# Trust Board - Part A

14 July 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 - 12th May 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 | Deborah Bowman | 02:25 PM-02:35 PM |
| 5. | Making The Trust A Great Place To Work | | |
| | 5.1 Workforce & OD Committee chair's report | Sola Afuape | 02:35 PM-02:40 PM |
| 6. | Reducing Inequalities | | |
| | 6.1 Equality & Diversity Committee chair's report | Doreen McCollin | 02:40 PM-02:45 PM |
| | 6.2 Diversity in Decision Making evaluation | Jenna Khalfan | 02:45 PM-02:55 PM |
| Break | | | 02:55 PM-03:10 PM |
| 7. | Ensuring Sustainability | | |

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|---|---|---|---|
| 7.1 | Finance and Performance Committee chair's report | Vik Sagar | 03:10 PM-03:15 PM |
| 7.2 | Finance Report | Philip Murray | 03:15 PM-03:25 PM |
| 7.3 | Estates Modernisation Committee chair's report - verbal update | Juliet Armstrong | 03:25 PM-03:30 PM |

8. Corporate Trustee Business

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|---|---|---|---|
| 8.1 | Charitable Funds Committee chair's report | Juliet Armstrong | |

9. Notified Questions From The Public and Staff — 03:30 PM-03:35 PM

10. Meeting Review

11. Next Meeting - Trust Board 8th Sept 2022 - 1.30pm

AGENDA

| Meeting | Board of Directors |
|---|---|
| Time of Meeting | **1.30pm to 4.00pm**<br>**Please note revised start time** |
| Date of Meeting | **Thursday 14th July 2022** |
| Location | **FACE TO FACE MEETING**<br>**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 12th May 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 | 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 | 14:35 |
| 6. | **REDUCING INEQUALITIES** | | | | |
| | 6.1 Equality and Diversity Committee chair's report | FR | Paper | SA | 14:40 |
| | 6.2 Diversity in Decision Making evaluation | FR | Paper | JK | 14:45 |
| | **BREAK** | | | | 14:55 |
| 7. | **ENSURING SUSTAINABILITY** | | | | |
| | 7.1. Finance and Performance Committee chair's report | FR | Verbal | VS | 15:10 |
| | 7.2. Finance report month 1 | FD | Paper | VS | 15:15 |
| | 7.3. Estates Modernisation Committee chair's report | FR | Verbal | VS | 15:25 |
| 8. | **CORPORATE TRUSTEE BUSINESS** | | | | |
| | 8.1 Charitable funds committee chair's report | FR | Paper | JuA/IG | 15:30 |
| 9. | **NOTIFIED QUESTIONS FROM THE PUBLIC AND STAFF** | FD | Verbal | AB | 15:40 |
| 10. | **MEETING REVIEW** | FD | Verbal | AB | 15:55 |
| 11. | **Next Trust Board business meeting –** 1.30pm on 8th Sept 2022 – Conference Room G, Springfield Hospital | | | | |

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|---|---|
| **Attendees:** | |
| Ann Beasley (AB) | Chair |
| Prof Deborah Bowman (DBo) | Non-Executive Director, Vice Chair and Senior Independent 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)* | Chief People Officer |
| David Lee (DL)* | Director of Corporate Governance |
| Ian Garlington (IG)* | Integrated Programme Director |
| **In attendance:** | |
| Nicola Mladenovic (NM) | Deputy Trust Secretary |
| **Apologies:** | |
| Jenna Khalfan (JK)* | Director of Communications and Stakeholder Engagement |
| Juliet Armstrong (JuA) | Non-Executive Director |
| Doreen McCollin (DM) | Non-Executive Director |
| Richard Flatman (RF) | Non-Executive Director |
| *=non voting | |

# Trust Board

# July 2022

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|---|---|
| **Paper Reference:** | |
| **Report Title:** | Service User Story |
| **Executive Summary:** | The Service User Story for July 2022 is being presented by James and Marie who were under the care of the Trust's Couples Therapy Clinic.<br><br>They will share the experience of Family Therapy. The report highlights the impact on their relationship and looks more widely at the services offered by the Prudence Skynner Family & Couple Therapy Clinic.<br><br>There will be an oral presentation from:<br><br>• James and Marie<br><br>Attending will also be:<br><br>• Heleni-Georgia Andreadi<br>Head of Systemic Family Therapy & Courses Director<br>Prudence Skynner Family and Couple Therapy Clinic |
| **Action Required:** | The Board is asked to note the Service User Story relating to Family Therapy & Courses Director Prudence Skynner Family and Couple Therapy Clinic |
| **Link to Strategic Objectives:** | The Trust launched its five-year Trust Strategy in 2018. The strategy 2018 – 2023 includes four strategic ambitions:<br><br>• **Increasing quality years -** Quality Improvement and Innovation<br>• **Reducing inequalities -** Service users and carers co-production<br>• **Making the Trust a great place to work -** Staff underpin all that we do<br>• **Ensuring sustainability -** Transformation<br><br>These ambitions move the Trust to focus on outcomes, not processes and are held together by the mission – Making Life Better Together – which is at the centre of the Trust's work. |
| **Risks:** | None |
| **Quality Impact:** | Patient Experience is a domain of the Quality Strategy. |
| **Resource Implications:** | None |
| **Legal/Regulatory Implications:** | None |

| | |
|---|---|
| **Equalities Impact:** | None |
| **Groups Consulted:** | Oral Presentation by James and Marie |
| **Authors:** | James and Marie<br>Jacqueline Ewers, Experience and Governance Lead<br>Heleni-Georgia Andreadi,<br>Head of Systemic Family Therapy & Courses Director<br>Prudence Skynner Family and Couple Therapy Clinic |
| **Owner:** | Sharon Spain, Executive Director of Nursing and Quality |

Making life better together

# Prudence Skynner Family & Couple Therapy Clinic

**July 2022**

## Background

This month's patient story to the Board is being presented by Marie and James, former patients of the Trust's Couples Therapy Clinic Service based in Kingston. Marie experienced anxiety after being sexually assaulted. Giving birth bought back flashbacks of her assault and led to self harming behaviour and to two admissions to a Mother and Baby Unit. She was later diagnosed with Emotionally Unstable Personality Disorder. James has engaged with talking therapies following bereavement. He struggled with thoughts of ending his life and not being good enough. After attending Dialectical Behavioural Therapy (DBT) Marie suggested they both attend Couple's Therapy.

## James and Marie's story.

The story is summarised using James and Marie's words from a video that they did as a way of sharing their story which is now used for learning by trainees in the therapy clinic. Marie and James will discuss their story in more detail in person at the board meeting.

**James' experience**

James explained that he initially did not want to partake in Family Therapy as he felt victimised and felt that this had only been suggested by services in order to support Marie with her mental health condition. James did agree to this however and he noted that once he started the therapy, he realised that this was not the case and that it was actually helpful for their relationship in improving their communication skills as a couple. James noted that he found it easier to talk to Marie about any issues in the relationship, and bring up any issues that annoyed him.

**James' experience continued**

James felt that the therapy was a safe space with no recrimination where both he and Marie could talk about their feelings. He noted that he feels that Family Therapy saved the relationship and he felt that without this he may have walked away from the relationship. Family Therapy helped him to listen to what Marie was trying to tell him and how much he loved Marie. James realised that he did not want to lose Marie.

**Maria's experience**

Marie explained that she felt there had been issues within the relationship from the start. When Marie started having DBT she started to realise that some of their behaviours within the relationship were not healthy. She noted that both she and James would look at each other's phones and use these to track each other's whereabouts which she felt was unhealthy.

After starting Family Therapy Marie noted that she felt that James struggled initially to bring issues to therapy that he wanted to talk about, and that he felt attacked when Marie would raise issues. Marie noted that after a while the couple were able to start talking about things in a healthy way, that in the past could have ended up being relationship ending.

Maria highlighted how nice it was for her to hear James being able to say things to her that he would have struggled to say in the past. She noted how helpful it was for the couple to learn not to react and how to listen to each other.

## Prudence Skynner Family & Couple Therapy Clinic

The Prudence Skynner Family & Couple Therapy Clinic is the only Family Therapy service for adults in the Trust, that works with partners, families, and extended networks across all five boroughs and one of the very few similar services nationally. It offers evidence based systemic family therapy (as recommended by NICE guidelines) to families and couples affected by a wide range and varying degrees of severity of mental health difficulties.

It works directly with parental mental health issues including families accessing early intervention services in CAMHS and social care as well as new parents accessing perinatal mental health services. It also works closely with community partners to promote early intervention and accessibility for families from a Black and minority ethnic background, reflected in the service's caseload.

Through consultation and systemic supervision, it supports and promotes systemically informed family work within many other Trust teams and services

The service:

i) Offers a Family & Couple Therapy service to couples/families affected by severe, acute or enduring, mental health difficulties. There is evidence that working with couples and families is effective with: relationship distress, recovery from previous domestic violence, anxiety, mood disorders including depression, substance misuse, psychosis and adjustment to physical illness. The service works within NICE guidelines. More than 50% of families worked with are from groups that define themselves as Asian, African, Black British or Other white - not from UK.

ii) Offers a four-year training programme in Family Therapy which is accredited by the Association of Family Therapy. The courses trained more than 80 people last year. These courses are income generating for the Trust

iii) Offers consultations to other teams in the Trust in the Community and Forensic services as well as Corporate teams and the Recovery College.

iv) Offers Medical training ST4 – ST6 psychiatrists in training – mandatory 100 hours of systemic practice. Medical Psychotherapy trainees from the Tavistock & Portman.

v) Community Networks for Family Care (CNFC)
This 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 the tertiary adult mental healthcare.

**CNFC**:
The aim is to offer community leaders systemic skills in working with families to continue providing early preventative work based in the community.

The CNFC featured as one of six examples of best practice in the UK for 2016 NICE guidelines - Community Involvement and Health Provision.

This work is ongoing, including annual training and monthly systemic consultation/supervision to CNFC trained practitioners. Some of our CFNC graduates have remained with the clinic after the completion of their intermediate training as volunteer clinicians.

**Further information about the service**
Following a comprehensive assessment clients may require other psychological therapies such as IAPT, Family Therapy, Trauma Therapy or in case of more complex mental health needs, referral to relevant secondary mental health services such as Early Intervention Teams or Recovery and Support Teams that provide ongoing care under the CPA approach.

The Prudence Skynner Family & Couple Therapy Clinic continues to work closely with the Wandsworth Ethnicity and Mental Health Improvement Project (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

# Compliments

“Thank you both for all of the amazing work you do - you both seem very exceptional at your job, and I can imagine do great work to help people navigate turbulent relationship dilemmas. “

‘Thank you for all your help and support with all our problems in life. Thank you for listening to me and J, and for guiding us both to a better, kinder life together.’

“The level of care is outstanding and goes above and beyond anything we have previously experienced through the NHS. The team have talked through achievable goals and we are gradually working towards them in a safe environment. We have had continuity of care throughout the pandemic, and even when one member of the team suffered a small stroke we were able to continue with treatment which was extremely helpful as the counselling is so helpful and such a necessary part of our care. The care offered is tailored to our needs and is flexible and reliable.”

“There was a point when I thought it wasn’t going to make a difference. It was a difficult process because of the emotions it brought up. But those emotions were acknowledged by the therapist and we were helped to accept them and listen to each person without judgement. That in and of itself is a huge change that has allowed us to continue to talk to each other without a therapist. This has put each one of use on a new journey as a family, but also as individuals. Particularly for my 71 year old mum, who has always been very anti-therapy. Who by the end of the sessions was evangelical about therapy! Going around telling everyone in our Afro-Caribbean community how important it was to seek professional help if/when necessary.”

“We can’t thank you enough for the support you have given us”

“Fantastic service, which helped me to achieve clarity and take action. My life – and my mental health – is so much better now. thank you also for the skilled and sensitive management of sessions where my children were present. I could not have afforded this service privately and I am hugely grateful to the NHS for making it available to me.”

South West London and St George’s Mental Health NHS Trust
Springfield University Hospital, 61 Glenburnie Road, London SW17 7DJ
**Telephone: 020 3513 5000**
**Website: www.swlstg-nhs.uk**

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**Board of Directors (Part A)**

Draft minutes of the meeting held by videoconference on Thursday 12th May 2022

**Present:**

| | |
|---|---|
| Ann Beasley (AB) | Chair |
| Richard Flatman (RF) | Non-Executive Director |
| Juliet Armstrong (JuA) | 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 |
| 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 | Interim Director of Human Resources |

**In attendance:**

| | |
|---|---|
| David Lee (DL) | Director of Corporate Governance |
| Nicola Mladenovic (NM) | Deputy Trust Secretary (minutes) |
| Suresh Desai (SD) | UNISON; Staff side Representative |
| Martin Haddon (MH) | Healthwatch Wandsworth |
| Sam Mughul | Kingston resident |

For item 22/40

| | |
|---|---|
| Jane Healey (JH) | Experience and Governance Lead |
| Diana Cassell (DC) | Clinical Director – CAMHS and All Age Eating Disorders |
| Joel Khor (JK) | Assoc Clinical Director - All Age Eating Disorders |
| J | Patient's mother |
| K | Partner of A's mother |

**Apologies**

| | |
|---|---|
| Professor Deborah Bowman (DBo) | Non-Executive Director and SID |
| Doreen McCollin (DM) | Non-Executive Director |
| Jenna Khalfan (JK) | Director of Communications and Stakeholder Engagement |

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

| Item | | Action |
|---|---|---|
| 22/39 | **Patient Story**<br>SS introduced and welcomed J, the mother of A and her mother's partner, Jane Healey and Drs Cassell and Khor from the CAMHS Community Eating Disorder Service. A has given her consent for her mother to speak on her behalf.<br><br>A is a 17 year old who has been under the care of the Trust for the treatment of Eating Disorders. She was diagnosed with Anorexia Nervosa by an independent therapist in June 2021. A was told in a telephone assessment with CAMHS, that she would be monitored but it was felt she did not need an appointment at that stage. A's initial CAMHS assessment occurred in August 2021, after J repeatedly called the service as A's weight declined rapidly. | |

Following the assessment appointment, A and J and their family were offered weekly Family Therapy Sessions with Steve McCluskey, Clinical Nurse Specialist, as well as six online parents' groups. J welcomed the support that she and A received from Mr McCluskey; however, A's mental health began to deteriorate and it was clear to J that she needed more support. J contacted CAMHS for further assistance and A then had a ten minute video call with a Psychiatrist who provided medication. As A remained unwell, J engaged a private nutritional therapist at the beginning of September 2021. The therapist sought to work collaboratively with Mr McCluskey to ensure that the sessions could continue.

Unfortunately, A continued to become more unwell and was losing weight and the family were informed by CAMHS that she would require inpatient care. However, there was an extended wait for this as there were no inpatient beds available for Adolescent Eating Disorders Patients within the SLP. A bed was also sought at The Priory, but they were also at capacity and not operating a waiting list; however, J noted that the CAMHS Team were not aware of this and believed A to be on the waiting list.

A continued to lose weight. J resorted to taking A to A&E in order to access help; however, was then told again and again that A would just need to wait until a bed became available. Due to the length of the wait for inpatient treatment, J then approached a private clinic. She was informed that if she chose to pursue the private treatment, A's case would not be kept open to CAMHS, and she would lose the option of an inpatient bed when it became available. J was then left with the option of either pursuing the private day treatment and losing the option of a bed on Wisteria Ward or continuing with the existing one hour a week treatment that A was receiving from CAMHS. At this point J was in despair and made contact through a friend with a member of the House of Lords who raised a question about the provision of Adolescent Inpatient Eating Disorders Beds.

J met with senior CAMHS staff, and it was agreed that A could remain on the Trust waiting list while accessing private treatment. This was a point of precedent as the situation had not arisen before. The service noted that in these circumstances, where the service was unable to be provided due to capacity, and a family were able to access appropriate private treatment in the community it would be appropriate for community care to be handed over to the private provider with the young person remaining on the Trust waiting list for an NHS inpatient bed.

A debate took place in the House of Lords on 17th January 2022 when questions were asked about the government's plans to ensure that young people were able to access Eating Disorders Services in a timely manner. A's case was referred to anonymously including the concern that A would not be able to continue to wait for an inpatient bed if she were to access private treatment was highlighted.

In February 2022 a bed was found for A at The Priory. At the time of writing the story, A was completing a phased return to school after leaving The Priory at the end of March 2022. J notes that A has continued to gain weight at home, and she is feeling confident in A's progress

VF thanked J for coming to present the story. She acknowledged that the trust needs to review, in partnership with commissioning colleagues, the arrangements for patients receiving private care as highlighted by J. **(Action: BB)** **BB**

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DRAFT

**22/40** **Apologies and Welcome**

Apologies were received and noted. The Chair welcomed Professor Charlotte Clark to the Board as the new University Non-Executive Director.

**22/41** **Declarations of Interest**

SA advised that she is a Trustee at the Innovation Unit, a social enterprise based in London SE1 that operates across various sectors. CC will complete her declarations of interest form shortly.

**22/42** **Chair's action**

There was no Chair's action to report.

**22/43** **Minutes of the last meeting**

The minutes of the meeting held on 10th March 2022 were agreed as a correct record with the addition of a reference in the Chief Executives Update minute 22/25 to heightened cyber risk due to the conflict in Ukraine.

PM assured the Board about resilience and investment in cyber security which has been considered by Audit Committee. A review of provider links to Russia had not identified any material cyber security risks.

**22/44** **Action Tracker**

I**tem 22/129** – this has been discussed at QSAC and the revised metrics will be live next month

**Item 21/135** – this is on the agenda for discussion, the RAG ratings have been amended for the 2022/23 proposal. This is to be closed.

**Item 22/27** – following the board seminar this is subject to regular updates. July Board to receive an update.

**22/45** **Chair's report**

The Board received and noted the report. AB reflected on the good work of the staff and this was evident in the recent Board Visits.

The Health and Care Act has received Royal Assent and changes to the Integrated Care System (ICS) will come into operation from 1st July 2022.

**The Board noted the report.**

**22/46** **Chief Executive's report**

VF presented her report and highlighted the following:

- Discussion on the Staff Survey, WRES and WDES results has highlighted the importance of staff being given do-able jobs that they enjoy.
- There has been a 23% increase in activity and service demand compared to the same period before Covid-19. This will be challenging especially given the finance constraints that the Trust is facing.
- Soft landings at the new hospital will commence in 9 weeks and then there will be three months of significant changes. This will bring exciting and challenging times.

Questions to consider:

- In light of the wider system pressure and increasing mental health demand, what more could we/should we be doing at system and place level to help people understand the challenges?
- How do we ensure the most effective treatment, for the most people - or people most in need - with the current resources we have, while giving people a doable job?
- Are we clear that the corporate objectives we are to sign off will deliver sustainable outcomes and are achievable in year with our current resourcing?

**The Board noted the CEO report.**

**22/47 Quality and Safety Assurance Committee chair's report**

The Board received the chair's report covering the March and April meetings:

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

VF thanked the Eating Disorder Team for their involvement in the cultural improvement work as this has now been included in the Improvement Plan and early feedback from the latest CQC inspection indicates improvements.

SS reported on work that has taken place since last year's CQC inspection which has led to the development of the Quality Plan including 11 Fundamental Standards of Care. This has recently been launched with staff and leads have been identified to support the roll out within teams.

**The Board noted the reports.**

**22/48 Quality and Performance report**

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

- There is an increased demand on clinical services as well as evidence of increased acuity of referrals
- The success of the HR recovery is critical alongside the Quality Plan and Community Transformation.

There was a discussion about long waits especially for Adult ADHD and CAMHS Neurodevelopment Services. It was noted that the waiting list has been fully automated and Easy Read guidance on the waiting list has also been developed. Discussions are commencing with SLaM and Oxleas to develop a patient portal to assist with a literature library and support sign posting to other services. Within CAMHS work has been progressing to ensure the links with schools and secondary CAMHS services is strong and further work has progressed with the Liaison Teams.

**The Board noted the Quality and Performance Report.**

**22/49 Workforce and OD Committee chair's report**

The Board received a report from SA on the meeting held in March and the seminar held in April. The following points were highlighted:

- A limited assurance position is being reported on the status of the HR Recovery and this is the main focus of the committee. In terms of the operational impact further work is required to increase assurance.

- The committee has agreed an approach of a 12-month People Plan to focus on establishing and embedding key elements of the HR service improvement plan and prioritising key workforce related areas that will support organisational quality and operational priorities.
- Key areas of focus include recruitment/retention, medical staffing, ER, Staff Survey and EDI.
- The Nurse revalidation report has been considered and it has been agreed that the report will focus on EDI and this will be received on an annual basis at the committee.
- The Freedom to Speak Up Guardian attends the committee on a six monthly basis. There was positive feedback from his attendance at the leadership event.

PM reported on improved feedback about the HR service at the Board visits earlier.

SA suggested that HR staff are to be commended for their continuing efforts to their support operational service provision.

**The Board noted the report and minutes from December 2021.**

**22/50 Staff Survey 2021/22 response and results**

The Board received the Staff Survey report and KR highlighted the following:

- Three key recommendations are How Do We Support our Leaders, career development and how this is visible and ensuring that people have do-able jobs.
- The HR Team had the lowest engagement score by service
- Bullying and harassment remains a theme; 17% of white staff and 25% of Black Asian and Minority Ethnic staff have experienced this over the past 12 months. Since 2020 this has decreased by 5% and 4% for white and BAME staff respectively however if everyone was living the Trust values this should not be our colleagues' experience.
- Only 35% of BAME staff believe the organisation provide equal opportunities for career progression or promotion while 55% of white staff believe the Trust does.
- 7% of white staff and 6% of BAME staff have experienced discrimination at work from a manager or team leader. A rise has been noticed in both ethnic groups
- 26% of staff with a long-term condition or illness felt pressurised to come to work compared to 18% of staff who don't have a long term condition.

The new quarterly pulse survey will complement the main Staff Survey.

The Board noted the themes of the report and agreed the actions recommended in response to this year's survey.

**22/51 Equality and Diversity Committee chair's report**

The Board received the chair's report and the February meeting minutes.

The Board welcomed the Stonewall Index silver award. In addition, it was noted that there is triangulation between the Staff Network updates at EDC and staff views expressed during Board visits.

**The Board noted the update.**

**22/52 Finance and Performance Committee chair's report**

The Board received a verbal update from VS and the following points were highlighted:

- Thanks are to be conveyed to Philip and the Finance Team for the good work in finalising the year-end accounts and managing despite the Covid-19 funding changes
- A clean report has been received from internal audit. The external auditors report is awaited.

**The Board agreed the Modern Slavery Statement** with one minor amendment. Future annual reviews of this statement will be received by FPC.

**22/53 Finance Report**

The Board received the Month 12 finance report and PM reported the following headlines:

- Currently the trust has met all its statutory targets and has broken even and is reported to have met the Capital Resource Limit (CRL).
- Profit and Loss account is showing a surplus of £2.7m, with a reckonable surplus of £1.6m, with a difference for impairments. During the year the Trust received a £1.9m overage receipt relating to a prior year asset sale. The underlying trend is just over £280k and is within the NHS 0.5% tolerance of break-even.
- There have been changes to pension contributions and some central income was received in M12.
- £49m is being held as a cash balance and this is required to support the Estate Modernisation Programme and is formed of land sales over a number of years.
- There are 9 weeks to soft landings of the new hospital.

**The Board noted the update.**

**22/54 Audit Committee chair's report**

The Board received Audit Committee chair's report and the following points were raised by RF:

- The Value for Money assessment has been completed and no significant issues have been raised.
- TIAA, the outgoing internal auditors have provided their Head of Internal Auditors Opinion giving Reasonable Assurance. There are some residual areas for further attention however there is positive assurance and TIAA do not feel this will change before the end of the year is confirmed. A Counter Fraud assessment against on the Government Functional Standards previously reported as Amber is now being reported as Green.
- The Board Assurance Framework (BAF) is a regular item
- Following a recent tender KPMG have been re-appointed and RSM have been appointed as internal auditors.

It was also reported that TIAA will continue with two important cases until these are concluded.

**The Board noted the report, and in particular in terms of assurance:**

- The results of the interim external audit
- Approval of the external audit plan and re-appointment of KPMG
- The expected internal audit annual opinion
- The change in internal auditors from TIAA to RSM
- The BAF, and the fact that more work is required on equality and diversity

- and received the minutes from the January 2022 meeting

**22/55 Estates Modernisation Committee chair's Report**

The Board received a verbal update from JuA on the meetings held in April and May and the following points were highlighted:

- Overall, the delivery status remains at Amber. The key challenges are in terms of people readiness.
- The construction work remains on track and is reported as Green.
- The committee has received assurance from the contract administrator to confirm that work is at the advanced stage of fix and snagging. The independent certifier has confirmed that low levels of issues are being reported.
- The committee has received two assurance reports and the recommendations are to strengthen clinical engagement, digital road map and programme reporting. The recommendations are already being implemented.
- The committee received assurance on the Communication Plan.
- Further work is required to progress Tolworth and Barnes sites and assurance has been given by ELT that this is remains a priority.
- The committee received assurance that some of the outstanding space and meeting space queries have been resolved. The Deaf Adult space needs are being resolved as previously reported.
- The artwork from Hospital Rooms is going well and this will be delivering 20 pieces of art and also art workshops for therapy.

SS reflected that the artists have co-produced work and this has been greatly received by the patients and services. Each piece of artwork is designed through 80 sessions of art therapy.

It was noted that when the Board next meets the Integrated Programme will be at Week 1 and the EMP Team will have already moved location.

**The Board noted the update.**

**22/56 Corporate Objectives**

**(a) Corporate Objectives 2021/22**

AS updated the Board on the following points:

- The reports have been to committees except WODC, there will be a separate discussion with SA and KR.
- In year the workforce objective was paused and replaced with the HR Recovery Plan. The apprenticeship and leadership programmes have continued in the year despite the objective changing.
- In terms of delivery the objectives on Finances and Partnership have been met. In Quality and Operations, some challenges have been experienced, however in physical health and metabolic assessment they overachieved the target. There has been good progress in reducing violence and aggression. The Quality Strategy/Plan and Fundamentals of Care have also been revised. Positive work has progressed for equality and diversity. Further work is required around WDES.

The Board noted the updated final year end delivery position for the 2021/22 corporate objectives.



DRAFT

**(b) 2022/23 Corporate Objectives**

- All committees have received the corporate objectives except WODC. The objectives have been grouped into six areas; quality, integrated programme, equality and diversity, people (to replace workforce), partnerships, financial sustainability.
- The objectives have been discussed through board seminars and ELT and it has been recognised that some objectives will require pausing for 3-4 months to create some space.
- Milestones and base lines have been developed to plan the RAG ratings to benchmark improvements.

VF asked the Executive Directors to be dissuaded from quick wins as these can be anti strategic.

**The Board approved the 2022/23 Corporate Objectives.**

**22/57 Questions from the members of the public and staff**

Martin Haddon, Healthwatch Wandsworth, asked what arrangements is the Trust making to make available the content of this Quality Plan and the Fundamental Standards of Care for public information and scrutiny in due course?

SS confirmed that this is currently available in InSite and she will liaise with Communications colleagues to promote it more widely. It was agreed that the Quality Plan is to be forwarded separately to Martin at Healthwatch Wandsworth by SS. **SS**

Martin asked how service users are involved in the development of the Standards. SS confirmed the Quality Plan and Fundamental Standards of Care are in line with the overarching Quality Strategy that was launched some time ago which was co-produced with internal and external stakeholders. The group involved service users and people with lived experience and their feedback was included. The Fundamental Standards of Care has been co-produced and carer/service users were involved in their creation.

Suresh Desai, Staff side, raised points about the need for sustained improvement in the HR service; the potential for an in house Freedom to Speak Up Guardian; the consultation on the move to Tolworth and the implications for HCAS

**22/58 Meeting review**

The meeting was reviewed and the change in time was well received as is a better time for public access. It was felt that the Board Visits enabled better discussions at the meeting. The Board welcomed a patient story that included challenging elements.

**22/59 Next meeting**

14th July 2022 at 13.30 at Springfield Hospital.

**ACTION TRACKER – for July 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. |
| 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** | | |
| 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** | | |
| | | | **NOT DUE** | | | |
| | | | | | | |
| | | | **COMPLETED AT LAST MEETING** | | | |
| 11/11/2021 | 21/135 | **Corporate objectives** | RAG ratings – to consider whether greater consistency is possible and to address the issue of rating of actions that have been delivered as specified but which have failed to deliver the change intended | **AS** | **March FPC May 2022 Board** | The RAG ratings have been amended for the 2022/23 proposal. This is to be closed |
| 11/11/2021 | 21/129 | **Quality and Performance report** | Priority metrics to be reviewed and reduced. To be reported as part of annual Q&P report review | **PM** | **April QSAC May 2022 Board** | This has been discussed at the May QSAC and also discussed at the May Board. The revised |

**Update as at: 14/07/2022**

**1**

**ACTION TRACKER – for July 2022 Board**

**BOARD OF DIRECTORS (Part A)**

**2.5**

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | metrics will be live next month |

**Update as at: 14/07/2022**

**2**

**3.1**

**Meeting:** Board of Directors

**Date of meeting:** 14th July 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. Chair's activity

A summary of my recent appointments is set out below

| **Internal** | **External** |
|---|---|
| NEDs Pre-Board discussion | NHS Providers Board |
| Quality and Safety Assurance Committee | Mental Health Chairs weekly meeting |
| Estates Modernisation Committee | CSG Chairs' monthly meeting |
| Trust Board and Ward/team Visits | SWL MH Strategy meeting with chair of ICS |
| Board Seminar | |
| Special Board to sign the Annual Accounts and Annual Report | |
| NEDs Catch Up | |
| Appointments Panel – Consultant Psychiatrist (various services) | |
| Audit Committee | |
| CEO Q&A | |
| Equality and Diversity Committee | |
| Trust Street Party | |

## 3. Board business

The part B meeting of the May Board discussed a range of issues including the Board Assurance Framework, 2022/23 financial planning and committee chairs' reports.

The Board had a seminar meeting in June where we discussed the People Plan. In addition, there was a comprehensive programme of visits to services by directors on the day of the seminar.

**3.1**

The Board met for a special meeting on 13th June 2022 to agree the latest version of the Annual Accounts, Annual Report and Quality Account. Following further updates the Annual Accounts and Annual Report were approved by myself and the Chief Executive these were submitted to NHS England/Improvement on Friday 24th June 2022.

## 4. South London Listens – key south west London highlights

### Be Well hubs

Be Well hubs are a key initiative of the South London Listens programme. Through engagement with our communities as part of the South London Listens action plan, we heard that 'Loneliness, social isolation and digital inclusion', as well as 'access to services' was of paramount importance. The first Hub in South West London opened in Kingston in June, alongside Hubs in Southwark, Croydon and Lambeth. The Hubs are being opened in community organisations where members of the community have had mental health training to become Be Well Champions. Across South London 40 hubs have been identified and 80 Champions have been trained. Prospective Be Well Hubs in Richmond and Wandsworth held their first listening circles in June, with Hubs also identified for Merton. More training with Champions based in Merton is also being planned over the next few months.

## 5. CAMHS virtual waiting room

The Trust has delivered initial designs for webpages that develop a CAMHS virtual waiting room, which will make wait times available. These new pages have been received and reviewed by community representatives with positive feedback.

## 6. Trust London Living Wage accreditation

Following the announcement in January that members of staff employed by the Trust's two main contractors will receive the London Living Wage (LLW), the Trust is currently agreeing an LLW uplift to the hourly rate paid to service user and carer involvement members. Once this has been agreed, the Trust will be in position to formally celebrate our London Living Wage accreditation.

## 7. South London Listens Survey

South London Listens has launched a second community survey to find out how the mental health and wellbeing of south Londoners has changed over the last year. The survey closes later in July and can be found here.

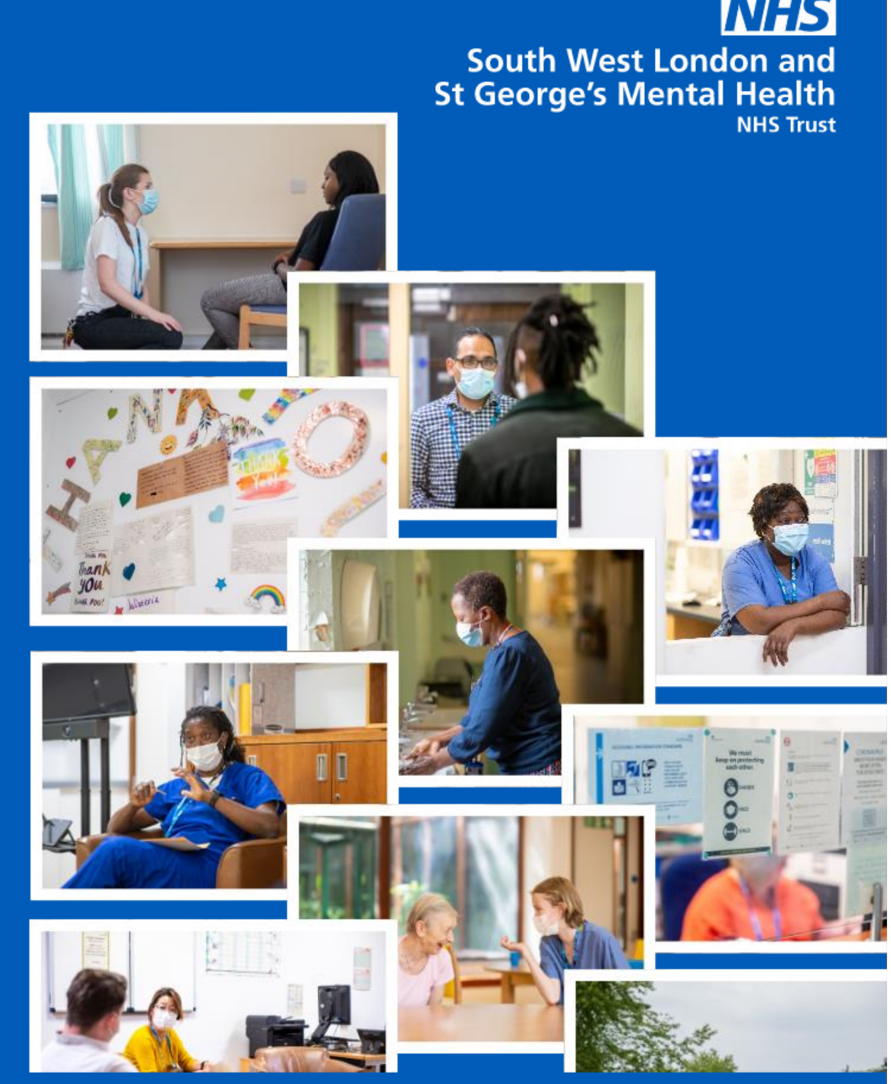
### RECOMMENDATION

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

## July 2022



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•Directorate report

# Thank you

- We would like to start by saying thank you to our service users, their carers and our local community for their ongoing support
- We know that our colleagues are still going the extra mile. Expecially given the pressures we are seeing, particularly in CAMHS and working age adult services. Colleagues are supporting each other, stepping forwards to fill gaps, working to keep patients safe and improving the experience for patients, carers and each other.
- Thank you for providing a safe and quality service for our service users, their carers and families.

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

# Our Trust

- Every two weeks I have a Q&A and every week I write to our staff with key messages:
  - Chief Executive Update - Friday 24 June
  - Chief Executive Update: Friday 17 June
  - Chief Executive Update - Friday 10 June
  - Cheif Executive Update – Friday 3 June
  - Chief Executive update: 27 May 2022
  - Chief Executive Update - Friday 20 May
  - Chief Executive Update - Friday 13 May
  - Chief Executive Update - Friday 6 May
- In July we will see our street parties return at Tolworth and Springfield – in celebration of the completion of Trinity and Shaftesbury

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# Good news:
# Specialist Eating Disorders

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

- The Trust received positive news from the CQC that, following much hard work and commitment, our Eating Disorders service has now been rated 'Good' in each domain, following an inspection of Avalon and Wisteria wards in March 2022.
- The inspection examined the 'must do' and 'should do' actions received in 2019 and 2020.
- The CQC fed back that it had seen considerable improvements, particularly in culture, on both Avalon and Wisteria and both are on an upward trajectory.

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# Activity and system pressure in line with national picture

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

- We continue to see significant increase in demand – 20% increase in both adults and CAMHS activity
- Our clinicians are also reporting increased acuity – particularly prevalent in urgent and acute service
- This is resulting in bed pressures and waits – as a comparator, the average number waiting for a bed in May 2020 was 7, the average number waiting in May 2022 was 15
- Compounding this we are experiencing challenges with recruitment and retention. Our overall vacancy rate is 19%. In community services it is 21% - although this includes new posts as part of community transformation and as part of the pilot underway in Sutton
- These challenges are impacting on the experience of both our patients and our colleagues

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# System changes

- On 1 July 2022, the South West London Integrated Care System launched, taking on statutory health and care responsibilities
- Our ICS has six 'places' – Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.
- From a Governance point of view, the ICS is made up of two parts:
  - **Integrated Care Board:** decide how the NHS budget for our area is spent and will develop a plan to improve people's health, deliver higher quality care, and better value for money
  - **Integrated Care Partnership:** will bring the NHS together with other key partners to develop a strategy to enable the Integrated Care System to improve health and wellbeing in its area

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# ICS leadership

**Sarah Blow**

Chief Executive Designate NHS South West London ICB

**Millie Banerjee CBE**

Chair Designate NHS South West London ICB

**Dick Sorabji**

NED

**Mercy Jeyasingham MBE**

NED

**Ruth Bailey**

NED

**Karen Broughton**

Deputy Chief Executive Officer and Director of People and Transformation

**Jonathan Bates**

Chief Operating Officer

**Dr John Byrne**

Executive Medical Director

**Dr Gloria Rowland**

Chief Nursing and Allied Professional Officer and Director for Patient Outcomes

**Helen Jameson**

Chief Finance Officer

**Charlotte Gawne**

Executive Director of Communications and Strategic Stakeholder Relations

•Directorate report

# System leadership

- We are the ICS – the Trust holds leadership roles at Place and across the ICS
- From 1 July, Vanessa Ford will sit on the Integrated Care Board as the representative for Mental Health
- Ann Beasley will be part of the Integrated Care Partnership
- Billy is Vice Chair of the ICS Clinical Summit
- **Merton:** Vanessa Ford – Merton place conveynor
- **Kingston and Richmond:** Jen Allen is Exec Lead and mental health place lead
- **Sutton:** Amy Scammell is Exec Lead and mental health place lead
- **Wandsworth:** Philip Murray is Exec Lead and mental health place lead

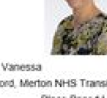
**Merton Transition Team Update**

20 May 2022

**Welcome**

This newsletter updates you on our progress in Merton towards becoming part of the South West London Integrated Care System (ICS). We also share examples of how working together is making a difference to people's lives in Merton.

The Health and Care Bill has been given Royal Assent which means we are on track for the ICS to take on its statutory responsibilities from 1 July. You can read highlights from our first Shadow Place Based Committee in Merton below.



Vanessa Ford, Merton NHS Transition Place Based Lead
Chief Executive, South West London & St George's Mental Health NHS Trust

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# National, system and local financial challenge

NHS
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- **National position**
  - The NHS received one off funding to support with Covid related costs, this extra funding is now stopping as the NHS resets its finances
  - There remains commitment to support mental health transformation funding
- **SWL position**
  - The ICS is facing a challenging 24 months with a real terms decrease in resource in excess of 5%, the highest challenge in run rate reduction in London.
  - As a system we have an aggregate efficiency target of 7.3% - the range being c4% to c10%
  - 2022/23 starts a two year plan to reach recurrent balance. In-year breakeven and an exit run rate balance are the aspirations.
- **SWLSTG position**
  - We have submitted a balanced annual plan to NHSE/I which includes an efficiency assumption of c5.5%
  - The challenge is of a greater magnitude than the Trust has faced for some time. It will be imperative to address the challenge with ongoing diligence and intelligence at all levels, especially quality governance and financial governance

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# Cost of living

- The increasing cost of living is impacting on our patients, their carers and our teams
- Through South London Listens we are capturing how our communities' mental health and wellbeing has changed over the last year – this will influence and shape our campaign across South London
- We are also putting together resources for our teams to support their patients and each other
- We are working through the ICS and at Place to better understand and communicate the support on offer from NHS, local councils and the voluntary sector, to better support patients, carers and our teams
- We are encouraging our teams to get actively involved in sessions being run by our local councils to help shape their offers of support
- We are working with Care First (our Employee Assistance Programme) to offer support to our teams
- We are ensuring that at a national and regional level the impact of the cost of living is clearly articulated and understood.

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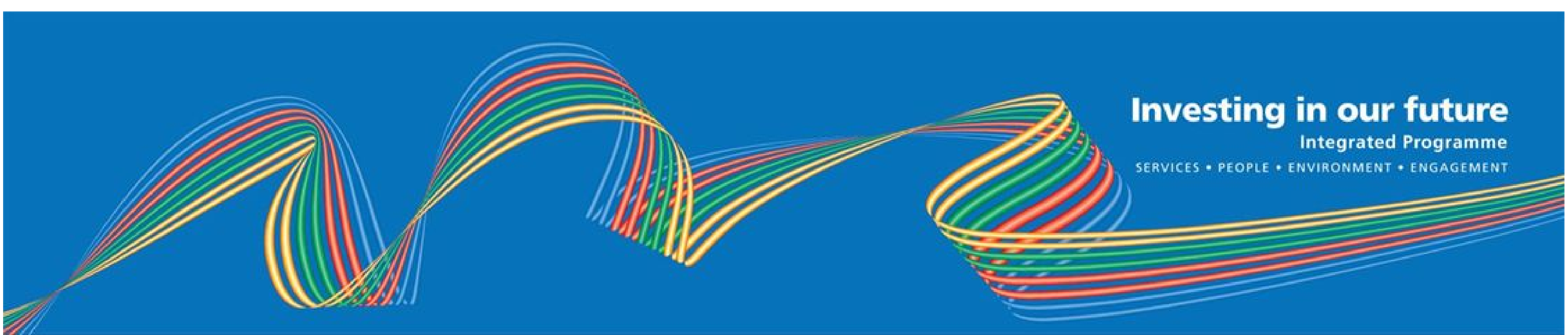
# Integrated programme

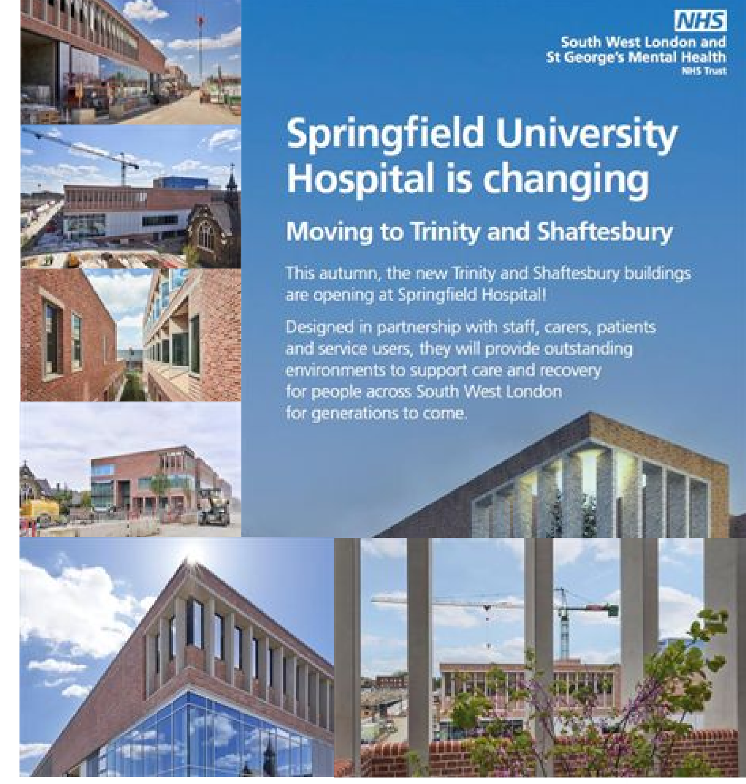
- Our integrated programme aims to transform the way people receive mental health care over the next four years
- We will be celebrating the progress so far at our Summer Street Parties with staff, our communities and stakeholders in early July. This event will be held at both Springfield (6 July) and Tolworth (13 July)
- Our APM on 21 July will focus on the role of our Integrated Programme in reducing stigma. Dr Jacqui Dyer MBE, President of the Mental Health Foundation will be offering a keynote speech



# Integrated programme - update

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

- **Springfield:** Work continues to prepare our teams for the moves to the new Shaftesbury and Trinity buildings in September and October 2022. We have agreed 11 of the 20 coproduced artworks for the new facilities.
- **Tolworth:** Neighbours and stakeholders joined us for a series of engagement events to find out more about the revised plans and designs for the redevelopment of Tolworth Hospital.
- **Barnes Hospital:** Beginning February 2023, this redevelopment will include a healthcare facility, a school which will specialise in social and emotion mental health and residential housing. Services will be temporarily located in Teddington while the work takes place.
- **Community adult mental health transformation** following the launch of the Sutton pilot in February, the development of community transformation in Kingston and Richmond is underway. Workshops to codesign the access and triage service have started and we have begun recruiting to over 30 roles within this programme.

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# Horizon Scanning

- The Government announced the Draft Mental Health Act Reform Bill during the Queen's Speech. The Government aims to tackle racial disparities with mental health reforms | The Independent
- Health and Social Care Secretary sets out vision for year ahead - GOV.UK (www.gov.uk) – during this speech, the Secretary of State praised the South London Partnership
- Health and Social Care Secretary of State made a speech on suicide prevention - GOV.UK (www.gov.uk)
- Data saves lives: reshaping health and social care with data - GOV.UK (www.gov.uk)
- New Government research identifies clear links between loneliness and mental health distress - GOV.UK (www.gov.uk)
- Health Secretary announces 10-year plan for dementia - GOV.UK (www.gov.uk)
- The Department of Health and Social Care mandate to Health Education England: April 2022 to March 2023 - GOV.UK (www.gov.uk)
- The Messenger Review of NHS leadership | NHS Confederation
- What are health inequalities? | The King's Fund (kingsfund.org.uk)
- Adding value: a strategic vision for volunteering in NHS trusts | The King's Fund (kingsfund.org.uk)

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# Key questions to have in mind

- In light of the challenges to cost of living, what more can we do as a Board to support our patients and staff? How can we make sure we have this in mind as we make and take our decisions?
- As we move into the next phase of the integrated programme, see the historic moves into our new facilities and support the changes through the ICS system, how do we effectively use our Board time, leadership and capacity to support patients and staff to remain focused?
- In light of the wider system pressure and increasing mental health demand, what more could we/should we be doing at system and place level to help people understand the challenges?
- How do we ensure the most effective treatment, for the most people - or people most in need - with the current resources we have, while giving people a doable job?

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# SWLStG at Pride

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| | |
|---|---|
| **Meeting** | Board of Directors |
| **Date of meeting:** | 14th July 2022 |
| **Report title:** | **Quality and Safety Assurance Committee Chair's Report** |
| **Author:** | Deborah Bowman, Non-Executive Director, Committee Chair |
| **Executive sponsor:** | N/A |
| **Purpose:** | For Information |

**Executive Summary**

1. **Introduction**

This report covers the June meeting of QSAC. At Board, I will provide verbal report on the July QSAC which took place on Monday 4th July, with a written report to follow at our next Board meeting.

QSAC met on 6th June 2022. The reports received and items discussed are described in the minutes. This report highlights key areas focusing on assurance, discussion and scrutiny, namely:

**1.1. Learning from Root Cause Analyses**

Further to a request made by QSAC, we received a report on the recurring themes from Root Cause Analysis investigations. Typical themes are care planning, physical health and the link to risk assessments and zoning. The report described a good balance between just culture and systemic accountability. QSAC was alert to the ongoing challenges with HR provision and clinical quality. As such, the committee was glad to note that few of RCAs reviewed were due to HR failures. The Fundamental Standards of Care will support our understanding and assurance of quality. The Learning Bulletins support the wider communication of points arising from an investigation.

QSAC welcomed the holistic overview of learning from RCAs, the attention to risk and the triangulation of recurrent themes with questions of quality that arise from other data reviewed by the committee.

**1.2. Quality Improvement and Innovation Update**

QSAC welcomed the progress achieved by QII work across the Trust, noting the development of the approach and its significance in enhancing quality in areas of focus. For example, the work on embedding The Framework for Developing for Culture of Openness and Continuous

Improvement following previous discussion about 'closed cultures', and the focus on care planning with in-patient units which has been a priority area for the Trust.

### 1.3. Patient Experience Annual Report

QSAC welcomed the report and acknowledged the considerable work by the team and those service-users, patients and carers who are vital to the Trust's understanding of, and improvement in, the patient experience. The Involvement Team is now working at pre-Covid levels, with activity having increased by 21%. Participation by those with Lived Experience has increased by 10% (271 people) with all participants receiving training specific to their role. The team aims to provide more substantive posts for those who bring lived experience to the Trust. QSAC was interested to understand the diversity of our patient and service-user community and to receive any insights into how SWLSTG benchmarks against other organisations in our patient experience work. Those data were not available in the report, but QSAC heard verbally that, compared with our SLP partners, SWLSTG has a more diverse network of patients, service-users, carers and those with lived experience. The presenting colleague noted that she considers the SWLSTG to be well-developed, for example, in offering approximately 1500 paid opportunities each year.

### 1.4. Quality & Performance Report

QSAC heard about the refinement of the KPIs in the report further to discussions about priorities. The way in which information is presented and the visual representation of themes and domains were welcomed by the Committee, noting the levels of demand, pressure and complexity that particularly manifest in relation to access and flow. QSAC noted that that there continue to be performance challenges in relation to almost most elements within the Q&P framework and the implications of that in terms of assurance and the likelihood of improvement were discussed. QSAC was advised that the primary focus and priority is patient safety. QSAC noted the importance of the Fundamentals Standards of Care and the need to "get things right, first time" in driving up performance. QSAC also noted the significant difficulties in terms of staffing, from recruitment to retention, which underpins the provision of quality clinical care and performance. QSAC will continue to consider the Q&P report and the context in which the Trust is working closely at each meeting.

### 1.5. Quality Account

The annual Quality Account was received in draft form, subject to final editorial amendments, having been circulated to the CCQ, HealthWatch, service users and carers and other stakeholders for comment. The report was considered by the Audit Committee subsequently ahead of the deadline for completion (30th June 2022).

### 1.6. Meeting Reflection

As Board knows, QSAC has been piloting a new way of working with the aim of creating space for focused and deeper consideration of key priorities whilst retaining effective oversight of the breadth of matters within its purview. Members were invited to share their feedback on the pilot via the meeting reflection and subsequently in writing to the Chair. Members value the starred items approach which was considered to facilitate thought, rigour, scrutiny, curiosity and analysis. Members consider that they are increasingly able to integrate and triangulate information, using discussion to analyse how different reports and sources of data inform our understanding and assurance of quality, safety and the patient experience at SWLSTG.

**RECOMMENDATIONS**

The Board is asked to

1) Note and receive this report
2) Note and receive the appended approved QSAC minutes

**Quality and Safety Assurance Committee (PART A)**

Minutes of the MS Teams meeting held **on Monday 10$^{th}$ January, 13:30-16:30**

**Attendance list**

**Present:**

| | |
|---|---|
| Prof Deborah Bowman (DBo) | Non-Executive Director – Chair |
| Doreen McCollin (DM) | Non-Executive Director |
| Ann Beasley (AB) | Trust Chair |
| Vanessa Ford (VF) | Chief Executive |
| Dr Billy Boland (BB) | Medical Director (until 4 p.m) |
| Sharon Spain (SS) | Director of Nursing & Quality |
| Jennifer Allan (JeA) | Chief Operating Officer |
| Richard Flatman RF) | Non-Executive Director – Audit Committee Chair |
| David Lee (DL) | Director of Corporate Governance |

**Attendees:**

| | |
|---|---|
| David Hobbs (DH) | Service User, Carer, Friends and Family Representative |
| Valerie Chin-You (VC-Y) | Lead Quality Manager – NHS South West London CCG |
| Farai Addy (FA) | Member of the Diversity in Decision Making Programme |
| Carole Tyrrell | Committee Governance Officer |
| Carol Anne Brennan (CAB) | Service User, Carer, Friends and Family Representative |
| Ryan Taylor | Associate Director of Clinical Governance & Risk |
| Emma Clark (EC) | Service Manager (*Attended for item 6.3)* |

**Apologies:**

| | |
|---|---|
| Terrance Nichols (TN) | Member of the Diversity in Decision Making Programme |

| Item | | Action |
|---|---|---|
| **A22/01** | ***Apologies** *(Agenda item 1.1)*<br>Apologies were noted. | |
| **A22/02** | ***Declarations of Interest** *(Agenda item 1.2)*<br>DBo informed members that she has been appointed Chair of Hospital Rooms. | |
| **A22/03** | ***Chair's Action** *(Agenda item 1.3)*<br>No Chair's action was reported. | |
| **A22/04** | ***Minutes of the previous Part A meeting** *(Agenda item 1.4)*<br>The minutes of the previous Part A meeting held on the 6th December 2021 were approved by the members subject to the following amendments:<br>• On page 3, the risk register report action, this item is to be allocated to either DL or RT.<br>• On page 9, under agenda item 6.3, it stated that: ' ...the additional beds at the cost of £515 which the Trust would say is probably unsafe.' SS clarified that this should have been £515k.<br><br>Once the corrections had been made the minutes were approved as a true and accurate record. | |
| **A22/05** | ***Action Tracker** *(Agenda item 1.5)*<br>The action tracker was reviewed and noted: | |

**A21/111 -** This would be discussed at Part B 10/01/2022.
**A21/117 2021/22 Mortality Report inc Suicide Prevention Strategy.** Inpatient deaths had been reviewed and a short report had gone to ELT. Action closed.
**A21/133 Risk Register.** There was a verbal update. A review had been undertaken and the proposed risk had reduced significantly. Action closed.
**A21/91 Quality & Performance Report.** This would be discussed under Agenda item 3.1.
**A21/133 Risk Register Report**. RT had circulated the cover sheet and report. Action closed.

**A22/06** **Matters Arising** *(Agenda item 1.6)*
No new matters arising were raised.

**A22/07** ***Risk Register Report *(Agenda item 2.1)***
The Committee received the Risk Register. The following highlights were presented by RT:

- QGG had met prior to Christmas and had reviewed the risk register. There had not been a great deal of activity. The deep dives had been deferred until January 2022 and it would be the medical risk register which was led by BB. There would be an update on that review in January.
- 2 new executive risks had been added:
  - Operational aspects on the acute pathway risk. This was on the BAF and was a significant red on the risk register.
  - The other risk was on face mask compliance. RT said that there had been areas where compliance was not as it should be. But, due to the Omicron virus, it may have improved. However, it was felt that it was right to have it on the Risk Register to ensure that checks can be made.

AB asked when the risk register would incorporate the new HR risks as the impact of the Trust's HR problems on the quality of service that was able to be delivered should not be underestimated. RT replied that the wording would be reviewed. DL added that, that at the Workforce and OD Committee meeting prior to Christmas, they had received a comprehensive and updated risk register. It had 54 entries, most of which had been new within the last 2 months. It would be a task to create a more digestible version for the executive risk register and the Board Assurance Framework. AB added that she thought that these risks needed to framed, not from the point of view of the HR function, but in relation to the impact of the HR function on clinical services. She suggested that it be on the risk register and considered through the lens of quality and safety.

AB also asked for clarification on the student nurse placement risks.

