Trust Board - Part A

Conference Room A, Trinity Building, Springfield Hospital

09 March 2023 01:30 PM London Standard Time

Agenda Topic			Presenter	Time
1.	Patient Story			01:30 PM-02:00 PM
2.	Standing Items			02:00 PM-02:05 PM
	2.1	Apologies		
	2.2	Declarations of Interests and Register 2022/23 DoI Register for approval	Ann Beasley	
	2.3	Chair's Action		
	2.4	Minutes of the previous meeting - 12th January 2023		
	2.5	Action Tracker		
3.	Chair's and Chief Executive's Reports			
	3.1	Chair's Report	Ann Beasley	02:05 PM-02:10 PM
	3.2	Chief Executive's Report	Vanessa Ford	02:10 PM-02:20 PM
4.	Increasing Quality			
	4.1	Quality and Safety Assurance Committee chair's report	Deborah Bowman	02:20 PM-02:25 PM
	4.2	Quality & Performance report	Jen Allan	02:25 PM-02:40 PM
	4.3	Corporate Objectives Q3 Report	Amy Scammell	02:40 PM-02:45 PM
5.	Making The Trust A Great Place To Work			
	5.1	Workforce & OD Committee chair's report	Sola Afuape	02:45 PM-02:50 PM
6.	Reducing Inequalities			
	6.1	Equality & Diversity Committee chair's report	Doreen McCollin	02:50 PM-02:55 PM
Break				02:55 PM-03:05 PM

7.	Ensuring Sustainability			
	7.1	Finance and Performance Committee chair's report -	Vik Sagar	03:05 PM-03:10 PM
	7.2	Monthly finance and savings reports	Philip Murray	03:10 PM-03:20 PM
	7.3	Estates Modernisation Committee chair's report	Juliet Armstrong	03:20 PM-03:30 PM
8.	CORPORATE TRUSTEE BUSINESS			
	8.1	Charitable Funds chair's report	Doreen McCollin	03:30 PM-03:35 PM
9.	Notified Questions From The Public and Staff			03:35 PM-03:40 PM
10.	Meeting Review			
11.	Next Meeting - Trust Board 11th May 2023 - 1.30pm-4pm - Conference Room B - Trinity Building, Springfield Hospital			

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

Provisional agenda to be confirmed following Chairs review

AGENDA

Meeting	**Board of Directors**
Time of Meeting	**1.30pm to 4.00pm**
Date of Meeting	**Thursday 9th March 2023**
Location	**Conference Room A, Trinity Building Springfield Hospital**

	PART A		Format	Lead	Time
1.	**PATIENT STORY**			**AB**	**13:30**
2.	**STANDING ITEMS**			**AB**	**14:00**
	2.1. Apologies	**FN**			
	2.2. Declarations of interests and register https://www.swlstg.nhs.uk/about-the-trust/trust-board/board	**FA**	**Paper**		
	2.3. Chair's action	**FE**			
	2.4. Minutes of the meeting held on 12th January 2023	**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**
	3.1.1. Committee Membership				
	3.2. Chief Executive's report	**FR**	**Paper**	**VF**	**14:10**
4.	**INCREASING QUALITY**				
	4.1. Quality and Safety Assurance Committee chair's report	**FR**	**Paper**	**DBo**	**14:20**
	4.2. Quality and Performance report	**FD**	**Paper**	**JeA**	**14:35**
	4.3. Corporate Objectives Q3 report	**FR**	**Paper**	**AS**	**14:45**
5.	**MAKING THE TRUST A GREAT PLACE TO WORK**				
	5.1. Workforce and OD Committee chair's report	**FR**	**Paper**	**SA**	**14:50**
6.	**REDUCING INEQUALITIES**				
	6.1 Equality and Diversity Committee chair's report	**FR**	**Paper**	**DM**	**14:55**
	BREAK				**15:00**
7.	**ENSURING SUSTAINABILITY**				
	7.1. Finance and Performance Committee chair's report	**FR**	**Paper**	**VS**	**15:10**
	7.2. Monthly finance and savings reports	**FD**	**Paper**	**PM**	**15:15**
	7.3. Estates Modernisation Committee chair's report	**FR**	**Paper**	**JuA**	**15:35**
8.	**CORPORATE TRUSTEE BUSINESS**				
	8.1. Charitable Funds chair's report	**FR**	**Paper**	**DM**	**15:45**
9.	**NOTIFIED QUESTIONS FROM THE PUBLIC AND STAFF**	**FD**	**Verbal**	**AB**	**15:50**
10.	**MEETING REVIEW**	**FD**	**Verbal**	**AB**	**15:55**
11.	**Next Trust Board business meeting –** 1.30pm on 11th May 2023 – Conference Room B, **Trinity Building, Springfield Hospital**				

Attendees:

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

In attendance:

Apologies:

Richard Flatman (RF)	Non-Executive Director

*=non voting

Making life better together

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

Jupiter and Lavender Ward assisted by the "Movemakers" from the Involvement Peer Support Workers

March 2023

Background

This month's patient story to the Board is being presented by R, Patient on Jupiter Ward as well as Sarah and Ayesha, Peer Support Workers at the Trust, who will share their experience of the recent ward moves. Jupiter and Lavender Wards moved into the new state of the art Trinity Building. This will give an insight to the conversations they had with patients and staff on the ward; and their views on the environment as a place where care and treatment is provided.

Their story will highlight the value of patient views in the Estates Modernisation Programme. Also the value of lived experience and the work of Peer Support Workers and Involvement Team in contributing to reviews of care environments, patient experience & engagement. This solidifies the importance of coproduction and collaboration with patients and our lived experience workforce.

Peer Support Work and Involvement

The key principles of Peer Involvement are:

• Through lived experience - fostering hope, enabling people to take back control over their lives, their problems, and the help they receive as far as possible and helping them to identify and access the opportunities they value.

• Co-creation of understanding and shared decision making.

• Promoting the needs of people with mental health problems and reducing the stigma associated with mental health care.

• Actively involving service users and carers in the planning and delivering of Mental Health services.

Movemakers

Movemakers are Peer Support Workers (Lived Experience Workforce) who have been involved in supporting and assisting patients and staff with moves to the new wards at the Trinity Building.

Movemakers came back onto Jupiter Ward after the move to review the inpatient experience of those they had supported as well as assessing whether initial concerns had been satisfactorily addressed.

Movemakers worked collaboratively with ward staff, actively feeding back their observations or any patient requests requiring action – both for immediate and long-term resolution.

Involvement Team

The Involvement Team published *Coproduction, Involvement, Service User and Carer Experience: A unified approach 2022 – 2025* framework which outlines the Involvement workstreams at the Trust.

• Coproduction & Involvement (including the Triangle of Care)
• The Volunteer Workforce
• The Lived Experience Workforce
• Service User and Carer experience

Under the Lived Experience Workstream, one of the key aims is to provide and promote development opportunities for employees with lived experience. Peer Support Workers, "Movemakers", were involved in the moves to the new wards at Trinity Building.

R's Story

Patient View on the move to Jupiter Ward and the new environment:

Summary of my experience on the new Jupiter ward:

Generally the experience has been largely positive. Initially there was a short period of adjustment for me, as I was quite used to the previous facilities. The living quarters are quite spacious, modern and well laid out and the en suite bathrooms were a welcome feature. The shared space of the dining room, lounge area and tv room are within the view of the staff office, which makes me feel safe when using these spaces. All spaces are kept clean regularly and are used often by all of us. The computer facilities help us with our day to day tasks and have also been used often.

Actions needed to taken by the trust:
I do not feel that any further actions need to be taken.

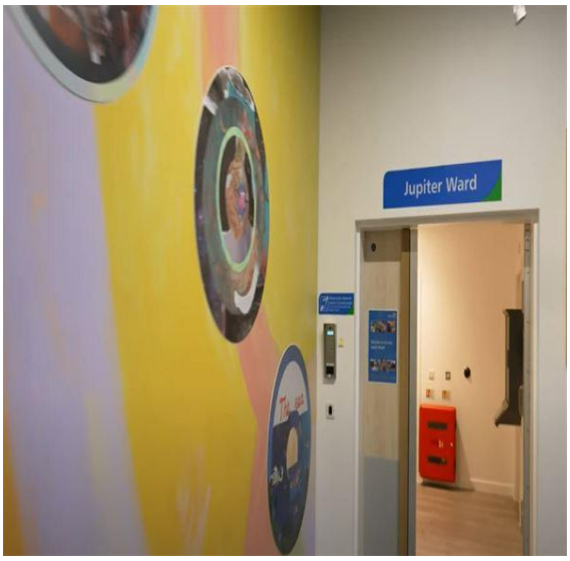
Sarah's Story

Experience as a Movemaker

Peer work being my passion allowed me to tap into my lived experience as a patient on the Springfield site during the early eighties, witnessing first hand the long awaited changes becoming a working reality!

