had changed and link it to the different funding streams. The Trust had more staff, more beds, higher occupancy and increased acuity.

The Committee discussed the risk of discharging a patient prematurely versus the risk to the patient who was waiting to be admitted. Consultants might be more willing to discharge patients if there was a fast-track route back if they deteriorated.

The Committee discussed the metrics in the dashboard and considered possible questions and topics for consideration at the workshop.

The Committee decided

- that some of the productivity metrics should be quantified in terms of what the improvement would mean in cash terms.
- The metrics should show where there's variation either internally or next to a recent external benchmark,
- It should be indicated which committee specific actions were going to and when,
- A slot on digital solutions should be included.

The Committee **noted** the report.

Item		Action
22/154	**Committee Workplan** The finance papers would not be ready at the next meeting. **PM** would give a verbal briefing and the final reports would be sent to the Committee later for comment or observation and submitted to the Board in January. The Q& P report would be ready at the next meeting. The Committee would spend more time on the performance section in the new year. Work would continue on the three focus areas.	
22/155	**Meeting Review** Members thought there were good discussions about productivity. They felt that VS had chaired the meeting well and had a brilliant plan. There was good progress on agency.	
22/156	**Date of Next Meeting** The next meeting would be held on Thursday 15 December 2022 by Microsoft Teams.	

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

Meeting:	Trust Board
Date of Meeting:	12 January 2023
Report Title:	Part A - Finance Update 2022/23 Month 8
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 8 is a £0.2m surplus improving the cumulative position to £.1.0m 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 realignment of income and expenditure budgets to reflect the reversal of the national insurance increase.
- The Trust continues to operate with agency costs higher than plan and additional controls are in place to reduce agency costs. In November the Trust spent £1.1m on agency, a £0.1m increase compared to October costs, and reflective of increased high cost agency medics. Temporary bank costs also increased and were £1.8m in November. The Trust must continue to reduce agency costs in line with national focus to improve quality and reduce premium agency costs.
- The savings target of £12.4m has been devolved to service lines and schemes have been identified to achieve the full target. Cumulatively delivery is £8.5m, £0.3m ahead of plan. Recurrent saving identification remain an issue though did increase in month.
- All clinical service lines are reporting break even or better except for Acute Services and Corporate. Acute Services is reporting a cumulative £3.0m 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 £0.3m adverse position due to overspends in Estates and HR.
- Of the £28.4m 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 £13.0m is £3.6m less than plan due to phasing of construction costs on the Springfield site and slippage in implementation costs on the Tolworth Site until final approval is received. 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 has been informed that IFRS16 impacts will be managed centrally this financial year.

- The Trust has a £99m loan taken out in previous years to support the construction of the Springfield redevelopment. No repayment is required in 2022/23. Cash balances will be used to fund construction in 2022/23.
- At the end of November, the Trust had a cash balance of £39.8m. High cash balances are being accumulated in preparation for loan repayments.
- The two major concerns remain 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 cover sheet.

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
8 Months to November 2022 – part A

Meeting	ELT
Date of Meeting	December 2022
Report Title	Finance Report 2022/23 – 8 Months to November 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

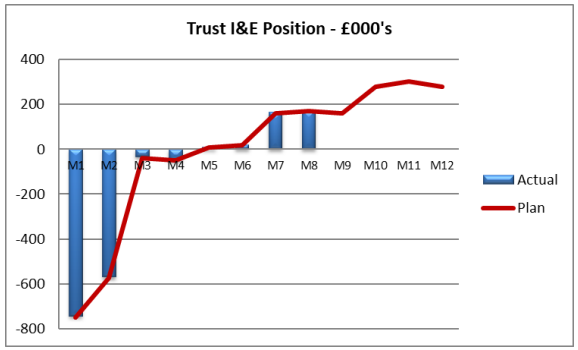
- In November, the Trust recorded a £0.2m surplus, marginally favourable to plan
- The cumulative deficit has reduced to £1.0m, also marginally favourable to plan
- The position fully reflects income flows agreed with South West London and other ICBs as part of 2022/23 contracting
- The expenditure position includes new year investments relating to MHIS and SDF. Unfunded pressures such as external bed usage and observation costs contribute to the current deficit
- The November position reflects the reductions in income and expenditure associated with the national reversal of the NI increase, and the allocation of additional SLP funding
- Further income is to be received in respect of Winter Pressures
- The forecast outturn is break-even in line with plan and requires a continued improvement in run rate during the remainder of the year. There remain significant risks associated with this.

