Trust Board - Part A

08 September 2022 01:30 PM - 04:00 PM London Standard Time

Agenda Topic			Presenter	Time
1.	Patient Story			01:30 PM-02:00 PM
2.	Standing Items			02:00 PM-02:05 PM
	2.1	Apologies		
	2.2	Declarations of Interests and Register		
	2.3	Chair's Action		
	2.4	Minutes of the previous meeting - 14th July 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	Vik Sagar	03:00 PM-03:10 PM

	7.2	Finance Report	Philip Murray	03:10 PM-03:20 PM
	7.3	Audit Committee chair's report	Richard Flatman	03:20 PM-03:30 PM
	7.4	Estates Modernisation Committee chair's report - verbal update	Juliet Armstrong	03:30 PM-03:40 PM
		7.4.1 Green Plan	Amy Scammell	03:40 PM-03:50 PM
8.	Notified Questions From The Public and Staff			03:50 PM-03:55 PM
9.	Meeting Review			
10.	Next Meeting - Trust Board 10th Nov 2022 - 1.30pm-4pm - Conference Room, Trinity Building			

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

AGENDA

Meeting	**Board of Directors**
Time of Meeting	**1.30pm to 4.00pm** **Please note revised start time**
Date of Meeting	**Thursday 8th September 2022**
Location	**FACE TO FACE MEETING** **Conference Room G, Springfield Hospital, Glenburnie Rd, London SW17 7DJ**

	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 14th July 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**	**14:25**
5.	**MAKING THE TRUST A GREAT PLACE TO WORK**				
	5.1. Workforce and OD Committee chair's report	**FR**	**Paper**	**SA**	**14:40**
6.	**REDUCING INEQUALITIES**				
	6.1 Equality and Diversity Committee chair's report	**FR**	**Paper**	**DM**	**14:45**
	BREAK				**14:50**
7.	**ENSURING SUSTAINABILITY**				
	7.1. Finance and Performance Committee chair's report	**FR**	**Verbal**	**VS**	**15:00**
	7.2. Finance report month 3	**FD**	**Paper**	**VS**	**15:10**
	7.3. Audit Committee chair's report	**FR**	**Paper**	**RF**	**15:20**
	7.4. Estates Modernisation Committee chair's report	**FR**	**Verbal**	**JuA**	**15:30**
	7.4.1. Green Plan	**FA**	**Paper**	**AS**	**15:40**
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 10th Nov 2022 – Conference Room A, Ground Floor, TRINITY BUILDING, Springfield Hospital **NEW LOCATION**				

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 Trust Secretary

Apologies:

*=non voting

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

Trust Board

September 2022

Paper Reference:	
Report Title:	Service User Story
Executive Summary:	The Service User Story for September 2022 is being presented by Russell (father of late service user Hannah) who will share the experience of his wife and family in regard to the care and treatment they received from the Sutton and Cheam Integrated Recovery Hub (Previously know as the Recovery Support Team). Russell is attending the Board meeting with his wife Akiko. Their experience highlights the importance of involving families and carers; including providing relevant verbal and documentary information around diagnosis and the various treatment options. Trust policies remain clear on the value that families bring to collaborative care planning with service users. Equally, the value to families of having access to relevant information and answers about medication and/or symptoms. Collaborative engagement and communication approaches during the continuous assessment and care planning processes ensure that care is individualised. This is through incorporating a service users background and spirituality into the care interventions based on the collateral information from families. The aim is to ensure that there is a balance between information exchanged by services with families around care, risk management and treatment interventions, and the individual needs of the service user and carers, in order for the care given to remain person centred. Sutton and Cheam Integrated Recovery Hub (RH) is a mental health service that provides recovery interventions to adults in the community, presenting with mental health needs. The service is for adults aged between 18 and 75 years of age who reside in the borough of Sutton. The team provides care and treatment planning and clinical risk assessment, care co-ordination (where indicated), therapeutic and psychiatric interventions to individuals. The care and treatment plans and interventions focus on a multidisciplinary approach to health, care and support needs. The Community Service Line has achieved great strides over the past year through the implementation of improvement action plans. This has been further strengthened by the Trustwide Community Transformation Programme implementation which has involved stakeholders and evidence that service user and carer views have formed key

	aspects of the improvements to the service delivery pathways. The service objective is to achieve the best possible clinical and social outcomes for the individual and the family/support network; that is aligned with evidence-based research into mental health care provision. There will be oral presentations from: • Russell and Akiko (Hannah's father and mother) Attending will also be: • Community Service Line Management • Sutton and Cheam Integrated Recovery Hub (IRH) – Heidi Philips, Team Manager, Kiran Toora, Clinical Manager, Dr Peter James, Consultant Clinical Psychologist; James McNally, Advanced Clinical Practitioner. The presentations emphasise the importance of family involvement, information provision (both verbal and documentary) around personal and family beliefs, spirituality, mental health diagnosis, medicines information including reducing access; and the Trust work on sharing learning through the Service Lines and as part of the Suicide Prevention strategy. Consent – Please note that consent has been provided to refer to the family using first names in the written story but during the Board meeting Hannah's father has expressed a preference to be referred to as Mr Gough, which should be respected. Hannah's mother Akiko will also be in attendance. -Rights are reserved for Mr Gough to make any changes to his consent at any time.
Action Required:	The Board is asked to note the Service User Story relating to Sutton and Cheam Integrated Recovery Hub (IRH) – which was a Recovery Support Team (RST) at the time of the care episode from the Community Service Line.
Link to Strategic Objectives:	The Trust launched its five year Trust Strategy in 2018. The strategy 2018 – 2023 includes four strategic ambitions: • **Increasing quality years -** Quality Improvement and Innovation • **Reducing inequalities -** Service users and carers co-production • **Making the Trust a great place to work -** Staff underpin all that we do • **Ensuring sustainability -** Transformation These ambitions move the Trust to focus on outcomes, not processes and are held together by the mission – Making Life Better Together – which is at the centre of the Trust's work. This story links to all our strategic ambitions as the Trust recognises that the views of our service users and

	carers/families/external agencies must not only be sought but evidenced to demonstrate that actions have been taken. The Trust promotes service review and improvement, which is effective through collaboration with service users, families, support networks/agencies and staff working in the services.
Risks:	None
Quality Impact:	Patient Experience is a domain of the Quality Strategy.
Resource Implications:	Russell and Akiko's attendance in person has been facilitated through the Quality Governance Department.
Legal/Regulatory Implications:	None.
Equalities Impact:	The Board is asked to note how services incorporate the personal and spiritual beliefs of those who use our services into collaborative care planning.
Groups Consulted:	Oral Presentations – by:- Service Users' father. Service Users' mother may also contribute. Service Line Management Service Leads and Clinicians Trust Pharmacy Quality Innovation and Improvement (QII)
Author:	Brenda Ndiweni, Experience and Governance Lead
Owner:	Sharon Spain, Executive Director of Nursing and Quality

Making life better together

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Sutton and Cheam Integrated Recovery Hub Community Service Line

September 2022

Background

This month's patient story to the Board is being presented by Russell, a carer for Hannah, who will share his family's experience of the Trust's Sutton and Cheam Integrated Recovery Hub (previously Recovery Support Team). This will give an insight to the care and treatment they have received.

Their story will highlight care pathways, medications, patient engagement and the importance of involving families in collaborative interventions, verbal and documentary communications and carers support.

Recovery Approach in the Community

Working with service users using the recovery approach that emphasises:

- Return to their full potential in day-to-day life
- Treatment and support directed towards fostering hope, enabling people to take back control over their lives, their problems, and the help they receive as far as possible and helping them to identify and access the opportunities they value.
- A team culture that fosters hope and raises expectations.
- Co-creation of understanding and shared decision making.
- Promoting the needs of people with mental health problems and reducing the stigma associated with mental health care.
- Actively involving service users and carers in the planning and delivering of Mental Health services.

Sutton and Cheam Recovery Support Team (RST) - now Integrated Recovery Hub (IRH)

The Sutton and Cheam Recovery Support Team provides mental health services to adults in the community, presenting with mental health needs. The service is for adults aged between 18 and 75 years of age who reside in the borough of Sutton.

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

Patients are placed on either standard care or Care Programme Approach (CPA) care. A collaborative care plan is agreed with the patient and family involved, as dependent on the consent provided by the patient, for information to be shared with their identified loved ones.

The team is comprised of a range of professionals, including medical, nursing, social work, occupational therapy, psychology, pharmacy, employment specialist and support workers, who seek to assess, treat, monitor, evaluate and progress to safe and effective discharge where possible back to Primary Care settings.

This approach is in accordance with the Health and Social Care Act (2012, DOH), The NHS 5 year forward plan for Mental Health (2016, DOH) and the NHS 10 year plan (2018, DOH) which explicitly states the priority for Mental Health care.

Care Programme Approach

The Care Programme Approach (CPA) provides a framework for care of people with mental health problems.

The term Care Programme Approach (from October 2008) describes the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics.

All patients offered treatment by the Integrated Recovery Hub are allocated a care co-ordinator as required by the Care Programme Approach, or a lead professional for non-CPA. Patients. patients assigned to CPA will be reviewed in accordance with the intervals specified in their Care Plan.

Russell's Story

Experience of mental health services whilst Hannah was under the Sutton and Cheam RST:

Writing this hasn't been easy because I've had to reflect on my own beliefs and opinions about the NHS approach to improving health and my own thoughts. As a religious believer, I'm familiar with the biblical verses describing the healing of the "possessed" by Jesus and his followers and so have felt that there are many aspects to the healing of a person, not just attributed to the physical. I know this is not in line with the scientific approach of modern medicine or the mental health approaches the NHS adheres to, as far as I'm aware but I think it should be considered when dealing with families, many whom hold strong religious views and be clear on how they view mental health.

I'm grateful for the support that the NHS supplied over the period of Hannah's illness. There are, however points which I feel can be improved upon.

On our first consultation with the trust at the Jubilee Health Centre in Wallington, we were assured that through the correct medication and therapies, Hannah would

Russell's Story: continued

be able to manage her condition and live a fairly normal life, continuing her studies and getting married/starting a family, etc. I think that gave us, as parents, a false sense of security. I believe we could have had the reality of her condition explained better and the two roads it could go down.

The confidentially issue also didn't help. We felt that we were excluded as part of the "care team" and weren't consulted enough. We know the law favours the rights of an individual but as her parents, we only is done on a trial-and-error basis, had her best interests in mind. She missed many appointments which we weren't aware of but could have supported her to attend if we were.
I understand that finding the right medication for sufferers however, I'm not sure how much reassurance was given about this process to Hannah. As a consequence, she wanted to come off the medications because of their side-effects or ineffectiveness.

When Hannah did attempt to end her life, we were given little guidance on how to speak with her and deal with suicidal ideation. I've since discovered there are definite ways to council those contemplating suicide. In line with this, I didn't feel the questioning by the home crisis teams really enabled Hannah to reveal why she was suicidal or her inner reality. The questioning largely required yes/no answers.

Hannah had a crisis plan in place but I wasn't aware that she rang anyone for help. I think there should be more ways to help sufferers express what they're going through. On one occasion, when Hannah was having a manic episode, she was admitted to a mixed ward at Queen Mary's Hospital in Roehampton.

This didn't help because she had male residents approaching her and entering her room. Things happened whilst she was in a sexually aroused state (a documented phenomenon when manic), which she later regretted.
Also, she was recommended to visit the hospital on a voluntary basis, only to be sectioned after she'd been there a couple of days. I feel we were misled in this regard.

On the plus side, we were able to contact and receive support from the home care teams at short notice. I was also able to speak privately to her consultant in Wallington and ask questions on several occasions.

I did feel her care-coordinators were trying their best to help Hannah but her last one Staff A told me she had little experience with patients who'd had multiple suicide attempts. Also, Staff B, one of the home visit team, when asked, was surprised how long Hannah had been in a low mood state. About 6 months. Is that normal?

Russell's Story: continued

I don't want to seem over-critical because I can see that Bipolar 1 disorder, in particular, is a severe illness and our own views on a more "spiritual" means of healing may have coloured Hannah's own thinking, causing her to engage less with the treatments offered. Going forward, apart from the specific points of care outlined above, I think the Trust should consider faith-based beliefs and how such patient's see their own healing process. Once acknowledged, the patient may engage more with the treatment. I must admit for our own part, we had shortcomings in our own approaches and I think Hannah lost hope in the space in between.

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

What Has Been Done

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

Next Steps and Way Forward

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

"I express my sincere thanks to Hannah's family for sharing their experience of our services despite the emotional challenges of reflecting on Hannah's death. I am extremely grateful to our carers, as without them, out staff and teams would be unable to effectively deliver safe and individualised interventions to our service users.

We continue to ensure that effective systems are in place for families and carers to voice their views and challenge us on the areas that we can improve on.

The Community Service Line has been progressing a Community Transformation Programme over the last three years by closely monitoring and reviewing the systems in place through our service line leadership forums and patient and carer council forums, to ensure that service delivery is improved to align with to modern ways of working; whilst strongly incorporating the views of those who use our services and are at the heart of what we do, our service users and families/carers.

A pilot commenced in Sutton around Integrated Care, with Sutton and Cheam now known as the Sutton and Cheam Integrated Recovery Hub.

We remain open to further feedback, opportunities to learning but more importantly to evidence that we are embedding the learning identified through staff training and development, adhering to our Trust values and to continue a culture of openness and effective communication. "

Presentations:

Carer for deceased: Russell

Service user: the late Hannah

Sutton and Cheam IRH:
Heidi Philips, Team Manager
Dr Peter James, Consultant Clinical Psychologist

Service Line:
Kiran Toora, Clinical Manager
Paula Robins, Head of Nursing and Quality

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

Draft minutes of the meeting held on Thursday 14th July 2022

Present:

Ann Beasley (AB)	Chair
Professor Deborah Bowman (DBo)	Vice Chair, SID and Non-Executive Director
Vik Sagar (VS)	Non-Executive Director
Sola Afuape (SA)	Non-Executive Director
Charlotte Clark (CC)	Non-Executive Director
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
Jenna Khalfan (JK) – Non - voting	Director of Communications and Stakeholder Engagement
Amy Scammell (AS) – Non-voting	Director of Strategy, Transformation and Commercial Development
Sharon Spain (SS)	Director of Nursing and Quality
Katherine Robinson (KR) – Non-voting	Director of People
David Lee (DL) – Non-voting	Director of Corporate Governance

In attendance:

Nicola Mladenovic (NM)	Deputy Trust Secretary (minutes)
Martin Haddon (MH)	Healthwatch Wandsworth

For item 22/60

Jacqueline Ewers (JE)	Experience and Governance Lead
Heleni- Georgia Andreadi (H-G A)	Head of Service at the Prudence Skynner Family and Couple Therapy Clinic

Apologies

Doreen McCollin (DM)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Juliet Armstrong (JuA)	Non-Executive Director

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

Item		Action
22/60	**Patient Story** SS introduced and welcomed Jacqueline Ewers from the Experience and Governance team and Heleni-Georgia Andreadi (H-G A) from the Prudence Skynner Family and Couple Therapy Clinic. J and M were not present however H-G A provided their update. J and M are former patients of the Trust's Couples Therapy Clinic Service based in Kingston and came to the service one year ago. M experienced anxiety after being sexually assaulted. Giving birth brought back flashbacks of her assault, leading to some self-harming behaviour, depression and two admissions to a Mother and Baby Unit after giving birth. After attending Dialectical Behavioural Therapy (DBT) M suggested that they both attend Couple's Therapy. At the time of therapy their daughter was two years old. The therapy has had a good outcome and the couple	

Item **Action**

do not feel their relationship would have succeeded if this did not take place. J and M are keen to help others who have been in the same situation as them.

The Board also heard about the Community Network for Family Care. Work between the clinic, the Wandsworth Community Empowerment Network and the leaders of Black Majority Churches and the Muslim Network began in 2009, recognising the over representation of Black men and women and increasing number of people from the Asian population in tertiary adult mental healthcare. The clinic is working with Wandsworth EMHIP to reduce inequalities in access, experience and outcome of mental health care and are currently in the process of developing a two-year programme for the EMHIP project in Croydon.

The Board asked for their thanks to be passed to J and M as they were not able to attend today.

22/61 **Apologies and Welcome**
Apologies were received and noted from DM, RF and JuA.

22/62 **Declarations of Interest**
No new declarations were raised

22/63 **Chair's action**
The Chair and CEO, as authorised by Audit Committee, signed off the final version of the Annual Report and Accounts in order for these to be published on the Trust website and submitted to NHS E/I.

22/64 **Minutes of the last meeting**
The minutes of the meeting held on 12th May 2022 were agreed as a correct record with the following amendment to item 22/47, 2nd para:

> *SS assured the Board about compliance which confirmed that the teams were confident to comply with the Mental Health Units (Use of Force) Act 2018.*

22/65 **Action Tracker**

I**tem 22/27 – Q&P Report.** FPC to consider the question of how best to report productivity and efficiency performance to the Board's committees. This will come back to Board in September
Item 21/136 – Charitable Funds Committee chair's report –included on the agenda
Item 22/39 – Patient Story – review of arrangements if a patient accessed private care. BB confirmed that clearer guidance is now available to support staff in managing this going forward - Closed
Item 222/59 – Questions from the members of the public - Martin has received the Fundamental Standards of Care. SS will forward the Quality Plan directly to Martin.

22/66 **Chair's report**
The Board received and noted the report. AB reflected on the great work that Trust staff continue to carry out in difficult circumstances including the increased acuity of patients. The Street Parties were well received by all staff on both sites.

AB attended the BeWell hub interfaith event held in Kingston.

Item		Action

The Board noted the report.

22/67 Chief Executive's report

VF presented her report and highlighted the following:

- Katherine Robinson, Director of People was welcomed in her new substantive role.
- The Avalon Ward specialist eating disorders service CQC report has been published. Much work has gone into improving the service which has now moved from 'requires improvement' to 'good.' All five domains were rated good.
- Wisteria Ward will move into their new accommodation from the end of this month
- 40 staff attended the Pride event and also two Street Parties have been held.
- EMP move timescales have been finessed to ensure staff and services are able to safely move locations.
- Integrated Care System – both AB and VF attend the Integrated Care Board and Integrated Care Partnership.
- The increasing cost of living is impacting on our patients, their carers and our teams.

The Board noted the CEO report.

22/68 Quality and Safety Assurance Committee chair's report

The Board received the chair's report covering the May meeting. In particular the following points were reported:

- A report has been received on the recurring themes from Root Cause Analysis investigations and an analysis of these investigations has been undertaken to ensure risk areas are considered. The Learning Bulletins are being well received however the impact of the bulletins needs to be explored further.
- The work of Quality Improvement and Innovation has been developed and continues to have a demonstrative impact in supporting teams to improve their productivity and manage change.
- The Patient Experience Annual Report was received which included some benchmarking information.
- QSAC met in June and July. There is a strong focus on the findings of the Quality and Performance Report. The impact of increased acuity in workload is notable
- The committee has trialled a "starred item" approach to prioritise the agenda, to make space for fuller discussion on strategic assurance issues. This has working well to date.

The Board noted and received:

- the QSAC Chair's report.
- the minutes of the January to June minutes of the QSAC meetings.
- Committee Annual Report.

22/69 Quality and Performance report

The Board received the Quality and Performance Report and JeA raised the following:

- There has been a stabilisation and improvement in patient safety performance.
- A root cause analysis approach is to be commenced to understand where there are performance deficits to identify areas where changes in practice or approach can be implemented. This work will be undertaken over the next two months.

Item		Action

The Board noted 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. **(Action : JeA)** **JeA**

The Board noted the Quality and Performance Report.

22/70 Workforce and OD Committee chair's report

The Board received a verbal update from SA. The following points were highlighted:

- The HR Recovery Plan was received and discussed at the last committee.
- The Board Assurance Framework workforce risk is being updated to include a greater amount of detail.
- In terms of performance there will be increasing committee oversight of key metrics and this is now starting to show improvements as 'green shoots.'
- In terms of culture there is an overlap between this and the Equality and Diversity Committee and this will be worked through.

It was reported that the HR services will separate from being joint with SLaM from September 2022.
VF advised that the first cohort of Team Leaders Development has concluded and a second cohort of the Leadership Programme has commenced this week.

The Board noted the verbal report and minutes from 22nd March 2022.

22/71 Equality and Diversity Committee chair's report

The Board received a verbal update from SA. The following points were highlighted:

- SA chaired the meeting in DMc's absence.
- Differences have been noted between the reports from the staff survey and updates from the Staff Network chairs. The newly appointed EDI Associate Director will support the co-ordination of updates.

The Board noted the update, Committee Annual Report and minutes from 21st April 2022.

22/72 Diversity in Decision Making evaluation

The Board received this report on the first cohort of the programme which had comprised six members of staff from Black, Asian and Minority Ethnic groups.

The programme's aims were to:

- Increase representation of those within protected groups (specifically Black, Asian and Minority Ethnic colleagues) in board-level committees.
- Increase development and experience for the representatives.
- Support representatives to have an impact and to be able to influence decisions.
- Improve decision-making within the committee.
- Increase representation of frontline staff in board-level committees.

The programme evaluation indicates that the programme has been a success for participants and Board committees. Involvement in committees has had a positive impact on the career development of participants. In addition, committee chairs welcomed the front-line experience that was brought to discussions.

Item		Action

Cohort 2 will start from September 2022. The need for support on specialist areas such as finance was highlighted. Cohort 1 has offered to mentor Cohort 2 members.

The next steps will be to implement an Executive Advisory Group to further support this programme and this will be supported by the work of the Making Life Better Together group.

The Board endorsed the recommendation to establish an Executive Advisory Group to develop greater diversity in decision making, to be led by the Chief Executive as part of the MLBT programme over the next six months. **(Action VF)** **VF**

22/73 Finance and Performance Committee chair's report

The Board received a verbal update from VS who drew attention to sector wide financial pressures, alongside which increased demand and workforce challenges are set to make 2022/23 a testing financial year.

The Board noted

- The FPC Chair's report.
- The Committee Annual Report.

22/74 Finance Report

The Board received the Month 2 finance report and PM reported the following headlines:

- The draft plan position was submitted in April 2022
- The reports from Month 3 will be reporting a changed trajectory to reach break-even.

The board received assurance that savings plans would be subject to quality and equality impact assessments processes.

The Board noted the report.

22/75 Estates Modernisation Committee chair's report

The Board received a verbal update from VS on the meetings held in June and July and the following points were highlighted:

- The construction programme is proceeding.
- The independent quality certifier is supporting snagging elements as required.
- The Government Infrastructure gateway review resulted in an amber rating. Two recommendations have been identified for clinical engagement and leadership.
- The Committee was positive about the action to prepare for the moves into new team bases, including the 'Move in a Box'.
- Issues around pedestrian access from Tolworth Station are being addressed in partnership with the local council.
- Community Transformation has gone live in Sutton.

The Board noted the report.

22/76 Charitable Funds Committee chair's report

The Board received and noted the report.

22/77 Questions from the members of the public and staff

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Item		Action
	No formal questions were received. Martin Haddon, Wandsworth HealthWatch, commented on the case for investment to address waiting times.	
22/78	**Meeting Review** The meeting was reflected upon.	
22/79	**Next meeting** 8th September 2022 at 13.30 at Springfield Hospital in Conference Room G.	

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

ACTION TRACKER – for September 2022 Board

BOARD OF DIRECTORS (Part A)

2.5

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
			DUE			
10/03/2022	22/27	**Quality and Performance report**	FPC to give further consideration to the question of how best to report productivity and efficiency performance to the Board's committees.	**VS/PM**	**July FPC Sept 2022 Board**	Following the April board seminar this is subject to regular updates. Sept Board to receive an update.
12/05/2022	22/57	**Questions from the public**	The Quality Plan is to be forwarded separately to Martin at Healthwatch Wandsworth by SS.	**SS**		SS is to forward the Quality Plan directly to Martin - completed
14/07/2022	22/70	**Quality & Performance Report**	There appear to be an issue with delays in patient discharge letters from the Huntercombe Hospital Roehampton. It was agreed that JeA is to explore this and provide an update.	**JeA**	**Sept 2022**	
14/07/2022	22/72	**Diversity in Decision Making**	To establish an Executive Advisory Group to develop greater diversity in decision making, to be led by the Chief Executive over the next six months	**VF**		
			NOT DUE			
			COMPLETED AT LAST MEETING			
11/11/2021	21/136	**Charitable Funds Committee chair's report**	Revised investment policy to CFC and to be referenced in CFC Chair's report to Corporate Trustee	**PM / DM**	**June CFC July 2022 Board**	An update is included in the CFC chair's report
12/05/2022	22/39	**Patient Story**	The trust is to review, in partnership with commissioning colleagues, the arrangements for patients receiving private care	**BB**		

Update as at: 08/09/2022

1

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

ACTION TRACKER – for September 2022 Board

BOARD OF DIRECTORS (Part A)

2.5

Update as at: 08/09/2022

2

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

3.1

Meeting:	Board of Directors
Date of meeting:	8th September 2022
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. Term of office

I am pleased to advise the Board that I have been re-appointed as Trust Chair for a term ending on 30th September 2024.

3. Chair's activity

A summary of my recent appointments is set out below

Internal	External
Trust Board	Taskforce Chairs pre-meeting
Ward/ Site Visits	Visit to Liaison Psychiatry at St George's Hospital
Trinity and Shaftesbury Site Visit	Chair of Royal Free London NHSFT
Annual Public Meeting	London Chairs meeting
Finance and Performance Committee	NHS Providers Board
Audit Committee	Visit to Neuropsychiatry, St George's Hospital
Quality and Safety Assurance Committee	Chair in Common of Kingston Hospital NHSFT and HRCH NHS Trust

4. Board business

The part B meeting of the July Board discussed a range of issues including the Estates Strategy, financial reports, SW London integrated care partnership, provider collaborative, Core20PLUS5, performance, new hospitals and serious incidents.

The monthly Board visits programme continues. Visits in July included CAMHS neurodevelopment, Merton Clozapine clinic, Wandsworth SPA, Wandsworth Older People RST, Richmond HTT, Ward One, Deaf Adult Community Team and Deaf enhanced support team.

5. South West London Integrated Care Board Chair

Millie Banerjee, the Chair of the South West London Integrated Care Board (ICB), has decided to step down. The ICP are working with NHS England on interim arrangements, and will advise when these have been confirmed. Working with system leaders, the ICP will continue to progress partnership work across South West London, build on actions around recovery from the pandemic, develop the strategic plan for the system and work to ensure that all services across health and care are prepared for the coming winter.

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

September 2022

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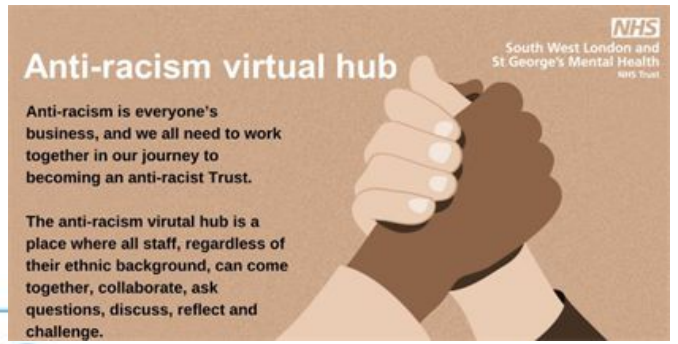
Our Trust

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

Every week I write to our staff with key messages and every two weeks I have a Q&A:

- Chief Executive Update - Friday 26 August
- Chief Executive Update - Friday 19 August
- Chief Executive Update - Friday 12 August
- Chief Executive Update - Friday 5 August - Integrated Programme and move special
- Chief Executive Update - Friday 29 July
- Chief Executive Update - Friday 22 July
- Chief Executive Update - Friday 15 July
- Chief Executive Update - Friday 8 July
- Chief Executive Update - Friday 1 July



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

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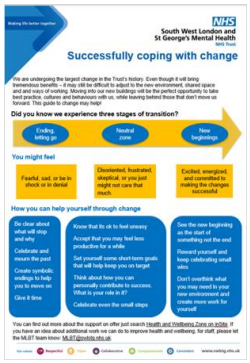
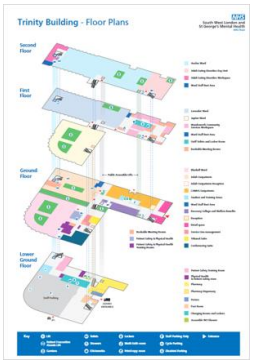
Moves into Trinity and Shaftesbury

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

- From October 2022, over 350 staff and over 100 patients will start their moves into Trinity.
- Following discussions with contractors, we now expect Shaftesbury to be handed over to us with a small delay (Nov) - with us moving in January 2023
- Our priority is to move into high quality, completed buildings that are safe for our patients and our teams
- We are focusing on the culture change needed to support the moves and changes to our ways of working.
- To support our patients and staff to physically and psychologically prepare we have developed a comprehensive move pack
- Operationally-led command and control meeting to manage the moves and their impact





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Tolworth development

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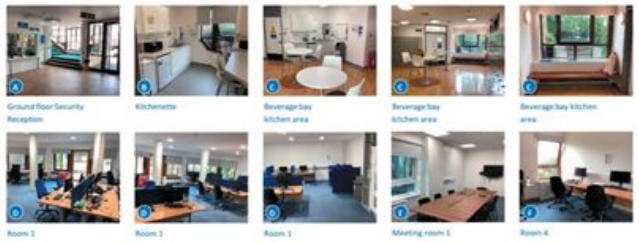
South West London and St George's Mental Health NHS Trust

- To support the recent refurbishment of wards at Tolworth, we will be further investing in a five ward unit, subject to approvals
- Tolworth redevelopment will complete our vision for transformed environments across our estate, supporting equity of access for all SWL patients
- In August we exchanged contracts on Phase 2b with Barratt Homes. Build scheduled to commence in late 2023
- Change of corporate depts base to Tolworth, in line with new ways of working confirmed following consultation. Moves to start in November / December
- Hot desking areas at Tolworth have been recently refurbished and limited additional hot-desking areas at Springfield



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Wisteria refurbishment

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

- Wisteria ward re-opened in August 2022 after a major refurbishment
- The new ward has been co-designed in partnership with staff, carers, patients and service users
- The renovation sees 12 new bedrooms which are light, spacious and modern, with bespoke bathroom and shower rooms, a large welcoming lounge area with comfortable modern furniture, a calming sensory room, and a larger staff base area.
- The re-opening of Wisteria followed the publication of the June CQC ratings where Wisteria and Avalon had their ratings raised to 'Good' following their inspection in March 2022.
- Avalon ward will be moving into brand new facilities in Trinity in October 2022

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Demand, pressures and winter

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

- We continue to see significant demand pressure across the Trust, but particularly in Acute and Urgent Care
- We are expecting additional pressure over winter with factors such as the cost of living and the aftermath of covid impacting on people's mental health – we are already seeing higher numbers of patients in crisis who were not previously known to us
- We have needed to use a high level of private beds, and we expect this to continue into winter, alongside working to support patients to recover and receive care at home as soon as possible
- We are encouraging patients to:
  - Contact the Crisis Line, and use their GP, community team and crisis plan if applicable
  - Adhere to their medication plan
  - Access local wellbeing support, IAPT and crisis cafes
  - 'Self help' if you can, by accessing online or local support
- Vaccination campaign planning underway

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Recruitment challenges

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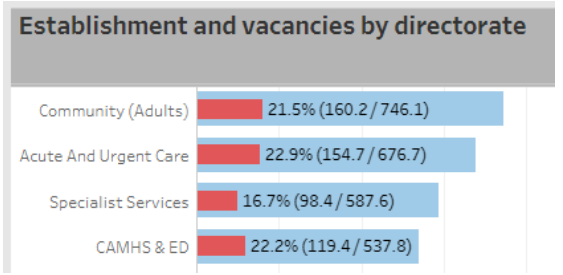
South West London and St George's Mental Health NHS Trust

- Increased demand and pressure in the system is being compounded by recruitment challenges: our overall vacancy rate is 20%
- These challenges are impacting on the experience of both our patients and our colleagues
- 12 week recruitment systems and processes improvement plan in place – managed jointly by HR and operations
- A number of HR & OD posts previously hosted at SLaM transferred to SWLSTG from 1 September



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Horizon Scanning: July and August

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

- Patient Safety Incident Response Framework and supporting guidance – with the Patient safety learning response toolkit
- Equality Delivery System 2022 – Guidance and resources
- Tackling inequalities in healthcare access, experience, and outcomes
- NHS Pay award 2022/23 and senior salaries review body report 2022
- Friends and Family Test data
- Guidance on the preparation of integrated care strategies
- Health overview and scrutiny committee principles
- Women's Health Strategy for England
- NHS Pension Scheme: proposed uplifts to the member contribution tier thresholds
- NICE annual report and accounts: 2021 to 2022
- Building the right support for people with a learning disability and autistic people action plan
- The NHS England (Healthcare Safety Investigation Branch) directions 2022
- NHS England 2022-23 Business Plan
- Freedom to speak up – guide for leaders

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CQC new single assessment framework

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

- CQC published a new single assessment framework in July.
- Quality ratings and five key questions will stay central to CQC's approach - ratings (Outstanding / Good / Requires Improvement / Inadequate) remain. The five key questions also remain
- Key lines of enquiry (KLOEs) and prompts will be replaced with new 'quality statements'.
- The aim is to reduce duplication and allow focus on specific topic areas under each key question. They set clear expectations of providers, based on people's experiences and the standards of care they expect.
- Six new evidence categories to organise information under the statements: people's experiences, feedback from staff and leaders, observations of care, feedback from partners, processes and outcomes of care
- Key questions and quality statements - Care Quality Commission (cqc.org.uk)
- Evidence categories - Care Quality Commission (cqc.org.uk)
- Our new single assessment framework - Care Quality Commission (cqc.org.uk)

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Key questions to have in mind

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

- As a Board we have discussed supporting the organisation to prioritise through the work we have done on our corporate objectives 22/23. We face increasing levels of demand, workforce challenges and at the same time we are moving into our new buildings and changing our ways of working. As a Board, how do we consistently support our teams and services to prioritise?
- In light of the challenges to cost of living, what more can we do as a Board to support the health and wellbeing of patients and staff? How can we make sure we have this in mind as we make and take our decisions?
- With the continuing changes at SLP, ICS and place, how do we continue to negotiate our relationships in this new commissioning environment?

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Celebrating our diversity

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


New student nurses


Monthly Exceptional People winner


Black Pride


South Asian Heritage Month

Street Parties


Lenka's Gold Medal


London Pride

Hospital Rooms Art

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Use of the Trust seal

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

Date	Type	Signatories
07/07/2022	Lease renewal – Mayfield Nursery.	Director of Finance & Performance and Medical Director
07/07/2022	Transfer of Title – Tolworth garages	Director of Finance & Performance and Medical Director
12/08/2022	Deed of Covenant – Land Plots K2 and K3 SWLSTG and City and Country Investments Ltd	Chief Executive Officer and Director of Nursing & Quality Standards
12/08/2022	Deed of Covenant – Inter Group Transfer Plots K2 and K3 (Chapel and Ballroom) SWLSTG. City and Country Investments Ltd and City and Country Group plc	Chief Executive Officer and Director of Nursing & Quality Standards
25/08/2022	Phase 2b sales contract to BDW Trading Ltd	Chief Executive and Director of Finance & Performance

NHS
South West London

South West London Mental Health strategy development

Update for Board September 2022

13

South West London Mental Health Strategy context

NHS South West London

A 3-year strategy is being developed for mental health services in SW London to respond to current challenges, drive forward service transformation and effective collaboration and ensure services deliver accessible and high-quality care to all.

The development of a mental health strategy was a key recommendation from the ICS commissioned report on the development of a mental health provider collaborative for SW London. In order for a SWL mental health provider collaborative to be successful we need a clear and robust mental health strategy and delivery plan.

The strategy will:

- Confirm and refresh mental health priorities
- Respond to current challenges and drive forward service transformation
- Focus on reducing fragmentation and unwarranted variation addressing legacy commissioning issues
- Support introduction of core models ensuring high quality care for all regardless of SWL location
- Focus on addressing population and community needs with a strong emphasis on prevention
- Support delivery of the broader aspirations of the ICS to improve outcomes, address inequalities and enhance collaboration, productivity, and value for money.

Approach to the SW London mental health strategy

NHS South West London

The SW London mental health strategy is being developed through:

1. **Assessment of population health need and the strategic landscape**. This has been completed using local and national benchmarking data and performance, quality, finance, activity and workforce data from the SWL CCG and NHS providers. JSNAs and LHCPs were reviewed and outputs were reviewed by a wide group of stakeholders.

2. **Identification of innovation and best practice has led to the development of a summary 'library'** to help inform future service transformation. Examples have been assessed based on evidence of change in outcomes wherever possible.

3. **Engagement with our local population** (including service users and carers) and professional stakeholders. To date virtual and F2F discussions have taken place and about 700 people have responded to an online survey. Key themes and areas are provided in the appendix.

4. **Synthesis of data and information** Is planned for the first two weeks of August with priorities and approaches then ready for testing with stakeholders.

The strategy is being developed in collaboration with the ICS place based leaders, NHS mental health providers, Local Authority leads, VCSE stakeholders, primary care.

Children and Young People (CYP) – population health needs, strategic landscape and priority areas

NHS South West London

The population health needs and strategic landscape reviews tell us that:

- CYP in SWL have a high need for mental health support and with under 18s accessing NHS community mental health services compared to other areas of London.
- Demand has risen through and post-pandemic and services are challenged to cope with this.
- CYP are affected by poverty with some SWL wards experiencing high deprivation.
- Educational attainment varies between wards and school readiness is a key area of public health concern.
- There are high numbers of admissions for self-harm with highest self harm rates in Kingston ad Richmond, followed by Sutton.
- Eating disorders are highest in Richmond.
- Richmond, Merton and Kingston have the highest numbers of Children Looked After and these are vulnerable groups.
- The special educational needs population is growing and the social, educational and emotional/ mental health needs of this group are high.
- CAMHS provision and models vary across our boroughs and we have fragmented pathways; the performance of services varies.
- Transition between CYP and adult mental health provision remains problematic.
- We have a high number of CYP inpatient admissions and our length of stay varies.
- Our perinatal service does not currently meet NHS LTP requirements.
- We do not have a consistent model of parenting support.
- CYP from Asian population groups are underrepresented in CYP MH services.
- The spend on CYP MH per head in SWL is low compared to other areas.

Working age adults (WAA) – population health needs, strategic landscape and priority areas

NHS South West London

The population health needs and strategic landscape reviews tell us that:

- Demand for mental health services has risen from working age adults over the period of the pandemic – this affects most areas. Addressing service demand pressures was considered as part of the 2022/23 planning process but not all proposals could be funded from the investment available and long waiting times persist in some services where capacity remains insufficient to meet current demand. Examples include ADHD and ASD services.
- There is demographic variation between boroughs in terms of ethnicity, income levels and employment rates.
- Adults in SWL have a higher prevalence of depression and a higher suicide rate compared to London.
- SWL has the lowest prevalence of SMI in London (1% of the population) yet we struggle to provide effective joined up physical and mental health for people with SMI and work effectively to support people with co-occurring long term conditions.
- The number of suicides have increased.
- Croydon has a lack of stable accommodation for people with mental health needs.
- There is a lack of comprehensive offer for our most complex service users who may have co-occurring substance misuse, housing issues (including homelessness) and physical health issues.
- Alcohol misuse is high across SWL.
- Service models vary between boroughs as to contact levels from services. Wandsworth and Croydon have the lowest proportion of contact with crisis teams and higher activity supporting people with mild/ moderate needs.
- Croydon has the highest proportion of inpatient admissions per head of population.
- Readmission rates vary between SWLSTG and SLaM.
- Mental Health Act detentions have increased.
- A&E attendances due to a mental health need have increased and these people spend 25% more time in A&E compared to those attending with a physical health issue.
- Black population groups are more likely to have contacts with secondary care MH services and be admitted than be supported by crisis teams; white people are more likely to be referred to services.

Older adults (OA) – population health needs, strategic landscape and priority areas

NHS South West London

The population health needs and strategic landscape reviews tell us that:

- SWL has a higher proportion of residents aged over 65 compared to London and the number of older adults in SWL is projected to grow by 27% over the next 10 years; the largest percentage growth is expected in the 80-89 age group.
- Richmond and Sutton have the highest proportion of older adults.
- Income deprivation is high in some SWL wards and this will impact on older adults.
- Loneliness and social isolation are key issues to tackle.
- SWL currently has the highest diagnosed dementia prevalence compared to other London ICSs but post-diagnostic support needs consideration.
- Older adults typically have longer lengths of stay compared to working age adults and CYP.
- Older adults are underrepresented in IAPT services.

Early engagement findings

NHS
South West London

Survey:

- The main difficulty people report when trying to get help is *long waiting times*. The second most highly ranked issue is "*stigma or shame*". *"I didn't know how to explain how I was feeling"* ranks third.

- What helps people stay well following a crisis is "*support from friends and family*" (75%). Other things that help are: *access to green spaces, activities that I enjoy, and NHS support*.

- The top things that help people manage their mental health are; *time with friends or family, taking exercise and spending time in nature*.

- The first place most people would go if they started to experience problems with their mental health would be to *friends and family*. *Contacting the NHS* ranked second.

F2F meetings:

- What more can be done with local authorities an education around prevention & early support in CYP mental health
- How can services across health, social care and VCSE develop better links and reduce fragmentation to prevent escalation and reduce demand on NHS services.
- How can social prescribing and VCSE services support more people experiencing mental ill health?
- How can access and waiting times be improved to CAMHS and adult psychological support services?
- Can primary care offer a greater provision of mental health services?
- How can people with both physical and mental health conditions be better supported to manage multiple morbidities?
- How can carers be more supported when caring for someone with dementia or mental ill health?

Vision and aims

NHS
South West London

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. We will 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.

Themes

NHS
South West London

We have developed four themes that will run through our strategy covering key elements determined through our understanding of the strategic landscape, the data analysis and engagement work:

1. Prevention and early support
   - Children, young people and family support
   - Health environments
   - Mental health literacy and reducing stigma

2. Bio-psycho-social model
   - Physical healthcare for people with mental illness
   - Neighbourhood teams and integration
   - Complex needs and co-occurring issue

3. Inequalities
   - Unwarranted variation
   - At risk communities

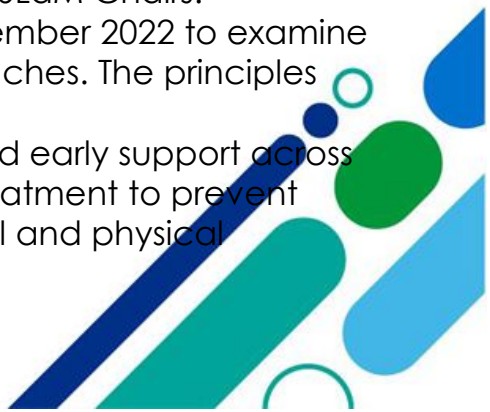
4. Timely access
   - Least restrictive care and recovery
   - Waiting times
   - Transitions
   - Discharge

Ongoing work

NHS South West London

There are a number of key elements to move forward

1. **Outcomes and metrics** – we are working to determine outcomes and measures for all areas. We are currently reviewing our current metrics and considering appropriate targets for key areas.
2. **Engagement and support** – our engagement work remains live with discussions and survey work in place. Reaching people not aware of/ in contact with MH services remains a live issue. We are also planning open reflective sessions in September 2022 where we can test vision, aims, themes and priorities by age range.
3. **Governance** – we are developing a governance map illustrating the changes that will be made. We are refreshing the current MH Transformation Board and setting up a MH Partnership Delivery Group which will include representation from all places and work to deliver not only the SWL MH Strategy but support development work for the MH provider collaborative.
4. **Leadership** – the development of the Strategy is led by a team of senior leaders from the SWL ICS, SWLSTG and SLaM with oversight from a Strategy Delivery Group including the SWL ICB MH Lead and SWL MH Clinical Leads. Regular review and reflection sessions are held with the SWL ICS, SWLSTG and SLaM Chairs.
5. **Funding** – we have mapped funding use in 2022/23 and have a session in early September 2022 to examine 2022/23 forecasts, confirm key areas for impact and define 2023/24 planning approaches. The principles around funding flow changes need development and discussion.
6. **Prevention & Physical Health** – we will ensure a much greater focus on prevention and early support across all age ranges and greater use of targeted prevention, promotion, and access to treatment to prevent widening of inequalities. We will ensure an integrated approach that supports mental and physical wellbeing.