The Transformation not only evident by the phenomenal changes to the infra-structure, but also the in-road towards embedding peers within services that continues to build on the foundations in delivery of services to recovery in acute settings.

I have worked at the Trust since 2003 as a Ward Clerk at Parkgate Day Hospital QMH now , moving to work within the User Employment Programme as an Employment Specialist until mid late year I joined Involvement as the Vocational Coordinator for the Team about the time a little before wards were beginning the earlier stages of transition across to the new accommodation. It was an exciting time and I was fortunate to a part of history in the making!



Ayesha's Story

Experience as a Movemaker

I had a Marital breakdown in 1995 and this began the start of the continued care and recovery received from the Trust. Trust has always been a backbone in my recovery journey. I was able to engage in voluntary and later paid employment with your committed support. Although it took many years of counselling and CBT and support from the Trust I feel that I have gained considerable Mental Health strength to be able to fulfill my goals for each year of my recovery each year gaining more strength of recovery and achievement.

I felt so much more better through the Trust and was able to give back by volunteering with the Trust to provide Peer Support. Involvement Team encouraged and gave me opportunities to assist others better by working towards certificate in being a Peer Support worker. The Trust has been so pivotal in my recovery and for other peers alike to reach where they could function well.

I have seen the changes of new building how it has so moved from an old institutional building and rigid services to one where I myself as Peer feel this was an ideal place for someone to receive great healing and care.

I am very impressed with the dedication of our Trust staff who have made recovery a nice challenge in our life. We are able to carry out Art therapy sensory therapy; communal areas, great bedrooms and shared space meant we could go and empty our minds when in distress and Psychosis. Thank you all to the Trust for making this possible for me and other Peers.

Jupiter and Lavender Ward moves: December 2022

I would just like to say how privileged we were for Jupiter and Lavender to allow us to Peer Support during this period of transition, it not only solidifies our role as Peers Support Workers it also enabled to us to offer valuable peer and team support during a delicate time in an Acute setting.

On arrival to Jupiter Ward, we were given an in-depth handover and alarms to use. We opted not to use the alarms on the second day. As we were able to spend considerable time on the ward, we observed the patients adjust to their new environment first hand. Once teething issues were promptly addressed and reported accordingly patients explored the spacious surroundings. Some of the female patients had already unpacked and organised their Ensuite Bedroom space adding their own personal touches.

Those who were yet to unpack declined our offer of support to assist, although welcomed our company all the same. It was through our conversations we were able to gain an insight into the issues they were experiencing. The maintenance issues were relayed to staff and were processed, given the magnitude of the move Jupiter appeared to be cohesive in approach and in maintaining equilibrium on the ward.

In fairness to Lavender Ward observations were limited to a 3-hour timeframe and therefore we were unable to peer support unlike on Jupiter. In addition, patients had travelled from QMH to settle into a new environment, coupled with then to be told their leave on hold presented different issues.

A brief handover informed us some patients were unhappy because of the leave status. We arrived in the midst of this situation and understandably we were initially met with reluctance when engaging with some patients. Once we shared, we were peers the ice melted, and we were able to assist some patients adjust to their new environment.

In my opinion Jupiter ward's layout appeared engaging and fostered inclusiveness when observing staff and patient compared to Lavender even though both stations are the same in design the only difference being in the location Lavender appeared in isolation especially when sitting at the far end of the Lounge.

It has also given me the opportunity to take value from the learning for the training and workshops I am currently developing.

We collectively thank you once again.

Movemaker Observations December 2022

Jupiter Ward Patient Initial Concerns

- Temperature/thermostat control – on arrival observed some patients still wearing outdoor clothing – expressing how cold they felt both in living and bedroom area, this was expressed throughout our visit.
- The ensuite floor soaks around the toilet area when using shower as water slow to drain away. Patient concerns of slipping whilst shower.
- Wardrobe units in Female Bedroom some female patients felt space needed further shelving to replace lack of hanging rail.
- Dining Area Taps function by keeping the tap button pressed to allow water to flow. Some patients expressed the difficulty when washing hands as the taps are not hands on.
- Female patient I engaged in conversation with spoke of her distress travelling to Trinity in a vehicle with 7 men and felt triggered. We spoke in depth, and she was fine for me to share with a staff member.
- Nearing the end of our visit a female patient had been waiting 45mins to get through to the DWP re a benefit issue. We offered to speak with WB adviser on site and update her the following day.
- The following day she informed me that she finally got through and the issue resolved.
- The entrance door had not closed completely which meant the airlock function would not allow us to exit the ward.
- Patient felt a large ward map on the notice board would be helpful.

Lavender Ward Patient Initial Concerns

- Some patients were unsettled owing to their leave being put hold during the transition across from QMH. Patients explained they were able come and go off the ward to smoke at QMH.

Immediate Actions By Staff to the Patient Initial Concerns

- By the end of our stay on Jupiter Ward staff had collected a list of issues.
- Issues were reported.
- A Peer mopped away excess water whilst engaging in dialogue to calm situation from escalating.
- Request made for maps to be added to patient packs.
- Accompanied the Ward Manager along with another member of staff taking 5 patients on an “Orientation” around the site we walked as far as the entrance onto Burntwood Lane.

Movemaker Observations Jupiter Ward: March 2023

It was a great opportunity to see patients alongside staff established within the new setting. Earlier teething issues and adjustments mostly resolved.
In comparison to the old Jupiter many say the miss the large garden – the greenery mostly. One mentioned the location referring to deliveries "not like on the old ward".

Nearly all loved the ensuite bathrooms – having your own personal clean space makes all the difference especially when in crisis.

I was fortunate to speak to a patient who had moved across from the old Jupiter, preparing for discharge taking time out to be interviewed and happy for me to share her final thoughts she said, "It's a good ward, if I'm being honest well run, best ward I've been on!" Her quote encapsulates not only the architectural design; therapeutic environment aiding recovery but most importantly a testament to Making Life Better Together!

Presentations:
Patient: R

Peers:
Sarah Gibbs, Involvement Vocational Coordinator
Ayesha Jeewa, Peer Support Worker

In attendance
Anna Barnes, Associate Director, Integrated Programme Delivery Team
Amanda Cummins, Deputy Head of Coproduction and Involvement

Thanks to:
Jupiter Ward:
Caroline Lekuru, Ward Manager
Lavender Ward:
Donald Kintu, Ward Manager
Service Line:
Gina Mogan, Matron
Michael Hever, Head of Nursing and Quality

Next Steps and Way Forward

Anna Barnes, Associate Director for the Integrated Programme Delivery Team comment:

"The story here demonstrates the value of peer-to-peer support, even during challenging situations like a ward move. The Integrated Programme Delivery Team (Estates Modernisation Programme) hope to utilise this expertise again when Shaftesbury moves in early summer".

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

Board Members' Declarations of Interest (2022-2023)

Board Members are required by the NHS Code of Conduct to declare their personal interests that may be relevant to their role in the NHS. Board Members' Declarations of Interest are listed on the Trust's website but available below.

Board Member	Name of Organisation	Nature of Interest
Non-Executive Directors		
Ms Ann Beasley – Chair	St. George's University Hospitals NHS FT	NED/ Vice Chair
	ACAS Audit Committee	Independent Financial Advisor
	Alzheimer's Trading Ltd (subsidiary of the Alzheimer's Society	Trustee
	Epsom and St Helier University Hospitals NHS Trust	Non-Executive Director
Mr Richard Flatman Non-Executive Director	London South Bank University	Group Chief Financial Officer
	South Bank University Enterprises Ltd (Commercial arm of LSBU)	Director
	South Bank Academies	Director and Member. Chair of Audit Committee
	South Bank Skills Limited (private training provider)	Director
	LSBU Limited (dormant)	Director
	SW4 Catering (Licensed Restaurants)	Director
	BDO	Daughter is employed
Prof. Deborah Bowman Non-Executive Director	Human Tissue Authority	Board Member
	Princess Alice Hospice	Trustee and Board Member; Member Clinical Governance and Strategy Committee
	Emeritus Professor of Bioethics, Clinical Ethics and Medical Law at St. George's, University of London (partner to SWLSTG)	Loyalty Interest
	Independent Office for Policy Conduct	Independent Director and Chair, People and Culture Committee
	NHS Resolution	Consultant
	Professional Standards Authority	Consultant
	Genomics England	Consultant/ Psychodynamic Coach
	General Osteopathic Council	Independent Council Member and Chair, Policy and Education Committee
	Good Governance Institute	Founding Faculty Member
	Cruse Bereavement Charity	Volunteer