Financial Reports 2022/23	Current Month			YTD month 8			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	21.6	21.587	0.0	173.0	172.0	(1.0)	258.0	258.3	0.3
Pay	(15.4)	(14.5)	0.9	(121.5)	(117.2)	4.3	(183.7)	(178.6)	5.1
Non Pay	(4.9)	(5.6)	(0.7)	(41.2)	(44.8)	(3.5)	(57.5)	(62.9)	(5.4)
EBITDA	**1.3**	**1.5**	**0.2**	**10.2**	**10.0**	**(0.2)**	**16.8**	**16.8**	**(0.0)**
Cap Charges - Depreciation	(1.0)	(1.0)	(0.0)	(7.7)	(7.7)	(0.0)	(11.5)	(11.8)	(0.3)
Cap Charges - Interest & Div	(0.4)	(0.4)	(0.0)	(3.4)	(3.4)	(0.0)	(5.1)	(5.1)	0.0
Interest	0.2	0.0	(0.2)	(0.2)	0.1	0.3	(0.2)	0.1	0.3
Post EBITDA	(1.2)	(1.3)	(0.2)	(11.3)	(11.0)	0.3	(16.9)	(16.8)	0.0
Underlying Surplus / (Deficit)	**0.2**	**0.2**	**0.0**	**(1.1)**	**(1.0)**	**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)	**0.2**	**0.2**	**0.0**	**(1.1)**	**(1.0)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**

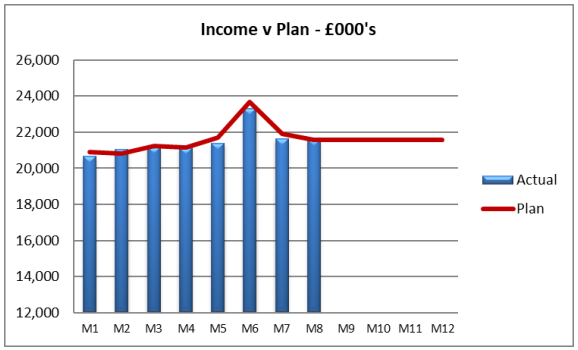
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

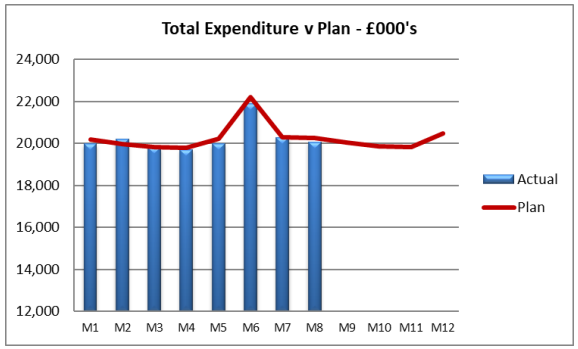
- Baseline surplus of £171k reported in month, £1k favourable to plan
- Cumulative deficit of £1,031k, £23k favourable to plan
- Deficit driven by external beds, Coral and Observation costs
- Profile reflects plan break-even submission to NHSE/I
- Significant risks to break-even position



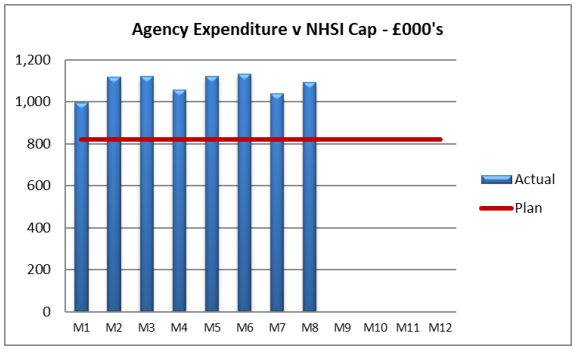
- Income received in month, £21.6m, in line with plan
- Reflects reduced funding in respect of NI reversal (£0.1m in month)
- Reflects SLP funding of legacy pressures (£0.2m in-month)
- Additional £0.2m expected for Winter Pressures