Key questions for consideration

NHS
South West London

In order to ensure the Strategy is effective and deliverable a number of questions are being worked through, including:

1. In order to impact on mental health and wellbeing at population level, we need to shift our pathways and delivery to focus on prevention and early intervention**. How should we approach changes to existing services and funding flows? What is our appetite for change?**

2. Marginalised groups, including people living in poverty with poor housing and unemployment, are at increased risk of mental disorder and poor mental wellbeing. **How should we work with Local Authorities and others to better address the issues of housing, employment, education and social care?**

3. Local leadership and determination of priorities is hugely important but borough structures can cut across communities. **How can we ensure that we connect communities across geographical boundaries and ensure that we provide culturally appropriate and accessible services regardless of SWL location?**

4. We know that collaborative working can deliver transformational change – we have shown this through our work in the South London Partnership. **Which areas would benefit from a provider collaborative approach?**

5. Stakeholder input and ownership is hugely important. **How would you like to be involved in the strategy development? How can we ensure the views of all stakeholders and ICP members are represented in the strategy? What conversations with stakeholders would you like to see progressed**?

Next steps in the SWL MH strategy and SWL MH PC development

NHS
South West London

There are a number of actions and deliverables to progress the implementation of a SWL MH PC from April 2023. These include:

1. Review outputs from the strategy engagement events and survey responses and develop strategy structure; core messages from synthesis of information – Aug 2022 (underway at present)

2. Develop draft strategy for review and discussion including reflective sessions with stakeholders – Sept 2022.

3. ICB to review and approve strategy – Oct/ Nov 2022.

4. Develop costed delivery plan and work with partners to agree resourcing and leadership team to implement and agree mechanism for ongoing monitoring of delivery and evaluation of outputs – December 2022

GUIDANCE ON SYSTEM WORKING

The Department of Health and Social Care (DHSC) has published four pieces of guidance in relation to system working and the Health and Care Act 2022 (the Act).

The **guidance for integrated care partnerships** (ICPs) outlines the statutory requirements they need to adhere to when developing integrated care strategies, which will set the direction of the system and identify priorities among system partners. The guidance also suggests some of the areas ICPs should consider in their strategies, and sets out some non-statutory expectations around its publication (initial versions are due to be published in December 2022).
Guidance on the preparation of integrated care strategies - GOV.UK (www.gov.uk)

Draft guidance for **engagement in relation to Health and Wellbeing Boards (HWBs)** sets out how HWBs will operate in the context of the Act. While HWBs maintain their existing responsibilities and core membership requirements, they are expected to develop ways of working across ICBs and ICPs.
Health and wellbeing boards: draft guidance for engagement - GOV.UK (www.gov.uk)

DHSC has also published expectations for how systems – particularly ICPs – will **work with adult social care providers** and ensure they are fully engaged in system working. The document positions them as key strategic partners within systems and sets out five high-level principles to guide their involvement.
Adult social care principles for integrated care partnerships - GOV.UK (www.gov.uk)

The document setting out **principles for health oversight and scrutiny committees** (HOSCs) clarifies that ICBs and ICPs now fall into their scope, and sets expectations for how they will work together.
Health overview and scrutiny committee principles - GOV.UK (www.gov.uk)

Trust

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

Quality and Performance Report

June 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.

In line with the wider NHS, our operating context continues to be very high demand for mental health services, alongside challenges recruiting and supporting the workforce we need to meet this. In the acute care pathway crisis presentations and patient acuity remain high, with ongoing pressure to support acute trusts and the wider system by improving flow. We are working with system partners to develop additional capacity proposals across all areas including crisis, inpatient and discharge. Initial feedback has been positive in response to the plans we intend to introduce through Q2/3. Building on the Multi-Agency Discharge Event in May, we are exploring wider opportunities for further collaboration with local authorities through the ICB including initiatives across discharge, prevention and pathway facilitation for winter 22/23. We are focused on embedding new processes as we ramp up preparations for moves into the new hospital buildings at Springfield in October.

Alongside this, community services for both adults and children and young people are under significant pressure from high demand as well as gaps in our workforce, notably in medical staffing and within key operational leadership roles. This is contributing to growth in waiting times in some areas reflected in this report such as adult ADHD/ASD services. We continue to focus on addressing priority areas with plans for improvement in place. Following positive progress to embed new transformed models for adults in Sutton, the community transformation continues with mobilisation in Kingston and Richmond. We are also working with partners to support alignment of primary MH and IAPT services to address a complicated local provider landscape in Kingston and Richmond. The CAMHS Transformation programme continues, and we are strengthening resources and establishing more integrated care pathways which optimise patients' recovery.

Overall, this remains a very challenging position for our services with substantial operational and strategic demands. Mental health trusts across London and nationally are seeing similar issues.

The focus of this report is June 2022 and our priority metrics to ensure patient safety and effective care, along with our integrated approach to quality and workforce. This is supported by detailed executive review and discussion at the bi-monthly Service Line Review meetings, which focus on key issues and action planning and accountability to address these. The QI-focussed monthly SLR improvement forums are working through priority issues around effective mandatory training processes collaboratively between the Service Lines. The streamlined Q&P report framework with greater focus on overall performance, key risks and issues, and improvement plans, has been welcomed by the service line teams and continues to be enhanced through the SLR meetings.

The HR Recovery Programme has agreed its key projects and deliverables across priority areas of Recruitment, Medical Staffing, and Employee Relations, with project plans now in development between HR and the operational teams. There is now a more SWLSTG-focussed service in a number of HR function, and it has been agreed to progress work to split services more fully and to develop an improved HR first point of contact and customer service offer for our teams. The executive team and HR and operational leads continue to monitor key workforce metrics as we work together to change the experience and outcomes for our teams.

The Trust recognises that it needs to improve upon its performance in a number of areas and as can be seen only 58% of our metrics have full or limited assurance meaning some 42% have no assurance (in accordance with our own internal assurance measures), whilst that position improves slightly when considering just the priority metrics it remains unacceptable. We know that in some cases we are setting of ourselves higher standards than those set nationally e.g. post discharge follow-up or are subject to externalities largely outside of our control such as Covid linked sickness however, we do appreciate that as leaders we need to work to address these wherever possible. It is also recognised that there is a national recruitment and retention problem, alongside a national shortage of staff with specific qualifications, that will be impacting upon our ability to address some of these issues at the pace we would desire.

The Trust has been struggling with gaining traction in a number of these areas through the pandemic and is undertaking a root cause analysis approach to understanding the key drivers behind the performance and what actions have been taken and their impacts. We appreciate that in some cases where the driver is caused, or exacerbated, by the pandemic we may need to recognise that short term improvement is unlikely. In addition as we move into our new buildings and of course focus upon a smooth and successful transition we will need to prioritise those actions, associated with the moves, in the medium term; the Trust will continue with its community transformation programme which will support the wider performance and quality agenda.

Although we are not able to take empirical assurance for formal reporting purposes, wherever possible we look at wider metrics and evidence to triangulate and assess our relative performance via available benchmarks and also the impact of target failure upon our population to provide ourselves with reassurance. This is showing us that whilst we may not be delivering to the levels we aspire we are in many cases we benchmark well in terms of actual performance attained.

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

- **HR Update:**
  - Employee Relations has been transferred from Capsticks and this contract was ceased on 11th July 2022. The Employee Relations work is now managed by our Business Partners with support from SLWSTG dedicated ER Advisers. Weekly stand up meetings and triage meetings ensure that ER work is managed effectively and responsively and with Just Culture principles at the core. A new draft Disciplinary Policy has also been developed and is out for discussion with all key stakeholders which will also improve the processes in this area.

- Medical Staffing support, has improved but there is still work to be done to provide comprehensive recruitment and retention plans for some roles. The Trust is utilsing an external company to support advertisement branding. A Physician Associate Open Day set up for 15th September 2022 to ensure recruitment of graduates due to qualify in October 2022. The Trust has also brought in a more experienced interim to work with our Head of Medical Staffing to create greater support in this area.
- The provision of detailed Recruitment and Retention plans for each service line still requires work. Some cohort recruitment has taken place but there are some tweaks to the approach which are necessary to ensure these are more robust. The Director of People and Deputy are urgently reprioritising work over the next two weeks to ensure the delivery of a robust recruitment and retention plan for each Service line and profession. This will be presented at the ELT week commencing 8th August 2022 and detailed plans to improve the position will be monitored and resources focussed appropriately.
- The consultation for Corporate and Clinical Staff impacted by the Integrated Care Programme has also closed and final decisions published.

- The work on Fundamental standards of care continues to be led through the Service line Leadership team with great engagement from frontline staff. The Trust recently defined a series of metrics to monitor the impact on the quality of care and has launched a dashboard to enable us to monitor the impact through the Service Line Reviews and this report. 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. We have seen improvements in some areas including care planning, formulation of risk assessment and physical health assessment using the #Alwaysready app. The leadership development programme has commenced with positive feedback from the attendees. The new Community (FSOC) Dashboard went live across the Trust on July 4th.
- 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. Improvement in the quality of the risk assessment is noted, focus needs to remain on the numbers completed. The Deputy Medical Director is currently undertaking a review of the Clinical risk assessment policy/recording.
- Adult ADHD/ASD services face significant demand and capacity pressures and the impact is seen across a number of metrics including annual risk assessments and waiting to commence treatment. There is also an increased risk of the Trust incurring 52 week breaches due to the long waits. Mitigations have included:-
  Wait list initiatives: ADHD long waiters will be seen by a third-party using waiting list initiative monies by July 2022 with first 50 scheduled with 110 being transferred as at 10th June. **Medication Reviews:** To undertake annual medication reviews and support caseload management two non-medical prescribers have been recruited. One appointee commenced in post in March 2022 whilst the other is due to start in June 2022. However, demand remains high and this is likely to be an area of continued long waits, given competing priorities for MH investment.
- 52 Week Breach: The Trust has incurred a 52 week breach in June 2022 linked to the Neuropsychiatry Service. The reason for breach was linked to multiple cancellations and client's preference to be seen in August 2022 (with appointment scheduled in diary). The referrer has been made aware of the delay.
- IAPT recovery rates remain above target YTD in 3 out of 4 services; only Sutton Uplift met their provisional access target. Marketing plans continue to evolve in order to promote and encourage self-referral and attract under-represented communities. In addition, the Trust is exploring the use of the CCG's Communications Team to further promote IAPT services and increase referral levels. We are exploring opportunities for sharing good practice through the integration of Richmond Wellbeing Service to the Trust in 2022/23. Active discussions are in progress with commissioners to understand the underlying issues and agree actions, acknowledging the challenge in achieving some of the standards and the need to work collaboratively. However, the volumes of waits over 30 weeks continues to rise and there is an expectation that numbers may increase further as Step 3 vacancies continue; this is a challenge for IAPT services nationally. It should be noted that the South West London sector benchmarks above national averages for both access and recovery rates in latest publication of Royal Psychiatric Mental Health Watch.
- Work to address internal waits over 30 weeks is on-going. Focus is now on ensuring a robust referral and waiting list management process for psychology and to optimise capacity and clinical treatment pathways. Reporting now incorporates treatment waits in CAMHS Tier 3 and Adult ED treatment waits.
- Crisis and acute inpatient services remain in a challenging position, with the need to balance demand, waiting times in crisis, and bed capacity. All mental health trusts across London are facing similar issues and many have adopted block purchase of private beds. We have been significantly stretched in terms of bed capacity and are utilising additional in-area block purchased beds, discharge to assess beds, crisis step up and discharge step down hostel places and further out of area placements. Following confirmation of the investment and financial plan, a number of our block purchase provisions have been stepped down and we are working through inpatient and community transformation to support improved crisis prevention, recovery, and flow with CCG and LA partners. Transformation work is closely linked with the Quality Plan programme to ensure fundamental standards of care for our inpatients are consistently achieved, while improving underlying systems, processes and skills to make this change sustainable.
- The New Working Discharge Summary process is due to be launched across the Trust on 1st August 2022. The new process will allow GP letters to be automatically submitted via Docman Connect within RiO. Training for Medical and Administration staff has been provided training on the new process and a new SOP has been disseminated across service lines.
- Performance on clients seen for assessment by liaison services within an hour remains a concern; with delays in St George's due to lack of cubicle space as well as very high demand, whilst there have been staffing difficulties in Kingston. Services are looking at creatively utilising existing establishment (e.g. creation of new twilight shift in order to meet demand at peak times).
- Standards set for face to face care delivery are a key focus for Community services, using the agreed decision support tool to ensure contact meets patients' needs, and considering also our zoning and clinical engagement practice and policy. There has been noted improvement within Specialist Service Line against both amber and red zone cohorts.
- There are significant concerns in Community Service Line on medical vacancy rate in Wandsworth & Richmond with mixed success from recovery effort to date.

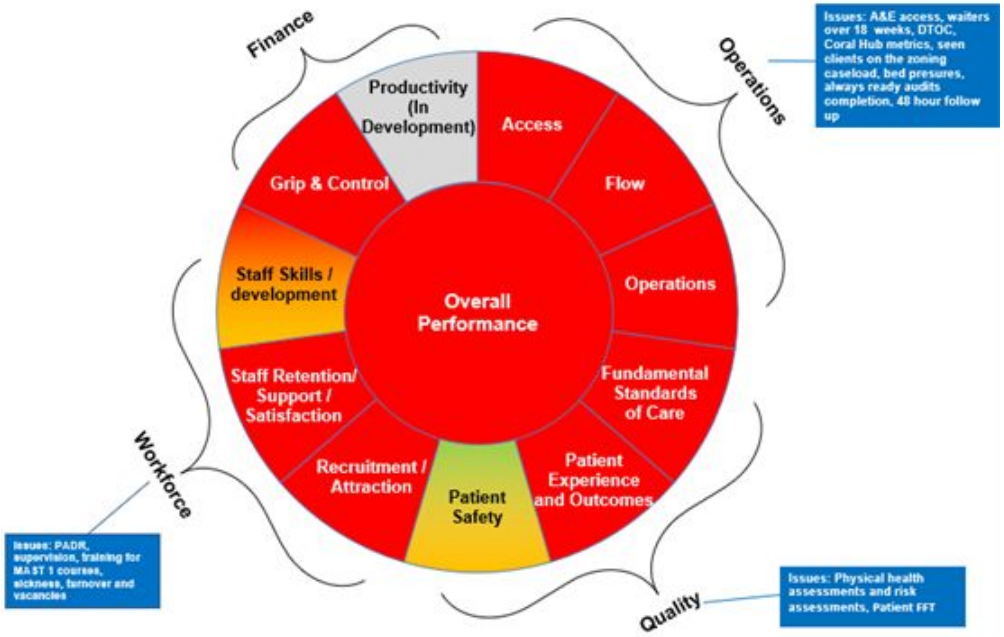
We continue to support front line staff and service line leadership teams to deliver improvements to our key priority areas in the context of ongoing demand and wider workforce pressure. We are seeing indicators moving in the right direction in a number of areas, but the challenges of meeting significant increased demand and acuity in all services mean that improvement is slow. Delivering the HR recovery programme and the Quality Plan programme, while progressing range of transformation programmes, are key to both safe and effective care for our patients now, and sustainably excellent services in the future. The executive and new Service Line leadership teams continue to work together to address these 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 3, the Trust remains on its target trajectory and has delivered £1.8m of cumulative savings. The challenge remains delivering efficiency through recurrent and sustainable means as we move forward.

Quality and Performance Summary

Board Assurance Framework – Latest Risks

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



Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	7	19	19	57.8%
Quality	4	10	5	73.7%
Workforce	3	2	7	41.7%
Finance	0	0	1	0.0%
Total	**18**	**24**	**30**	**58.3%**

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 16 for detailed explanation
- The metrics in each of the five domains 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 6 domains and excludes financial metrics
- 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.
- The finance section of the donut is based on how much the actual position is in line with the budget position (plan) and is calculated as a percentage:

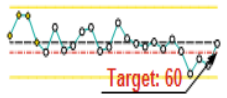
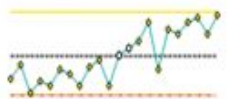
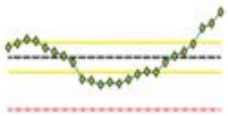
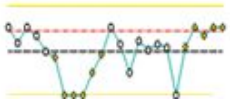
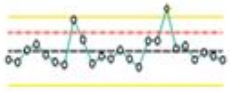
Achievement of plan	≥ 100%	≥ 98% and < 100%	< 98%

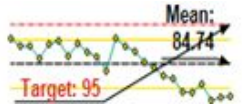
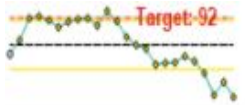
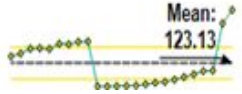
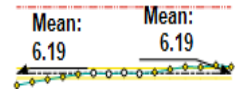
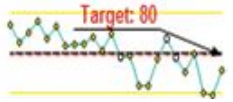
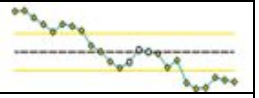
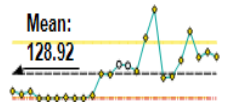
Possible Donut ranking: 5 = best, 1 worst

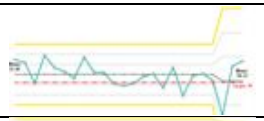
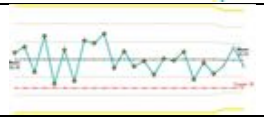
Limits	✓	?	✗
↗	5	3	2
↘	5	3	2
→	5	2.5	1
↗	4	2	1
↘	4	2	1

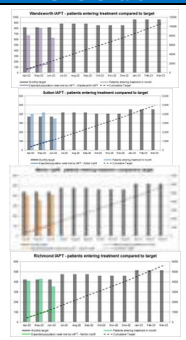
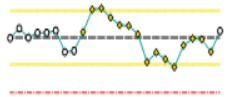
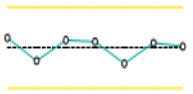
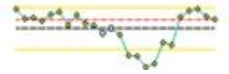
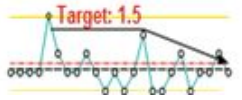
Colour	Limits
Green	> 3.5
Amber/Green	≥ 3 and ≤ 3.5
Amber/Red	≥ 2.5 and < 3
Red	< 2.5

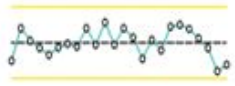
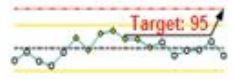
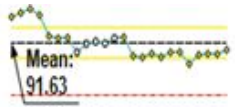
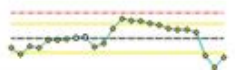
Priority Metrics

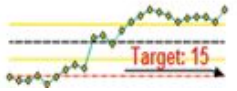
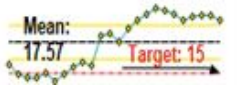
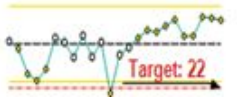
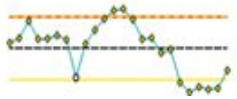
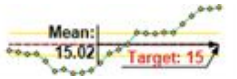
	Priority Metrics	Jun-22	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 11)	66.7	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 12)	34	= 0	↗	X	
	Access					
	No one is waiting more than 30 weeks for treatment - Number of breaches (including CAMHS Neuro, IAPT & Non-RTT teams) (see page 13)	875	0	↗	X	
	Access					
	Adult and Older People's CMHTs - Non-Urgent Referrals assessed within 28 days (%) (see page 14)	79.5	≥ 80.0	→	?	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 15)	100	≥ 95.0	↗	?	
	Access					
	Emergency readmission within 30 days - Adult Acute & PICU (%) (see page 16)	4.5	≤ 8.5	→	?	
	Flow					
	Zoning caseload seen as required (%) – Red (see page 17)	80.7	≥ 95.0	→	X	
	Flow					
	Adult acute average length of stay (Excluding PICU) (see page 18)	54.3	≤ 38	→	?	
	Flow					
	Follow up within 48 hours of discharge from inpatient services (%) (see page 20)	83.4	≥ 95.0	→	X	
	Flow					
	Delayed transfers of care (%) (see page 21)	7.1	≤ 2.5	↗	X	
	Flow					

	Priority Metrics	Jun-22	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (see page 11)	76.4	≥ 95.0	↘	X	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 12)	82.9	≥ 92.0	↘	X	
	Access					
	Internal waits for treatment of over 30 weeks (see page 14)	401	-	→	-	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 15)	6.6	≥ 10.0	↗	X	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 16)	74.5	≥ 80.0	↘	?	
	Access					
	Zoning caseload seen as required (%) - Amber (see page 17)	74.2	≥ 95.0	→	X	
	Flow					
	Time on caseload by zone (days) (see page 18)	448.2	-	→	-	
	Flow					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 19)	218	= 0	↗	X	
	Flow					
	Inpatient discharge letters sent within 24 hours (%) (see page 21)	92	≥ 90.0	→	?	
	Flow					
	Number of people accessing Individual Placement and Support (IPS)	-	TBC	-	-	Metric to be defined
	Flow					

	Priority Metrics	Jun-22	Target	Trend	Assurance*	SPC Chart
Operations	IAPT recovery rate - Merton Uplift (%) (see page 22)	50.0	≥ 52.0	→	?	
	Flow					
	IAPT recovery rate - Sutton Uplift (%) (see page 22)	55.1	≥ 50.0	→	?	
	Flow					
	IAPT recovery rate - Talk Wandsworth (%) (see page 22)	54	≥ 50.0	→	✓	
	Flow					
	Data quality maturity index (DQMI) (%) (see page 23)	98.1	≥ 95.0	→	✓	
	Operations					
Quality	Inpatient Risk assessments completed within 48 hours of admission (%) (see page 24)	92	≥ 95.0	→	✗	
	Fundamental Standards of Care					
	Physical Health Assessment completed within 7 days of admission (%) (see page 25)	80.2	≥ 90.0	→	✗	
	Fundamental Standards of Care					
	Safe Staffing: national Compliance - Inpatients (%) (see page 26)	126.6	≥ 95.0	→	✓	
	Fundamental Standards of Care					
	Safe Staffing: Community safe staffing indicator	-	TBC	-	-	Metric to be defined & developed
	Fundamental Standards of Care					
	Always Ready Audit Compliance (%) (see page 28)	87.0	≥ 90.0	↘	?	
	Fundamental Standards of Care					
	Patient Friends and Family Test (%) (see page 29)	86.8	≥ 92.0	↘	✗	
	Patient Experience and Outcomes					

	Priority Metrics	Jun-22	Target	Trend	Assurance*	SPC Chart
Operations	Expected population need met by IAPT (see page 22)	TW 2115 SU 1171 MU 1173 RI 1198	TW 2453.1 SU 1115.1 MU 1324.8 RI 1269	-	-	
	Flow					
Quality	Community risk assessments reviewed within the last 12 months (%) (see page 24)	92.3	≥ 95.0	→	✗	
	Fundamental Standards of Care					
	Physical Health Assessment attempted within 48 hours of admission (%) (see page 25)	95.6	≥ 95.0	→	?	
	Fundamental Standards of Care					
	Cardiometabolic Assessments - Community and EIS (%) (see page 26)	85.4	≥ 75.0	↘	✓	
	Fundamental Standards of Care					
	Safe Staffing: baseline includes requirements related to observation levels (see page 27)	84.8	-	→	-	
	Fundamental Standards of Care					
	Always Ready Audits Completed (%) (see page 27)	85	≥ 90.0	↗	✗	
	Fundamental Standards of Care					
	Complaints Answered Within 25 Days (%) (see page 28)	85.2	≥ 85.0	↗	?	
	Patient Experience and Outcomes					
	Patient Safety Incidents – Severe Harm (see page 30)	1	≤ 1.5	→	?	
	Patient Safety					

	Priority Metrics	Jun-22	Target	Trend	Assurance*	SPC Chart
Quality	Total number of restraints (physical restraints and rapid tranquilisation) (see page 31)	81	-	→	-	
	Patient Safety					
	Death - Suspected suicide (see page 32)	5	≤ 4	→	?	
	Patient Safety					
Workforce	Vacancies in active recruitment (%) (see page 34)	58	≥ 90.0	→	✗	
	Recruitment/ Attraction					
	Percentage of BAME staff - Band 8+ and Medical	28.4	≥ 50.0	↗	✗	
	Recruitment/ Attraction					
	Temporary staffing - Community Service Line (%) (see page 36)	20.4	≤ 22	→	✓	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 2 (%) (see page 37)	90.7	≥ 85.0	↘	✓	
	Staff Skills/ Development					
	Staff Leaving within 12 months of appointment (%) (see page 38)	18.7	≤ 20	↘	✓	
	Staff Retention/ Support / Satisfaction					
	PADR (%) (see page 39)	77.6	≥ 95.0	↘	✗	
	Staff Retention/ Support / Satisfaction					
	ER cases exceeding 90 days	32	TBA	-	-	Metric to be developed
	Staff Retention/ Support / Satisfaction					
Finance	Agency as a % to NHSI Target (%) (see page 41)	173	≤ 100	↗	✗	
	Grip & Control					

	Priority Metrics	May-22	Target	Trend	Assurance*	SPC Chart
Quality	Reducing restrictive practices – Prone Restraint (see page 31)	30	-	↘	-	
	Patient Safety					
Workforce	Vacancy Rate (%) (see page 33)	20.4	≤ 15	↗	✗	
	Recruitment/ Attraction					
	Time to Recruit (days) (see page 34)	47.4	≤ 49	↗	?	
	Recruitment/ Attraction					
	Temporary staffing - Acute and Urgent Care Service Line (%) (see page 35)	31.2	≤ 22	↗	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 1 (%) (see page 37)	92.3	≥ 95.0	↘	✗	
	Staff Skills/ Development					
	Turnover (%) (see page 38)	18	≤ 15	↗	✗	
	Staff Retention/ Support / Satisfaction					
	Supervision (%) (see page 39)	83.2	≥ 85.0	→	?	
	Staff Retention/ Support / Satisfaction					
	Active ER cases (see page 40)	77	TBA	-	-	
	Staff Retention/ Support / Satisfaction					
	Staff Friends and Family Test (recommend treatment) (reported quarter in arrears) (%) (see page 40)	-	≥ 75.0	-	-	Metric to be developed
	Staff Retention/ Support / Satisfaction					
Finance	% forecast budget overspend	-	TBA	-	-	Forecast reporting not available until month 4
	Grip & Control					

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

Performance overview of COVID-19 priority metrics – key areas and methodology for improvement

The executives have reviewed the totality of the indicators across all domains. The information within the priority metrics section of this report captures a subset of key issues for your attention and information.

This information is taken from reports discussed at the monthly service line review meetings and reviewed by the Chief Operating Officer and the wider Executive Team through the assurance structure. The subset gives focus, but it is not intended that this will discourage discussion around broader issues where necessary.

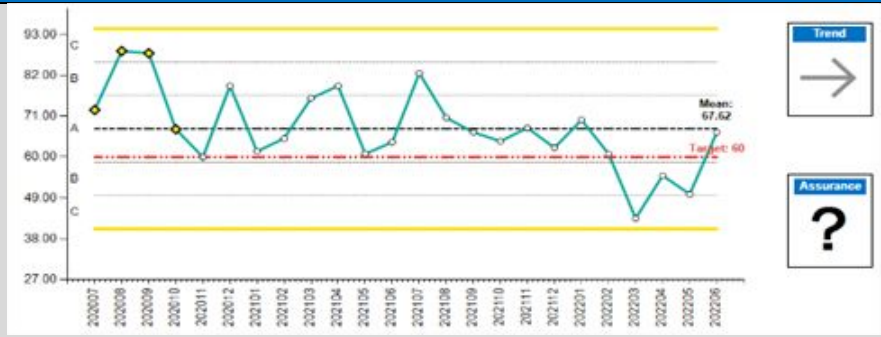
The following pages provide more detail on the priority metrics including the underlying issues, benchmarking, risks actions and assurance.

Service lines have access to dashboards to identify outlying teams and distinguish sustained improvement from expected variation related to key indicators. Performance and progress against action plans are discussed at the weekly/monthly domain performance meetings Chaired by the responsible executive with Clinical Directors in attendance. Following a review in June 2020, Clinical Directors now meet with Executive Directors each month to review performance and discuss underlying issues and actions.

Operations Domain

Access

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



Team Breakdown – June 2022

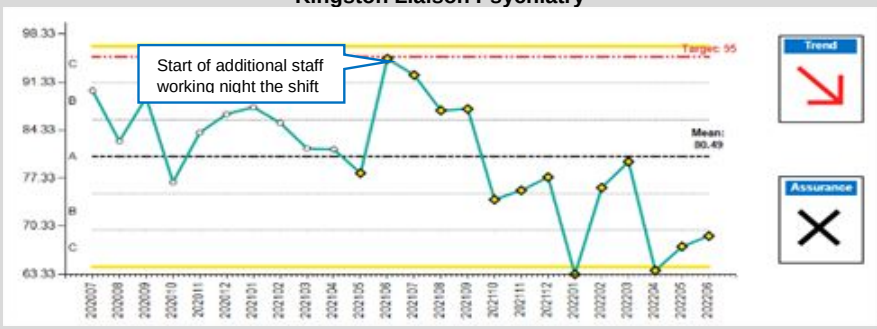
EI Team	Treatment Within14 Days	Referrals	%
Kingston Early Intervention Service	4	7	57.1%
Merton Early Intervention	3	3	100.0%
Richmond Early Intervention Team	2	2	100.0%
Sutton Early Intervention	1	1	100.0%
Wandsworth Early Intervention	4	8	50.0%
Grand Total	14	21	66.7%

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

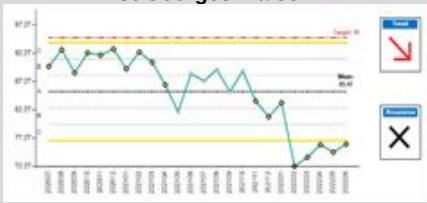
Actions:
- Trust to explore digital solution to initiate a prompt in Rio upon entry of diagnosis of psychosis.
- Targeted training for SPA teams to continue in order to reinforce the importance of timely referrals to EIS.
- Management support in K&R EIS: locum management cover to be sourced in June to support interim Team Manager to recover performance including monitoring of outcome recording. New Richmond Clinical Manager to commence in post on 25th July.
- To maintain performance over 60% for all teams through core structures of daily huddles and use of dashboards by each EIS team.

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

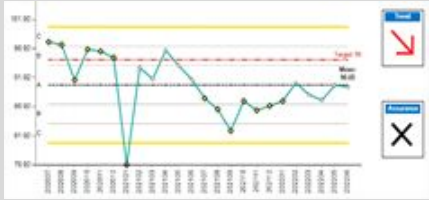
Kingston Liaison Psychiatry



St Georges Liaison



St Helier Liaison



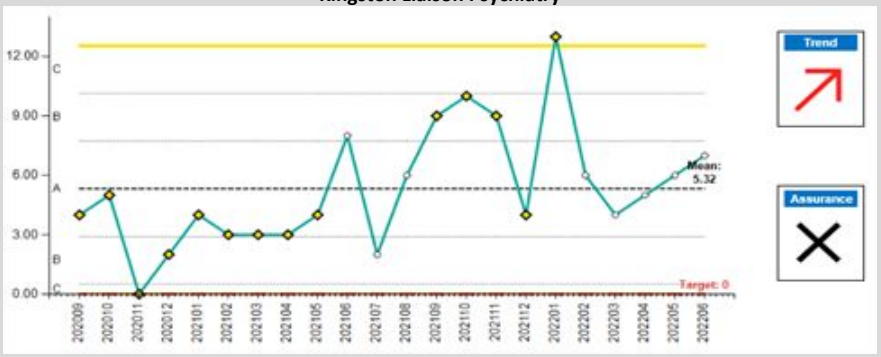
Background
Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care' published by NICE in 2015 states that an emergency liaison mental health service should respond within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment.
What the charts tells us
St Helier will sometimes exceed the target; it is extremely unlikely that Kingston and St George's will meet the target without a change in process.
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.
- 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.
- In Kingston there have been some staff shortages due to sickness which led to a number of shifts being unfilled.
- Practice issues which Acute and Urgent Care Management Team are to work through with the liaison services.

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.
- In Kingston costing completed to combined non nursing post to create a twilight shift Band 7 shift to cover 4pm-midnight (breaching referrals are usually between 6pm-midnight).
- Liaison Consultant and Team Managers are working together using QI methodology for improvement in 1- hour response time by also understanding efficiency/productivity by accurate use of RiO, task prioritisation.
- Recruitment of new Clinical Service Leads and Team Managers as part of the work of creating an MDT leadership culture and ownership of key liaison KPIs.

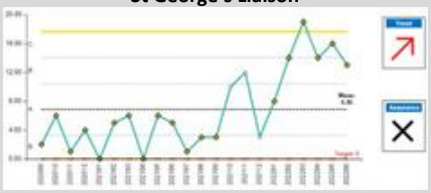
Access

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

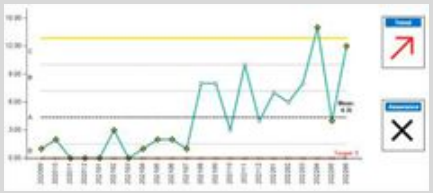
Kingston Liaison Psychiatry



St George's Liaison



St Helier Liaison



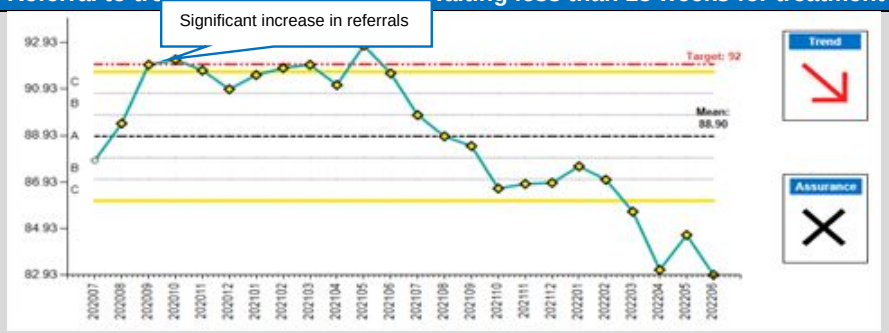
Background
Patients assessed at A&E by Liaison Psychiatry should not experience long waiting times if access to a bed is required.

What the charts tells us
The level of 12-hour breaches generally remains low in Kingston; significant increase in St Georges and St Helier in March 2022.

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

Actions
- Breaches are discussed and escalated in a daily pathway meeting where patient clinical needs and risks are rated using a bed prioritisation scoring.
- The new Acute & Urgent Care Service Line management are to have discussions with liaison services in November 2021 as part of a review and update of action plans related to consistently underperforming metrics.
- The Trust has extended its contract for use of 12 beds at Huntercombe in Roehampton until the end of the financial year.
- Meeting took place to review use of trusted assessor framework to minimise need for admission.
- Recruitment of Consultant Psychiatrist to Kingston Liaison Psychiatry on short term contract; there is also ongoing recruitment process for substantive Consultant posts within the service.
- Trust recently reviewed the Trusted Assessors Framework which will prevent duplicate assessments pre-admission i.e. once assessed by liaison or HTT there should be no need for further assessment as long as all points of framework are covered.

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



% waiting less than 18 weeks including / excluding ADHD teams – June 2022

Including ADHD/ASD teams	82.9%
Excluding ADHD/ASD teams	91.0%

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.

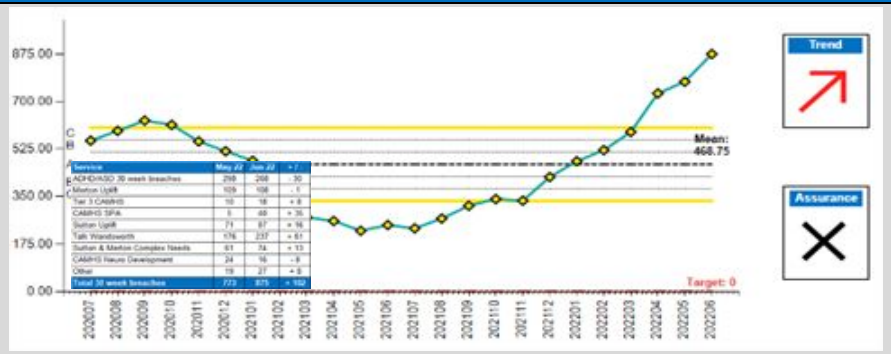
What the chart tells us
Mean performance is below target and there has been a significant downturn trend in performance since April 2021. A change in process is required in order to improve performance.

Underlying issue
- **Adult ADHD:** There are known demand and capacity issues within the service; in June 2022, 55.4% (557/993) 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 this will provide more accurate waiting times and enable teams to have more control in determining when treatment has commenced. Dashboards are currently being realigned to support local monitoring.
- **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 June 2022 to assist with clearing screening backlog.
- Therapy waiting cases are reviewed through 8 weekly review calls and all waiting patients are provided with a Whileyou 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 Line Breakdown - RTT Teams	Waiting to commence treatment	Longest Wait	< 18 weeks	RTT Compliance	> 18 weeks	18-39 weeks	40-52 weeks	> 52 weeks
Acute & Urgent Care	326	21	326	99.4%	2	0	0	0
CAMHS & ED	2375	38	2033	85.6%	342	74	0	0
Community	1363	34	1257	96.5%	45	7	0	0
Specialist Services	1817	53	1208	66.7%	603	215	82	1
Total RTT Teams	5,817	53	4824	82.9%	993	296	82	1

Service Line Breakdown - Non-RTT Teams	Waiting to commence treatment	Longest Wait	< 18 weeks	RTT Compliance	> 18 weeks	18-39 weeks	40-52 weeks	> 52 weeks
CAMHS & ED (exc CAMHS Neuro)	293	38	247	84.3%	46	8	0	0
CAMHS Neurodevelopment	143	78	79	55.2%	64	14	0	2
Community (excluding IAPT)	189	91	78	41.3%	111	25	20	35
IAPT	5,230	59	3,938	75.3%	1292	428	67	0
Specialist Services	145	45	128	88.3%	17	0	1	0
Total Non-RTT Teams	6,000	91	4516	75.3%	1484	475	88	37

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.

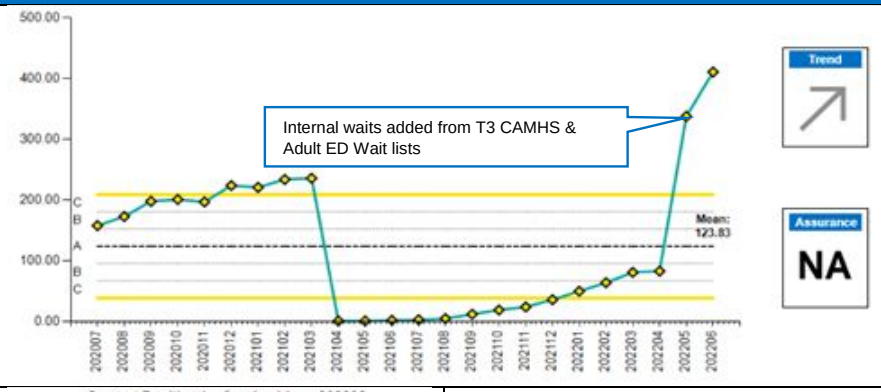
What the chart tells us
Following long-term poor performance, the trust was able to consistently improve but there has been further deterioration over recent months.

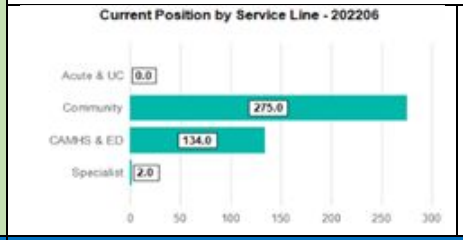
Underlying issues
- Relates to a small number of services with longstanding demand and capacity issues (see table opposite).
- **Adult ADHD:** Significant increase in referrals and insufficient capacity. Additional monies have been received but recruitment has been challenging and will not resolve the 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; 35 people waiting more than 52 weeks for treatment while under support of the RST.
- **IAPT:** Insufficient resources to meet the demand for therapies as well as exceed other targets related to recovery and waiting times. Staff numbers are critical to support a reduction in waiting times and recruitment is an on-going challenge in Sutton and Merton. Long waiters have been outsourced to 3rd party provider and there are concerns about capacity and performance and longer waits. The Trust believes this is common among many third party providers. Administration resources stretched and unable to get cover via Trust Bank.

Actions
- The reporting of RTT by appointment type commenced on 1st July 2022 this will provide more accurate waiting times and enable teams to have more control in determining when treatment has commenced. Dashboards are currently being realigned to support local monitoring.
- **Adult ASD/ADHD**: **Waitlist initiative**: ADHD long waiters will be seen by a third-party using waiting list initiative monies by July 2022 with first 50 scheduled to be completed in May 2022 and 200 by end of July. **Medication Reviews:** To undertake annual medication reviews and support caseload management two non-medical prescribers have been recruited. One appointee commenced in post in March 2022 whist the other is due to start in June 2022. Specialist Service line in conjunction with Community Service Line exploring option of using Non Medical Prescribers within primary care service.
- **CAMHS Neurodevelopmental Service:** A waiting time initiative commenced in December 2020 and ran till July 2021 and led to a significant reduction in long waiters. The clinical pathway and service capacity has also been revised.
- **Sutton & Merton Complex Needs (non-RTT):** More resource and a strengthened Trust-wide PD pathway are being introduced through community transformation and additional investment of 3.6 wte therapists recently secured. The development of new roles including Structured Clinical Management Workers (12 new posts added January 2022 with an additional 6 for 22/23) will create a stepped model to improve access to PD therapies in community teams. Improvement plan for service is in place but will only slow increase in wait list given disparity between demand and capacity. Community P&P lead is continuing to work with service improve position.
- **IAPT:** IAPT services recruitment is ongoing, Service review waiting lists against DNA policy, and are work with sub-contractor to support. Patients are reviewed during wait to ensure safety. IAPT services are looking to build on existing extended hours working in order to create greater flexibility for patient appointments
- A performance review for IAPT services was held with the COO in April with the next planned in August 2022.

Access

Internal waits for treatment of over 30 weeks (based on RiO Psychology waits) Target = 0





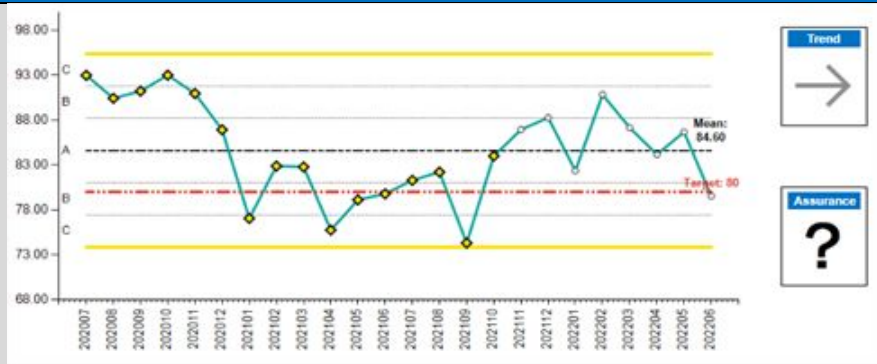
Background
Psychological interventions, such as the use of Cognitive Behavioural Therapy (CBT) are an important part of patient treatment and lead to improved outcomes. Delays or barriers to treatment are likely to adversely affect patient outcomes. This is a new priority metric for the Trust Board introduced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

What the chart tells us
Period of significant increase has been followed by a decrease in long waiters in recent months.