	Hospital Rooms	Chair
	The Royal Marsden NHS Foundation Trust	Volunteer befriender
	WPF Therapy	Trainee Psychotherapist
	Think Ahead Programme	Son is a trainee mental health social worker
Mr Vikas Sagar Non-Executive Director	Cogital Group	Substantive role
Ms Juliet Armstrong Non-Executive Director	The Berkeley Partnership	Equity Partner (01/2002 – 06/2019)
	The Makaton Charity	Trustee
	Digitalhealth London	Mentor
	NHS Innovation Accelerator	Mentor and interview panel member
	Smallpharma	Shareholder
Ms Doreen McCollin Non-Executive Director	Coventry and Warwickshire Partnership NHS Trust	Non-Executive Director
Ms Sola Afuape Non-Executive Director	Care Quality Commission	Advisor to support Well-Led inspections
	Nursing and Midwifery Council	Consultant
	NHS Innovation Accelerator	Consultant
	Norfolk and Suffolk Foundation Trust	Consultant
	Beezee Bodies	Consultant
	Kent Community Health Foundation Trust	Non-Executive Director (Jan 2019 – Jan 2022)
	The Innovation Unit Ltd (Company No. 05997039)	Non-Executive Director advisor
	Systems Anti-Racist Strategy and Implementation Group	Chair
Prof. Charlotte Clark Non-Executive Director	Employed by St George's, University of London (SGUL)	Substantive role
Executive Directors		
Ms Vanessa Ford Chief Executive	NHS Confederation Mental Health Digital Forum	Co-chair
	ICS Digital Programme	Joint Senior Responsible Officer
	Merton Place based leader	
	Regional NHS 111 programme for mental health	Senior Responsible Officer
	South West London Integrated Care Board	Partner member on the ICB

Mr Philip Murray Director of Finance & Performance	London Reciprocal Mentoring Scheme – Reverse Mentoring Frimley Healthcare NHS Foundation Trust	 Spouse is seconded to Frimley Healthcare NHS Foundation Trust
Ms Sharon Spain Director of Nursing and Quality	None	None
Ms Amy Scammell Director of Strategy, Transformation and Commercial	Chwumba	Director – independent company to hold freehold interest of a building
Dr Billy Boland Medical Director	NHS England (London) Royal College of Psychiatrists Money and Mental Health Policy Institute University of Hertfordshire NHS North of England Commissioning Support Unit Royal Manchester Children's Hospital NHSE Bristol	Co-Clinical Director – Mental Health Elected Chair – Faculty of General Adult Psychiatry (July '19 – July '23) Advisory Board Honorary Senior Lecturer (Clinical) Department of Clinical and Pharmaceutical Sciences (CAPS) Sister employed as Transformation & Delivery Project Manager at NHS NESC Nephew is a trainee doctor Sister-in-law employed as Evidence and Policy Manager - National EDI Team at NHSE, Bristol
Ms Jennifer Allan Chief Operating Officer	None	None
Katherine Robinson Director of People	None	None
Ms Jenna Khalfan Director of Communications & Stakeholder Engagement	Different Planet Arts Brighton and Sussex Medical School	Trustee Personal links with the DETERMIND research programme
Mr Ian Garlington * Integrated Programme Director	Mind (Rotherham & Barnsley) Capita Plc	Charitable Trustee Spouse is a director of *Head of Growth, Health & Welfare*
Mr David Lee Director of Corporate Governance	Managers in Partnership trade union London Borough of Redbridge BMA	Member Spouse is an elected member and member of Health Scrutiny Committee and ONEL JHOSC Daughter is a student member

* Member of the Executive Leadership Team but not a Trust Board member
09.03.2023

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

Board of Directors (Part A)

Draft minutes of the meeting held on Thursday 12th January 2023.

Present:

Ann Beasley (AB)	Chair
Vik Sagar (VS)	Non-Executive Director
Sola Afuape (SA)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Charlotte Clark (CC)	Non-Executive Director
Doreen McCollin (DM)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Dr Billy Boland (BB)	Medical Director
Philip Murray (PM)	Director of Finance and Performance
Sharon Spain (SS)	Director of Nursing and Quality
Jennifer Allan (JeA)	Chief Operating Officer
Jenna Khalfan (JK) – Non - voting	Director of Communications and Stakeholder Engagement
Amy Scammell (AS) – Non-voting	Director of Strategy, Transformation and Commercial Development
Katherine Robinson (KR) – Non-voting	Director of People
David Lee (DL) – Non-voting	Director of Corporate Governance

Observing

Chris Lake	Board Development

In attendance:

Nicola Mladenovic	Deputy Director of Corporate Governance
Ian Garlington (IG)	Integrated Programme Director

Patient Story (item 23/1)

Jane Healey	Experience and Governance Lead

Apologies

Juliet Armstrong (JuA)	Non-Executive Director
Professor Deborah Bowman (DBo)	Vice Chair, SID and Non-Executive Director

Item		Action
23/1	**Patient Story** The Board heard from Kieran who was sharing his experience of Hume Ward. Kieran was supported by the Hume Ward staff and also Jane Healey, Experience and Governance Lead. Kieran reported that everyone is friendly and that he has been on the ward since February 2022 and prior to this he has been in prison. Kieran has joined various groups on the ward including art therapy and mentalization groups. He reported using the gym also. Previously he has had escorted ground leave and is now working towards unescorted leave. His aim is to be discharged into the community to live in supported housing and to work as a freelance Graphic Designer. He reports being able to practice his religion effectively in a safe manner and is visited regularly by the Iman. If he had to report anything negatively it would be the lack of male staff to undertake escorted ground leave and also a lack of staff to support visits or searches. The Board was interested to understand how Kieran felt about the ward move into a new building and to understand if he felt informed about the building delays.	

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

Item		Action
	Kieran reported being informed by ward staff, however he shared that the patients are reluctant to move to the new location but have heard that the new location will have improved facilities. Kieran reported that he is supported in being able to observe his religious beliefs and this also in turn supports his mental health. He has been able to receive religious books and other spiritual items to support him further. The Chaplaincy Team are able to support all religious beliefs within all the wards at the hospital. The Board heard that being supported by family and friends whilst in hospital is key and Kieran has reported being able to make contact with his own family members and also for them to come to see him. AB thanked Kieran for attending to provide his story and the Board wished him well for the rest of his recovery journey.	
23/2	**Apologies and welcome** Apologies were received.	
23/3	**Declarations of Interest** No new declarations were reported.	
23/4	**Chair's action** No Chair's action was taken.	
23/5	**Minutes of the last meeting** The minutes of the meeting held on 10th November 2022 were agreed as a correct record.	
23/6	**Action Tracker** The action tracker was noted. **Action Item 22/112 -** KR reported that the new People Committee structure will support the Staff Network chairs going forward. It is anticipated that the Equality Engagement Champions will support the Staff Network chairs. **Action** – People Committee to seek clarification on this and to report back in a few months to a future board. The Staff Networks will continue to report their annual presentations to the Committee and will be invited to join an Executive Advisory Committee to ensure their continued involvement whereby quarterly updates will also come to the People Committee.	**People Com'tee**
23/7	**Chair's report** AB thanked all staff for their dedication and commitment to their work. A review is being undertaken by Rt Hon Patricia Hewitt and this is being closely monitored by NHS Providers. A new Chair has been appointed for the ICS. The new post holder is awaiting confirmation by the Secretary of State and will be announced shortly. **The Board noted the Chair's report.**	
23/8	**Chief Executive's report**	

Item **Action**

VF highlighted the following points:

- The new hospital has now opened in December and all staff, patients and services have now moved into Trinity. Thanks are to be given to all Matrons and estates staff in making the move into services in a safe and managed way.
- There are other redevelopment projects taking place for Barnes Hospital and Richmond Royal.
- Service changes and transformation have taken place since the last board for Richmond Wellbeing Service, Coral Crisis Hub, Forensic Learning Disabilities ward, Corner House and Adult Community services for IAPT.
- The latest CQC inspection of services has confirmed that the Rehabilitation Services have been rated as Good across the board. This builds upon the work previously on Avalon Ward where this service was rated as Good at the end of the COVID pandemic.
- Demand pressures remain high especially within the clinical services and Length of Stay (LoS) is on average 44 days. Having this LoS puts pressure on the rest of the Trust.
- Services are continually being managed, especially during periods of industrial action at other trusts.
- To support patients and carers in managing the Cost of Living an Involvement workshop was held to develop ideas / support for those struggling with cost of living.
- To support staff in managing the Cost of Living a support package has been launched which includes individualised advice and support, alongside financial support such as hardship grants, subsidised meals and car parking.