RF asked about the summary of executive risks and reminded RT that there were 245 risks on the register in total. The report had said that they were a summary of the risks that had been on the executive risk register for over 12 months. RT replied that it was a summary of the executive risks of which a subset had been on it for over 12 months. RF commented that none of them had moved which demonstrated that a review was important. He added that a review of the last 12 months was to give more assurance as to whether it was due to the inherent nature of the risk itself or whether there had been issues with the mitigation or controls.

The audit of risks had commenced and its findings would be brought back to QSAC.

RT referred the Committee to the section on general risks. There had been several reductions which had been largely due to the removal of some generic risk in terms of FFP.

The Assurance Review on Emergency planning was going ahead.

QGG had focussed on the new risks and had commented on the clarity of the student nurse placement risks.

QGG had also asked about the CAMHS on call rota and some of the gaps. The situation stabilising; the service was keen that it be reflected on their CAMHS register which was why it had been added. RT was due to meet with the service line to see if it had stabilised sufficiently.

RF commented that some of the actions were overdue and he wanted more of a sense of what the overdue actions were. He suggested a brief summary of what the Executive thought were the key overdue actions were and he also felt that it would be helpful to have them on the cover sheet. RT agreed and said that he would consider it for the next Risk Register report.

DBo agreed with AB about the HR risk as it was a high-level risk that demonstrated a failure to reflect and recognise the impact of HR (throughout the whole life cycle from recruitment to retention) on quality and safety. She had mentioned it in the December Chair's Report and asked RT if it could come to QSAC in the next iteration of the Risk Register. RT said he would work with DL on it. DBo said that he might reference QSAC's request, if it would be helpful. She added that overdue actions were not all equal in terms of importance and impact and QSAC wanted a sense of that.

**A22/08** ***Quality and Performance Report** *(Agenda item 3.1.)*

The committee received the Quality & Performance Report. JeA began by reminding everyone of the Level 4 incident that had been declared and the impact of the Omicron variant.

- The clinical frontline had done a very good job in maintaining services during December and the festive period.
- Primary impact had been on staff who needed to self-isolate and the difficulty of maintaining business continuity. Staff had been very flexible and had responded well.
- There had been an increasing number of outbreaks amongst staff and patients which were being well managed. No patients had been very unwell as a result. It was a similar scenario with the Omicron virus which was very transmissible but it had not had as severe an impact as with previous variants. The staffing position had now stabilised.
- Acute Care business continuity plans involving acute and emergency care. QSAC had previously discussed the actions that needed to be taken to support the acute pathway and that Lotus and Coral needed to work together to support their respective teams. Additional acute bed capacity had been commissioned to support the pathway as there had been an increase in acuity and demand. The actions had taken effect.
- The private block purchased beds had enabled the super surge beds to be closed in response to the staffing and the quality constraints seen at Queen Mary's Hospital. Reducing the additional numbers of patients on QMH's wards had been appreciated, but it was not intended to be a regular occurrence. However, the situation there was now more stable.

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- Morale and workforce in acute and urgent care was being worked upon to be able to move forward. The transformation of acute services with community-based transformation was also important.
- JeA also discussed the challenges with the HR recovery plan as she and SS were closely engaged. It was still a key risk and Trust was still working on improving recruitment and retention, learning from staff feedback and experience.
- In the February report, there would be a focus on HR data as Trust moved into the next phase of the HR recovery.
- JeA also outlined plans for a team leader development programme. BB said that quality improvement skills would be considered as part of the core leadership and management training. Care planning and risk assessment would be embedded into a quality improvement approach.
- With the long waiting times for CAMHS adult ADHD, a waiting list initiative was about to start which was similar to the CAMHS one which had been successful.

DH was concerned that in IAPT the 3rd party providers are not properly recording data and then going through the triage/discharge processes. JeA said that she would look further into this for him but acknowledged that she knew that there had been some challenges with some 3rd party contractor providers.

AB said that she had looked at the Covid-19 priority metrics and that there were very few where there was assurance that the target was going to be met. They were a subset of the metrics that were prioritised. She wondered if it was now time to revisit that prioritisation because the danger was that people might make their own choices. JeA confirmed that the priority sub-sets will be re-considered as these had been specifically set for acute and urgent care and that they would be reviewed prior to the new financial year. AB replied that consideration should be given to setting priorities that can be achieved. She was concerned that as an Assurance Committee, QSAC receives at each meeting a set of metrics on which there is no assurance. She suggested that it was we should be able to say which metrics are our priorities and obtain assurance.

RF asked for reassurance on how the Committee could be assured whereby targets were exceeded and JeA said that it would be reviewed in the next 8 weeks

**A22/09 Mental Health Units (Use of Force) Act 2018**

The Committee received and noted this report.

**A22/10 *Serious Incident and Incident Reporting including inquests and claims six-month report (***Agenda item (4.1)*

RT began by informing the Committee that this had been presented to QGG the previous week. QGG had requested some changes.

- In general, there had been a decrease in the number of incidents that had been reported during the period.
- However, there had been an increase in AWOL/absconding incidents which would be in the Quality Matters report. QGG had asked, and the head of service had undertaken a rapid review of the number of AWOL/absconding incidents due to a serious reported incident involving a patient. It would be discussed and was on the agenda at a security meeting on 17/01/2022 where it could be focussed on.
- There had been a slight decrease in safeguarding incidents after an increase in the preceding months and he mentioned some of the possible reasons for this fluctuation. The national reporting learning system data was now being populated annually instead of bi-annually a factor. RT thought that it was positive that most of the incidents were either no harm or low harm.

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- There had been an increase in the number of SIs over the period and these totalled 28. The vast majority were attempted suicide and he mentioned the tragic death on Rose Ward. The rest had been community-based suicides. Of these deaths, the majority had been RCAs or unexpected deaths and had mainly occurred within the community. However, it is to be noted that some incidents might change to be recorded as suspected suicide. If physical health was a cause, then it could become a suspected suicide as in the investigation progressed.
- The Committee would see some of the learning and what had been identified through the investigations in the Mortality Report.

BB commented on support being provided for staff, especially, junior doctors, with the aftermath of incidents.

AB commented on root cause analyses are taking a long time and need to be undertaken in a timely manner with any learning from them was very important. DBo noted that SS and RT would be bringing a paper on RCAs to QSAC in March. She observed that risk management and care planning were themes that recurred and were of ongoing interest to QSAC.

CAB asked if patients had been asked about these events on wards. She suggested that the comments of service users are insufficiently included and sometimes perhaps their comments did not seem to be believed. She felt that the purpose was to ensure the safety of patients on the wards. SS agreed with CAB and added that it caused great distress to patients when there were incidents on the wards. However, she also felt that the Trust had improved on debriefs and listening to the patients as a continuous process. Patients feedback informed the process. SS felt that patients not being believed was challenging, but important; obtaining evidence is not always easy.

**A22/11** ***Medicines Optimisation** *(Agenda item 4.2)*

The report was received and the update from MS concentrated on 4 areas:

- Electronic prescribing and medicines administration within the Trust. The department was required to upgrade software because the current version would be unsupported by the end of 2022. A project had been initiated but there had already been delays from the providers in making a test version available. At present, April was when testing would begin testing with implementation by August. But if there were delays, it would overlap with moving into the new building. This could be problematic if trying to implement an upgraded electronic system for prescribing and medicines administration while department also moving premises. It was being monitored.
- Mind Meds app. She reminded the Committee of the lithium app and there had been an aspiration to be able to upgrade it to an app where more medicines could be recorded. It could also be more user friendly to enable people to record side effects. The app had now been developed and a Hazard workshop needed to be done. Approvals also needed to be sought from the Trust and then the app could go live. The team had worked with service users and team hope that it would be useful for them. MS explained the app to CAB.
- There had been changes in relation to medicines in SW London. There was now a Joint Formulary for SW London and the Trust no longer had its own. The department was expected to prescribe within the SW London Formulary. She assured the Committee that the department had representation on the Joint Formulary Committee. There was also an integrated Medicines Optimisation Committee with departmental representation on it also. When the Joint Formulary Committee was first set up, there was no one from mental health services was

on it but MS had made sure that was representation on it. If people with mental health conditions did not have their medicines on the Formulary, it could affect their ongoing care.

- Valproate had been on the risk register for some time. This had been a failure to implement the pregnancy prevention programme for women who at risk of becoming potentially pregnant if they were on Valproate. This had just been re audited and it seemed that there was still no assurance that the process was being followed of completing an annual risk assessment for people that were on Valproate and were of childbearing age. Focused work needed to be done with the prescribers in which it was not being done to understand why it was not being done as there was processes and procedures already in place on what to do.

DBo thanked MS for the report and added that QSAC needed to see progress on the Valproate issue which was longstanding.

AB highlighted 2 items from the report which were unlawful treatment under the Mental Health Act and expired medicines. The latter had been a finding by the CQC. MS said that expired medicines had been found on wards and so prescribing staff undertook regular checks. She would also expect nursing staff to do checks as well. It was constantly being audited. SS reminded everyone that medicines management was also part of the Quality Plan.

MS clarified that unlawful treatment was where medicines were prescribed that were not covered under the relevant provision of the Mental Health Act. This had been picked up on through the acute and urgent care urgent response work. A bulletin had been sent to all prescribers to ask them to make sure when they are prescribing the medicines that are lawful. She clarified the changes to the EPMA process as a result. However, she could not give full assurance on it until staff had seen the actual product and ascertained whether it would work or not. DBo thanked her and said that she would prefer people to be open and say that they did not have full assurance as it allowed QSAC to focus their time and attention on those as priorities and to continue to review these areas of practice.

**A22/12** ***Emergency Preparedness, Resilience and Response assurance Review 2021/22** *(Agenda item 4.3)*

RT began by reporting that this was the first time that the team had been fully complaint with no amber areas. However there were a couple of items that had been identified and they were in the report.

- The team had wanted to make improvements to the business continuity plans which was a key objective.
- RF was the NED Champion and he asked if he could be more involved in future. QSAC supported that suggestion.

DBo thanked RT for a positive report and that QSAC would be following up on the actions.

**A22/13** ***Mortality and Suicide Prevention Q2** *(Agenda item 4.4)*

BB reminded everyone that the report had previously come to QSAC and as result it had been reworked. He clarified the changes and restructure of the paper. The learning points are clearer in the revised version. DBo agreed and there was a discussion about the changes that had been suggested at the earlier meeting.

VF thanked the team for the revised version and feels that the cover sheet is strengthened. In addition VF asked if the Committee were satisfied as, across the

year, there had been several inpatient deaths from natural causes and attempted suicide and the Committee were taking the report as an assurance position around Trust's mortality. She wanted to ensure that everyone was comfortable with the Trust's position as this report said that there was not anything out of the ordinary to be concerned about and that there were good assurance processes in place.

RT added that work was currently being commissioned on several thematic reviews on a broader range of deaths, such as all the inpatient deaths and inpatient suicides. It was hoped that it would give QSAC the same assurance but over a longer period and focus on Q2.

**A22/14** **Involvement – Patient and Carer Report six-month report (***Agenda item 5.1)*
The Committee received and noted this report.

**A22/15** ***Community patient survey results** (*Agenda item 5.2*)
DBo informed everyone that QSAC was receiving the results earlier than usual, but were grateful for early sight of them.

SS wanted QSAC to have sight on the CQC mental health community survey initial findings as these were due to be published. In areas where it was felt that there had been some deterioration, an action plan would be developed and this would be brought back through ELT mid-February with the full report and the actions. The plan would come to QSAC in March. Although SS had referred to areas of deterioration, although there had been some areas of improvements. It should be noted that IAPT services had not been included in the patient survey.

The areas of positive improvements include crisis care, privacy and dignity and involvement in treatment, including medication, and knowing who to contact within services.

Areas for development include meeting and supporting needs, help/advice on finance/benefits and being involved in services provided to those close to you.

DH reflected on the scores and suggested that the Advocacy Service does well. He noted that the recovery and Support Teams give good employment support, but was not clear why this seemed not to be reflected in the report.

VC-Y suggested that the metrics that more focus on those metrics that need to be improved should be considered.

**A22/16** ***Quality Matters (***Agenda item 6.1***)**
The report received was for November.

- There had been 11 serious incidents meeting the national SI criteria that were reported to commissioners (via STEIS), including 3 Unexpected Deaths and 4 Suspected Suicides.
- Bed Management Policy Escalation Review was presented to the QM Meeting and consideration has been given to understanding if a rise in incidents has been due to the pressure on beds.
- A near miss was reported with a cast iron hopper that supports the guttering system on Building 1. It is reported to have fallen, narrowly missing a member of staff. The cast iron hopper is not linked to the EMP and a review has ensured that these areas are safe.
- The reporting system, Ulysses has been updated to reflect the changes made in the Service lines. Outstanding Actions have been reviewed to ensure the

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appropriate staff are allocated as Owner. There has been a slight improvement in the number of overdue Actions down to 38 from 43.

- 5 RCAs were submitted in the month. Of the 5 Reports, three identified Care and Service Delivery problems, which have recommendations to prevent reoccurrence and there has been learning noted.
- 3 inquests concluded in the month. One recorded an Open Conclusion
- Emergency Responses continue to be overseen by the Heads of Nursing.
- Work continues with the CQC including patient complaints.
- There have been no Mental Health Act reviewer visits this month. All patients are having their Section 132 rights read at the start of their section or Community Treatment Order (CTO). However some teams are not meeting the target to 're-read' the rights on a regular basis.
- A high number of PALS contacts and the number and complexity of complaints continues to have an impact on the timeliness of complaints responses. A 12-week improvement plan has been put in place.

DBo reflected on the CQC and its request for further detail on some of the actions. RT confirmed that if the CQC were not happy with the evidence or detail provided then they would not close the cases and cases are being closed. The CQC meetings with the Trust are noted so there is a record to check. VF confirmed that surveillance meetings take place and these will include the Integrated Care System (ICS) with the Trust still being a participant.

DBo asked for an update on the outstanding actions in the appendices. RT reported that these are being reviewed and updates will be reported in the coming months.

**A22/17** ***EDI Implementation – Q1 approach to psychological safety** *(Agenda item 6.2)*
This item was withdrawn.

**A22/18** ***Learning Disabilities including Green Light Toolkit** (*Agenda item 6.3)*
The Committee received and noted the report. Emma Clark, Clinical Manager Learning Disability Services was welcomed to the meeting as Denise Gentry, previous LD Lead had moved roles. The service will be recruiting into the vacant role.

- The NHS Improvement Standards have been received and an action plan has been devised through a Working Group.
- Some audits are being planned/started - Autism spectrum disorder in adults: diagnosis and management. A pilot is being started in Merton to provide interventions.
- More work is being undertaken in terms of the care record.

DBo reflected on the vacant role as Denise was key in leadership and advocacy for LD. EC updated that the role would include Neurodevelopment Disorder services, in the interim there is a focus on risk and acute services.

DH asked for further detail regarding the Merton pilot in terms of numbers and those invited to take part. EC updated that the pilot was funded for one clinician to provide post-diagnostic support for referred patients. This will be supported in the form of a small programme; it is planned the pilot will be operational from March 2022. Further detail is not currently available.

The Committee formally thanked Denise Gentry for her great contribution, leadership and advocacy.

**A22/19 Committee Governance**

*Quality Governance Group minutes (Agenda item 7.1) – received and noted*
*Mortality & Suicide Prevention Group minutes* **(***Agenda item 7.2) – received and noted*
*Clinical Ethics Committee minutes (Agenda item 7.3)* -These had not been received as there had been a seminar in November and no meeting was held in December. DBo reported that a report is being developed that will come to a future meeting.

**A22/20 Matters for the Board of Directors (**Agenda item 7.4)

- The Q&P report, including priority metrics, metrics within service lines and linking this back to the Quality Plan.
- HR Risks
- Medicines Management Report, to include the interface between the digital strategy, quality and the patient experience. Including expired medicines and the Mental Health Act. Also to note the Valproate discussion.
- Complaints and the timeliness, inc 12-week improvement plan
- Good achievements in the EPRR

**A22/21 Meeting Review**

CAB asked to understand the process to raise a query if the report is not presented. DBo asked that this can be raised with either David Lee or Nicola ahead of the meeting.

AB reflected that the new starred approach is working well as this leads to a better debate at the committee.

VC-Y asked for more time in receiving the papers as the papers were received on the previous Friday when the meeting was on Monday.

**A22/22 Noting only** *(Agenda items 8.1)*

The following minutes were received and noted by the Committee:

- Smoke Free Impact and Effectiveness Annual Report

DBo asked that this item is now treated as business as usual. SS confirmed that this is already received at the Quality Governance Group and so this does not need to come as a separate paper.

The Committee agreed to this approach.

**A22/23 Date of Next Meeting (***Agenda item 10)*

The next meeting will be held on **Monday 7th February 2022, 13:30-16:30** via MS Teams.

The Part A meeting closed at 15.58.

**Quality and Safety Assurance Committee (PART A)**

Minutes of the MS Teams meeting held on **Monday 7th February 2022, 13:30-16:30**

**Attendance list**
**Present:**

| | |
|---|---|
| Professor Deborah Bowman (DBo) | Non-Executive Director – Chair |
| Ann Beasley (AB) | Trust Chair |
| Dr Billy Boland (BB) | Medical Director |
| Sharon Spain (SS) | Director of Nursing & Quality |
| Doreen McCollin (DM) | Non-Executive Director |
| Jennifer Allan (JeA) | Chief Operating Officer (Joined at 13.50) |
| David Lee (DL) | Corporate Governance Director |

**Attendees:**

| | |
|---|---|
| Ryan Taylor (RT) | Associate Director of Clinical Governance & Risk |
| David Hobbs (DH) | Service User, Carer, Friends and Family Representative |
| Carol Anne Brennan (CAB) | Service User, Carer, Friends and Family Representative |
| Michael Hever (MH) | Deputy Director of Nursing |
| Valerie Chin-You (VC-Y) | Lead Quality Manager, NHS South West London CCG |
| Elaine Holder | Committee Governance Officer (Minutes) |

**Apologies:**

| | |
|---|---|
| Vanessa Ford (VF) | Chief Executive |
| Farai Addy (FA) | Experience & Governance Lead and Member of the Diversity in Decision Making Programme |
| Terence Nichols (TN) | Staff Nurse, Ward 1 and Member of the Diversity in Decision Making Programme |

**Item**

**A22/24 Apologies**
Apologies were noted.

**A22/25 Declarations of Interest**
No new declarations of interest were reported by the members.

**A22/26 Chair's Action**
Chair advised members of a conversation with BB where they discussed having a Suicide and Mortality Report taken formally to Board. Chair normally references the report verbally as part of the QSAC Chair's report but thought it would be a good idea in the spirit of openness and accountability to have a formal Board report. Chair welcomes ideas from members on how this is reported and aims to have the first report in April further to consideration of how other Boards present such reports.

**A22/27 Minutes of the previous Part A meeting**
The minutes of the Part A meeting held on 6th December 2021 and 10th January 2022 were approved as an accurate record.

**A22/28** Action Tracker (Agenda item 1.5)
The action tracker was reviewed and noted:

**A22/29 Matters Arising**

No new matters arising were raised.

**A22/30 Risk Register Report**

The Committee received the Risk Register report. The following highlights were presented by RT.

- The size of the Risk Report is being reviewed due to the size of the PDF document. A few people are concerned they may miss information owing to the amount of reading needed. This has been impacted by the absence of the Trust's Risk Manager. The role has been vacant for some time although there are mitigations in place to cover this. It has been noted that all information should be aligned so it is suitable for all Board reporting.
- The focus for ELT this week was the Medical Risk Register (including the Pharmacy Risk Register). ELT were satisfied and assured with this although they did point out that works needs to be done in respect of Medical Workforce issues.
- ELT also noted the annual risk tier 1 audit. ELT were asked to consider risks that have been open for more than a year (which have been previously discussed at QSAC). A few risks have been closed working alongside Service Lines.
- A new risk has been added at level 16 which is the operational ability to deliver the Integrated Programme. ELT were satisfied with mitigating actions and were happy to accept this level.
- The Acute Care Pathway Plan (1994) risk has now been reduced to level 16.
- ELT discussed HR risks and the impact of staffing pressures over the last few months. This has been reflected on the BAF risk register. RT informed the Committee that he is due to meet with the HR Director to decide how this is reflected on the Executive Risk Register.
- RF questioned whether Risk 2281 and 1994 were new risks. RT advised these have previously been on the BAF risk register.
- AB asked why the 1994 Acute Pathway risk had been reduced and what issues are driving the score and whether this could be separated out with the for causes for increase demand and the failure to recruit staff. RT advised the cover sheet does not show mitigations and actions and this is covered in the body of the risk report. JeA pointed out 1994 had been discussed at ELT and they agree this should remain at 20.
- JeA advised there is a review for the structure of the BAF and Executive Risk Registers.
- DH asked re Tolworth Redevelopment risk and the failure to achieve internal and external approval and lack of system sign up? RT will feedback to DH and DBo outside of this meeting.

  **Action RT to feedback to DBo and DH**
- VC-Y questioned why risk 2266 has remained the same at 16 even though there has been a lot of work on it. RT advised that in the main PDF document the risk had been reduced to 9 but this was not shown on the cover sheet.
- RT advised there has been a new risk added on Fluency Direct which has been isolated to CAMHS.
- RT informed another 2 new risks had been added regarding the quality of food and portion sizes. A new food online ordering system is helping to mitigate this.
- RT informed the Committee that outstanding complaint actions have significantly improved.
- RT informed that a VCOD Risk has been added in respect of posts which has now been significantly reduced. There was a suggestion to have one overarching risk to cover the whole of VCOD going forward.
- VC-Y asked why Risk 1258has remained the same. RT advised that he will meet with HR to find out the outcome of work around this risk.

**Action: RT to meet with HR Director and report back to Committee at next meeting.**

**A22/31 Quality and Performance Report**

The Committee received the Quality and Performance Report.

JeA discussed the Q& P Report and highlighted the following.

- There is ongoing work with Keith Williams to look at the restructuring the framework of the Q & P report for QSAC and other Boards to include feeder meetings across domains and service lines.
- JeA informed Committee that VCOD work has been paused awaiting outcome of the national consultation.
- There is a plan to move away from business continuity arrangements in Acute Care where staffing levels have improved.
- Workforce issues have not improved there are delays in recruitment and challenges with Employee Relations with a lack of support on the Medical Recruitment side.
- AB commented on the late change to VCOD and wanted to put on record her thanks for the amount of effort that has been in for this in the Trust and also the fact that Richmond is now reaching target.
- VC-Y asked if VCOD was affecting Workforce Morale. JeA replied that there have been difficult dynamics with staff and difficulties between vaccinated and unvaccinated staff which have definitely affected morale.
- DB noted South West London and St George's stands out in respect of tone and thoughtfulness with regard to VCOD comms.
- RF questioned the RCA actions: JeA informed RCA actions have stabilised and there is issues with people closing actions.
- DH questioned why there were capacity problems in the Lotus suite and also cubicle issues across the Trust. JeA informed this was due to staffing issues in Lotus which is now improving and due to HR shortages people were late in starting in post.

**A22/32 Quality Improvement Plan**

The Committee received and noted the Quality Improvement Plan and the following points were presented by SS.

- The main focus has been the on the eleven Fundamental Standards of Care and the four main areas for front line staff to focus on are Physical Health, Observations and Engagement, Risk Assessments and Care Plans.
- Data had been taken from January when there were lots of staff shortages, this has now improved.
- ELT have agreed to reset the timeframes for another 3 months for certain wards.
- Overall there has been quite an improvement in quality.
- Some wards feel they have been set unrealistic targets – going forward wards not doing so well will be given extra support.
- DBo asked how staff will navigate different agenda titles such as Q&P also known as The Always Ready Plan. SS explained the language has been agreed with ELT which incorporates all CQC domains.
- VC-Y asked if there was a buddying system in place so that wards doing well could support those not doing so well. SS informed members that this was in the plan.
- RF asked if risks are escalated? SS informed risks are escalated to ELT.

**A22/33 CQUIN Quality Priorities & Quality Account Q3 Report**

DBo informed Committee she has raised questions regarding this report with SS.

**Action SS has agreed to meet with DBo to discuss**

**A22/34 Queen Mary's Hospital Ligature Report**

The Committee received and noted the Ligature Report. The following key highlights were presented by SS.

- A ligature paper was put in place last year following the CQC changes.
- The en-suite bathrooms at Queen Mary's Hospital have ligature risks.
- In August 2021 there was a suicide on Rose Ward using one of the taps identified in the risk
- Following this incident there was an extraordinary ligature review where mitigations were reviewed.
- Robin Bruce undertook a costing and timeframe review. The review highlighted the works would cost. approx. £1m and would take 12 months to complete. This would cause quite a lot of disruption to patients.
- Additional staffing levels have been agreed between now and moving to the new building.
- The Post Incident Review for the suicide highlighted that the ligature was not the main cause, there were other mitigations which were not in place. The external investigation is still ongoing. RT informed the staff member looking after the patient was busy doing other patient observations at the time of the suicide, but it was felt she was not being remiss.
- RT informed additional staff resources were put in place in 2017 after the initial ligature review.
- AB asked if the report of the suicide needed to be in the public domain at this present time? RT informed it is usual practice to report for initial conclusions even though the investigation is still ongoing.
- VC-Y questioned whether additional members of staff have had adequate training bearing in mind the large number of ligature risks. SS informed there is a robust training in place especially around high-risk ligature points.
- RT informed staff need to sign to evidence they have awareness of all ligature risks.
- DM asked if ligature risks are regularly reviewed? RT informed reviews are undertaken every 12 months and a review by H&S Manager and Ward Manager is undertaken every six months to ensure nothing had changed since the last review. There is a robust capital programme in plan for all wards.

**A22/35 Safety in Motion (Violence and Aggression & Restrictive Practice Report)**

The Committee received and noted the Safety in Practice Report. The following key highlights were presented by Michael Hever.

- MH informed the Committee that not all practices and procedures have been embedded into the wards of yet and that was natural confusion about zoning boards etc.
- EMHIP project should reduce use of restrictive practices.
- Lessons learnt will follow and policies will be updated.
- MH has requested more data from IT regarding patient incidents.
- AB asked in respect of EMHIP how practical it is to call someone during the procedure and why there have been errors in the administering the rapid tranquilisation drugs. RT informed this was due to a reporting issue and wards need to be challenged regarding this.
- AB stated this should be evidence based going forward.

- MH informed the plan is to have onsite mediators as well as community mediators.
- DBo asked for assurance on this.
- DM asked for the opportunity to discuss outside of the meeting with metrics to ensure quality assurance, pharmacists review and review of policies and prone restraints.
- **Action: DM & MH to have further discussions requested the opportunity to discuss quality assurance, pharmacists review and review of policies and prone restraints and how assurance can be provided.**

**A22/36 Quality Matters Effectiveness**

The Committee received and noted the Quality Matters Report. The following points were highlights were SS.

- It is difficult to find suitable placements for people with ADHD etc.
- There is more work to do around the Physical Health Framework.
- RT informed there are several complaints overdue, this has progressed and this will be shown in the next Q&P report.
- DM mentioned there has been an increase in the number of people with physical health problems and asked what the physical conditions were and whether the staff had the skills and abilities to address these. Also is as the safeguarding matter at St Georges Hospital included in this report. SS confirmed that work is currently being undertaken around this in the Corporate Framework and there is new matron in place which will help. There is additional funding for a new Band 6 post for a year.
- DM asked how we compare to other Trusts in London on suicide rates. RT confirmed other Trusts have also seen an increase.
- CAB commented that there should be plans in place for patients with long covid.
- DBo asked SS to compete a report to give un update on the physical health **Action SS**

**A22/37 5Corporate Objectives**

SS confirmed ELT were comfortable that the objectives remain amber.
**Committee accepted the objectives**

**A22/38 Homicide Independent Inquiry Report**

SS informed this report was completed last year and was published last week.
**The Committee noted the Report**

**A22/39 Committee Governance & Reporting**

**The Committee noted and accepted the minutes from the Quality Governance Group.**

**A22/40 Matters for the Board of Directors**

- Chair will report back to Board that evolution of papers and thinking at QSAC as well the striving for assurance was greatly appreciated.

- The update of the Q& P Report and assurance for ligature review mitigations around this has been very important work for QSAC,

- Chair will report the complaints process which now Committee now has assurance on.

- Chair will notify Board that thinking and discussion on the Always Ready Report has started.

**A22/41 Noting Only**
**The Committee noted the following reports:**

- **Board Service Visits and Actions**
- **Infection Prevention & Control Q2 Report & Control Board Assurance Framework**
- **Patient Story Annual Report**
- **Mediation Outcome and Actions**

**A22/42 Meeting Review**

- VC-Y noted the format of the meeting went very well and asked if she could ask questions under AOB and noted some papers were received late.

- VC-Y commented on the Coral Crisis Service - Operational Policy to be ratified. VC-Y informed the Board that there were several issues around Equality and Quality Impact Assessment issues outstanding and action plans that needed to be taken forward. CGG have not yet received these and she was concerned the policy had been agreed when the policy and not been formalised.
  **Action JeA/SS to report back to VC-Y**

- RT prefers the meetings being held during the afternoon.

- DH mentioned the impact of IT problems across the Trust and if there was a planned upgrade and if this would in turn be feedback to QSAC. JeA informed there is an 18-month systems and software implementation plan and a new digital strategy. ELT are aware and are looking at this.

- DH mentioned that the food issue is still ongoing.

- CAB questioned if she had received all papers in Diligent
  **Action DBo to liaise with DL/NM/EH for next meetings papers.**

Part A meeting closed at 15.40

**Quality and Safety Assurance Committee (PART A)**

Minutes of the MS Teams meeting held on **Monday 7th March 2022, 13:30-16:30**

**Attendance list**
**Present:**

| | |
|---|---|
| Professor Deborah Bowman (DBo) | Non-Executive Director – Chair |
| Vanessa Ford (VF) | Chief Executive |
| Ann Beasley (AB) | Trust Chair |
| Sharon Spain (SS) | Director of Nursing & Quality |
| Doreen McCollin (DM) | Non-Executive Director |
| Jennifer Allan (JeA) | Chief Operating Officer (Joined at14.50) |
| David Lee (DL) | Corporate Governance Director |
| Chris Lambourne (CL) | Director of Nursing |
| Paula Robins (PR) | Head of Quality and Nursing (Joined for item A22/52) |

**Attendees:**

| | |
|---|---|
| Ryan Taylor (RT) | Associate Director of Clinical Governance & Risk |
| David Hobbs (DH) | Service User, Carer, Friends and Family Representative |
| Carol Anne Brennan (CAB) | Service User, Carer, Friends and Family Representative |
| Ruth Harkness (RH) | Lead Quality Manager, NHS South West London CCG |
| Elaine Holder | Committee Governance Officer (Minutes) |

**Apologies:**

| | |
|---|---|
| Dr Billy Boland | Medical Director |
| Farai Addy | Experience & Governance Lead and Member of the Diversity in Decision Making Programme |
| Terence Nichols | Staff Nurse, Ward 1 and Member of the Diversity in Decision Making Programme |

**Item**

**A22/43 Apologies**
Apologies were noted.

**A22/44 Declarations of Interest**
No new declarations of interest were reported by the Members.

**A22/45 Chair's Action**
No Chair's action

**A22/46 Minutes of the previous Part A meeting**
The minutes of the Part A meeting held on 7th February 2022 were approved as an accurate record.

**A22/47 Action Tracker (Agenda item 1.5)**
The action tracker was reviewed and noted:

**A22/48 Matters Arising**
No new matters arising were raised.

**A22/49 Risk Register Report**

The Committee received the Risk Register report. The following highlights were presented by RT.

- Annual TIAA Meeting closure meeting has taken place with assurance level being awarded as reasonable
- The focus at the moment is a service line risk review with a number of actions taken
- There are two new risks, one is in respect of the failure to recruit three substantive Consultant roles which is being linked to the Medical Risk Register and has now been reduced and there is an increased risk in respect of Community Workforce recruitment and retention
- Acute pathway risk has been reduced to 16
- Floaty Direct and Psychotherapy (Wandsworth) risks have now been closed
- ELT have agreed with HR to close legacy risks and start a new HR Risk Register
- There was a new risk added from CAMHS ED with regarding the screening referrals for children and young people. It was discovered there were 200 referrals that were hidden which has caused concern at Quality Matters. However, a lot of resource has been put into this and this has now been fully rectified and closed.
- Another new risk is the failure to secure the necessary level of staff engagement with QI training which reduces the effectiveness of the QI as an enabling programme for the Trust Strategy
- There are a number of issues regarding the KEGS service risk and the challenges regarding staffing and the skillset of the staff needed, which has been problematic in A&E which has not been easy to fill. A lot of effort being put into this

AB questioned if Risk 225 potential wait for treatments was the same as the risk as the one mentioned by RT re hidden referrals.

PM stated this is linked but the risk AB referred to is part of a wider risk and the one mentioned above is part of the Richmond Spa referral.

AB commented it will be difficult to mitigate risks if they are hidden.

RT to ask JeA to comment on this when she joins the meeting

DH asked about the IT Data Warehousing Risk - was this a case of not being able to keep up with demand?

RT explained this is in respect of the organisational Data Warehouse and this risk is in respect of capacity and having the right people in place. There is currently a review to address this.

VF explained this risk has been placed on the BAF register to deal and the F& P Committee will also be reviewing this.

DB asked how big is risk 2294 (FOS staffing) and do staff understand the risk.

RT explained this risk was debated at QGG – RT is working with the team to finesse the risk and downgrade level.

DB asked for assurance on how HR risks will be managed to ensure that none slip through the gaps

VF explained the HR Recovery Board has an extensive risk register. This is chaired by Phillip Murray (Director for Performance and Finance). They are in the process of tidying up the HR risk register as well as compiling a new risk log for HR which is workable and doable. This will go through the Workforce & OD , EDI and QSAC Committees and will hopefully be available in 6/8 weeks. The BAF risk for HR has also been reworked so the Board will have full sight of all HR Risks.

**A22/50 Safeguarding Adults**

Committee accepted and noted report

DBo commented that the Safeguarding Adult Report was quite hard to read.

SS said there is set reporting done on a monthly basis as well a compiling report that goes to the Local Authority. The two have been combined and as they are not clear this is causing problems.

DM asked about the backlog of DBS applications and would like assurance on how this is being addressed and also whether the backlog is for new staff members or renewals?

SS informed the figures are improving and will be detailed in the next review. There is a trajectory for this and SS explained this is for both new and exisiting staff

VF asked why this has happened and if this a reporting or change issue?

SS explained there has been a change in staff who process applications and this has caused confusion regarding the reporting and data requests and there are no assurance issues.

**Action SS to provide assurance to QSAC.**

DH asked what is Compass and what is causing the delay in uploading information?

SS explained this is an e-learning platform which is not compatible with SLAM's system.

VF explained the Compass and DBS issues were flagged for 6/12 months and this was resolved through the joint HR function.

CAB raised concerns reagrding Safeguarding allegations that where not upheld and wanted to ensure this was monitored and reported outside of the organisation. CAB requested her concerns were noted in the minutes.

SS informed this has been discussed at Executive Safeguarding and only allegations that have 100 per cent assurance that an incident did not happen would not be reported. However, they would still go throught the Trust Safeguarding Lead.

SS wanted to note Frankie Campbell had reviewed the Children's report which has been co-produced with schools.

**A22/51 Patient Experience**

Committee noted and accepted the report.

RT talked through the key headlines

- Since this report was published an improvement workplan has commenced which was signed off by ELT this week. The Terms of Reference have been agreed and the Patients Outcome Group has been revised. Dr Victoria Hill is the new Chair.

- Feedback Live is a key workstream in the new workplan. There has been a review to ensure questions are not duplicated and there is co-production with Service Users. This report is a good news story as over 3000 patients were surveyed with 18,000 items of feedback. The focus will be the 'so what' and how this links with exisiting workstreams across the organisation.

- The report shows the Friends and Family test and the good news story has improved and is now 82%.

- A new PALs Clinic has opened.

- Victoria Gregory will be leaving the Trust however, interim plans have been put in place to cover her role.

DH asked what does the Trust do with the information from Feedback Live and how does this improve services

RT informed this information is used to form workstreams.

AB was diappointed to see low scores for communciations and it hoped to see this improve after looking at the 'so what' work.

AB questioned why the graph shows the percentage figure on page 16 of the report has gone down from May to September although the graph shows the figures are going up.

**Action RT will look into this and report back to AB**

SS informed as part of the Quality plan there will shortly be a launch of 11 fundamental standards of care have which have been introduced. There has been ongoing work with patients and staff to establish what a good care plan looks like.The quality of these plans will be monitored to ensure they have been co-produced to take into acoount patient experience and triangulate with complaints.

VF asked when will the Trust show an improvment in patient experience

SS informed patient experience should improve month on month.

RT informed there will soon be a new Development and Integrated Patient dashboard which will bring together all aspects such as complaints, CQC survey, feedback live etc This will be ready in March/April.

Chair would like to record thanks to Victoria Gregory for all her work.

**A22/52 #Always Ready**

The Committee received and noted the report.

AB commented there is still limited assurance on food and plans to manage physical health.

SS informed these items are still high priority and are looked at every two weeks

VF commented there has been limited assurance on some actions for two years and wanted to know how she would know these actions have improved noting the pandemic.

SS informed some actions have greatly improved but there still outstanding issues around process and systems.

VF would like more focus on outcomes rather than actions.

DBo commented the wording in the reports should provide evidence for assurance.

DM questioned why CQC outstanding actions that are due to be closed have not been closed.

SS informed the Service Lines have requested these remain open as they are not yet fully comfortable.

**A22/53** Mental Health Community Survey (including action Plans)

PR highlighted the following

- The paper includes the 2022 action plan in response to the published results of the 2021 CQC Mental Health Community Survey. It also attaches a review of the 2021 action plan that was in place for the 2020 CQC Community Survey and where those actions were not completed, they have been rolled over into the 2022 action plan.

- Community Services have successfully completed a wide range of actions. Only two recommendations were not met. These actions along with the actions showing amber have also been brought into the 2022 action plan. There is planning to review this on a regular basis.

DBo commented that almost all items are amber and asked when these will go to green and red and what mechanisms are built into the plan to think about outcomes and impact.

PR informed this was a challenge. However, when she met with Leads the work had been completed. This is a generalised plan and PR will look at developing the plan to add outcome measures and timescales.

VF commented the action plan on its own is not enough. The action plans need to feed through to inductions etc and (with the current workforce challenges) so the work is not lost

SS informed The Community Action Plan will be used to collate all the actions/plans.

**A22/54 Quality and Performance Report**

JeA gave a highlight of the report

- In terms of Covid The Trust is now stabilising. There is demand pressure in ongoing exposure of unmet demand and newly generated demand. We are working through with Commissioners to invest in services and support commissioning to have the right capacity to cope with this demand. There are limited resources to invest in Mental Health, so the trust is working on how best to use these limited resources to support pressures and work strategically to address this balance.

- The Acute Pathway crisis and bed pressures are unrelenting with both the number and the acuity of patients being difficult to manage with numbers higher than seen before. The Trust are reliant on intense operational management and also waiting for transformation in Community and the Wider Social care landscape. This remains a key concern in terms of quality and care for patients

- We have not yet seen any improvement in service delivery. As yet there are still lots of medical workforce vacancies and problems with Employee Relations. There are longer waiting times for CAMHS and Access. next

- AB commented regarding the workforce issue and asked if the problem is that there are not enough people for defined roles. Therefore, should we be thinking about role re-design to find people to fit the roles or is that the Trust needs to be more pro-active in receiving funds through the Elective Recovery funds.

- JeA agreed and said there has been work on role-design already which is still ongoing. The trust is at a disadvantage due to problems with recruitment onboarding and retention experience and there is a need to do better to become a desirable employer. The trust receives investment through the MH Standard and Transformation Fund however work will continue to advocate the importance of the MH waiting list and the need to make a strong case to receive funds through the Elective Recovery.

- DBo asked re the direction of travel for the funds and the timeline for when we will know the risks for Quality and Safety.

- JeA informed it will be a few weeks. CAMHS and Adult Community will take up a lot of the budget. ELT are looking at how Acute services will be supported which will be financially challenging. SDF funds will be prioritised to go towards transformational changes to services which will then improve long term services to patients. The focus needs to be on workforce to help transform service and maintain quality.

- JeA informed that the Q&P framework report will be refreshed and has been agreed by ELT. The report will then go F&P and Audit Committees. Accompanying the report will be a proposal to streamline metrics to understand the performance for the coming year. KPIs will be streamlined and focused and supporting KPIs will be added. There will be meetings to focus on actions and how actions are followed through to reduce the time and length of report. This will

result in a more focused report for Board. Proposals will be shared with QSAC in April.

DH asked if bed pressures are London wide and are if we are buying extra private beds.

JeA informed bed pressure is nationwide and there are no available private beds to buy at the moment. There are 18 contracted in area beds to support bed pressure and 10 patients in out of area beds.

**A22/55 Quality Matters**

SS gave a highlight of the January Report.

- In January 2021 there were 9 serious incidents meeting the national SI criteria that were reported externally to commissioners (via STEIS). This includes 3 Unexpected Deaths and 2 Suspected suicides which is within normal range.
- It was reported that there were 4 young people admitted to the Place of Safety (136 suite) over the past 5 days. It was suggested this may be due to the challenges of the CECs team to ensure safe staffing levels due to COVID, staff sickness, and vacancies.
- Staffing levels are being looked at by Sean Whyte (Deputy Medical Director) however this is not impacting on136 suite
- Significant staff shortages in January however no services were closed
- 31 outstanding RCAs and 4 RCAs in January
- 3 inquests
- Emergency responses are being monitored
- 132 rights are improving
- Complaints being answered within 25 days is improving

DBo asked why CAMHS ward were booking Bank staff when wards were empty

SS explained that staff were booked when young people went home for the weekend. The staff should have been deployed elsewhere if they were not needed. This is be investigated as staff were not being redeployed when the wards were empty.

**A22/56** Mental Health Act (including Advocacy Services and Regulatory Compliance relating to MH Act)
The Board accepted and noted the Mental Health Act Report

- RT informed the QGG gave Mental Health Act Team reasonable assurance around workstreams and issues for the MH and Capacity Act. The Government review stated the Trust will retain Hospital Mangers in their current form
- CQC Mental Act Reviews had some learnings with corresponding action plans
- 132 Rights have reached 80%
- Access to advocacy has had a net impact on service users
- Deputation of liberty work is ongoing
- MH Act reviewers will have additional resourcing

**These minutes represent the record of the entire Part A QSAC meeting. They should be read in conjunction with the agenda and papers and should not be distributed to anyone outside the Committee members.**

DBo mentioned key issue 5 needs to show IMHA and IMCA as two different services

DBO asked when there will be an impact in respect of 'unlawful prescribing' as the report states there is now a coordinated approach to auditing consent to treatment certificates.

SS informed electronic prescribing has now been introduced. However, this does not show up a new medication that is part of T2 and T3 which is proving difficult for nurses and junior doctors. Coordinated response are input manually which relies on people putting these in correctly.

DBo and VF both thanked RT for his hard work on this.

**A22/57** Committee and Governance Reporting
The Committee noted and received the following minutes

- Quality Governance Group minutes
- Mortality & Suicide Prevention Group minutes
- Clinical Ethics Committee minutes

**A22/58** **Matters for The Board**

- RT analysis of Patient Experience
- Community Survey becoming outcome focused
- Quality and Performance Report

**A22/59** **Meeting review**

- AB - Bidding for Elective Recovery Funds
- VF – emphasing Workforce issues how do we use QSAC to manage quality challenges within The Trust.
- AB discussions more focused we do not need to discuss all papers have had more time to discuss connecting issues
- DM - good papers – questions should not be asked just for the sake of it – the better the paper the less questions- Issues regarding Health Inequalities and unfairness and people not being treated the could be a thread in papers in the same as staffing I and as a Trust we are not looking at this on the side and should talk more openly regarding this

Part A meeting closed at 15.40

Part A meeting closed at 15.40

**Quality and Safety Assurance Committee**

Draft Minutes of the MS Teams meeting held on Monday 4th April 2022 at 13:30

**Present:**

| | |
|---|---|
| Ann Beasley (AB) | Trust Chair – (Chairing meeting) |
| Dr Billy Boland (BB) | Medical Director |
| Sharon Spain (SS) | Director of Nursing & Quality |
| Doreen McCollin (DM) | Non-Executive Director |
| Richard Flatman (RF) | Non-Executive Observer |
| David Lee (DL) | Corporate Governance Director |

**Attendees:**

| | |
|---|---|
| Ryan Taylor (RT) | Associate Director of Clinical Governance & Risk |
| Farai Addy (FA) | Experience & Governance Lead and Member of the Diversity in Decision Making Programme |
| David Hobbs (DH) | Service User, Carer, Friends and Family Representative |
| Carol Anne Brennan (CAB) | Service User, Carer, Friends and Family Representative |
| Clair Hartley (CH) | Committee Governance Manager (Minutes) |

**Apologies:**

| | |
|---|---|
| Vanessa Ford (VF) | Chief Executive |
| Deborah Bowman (DB) | Non-Executive Director |
| Jenifer Allan (JeA) | Chief Operating Officer |

**Item**

**A22/24 Apologies**

Apologies were noted.

**A22/25 Declarations of Interest**

No new declarations of interest were reported by the members.

**A22/26 Chair's Action**

There were none.

**A22/27 Minutes of the previous Part A meeting**

The minutes of the meeting of 7 March 2022 were approved as an accurate record subject to two amendments:-

RF reported that he had sent apologies which weren't noted.

DH pointed out that the wording in Para A22/51 – Patient Experience should be changed from "RT informed this information is used to form workstreams" to RT informed this information is used to inform workstreams.

**A22/28 Action Tracker**

The action tracker was reviewed.

The first item was on the agenda, It had been agreed that in DB's absence the action around the root cause analysis would be deferred.

RF queried item A21/90. The Chair explained that the item had been deferred pending the finalisation of priorities for the year. The wording in the Action Tracker should be updated.

**A22/29 Matters Arising**

There were none.

**A22/30 Risk Report**

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

- ELT focused on the integrated programme risk (IPR) for April. ELT decided that the risk regarding the capacity and capability for clinical staff to engage with the IP should remain on the risk register.
- ELT was pleased to note that the Trust had a finding of reasonable assurance in the annual risk management audit. All the recommendations had been accepted and would be presented to the Audit Committee.
- RT reported on two new risks, patients waiting longer than 28 days for initial assessment and heavy reliance on the bank workforce.
- RT informed the Committee of the risks which had been closed.

The Committee discussed the following issues:

- The Avalon Culture Risk – There had been a significant improvement but they would wait for the CQC report before deciding to reduce the risk.
- Review of the BAF timetable – ELT had decided on a new timetable and a revised approach to the review of individual BAFs to ensure that better reports were presented to the Audit Committee.
- Use of the risk register in a live way –Constant changes to risks had to be considered and demands had to be tailored accordingly.
- Increased Cyber- Security Threat – DH raised the possibility of an increased cyber-security threat arising from the use of Russian software. He asked whether other Trusts used the same software. RT stated that they were not overly concerned about the risk and had assessed it as a low-level risk. There were measures in place to prevent breaches. It was agreed that the possibility of an increased cyber-security threat should be considered.
- **Action - RT would liaise with IM&T in regard to the risk and controls around Cyber-security and how this is reflected on our corporate risk register (ERR), plus clarify via IM&T if other Trusts in the South London partnership have increased cybersecurity threats and whether there was any collective mitigating measure that we may wish to consider.**

**A22/31 Quality and Performance Report**

SS presented the Quality and Performance Report. She reported that a number of the risks in the Risk Register had been triangulated in the QP report. The focus of the report was February 2022.

She informed the Committee of the following issues, in particular:

- The priority metrics were to ensure patient safety and effective care, along with an integrated approach to quality and workforce.
- The key focus areas were supported by detailed executive review and discussion at the bi-monthly Service Line Review meetings.
- They were experiencing high acuity and bed occupancy,
- Staffing challenges were experienced due to shortages of bank and permanent staff. Certain posts were more difficult to fill eg consultants. The HR Recovery Programme was continuing.
- Development of the Quality Plan commenced in October 2021. 11 Fundamental standards of care (FSOC) SOPs have been launched formally.
- There had been an improvement in responses to complaints within 25 days.

The Committee discussed the following points:

- Whether resources would be dedicated to address issues in the staff survey report eg culture, relationships and morale, particularly in medical staffing. An action plan had been created to respond to the issues in the staff survey. Teams would decide on their own priorities.
- Difficulties in finding candidates for certain posts such as consultants were over and above any issues in the staff survey.
- The impact that the scarcity of consultants had on patients. The shortages were being managed by cross- cover arrangements, although this led to staff having a larger workload. It was essential that medical staff were recruited to avoid this.
- The timeliness of the launch of the Quality plan, considering the CQC visit. There had been good feedback.

The Committee noted the Quality and Performance report.

**A22/32 Mortality and Suicide Prevention Report.**

The Medical Director presented a quarterly report on the number of deaths for the period 1 October to 31 December 2021. He highlighted the following issues:

- The report structure and information had changed.
- There were 80 deaths during the quarter. This was an increase of one death from quarter 1 but this did not appear to be statistically notable when compared with previous periods.
- The majority of the deaths were within specialist services. All but two of them were reported to be by natural causes and most deaths were in people over the age of 66.
- There were 12 suspected suicides of current patients in the period. There was concern about the higher number of suspected suicides month on month.
- The post incident reviews identified areas for further review as part of the Terms of Reference.
- The Trust 3-year Suicide Prevention Strategy was a standing Agenda item on the Mortality and Suicide prevention Committee meetings.

The Committee discussed the following issues:

- The accidental death of a patient who escaped from a inpatient ward using keys that were not being managed in line with Trust policy. SS informed the members that she had

chaired the SI panel that dealt with the incident and they found that there was a problem with the key management system, but they had learnt from the incident.

- Whether there were any learnings from the four suicides who were not known to the Trust? BB explained that the suicides were self-referrals. Reviews were held but no areas of concern were found.
- That it was concerning that the review of 229 care plan audits found that there was no evidence of family involvement in care plans.
  **Action - FA would find out whether it was correct that there was no family involvement**.
- CAB expressed concern that the use of the word 'escape' in the report as it suggested that patients were imprisoned. The Committee discussed whether the word absconded should be used instead. DM explained that escaping and absconding are defined differently. Escape involves a breach of the physical perimeter of a building whereas abscond generally refers to a breach of the conditions of regulated authorised absences by not returning after the authorised time.

The Committee noted the report.

**A22/33 Homicide – Assurance Review of Trust Investigation**

SS informed the Committee about the outcome of the stabbing incident where a patient who had previously received care and treatment from the Trust stabbed two people, wounding one of them and killing the other.

The Trust conducted a RCA investigation. NHS England commissioned Veritas to conduct an Assurance Review of the Trust's investigation into the care and treatment of the patient. Veritas report set out key learning points, conclusions and recommendations.

The following actions were taken:

- The Trust initiated a monthly audit of care plans which includes an assurance that any change in patient circumstances is reflected in their plan and patients care plan.
- Appointment of a Primary Care Liaison Manager in post 1.0wte was planned. Key aspects of this role were to improve communication with GP services.
- A pre-publication meeting chaired by NHS England was held on the 23 March. The Victims family, Senior leaders from South West London & St Georges Mental Health Trust, as well as Veritas and the SWL CCG were in attendance.

SS reported that the Trust was compliant in all areas. Veritas were complimentary of the Trust RCA Investigation and Action plan and the evidence provided by the Trust during the assurance review of actions taken.

The Committee discussed the following issues:

- The appointment of the Primary Care Liaison manager – It was planned that the appointee would commence work at the beginning of April 2022.

The Committee noted the report.

**A22/34 Mental Health Units (Use of Force) Act 2018: Assurance Report**

SS presented a paper on the change to the law regarding the use of force on 1 April 2022. The Trust had been involved in the consultation process and submitted responses which had been incorporated into the final version.

SS informed the Committee that the Trust was compliant with all 10 key areas of the new law. The staff have been trained. Policies had been updated accordingly.

The Committee discussed the following matters:

- That external validation of compliance should be conducted either through internal audit or peer review.
- RF informed the Committee that one of the drivers for the Act was the death of a young Black man. Providers are encouraged to think about the use of force on people with protected characteristics, including race. An event was held for the launch of the Act and EMHIP was looking forward to the implementation of the Act.

The Committee noted the report.

**A22/35 Patient Led Assessments of the Care Environment**

SS reported that a patient- led assessment had not been held for three years due to the pandemic. They would be reinstated, although a date had not been set yet.

**A22/36 Quality Matters**.

SS presented a report on quality matters for the month of February. She highlighted that there had been 13 serious incidents meeting the national SI criteria. This was a small increase from previous months and above the average, but the numbers had not peaked past previous points / months in 2021. This included six unexpected deaths and four suspected suicides within the community and an inpatient assault, which were under investigation.

The Committee discussed the following issues:

- That it was troubling that the AMHP who was witnessed dragging a patient to the 136 Suite was still working. SS explained that an investigation had been held but the situation was complex and more difficult than it was phrased. The decision had been made that the AMHP should continue working. Descriptions of incidents of this sort should be carefully worded. However, incidents were recorded in the words of people who witnessed the incident and thought that the behaviour was unacceptable. An investigation might reveal that there were mitigating circumstances.
- The nature of the concern about the liaison between care coordinators and GP with physical health checks - This related to one specific case about a medicines management issue and communication with the GP about monitoring the medication. It wasn't causative, it was learning that was identified in one case for the period of the report.

**A22/37 Quality and Equality Impact Assurance**.

SS reported that impact, quality and equality impact assessments, policy and procedure had all been reviewed. A much easier, simpler template for service lines had been compiled and signed off by QCC. SS and BB would oversee all the quality impact assessments for any key changes to any services.

**A22/38 Quality Governance Group minutes**

The Committee noted the minutes.

**A22/39 7.2 Impact assessment policy and procedure**

The Committee noted the report.

**A22/40 7.3 Making A Difference (MKAD) Quality Alerts Q2/Q3**

The Committee noted the report.

**A22/41 7.4 Care quality reviews (CQR)**

The Committee noted the report.

**A22/42 7.5 Matters for the Board of Directors**

- Problems experienced with medical staffing;
- Fundamental standards of care;
- Improvement in response to complaints;
- Issues around mortality and suicide prevention strategy - whether the increase in suicides correlated with increased demand for services.
- Outcome of the investigation into the homicide committed by a previous patient;
- The Trust's compliance with the changes to the law regarding the use of force but need for external validation and linkage to EMHIP pilot.

**A22/43 Meeting Review**

(a) Patient Focus

There had been substantial patient focus, especially regarding discussions on the Use of Force Act and that incidents which were perceived to be inappropriate and in contravention of the law should be reported as they happened although investigation of the incident might show that there were mitigating circumstances.

(b) Quality of challenge

The importance of suicide prevention training in the community was discussed. Meetings in the community showed recurring areas of concern, being waiting lists in CAMHS and ADHD. Uncertainty about waiting time was problematic. The possibility of creating a virtual waiting room where people could see where they were in the system would assist. Long waiting times led to deterioration in peoples' conditions. Charities like Mind could assist people to cope while they were on the waiting list.

Unemployment had a negative impact and people were finding difficulty in getting back to work. Alternatives to medication should be used to assist them. The Hampton City Council facilitated the training of barbers, hairdressers and nail technicians in mental health awareness.

**A22/44 Thanks to FA**

The Chair thanked FA for her assistance and for the huge difference that she had made to the Committee's discussions. The committee had benefited from her presence and her contribution to debates. FA thanked the Committee for welcoming her and said that the participation had been a valuable experience for her.

**A22/45** The Meeting ended at 15h30.

The next meeting would be held on Monday 9th May.