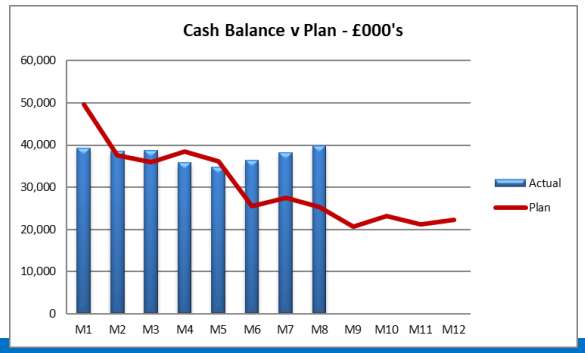
- Spend of £20.1m in month, £0.2m below plan
- External bed expenditure of £642k in month
- External Bed pressure continues into M9, currently funded by slippage
- Pay expenditure reduced by £0.1m due to NI reversal
- Changes in expenditure patterns due to EMP and Richmond Wellbeing expected from December



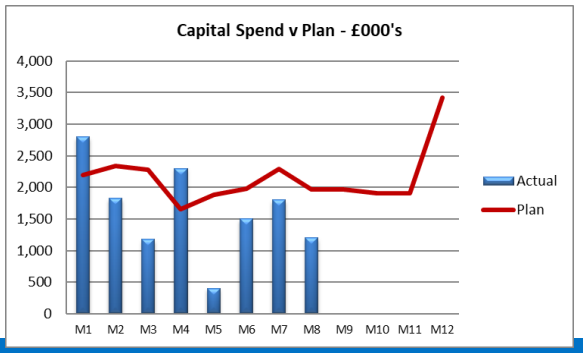
- Agency spend in month £1,092k, £254k above 2021/22 average spend
- £273k above plan
- Cumulatively, £2,112k above plan
- Community spend in M8 of £623k (57% of total)
- Cumulative Community spend now £4.3m (50% of total)
- Corporate spend of £88k in-month



- Cash balance at end of November £39.8m
- £14.5m favourable to plan
- Key drivers are capital underspends, creditors, and receipts
- Expected to equalize over the remainder of the year
- Cash balances required for loan repayment
- Loan repayments of £99m commence in 2023/24



- In month capital spend of £1.2m, £0.8m below plan
- Cumulative spend of £13.0m, £3.6m 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 8 the Trust reported £21.6m of income in line with plan, and cumulatively £1.0m adverse to plan
- All income budgets and actuals are fully reflective of the additional pay award funding received and subsequent reductions in relation to the NI increase reversal
- Local Contracts are £0.3m adverse variance. This is a phasing issue and will equalise over the remainder of the year
- NHSE income is, following the resolution of the £2.8m funding error, showing a broadly balanced position
- Education income is £0.2m favourable to plan due to additional salary replacement funding being received
- Other non-clinical income is £0.9m behind plan as planned income flows associated with complex care have yet to materialise. This is partially offset by an over-recovery on other NHS income as additional income from the SLP has now been agreed
- 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 8			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	16.2	16.3	0.0	130.5	130.2	(0.3)	195.7	195.7	0.0
Nhs England	1.7	1.7	(0.0)	13.3	13.3	(0.0)	20.0	19.9	(0.0)
Npsa Income	0.0	0.1	0.0	0.4	0.4	0.0	0.5	0.6	0.1
Provider Collaborative Income	1.8	1.8	0.0	13.6	13.6	0.0	20.0	20.0	0.0
Other Nhs Clinical Income	0.2	0.4	0.2	2.5	2.7	0.1	3.3	3.8	0.5
Nhs Clinical Income	**20.0**	**20.2**	**0.2**	**160.3**	**160.1**	**(0.2)**	**239.5**	**240.1**	**0.5**
Education & Training	0.7	0.7	(0.0)	5.3	5.5	0.2	7.9	8.9	1.0
Other Non Clinical Income	0.5	0.3	(0.2)	3.7	2.8	(0.9)	5.2	4.2	(1.0)
Merit Award Income	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.1	0.0
Non Clinical Income	**1.2**	**1.0**	**(0.2)**	**9.1**	**8.4**	**(0.7)**	**13.2**	**13.2**	**0.1**
Non NHS Clinical Income	0.4	0.4	(0.0)	3.6	3.4	(0.1)	5.3	5.1	(0.2)
Non Nhs Clinical Income	**0.4**	**0.4**	**(0.0)**	**3.6**	**3.4**	**(0.1)**	**5.3**	**5.1**	**(0.2)**
Income	**21.6**	**21.6**	**0.0**	**173.0**	**172.0**	**(1.0)**	**258.0**	**258.3**	**0.4**