To support staff further, staff accommodation was discussed to explore how this would help staff across south west London and whether this could help in a wider context system-wide. The Board heard that staff requiring accommodation have been identified as having 'key worker status' although this is means tested this will give them priority access to future accommodation.

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

23/9 Quality and Safety Assurance Committee chair's report

The Board received an update from CC in DBo's absence.

The following points were highlighted:

- Patient Survey, overall nationally the Trust was 25th out of 51. This is an increase by 4 points from last year. The weakest response was in relation to 'Responsive Care' and the Trust was 37th nationally. The Committee discussed implications and areas to receive focus with action plans being in place.
- The Committee was assured by the results of the annual review for Safer Staffing.
- Work has progressed in the review of the Q&P report priority metric standards. Proposals have been received to support realistic ambitions for improving performance and this will take into account the national perspective.
- The Committee remains informed of the clinical risk and demand for capacity, specifically intense demand for mental health services and national/local workforce pressures.
- Further work has progressed in the root cause analysis approach to performance improvement. It is anticipated that focussing on a few stuck KPIs will have a positive impact and will ultimately improve the financial position.

Item **Action**

- There is an improvement in the reporting of incidents of violence and aggression, however the number of reports has doubled compared to the previous year.

The Board:

1. **Noted the QSAC Chair's report**
2. **Endorsed the Safer Staffing Report**
3. **Received the minutes of the QSAC meetings held on 3rd October and 7th November 2022.**

23/10 Quality and Performance Report

JeA introduced the report and highlighted the following points:

- The report details a stable position however there continues to be a high level of acuity with constraints on capacity; in terms of funding and workforce.
- There is an improvement in the Patient Safety domain. However challenging areas remain for patient access and flow including HR; staff recruitment and retention.
- 52 week breaches in the ADHD service have started to come through. Unfortunately the service is not resourced for the level of current demand however mitigations are in place to manage the risk to best support the patient population.
- There are improvements in clinical quality. Progress is slow but there are early signs of impact from the HR improvement work.
- Moving forward the Q&P Report will be aligned further to support the four sub-committees and this will ensure the key areas are discussed in the relevant sub-committee.

The Board noted the Quality and Performance Report.

23/11 Workforce and OD Committee chair's report

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

- The Committee held a seminar in December and the People Plan was considered. The three priorities receiving attention are recruitment and retention, medical staffing and employment relation cases.
- Full assurance has been received in relation to the Nurse Validation Report. The Committee will continue to receive an annual update following this being reviewed by QSAC.
- Full assurance regarding the engagement approach for the Picker Staff Survey has been received and the comprehensive engagement across the Trust has built on the activities and learning from previous years.
- The Guardian Report is received routinely and the Committee heard that key areas relate to bullying and harassment and staff concerns with managers. The report details there are some staff groups who do not engage with the service and these were evident in previous Staff Survey results.
- Progress is being made in Making Life Better Together, this remains on target and actions are being completed to address risks identified in the BAF.

The Board considered the improvements that have been made since the Human Resources Team has changed. Staff have moved into their new roles and the joining of medical staffing within the team will bring further improvements.

Item		Action

The Board heard that the changes within the Human Resources Team are having a positive impact and this means that more new staff want to work at the Trust. However the current improvements need to continue as this is early in the embedding process. The work of MLBT is supporting the great work that is being undertaken co-productively.

The Board noted concerns and agreed to review the Human Resources position at the May Board. The Board is supportive of the financial investment in the service. **KR/SA**

The Board:

1) **noted the WODC chair's report**
2) **received the approved Committee minutes held on 27th September 2022**
3) **received the Committee's Annual Report**

23/12 Equality and Diversity Committee chair's report

The Board received the chair's report and AB updated on behalf of DM as AB chaired the meeting. The following were highlighted:

- The Committee received the Deaf Staff Network presentation. There appears to be an on-going problem in booking BSL interpreters by default. It appears that they are only booked when it is known that deaf staff are in attendance but they need to be booked all the time.
- The Equality Impact Assessment for the integrated programme was received and the learning from the Springfield Hospital development will be incorporated into the Tolworth Hospital Development.

The Board noted the report and received the approved committee minutes held on 20th October 2022.

23/13 Finance and Performance Committee chair's report

VS provided a verbal update and confirmed that the plan is to break even this year and the financial plan for next year will be challenging. It was heard that there are not as many recurring CIPs as would be preferred however some non-recurrent savings are being reclassified for vacancies that have not been filled. Three main areas for further work are agency costs, external beds and increasing productivity.

The Board noted the verbal FPC chair's report and received the minutes of 27th October and 28th November 2022 meetings.

23/14 Finance and Savings Reports (M08)

PM introduced the report and highlighted the following points:

- Recurrent savings are 30% and this is a 22% increase from the previous month. The assurance that has been received to deliver the savings has improved to 95% confidence, whereas at the equivalent point last year this was 72%.
- Cash being held is £15m more due to slippages in the capital programme and the purchase of the Ronald Gibson House. It is planned that this will be confirmed in Q4 and will close the gap. Other slippages in the Tolworth Hospital redevelopment will come through in 2023/24 and there are also some delays in the current main building redevelopment.

Item **Action**

- There are delays in invoices being received in the Trust, however the Finance Department are accruing for these.
- Agency Use is high. It is anticipated that this will be restricted to 3.7% for next year however this is currently half of the current use for this year. It is a national position to effectively manage agency staff.

23/15 L Estates Modernisation Committee chair's report

The Board received a verbal update from VS on behalf of JuA. Items raised include:

- The Trinity Building is now open, learning has been captured and will be reflected upon. Thanks are to be passed to the Estates Team and everyone else involved to ensure the moves took place safely.
- The People Readiness and Culture update is planned to come to a future Committee.
- Planning permission has been applied and confirmed for Tolworth Hospital. This is now subject to the approval of the full business case.
- Clinical transformation continues and the benefits continue to be tracked. This will be reported back to the Committee in May.
- Digital skills training continues to ensure staff are using technology in the most effective way.

IG reported that vacant possession of the Diamond Estate is taking place currently and will proceed over the next few weeks.

The Board noted the verbal Estates Modernisation Committee chair's report.

23/16 Notified questions from the public and staff

No questions were raised.

23/17 Any Other Business

VF congratulated Philip Murray, Director of Finance & Performance in being recently appointed to the post of Deputy Chief Executive.

23/18 Meeting Review

The Board reflected on the discussion around workforce. In the main this was helpful and supports other aspects in terms of managing the priorities and outcomes.

It was considered whether the Board meeting is accessible to members of the public as during COVID there were more attendees than have attended lately. Having the option of live streaming might support this further as this is adopted by local government however other NHS organisations do have a small attendance. It was reflected that the Tolworth meeting room was not conducive to support visibility however the type of rooms across the Trust are limited.

The order of having the Part A meeting after Part B means that fuller discussions are had in private and this may reduce the discussion in public. This is something to consider going forward.

The patient story update was considered and the Board agreed that having an MS Teams presentation to an in-person meeting was not effective however the Board was mindful that this took place due to the constraints in Kieron being able to leave

Item		Action
	Hume Ward to attend in person. It was agreed that SS would brief the ward team on some aspects of the presentation.	
23/19	**Next meeting** – The next Trust Board meeting in public will be held on Thursday 9th March 2023 at 1.30pm at Springfield Hospital	

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

ACTION TRACKER – for March 2023 Board

BOARD OF DIRECTORS (Part A)

2.5

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
DUE						
			Nothing due			
NOT DUE						
14/07/2022	22/72	**Diversity in Decision Making**	To establish an Executive Advisory Group to develop greater diversity in decision making, to be led by the Chief Executive over the next six months	**VF**	**11/05/2023**	To be completed at the end of Q4 (April 2023)
12/01/2023	23/6	**Action Tracker**	The new People Committee structure will support the Staff Network chairs going forward. It is anticipated that the Equality Engagement Champions will support the Staff Network chairs. People Committee to seek clarification on this and to report back to a future board.	**KR/People Committee**	**11/05/2023**	
12/01/2023	23/12	**Workforce & OD Committee**	An update on the Human Resources position including updates on plans implemented is to come to the May Board	**KR/ SA**	**11/05/2023**	
			COMPLETED AT LAST MEETING			
10/11/2022	22/112	**Equality and Diversity Committee chair's report**	Emdad Haque, the new Associate Director of EDI and KR to support the staff network chairs to manage pressures in undertaking their staff network chair role	**KR**	**Jan 2023**	

1

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

Chief Executive's Board report Part A

March 2023

making life better together

making life better together

Our Trust

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

Every week, I write to our staff with key messages and every two weeks I have an all staff Q&A. Alongside this I regularly informally visit our sites.