**Quality and Safety Assurance Committee (PART A)**

Minutes of the MS Teams meeting held on **Monday 7th May 2022, 13:30-16:30**

**Attendance list**
**Present:**

| | |
|---|---|
| Ann Beasley | Trust Chair |
| Professor Deborah Bowman (DBo) | Non-Executive Director – Chair |
| Richard Flatman (RF) | Non-Executive Director |
| Vanessa Ford (VF) | Chief Executive |
| Dr Billy Boland (BB) | Medical Director |
| Sharon Spain (SS) | Director of Nursing & Quality |
| Doreen McCollin (DM) | Non-Executive Director |
| Jennifer Allan (JeA) | Chief Operating Officer |
| David Lee (DL) | Corporate Governance Director |
| Chris Lambourne (CL) | Director of Nursing |
| Charlotte Clark (CC) | Non-Executive Director |

**Attendees:**

| | |
|---|---|
| Ryan Taylor (RT) | Associate Director of Clinical Governance & Risk |
| David Hobbs (DH) | Service User, Carer, Friends and Family Representative |
| Elaine Holder | Committee Governance Officer (Minutes) |

**Apologies:**

**Item**

**A22/82 Apologies**
Apologies were noted.

**A22/83 Declarations of Interest**
No new declarations of interest were reported by the Members.

**A22/84 Chair's Action**
Chair informed the committee that SS would be attending the Oxleas Quality meeting and any learning will be reported back to QSAC in June,

**A22/85 Minutes of the previous Part A meeting**

Minutes were agreed subject to comments by BB

**A22/86 Action Tracker**
The action tracker was reviewed and noted.

**A22/87 Matters Arising**
No new matters arising were raised.

**A22/88 Risk Register Report**

The Committee received the Risk Register report

RW highlighted the following:

- The report was presented at last week's ELT and QGG
- The main focus for ELT was the HR Risks which have also been reflected as new risks on the BAF Register
- ELT noted there is ongoing work to determine exactly which items go on the BAF and ERR.
- There is now a Trust-wide risk for E-Obs . There are interim arrangements in place to ease the burden on front line staff whilst being safe in how observations are captured.
- There was an error in respect of the Integrated Programme Risk which was closed instead of being downgraded – this has now been rectified and is now Amber
- No Executive Risks have been closed.
- QSAC questioned the Cyber risk at the last meeting which has been discussed at ELT which has decided that this does not need to be on the ERR.
- ELT and QSAC discussed the cultural improvement on Forensic wards and capacity demand in Kingston and Richmond, as well as the lack of provision of laptops; the latter has now been resolved.
- QSAC previously requested more high-level information to be included on risks which has been done.
- QGG noted a risk in respect of ligature and fire and have asked for a review. There was a post-meeting note and QGG are now reassured about controls and mitigations
- AB questioned if the CQC would be concerned that E-Obs are being recorded on two different systems.
- SS informed there is a lot to consider about hourly general observations which are logged on a sheet for Health & Safety rather than clinical reasons. There was a decision made to remove these from E-Obs to see if it made a difference to the amount of time spent recording. It may change once there is a review. SS did not consider there to be a risk in terms of clinical quality and safety.
- BB informed the Committee the Integrated risk includes the Clinical Transformation Programme. There has been discussion regarding this at ELT who have decided this should stay on the Risk Register.
- RF questioned the overlap of BAF and ERR to ensure risks do not slip through the gaps and would like this to be discussed at the next Audit Committee meeting. RT also noted the red risks that are overdue and need to be updated.
- DH asked if there was a degree of financial risk for the Transformation Programmes.
- JeA advised that due to the overall NHS financial risk there could be some elements of Community Transformation that may not be funded. The Trust and System will focus on the Community Transformation Programme although there will be limited funding for resources for year 3.
- VF advised there will be a challenge regarding demand levels which were not evident when the long-term plan was developed which is reflected in the organisational risk.

**A22/89 Quality Matters**
The Committee received and noted the report.

SS gave an overview of the key points:

- 7 serious incidents (is a decrease from last month, 3 suicides and 1 unexpected death)
- 1 incident raised in respect of Speech and Language Therapy across the Trust. This is a system issue as there is a shortage of Therapists. The Trust has requested help from St George's and the CCG
- RCAs have slightly increased to 20 outstanding this month
- Unmanaged incidents have increased
- Signing off PRI reviews have improved
- 2 new claims
- 2 suicides with no notable causes from the Trust
- Emergency responses are good
- 3 informal enquires from CQC that ended up as complaints
- 1 CQC visit to Ward 1 which has received good feedback
- Reading of s.132 rights have improved
- Complaints have greatly improved and are now at 97%
- Feedback live response has been positive and a review is being undertaken
- AB commended the Complaints team and questioned regarding the change in definition in respect of degree of harm?
- RT explained this is in line with the National learning reporting system and was triggered when this was cross-referenced with the National learning which has now been rectified. AB commented that this did not provide assurance as to how we were unaware of the issue and requested further information.

  **Action RT will update with further details**
- RF noted one person has made 8 claims – RT explained this was a person who has a clinical presentation that is relevant. RT has requested the claim is defended in order to protect the Trust's reputation. Previous claims were not upheld.
- AB questioned about the learning from recurring themes – SS outlined since the pandemic people are confused about their responsibilities as well as training and development. RT explained there is an ongoing review regarding recurring themes
- DH asked how can we know improvements are being made and monitored
- JeA explained there is work to ensure KPIs are joined up with the Quality Plan and Quality Governance alongside the Fundamental Standards of Care.

**A22/90 Quality and Performance Report**

The report was received and noted by the Board

JeA highlighted the following

- JeA explained the increase in demand and the lack of workforce as well as HR capability is causing huge demand pressure. This means it is a difficult time for staff to make transformational changes due to clinical pressures. There will be incremental changes to get things right first time.
- There has been progress in respect of The Quality Plan implementation and The Fundamental Standards of Care as well as the Dashboard within the report going forward.
- There are a lot of challenges in acute and crisis services and there is pro-active work in respect of this.
- Discharge flow needs to be managed.
- There are ongoing pressures in CAMHS and Community.

- There needs to be further improvement in the HR function in respect of turnover, sickness and stress on staff. Deliverables are being addressed through the HR Recovery Plan. However, there is light at the end of the tunnel as there are plans in place to address the resource issues.
- DH asked re IAPT access rates as Richmond is doing far better – JeA explained this is mainly due to resourcing. However this will be challenging going forward as investment will be limited therefore access rates target rates for 22/23 will most likely not be met.
- BB informed that the Trust consistently out performs in respect of IAPT targets in England.

**A22/91 Corporate Objectives**

SS gave an overview

- Objectives for 21/22 were agreed by Trust Board May 2021
- There are quarterly reviews against metrics set. Due to the pandemic the Board agreed in November last year that some of the deliverables were reset.
- Some work was paused e.g. income generation, co-production, EDI, some elements of the HR Recovery Plan and some external events
- The report detailed which objectives have been met, partially met or carried forward to 22/23
- Details for WRES, DES and Staff survey objectives are currently being updated

**A22/92 NHS Patient Safety Strategy**
Report was received and noted

DBo pointed out that Boards are required to be engaged in, and aware of, the patient safety strategy and how progress is evaluated. DBo and SS have discussed how best to engage Board Members who are not part of QSAC.

RT highlighted the following

- This is the first time this report has come to QSAC
- QGG have been dealing with subset areas
- The report includes an action plan which is owned by QGG
- Key priorities will be monitored
- Service users and carers will be included to have a say on patient safety
- The strategy is across the NHS and driven by the ICSs and the CCGs
- There are 11 areas in respect of key work areas
- There is a requirement for the Trust to have a patient safety specialist who is currently RT
- The key areas are Patient Safety Partners and there is a detailed action plan for this as well as Patient Safety Training (which is not mandatory) which can be completed online. However, the opinion is that this should be mandatory. HR Director is due to take a paper to ELT for an options appraisal regarding this.
- RT has met with HR in respect of Patient Safety culture to ensure this is incorporated into Performance, Disciplinary and Grievance Policies
- AB commented the action plan contained a lot of green items and there is a need to clarify what green actually means and whether this mean we have a 'just culture' '

- AB highlighted Trust Board members needed to discuss and be aware of the item by Feb 2022 and that this deadline has not been met. AB suggested this be put back to the Board meeting July 2022 and reviewed at the next two QSAC meetings to give the Board a more assured position.

**A22/93** **Emergency Planning, Resilience & Response Annual Report**

Board received and noted the report.

RT highlighted the following

- The Trust have moved from substantial to full compliance.
- There is a work plan in place to ensure the Trust stays in full compliance and addresses particular areas that need progress - the biggest objective being to review the Business Continuity Plan
- The Trust have been sighted on some areas as model best practice
- There is some anxiety within teams that there are not many Senior Mangers on site due to agile working.
- RF questioned the BCP and challenges regarding remote working and whether this will be looked at as part of the Integrated Programme
- RT informed there is a meeting regarding this tomorrow to oversee these risks?
- AB questioned if Governance will come to QSAC or EMC?
- SS informed this will got to QDIG and then EMC.

**A22/94** **Quality Plan**

Board received and noted the report and progress made

SS gave an overview

- The plan was developed in initial response to CQC in respect of areas that were not progressed.
- The plan is broken down into 2 themes Leadership Skills and Development and Robust Systems and Processes to monitor and gain assurance.
- Areas are still in progress and on track and there is work to do in respect of QII and skills resources.
- There have been three fundamental of care launch events which were attended by approximately three hundred staff.
- The Fundamental Care In-patient Dashboard is under development and will be aligned to Corporate Objectives.
- VF commented the challenge is to ensure the Fundamental Standards of Care is embedded across the organisation and looks forward to seeing the outcomes.

**A22/95** **Committee Governance and Reporting**

The Board received and noted the minutes listed on the agenda .

- DH asked if the use of handcuffs is reviewed as there was an incident in which a patient was handcuffed whilst being taken to A&E
- SS advised that handcuffs should only be used in a forensic setting and this incident is being investigated.

**A22/96** **Matters for Escalation to the Board**

- Relationship between workforce and quality and understanding different risks
- Verbal update on Patient Safety with a more substantive update in July
- EPRR annual report update on best practice and achievement as well as contextual changes.
- The Quality Plan

**A22/97 Trust Security Framework**

Report was noted and accepted by the Board

QSAC noted their thanks to the Security Team for their work and leadership in developing the Framework.

**A22/98 Meeting Review**

DH found the meeting very informative and received clarification on all points raised
AB commented that the quality of the papers has improved.

Part A meeting closed at 15.30

| | |
|---|---|
| **Meeting:** | Quality & Safety Assurance Committee |
| **Date of Meeting:** | 6th June 2022 |
| **Report Title:** | Committee Annual Report |
| **Author(s):** | Nicola Mladenovic, Deputy Trust Secretary |
| **Executive Sponsor(s):** | David Lee, Director of Corporate Governance |
| **Purpose:** | For Approval |
| **Scrutiny Pathway:** | N/A |
| **Transparency:** | Public |

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**Executive Summary**

Each Committee of the Board is required to complete a self-assessment of its work during the year.

This report contains the outline of the activity completed by the Quality & Safety Assurance Committee during the period 01 April 2021 to 31 March 2022.

The report sets out the annual position and provides details of the forward plan for the Committee in addition to its Terms of Reference.

The Committee is required to submit its final report at the next meeting of the Board.

It is good practice for the Committee to provide an assurance position statement to the Board. A draft statement is included for the Committee's consideration, revision and approval.

**Recommendation**

**The Committee is asked to:**

1) **Consider the contents of the draft annual committee report and offer any comments and suggested changes;**

2) **Finalise and agree the assurance position statement in section 4;**

3) **Review the revised Terms of Reference;**

4) **Subject to any changes agree the revised Committee Annual Report be sent to the Board for consideration and approval in July 2022.**

| Corporate Risk | | | Board Assurance Risk | |
|---|---|---|---|---|

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

| | |
|---|---|
| **Assurance/Governance:** | As a matter of good practice it is important that the Committee reviews its work. This ensures that there is effective engagement with, and assurance of, matters which are important to the Board. The review is focused both on how we work as well as the content of what we do. This practice is a key element of the well-led framework |
| **Clinical:** | There are no direct implications. |
| **Equality & Diversity:** | All committees must consider how they work and the EDI implications of the same. As a committee that is focused on quality and safety, attention to the EDI implications of all agenda items, especially in relation to health inequalities, is central to our work. In addition, as a Board Committee that benefits from service user and carer members, we have to consider the ways in which how we run the committee potentially influences the extent to which those members can participate, particularly given the move to online meetings as a result of the pandemic. We have been glad to welcome two members to QSAC as part of the diversity in decision-making initiative and we look forward to learning from their contributions and perspectives. Focusing on the EDI implications of the committee's work remains a priority for the coming year. |
| **Estates:** | There are no direct implications. |
| **Financial:** | There are no direct implications. |
| **Legal:** | There are no direct implications. |
| **Quality:** | There are no direct implications. |
| **Reputation:** | Quality and safety are central to the Trust's purpose and QSAC's work often has reputational implications. If the Trust cannot demonstrate that it has a robust governance system, and the organisation is not well-led it can lead to reputational damage. |
| **Strategy:** | There are no direct implications. |
| **Workforce:** | There are no direct implications. |
| **Other (specify):** | N/A |

**Appendices/Attachments**:

- **Draft Annual Committee Report – Quality, Safety and Assurance Committee**

## Annual Committee Report
## Quality & Safety Assurance Committee

### 1. Introduction

#### 1.1. Committee Establishment

The Quality & Safety Assurance Committee (the Committee) is an established sub-committee of the Board of Directors.

#### 1.2. Committee Purpose & Duties

The Committee is charged with ensuring that there are effective mechanisms, controls and systems in place to:

- Promote safety and high-quality care for service users and carers;
- Identify and manage risks arising from clinical care;
- Reflect on, and be responsive to, the views of service users, carers, friends and family;
- Ensure the effective and efficient use of resources through evidence based clinical practice; and
- Ensure compliance with quality regulatory standards and best practice.

#### 1.3. Terms of Reference

The full details of the Committee's duties are outlined in the current Committee's Terms of Reference as previously approved at the Trust Board in June 2021.

### 2. Membership & Meeting Attendance

The Committee comprises non-executive directors and executive directors. Other regular attendees included carer/friend and family representatives, service user representatives, the governance and risk lead, a representative from the local commissioners, Diversity in Decision-Making representatives and the Director of Corporate Governance.

During the period the Committee met 11 times and the number of meetings attended by members and contributing attendees are detailed in **Table 1: Members and Meeting Attendance – 01 April 2021 to 31 March 2022 and Table 2: Regular Attendees and Meeting Attendance – 01 April 2021 to 31 March 2022.**

The Committee commissions and reviews many detailed reports and therefore a range of different presenters have attended the meetings during the period of this report, including the internal auditors.

**Table 1: Members and Meeting Attendance - 01 April 2021 to 31 March 2022**

| Members | Role | Attendance (Actual/Eligible) |
|---|---|---|
| **Prof. Deborah Bowman** | Non-Executive Director, Committee Chair | 11/11 |
| **Doreen McCollin** | Non-Executive Director | 10/11 |
| **Vanessa Ford** | Chief Executive | 7/11 |
| **Sharon Spain** | Director of Nursing & Quality Standards | 10/11 |
| **Dr Billy Boland** | Medical Director | 10/11 |
| **Jen Allan** | Chief Operating Officer | 10/11 |

**Table 2: Regular Attendees and Meeting Attendance - 01 April 2021 to 31 March 2022**

| Attendees | Role | Attendance (Actual) |
|---|---|---|
| **David Hobbs** | Service User Representative | 11 |
| **Carol Anne Brennan** | Service User Representative | 9 |
| **Farai Addy** | Diversity in Decision-Making Representative | 7 |
| **Terence Nichols** | Diversity in Decision-Making Representative | 2 |
| **Ryan Taylor** | Associate Director, Clinical Governance and Risk | 10 |
| **Ann Beasley** | Trust Chair | 11 |
| **David Lee** | Director of Corporate Governance | 10 |
| **Valerie Chin-Yu** | Quality Lead, South West London CCG | 6 |
| **Richard Flatman** | Non-Executive Director Observer | 3/6 |

## 3. Committee Work & Activities

The Committee has conducted its work in line with its purpose, namely reviewing key quality, safety and governance-related matters, according to its Terms of Reference and an agreed workplan, whilst retaining the flexibility to adapt, respond and prioritise as required. Since the Covid pandemic the committee has continued to meet virtually rather than as a face-to-face meeting.

The reports commissioned and reviewed by the Committee are broad and fall within five broad categories, namely:

- Quality
- Safety
- Governance
- Risk
- Experience

The items featured on the Committee's agenda during the period are shown in **Table 3: Committee Activity – 01 April 2021 to 31 March 2022.** Some of the reports presented to the Committee are standing agenda items and therefore reviewed at each meeting. Other reports and items are scheduled to be considered by the committee on a quarterly, bi-annual and annual basis. The Committee Chair and members can request updates on an adapted schedule if required and seek further information at any point about specific matters of quality, safety, risk and experience that may arise during the year, including those raised by members of the Executive Team and delegated by the Board.

### 3.1. Forward Planning - April 2022 to March 2023

The Committee has developed a workplan for the period April 2022 to March 2023 which includes continued monitoring of key elements of the clinical and quality strategy, outcomes, safety matters, risks (especially those on the corporate registers and the board assurance

framework) and emerging quality and governance matters, both internal and external, for example changes in the CQC's approach to quality and materials from the National Quality Board e.g. in relation to integrated care systems.

**The workplan is detailed in Table 4: Forward Workplan – 01 April 2022 to 31 March 2023.**

## 4. Assurance & Position Statement (to be agreed by Committee Chair on 6th June 2022)

The Committee has covered a wide range of matters in the last year in both Parts A & B of its agendas. In the Board's stead, QSAC has conducted detailed review of key quality, safety and assurance matters in many domains, the detail of which is set out elsewhere in this report. QSAC continues to develop in how it works as well as in its discussion of specific items with a growing emphasis on:

a) Making links between different sources of information and individual reports to deepen our understanding of quality, safety and experience within SWLSTG, identifying recurrent themes, recognising connections and using information intelligently to prioritise work;
b) Reflecting on, and refining performance measures to reflect increasing complexity, the need to prioritise and the importance of clear and consistent leadership;
c) Developing a whole system approach to quality, standards and patient care, including the Quality strategies and plan and the fundamental standards of care.
d) Creating space on the agenda for rigour in discussion and constructive inquiry that is assurance focused;
e) Expecting and advocating for co-production as a way of working that is not only ethically desirable but also drives sustained and meaningful improvement in services and the patient experience;
f) Broadening the approach to QII within the Trust to draw on the methodology and opportunities in ways that support organisational priorities and strategic change;
g) Requiring an EDI lens, particularly in relation to inequalities and inequity, in all matters relating to quality, safety and the patient experience at SWLSTG; and
h) Encouraging the development of members of QSAC to enable us to adapt to a fast-changing external landscape and ensure we remain informed about, and learn from, best practice and evidence in relation to quality and safety.

Service lines present updates to the Strategic Business Review meeting whereby all Executive Directors and Non-Executive Directors are invited. The Chair of QSAC attends these strategic review meetings and seeks to facilitate consideration of, and communication about, the emerging quality and safety matters between QSAC and the strategic review.

The Committee notes where there are overlaps and connections with other committee work. These commonly arise in respect of workforce and financial and resource matters. The Chairs of the relevant committees have strengthened their communication and the referral process to ensure that each committee works within its remit and can consider the intersections. During the year that is the subject of this report, QSAC has requested and received updates from other committees on key financial, training and workforce issues that might have an impact on the Trust's ability to meet its national and commissioning performance targets and indicators. As the integrated programme develops, it will be increasingly important for QSAC to be proactive about matters of quality and safety that arise from the programme and to liaise effectively, both formally and informally, with colleagues, especially on EMC.

The following reports are received on a regular basis as shown in the workplan and committee activity:

- Mental Health Law;
- Violence and Aggression;
- Reducing Restrictive Practice (Safety in Motion);
- Learning Disabilities, including the Green Light Toolkit;

- Mortality and Suicide;
- Safer Staffing Reviews;
- Quality priorities, including the Quality Strategy and Plan;
- Physical Healthcare;
- Infection Prevention and Control
- Health and Safety;
- Emergency Planning
- Medication Management and Optimisation
- Patient Experience and Complaints
- CQC Inspection Reports and Actions
- Mandatory and Statutory Training; and
- The Workplan Review.

The Committee has received reports following Root Cause Analyses and the learning outcomes arising from serious incidents. During the year under review, the Committee has emphasised the value of considering recurrent themes that arise from such reports and analyses noting where there are overlaps and responding in a systemic way. That approach has enabled deeper discussions of emerging and recurrent issues that may be arising in a clinical service or more broadly than might otherwise be considered if the focus remained on a single incident. The development of the just culture approach is welcome and QSAC continues to take an interest in how it can be evaluated within SWLSTG.

The Committee has received updates pertaining to the Board Assurance Framework and ensures that the Risk Management and Suicide Prevention Strategies support the framework. Considerable discussion and work have led to a review of the approach towards presenting and considering risk at QSAC with an emphasis on timelines, mitigation, rationale and ongoing review. The Risk Register is regularly received and is subject to robust scrutiny at each meeting where actions and updates are considered, recognising the link to the Board Assurance Framework.

Following the Covid-19 pandemic, it has been agreed that the Quality Accounts will not be formally audited by KPMG however we expect the Quality Accounts to be available on the Trust's website from September 2022. The Quality Account is an annual report detailing the quality of services that have been provided and is a look back at the previous year, highlighting where we are doing well and identify where we need to improve. The Quality Account is shared with external stakeholders; Healthwatch that cover SW London, the Health and Oversight Scrutiny Committees (HOSCs), the SWL Clinical Commissioning Group (CCG). Feedback is also sought from the Quality Account Review Group (QARG) with service users and carers.

Since Covid-19, the Trust has had to work in a challenging and changing environment. It is QSAC's view that the Trust has risen to those challenges and provided good care to its patients. It is clear as we close the committee's year that although safety has rightly been prioritised, there have been implications of changes to services for the patient experience. QSAC welcomes the ongoing work that is now focusing on what those changes mean for the patient experience and the learning from the pandemic, for example, via the meaningful contact work that is ongoing. QSAC is increasingly able to encourage thought, reflection and development, including in relation to the cultural considerations that underpin the quality of care, in its meetings as well as navigating a full agenda.

## Table 3: Committee Activity - 01 April 2021 to 31 March 2022

| Quality | Safety | Governance | Risk | Experience |
|---|---|---|---|---|
| Quality & Performance Reports | Mortality & Suicide Prevention Reports | Quality Governance Group (Minutes) | Board Assurance Framework | Patient Experience Update |
| Corporate Objectives | Adult Safeguarding Reports | Mental Health Act Law and Compliance Reports | Risk Register | Review of Safer Staffing and Nursing Establishments |
| Quality Matters | Childrens Safeguarding Reports | Information Governance Report | CAMHS key risk overview and mitigation plans | Carer & Patient Engagement & Involvement Update |
| National Quality Board | Various Root Cause Analysis Reports and SUIs | Mortality & Suicijde Prevention Group minutes | Risk Management Framework | Complaints & Compliments Report |
| Nurse Validation Report | Various Patient Incident Reviews (Deaths etc) | Ethics Committee minutes | Covid-19 BAF | Involvement Report |
| Quality Account 2020/21 and Priorities | Various Serious Incident Reports | Terms of Reference | R&D collaboration pilot | Privacy and Dignity Assessment Report |
| Infection Prevention and Control Reports | Infection Control & Prevention Reports | Mental Health Units (Use of Force) Act 2018 | CQC Well-Led prep | Patient Surveys - inpatient and community |
| Physical Healthcare & Medical Emergency Reports | Health & Safety Report | | Internal Audit report - care and crisis planning and risk assessments | Virtual Board Visits update |
| Quality Strategy | Medicines Management Report | | | Patient Story Annual report |
| Learning Disabity Annual Report | Safety in Motion: Violence & Aggression and Reducing Restrictive Practice Report | | | |
| Mental Ill-Health Prevention and Recovery Programme | Emergency Preparedness, Resilience and Response Assurance Reports | | | |
| CQC initial feedback and response | Incidents, Claims and Inquests Report | | | |
| CQC Report on acute working adult wards and PICU | Sexual Safety Report | | | |
| Clinical Effectiveness Annual Report | Safe Working Hours | | | |
| Review of IAPT | Homicide Annual Report and independent inquiry rport | | | |
| Quality Improvement & Innovation Reports and Qualty Improvement Plan | Developing a Framework for Improving Team Culture | | | |
| QII Review | Appraisal Validation annual report - medical and nursing | | | |
| CQUIN and Quality Priorities | Duty of Candour Reports | | | |
| # Always Ready 2020/21 Report | Claims Report | | | |
| Review of Serenity Integrated Mentoring Project | Security Annual Report | | | |
| Clinical Effectiveness Report | Smoke Free Impact and Effectiveness Report | | | |
| | Queen Mary's Hospital Ligature Position Report | | | |

## Table 4: Forward Workplan – 01 April 2022 to 31 March 2023

| QUALITY & SAFETY ASSURANCE COMMITTEE 2022-2023 AGENDA ITEM | FREQUENCY | EXEC LEAD | AUTHOR | 4 APRIL 2022 | 9 MAY 2022 | 6 JUNE 2022 | 4 JULY 2022 | AUGUST 2022 NO MEETING | 5 SEPTEMBER 2022 | 3 OCTOBER 2022 | 7 NOVEMBER 2022 | 5 DECEMBER 2022 | 9 JANUARY 2023 | 6 FEBRUARY 2023 | 6 MARCH 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ASSURANCE & RISKS** | | | | | | | | | | | | | | | |
| Board Assurance Framework & Registers | M | DNQS/TS | AD of Clinical Gov & Risk | M | M | M | M | --- | M | M | M | M | M | M | M |
| Risk Register in year focus - dates TBC | Q | DNQS | AD of Clinical Gov & Risk | | | | | --- | | | | | | | |
| Risk Management Framework | A | DNQS | AD of Clinical Gov & Risk | | | | | --- | | A | | | | | |
| **SAFETY** | | | | | | | | | | | | | | | |
| Infection Prevention and Control | A | DNQS | Infection Control Nurse | | | | A | --- | | | | | | | |
| Safeguarding (Adults and Children) | Q & A | DNQS | Heads of Safeguarding | | | Q4 | | --- | A | Q1 | | Q2 | | | Q3 |
| Sexual Safety | A | DNQS | Head of Safeguarding Adults | | | | | --- | A | Q1 | | | | | |
| Serious Incident and Incident Reporting Report incl inquests and claims (inc learning) | A/6M | DNQS | Patient Safety Manager | | | | Q4 | --- | | A | | | 6M | | |
| Health & Safety and Ligature Risk Assessment and Management (in-patients and community) | A/6M | DNQS | Health, Safety & Risk Manager | | | | | --- | | A | | | | 6M | |
| Emergency Preparedness, Resilience & Response Assurance Review | A | DNQS | AD of Clinical Gov & Risk | | | | 6M | --- | | | | | A | | |
| Medicines Management and Optimisation | A / 6M | DNQS | Chief Pharmacist | | | | A | --- | | | | | 6M | | |
| Physical Healthcare (including health promotion and awareness) & Med Emergency | A | DNQS | Deputy Director of Nursing | | | | A | --- | | | | | | | |
| Smoke Free Impact and Effectiveness | A | DNQS | Deputy Director of Nursing | | | | | --- | | | | | A | | |
| Homicide Report | A | MD | Patient Safety Manager | | | | | --- | A | | | | | | |
| Mortality Review incl Suicide Prevention Strategy | Q & A | MD | Patient Safety Manager | Q3 | | | Q4 | --- | A | | Q1 | | Q2 | | |
| Duty of Candour Assessment | A | DNQS | Patient Safety Manager | | | | | --- | | | | A | | | |
| Safety in Motion (Violence and Aggression & Restrictive Practice Report) | A/6M | DNQS | Deputy Director of Nursing | | | | | --- | | A | | | | 6M | |
| Safe Working Hours | 6M | MD | Ben Nereli | 6M | | | | --- | | | 6M | | | | |
| Security Strategy and self-assessment | A | | Marcus Hamilton-Holman | | | | | | | | | | A | | |
| Appraisal validation | A | MD/DONQ | | | | | | --- | | | A | | | | |
| **EXPERIENCE** | | | | | | | | | | | | | | | |
| Involvement - Patient and Carer Report (inc Carers, Friends & Family Reference Group, PQF and Triangle of Care | A/6M | DNQS | Head of Involvement | | | A | | --- | | | | | 6M | | |
| Privacy and Dignity Assessment - single gender accommodation | A | DNQS | Deputy Director of Nursing | | | | | --- | | | A | | | | |
| PLACE (due to covid no assessents took place in 2020 and 2021, lite asessments to commence Oct 2021) | A | DFP | HFM | A | | | | --- | | | | | | | |
| Seclusion facilities and practice assurance position | A | DNQS | Deputy Director of Nursing | | | | | --- | | A | | | | | |
| Complaints Report (inc learning) | A / 6M | DNQS | Deputy AD of Governance | | | A | | --- | | | | 6M | | | |
| Patient Experience Report (incl learning) | A / 6M | DNQS | Deputy AD of Governance | | | | | --- | A | | | | | | 6M |
| Community Patient Survey - CQC (incl action plan) | A | DNQS | Deputy AD of Governance | | | | | --- | | | | | A | | |
| **EFFECTIVENESS** | | | | | | | | | | | | | | | |
| Quality Matters - Monthly Position on Incidents, Complaints and Compliance | M | DNQS | AD of Clinical Gov & Risk | M | M | M | M | --- | M | M | M | M | M | M | M |
| # Always Ready (CQC and regulatory compliance) | Q | DNQS | CQUIN & Quality Account Manager | | | Q4 | | --- | Q1 | | | Q2 | | | Q3 |
| Safer Staffing - in-patient services | A / 6M | DNQS | Deputy Director of Nursing | 6M | | | | --- | | | | A | | | |
| Clinical Effectiveness (Including NICE & Clinical Audit) | A / 6M | MD | Deputy AD of Governance | | | | | --- | A | | | | 6M | | |
| Research and Development | A | MD | HQGR | | | | | --- | | | | | | | A |
| Quality Improvement | 6M | MD | Lead for Quality Improvement & Innovation | | A | | | --- | | | 6M | | | | |
| Mental Health Act (including Advocacy Services and regulatory compliance relating to MHAct) | A / 6M | DNQS | Mental Health Law Manager | | | | | --- | A | | | | | | 6M |
| Information Governance inc Caldicott - noting only | A | DFP | IG Manager | | | | | --- | A | | | | | | |
| Quality and Equality Impact Assessments incl CIP | Q & A | DFP | Assoc Director of PMO | Q3 | | A | | --- | | Q1 | | | | | |
| Learning Disability incl Greenlight Toolkit (including Transforming Care (Winterbourne) update and access to services LD) - noting only | A / 6M | DNQS | LD Clinical Lead | | | | A | --- | | | | | 6M | | |
| Response to External Reports and Recommendations | AR | DNQS | Various | | | | | --- | | | | | | | |
| **QUALITY PERFORMANCE** | | | | | | | | | | | | | | | |
| Quality and Performance Report | M | COO | --- | M | M | M | M | --- | M | M | M | M | M | M | M |
| Quality Account | A | DNQS | Deputy AD of Governance | | | A | | --- | | | | | | | |
| Quality Priorities / CQUINs | Q | DNQS | CQUIN & Quality Account Manager | | | | | --- | | | | | | Q3 | |
| **COMMITTEE GOVERNANCE & REPORTING** | | | | | | | | | | | | | | | |
| Committee's Annual Report and Terms of Reference | A | TS | Deputy Trust Secretary | | | Annual Report and ToRs | | --- | | | | | | | |
| Committee Effectiveness and Future Workplan | A | TS | Deputy Trust Secretary | | | | | --- | | | | | | | A |
| Approval of Terms of Reference for Quality Governance Group (QGG) | A | DNQS | AD of Clinical Gov & Risk | | | A | | --- | | | | | | | |
| Minutes for Quality Governance Group (QGG) | M | DNQS | AD of Clinical Gov & Risk | M | M | M | M | --- | M | M | M | M | M | M | M |
| Minutes for Mortality & Suicide Prevention Committee | M | MD | Patient Safety Manager | M | M | M | M | --- | M | M | M | M | M | M | M |
| Minutes for Ethics Committee | M | MD | Deputy Medical Director | M | M | M | M | --- | M | M | M | M | M | M | M |
| Matters for escalation to the Board | M | Chair | --- | M | M | M | M | --- | M | M | M | M | M | M | M |

**KEY**

A=ANNUALLY / BA=BI-ANNUALLY / 6M=SIX MONTHLY / Q=QUARTERLY / M=MONTHLY / AR=AS REQUIRED

FD=FOR DISCUSSION / FA=FOR APPROVAL / FI=FOR INFORMATION / FE=FOR ENDORSEMENT / FN=FOR NOTE / TR=TO RECEIVE

Red Text = New or changed Agenda Items

Black Text = Public Agenda

**APPENDIX**
**Terms of Reference**

| Committee | QUALITY AND SAFETY ASSURANCE COMMITTEE |
|---|---|
| **Strategic ambitions** | **All of the Trust's strategic ambitions fit within the scope of this Committee.** |
| **Chair** | Non-Executive Director |
| **Executive Lead** | Director of Nursing and Quality |
| **Secretary** | Trust Secretariat |
| **Members** | x2 Non-Executive Director, one of whom is the Chair<br>Chief Executive Officer<br>Chief Operating Officer<br>Medical Director<br>Director of Nursing and Quality<br>Director of Human Resources<br>2 x Diversity in Decision Making Representatives |
| **Attendees** | Clinical Directors for updates on serious incidents and investigations and key items<br>x 4 Service User, Carer and Friends/Family Representatives<br>Clinical Commissioning Group Representative<br>Director of Corporate Governance<br>The Committee may invite any other Trust representative and/or external professional advisors as it deems necessary from time to time. |
| **Frequency** | The Committee will meet at least ten times per year. |
| **Quorum** | The quorum of the Committee shall be four members one of whom must be a Non-Executive Director, another the Director of Nursing and Quality or a duly appointed deputy.<br><br>Where an executive director is not able to attend the meeting, he/she must send a deputy who is authorised to make decisions on their behalf. |

**Purpose**

This Committee has been established to ensure, on behalf of the Board, that there are effective mechanisms, controls and systems in place to:

- Support the Trust attaining an 'Outstanding' rating;
- Promote safety and high-quality patient care;
- Identify and manage risk arising from clinical care;
- Reflect and be responsive to the views of patients and carers;

- Ensure the effective and efficient use of resources through evidence based clinical practice; and
- Keep abreast of key staffing issues which may impact on the quality of the service provided.

**Duties**

Through its work the Committee will:

- provide assurance to the Board that high standards of care are being provided;
- agree Trust-wide quality governance priorities;
- provide assurance that the Trust has a robust framework to manage risks to the delivery of safe, quality care;
- scrutinise assurance on delivery of the quality aspects of the Trust Strategy; and
- oversee the production of the Trust's annual Quality Accounts.

**Assurance and risk**

- Keep under review the quality related Board Assurance Framework risks and risks on the Trust's risk registers.
- Ensuring that risks to patient care are minimised.

**Safety**

- Ensuring the review of serious patient safety incident (including safeguarding) and of complaints and claims. Through such review to secure assurance that necessary improvements are made and learning shared across the Trust.

**Experience**

- Receiving service user, carer and staff feedback.

**Effectiveness**

- Receiving and approving the annual clinical audit programme.

**Governance**

- Ensuring compliance with statutory elements of quality governance.
- Considering internal audit reports in respect of areas which directly impact on the delivery of care.
- Reporting to the Audit Committee its findings in regard to the system of control in place to manage care risks.
- Receiving updates from the Clinical Transformation Programme, People Readiness & Culture Change Programme and Estates Modernisation Programme via the Estates Modernisation Management Group/ Estates Modernisation Committee, where key areas from these programmes fall within the Committee remit. In addition, the Estates Modernisation Committee will from time to seek assurance from QSAC on any clinical or quality related change resulting from the Clinical Transformation Programme that might impact EMP
- Agreeing the work plan and monitoring the work of the Quality Governance Group.

**Quality**

- Scrutinising the monthly quality and performance information prior to Trust Board.
- Reviewing the development of the Trust Annual Quality Account on behalf of the Trust Board and to recommend to the Board priorities for the year ahead and monitor and review progress throughout the year.

- Undertake service pathway performance deep dives.
- Receiving highlight reports from the Clinical Quality Review Group.
- Receiving reports on impact assessments of proposed changes to Trust services.

- Report to the Finance and Performance Committee any matters which give rise to non-achievement of the Trust's performance targets.
- Report to the Estates Modernisation Committee any matters which give rise to the non-delivery of the Clinical Transformation Programme, People Readiness and Culture Change Programme and Estates Modernisation Programme. Significant clinical and quality changes proposed through the Clinical Transformation Programme, such as new models of care, will be assured by QSAC.

**Authority**

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

**Operation**

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

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

**Reporting**

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

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

Reporting Groups
The Committee will receive the minutes and regular reports from the following working groups:

- Quality Governance Group
- Estates Modernisation Management Group

For Board review July 2022

Trust
NHS
South West London and
St George's Mental Health
NHS Trust
Quality and Performance Report
May 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 |

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# 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.

As seen across the 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. A Multi-Agency Discharge Event was held at the end of May and an action plan is in place to address themes identified, but overall the event highlighted the complexity of MH pathways and patients, with the majority of delays being multi-factorial and difficult to resolve even with the most senior input. We are also working with South London Partnership colleagues to develop short and medium term schemes to support the acute pathway through winter and address future demand. Improvement and transformation work on our inpatient pathway is moving into its next phase, including reviewing our crisis assessment service, adopting consistent, digitally-supported ward workflows and embedding these as we move into our new buildings, and improving the care we offer our complex rehab and emotional needs patients.

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. We continue to focus on recruitment and staff wellbeing, particularly medical recruitment, as well as developing our Adult Community and CAMHS Transformation programmes to deliver more integrated care pathways and optimise patients' recovery. We are also working with partners to support alignment of services across a complicated local provider landscape in Kingston and Richmond boroughs, in line with our transformation priorities this year. Overall, this is a very challenging position for our services and we know that mental health trusts across London and nationally are seeing similar issues.

The focus of this report is May 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 Executive recognises the need to provide the Trust Board with enhanced oversight on metric assurance & trends. In 2022/23 reporting, a summary assurance overview on priority metrics is being developed to provide greater transparency on the assurance position; the overall picture can be seen on page 6 and reflects significant challenges with Access and Flow, and with Workforce, while there is a more stable position around Quality and Finance. This is consistent with the context of very high demand and constraints on workforce, as well as the HR recovery process. The significant system pressures currently, as well as ongoing workforce challenges, contribute to slow progress in improving key metrics. The Director of Finance and Chief Operating Officer are also developing an overview of performance across all four domains and their related themes, to draw out areas of continued challenge and identify new approaches to address these, collaborating with the wider executive team and Service Line leadership.

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

- We have previously reported on the key risks for workforce being Medical Staffing, Employee Relations and Recruitment. The new Interim Medical Staffing Manager is now in place and is working closely with the Medical Director and Clinical Directors to ensure improvements in the service. The Employee Relations Service will move to SWLSTG from a joint approach from the middle of July and our support from Capsticks will cease. The ER caseload has now reduced to 70 cases, 49 of which are absence related. New ER cases are being triaged more robustly and so the number of cases is not growing and quarterly ER reviews are in place with the COO, DON and Service Leads. The Recruitment team workload is now coming under control and focus is on separating the function so that the attention can be on SWLSTG only. 10 People Priorities including these high risk areas, and others focussed on Temporary Staffing, CIP targets, sickness absence, engagement etc are now being mapped with project plans for each and KPIs to demonstrate progress. These will be used to monitor ongoing progress through WODC and ELT. The separation of the whole HR & OD function is progressing, consultation has started with those in joint posts in senior positions and the revised structure is being finalised. The detail of the separation is included within the Proposal for The Future of HR & OD Services has been reviewed by the ELT and will be presented to the WODC at the end of July 2022.
- Development of the Quality Plan commenced in October 2021 to place care quality at the centre. The 10 workstreams of the plan tackle a broad range of enabling themes including clinical systems, staff training, policy development and quality improvement, forming a holistic approach to the implementation of the Fundamental Standards of Care. As part of the Quality Plan the 11 Fundamental standards of care (FSOC) SOPs have been launched and a range of FSOC Trustwide webinars delivered throughout March led by the professional leads. 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 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.

- 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, but the completion has not improved.
- The improvement in complaints responses within 25 days has been sustained following successful implementation of a recovery plan commissioned by the Director of Nursing and Quality.
- 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 breaches due to the long waits. Mitigations have included:-
  **Waitlist initiative:** 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 whist 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.
- 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. There may be further opportunities for improvement throughs 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, there are higher volumes of waits over 30 weeks and there is an expectation that numbers may increase further if the level of Step 3 vacancies continues; this is a challenge for many IAPT services. 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. From June reporting will incorporate waits for therapy within tier 3 CAMHS. Scrutiny on internal waits is via the monthly Trust Access meeting.
- Crisis and acute inpatient services remain in a challenging position, with 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.
- Performance on clients seen for assessment by liaison services within an hour is remains a concern; with delays in St Georges 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). A Liaison teams improvement plan is in place as these teams continue to experience significant challenges with demand and performance, exacerbated by delays in bed availability and flow.
- Standards set for face to face care delivery are a key focus for Community services, using the agreed decision 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.
- Initial investment into CAMHS SPA and Tier 3 teams to address demand challenges and historic under-resourcing has now been put in place for all 5 boroughs in-year. Recruitment drive continues for CAMHS Eating Disorder community teams and a process has been developed in partnership with St George's to improve the clinical pathway for young people to coordinate and make best use of resources across the acute, eating disorders, crisis and Tier 3 teams. Workforce remains a challenge with CAMHS pathways a priority area. There has been successful recruitment (all started in March 2022) Clinical Nurse Specialist -Risk Management nurses in Tier 3 and a Clinical Nurse Specialist - non-medical prescribing to focus on ADHD titration this should have a positive impact in addressing the ADHD back log in Tier 3 CAMHS. In addition the development of the CAMHS website will provide access to waiting time information. In respect of EDI, the CAMHS anti-racism statement has been signed off at QGG and will be incorporated in the operational policy. The steering group continue to meet to discuss implementation and are planning a launch of the statement and CAMHS anti-racism CPD event for September. A gender identity working group has been set up to ensure best practice within CAMHS.
- PADR and Supervision rates continue to deteriorate; work is planned to support staff in response to feedback about stress and burn out following the pandemic and with increasing MH demand. PADR rates are expected to improve in quarter 1 2022/23 as Trust managers are expected to complete in this period.

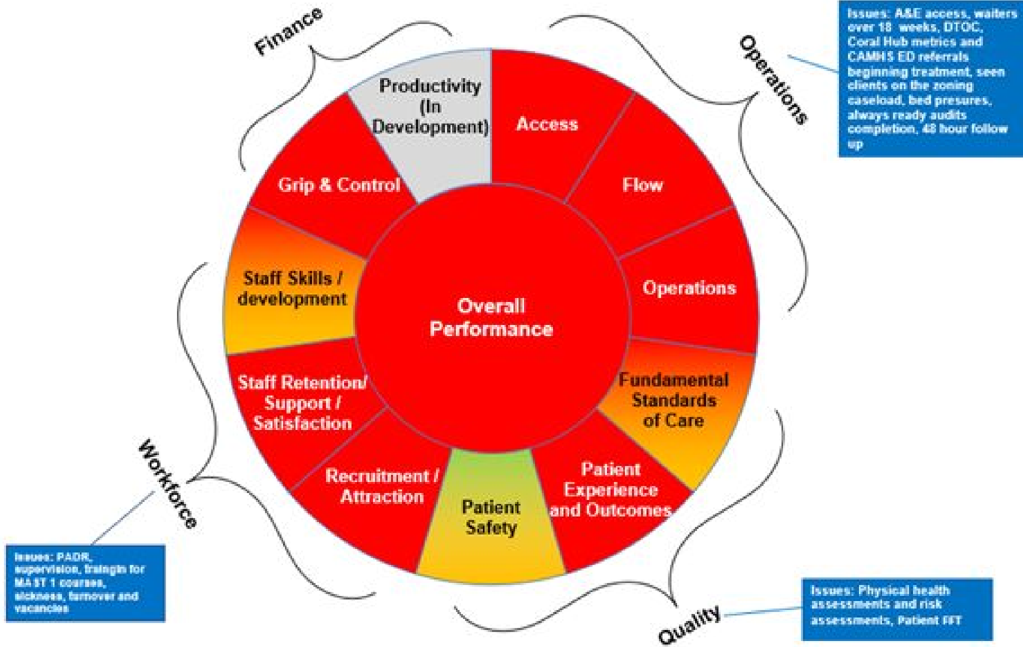
We continue to support front line staff and service line leadership teams to deliver improvements to our key priority areas in the context of ongoing demand and wider workforce pressure. We are seeing indicators moving in the right direction in a number of areas, but the challenges of meeting significant 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 its annual plan in April 2022, which returned a deficit for the 2022/23 financial year of £4.1m. NHSE/I has requested an improved return by 20th June. This has now been submitted and shows the required position of break-even. The CIP requirement within this submission is £12.4m. At M2, the Trust remains on its target trajectory and has delivered £1.2m of cumulative savings. The challenge will be to reach March 2023 with an underlying run-rate that secures a break-even position for 2023/24 and beyond.

# Quality and Performance Summary

**Board Assurance Framework – Latest Risks**

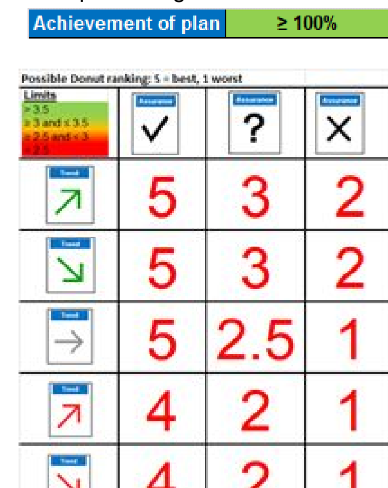
A failure to effectively position the organisation within the external environment.




| Domain | Full Assurance | Some Assurance | No Assurance | % Full/Some Assurance |
|---|---|---|---|---|
| Operations | 8 | 18 | 19 | 57.8% |
| Quality | 6 | 7 | 6 | 68.4% |
| Workforce | 3 | 1 | 7 | 36.4% |
| Finance | 0 | 0 | 1 | 0.0% |
| **Total** | **18** | **24** | **30** | **58.3%** |

- 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 | | May-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) | Access | 50 | ≥ 60.0 | ↘ | ? | Target: 60 |
| Operations | Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 12) | Access | 28 | = 0 | ↗ | X | |
| Operations | No one is waiting more than 30 weeks for treatment - Number of breaches (including CAMHS Neuro, IAPT & Non-RTT teams) (see page 13) | Access | 773 | 0 | ↗ | X | |
| Operations | Adult and Older People's CMHTs - Non-Urgent Referrals assessed within 28 days (%) (see page 14) | Access | 86.8 | ≥ 80.0 | → | ? | Target: 80 |
| Operations | CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 15) | Access | 100 | ≥ 95.0 | → | ? | |
| Operations | Emergency readmission within 30 days - Adult Acute & PICU (%) (see page 16) | Flow | 5 | ≤ 8.5 | → | ? | |
| Operations | Zoning caseload seen as required (%) – Red (see page 17) | Flow | 85.7 | ≥ 95.0 | → | X | Target: 95 |
| Operations | Adult acute average length of stay (Excluding PICU) (see page 18) | Flow | 51.1 | ≤ 33.2 | → | ? | Target: 38 |
| Operations | Follow up within 48 hours of discharge from inpatient services (%) (see page 20) | Flow | 80.6 | ≥ 95.0 | → | X | Target: 95 |
| Operations | Delayed transfers of care (%) (see page 21) | Flow | 6.9 | ≤ 2.5 | ↗ | X | Target: 2.5 |

| | Priority Metrics | | May-22 | Target | Trend | Assurance* | SPC Chart |
|---|---|---|---|---|---|---|---|
| Operations | Liaison psychiatry - Seen within 1 hour in A&E (%) (see page 11) | Access | 76.1 | ≥ 95.0 | ↘ | X | Target: 95 |
| Operations | Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 12) | Access | 84.6 | ≥ 92.0 | ↘ | X | Target: 92 |
| Operations | Internal waits for treatment of over 30 weeks (see page 14) | Access | 237 | 0 | ↗ | - | |
| Operations | Perinatal: women accessing specialist PMH services as a proportion of births (see page 15) | Access | 6.6 | ≥ 10.0 | ↗ | X | Mean: 6.16 Mean: 6.16 |
| Operations | CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 16) | Access | 66.4 | ≥ 80.0 | ↘ | ? | Target: 80 |
| Operations | Zoning caseload seen as required (%) - Amber (see page 17) | Flow | 77 | ≥ 95.0 | → | X | Mean: 69.33 Target: 95 |
| Operations | Time on caseload by zone (days) (see page 18) | Flow | 92.8 | - | → | - | |
| Operations | Inappropriate out of area placement bed days - Adult Acute & PICU (see page 19) | Flow | 243 | = 0 | ↗ | X | Mean: 122.04 |
| Operations | Inpatient discharge letters sent within 24 hours (%) (see page 21) | Flow | 90 | ≥ 90.0 | → | ? | Target: 90 |
| Operations | Number of people accessing Individual Placement and Support (IPS) | Flow | - | TBC | - | - | Metric to be defined |

| | Priority Metrics | May-22 | Target | Trend | Assurance* | SPC Chart |
|---|---|---|---|---|---|---|
| Operations | IAPT recovery rate - Merton Uplift (%) (see page 22)<br>**Flow** | 50.2 | ≥ 52.0 | → | ? | |
| Operations | IAPT recovery rate - Sutton Uplift (%) (see page 22)<br>**Flow** | 49.7 | ≥ 50.0 | → | ? | |
| Operations | IAPT recovery rate - Talk Wandsworth (%) (see page 22)<br>**Flow** | 56.6 | ≥ 50.0 | → | ✓ | |
| Operations | Data quality maturity index (DQMI) (%) (see page 23)<br>**Operations** | 98.1 | ≥ 95.0 | → | ✓ | Mean: 98.28 / Mean: 98.28 |
| Quality | Inpatient Risk assessments completed within 48 hours of admission (%) (see page 24)<br>**Fundamental Standards of Care** | 90.8 | ≥ 95.0 | → | ✗ | Target: 95 |
| Quality | Physical Health Assessment completed within 7 days of admission (%) (see page 25)<br>**Fundamental Standards of Care** | 77.5 | ≥ 90.0 | → | ✗ | Target: 90 |
| Quality | Safe Staffing: national Compliance - Inpatients (%) (see page 26)<br>**Fundamental Standards of Care** | 127.4 | ≥ 95.0 | → | ✓ | Target: 95 |
| Quality | Safe Staffing: Community safe staffing indicator<br>**Fundamental Standards of Care** | - | TBC | - | - | Metric to be defined & developed |
| Quality | Always Ready Audit Compliance (%) (see page 28)<br>**Fundamental Standards of Care** | 87.7 | ≥ 90.0 | ↘ | ? | Target: 90 |
| Quality | Patient Friends and Family Test (%) (see page 29)<br>**Patient Experience and Outcomes** | 80.8 | ≥ 92.0 | ↘ | ✗ | Target: 92 |

| | Priority Metrics | May-22 | Target | Trend | Assurance* | SPC Chart |
|---|---|---|---|---|---|---|
| Operations | Expected population need met by IAPT (see page 22)<br>**Flow** | TW 1483<br>SU 819<br>MU 755<br>RI 432 | TW 1635.4<br>SU 743.4<br>MU 883.2<br>RI 846 | - | - | |
| Quality | Community risk assessments reviewed within the last 12 months (%) (see page 24)<br>**Fundamental Standards of Care** | 92.1 | ≥ 95.0 | → | ✗ | Target: 95 |
| Quality | Physical Health Assessment attempted within 48 hours of admission (%) (see page 25)<br>**Fundamental Standards of Care** | 95.3 | ≥ 95.0 | → | ? | Target: 95 |
| Quality | Cardiometabolic Assessments - Community and EIS (%) (see page 26)<br>**Fundamental Standards of Care** | 81.9 | ≥ 75.0 | ↘ | ✓ | Mean: 84.28 |
| Quality | Safe Staffing: baseline includes requirements related to observation levels (see page 27)<br>**Fundamental Standards of Care** | 85.5 | - | → | - | |
| Quality | Always Ready Audits Completed (%) (see page 27)<br>**Fundamental Standards of Care** | 76.5 | ≥ 90.0 | ↗ | ✗ | Target: 90 |
| Quality | Complaints Answered Within 25 Days (%) (see page 28)<br>**Patient Experience and Outcomes** | 89.4 | ≥ 85.0 | ↗ | ? | Target: 85 |
| Quality | Patient Safety Incidents – Severe Harm (see page 30)<br>**Patient Safety** | 3 | ≤ 1.5 | → | ? | |

| | Priority Metrics | May-22 | Target | Trend | Assurance* | SPC Chart |
|---|---|---|---|---|---|---|
| Quality | Total number of restraints (physical restraints and rapid tranquilisation) (see page 31)<br>**Patient Safety** | 64 | - | → | - | |
| Quality | Death - Suspected suicide (see page 32)<br>**Patient Safety** | 3 | ≤ 4 | ↗ | ? | Mean: 2.92 Target: 4 |
| Workforce | Vacancies in active recruitment (%) (see page 34)<br>**Recruitment/ Attraction** | 69.2 | ≥ 90.0 | → | ✗ | Target: 95 |
| Workforce | % BAME Managers (band 8a and above)<br>**Recruitment/ Attraction** | - | TBC | - | - | Metric definition being progressed |
| Workforce | Temporary staffing - Community Service Line (%) (see page 35)<br>**Recruitment/ Attraction** | 21.4 | ≤ 22 | → | ✓ | |
| Workforce | Statutory and Mandatory Training: 2 (%) (see page 36)<br>**Staff Skills/ Development** | 90.2 | ≥ 85.0 | ↘ | ✓ | Mean: 91.79 |
| Workforce | Staff Leaving within 12 months of appointment (%) (see page 37)<br>**Staff Retention/ Support / Satisfaction** | 19 | ≤ 20 | ↘ | ✓ | Mean: 21.12 Target: 20 |
| Workforce | PADR (%) (see page 38)<br>**Staff Retention/ Support / Satisfaction** | 73.7 | ≥ 95.0 | ↘ | ✗ | |
| Workforce | ER cases exceeding 90 days<br>**Staff Retention/ Support / Satisfaction** | - | TBA | - | - | Metric to be developed |
| Finance | Agency as a % to NHSI Target (%) (see page 40)<br>**Grip & Control** | 172 | ≤ 100 | ↗ | ✗ | Target: 100 |

| | Priority Metrics | May-22 | Target | Trend | Assurance* | SPC Chart |
|---|---|---|---|---|---|---|
| Quality | Reducing restrictive practices – Prone Restraint (see page 31)<br>**Patient Safety** | 13 | - | ↘ | - | |
| Workforce | Vacancy Rate (%) (see page 33)<br>**Recruitment/ Attraction** | 19.4 | ≤ 15 | ↗ | ✗ | Mean: 17.57 Target: 15 |
| Workforce | Time to Recruit (days) (see page 34)<br>**Recruitment/ Attraction** | 51.7 | ≤ 49 | ↗ | ✗ | Target: 49 |
| Workforce | Temporary staffing - Acute and Urgent Care Service Line (%) (see page 35)<br>**Recruitment/ Attraction** | 31.4 | ≤ 22 | ↗ | ✗ | |
| Workforce | Statutory and Mandatory Training: 1 (%) (see page 36)<br>**Staff Skills/ Development** | 91.4 | ≥ 95.0 | ↘ | ✗ | |
| Workforce | Turnover (%) (see page 37)<br>**Staff Retention/ Support / Satisfaction** | 17.7 | ≤ 15 | ↗ | ✗ | Target: 15 |
| Workforce | Supervision (%) (see page 38)<br>**Staff Retention/ Support / Satisfaction** | 83.9 | ≥ 85.0 | → | ? | Target: 85 |
| Workforce | Active ER cases (see page 39)<br>**Staff Retention/ Support / Satisfaction** | - | TBA | - | - | Metric to be developed |
| Workforce | Staff Friends and Family Test (recommend treatment) (reported quarter in arrears) (%) (see page 39)<br>**Staff Retention/ Support / Satisfaction** | - | ≥ 75.0 | - | - | Metric to be developed |
| Finance | % forecast budget overspend<br>**Grip & Control** | - | TBA | - | - | Forecast reporting not available until month 3 |

* 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

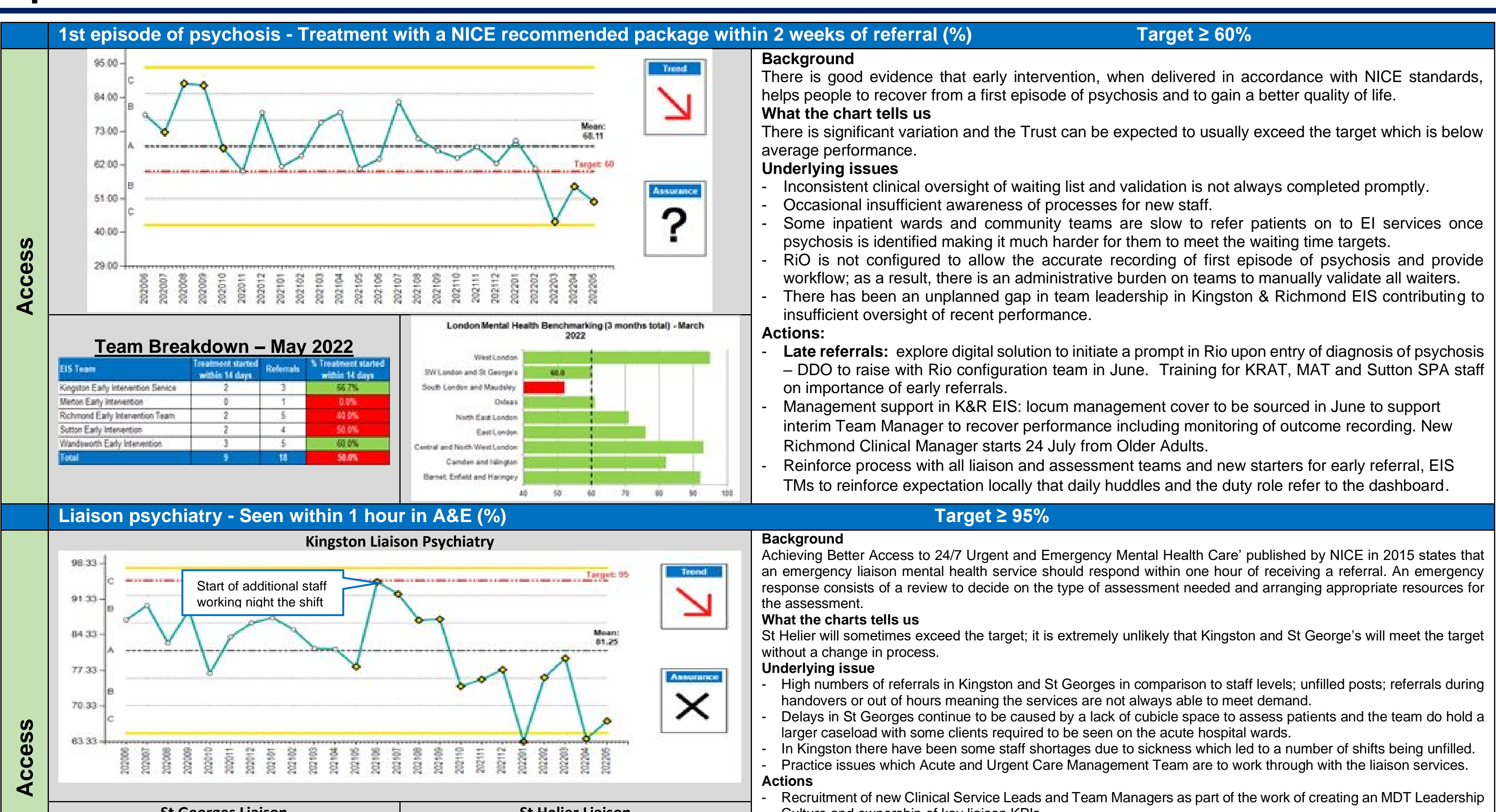
The executives have reviewed the totality of the indicators across all domains. The information within the priority metrics section of this report captures a subset of key issues for your attention and information.