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

Pay Position

- Pay amounted to £14.5m in November, £0.9m favourable to plan
- The in-month pay position is again suppressed by the release of provisions
- Medical Staff are now overspent by £0.6m due to continued and increased high agency and bank usage
- Despite continued acuity pressures, Nursing budgets are now showing a £0.3m underspend cumulatively
- Other Clinical Staff (principally Psychologists) have continued the trend reported in previous years and have returned a £4.9m cumulative underspend to date
- Non-Clinical staff are showing a £0.3m adverse variance due to agency usage, although this is now reducing
- Both budgets and actuals are reflective of the reversal of the NI increase

Financial Reports 2022/23	Current Month			YTD month 8			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.4)	(2.5)	(0.1)	(19.2)	(19.8)	(0.6)	(29.2)	(29.8)	(0.6)
Nursing	(6.5)	(6.4)	0.1	(51.8)	(51.5)	0.3	(77.8)	(78.4)	(0.6)
Other Clinical	(3.9)	(3.1)	0.8	(29.5)	(24.7)	4.9	(45.0)	(38.0)	6.9
Non Clinical	(2.6)	(2.5)	0.1	(21.0)	(21.3)	(0.3)	(31.6)	(32.3)	(0.6)
Total Pay	**(15.4)**	**(14.5)**	**0.9**	**(121.5)**	**(117.2)**	**4.3**	**(183.7)**	**(178.5)**	**5.1**

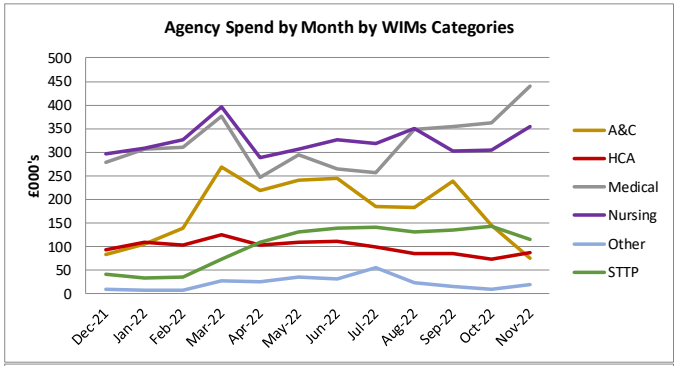
- Agency expenditure of £1.1m in November was £0.3m above both the Trust's plan and average 2021/22 monthly spend
- Bank expenditure was £1.8m, £0.1m adverse to plan. The cumulative position is now £0.9m above plan
- Permanent pay amounted to £11.5m in month. This was £1.3m favourable to plan due to continued vacancies and provision releases. Permanent pay is now £7.3m favourable to plan cumulatively with the underspend driven by Psychologist vacancies and provision releases