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

Actions
- The Head of P&P has summarised the issues, risks and recommended actions and this was discussed by the Executive Leadership Team on 30th September 2021.
- Trust wide SOP for managing patients only on P&P wait list.
- 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.
- Resources required to address excessive waits beyond those currently available through demand pressure/ transformation funding or productivity will be identified by service lines and put forward to the 2022/23 commissioning process as appropriate and before March 2022.
- Comprehensive action plan for Complex Needs services in place.
- In Richmond CAMHS 2x 8a posts are out to advert following recent departures in the team.

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



Underperforming Teams

Assessment Team	Assessed 28 Days	Assessments	% Assessed 28 Days
Morden Recovery and Support Team	7	9	77.8%
Wandsworth SPA	124	154	75.6%
Central Wandsworth & West Battersea CMHT	2	3	66.7%
Richmond OP Care Home Liaison Service	4	6	66.7%
North Kingston CMHT	3	5	60.0%
Sutton Adult Assessment Team	47	87	54.0%
Sutton Memory Assessment Service	29	55	52.7%
Wimbledon Recovery and Support Team	2	4	50.0%
Twickenham RST	9	20	45.0%
Merton Memory Assessment Service	15	35	42.9%
Richmond Memory Assessment Service	18	43	41.9%
Memory Assessment Service Wandsworth	17	45	37.8%
Richmond RST	2	7	28.6%
South East Wandsworth CMHT	1	5	20.0%
Sutton Primary Care Recovery Team	0	1	0.0%

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

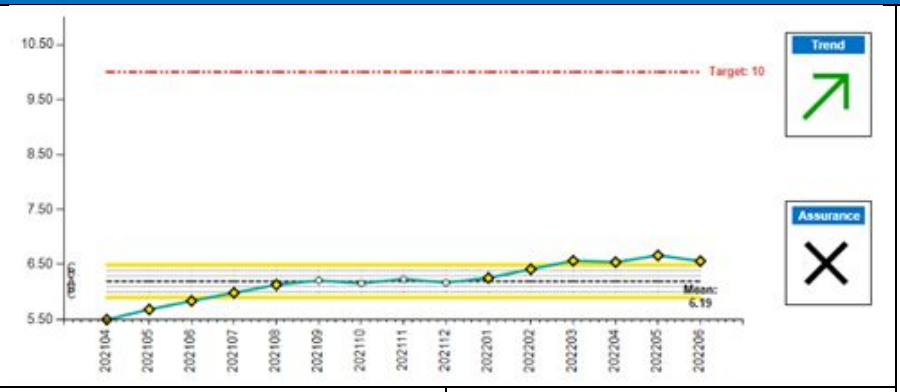
What the chart tells us
There has been historic variation in performance with a period of high performance followed by a period below target. Recent access performance has shown improvement.

Underlying Issue
- **Trust:** Increased demand has placed significant capacity pressure on some assessment teams/CMHTs.
- **Sutton:** There has been an increase in referrals for NHS Sutton clients; with past seven months referrals above the mean. There was also reduced medical capacity for a period due to sickness which has led to a wait list back log which the service is working through.

Actions
- **Trust:** New SOP for appointment recording was approved at Quality Governance Group in November 2021 and issued to clinical; teams on the 24th January 2022. This will enable clinical teams to have more autonomy on determining when patient assessments and treatment have commenced. This is expected to lead to the reporting of more accurate waiting times.
- Trust to embed Contact Recording SOP to enable better recording of "Treatment" started
- The reporting of access within 28 days 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.
- **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. A part-time locum Consultant commenced in post in May 2022, a full-time locum has been sourced in July.
- Additional management support is being provided to the team via the Service and Clinical Manager.
- **Wandsworth**: Two locum Consultants have recently commenced in post in (May and June 2022 respectively).

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

Access



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

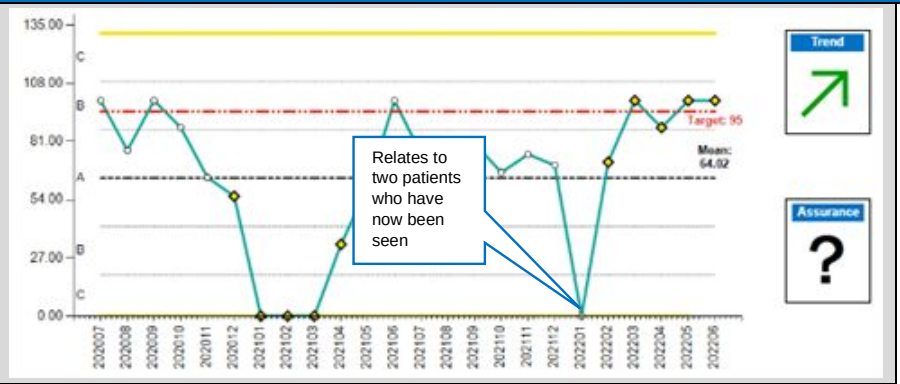
What the chart tells us
Although positive upward trend mean performance is considerably below national requirement (target).

Underlying issue
- National target is based on predicted birth rate which is higher than the actual local birth rate.
- Number of referrals received progressing to assessment is too low in order to reach access requirements of 10% of PMH population.
- Data quality in recording is impeding performance.
- Limited financial investment will prevent expansion of team –lack of capacity to increase access rates to required levels and reduce ability to reduce inequalities.

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

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

Access



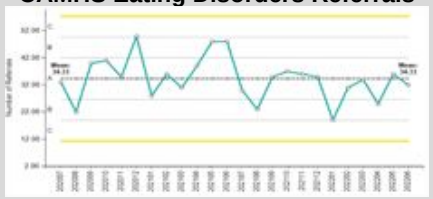
Background
To ensure that young people in urgent need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target and target will not be consistently met unless there is a change in process.

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.
- Team fully complaint with target in June 2022. Denominator is low (n=8 in May 2022) so any case seen outside 28 days is likely to lead to target being missed.
- Recruitment into the service has been challenging with certain posts difficult to recruit to.

Actions
- Additional training and intensive supervision have been provided to nurses in fixed term / seconded posts in the team to provide first line family focused eating disorder therapy.
- There is ongoing recruitment within the service with all vacant posts either out for advert or about to be advertised. The service has successfully recruited to a new Consultant post with successful candidate due to start in July 2022; two new members of staff (Clinical Psychologist and ED specialist) commenced in post in January 2022.
- Improved recording process and dashboards have been introduced to support more accurate reporting.
- New Service Manager is now in post and improving waiting times has been identified as a priority.

CAMHS Eating Disorders Referrals



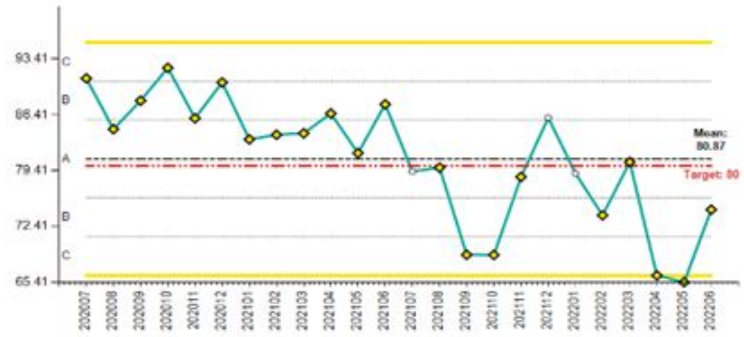
Waiting for Treatment Summary June 2022

		00 - 01	01 - 02	02 - 03	03 - 04	07 - 08	08 - 09	12+	Total
Waited	Standard	1	4	2	1	0	0	0	8
	Urgent (7days)	1	0	0	0	0	0	0	1
Waiting	Standard	7	2	1	0	1	1	1	13
	Urgent (7days)	1	0	0	0	0	0	0	1

Access

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

Target ≥ 80%



Team Breakdown

Access Team	Access Within 8 Weeks	Total Assessed	%
Kingston CAMHS Tier 3	18	22	81.8%
Merton CAMHS Tier 3	15	23	65.2%
Richmond CAMHS Tier 3	12	18	66.7%
Sutton CAMHS Tier 3	28	35	80.0%
Wandsworth CAMHS Tier 3	3	4	75.0%
Total	76	102	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 just above target indicating target will frequently be met but there will be variation.

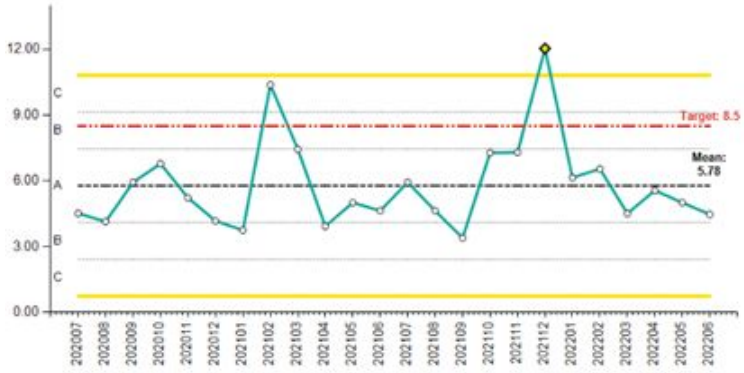
Underlying issue
- Most breaches relate to waits for ADHD medication and Psychiatry. As T3 CAMHS continues to assess more of the backlog of ADHD waiters this KPI will continue to deteriorate of until the backlogs are cleared.
- There are delays in ADHD medication due to the prioritisation of urgent referrals, screening forms being returned late, patients cancelling appointments and a small number of errors in recording.
- Delays in receipt of further information from external agencies, and opt-in and rescheduling of appointments by parents have contributed to not meeting target.

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

Flow

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

Target ≤ 8.5%



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.

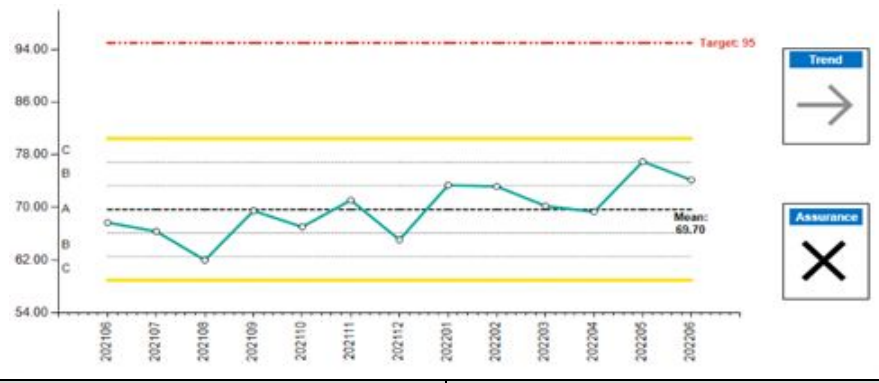
Underlying issue
- 5 emergency re-admissions reported in June 2022.

Actions
- Acute & Urgent Care Service Line continue to review re-admissions

Zoning caseload seen as required (%) - Amber

Target ≥ 95%

Flow



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

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

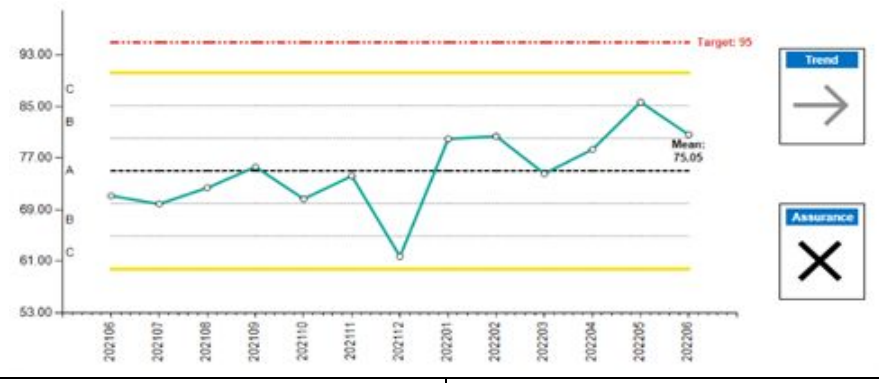
Underlying issue
- Slow adoption of some teams of standard operating procedures relating to recording the correct zone and the prompt recording of contacts.
- In CAMHS initial audit findings have found cases when the client's zone needs to be downgraded to i.e. red to amber or amber to green so they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

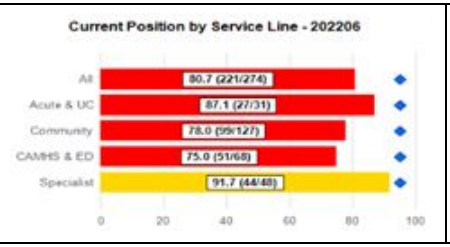
Actions
- Standards for frequency of face-to-face contact have been agreed with the service lines and zoning dashboards have been enhanced to reflect the revised standards and support the process.
- A decision support tool has been introduced across all service lines to support staff to deliver care in the appropriate setting and at the right frequency
- The CAMHS Service Line has developed and issued revised guidance (developed by the Advanced Clinical Practitioner) in order to support Tier 3 services.
- Zoning audits are being across service lines to inform on learning and local practice.
- Specialist Services are also undertaking regular audit on zoning breaches to inform on learning and Clinical Managers/Modern Matrons are ensuring teams are using dashboards in meetings and reviewing breaches when there is no contact.

Zoning caseload seen as required (%) – Red

Target ≥ 95%

Flow





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

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

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

Actions
- Standards for frequency of face-to-face contact have been agreed with the service lines and zoning dashboards have been enhanced to reflect the revised standards and support the process.
- A decision support tool has been introduced across all service lines to support staff to deliver care in the appropriate setting and at the right frequency
- Specialist Services are also undertaking regular audit on zoning breaches to inform on learning and Clinical Managers/Modern Matrons are ensuring teams are using dashboards in meetings and reviewing breaches when there is no contact.
- The CAMHS Service Line has developed and issued revised guidance (developed by the Advanced Clinical Practitioner) in order to support Tier 3 services.
- Zoning audits are being across service lines to inform on learning and local practice

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

Flow

Audit 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.

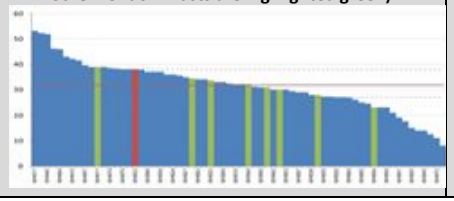
Underlying issue
- Community: Some patients remain for long periods on caseload due to being prescribed Clozapine.
- GPs in some areas are still reluctant to accept patients on depot and therefore these patients remain on the RST/CMHT caseloads.

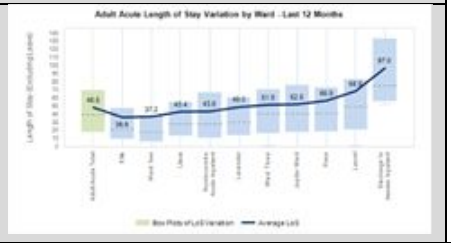
Action
- As part of transformation of community services and the introduction of new roles and processes, the service line is reviewing the process of stepdown/discharge following recovery.
- Analysis undertaken in May 2022 to look at the teams with the longest average waiting times. This was reviewed in the June Flow Meting.
- In CAMHS a review is being undertaken on Tier 3 caseloads to identify any variation between services.
- KPI definition document to be worked up in order to provide greater clarity for time on caseload

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

Flow

2020/21 Benchmarking (Trust is highlighted red, other London Trusts are highlighted green)





Background
Average length of stay is important as it informs future bed planning. This definition was agreed by the Bed Management Project Group and approved by Trust Executive. It includes out of area placements and excludes stays on PICU wards and leave.
What the chart tells us
Trust average performance exceeds the national average in 2020/21 (denoted as the target).

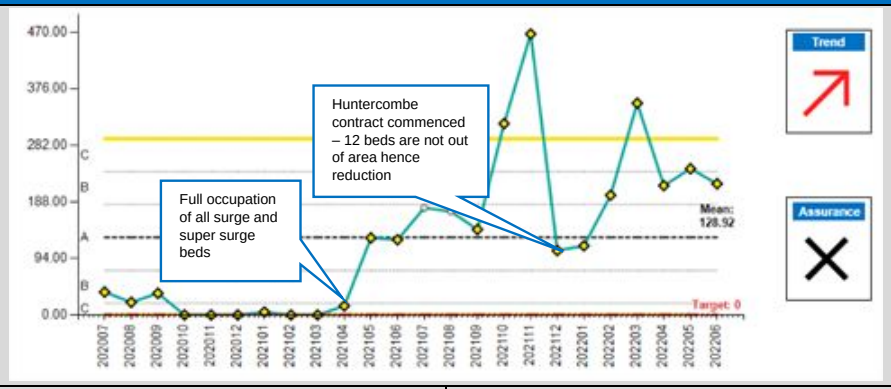
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds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

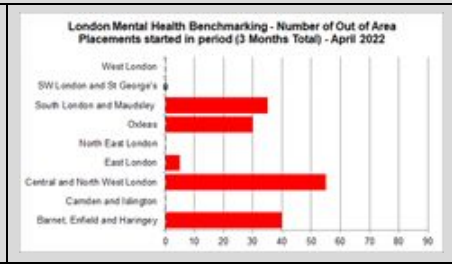
Action
- Consistent use of estimated discharge dates (EDD); reviews of patients with stays of over 90 days.
- More assertive use of the improved delayed transfer of care (DTOC) process
- A revised draft choice/discharge policy for use by the discharge co-ordinators has been issued to partners for comment.
- Monthly variability will continue as complex patients are discharged as part of transformation programme, which aims to improve the efficiency of all ward processes. The core & complex and inpatient processes workstream should gradually reduce stays towards the 33-day target during the next 6-12 months.
- As part of data assurance process the Trust is undertaking a review of the definition of length of stay.
- The Trust held a MADE event held on 25th May and follow up actions in place.
- In-reach worker reviewing clients with LOS greater than 60 days at Queen Mary's site.

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.
- Lower occupancy rates related to a reduction in acute demand and an increase in discharges to home treatment teams as part of the Trust COVID-19 response resulted in sudden reduction in April 2020.
- Increase after May 2021 a result of fully occupied surge and super surge beds, related to acuity, demand and available staffing issues. On occasion super surge beds are not available to ensure the safe staffing of patients.

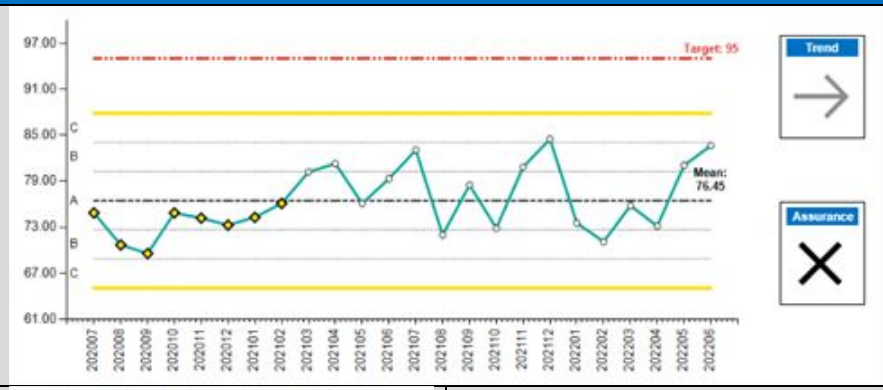
Actions

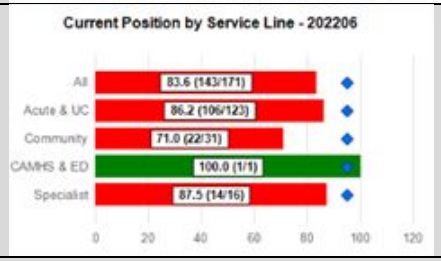
- The Trust has extended its contract for use of 12 beds at Huntercombe in Roehampton until the end of the financial year.
- Due to continuing demand pressure on beds, the Trust is evaluating options for use of further Huntercombe beds (preferred) against potential use of an internal option.
- The Cygnet Discharge to Assess arrangement ended in May 2022 and patients are being moved on to appropriate settings in a phased way.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum.
- MADE event held on 27th May 2022 and follow up meetings booked for June 2022.
- Community service line has joined pathways meeting to support with discharge, care co-ordinator allocation and flow.

Flow

Follow up within 48 hours of discharge from inpatient services (%)

Target ≥ 95%





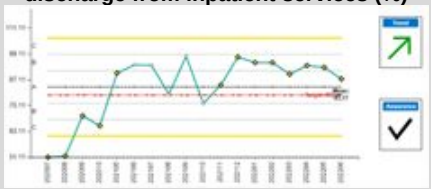
Performance by service – June 2022

Responsible Service Type	Followed Up within 48 hours	Discharges	%
Community	28	38	73.7%
HTT	61	66	92.4%
Lotus	22	31	71.0%
Ward	32	36	88.9%
Total	143	171	83.6%

Follow-up summary including attempts – June 2022

	Discharges	48 HR Followup				7 Day Followup	
		Seen as required	Breaches	Seen any	Attempted	Seen	Breaches
Acute And Urgent Care	123	86%	17	87%	93%	97%	4
CAMHS & ED	1	100%		100%	100%	100%	
Community (Adults)	30	70%	9	80%	90%	93%	2
Specialist Services	16	88%	2	94%	94%	94%	1
Total	170	84%	28	86%	93%	96%	7

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



Background

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

What the chart tells

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

Underlying issues

- Previous process mapping highlighted inadequacies in the referral system for follow up; responsibilities are not always clear, inadequate communication between wards and community teams and systems are overly reliant on individuals rather than process.
- High sickness and vacancy rate has meant reliance at times on agency staff who are less familiar with follow up processes
- Inconsistent documentation of clinical record; appointments not recorded in diary or discharge planning form
- Lotus Assessment Suite has highest number of breaches and relates to patients who are more difficult to engage (i.e. patients not answering phone calls) and where processes have not been amended to resolve this issue. Lotus have also identified staffing issues (vacancies) as a contributing factor in follow up processes not always being implemented.
- Whilst patients may not be seen, the Trust has assurance that attempts were made (see table) to contact most people.
- Attempts to contact noted in June 2022 was 86% ideally this needs to be at 100%.

- **7 day follow Up:** The Trust incurred 7 breaches in June 2022 with 4 clients subsequently seen. Of the remaining 3 not seen; the first case had multiple attempts to contact without success patient has now discharged to GP; client subsequently contacted the police after being reported missing; second case had Multiple attempts to contact without success; the third case had multiple attempts to contact; police have been contacted to undertake welfare check.

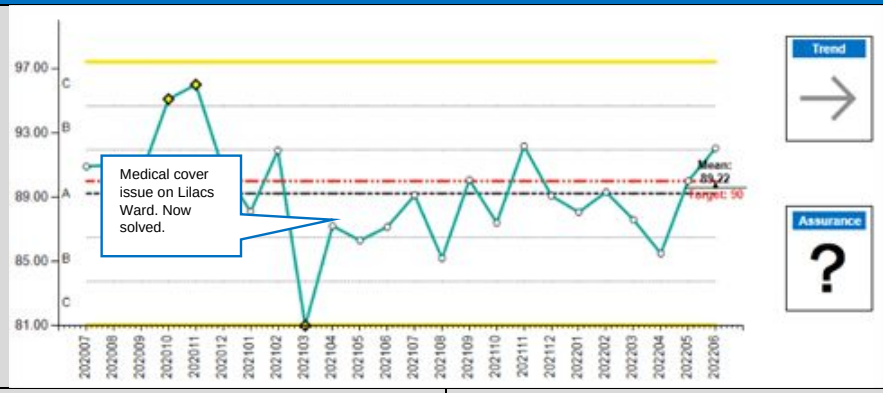
Actions

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

Flow

Inpatient discharge letters sent within 24 hours (%)

Target ≥ 90%



Letters sent within 24 hours – June

Compliant	Total Letters	%
104	113	92.0%

14 / 19 wards were 100% compliant

Letters sent within 7 days – June

Compliant	Total Letters	%
111	113	98.2%

18 / 19 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.

Underlying issue
- A small number of adult acute wards do not have a robust process due to insufficient and unresolved medical cover and administrative staff continuity.
- The Trust is unable to receive automated data on the transmission of discharge summaries leading to a reliance on an inefficient recording and monitoring system that is a burden to clinical staff.
- Bank/Locum Dr's are not always aware of processes which can lead to delay in letter generation.

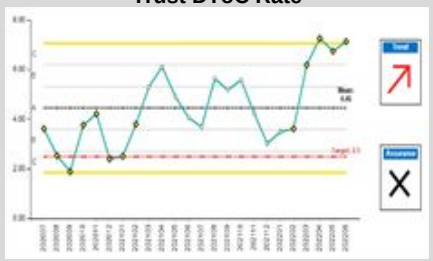
Action
- Following completion of pilot the Trust new process for Working Discharge Summary Completion will be rolled out across on 1st August 2022. This will include the automatic submission of the Discharge Summary to the GP via Docman Connect in RiO.
- Clinical and Administration staff have been trained on new Working Discharge Summary process and a new SOP has been issued across inpatient services.
- Work is in progress to embed the use of a dashboards report for daily checking of physical health assessment compliance, post-discharge follow-up and discharge letters, with the aim being for inpatient teams to be able to access and act on key standards of care in one place.
- There needs to be improved MDT working in order facilitate the discharge summary completion process.

Flow

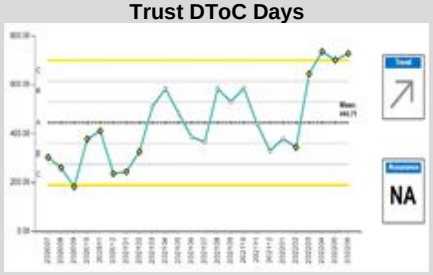
Delayed transfers of care (%)

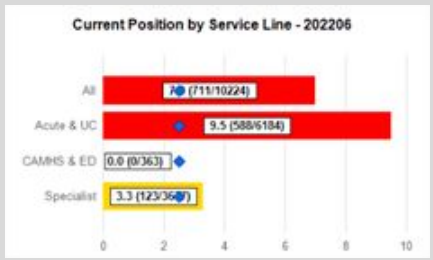
Target ≤ 2.5%

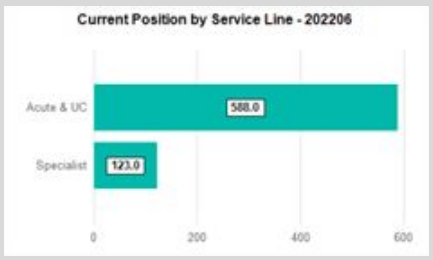
Trust DToC Rate



Trust DToC Days







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

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

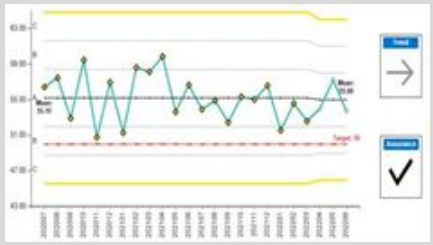
Underlying issue
- Improved identification of delays for non-medical reasons through use of an estimated discharge date.
- An increase in the proportion of more complex cases as bed numbers are reduced.
- Delays are often beyond the control of the Trust and reliant on LA engagement and resources.
- A reduction in care home places due to COVID has led to increase in delays for some older people.
- The involvement of the South London Partnership means the process is now more complex and at times there have been delays in response.
- Staffing issues in social services (although improved) have continued into June 2022.

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).
- The Trust held a MADE event held on 25th May for South West London sector to explore and address issues which effect patient flow; follow up sessions are also scheduled.

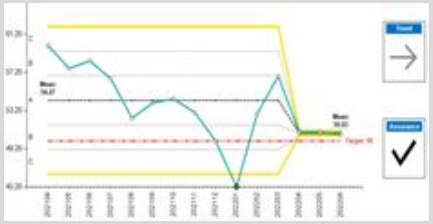
IAPT recovery rate (%) — Target ≥ 50%

Flow

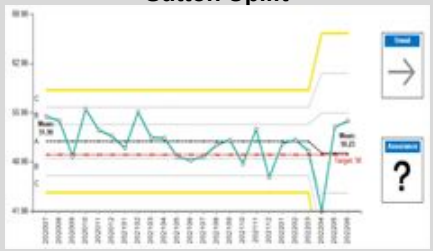
Talk Wandsworth



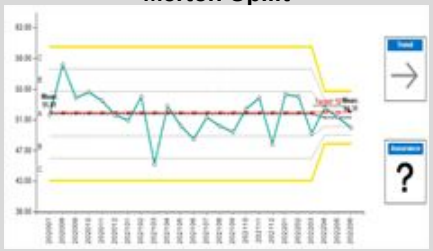
Richmond IAPT



Sutton Uplift



Merton Uplift



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

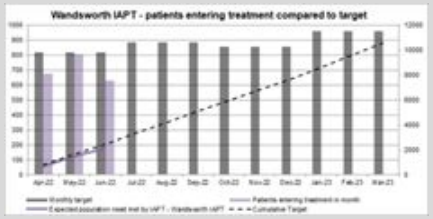
- Clients who 'drop-out' and fail to attend appointments (DNA) may be discharged before they have 'recovered'. This can be more apparent with sub-contracted services.
- Routine audits have shown that some processes around discharging clients (who were unrecovered) are not always being followed.
- In 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.

Expected population need met by IAPT (numbers entering treatment) — Target ≥ 95%

Flow



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

Sutton Uplift is above target whilst Richmond Well Being Service is in line with requirement; Talk Wandsworth and Merton Uplift are below their access requirements.

Underlying issues

- Insufficient referrals in Talk Wandsworth and increased recent vacancies in Step 2 affecting clinical resource for triaging of patients.
- Staff absences due to long term sickness/unplanned leave can lead to lost triage slots.
- National lack of available of PWP trained clinicians contributing to high vacancy rates.
- Issue with self-referral referral link on website for Merton Uplift which is impacting on incoming numbers and referral rates. Issue picked up in June 2022.

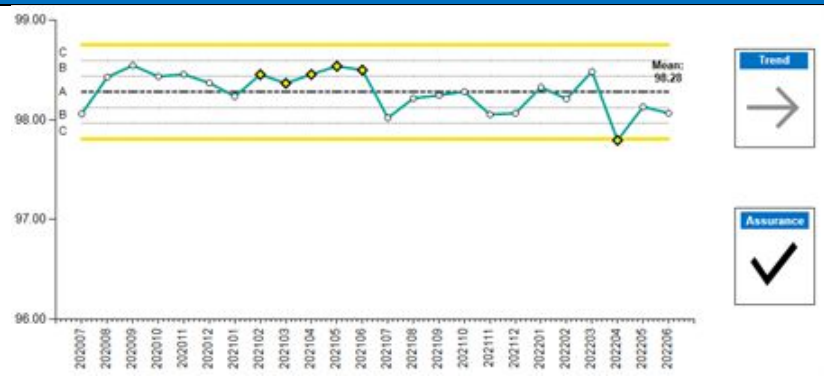
Actions

- The Trust has met with the third-party provider that is underperforming and an action plan is in place to address known issues including people who disengage with the service.
- Services continually review marketing plans; initiatives include face to face engagement, health and social care meetings and use of social media platforms.
- On-going recruitment across all services; increased marketing including working with partners, local authorities and community hub partners are in place in order to promote services and increase referrals; calls to all users in Sutton to support digital offer from online partner agencies.
- Following the Trust designation as contractual lead for Richmond IAPT with delivery sub-contracted to ELFT, there has ongoing dialogue to share best practice including identifying key factors, such as embedding staff in primary care, which have underpinned sustained high levels of access in Richmond. Trust trialling engagement system based on the model currently being used in Richmond.
- Recruitment of fixed term recruitment of Project Manager to standardise admin processes. Practices on IAPT referrals and SOP to also be produced.
- Careful monitoring of new IESO marketing sub-contract started in June for realisation of 125 converted referrals per month across Trust IAPT services. Increase of referrals via social media has been noted.

Operations

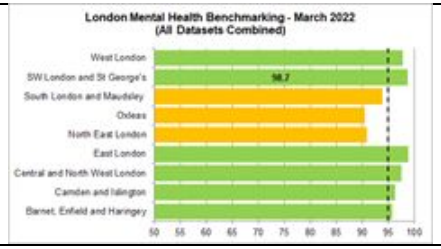
Data quality maturity index (DQMI) (%)

Target ≥ 95%



DQMI Areas for Improvement – June 2022

DQMI Item	% Compliance
Primary reason for Referral	92.3%
Care Contact Time (hour)	93.9%
Ethnicity Category Code	94.3%
Referral Closure Reason	90.3%
Ex British Armed Forces	88.3%



Background

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

What the chart tells us

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

Underlying issues

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

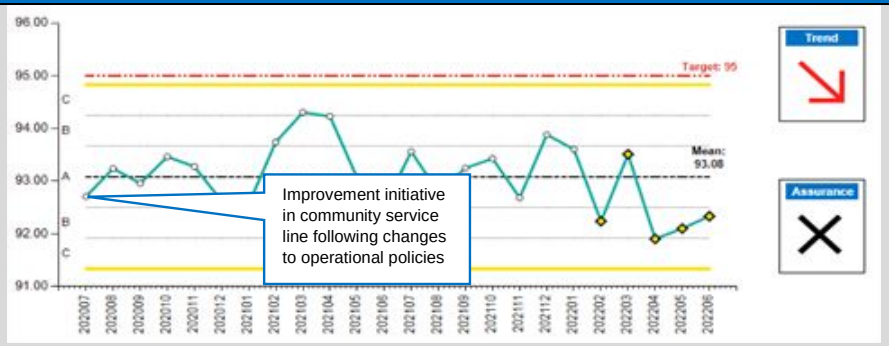
Actions

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

Quality Domain

Fundamental Standards of Care

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



CPA Breakdown – June 2022

CPA	93.3%
Non-CPA	92.8%

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

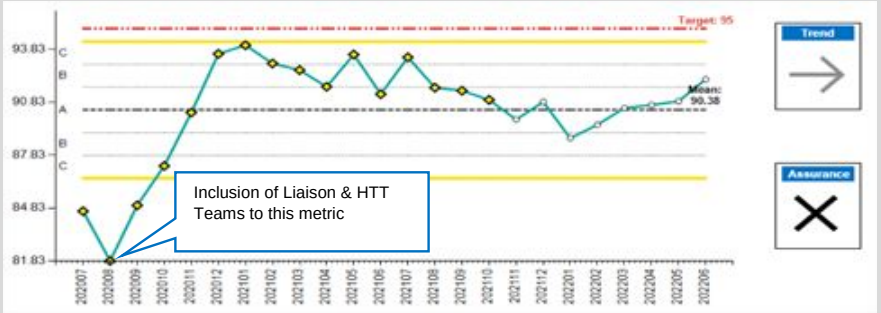
What the chart tells us
Target is in line with upper control limit suggesting it is unlikely that the target will be met without a change in process.

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

Actions
- The Fundamental Standards of Care community campaign and dashboard was launched in July 2022 across Community Services.
- Deputy Medical Director is currently undertaking a review of clinical risk assessment policy/recording.
- The Trust has shared with the CCG a proposal to increase service capacity by transferring the care of some stable adult ADHD patients (who require an annual specialist review) to primary care to create more capacity within the service.
- Dashboard report has been enhanced and provides greater detail on risk assessments that are out of date or invalid and these will support operational processes such as daily team meetings and 'huddles.
- **Community Service Line:** Care planning training programme also has a section on risk assessments. Locum and medical training to be introduced to ensure risk assessment completion. Also, service line focussing on 11 outlier services ensuring that updates to risk assessment updates are embedded in local practice.

Fundamental Standards of Care

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



Compliance by Service Type – June 2022

Event Type	RA in 48HRs	Admissions / Community Assessment	% RA in 48Hrs
Admission	111	114	97.4%
HTT Assessment	270	302	89.4%
Liaison Assessment	579	634	91.3%
Lotus assessment	103	104	99.0%
Grand Total	1,063	1,154	92.1%

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.

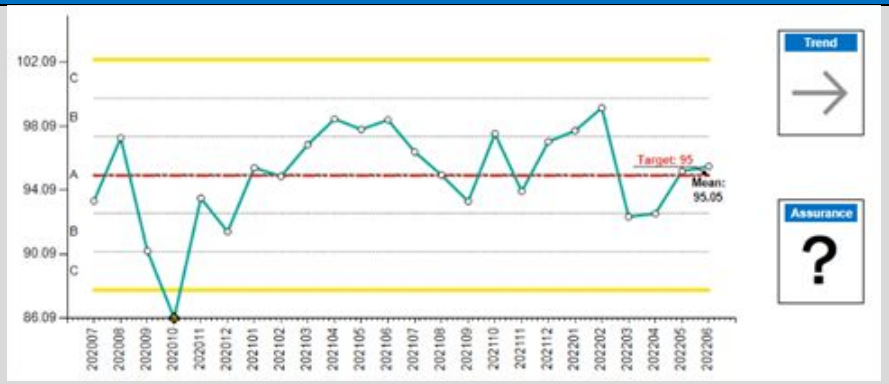
What the chart tells us
Following a change in reporting there was a period of improvement which has now plateaued. Target will not be met under current process.

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

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

Fundamental Standards of Care

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



June 2022 (Underperforming wards)

Admission Ward	Admissions	Attempted 48 Hrs	% Attempted 48 Hrs
Jupiter Ward	8	7	87.5%
Laurel	7	6	85.7%
Wisteria (ED Inpatient CAMHS)	3	1	33.3%

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.

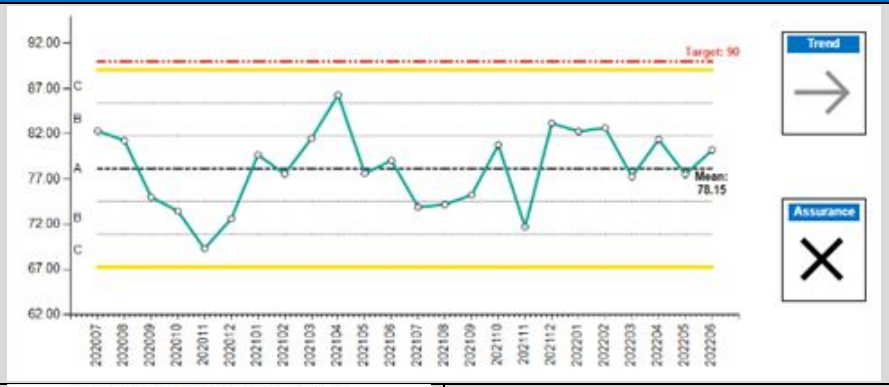
What the chart tells us
Historic under performance followed by recent sustained improvement above target.

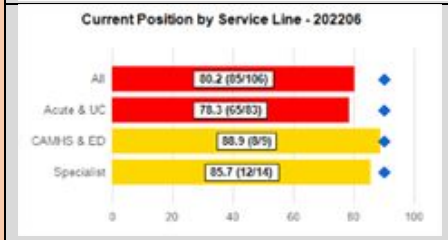
Underlying issue
- Consistent under performance linked to an inadequate configuration of the clinical IT system to support workflows and a need to improve daily ward processes to ensure assessments are consistently completed.
- The deterioration in May 2020 reflects the increase in transfers between COVID-19 admission wards and the weak processes to check that physical health information has been recorded
- 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.

Actions
- Data forms have been simplified following review by a task and finish group and were implemented across the Trust in September 2020. Guidance has been issued to all staff and induction training for junior doctors will be revised.
- Work is in progress to rationalise PHA forms in RiO and to embed the use of a dashboards for daily checks that assessments have been carried out.
- 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 been progressed to remove paper NEWS2 forms from the adult wards.
- 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%





June 2022 (Underperforming wards)

Admission Ward	Completed 7 Days	Admissions	% Completed 7 Days
Ward Three	12	14	85.7%
Laurel	5	6	83.3%
Lavender	4	5	80.0%
Rose	4	5	80.0%
Wisteria (ED Inpatient CAMHS)	2	3	66.7%
Ellis	4	8	50.0%
Halswell	1	2	50.0%
Ward One PICU	4	9	44.4%
Jupiter Ward	2	5	40.0%
Hume	0	1	0.0%

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.

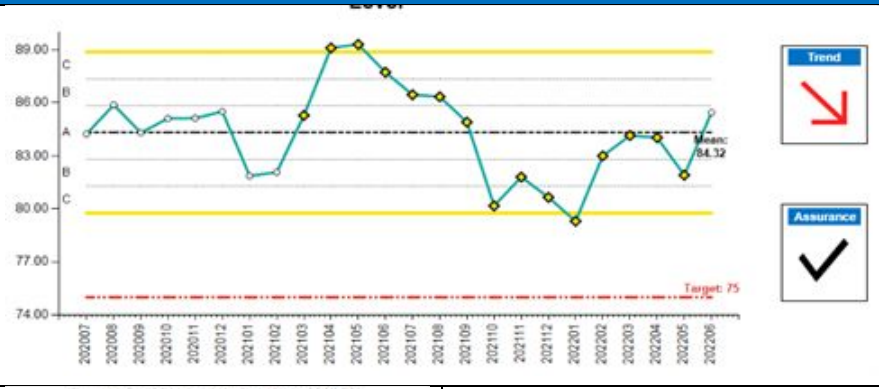
Underlying issue
- Consistent under performance linked to an inadequate configuration of the clinical IT system to support workflows and a need to improve daily ward processes such as handover to ensure assessments are consistently completed.
- A high number of patients initially refusing to undertake 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.

Actions
- A revised pilot of the new inpatient caseload dashboard is in progress on Lilacs and Lavender. Update on project progress is reported to the Ward Workflows Programme chaired by the Chief Operating Officer.
- Audits to understand underlying quality of care for patients suggest that physical health is being actively managed but not being recorded in the right place. The improvement plan will be re-visited to address this specific issue and any further actions.
- QII 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.
- See above for additional actions related to physical health monitoring.
- Inpatient caseload dashboard is used daily in safe staffing meetings.

Fundamental Standards of Care

Cardio metabolic Assessments – Community and EIS (%)

Target ≥ 75%



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

What the chart tells us
Community: It is highly likely that the target will always be exceeded

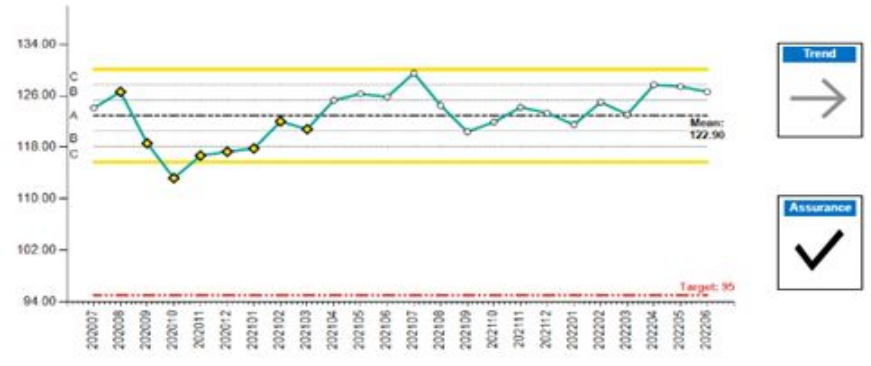
Underlying issue
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised. Trust clinical systems do not support workflow and performance is expected to dip in Q3 when annual re-reviews are required. Some medical staff do not follow processes and there is more focus required on supporting/training junior doctors to complete; difficulty accessing service users during Covid-19 due less face to face contacts meaning more reliance on GP and Clozapine clinics to obtain missing data.
- Number of community patients have declined assessments i.e. due to covid or personal choice. Community Service line have focus on improving the number of clients who receive a full CMA check.