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




## Team Breakdown – May 2022

| EIS Team | Treatment started within 14 days | Referrals | % Treatment started within 14 days |
|---|---|---|---|
| Kingston Early Intervention Service | 2 | 3 | 66.7% |
| Merton Early Intervention | 0 | 1 | 0.0% |
| Richmond Early Intervention Team | 2 | 5 | 40.0% |
| Sutton Early Intervention | 2 | 4 | 50.0% |
| Wandsworth Early Intervention | 3 | 5 | 60.0% |
| Total | 9 | 18 | 50.0% |

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

**What the chart tells us**
There is significant variation and 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 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.

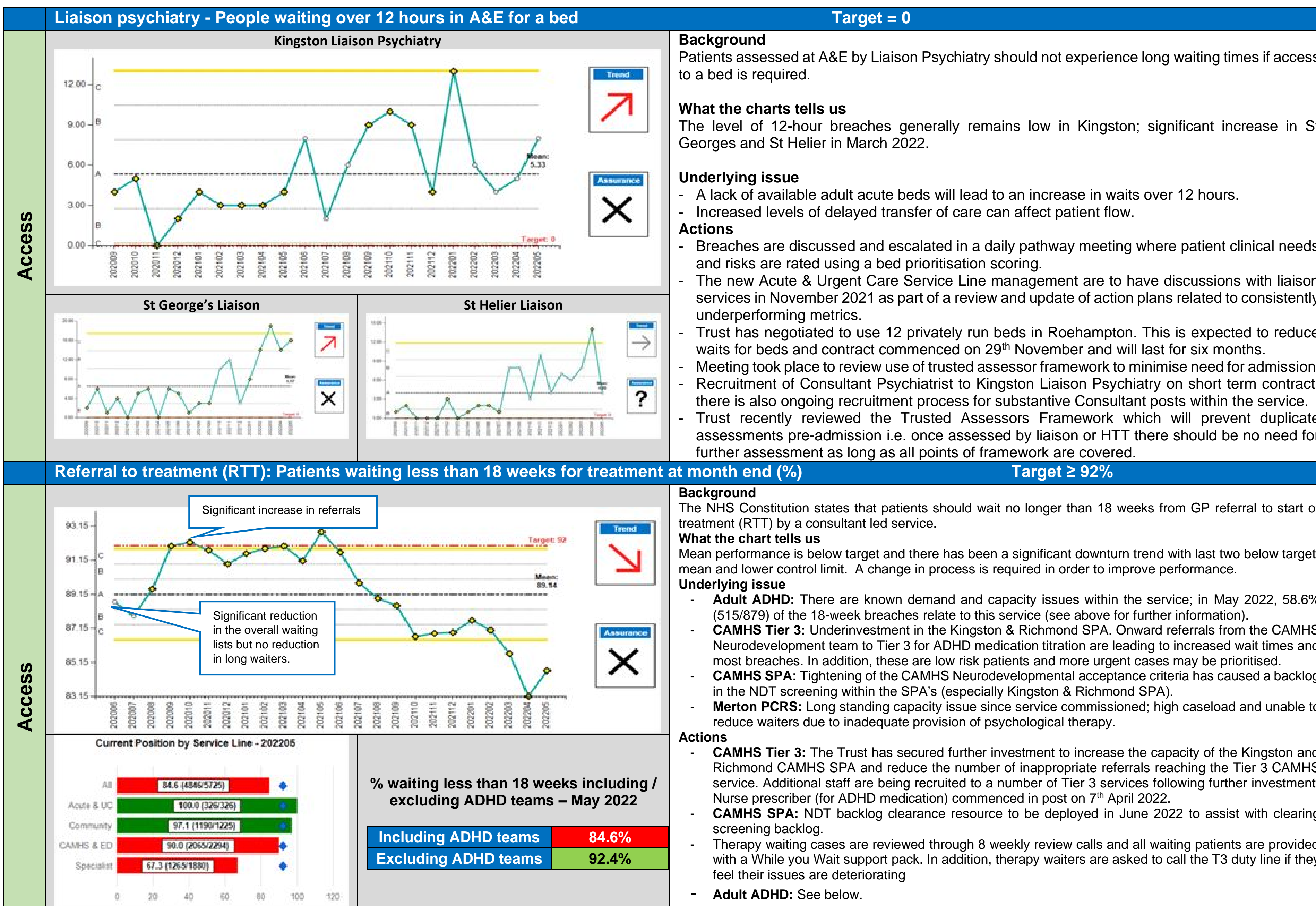
**Actions:**
- **Late referrals:** explore digital solution to initiate a prompt in Rio upon entry of diagnosis of psychosis – DDO to raise with Rio configuration team in June. Training for KRAT, MAT and Sutton SPA staff on importance of early referrals.
- Management support in K&R EIS: locum management cover to be sourced in June to support interim Team Manager to recover performance including monitoring of outcome recording. New Richmond Clinical Manager starts 24 July from Older Adults.
- Reinforce process with all liaison and assessment teams and new starters for early referral, EIS TMs to reinforce expectation locally that daily huddles and the duty role refer to the dashboard.

**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.




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

**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.
- Trust has negotiated to use 12 privately run beds in Roehampton. This is expected to reduce waits for beds and contract commenced on 29th November and will last for six months.
- 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 – May 2022**

| | |
|---|---|
| Including ADHD teams | 84.6% |
| Excluding ADHD teams | 92.4% |

**Background**

The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to start of treatment (RTT) by a consultant led service.

**What the chart tells us**

Mean performance is below target and there has been a significant downturn trend with last two below target, mean and lower control limit. A change in process is required in order to improve performance.

**Underlying issue**

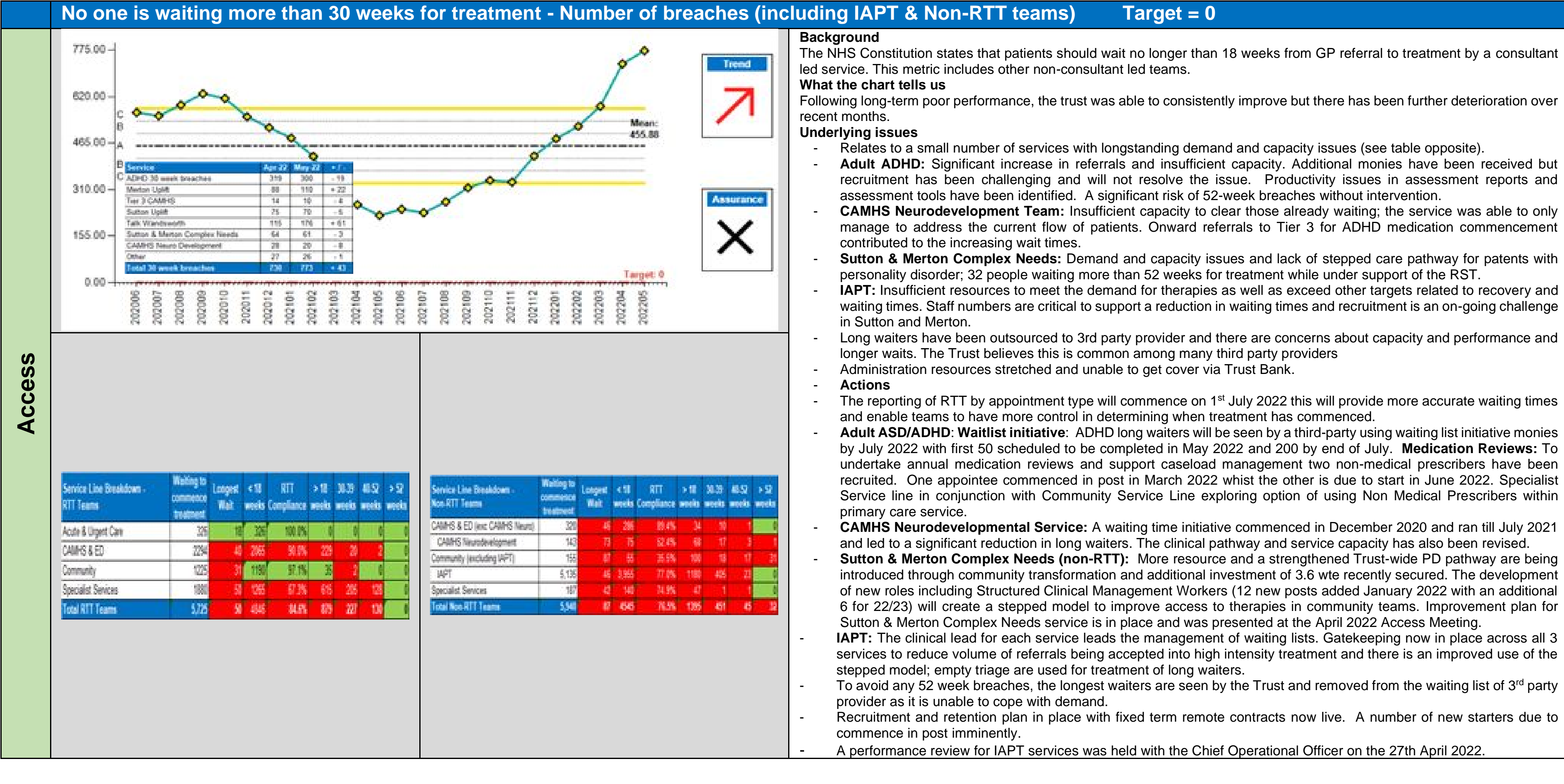
- **Adult ADHD:** There are known demand and capacity issues within the service; in May 2022, 58.6% (515/879) of the 18-week breaches relate to this service (see above for further information).
- **CAMHS Tier 3:** Underinvestment in the Kingston & Richmond SPA. Onward referrals from the CAMHS Neurodevelopment team to Tier 3 for ADHD medication titration are leading to increased wait times and most breaches. In addition, these are low risk patients and more urgent cases may be prioritised.
- **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).
- **Merton PCRS:** Long standing capacity issue since service commissioned; high caseload and unable to reduce waiters due to inadequate provision of psychological therapy.

**Actions**

- **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 (for ADHD medication) commenced in post on 7th April 2022.
- **CAMHS SPA:** NDT backlog clearance resource to be 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 While you Wait support pack. In addition, therapy waiters are asked to call the T3 duty line if they feel their issues are deteriorating
- **Adult ADHD:** See below.

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

**Access**




| Service | Apr 22 | May 22 | + / - |
|---|---|---|---|
| ADHD 30 week breaches | 319 | 300 | - 19 |
| Merton Uplift | 88 | 110 | + 22 |
| Tier 3 CAMHS | 14 | 10 | - 4 |
| Sutton Uplift | 75 | 70 | - 5 |
| Talk Wandsworth | 115 | 176 | + 61 |
| Sutton & Merton Complex Needs | 64 | 61 | - 3 |
| CAMHS Neuro Development | 28 | 20 | - 8 |
| Other | 27 | 26 | - 1 |
| Total 30 week breaches | 730 | 773 | + 43 |

| Service Line Breakdown - RTT Teams | Waiting to commence treatment | Longest Wait | < 18 weeks | RTT Compliance | > 18 weeks | 30-39 weeks | 40-52 weeks | > 52 weeks |
|---|---|---|---|---|---|---|---|---|
| Acute & Urgent Care | 326 | 18 | 326 | 100.0% | 0 | 0 | 0 | 0 |
| CAMHS & ED | 2294 | 40 | 2065 | 90.0% | 229 | 20 | 2 | 0 |
| Community | 1225 | 31 | 1190 | 97.1% | 35 | 2 | 0 | 0 |
| Specialist Services | 1880 | 50 | 1265 | 67.3% | 615 | 205 | 128 | 0 |
| Total RTT Teams | 5,725 | 50 | 4846 | 84.6% | 879 | 227 | 130 | 0 |

| Service Line Breakdown - Non-RTT Teams | Waiting to commence treatment | Longest Wait | < 18 weeks | RTT Compliance | > 18 weeks | 30-39 weeks | 40-52 weeks | > 52 weeks |
|---|---|---|---|---|---|---|---|---|
| CAMHS & ED (exc CAMHS Neuro) | 320 | 46 | 286 | 89.4% | 34 | 10 | 1 | 0 |
| CAMHS Neurodevelopment | 143 | 73 | 75 | 52.4% | 68 | 17 | 3 | 1 |
| Community (excluding IAPT) | 155 | 87 | 55 | 35.5% | 100 | 18 | 17 | 31 |
| IAPT | 5,136 | 46 | 3,955 | 77.0% | 1180 | 405 | 23 | 0 |
| Specialist Services | 187 | 42 | 140 | 74.9% | 47 | 1 | 1 | 0 |
| Total Non-RTT Teams | 5,940 | 87 | 4545 | 76.5% | 1395 | 451 | 45 | 32 |

**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**

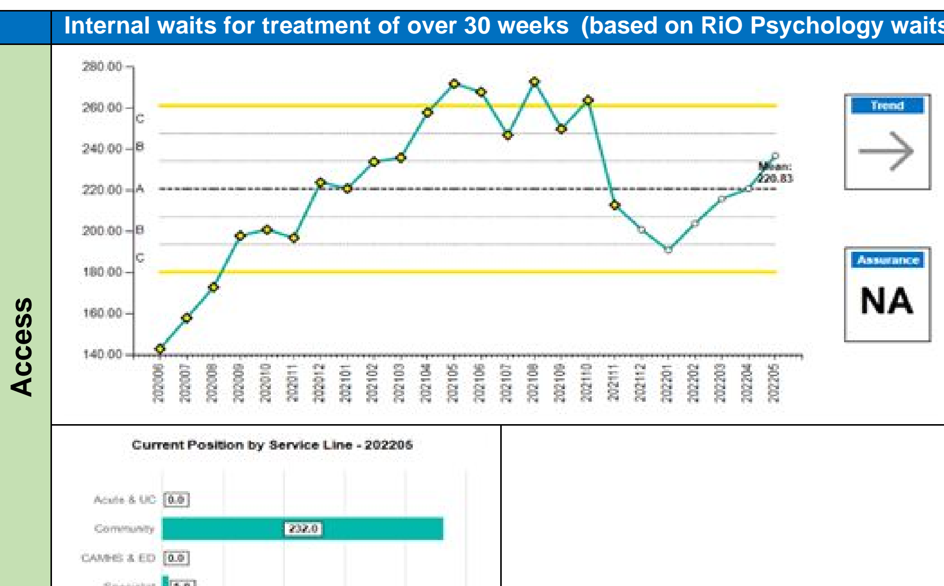
Following long-term poor performance, the trust was able to consistently improve but there has been further deterioration over recent months.

**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; 32 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 will commence on 1st July 2022 this will provide more accurate waiting times and enable teams to have more control in determining when treatment has commenced.
- **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 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 therapies in community teams. Improvement plan for Sutton & Merton Complex Needs service is in place and was presented at the April 2022 Access Meeting.
- **IAPT:** The clinical lead for each service leads the management of waiting lists. Gatekeeping now in place across all 3 services to reduce volume of referrals being accepted into high intensity treatment and there is an improved use of the stepped model; empty triage are used for treatment of long waiters.
- To avoid any 52 week breaches, the longest waiters are seen by the Trust and removed from the waiting list of 3rd party provider as it is unable to cope with demand.
- Recruitment and retention plan in place with fixed term remote contracts now live. A number of new starters due to commence in post imminently.
- A performance review for IAPT services was held with the Chief Operational Officer on the 27th April 2022.

## Access

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




Trend

Assurance

NA

**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**

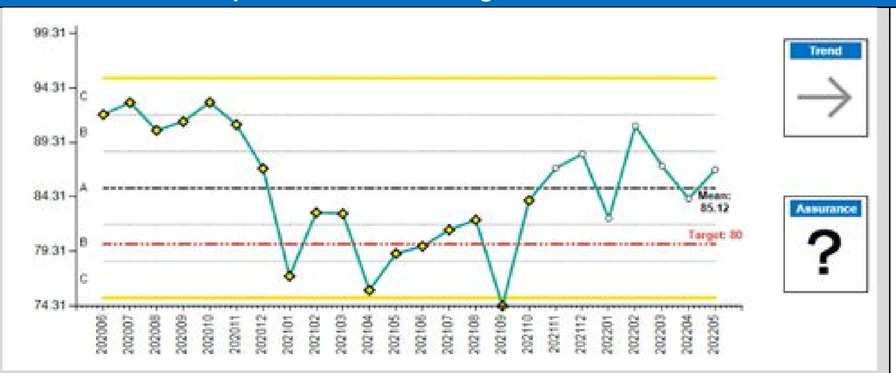
- No consistent system for recording referrals and calculating waiting times with Specialist Services and CAMHS using spreadsheets. This hampers addressing resource gaps and long waiting times.
- Historically services have not been reviewing existing dashboards resulting in data quality issues.
- An 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. Plan includes recruitment of Trainee Clinical Associate Psychologists and review of job plans to ensure consistency across service.
- 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.
- CAMHS have confirmed that accurate waiting data for Tier 3 is now available and this metric will be amended to reflect this in the June report.

## Access

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




Trend

Assurance

?

### Underperforming Teams

| Assessment Team | Assessed 28 days | Assessments | % Assessed 28 days |
|---|---|---|---|
| Morden Recovery and Support Team | 7 | 9 | 77.8% |
| Richmond OP Recovery & Support Team | 10 | 13 | 76.9% |
| Twickenham RST | 7 | 10 | 70.0% |
| Richmond RST | 4 | 6 | 66.7% |
| South Kingston CMHT | 5 | 9 | 55.6% |
| Sutton Adult Assessment Team | 31 | 57 | 54.4% |
| North Kingston CMHT | 4 | 9 | 44.4% |
| Sutton and Cheam RST | 2 | 5 | 40.0% |
| South East Wandsworth CMHT | 3 | 10 | 30.0% |
| Wimbledon Recovery and Support Team | 3 | 14 | 21.4% |

**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**

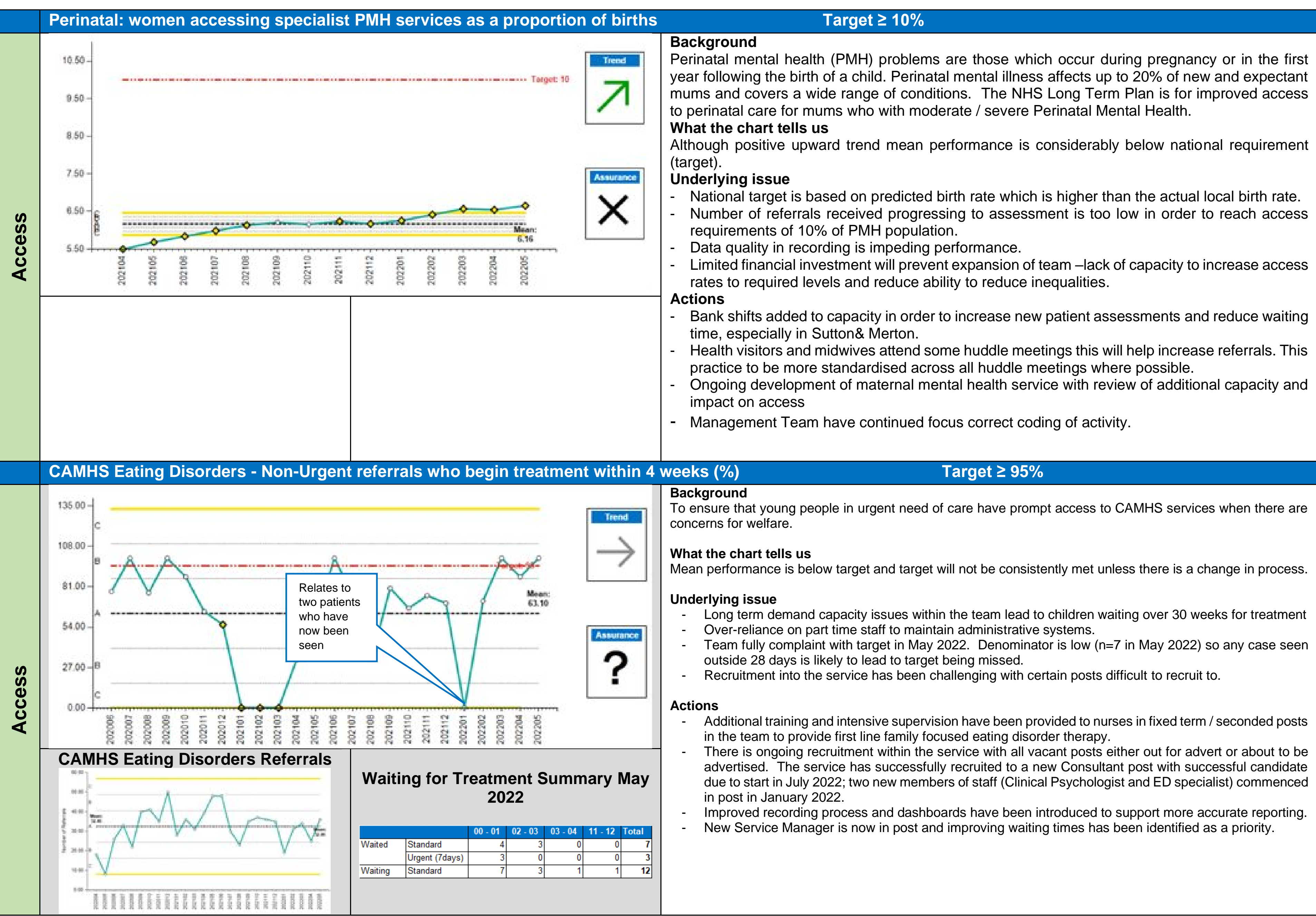
There has been historic variation in performance with a period of high performance followed by a period below target. Recent access performance has shown improvement.

**Underlying Issue**

- **Wandsworth:** Growth in proportion of referrals marked as urgent has generated increased team workload for Wandsworth SPA but with no change in capacity. This affects response times to see non-urgent appointments where the target is 28 days.
- **Sutton:** There has been an increase in referrals for NHS Sutton clients; with past seven months referrals above the mean. There was also medical capacity for a period which has led to a wait list back log which service is working through.
- Older People's teams were fully complaint with target (8/8) in May 2022.

**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.
- The reporting of access within 28 days by appointment type will commence 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 Assessment Team currently working through wait list backlog and completing lessons learned review with focus on contact recording.
- Team Consultant is to provide two additional assessment slots per week until end of March – resourced via winter pressures monies.
- Additional management support is being provided to the team via the Service and Clinical Manager.



## Access

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



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

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

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

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

## Access

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



**Waiting for Treatment Summary May 2022**

| | | 00 - 01 | 02 - 03 | 03 - 04 | 11 - 12 | Total |
|---|---|---|---|---|---|---|
| Waited | Standard | 4 | 3 | 0 | 0 | 7 |
| | Urgent (7days) | 3 | 0 | 0 | 0 | 3 |
| Waiting | Standard | 7 | 3 | 1 | 1 | 12 |

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

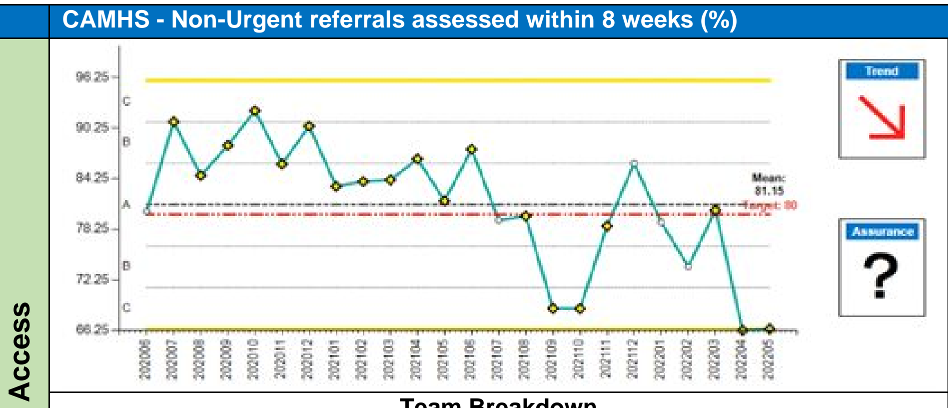
**What the chart tells us**
Mean performance is below target and target will not be consistently met unless there is a change in process.

**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 May 2022. Denominator is low (n=7 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.

## Access

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




Trend

Assurance

?

**Team Breakdown**

| Assessment Team | Assessed within 8 weeks | Assessments | % Assessed within 8 weeks |
|---|---|---|---|
| Kingston CAMHS Tier 3 | 17 | 31 | 54.8% |
| Merton CAMHS Tier 3 | 25 | 38 | 65.8% |
| Richmond CAMHS Tier 3 | 13 | 21 | 61.9% |
| Sutton CAMHS Tier 3 | 14 | 23 | 60.9% |
| Wandsworth CAMHS Tier 3 | 17 | 19 | 89.5% |
| Total | 86 | 132 | 65.2% |

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

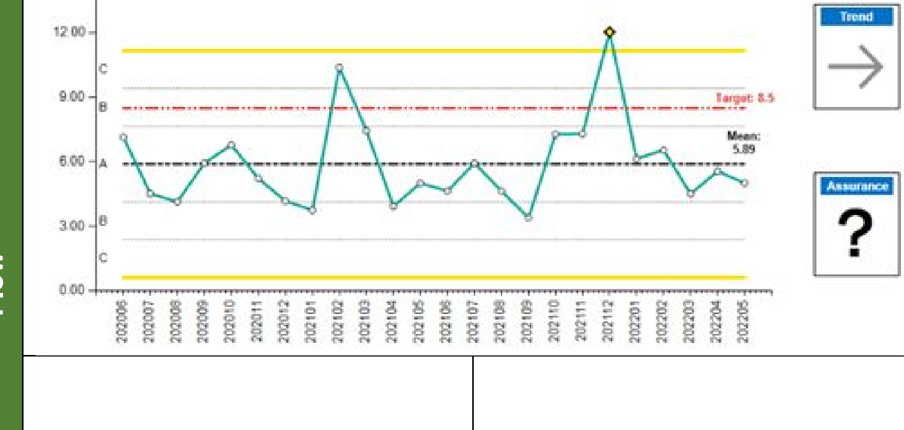
**What the chart tells us**
Mean performance is just above target indicating target will frequently be met but there will be variation.

**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.

**Actions**
- Psychiatry continue 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 June 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 April 2022.

## Flow

### Emergency readmission within 30 days - Adult Acute & PICU (%) — Target ≤ 8.5%




Trend

Assurance

?

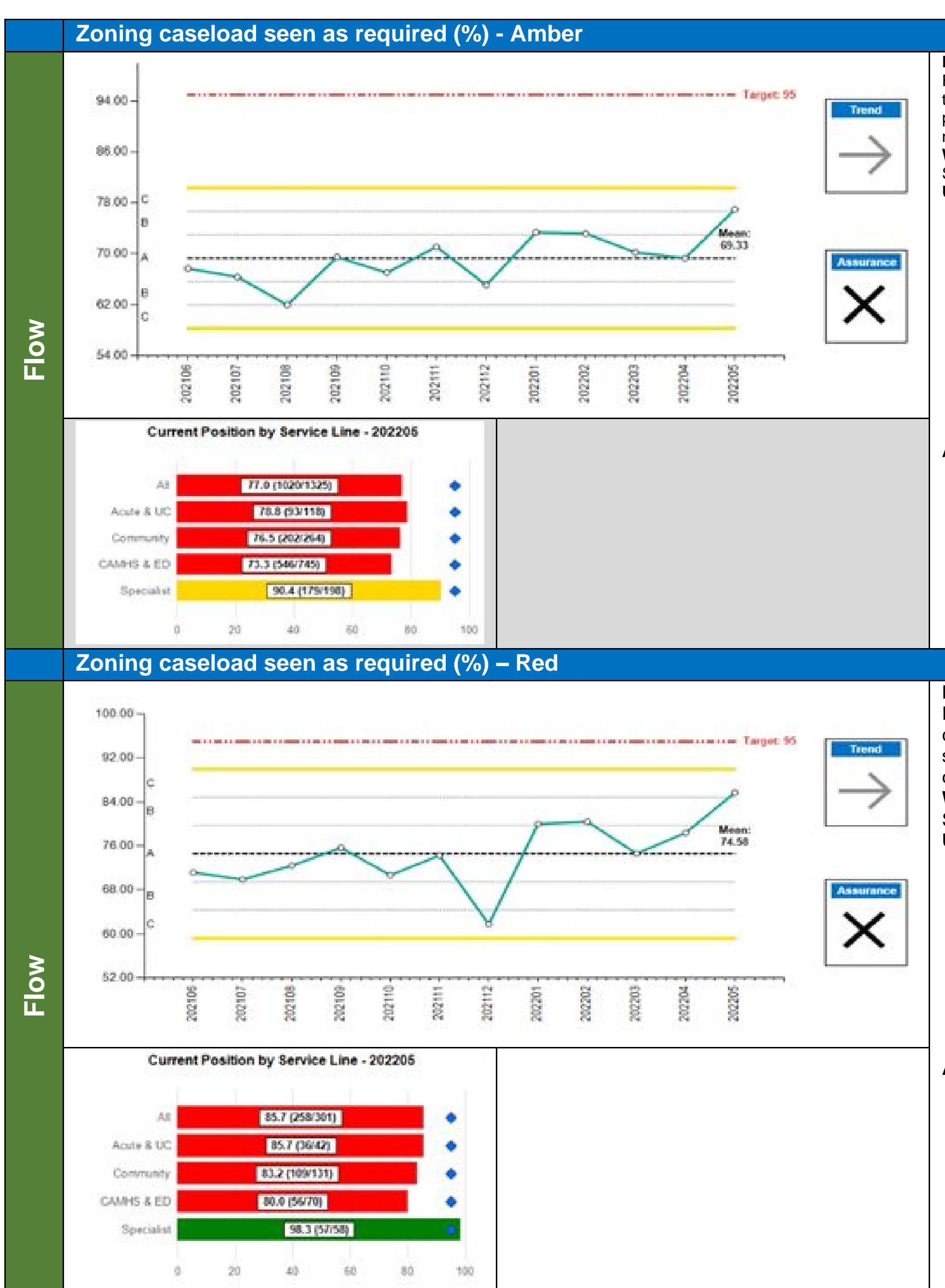
**Background**
This indicator aims to measure the success of the NHS in helping people to recover effectively from illnesses. If a person is not at the correct point in their recovery journey for discharge it is more likely that they will require hospital treatment again within the 30 days following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

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

**Underlying issue**
- 5 emergency re-admissions reported in May 2022.

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

## Zoning caseload seen as required (%) - Amber — Target ≥ 95%




**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 targets 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%

**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**

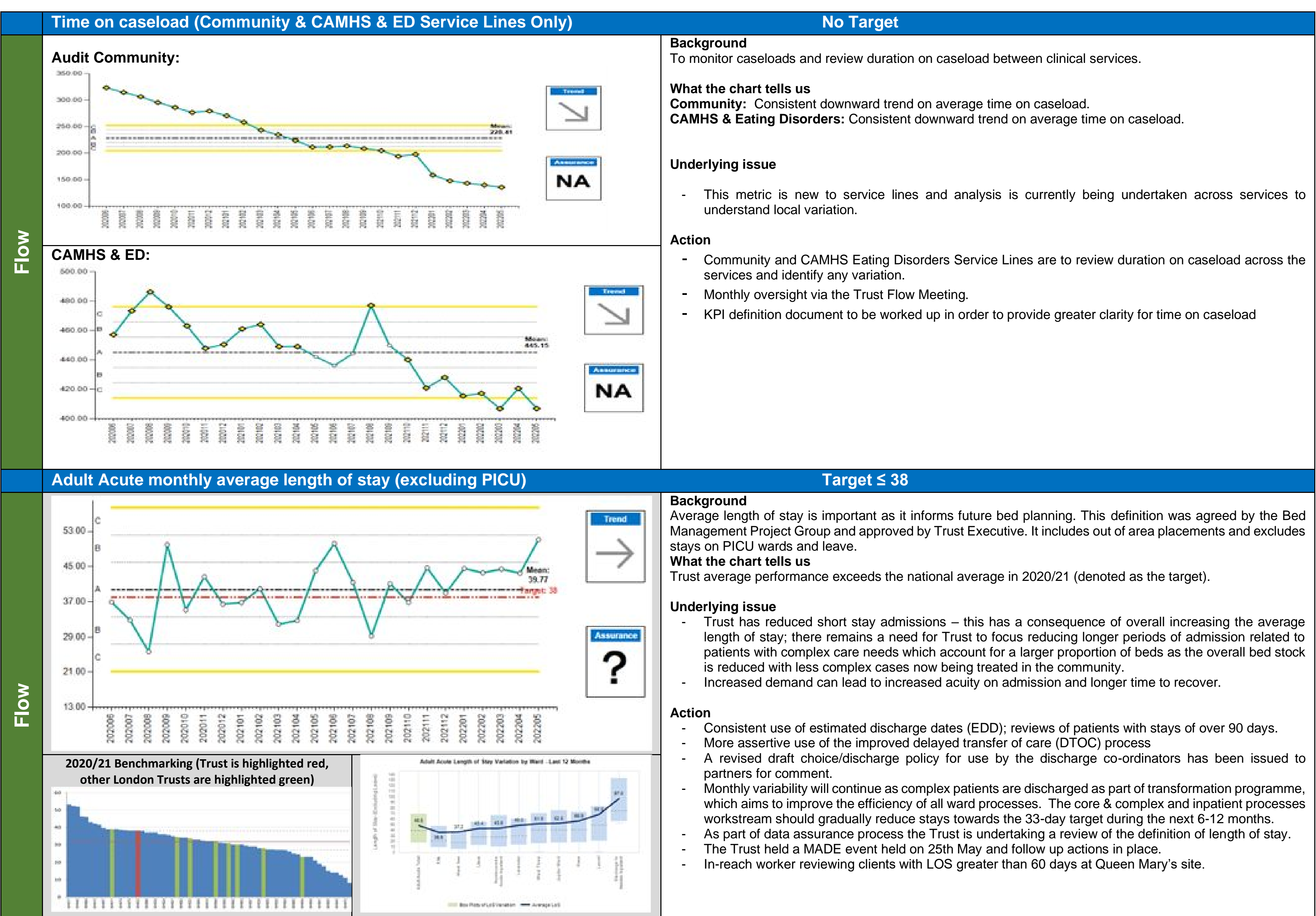
Significant underperformance, the target will not be met without a change in process.

**Underlying issue**

- Slow adoption of some teams of standard operating procedures relating to recording the correct zone and the prompt recording of contacts.
- **CAMHS:** significant and unresolved variation in clinical practice, relating to risk-management and the categorisation of 'amber zone' patients.
- Significant numbers of patients are either shielding or do not feel it is safe and so are unwilling to agree to a face to face contact, preferring a telephone or video call. Ration of diary in RIO
- 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**

- This metric is new to service lines and analysis is currently being undertaken across services to understand local variation.

**Action**

- Community and CAMHS Eating Disorders Service Lines are to review duration on caseload across the services and identify any variation.
- Monthly oversight via the Trust Flow Meeting.
- 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.

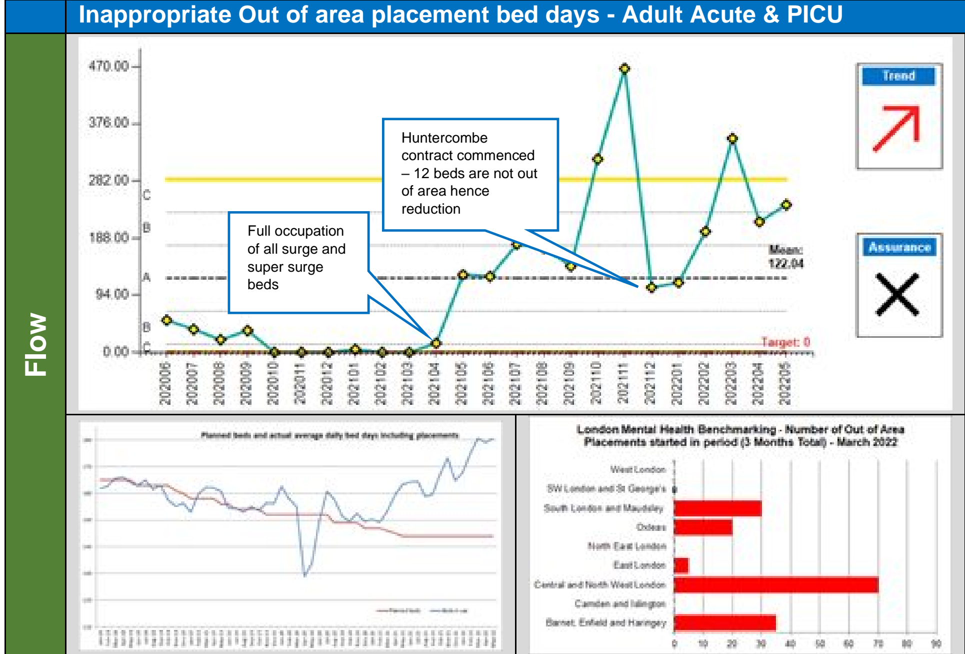
**Action**

- 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**

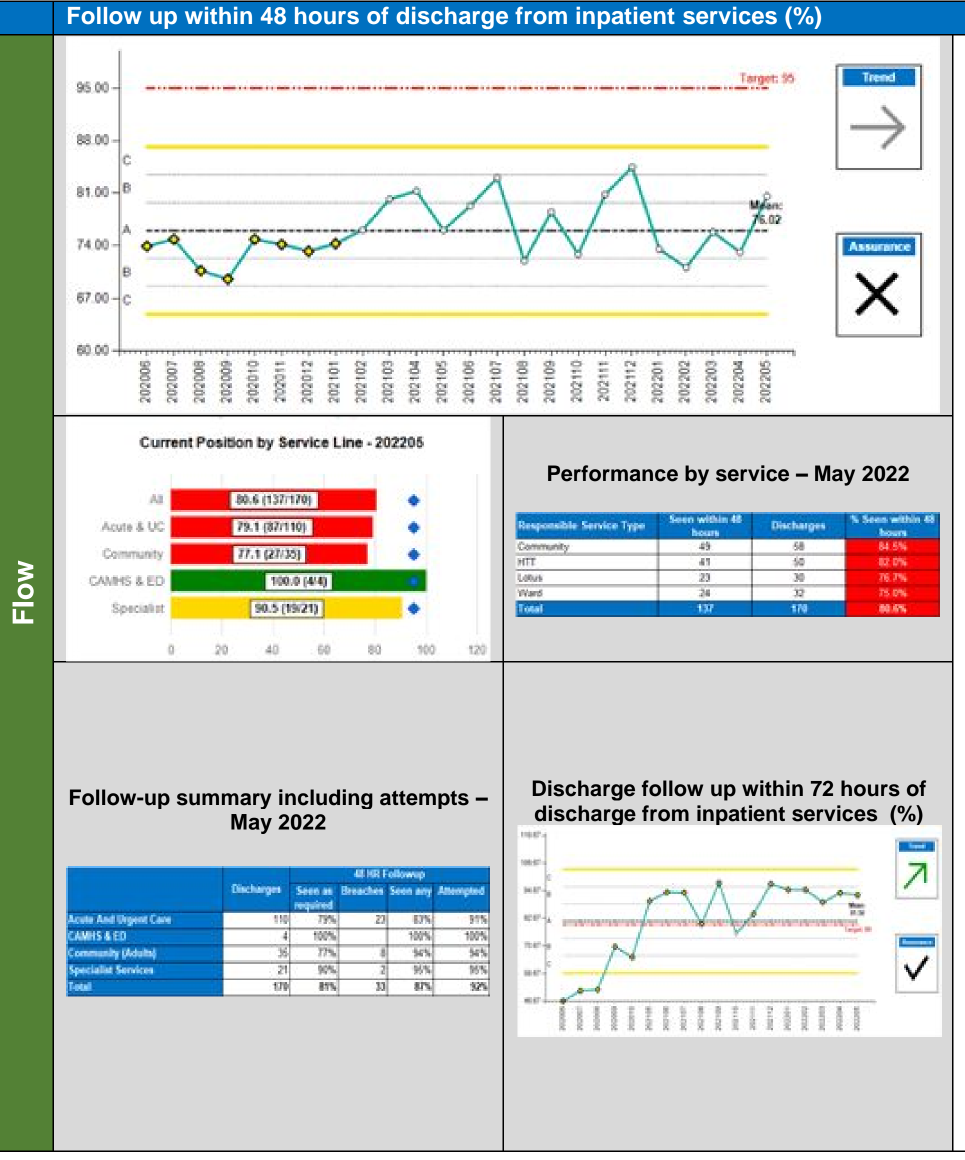
- Performance is related to the demand for adult acute and PICU beds. High and continual occupancy rates that exceed 95% inevitably lead to the use of out of area beds at times of peak demand.
- Lower occupancy rates related to a reduction in acute demand and an increase in discharges to home treatment 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**

- Trust successfully negotiated contract for use of 12 beds on Huntercombe, a private contractor in Roehampton – contract commenced on 29th November 2021.
- Cygnet contract comes to an end at end of May 15. Trust to review use of private sector contracted beds for May.
- The 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 – May 2022**

| Responsible Service Type | Seen within 48 hours | Discharges | % Seen within 48 hours |
|---|---|---|---|
| Community | 49 | 58 | 84.5% |
| HTT | 41 | 50 | 82.0% |
| Lotus | 23 | 30 | 76.7% |
| Ward | 24 | 32 | 75.0% |
| Total | 137 | 170 | 80.6% |

**Follow-up summary including attempts – May 2022**

| | Discharges | 48 HR Followup | | | |
|---|---|---|---|---|---|
| | | Seen as required | Breaches | Seen any | Attempted |
| Acute And Urgent Care | 110 | 79% | 23 | 83% | 91% |
| CAMHS & ED | 4 | 100% | | 100% | 100% |
| Community (Adults) | 35 | 77% | 8 | 94% | 94% |
| Specialist Services | 21 | 90% | 2 | 95% | 95% |
| Total | 170 | 81% | 33 | 87% | 92% |

**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**

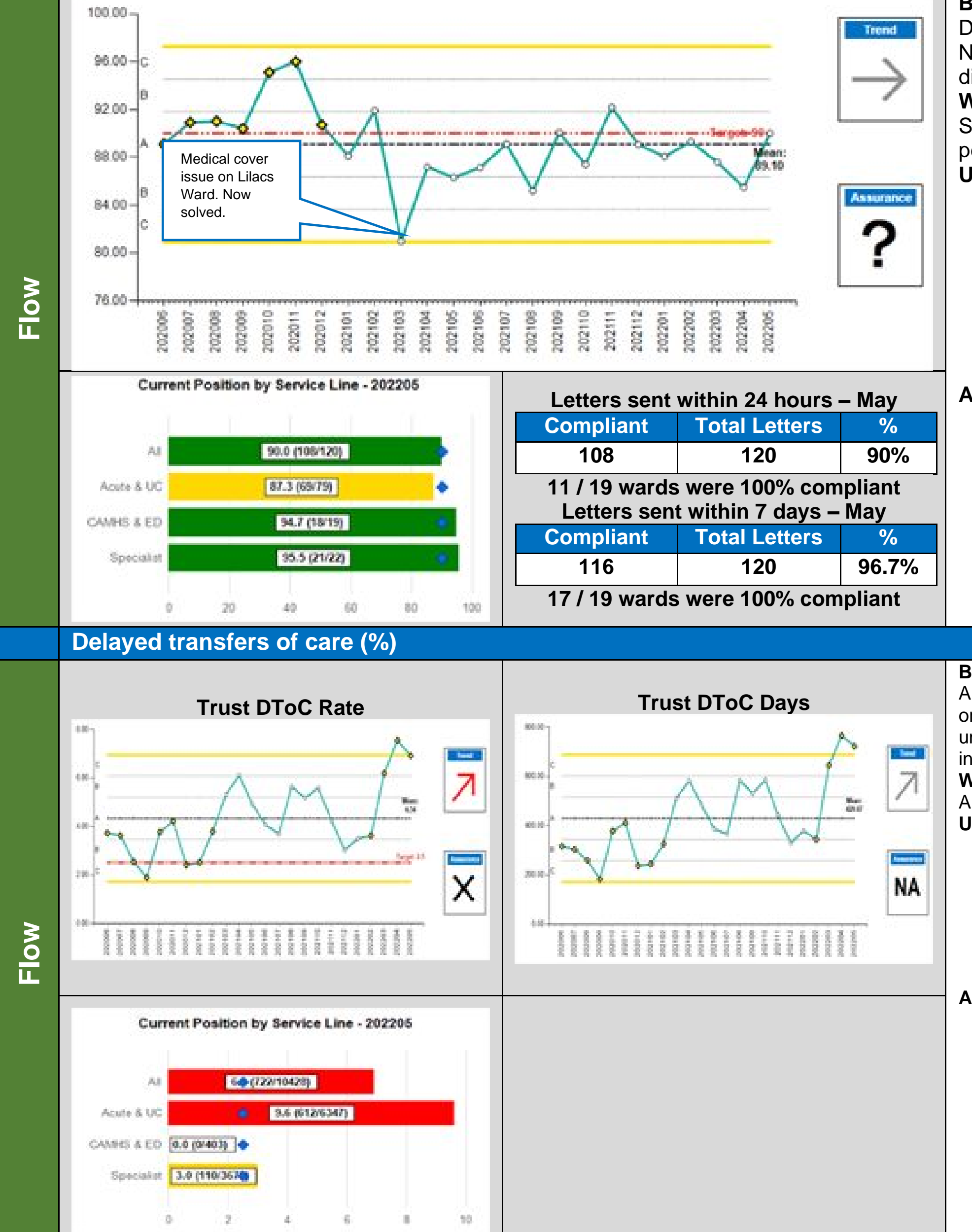
- Previous process mapping highlighted inadequacies in the referral system for follow up; responsibilities are not always clear, inadequate communication between wards and community teams and systems are overly reliant on individuals rather than process.
- High sickness and vacancy rate has meant reliance at times on agency staff who are less familiar follow up processes
- Inconsistent documentation of clinical record; appointments not recorded in diary or discharge planning form
  Use of agency/bank staff (due to sickness/vacancies) who are less familiar with follow up policy and procedures can impact on performance.
- 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.
- Some improvement on attempts to contact noted in May but this need to be ideally at 100%.

- **7 day follow Up:** The Trust incurred 6 breaches in May 2022 with 3 clients subsequently seen. Of the remaining 3 not seen; the first case contact was made with family who indicated client was doing well; 2nd case there were multiple attempts to contact whilst the 3rd case client was returning to United States and therefore unable to contact but family were emailed.

**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.
- The Trust needs a structural rational for staff highlight 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.
- Acute: SOP has been recirculated to new Clinical Service Leads now in post to disseminate amongst teams.

## Inpatient discharge letters sent within 24 hours (%) — Target ≥ 90%




Letters sent within 24 hours – May

| Compliant | Total Letters | % |
|---|---|---|
| 108 | 120 | 90% |

11 / 19 wards were 100% compliant

Letters sent within 7 days – May

| Compliant | Total Letters | % |
|---|---|---|
| 116 | 120 | 96.7% |

17 / 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.
- Can be a challenge for junior doctors to get up to speed with Trust recording requirements.
- Bank/Locum Dr's are not always aware of processes which can lead to delay in letter generation.

**Action**

- The Trust is piloting use of DocMan API (Application Programming Interface) on two wards (Lavender & Jupiter) which will enable the Trust to a fully automated solution for discharge letter completion. If pilot is successful DocMan API will be deployed throughout the Trust by the end of June 2022.
- 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.

## Delayed transfers of care (%) — Target ≤ 2.5%

**Background**

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

**What the chart tells us**

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

**Underlying issue**

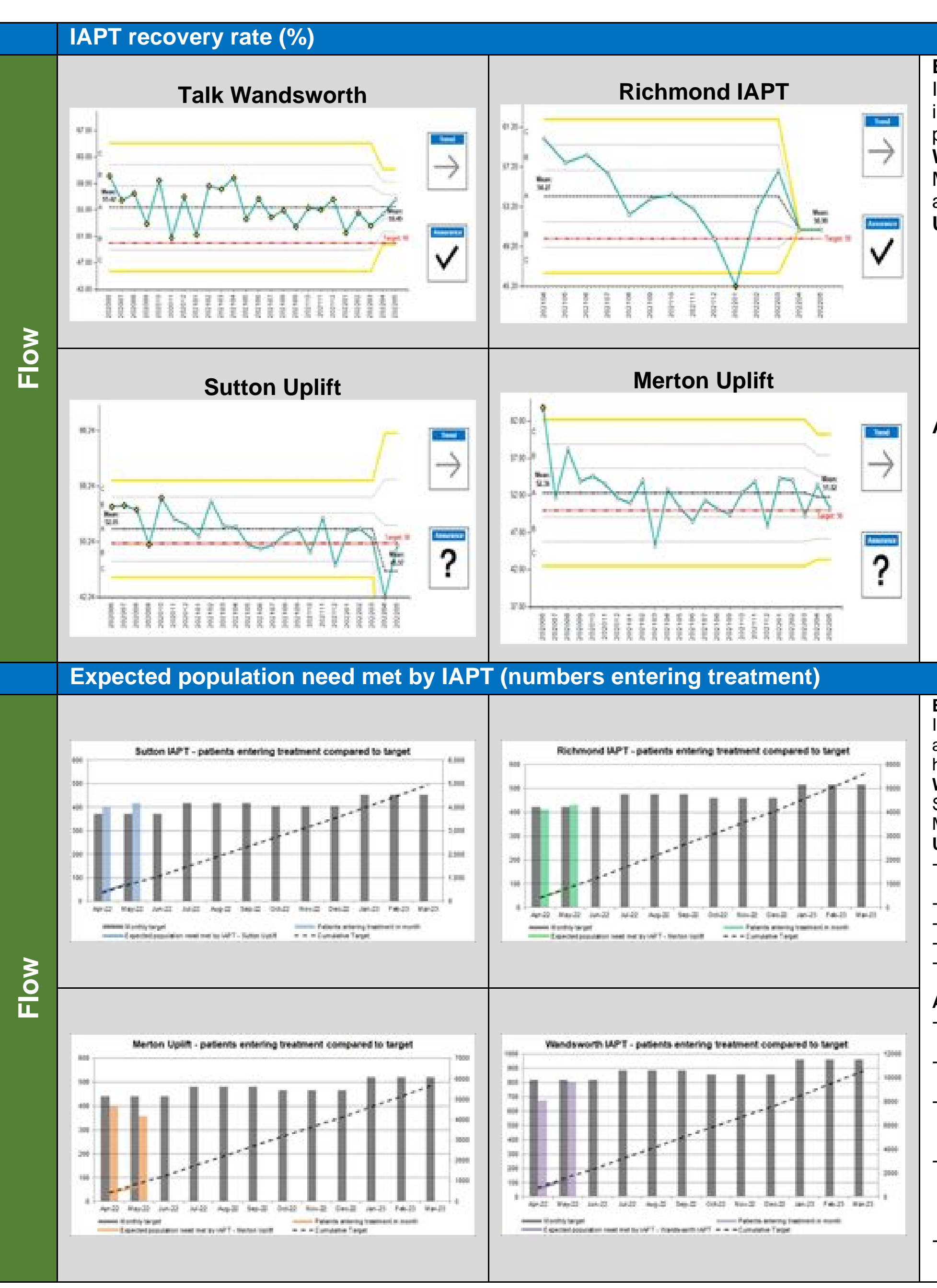
- Improved identification of delays for non-medical reasons through use of an estimated discharge date.
- An increase in the proportion of more complex cases as bed numbers are reduced.
- Delays are often beyond the control of the Trust and reliant on LA engagement and resources.
- A reduction in care home places due to COVID has led to increase in delays for some older people.
- 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 May 2022.