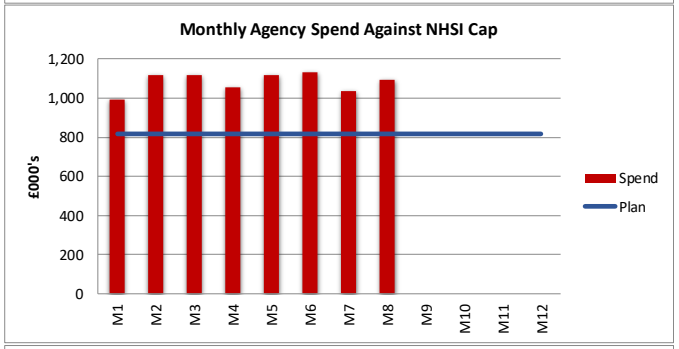
Financial Reports 2022/23	Current Month			YTD month 8			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(12.8)	(11.5)	1.3	(101.1)	(93.8)	7.3	(153.1)	(143.9)	9.2
Bank	(1.7)	(1.8)	(0.1)	(13.8)	(14.7)	(0.9)	(20.7)	(22.3)	(1.6)
Agency	(0.8)	(1.1)	(0.3)	(7)	(8.7)	(2.1)	(9.8)	(12.4)	(2.6)
Total Pay	**(15.4)**	**(14.5)**	**0.9**	**(121.5)**	**(117.2)**	**4.3**	**(183.7)**	**(178.6)**	**5.1**

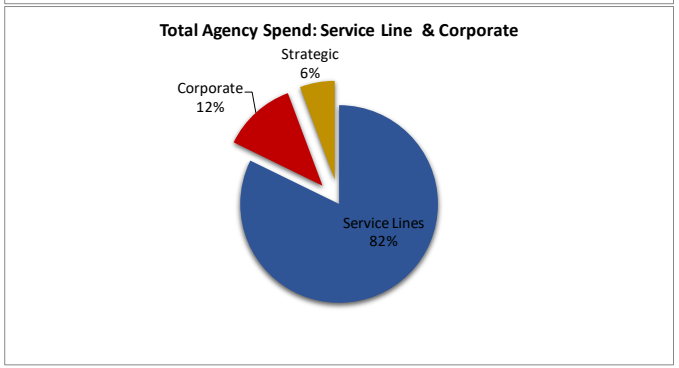
South West London and St George's Mental Health NHS Trust

Agency - in month and cumulative position

- Month 8 agency expenditure amounted to £1,092k
- Increase of £54k on Month 7 expenditure
- Equates to 7.5% of pay costs (7.4% cumulatively, 6.1% in 2021/22, London average 4.4%)
- Highest areas of monthly spend: Medical £440k, Nursing £354k, and Scientific £116k.
- Above the current plan by £273k in month
- The reduction in agency expenditure remains a Trust priority with Service Lines asked to identify exit strategies for all agency staff
- The key pressure area remains the Community Service Line; of the £1,092k total spend, £623k (57%) was incurred in Community. This represented an increase of £33k from October expenditure
- 82% of agency expenditure to date has been incurred within the Trust's 4 clinical service lines, with 12% relating to corporate areas, and 6% relating to agreed strategic investments
- Including strategic investments, cumulative Corporate expenditure has amounted to £1,539k for the first 8 months. This compares to £326k for the same period in 2021/22







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

Non-Pay & Post EBITDA

- Non-Pay expenditure amounted to £5.6m in month, a £0.7m overspend (cumulatively £3.5m)
- External bed expenditure amounted to £0.6m in November, £0.3m above plan. This position will continue to deteriorate in future months if usage does not reduce as budgets were based on reduced usage over the year
- Other costs are now cumulatively £1.8m overspent. This is spread across several areas including: soft FM costs, estates maintenance, property rentals and additional provisions made
- 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 (£4.2m) cumulatively

Financial Reports 2022/23	Current Month			YTD month 8			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Drug Costs	(0.2)	(0.2)	(0.0)	(1.5)	(1.5)	(0.0)	(2.2)	(2.2)	0.0
Clinical Supplies & Servs Cost	(0.0)	(0.1)	(0.0)	(0.4)	(0.4)	(0.0)	(0.5)	(0.5)	(0.0)
Secondary Commisioning Costs	(2.8)	(3.1)	(0.3)	(22.7)	(24.5)	(1.7)	(32.1)	(35.2)	(3.1)
Other Costs	(2.0)	(2.4)	(0.4)	(16.3)	(18.1)	(1.8)	(22.6)	(24.9)	(2.3)
Contingency	0.1	0.1	0.0	(0.3)	(0.3)	(0.0)	0.0	0.0	0.0
Total Non Pay	**(4.9)**	**(5.6)**	**(0.7)**	**(41.2)**	**(44.8)**	**(3.5)**	**(57.5)**	**(62.9)**	**(5.4)**