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

- Chief Executive update - January 6th
- Chief Executive update - January 13th
- Chief Executive update - January 20th
- Chief Executive update - January 27th
- Chief Executive update - February 3rd
- Chief Executive update - February 10th
- Chief Executive update -February 17th
- Chief Executive update - February 24th

Following our February Board Development Day, we made proposals to further enhance transparency and impact of public board meetings. We agreed that the Chairs and Executive Leads for each Board Committee will develop a new style of Committee Report to come to Board and there will be a greater use of Board time to focus on strategic and wicked issues, where the Board can add the most value.

making life better together

Demand and acuity

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

- Since the New Year, we have continued to see demand pressure across the Trust, particularly in our Urgent Care pathways. Patients are presenting to services in crisis with higher acuity of illness, and we are seeing longer lengths of stay in our acute wards.
- We are continuing to use high numbers of private beds, although we have a plan in place to bring usage down – we want our patients to be cared for as close as possible to their home, family and community, so we can most effectively support them.
- Through our service transformation work, we are working with colleagues to reduce length of stay, the need for avoidable crisis care and to enable people to stay well in the community:
  - The new Coral rapid access clinic has launched to support people in crisis. We are improving S136 pathways through our collaborative working with LAS and the Met Police, and developing the NHS111 Press 2 for mental health service. We are also working to reduce delays to transfers of care with our Local Authority colleagues
  - Service transformation across our teams is seeing enhanced offers that will support people to recover and live well in the community. The programmes aim to improve access and support crisis avoidance and recovery through more effective treatment pathways and additional new roles within our community teams.
- We have been working closely through our ICS to develop an insight informed campaign and training package to support under represented groups to access the right Mental Health support, including the crisis line.

making life better together

Service change and transformation

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

- **Adult Eating Disorders enhanced treatment team** Our adult eating disorders outpatient service is piloting a new team which offers intensive support and treatment to patients in their own homes or in the community. The new Enhanced Treatment Team (ETT) targets patients referred for an inpatient admission, offering intensive community support as an alternative. It also supports inpatient who are discharged home.
- **Community rehabilitation pilot in Kingston:** This pilot aims to support inpatients to rejoin the community through support and care from a specialist team. This 'supported living' pilot, run in collaboration with the SLP, also aims to reduce the length of inpatient stay for adult service users with severe and enduring mental health issues, many of whom will have spent years in inpatient wards. A team of experts, including community partner organisation Bridge 86, will support people in their rehabilitation in the community, based in two six-bedroom houses in Kingston.
- **Enhanced Crisis Support:** Our Coral Mental Health Crisis Hub has changed how it works by seeing patients at our Springfield site at booked appointments, 10am-10pm, seven days a week. The hub provides a single 24/7 point of access for local people in mental health crisis. These changes aim to make our service work more efficiently for our patients. Access to the service remains the same.

Upcoming

- **Corner House:** Corner House, our inpatient service for Deaf children and young people, is due to reopen at the start of April. This follows a review and remodel of the service to ensure it as accessible, responsive, flexible and high quality as possible. The review was carried out in partnership with families, carers, the wider national Deaf CAMHS community and adult Deaf services.
- **Forensic Intellectual Disabilities ward:** The Trust is working with the SLP to repurpose a space in the new Shaftesbury Building into a unit that will offer expert low secure care for forensic patients who have an intellectual disability, and who require specialist mental health care in a forensic setting. The aim will be to bring patients in placements all over the country closer to home or their community and improve length of stay.
- **NHS 111 Crisis Hub:** The Trust is working with the SLP to improve the care we offer to our most acutely unwell patients by developing a 111 crisis hub. This would see south Londoners accessing mental healthcare more easily using just one phone number - calling NHS 111 then pressing two to contact their local mental healthcare provider's crisis line. This work is ongoing.

making life better together

CQC inspection report: rehab units

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

Following a recent inspection, the CQC has rated our rehabilitation wards for working age adults as **Good** for Safe, Effective, Caring, Responsive and Well-led and **Good overall**. They found:

- Significant improvements at Burntwood Villa and improvements in all areas of concerns.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. Staff involved patients in care planning. Staff used kind words and tone when speaking with patients.
- The service provided a rehabilitation model, that staff understood, in line with the operational policy.
- The service had enough staff, who knew the patients and received appropriate training to keep them safe from avoidable harm. Staff assessed and managed risk and followed good practice with respect to safeguarding.
- The service was well-led and staff worked well together as a multidisciplinary team.
- The acuity of patients admitted to Burntwood Villa had reduced and the service was admitting patients in accordance with its inclusion and exclusion criteria.
- Staff planned and managed discharge well and had alternatives for people whose needs it could not meet.
- The ward environments were clean and well furnished.
- Staff developed care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice.
- Some improvements were identified: cleanliness of the medicines trolley and fridge, repetition of vital signs monitoring of patients with elevated NEWS, updating of risk assessments and fire drill procedure.