**Actions**

- Escalation processes involving local authorities & CCG's is being developed by Deputy Medical Director.
- 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).
- Plans being formulated to utilise mental health discharge monies to facilitate delayed transfer of care.
- Funding for hostel has been extended and the model reviewed to incorporate step up patients from Lotus to avoid admissions.
- 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




**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 drop outs (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**

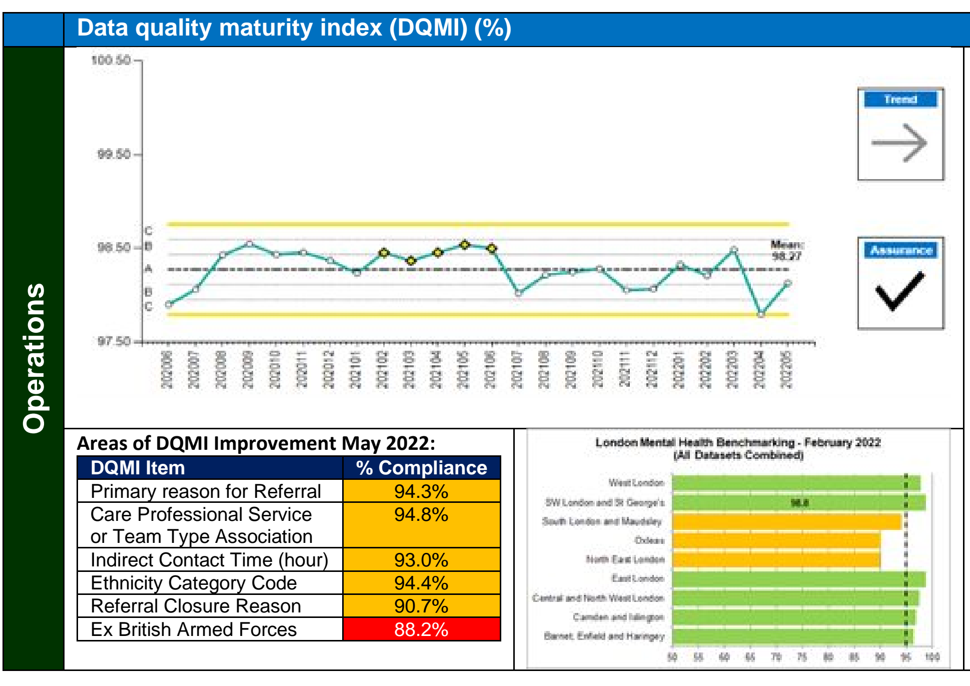
- Insufficient referrals in Talk Wandsworth and increased recent vacancies in Step 2 affecting clinical resource for triaging of patients.
- Staff absences due to long term sickness/unplanned leave can lead to lost triage slots.
- National lack of available of PWP trained clinicians contributing to high vacancy rates.
- Access targets for 22/23 require final confirmation
- 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.

| | Data quality maturity index (DQMI) (%) | Target ≥ 95% |
|---|---|---|

**Operations**




**Areas of DQMI Improvement May 2022:**

| DQMI Item | % Compliance |
|---|---|
| Primary reason for Referral | 94.3% |
| Care Professional Service or Team Type Association | 94.8% |
| Indirect Contact Time (hour) | 93.0% |
| Ethnicity Category Code | 94.4% |
| Referral Closure Reason | 90.7% |
| Ex British Armed Forces | 88.2% |

**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.

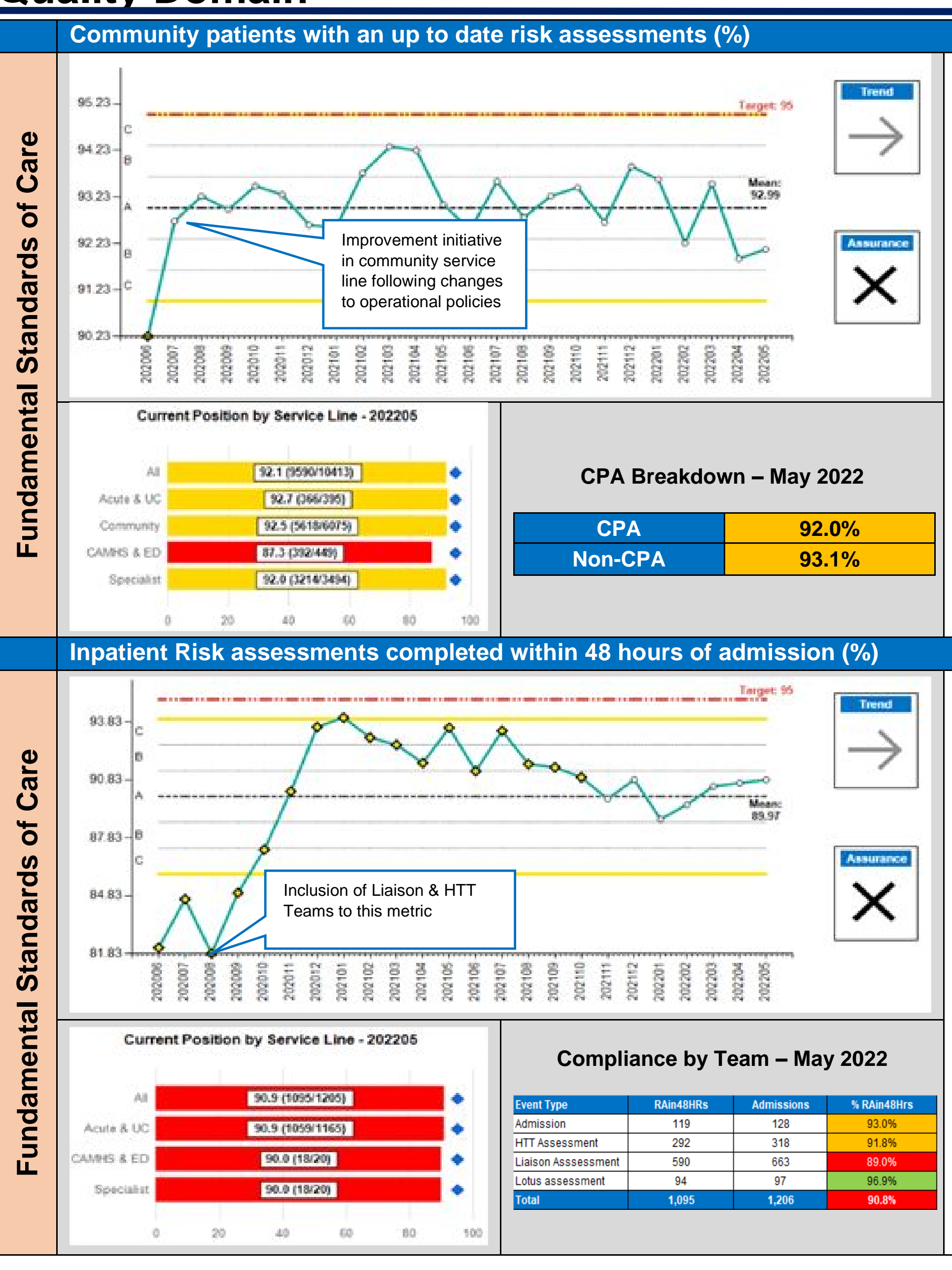
**Underlying issues**

- 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




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

**CPA Breakdown – May 2022**

| CPA | 92.0% |
|---|---|
| Non-CPA | 93.1% |

**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**

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 campaign (which incorporates quality risk assessments) is being launched across Community Services.
- Deputy Medical Director is currently undertaking a review of the 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.

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

**Compliance by Team – May 2022**

| Event Type | RAin48HRs | Admissions | % RAin48Hrs |
|---|---|---|---|
| Admission | 119 | 128 | 93.0% |
| HTT Assessment | 292 | 318 | 91.8% |
| Liaison Asssessment | 590 | 663 | 89.0% |
| Lotus assessment | 94 | 97 | 96.9% |
| Total | 1,095 | 1,206 | 90.8% |

**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**

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**

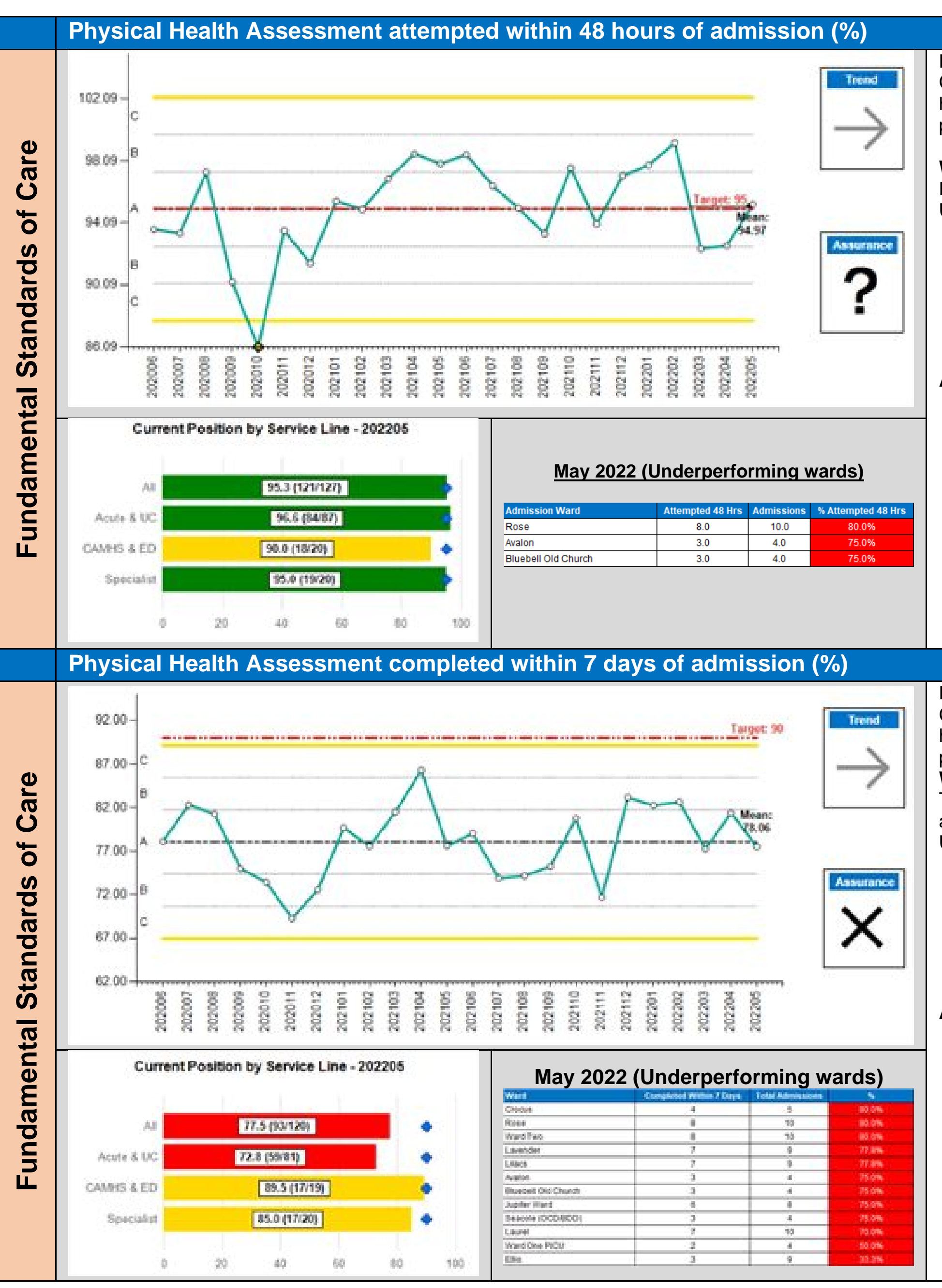
- Risk assessments have been a priority focus for our clinical services, as part of the Fundamental Standards of Care, which is being monitored through the quality plan, there has been an improvement in the quality of the risk assessment, but the quantity has not improved. This is due to the 3rd wave 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%




**May 2022 (Underperforming wards)**

| Admission Ward | Attempted 48 Hrs | Admissions | % Attempted 48 Hrs |
|---|---|---|---|
| Rose | 8.0 | 10.0 | 80.0% |
| Avalon | 3.0 | 4.0 | 75.0% |
| Bluebell Old Church | 3.0 | 4.0 | 75.0% |

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

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

**Underlying issue**
- Consistent under performance linked to an inadequate configuration of the clinical IT system to support workflows and a need to improve daily ward processes to ensure assessments are consistently completed.
- 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%

**May 2022 (Underperforming wards)**

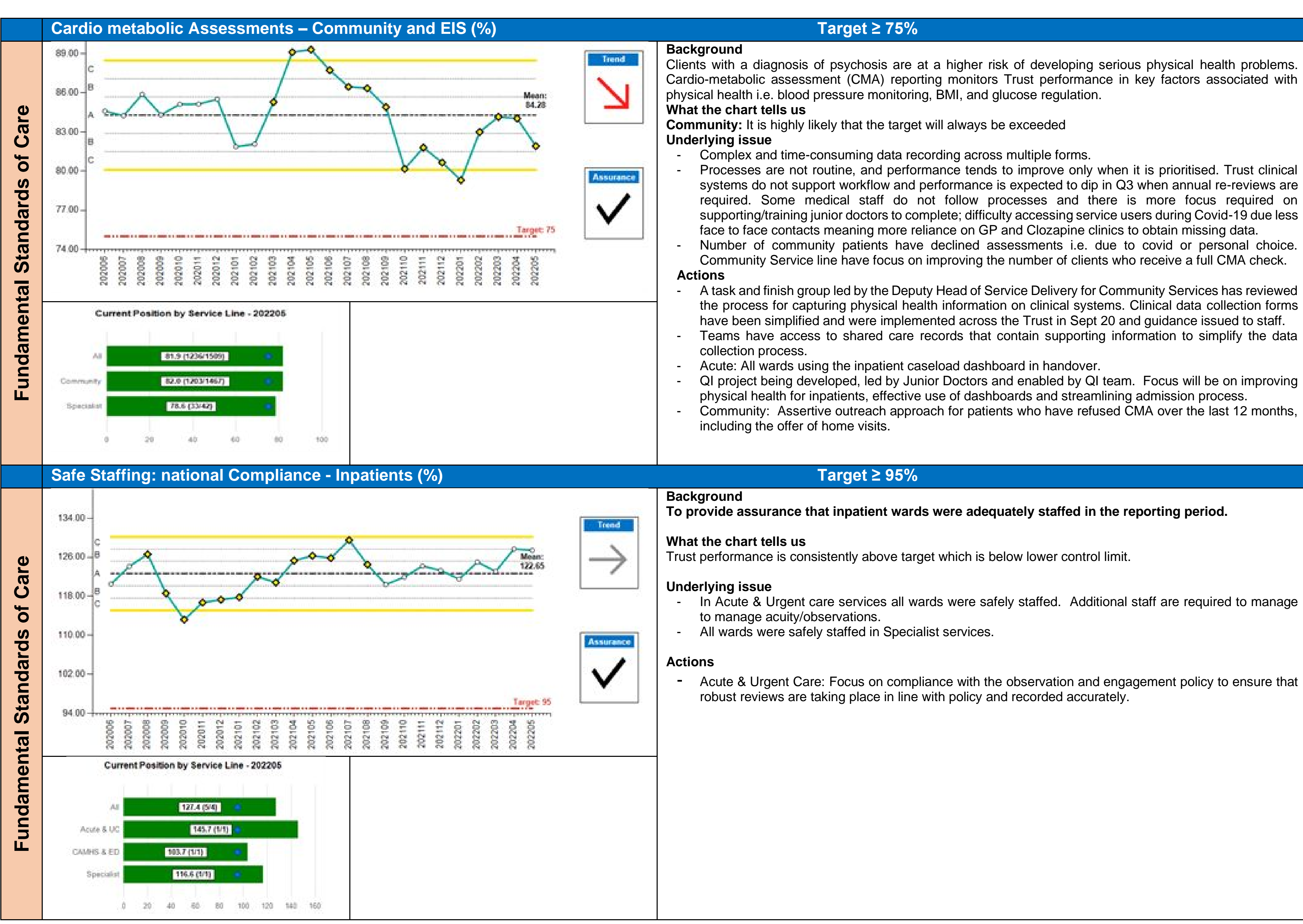
| Ward | Completed Within 7 Days | Total Admissions | % |
|---|---|---|---|
| [illegible] | 4 | 5 | 80.0% |
| Rose | 8 | 10 | 80.0% |
| Ward Two | 8 | 10 | 80.0% |
| Lavender | 7 | 9 | 77.8% |
| Lilacs | 7 | 9 | 77.8% |
| Avalon | 3 | 4 | 75.0% |
| Bluebell Old Church | 3 | 4 | 75.0% |
| Jupiter Ward | 6 | 8 | 75.0% |
| Seacole (OCD/BDD) | 3 | 4 | 75.0% |
| Laurel | 7 | 10 | 70.0% |
| Ward One PICU | 2 | 4 | 50.0% |
| Ellis | 3 | 9 | 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**
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 Work Flows 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.




## 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.

## 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.

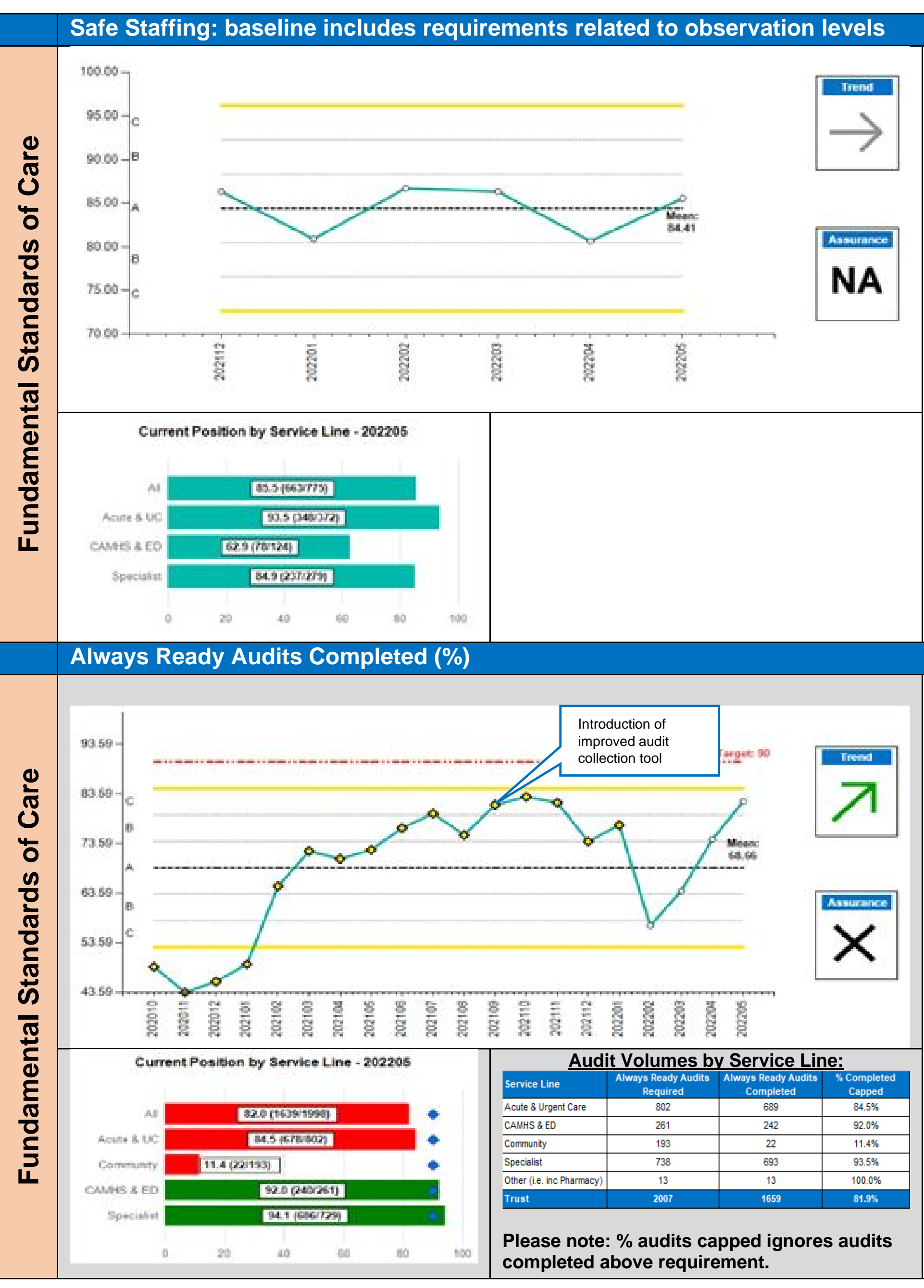
**Underlying issue**

- 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.

## 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,

## Always Ready Audits Completed (%) — Target ≥ 90%

**Audit Volumes by Service Line:**

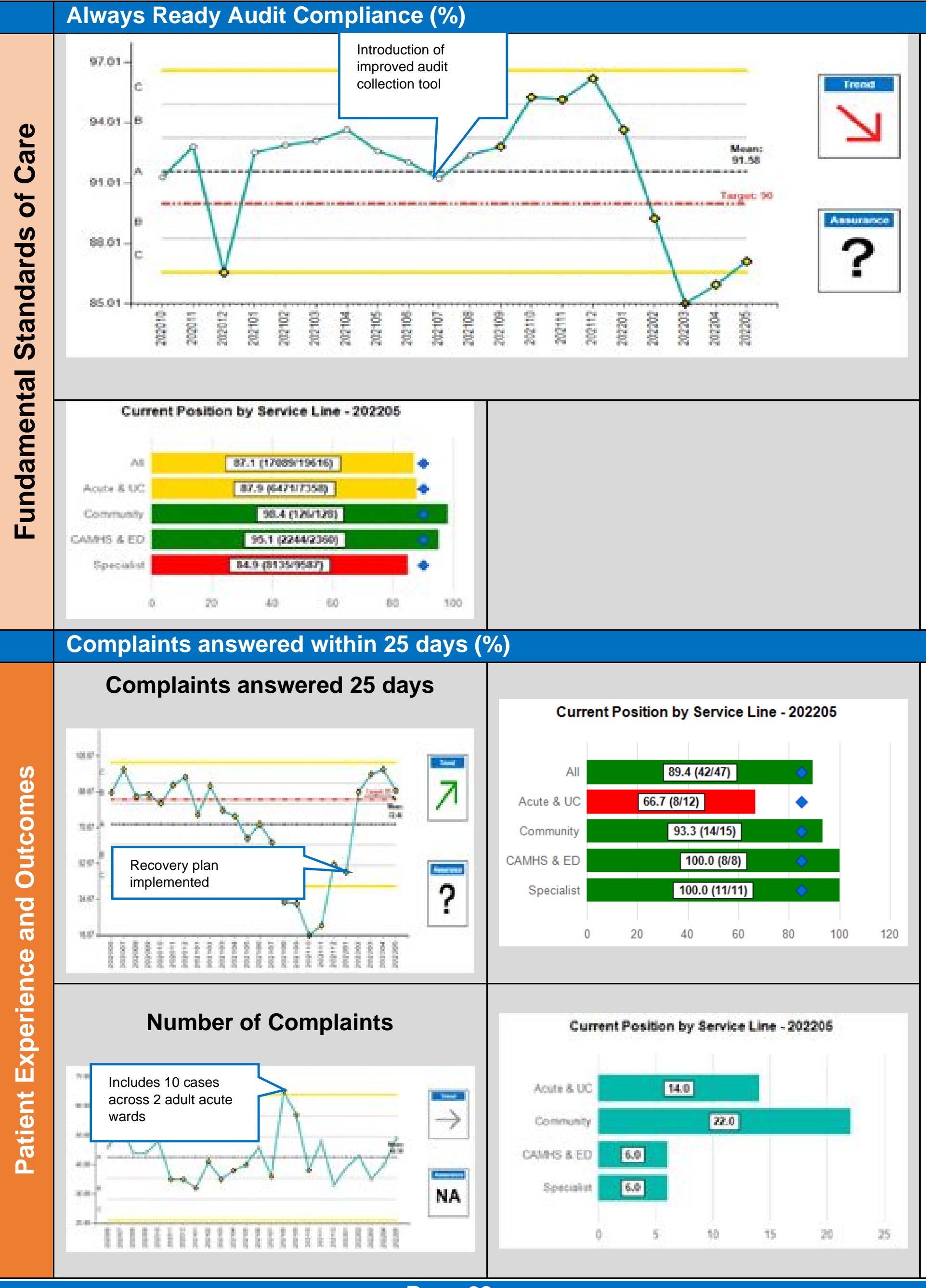
| Service Line | Always Ready Audits Required | Always Ready Audits Completed | % Completed Capped |
|---|---|---|---|
| Acute & Urgent Care | 802 | 689 | 84.5% |
| CAMHS & ED | 261 | 242 | 92.0% |
| Community | 193 | 22 | 11.4% |
| Specialist | 738 | 693 | 93.5% |
| Other (i.e. inc Pharmacy) | 13 | 13 | 100.0% |
| Trust | 2007 | 1659 | 81.9% |

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

**Background:**
The Trust has implemented an electronic system called ‘Always Ready’ to collect and measure the quality of audits in key areas linked to quality and safety. This is to evidence that the Trust is delivering the required standards of care.
This metric measures quantity by comparing the number of audits undertaken against total number of required audits. It gives no indication of the quality of the audit results which is provided by the metric below.
**What the chart tells us:**
Whilst performance continues to improve, mean performance is significantly below target indicating that the target will not be met unless there is a change in process.
**Underlying issue**
- The Always Ready application improved and implemented in June 2021 before some staff had received training and a period of familiarisation.
- Enhanced reporting has highlighted that in CAMHS Service Line has concern for Consent to Treatment and Safety in Motion. Audits requirements for Corner House are not commensurate with service operation i.e. ward is often closed on weekends.
- 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. Improvement is expected by June 2022.
- 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. In addition an updated video on dashboard use to support staff is under development and will be deployed in the coming weeks.

## 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.
- Community Service Line are undertaking a reset on recording so all Clozapine Clinics will be required to report via the Application.
- 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.

## Complaints answered within 25 days (%) — Target ≥ 85%

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

**What the chart tells us**
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.

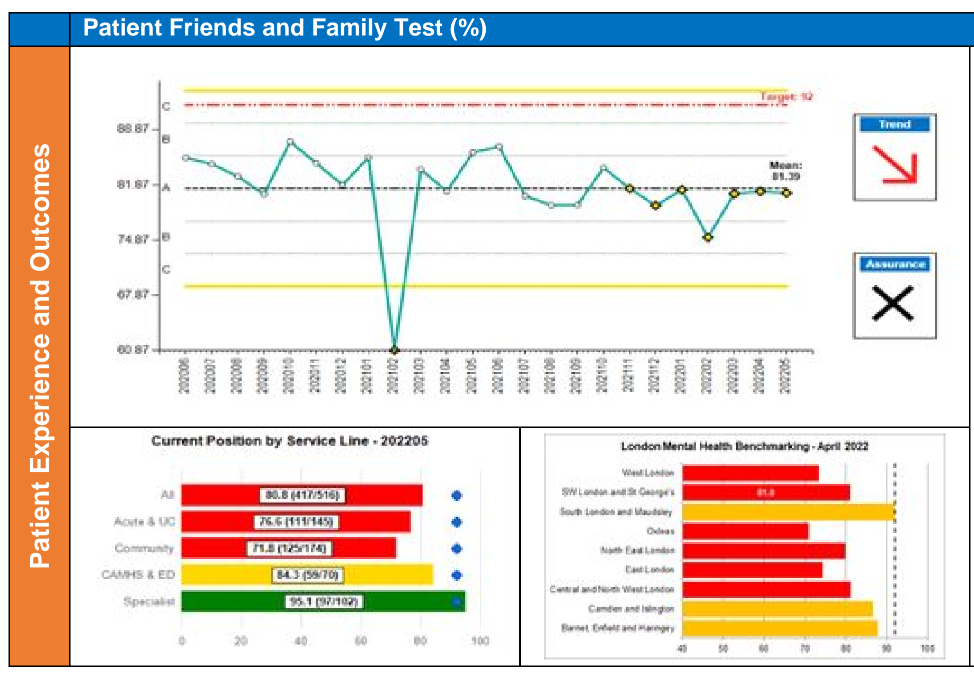
**Underlying issue**
- The Patient Experience Team are managing increased workload due to an increase in the number of complaints and acuity of patients presenting to the Patient Advice Liaison Service (PALS). However, this is now starting to stabilise.
- There are some delays with obtaining executive 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.
- December is a known point for reduction in activity due to annual leave and a confident pattern that there are just less complaints received over this period. However, a notable improvement was still achieved.

**Actions:**
- A 12 week turn-around plan was approved at ELT in December and improvement has been sustained.
- 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.

**Patient Experience and Outcomes**

## Patient Friends and Family Test (%) — Target ≥ 92%




**What the chart tells us:**

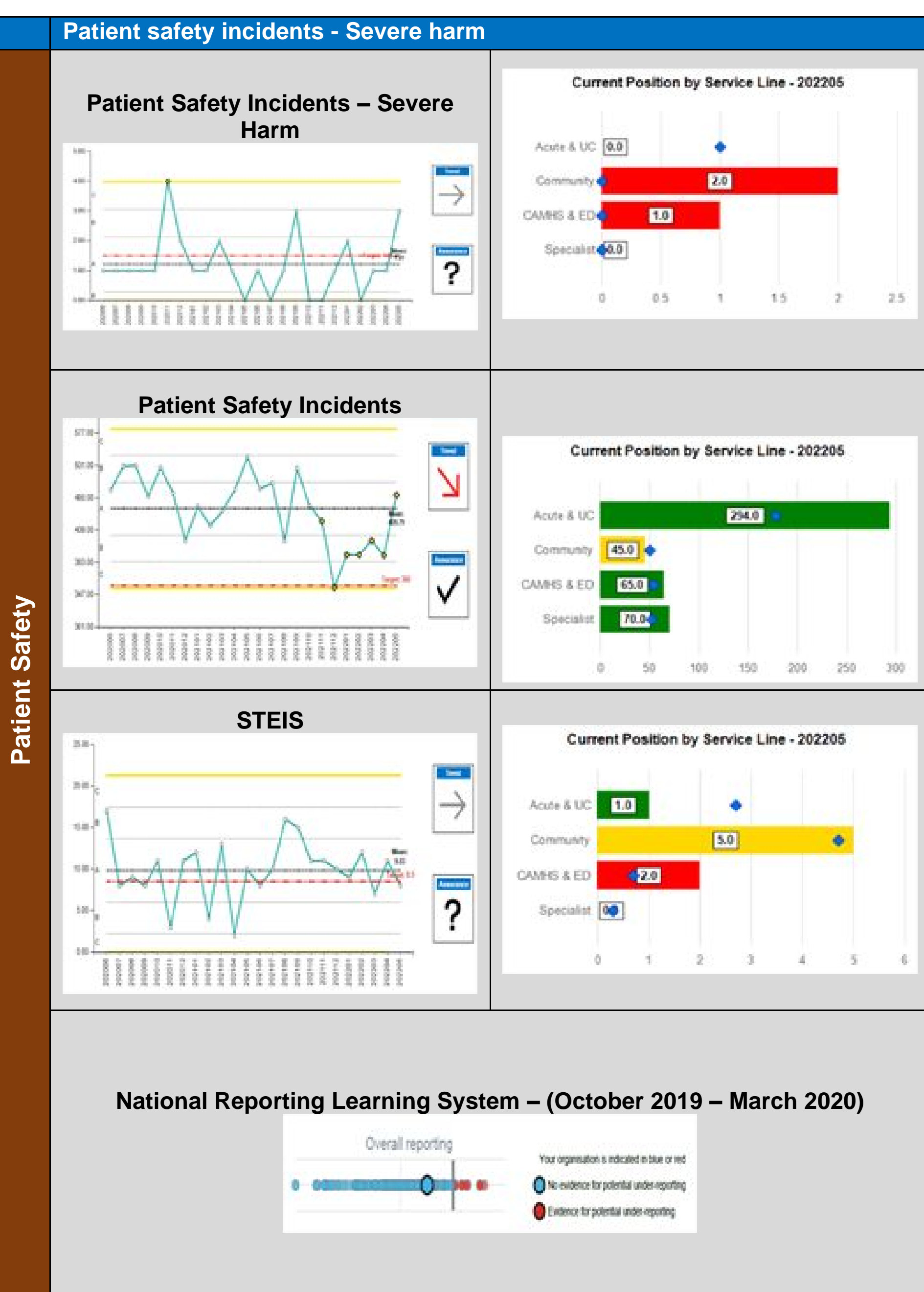
Mean performance is consistently below target a change of process required.

**Underlying issues:**

- Challenges with engaging patients to complete at appropriate points in their pathway.
- An analysis task is being undertaken by the Patient Outcomes Group to further understand the survey feedback.

**This and next months: actions and timescales:**

- Review with governance team on how to perform on a regular monthly basis
- Improve engagement over next 3 months
- The Trust is streamlining the Feedback Live system by reducing the number of questions on survey from 200 – 50.




**Target ≤ 1.5%**

**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 May there were 8 serious incidents reported to STEIS, which includes three suspected suicides and two unexpected deaths.
-

**Actions:**

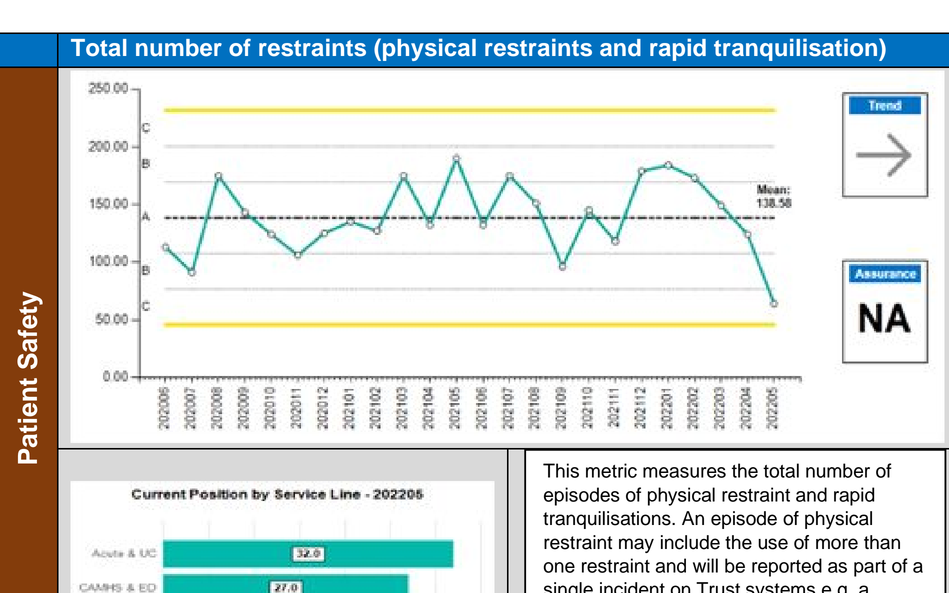
- A Training session has been delivered to Ward Managers on incident management and included information on the new dashboard enabling visual access to incidents reported by Ward/Team.
- Mortality Committee have commissioned thematic reviews of the last two years of community suicides, inpatient deaths, 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 is being reviewed which may have a positive impact on the number of incidents in future months.
- 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



Current Position by Service Line - 202205

Acute & UC 32.0
CAMHS & ED 27.0
Specialist 5.0

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**

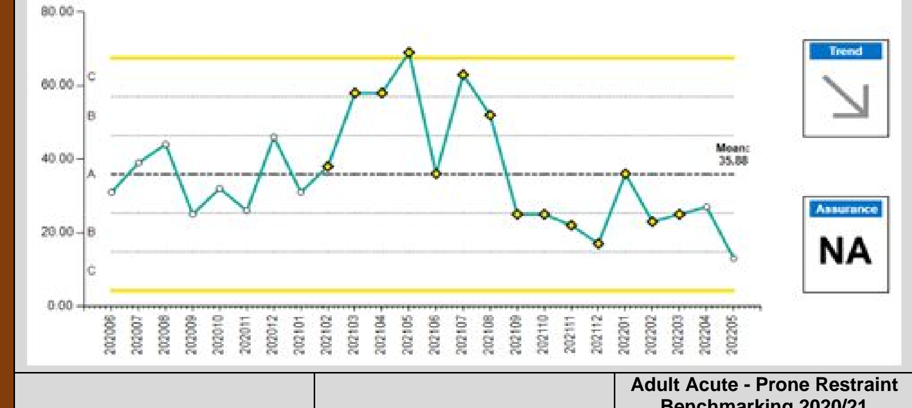
- In February 2020 restrictive practice recording changed from the Ulysses incident system to the RiO clinical system. This change was introduced to ensure that clinical information is recorded in one system, to enable the Trust to report restraint data as part of the Mental Health Services Data Set 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.

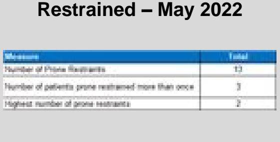
## Patient Safety

## Reducing restrictive practices - Prone restraint — No Target




Current Position by Service Line - 202205

**Number of Clients Prone Restrained – May 2022**



| Measure | Total |
| --- | --- |
| Number of Prone Restraints | 13 |
| Number of patients prone restrained more than once | 3 |
| Highest number of prone restraints | 2 |

**Adult Acute - Prone Restraint Benchmarking 2020/21**

**Background**

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

**What the chart tells us**

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

**Underlying Issue:**

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

**Actions:**

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

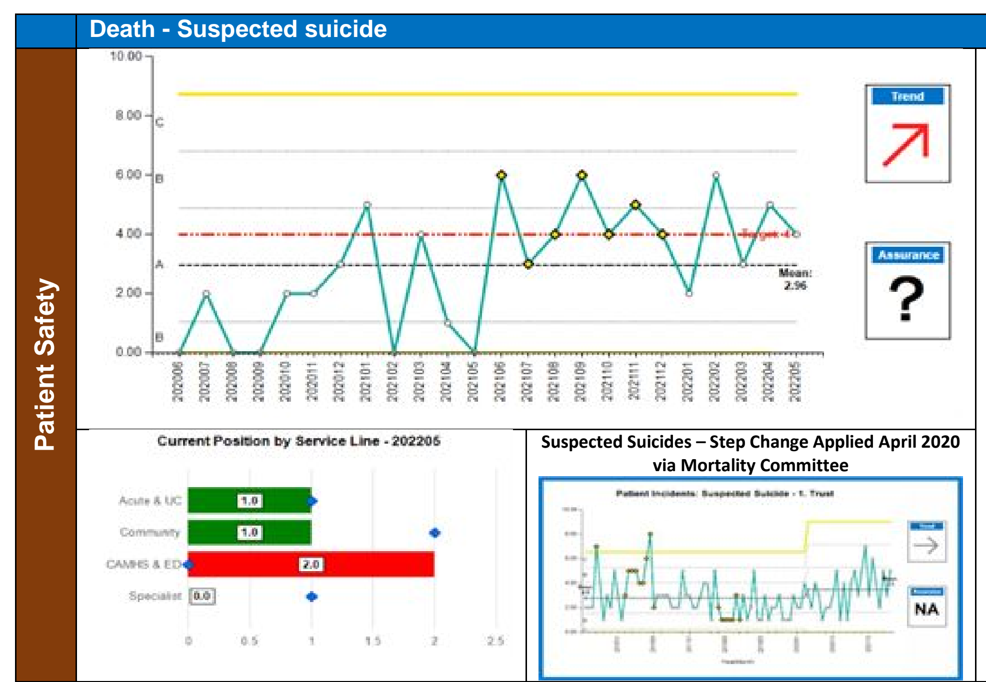
**Themes and Learning:**

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

## Death - Suspected suicide

**No Target**

Patient Safety




**Background**

**What the chart tells us**

Mean position is below target indicating target will be met frequently but there will be occasional variation.

**Underlying Issue:**

- There were 5 suspected suicides reported in May 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).

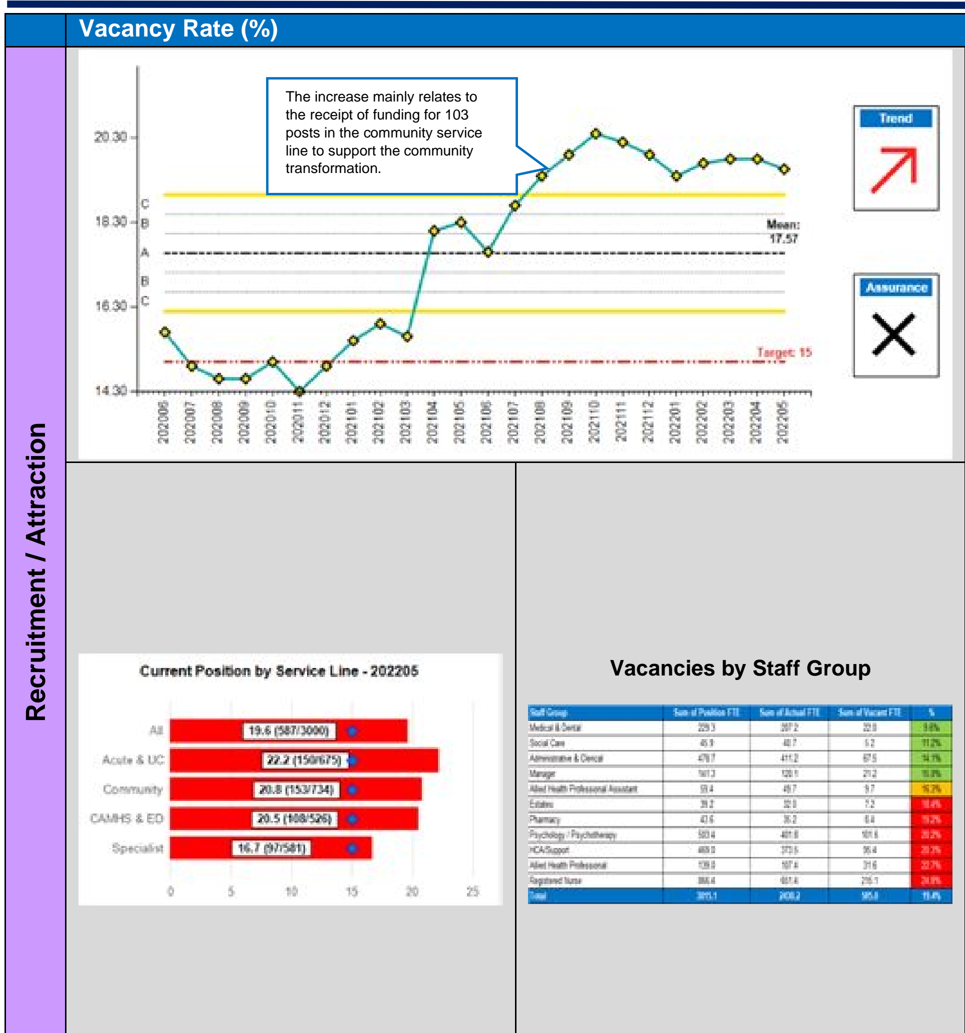
**Actions:**

- 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.

# 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 | % |
|---|---|---|---|---|
| Medical & Dental | 229.3 | 207.2 | 22.0 | 9.6% |
| Social Care | 45.9 | 40.7 | 5.2 | 11.2% |
| Administrative & Clerical | 478.7 | 411.2 | 67.5 | 14.1% |
| Manager | 141.3 | 120.1 | 21.2 | 15.0% |
| Allied Health Professional Assistant | 59.4 | 49.7 | 9.7 | 16.3% |
| Estates | 39.2 | 32.0 | 7.2 | 18.4% |
| Pharmacy | 43.6 | 35.2 | 8.4 | 19.3% |
| Psychology / Psychotherapy | 503.4 | 401.8 | 101.6 | 20.2% |
| HCA/Support | 469.0 | 373.6 | 95.4 | 20.3% |
| Allied Health Professional | 139.0 | 107.4 | 31.6 | 22.7% |
| Registered Nurse | 866.4 | 651.4 | 215.1 | 24.8% |
| Total | 3015.1 | 2409.2 | 605.8 | 19.4% |

**Background**

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

**What the chart tells us**

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

**Underlying issue**

- The 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.
- CAMHS: Higher levels of vacancy in CAMHS Eating Disorders due to increased investment. This is a similar position for the DBT and Tier 3 teams. New posts are being established faster than the Trust is able to fill them.
- 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 are already underway.

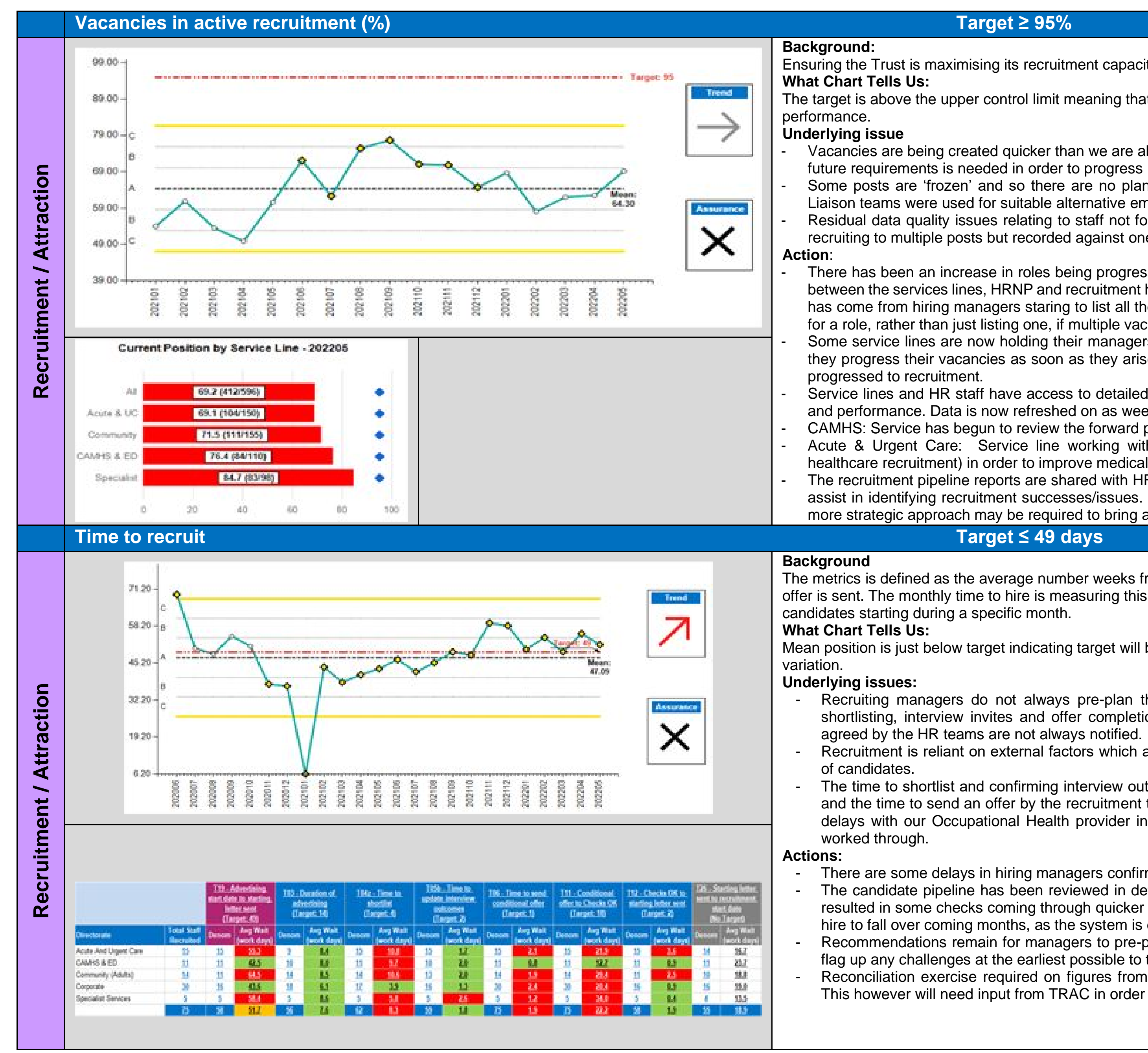
**Actions**

Vacancy rate is linked to turnover, retention strategies needs 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.

## 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**

- Vacancies are being created quicker than we are able to fill. 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.

**Action**:

- There has been an increase in roles being progressed to recruitment as a result of ongoing conversation between the services lines, HRNP and recruitment having ongoing conversation. Additionally, the increase has come from hiring managers staring to list all their vacant position numbers when they are advertising for a role, rather than just listing one, if multiple vacancies are available.
- 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.
- CAMHS: Service has begun to review the forward planning of use of agency staff with Temp Staffing.
- Acute & Urgent Care: Service line working with recruitment agency Remedium (who specialise in healthcare recruitment) in order to improve medical recruitment.
- The recruitment pipeline reports are shared with HRBP's and service leads on a monthly basis, which will assist in identifying recruitment successes/issues. This will continue to help in identifying areas where a more strategic approach may be required to bring about the required outcome.

### 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.

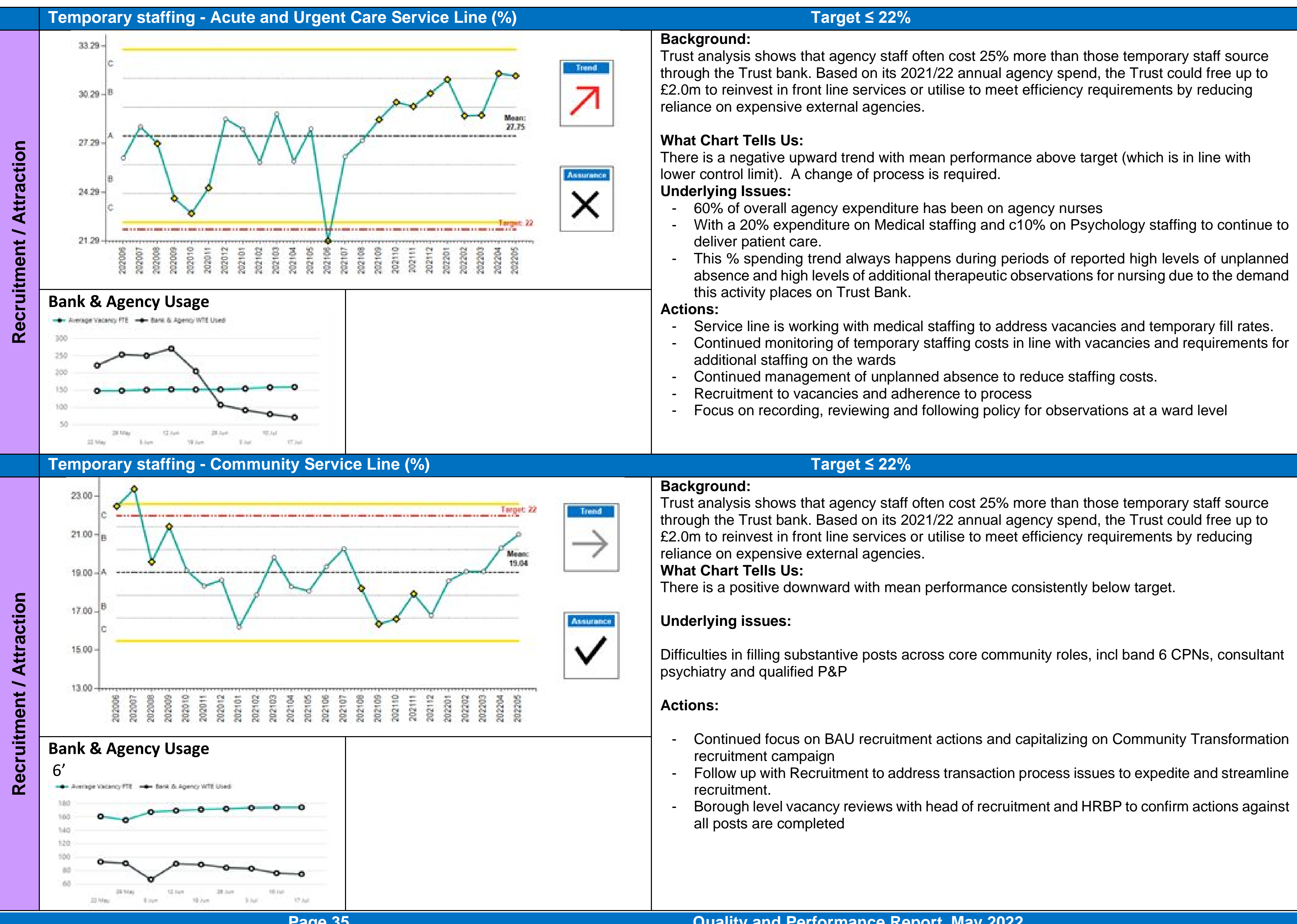
**What Chart Tells Us:**
Mean position is just below target indicating target will be met fairly frequently but there will be some variation.