- Post EBITDA costs are now cumulatively £0.3m favourable to plan. This is as a result of the Trust capitalising interest payable in relation to the EMP loan
- The increase in depreciation budgets reflect the impact of IFRS 16 (detailed above)
- There are no asset sales expected in year. There are significant impairments anticipated in year, not yet quantified, following the completion of the two new hospital builds at Springfield. These impairments, whilst generating a deficit position for the Trust, are treated as below the line for financial performance monitoring by NHSE.

Financial Reports 2022/23	Current Month			YTD month 8			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)	(7.7)	(7.7)	(0.0)	(11.5)	(11.8)	(0.3)
Cap Charges - Pdc Dividend	(0.4)	(0.4)	(0.0)	(3.4)	(3.4)	(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	0.2	0.0	(0.2)	(0.2)	0.1	0.3	(0.2)	0.1	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	**(1.2)**	**(1.3)**	**(0.2)**	**(11.3)**	**(11.0)**	**0.3**	**(16.9)**	**(16.8)**	**0.0**

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 £3.0m cumulatively overspent as a result of acuity and external bed pressures. These are ongoing pressures that require continued central actions to mitigate
- CAMHS & ED is £2.1m underspent due to continued recruitment slippages
- Community is cumulatively £0.3m underspent. This is starting to reduce due to additional IAPT and agency expenditure. The forecast is being revisited in this light
- Specialist Services is £0.6m underspent as vacancies continue to outweigh CIP non-achievement and acuity issues in the Older Peoples wards
- The Corporate deficit is largely caused by adverse positions within the Estates and HR functions. The positive in-month movement is largely reflective of the release of provisions in line with plan
- The capital position is expected to break-even overall
- The forecast for the year remains 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 and continued capacity pressures

Financial Reports 2022/23	Current Month			YTD month 8			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	(3.9)	(4.4)	(0.5)	(31.6)	(34.6)	(3.0)	(47.0)	(51.3)	(4.3)
Camhs & Ed	(2.6)	(2.2)	0.4	(19.7)	(17.6)	2.1	(30.1)	(27.7)	2.4
Community (Adults)	(3.8)	(4.0)	(0.1)	(30.9)	(30.6)	0.3	(46.4)	(45.4)	1.0
Specialist Services	(2.7)	(2.6)	0.2	(21.0)	(20.3)	0.6	(31.7)	(30.7)	1.0
Corporate	14.4	14.7	0.3	113.5	113.2	(0.3)	172.1	172.0	(0.2)
Capital Costs	(1.2)	(1.3)	(0.2)	(11.3)	(11.0)	0.3	(16.9)	(16.8)	0.0
Total	**0.2**	**0.2**	**0.0**	**(1.1)**	**(1.0)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**

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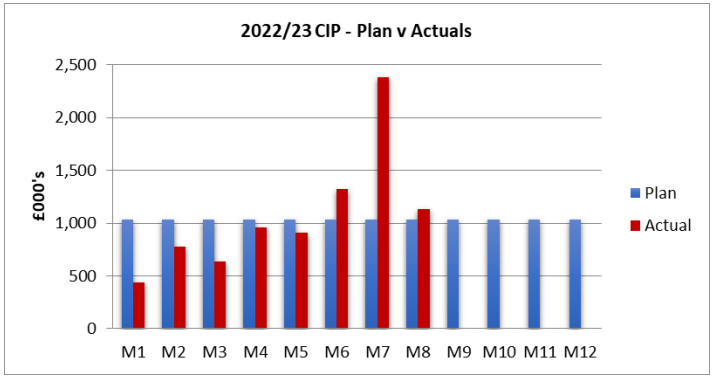
Savings