making life better together

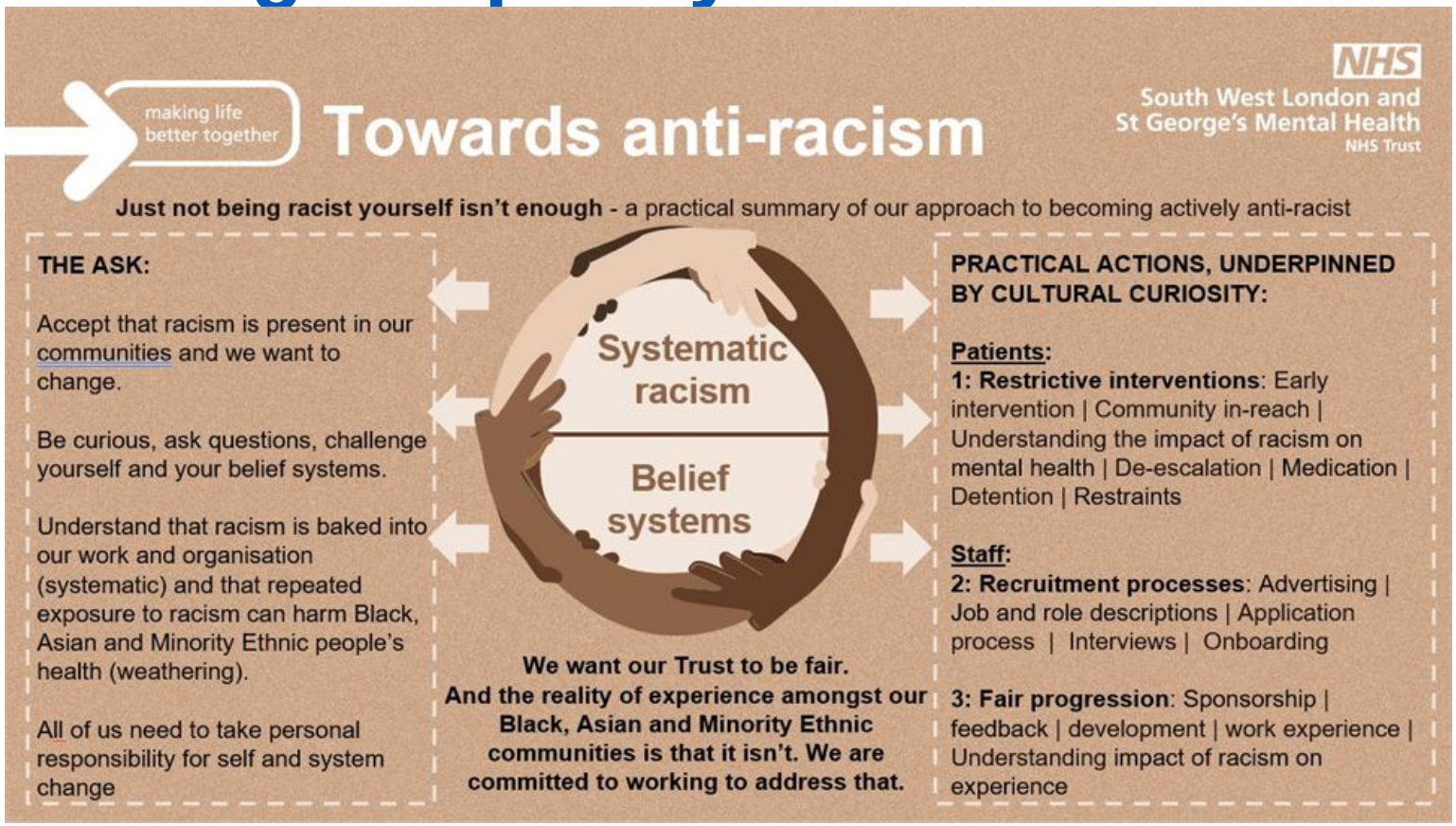
Developing our workforce

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

- Our workforce remains the most important part of us providing high quality care at SWLSTG – and this is our biggest challenge
- Increased demand, pressure in the system and internal change is impacting on the experience of both our patients and our colleagues, in terms of job satisfaction and joy at work and ultimately turnover is being affected
- With further ballots for strike action taking place in the NHS we are focussed on ensuring preparedness and use of business continuity plans. For us the first industrial action directly affecting us is the BMA Junior Doctors Strike – where no derogations will be agreed.
- **Recruitment:** like the NHS nationally, we are facing recruitment challenges. Following our focus on recruitment, our overall vacancy rate has reduced to 17.4% which is an improved position but more needs to be done. Our focus now is on supporting those teams and services with critical hard to recruit to posts. This is being driven by our workforce planning programme.
- Our focus now is turning to retention. Despite high recruitment levels, we are losing a similar number of existing employees. We have agreed a focussed piece of work on retention, understanding hotspots, improving stay and exit interviews and supporting managers in retaining staff.
- With this level of pressure on workforce, our leaders are key to helping support our colleagues and so a leadership framework is in development leading to an improved leadership offer for each level of leadership. This will be launched in April 2023.
- **Staff survey:** closed at the end of November 2023, we had a response rate of 52% - a reduction on last year. The full NHS Staff Survey Report Findings will be published in March 2023. We intend to maintain the same approach as last year, building on the three key areas for action as we recoginse the need for consistency and that culture change takes time

Active Anti-Racism and reducing inequality

- Our Anti-Racism steering group has developed a new active anti racism approach for the organisation
- This is being championed by Evolve and White Allies
- We have summarised this approach on one slide



making life better together

Cost of living support for patients and colleagues

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

Patients and carers

- The Director of Nursing and Head of Therapies and Involvement, continue to develop ideas and support for those patients struggling with cost of living. Including utilising the knowledge of local resources and sharing current resources and help within each borough on our website and our newsletters. Work is ongoing with the Recovery College to also offer more tailored support

Staff and colleagues

- Following the November 2022, launch of MLBT Cost of Living support package (including individualised advice and support, alongside financial support such as hardship grants, subsidised meals, car parking). The majority of people who have contacted the service, have been clinical staff
- Support has included general cost of living information and those who contact the service are offered a 1:1 conversation identifying specific cost of living support including: housing support, support around car parking charges and subsidised lunches
- We continue to promote this service with managers, alongside the more general cost of living resources on inSite.
- We are working with the Money and Pensions Advisory Service to develop a series of workshops for staff on debt, money and pensions.

making life better together

Recognising our monthly exceptional people

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

September 2022: Pamella Kangwa

- Interim Team Manager at North East Wandsworth Community Mental Health Team, been with the Trust for 8 years
- Nominated by her colleagues for her hard work and supporting her teammates
- Known for her strong leadership skills and as someone who always treats patient care as a priority.
- Her teammates have commented that they admire her compassion and excellent critical clinical thinking

October 2022: Claire Reid

- Lead Administrator in the National Deaf CAMHS Team, been with the Trust for 18 years
- Nominated by her colleagues for being someone who always goes above and beyond for the team
- Her teammates have said that Claire 'The Brain Trust' Reid is not only the memory bank of the service but part of the beating heart. She gives of herself selflessly

November 2022: Llewellyn Forde

- Been with the Trust for 17 years, and is working as a Staff Nurse in our forensic services
- Nominated by his colleagues for being a highly skilled nurse with the ability to de-escalate agitated service users effectively while maintaining a therapeutic rapport with all
- His teammates have been full of praise for him, both professionally and personally

December 2022: Vicki Voumvoulaki

- Information Services Team Leader, been with the Trust since 2018
- Nominated for her kind and supportive nature
- She has been described by colleagues as someone who is always there to support others no matter the issue, and as a key figure in the Trust's transition to a hybrid way of working

making life better together

Moves into Springfield

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

- Teams continue to move into Trinity with Wandsworth Outpatients moving in, in January and CAMHS outpatients moving in in March 2023.
- To support patients and carers to familiarise themselves with the new building, we have developed a guided video tour of the facilities that has been widely shared
- We expect formal handover of Shaftesbury in the spring. We will work with teams to develop move dates during the summer
- An operationally-led resilience group continues to review each move, each 'go' / 'no go' decision, and each post move review
- Our teams are starting to settle into their new surroundings, and we have been putting on 'neighborhood events' to support our new Trinity and Tolworth community. A Trinity leadership group has also been developed and is meeting regularly.
- Anecdotally, we are starting to see feedback that patient experience and quality of care is improving as a result of the new environment, we hope to see some of these improvements in the Quality and Performance report over the next few months.
- To highlight our new facilities, and transformed services, and to support our future transformation work, we have welcomed a series of visitors to Trinity, including National Medical Director, Professor Sir Stephen Powis, Chair of the NHS Confederation's Mental Health Network, Sean Duggan and Chair of Arts Council England, Nicholas Serota

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

www.swlstg-tr.nhs.uk

making life better together

Changes at Tolworth, Barnes and Richmond

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

- **Barnes and Richmond:** Teams at Barnes are preparing to relocate adult and young people's services to Livingstone house, in near-by Teddington. The Barnes site will then undergo a 15-month development which proposes that the current healthcare family replaces with a new mental healthcare facility, SEN school and residential housing
- Richmond Child and Adolescent Mental Health Services (CAMHS) will move to a newly refurbished facility at the former Richmond Royal site in autumn 2023. Adult outpatient services will relocate to Barnes Hospital once works are complete in the spring of 2024.
- **Tolworth:** Our plans for Tolworth Hospital received approval from Kingston Council Planning Committee and work to finalize our Financial Business Case for the development of a new five-ward facility at Tolworth continues. 170 corporate services teams also successfully moved to our newly refurbished corporate base at Tolworth over Nov and Dec 2022.
- These redevelopments will complete our vision for transformed environments across our estate, supporting equity of access for all SWL patients

making life better together

Horizon Scanning

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

- **National WRES published:** NHS England has published it's 2022 Workforce Race Equality Standard (WRES) report which offers a national picture of WRES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda

- **NHS England safe and wellbeing thematic review:** NHS England has published a thematic review and lessons learned from its national review to check the safety and wellbeing of all people with a learning disability and autistic people who are being cared for in a mental health inpatient setting.

- **Rapid review into mental health inpatient settings:** The Department of Health and Social Care (DHSC) has today published the terms of reference for the rapid review into data on mental health inpatient settings it announced last month. Our earlier press release responding to the announcement of the rapid review can be read here.

- **London Mental Health Compact:** A Compact between London's Mental Health and Acute Trusts, Local Authorities, CCGs, NHS England, NHS Improvement, Ambulance Service and London's Police services has also been published. This Compact is intended to establish a common understanding of what is expected from each part of the health and care system in providing access to mental health inpatient facilities, including Health-Based Places of Safety, for patients in mental health crisis.

making life better together

Suggested questions and points to have in mind

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

Questions

- For the 2022 Staff Survey, we are predicting that we will hold a stable position, given the scale of change the organisation was going through. What is our scale of ambition for next year? Are we happy with the consistent 3 action approach to gradual improvement?
- We have worked to develop our Corporate objectives for 2023/24 - is the scale of ambition right?
- The context in which we are working is complex and conflicting (agency reduction vs strike action / ICS delivery plans vs Tolworth business case / increased productivity vs staff morale). Is our current approach to system working effective for the mental health and wellbeing of the people in South West London

Key points to flag for future board discussion

- We are very thoughtful of the landscape around us. The NHS in a challenged position nationally, and across South West London. There is a focus on productivity and financial control, whilst also ensuring quality is maintained.
- The number of working age adults currently receiving care out of area does not align with our quality approach. An improvement trajectory has been set. However to achieve this in a sustained way, practice change and collaboration with stakeholders is required.
- Workforce remains our biggest risk to the quality of care and experience of staff. We are developing workforce plans throughout March, with actions plans in April. These will come to People Committee in April.