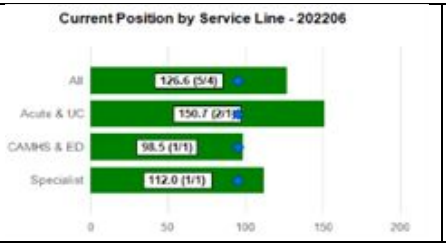
Actions
- A task and finish group led by the Deputy Head of Service Delivery for Community Services has reviewed the process for capturing physical health information on clinical systems. Clinical data collection forms have been simplified and were implemented across the Trust in Sept 20 and guidance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

Fundamental Standards of Care

Safe Staffing: national Compliance - Inpatients (%)

Target ≥ 95%





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

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

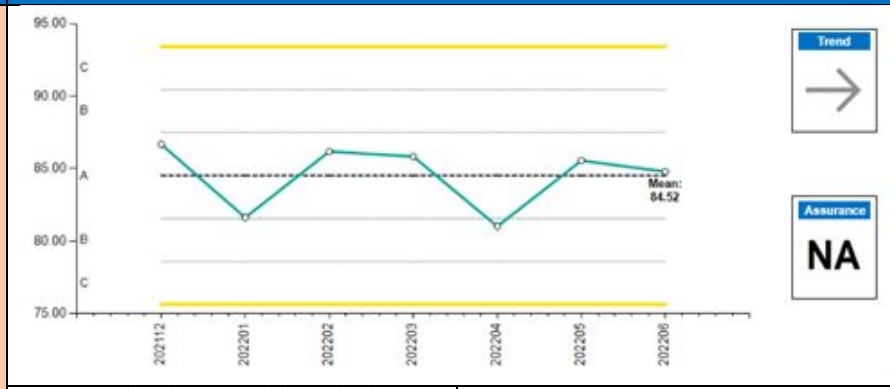
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.
- All wards were safely staffed in Specialist services.

Actions
- Acute & Urgent Care: Focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.

Fundamental Standards of Care

Safe Staffing: baseline includes requirements related to observation levels

Target TBC



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

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

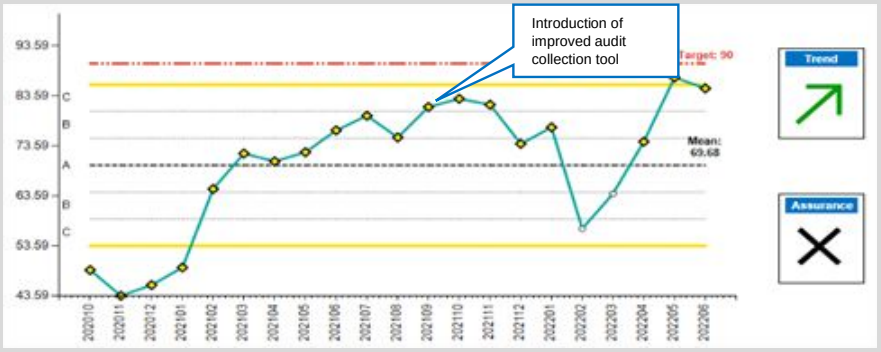
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.

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.

Fundamental Standards of Care

Always Ready Audits Completed (%)

Target ≥ 90%



Audit Volumes by Service Line:

Service Line	Always Ready Audits Required	Always Ready Audits Completed	% Completed Capped
Acute & Urgent Care	872	752	86.2%
CAMHS & ED	312	236	75.6%
Community	60	26	41.7%
Specialist	818	756	92.4%
Other (i.e. inc Pharmacy)	13	12	92.3%
Trust	2075	1784	85.8%

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.

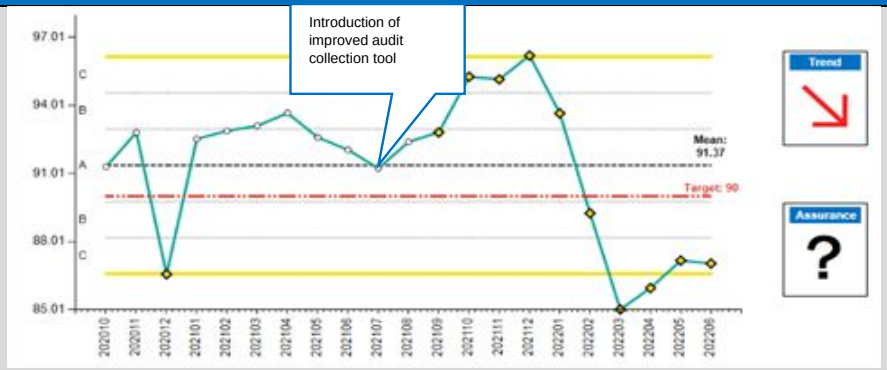
Underlying issue
- The Always Ready application improved and implemented in June 2021 before some staff had received training and a period of familiarisation.
- Deterioration in CAMHS linked to technical issue with Corner House submissions.
- Some teams have required support and training with understanding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

Action
- Service lines to agree the audit cycle (action plan template) in order to provide a standard feedback process for teams to review actions.
- In Acute & Urgent care Service Line dashboard training has been provided via Performance & Information Team.
- Community Service Line are undertaking a reset on recording so all Clozapine Clinics will be required to report via the Application. Some improvement noted in June 2022 but there are still some technical issues to address which are being worked through by Applications Development.
- CAMHS are working with Applications Development to address technical issues with Corner House.
- 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%



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

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

Underlying issue

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

Action:

- Additional information of the quality of audits, themes and risks and any outlying areas will be provided next month
- Always Ready dashboard has been developed to assist completion and improve performance. A Training video for use of new Always Ready Dashboard is also available on My Dashboards.
- The acute service line undertakes formal weekly meetings to review compliance and actions. Additional training for staff was undertaken in April 2022 supported by Applications Development and Information Management.

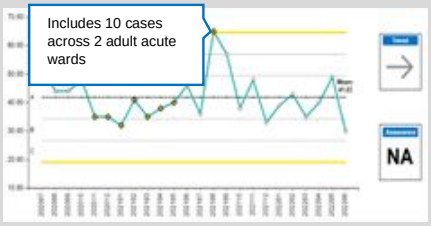
Patient Experience and Outcomes

Complaints answered within 25 days (%)

Target ≥ 85%

Complaints answered 25 days

Number of Complaints



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

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

Underlying issue

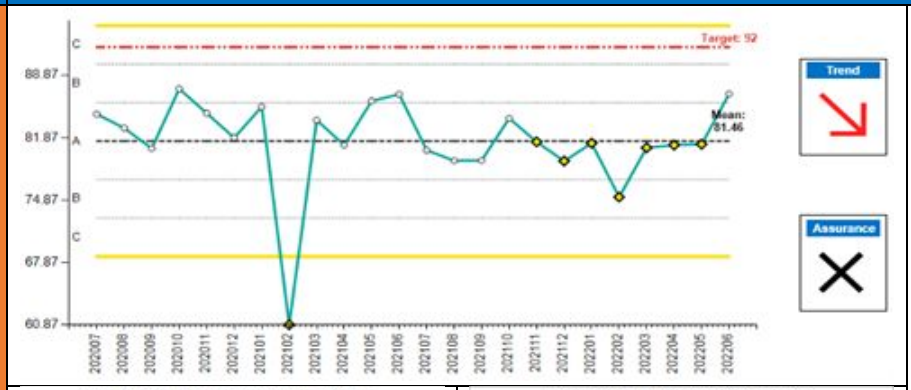
- The Patient Experience Team are managing increased workload due to an increase in the number of complaints and acuity of patients presenting to the Patient Advice Liaison Service (PALS). However, this is now starting to stabilise.
- There are some delays with obtaining executive level sign-off.
- Some Service Lines struggle to provide the required information, with Adult Community experiencing the most challenges. The senior leadership team have drawn up plan to mitigate.
- The Complaints team are planning to raise awareness via Ward/Team Manager events on requirement to respond within timeframes.

Actions:

- Service Line learning events continue to increase and evolve, helping focus on learning from incidents, complaints, and good practice.
- The Community Service Line has made successful changes to their sign-off process.

Themes and Learning:

- Main themes have been linked to access to services and referrals either not being accepted, or families who are not happy with the outcome of referrals, particularly in CAMHS.
- Waiting times for access to services, i.e. Complex Needs continues to be an issue, especially in Sutton & Merton.
- A project to strengthen the subcategories of complaints to improve the ability to focus and analyse themes / information is underway (part of the wider work plan around PE information which is being overseen by the revised Improvement Patient Outcome Group.
- The Integrated dashboard bringing together the themes from all Patient Experience is in final stages of completion).

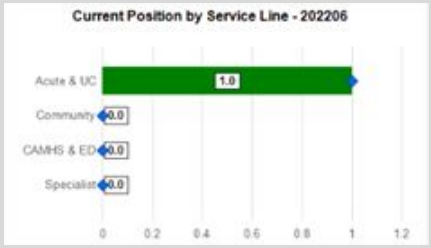
	Patient Friends and Family Test (%)	Target ≥ 92%
Patient Experience and Outcomes	  	**What the chart tells us:** Mean performance is consistently below target a change of process required. **Underlying issues:** - Challenges with engaging patients to complete at appropriate points in their pathway. - An analysis task required by the Patient Outcomes Group to further understand the survey feedback and ensure feedback is representative of the Trust as a whole. **This and next months: actions and timescales:** - The Improving Patient Outcomes group is to take a lead on FFT collection and analysis. - This includes a review of all patient feedback systems including Feedback Live! In order to improve the data collected. - Community Service Line are promoting use of the QR code for service users and carers. - IPO group is to review and amend the SMS algorithm for requesting FFT from patients to ensure it is fully representative.

Patient Safety

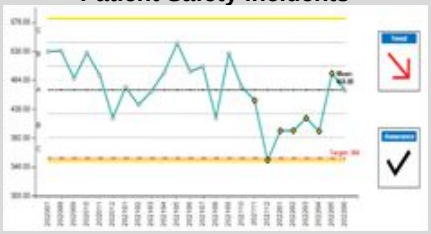
Patient safety incidents - Severe harm

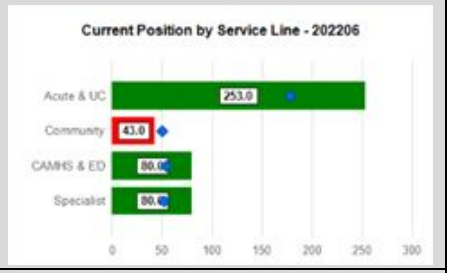
Target ≤ 1.5%

Patient Safety Incidents – Severe Harm



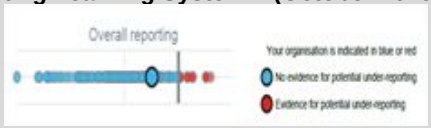
Patient Safety Incidents





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 June there were 8 serious incidents reported to STEIS, which includes four suspected suicides and one unexpected death.
-

Actions:

- A Training session has been delivered to Ward Managers on incident management and included information on the new dashboard enabling visual access to incidents reported by Ward/Team.
- Mortality Committee have commissioned thematic reviews of the last two years of community suicides, inpatient deaths, unexpected deaths with a focus on zoning and physical health, homicides involving trust patients and serious incidents that have occurred in the community assessment teams.
- The NG policy has been reviewed which has shown an impact on the number of incidents reported; a reduction overall.
- The Trust's Suicide Prevention Strategy was launched on 14 March 2022. The milestones from the strategy will be monitored via the Mortality & Suicide Prevention Group.

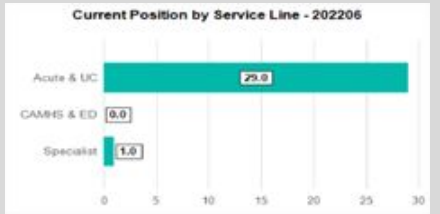
Themes and Learning:

- Acute: Learning event was hosted by the AUC Service line on the 9th of December to review two serious episodes of violence and aggression on inpatient wards. The learning related to medicine optimisation and arrangements for conveying clients within the Trust.
- Acute: Learning event scheduled for February 2022 with focus on escalation of physical health concerns within inpatient settings.
- There are gaps and interface issues across the patient pathway that can lead to service delivery issues. In particular, focus is needed on the interface between assessment teams, RSTs, HTTs and the CORAL Crisis Hub.

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.
- An audit in November 2020 identified under recording of up to 30% in the acute service line. This relates to poor adoption to a change in recording process in February 2020.
- 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.

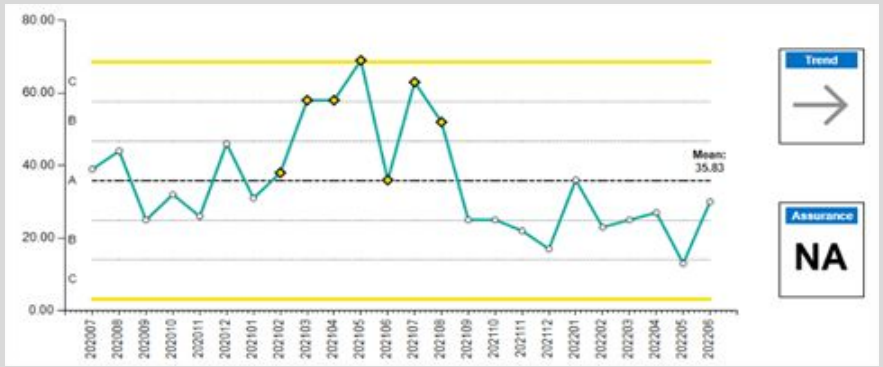
Actions
- In February 2020 restrictive practice recording changed from the Ulysses incident system to the RiO clinical system. This change was introduced to ensure that clinical information is recorded in one system, to enable the Trust to report restraint data as part of the Mental Health Services Data Set and to support business processes including physical health monitoring post rapid tranquilisation.
- Restrictive Practice Policy is to be reviewed in the Restrictive Practice Group.
- Restrictive Practice Groups review data to understand issues and inform learning.
- Following the publication of revised guidance wards have recorded all missing data since April 2021
- Acute: Safety in Motion Interventions have been reintroduced and discussed with teams.

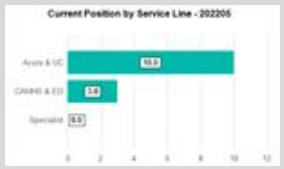
Themes and Learning:
- **Acute and Urgent Care:** The main for physical restraint continue to be administration of medication followed by harm to others and self.

Patient Safety

Reducing restrictive practices - Prone restraint

No Target

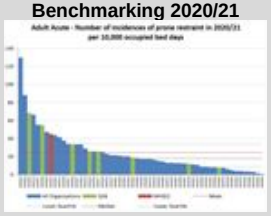




Number of Clients Prone Restrained – June 2022

Measure	Total
Number of Prone Restraints	30
Number of patients prone restrained more than once	7
Highest number of prone restraints	5

Adult Acute - Prone Restraint Benchmarking 2020/21



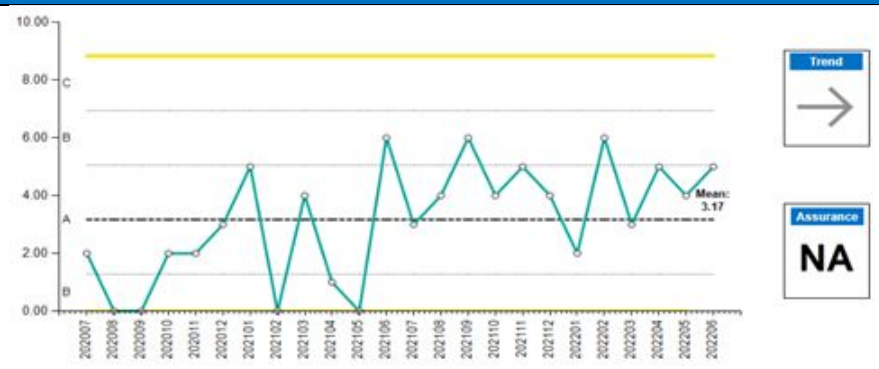
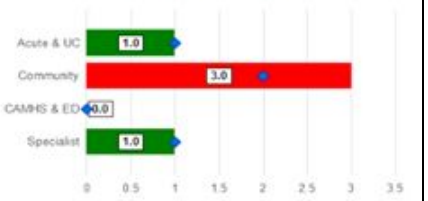
Background
It is important that restraint is used appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. The Trust reports all incidents of prone restraint in line with the new draft NHS guidance.

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

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

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

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

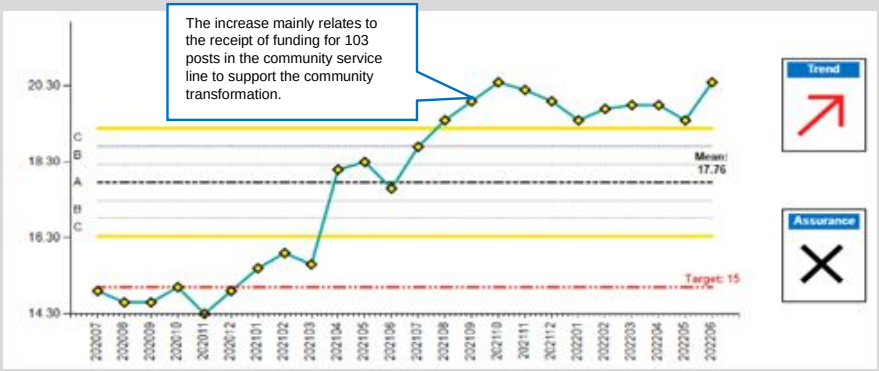
	Death - Suspected suicide	No Target
Patient Safety		**Background** **What the chart tells us** The number of suicides each month is subject to variation. Numbers reported are low. **Underlying Issue:** - There were 5 suspected suicides reported in June 2022. - The number of suicides being reported month to month continues to be variable. This data was reviewed in the bi-monthly Mortality & Suicide Prevention Committee. With the data points for the last two years highlighting an increasing trend in deaths by suspected suicides. The mean monthly average has increased from 2.9 (pre-April 2020) to 3.5 (post April 2020). **Actions:** - All such incidents will be subject to an investigation and are signed off by a Serious Incident panel chaired by Director of Nursing and Quality. - The Trust's Suicide Prevention Strategy was launched on 14 March 2022. The milestones from the strategy will be monitored via the Mortality & Suicide Prevention Group. - Mortality Committee have commissioned thematic reviews of the last two years of community suicides, inpatient deaths, unexpected deaths with a focus on zoning and physical health, homicides involving trust patients and serious incidents that have occurred in the community assessment teams.
	Current Position by Service Line - 202206 	Suspected Suicides – Step Change Applied April 2020 via Mortality Committee 

Workforce Domain

Recruitment / Attraction

Vacancy Rate (%)

Target ≤ 15%



Vacancies by Staff Group

Staff Group	Sum of Position FTE	Sum of Actual FTE	Sum of Vacant FTE	%
Registered Nurse	880.8	654.3	226.5	25.7%
Allied Health Professional	139.1	103.8	35.1	25.3%
Pharmacy	45.8	34.2	11.4	25.0%
Psychology / Psychotherapy	514.8	404.8	110.0	21.4%
HCA/Support	470.7	372.8	98.2	20.9%
Allied Health Professional Assistant	59.4	47.7	11.7	19.7%
Social Care	46.1	38.0	8.2	17.8%
Manager	140.2	116.5	23.7	16.9%
Administrative & Clerical	467.3	418.4	68.9	14.1%
Medical & Dental	229.5	205.2	24.3	10.6%
Estates	37.2	34.0	3.2	8.6%
Grand Total	3050.4	2429.2	621.1	20.4%

Background

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

What the chart tells us

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

Underlying issue

- Service leads are not proactively reviewing their vacancies and end those which are no longer existing in their establishments, which results in an artificial higher vacancy rate.
- The Trust has created a significant number of new roles resulting in an expected increase to the vacancy rate as posts are advertised and subsequently filled. These newly created roles will take to time to recruit; the Trust does expect a further increase in vacancy rate for a few more months.
- **Community**: There has been difficulty in the recruitment of medical staff particularly in Richmond and Wandsworth.
- The Trust turnover have increased steadily in 2021 into 2022, which impacts on the vacancy rates, in addition to the newly create roles.
- Year 2 of the community transformation project has 64 newly created role, which has increased the vacancy rate slightly. Recruitment for these roles is already underway.

Actions

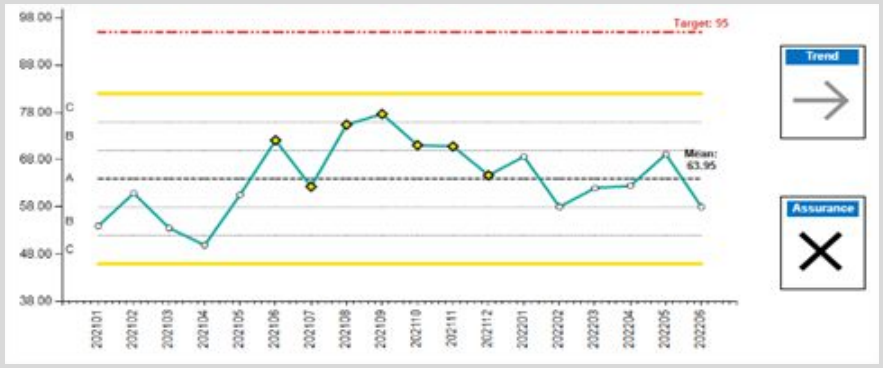
Vacancy rate is linked to turnover, retention strategies need to be developed

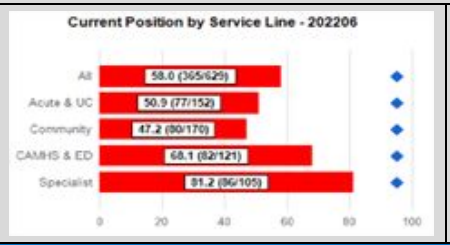
- **Community:** Review of core skill mix within the RSTs/CMHTs from band 5-7 as part of transformation of community services year 2 programme.
- Medical workforce strategy has range of actions in progress. Medical posts in Wandsworth and Richmond are back out to advert. Medical recruitment weekly meetings with HR.
- Review hard to recruit posts to developmental role in order to attract suitable candidates as career pathways to fill the vacancies.
- Communication Team is supporting with advertising via Social media on Facebook, Twitter, LinkedIn for targeted adverts and currently developing YouTube content.
- Mass recruitment across the Trust for HCAS and band 5 nurse roles is underway on monthly (rolling) basis, and this include bank recruitment on mass on a monthly basis. This has now been expanded and includes mass recruitment for Nursing Associates, band 4 and Band 5 OT's. Continued review on another roles which can be done via mass recruitment is underway.
- The bank / agency to permanent conversion is still happening across the Trust to help fill our vacancies. Managers will need to continue to review and convert bank and/or agency staff to help close the vacancy rate and reduce spend.
- HRBPS, Recruitment and Service Leads are working together to identifying suitable strategies to assist recruitment within areas with high vacancy rates. This is resulting in proactive recruitment and more candidates in the pipeline.
- The Trust is expects to see a reduction in the vacancy rate in the coming months. There are currently 88 band 5 staff nurses role and 28 HCAs in the recruitment pipeline who are expected to commence in post in August / September 2022.

Recruitment / Attraction

Vacancies in active recruitment (%)

Target ≥ 95%





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

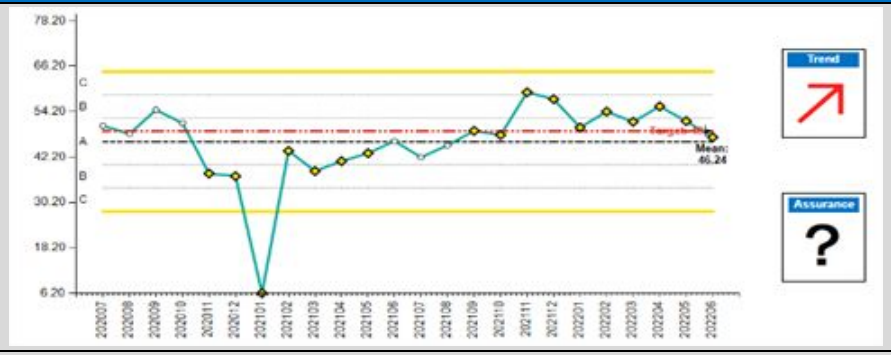
- Service leads are not proactively progression their vacancies into recruitment, despite a very proactive and support approach from recruitment, which includes creation of recruitment drop in sessions and support workshops.
- More in-depth conversations with services on future requirements is needed in order to progress recruitment at the point of new role creation.
- Some posts are 'frozen' and so there are no plans to recruit. For example, vacancies within HTT and Liaison teams were used for suitable alternative employment in the Crisis Hub.
- Residual data quality issues relating to staff not following prescribed recording processes. For example, recruiting to multiple posts but recorded against one position on IT systems.
- Community: There have been some manager capacity issues (due to vacancies) particularly in Richmond which has resulted in some delay in recruitment process.

Action:

- Some service lines are now holding their managers account for their recruitment activities, ensuring that they progress their vacancies as soon as they arise. This has also resulted in an increase in roles being progressed to recruitment.
- Service lines and HR staff have access to detailed automated dashboards to identify data quality issues and performance. Data is now refreshed on as weekly basis.
- New Clinical Manager has been recruited for Richmond who commenced in post on the 25th July.
- CAMHS: Service has begun to review the forward planning of use of agency staff with Temp Staffing.
- 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.

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 be some variation.
Underlying issues:

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

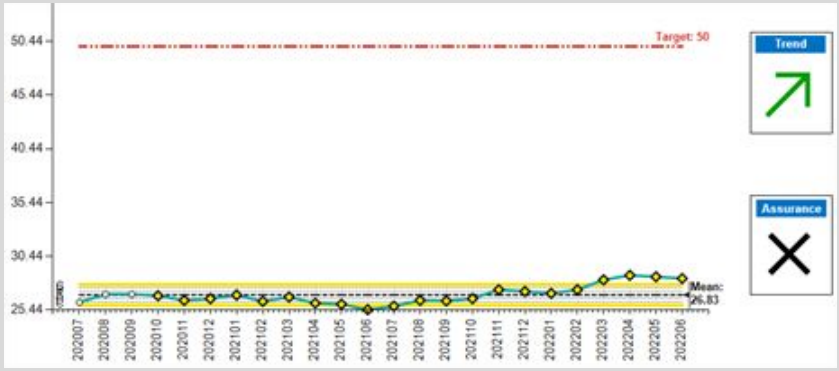
Actions:

- There are some delays in hiring managers confirming agreed start dates to recruitment
- 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. We are expecting the time to hire to fall over coming months, as the system is currently being cleansed.
- Recommendations remain for managers to pre-plan (proactive approach) their recruitment activity and flag up any challenges at the earliest possible to the recruitment team.
- Reconciliation exercise required on figures from Dashboard and TRAC as currently not fully aligned. This however will need input from TRAC in order to complete exercise.

Recruitment / 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.

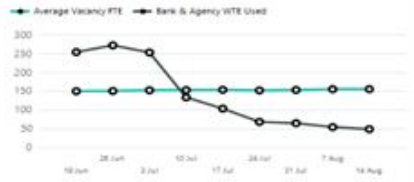
Actions:
- Diversity in Recruitment representatives are on interview panels for band 7 and above roles across the Trust.

Recruitment / Attraction

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

Target ≤ 22%

Bank & Agency Usage

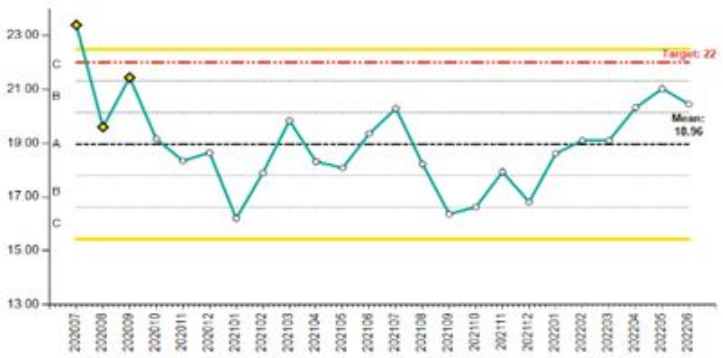
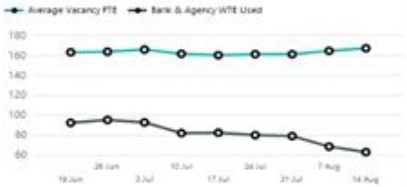


Background:
Trust analysis shows that agency staff often cost 25% more than those temporary staff source through the Trust bank. Based on its 2021/22 annual agency spend, the Trust could free up to £2.0m to reinvest in front line services or utilise to meet efficiency requirements by reducing reliance 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:
- 60% of overall agency expenditure has been on agency nurses
- With a 20% expenditure on Medical staffing and c10% on Psychology staffing to continue to deliver patient care.
- This % spending trend always happens during periods of reported high levels of unplanned absence and high levels of additional therapeutic observations for nursing due to the demand this activity places on Trust Bank.

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

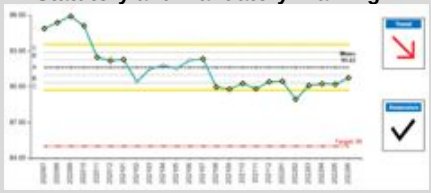
	Temporary staffing - Community Service Line (%)	Target ≤ 22%
Recruitment / Attraction		**Background:** Trust analysis shows that agency staff often cost 25% more than those temporary staff source through the Trust bank. Based on its 2021/22 annual agency spend, the Trust could free up to £2.0m to reinvest 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 	

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

Staff Skills / Development

Statutory and Mandatory Training 1

Statutory and Mandatory Training 2



Current Position by Service Line - 202206

Current Position by Service Line - 202206

Training Compliance Projection – MAST 1

Certificate Name	Actual				Projection			
	May-22	Jun-22	Jul-22		Aug-22	Sep-22	Oct-22	
	%	%	%	Breaches	%	%	%	Breaches
Adult Basic Life Support (1 year)	62.5%	65.0%	65.4%	571	77.0%	73.2%	68.2%	525
FFP3 Mask Testing (2 Year)	92.6%	93.2%	92.8%	20	73.6%	65.8%	58.4%	137
Fire Safety Awareness (Community) (2	94.8%	94.9%	95.2%	59	93.1%	89.6%	84.9%	188
Fire Safety Awareness (Inpatient) (1 Year)	89.0%	88.4%	86.8%	83	83.0%	77.8%	70.3%	187
Fire Safety Awareness (Non-Clinical) (2	95.4%	97.0%	97.1%	20	94.1%	91.2%	88.0%	83
Infection Prevention and Control L1 (3	80.0%	87.9%	88.5%	54	85.1%	85.1%	85.1%	70
Infection Prevention and Control L2 (1 Year)	93.1%	92.8%	92.6%	156	89.4%	86.5%	83.0%	357
Information Governance (1 Year)	95.1%	94.8%	94.6%	138	84.3%	76.4%	68.2%	855
Medical Emergency Training (1 Year)	73.9%	76.5%	78.6%	48	85.7%	81.7%	75.6%	55
Medicines Management (Community) (2	89.9%	90.8%	90.8%	40	86.7%	84.4%	81.0%	83
Medicines Management (Inpatient) (2	93.7%	94.1%	92.9%	18	89.7%	85.0%	82.6%	44
Naso-gastric Intubation & Enteral Feeding	95.7%	95.5%	95.2%	1	95.2%	95.2%	95.2%	1
Proactive Physical Interventions (3 Years)	82.3%	84.0%	83.5%	89	84.8%	83.5%	83.7%	88
Safeguarding Adults Basic Awareness -	96.7%	97.3%	97.1%	73	96.5%	96.1%	94.7%	134
Safeguarding Adults Level 2 (3 Years)	95.7%	96.7%	96.3%	69	96.1%	96.0%	91.9%	151
Safeguarding Children and Young People	94.9%	96.3%	96.6%	18	95.7%	95.7%	95.2%	26
Safeguarding Children and Young People	89.6%	90.3%	90.7%	68	88.1%	85.4%	83.7%	119
Safeguarding Children and Young People	91.1%	92.9%	92.9%	73	93.9%	94.5%	94.2%	60
Safeguarding Children and Young People	83.2%	84.9%	85.9%	36	84.4%	84.4%	75.0%	64
All Certificates (95% Target)	90.1%	91.1%	91.0%	1634	89.2%	88.4%	82.4%	3187

Training Compliance Projection – MAST 2

Certificate Name	May-22	Jun-22	Jul-22		Aug-22	Sep-22	Oct-22	
	%	%	%	Breaches	%	%	%	Breaches
Advanced Patient Handling (2 Years)	78.6%	77.8%	77.5%	118	85.2%	87.4%	90.1%	51
Care Certificate	72.0%	74.2%	74.4%	84	79.8%	79.8%	79.8%	69
Conflict Resolution and Breakaway (3	76.6%	77.8%	76.9%	346	75.8%	77.2%	78.3%	355
Equality and Diversity (3 Years)	96.0%	96.5%	96.0%	101	93.0%	91.1%	88.7%	288
Food Hygiene Basic Awareness (Inpatient)	97.7%	97.2%	97.6%	5	93.7%	92.7%	89.3%	22
Food Hygiene Level 2 (3 Year)	86.7%	86.8%	87.0%	20	86.4%	86.2%	84.3%	55
Food Hygiene Level 3 (3 Year)	100.0%	100.0%	100.0%	0	100.0%	100.0%	100.0%	0
Health and Safety General Awareness (3	95.6%	96.3%	96.0%	102	92.8%	91.0%	88.6%	290
Load Handling (2 Years)	97.6%	95.2%	95.2%	2	95.2%	83.3%	83.3%	7
Mental Health Law Training (3 Year)	78.4%	80.3%	77.6%	304	82.6%	76.8%	71.8%	382
National Early Warning Score (3 Years)	98.9%	98.5%	98.4%	9	98.4%	98.4%	98.5%	328
Observation and Intensive Engagement (3	95.8%	97.2%	97.6%	12	96.0%	94.8%	93.0%	35
Prescribers Medicines (2 Years)	78.4%	76.1%	76.2%	54	71.8%	68.3%	65.6%	78
PREVENT Basic Awareness - Level 1-2 (3	84.9%	88.8%	89.6%	72	89.6%	89.6%	89.6%	72
PREVENT Raising Awareness - Level 3-4	90.8%	92.0%	91.8%	151	91.0%	89.7%	88.6%	213
Rapid Tranquilisation (3 Years)	96.0%	96.3%	96.3%	21	93.6%	92.3%	89.5%	59
RATE Training (3 Year)	78.3%	77.8%	76.9%	289	80.4%	81.5%	79.5%	256
Security Awareness (Forensic) (1 Year)	90.5%	89.5%	88.8%	19	79.4%	72.4%	63.5%	62
All Certificates (85% Target)	88.5%	89.2%	88.6%	1709	88.1%	86.6%	82.5%	2622

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.
- There was 1 week in January when Cancellations and DNAs ran at 50% together.
- Significant amounts of staff sickness across the Trust resulted in cancelations and DNAs; high vacancy rates may prevent staff from being released for training.

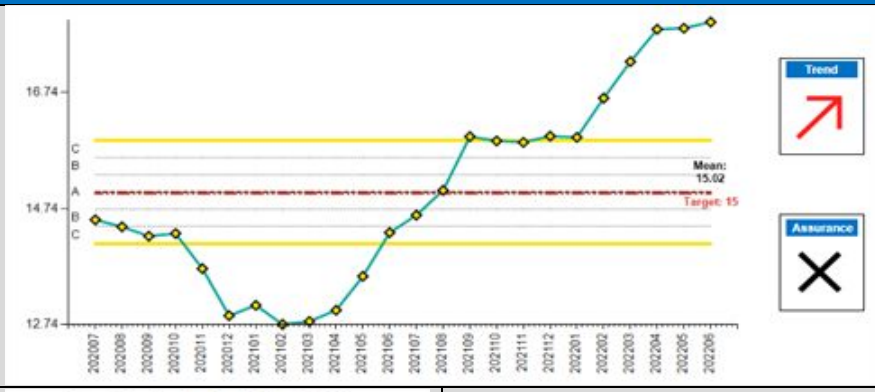
Actions

- Classroom training is available for staff; trajectories of performance are reviewed at the monthly Service Line Reviews with executives.
- Managers receive regular reports on DNAs; staff receive booking reminders to attend courses
- Health Education England have released one-off funding for the rest of this financial year for Health Care Support Worker development. A post will be put in place for 6 months to reduce the backlog in Care Certificate – now sitting in Nurse Education Team.
- In 2022/23 a MAST Steering Group is to be set up in order to formalise decision making with respect to MAST and training delivery.
- There are currently sufficient ABLS training courses following an increase in capacity to 4 days per week and courses are now planned up to 6 months in advance. Cancellations and No Shows at these courses are high and work needs to be done to ensure that where possible, those booked on the courses do attend.
- Infection Prevention & Control and Prevent training have just been made available on Compass with the normal 3 month's grace period.
- Education is reviewing how far in advance courses are made available on Compass.
- A QI project is underway in conjunction with service line leads to improve communications, take-up of places, booking protocols and to reduce DNAs.
- Education to work with EMP about room availability and priority bookings from September 2022.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%



London Benchmark - January 2022

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

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

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

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

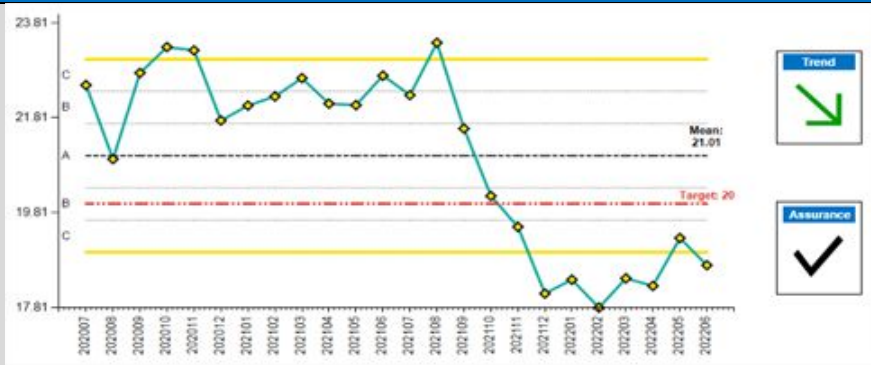
Underlying issue
- Over the past few years, Community Service Line teams have experienced significant workforce challenges with workload and capacity frequently cited as a factor behind staff leaving the Trust.
- An ineffective, inconsistent process to collect meaningful exit interview data means that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

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

Staff Retention/ Support / Satisfaction

Staff leaving within 12 months of appointment (%)

Target ≤ 20%



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

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

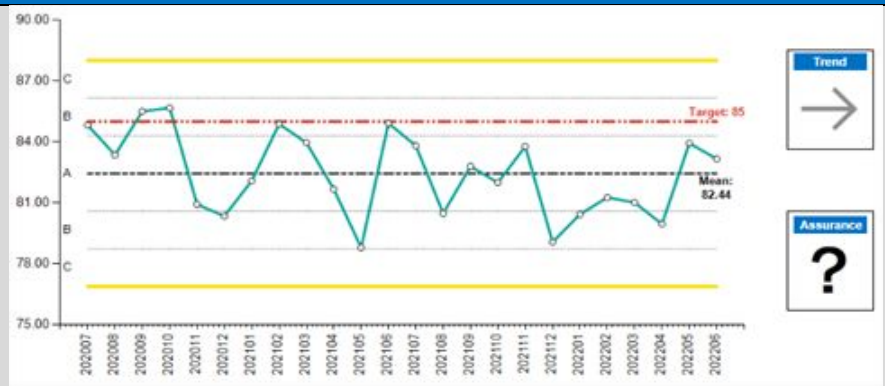
Underlying issue
- Whilst the Community service line have experienced significant workforce challenges, over 50% of the 'leavers within 1 year of starting' were Psychological Well Practitioners working for IAPT teams left to progress their career.
- Historically the Acute service line has had high turnover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

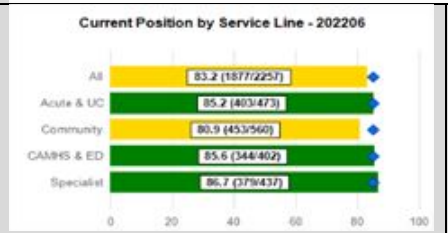
Actions:
- Onboarding / stay questions are being launched for managers to ask their new starters on their experience during the first, third and sixth month in post.
- **IAPT:** plan to offer some PWP staff band 5 high intensity roles
- **Acute & Urgent Care:** Implementation of retention actions identified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

Staff Retention/ Support / Satisfaction

Supervision (%)

Target ≥ 85%





Supervision by staff group / Corporate – June 2022

Clinical Staff	84.4%
Non-Clinical Staff (inclusive of Corporate)	74.6%
Corporate Services	77.3%

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.

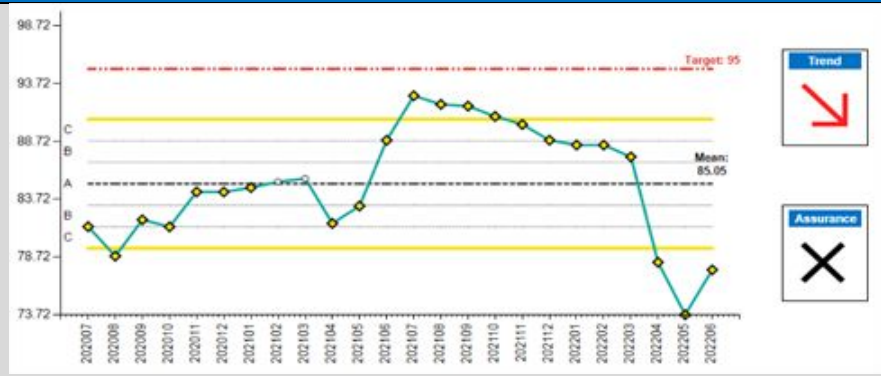
Underlying issue
- Trust is unable to consistently maintain performance on this metric.
- Supervision is below target overall for both clinical and non-clinical staff.
- Workload pressures, cancellations of meetings due to incidents on wards, high sickness levels in some areas (AUC) and high numbers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

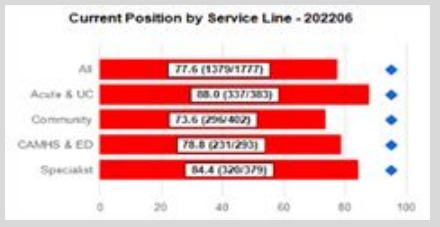
Actions
- Chief Executive Officer has reiterated to staff that supervision remains a priority for the Trust. Senior team to work with all consistently underperforming areas
- Community Service Line have instructed supervision to be carried out every 4 weeks as routine. Community to spot check this is 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 – June 2022

Clinical Staff	80.9%
Non-Clinical Staff (inclusive of Corporate)	56.0%
Corporate Services	61.2%

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.