**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

### Temporary staffing - Acute and Urgent Care Service Line (%) — Target ≤ 22%



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

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

**Underlying Issues:**
- 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.
- Continued monitoring of temporary staffing costs in line with vacancies and requirements for additional staffing on the wards
- Continued management of unplanned absence to reduce staffing costs.
- Recruitment to vacancies and adherence to process
- Focus on recording, reviewing and following policy for observations at a ward level

## Recruitment / Attraction

### Temporary staffing - Community Service Line (%) — Target ≤ 22%



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

**What Chart Tells Us:**
There is a positive downward with mean performance consistently below target.

**Underlying issues:**

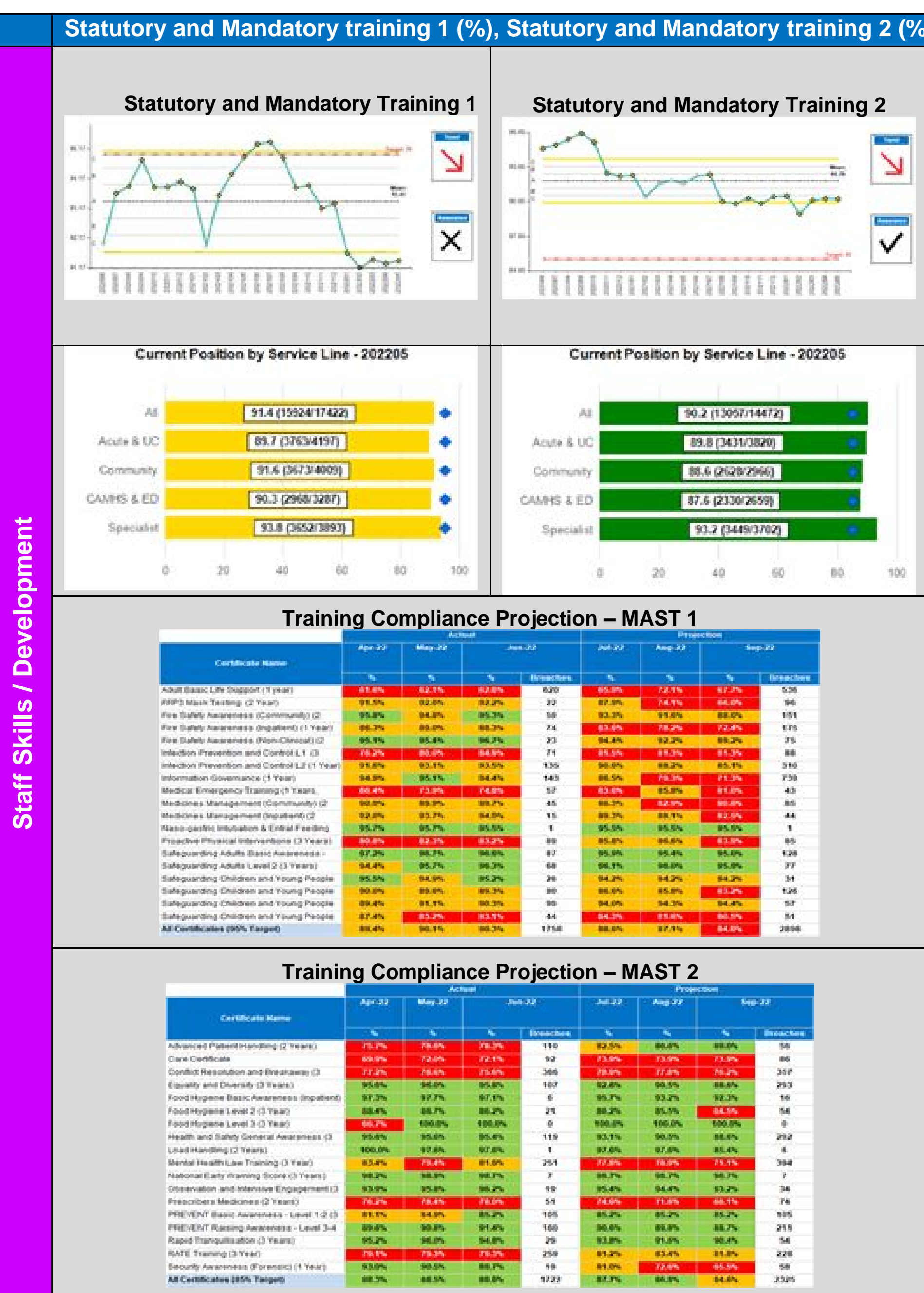
Difficulties in filling substantive posts across core community roles, incl band 6 CPNs, consultant psychiatry and qualified P&P

**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

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

**Staff Skills / Development**




**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**

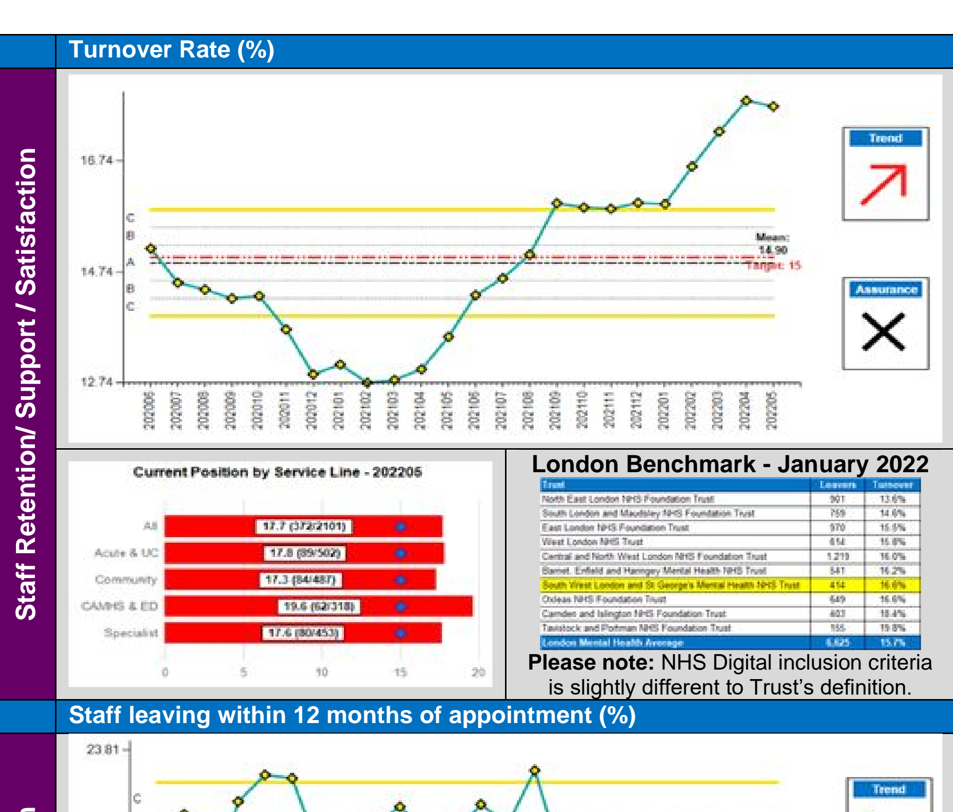
- Evidence shows that in higher performing areas managers proactively book staff onto courses and staff are able to cancel any MAST course within reason if their direct line manager is copied in the email sent to E&D.
- The training budget has not been adjusted to reflect the change in audiences for Advanced Patient Handling, Food Hygiene, or British Sign Language Training.
- The Care Certificate Trainer retires in May 2022. A temporary post is in place in the nurse education team.
- 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**

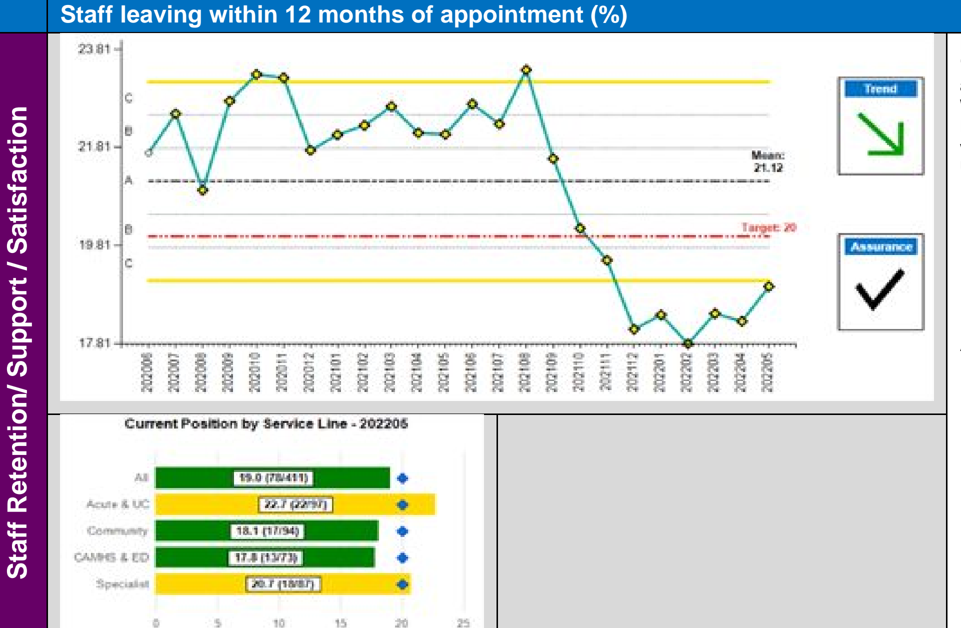
- Over the past few years, Community Service Line teams have experienced significant workforce challenges with workload and capacity frequently cited as a factor behind staff leaving the Trust.
- An ineffective, inconsistent process to collect meaningful exit interview data means that the Trust has imperfect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

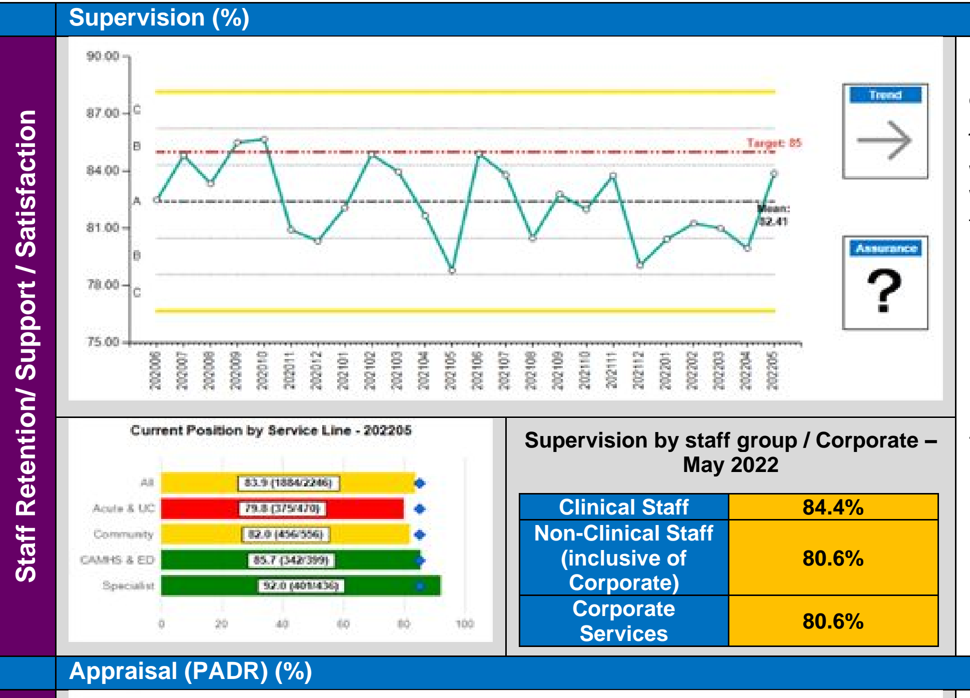
- Whilst the Community service line have experienced significant workforce challenges, over 50% of the 'leavers within 1 year of starting' were Psychological Well Practitioners working for IAPT teams left to progress their career.
- Historically the Acute service line has had high turnover as a number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

| Staff group | % |
|---|---|
| Clinical Staff | 84.4% |
| Non-Clinical Staff (inclusive of Corporate) | 80.6% |
| Corporate Services | 80.6% |

**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**

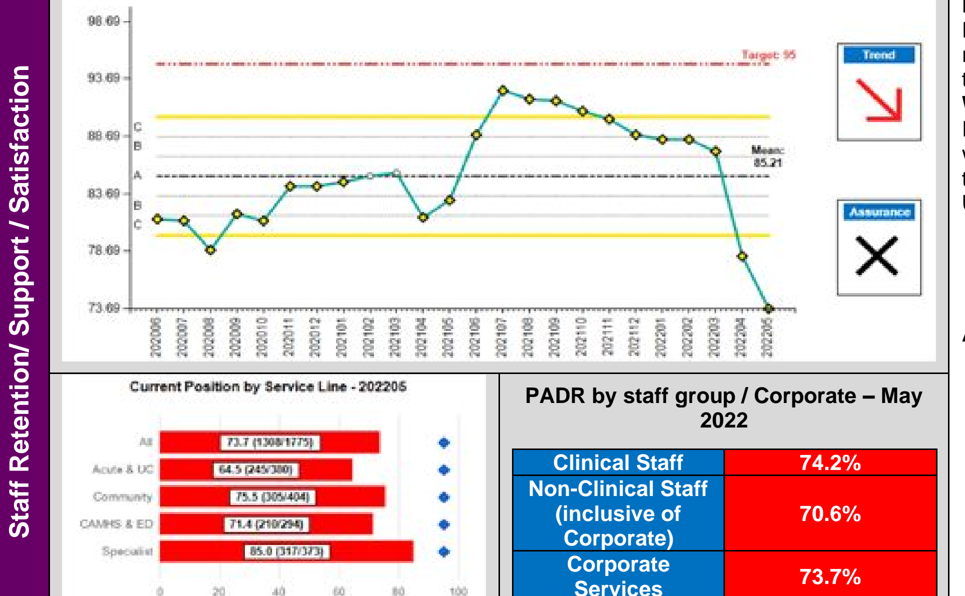
- Trust is unable to consistently maintain performance on this metric.
- Supervision is below target overall for both clinical and non-clinical staff.
- Workload pressures, cancellations of meetings due to incidents on wards, high sickness levels in some areas (AUC) and high numbers of staff allocated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

| Staff group | % |
|---|---|
| Clinical Staff | 74.2% |
| Non-Clinical Staff (inclusive of Corporate) | 70.6% |
| Corporate Services | 73.7% |

**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 extremely 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.

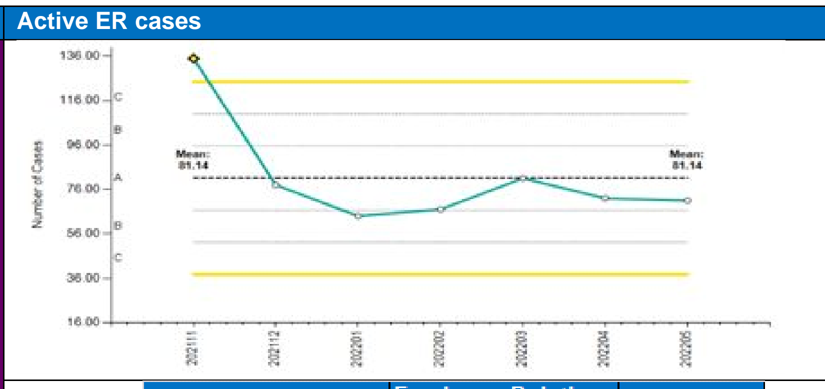
**Actions**

- 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 | 0 | 0.0% |
| Disciplinary | 7 | 9.9% |
| Grievance | 11 | 15.5% |
| Bullying & Harassment | 4 | 5.6% |
| Performance | 3 | 4.2% |
| Sickness Absences | 46 | 64.8% |
| Grand Total | 71 | |

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

**Factors Affecting Employee Relations Cases:**

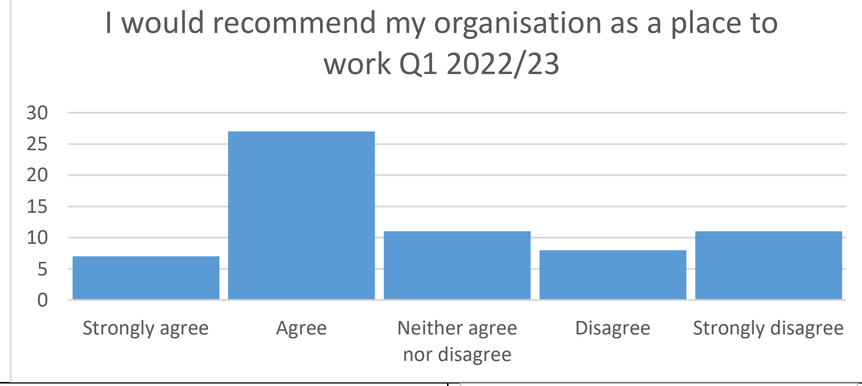
- At the end of May the ER team had 71 open cases, 80% of these cases being supported by the HR Advisory Team at Capsticks
- Bullying & harassment cases continue to primarily centre around allegations of discrimination relating to race
- Disciplinary cases are 10% of overall caseload and have steadily decreased from 19 in January to 7 in May. There has been a reduction in R&R's due to greater scrutiny.

**Actions:**
- All current disciplinary cases, with the exception of 1, 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 65% of the overall caseload. This increased by 50% in February indicating better management of staff absence.
- Informal resolution (mediation and facilitation pilot) – 1 in progress, with a further 2 recommended by Capsticks

Staff Retention/ Support / Satisfaction

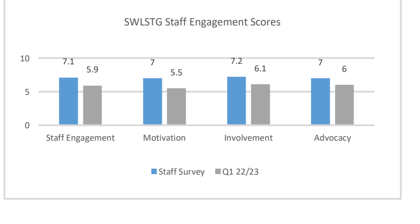
## Staff Friends and Family Test (recommend treatment) (reported quarter in arrears) (%)

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

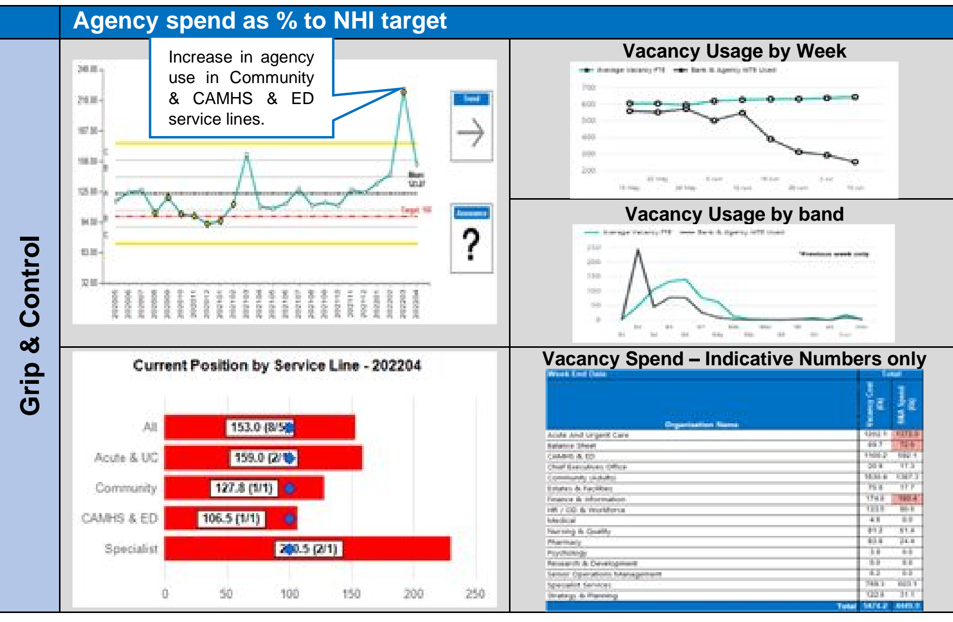
**Underlying Issues:**
- We are in the early stages of collecting data through NQPS and with a low response rate it looks like we are in a healthy position. Trend analysis will be built in as more data becomes available.

**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

| Grip & Control | Agency spend as % to NHI target | Target TBA |
|---|---|---|




| Organisation Name | Total | |
|---|---|---|
| Acute And Urgent Care | [illegible] | [illegible] |
| Balance Sheet | [illegible] | [illegible] |
| CAMHS & ED | [illegible] | [illegible] |
| Chief Executives Office | [illegible] | [illegible] |
| Community (Adults) | [illegible] | [illegible] |
| Estates & Facilities | [illegible] | [illegible] |
| Finance & Information | [illegible] | [illegible] |
| HR / OD & Workforce | [illegible] | [illegible] |
| Medical | [illegible] | [illegible] |
| Nursing & Quality | [illegible] | [illegible] |
| Pharmacy | [illegible] | [illegible] |
| Psychology | [illegible] | [illegible] |
| Research & Development | [illegible] | [illegible] |
| Senior Operations Management | [illegible] | [illegible] |
| Specialist Services | [illegible] | [illegible] |
| Strategy & Planning | [illegible] | [illegible] |
| Total | [illegible] | [illegible] |

**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.

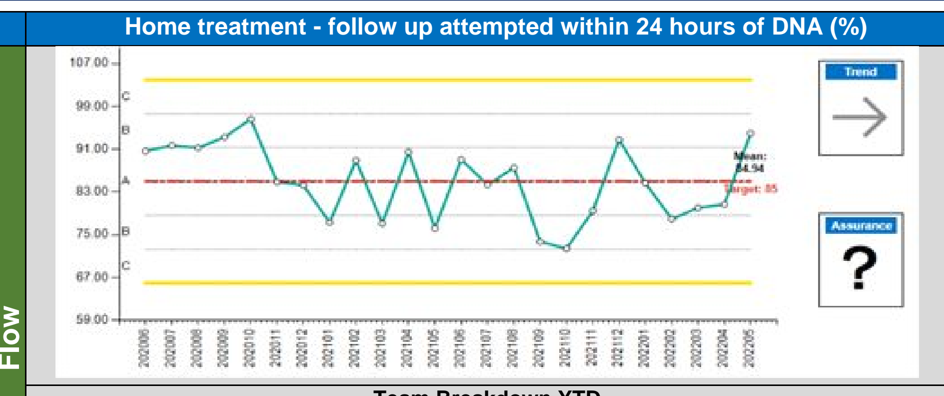
**Actions:**

- 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.

# Non-Priority Metrics: reported by exception

Flow

## Home treatment - follow up attempted within 24 hours of DNA (%) — Target ≥ 85%




**Team Breakdown YTD**

| Team | DNAs | Followed up in 24Hrs | % Followed up in 24Hrs |
|---|---|---|---|
| Kingston Crisis & Home Treatment Team | 6.0 | 5.0 | 83.3% |
| Merton Home Treatment Team | 35.0 | 29.0 | 82.9% |
| Richmond HTT CRT | 78.0 | 68.0 | 87.2% |
| Sutton Home Treatment Team | 11.0 | 11.0 | 100.0% |
| Wandsworth Crisis & Home Treatment Team | 31.0 | 30.0 | 96.8% |
| **Total** | **161.0** | **143.0** | **88.8%** |

**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:**

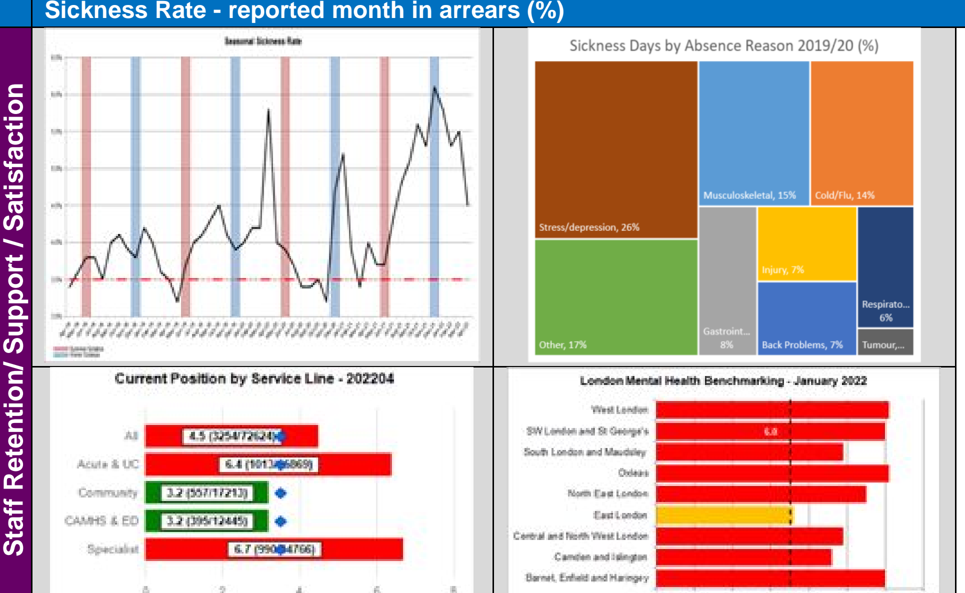
- An audit of breaches in July 2021 shows that underperformance mainly relates to staff not recording contacts on clinical systems.

**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

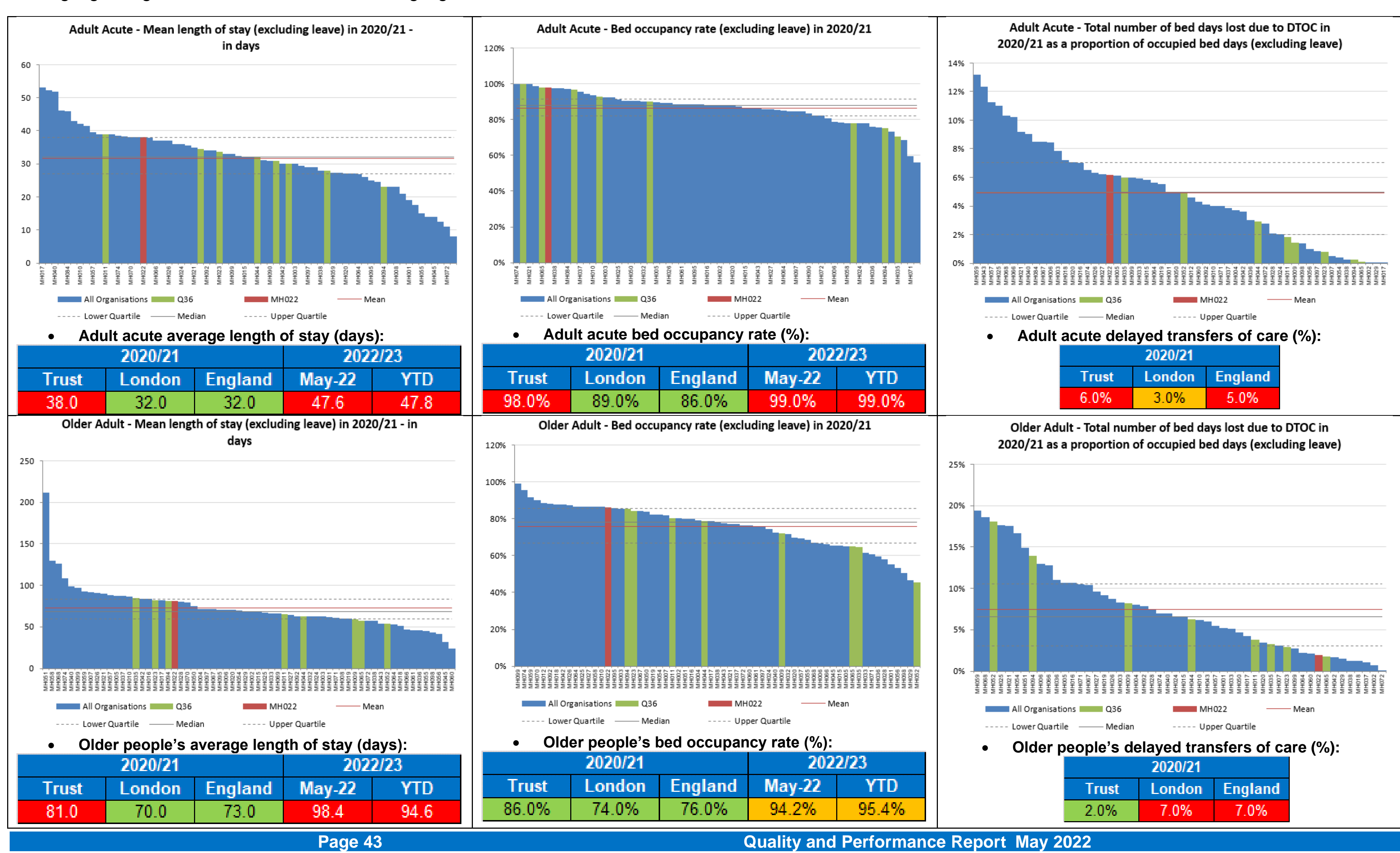
This dashboard is currently displaying information for All Wards. Click the filter icon at the top right of the page to view a single Ward, Ward Category or Service Line.

### 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 |

# 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 | May-22 | YTD |
| 38.0 | 32.0 | 32.0 | 47.6 | 47.8 |

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

| 2020/21 | | | 2022/23 | |
|---|---|---|---|---|
| Trust | London | England | May-22 | YTD |
| 98.0% | 89.0% | 86.0% | 99.0% | 99.0% |

- **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 | May-22 | YTD |
| 81.0 | 70.0 | 73.0 | 98.4 | 94.6 |

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

| 2020/21 | | | 2022/23 | |
|---|---|---|---|---|
| Trust | London | England | May-22 | YTD |
| 86.0% | 74.0% | 76.0% | 94.2% | 95.4% |

- **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 | May-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 | 81.9 | ≥ 75.0 | ↘ | ✓ | Mean: 84.28 | 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 | → | ✓ | Mean: 99.92 | Performance is consistently above target. |
| IAPT/talking therapies - Waiting time to begin treatment within 6 weeks (%) | 98.4 | ≥ 75.0 | → | ✓ | | Performance is consistently above target. |
| IAPT recovery rate - Talk Wandsworth (%) see page 22 | 56.6 | ≥ 50.0 | → | ✓ | | Performance is consistently above target for Talk Wandsworth. |
| Cardiometabolic Assessments - Inpatients (%) | 90 | ≥ 90.0 | → | ? | Target: 90 | 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 | 50.2 | ≥ 50.0 | → | ? | | Average performance for 2022/23 is currently above target. |
| IAPT recovery rate - Sutton Uplift (%) see page 22 | 49.7 | ≥ 50.0 | → | ? | | Average performance for 2022/23 is currently below target. |
| 1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) see page 11 | 40 | ≥ 60.0 | ↘ | ? | Target: 60 | There has been a recent decline in performance, mainly due to referrals from wards and assessment teams. |
| Inappropriate out of area placement bed days - Adult Acute & PICU ℗ see page 19 | 243 | = 0 | ↗ | X | Mean: 122.04 | 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 | 84.6 | ≥ 92.0 | ↘ | X | Target: 92 | 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

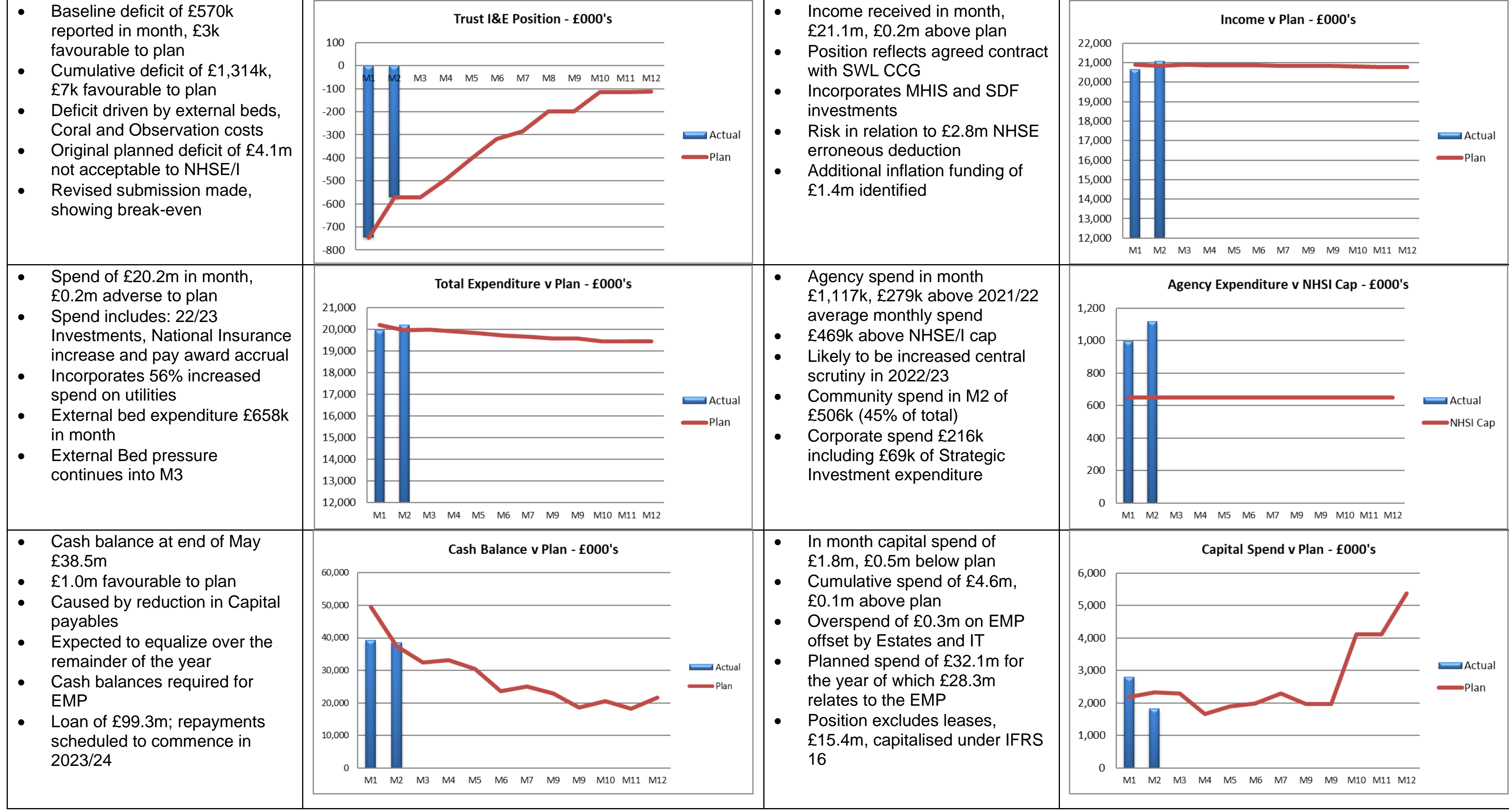
**Overall Dashboard**

**The Mental Health CQUIN team are currently developing schemes for 2022/2023 – reporting will re-commence from July 22.**

| Effective: CQUIN Key Measures | Target | Jul-22 | YTD | Key Points | Actions |
|---|---|---|---|---|---|
| Health and wellbeing - Uptake of flu vaccination (frontline staff) (%) | ≥ 90.0 | | | Reporting will recommence in July 2022. A fuller update will be provided in next month's report. | The Trust will not be progressing the CCG CQUINS, which are:<br><br>• CCG2- Cirrhosis and fibrosis tests for alcohol dependent patients<br>• CCG5- Staff Influenza Vaccination (The Trust will continue to plan and progress with Flu for 2020/21)<br>• CCG6- Use of anxiety disorder specific measures in IAPT services<br>• CCG7 a and b- Routine outcome monitoring in CYP, perinatal mental and community services (incl. HTT) health services<br>• CCG8- Biopsychosocial assessments by MH Liaison services<br><br>For the Specialist Services CQUINS (PSS2, PSS3 and PSS4), the option was given to the Trust to continue to implement some of the elements to ensure the Trust is ready if the schemes roll over to 2021/22. After speaking with the FSN service line, the decision was taken to continue with the PSS CQUINs. There is no additional cost to continuing with these it is absorbed within the service line.<br><br>• PSS4 (D/deaf Communications) is well underway as this started in 2019/20 and is becoming part of practice.<br>• PSS3 (CAMHS formulations) is a joint CQUIN with SLAM, who are also progressing this year. It is a CQUIN that has direct impact on staff and young people.<br>• PSS2 (Forensic Healthy Weight) has a resource part time and it is proposed to continue to embed practice into core business. This is also a continuation of 2019/20<br><br>The Trust will need to submit the national template report on CQUIN as we are not pausing the PSS CQUINs. |
| Use of anxiety disorder specific measures in IAPT | ≥ 65.0 | | | | |
| Healthy weight in Forensic Patients | | | | | |
| Deaf Communication (Adult and CAMHS) | | | | | |
| CAMHS Training T4 services | | | | | |
| Cirrhosis and fibrosis tests for alcohol dependent patients | | | | | |
| Routine outcome monitoring in CYP, perinatal mental and community services (incl. HTT) health services | | | | | |
| Biopsychosocial assessments by MH Liaison services | | | | | |
| Liaison and Diversion team | | | | | |

# Appendix 4: Finance Domain

## Trust Wide




- Baseline deficit of £570k reported in month, £3k favourable to plan
- Cumulative deficit of £1,314k, £7k favourable to plan
- Deficit driven by external beds, Coral and Observation costs
- Original planned deficit of £4.1m not acceptable to NHSE/I
- Revised submission made, showing break-even

- Income received in month, £21.1m, £0.2m above plan
- Position reflects agreed contract with SWL CCG
- Incorporates MHIS and SDF investments
- Risk in relation to £2.8m NHSE erroneous deduction
- Additional inflation funding of £1.4m identified

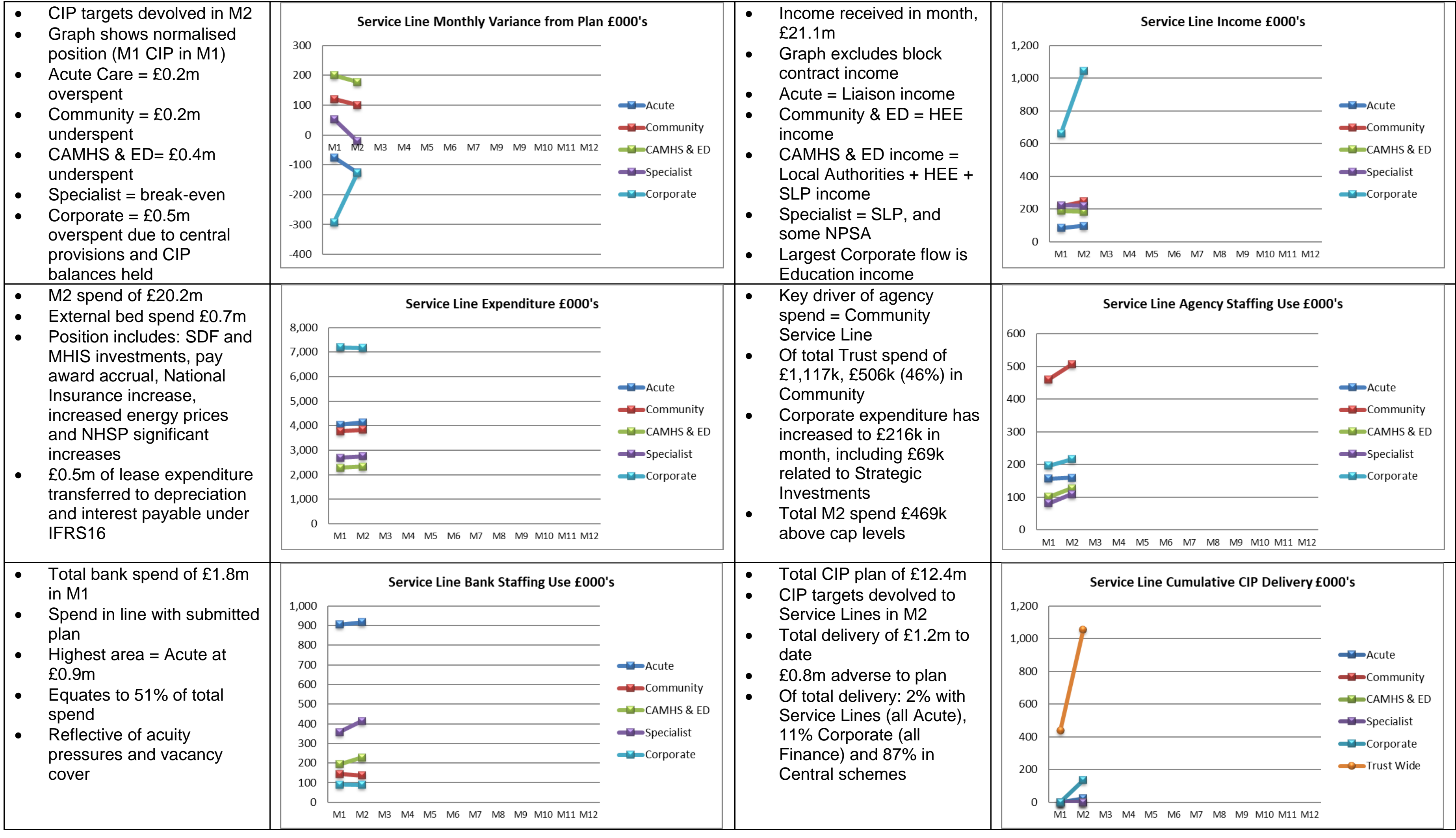
- Spend of £20.2m in month, £0.2m adverse to plan
- Spend includes: 22/23 Investments, National Insurance increase and pay award accrual
- Incorporates 56% increased spend on utilities
- External bed expenditure £658k in month
- External Bed pressure continues into M3

- Agency spend in month £1,117k, £279k above 2021/22 average monthly spend
- £469k above NHSE/I cap
- Likely to be increased central scrutiny in 2022/23
- Community spend in M2 of £506k (45% of total)
- Corporate spend £216k including £69k of Strategic Investment expenditure

- Cash balance at end of May £38.5m
- £1.0m 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 £1.8m, £0.5m below plan
- Cumulative spend of £4.6m, £0.1m above plan
- Overspend of £0.3m on EMP offset by Estates and IT
- Planned spend of £32.1m for the year of which £28.3m relates to the EMP
- Position excludes leases, £15.4m, capitalised under IFRS 16

## Service Line Analysis




- CIP targets devolved in M2
- Graph shows normalised position (M1 CIP in M1)
- Acute Care = £0.2m overspent
- Community = £0.2m underspent
- CAMHS & ED= £0.4m underspent
- Specialist = break-even
- Corporate = £0.5m overspent due to central provisions and CIP balances held

- Income received in month, £21.1m
- 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

- M2 spend of £20.2m
- External bed spend £0.7m
- 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 £1,117k, £506k (46%) in Community
- Corporate expenditure has increased to £216k in month, including £69k related to Strategic Investments
- Total M2 spend £469k above cap levels

- Total bank spend of £1.8m in M1
- Spend in line with submitted plan
- Highest area = Acute at £0.9m
- Equates to 51% of total spend
- Reflective of acuity pressures and vacancy cover

- Total CIP plan of £12.4m
- CIP targets devolved to Service Lines in M2
- Total delivery of £1.2m to date
- £0.8m adverse to plan
- Of total delivery: 2% with Service Lines (all Acute), 11% Corporate (all Finance) and 87% 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.<br>▪ 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)<br>▪ 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<br>▪ The three requirement notices from previous inspections were lifted. However, five new notices were issued in respect of the EDS, along with six associated 'must do' actions<br>▪ A list of these notices can be found in the appendix A, along with the current grid rating.<br>▪ 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.<br>▪ The CQC noted many outstanding features, such as;<br>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<br>o Staff provided a very high standard of physical health care and treatment to patients.<br>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.<br>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.<br>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.<br>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.<br>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 | ▪ 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<br>▪ 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.<br>▪ The actions were formally agreed at QGG in January 2020 and presented to QSAC for assurance also in January 2020.<br>▪ 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.<br>▪ The Trust received the draft report for the Eating Disorder services inspection on 19th May 2022.<br>▪ The draft report had a very welcomed result 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.<br>▪ The six requirement notices from the previous inspections of the Eating Disorder services will be lifted on publication of the final report and there were no new notices issued (or 'must do' actions). The must do's will be removed from Appendix A once the final report has been received.<br>▪ 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.<br>▪ The Trust are currently completing the factual accuracy document for the draft report, which will be sent to the CQC in early June.<br><br>**Ratings on how Trust Scored for each core service:** |

of care provided in Lotus Psychiatric Decision Unit - which is important as we are leading the way nationally in this area

- They found strong evidence of good risk management, learning from incidents and teamwork

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

## Appendix A – Current regulation notices

| Regulation | Service | Issue |
|---|---|---|
| Regulation 11 HSCA (RA) Regulations 2014 Need for **consent**<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Specialist Eating Disorders Services | The trust must ensure that staff working with children and young people on Wisteria Ward understand the issues of competence and consent to treatment in this age group. The trust must ensure staff follow the guidance of Gillick compete |
| Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment**<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Specialist Eating Disorders Services | The trust must ensure that in the eating disorder service information about patients' physical health care is recorded accurately and that the information is transferred promptly on to patients' electronic records so that it can be followed up quickly when concerns are identified. Where decisions have been made not to escalate concerns these should be clearly recorded in patient care plans<br>And<br>The trust must ensure that all staff in the eating disorder service know where potential ligature points are throughout the ward and how the risks are mitigated. All staff, including temporary staff must be aware of where the ligature cutters are located. The induction pack for new staff must include where the ligature points and ligature cutters are on the ward, especially on Wisteria Ward. |

| Regulation | Service | Requirement |
|---|---|---|
| Regulation 13 HSCA (RA) Regulations 2014 **Safeguarding** service users from abuse and improper treatment<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Specialist Eating Disorders Services | The trust must ensure they review the use of overly restrictive blanket restrictions on Wisteria Ward to ensure that they are appropriately applied and based on patients' individual needs and risks |
| Regulation 14 HSCA (RA) Regulations 2014 Meeting **nutritional and hydration** needs<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Specialist Eating Disorders Services | The trust must ensure that food on Wisteria Ward is of good quality and suitable for young people with an eating disorder |
| Regulation 17 HSCA (RA) Regulations 2014 **Good Governance**<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Specialist Eating Disorders Services | The trust must ensure that systems in place to assess, monitor and improve the quality of service in Wisteria Ward are effective. The trust must ensure that audits are of good quality and address all necessary areas of practice. Where shortfalls or gaps are identified, a clear time limited action plan with named people responsible for implementation is in place and monitored |
| Regulation 14 HSCA (RA) Regulations 2014 Meeting **nutritional and hydration** needs<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Specialist Eating Disorders Services | The trust must ensure that patients receive the meal ordered and that where this is not possible patients are informed in advance of their mealtime. Portion sizes must be in accordance with the patients agreed meal plan. Regulation 14(1)(4)(c) |
| Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment**<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>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**<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>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**<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>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) |

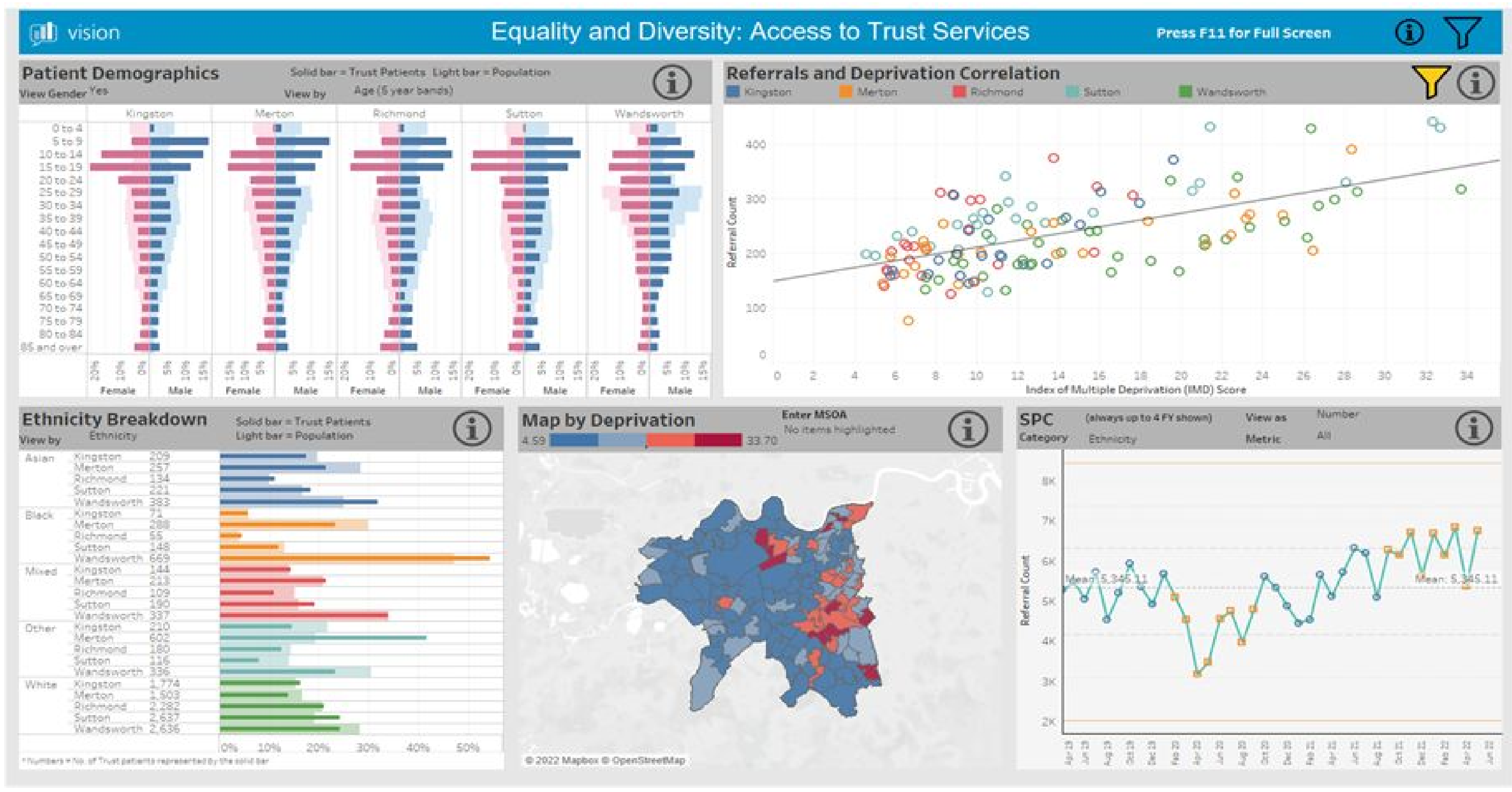
| | | |
|---|---|---|
| Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment**<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Acute wards for adults of working age and psychiatric intensive care 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 |

# 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.

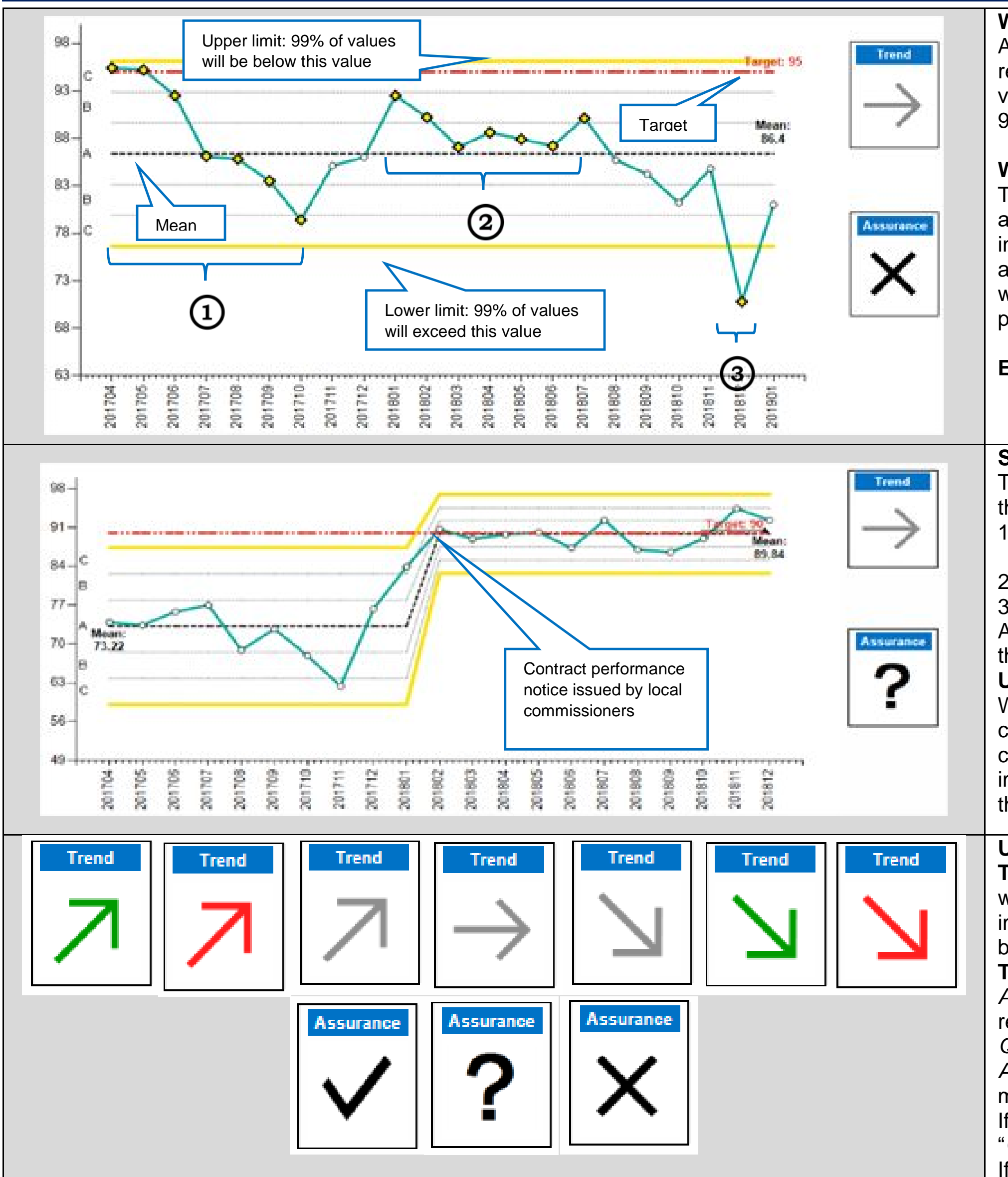
# Appendix 8: Data quality assurance

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*").

## WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of the meeting held on **Tuesday 22nd March 2022**, 15:00-17:00 via MS Teams

**Attendance list**

**Present:**

| | |
|---|---|
| Sola Afuape (SA) | Non–Executive Director (Chair) |
| Katherine Robinson (KR) | Interim Director of Human Resources |
| Vanessa Ford (VF) | Chief Executive Officer (from 4pm) |
| Jen Allan (JeA) | Chief Operating Officer |
| Doreen McCollin (DM) | Non–Executive Director |
| Ann Beasley (AB) | Trust Chair |
| Sharon Spain (SS) | Director of Nursing |

**Attendees:**

| | |
|---|---|
| David Lee (DL) | Director of Corporate Governance |
| Nicola Mladenovic (NM) | Deputy Trust Secretary – Minutes (from 4pm) |
| Lincoln Murray (LM) | FTSU Guardian (attended from 22/9) |

**Observer with speaking rights:**

| | |
|---|---|
| Shikainah Champion (SC) | Diversity Representative and Specialist Clinical Psychologist for Sutton Uplift |

**Apologies:**

| | |
|---|---|
| Jenna Khalfan (JK) | Director of Communications and Stakeholder Engagement |
| Sarah James (SJ) | Associate Director Human Resources – Training & Development |
| Deborah Bowman (DBo) | Non Executive Director |

**Item** **Action**

**22/1 Welcome and Apologies**

Apologies for absence were received and noted.

**22/2 Declarations of Interest**

No new declarations were reported.

**22/3 Chair's Action**

The Chair took no action on behalf of the Committee outside of the meeting. However, it is to be noted that Sola attended the newly set up twice yearly Joint Equality & Diversity and Workforce Committees meeting on 17th February 2022. The Chair will meet with the EDC Chair to discuss how added value outcomes will be captured and reported.

**22/4 Minutes of the previous meeting**

The minutes of the meeting held on 20th December 2021 were approved as an accurate record.

**22/5 Action Tracker and Matters Arising**

The Committee received and noted the action tracker, this also incorporated updates from KR to reflect the HR recovery progress. The following updates were received on the following:

**Item 21/62 Disciplinary Deep Dive Outcome report.** As a result of the changes the Disciplinary Policy is being re-drafted as a single policy only for SWLSTG. KR will provide an update on the timeframes for the policy review and an update on the underlining issues that were identified as part of the deep dive review that had been taken as part of the last policy review. This is to come to the May meeting. **(Action: KR)** **KR**

**Item 21/83 – Stress Assessment Update.** This has been recently discussed at the Board Development session regarding organisational priorities and it has been agreed that there are other pieces of work that need to be prioritised to address the underlining causes contributing to workplace stress. Therefore, the requirement for Stress Assessments will be reviewed when appropriate. An update will come to the May committee meeting. **(Action: KR)** **KR**

**Item 21/85 – Preparing for the next Staff Survey.** The Staff Survey Report for 2021 and recommended actions will be presented to the committee seminar in April as currently the results are embargoed until 31st March 2022. The Committee chair will be sighted on them in advance of the March Board.