making life better together

Use of the Trust seal

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

Date	Type	Signatories
25.01.2023	Transfer Deed Between East London NHS Foundation Trust to SWLSTG, relating to transferring part of the premises of St Johns Health Centre, Oak Lane, Twickenham	Chief Executive Officer and Director of Nursing and Quality Standards
24.01.2023	Car Parking Lease Lease of some parking spaces in Car Park B – between SWLSTG and Greensleeves Homes Trust	Chief Executive Officer and Director of Nursing and Quality Standards
24.01.2023	Car Parking Lease Lease of underground parking at Shaftesbury Building, Springfield University Hospital Between SWLSTG, BDW Trading Ltd and Springfield Village Estate Ltd	Chief Executive Officer and Director of Nursing and Quality Standards
24.01.2023	Car Parking Lease Lease of underground parking at Shaftesbury Building, Springfield University Hospital Between SWLSTG, City & Country Springfield Ltd and Springfield Village Estate Ltd	Chief Executive Officer and Director of Nursing and Quality Standards
16.02.2023	Parking – Shaftesbury Lease Between SWLSTG and BDW Trading Ltd	Chief Executive Officer and Medical Director
16.02.2023	Title Transfer – Ronald Gibson House Between SWLSTG, BrendonCare Foundation and Springfield Village Estate Ltd	Chief Executive Officer and Medical Director

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

Meeting:	Trust Board
Date of meeting:	9th March 2023
Transparency:	Public
Committee Name	Quality & Safety Assurance Committee
Committee Chair and Executive Report	Deborah Bowman and Sharon Spain

BAF and Corporate Objective for which the committee is accountable:

QSAC has responsibility for the following BAF risks:

- A failure to effectively respond to equality and diversity issues facing the Trust
- A failure to meet the increasing demand on services relating to acute care pathways

QSAC is responsible for the following corporate objectives:

- Objective 1: To improve the quality of services through delivering a stepped change in fundamental standards of care and empowering service users and carers.
- Objective 3: To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences.

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

The following are three themes that informed and reflect the discussion at the February meeting of QSAC:

1. The relationship between workforce challenges and the quality and safety of care/the patient experience remains evident in many areas of QSAC's discussion. Close working between executive leads for quality and safety and HR and communication between the Chairs of QSAC and WFOD foster understanding and governance of this priority area. There are also resource and financial implications Board will wish to hold in mind.

2. QSAC continues to think about how to fulfil its terms of reference in relation to health inequalities and ensure it is embedded in our work following the expansion of its terms of reference. At the February meeting, we worked through several examples that helped elucidate our responsibilities when we discussed the restrictive practice annual report, and differential experiences in terms of the repetition of rights under the Mental Health Act. QSAC also considered the quality

of data we hold as part of patient experience information/reporting that might enrich our understanding and inform priorities in relation to health inequalities. Board may wish to explore how QSAC is fulfilling its terms of reference in relation to health inequalities and contributing to our organisational commitment to be an anti-racist organisation.

3. Demand, resource and capacity continue to be the biggest and most persistent challenge that QSAC considers and it imbues most of the papers/agenda items that are discussed, explicitly and implicitly. The February meeting was due to be the first opportunity for QSAC to do a deep dive into an important dimension of demand, resource and capacity challenges, namely waiting times which encompasses both quality/patient experience and questions of financial stability/sustainability as well as enabling functions such as digital capacity and operational processes. Unfortunately, the paper was not distributed in sufficient time for all members to be able to engage with the significant amount of work and analysis presented by the COO, and therefore we agreed to prioritise the discussion at our next meeting.

Areas of Risk Escalation to the Board:

- Specific risks relating to emergency response times which are being reviewed; see below. They perhaps suggest a wider contextual challenge about staff capacity and workforce challenges. The review of this specific risk is important with wider implications for patient care and our understanding of the challenges for our staff. It will be reported to QSAC.

- Ongoing attention to health inequalities is welcome. It does raise new questions for SWLSTG both in terms of specific experiences and disparities and in relation to effecting cultural change in practice in a way that is thoughtful, outcome-focused and sustainable. It is likely to be neither quick nor easy.

- The context within which we work is immensely difficult raising questions about increased risk, persistent 'wicked problems, the balancing of multiple demands and priorities and potential choices for Board; see below for further discussion in the Q&P item.

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

<u>Risk Register</u>

What: QSAC reviewed and discussed the risk register, noting new risks, including some relating to the new building, and closed risks and the draft internal audit report from the internal auditors which will be considered by the Audit Committee. The risk register demonstrates how risk is considered and mitigated at different levels within the Trust. QSAC continues to make suggestions regarding the analysis of the risk register as well as deepening understanding about specific risks that correlate with other sources of information e.g. response to emergencies. QSAC noted an ongoing discussion about smoking policy and practice which will return to the committee for further consideration. QSAC considered the relationship of the Executive risk register and the BAF, noting this will be developed further when there is capacity within the staff team.

So what: QSAC welcomed the assurance and feedback provided by the internal audit, recognising its importance especially in relation to process and effectiveness. There are several risks that speak directly to patient experience, safety and quality e.g. emergency responses and others raise wider questions about how the Trust enacts co-production e.g. the smoking policy.

What next? QSAC has requested further updates on specific work e.g. every emergency response is being reviewed by the Director of Nursing and the Deputy Director of Nursing and DNAs are to be addressed in 'real time', and the smoking policy/co-production approach. Those will be reported at future meetings.

Corporate Objectives

What: The Corporate Objectives report was reviewed. The committee noted amber progress in respect of the objectives for which it is responsible. The Director of Nursing advised the committee that she is confident that all quality objectives will be achieved by Quarter 4.

She reported that the auditor reviewed the Use of Restrictive Practices and Force within The Trust, providing positive. That feedback was considered by the Committee in the context of a later item – the annual report on the Use of Restrictive Practices and Force; see below.

So what: The committee reflected on the amber progress ratings in the context of demand, capacity limitations and challenge within SWLSTG, recognising that ambition and realism must be balanced as we approach the development of corporate objectives for the coming year.

What next? The Director of Nursing and Quality will continue to support the quality objectives through her leadership and programme of work according to the timeline she conveyed in the meeting.

One member of the committee made a wider point about the overall Amber status of progress and questioned whether the ambition of the objectives was appropriately pitched. She agreed to raise that question at Board.

Quality Matters

What: The Committee noted good progress in respect of unmanaged incidents which is attributed to changes in the Patient Incident Safety Framework. Response times to complaints are improving (see below) but remain an area of challenge following staff changes within the team. QSAC was advised of work to enhance performance. The Committee noted differential experiences for patients of racialised minorities in the re-reading of s 132 rights and discussed this point.

So What: Quality Matters is an essential document that provides triangulation, prompts consideration of the relationship between strategic aims and operational practice and reflects the 'Ward to Board' understanding of quality, safety and the patient experience. QSAC noted the coherence with the Risk Register (see above) regarding emergency responses and their significance.

The discussion regarding ethnic differences and the re-reading of s.132 rights speaks directly to QSAC's responsibility for health inequalities and our commitment to being an anti-racist organisation. QSAC recognises that this is a complex process in which understanding our data and being honest about painful disparities are the first steps in effecting change. It takes assurance from the openness demonstrated by Executive colleagues in the discussion.

What next? QSAC understands the specific actions that are being taken in respect of the areas that prompted most discussion i.e. the review of emergency responses.' QSAC welcomed a proposal to review section 132 rights through the lens of ethnicity.

Complaints & Patient Experience Reporting

What: The committee heard that there has been a reduction in both complaints and compliments received by the Trust. After a period of challenge in relation to response times, there is evidence of improvement e.g. 95% of complaints are answered within 3 days, and 85% receive a response within 25 days. QSAC noted the impact of complex complaints on timeliness. Most complaints are about communication and access to treatment, and there has been an increase in complaints about waiting times. Feedback Live, which has been a long-standing challenge in terms of engagement and response rates, has been reviewed.

So What: QSAC recognises the balance between a compassionate, accurate and thorough response and a timely reply. QSAC welcomes the way in which the Complaints Review Group takes a co-produced approach to considering responses.

QSAC welcomed the review of Feedback Live. There remain challenges with decreasing responses and work to do in terms of meeting the needs of some of our patients and familied e.g. those with learning disabilities, who speak a language other than English and who are Deaf/deaf. QSAC was interested in the recording of data about ethnicity and how that might deepen our understanding of difference and potentially health inequalities.

What Next? Complaint themes will continue to be embedded into organisational learning with the aim of improving the patient experience. The work proposed in terms of Feedback Live will be progressed and reported to QSAC.

Annual Community Patient Survey

What? QSAC received a presentation about the Annual Community Patient Survey, noting areas of progress e.g. wellbeing and support, CPA and medication reviews, specific areas for improvements e.g. crisis care, and a decline in overall performance (dropping from 13 to 22 nationally). QSAC noted the action plan from 2021/22 and was advised that outstanding actions will be carried over to 2022/23.