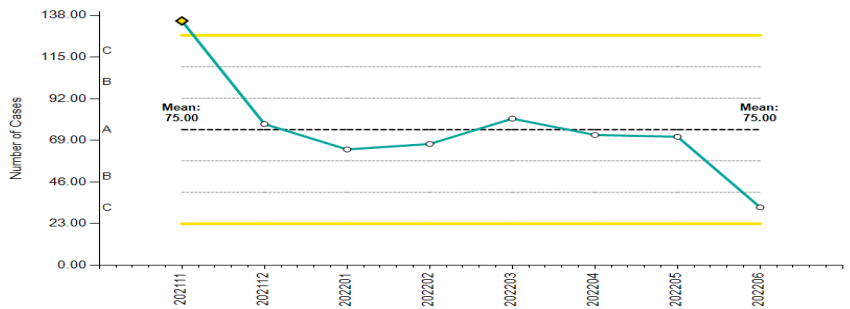
Underlying issue
- Processes are not routine; performance tends to improve only when it is prioritised over other indicators.
- Expected deterioration in April 2022 as PADR's become out of date due to push for PADR completion by Q1 2021/22. Improvement expected by Q1end 22/23.
- Incomplete paperwork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



Type	Employee Relations Cases	%
Appeal only	1	1.29%
Disciplinary	4	5.0%
Grievance	12	16.0%
Bullying and Harrassment	3	4.0%
Performance	2	2.6%
Sickness Absence	48	62.0%
ET's	7	9.0%
Total	77	

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

Factors Affecting Employee Relations Cases:

- At the end of June the ER team had 77 open cases, 82% of these cases being supported by the HR Advisory Team at Capsticks.

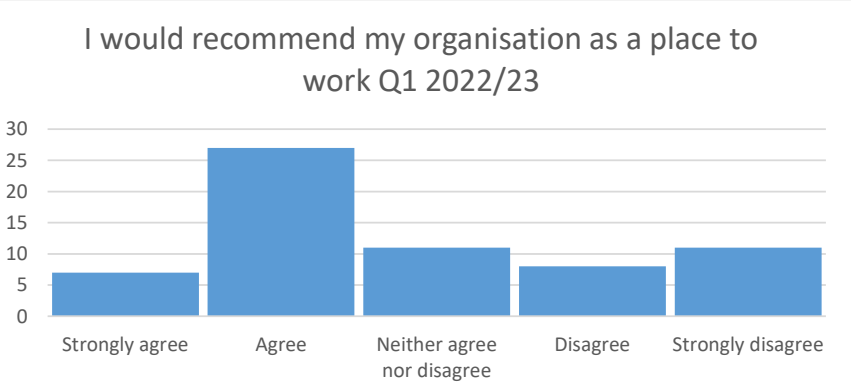
Actions:

- All current disciplinary cases, with the exception of 2, are being managed within a 3-month period. There are no cases that have exceeded a 6-month period
- Active health and wellbeing cases make up 53% of the overall caseload. This is forecasted to increase over the coming months due to the new system currently being implemented to support managers to better manage sickness absence.
- Informal resolution (mediation and facilitation pilot) is due to end with the service going live in September 2022.

Staff Retention/ Support / Satisfaction

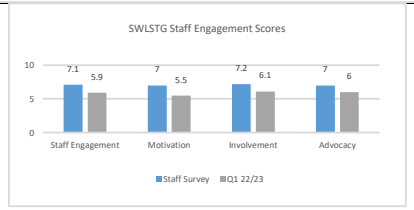
Staff Friends and Family Test (recommend treatment) (reported quarter in arrears) (%)

Target ≥ 75%



Current Response Rate:

2.3%



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

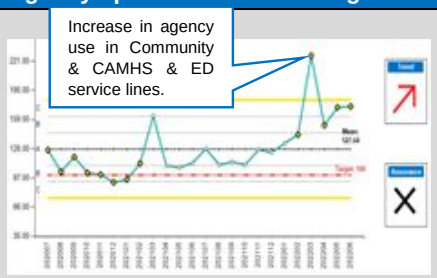
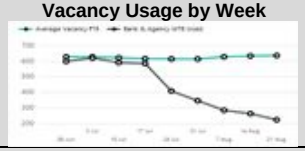
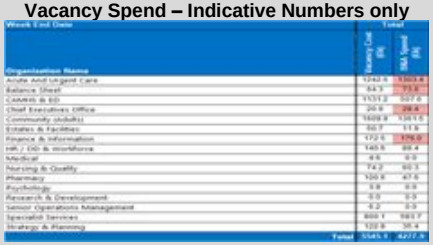
Underlying Issues:

- 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:

- Continue to use the staff survey results to engage with staff through the workshops
- As we start to be able to do more face-to-face events post-COVID we will be considering visits to wards, 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
- Additional promotion is also being carried out to increase the response rate of the NQPS which will provide a more representative picture of staff this measure
- A KPI definition document to be worked up by Human Resources Department and Performance & Information.

Finance Domain

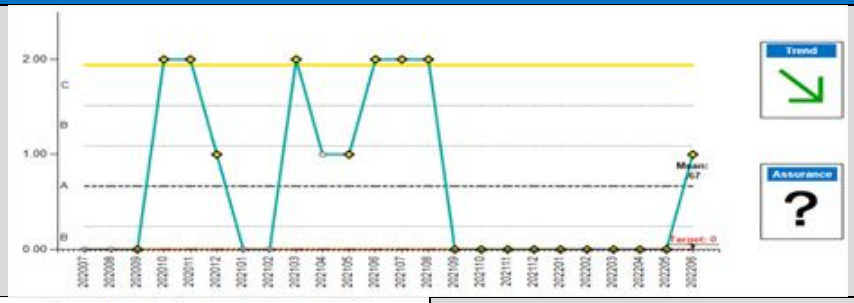
	Agency spend as % to NHI target		Target TBA
Grip & Control		Vacancy Usage by Week  Vacancy Usage by band 	**Background** The Trust is assigned an agency cap by NHSI. Aside from being good practice to minimise agency expenditure, breaching this cap produces adverse impacts on the Trust's overall financial risk rating. **What Chart Tells Us:** Performance has mainly been above target; target unlikely to be met unless there is a change in process. **Underlying issues:** - Financial incentives and flexibility afforded by agency working remain key barriers to transitioning staff to bank or permanent contracts. - There are particular difficulties in recruiting to CPN and high cost medical posts. - Trust processes to record future agency costs are not followed and are not sufficiently enforced. - Managers sometimes fail to pre-plan or carry out recruitment activity, leading to avoidable delays and the need for short-term agency staffing. - **Community:** Vacancies and difficulties recruiting in particular nurses and doctors, operational pressures including cover for long-term covid are factors in agency spend. **Actions:** - Revised Trust processes to approve the hiring of agency workers were introduced in May 2021. - Trust guidance is for managers to pre-plan (proactive approach) their recruitment activity and to raise and resolve issues with the recruitment team. Guidance is also available on converting agency staff into bank or permanent roles. - Dashboards enable HR and service managers to understand and manage delays in recruitment. - Monthly recruitment meetings between services and HR leads try to resolve long term agency contracts - Community services are implementing an improvement plan to recruit medical staff with reductions in agency spend expected within the coming months. - Trust has signed contract with recruitment consultancy Remedium to assist with medical recruitment and the Trust has reviewed locum rates and the CAMHS middle grade rota with Junior doctors. - **Community Service Line:** Skills mix review of core CMHT/RST band 4-6 roles as part of transformation. (POD Model). Direct employment of 13 new band 5 nurses who will commence in post in September 2022.
		Vacancy Spend – Indicative Numbers only 	

Non-Priority Metrics: reported by exception

Referral to treatment (RTT): 52-week breaches

Target = 0

Flow



52 Week Breach - June 2022

Team	Breaches	Weeks Wait
Neuropsychiatry	1	53

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

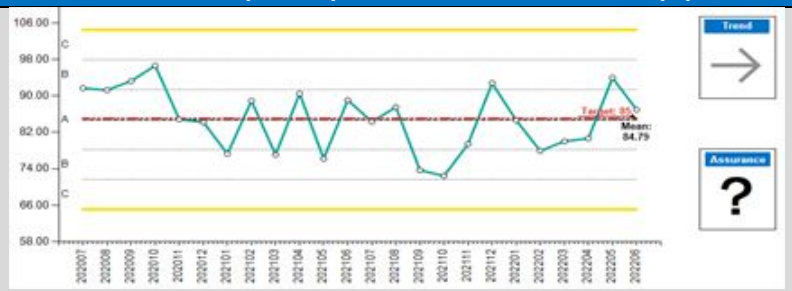
Underlying issues that prevent us from consistently reaching the target:
- There have been medical capacity issues within the service which has led to longer waits within the service.
- Cancellations from the team (due to rescheduling of clinics) as well as from the patient have also contributed to the delay.

Actions:
- Client due to be seen in August and does not want an earlier appointment. If not seen at next scheduled appointment client will be discharged; referrer is aware of the current position.

Home treatment - follow up attempted within 24 hours of DNA (%)

Target ≥ 85%

Flow



Team Breakdown YTD

Team	Followed up in 24Hrs	DNAs	% Followed up in 24Hrs
Kingston Crisis & Home Treatment Team	7.0	8.0	87.5%
Merton Home Treatment Team	47.0	55.0	85.5%
Richmond HTT CRT	101.0	121.0	83.5%
Sutton Home Treatment Team	15.0	15.0	100.0%
Wandsworth Crisis & Home Treatment Team	54.0	55.0	98.2%
Total	224.0	254.0	88.2%

What the chart tells us:
Trust: Mean performance is above target indicating performance will frequently meet target. There has been considerable variation in performance in recent months with target only being met in four of the last ten months.

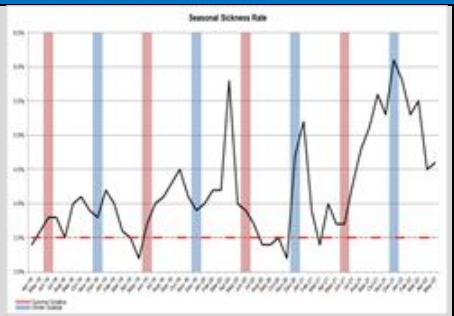
Underlying issues that prevent us from consistently reaching the target:
- An audit of breaches in July 2021 shows that underperformance mainly relates to staff not recording contacts on clinical systems.

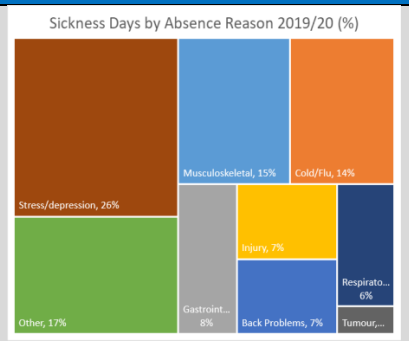
Actions:
- Clinical Service Lead and Clinical Matron to meet with team manager of Richmond HTT to devise a recovery plan to improve performance. This will include writing a revised SOP for Richmond HTT.
- Team Manager/admin to routinely review HTT follow up dashboard to support performance monitoring.

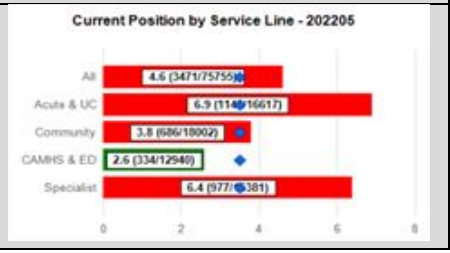
Staff Retention/ Support / Satisfaction

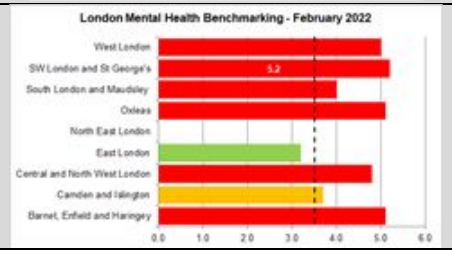
Sickness Rate - reported month in arrears (%)

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.

Actions

- COO & DoNQ held a review meeting with service lines to identify key challenges and themes related to sickness.
- 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.
- Stress risk assessment for staff on sick leave will be trialled in October in AUC and community service lines.
- Acute & Urgent care: HR Surgeries with Matrons and team managers to address sickness absence challenges within the team/ward to be continued.
- HR to continue to facilitate sickness absence training every two months for managers.

Fundamental Standards of Care Dashboard

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

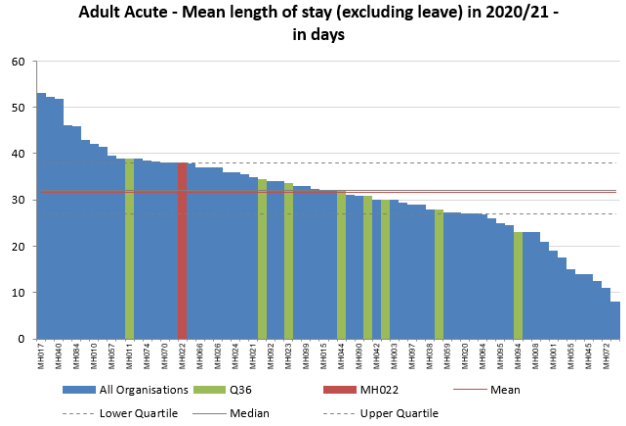
Group	KPI	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
FSOC 1	Annual care plan review (%)	95%	95.9	93.9	94.5	95.5	97.2	100	97.5	93.6	90.1	94.2	87.8	87.1
	Care planning audit compliance (%)	90%												92.4
	Care planning audits completed (%)	90%												68.3
FSOC 2	Cardiometabolic Assessments - Inpatients (%)	90%	86.6	85.7	85.7	87.5	89.2	85.9	83.4	88.6	88.4	82.4	90	83.8
	Physical Health Assessment attempted within 4..	95%	96.5	95	93.4	97.6	94	97.1	97.8	99.2	92.4	92.6	95.3	93.1
	Physical Health Assessment completed within 7..	90%	73.9	74.2	75.2	80.8	71.7	83.2	82.3	82.6	77.2	81.4	77.5	80.8
FSOC 3	Risk Assessments within 48 hours of admission ..	95%	94.6	95.3	96.2	96.9	92.9	97.1	94.7	97.8	96.1	94.1	94.7	97.9
FSOC 4	Observation reviews completed against standar..	Null								35.8	34.8	39	45.4	38.1
	Observations required vs completed (%)	Null								80.6	79.8	74.7	69.1	70.1
FSOC 5	Number of safeguarding adults alerts	Null	24	11	16	19	16	15	15	21	13	16	13	21
	Number of safeguarding children incidents repo..	Null	4	5	2	10	4	3	5	6	2	1	0	2
	Safeguarding adults training (%)	95%	98.3	98.7	98	98.2	98.3	98.2	98.5	98.9	98.7	98.7	98.9	99.1
	Safeguarding children training (%)	95%	92.1	92.4	92.1	92.9	92.8	92.9	93.2	88.4	90.4	90.5	90.5	91.4
FSOC 6	Infection prevention control audit compliance (..	90%	99.5	98.7	97.4	98.4	99.3	99.8	99.5	96.3	96.2	97.7	98.4	98.6
	Infection prevention control audits completed (..	90%	87.5	91.7	87.5	100	79.2	79.2	79.2	54.5	64.3	77.9	90.1	89.3
FSOC 7	Pharmacy audit compliance (%)	90%	91.6	89.9	89.2	89.1	87.8	89.1	87.1	87.5	89.7	89.1	90.9	
	Pharmacy audits completed (%)	90%	95.8	48.8	95.8	100	95.8	53.7	87	95.7	73.9	100	95.7	
FSOC 8	Mental health act audit compliance (%)	90%	76.9	83.4	83.1	84.9	86.9	88.4	89.3	90.8	93.3	92.3	92	93.5
	Mental health act audits completed (%)	90%	64.3	63	62.7	71.5	75.8	68.1	68.8	67.5	70.8	77.5	84.7	90.3
	Mental Health Law Training (3 Year)	85%	92.6	92.5	91.6	91.2	89.4	89.7	89.9	88.7	88.3	89.8	83.7	83.8
	Section 132 Patient Rights Repetition	100%	70.9	76.3	82.3	78.8	80.2	82.1	83.4	87.6	92.4	87.2	86.4	91.6
FSOC 9	Duration of physical restraint (average minutes)	Null	10	6.1	7.7	7.4	7.3	6.7	10.6	4.9	8.7	9.1	4.9	7.2
	Duration of prone restraint (average minutes)	Null	2.6	2.7	2.2	2.7	8	4.5	2.1	1.8	2.9	3	1.6	2.4
	Reducing restrictive practices - Prone restraint	Null	63	52	25	25	22	17	36	23	25	27	13	22
	Total number of restraints (physical restraints..	Null	175	151	96	145	118	179	184	173	149	124	64	60
FSOC 10	Patient Safety incidents	Null	366	315	343	328	328	259	259	249	275	286	335	227
	Root Cause Analysis (RCA) actions that are over..	0	17	22	15	13	8	11	9	8	7	7	5	5
	Serious incidents	Null	5	14	13	14	15	25	22	18	11	13	15	22
FSOC 11	Safe Staffing: Shift Assurance, inc Obs Require..	Null						86.7	81.6	86.2	85.8	81	85.6	84.7

Comments

- Dashboards for monitoring inpatient Fundamental Standards of Care were deployed in April 2022.
- Care planning physical health are areas for further focus in coming months, the training and quality in these areas have improved, further focus to improve staff appropriately updating the systems. In addition MHA training & section 132 reading of rights compliance are of concern. These areas are reviewed in the service line quality governance meetings and through the service line reviews.
- In Specialist Service Line FSOC inpatient exception report meetings have been in place since Dec 2021 and reporting monitored monthly and weekly in our regular Monday meetings
- New Community Dashboard for Community Fundamental Standards of Care was launched on the 4th July 2022.

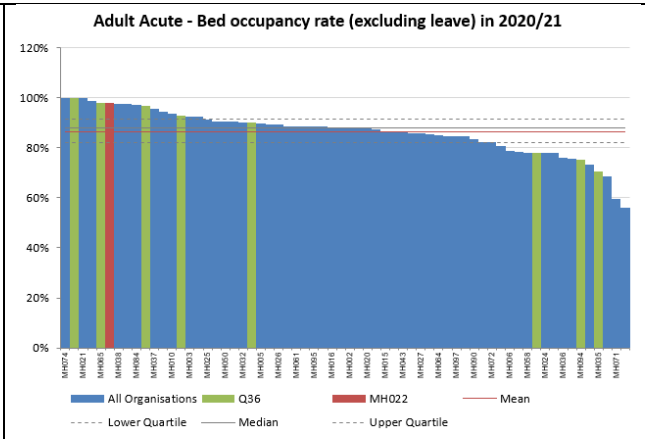
Appendix 1: Benchmarking

The NHS Benchmarking Network's 2020/21 Inpatient and Community Mental Health Benchmarking Report was issued in October 2021 and allows Trusts to benchmark their performance against other participating Trusts throughout England and within their local region. Our Trust is highlighted red in the graphs below, London Trusts are highlighted green and all other Trusts are highlighted blue.



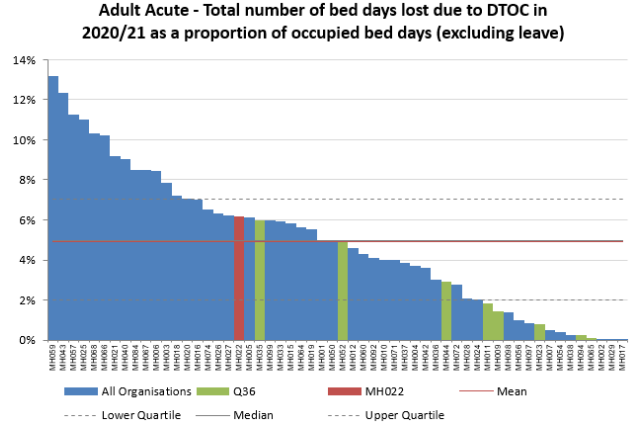
- **Adult acute average length of stay (days):**

2020/21			2022/23	
Trust	London	England	Jun-22	YTD
38.0	32.0	32.0	47.4	47.7



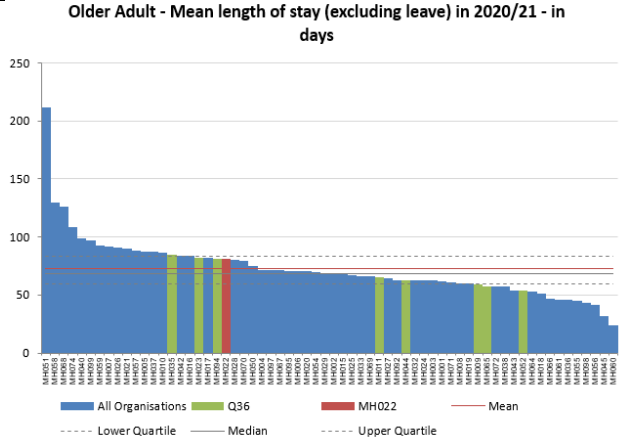
- **Adult acute bed occupancy rate (%):**

2020/21			2022/23	
Trust	London	England	Jun-22	YTD
98.0%	89.0%	86.0%	98.3%	98.7%



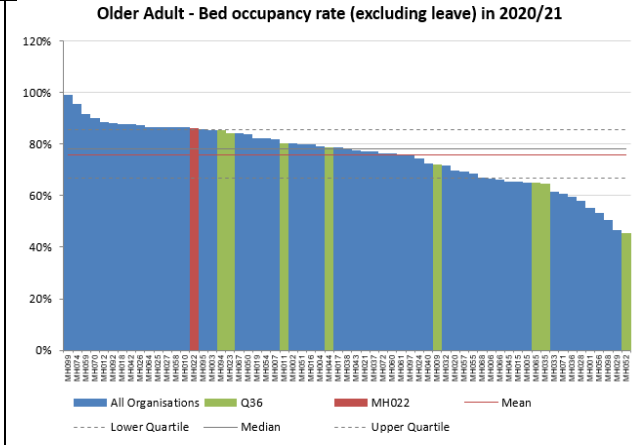
- **Adult acute delayed transfers of care (%):**

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



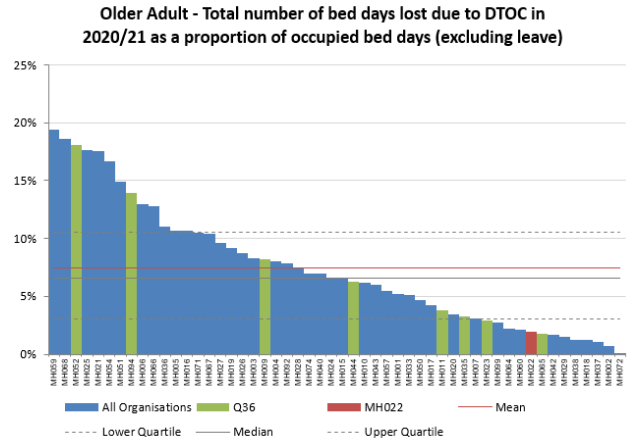
- **Older people's average length of stay (days):**

2020/21			2022/23	
Trust	London	England	Jun-22	YTD
81.0	70.0	73.0	96.3	95.2



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

2020/21			2022/23	
Trust	London	England	Jun-22	YTD
86.0%	74.0%	76.0%	89.5%	93.4%



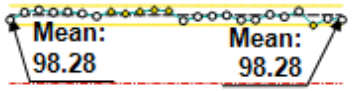
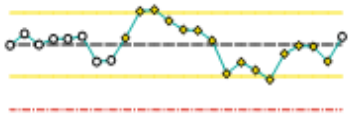
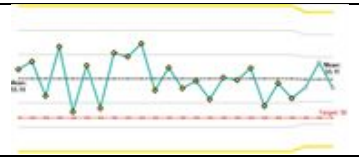
- **Older people's delayed transfers of care (%):**

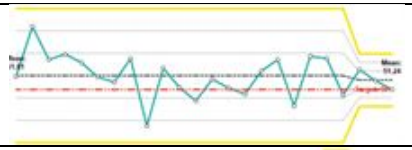
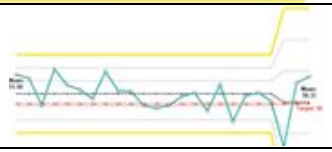
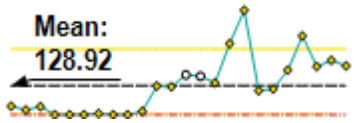
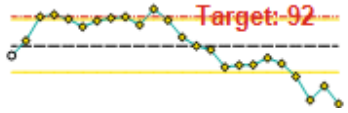
2020/21		
Trust	London	England
2.0%	7.0%	7.0%

Appendix 2: NHSI Compliance Overview

Following best practice guidance from NHSI the summary of performance against SOF NHSI metrics replaces RAG (red, amber, green) ratings with statistical process control (SPC) charts to provide assurance and trend analysis. An explanation of the use of icons and charts is provided in Appendix 9 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	Jun-22	Target	Trend	Assurance on consistently meeting the target	SPC Chart	Comments
Data quality maturity index (DQMI) (%) see page 23	98.1	≥ 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.
Cardiometabolic Assessments - Community & EIS (%) see page 26	85.4	≥ 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.
IAPT/talking therapies - Waiting time to begin treatment within 18 weeks (%)	99.9	≥ 95.0	→	✓		Performance is consistently above target.
IAPT/talking therapies - Waiting time to begin treatment within 6 weeks (%)	98.2	≥ 75.0	→	✓		Performance is consistently above target.
IAPT recovery rate - Talk Wandsworth (%) see page 22	54	≥ 50.0	→	✓		Performance is consistently above target for Talk Wandsworth.
1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) see page 11	66.7	≥ 60.0	→	?		There has been a recent decline in performance, mainly due to referrals from wards and assessment teams.

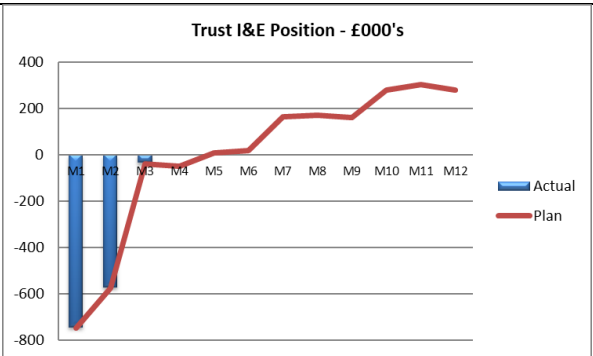
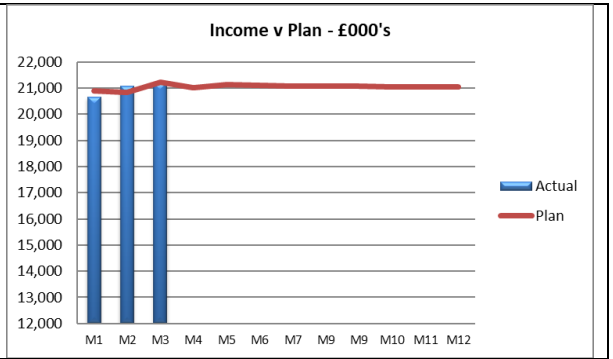
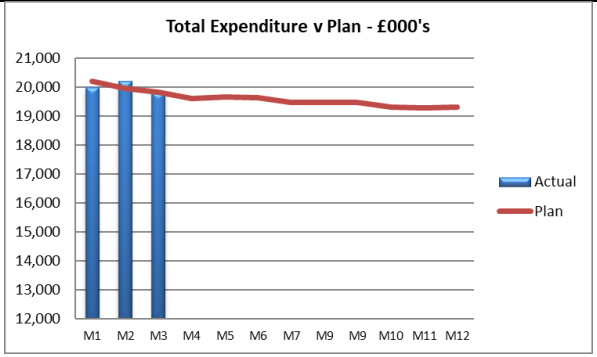
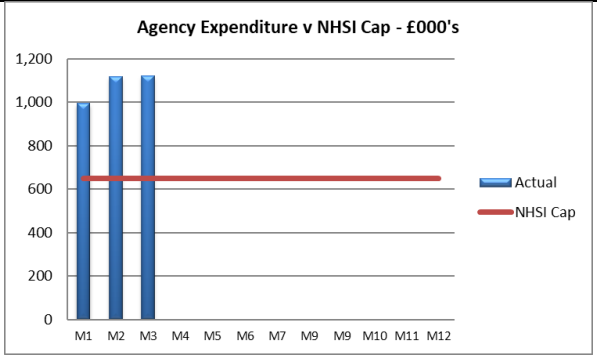
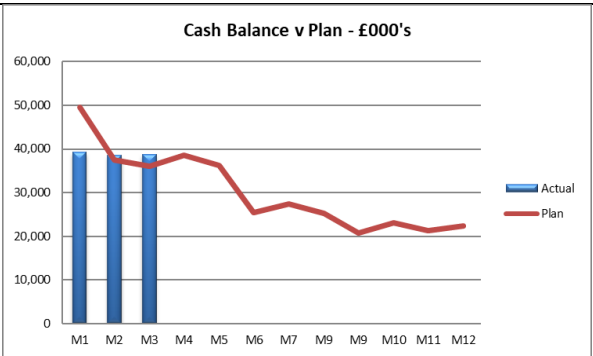
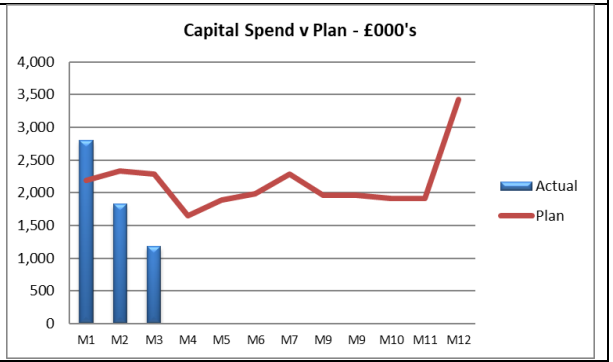
Cardiometabolic Assessments - Inpatients (%)	86.6	≥ 90.0	→	?		A task and finish group has reviewed the process for capturing physical health information on clinical systems. Clinical data collection forms have been simplified and were implemented across the Trust in Sept 20. Guidance has been issued to all staff.
IAPT recovery rate - Merton Uplift (%) see page 22	50	≥ 50.0	→	?		Average performance for 2022/23 is currently above target.
IAPT recovery rate - Sutton Uplift (%) see page 22	55.1	≥ 50.0	→	?		Average performance for 2022/23 is currently above target.
Inappropriate out of area placement bed days - Adult Acute & PICU Ⓟ see page 19	218	= 0	↗	X		The Trust has opened surge beds to help manage peak demand and keep out of area usage to minimum and has negotiated a six month contract for use of 12 beds at Huntercombe unit which commenced on the 29th November 2021.
Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) see page 12	82.9	≥ 92.0	↘	X		There have been demand and capacity issues within adult ADHD services. A wait list initiative targeted at longest waiters is due to commence in March 2022. Additional resources for non-medical prescribing have also been out in place, although these post have been delayed.

Appendix 3: Effective: CQUIN key measures

Overall Dashboard					
The Mental Health CQUIN team are currently developing schemes for 2022/2023 – full reporting will commence from July 22.					
Effective: CQUIN Key Measures	**Target**	**Jun-22**	**YTD**	**Information**	**Actions**
Flu vaccinations for frontline healthcare workers (%)	≥ 90.0			Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	Action update to be provided next month.
Cirrhosis and fibrosis tests for alcohol dependent patients (%)	≥ 35.0			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.	
Routine outcome monitoring in CYP and perinatal mental health services (%)	≥ 40.0			Achieving 40% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measured at least twice	
Routine outcome monitoring in community mental health services (%)	≥ 40.0			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.	
Use of anxiety disorder specific measures in IAPT (%)	≥ 65.0			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).	
Biopsychosocial assessments by MH liaison services (%)	≥ 80.0			Achieving 80% of self-harm [1] referrals receiving a biopsychosocial assessment concordant with NICE guidelines	

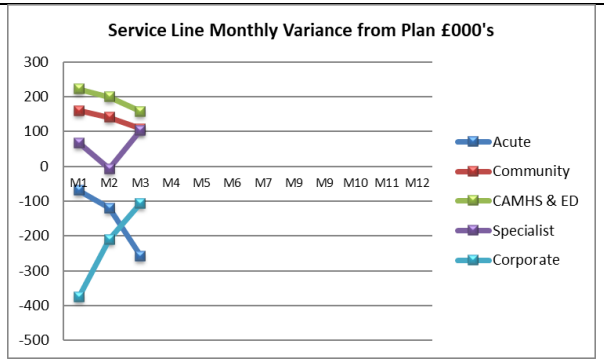
Appendix 4: Finance Domain

Trust Wide

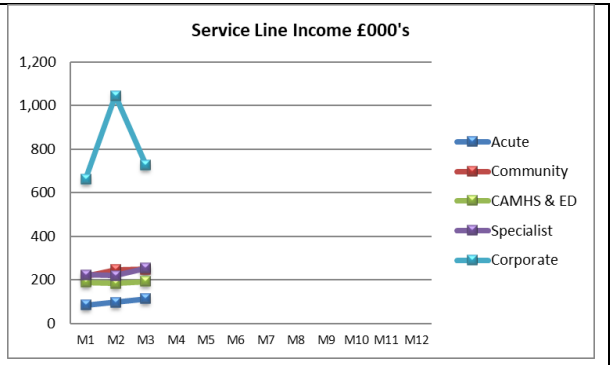
• Baseline deficit of £34k reported in month, £5k favourable to plan • Cumulative deficit of £1,347k, £12k favourable to plan • Deficit driven by external beds, Coral and Observation costs • Profile reflects revised plan break-even submission to NHSE/I		• Income received in month, £21.2m, marginally behind plan • Position now incorporates additional 0.7% inflation funding • Incorporates MHIS and SDF investments • Risk in relation to £2.8m NHSE erroneous deduction remains	
• Spend of £19.8m in month, marginally favourable to plan • Spend includes: 22/23 Investments, National Insurance increase and pay award accrual • Incorporates 56% increased spend on utilities • External bed expenditure £633k in month • External Bed pressure continues into M4		• Agency spend in month £1,120k, £282k above 2021/22 average monthly spend • £472k above NHSE/I cap • Likely to be increased central scrutiny in 2022/23 • Community spend in M3 of £508k (45% of total) • Corporate spend £224k including £88k of Strategic Investment expenditure	
• Cash balance at end of June £38.8m • £2.8m favourable to plan • Caused by reduction in Capital payables • Expected to equalize over the remainder of the year • Cash balances required for EMP • Loan of £99.3m; repayments scheduled to commence in 2023/24		• In month capital spend of £1.2m, £1.1m below plan • Cumulative spend of £5.8m, £1.0m below plan • Underspend found in EMP (£0.9m) and IT (£0.1m) • Planned spend of £25.8m for the year • Position excludes leases, £15.4m, capitalised under IFRS 16	

Service Line Analysis

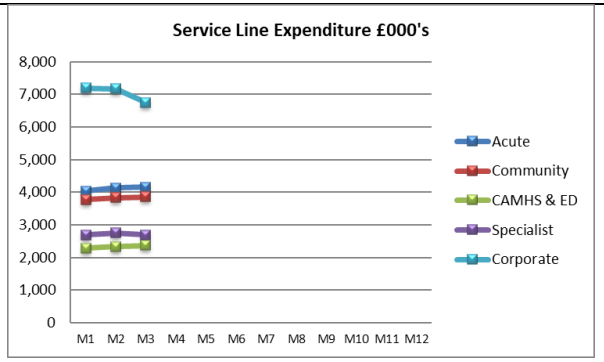
- CIP targets adjusted in M3
- Graph shows normalised position (e.g. M1 CIP in M1)
- Acute Care = £0.4m overspent
- Community = £0.4m underspent
- CAMHS & ED= £0.6m underspent
- Specialist = £0.2m under
- Corporate = £0.7m over due to central provisions and CIP balances held



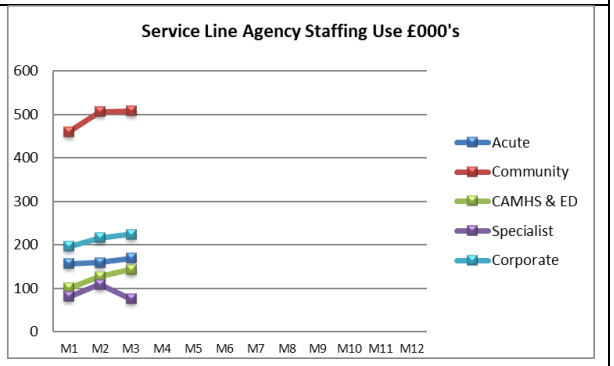
- Income received in month, £21.2m
- Graph excludes block contract income
- Acute = Liaison income
- Community & ED = HEE income
- CAMHS & ED income = Local Authorities + HEE + SLP income
- Specialist = SLP, and some NPSA
- Largest Corporate flow is Education income, N/R income in M2



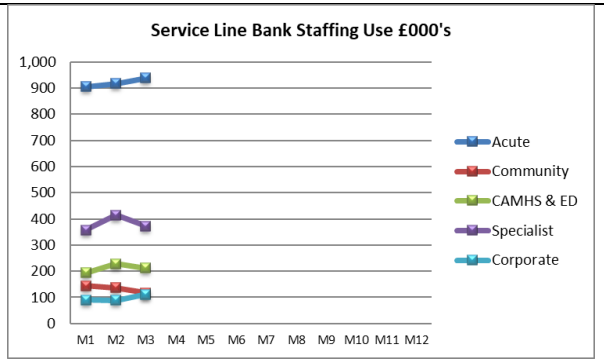
- M3 spend of £19.8m
- External bed spend £0.6m
- Position includes: SDF and MHIS investments, pay award accrual, National Insurance increase, increased energy prices and NHSP significant increases
- £0.5m of lease expenditure transferred to depreciation and interest payable under IFRS16



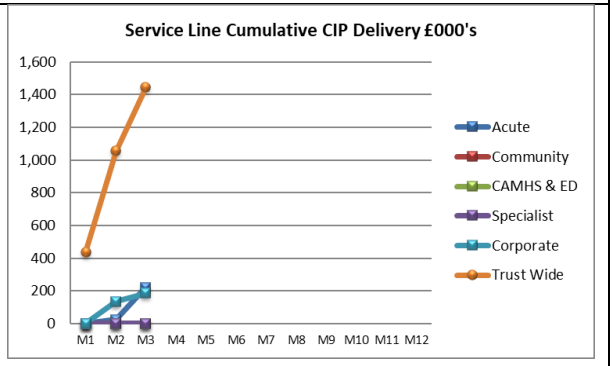
- Key driver of agency spend = Community Service Line
- Of total Trust spend of £1,120k, £508k (45%) in Community
- Corporate expenditure has increased to £224k in month, including £88k related to Strategic Investments
- Total M3 spend £472k above cap levels



- Total bank spend of £1.8m in M3
- Cumulative spend £0.1m above submitted plan
- Highest area = Acute at £0.9m
- Equates to 54% of M3 spend
- Reflective of acuity pressures and vacancy cover



- Total CIP plan of £12.4m
- Revised CIP targets devolved to Service Lines in M3
- Total delivery of £1.8m to date
- £1.2m adverse to plan
- Of total delivery: 12% with Service Lines (all Acute), 10% Corporate (all Finance and IT) and 78% in Central schemes



Appendix 5: 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 CQC inspected the Eating Disorder Services on 30th and 31st March, visiting both Avalon and Wisteria wards. Verbal feedback was given to the Trust during a quarterly engagement meeting and data was requested from the Trust. ▪ The final report for the Eating Disorder services inspection was published on 15th June 2022. The CQC had accepted the factual accuracy changes put forward by the Trust. ▪ The final report confirmed the new ratings for the Trust, with the core service being re-rated overall 'good' and with the Safe, Effective, Responsive and Well-led domains re-rated as 'good' also. ▪ The 2019 and 2020 requirement notices associated with the Specialist Eating Disorder services, were lifted and there are no new requirement notices for this core service. ▪ Though there were no new must do actions received, five should do actions have been issued, which covered recruitment, environment, prompt recording of vital signs in patient's electronic records, up to date life support training and ensuring that patients and carers have information on how to complain. ▪ The requirement notices have reduced to 8 (from 15) and are shown in Appendix A **Ratings on how Trust Scored for each core service:**

Appendix A – Current regulation notices

Regulation	Service	Issue
Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Long stay or rehabilitation mental health wards for working age adults	The trust must ensure that staff at Burntwood villas have access to adrenaline and know where it is stored and that risk assessments are undertaken where needed for patients with specific medication requirements. Regulation 12 (2)(f)
		The trust must ensure that staff always follow infection prevention and control policies. Regulation 12 (1)(2)(h)
Regulation 17 HSCA (RA) Regulations 2014 **Good governance** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Long stay or rehabilitation mental health wards for working age adults	The trust must ensure there is a robust model of care, that patients are admitted in accordance with the defined admission and exclusion criteria and that where a patient no longer meets the criteria, they are transferred promptly to a more suitable service. Regulation 17(2)(a)
		The trust must ensure that operational risks relating to the service are documented, monitored and managed. Regulation 17(2)(a)(b)
		The trust must ensure fire safety arrangements are adequate so that risks are mitigated to safeguard patients and staff and that issues identified through risk assessments and fire drills are acted on promptly. Regulation 17(2)(b)

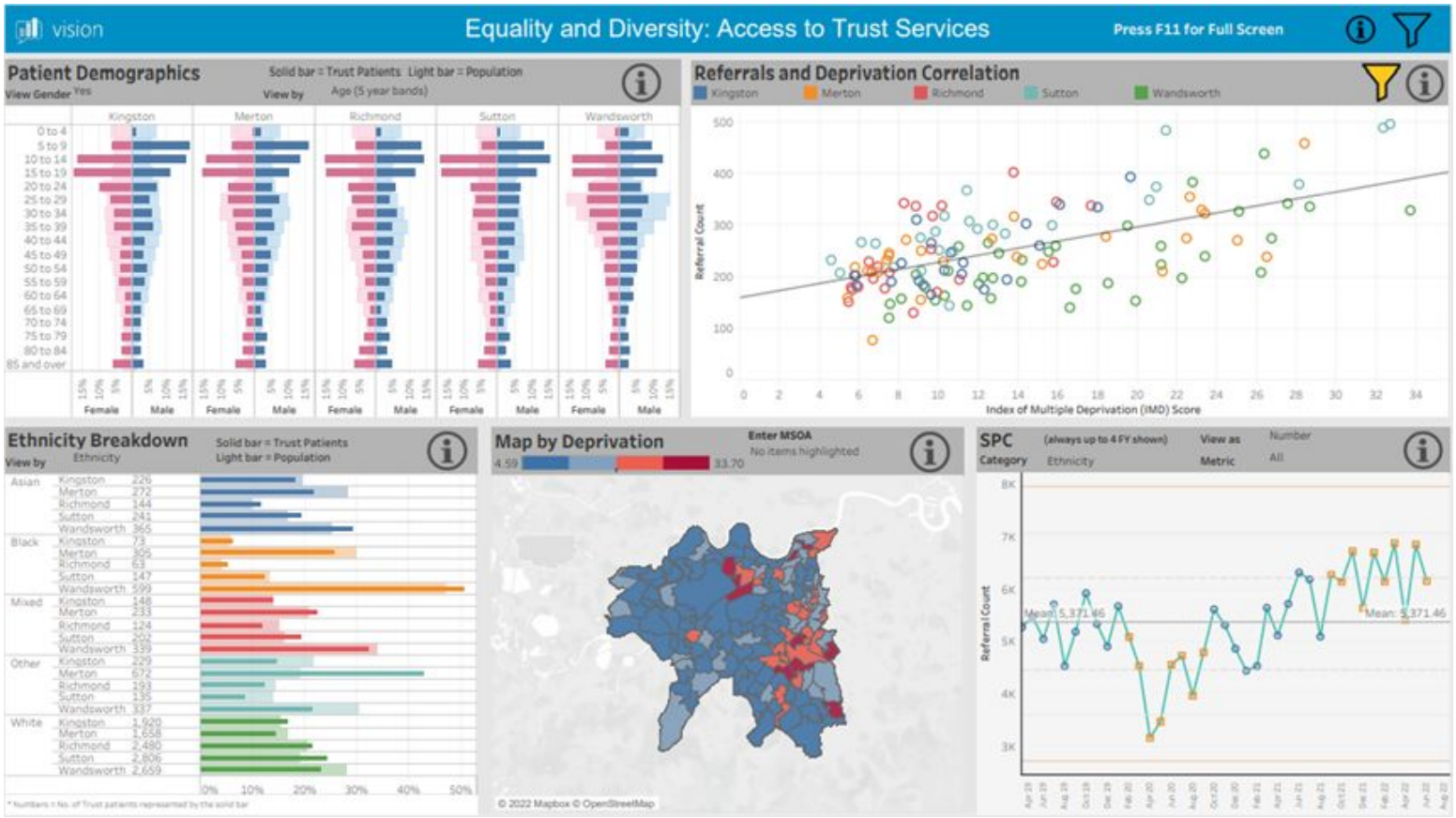
Regulation 18 HSCA (RA) Regulations 2014 **Staffing** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Long stay or rehabilitation mental health wards for working age adults	The trust must ensure that the service is suitably staffed, with the right skill mix, to provide the level of care required to meet patients' needs and that this is aligned to the model of care on offer. Regulation 18(1)
Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Acute wards for adults of working age and psychiatric intensive care units	The trust must ensure that there are appropriate and detailed plans in place to manage patients' physical health risks and that specialist advice is followed after a review of patients' needs. Regulation 12 (1)(b)
		The trust must ensure that staff do not complete intermittent observations at regular, predictable intervals. Regulation 12 (1)(b)

CQC MHA monitoring visits

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

Appendix 6: 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 7: 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.