**Item 21/93 – Safer Staffing**. Further work in regard to the DBS checks has taken place. Significant improvements have been reported. KR to share the SWLSTG report with the Chair.

**Item 21/88 – Employee Relations**. This will be included in the main update.

**Item 21/62 – Nurse Revalidation Report**. This is on the agenda.

**22/6 Q3 Corporate Objectives Report**

The Committee received the Q3 Corporate Objectives report.

KR reported that some elements of the report have now been superseded and the content of the objectives will need to be considered by KR as the report is written by the Strategy Team.

The Committee noted that the current report gives detail on the objectives that have passed however requested that future reports include more EDI content to demonstrate how this is reflected in the delivery of the objectives. The HR corporate objectives for 2022/23 will be circulated shortly and the committee will be sighted on these at the April seminar.

**22/7 People Priorities 2022**

The Committee received a presentation on the draft People's Plan 2022.

The following points were raised:

- The HR Recovery Programme has highlighted a greater focus is required for the staff within the Trust and a set of priority actions will move towards the goal.
- Given the operational challenges and emerging 'green shoots' of progress made with the Recovery plan, the recommendation to focus on delivery a 12 month plan was supported with the proviso that work continues towards developing a longer term People Strategy and this is incorporated in the tail end of the plan.
- The Director Nursing and Chief Operating Officer are working closely with the development of the People's Plan to ensure that it is aligned with the immediate operational and quality challenges.
- The dashboard is undergoing further development and will be presented at the next WODC meeting providing clearer oversight of progress against key workforce metrics and HR and OD service delivery.

- A timeline for delivery was presented which included designing and set up of the future workforce and OD model, recruitment to the HR team - including the substantive HR Director role, transformation consultation and supporting the move to the new hospital. During Jan-March the People Strategy for 2022-25 will be developed.
- The People's Plan follows five themes – attraction – development – retention – EDI – HR Recovery and the golden thread running through the People's Plan is equality, diversity and inclusion. The sections will mean that staff will want to come and work for the Trust, through their employment will be developed and through this development staff will stay and make a commitment to the services the Trust provides.

  The priorities identified as part of this work will be brought together with a project plan for each. Highlight reports can also be provided against each for WODC.

The Committee agreed with the recommendations and timelines and looked forward to receiving further iterations.

**22/8 Quality & Performance Report**

The Committee received and noted the Q&P Report. The following points were reported:

- There are similarities between this report and the scorecard and this will support the automation of reporting i.e. time to recruit and mandatory training
- The Employee Relations element is not automated and this will be developed with a case management system

Through discussion it was raised that an improved system is required to support monitoring the referrals to the NMC in terms of revalidation and to also determine if there is a disproportionate number of referrals of ethnic minority staff being submitted to the NMC. This piece of work is currently in progress and is reported to QSAC. A workforce related update will come back to the committee at a future point. It was noted that this view of disproportionate referrals to professional bodies is just a relevant to other professions e.g. junior doctors etc. It was noted that the Committee will review its forward plan and consider where it is appropriate to seek oversight of this at a future date.

It was acknowledged that there are a number of proposed metrics being considered but having a PADR and supervision might be the most useful metric to be monitored.

KR reported that the workforce related EDI metrics are also to be included and would be received at the Equality & Diversity Committee shortly as part of their forward plan.

Health inequalities would also be included in the Q&P metrics and future metrics would look at restrictive practice broken down by ethnicity as this is aligned to the EMHIP work.

**22/9 BAF Update**

The Committee received and noted the BAF. KR reported that the BAF has been updated and is now aligned with the People Plan. It was noted that the management information presented was intelligence dense and agreed that future iterations will focus on high level reporting. **(Action KR)** **KR**

**22/10 Freedom to Speak Up Guardian Report**

The Committee received and noted the Freedom to Speak Up Guardian report.

KR updated the committee to confirm that she will now be meeting regularly with Lincoln Murray, Freedom to Speak Up (FTSU) Guardian in addition to the meetings that the

**These minutes represent the record of the entire meeting, they should be read in conjunction with the agenda's papers and should not be distributed to anyone outside the Committee members.**

CEO has with LM. Going forward VF will continue to meet with LN and will now have a joint meeting to include Deborah Bowman, as the Senior Independent Director and FTSU Champion, as well as a standing member of WODC. The reporting structure has also been changed so that the FTSU Guardian reports through the Trust Secretariat rather than the HR Director. LN attended for this item and reported the following:

- The report has been divided into quarters; between April to the end of December 2021 there were 86 concerns raised this year, 68 have been closed and 18 remain open.
- The majority of themes have been due to management issues as opposed to bullying/harassment as might be expected. Staff bring up items they are not happy about, they might construe this as them being bullied but in actual fact this is based on a communication issue. Where issues have arisen, this is in the main due to how managers speak to staff and this could be compounding the differences in cultures and how the communication is perceived. It has been reported that there are varying levels of different communication techniques and this is having an impact.
- Looking across the London region it is clear that the Trust differs from other Trusts. Kingston Hospital had 42 concerns raised and the Trust is 4th with 30 concerns raised in the same period. It is clear that the number of cases relate to behavioural issues and these are much higher in other Trusts and this demonstrates the communication concerns including bullying and harassment.
- Some recommendations are concerned with the time that the investigation has taken however some Trusts give an expectation on the investigation duration. Currently a timeframe is not given to staff and this would assist the communication of the process.
- Staff who are going through a formal process do not feel they have sufficient support to attend meetings or interpreting letters that they have received.
- Disabled staff needing reasonable adjustments in the form of specialist equipment requests are taking a long time for the IT Team to source the equipment.

LM has worked with the Trust for five years and this year he has been included in the leadership events and has reported that this has been most helpful in supporting the work that he does. By having the connections with the Heads of Service Line, he has been able to raise ward concerns to reach a satisfactory outcome.

KR stated that 8-12 weeks is an expected time for a management investigation and can be used as a guide should the timescales need to be escalated. The cases are now being reviewed on a weekly basis by the Deputy Director of HR.

The Chair noted the outcomes of the 12-month People's Plan and emphasised the importance of being able to track these against the themes from the Guardian's report and imminent Staff Survey.

**22/11 Recovery Advisory Board Assurance Report**

The Committee received and noted the highlight report.

- Good progress is being made in terms of the People Priorities.
- The BAF has been updated.
- A key decision has been to separate the HR function from SLaM. A series of workshops have been set up to manage the services going forward, this will also include linking with the service lines to ensure the new HR provision meets their needs also.
- The senior HR Team are now in place.
- Specialist support in now in place to support recruitment, to plan recruitment strategies and to ensure the team is in the right place to manage this going forward.

- Employee Relations – Capsticks have now been supporting for the last 8 weeks. The pace of work needs to be increased and actions are in place to deliver this ad to improve the triage process.
- A policy development framework is being put in place, ensuring that the development of policies is more inclusive with key stakeholders involved. Each policy will be timetabled throughout the year so that these are more robustly reviewed and managed.
- More work is continuing to support the Medical Staffing team and weekly meetings have been held with the Clinical Directors to ensure the team is supporting them as effectively as possible.
- More work is continuing to develop the recruitment strategy.
- The scorecard is still being reported with a lot of red areas but more work will focus on the next steps to change the 'sea of red.'

The chair invited the COO and DON to indicate what impact this is having on quality and operations. JeA reflected that there still remains a challenge in Medical Staffing, employee relations and delivering the level of recruitment that is needed by the services. Improvements have been noted over that last three months however this has not been at the pace expected. It is hoped that improvements reported in the next quarter will be closer to that expected.

SS agreed with JeA and asked that the training and needs analysis should be considered as this is a vital element.

SA reflected that there is limited assurance in the delivery of the HRI recovery outcomes and that clearer tracking of the key metrics for sharper oversight is required. **(Action: KR)** — **KR**

VF recognised the work undertaken by the HR Team to move from No Assurance to Limited Assurance and that the People Plan timeline will give further detail in managing the timeline expectations. The Committee requested that this positive feedback is fed back to the HR Team.

**22/12 Nurse Validation Annual Report**

The Committee received and noted the Nurse Validation Report. The Board will receive an update through the QSAC Chair's Report. A further analysis of NMC referrals by ethnicity will be added to future reporting starting from the next iteration. It was agreed that future Annual reports would come to this Committee for noting.

The Committee sought confirmation on the robustness of the internal controls as the current system is a manual process. SS confirmed that further work was required by the Informatics Team however provided assurance that no members of staff has worked without being fully compliant with the NMC Code of Conduct revalidation process.

The Committee was also given assurance that there is a process in place if registered staff are not compliant with the revalidation process and that this process had not been required as all staff are compliant.

SS is currently working with the HR Team and an update on the controls process will come back to a future meeting. **(Action: SS to provide an update on the control process)** — **SS**

**22/13 Estates Modernisation Programme Consultation, briefing and update**

The Committee received and noted the Estates Modernisation programme consultation briefing and update.

- The consultation for corporate and clinical staff that are affected by the Springfield Hospital move has been launched on 17th March 2022 and will close on 22nd April 2022.
- The proposal is for colleagues to work a 60/40 split with home working/ on-site working.
- High cost allowance will be protected as Tolworth (outer) rather than Springfield (inner) once the change takes effect.
- Staff representatives have been informed, 1:1 meetings have commenced with staff about the proposals and the impact for individuals.
- Feedback and learning from the previous consultation will be included in the form of FAQs.
- A Governance Group will meet on a weekly basis throughout the consultation to review feedback and provide responses.
- The outcome of the consultation will be distributed between early and mid-May and will be included in the new Ways of Working plan.

AB acknowledged that support is given to the new members of staff who have joined the organisation since the construction has started as they might not be aware that they will be affected by the relocation to Tolworth. Further updates will be provided to the Committee.

**22/14 Committee Terms of Reference**

The Committee received and noted the Committee Terms of Reference.

- A correction of Estates Management Committee to Estates Modernisation Committee was noted.
- Two seminars a year have been set jointly with the Equality & Diversity Committee. The outcomes of this arrangement are to be captured**. (Action: SA to meet with the EDC chair to discuss the approach)** **SA**

**The Committee agreed the ToRs with these amendments.**

**22/15 Committee Forward Plan**

The Committee received the forward plan. The forward plan is to align with delivery against the BAF and to include EMP workforce related updates.

**The Committee agreed the forward plan.**

**22/16 Matters to Report to the Board**

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

- Limited Assurance relating to BAF risks but support for the 12-month People Plan approach
- Acknowledgement of the current challenges still impacting quality and services operationally
- Oversight of controls of Nurse validation and future analysis by ethnicity
- Guardian report and strengthened embedding of the service in the organisation

**22/17 Meeting Review**

The Committee reflected on the meeting and it was noted that steady progress is being made. There are positive updates and the direction of travel is clear. In terms of EDI it is clear that this is feeding into the overall business as usual. SA commended the openness and approachability of KR in presenting the key items and cited this as

contributing to increased confidence in the approach undertaken to date. SA also noted the importance of having the COO and Director of Nursing in attendance at the meeting to triangulate and comment on the impact of workforce related matters.

**22/18 Date of Next Meeting**

The next meeting will be held on 24th May 2022.

**Equality & Diversity Committee**

Minutes of the MS Teams meeting held on **Thursday 21st April 2022, 14:30-17:00**

| **Present:** | |
|---|---|
| Doreen McCollin (DMc) | Non-Executive Director (Committee Chair) |
| Ann Beasley (AB) | Trust Chair |
| David Lee (DL) | Director of Corporate Governance |
| **Attendees:** | |
| Jenna Khalfan (JK) | Director of Communications and Stakeholder Engagement |
| Billy Boland (BB) | Medical Director |
| Andrew Francalanza (AF) | Equality & Diversity Inclusion HR Lead |
| Lenka Novakova (LN) | Deaf Staff Network |
| Ashley Painter (AP) | DiverseAbility Staff Network |
| Andy Cohen (AC) | LGBTQIA+ Staff Network |
| Sarah Burrell (SB) | Service User and Carer representative |
| Emily Downey (ED) | Women's Staff Network |
| Johnny Steyn (JS) | Employee Engagement Manager |
| Nicola Mladenovic (NM) | Deputy Trust Secretary (minutes)r |
| **Apologies** | |
| Ranti Lawuni (RL) | Evolve Staff Network |
| Vanessa Ford (VF | Chief Executive |
| Deborah Bowman (DBo) | Non-Executive Director |
| David Heasman (DH) | Christian Staff Network |
| Katherine Robinson (KR) | Interim Director of Human Resources and OD |
| Pam Warren (PW) | Deputy Director of Human Resources |
| Melena Blake (MB) | Service User and Carer representative |
| Jacqueline Ewers (JE) | Evolve Staff Network |

| Item | | Action |
|---|---|---|
| 22/19 | **Introduction and Apologies**<br>Apologies were noted. | |
| 22/20 | **Chairs Action**<br>No Chair's Action has been taken. | |
| 22/21 | **Minutes from the last meeting**<br>The minutes from the last meeting were agreed as correct. | |
| 22/22 | **Action Tracker**<br>**22/7 Committee Forward Plan** – JK confirmed that the board pledges have been completed and these will feed into the Trust's Annual Report.<br>**22/14 Deaf Service community space** – JK confirmed that a meeting has been scheduled to include members from the PRCC Team and LN and an update will come to the next meeting. | |

**These minutes represent the record of the entire meeting, they should be read in conjunction with the agenda's papers and should not be distributed to anyone outside the Committee members.**

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| **22/23** | **EDI Review Learning – People – Discussion Document**<br>The Committee received the EDI Action Plan. However in the absence of KR and PW an overview was provided by DL<br><br>• The presentation provides an overview of EDI, with the current action plans and workstreams in relation to the EDI workforce.<br>• The existing actions have been reviewed by Katherine Robinson and the HR Team in relation to the EDI agenda in order to further understand why there has been minimal progress of the actions.<br>• The presentation sets out the proposed plan, and it is acknowledged that further engagement with stakeholders is required in developing the action plan.<br>• The monitoring of EDI actions will be updated at the committee in the next few months with a progress report.<br><br>DMc commented on the direction of travel and was impressed with the work that KR has undertaken so far.<br><br>AB was in support of the initial proposal and welcomed the new Associate Director of EDI when they start in post to move this item forward.<br><br>**The Committee agreed the EDI Action Plan Review.** | |
| **22/24** | **Staff Survey – EDI Summary Result**<br>The Committee received an update on the Staff Survey by Johnny Steyn, Employee Engagement Manager.<br><br>The following points were reported:<br>• There are three main recommendations/priorities and these focus on:<br>  o Looking after colleagues<br>  o Learning and Development<br>  o Equality, Diversity and Inclusion<br>These themes are in addition to the actions for Service Leads and leaders whereby through discussion one theme is worked through and successes are shared making a meaningful difference in their experience at work.<br>• The results were initially embargoed but these can now be shared across different areas of the Trust and staff know that their feedback has been heard and work will commence to address concerns.<br>• The changes are to be embedded and staff teams are to encouraged in this process.<br><br>Through discussions the following points were raised:<br>• The new buildings will bring both new ways of working, different interdependencies as well as working in a new environment so these will need to be factored in to the action plans. It is hoped that these points will be picked up within the action plans as part of the service line workshops.<br>• JK reflected on the previous Staff Surveys where harassment and bullying featured highly and following some intensive work with teams this is now not a main point being raised in the Staff Survey. Using pulse surveys will enable the Trust to receive feedback in areas of concern as well as using the dashboards.<br>• AP raised that the disability declaration rate has been increased to 10% and this is higher than the NHS national average and would be due to the work on hidden disabilities some time ago. However there is still some reticence in staff declaring that they have a disability as this could be perceived to hinder their career prospects. It does appear that more confidence is needed in being comfortable in sharing an individuals disability. By having a disability passport this will support | |

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| | the processes in regard to Occupational Health, Access to Work and the Trust's Disability Lead will be integral in future training and discussions.<br><br>To further support the reader in understanding the report it was felt that being able to compare the data from previous years would be beneficial.<br><br>**The Committee agreed the proposed steps as outlined in the report.** | |
| **22/25** | **Staff Network Reports**<br>The Committee received an update on the Staff Networks. The following points were reported by AF:<br><br>• Previously the Staff Network chairs were asked to provide feedback following the updates that were presented in September 2021 and this was reviewed by Mary Foulkes, Director of HR & OD. Mary reported back to the committee on the themes, potential solutions and next steps.<br>• A lot of work has been undertaken by the Staff Networks as well as attending meetings including VCOD<br>• The report details the challenges faced by the Staff Network in order for support and solutions to be given. Areas of challenge include interpreters, training and capacity concerns.<br><br>JK thanked all the Staff Network chair's for their great work as well as Lenka Novakova and Miles Rinaldi for their work on the disability leave guidance. The Evolve Network are also to be thanked for their involvement in the Anti-Racism hub, this is a piece of work that has recently been launched and was included in the recent Chief Executives Q&A. The work of the BSL interpreters at the Chief Executives Q&A is immensely invaluable and makes these sessions more accessible.<br><br>It was raised to the Committee that there appears to be an overreliance on the Staff Networks and this should be organisationally lead and the Trust should bring in the Staff Networks to support conversations rather then expecting the networks to lead on this.<br><br>***Deaf Staff Network*** – the key priority is to have deaf interpreters to be booked for staff training. The funding for training using BSL translators is part of a reasonable adjustment needed when employing staff, however this is separate from the Access to Work interpreters. JK is involved in these discussions and this item is to remain on the action tracker. It does not appear that there is enough to support deaf staff being part of Unconscious Bias training. Currently there is no Deaf Awareness Training taking place and JK confirmed that this would also be considered within the scheduled meeting.<br><br>***DiverseAbility Staff Network*** **–** the self assessment on the Disability Level 2 Confident has been undertaken and AP requested that the standard three year review is amended to be brought forward as the gap is too long. DMc thanked AP and LN for completing the Level 2 training.<br><br>***LGBTQ+ Staff Network*** – There has been more awareness being raised and it is planned that feedback is required to guide the direction. The Stonewall Index report is certainly helping current staff and being awarded Silver will attract new staff to the Trust. | |

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| | ***Mental Health Staff Network*** – Miles Rinaldi has now left so a replacement chair will need to be identified.<br><br>***Women's Staff Network*** - International Women's Day was recently celebrated and this attracted more members to join the staff network. Involved in the Gender Pay Gap report going forward. The previous chair Hina Rahimi has left and so going forward Melissa Heath and Emily Downey will be sharing the chair responsibility. | |
| **22/26** | **Calibre Workplace Passport Leadership Presentation**<br>The Committee received a presentation from Ashley Painter. The area of presentation was for a Workplace Passport. The following points were raised:<br><br>• This is a framework within which the employee's health or impairment is managed within. This will support the changes that can be made at work to assist them and will support effective communications between the member of staff and the manager.<br>• The passport is to be regularly reviewed with the manager and staff member incase the employee's needs or the role has changed.<br>• The passport should be binding so that the employee sees that their input and honesty is valued.<br>• Other workplace passports have been implemented in other acute and mental health Trusts, Civil Service and public sector authorities and they have found that job retention has improved, strained workplace relations have reduced and the levels of sickness attributed to work stress or burnout have also reduced.<br>• Calibre Leadership have asked AP to present the Workplace Passport at future conferences.<br>• The passport will support the Trust in achieving Level Competent Leader status, being an anchor employer and supporting the Making Life Better Together programme.<br><br>The Committee thanked Ashley for his presentation and requested that an update is provided at the September meeting. | |
| **22/27** | **Calibre Presentation – Deaf Employability**<br>The Committee received a presentation from Lenka Novakova about deaf employment in the NHS. The following points were raised:<br><br>• Calibre Leadership have asked LN to present Deaf Employment in the NHS at future conferences.<br>• The presentation focusses on employability and progression for deaf people as there is a considerable lag in stats behind hearing people.<br>• Since the inception of the NHS it has taken 60 years for deaf staff to be employed; in 1977 the first deaf nurse qualified and in 2003 the first deaf mental health nurse qualified.<br>• Over the years access and education has improved but there are increasing costs especially for interpreters and there are not enough interpreters available to meet the demand.<br>• In 2017 an audit was undertaken and this demonstrated that over 70% of employment opportunities are limited, 68% of deaf staff working in the NHS feel isolated/excluded.<br>• The overarching difficulty is the perceived costs in recruiting staff and there are health and safety issues.<br>• The survey reports that it is expensive to employ deaf people, it is a risk and will be very difficult in terms of communication. | |

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| | • The WRES does not have deaf as a selection criteria, so it seems they are not there.<br>• There needs to be a culture change and there are difficulties in deaf staff in being able to progress.<br>• Access to Work is a support to the deaf member of staff but this doesn't help the member of staff to find employment and perhaps needs to be turned around to 'help accessing work' and to assist in attending interviews.<br>• A nurturing environment is needed to overcome attitude, to have cultural leadership, feel empowered and to have role models in order to progress the career ladder.<br><br>The Committee thanked Lenka for her presentation and reflected that deaf staff should be celebrated for their input and their worth. It was acknowledged that there is still immense work to do, not only in the Trust but in society.<br><br>JK acknowledged the work that she has been involved in with Lenka and that future discussions will lead to further improvements. | |
| **22/28** | **Staff Demographics Annual Report**<br>The Committee received the Staff Demographics Annual report and DL provided an update. The following points were reported<br><br>• The Trust is ranked 16th out of 280 NHS Trusts for staff as identifying as coming from a black and ethnic minority.<br>• There are 9 Trust's scoring between 50-54%<br><br>The ethnic data is reported as 49.5% of the Trust workforce being from ethnic minorities. Of the data reported in March 2021 77.9% of NHS staff were white, 22.1% were from other ethnic groups combined.<br><br>The Committee requested that the data is reported across the characteristics, training and whether staff have applied for promotion as some staff have been in the same bands for a particularly long amount of time. (**Action**: KR to look at the data and report an updated version at the next meeting) | **KR** |
| **22/29** | **Q4 Corporate Objectives**<br>The Committee received the Corporate Objectives report. The following points were reported by BB:<br><br>• There has been an improvement in the corporate objectives #3 for EDI, in particular for WRES and Stonewall Index Score.<br>• WDES indicator was not met as well as the standardised data set being embedded in the systems.<br>• An overall amber RAG rating has been achieved.<br>• Work has progressed in regard to Anti Racism and this will continue into next year.<br>• Ranti Lawuni is the Health Inequalities Lead.<br>• Assoc Director for EDI is being recruited and this will support the EDI Strategy.<br><br>**The Committee noted the corporate objectives and the improvements that have been made and acknowledged the amount of work that has gone into this.** | |
| **22/30** | **Stonewall Workplace equality index update**<br>The Committee received the Stonewall Index Update report. The following points were reported by AF: | |

| | | |
|---|---|---|
| | • The Stonewall Workplace Equality Index (WEI) 2022 had 403 submissions and the Trust was placed 160th with a score of 70.5.<br>• The Trust was ranked 15th out of 55 in the health sector.<br>• The Trust was awarded a Silver Employer Award for the commitment to workplace equality.<br><br>**The Committee noted the report and the considerable amount of work that was required to get to this stage.** | |
| **22/31** | **WRES 2021**<br>The Committee received the WRES Annual report for 2021. The following points were reported by DL:<br>SWLSTG featured in the top 10 for one measure – Relative likelihood of BME staff accessing non-mandatory training and CPD compared to white staff – 7th nationally, 2nd in London and 3rd for Mental Health Trusts reporting.<br><br>Unfortunately not as much progress has been made in respect of other key indicators, highlighting in particular. | |

| | National Rank (Out of 217) | National centile | London Rank (Out of 36) | MHT rank (Out of 52) | Ldn MHT rank (Out of 10) |
|---|---|---|---|---|---|
| Clinical skill mix - % BAME senior staff as % BAME support staff | 183 | 85th | 32nd | 45th | 8th |
| Non clinical skill mix - % BAME senior staff as % BAME support staff | 169 | 78th | 28th | 40th | 9th |
| Relative likelihood of BME staff entering the formal disciplinary process compared to white staff | 182 | 84th | 26th | 34th | 4th |
| Relative likelihood of BAME staff being appointed from shortlisting compared to white staff | 102 | 48th | 15th | 27th | 6th |

| | | |
|---|---|---|
| | An action plan is in place to monitor this going forward.<br><br>Additionally DL reported that the Board membership is being reported as 22nd highest out of 270 Trust's for staff being represented from black and ethnic minorities. The Committee requested to see previous years submissions to understand the improvements or lack of progress.<br><br>The Committee asked if the EDI Strategy should be reviewed against the action plan to check it runs in accordance and requested that the data on staff accessing the Freedom to Speak up Guardian is to be included in future reports | |
| **22/32** | **Board Assurance Framework**<br>The Committee received and noted the BAF. | |

| | | |
|---|---|---|
| **22/33** | **Committee Forward Plan**<br>The Committee received and noted the committee workplan. | |
| **22/34** | **Committee Terms of Reference**<br>The Committee received and noted the Committee Terms of Reference. LGBTQ+ is to be amended to LGBTQIA+ Staff Network and with this change the Committee agreed the ToRs. | |
| **22/35** | **Matters to Report to the Board**<br>It was agreed that the following points will be reported to the Trust Board:<br><br>• Strategy discussion document<br>• Staff Survey and the 3 priorities that the Committee have agreed<br>• Overview of the challenges that the Staff Networks that raised and the caution raised of the over reliance on Staff Networks<br>• Level 2 Disability Competent Employer<br>• Workplace Passport<br>• Staff Demographics Annual Report<br>• Celebration of the Stonewall silver award<br>• Corporate Objectives<br>• WRES overview of data<br>• Terms of Reference | |
| **22/36** | **Meeting Review**<br><br>The Committee reflected on the meeting and agreed that this lived up to the Trust's values. | |
| **22/37** | **Date of Next Meeting**<br>The next meeting will be held on 23rd June 2022 at 14:30-17:00 via Teams meeting. | |

| | |
|---|---|
| **Meeting:** | Board |
| **Date of Meeting:** | 14 July 2022 |
| **Report Title:** | Diversity in Decision Making – Cohort 1 evaluation |
| **Author(s):** | Jenna Khalfan, Director of Communication and Stakeholder Engagement |
| **Executive Sponsor(s):** | Vanessa Ford, Chief Executive |
| **Purpose:** | For discussion |
| **Scrutiny Pathway:** | Board |
| **Transparency:** | Public |

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**Executive Summary**

The Diversity in Decision Making (DiDM) programme began in early 2021 with the aim of increasing diversity on Board level Committees to ensure that staff from protected groups have more influence over decisions that affect them.

Over the last 12 months, Board level Committees have had one or two positions available for Diversity in Decision Making Representatives (DiDMRs).

The programme aimed to ensure:

- Increased representation of those within protected groups (specifically Black, Asian and Minority Ethnic colleagues) in board-level committees
- Increased development and experience for the representatives
- The representatives have impact and are able to influence decisions
- Improved decision-making within the committee
- Increased representation of frontline staff in board-level committees

After the first six months and then at 12 months, short evaluation meetings took place. The results of this evaluation are reported in this paper (section 3). The paper also covers the background to the DiDM programme (sections 1 and 2), recommendations (section 6) and next steps (section 7).

A recommendation is made in 6.2 to develop an Executive Advisory Group to ensure a greater diversity in decision making. Some early thoughts about what this might look like and how this may be used is outlined in this paper. This will be further developed, led by the Chief Executive, as part of the MLBT programme over the next six months.

**Recommendation:**

1. Board is asked to note the evaluation and recommendations and discuss and agree next steps

| Corporate Risk | Cross ref. RR |
|---|---|
| | |

| Board Assurance Risk | Cross Ref |
|---|---|
| | |

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

| | |
|---|---|
| **Assurance/Governance:** | Positive: The update paper seeks to evaluate Cohort 1 of the DiDMR which aims to increase diversity on Board level Committees |
| **Clinical:** | Positive: As part of the DiDM initiative we sought to increase the representation of frontline staff on Board-level Committees to support decision-making Participants reported that the input of the DiDMRs increased clinical understanding within Committees. |
| **Equality & Diversity:** | Positive: The DiDM programme began in early 2021 with the aim of increasing diversity on Board level Committees to ensure that staff from protected groups have more influence over decisions that affect them |
| **Estates:** | Positive: The DiDM programme supported Estates Management Committee by increasing representation and diversity on the Committee |
| **Financial:** | Positive: The DiDM programme supported Finance and Performance Committee by increasing representation and diversity on the Committee |
| **Legal:** | Neutral |
| **Quality:** | Positive: As part of the DiDM initiative we sought to increase the representation of frontline staff on Board-level Committees to support decision-making Participants reported that the input of the DiDMRs increased understanding of quality and the impact on patients and carers within Committees. |
| **Reputation:** | Positive: The DiDM programme supported the reputation of the organisation by increasing representation and diversity on its Committees |
| **Strategy:** | Positive: Our plans will underpin our mission and vision, Making Life Better Together and our strategic objectives and corporate priorities. |
| **Workforce:** | Positive: The DiDM programme supported the workforce by increasing representation and diversity on Trust Committees |
| **Other (specify):** | |

# Diversity in Decision Making
# Cohort 1 Evaluation

## 1. Background

The Diversity in Decision Making (DiDM) programme began in early 2021 with the aim of increasing diversity on Board level Committees to ensure that staff from protected groups have more influence over decisions that affect them.

Each Board level Committee would have one or two positions available for newly appointed Diversity in Decision Making Representatives (DiDMRs) which would include a speaking role at the Committee. The Committees included in the programme were:

- Workforce & OD Committee (WODC)
- Finance & Performance Committee (FPC)
- Quality and Safety Assurance Committee (QSAC)
- Equality and Diversity Committee (EDC)
- Estates Modernisation Committee (EMC)

Each representative would need to commit approximately five hours each month, which would cover reading the papers in advance, meeting with the Committee Chair and attending the Committee itself. The managers of the new DiDMRs, especially those working in patient facing roles, would be offered back-fill to support the DiDMR to attend the Committees and make a meaningful impact.

The stated benefits for the attendees were:

- Development and experience
- Increased representation
- Ability to have impact and influence decisions

The stated benefits for the Committees were:

- Improving decision making
- Hearing the voices of frontline staff

Initially it was agreed that the programme would run until December 2021, at which point we would evaluate.

## 2. Cohort 1 development

The programme was advertised internally, supported by Evolve, and initially targeted staff from Black, Asian and Minority Ethnic backgrounds.

Seven people put themselves forward for the first cohort. The DiDMRs were asked to express a preference for the Committee that they would like to sit on. Overwhelmingly the interest was to sit on the EDI Committee, followed by WOD Committee, and then QSA Committee. Following conversations with those who had put themselves forward, the following DiDMRs were assigned to these Committees.

| Committee | Chair | Representative |
|---|---|---|
| **Workforce & OD Committee (bi-monthly)** | Jean Daintith | Shikainah Champion |
| **Finance & Performance Committee (M)** | Vik Sagar | Aki Bola-Emerson |
| **Quality and Safety Assurance Committee (M)** | Deborah Bowman | Terrance Nichols and Farai Addy |
| **Equality and Diversity Committee (bi-monthly)** | Sola Afuape | Oladimeji Adeyemi and Lani Sakatira |
| **Estates Modernisation Committee (M)** | Juliet Armstrong | Janet Idowu |

The first cohort began with a training session in May 2021 that was hosted by Ann Beasley and Vanessa Ford. At this session, the cohort were taken through the programme, the Committees and some of the benefits that we were expecting from the programme.

Working with the first cohort, a series of 'shared expectations' were developed which were agreed as part of this initial training session. These included:

- To approach the role in line with our values
- Read at least front sheet of all papers in advance – this will allow you to get the most out of the Committee
- Confidentiality – can share experience, but not share content or who said what, where and when. Mutual understanding to not compromise this.
- Take notes on what on what worked, what didn't work, what they felt could be improved, if they felt their input was recognised and learnings.
- Pre-meeting with Committee Chairs
- Raise any concerns with the MLBT team

Following this session, introductory meetings were arranged between each DiDMR and Committee Chair, and the new cohort of DiDMRs were invited to their first meetings in May and June 2021.

## 3. Six-month evaluation

In December, we held a light evaluation of the first 6 months. The DiDMRs, the Committee Chairs, Ann Beasley and Vanessa Ford invited to an evaluation session.

### 3.1. Key themes that came from the meeting:

- The DiDMRs and the Committee Chairs were clear that there was value to the programme, however they noted that it felt that the programme was just getting started. The DiDMRs reported that they had started to find their feet and were better understanding the Committee they were assigned to and their contributions to it
- It was more challenging for inpatient staff to join the meetings and take an active part in the programme and find time to do the pre-reading. Corporate and Community Team DiDMRs felt they had more flexibility to engage

- While the flexibility of the Committee, Committee Chair and the offer of backfill was welcomed, the DiDMRs reflected that practically it was hard to find backfill for 5 hours a month, especially those DiDMRs who worked in inpatient areas. The DiDMRs often found that they were making up the time to read the Committee papers themselves
- All of the DiDMRs reported that the Committee Chairs had been welcoming and had offered time to embed them in the Committee
- All of the DiDMRs reported that their managers were supportive of them being in the programme, but again noted that it was sometimes challenging to be released at specific times
- There was some frustration about late papers and the impact the DiDMRs felt this had on their contribution

### 3.2. Recommendations following the 6-month evaluation meeting:

- To extend the programme to be a year – rather than six months (to run until June 2022)
- To offer managers of the DiDMRs the budget to get backfill to encourage participation

## 4. End of Year evaluation

In May a fuller evaluation of the first-year cohort started, with Jenna Khalfan arranging one to one interviews with each of the DiDMRs and the Chairs of the Committees. A standard set of questions were drawn up to understand:

- the participant's experience of the programme
- whether the benefits stated were realized
- any other benefits or challenges encountered
- recommendations going forward – specifically if a second cohort should be recruited for 22/23

### 4.1. General experience of the programme

The experience of both the DiDMRs and the Committee Chairs was overwhelmingly positive. Everyone was clearly able to articulate the benefits to themselves, although the Committee Chairs were better able to articulate the impact that the DiDMRs had on the Committee and the decision making. This is understandable in a way, as the Committee Chairs had a longer frame of reference for the Committee.

The general feeling was that the DiDMRs had worked particularly well in EMC and QSAC – this was for a range of reasons. Whilst the DiDMRs and Committee Chairs had said that the programme had been positive for EDC and WOD Committee – and could cite specific examples of that impact - there had been a number of diary clashes and meeting date changes which meant that the DiDMRs had been unable to attend some meetings. With the FPC Committee, the DIDMR was very complimentary of the Committee and the Chair and the efforts that had been made to make the Committee accessible to them. However, they felt that their knowledge and understanding of finance limited their ability to contribute to the Committee.

### 4.2. Logistics and processes

- **On papers:** Some of the DiDMRs continued to express frustration about late papers – with one DiDMR stating that they would not attend one Committee meeting as they didn't have time to read the papers in advance so they felt their contribution would be limited.
- The DiDMRs for QSAC had said specifically that they felt that the quality of papers, and the focus on the patient had become stronger through the year
- All DiDMRs reported that they felt a little intimidated by the paper pack, however this had reduced throughout the year. All reported the importance of clear and accessible coversheets to support their understanding of papers

- **On accessibility:** All DiDMRs reported that the meetings being on MSTeams made them more accessible, especially those who worked on in-patient wards
- All DiDMRs reported initial anxiety and nervousness about being part of a Board Committee, but all reported that they were made to feel at ease and were able to ask questions. DiDMRs noted that they had used their informal contact with the Chair to sound out questions in advance or following the meeting, that they had not initially felt able to ask.

- **On pre-meetings**: All DiDMRs reported that the Committee Chairs had taken seriously their commitment to meeting with the DiDMRs ahead of each meeting – although this wasn't always possible. Some also had meetings following the Committee too, and some had specific meetings about a point that had been made during the Committee to investigate further

- **On the time commitment:** The DiDMRs felt that overall, the five hours a month time allowance was about right
- The DiDMRs working in inpatient roles stated again that it was more of a challenge to be released – they were clear that this wasn't to do with their manager's willingness or their own willingness, more about the 'pressures of their day job'.
- The DiDMRs noted that they often felt that they had to add the time to read papers and join the meeting to their existing role, rather than being able to take the time out of their role. However, because of the personal value of the programme on their development, most were sanguine about this.

- **On confidentially:** The Committee Chairs noted that confidentially had been kept, even during some very sensitive conversations

- **On the change from 6 months to twelve months:** All felt that their impact had increased as the year had gone on – the nervousness had reduced and their understanding of the Committee had increased

- **On relationships:** Many interviewees noted that strong relationships had been formed between the DiDMRs and the Committee Chairs.

### 4.3. Benefits realization

- **On development and experience:** All DiDMRs bar one stated that this had been valuable to their own learning and development – with four saying that they would like to carry on past the first year. Two stated that it had helped them get different jobs within

the Trust. They reported feeling more confident in their understanding of the Trust and one reported that they had a better understanding of how to write papers. The one DiDMR who didn't, said this was due to them not being able to attend more meetings.

- **On increased representation:** All Committee Chairs and DiDMRs reported that their input had been important in increasing representation. Interestingly, this wasn't always about their protected background, it was more about them as frontline members of staff who were affected by the decisions being made.

- **On ability to have an impact and influence decisions:** All DiDMRs reported at least one example of a question they had asked that they had felt had had impact. Either taking the Committee in a different or more positive direction or refocusing on the impact of the decision on patients, carers or frontline colleagues. For instance, the DiDMRs in QSAC noted that they felt their contributions often meant that the impact of the paper or decision 'on the ground' was more greatly felt by the Committee. The DiDMR in WOD Committee reported an example of a question they asked about turnover in the first 12 months that had resulted in a number of conversations following the Committee, and an amended paper that came to the next meeting.

- **On Improving decision making:** Most Committee Chairs felt that having the DiDMRs as part of the Committee had strengthened the decision making, and in two cases could give examples of different decisions being made because of a contribution from the DiDMR. More generally however, the Committee Chairs felt more confident about understanding the impact of a decision on frontline colleagues.

- **On Hearing the voices of frontline staff:** This was universally agreed to be a positive for both the DiDMRs and the Committee Chairs. Interestingly this was raised more than hearing the voices of staff with protected characteristics.

### 4.4. Other benefits

- **Understanding of the Trust and its processes:** All DiDMRs in some way said that it had been an important chance for them to see 'behind the curtain' of the Committees and decision making at the trust. The DiDMRs said that they had been pleasantly surprised at the level of scrutiny from the Committees and how much the discussion focused on the impact of a decision on patients and members of staff. So much so, that two reported that they had make this point to other colleagues

## 5. Selected quotes from the interviews

"The big change that I felt was that we spent more time on quality of care and impact on patients."

"I felt like a better employee. I'm more aware about the wider Trust and how the day-to-day action fits into the bigger picture"

"Struck by the transparency of things… There's a perception that people at the top are shrouded in mystery. I felt it was transparent, above board and that people were on the same page"

"I was quite happy to make contributions - from a front-line perspective. The Chair followed up on a number of conversations outside of the meeting. Health and well-being and turnover in IAPT. I think I made a difference there"

"The Committee makes more thoughtful decisions, especially the impact of EDI."

"There were challenges – acronyms, papers were difficult to follow. Might be helpful to have a crib sheet. However, the Chair took time to try and help me understand."

"The biggest benefit for me was the way I've developed on a personal level – with the support of the Committee Chair. She never made me feel inadequate – just challenged me."

You can watch Farai at our CEO Q&A in May talking about her experiences of the programme

**6. Recommendations following the year one evaluation**

**6.1. On the future of the programme:**

a) To continue the DiDM programme and recruit for a second cohort
b) Second Cohort would be advertised for a year, starting in September 2022 (to allow the August break for training and support for future cohorts).
c) To expand the DiDM scheme to Deaf staff and staff with a Disability, through the staff networks
d) To increase support ahead of the Committees starting – all of cohort 1 have offered to mentor future cohorts.
e) As noted above, the DiDMR for FPC reported that despite the support from the Chair, they didn't feel able to add value to the Committee, citing their lack of experience in finance. For cohort 2, we will put in place additional support measures to support the DiDMR to engage with FPC
f) Alongside scheduling in pre meetings, post meetings should also be scheduled as a matter of course
g) Offer the backfill budget to mangers to help support capacity

**6.2. On supporting decision making more generally in the Trust**

As noted above, all DiDMRs felt that they had learned more about decision-making at the Trust and this had been an important part of their personal development. Committee Chairs were also clear about the importance of the DiDMRs in providing insight about the impact of decisions on frontline teams.

Therefore, in addition to the recommendations above, it is also recommended that using the expertise of our DiDMRs, we set up Executive Advisory Group.

The group would not be decision making, instead acting as an informal sounding-board to support our Executive to actively listen to members of staff's lived experience and inform strategic thinking and decision making. The Executive could pose questions to the Group on decisions it is planning, to test how something might land. The Executive would use the insights to triangulate information they receive to inform their assurance. The matters raised will not be solely workforce related rather the group will be encouraged to also share their insights about patients, carers and families for holistic organisational view.

The group would report to the Executive as part of the MLBT programme. It would not replace, duplicate or supersede any existing staff engagement arrangements. It is intended to be independent of formal governance arrangements and to complement and function alongside existing engagement activities and official working arrangements with trade unions or employee representatives, like JCC.

The membership of the group would be the current and last years' (2 years' worth of) DiDMs and Chairs or representatives our staff networks. The group would be Chaired by the Chief Executive and the co-Chair would be elected from the membership.

The group would be convened on an adhoc basis and would be used to seek informal insight in between these meetings as necessary.

**7. Next steps**

a) Recruitment to Cohort 2 has begun and 11 people have put themselves forward. We are currently talking to each person about the best Committee for them
b) As part of Cohort 2, we are taking forward each of the recommendations in 6.1, including training in August
c) The recommendation in 6.2 to develop an Executive Advisory Group will be further developed, led by the Chief Executive, as part of the MLBT programme over the next six months.

| | |
|---|---|
| **Meeting:** | Finance & Performance Committee |
| **Date of Meeting:** | 26 May 2022 |
| **Report Title:** | Draft Committee Annual Report |
| **Author(s):** | Nicola Mladenovic, Deputy Trust Secretary |
| | Debbie Hollinghurst, Deputy Director of Finance |
| **Executive Sponsor(s):** | David Lee, Director of Corporate Governance |
| | Philip Murray, Director of Finance & Performance |
| **Purpose:** | For Approval |
| **Scrutiny Pathway:** | N/A |
| **Transparency:** | Public |

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**Executive Summary**

All Committees of the Board are required to complete a self-assessment of its work during the year.

This report contains the outline of the activity completed by the Finance & Performance Committee during the period 01 April 2021 to 31 March 2022.

The report provides both an annual review of the committee's work in the prior year and details of the forward plan for the Committee in addition to terms of reference.

The Committee is required to submit its final report to the July meeting of the Board.

It is also useful and good practice for the Committee to provide an assurance position statement to the Board. A draft statement is included for the Committee's consideration, revision and approval.

**Recommendation**

**The Committee is asked to:**

1) **Consider the contents of the draft annual committee report and offer any comments and suggested changes;**

2) **Finalise and agree the assurance position statement in section 4;**

3) **Consider the annual workplan in respect to performance oversight;**

4) **Note the agreed Terms of Reference as agreed by the Trust Board in June 2020; and**

5) **Subject to any changes agree the revised Committee Annual Report be sent to the Board for consideration and approval.**

| Corporate Risk | | | Board Assurance Risk | |
|---|---|---|---|---|

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

| | |
|---|---|
| **Assurance/Governance:** | As a matter of good practice it is important that the Committee review its work. This ensures that there is robust coverage of matters which are important to the Board. This practice is a key element of the well-led framework |
| **Clinical:** | There are no direct implications. |
| **Equality & Diversity:** | There are no direct implications. |
| **Estates:** | There are no direct implications. |
| **Financial:** | There are no direct implications. |
| **Legal:** | There are no direct implications. |
| **Quality:** | There are no direct implications. |
| **Reputation:** | If the Trust cannot demonstrate that it has a robust governance system and the organisation is not well-led it can lead to reputational damage. |
| **Strategy:** | There are no direct implications. |
| **Workforce:** | There are no direct implications. |
| **Other (specify):** | N/A |

**Appendices/Attachments**:
- **Draft Annual Committee Report - Finance & Performance Committee**

**Draft Annual Committee Report**
**Finance & Performance Committee**

## 1. Introduction

### 1.1. Committee Establishment

The Finance & Performance Committee (the Committee) is a long-established sub-committee of the Board of Directors (Trust Board) and operated during the reporting period 01 April 2021 to 31 March 2022 (the period).

### 1.2. Committee Purpose & Duties

The Committee is expected to carry out objective scrutiny of the Trust's financial plans, investment policy, major investment decisions, including those relating to the Trust's estate as well as providing support to the development, evolution, and scrutiny of the key operational effectiveness performance indicators. The Committee reviews the Trust's monthly financial performance and identifies key issues and risks requiring discussion or decision by the Trust Board.

The Committee's key strategic objectives are:

- Financial - Achieve long term financial sustainability, fully integrating financial plans with the Trust's Estates Modernisation Programme
- Performance – Ensure services are appropriately funded and ensuring services are benchmarked against KPI metrics
- Tenders and costs – to have a continued focus on tenders for new services and transformation, ensuring value for money
- Oversight of those risks pertinent to its purpose including the BAF and Corporate Objectives

### 1.3. Terms of Reference

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

An internal audit report on Corporate Risks Management flagged the importance of ensuring that all Board Committees have oversight of the relevant key risks. As a matter of good practice the Committee does review key financial related risks and gives focus to Board Assurance Framework risks such as Agency and CIPs. This requirement to review the financial related risk is enshrined in the Terms of Reference located in Appendix 1**.**

The terms of reference include oversight of the Trust's operational performance as part of the Committee's duties.

## 2. Membership & Meeting Attendance

The Committee comprises a mixture of non-executive directors and executive directors. Other attendees included the Deputy Director of Finance, Associate Director of Performance and Information and the Director of Corporate Governance.

During the period the Committee met 10 times. Under the Terms of Reference, the Committee is required to meet monthly except in August. The Committee unexpectedly was unable to be convened in December due to sickness. The December agenda was considered by the Committee Chair and Director of Finance, and the in month financial position reviewed; there were no other urgent matters which needed to be addressed prior to the January committee.

The number of meetings attended by members and contributing attendees are detailed in **Table 1: Members and Meeting Attendance - 01 April 2021 to 31 March 2022 and Table 2: Regular Attendees and Meeting Attendance - 01 April 2021 to 31 March 2022.**

**Table 3: Members and Meeting Attendance - 01 April 2021 to 31 March 2022**

| Members | Role | Attendance (Actual/ Eligible)** |
|---|---|---|
| **Vik Sagar** | Non-Executive Director and Committee Chair | 10/10 |
| **Juliet Armstrong** | Non-Executive Director | 10/10 |
| **Vanessa Ford** | Chief Executive | 7/10 |
| **Philip Murray** | Director of Finance and Performance | 8/10 |
| **Billy Boland** | Medical Director | 3/10 |
| **Jen Allan** | Chief Operating Officer | 8/10 |
| **Amy Scammell** | Director of Strategy and Commercial Dev. | 9/10 |

There was also a temporary reduction of some executive attendance during the covid pandemic between March 2020 and March 2022.

**Table 4: Regular Attendees and Meeting Attendance - 01 April 2021 to 31 March 2022**

| Attendees | Role | Attendance (Actual)** |
|---|---|---|
| **Debbie Hollinghurst** | Deputy Director of Finance | 10 |
| **Keith Williams** | Associate Director Performance and Information | 2 |
| **David Ince** | Associate Director of Contracting | 2 |
| **David Lee** | Director of Corporate Governance | 3 |
| **Ian Garlington** | Integrated Programme Director | 3 |

***Regular attendees are not members of the Committee therefore are only expected to attend to support specific agenda items; there is not technical requirement for them to attend all meetings.*

**3. Annual Review - 01 April 2021 to 31 March 2022**

The Committee has conducted work in line with its purpose reviewing key financial related matters and during the period developed and agreed its terms of reference and a workplan. The Committee's agendas have been centred around a core set of headings (financial, commercial strategy (to include commercial tenders and bids), performance plus general items of business) to enable the Committee to gain assurance over those responsibilities delegated to it by the Trust Board.

**Financial Performance 2021/22**

Changes to the Finance Regime in response to Covid resulted in
separate financial plans being approved for H1 and H2. The Trust Board delegated approval of these plans to the Committee. In addition to the planning update, the Committee received the current financial
position each month. The report included performance against the key financial metrics against which the Trust was measured during 2021/22. These financial reports were also included as part of reports to the Trust Board. The reports covered key financial risks and their mitigation together with detailed monitoring of savings plans, agency and underlying run rates.

In year the committee considered a number of technical accounting matters including the approach to asset valuation and the management of the capital programme under the new national regime and the impact upon available CDEL to support Trust plans. It also reviewed and supported business cases associated with the estate management including the eradication of our last dormitory facility and the upgrade of our PICU.

The Trust reported an 'unaudited' financial performance for the year of an overall surplus of £2,661k. This is comprised a baseline deficit of £280k, depreciation on donated assets £36k, impairment benefit of £1,036k, and a non-recurring overage receipt of £1,941k.

The overage receipt, depreciation on donated assets and the impairment benefit are recorded 'below the line' and not included in the underlying position against which the Trust is performance monitored. After adjusting for these the adjusted position is a £280k deficit, £20k better than plan; this is representative of strong operational success in delivering challenging cost improvements and selling of surplus assets, whilst managing the impacts of the Covid pandemic alongside high levels of inpatient demand, and achieves the financial performance requirements as noted below.

In addition, the Trust delivered against the Department of Health and Social Care (DHSC) targets set out below:

- ✓ Breakeven or better for Income and Expenditure
- ✓ Operate within an External Financing Limit of £74.1m
- ✓ Operate within a Capital Resource Limit of £77.7m
- ✓ Maintain a Capital Cost Absorption rate of 3.5%
- ✓ Achieve the Public Sector Prompt Payment target by value

The Trust secured a £99m loan from the Department of Health and Social Care to fund the construction costs of the new hospital on the Springfield site. This construction is nearing completion. Over 85% of the Trust's capital expenditure in the year was spent on the Estate Modernisation Programme and the development of the Springfield site; the new buildings, which will transform our fabric into a modern mental health facility fit for the 21$^{st}$ century, are now a very visible sign of that exciting future. In total capital expenditure for the year was £77.7m which was used to modernise the Trust's estate and IT infrastructure for both patients and staff.

The Trust's cash balance of £49.4m remains at a healthy level and will be used to fund the estate modernization and support servicing the loan.

The audited Annual Report and Accounts were submitted by the 22nd June 2022 deadline.

**Financial Planning 2022/23+**

The Trust Board delegated approval of the Trust budgets for 2022/23 to the Committee. The national deadline of late April 2022 for plan submissions was not aligned to the requirement to approve budgets by 31 March.

Consequently during the period, revenue budgets were approved in line with the draft plan submission (March 2022) of £12.5m deficit which was subsequently improved to £10m deficit, and with an expectation that the position would improve further prior to the final plan submission in April 2022.

Similarly, the capital budget was approved by Committee in line with the draft plan submission (March 2022). The capital budget for 2022/23 was approved at £26.4m for EMP and £3.7m for business as usual capital spend. The submission covered five years and included reserves in 2023/24 held on behalf of the ICS and generated by asset sales.

**Commercial Activities and Investments**
The Committee received regular updates on the commercial tenders and funding bids that the Trust was submitting for clinical services. The Committee ratified or approved submissions of commercial bids where the Committee had delegated authority.

**Performance Reporting**
The Committee received updates regarding performance reporting and continued to monitor the improved set of dashboards to support the ward-to-board reporting. Service lines attend and provide updates on determined sub-service lines by focussing on unwarranted variation in the following areas:

Service lines and performance management team attended and provided updates on of unwarranted variation. Presentations were also received upon national benchmarking exercises and how the trust's relative performance had moved over recent year.

Performance against key national targets and indicators and internal key performance indicators were considered during the year; Committee received updates regarding performance reporting and continued to monitor the improved set of dashboards to support the ward-to-board reporting.

The items featured on the Committee's agenda during the period is included in **Table 5: Committee Activity - 01 April 2021 to 31 March 2022.**

**4. Forward Planning - April 2022 to March 2023**

The Committee has developed a robust forward workplan for the period April 2022 to March 2023 which includes robust monitoring of key elements and challenges of the financial strategy. The current version of the forward workplan is detailed in **Table 6: Forward Workplan – 01 April 2022 to 31 March 2023.**

**5. Assurance & Position Statement (agreed by Committee on 26 May 2022)**

The Committee's agenda has been mainly focussed on the increased challenges faced by the Trust relating to the uncertainty of the framework within which the Trust was operating due to the national response to the Covid -19 pandemic, the introduction of ICSs and system working and the achievement of the financial position in H1, H2 and in future years.

During the year the Committee reported to the Trust Board the financial position regarding the progress against identifying savings to achieve the control total. Committee considered ways of strengthening the balance sheet whilst also considering strategic investments to generate future opportunities. In addition, Committee has escalated the impact upon the potential savings target for 2022/23 caused by the non-recurrent nature of many of the efficiencies found in 2021/22. In November 2021, £6m was estimated as the 2022/23 opening underlying deficit. This figure was further refined following the publication of National Planning assumptions leading to a £12.5m deficit draft plan being submitted in March 2022.

Getting traction in delivery of recurrent savings remains a challenge particularly due to the continued impact of the pandemic on service provision and senior leadership capacity. The national economic situation means that additional funding opportunities, whilst investment in Mental Health within the long-term plan is ringfenced, are limited. In real terms funding is reducing whilst demand for our services is increasing. As the financial position becomes tighter the Trust faces difficult decisions to ensure that the maximum value is obtained from any new investment. With insufficient funding available the Trust will not be able to do everything it would want; there will be insufficient funds to meet all the new pressures of demand and acuity which have been exacerbated by conditions of isolation and lack of social contact during the pandemic. Inevitably expectations of Place will not be fully met. The need to transform our community services is key to long term sustainability as improved community services will help to prevent demand for acute services, improve wider system flow and above all treat our patients in the least restrictive environment.

During the year the committee received updates on the work across the South London Partnership with Oxleas and South London and Maudsley NHS Foundation Trusts, within which it is the lead Provider Collaborative for Eating Disorders. Services within the SLP continue to improve quality of care and reduce costs. Careful consideration is now needed as to how the savings should be utilised.

The Trust is committed to the ongoing modernisation of its sites, transforming them into a collective modern mental health facility. The Trust continues to sell land and buildings that are surplus to requirements in order to fund the construction of new hospital buildings. The Trust exchanged on phase 2a in March 2022 with completion anticipated in May 2023. The Trust anticipates the partial sale of Barnes in 2022/23 and is closely monitoring the situation regarding Edward Wilson House. In year actions taken by the Trust to review the valuation of assets being sold has created a mechanism for resolving the CDEL shortfall for capital spend. Work now needs to focus on cash flow to inform loan repayments and investments in Tolworth capital developments.

The Committee ended the period with remaining uncertainty as to the expected outturn required in 2022/23. The final plan was submitted in April, outside the period, and with a deficit of £4.1m against at total £124m deficit plan within the SWL ICS. The position had a required efficiency figure assumed and the Trust highlighted significant risks associated with this position to the ICS. The SWL ICS has been advised that an improved plan will need to be

submitted in June and the scale of the challenge would indicate that there will a considerable unidentified savings gap as we enter 22/23, the targets within the Long Term Plan will require dilution and our ability to tackle increased demand will stretched.