- 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
- Schemes have been identified to deliver the full target of £12.5m. The current level of identification means a theoretical over-delivery of £0.7m is possible.
- Once risk adjusted expected delivery falls to £11.8m, leaving a £0.6m shortfall (£1.2m last month)
- This gives a 95% confidence level in delivery – the equivalent value for M8 last year was 72%
- In month delivery amounted to £1.1m against a target of £1.0m – a £0.1m positive movement in month.
- Cumulative delivery now stands at £8.5m against a plan of £8.2m - £0.3m positive
- Despite positive recurrent movements during the month, a significant majority of savings delivered to date are non-recurrent
- The challenge facing the Trust remains to
  - Turn red and amber schemes to green, and,
  - To significantly reduce the reliance on non-recurrent schemes and reduce the potential opening deficit for 2023/24

Status	2022/23 £000's	Risk Level %	Expected £000's
Green - Rec	3,691	0%	3,691
Green - Non-Rec	7,612	0%	7,612
Amber	254	50%	127
Red	1,534	75%	384
Unidentified	-704	100%	0
Total	**12,387**	**95%**	**11,814**

Gap	**-574**



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	1.6	0.8	0.9	14.0	10.4	3.6	21.9	21.9	0.0
Estates Maintenance	0.2	0.3	(0.1)	1.3	1.3	(0.0)	1.9	1.9	0.0
IT/Digital	0.2	0.1	0.1	1.3	1.3	0.0	2.0	2.0	0.0
Operational Total	2.0	1.2	0.8	16.6	13.0	3.6	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**	**1.2**	**0.8**	**32.0**	**28.4**	**3.6**	**41.2**	**41.7**	**(0.6)**

- The Trust is forecasting to spend £41.7m, including £16.0m on leases which are 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 in December. Once this value has been confirmed the Trust will be seeking a CRL budget uplift to offset.

- Capital expenditure for the month is £1.2m (£0.8m below the monthly plan); £28.4m cumulatively which is £3.6m below plan

- The Estates Modernisation Programme (EMP) is underspent by £3.6m year to date (£0.9m in the month) due to the continued delay in construction and handover of the buildings at Springfield, along with pausing works at Tolworth whilst awaiting DHSE approval. 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 November 2022	Actuals as at end November 2022	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	7.3	6.4	(0.9)
Plant, Property and Equipment	345.0	346.5	1.5
Receivables	26.7	26.7	0.0
Total Non-Current Assets	**379.1**	**379.7**	**0.6**
Total Non-Current Assets Held for sale	**0.0**	**0.0**	**0.0**
CURRENT ASSETS:			
Inventories	0.2	0.2	0.0
Receivables due in less than 1 year	5.7	5.7	0.0
Other Financial Assets (Accrued Income)	1.6	2.3	0.7
Prepayments	0.0	1.9	1.9
Cash and Cash Equivalents	25.3	39.8	14.5
Total Current Assets	**32.8**	**49.9**	**17.1**
CURRENT LIABILITIES:			
Trade Payables	(34.2)	(16.8)	17.4
PDC Dividend Payable	(0.0)	(0.9)	(0.9)
Capital Payables	(28.0)	(27.4)	0.7
Provisions	(4.4)	(4.2)	0.2
Other Financial Liabilities (Accruals)	0.0	(30.2)	(30.2)
Deferred Revenue	(2.6)	(7.4)	(4.8)
Total amounts falling due within one year	**(69.3)**	**(86.8)**	**(17.6)**
NET CURRENT ASSETS/(LIABILITIES)	**(36.5)**	**(36.9)**	**(0.5)**
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	**236.5**	**236.5**	**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	(1.0)	(1.0)	(0.0)
Revaluation Reserve	64.6	64.6	(0.0)
TOTAL TAXPAYERS EQUITY	**236.5**	**236.5**	**0.0**

- Receivables stand at £5.7m, in line with plan.
- Cash is £39.8m, £14.5m more than plan, see next slide.
- Late receipt of invoices is resulting in a £17.4m favourable variance on Trade Payables offset by a £30.2m 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