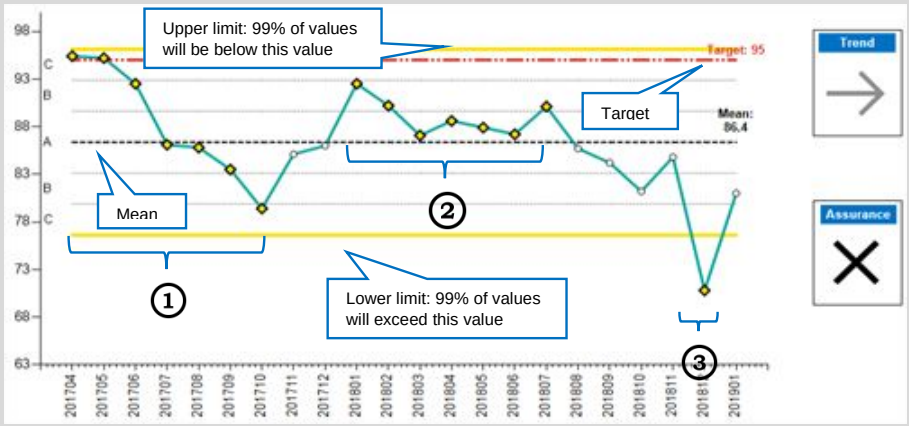
Appendix 8: Data quality assurance

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.

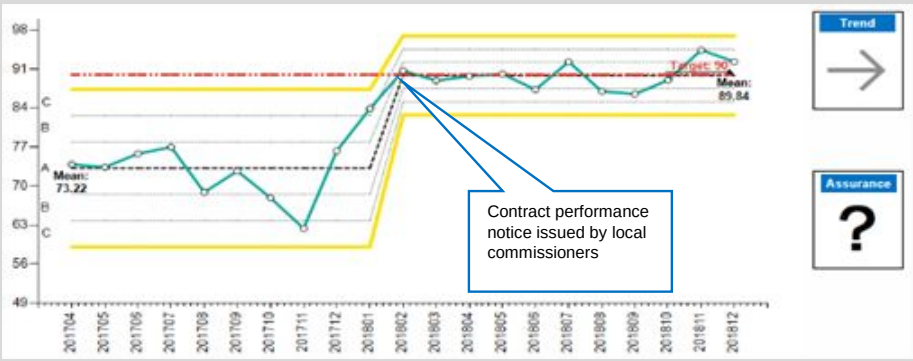
Appendix 9: Statistical Process Control (SPC) Charts explained



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.

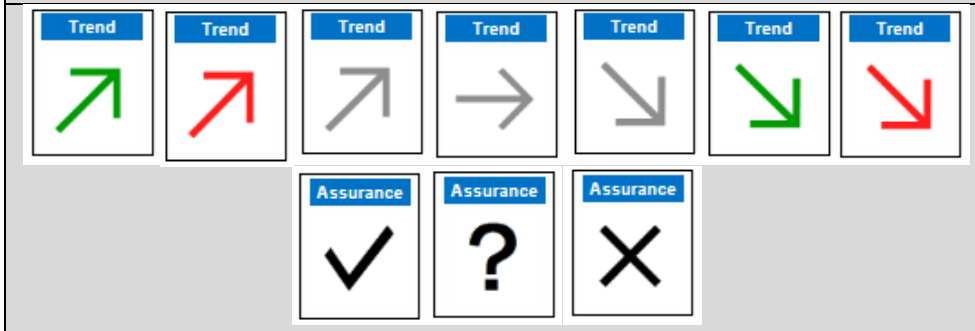
Evidence suggests that we make better decisions when we've analysed data using SPC



Special-cause variation
These are statistically significant patterns in data which may require investigation and includes the following (as illustrated in the chart above):
1. Trend: 7 consecutive points trending up or trending down (a 0.8% chance of this happening naturally).
2. Zone A: 7 or more consecutive points on one side of the average (Zone A or beyond).
3. 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*").

Meeting	Board of Directors
Date of meeting:	8th September 2022
Report title:	**Workforce and Organisational Development Committee Chair's Report**
Author:	Sola Afuape, Non-Executive Director, Committee Chair
Executive sponsor:	N/A
Purpose:	For Information

Executive Summary
The Workforce and Organisational Development Committee met on 6th June 2022 and on 26th July 2022.

Matters discussed in June Committee were as follows:

- HR Transformation and Performance Outcomes
- Q3 Corporate Objectives 2021/22 and 2022/23
- Committee Annual Report
- 10 HR Report recommendations and progress Update
- Workforce Board Assurance Framework
- Nurse Validation update
- Stress Risk Assessment update
- Committee Forward Plan

The following items are for reporting to the Trust Board:

HR Transformation and Performance Outcomes

The Committee reflected on:

- There is limited assurance on the progress towards recovery. Recruitment, Employee Relations and Medical Staffing still remain the principal areas of significant risk. However the Committee is increasingly assured by the updates setting out planning in place to address this and notes the very early signs of small areas of improvements. E.g. reduction of ER cases
- The wellbeing and morale of the team was discussed and the importance of maintaining active oversight and providing visible support. SA to meet the HR and OD Team as part of their monthly Q&A meeting.
- Governance arrangements have strengthened with the People Matters meeting established and oversight of HR and OD operational effectiveness provided through the minutes noted at each Committee.
- Whilst Recruitment, Employee Relations and Medical Staffing remain agreed priority areas of focus, the risk associated with limited resources and joint arrangements within the L&OD

function was noted, along with the impact of these risks on supporting the Trust with skilled enabled staff. Plans are in place to explore different approaches to how this might be provided. The Committee will continue to receive updates to maintain oversight.

- The separation of the two HR services is ongoing and is set to conclude in September. It was acknowledged that this will be a particularly unsettling period with both planned and unforeseen risks. In addition to regular updates, a detailed progress report will come to the November Committee.

Nurse Validation update

The Committee received an update on the Nurse Validation Process. The Committee was assured to receive an account of the processes in place to follow up NMC alerts that are circulated at six months, three months and when this validation is due to expire. The Director of Nursing confirmed that if staff are not at work due to sickness/maternity leave this is followed through with staff and should re-validation not be completed by any staff who are working they would be removed from clinical practice until this has been addressed.

Matters discussed in the July Committee are as follows:

- HR Proposal
- Workforce Board Assurance Framework
- Q1 Corporate Objectives 2022/23
- Workforce Update
- Making Life Better Together Update
- Guardian Service Report
- Ways of Working Policy and draft Disciplinary Policy
- Disciplinary deep dive
- Committee Forward Plan

The following items are for reporting to the Trust Board:

The Chair attended the HR and OD staff Q&A as Chair of Workforce and OD Committee to listen to staff and hear about progress towards HR and OD Recovery, acknowledge their challenges and offer encouragement and support. Staff reported feeling unsettled and keen for matters to be resolved. They set out concerns which will be incorporated in the oversight and scrutiny at future Committees. This is a department working hard under enormous pressure to recover, build and move forward. The Committee will continue to prioritise a focus and oversight of the HR & OD staff's wellbeing and progress with matters they raised such as career development, workload and acknowledgment of their current challenges. The Chair was pleased by the manner in which the HR leadership team encouraged open dialogue from staff which some but not all staff responded to. On-going work is required to encourage a wider range of contributions.

It was noted that the HR proposal has been through Executive Leadership Team, underwent rigorous scrutiny and was well received. The Committee was pleased to hear there was support from Executive colleagues that activities proposed would bring us back on track. The timeline for full separation is scheduled for September 2022 with further work required to set out the budget envelope. Separation of joint roles at SLT level is underway and the Committee were asked to note that this and further separation would likely increase vacancies in the short term and impact capacity within the department, the latter of which was highlighted as a heightened risk.

The Committee noted these risks and sought clarity as to whether this should result in any changes to the BAF. The service is undergoing a period of transition with levels of risks varying

dynamically as improvement activities are implemented. It was also noted the BAF remains a comprehensive document with significant detail. It was agreed that the current risks discussed are appropriately captured and the level of detail still required. These would, however, be truncated over time as the improvement work beds in and assurance increases and the BAF reviewed.

The Workforce Update report contained the first presentation of the HR and OD Dashboard. This is a turbulent period for the department with a significant number of workforce indicators given as red providing very limited assurance. These were notably agency spend, vacancy, turnover and stability. Work is underway to address these through seeking to retain good interims in permanent roles and secure the full complement of substantive posts. There was a robust discussion and oversight of the risks, mitigation and staff morale. The Committee was agreed that both the HR & OD and the Q&P dashboards would continue to come to the Committee to triangulate and track the impact of progress with HR and OD KPIs on quality and operational performance. It is also noted that the position for the Trust's HR&OD function is somewhat obscured by the overlap with SLAM and that clearer oversight will be possible following full separation post September.

The HR &OD Director indicated that it is expected that notable improvements in HR and OD **key performance indicators** should be seen within about 6 months from September 2022. It was agreed that a review of the BAF would come to the January/February Committee and preceding that the HR and OD performance review to the November Committee.

The service is planning to deliver a 6% **CIP saving**. A report setting out the detail will come to a future Committee, to which the Finance and Performance Committee chair will be invited.

A comprehensive Ways of Working policy was presented to the Committee. A request was made for a user friendly summarised version and an update to come to a future Committee setting out staff feedback and review of the impact on staff and operations.

A comprehensive presentation was given of the priorities and future planning of the Making Life Better Together programme with an emphasis on staff engagement and well-being. The question was asked as to where the integrated picture across all stakeholder engagement (staff, external stakeholders and patients), its benefit and impact was considered and how MBLT targets it's approach to support the Trust tackle high risk areas; the HR &OD department was given as an example. Future presentations will set out and focus on outlining the impact of MLBT in improving areas of organisational challenge and with outline case studies of localised MLBT activities targeting key hotspot areas.

The Guardian report will now be received quarterly and on-going efforts will be made to triangulate these insights with insights from the staff and pulse surveys for a greater depth of analysis and oversight.

A meeting is to be arranged in September with the chair of the Committee, the EDC chair and new Head of EDI lead to discuss the overlap in workforce equality and governance.

The **forward plan** has been revised to include seminars to undertake deep dives into key areas of risk. The three priority areas will be the first; recruitment and retention, employee relations and medical staffing and will come to the December Committee Seminar along with item; the People plan and Strategy development.

Recommendation
The Board is asked to note the report and receive the minutes from 6th June 2022.

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

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the meeting held on **Monday 6th June 2022**, 08:30-10:30 via MS Teams

Attendance list

Present:

Sola Afuape (SA)	Non–Executive Director (Chair)
Katherine Robinson (KR)	Director of People
Jen Allan (JeA)	Chief Operating Officer
Sharon Spain (SS)	Director of Nursing

Attendees:

Nicola Mladenovic (NM)	Deputy Trust Secretary – Minutes
Sarah James (SJ)	

Observer with speaking rights:

Shikainah Champion (SC)	Diversity Representative and Specialist Clinical Psychologist for Sutton Uplift (attended until 9.40am)

Apologies:

Jenna Khalfan (JK)	Director of Communications and Stakeholder Engagement
David Lee (DL)	Director of Corporate Governance
Vanessa Ford (VF)	Chief Executive Officer
Deborah Bowman (DBo)	Non Executive Director
Doreen McCollin (DM)	Non–Executive Director

Item		Action
22/19	**Welcome and Apologies** Apologies for absence were received and noted.	
22/20	**Declarations of Interest** No new declarations were reported.	
22/21	**Chair's Action** The Chair took no action on behalf of the Committee outside of the meeting.	
22/22	**Minutes of the previous meeting** The minutes of the meeting held on 22nd March 2022 were approved as an accurate record.	
22/23	**Action Tracker and Matters Arising** The Committee received and noted the action tracker. The following updates were received on the following: **Item 21/62 - Disciplinary Deep Dive Outcome Report.** SA and KR are to meet to discuss this further and an update will come to the July meeting. **Item 21/83 – Stress Risk Assessment Update** – Agenda item **Item 22/9 – BAF Update** – Agenda item	

Item 22/12 - Nurse Validation Report – the update report is to be forwarded by SS to SA for inclusion in the chair's report to the Board to acknowledge confirmation of matters raised regarding process. SS confirmed that the re-validation process takes place following the NMC alerts, these are circulated at six months, three months and when this is due to expire. This is managed within the Employee Relations and Payroll function. This is followed up by the Nurse Development Team with any relevant individuals. Should staff not be at work due to sickness/maternity leave this is followed up with staff and should the re-validation not be complete, staff at work would be removed from clinical work until this is renewed. The duration of processing an expired re-validation could be 6-8 weeks. **SS**

Item 22/11 - Recovery Advisory Board Assurance Report – a report will be drafted to detail the outputs from the HR Service Improvement Recovery Group (SIRG). The first update will come to the next committee. The SIRG Terms of Reference is to be included in the Committee Annual Report. (**Action – NM** to update the action tracker and to link with KR to expand this further. **NM**

Item 22/14 – Committee Terms of Reference – SA to meet with Doreen to go through the overlap between the Equality & Diversity and Workforce & OD Committee's.

22/24 Stress Risk Assessment Update

The Committee received and noted the Stress Risk Assessment Update. KR reported on the following:

- Stress risk assessments were implemented in 2021 and further work has progressed since concerning the impact this has made including the resources needed to support stress risk assessments especially as a result of the Covid-19 pandemic.
- In addition to the above, the Staff Survey has highlighted the causes of stress as being; resourcing issues, staff having do-able jobs, reducing the bureaucracy associated with recruiting to vacant posts and having an effective bank to support the service lines. It was agreed that to address this the priority was to tackle the underlying causes and therefore focus on standing up and strengthening the HR function through effective delivery of the HR Recovery and recruitment and retention to minimise vacancies and the root cause of sickness absence. In addition further support will be provided to managers and the Stress Policy will be developed to better reflect and respond to the root causes. Assessments will be on-going but will undertaken on a case by case basis.
- It was requested that training including webinars be carried out to support managers. **(Action: KR)**

The Committee heard that some learning has been taken from the Kings Health Partners regarding support and training for staff and managers. It is being considered whether a joint approach with the SLaM Health Promotion Team is the proposed direction of travel or the training will be procured separately.

The Committee agreed this as a sensible approach and will receive regular updates as part of the performance reporting.

22/25 HR Transformation and Performance Outcomes

The Committee received and noted the HR Transformation and Performance Outcomes Report. The following points were reported:

- HR Transition plans have been developed to separate the service from SLaM. Initially it was proposed to split all areas except where there are cross over areas. The decision is now to undertake a full split which is underway. The focus of the

emerging HR service include putting the customer first, the digital solutions needed to support the service, building a strong foundation to enable continuous improvement and providing value for money.

- Various workshops have been held to capture staff feedback which includes operational feedback recognising that previous changes in HR did not reflect the views of the team.
- The business case for change has been developed with the support of the Director of Finance and has been received at ELT. The implementation phase will commence in June 2022 and focus is on recruitment, medical staffing and ER. The key areas of risks are staff currently in joint roles and/or interim positions. In particular are the following areas recruitment, HR transactional, organisation development, medical staff and pay/reward. Education and learning is a separate area for further development which will is for further considered at a later date and does represent an area of risk that the Committee will seek to be sighted on.
- Complete separation is planned for the end of the HR Recovery period in September 2022.
- Implementation Approach:
    - Phase 1 – Implementing a First Point of Contact offering an advisory 'triage' service by a qualified HR professional. This should a responsive service that filters, signposts and addresses a significant portion of queries. Cases not resolved at this stage will be managed by specialist staff.
    - The recruitment function will be brought together for full oversight and sharper management of the service. This will include medical staffing with the addition of a dedicated medical staffing lead recruited to support this function
    - The Employee Relations, Business Partnering and advisory services will be brought under a senior lead.
    - Phase 2 – consultation and engagement will start with the recruitment and transactional teams

The Committee noted the full complement of workstreams and the key priority areas identified. Work, however, will still need to be undertaken, in other key workforce areas such as EMP consultations, EDI refresh and planning for the next Staff Survey.

The Director of Nursing and Chief Operating Officer have worked in partnership to shape these priorities. Whilst they acknowledged the complicated challenges that need to be worked through especially in terms of all the areas of recruitment pressed for progress to be made more swiftly given the impact on quality and operations.

Katherine reported that the future HR model will need to consider the impact of the changes in ICS and the location of staff across both Springfield and Tolworth sites will not reduce the ability to make contact with HR as this is accessible through phone, messaging or email. Katherine updated that even though the services will be separating there will still be opportunities to learn from the joint working. The focus is on recruiting substantively to create a strong HR team and reduce the relatively high number of interim staff some of whom have expressed a wish to become substantive.

22/26 Workforce BAF Update

The Committee received and noted the BAF. KR reported that the BAF has been refreshed in line with the previously agreed priorities.

- The BAF will include a section setting out progress to date and clear time line. SA and KR to take a discussion off line to finesse this.
- It was noted that a gap and risk for the organisation is understanding the training needs of staff and undertaking training needs analysis. OD is still currently a joint function with SLaM provided by one person covering both Trusts..

- Critical areas of key risks and focus for the committee are recruitment, medical staffing and Employee Relations. However two other areas recently added are occupational health and workforce planning.

Resourcing issues were highlighted for the training function and identified as a key risk as this team supports the mandatory and statutory training provision.

22/27 Q3 Corporate Objectives 2021/22 and 2022/23

The Committee received the Corporate Objectives report for 2021/22 and 2022/23.

KR reported on the corporate objectives for 2021/22 and informed the Committee that Objective 3 (EDI) and Objective 6 (Workforce) have not been met. Next year's objectives have been presented to ELT. The Committee Chair and Executive Lead and have yet to meet with the objectives lead, Amy Scammell to go through the HR objectives for 2022/23. (**(Action: AS)** **AS**

The Committee noted last years objectives and the updated objectives will be circulated. **(Action: KR)** **KR**

22/28 Committee Annual Report

The Committee received the draft Annual Report. It was agreed that this will be circulated to the committee for agreement ahead of being received at the Trust Board. **(Action: NM)** **NM**

22/29 10 HR Report Recommendations and Progress Update

The report into the previously reported HR Recommendations was completed in October 2021. The 10 recommendations were presented and the progress made against each:

- Stabilise the turnover
- Establishing a digital interface across both Trusts to access systems. This is not needed as the initial priority but the service needs to be future fit.
- Establishing a business case for a shared service – this is no longer required as the service is splitting into one service
- Creating space to develop thinking and planning
- Review governance arrangements - a People Matters group has been stablished and has strong links to this committee
- Review of shared roles – no longer reviewed as splitting the services
- Building workforce planning capability and locate this at HR business partner level – this is now in place however some interims are in post
- Review of priorities
- Managing expectations of service users, the change in HR model has taken some time and so the impact of the new model needs to be understood by the whole staff team
- Leadership Challenges – the reporting lines have been made clearer and risks are regularly reviewed as part of the reporting of the Service Improvement Recovery Board.

The actions against the recommendations are to be closed as the priorities have changed. These will now be incorporated into business as usual reporting and operationalisation and implemented as part of the business plan.

The Committee considered the move to business as usual and the transitional structures in place. KR is to provide additional information that sets this out for the chair's report to the Trust Board **(Action: KR)** **KR**

22/30 Approach to the June Board Seminar
KR updated that the Seminar on 9th June 2022 will receive a presentation on the changes for HR, progress to date and include priority areas, leadership & development and risk.

22/31 Local Clinical Excellence Awards Scheme
The Committee received a verbal update from KR.

The Awards are in place to acknowledge the work undertaken over above clinician's main role, which should be demonstrated for the award to be received. There is evidence that there are disparities in its application. The BMA has indicated that there will be changes to ensure that there is greater equality and a fair split.

A paper will come to the next Committee supported by Billy Boland, Medical Director and the Interim Medical Staffing Manager. (**Action: NM to invite**) **NM**

22/32 People Matters minutes
None were received these are to be circulated and members are to be asked to respond with any queries within one week. **(Action: NM)** **NM**

22/33 HR and ODC SIRG Terms of Reference
The Committee received the HR and ODC SIRG Terms of Reference. **(Action: NM to include SIRG into the Committee Terms of Reference)** **NM**

The Committee noted the Terms of Reference.

22/34 Committee Forward Plan
The Committee received the forward plan.

The Committee noted the items on the forward plan and agreed that this will be updated following the latest changes and should be themed to align with the recruitment, development and retention.

The themes from People Matters should feature on the agenda. **(Action: SA and KR to update the forward plan and forward to NM)** **KR**

22/35 Matters to Report to the Board
The Committee is to report a summary of items discussed to the Trust Board.

- The next meeting will focus on the standard metrics from the main Q&P report.

22/36 Meeting Review
The Committee reflected on the meeting and SA thanked the members for the feedback that has been received. Committee members feedback can be submitted directly to SA. Some clarity on members roles was asked and this will be considered for future meetings.

22/37 Date of Next Meeting
The next meeting will be held on 26th July 2022.

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

Meeting:	Trust Board
Date of Meeting:	8th September 2022
Report Title:	**Equality and Diversity Committee chair's report**
Author:	Doreen McCollin, Non-Executive Director, Committee Chair
Purpose:	For assurance and for agreement
Transparency:	Public

WRES and WDES annual reports.
To comply with the NHS England 31 October deadline, the Board is asked to agree that the sign off for the Trust's WRES and WDES annual reports and action plans is delegated to the Chair and CE. These will be reviewed at the committee on 20th October 2022 and a report will back to come to the November Board under the EDC chair's report.

Recommendations

The Board is asked:

1. To note the key points of this report.

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

Meeting:	Trust Board
Date of Meeting:	8 September 2022
Report Title:	Part A - Finance Update 2022/23 Month 4
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 the plan submitted to NHSE/I in June.
- The position for Month 4 is break-even bringing the cumulative position after two months to £1.4m deficit, broadly on plan.
- Underspends against Pay are offsetting overspends in non-pay where the unidentified savings target is held.
- The position currently assumes a 2% increase in pay inflation offset by national funding of 2%. This is in line with planning guidance. Following the recent announcement on pay awards, the ICB has calculated the revised figure to be closer to 5.5%, an additional cost of £3.7m which will be funded.
- The Trust continues to operate with agency costs higher than the historic NHSE cap; NHSE have issued new caps at ICB level and the Trust is waiting for confirmation of its cap allocation. The small reduction in agency in July compared to June, was due to the holiday period. Excluding seasonal variation, agency costs continue to be an upward trajectory as recruitment continues to be a challenge, particularly within Community Services. The Trust spent £1.1m on agency in July, and £1.9m on temporary bank.
- The savings target of £12.4m has been devolved to service lines. Cumulatively delivery is £2.8m, £1.3m behind plan. Schemes have been identified to achieve 93% of the savings target for the year.
- All clinical service lines are reporting break even or better except for Acute Services and Corporate. Acute Services is reporting a cumulative £0.9m adverse position reflective of high levels of acuity on inpatient wards. Corporate is reporting a cumulative £0.7m adverse position due to central provisions against known trust wide liabilities and low delivery to date against central savings schemes.
- Of the £23.5m capital spend to date, £15.4m is due to a technical adjustment relating to leases required to comply with the introduction of accountancy standard IFRS16. Operational capital of £8.1m is £0.4m less than plan due to phasing of construction costs on the Springfield site.
- The Trust has a £99m loan taken out in previous years to support the construction of the Springfield redevelopment. No repayment is anticipated in 2022/23. Cash balances will be used to fund construction in 2022/23.

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

- At the end of July, the Trust had a cash balance of £35.8m; £2.7m adverse to plan.
- The main concern is the ability to deliver the required savings whilst maintaining appropriate quality and safety standards, and ensuring there is no unacceptable detrimental impact on patient care e.g. through extended waiting times.

Recommendation:

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

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

Corporate Risk	**1025/27**	**Board Assurance Risk**	**1025/27**

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

Assurance/Governance:	Positive impact – This paper provides update to the financial targets against which the Trust is performance monitored against
Clinical:	Positive impact – Trust Funds are spent to get the best value to support our clinical services and patients
Equality & Diversity:	Positive impact – The Trust spends money to improve equality and diversity for patients and staff.
Estates:	Positive impact – The Trust is investing in its Estate to provide modern mental health facilities
Financial:	Positive impact - Provides information on the delivery of key financial targets
Legal:	Positive impact - Provides information on the statutory requirement of achieving break even
Quality:	Positive impact – Trust funds are spent providing good quality services to our patients whilst achieving financial targets
QII:*	n/a
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Involvement (SUCFF):*	n/a
Strategy:	Positive impact – Underlying financial sustainability is a key part of the Trust's strategy
Workforce:	Positive impact – Trust funds supports the employment of a secure permanent and stable workforce, the report provides information on the cost of agency
Other (specify):	n/a

QII = Quality Improvement & Innovation; Involvement (SUCFF)= Service User, Carers' Friends & Family Engagement and Involvement

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

Finance Report 2022/23
4 Months to July 2022 – part A

Meeting	ELT
Date of Meeting	August 2022
Report Title	Finance Report 2022/23 – 4 Months to July 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

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

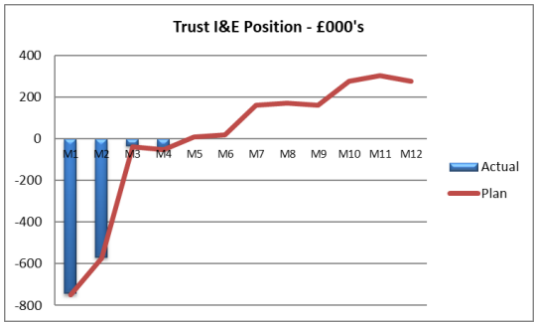
- In July, the Trust recorded a £0.05m deficit, marginally favourable to plan
- This brings the cumulative deficit to £1.4m, also marginally favourable to plan
- The position fully reflects income flows agreed with South West London and other ICBs as part of 2022/23 contracting
- The expenditure position includes new year investments relating to MHIS and SDF. Unfunded pressures such as external bed usage and observation costs contribute to the current deficit
- Expenditure also reflects new year inflationary pressures such as national insurance and energy price increases. The pay award is assumed at 2% in line with current funding in the plan
- The ICB expects the pay award to be closer to 5.5%, with an additional cost of £3.7m (which will be funded). The Trust is validating these figures
- The forecast outturn is break-even in line with plan and requires an improvement in run rate during the remainder of the year. There are a number of risks associated with this.

Financial Reports 2022/23	Current Month			YTD month 4			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	21.2	21.1	(0.0)	84.1	84.1	(0.1)	252.7	252.7	(0.1)
Pay	(14.8)	(14.4)	0.4	(59.9)	(58.0)	1.9	(181.2)	(175.0)	6.2
Non Pay	(5.0)	(5.4)	(0.4)	(19.8)	(21.7)	(1.9)	(54.2)	(60.6)	(6.4)
EBITDA	**1.4**	**1.4**	**(0.0)**	**4.4**	**4.3**	**(0.1)**	**17.4**	**17.1**	**(0.3)**
Cap Charges - Depreciation	(1.0)	(1.0)	(0.0)	(3.8)	(3.8)	(0.0)	(11.5)	(11.5)	0.0
Cap Charges - Interest & Div	(0.4)	(0.4)	(0.0)	(1.7)	(1.7)	(0.0)	(5.1)	(5.1)	0.0
Interest	(0.1)	(0.0)	0.0	(0.2)	(0.2)	0.1	(0.8)	(0.5)	0.3
Post EBITDA	(1.4)	(1.4)	0.0	(5.8)	(5.7)	0.1	(17.4)	(17.1)	0.3
Underlying Surplus / (Deficit)	**(0.1)**	**(0.0)**	**0.0**	**(1.4)**	**(1.4)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus / (Deficit)	**(0.1)**	**(0.0)**	**0.0**	**(1.4)**	**(1.4)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**

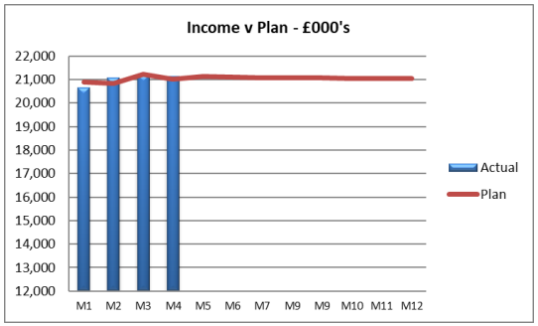
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

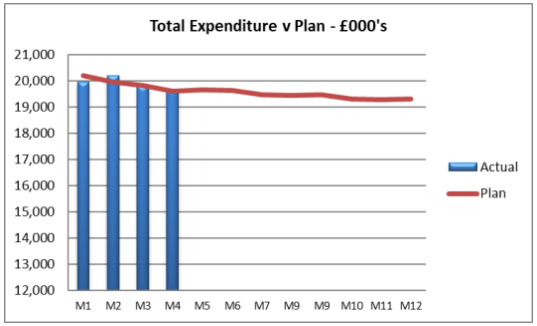
- Baseline deficit of £49k reported in month, £2k favourable to plan
- Cumulative deficit of £1,397k, £16k favourable to plan
- Deficit driven by external beds, Coral and Observation costs
- Profile reflects revised plan break-even submission to NHSE/I



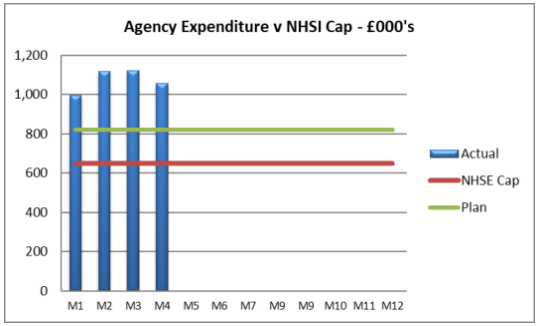
- Income received in month, £21.1m, marginally behind plan
- Position incorporates additional 0.7% non-pay inflation funding
- Incorporates MHIS and SDF investments
- Risk in relation to £2.8m NHSE erroneous deduction remains
- Draft allocation of £3.7m identified by ICB for pay award pressure



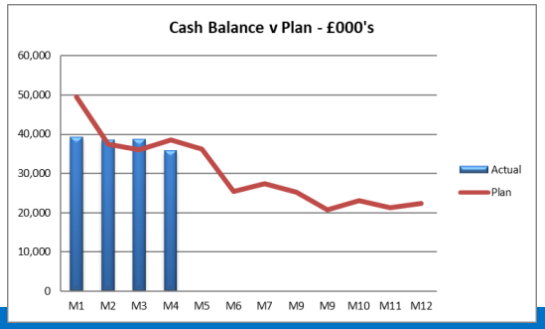
- Spend of £19.8m in month, in line with plan
- Spend includes: 22/23 Investments, National Insurance increase and 2% pay award accrual
- Final pay settlement to cost £3.7m above current plan
- Incorporates 56% increased spend on utilities
- External bed expenditure £647k in month
- External Bed pressure continues into M5



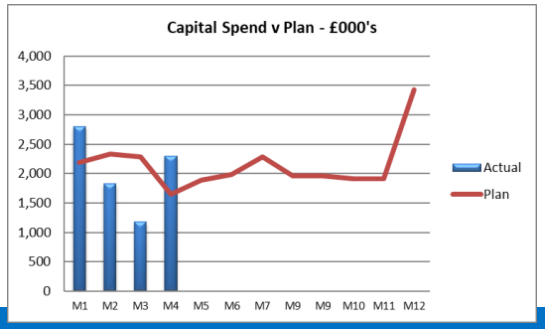
- Agency spend in month £1,055k, £218k above 2021/22 average spend
- £407k above NHSE cap
- ICB agency cap set and needs to be allocated to providers., cap will be on or below plan but above previous cap
- Community spend in M4 of £507k (48% of total)
- Corporate spend £197k including £46k of Strategic Investment expenditure



- Cash balance at end of July £35.8m
- £2.7m adverse to plan
- Caused higher than planned working capital movements
- Expected to equalize over the remainder of the year
- Cash balances required for EMP
- Loan of £99.3m; repayments scheduled to commence in 2023/24



- In month capital spend of £2.3m, £0.6m below plan
- Cumulative spend of £8.1m, £0.4m below plan
- Underspend found in EMP (£0.3m) and Estates (£0.1m)
- Planned spend of £25.8m for the year
- Position excludes leases, £15.4m, capitalised under IFRS 16



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

Income Position

- For Month 4 the Trust reported £21.1m of income, marginally behind plan month and cumulatively £0.1m adverse
- The position now reflects the additional 0.7% inflationary funding made available to the Trust to cover in-year pressures
- Local Contracts are showing a £0.3m adverse variance. This is a phasing issue and will correct itself later in the year
- NHSE income is £0.9m behind plan. This is a continuation of the error first made by NHSE in 2020 reducing income to the Trust by £2.8m
- Other NHS Clinical Income is above plan by £1.1m. This is primarily to offset the NHSE shortfall. The Trust has been assured by NHSE that there is enough money in the system to resolve the issue. Following confirmation that NHSE will make no further deductions, the Trust is now closer to resolving this
- Education income is £0.2m favourable to plan due to additional salary replacement funding being received
- Other non-clinical income £0.1m behind plan as expected income flows have yet to crystallise
- The shortfall of £0.1m on Non-NHS Clinical Income primarily relates to salary and interpreter recharges – the income shortfall is matched by expenditure reductions

Financial Reports 2022/23	Current Month			YTD month 4			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	16.0	16.0	0.0	64.0	63.7	(0.3)	192.0	192.0	0.0
Nhs England	1.9	1.6	(0.2)	7.5	6.5	(0.9)	22.4	19.6	(2.8)
Npsa Income	0.0	0.1	0.0	0.2	0.2	0.0	0.5	0.4	(0.1)
Provider Collaborative Income	1.5	1.5	0.0	6.0	6.0	0.0	18.2	18.2	0.0
Other Nhs Clinical Income	0.2	0.5	0.3	0.7	1.7	1.1	2.0	4.7	2.7
Nhs Clinical Income	**19.6**	**19.7**	**0.1**	**78.3**	**78.1**	**(0.1)**	**235.0**	**234.9**	**(0.2)**
Education & Training	0.6	0.7	0.0	2.5	2.7	0.2	7.6	8.2	0.6
Other Non Clinical Income	0.5	0.3	(0.2)	1.6	1.5	(0.1)	4.8	4.4	(0.3)
Merit Award Income	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0
Non Clinical Income	**1.1**	**1.0**	**(0.1)**	**4.1**	**4.2**	**0.1**	**12.5**	**12.8**	**0.3**
Non NHS Clinical Income	0.4	0.4	(0.0)	1.7	1.7	(0.1)	5.2	5.0	(0.2)
Non Nhs Clinical Income	**0.4**	**0.4**	**(0.0)**	**1.7**	**1.7**	**(0.1)**	**5.2**	**5.0**	**(0.2)**
Income	**21.2**	**21.1**	**(0.0)**	**84.1**	**84.1**	**(0.1)**	**252.7**	**252.7**	**(0.1)**

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

Pay Position

- Pay amounted to £14.4m in July, £0.4m favourable to plan
- This includes a provision for the pay award currently funded and assumed at 2%. The actual award (due September) will be over 5% but will be accompanied by additional funding
- The in-month pay position is again suppressed by the release of provisions to support the in-month position
- Medical Staff are now overspent by £0.3m due to continued high agency and bank usage
- Acuity pressures persist and despite increasing the budget for the year by £1.5m Nursing is £0.2m overspent due to high levels of observation
- Other Clinical Staff (principally Psychologists) have continued the trend reported in previous years and have returned a £2.4m cumulative underspend to date
- Non-Clinical staff are showing a £0.1m adverse variance due to agency usage

Financial Reports 2022/23	Current Month			YTD month 4			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)	(2.4)	0.0	(9.6)	(9.8)	(0.3)	(29.0)	(29.5)	(0.5)
Nursing	(6.3)	(6.4)	(0.1)	(25.4)	(25.5)	(0.2)	(76.4)	(77.8)	(1.4)
Other Clinical	(3.6)	(3.0)	0.5	(14.6)	(12.2)	2.4	(44.5)	(36.6)	7.9
Non Clinical	(2.5)	(2.6)	(0.1)	(10.3)	(10.4)	(0.1)	(31.3)	(31.1)	0.2
Total Pay	**(14.8)**	**(14.4)**	**0.4**	**(59.9)**	**(58.0)**	**1.9**	**(181.2)**	**(174.993)**	**6.2**

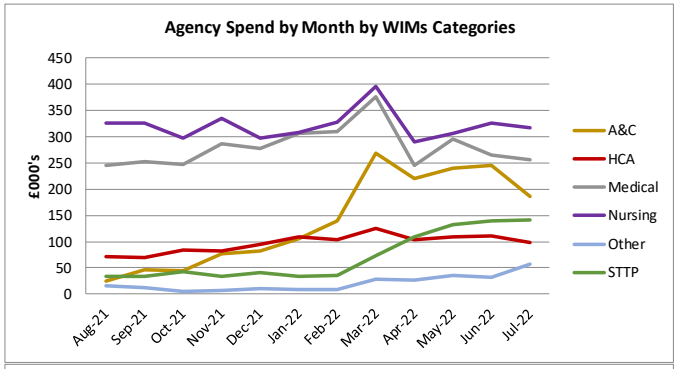
- Agency expenditure of £1.1m was £0.2m above the Trust's internal plan and £0.4m above the current NHSE/I cap. Month 4 was slightly below that experienced in the first quarter and £0.3m more than the 2021/22 average
- Bank expenditure was £1.9m, £0.1m above plan (£0.2m above cumulatively)
- Permanent pay amounted to £11.5m in month. This was £0.8m favourable to plan due to continued vacancies and provision releases. Permanent pay is now £3.1m favourable to plan cumulatively

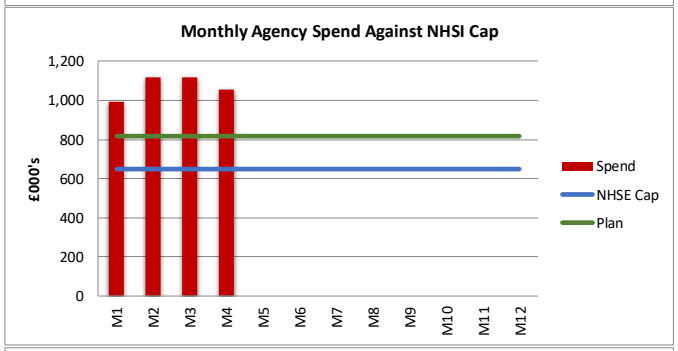
Financial Reports 2022/23	Current Month			YTD month 4			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(12.2)	(11.5)	0.8	(49.7)	(46.7)	3.1	(150.5)	(143.9)	6.6
Bank	(1.7)	(1.9)	(0.1)	(6.9)	(7.1)	(0.2)	(20.8)	(21.3)	(0.5)
Agency	(0.8)	(1.1)	(0.2)	(3.3)	(4.3)	(1.0)	(9.8)	(9.8)	0.0
Total Pay	**(14.8)**	**(14.4)**	**0.4**	**(59.9)**	**(58.0)**	**1.9**	**(181.2)**	**(175.0)**	**6.2**

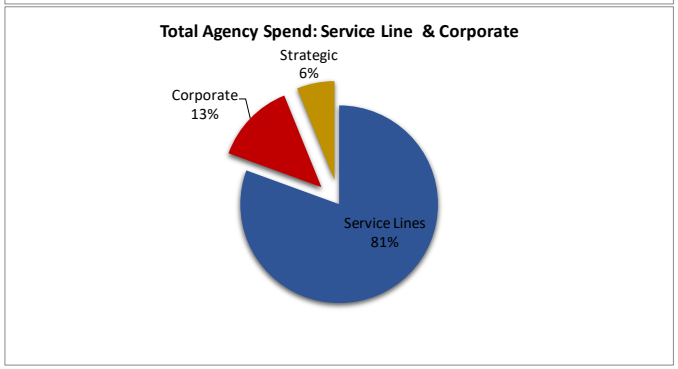
South West London and St George's Mental Health NHS Trust

Agency - in month and cumulative position

- Month 4 agency expenditure was £1,055k
- Decrease of £65k on Month 3 expenditure
- Equates to 7.3% of pay costs (7.4% cumulatively. 6.1% in 2021/22)
- Highest areas of monthly spend: Medical £256k, Nursing £318k, and A&C £186k
- Above the current NHSE Cap of £648k by £407k
- ICBs have now received overall agency targets. Further work is required to devolve these to providers but the likely outcome is that these will be above the current cap and, on or below the current plan
- These will be implemented from 1st September and will form part of performance monitoring
- The key pressure area remains the Community Service Line; of the £1,055k total spend, £507k (48%) was incurred in Community
- 81% of agency expenditure to date has been incurred within the Trust's 4 clinical service lines, with 13% relating to corporate areas, and 6% relating to agreed strategic investments
- Including strategic investments, Corporate expenditure has increased from £25k in M1 2021/22 to £197k in M4 2022/23







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

Non-Pay & Post EBITDA

- Non-Pay expenditure amounted to £5.4m in month, a £0.4m overspend (cumulatively £1.9m)
- The position includes the 56% increase in gas and electricity prices
- External bed expenditure amounted to £0.6m in July, some £0.3m above plan. This position is likely to further deteriorate in future months as budgets were predicated on reduced usage
- Other costs are now cumulatively £1.6m overspent, with £1.3m of this relating to CIP non-achievement
- 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 (£1.5m) cumulatively