The Trust continues to be part of the South London Partnership with Oxleas and South London and Maudsley NHS Foundation Trusts and the achievement of positive outcomes in the Forensic, Adult Eating Disorders and CAMHS pathways. Committee will engage in the use of efficiency savings so far generated to ensure that developments offer the best return and support the overarching aims of the Trust.

The Committee will focus its work in the coming year in line with the agreed Trust Objectives for the year under the following broad headings:

Financial Sustainability including underlying cost management
Performance
Commercial Opportunity

## Table 5: Committee Activity - 01 April 2021 to 31 March 2022

| Financial Strategy & Reporting | Investment, Commercial Tenders and Bids | Governance & Performance Reporting |
|---|---|---|
| Financial Reports | Commercial Priorities and Update Report | Committee Workplan |
| Savings Reports | Corporate Objectives | Committee Annual Report |
| Annual Plan 2022/23 | Community Transformation | Quality & Performance Metrics for 2022/23 |
| SWL Collaboration Report | Adult Eating Disorders Update | Q&P Governance Framework |
| Valuation f Assets Held for Sale | Complex Care Programme 2021/22 Update | NHSBN Mental Health Benchmarking - ONS resident population report |
| Estates Strategy | Sutton Health & Care Alliance Agreement | |
| Digital /Estates Update | Inspire Sutton Substance Misuse | |
| Private Bed Purchase | Ward One Business Case | |
| EMP Finanial Loan Future Potential Options | Eradication of Dorms/Wisteria Business Case | |
| Savings Plan 22/23 update | Development of a MH Provider Collaborative for SWL | |
| Capital Plan 2021 to 2026 | | |
| Digital 18 Month Plan | | |
| Contracting Strategy and Updates | | |
| Review of Board Assurance Framework risks | | |
| Capital Programme Board Terms of Reference | | |
| National Costing Update | | |
| System Update - H2 and future planning | | |
| Financial Plan H1 2021/22 | | |

## Table 6: Forward Workplan – 01 April 2022 to 31 March 2023

| Items | Frequency | Executive Lead | 2022 - 2023 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 28/04/2022 | 26/05/2022 | 30/06/2022 | 28/07/2022 | 29/09/2022 | 27/10/2022 | 24/11/2022 | 15/12/2022 | 26/01/2023 | 23/02/2023 | 30/03/2023 |
| **Standing Items** | | | | | | | | | | | | | |
| Apologies | M | TS | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Declarations of Interests | M | TS | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Chair's Action | M | TS | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Previous Minutes | M | TS | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Action Tracker & Matters Arising | M | TS | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Committee Workplan | M | TS | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Year Ahead | M | TS | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Financial Reporting & Planning** | | | | | | | | | | | | | |
| Monthly Finance Report - Part A and B, including*: | M | DFP | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Service Line and other Directorate Peformance* | M | DFP | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Assessement against National criteria and benchmarks* | M | DFP | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| *Savings Report* | M | DFP | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| *Risk Register* | M | DFP | | √ | | | √ | | √ | | √ | | |
| Non Pay Reporting | 6M | DFP | | | | | √ | | | | | | |
| National Cost process paper | A | DFP | | | √ | | | | | | | | |
| National Costs post submission paper | A | DFP | | | | | √ | | | | | | |
| National Costs final score | A | DFP | | | | | | | | √ | | | |
| Long Term Financial Modelling (3 Year Financial Plan) | 6M | DFP | | | | | focus on cashflow | | | | | | |
| Catering) | 6M (each) | DFP | | | | √ | √ | | | | | √ | √ |
| Contracting Updates | Q4 monthly | DFP/DSOC | √ | √ | | | | | | | √ | √ | √ |
| Contracting Strategy | A | DFP/DSOC | | | | | √ | | | | | | |
| Operating Plan /Budget Setting paper | Q4 monthly | DFP | √ | √ | | | | | | | √ | √ | √ |
| Trust statement - Modern Slavery | A | DFP | | | | | | | | | | | √ |
| Business Cases (dependent on levels) | AR | DFP | | | | | | | | | | | |
| **Performance Reporting** | | | | | | | | | | | | | |
| Overall Operational Performance and Forecasts to year-end includin | M | COO | | | | | | | | | | | |
| **Service Line and other directorate performance and forecasts to year-end (6 monthly reports for each directorate) incl clinical variances* | M | COO | | | | | | | | | | | |
| **Full exception reports and/or turnaround plans at least every 2 months for core dimensions and for metrics at service-line or organisational level that are "red" rated* | M | COO | | | | | | | | | | | |
| Performance - Integrated Dashboard Upate | 6 M | COO | | | | | | | | | | | |
| **Commercial Strategy & Reporting** | | | | | | | | | | | | | |
| Various/Relevant Strategies | AR | Various Directors | | | | | | | | | | | |
| Partnership Update | | DSCD | | | | | | | | | | | |
| Demand and Capacity Organisational Approach | | DSCD | | | | | | | | | | | |
| SLP Business Rules | | DFP | | | | | | | | | | | |
| Corporate Objectives | Q | DSCD | √ | | | √ | | √ | | | √ | | |
| Commercial Report *(contract performance, commercial pipeline, commercial relationships, and any other relevant matters)* | M | DSCD | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| **Committee Governance & Reporting** | | | | | | | | | | | | | |
| EMC business as usual updates | **As required** | EMC Chair | **As required** | | | | | | | | | | |
| Review BAF Risks | M | TS | | | | Place/Partnership Transformation | Full Review for AC | Finance | E&D Adult Care P/Way | Full review for AC | Place/Partnership Transformation | Full review for AC | Integ Prog. |
| Various/Relevant Policies | A | TS | ***As required*** | | | | | | | | | | |
| Terms of Reference | A | TS | | √ | √ | | | | | | | | |
| Committee Workplan & Standing Agenda | BA | TS | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Committee Annual Report | A | TS | | √ | √ | | | | | | | | |

**KEY**

A=ANNUALLY; M=MONTHLY; Q=QUARTERLY; BA=BI-ANNUALLY; AR=AS REQUIRED; BM=BI-MONTHLY

FD = FOR DESCISION; FA = FOR APPROVAL; FI = FOR INFORMATION; FE = FOR ENDORSEMENT; FN = FOR NOTE; TR = TO RECEIVE

**Appendix 1: Finance & Performance Committee Terms of Reference**

| Committee | FINANCE AND PERFORMANCE COMMITTEE |
|---|---|
| **Strategic ambitions** | All of the Trust's strategic ambitions fit within the scope of this Committee. |
| **Chair** | Non-Executive Director |
| **Executive Lead** | Director of Finance and Performance |
| **Secretary** | Trust Secretariat |
| **Members** | x2 Non-Executive Director, one of whom is the Chair<br>Chief Executive Officer<br>Director of Finance and Performance<br>Chief Operating Officer<br>Director of Strategy, Transformation & Commercial Development<br>Medical Director |
| **Attendees** | Deputy Director of Finance<br>Associate Director of Performance and Information<br>Director of Estates Modernisation Programme (by invitation)<br>Director of Corporate Governance<br>The Committee may invite any other Trust representative and/or external professional advisors as it deems necessary from time to time. |
| **Frequency** | The Committee will meet at least monthly (the exception being August). |
| **Quorum** | The quorum of the Committee shall be three members one of whom must be a Non-Executive Director, another the Director of Finance and Performance or a duly appointed deputy.<br><br>Where an executive director is not able to attend the meeting they must send a deputy who is authorised to make decisions on their behalf. |

**Purpose**

This Committee has been established to objectively scrutinise, on behalf of the Board, the Trust's:

- Financial Plans;
- Investment policies and major investment decisions;
- Key Trust strategies and plans
- Monthly financial performance, identifying key issues and risks which require discussion or decision by the Board; and

- Performance against key national targets and indicators, internal key performance indicators and other performance issues.

**Duties**

Through its work the Committee will be able to provide the Board with assurance that the financial, investment and performance targets and indicators are being met and in the event of issues that there are robust plans in place to redress downward trends in performance.

For the avoidance of doubt this Committee's remit will be to give strategic support and guidance it is not established as an operational Committee.

**Financial policy, management and reporting**

Key duties will include:

- Advising the Audit Committee on financial policies;
- Reviewing and consider the monthly financial performance against agreed targets and contractual obligations escalating key issues and risks to the Board of Directors including income and expenditure, aged debtors and creditors, projected cash flows;
- Supporting the development, implementation and monitoring of the Trust's medium to long term financial strategies (capital and revenue);
- Review and monitor the Trust's performance against finance and use of resources as set out in the NHSE/I Single Oversight Framework;
- Review and monitor the Trust's development of savings programmes and monitor their performance and delivery;
- Reviewing performance against key commercial programmes and delivery;
- Supporting the development of robust annual budgets and forecasting;
- Reviewing appropriate policies;
- Reviewing compliance with the self-assessment quality checklist for the annual reference cost submission; and
- Considering the annual plan for submission to NHSE/I

**Performance**

Key duties will include:

- Monitoring the Trust's performance against key national targets and indicators and seeking assurance that there are robust plans in place to bring performance back on target in the event of a downward trend;
- Having oversight of the Trust's performance against key commissioner contractual targets;
- Monitor performance against internal and local scorecard indicators;

- Receive performance scorecard for each service line and seek assurance that robust plans are in place to adequately address key issues that could impact on the Trust's ability to meet its national and commissioning contractual performance indicators;

- Keeping under review the Trust's performance submissions to NHSE/I

- Regularly review the Trust's performance against the operational performance targets as set out in the Single Oversight Framework;

- Scrutinising and monitoring the profitability of services within service lines in order to support strategic decision making;

- Monitoring delivery of the annual objectives in support of delivery of key strategies; and

- Consider any recommendation from Quality and Safety Assurance Committee (QSAC) and any key issues which may impact on the Trust's ability to meet its national and commissioning performance targets and indicators.

For the avoidance of doubt whilst the Committee's review of performance will include consideration of key quality performance indicators its duties will differ from the QSAC.

QSAC's duty in this respect is to scrutinise the quality issues and to support development of mechanisms and action plans which will ensure that the safety and quality of the service provided by the Trust is of the highest standard and eliminate or reduce the risk of harm to patients.

The performance remit of this Committee is to ensure that the Trust's performance against key indicators and metrics is maintained and where there are issues of deteriorating performance Trust-wide actions are put in place to redress the overall performance position.

**Investment and Commercial**

Key duties include:

- Scrutinising commercial proposals and make recommendations to the Board of Directors as and when required;
- Approving and keeping under review, the Trust's investment and borrowing strategies and policies;
- Reviewing and recommending to the Board of Directors the Trust's Investment Strategy including, methodology, processes, controls and investments;
- Reviewing and recommending to the Board of Directors the Trust's Treasury Management, and Working Capital strategies;
- Evaluating proposed investments and keep approved investments under review;
- Considering and approving business cases and tender submissions within the delegated limits;
- Considering and making recommending to the Board the efficacy of business cases which are in the limits for the Board's reserved authority.
- Ensuring transformation activities within the Trust form a core part of any commercial developments and ensuring transformation supports the ongoing sustainability of the Trust.
- Oversight of the Clinical Transformation Programme

**Governance**

Key duties include:

- Scrutinising the Trust's delegated authority and scheme of delegation and ensure they are fit for purpose and advise the Audit Committee;
- Scrutinise the Trust's procurement policies and advise the Board of Directors.
- Receiving updates from the Clinical Transformation Programme, People Readiness and Culture Change Programme and Estates Modernisation Programme via the Estates Modernisation Management Group, where key areas from these programmes fall within the Committee remit

**Authority**

The Board of Directors has delegated authority to the Committee to approve:

- The disposal, including sale, of Trust land and buildings and leases up to £1m;
- Revenue Expenditure business case approval up to £5m;
- Capital Expenditure business case approval up to £5m; and
- Capital Expenditure formal tender acceptance up to £5m.

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

**Operation**

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

The Committee will develop a robust work plan each year which outlines the business it will consider.

**Reporting**

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

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

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Approved Trust Board - June 2020

| | |
|---|---|
| **Meeting:** | Trust Board |
| **Date of Meeting:** | 14 July 2022 |
| **Report Title:** | Part A - Finance Update 2022/23 Month 2 |
| **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 £4.1m deficit for the year in line with the plan submitted to NHSE/I in April. A revised plan of break-even will be submitted to NHSE/I in June and if accepted by them will be reflected in the Trust financial reports for Month 3 reporting.
- The position for Month 2 is £0.6m deficit bringing the cumulative position after two months to £1.3m deficit, broadly on plan. The in-month position I&E was a marginal (£174k) improvement on Month 1.
- Underspends against Pay are offsetting overspends in non-pay where the unidentified savings target is held.
- The Trust continues to operate with agency costs higher than the historic NHSE/I cap; no updates to this have been notified. Agency costs are on an upward trajectory as recruitment continues to be a challenge particularly within Community Services.
- The savings target of £12.4m previously held within Corporate has now been devolved to all service lines. Cumulatively delivery is £0.8m behind plan. Schemes have been identified to achieve 91% of the savings target for the year.
- All clinical service lines are reporting break even or better except for Acute Services. Acute Services is reporting a cumulative £0.2m adverse position reflective of high levels of acuity on inpatient wards.
- Of the £20m 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 is £0.1m more than plan due to earlier than anticipated EMP costs.
- The Trust has a £99m loan taken out in previous years to support the construction of the Springfield redevelopment. No repayment is anticipated in 2022/23. Cash balances will be used to fund construction in 2022/23.
- At the end of May, the Trust had a cash balance of £38.5m; £1m better than 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:**

Trust Board 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***

# Finance Report 2022/23
# 2 Months to May 2022 – part A

| Meeting | ELT |
|---|---|
| Date of Meeting | June 2022 |
| Report Title | Finance Report 2022/23 – 2 Months to May 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 |

# Executive Summary

This report provides an update on :

Page 3 I&E Position – £1.3m deficit to date, in line with plan. Forecast £4.1m deficit

Page 4 Key Finance Metrics – Graphical summary of Trust position

Page 5 Income Position – on plan, shortfall of £2.8m NHSE funding remains a risk

Page 6 Pay Position – £0.6m favourable to plan

Page 7 Agency – M2 spend of £1.1m (£0.5m in Community), £469k above NHSE/I cap

Page 8 Non-Pay – £0.6m adverse to plan

Page 9 Service Line Positions – Underspends in Community, CAMHS & ED, and Specialist offset by Acute Care and Central costs

Page 10 Savings – Current target of £12.4m (4.5%)

Page 11 Capital – forecast for the year is £47.5m including £15.4m leases brought onto the balance sheet at the start of the year. Year to date expenditure is £20.0m including leases

Page 12 Statement of Financial Position - Current receivables are £4.0m

Page 13 Cash – the cash balance is £38.5m and a loan of £99.4m

Page 14 Monthly Cashflow – 10 days operating expenditure maintained throughout.

Page 15 Solvency Dashboard – One Red – Net Current assets

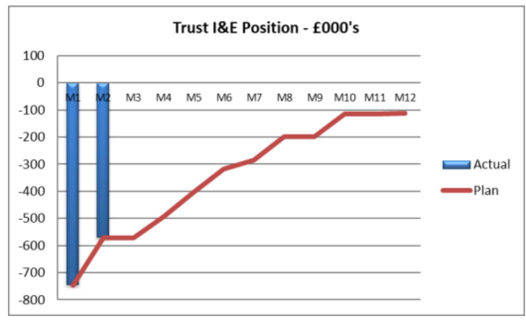
# Overall – I & E Position

- In May, the Trust recorded a £0.6m deficit, marginally favourable to the plan submitted to NHSI/E in April
- This brings the cumulative deficit to £1.3m, also marginally favourable to plan
- The position fully reflects income flows agreed with South West London and other CCGs 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 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 funding
- The planned year end deficit of £4.1m is not acceptable to NHSE/I. The Trust has made a revised plan submission that shows a break-even position. This will be incorporated for M3 on the assumption that the revised submission is acceptable to NHSE/I

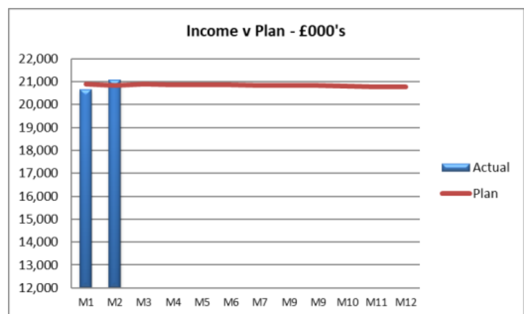
| Financial Reports 2022/23 | Current Month | | | YTD month 2 | | | 12 Mths to 31 March 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | (Adv)/ Fav'ble | Budget | Actual | (Adv)/ Fav'ble | Budget | F/Cast | (Adv)/ Fav'ble |
| Income | 20.8 | 21.1 | 0.2 | 41.7 | 41.7 | (0.0) | 250.1 | 250.1 | 0.0 |
| Pay | (15.0) | (14.9) | 0.1 | (30.0) | (29.4) | 0.6 | (180.4) | (180.4) | 0.0 |
| Non Pay | (5.0) | (5.3) | (0.4) | (10.1) | (10.7) | (0.6) | (56.4) | (56.4) | 0.0 |
| **EBITDA** | **0.9** | **0.9** | **(0.0)** | **1.6** | **1.5** | **(0.0)** | **13.3** | **13.3** | **0.0** |
| Cap Charges - Depreciation | (1.0) | (1.0) | 0.0 | (1.9) | (1.9) | (0.0) | (11.5) | (11.5) | 0.0 |
| Cap Charges - Interest & Div | (0.4) | (0.4) | 0.0 | (0.9) | (0.9) | (0.0) | (5.1) | (5.1) | 0.0 |
| Interest | (0.1) | (0.0) | 0.0 | (0.1) | (0.1) | 0.0 | (0.8) | (0.8) | 0.0 |
| Post EBITDA | (1.5) | (1.4) | 0.0 | (2.9) | (2.9) | 0.0 | (17.4) | (17.4) | 0.0 |
| **Underlying Surplus / (Deficit)** | **(0.6)** | **(0.6)** | **0.0** | **(1.3)** | **(1.3)** | **0.0** | **(4.1)** | **(4.1)** | **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)** | **(0.6)** | **(0.6)** | **0.0** | **(1.3)** | **(1.3)** | **0.0** | **(4.1)** | **(4.1)** | **0.0** |

# Key Finance Metrics

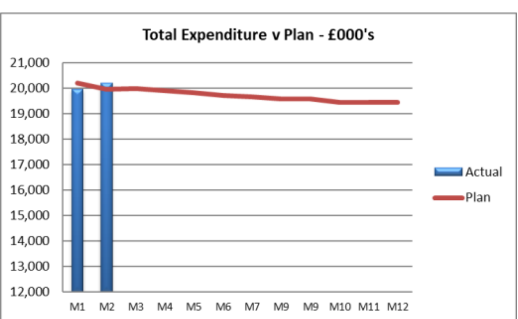
- Baseline deficit of £570k reported in month, £3k favourable to plan
- Cumulative deficit of £1,314k, £7k favourable to plan
- Deficit driven by external beds, Coral and Observation costs
- Original planned deficit of £4.1m not acceptable to NHSE/I
- Revised submission made, showing break-even



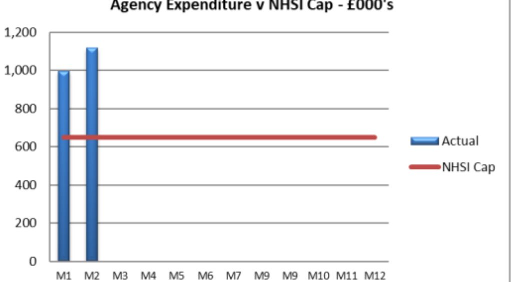

- Income received in month, £21.1m, £0.2m above plan
- Position reflects agreed contract with SWL CCG
- Incorporates MHIS and SDF investments
- Risk in relation to £2.8m NHSE erroneous deduction
- Additional inflation funding of £1.4m identified



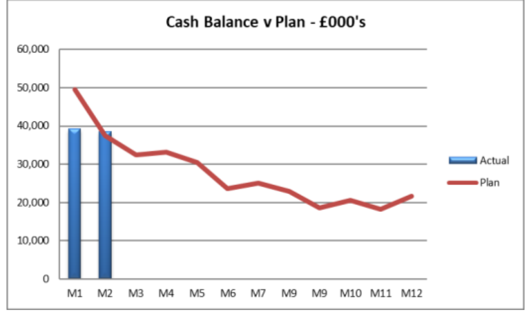

- Spend of £20.2m in month, £0.2m adverse to plan
- Spend includes: 22/23 Investments, National Insurance increase and pay award accrual
- Incorporates 56% increased spend on utilities
- External bed expenditure £658k in month
- External Bed pressure continues into M3




- Agency spend in month £1,117k, £279k above 2021/22 average monthly spend
- £469k above NHSE/I cap
- Likely to be increased central scrutiny in 2022/23
- Community spend in M2 of £506k (45% of total)
- Corporate spend £216k including £69k of Strategic Investment expenditure




- Cash balance at end of May £38.5m
- £1.0m 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 £1.8m, £0.5m below plan
- Cumulative spend of £4.6m, £0.1m above plan
- Overspend of £0.3m on EMP offset by Estates and IT
- Planned spend of £32.1m for the year of which £28.3m relates to the EMP
- Position excludes leases, £15.4m, capitalised under IFRS 16

# Income Position

- For Month 2 the Trust reported £21.1m of income, £0.2m ahead of plan, cumulatively on target
- The position fully reflects the outcomes of contract negotiations for 2022/23 and revised income flows as the Covid regime begins to unwind
- Local Contracts are showing a £0.1m adverse variance. This is a phasing issue and will correct itself later in the year
- NHSE income is £0.5m behind plan. This is a continuation of the error first made by NHSE in 2020 that has reduced income to the Trust by £2.8m
- Other NHS Clinical Income is above plan by £0.5m. This is to offset the NHSE shortfall. The Trust has been assured by NHSE that there is enough money in the system resolve the issue. For the past 18 months, the Trust has received reimbursement from SLaM
- Other non-clinical income is break-even following the receipt of £0.2m of non-recurring income in month (pension and rates rebates)
- 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 2 | | | 12 Mths to 31 March 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | (Adv)/ Fav'ble | Budget | Actual | (Adv)/ Fav'ble | Budget | F/Cast | (Adv)/ Fav'ble |
| Local Contracts | 15.9 | 15.9 | (0.0) | 31.8 | 31.7 | (0.1) | 190.7 | 190.7 | 0.0 |
| Nhs England | 1.9 | 1.6 | (0.2) | 3.7 | 3.2 | (0.5) | 22.3 | 22.3 | 0.0 |
| Npsa Income | 0.0 | 0.1 | 0.0 | 0.1 | 0.1 | 0.0 | 0.5 | 0.5 | 0.0 |
| Provider Collaborative Income | 1.4 | 1.4 | (0.0) | 2.9 | 2.9 | (0.0) | 17.1 | 17.1 | 0.0 |
| Other Nhs Clinical Income | 0.2 | 0.4 | 0.3 | 0.3 | 0.9 | 0.5 | 2.0 | 2.0 | 0.0 |
| **Nhs Clinical Income** | **19.4** | **19.4** | **(0.0)** | **38.8** | **38.7** | **(0.1)** | **232.6** | **232.6** | **0.0** |
| Education & Training | 0.6 | 0.7 | 0.0 | 1.3 | 1.3 | 0.1 | 7.5 | 7.5 | 0.0 |
| Other Non Clinical Income | 0.4 | 0.6 | 0.2 | 0.8 | 0.9 | 0.0 | 4.6 | 4.6 | 0.0 |
| Merit Award Income | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 |
| **Non Clinical Income** | **1.1** | **1.3** | **0.2** | **2.1** | **2.2** | **0.1** | **12.2** | **12.2** | **0.0** |
| Non NHS Clinical Income | 0.4 | 0.4 | 0.0 | 0.9 | 0.8 | (0.1) | 5.2 | 5.2 | 0.0 |
| **Non Nhs Clinical Income** | **0.4** | **0.4** | **0.0** | **0.9** | **0.8** | **(0.1)** | **5.2** | **5.2** | **0.0** |
| **Income** | **20.8** | **21.1** | **0.2** | **41.7** | **41.7** | **0.0** | **250.1** | **250.1** | **0.0** |

# Pay Position

- Pay amounted to £14.9m in May, £0.1m favourable to plan
- This includes a provision for the pay award currently funded and assumed at 2%
- Medical Staff overspent by £0.3m due to additional trainee costs and agency usage in May
- Acuity pressure 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 £1.1m cumulative underspend to date
- Non-Clinical staff are showing a small cumulative adverse variance due to agency usage
- The pay position will change in future months as saving schemes are identified and removed from budgets

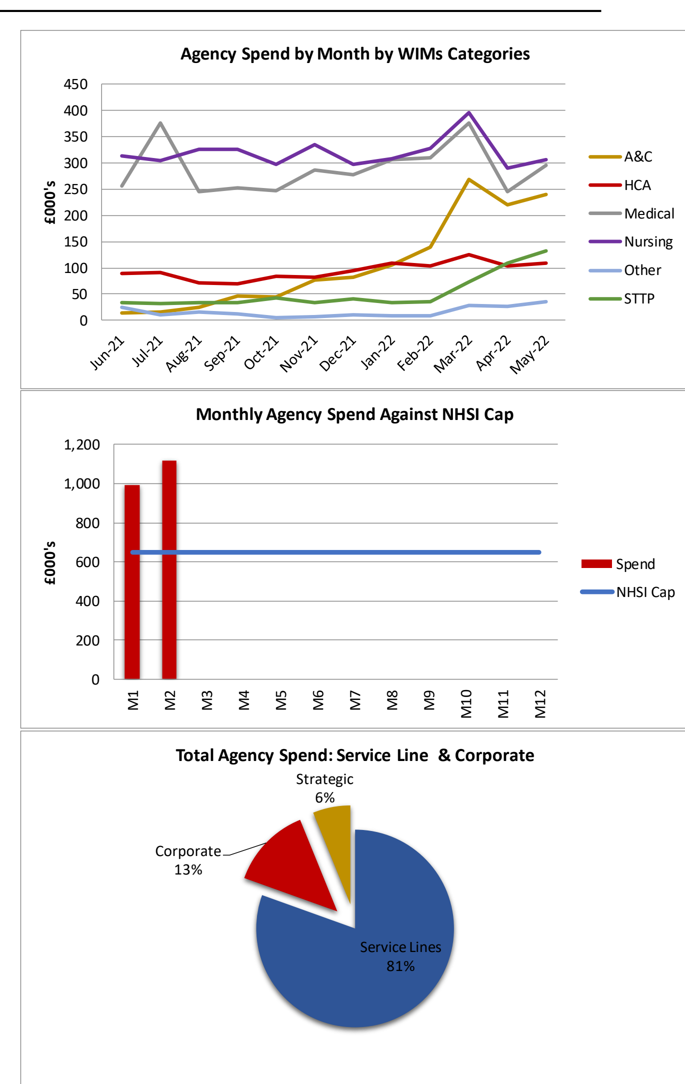
| Financial Reports 2022/23 | Current Month | | | YTD month 2 | | | 12 Mths to 31 March 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | (Adv)/ Fav'ble | Budget | Actual | (Adv)/ Fav'ble | Budget | F/Cast | (Adv)/ Fav'ble |
| Medical | (2.4) | (2.6) | (0.3) | (4.8) | (5.1) | (0.3) | (29.0) | (29.0) | 0.0 |
| Nursing | (6.3) | (6.4) | (0.1) | (12.7) | (12.9) | (0.2) | (76.0) | (76.0) | 0.0 |
| Other Clinical | (3.7) | (3.1) | 0.5 | (7.3) | (6.2) | 1.1 | (44.1) | (44.1) | 0.0 |
| Non Clinical | (2.6) | (2.7) | (0.1) | (5.2) | (5.3) | (0.0) | (31.3) | (31.3) | 0.0 |
| **Total Pay** | **(15.0)** | **(14.9)** | **0.1** | **(30.0)** | **(29.4)** | **0.6** | **(180.4)** | **(180.4)** | **0.0** |

- Agency expenditure of £1.1m was £0.3m above the Trust's internal plan and £0.5m above the ytd NHSE/I cap
- Month 2 expenditure was £0.1m more than Month 1 and £0.3m more than the 2021/22 average
- Bank expenditure was £1.8m, £0.1m above plan (£0.1m above cumulatively)
- Permanent pay amounted to £12.0m in month. This was £0.5m favourable to plan (principally Psychologists). Permanent pay is cumulatively £1.1m below plan

| Financial Reports 2022/23 | Current Month | | | YTD month 2 | | | 12 Mths to 31 March 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | (Adv)/ Fav'ble | Budget | Actual | (Adv)/ Fav'ble | Budget | F/Cast | (Adv)/ Fav'ble |
| Permanent | (12.5) | (12.0) | 0.5 | (25.0) | (23.8) | 1.1 | (150.1) | (150.1) | 0.0 |
| Bank | (1.7) | (1.8) | (0.1) | (3.4) | (3.5) | (0.1) | (20.576) | (20.6) | 0.0 |
| Agency | (0.8) | (1.1) | (0.3) | (1.6) | (2.1) | (0.5) | (9.754) | (9.8) | 0.0 |
| **Total Pay** | **(15.0)** | **(14.9)** | **0.1** | **(30.0)** | **(29.4)** | **0.6** | **(180.4)** | **(180.4)** | **0.0** |

# Agency - in month and cumulative position

- Month 2 agency expenditure was £1,117k
- Increase of £123k on Month 1 expenditure
- Equates to 7.5% of pay costs (7.2% cumulatively. 6.1% in 2021/22)
- Highest areas of monthly spend: Medical £295k, Nursing £306k, and A&C £240k
- Above NHSE/I Cap of £648k by £469k
- No inflationary adjustment has been made to the Cap at the start of the year, nor has it been uplifted for the investment in Mental Health either in 2022/23 or in previous years.
- The key pressure area remains the Community Service Line; of the £1,117k total spend, £506k (45%) 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 £216k in M2 2022/23



# Non-Pay & Post EBITDA

- Non-Pay expenditure amounted to £5.3m in month, a £0.4m overspend (cumulatively £0.6m)
- The position includes the 56% increase in gas and electricity prices
- External bed expenditure amounted to £0.7m in May
- The £0.4m overspend on other costs reflects CIP targets that have yet to be allocated to specific schemes
- 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 (£1.0m) cumulatively

| Financial Reports 2022/23 | Current Month | | | YTD month 2 | | | 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) | (0.1) | 0.1 | (0.4) | (0.3) | 0.1 | (2.5) | (2.5) | 0.0 |
| Clinical Supplies & Servs Cost | (0.0) | (0.0) | (0.0) | (0.1) | (0.1) | 0.0 | (0.5) | (0.5) | 0.0 |
| Secondary Commisioning Costs | (2.8) | (2.8) | (0.0) | (5.5) | (5.6) | (0.1) | (30.7) | (30.7) | 0.0 |
| Other Costs | (1.9) | (2.2) | (0.4) | (3.9) | (4.6) | (0.6) | (21.7) | (21.7) | 0.0 |
| Contingency | (0.1) | (0.1) | (0.0) | (0.2) | (0.2) | (0.0) | (1.0) | (1.0) | 0.0 |
| **Total Non Pay** | **(5.0)** | **(5.3)** | **(0.4)** | **(10.1)** | **(10.7)** | **(0.6)** | **(56.4)** | **(56.4)** | **0.0** |

- Post EBITDA costs remain in line with expectations
- 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 2 | | | 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 | (1.9) | (1.9) | (0.0) | (11.5) | (11.5) | 0.0 |
| Cap Charges - Pdc Dividend | (0.4) | (0.4) | 0.0 | (0.9) | (0.9) | (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 | (0.1) | (0.1) | 0.0 | (0.8) | (0.8) | 0.0 |
| Profit / (Loss) On Asset Disps | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Post EBITDA** | **(1.5)** | **(1.4)** | **0.0** | **(2.9)** | **(2.9)** | **0.0** | **(17.4)** | **(17.4)** | **0.0** |

# Service Line Positions

- CIP targets were devolved to all Service Lines and Corporate areas in Month 2
- Acute Care is £0.2m overspent following the devolution of CIP targets in month and reflective cumulatively of the high acuity on inpatient wards
- CAMHS & ED is £0.4m underspent as continued recruitment slippages are greater than the CIP target
- Community has a £0.3m underspend in-month. This is primarily the result of non-recurring vacancies partially offset by CIP targets
- Specialist Services is reporting a break-even position
- The Corporate overspend is primarily due to central provisions against known liabilities and has shown an improved position in-month following the devolution of CIP targets
- The forecast is currently a £4.1m deficit. As detailed on Slide 3, this is not viewed as acceptable by NHSE/I, and Month 3 reporting will show a break-even position

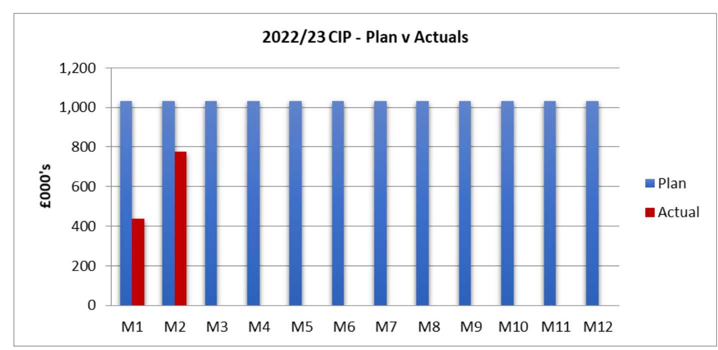
| Financial Reports 2022/23 | Current Month | | | YTD month 2 | | | 12 Mths to 31 March 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | (Adv)/ Fav'ble | Budget | Actual | (Adv)/ Fav'ble | Budget | F/Cast | (Adv)/ Fav'ble |
| Acute And Urgent Care | (3.8) | (4.0) | (0.2) | (7.8) | (8.0) | (0.2) | (43.5) | (43.5) | 0.0 |
| Camhs & Ed | (2.2) | (2.1) | 0.1 | (4.6) | (4.2) | 0.4 | (27.8) | (27.8) | 0.0 |
| Community (Adults) | (3.5) | (3.6) | (0.1) | (7.4) | (7.1) | 0.2 | (44.0) | (44.0) | 0.0 |
| Specialist Services | (2.4) | (2.5) | (0.1) | (5.0) | (5.0) | 0.0 | (29.9) | (29.9) | 0.0 |
| Corporate | 12.4 | 12.6 | 0.3 | 25.3 | 24.8 | (0.5) | 152.2 | 152.2 | 0.0 |
| Capital Costs | (0.9) | (0.9) | 0.0 | (1.9) | (1.8) | 0.0 | (11.1) | (11.1) | 0.0 |
| **Total** | **(0.6)** | **(0.6)** | **0.0** | **(1.3)** | **(1.3)** | **0.0** | **(4.1)** | **(4.1)** | **0.0** |

# Savings

- The Trust has a recurrent savings target of £12.4m (4.5%) to achieve the planned £4.1m deficit 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, £11.3m of the target has been identified. However, only £1.3m of this is currently rated green, and the majority of schemes are rated red or amber
- Once risk adjusted values have been applied, expected delivery falls to £4.8m, leaving a £7.5m shortfall
- This gives a 39% confidence level in delivery – the equivalent value for M2 last year was 35%
- In month delivery amounted to £775k against a target of £1,032k – a £257k shortfall
- Cumulative delivery now stands at £1,212k against a plan of £2,064k - £852k adverse
- All savings delivered to date are non-recurrent
- The challenge facing the Trust is to close
  - Identify new schemes to close the £1.1m gap
  - To 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 | 1,328 | 0% | 1,328 |
| Amber | 4,117 | 50% | 2,059 |
| Red | 5,826 | 75% | 1,456 |
| Unidentified | 1,116 | 100% | 0 |
| **Total** | **12,387** | **39%** | **4,843** |

| Gap | -7,544 |
|---|---|



# Capital

| | Month | | | YTD | | | Annual | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget £m | Actual £m | Variance £m | Budget £m | Actual £m | Variance £m | Budget £m | Forecast £m | Variance £m |
| **Schemes** | | | | | | | | | |
| EMP | 2.0 | 1.8 | 0.2 | 3.9 | 4.2 | (0.3) | 28.3 | 28.3 | 0.0 |
| Estates Maintenance | 0.2 | 0.0 | 0.1 | 0.3 | 0.3 | 0.0 | 1.9 | 1.9 | 0.0 |
| IT/Digital | 0.2 | (0.0) | 0.2 | 0.3 | 0.2 | 0.1 | 2.0 | 2.0 | 0.0 |
| **Operational Total** | 2.3 | 1.8 | 0.5 | 4.5 | 4.6 | (0.1) | 32.1 | 32.1 | 0.0 |
| Leases | 0.0 | 0.0 | 0.0 | 15.4 | 15.4 | 0.0 | 15.4 | 15.4 | 0.0 |
| **Total Capital Expenditure** | **2.3** | **1.8** | **0.5** | **19.9** | **20.0** | **(0.1)** | **47.5** | **47.5** | **0.0** |

- The Trust is forecasting to spend £47.5m, including £15.4m of leases which are now shown on the balance sheet in line with the new IFRS 16 requirements
- Capital expenditure for the month is £1.8m; £20m YTD which is £0.1m adverse to plan
- The leases figure is subject to audit as part of the 2021/22 annual accounts process which is due to complete in June 2022
- The Estates Modernisation Programme (EMP) is overspent by £0.3m due to earlier than anticipated 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

# Statement of Financial Position

| Statement of Financial Position (£m) | Plan as at end May 2022 | Actuals at end May 2022 | Variance to YTD Plan |
|---|---|---|---|
| **NON CURRENT ASSETS:** | | | |
| Intangible assets | 7.0 | 7.1 | 0.1 |
| Plant, Property and Equipment | 339.3 | 340.3 | 1.0 |
| Receivables | 26.9 | 26.9 | 0.0 |
| **Total Non-Current Assets** | **373.2** | **374.3** | **1.1** |
| **Total Non-Current Assets Held for sale** | **0.0** | **0.0** | **0.0** |
| **CURRENT ASSETS:** | | | |
| Inventories | 0.2 | 0.2 | 0.0 |
| NHS Trade Receivables due in less than 1 year | 1.5 | 3.5 | 2.0 |
| Non-Nhs Trade Receivables due in less than 1 year | 4.3 | 0.5 | (3.9) |
| Other Receivables | 0.0 | 1.4 | 1.4 |
| Other Financial Assets (Accrued Income) | 1.0 | 1.9 | 0.9 |
| Prepayments | 0.0 | 0.9 | 0.9 |
| Cash and Cash Equivalents | 37.5 | 38.5 | 0.9 |
| **Total Current Assets** | **44.5** | **46.8** | **2.3** |
| **CURRENT LIABILITIES:** | | | |
| Trade Payables | (33.7) | (35.1) | (1.4) |
| PDC Dividend Payable | (0.0) | (0.9) | (0.9) |
| Capital Payables | (30.1) | (33.5) | (3.4) |
| Provisions | (4.3) | (4.3) | 0.0 |
| Other Financial Liabilities (Accruals) | 0.0 | 0.0 | 0.0 |
| Deferred Revenue | (7.2) | (5.0) | 2.3 |
| **Total amounts falling due within one year** | **(75.3)** | **(78.7)** | **(3.4)** |
| **NET CURRENT ASSETS/(LIABILITIES)** | **(30.8)** | **(31.8)** | **(1.1)** |
| **NON CURRENT LIABILITIES:** | | | |
| Provision for Liabilities and Charges | (1.7) | (1.7) | 0.0 |
| Capital Payables | (5.2) | (5.2) | 0.0 |
| Borrowings | (99.4) | (99.4) | 0.0 |
| **Total amounts falling due within after one** | **(106.2)** | **(106.2)** | **0.0** |
| **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) | 33.5 | 30.6 | (2.9) |
| Retained Surplus(Deficit) in year | (4.2) | (1.3) | 2.9 |
| Revaluation Reserve | 64.6 | 64.6 | 0.0 |
| **TOTAL TAXPAYERS EQUITY** | **236.2** | **236.2** | **0.0** |

- Trade receivables stand at £4.0m, which is £1.8m favourable to plan, and relates to payment of the Provider Collaborative invoices. Prior year debtors account for £1.2m of the £4.0m.
- Cash is £38.5m, £0.9m more 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

# Cash

All figures £k

| | Plan as at end May 22 | Actual as at end May 22 | Variance to plan |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Operating Surplus/(Deficit) | (334) | (397) | (63) |
| **Non Cash Adjustments** | | | |
| Depreciation and Amortisation | 1,916 | 2,161 | 245 |
| Interest Received | (2) | (46) | (44) |
| Interest Paid | 0 | 0 | 0 |
| (Increase)/Decrease in Inventories | 0 | 0 | 0 |
| Increase/(Decrease) in Working Capital | (8,797) | (1,398) | 7,399 |
| **Net Cash Inflow/(Outflow) from Operating Activities** | **(7,217)** | **320** | **7,538** |
| **Cash Flows from Investing Activities** | | | |
| Interest Received | 2 | 46 | 44 |
| (Payments) for Property, Plant and Equipment | (4,524) | (11,305) | (6,781) |
| Proceeds from sales of property, plant and equipment | 0 | 0 | 0 |
| **Net Cash Inflow/(Outflow) from Investing Activities** | **(4,522)** | **(11,260)** | **(6,738)** |
| **Net Cash Inflow/(Outflow) before financing** | **(11,739)** | **(10,939)** | **800** |
| **Cash Flows from Financing Activities** | | | |
| Interest element of finance lease | (130) | 0 | 130 |
| **Net Cash Inflow/(Outflow) from Financing Activities** | **(130)** | **0** | **130** |
| **Net Increase/(Decrease) In Cash And Cash Equivalents** | **(11,869)** | **(10,939)** | **930** |
| **Cash / Cash Equivalents at beginning of month** | **49,403** | **49,403** | **0** |
| **Cash / Cash Equivalents at end of month** | **37,534** | **38,464** | **930** |

- The cash balance at the end of the month was £38.5m compared with the plan of £37.5m.
- The increase of £0.9m relates to:
  - Capital spend, -£6.8m
  - Movements in working capital, +£7.5m
  - Other £0.2m
- 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.

# Monthly Cashflow

| | April Actual £'000 | May Actual £'000 | June Forecast £'000 | July Forecast £'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 | 24,485 | 24,039 | 23,446 | 20,098 | 19,226 | 18,763 | 18,298 | 17,972 | 19,359 |
| **Receipts** | | | | | | | | | | | | |
| SLA Income | 18,230 | 18,615 | 20,035 | 20,035 | 20,035 | 20,035 | 20,035 | 20,035 | 20,035 | 20,035 | 20,035 | 20,369 |
| Other NHS Income | 2,111 | 1,035 | 1,094 | 799 | 799 | 799 | 778 | 778 | 778 | 778 | 778 | 824 |
| Other income | 584 | 337 | 501 | 250 | 250 | 250 | 250 | 250 | 250 | 2,450 | 2,450 | 6,960 |
| Loans | - | - | - | - | - | - | - | - | - | - | - | - |
| PDC Income | - | - | - | - | - | - | - | - | - | - | - | - |
| Asset Sales | - | - | - | - | - | - | - | - | - | - | - | - |
| **Total Receipts** | **20,926** | **19,987** | **21,630** | **21,084** | **21,084** | **21,084** | **21,064** | **21,064** | **21,064** | **23,264** | **23,264** | **28,153** |
| **Payments** | | | | | | | | | | | | |
| Payroll costs | (12,936) | (13,189) | (14,602) | (14,588) | (14,588) | (14,588) | (14,615) | (14,615) | (14,615) | (14,615) | (14,615) | (14,629) |
| Suppliers (Revenue) | (8,280) | (4,111) | (6,370) | (5,288) | (5,201) | (5,114) | (5,034) | (4,947) | (4,947) | (4,863) | (4,863) | (6,244) |
| Suppliers (Capital) | (1,254) | (562) | (1,251) | (322) | (324) | (324) | (324) | (324) | (325) | (325) | (326) | (326) |
| Suppliers (EMP) | (6,565) | (2,783) | (9,943) | (1,332) | (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) | (18) | - | - | - | - | - | - | - | - | - |
| PDC Dividend | - | - | - | - | - | (2,571) | - | - | - | - | - | (2,571) |
| Loans & interest | - | - | - | - | - | (178) | - | - | - | - | - | (178) |
| **Total Payments** | **(29,145)** | **(20,707)** | **(35,608)** | **(21,530)** | **(21,677)** | **(24,432)** | **(21,936)** | **(21,526)** | **(21,528)** | **(23,589)** | **(21,877)** | **(27,280)** |
| **Net Receipts/ (Payments)** | **(8,220)** | **(721)** | **(13,978)** | **(446)** | **(593)** | **(3,348)** | **(873)** | **(463)** | **(465)** | **(326)** | **1,387** | **874** |
| **Bank Balance c/f** | **39,183** | **38,463** | **24,485** | **24,039** | **23,446** | **20,098** | **19,226** | **18,763** | **18,298** | **17,972** | **19,359** | **20,233** |
| **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 | 17,485 | 17,039 | 16,446 | 13,098 | 12,226 | 11,763 | 11,298 | 10,972 | 12,359 | 13,233 |

- 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.

# Solvency Dashboard

| | | | |
|---|---|---|---|
| Trading Position | G | The Trust delivered a deficit of £1.3m in the year to date compared to a planned deficit of £1.3m. | G : Forecast surplus in line with plan<br>A : Forecast breakeven<br>R : Trading at a loss |
| Net Current assets | R | The Trust has net current liabilities of £31.8m, with current assets of £46.8m and current liabilities of £78.7m. | G : Greater than £7m<br>A : Positive net current assets<br>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 £5m. | G : 13 week forecast always above 10 days operating expenses<br>A : 13 week forecast always positive<br>R : 13 week forecast is not always positive |
| Debtors Ageing | G | The level of non-current aged debt was £1.3m at the end of May. It consists of £0.6m NHS and £0.7m of Non NHS organisations. The total current debt not due is £2.7m making a total debtors position of £4.0m. Prior Year debt which was £6.0m was £1.2m up to the end of May, a reduction in the financial year of £4.8m. | Excluding (current)<br>G : Less than £2m debts<br>A : Greater than £2m debts but less than £4m debts<br>R : Greater than £4m debts |
| Creditors Ageing | G | The Trust has £100k outstanding greater than 30 days, the less than 30 days balance is £0.58m, the majority of of which relates to non-NHS organisations. | Excluding less than 30 days (current)<br>G : Less than £200k creditors<br>A : Greater than £200k and less than £500k<br>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<br>A : Less than £500k<br>R : Greater than £500k |

| | |
|---|---|
| **Meeting** | Board of Directors |
| **Date of meeting:** | 14 July 2022 |
| **Report title:** | **Chair's report – June Charitable Funds Committee (CFC)** |
| **Author:** | Juliet Armstrong, Non-Executive Director |
| **Executive sponsor:** | Ian Garlington, Integrated Programme Director |
| **Purpose:** | For noting |
| **Transparency:** | Public |

**Introduction**

The key items discussed at the CFC meeting on 16th June 2022 were i) Finance report ii) Investment policy iii) Progress report.

The Board is asked to:

- Note the key discussion and assurance points below
- Note the minutes from the January 2022 CFC meeting.

1. **Charitable Funds Finance Report**

The financial position is summarised below with comparison to Q3: As at 31st March, there is a balance of £90,297, subject to independent examination.

| | 31/12/2021 | As at 31/03/2022 | | |
|---|---|---|---|---|
| | Total Balance | Restricted Funds £ | Unrestricted Funds £ | Total £ |
| Department Funds | 19,278 | 18,620 | 674 | 19,294 |
| Directorate Funds | 31,850 | - | 32,210 | 32,210 |
| Other Funds | 1,316 | - | 1,566 | 1,566 |
| General Funds | 41,256 | - | 37,227 | 37,227 |
| **Total** | **93,700** | **18,620** | **71,677** | **90,297** |

It was noted that in Q4 c £4k was spent from the General Springfield Fund. We are expecting at least £30k to be transferred from the Kingston and Tolworth League of Friends as it is winding up.

Awareness of the charity and funds available is still low although there are plans to change this – see progress report.

We noted the re-appointment of GSM as the independent examiner, and that more work is required to identify the restricted dormant funds. Less progress has been made than planned due to Finance priorities for year end and 22/23 budgeting/planning.

**2. Investment policy**

The committee received an updated investment policy after the Board had asked the committee to review the exclusions made on ethical grounds, and the reasons for exclusion. This updated paper set out the reasons for funds exclusion, which fall into a number of categories, broadly a) links to addiction therefore not aligned with strategic ambitions of the Trust to increase quality years b) links to harm and exploitative practice which can exacerbate mental health conditions c) not aligned to NHS policy e.g. net zero targets d) unethical on ground of human rights abuses and types of persecution such as religious persecution. All these categories can pose reputational damage risks to the Trust.

The committee also received assurance that the performance of ethical funds had outperformed all non-ethical funds over several timescales, recognising this can change and should therefore be subject to regular review.

The committee supported the next steps to implement the updated policy proposed in the updated paper, but suggested this should be subject to Board ratification.

**3. Progress report**

The committee noted the progress update and in particular the implications of de-prioritising charity activities as agreed as part of the overall Trust priorities. The re-focus of the charity activities until autumn, including the pausing of the charity working group was noted.

It was good to hear there is a positive relationship with Momark currently, who have also agreed to fund the Equine Care request from Corner House to help young deaf people with their recovery.

The new charity branding was reviewed which will help with raising awareness once more activity is re-launched in Autumn after the hospital moves are complete.

# CHARITABLE FUNDS COMMITTEE

Minutes of the meeting of the Charitable Funds Committee held online on 26th January 2022.

| **Present:** | |
|---|---|
| Doreen McCollin (DM) | Non-Executive Director – Chair |
| Juliet Armstrong (JuA) | Non-Executive Director |
| Ian Garlington (IG) | Integrated Programme Director |
| Jenna Khalfan (JK) | Director of Communications and Stakeholder Engagement |
| **Attendees:** | |
| Debbie Hollinghurst (DH) | Deputising for Philip Murray |
| David Lee (DL) | Director of Corporate Governance (Minutes) |
| Sharon Spain (SS) | Director of Nursing and Quality Standards |

| No. | Details | Actions |
|---|---|---|
| **C22/01** | **Apologies**<br>Apologies were received from Philip Murray, Director of Finance and Performance. | |
| **C22/02** | **Declarations of interest**<br>None. | |
| **C22/03** | **Chair's Action**<br>None to report. | |
| **C22/04** | **Minutes of the last meeting**<br>The minutes of the meeting held on 13th October 2021 were agreed as a correct record. | |

<table>
<tr><td>C22/05</td><td>Action Tracker<br>IG advised that work on identifying a Patron has been paused and that he would report back to the next meeting. ACTION - IG</td><td>IG</td></tr>
<tr><td>C22/06</td><td>CHARITABLE FUNDS FINANCIAL POSITION<br>The committee received a report on charitable funds finances, summarized below<br><br>
<table>
<tr><th></th><th>Restricted Funds £</th><th>Unrestricted Funds £</th><th>Total £</th></tr>
<tr><td>Department Restricted Funds</td><td>18,604</td><td></td><td>18,604</td></tr>
<tr><td>Directorate Restricted Funds</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Directorate Unrestricted Funds</td><td></td><td>31,850</td><td>31,850</td></tr>
<tr><td>Department Unrestricted Funds</td><td></td><td>674</td><td>674</td></tr>
<tr><td>Other Funds</td><td></td><td>1,316</td><td>1,316</td></tr>
<tr><td>General Funds</td><td></td><td>41,256</td><td>41,256</td></tr>
<tr><td>Total</td><td>18,604</td><td>75,096</td><td>93,700</td></tr>
</table>
<br>It was noted that discussions are ongoing with the League of Friends of Surbiton and Tolworth Health Community as to whether to consolidate their funds, c£65k, into the Trust's Charitable Funds and the ring-fencing arrangements that would be appropriate for this to proceed. ACTION – IG to update next meeting<br><br>The Committee approved the transfer of 'unrestricted' dormant funds, where the fund is less than £2,000, to the general fund and the closure of funds with a zero balance or negative balance. Work is ongoing to address a number of small dormant restricted funds to enable action to be taken on those funds as well – this will be addressed in the finance report to the next meeting.</td><td>IG</td></tr>
<tr><td>C22/07</td><td>CHARITY WORKING GROUP<br>The committee received an update on the activities of the Charity Working Group.<br><br>Key outputs from the working group have included:<br><ul><li>research on alternative fundraising platforms as the Trust Charity's current provider Virgin Money Giving ceased trading on 30th November 2021. CAF Donate have been selected as this is UK based and has been providing services to charities for over 90 years. Danny Dignan has now taken over from David Palmer and is in the process of setting this up.</li></ul></td><td></td></tr>
<tr><td>C22/07.1</td><td>Using the new application form created by the Charity Working Group, three applications for charity funding have been considered:<br>A set of 19 high quality Djembe African drums to use as music therapy for service users, staff wellbeing and community engagement.</td><td></td></tr>
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<tr><td></td><td>- Equine Care weekly sessions for 1 year for 3 deaf children at Corner House - funding may partially or fully come from MoMark as they currently fund fortnightly sessions.<br>- An exercise bike for Lavender Ward to improve service user experience and increase benefits of exercise to health and wellbeing.<br>The Committee approved the three proposals.</td><td></td></tr>
<tr><td>C22/07.2</td><td>Barratt London donated £1,000 to the Trust Charity. The donation was part of Barrett's National programme of donation.</td><td></td></tr>
<tr><td>C22/07.3</td><td>• Engagement plan: Branding options are being worked on by the Trust's graphic designer and will be reported back to the working group by March 2022 to be rolled out throughout the year. These will be based on several workshops that took place with service users, carers, staff and the wider community to understand what is important for the Charity brand and vision.<br>• The Committee decided that while it was a good idea to invite service users to attend the meetings, it was not the right time to introduce this.</td><td></td></tr>
<tr><td>C22/08</td><td>HOSPITAL ROOMS<br>It was noted that Hospital Rooms have successfully reached their top fundraising target of approximately £350,000 through donations and grants and have commissioned 20 major artworks to transform how the new buildings are experienced by service users and staff. We approved a contribution of £5000 from charitable funds for this activity. Between January and June 2022, the Hospital Rooms artists will lead more than 80 art workshops with service users and staff which will inform the artworks for the new buildings at Springfield. Hospital Rooms are also working with Norwich University of the Arts and the World Health Organisation to adapt their evaluation methodology for Springfield.</td><td></td></tr>
<tr><td>C22/09</td><td>NHS CHARITIES TOGETHER<br>The Trust Charity has received nearly £100,000 from NHS Charities Together in Stages 1 and 2 of their Covid-19 grant funding and any outstanding projects it was allocated to are being monitored to ensure delivery. The deadline to apply for Stage 3 Covid Recovery Grant funding is August 2022 with the Trust being able to apply for a maximum of £55,000. It has been agreed to apply for this funding for South London Listens to benefit South- West London communities which already has project management in place and has secured less funding to date than South-East London.</td><td></td></tr>
<tr><td>C22/10</td><td>MOMARK<br>The committee received a positive report about our relationship with Momark (formerly known as the Friends of Springfield). Regular meetings have been re-instated and there is full agreement that the</td><td></td></tr>
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| | | |
|---|---|---|
| | charities are not in competition for fundraisers. There is an ongoing commitment from Momark to support the Springfield wards. | |
| **C22/11** | **Next meeting**<br>The next meeting will be held on 16th June 2022 at 2.30pm. | |