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

Cash

All figures £k

	Plan as at end November 2022	Actuals as at end November 2022	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	2,893	2,866	(26)
Non Cash Adjustments			
Depreciation and Amortisation	7,727	7,790	63
Interest Received	(8)	(340)	(332)
Interest Paid	0	(185)	(185)
(Increase)/Decrease in Inventories	0	0	0
Increase/(Decrease) in Working Capital	367	6,134	5,767
Net Cash Inflow/(Outflow) from Operating Activities	**10,979**	**16,266**	**5,287**
Cash Flows from Investing Activities			
Interest Received	8	339	331
(Payments) for Property, Plant and Equipment	(31,984)	(24,582)	7,402
Proceeds from sales of property, plant and equipment	0	0	0
Net Cash Inflow/(Outflow) from Investing Activities	**(31,976)**	**(24,243)**	**7,733**
Net Cash Inflow/(Outflow) before financing	**(20,997)**	**(7,977)**	**13,021**
Cash Flows from Financing Activities			
Interest element of finance lease	(520)	(185)	335
PDC dividend (paid)/refunded	(2,571)	(1,436)	1,135
Net Cash Inflow/(Outflow) from Financing Activities	**(3,091)**	**(1,621)**	**1,470**
Net Increase/(Decrease) In Cash And Cash Equivalents	**(24,088)**	**(9,598)**	**14,490**
Cash / Cash Equivalents at beginning of month	**49,403**	**49,403**	**0**
Cash / Cash Equivalents at end of month	**25,315**	**39,805**	**14,490**

- The cash balance at the end of the month was £39.8m compared with the plan of £25.3m.
- The increase of £14.5m relates to:
- Capital spend, +£7.4m (of which £3.4m relates to the Care Home purchase provided for in 21/22 and not yet completed, along with other capital underspends)
- Movements in working capital, +£5.3m driven largely by late receipt of invoices
- PDC Dividend,+£1.1m
- Other £0.7m
- 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 Actual £'000	November Actual £'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	38,210	39,805	34,989	30,963	28,650
Receipts												
SLA Income	18,230	18,615	19,986	20,901	17,659	20,058	18,935	20,351	20,035	20,035	20,035	20,369
Other NHS Income	2,111	1,035	2,816	861	609	6,864	1,300	1,580	2,940	778	778	824
Other income	584	337	327	455	2,469	86	448	692	248	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**	**20,683**	**22,623**	**23,224**	**21,064**	**21,064**	**26,203**
Payments												
Payroll costs	(12,936)	(13,189)	(13,536)	(13,070)	(13,198)	(14,546)	(15,309)	(14,099)	(14,677)	(14,615)	(14,615)	(14,629)
Suppliers (Revenue)	(8,280)	(4,111)	(6,293)	(10,319)	(4,913)	(8,843)	(2,590)	(4,711)	(8,007)	(6,363)	(6,363)	(6,244)
Suppliers (Capital)	(1,254)	(562)	(1,572)	(557)	(2,719)	(621)	(526)	(945)	(260)	(325)	(326)	(326)
Suppliers (EMP)	(6,565)	(2,783)	(1,296)	(1,165)	(835)	(63)	(257)	(1,174)	(1,641)	(3,786)	(2,073)	(3,333)
Asset Purchases	-	-	-	-	-	-	-	-	(3,425)	-	-	-
Other Non Pay Costs	(110)	(63)	(67)	(89)	(93)	(78)	(150)	(98)	(30)	-	-	-
PDC Dividend	-	-	-	-	-	(1,135)	-	-	-	-	-	(4,007)
Loans & interest	-	-	-	-	-	(185)	-	-	-	-	-	(178)
Total Payments	**(29,145)**	**(20,707)**	**(22,764)**	**(25,201)**	**(21,757)**	**(25,471)**	**(18,832)**	**(21,028)**	**(28,039)**	**(25,089)**	**(23,377)**	**(28,716)**
Net Receipts/ (Payments)	**(8,220)**	**(721)**	**364**	**(2,985)**	**(1,020)**	**1,536**	**1,852**	**1,595**	**(4,815)**	**(4,026)**	**(2,313)**	**(2,512)**
Bank Balance c/f	**39,183**	**38,463**	**38,827**	**35,842**	**34,822**	**36,358**	**38,210**	**39,805**	**34,989**	**30,963**	**28,650**	**26,138**
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	31,210	32,805	27,989	23,963	21,650	19,138

- 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.