Financial Reports 2022/23	Current Month			YTD month 4			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	(0.8)	(0.7)	0.1	(2.5)	(2.3)	0.1
Clinical Supplies & Servs Cost	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.0	(0.5)	(0.5)	(0.0)
Secondary Commisioning Costs	(2.6)	(2.9)	(0.3)	(11.1)	(11.4)	(0.4)	(31.4)	(33.1)	(1.7)
Other Costs	(2.1)	(2.3)	(0.1)	(7.4)	(9.1)	(1.6)	(19.8)	(24.6)	(4.8)
Contingency	(0.1)	(0.1)	0.0	(0.3)	(0.3)	(0.0)	0.0	0.0	0.0
Total Non Pay	**(5.0)**	**(5.4)**	**(0.4)**	**(19.8)**	**(21.7)**	**(1.9)**	**(54.2)**	**(60.6)**	**(6.4)**

- Post EBITDA costs are now cumulatively £0.1m favourable to plan due to higher than planned interest receipts
- The increase in depreciation and interest budgets reflect the impact of IFRS 16 (detailed above)
- There are currently no asset sales included in the plan due to their uncertain nature
- There are no planned impairments

Financial Reports 2022/23	Current Month			YTD month 4			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)	(3.8)	(3.8)	(0.0)	(11.5)	(11.5)	0.0
Cap Charges - Pdc Dividend	(0.4)	(0.4)	(0.0)	(1.7)	(1.7)	(0.0)	(5.1)	(5.1)	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest	(0.1)	(0.0)	0.0	(0.2)	(0.2)	0.1	(0.8)	(0.5)	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	**(1.4)**	**(1.4)**	**0.0**	**(5.8)**	**(5.7)**	**0.1**	**(17.4)**	**(17.1)**	**0.3**

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 £0.9m overspent cumulatively as a result of acuity and external bed pressures. These are likely to be recurring pressures that require central actions to mitigate.
- CAMHS & ED is £0.8m underspent as continued recruitment slippages are greater than the CIP target
- Community is cumulatively £0.5m underspent. This is primarily the result of non-recurring vacancies partially offset by unachieved CIP targets
- Specialist Services is now £0.3m underspent as vacancies continue to outweigh CIP non-achievement
- The Corporate overspend is primarily due to central provisions against known liabilities and central CIP balances. This position will improve as mitigating actions are taken to offset the pressures within the Acute Service Line
- Following the revised plan submission in June, the forecast for the year remains one of break-even. There is significant risk in achieving this position as an improved profile is required during the remainder of the year to offset Q1 deficits

Financial Reports 2022/23	Current Month			YTD month 4			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	(3.7)	(4.1)	(0.5)	(15.2)	(16.2)	(0.9)	(44.2)	(47.3)	(3.1)
Camhs & Ed	(2.3)	(2.1)	0.2	(9.3)	(8.5)	0.8	(28.1)	(26.5)	1.6
Community (Adults)	(3.7)	(3.7)	0.1	(14.9)	(14.4)	0.5	(44.6)	(44.6)	(0.0)
Specialist Services	(2.5)	(2.4)	0.1	(10.1)	(9.8)	0.3	(30.2)	(30.2)	0.0
Corporate	13.1	13.2	0.1	51.8	51.1	(0.7)	158.2	159.7	1.5
Capital Costs	(0.9)	(0.9)	0.0	(3.7)	(3.6)	0.1	(11.1)	(11.1)	0.0
Total	**(0.1)**	**(0.0)**	**0.0**	**(1.4)**	**(1.4)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**

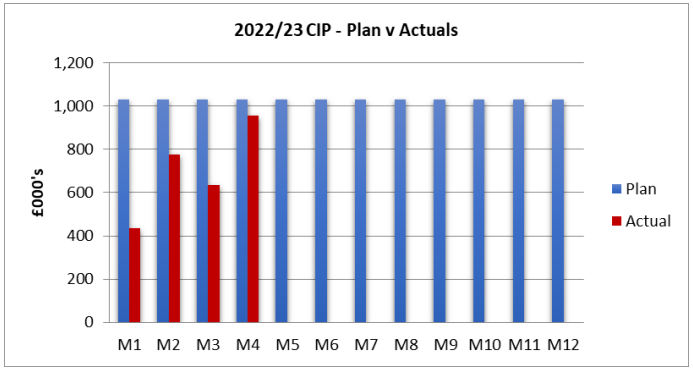
South West London and St George's Mental Health NHS Trust

Savings

- The Trust has a recurrent savings target of £12.4m (4.5%) to achieve the planned break-even position for 2022/23
- The savings target is phased equally across the year with a greater proportion of non-recurring schemes being achieved earlier in the year
- To date, £11.5m of the target has been identified. However, only £3.0m of this is currently rated green, most schemes are rated red or amber
- Once risk adjusted values have been applied, expected delivery falls to £6.6m, leaving a £5.8m shortfall
- This gives a 53% confidence level in delivery – the equivalent value for M4 last year was 53%
- In month delivery amounted to £0.9m against a target of £1.0m – a £0.1m shortfall
- Cumulative delivery now stands at £2.8m against a plan of £4.1m - £1.3m adverse
- A high proportion of savings delivered to date are non-recurrent
- The challenge facing the Trust is to
  - Identify new schemes to close the £1.1m gap
  - Turn red and amber schemes to green, and,
  - To reduce the reliance on non-recurrent schemes

Status	2022/23 £000's	Risk Level %	Expected £000's
Green - Rec	397	0%	397
Green - Non-Rec	2,646	0%	2,646
Amber	5,833	50%	2,916
Red	2,648	75%	662
Unidentified	863	100%	0
Total	**12,387**	**53%**	**6,622**

Gap	**-5,765**



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	1.3	1.9	(0.6)	7.2	6.8	0.3	21.9	21.9	0.0
Estates Maintenance	0.2	0.1	0.0	0.6	0.5	0.1	1.9	1.9	0.0
IT/Digital	0.2	0.2	(0.1)	0.7	0.7	(0.0)	2.0	2.0	0.0
Operational Total	1.7	2.3	(0.6)	8.5	8.1	0.4	25.8	25.8	0.0
Leases	0.0	0.0	(0.0)	15.4	15.4	0.0	15.4	15.4	0.0
Total Capital Expenditure	**1.7**	**2.3**	**(0.6)**	**23.9**	**23.5**	**0.4**	**41.2**	**41.2**	**0.0**

- The Trust is forecasting to spend £41.2m, including £15.4m on leases which are now shown on the balance sheet in line with the new IFRS 16 requirements
- Capital expenditure for the month is £2.3m; £23.5m YTD which is £0.4m below plan
- The Estates Modernisation Programme (EMP) is underspent by £0.3m due to phasing of construction costs. 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 July 2022	Actuals at end July 2022	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	7.3	6.9	(0.4)
Plant, Property and Equipment	340.8	343.0	2.2
Receivables	26.7	26.7	0.0
Total Non-Current Assets	**374.9**	**376.6**	**1.7**
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	5.5	3.4	(2.1)
Other Financial Assets (Accrued Income)	0.9	5.0	4.1
Prepayments	0.0	2.3	2.3
Cash and Cash Equivalents	38.6	35.8	(2.7)
Total Current Assets	**45.2**	**46.7**	**1.6**
CURRENT LIABILITIES:			
Trade Payables	(34.9)	(13.3)	21.6
PDC Dividend Payable	(0.0)	(1.7)	(1.7)
Capital Payables	(33.5)	(26.8)	6.7
Provisions	(4.4)	(4.3)	0.1
Other Financial Liabilities (Accruals)	0.0	(28.2)	(28.2)
Deferred Revenue	(5.0)	(6.7)	(1.7)
Total amounts falling due within one year	**(77.8)**	**(81.0)**	**(3.2)**
NET CURRENT ASSETS/(LIABILITIES)	**(32.7)**	**(34.3)**	**(1.6)**
NON CURRENT LIABILITIES:			
Provision for Liabilities and Charges	(1.5)	(1.7)	(0.1)
Capital Payables	(5.2)	(5.2)	0.0
Borrowings	(99.4)	(99.4)	0.0
Total amounts falling due within after one year	**(106.1)**	**(106.2)**	**(0.1)**
TOTAL ASSETS EMPLOYED	**236.2**	**236.2**	**0.0**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	142.3	142.3	(0.0)
Retained Earnings (accumulated losses)	30.6	30.6	0.0
Retained Surplus(Deficit) in year	(1.4)	(1.4)	0.0
Revaluation Reserve	64.6	64.6	(0.0)
TOTAL TAXPAYERS EQUITY	**236.2**	**236.2**	**0.0**

- Receivables stand at £3.4m, which is £2.1m favourable to plan, and relates to better than expected debtor payments. Prior year debtors account for £0.7m of the £3.4m.
- Cash is £35.8m, £2.7m less than plan.
- There are no further loan drawdowns due, with the loan remaining at £99.4m. There are no plans to repay any of the principal in 2022/23

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

Cash

All figures £k

	Plan as at end Jul 22	Actual as at end Jul 22	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	561	439	(122)
Non Cash Adjustments			
Depreciation and Amortisation	3,961	4,329	368
Interest Received	(4)	(113)	(109)
Interest Paid	0	0	0
(Increase)/Decrease in Inventories	0	0	0
Increase/(Decrease) in Working Capital	8,764	(931)	(9,695)
Net Cash Inflow/(Outflow) from Operating Activities	**13,282**	**3,724**	**(9,558)**
Cash Flows from Investing Activities			
Interest Received	4	113	109
(Payments) for Property, Plant and Equipment	(23,863)	(17,397)	6,466
Proceeds from sales of property, plant and equipment	0	0	0
Net Cash Inflow/(Outflow) from Investing Activities	**(23,859)**	**(17,284)**	**6,575**
Net Cash Inflow/(Outflow) before financing	**(10,577)**	**(13,560)**	**(2,983)**
Cash Flows from Financing Activities			
Interest element of finance lease	(260)	0	260
Net Cash Inflow/(Outflow) from Financing Activities	**(260)**	**0**	**260**
Net Increase/(Decrease) In Cash And Cash Equivalents	**(10,837)**	**(13,560)**	**(2,723)**
Cash / Cash Equivalents at beginning of month	**49,403**	**49,403**	**0**
Cash / Cash Equivalents at end of month	**38,566**	**35,843**	**(2,723)**

The cash balance at the end of the month was £35.8m compared with the plan of £38.6m.

The decrease of £2.8m relates to:

- Capital spend, +£6.5m
- Movements in working capital, -£9.6m
- Other £0.4m

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 principial 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 Forecast £'000	September Forecast £'000	October Forecast £'000	November Forecast £'000	December Forecast £'000	January Forecast £'000	February Forecast £'000	March Forecast £'000
Bank Balance b/f	47,403	39,183	38,463	38,827	35,843	32,268	28,919	28,047	27,584	23,694	21,169	20,355
Receipts												
SLA Income	18,230	18,615	19,986	20,901	20,035	20,035	20,035	20,035	20,035	20,035	20,035	20,369
Other NHS Income	2,111	1,035	2,816	861	915	799	778	778	778	778	778	824
Other income	584	337	327	454	325	250	250	250	250	250	250	260
Loans	-	-	-	-	-	-	-	-	-	-	-	-
PDC Income	-	-	-	-	-	-	-	-	-	-	-	250
Asset Sales	-	-	-	-	-	-	-	-	-	-	-	4,500
Total Receipts	**20,926**	**19,987**	**23,128**	**22,216**	**21,275**	**21,084**	**21,064**	**21,064**	**21,064**	**21,064**	**21,064**	**26,203**
Payments												
Payroll costs	(12,936)	(13,189)	(13,536)	(13,070)	(14,648)	(14,588)	(14,615)	(14,615)	(14,615)	(14,615)	(14,615)	(14,629)
Suppliers (Revenue)	(8,280)	(4,111)	(6,293)	(10,318)	(4,971)	(5,114)	(5,034)	(4,947)	(4,947)	(4,863)	(4,863)	(6,244)
Suppliers (Capital)	(1,254)	(562)	(1,572)	(557)	(3,668)	(324)	(324)	(324)	(325)	(325)	(326)	(326)
Suppliers (EMP)	(6,565)	(2,783)	(1,296)	(1,165)	(1,564)	(1,658)	(1,963)	(1,640)	(1,641)	(3,786)	(2,073)	(3,333)
Asset Purchases	-	-	-	-	-	-	-	-	(3,425)	-	-	-
Other Non Pay Costs	(110)	(63)	(67)	(89)	-	-	-	-	-	-	-	-
PDC Dividend	-	-	-	-	-	(2,571)	-	-	-	-	-	(2,571)
Loans & interest	-	-	-	-	-	(178)	-	-	-	-	-	(178)
Total Payments	**(29,145)**	**(20,707)**	**(22,764)**	**(25,200)**	**(24,851)**	**(24,432)**	**(21,936)**	**(21,526)**	**(24,953)**	**(23,589)**	**(21,877)**	**(27,280)**
Net Receipts/ (Payments)	**(8,220)**	**(721)**	**364**	**(2,984)**	**(3,575)**	**(3,348)**	**(873)**	**(463)**	**(3,890)**	**(2,526)**	**(813)**	**(1,076)**
Bank Balance c/f	**39,183**	**38,463**	**38,827**	**35,843**	**32,268**	**28,919**	**28,047**	**27,584**	**23,694**	**21,169**	**20,355**	**19,279**
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	28,843	25,268	21,919	21,047	20,584	16,694	14,169	13,355	12,279

- 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 partly fund the hospital construction.

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

Solvency Dashboard

Solvency Tests	RAG	Comments	Criteria
Trading Position	G	The Trust delivered a deficit of £1.4m in the year to date compared to a planned deficit of £1.4m.	G : Forecast surplus in line with plan A : Forecast breakeven R : Trading at a loss
Net Current assets	R	The Trust has net current liabilities of £34.3m, with current assets of £49.9m and current liabilities of £84.1m. The plan was for current liabilities of £32.7m.	G : Greater than £7m A : Positive net current assets R : Negative net current assets
Liquidity Ratio	G	Based on the forecast phasing of cash flow for the next 13 weeks , the Trust has no weeks below the 10 day operating expenses amount of £7m.	G : 13 week forecast always above 10 days operating expenses A : 13 week forecast always positive R : 13 week forecast is not always positive
Debtors Ageing	G	The level of non-current aged receivables was £1.5m at the end of July. It consists of £0.9m NHS and £0.6m of Non NHS organisations. The total current trade receivables not due is £0.2m making a total debtors position of £1.7m. There is also £1.7m of non trade receivable debt outstanding consisting of £1.4m PDC receivable and £0.3m VAT (paid in August), giving a total receivables figure of £3.4m. Prior Year debt which was £6.0m was £0.7m up to the end of July, a reduction in the financial year of £5.3m.	Excluding (current) G : Less than £2m debts A : Greater than £2m debts but less than £4m debts R : Greater than £4m debts
Creditors Ageing	G	The Trust has £0.25m outstanding greater than 30 days, the less than 30 days balance is £0.2m, the majority of of which relates to non-NHS organisations.	Excluding less than 30 days (current) G : Less than £200k creditors A : Greater than £200k and less than £500k R : Greater than £500k
Legal claims against Trust (not covered by NHS Resolution)	G	The Trust has no outstanding legal claims not covered by NHS Resolution	G : Less than £100k A : Less than £500k R : Greater than £500k

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

Meeting:	Trust Board
Date of Meeting:	8 September 2022
Report Title:	Savings Update 2022/23 M4
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Author:	Debbie Hollinghurst, Deputy Director of Finance
Purpose:	For discussion and note
Scrutiny Pathway:	Director review / ELT / FPC
Transparency:	Public

Executive Summary

This report provides an update on 2022/23 savings and progress towards delivery.

- **Summary CIP Position**
    - Full year - £11.5m identified against a £12.4m target, £0.9m adverse, a marginal improvement compared to last month
    - Delivery Confidence – The risk assessed forecast delivery is £6.6m therefore delivery confidence is 53%, a £1.2m improvement compared to last month
    - Year to date - £2.8m delivered primarily from central and technical schemes (72%), target £4.1m, £1.3m adverse to plan
    - Underlying position – focus must be maintained on achieving recurrent savings to ensure the Trust exits 2022/23 with a run rate that achieves breakeven
    - Cash – focus must be maintained on achieving cash releasing savings as the Trust has a £99m loan to repay on the EMP

- **Workstream Summary**

  Existing Establishment Vacancies (target £2.1m) - £0.2k behind plan to date, services to assign pay underspends instead of netting them off new/existing cost pressures.

  Temporary Staffing Reductions (total target £1.9m) - £0.6k behind plan, with zero delivery to date. Scheme includes:
  1. Reduction of the cost and volume of agency shift requests (£1.4m); greater national focus, ELT to receive weekly status reports on recruitment
  2. Tighter sickness management (£300k); weekly meetings with services in place
  3. Process Compliance (£200k); roster management, improved on/off boarding experience revised process being implemented

  Clinical Efficiency (target 0.5m) - £0.1k behind plan to date. The previously reported risk still exists for both the Job Planning and Operational Efficiency workstreams; unmet demand and growth in services could absorb any savings identified. The slippage against the YTD plan has not yet been incorporated in the year end forecast. Mitigation options to recover slippage on these schemes has been requested by the Delivering Value Meeting Group.

Site Utilisation (target £0.2m) - linked to existing EMP/PCRR/Estates projects including the review of existing leases and room hire arrangements.

Drugs Management (target 0.2m) – No reported savings to date. Staff training on medicine optimisation in place. Challenges exist in the transfer of depot patients to GPs; linked to system working and further Exec support required in this area.

Corporate Savings (target £2.1m) - incorporating workforce savings and stretch target. Improvement in month reported. There remains £0.9m unidentified and finance meetings (supported by the HCIPD where required) are being arranged with budget holders to help close the gap in delivery.

Technical savings (target £4m) – primarily non-recurrent release of balance sheet reserves; could release these earlier, however, this would deflect focus from the need to achieve recurrent savings.

Minimal recurrent savings (currently 3%) is resulting in a risk to the Trust's future financial stability. Efforts continue to convert non-recurrent savings to recurrent and to progress existing schemes to a lower rated RAG status.

Appendices/Attachments:

A power point report accompanies this report.

Recommendation:
FPC is asked to**:**

1. **Note** the delivery to date, the work required for future delivery and run rate reductions and the requirement to improve the 2022/23 position.

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 – Provides effective estates utilisation
Financial:	Positive impact - Provides information on the delivery of key financial targets through CIP delivery
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:*	Positive impact – Provides quality improvements and eliminates waste
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Involvement (SUCFF):*	Positive Impact - feedback from service users is important for recognising areas for improvement
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
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

Trustwide Progress 2022/23 Savings Update M4

Meeting	ELT
Date of Meeting	August 2022
Report Title	Trustwide Progress 2022/23 - Savings Update M4
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Director of Finance & Performance
Purpose	For Information
Scrutiny Path	ELT/FPC/Trust Board
Transparency	Public
Recommendation	None
The Board is asked to	Discuss and note

NHS
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Executive Summary

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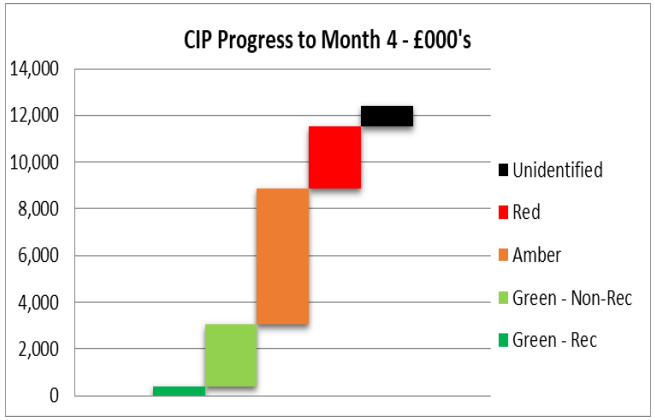
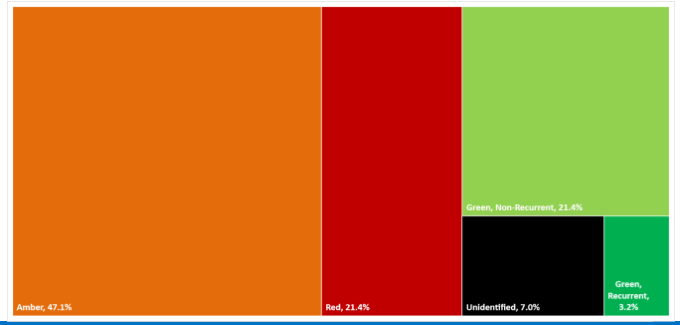
Current Status

- Total schemes identified amount to £11.5m against a target of £12.4m, £0.9m (7%) below target, a marginal improvement compared to last month
- Recurrent savings (Green) have increased to £0.4m (3%) from £0.3m last month
- This increases Green schemes from 17% to 24%.
- Non Green schemes account for c75% of the £12.4m target and therefore a significant risk.
- Non-recurring schemes (including technical schemes, slippage, and some Service Line plans) now total £6.9m
- If all remaining scheme identifications were recurrent the Trust would open 2022/23 with a £6.9m deficit
- The challenge for the Trust is therefore fourfold:
  - To identify the remaining gap, ideally recurrently
  - To turn Red and Amber schemes to Green
  - To turn non recurrent schemes to recurrent
  - To ensure that recurring schemes have a full year impact that offsets the in year non recurrent mitigation

Status	2022/23 £000's	2022/23 %
Green - Rec	397	3%
Green - Non-Rec	2,646	21%
Amber	5,833	47%
Red	2,648	21%
Unidentified	863	7%
Total	**12,387**	**100%**

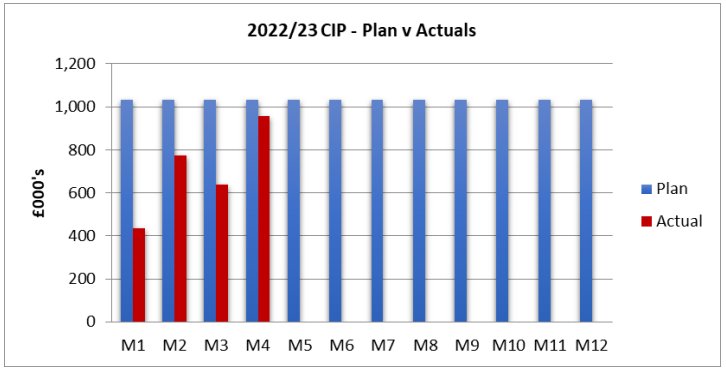




South West London and St George's Mental Health NHS Trust

Month 4 Delivery

- In month, c£1.0m CIPs were delivered, which after rounding is a £0.1m shortfall against a plan of £1.0m
- Cumulative savings total £2.8m, £1.3m shortfall against plan
- Most schemes (except technical and some corporate areas) are behind plan
- All operational service lines, other than Acute, are reporting cumulative under performance against CIP targets at the same time as reporting overall underspends
- Service Lines have therefore been tasked with reviewing underspends and where possible, releasing them against their unachieved CIP targets e.g. Community is showing a net £0.5m underspend at M4, and £0.5m CIP non-achievement
- Corporate Services lines have improved their identification and delivery of schemes in month. See slide 9 for more detail on corporate positions.



Service Line SRO level	M4 YTD Plan £000's	M4 YTD Actuals £000's	Variance £000's
Acute and Urgent Care	323	307	-16
CAMHS & ED	256	0	-256
Community (Adults)	483	0	-483
Specialist Services	293	127	-166
Nursing & Quality	77	89	12
Estates, Finance, Digital & Perf.	424	216	-208
Strategy & Planning	19	56	37
H R / O D & Workforce	49	0	-49
Chief Executive, TSec & Comms	19	0	-19
Senior Operations Management	5	0	-5
Medical	97	0	-97
Central & Technical	2,083	2,010	-73
Totals	**4,129**	**2,805**	**-1,324**

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

Movements in Month

- Identified schemes improved by £0.1m and there were significant BRAG improvements.
- Red reduced by £2.8m, with technical savings moving to amber following the audit of 21/22 accounts.
- Other movement in month include:
  - Technical: releases from the balance sheet delivered £347k non-recurrently
  - Central: slippage against investments delivered £220k
  - Specialist: identified £137k of non-recurrent savings due to vacancies
  - Nursing & Quality: delivered £89k of non-recurrent savings across pay (£68k), non-pay (£5k) and income (£16k)
  - Acute & Urgent Care: recognised £75k of non-recurrent pay savings from HTT (£25k) and Liaison services (£50k)
  - Strategy: cleared its full year target recurrently (£58k)
  - Contracts: cleared its full year target £14k non-recurrently

	Green R £000's	Green NR £000's	Amber £000's	Red £000's	Unidentified £000's	Total £000's
RAG Status M4 Report	397	2,646	5,833	2,648	863	12,387
RAG Status M3 Report	339	1,764	3,891	5,477	916	12,387
Movement	**58**	**882**	**1,942**	**-2,829**	**-53**	**0**
Caused by:						
Slippage against 21/22 investments		50	-50			0
Slippage against 22/23 investments		170	-170			0
Strategy Establishment Review	56		-38	-2	-15	0
Strategy Non Pay review	2				-2	0
Technical savings - balance sheet releases		347	-347			0
Acute Care - HTT pay underspend		25	-25			0
Acute Care - Liaison pay underspend		50	-50			0
Specialist - Cognition vacancies		30	-30			0
Specialist - NDD vacancies		37	-37			0
Specialist - Adult Specialist vacancies		70	-70			0
Nursing & Quality - Governance pay underspend		12	-12			0
Nursing & Quality - Therapies pay underspend		26	-26			0
Nursing & Quality - Nursing pay underspend		30	-30			0
Nursing & Quality - Governance non-pay underspend		3			-3	0
Nursing & Quality - Therapies non-pay underspend		2			-2	0
Nursing & Quality - Governance income overachievement		2			-2	0
Nursing & Quality - Nursing income overachievement		14			-14	0
Finance - FPC Reassessment Return		1			-1	0
Contracts - Additional interest received in-year		14			-14	0
Change in RAG - Technical savings			2,827	-2,827		0
Total	**58**	**882**	**1,942**	**-2,829**	**-53**	**0**

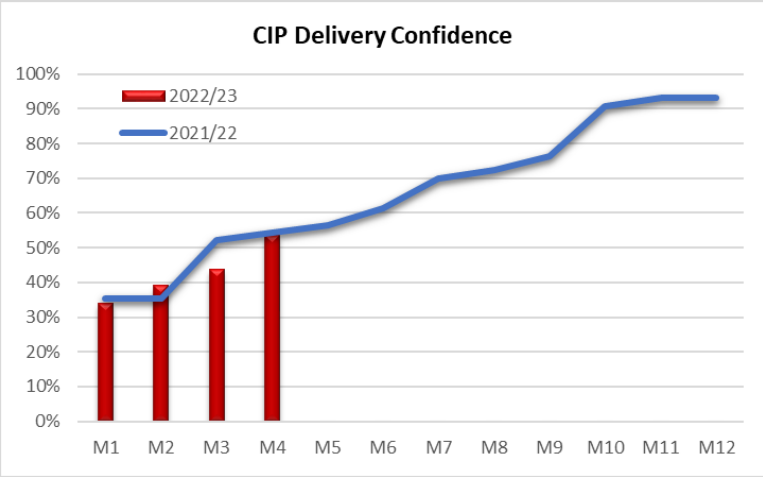
South West London and St George's Mental Health NHS Trust

Risk and Delivery Confidence

- Total CIP identification stands at £11.5m
- As they are unlikely to deliver in full, Amber schemes and Red schemes are assigned risk levels of 50% and 75% respectively
- Risk assessed delivery is now £6.6m, £5.8m behind target (£5.4m last month hence a £1.2m improvement)
- Resulting delivery confidence currently stands at 53%, compared to 54% at Month 4 last year
- Confidence could be improved by releasing the balance sheet reserves earlier, however, this would deflect focus from the need to achieve recurrent savings
- Recurrent savings identified to date total £0.4m (3%)

Status	2022/23 £000's	Risk Level %	Expected £000's
Green - Rec	397	0%	397
Green - Non-Rec	2,646	0%	2,646
Amber	5,833	50%	2,916
Red	2,648	75%	662
Unidentified	863	100%	0
Total	**12,387**	**-47%**	**6,622**

Gap	**-5,765**



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CIP Delivery by Scheme - £'000

Ref.	Scheme	BRAG	22/23 Target	22/23 Forecast	22/23 Variance	YTD Plan	YTD Actual	YTD Variance	Narrative
1	Technical (NR)	Amber	4,050	4,050	0	1,350	1,570	220	Release of balance sheet reserves, primarily non-recurrent.
2	Existing Establishment Vacancies (NR)	Amber	2,120	2,120	0	707	516	-191	Challenges exist in the conversion of non-recurrent vacancies to recurrent savings due to the management of other cost pressures including planned EMP ward moves, increased patient acuity and the requirement to recruit to vacant posts.
3	Slippage against new investment funds (NR): - 2022/23 £7m - 2021/22 £2m	Amber	1,700	1,700	0	567	340	-227	Investment is allocated as new posts are recruited to; slippage of 25% in recruitment and mobilisation of services is expected. Amber rated as delivery will depend on the speed of filling vacant posts. Greater delivery is expected in Q1-Q2.
4		Amber	500	500	0	167	100	-67	
5	Clinical Efficiency	Red	500	500	0	167	42	-125	**Operational efficiency incl. DNAs/cancellations, travel, staff support**: priority areas include the use of digital reminder services to support improved admin processes, improved data recording and better understanding service user feedback on the reasons for DNA/cancellations. **Job Planning**: project group expanded to include all HoSD / CDs. Staff engagement plan agreed, and the pilot will commence in Sept; communication plan to be approved. The previously reported risk still exists for both workstreams; unmet demand and growth in services could absorb any savings identified. Slippage against the YTD plan has not yet been incorporated in the year end forecast; mitigation options to recover slippage on these schemes has been requested by the Delivering Value Meeting Group; Aug meeting was cancelled following low staff attendance therefore updates are expected in Sept.

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

CIP Delivery by Scheme - £'000

Ref.	Scheme	BRAG	22/23 Target	22/23 Forecast	22/23 Variance	YTD Plan	YTD Actual	YTD Variance	Narrative
6	Temporary staffing reductions	Red	1,886	1,886	0	629	0	-629	**Reduction in the cost and volume of agency shift requests (target £1.4m)** Schemes in scope include: 1. Information and reports including dashboard reporting 2. Line bookings 3. Rate card and pan London agreement 4. Medical Locum rates and breaking glass 5. Approval / re-approval processes (simplified user guides) **Tighter Sickness Management (target £0.3m; c£4m opportunity)** Weekly HR meetings with Services in place. **Process Compliance (target 0.2m)** includes tighter roster management, improved on/off boarding experience, recruitment and retention and skill mix opportunities. Successful meeting in month with HRBPs and FBPs to agree a joint up approach to savings delivery, including the agreement of key assumptions and reporting requirements.
7	Stretch target to 4.5%: Corporate	Black	1,105	1,105	0	368	238	-131	New schemes to be identified; Challenging Decisions list to be considered along with findings from the 21/22 Corporate Benchmarking Review.
8	Site utilisation	Red	200	200	0	66	0	-66	Project remit includes improved occupancy levels, extended / out of hours of working, marketing spare space, lease review and room hire arrangements. PID and objectives are being scoped and agreed, including realistic delivery timescales.
9	Drugs Management	Red	200	200	0	67	0	-67	Introduction of staff training sessions to support the optimisation of medicines management. Further Exec support required for the scheme; transfer of depot patients to GPs
10	Corporate Efficiency: HR	Black	127	127	0	42	0	-42	No savings reported to date, department structure being reviewed.
Target			**12,387**	**12,387**	**0**	**4,129**	**2,805**	**-1,324**	

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

Corporate Savings – Target £2.1m

- Positive movement in the month by Strategy, Nursing and Contracts
- Unidentified has improved by 6% and now stands at £863k
- Delivery has increased from 16% to 24%
- Finance, Contracts and Strategy have delivered their target
- Digital Services have achieved 77% of their target recurrently
- Meetings are in place with the remainder services where there has been no/limited savings identified to date and will be attended by the HCIPD where required.

Service Line RAG	Target £000's	Green Recurrent £000's	Green Non-Rec £000's	Amber £000's	Red £000's	Unidentified £000's	Total Delivery £000's	Over Delivery £000's
Chief Operating Officer*	15	0	0	15	0	0	0	0
Nursing & Quality	232	0	89	23	18	102	89	0
Medical	174	0	0	16	1	156	0	0
Pharmacy	95	0	0	26	19	50	0	0
Psychology	9	0	0	6	0	3	0	0
Research & Development	13	0	0	0	0	13	0	0
Strategy & Planning	58	58	0	0	0	0	58	0
H R / O D & Workforce	146	0	0	0	19	127	0	0
Estates & Facilities	831	0	0	240	208	384	0	0
Digital Services	261	200	0	19	32	10	200	0
Contracts	14	0	14	0	0	0	14	0
Finance & Procurement	120	0	136	0	0	-16	136	16
Performance & Information	48	0	0	14	0	34	0	0
Chief Executives Office /Tsec	32	0	0	32	0	0	0	0
Communications	24	0	0	24	0	0	0	0
Totals	**2,071**	**258**	**238**	**414**	**298**	**863**	**496**	**16**

*moved from Operational Services to Corporate in M4

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

Appendix A – 2022/23 Full List of Schemes (1)

Area	Big Ticket Scheme	SRO Lead	Service	Description	Risk Rating	Plan £000's
Corporate	Existing Establishment Vacancies	COO	Chief Executives Office /Tsec	Work in progress	Amber	32
Corporate	Existing Establishment Vacancies	COO	Chief Operating Officer	Work in progress	Amber	15
Corporate	Existing Establishment Vacancies	COO	Communications	Work in progress	Amber	24
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Contracts	Additional interest received in-year	Green	14
Corporate	Existing Establishment Vacancies	COO	Digital Services	Work in progress	Amber	19
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Digital Services	Mobile phones	Green	200
Corporate	Temporary staffing reductions	DoF / CPO	Digital Services	Work in progress	Red	32
Corporate	Existing Establishment Vacancies	COO	Estates & Facilities	Work in progress	Amber	240
Corporate	Site utilisation	DoF / IPD	Estates & Facilities	Work in progress	Red	190
Corporate	Temporary staffing reductions	DoF / CPO	Estates & Facilities	Work in progress	Red	17
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Finance & Procurement	FPC Reassessment Refund	Green	136
Corporate	Temporary staffing reductions	CPO	H R / O D & Workforce	Work in progress	Red	19
Corporate	Existing Establishment Vacancies	COO	Medical	Work in progress	Amber	16
Corporate	Temporary staffing reductions	MD / CPO	Medical	Work in progress	Red	1
Corporate	Existing Establishment Vacancies	COO	Nursing & Quality	Work in progress	Amber	23
Corporate	Existing Establishment Vacancies	COO	Nursing & Quality	Governance Directorate pay underspends	Green	12
Corporate	Existing Establishment Vacancies	COO	Nursing & Quality	Therapies Directorate pay underspends	Green	26
Corporate	Existing Establishment Vacancies	COO	Nursing & Quality	Nursing Directorate pay underspends	Green	30
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Nursing & Quality	Governance Directorate non-pay underspends	Green	3
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Nursing & Quality	Therapies Directorate non-pay underspends	Green	2
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Nursing & Quality	Governance Directorate income over-achieveme	Green	2
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Nursing & Quality	Nursing Directorate income over-achievement	Green	14
Corporate	Temporary staffing reductions	DoN / CPO	Nursing & Quality	Work in progress	Red	18
Corporate	Existing Establishment Vacancies	COO	Performance & Information	Work in progress	Amber	14
Corporate	Existing Establishment Vacancies	COO	Pharmacy	Work in progress	Amber	26
Corporate	Temporary staffing reductions	MD / CPO	Pharmacy	Work in progress	Red	19
Corporate	Existing Establishment Vacancies	COO	Psychology	Work in progress	Amber	6
Corporate	Existing Establishment Vacancies	COO	Strategy & Planning	Strategy Establishment Review	Green	56
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Strategy & Planning	Strategy Non Pay review	Green	2
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Acute and Urgent Care	Female PICU - Non-Pay	Green	83
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Acute and Urgent Care	Perinatal - Non-Pay	Green	42
Operations	Drugs Management	MD / COO	Acute and Urgent Care	Work in progress	Red	50

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

Appendix A – 2022/23 Full List of Schemes (2)

Area	Big Ticket Scheme	SRO Lead	Service	Description	Risk Rating	Plan £000's
Operations	Existing Establishment Vacancies	COO	Acute and Urgent Care	Work in progress	Amber	271
Operations	Existing Establishment Vacancies	COO	Acute and Urgent Care	Perinatal - Pay	Green	14
Operations	Existing Establishment Vacancies	COO	Acute and Urgent Care	HTT underspends	Green	115
Operations	Existing Establishment Vacancies	COO	Acute and Urgent Care	Liaison underspends	Green	146
Operations	Temporary staffing reductions	COO / CPO	Acute and Urgent Care	Work in progress	Red	249
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Camhs & ED	Work in progress	Red	135
Operations	Existing Establishment Vacancies	COO	Camhs & ED	Work in progress	Amber	416
Operations	Site utilisation	DoF / IPD	Camhs & ED	Work in progress	Red	1
Operations	Temporary staffing reductions	COO / CPO	Camhs & ED	Work in progress	Red	216
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Community (Adults)	Work in progress	Red	240
Operations	Drugs Management	MD / COO	Community (Adults)	Work in progress	Red	150
Operations	Existing Establishment Vacancies	COO	Community (Adults)	Work in progress	Amber	92
Operations	Site utilisation	DoF / IPD	Community (Adults)	Work in progress	Red	6
Operations	Temporary staffing reductions	COO / CPO	Community (Adults)	Work in progress	Red	963
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Specialist Services	Work in progress	Red	85
Operations	Existing Establishment Vacancies	COO	Specialist Services	Work in progress	Amber	401
Operations	Existing Establishment Vacancies	COO	Specialist Services	Cognition Vacancies	Green	30
Operations	Existing Establishment Vacancies	COO	Specialist Services	NDD Vacancies	Green	37
Operations	Existing Establishment Vacancies	COO	Specialist Services	Adult Specialist Vacancies	Green	70
Operations	Temporary staffing reductions	COO / CPO	Specialist Services	Work in progress	Red	255
Trustwide	Slippage against 2021/22 Investment funds	DoF	Central	Work in progress	Amber	400
Trustwide	Slippage against 2021/22 Investment funds	DoF	Central	Slippage against 2021/22 Investment funds	Green	100
Trustwide	Slippage against 2022/23 Investment funds	DoF	Central	Work in progress	Amber	1,360
Trustwide	Slippage against 2022/23 Investment funds	DoF	Central	Slippage against 2022/23 Investment funds	Green	340
Trustwide	Technical NR	DoF	Technical Savings - NR	Technical Savings (Trust position)	Amber	2,480
Trustwide	Technical NR	DoF	Technical Savings - NR	Balance sheet release - Income	Green	390
Trustwide	Technical NR	DoF	Technical Savings - NR	Balance sheet release - Pay	Green	561
Trustwide	Technical NR	DoF	Technical Savings - NR	Balance sheet release - Non-Pay	Green	619

Total Identified (Green, Amber, Red)	**11,524**
Target	**12,387**
Unidentified	**863**

Meeting	Trust Board
Date of Meeting:	8th September 2022
Report Title:	**Audit Committee Chair's Report**
Author:	Richard Flatman, Audit Committee Chair, Non-Executive Director
Purpose:	For report
Transparency	Public

The Audit Committee met on 20th July 2022. The Board is asked to note the following key points addressed at the meeting.

- **External audit**

The Committee received an update on the audit plan from KPMG and agreed that a de-brief is scheduled with the Finance Team to learn from the recent audit and confirm actions for 2022/23 and subsequent years.

- **Internal audit**

The Committee received and noted the progress report from RSM. Since the last meeting 13 actions (6 medium and 7 low) have been implemented and, 5 actions (2 high and 3 medium) are overdue but in progress. The Committee received an update to confirm that the Audit Plan 2022/23 has been amended to now include an audit into NHS Financial Sustainability as this is now a national requirement. This will cover 8 areas including CIPs, financial planning and budgetary requirements. The review will be broad ranging and evidence to meet the requirements will be required. This will take the form of a self-assessment that will be reviewed by RSM.

- **Financial Accounts update**

It was reported that NHS England will not impose any penalties as a result of late submission of the final accounts. The Value for Money assessment was rated as GREEN. To date the post-balance sheet event requirements have not identified anything necessary of report.

Other matters to report:

Committee:

- **Approved** the Anti-Fraud, Bribery and Corruption Policy.
- **Agreed** to the extension of the Scheme of Delegation and Standing Financial Orders
- **Agreed** to the re-appointment of GSM as the Charitable Fund independent assessors.
- **Agreed** to write-offs relating to £3,064. These resulted from a system error whereby staff received incorrect payments for Bank Holiday unsocial hours enhancements.
- Received the **QSAC minutes.**
- Received the **EMC minutes.**

RECOMMENDATIONS

The Board is asked to:

a. Note the contents of this report
b. Receive the approved minutes of the committee held on 13th June 2022

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

Audit Committee

Minutes of the virtual meeting held on Monday 13th June 2022, 13:30-16:00

Present:

Richard Flatman (RF)	Non-Executive Director (Chair)
Doreen McCollin (DMc)	Non-Executive Director, representative from QSAC
Vik Sagar (VS)	Non-Executive Director, Chair of FPC

Attendees:

Vanessa Ford (VF)	Chief Executive
Philip Murray (PM)	Director of Finance & Performance
Debbie Hollinghurst (DH)	Deputy Director of Finance
Ann Beasley (AB)	Trust Chair
Juliet Armstrong (JuA)	Non-Executive Director
Joanne Lees (JL)	External Audit – KPMG
Ashley Norman (AN)	Internal Audit – TIAA (attended for minute item 22/59)
Clive Makombera (CM)	Internal Audit - RSM
Matt Wilson (MW)	Internal Audit - RSM
Heather Greenhowe	Internal Audit – RSM
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial Development
Jenna Khalfan (JK)	Director of Communications and Stakeholder Engagement
Sharon Spain (SS)	Director of Nursing and Quality Standards
Claire Reid (CR)	CQUIN, Quality Account and Compliance Manager (attended for minute item 22/58)
Nicola Mladenovic (NM)	Deputy Trust Secretary (Minutes)

Apologies

Charlotte Clark (CC)	Non-Executive Director
Deborah Bowman (DB)	Non-Executive Director, Vice Chair and SID
David Lee (DL)	Director of Corporate Governance
Billy Boland (BB)	Medical Director
Jen Allan (JeA)	Chief Operating Officer
Sola Afuape (SA)	Non-Executive Director

Item		Action
22/49	**Welcome and Apologies** Apologies for absence were received. The Chair of the Audit Committee welcomed representatives from RSM who are the internal auditors from April 2022. Matt, Clive and Heather were welcomed.	
22/50	**Declarations of Interest** No additional declarations of interest were reported for noting.	
22/51	**Chair's Action** No Chair's Action has been taken. However communication has taken place regarding the Counter Fraud Self Review Report and this has now been approved. The overall rating is green for the self assessment.	
22/52	**Minutes of the previous meeting** The minutes of the previous meeting held on 17th March 2022 were approved as a correct record.	

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

22/53 Action Tracker/Matters Arising

The Committee received the action tracker and noted nothing is due.

22/54 Draft Annual Accounts 2021/22

The Committee received an update from PM and the following points reported:

- The draft accounts were submitted on time, 26th April 2022 in line with the national timetable.
- The audit process has been worked through with KPMG, Finance Team and the Human Resources Team.
- The audit opinion is nearing completion. Even though this is not yet complete the primary statements have remained unchanged. i.e. the SOCI, SOFP and SOCF.
- There was a change to the External Financing Limit (EFL) and a significant undershoot was reported earlier in the year. The Trust has a statutory duty to not exceed its Capital Resourcing Limit (CRL) and EFL targets in a financial year. Being below the limit is allowed. For 2021/22 the Trust is on target for EFL and has an allowable £75k CRL undershoot. There has been a small movement since the draft submission due to final targets being confirmed by NHSE/I on 13 May 2022.
  Notes 33 and 34 give further detail. Capital Resourcing Limit (CRL) / External Financing Limit (EFL) adjustments.

Note 33 External financing limit
The Trust is given an external financing limit against which it is permitted to underspend.

	2021/22 £000	2020/21 £000
Cash flow financing	43,637	28,268
External financing requirement	**43,637**	**28,268**
External financing limit (EFL)	43,637	55,803
Under / (over) spend against EFL	**-**	**27,535**

Note 34 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	77,689	62,185
Charge against Capital Resource Limit	**77,689**	**62,185**
Capital Resource Limit	77,764	64,030
Under / (over) spend against CRL	**75**	**1,845**

- The Committee received the Impairments report. The District Valuer provided the 2021/22 valuation report which showed an increase in the valuation from 2020/21 of £2.9m from £137.3m to £140.2m (2.1%). The plots P & Q were revalued at £16.9m giving a total valuation of £157.1m and an overall gain £20m for impairments. The initial asset life to value the modular building (building 32) was initially 29 years based on assumptions at the time of construction and the building was valued at £3.98m. The building asset life has now been reduced to 2 years and this reduces the value by £1.9m as this building is not required in the new Estates Plan. This change was discussed and agreed at the Audit Committee.
- IFRS 16 Lease Accounting will be applied from 1st April 2022. The impact of adopting this is £6.3m compared to the IAS 17 basis of £6.2m meaning there

is a small cost pressure of £0.1m in 2022/23 and at present no central funding has been provided.

The accounts were discussed and PM raised the following:

- Statement of Comprehensive Income (page 21) – a gross surplus of £2.6m has been delivered compared to a deficit of £4.367m last year. This year the reckonable surplus of £1.6m which includes the Richmond Royal sale overage of £1.941m. Overall the Trust has met its plan and the small trading deficit of £0.3m this remains in tolerance and doesn't trigger a further audit reporting. RF commended PM and the team for achieving the agreed plan.

- Mental health provider collaboratives (page 27). The Trust is the lead provider for Eating Disorders and is accountable to NHS England and Improvement and as such the income and expenditure is associated in commissioning of services from other providers.

- IFRS 16 Leases (page 36) is a change in accounting treatment and will be included in the accounts from April 22; this note signposts the impact.

- Income from patient care activities (page 41) – note 3.1 – This equates to a change of £40m (20%) from 2020/21 to 2021/22 and relate to full year service costs for Complex Care and Provider Collaboratives, funds relating to Covid and some funding for IT, autism and NHSE growth.

- Other operating income (page 42) reduced by c £11m - £8m was the reduction in Covid income, £1m HEE income deferral and smaller amounts linked to national PPE funding and for Access to Work.

- Operating expenses (page 44) – note 6.1.
  - The expenditure has increased by £27.7m to £244,443m (13% increase). PM highlighted the main drivers to the increase:
  - Purchase of healthcare from the NHS – c£5.8m: Richmond Wellbeing Service, Complex Care linked with Croydon, cross charges within the SLP and the use of external beds.
  - Healthcare from non-NHS risen by c£8m – c£5m complex care packages and £3m of external beds
  - Staff Costs £11.6m - There are costs relating to staff and executive directors (7% increase),a £6m pay award, £2m associated in specialing of patients on the wards and £4m of new investments.
  - Depreciation on property, plant and equipment £3.8m (98% increase) - this relates to the life changes to the modular building and changes to digital assets.

- Net impairments reduced by c£2m– this relates to the District Valuers impairment for £1m and is unusual in being a valuation increase.

- Legal fees equate to Capsticks support for the HR recovery and increased provision to support inquests and other claims.

- Other £1.7m - relates to the provision on the charge for the Ronald Gibson House; the Trust is legally responsible for the charges associated with the building however is working with NHSE&I and Treasury to have this change removed.

The Committee thanked Philip and the Finance Team for their work in bringing the Accounts Report together.

22/55 Letter of Representation

The Committee received the Letter of Representation. The letter confirms to the auditors that the Trust Board declares that the accounts have been prepared on a going concern basis. This has been approved previously by the Committee and it is to be noted that there are amendments to be made to sections 3.4 and 3.5.

It was reported that at the point of audit conclusion the statement will be updated to confirm that the accounts and Value for Money have a clean opinion. Joanne Lees from KPMG confirmed that the accounts are in-line with a Going Concern basis.

The Committee approved the appropriateness of applying a Going Concern basis and authorised the Director of Finance and Performance to make any necessary amendments as required for inclusion in the Annual Report.

The Committee approved the Accounts and Letter of Representation for onward submission to the Trust Board and delegated to the Committee Chair, Board Chair, CEO and DoF to agree any subsequent changes required.

22/56 ISA 260 External Audit Report

The Committee received the ISA 260 Report and Joanne Lees, KPMG thanked Philip and the Finance Team for their support in progressing the audit. The following points were reported:

- An unqualified opinion is being reported on the financial statements.
- For the ISA 260 there are still some areas to be finished for audit purposes and include the agreement of balances. These are linked with the unadjusted audit differences.
- Significant risk areas are
    - Property evaluation of land and buildings – the audit has been completed and there are no items to bring to the Committees attention
    - Fraudulent expenditure revenue recognition – this is substantially complete but work continues in the agreement of balances. At this stage there is nothing to bring to the Committees attention
    - Management over-ride – the audit into journals is continuing however nothing significant has been audited in terms of fraud or over-ride
- IFRS 16 - this came into operation from 1st April 2022, this will come on the balance sheet for next year however work has started to further understand this and to be in a good place to start auditing from next year
- No new controls observations are being recommended for this year and the one recommended previously has been fully implemented.
- Audit differences on page 18 were highlighted but these have not been concluded as yet. These relate to the restructuring provision – this doesn't meet the requirements of the accounting standard as this is consumed over a period of time and not a point in time and relates to income.
- Agreement of balance differences. The differences are reported where they are greater than £0.3m and many of the differences will be resolved in the final report this remains a work in progress.
- Value for Money audit has been completed and no significant changes or weaknesses have been identified.

- The Auditors Annual Report is due for completion and when agreed this will be published on the Trust website alongside the Trust's Annual Report.

PM confirmed that there are some differences and not all will be agreed upon; this relates to NHS South West London CCG. However it is anticipated that Health Education England will be considered for a change however making the changes would not have a change to the profit and loss account. The Committee agreed to this approach.

It was commented that the accounts appear to be the subject of last-minute changes and some areas could have been finalised earlier.

The Committee Chair commented notwithstanding the timings, that the opinions are positive for the financial accounts and Value for Money opinion. There are no material adjustments required and there are no significant change control processes required. Considering this has been a difficult year in terms of process this is a good outcome.

The Committee agreed:

1) **to recommend the Accounts to the Trust Board.**
2) **to receive the Auditors Annual Report for approval ahead of this being published on the Trust website**

22/57 Draft Annual Report 2021/22 (Incl Annual Governance Statement)

The Committee received the draft Annual Report and this was introduced Jenna Khalfan, Director of Communications and Stakeholder Engagement. The following points were reported:

- The report covers three sections; overall corporate summary, performance summary and Annual Governance Statement.
- This draft version has been received by executive directors and updates have been incorporated. Some auditor updates are to be included in the final version.

The Committee commented that the whole report has been refreshed and is an improvement on previous years.

JuA noted that the HR issues are not referenced until further into the report and perhaps these could have been referenced earlier; she reflected that some of the performance domains need some clarification where the metrics are not being achieved.

To support Lessons Learnt it was agreed that going forward a log of responses to the Annual Report would be maintained, similar to the process adopted when receiving the CQC reports, that comments would be received and an update provided to support the acceptance or the reason why the comment was not incorporated. It was agreed that some consistency checking is required to ensure the Quality Account reference to the CQC reporting is the same as in the Annual Report.

To support the reporting of metrics PM confirmed that the following sentence will be added into the report:

Whilst the Trust has been rated at level 1 within the System Oversight Framework we recognise the importance of constant improvement and the

need to improve the assurance we can take over the certainty of our delivery against performance targets. The Trust has initiated an internal Quality Plan and a Fundamental Standards of Care Approach to improve the excellence of care we aspire and to focus upon those key targets that are so important to our patients' care.

KPMG confirmed that the compliance with the guidance for the Annual Report and Annual Governance Statement have been reviewed and no changes are required.

The deadline for publication is 30th June 2022.

The Committee agreed the following:

1) **An update would be included in the executive summary to detail the challenges that have been experienced in respect of recruitment and retention of staff overall.**
2) **An update would be included to recognise that the internal ratings have not been achieved but that these areas would be the focus of further work included with the Fundamental Standards of Care Approach and approach to the Quality Plan.**
3) **The Quality Account reference to the CQC reporting is to be consistency checked with the Annual Report.**
4) **To delegate approval and final sign-off of the Annual Report to the Chair and Chief Executive.**

22/58 Draft Quality Accounts 2021/22

The Committee received the draft Quality Accounts. Sharon Spain thanked the work carried out by Claire Reid, CQUIN and Quality Accounts Lead and her team. The following was reported:

- Comments have been received by QGG, ELT and QSAC however these have not been incorporated into the version received at the Committee. SS reported that the report is a fair balanced report and noted that the services are still recovering post-Covid.
- Updates are to be emailed directly rather than going through line by line.
- Service users and representatives have been included in the quality review and reported that this is an open and honest view.
- The Executive Summary has details of the CQC inspections. The Eating Disorder CQC report has been received and this has confirmed the service as Good. It is proposed that the final version of the Quality Account should have the updated table ready for publication.
- An update has been included on the Trust Quality Priorities and these will be continued in 2022/23 with a change for physical health as this will now include general physical health conditions rather than focussing on Long Covid s has been the case for 2021/22.
- Highlights for service improvements have been included (page 69)

Through discussion it was noted that the report has received good engagement from service users and representatives and this supports having a balanced view.

It was noted that the report does not have comments from HealthWatch, the HOSCs or the CCG. It was acknowledged that the consultation dates might need to be amended to ensure comments are received as the Quality Account Team made contact with HOSCs and HealthWatch and the review period did not fit in with their own meeting schedules.

It was reported that the deadline for submission is 30th June 2022 so there is still time for comments to be incorporated. The Quality Accounts have not been audited this year as there is no requirement to be fully audited.

The Information Governance toolkit has been audited by RSM and this is also required for submission on 30th June 2022. If there are any issues raised then these will be notified to the Chair of the Audit Committee.

The Committee approved the Quality Account subject to comments being received. The Chair of the Trust has responsibility to give final approval of the Quality Account.

22/59 Internal Audit Annual Report and Head of Internal Audit's Opinion

The Committee received the Annual Report and Head of Internal Audit's Opinion and Ashley Norman from TIAA updated on the following points:

HEAD OF INTERNAL AUDIT'S ANNUAL OPINION

TIAA is satisfied that, for the areas reviewed during the year, South West London and St George's MHT has reasonable and effective risk management, control and governance processes in place.

Assurance Assessments	Number of Reviews
Substantial Assurance	4
Reasonable Assurance	4
Limited Assurance	3
No Assurance	0

The audit summary confirms that there is a governance framework in place however most of the recommendations are for compliance areas, procedures and policies.
The audit work is detailed in Annex A, there is one audit due to be closed and this is for Temporary Staffing and Agency Costs however this will not affect the change of the opinion.

The DSP toolkit was not undertaken, RSM will continue with this audit, however this will not impact on the opinion.

The Chair of the Committee thanked Ashley Norman and TIAA for the work that the internal auditors have undertaken.

22/60 Internal Audit recommendation Tracker

The Committee received the progress update and noted the following:

- The report has some outstanding actions for Priority 1 recommendations and updates have come in from the Responsible Officers
- 253787 and 253788 relating to care/crisis planning and risk assessments do not have an update associated with them (**Action: NM to support RSM to receive updates)** **NM**

The Committee agreed to receive a full update on the recommendation tracker at the July Committee.

22/61 Internal Audit Annual Plan

The Committee received the IA Audit Plan 2022/23 and Clive Makombera from RSM provided an update:

- The Annual Workplan, Board Assurance Framework and risk registers have been reviewed by RSM for internal audit purposes and regulatory compliance.
- This has formed the Audit Plan for Year 1 and this has supported the later years for Yr3-5 in the Audit Universe and Audit Strategy.
- An audit assurance map will be completed and will support the Audit Strategy.
- The plan has been agreed by the Executive Directors.
- Where assurance is in place then other audits will be prioritised however some audits are statutory and support the Head of Internal Audits Opinion.

It was noted that the plan represents the collective concerns of the Executive, the original draft was c£7k over budget however in view of the other sources of assurance available to the Trust the EMP audit had been removed from the plan. This was agreed by the Committee.

Through discussion it was requested that consideration is given to expanding audits into CIP. It was suggested that some areas on the workplan need to be brought forward as areas like project management would support service change if this was reviewed earlier then taking place in 2026/27.

It was proposed to bring the further detail on the Audit Plan back to the July Audit Committee, however approved the workplan at this stage.

22/62 Counter Fraud Progress Report

The Committee received the update on the Counter Fraud progress report and Heather Greenhowe from RSM reported the following:

- The new style reporting template was described and this details the work undertaken, planned work, reactive work summaries, emerging risks, and mandate fraud table. The report also includes Action Plans.
- There are four on-going investigations to incl abuse of position, alleged dual work, invoicing mandate fraud and working whilst sick.

Through discussion the process for remote interactive fraud awareness sessions was raised and the process of recording the attendees and the tracking of responses is an area that is audited.

22/63 Counter Fraud workplan

The Committee received the Counter Fraud workplan and noted the approach to the workplan is based on the NHS CFA requirements.

The plan is risk based, it would be normal that risks prevalent as a Trust would be reported but as this is the first report this is a cyber fraud and fraud risk assessment.

Work will be carried out in regard to detection activity and the team will work jointly with internal audit team. Areas focussed on will be for Payroll and

Accounts Payable. Going forward a Counter Fraud Strategy will be reported but at this stage this is not fully populated.

It is planned that the risk assessment will be ready for discussion at the July Committee. **RSM**

The Committee agreed the workplan.

22/64 Board Assurance Framework

The Committee received the BAF. The following was reported:

- The BAF has recently been received at the May Board and that the finance risks have increased.

VF confirmed that the main changes are to workforce and the other is for system-wide pressures.

The Committee requested that the coversheet supports the BAF as this assists the reader to understand the report further as the more detailed BAF review is expected at the July Committee. **DL**

22/65 Committee Annual Report

The Committees draft Annual Report was received.

The report covers the meeting attendance, activity received, the forward plan and an assurance statement. The updates have been received for external and internal audit – these will be updated in the final version that is received at the July Trust Board. **(Action: NM to update the report)** **NM**

22/66 EMC Minutes

The Committee received and noted the meeting notes from EMC for January, February, March and April 2022. In addition it is to be noted that the committee separately received the Attain report as this was circulated outside of the meeting.

22/67 QSAC Minutes

The Committee received and noted the meeting notes from QSAC for January, February, March and April 2022.

22/68 Meeting Reflection

The transition between the separate internal audit teams has been reassuring.

22/69 Matters to Report to the Board

The Committee agreed that a meeting will be reported to the Trust Board:

22/70 Any Other Business

VF asked for her thanks to be conveyed to the Finance Team and their great work that has lead to the submission deadline being met.

22/71 Date of Next Meeting

Wednesday 20th July 2022 via MS Teams Meeting.

Meeting:	**Trust Board – Part A**
Date of Meeting:	**8th September 2022**
Report Title:	**Green Plan**
Authors:	**Sharon Le Coq – EMP Liaison Team** **Robin Bruce – Associate Director of Capital and Estate Management (Operational)** **Sally Jones – Associate Director of PRCC** **Amy Scammell – Director of Strategy, Transformation and Commercial Development**
Executive Sponsors:	**Amy Scammell, Director of Strategy, Transformation and Commercial Development**
Purpose:	**For approval**
Scrutiny Pathway:	**N/A**
Transparency:	**Public**

Executive Summary

1.1. Climate change is a significant and real issue that is already having irreversible impacts on the Earth and our way of life. Human-made greenhouse gas emissions need to be significantly reduced to prevent further detrimental effects.

1.2. The UK has clear carbon zero targets in place and the NHS – as an organisation responsible for 4% of our national emissions – has a significant role to play in reaching these.

1.3. In October 2020 the NHS published a new strategy and clear expectations around reaching net zero by 2040 for emissions under its direct control and 2045 for those it can influence (such as those embedded within the supply chain). To support this each NHS organisation is required to publish a Green Plan setting out vision, aims and delivery areas across key standardised headings.

1.4. The Trust has developed its Green Plan over the past 18 months and a draft version was reviewed by EMMG in March 2022. The Green Plan work has in the main been led by colleagues in Estates and Facilities and EMP with additional input being provided latterly by the Director of Strategy, Transformation and Commercial Development. Staff have also participated in workshops to provide input, ideas and challenge.

1.5. This paper provides the Trust Green plan highlighting context, delivery in the sustainability agenda to data, engagement findings, vision, objectives and delivery areas, risks and challenges and next steps. The Green Plan is necessarily high level and further work is no required to set up governance and acquire support/ resourcing, detail the work ahead, conduct wider engagement and begin delivery.

1.6. EMMG received and discussed the Green Plan on 23.08.22 and agreed for this to travel onwards to EMC with additions to the SWOT (slide 14), including an objective on prioritising green initiatives that deliver cost neutral/ saving (slide 19) and workforce (slide 21). EMMG agreed a pragmatic approach to moving forward noting potential issues around expertise and understanding benefits and the inherent conflicts or contradictions that can arise in delivering green and sustainable elements against other priorities. EMC received the Green Plan on 01.09.22 and agreed onwards submission to the Trust Board.

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

- **Note and approve the Green Plan.**

Corporate Risk	**N/A**	**Board Assurance Risk**	**1347**

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 ensures the Trust has an approved Green Plan thereby fulfilling governance requirements.
Clinical:	Positive impact – The Green Plan will support work to ensure care is provided as close to home as possible for our service users and carers and also that care models are sustainable.
Equality & Diversity:	Positive impact – Climate change disproportionately affects vulnerable groups. Our Green Plan will act as a catalyst to link sustainability and green actions into our health inequalities work.
Estates:	Positive impact – Our Green Plan will support changes to estates and facilities to ensure they are modern, fit for purpose and in line with the net zero carbon agenda.
Financial:	Unclear impact – Green and sustainable initiatives require funding. At present the Trust has not been successful in securing funding but we will fully investigate these opportunities with an aim to secure funding in future investment rounds. This may be financially beneficial for the Trust. For Trust investment via capital or revenue routes there is a need to consider the balance between initial outlay and future financial savings.
Legal:	N/A
Quality:	Positive impact – The green and sustainability agenda is linked to improving health outcomes for people and reduce adverse health effects brought about by climate change impacts.
Reputation:	Positive impact – Driving forward the green agenda will positively position the Trust in terms of sustainable care, local community development work and future planning. This work also links to our ethos as a valued led organisation.
Strategy:	Positive impact – The community transformation programme is a key element of the Trust Strategy and measuring outcomes is a critical path of judging its success.
Workforce:	Mixed impact – Previous surveys of NHS staff have found very high support for increasing sustainability and green actions and there has been positive engagement to date by Trust staff in the development of our Green Plan. Delivery of green actions will, however, require behaviour change, capacity and energy. These may be challenging for staff at times.
Other (specify):	N/A

Appendices:

Green Plan slides

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

Our Green Plan

EMC 1st September 2022

Introduction

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

Climate change is real and impacting now. In South West London and St George's NHS Mental Health NHS Trust we are committed to delivering the net zero carbon and emission reduction agenda in the NHS.

We believe that sustainable and greener actions can be taken and will have positive impacts on the care that we deliver, our ways of working and the wellbeing of our communities.

We will work collaboratively over the next 3 years to implement both strategic and small scale actions that will have positive impact and which build on our current success. We will integrate green and sustainability thinking into our existing practice and delivery.

This Green Plan lays out our vision and objectives and sets out key delivery areas to meet the Greener NHS agenda. We recognise there are challenges to be overcome but we are hopeful and optimistic about the changes we can make. Please join us on this journey.

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Contents

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

Our Green Plan has a number of sections and is set out as follows:

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

Context

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Climate change and the NHS

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

Climate change is a real and current issue – it is happening now and is one of the biggest challenges we face. It has already caused irreversible damage to the Earth – both in terms of habitats and species – and our way of life.

There is clear evidence demonstrating the reality and pace of global warming due to human-made greenhouse gases. It is likely that warming will continue and the impacts we are experiencing will worsen.

Given this we must redouble our efforts to achieve net zero and to raise awareness and ambitions around sustainability and tackling climate for generations now and in the future and the wider planet. We need to recognise the severity of the situation and remain hopeful and support opportunities for change.

The UK has clear commitments to addressing climate change but the impact of agreed plans and activities is under question. In June 2019 the UK became the first major global economy to pass a law that requires 'net zero' greenhouse gas emissions by 2050. As one of the largest employers in the world and a significant producer of emissions, the NHS has a key role to play in tackling climate change.

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A Greener NHS

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In October 2020, the Greener NHS programme published a new strategy – Delivering a Net Zero NHS. This report highlighted the impact of climate change and poor environmental health in contributing to the burden of major disease and disrupting care.

Trajectories and actions for the whole of the NHS were outlined around reducing carbon emissions. The aim is to:

- Ensure very NHS organisation is supporting care emission reduction by 2040-2045
- Prioritise interventions which both improve patient care & community wellbeing, and tackle climate change and broader sustainability issues
- Support organisations to plan and make prudent capital investments whilst increasing efficiencies.

Furthermore the Health and Care Act 2022 places responsibilities on the NHS to address the UK net zero emissions target, targets within the Environment Act 2021 and adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

In July 2022, further guidance was published by NHSE – Delivering a Net Zero NHS – which provides a detailed account of the NHS's modelling and analytics underpinning the latest NHS carbon footprint, trajectories to net zero and the interventions required to achieve that ambition. It lays out the direction, scale and pace of change and an iterative and adaptive approach.

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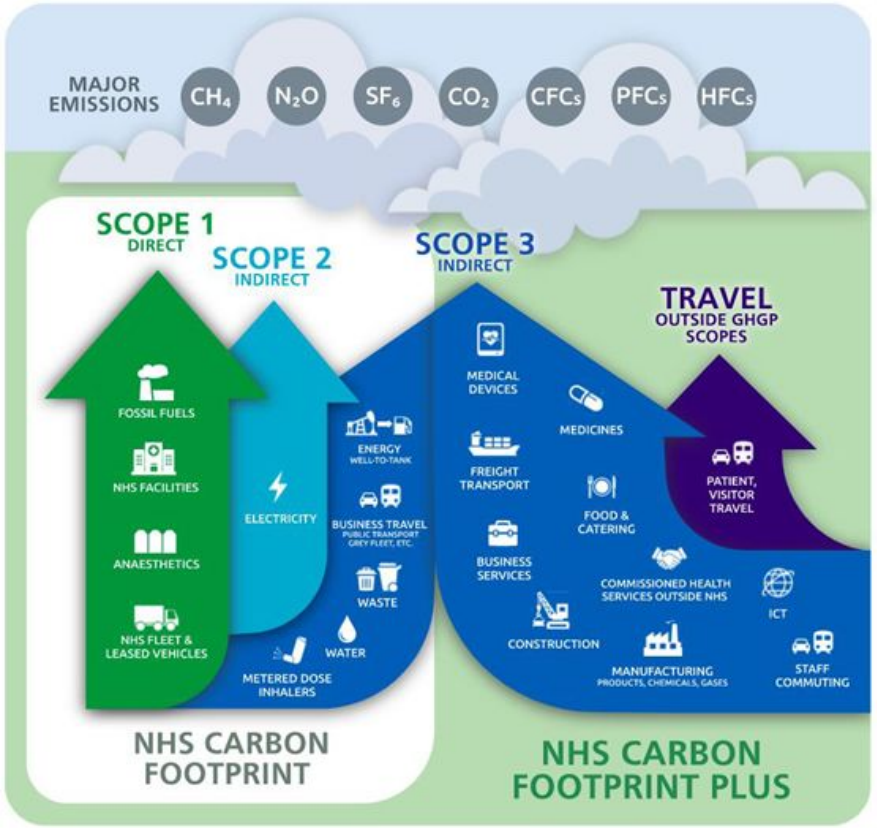
Carbon emissions

Carbon emissions arise from both direct and indirect activities and these can be categorised into different types (scopes). Direct and some indirect activity data is used to calculate the NHS carbon footprint. However in recognition of wider impact and the breadth of indirect activities a NHS Carbon Footprint Plus has also been constructed.

NHS organisations need to tackle emissions arising from scopes 1-3 as described opposite.



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Green Plan requirements

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

All of us have a role to play in supporting the development of a Greener NHS and every NHS organisation is required to publish a three year Green Plan (building on earlier Sustainable Development Management Plans). Green Plans need to be situated within the organisation's context, include a clear vision and priorities for carbon reduction and sustainable development, and, consider which environmental/ financial/ social issues are most important and which improvements will most benefit local communities, staff and the overall organisation.

There are a number of focus areas upon which Green Plans should address:

1. Workforce and system leadership
2. Sustainable models of care
3. Digital transformation
4. Travel and transport
5. Estates and facilities
6. Medicines
7. Supply chain and procurement
8. Food and nutrition
9. Adaptation

Green Plans should be Board led and be developed with input from across a broad range of disciplines – clinicians, estates and facilities representatives, procurement and finance teams and human resources. Green Plans need to link up across our ICS area and delivery/ progress will be monitored.

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Our Trust

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

We serve 1.2 million people across the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth as well as providing specialist services that extend to regional and national populations. We are based at Springfield University Hospital in Tooting with major inpatient services provided from Tolworth Hospital in Kingston, and Queen Mary's Hospital in Roehampton. We also operate from many other community locations across the south east.

We employ over 2000 staff, 87% of whom are clinical. Our staff are among some of the most advanced and experienced practitioners in their fields and we are proud of the positive impact our mental health services have for both patients and the wider community.

In the last year we:

- Saw 38,725 service users
- Had 413,743 individual contacts with our service users
- Received 48,377 referraks to our secondary care services
- Supported 1,695 service users on our inpatient wards
- Took 39,435 calls to our Mental Health Crisis Line

We invest in research, innovation and training in mental health and are connected to a number of academic and research organisations. We also provide education, training and research in partnership with a number of universities. We work collaboratively with colleagues in the South London Partnership and also the SWL Integrated Care System.

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Our Trust Strategy

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

Our Trust Strategy defines our mission, philosophy, values and strategic ambitions.

The Trust mission is 'Making Life Better Together' and we believe that through partnership working we can deliver improvements to care, services and population wellbeing.

We aim to do this through a philosophy of being influential, asset-based, outcomes and prevention focused and collaborative.

We have four strategic ambitions that:

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

We work within five Trust values which outline how we work with others and behave towards one another.

Our Green Plan is both informed by, and will support, this strategic context.

Our environment and our communities

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

As an organisation are committed to delivering NHS wide goals and ambitions related to the integrated care, collaborative working and the NHS Long Term Plan.

We work within a complex environment that impacts on our delivery. At present we are experiencing considerable increases in demand for services and acuity of service users post-pandemic; we are also experiencing financial challenges and workforce pressures.

The communities that we serve across SWL are ethnically diverse, include some areas of high deprivation and also have mobile population groups. Environmentally we see issues such as poor housing, lack of employment and traffic congestion and we know these impact adversely on people's health and wellbeing. In addition, our service users with serious mental illness face significant health inequalities as outlined in the CORE20PLUS5 work.

We need to work collaboratively with our communities to illustrate how the sustainability agenda can bring benefit to local neighbourhoods and tackle key issues.

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Developing our Green Plan

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Our starting point

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

In developing our Green Plan we have reviewed our delivery of sustainability elements to date. We have a solid foundation to build upon – key elements include:

- We are in the final stages of completing the Springfield construction of Trinity and Shaftsbury buildings. EMP achieve BREEAM "Excellent" rating (BREEAM UK NC 2014) and BREEAM "Excellent" Design Stage Certificate for both Forensic and Non-Forensic Buildings. The creation of the new environments has also supported modern building methods with zero 'cart-away' from site of excavated material and 100% reuse of all concrete and brick salvage (into hardcore). Our new buildings include sustainable urban drainage, water retention lagoons that help attenuate water into the drainage systems, increased permeable surfaces to reduce water run-off and designed flora to support natural biodiversity.
- Our new buildings allow us to vacate old inefficient infrastructure and reduce our carbon footprint.
- EMP is also delivering a 32-acre park in Tooting that all residents will have access to encouraging cycling and walking and enjoyment of green spaces.
- Consolidated our estate use and reduced our geographic footprint.
- Reduced business miles travelled using vehicles.
- Significantly reduced our paper usage and printing costs.
- All our energy is now provided by a renewable supply and recycling is in place as standard. All waste is currently incinerated or processed using an energy recovery plant so we have zero waste to landfill. Waste levels have reduced.
- We have excelled in the digital delivery arena supporting virtual working. Key achievements include electronic ordering systems, hybrid mail reducing printing, eWorkflows removing paper forms, eObs has removed end of bed charts and replaced them with forms on RiO, .eDischarges and eReferrals, text messaging service to send service users appointments in place of appointment letters, roll out of agile working and technology to support this, eConsultations and digital platforms for clinical support.
- Begun our clinical transformation programme with a focus on care closer to home and community based.

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Green SWOT analysis

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

We have carried out a strengths, weaknesses, opportunities, and threats (SWOT) analysis to help us understand where our Green Plan needs to focus

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Our Green Plan journey so far

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

We have developed our Green Plan through a range of activities:

- Review of our previous Sustainability Development Plan and delivery
- Review of data around key elements – emissions, travel, use of resources for example
- Discussion via the Estates Modernisation Management Group
- Reviewed other NHS organisation Green Plan commitments
- Connected with the SWL ICS Green Plan work
- Engagement workshops with staff during August 2022 to ask for views on what we do well, what we could improve and where we should focus, and to seek interest in progressing this agenda

We still have more work to do to test our priorities and commitments with our service users, carers and local communities.

We also need to develop a detailed workplan and ensure we resource delivery appropriately.

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Engagement feedback – approaches

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

Our staff have told us that we need multiple approaches to the green and sustainability agenda.

- Engagement – there is a real interest in this agenda and we need to harness this and support people to move areas forward.
- Carbon literacy and understanding – there are variable levels of understanding around these topics. we need to educate ourselves and one another – there is appetite for knowledge!
- Visibility – the green and sustainability agenda in the Trust is not visible. We do not routinely consider, talk about or communicate green issues or refer to these in reports. Most references to sustainability refer to financial sustainability. There should be identifiable and clear leadership around this agenda.
- Measurement – people do not understand how we benchmark with other organisations nor how well we are doing.
- Scale – we need to progress both small scale and strategic, large scale actions.
- Behaviour change – as a mental health trust many of our workforce have expertise in behaviour change; we should capitalise on this and also incentivise people to make changes.

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Engagement feedback – content

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

Our staff have told us there are a number of themes and topics that are important to include in our green and sustainability agenda:

- **Care models and digital delivery:** The move into new buildings provides fantastic opportunities to reset our care models and support the green agenda. Work with communities, service users and carers to provide support to people closer to home, and using virtual working, where this is indicated. Digital
- **Travel:** Car use is a significant issue and we ought not to shy away from tackling this. Challenges exist for staff needing to visit patients at home. Public transport across SWL is poor with driving and cycling the only efficient options. Cycling has increased and may further if we tackle safety, confidence and secure bike storage.
- **Energy efficiency:** We can become more efficient in our use of heating, lighting and water. Many items are left on standby or on entirely. We should model behaviours around this as well as investigating new smart environment technology, purchasing low power use hardware and using of lower power use settings.
- **Reduce, reuse, recycle:** Recycling does appear to happen consistently across the Trust but there is concern about what happens to recycling. Reuse of furniture/ technology should be improved with logistical challenges overcome. The presumption to 'buy new' should be challenged. When buying new we should aim to buy using recycled materials (paper is good example here) and extend our purchases via the supply chain from suppliers with sustainability commitments. There is work to do on reducing use of disposable items – cups, individual sachets, cutlery.

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

Our Green Plan

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Vision and objectives

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

Vision:

We are an organisation that is committed to delivering the green agenda and tackling both the causes and impacts of climate change. We believe in delivering sustainable care, improving population health and reducing our environmental impact for the benefit of all. We talk about the green agenda openly and are successfully delivering positive changes and reducing our carbon footprint.

Objectives:

- Value our natural environment and resources and operate responsibly and efficiently in relation to these.
- Meet carbon emissions and pollution reduction targets for the NHS – net zero by 2040 and 2045.
- Meet an internal carbon reduction target from direct (scope 1) emissions of 50% by 2028.
- Prioritise uptake of green initiatives that are cost neutral or delivery cost savings.
- Adapt our services to climate change impacts without increasing carbon emissions.
- Develop a healthy environment from which to deliver care and in which to work.
- Design and embed sustainable care models and ways of working which focus on social and environmental aspects, promote health and wellbeing and reduce the burden of disease and resource pressure.
- Work collaboratively with our workforce, service users and carers, partners, stakeholders and communities to address climate change and its impact.
- Link the green agenda into wider NHS work on anchor institutions, a circular economy and social value.

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Our approach

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

We recognise that there is much we can do across our existing infrastructure to support the green agenda. We will carry out the following enabling actions:

- Valuing and driving forward both macro and micro approaches with short and long term outcomes – from large scale strategic programmes of work to supporting and recognising individual actions.
- Promoting and supporting behaviour change approaches to support delivery of outcomes.
- Ensuring sustainability and green policies are in place and building a consideration of green/ sustainability issues into all policy reviews.
- Including green and sustainability as a criteria within impact assessments, business case development and risk/ benefit assessment.
- Defining key sustainability and green measures and auditing and benchmarking delivery against these.
- Integrating Green Plan activities into existing programmes of work – health inequalities, QI, R&D for example – to add value.
- Communicating clearly and regularly around sustainability and support our staff to increase their awareness and expertise in this area.
- Actively seeking funding to support initiatives.
- Including green and sustainability elements within our annual corporate objectives from 2023/24 onwards.

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1. Workforce, networks and leadership

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

Objective: To engage and develop our workforce in defining and delivering carbon reduction initiatives and sustainability.

Our planned actions are to:

1. Refresh our sustainability governance implementing a 'Green Group'.
2. Employ a Sustainability Lead to provide expertise and to drive the green agenda forward.
3. Make sustainability and green training available to educate staff and include this in a staff pack illustrating the behaviours we need our staff to adopt to support this.
4. Develop regular and clear communications around sustainability and green issues providing information via a green hub on our Trust intranet for staff, a dedicated page on our website to promote our vision, plans and progress and a regular newsletter for all staff, the public and relevant partners.
5. Develop incentive and pledge approaches for staff and teams.
6. Provide tools to our teams to enable calculations/ tracking of their carbon footprints.
7. Encourage our workforce to develop QI initiatives in this area and develop a Quality Award category to recognise achievements.
8. Contribute to SWL ICS leadership around the green agenda.

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2. Sustainable models of care

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

Objective: To embed net zero principles in care delivery through delivering care closer to home, reducing unwarranted variations and promoting health and wellbeing initiatives.

Our planned actions are to:

1. Measure carbon footprints of clinical and corporate areas.
2. Review our clinical transformation programme and identify how each element will support the net zero agenda.
3. Reduce unwarranted variation and focus on Getting it Right the First Time (GIRFT) to improve performance against core indicators where efficiency and quality are impacted.
4. Use virtual consultation to support reduced travel where clinically appropriate and mindful of service user choice.
5. Continuing to support staff to work flexibly reducing unnecessary travel.
6. Encourage lifestyle changes, exercise and dietary advice and the use of green spaces and nature to aid recovery via partnership working and schemes such as social prescribing.
7. Understand and harness the assets that exist in local communities to enable a more sustainable delivery of health care

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3. Digital

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

Objective: To harness technology, reduce paper records, printing & postage and support innovation.

Our planned actions are to:

1. Create a stretch target to harness the alto print project to further reduce our paper usage.
2. Create a stretch target to increase uptake and usage of video conferencing.
3. Review opportunities and carry out cost benefit analysis around investing in energy saving infrastructure.
4. Extend piloting of refurbishment of technology and hardware saving costs and also reducing new items purchased.

4. Travel and transport

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

Objective: To increase active travel and public transport, investing in low and zero emissions vehicles.

Our planned actions are to:

1. Carry out review work to identify how to decarbonise the Trust fleet (including grey fleet) and implement recommendations.
2. Review opportunities for supportive travel and transport actions such as car sharing and route planning, lease schemes to incentivise electric vehicle choice, use of e-bikes.
3. Ensure all cars purchased or leased support low and ultra-low emission and that any leasing schemes restrict the availability of high-emission vehicles.
4. Invest in active travel options including improving bicycle purchase under salary sacrifice, cycle safety and secure bike storage.
5. Use the Health Outcomes of Travel Tool (HOTT) tool to identify impacts on local air quality.
6. Work with wider partners to consider promotion and incentivisation of active travel options.

4. Estates and facilities

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

Objective: To improve energy efficiency and reduce energy use, decarbonise heating and hot water systems, reduce waste and ensure building design and refurbishments support carbon emission reductions.

Our planned actions are to:

1. Implement green and sustainability elements into the Tolworth design and achieve BREAAM accreditation for Tolworth, Barnes and Richmond Royal site redevelopments.
2. Review our energy strategy to consider newer technologies such as solar and heat pumps.
3. Get the basics right with energy and water efficiency policies, accurate baselining of carbon, energy and water use and increased usage monitoring – smart meters, utility bill close checking, forecasting energy use.
4. Instal new equipment to (a) improve energy efficiency such as insulation, lagging, voltage optimisers, timers, motion sensors etc and (b) reduce water usage such as sensor taps, controlled flush devices, flow restrictors (where appropriate) etc.
5. Continue with the replacement of lighting with LED alternatives during routine maintenance activities on the buildings that will remain part of the estate.
6. Provide waste, energy and recycling awareness training for our workforce.
7. Increase reuse of furniture and large items through donation and upcycling exploration.
8. Support green walls and roofing and reduce grass mowing to encourage biodiversity

6. Medicines

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

Objective: To increase medicines optimisation and medicines waste reduction, and support using lower carbon medicines and low carbon medicines delivery.

Our planned actions are to:

1. Reduce waste medicines and return waste medicines for use where appropriate
2. Encourage patients to bring in their own medicines on admission including inhalers
3. Encourage patients to take their waste medicines (including inhalers) to community pharmacies for destruction
4. Implement sustainable prescribing of antipsychotic depot/ long acting injections – for example reducing frequency of depot administration where appropriate from weekly to 2 weekly or 4 weekly or monthly to 3 monthly/6 monthly depending on the antipsychotic or using concentrated strengths so less vials are used
5. Review the potential for switching inhalers/ increasing use of Dry Powder Inhalers (DPIs) and whether it would be appropriate to make those switches in a mental health setting.
6. Support the innovation from suppliers in and use of lower carbon propellant an alternative

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7. Supply and procurement

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

Objective: To use our purchasing power to reduce carbon in supply chains, reuse/ repurpose equipment and use lower carbon supplies.

Our planned actions are to:

1. Ensure there is a commitment to use the eProcurement system and use NHS Supply Chain where possible, and use frameworks where suppliers have confirmed sustainability commitments and provenance of goods.
2. Reduce demand for unnecessary procurement.
3. Apply a whole life costing approach to assess value for money
4. Purchase environmentally friendly items and reduce un-necessary packaging.
5. Review and extend green, sustainability, carbon efficiency and social value elements in future tendering processes and ensure these are scored and given appropriate weighting for all contracts. Encourage and enable suppliers to provide innovative solutions.
6. Stop the use of single use plastics and if required source suitable recyclable alternatives where necessary and continue to reduce the need for plastic and sign up to the plastics pledge.
7. Only purchase small electrical plug in equipment (office equipment, supplementary heating equipment, etc) that has the highest energy ratings.
8. Review our procurement policy to extend sustainable and ethical practice expectations.

8. Food and nutrition

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

Objective: To reduce carbon emissions related to food, reduce food waste and ensure provision of healthier and locally sourced, seasonal menus.

Our planned actions are to:

1. Work with our existing catering provider to reduce the use of disposable items and packaging and increase reusable items for food storage and serving.
2. Reduce food wastage in wards and restaurants
3. Promote health and well-being by cooking with generous portions of vegetables, fruit and starchy staples such as whole grains and cutting down on salt, fat and oils, and cutting out artificial additives, and aiming to use local, in-season ingredients where possible, to minimise energy used in food production, transport and storage.
4. Consider how to integrate healthy eating into existing physical health programmes for service users.
5. Integrate additional green and sustainability requirements into the upcoming catering services tender and any future food and nutrition contracts.

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9. Adaptation

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Objective: To mitigate the effects of climate change and severe weather on business and functions.

Our planned actions are to:

1. Review our business continuity plans to ensure current inclusions are fit for purpose.
2. Audit the success or failure of plans around 2022 weather events – eg heatwave
3. Review and strengthen our approaches to ensure that we do not implement reactive activities which are detrimental to overarching net zero goals in response to severe weather or current circumstances (eg purchase and use of air conditioning for summer heat and increased heating of sites in winter)

Delivery and governance

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Our Green Plan is owned by our Trust Board and we will lead the delivery of this work as follows:

- Securing executive direction from our Integrated Programme Director
- Developing detailed delivery plans and funding source review by a small working group
- Establishing a regular Green Group for our staff and service user to attend where progress on delivery of the Green Plan can be reviewed and project work can be agreed/ discussed
- Engaging and communicating the green agenda and ensuring this is part of everything that we do
- Employing a sustainability/ green lead and identifying sustainability/ green champions
- Utilising technical resources to understand and benchmark our progress and make available assessments of impact to our teams
- Working to secure external funding to support green initiatives
- Regularly reporting to our Trust Board on progress
- Reporting on our delivery via the NHS Futures platform and into the SWL ICS

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Risks and challenges to delivery

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There are a number of challenges and risks to delivery:

- Capacity and capability to delivery this agenda – we will mitigate by bringing in expertise, educating ourselves and harnessing the passion of our workforce and communities.
- Tension between delivering net zero and adapting delivery to cope with the impacts of climate change – we will need to balance long term goals with short term behaviours and we will need to identify net zero supporting adaptation activities. This is particularly important in relation to dealing with increasing summer temperatures and rising energy costs in winter 2022/23 which may increase numbers of staff working from Trust sites.
- Understanding measurement and technical elements and illustrating benefits/ impacts – there are a variety of tools to support NHS organisations in measuring impact, understanding progress and monitoring outcomes.
- Immediate outlay vs future savings – we will need to review and make decisions around how to offset initial, upfront costs of implementing green approaches with future projected savings.

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Our next steps

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Next steps

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Our immediate next steps to progressing the Trust Green Plan are:

- Set up our Green Group and confirm our leadership approaches – Sept 2022
- Engage with partners, communities and service users & carers to discuss the Green Plan and identify local initiatives – Sept 2022 – and design an ongoing engagement process – Oct 2022
- Develop a communications approach (including media, campaigns and incentives) around this agenda for our workforce and begin delivering this – Oct 2022
- Recruit our sustainability lead – Oct 2022
- Develop detailed delivery plans for core areas with associated milestones and clear leadership – Nov 2022
- Set up reporting to Trust Board, SWL ICS and the Greener NHS programme – Dec 2022

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