So What: QSAC noted that recruiting a new employment specialist was reflected in positive feedback and performance relating to wellbeing and support demonstrating that a focused approach is valuable in effecting progress.

QSAC queried the action plan from 2021/2022 and observed that there could be more analysis, focus and reflection in the way in which the survey results were received,

drawn on to develop an effective and targeted action plan and linked to other sources of data/Trust priorities e.g. community transformation. QSAC made recommendations regarding the future analysis, development and presentation of the survey seeking more coherence with the results, action plans, other data sources and strategic priorities.

What next? The lead for the survey has been asked to reflect on the feedback provided and the discussion at QSAC, working with the Director of Nursing and Quality. Specific work on the themes arising from the survey and the consolidation of action plans will also follow.

Mortality Review, Including Suicide Prevention Review

What? The Committee heard that the number of suspected suicides has reduced. However, it is too early to see if there is an overall reduction given the data from Q1 & Q2. There are questions that arise in respect of ethnicity, suicide and mortality, noting too data on differences in life-expectancy that reflect health inequalities.

So What: Questions regarding our understanding of, and response to, differences by ethnicity and wider health inequalities e.g. those with learning disabilities formed a key element in the discussion of this item reflecting both QSAC's responsibilities and the Trust's commitments/corporate objectives on lost years for those who live with mental illness. Deepening our insight into differences and ensuring we remain focused on this most important area of our work are priorities for QSAC and the Board.

What Next? Ways of understanding health inequalities in respect of ethnicity are being developed and the questions regarding those who have learning disabilities will be followed up. Each will be presented at future QSAC meetings when the report returns as an agenda item.

Restrictive Practice

What: The Committee received the Restrictive Practice paper and welcomed the inclusion of ethnicity data which show that rates of seclusion and restraint are higher in those patients from racialised minorities. The work of EMHIP was discussed in relation to plans to address the differential experiences and inequalities shown within the report.

So what: Understanding where we are is the first and important step in making progress with our Safety in Motion programme and our commitment to reducing health inequalities in experience and outcomes. QSAC commends colleagues on the work they have done to help us in understanding our position more accurately.

QSAC heard about the organisational thought required to engage staff in the data presented, particularly about health inequalities, and the ways in which to effect meaningful change. Other aspects of potential health inequalities were discussed e.g. the experience of people with autism and disabilities, visible and invisible. The committee welcomed the open and considered approach by Executive colleagues and looks forward to the development of this important area of our work.

What Next? Further work on communicating and responding to the data presented in, and questions raised by, this report will follow within the Trust and in collaboration with colleagues as part of the EMHIP programme, particularly focused on ethnic difference and other potential inequalities.

Executive colleagues will propose ways in which health inequalities can be embedded consistently and effectively into the presentation and discussion of papers to QSAC.

Quality and Performance Report

What: QSAC received the report and discussed priorities arising, noting especially the ongoing and increasing tensions created by increased demand, limited capacity and constrained resources. Points of specific and ongoing quality and safety challenges relating to HR e.g. Mandatory and Statutory Training were noted.

So What: The context within which patient care is provided will continue to be difficult and there are further exacerbating factors to consider e.g. industrial action and its impact. QSAC welcomes the commitment of the team to take a different approach to understanding and responding to 'wicked problems' e.g. waiting times.
From a Board perspective, the fundamental questions relate to:

- our collective understanding of the risks presented by the context in which we are working;
- what choices we might make to mitigate those risks and develop a shared understanding of the care we provide;
- how quality and safety are understood alongside other commitments e.g. financial and workforce; and
- what facilitators and barriers exist to support progress with our most challenging problems, both organisational and systemic.

What next? A deep dive into waiting times and interdependencies will be reported to the Committee in March.

QSAC will continue to identify how performance both in specific areas and overall in the wider context are being reported, and to consider the implications of the same for the Board.

Appendices
Minutes of the January '23 meeting

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

Quality and Safety Assurance Committee (Part A)

Final Minutes of the MS Teams meeting held on Monday 5th January 2023

Present:

Professor Deborah Bowman (DBo)	Committee Chair – Non-Executive Director
Prof Charlotte Clarke	Non-Executive Director
Billy Boland (BB)	Medical Director
Jennifer Allan (JeA)	Chief Operating Officer
David Lee (DL)	Corporate Governance Director
Sharon Spain (SS)	Director of Nursing & Quality
Doreen McCollin (DM)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Valerie Chin Yu (VCY)	Lead Quality Manager - NHS South-West London Integrated Care Board

Attendees:

Carol Anne Brennan (CAB)	Lived Experience Representative
David Hobbs (DH)	Lived Experience Representative
Sofia Hussain (SH)	Lived Experience Representative
Jaydene Campbell (JC	Lived Experience Representative
Frankie Campbell (FC)	Head of Safeguarding (Children)
Ryan Taylor (RT)	Associate Director of Clinical Governance & Risk
Emdad Haque (EHa)	Associate Director of EDI
Elaine Holder (EH)	Committee Governance Manager (Minutes)
Seema Shah (SS)	Deputy Chief Pharmacist
Tara Osbourne-Wallace (TOW)	Safeguarding Adults & Prevent Lead

Apologies:

Vanessa Ford	Chief Executive Officer
Ijeoma Ndubuisi (IN)	Clinical Team Manager, DIDMR

Item

A23/1 **Apologies**

Apologies were noted.

A23/2 **Declarations of Interest**

No new declarations of interest were reported.

A23/3 **Chair's Action**

Chair advised the meeting that Ann Beasley (Chair) will no longer be attending QSAC meetings due to her no longer working on Mondays. Ann, as Trust Chair, will review the papers and send comments to the Chair who will brief her after the meetings.

A23/4 **Minutes of the last meeting -** Minutes of the last meeting were agreed as a true record

A23/5 **Action Tracker**

The action tracker was received, and all outstanding actions have been complete and closed.

A23/6 **Risk Register**

The Committee received and noted the minutes.

RT highlighted the following:

- QGG have gone back to 2 meetings a month.
- In December ELT reviewed the BAF where risks are linked with follow up actions that are being worked through
- No changes on the Executive Risk Register
- There was a conversation on whether the BAF and Executive Risk Register should be handled via Ulysses which will be revisited in a few weeks
- ELT noted all actions were completed so the way these are worked through has been changed so none are missed.
- ELT also asked RT to see if there are any implications from the staff survey which may need to go on the risk register.
- Incident management performance will now be reflected on service line risk register
- RF will highlight the use of Ulysses for the BAF and Risk Register at the next Audit Committee meeting.
- RF also questioned the deterioration of culture on Aquarius Ward.
- RT explained that the issues have been worked through for a while.
- SS informed the meeting that the report is retrospective and that there has been a change in Leadership which happened in the last 6-8 weeks. Aquarius Ward is in a much better place and the improvement plan has led to progress. Safeguarding issues are being appropriately addressed.
- DH asked if risks that are flagged by the internal audit are automatically put on the risk register.
- RF informed all internal risks go to Audit Committee and then on to other Committees if necessary.
- CC asked about the new risk regarding Richmond staff shortages and reassurance for the plan.
- RT informed the meeting that this was an issue at QGG who have asked for this to be followed up. RT to follow up with the service.
- **Action RT**
- BB informed the meeting that that ELT intend to refresh rework the workforce plan for the whole of the organisation which will be led by an Executive Director alongside the service lines.
- JC asked if the workforce plan will address why there is constant staff shortage with regards to the 'what and why' and any emerging trends.
- SS informed this is part of workforce plan and workforce planning will look at retention and new roles. This will include developing people and looking after the Trust's workforce.
- BB informed the meeting that the Trust is looking at new ways of working with the Community in SW London through EMHIP and the Wandsworth Community Engagement Network to include family therapy training. The Trust is also engaging with the Wandsworth Community Empowerment Network for people with lived experience to work with the Trust which will include new recruitment practices.

A23/7 **LDA Forensic Unit**

Committee accepted and noted the report.
SS highlighted the following:

- ELT has approved the business case to support the repurposing of the current 18 bed Turner Ward Medium Secure Unit (MSU) in to a new 12 bed Learning Disability with/without Autism (LDA) Low Secure Unit (LSU) in SWLSTG as part of the new LDA secure pathway being proposed by South London Partners (SLP).
- This will allow for a reduction in out-of-area placements by allowing the repatriation of patients, thus bringing patients closer to home and allowing a full pathway approach to be undertaken that will facilitate eventual discharge into the community via quicker more progressive moves out of hospital and reduce the likelihood of failed discharges/readmissions.
- The Business Case has been through BCAG, Portfolio Board, SMP and ELT as well as the CQC.
- This part of SLP strategic programme and there is opportunity for this nationally.
- The Unit is filling a gap which will mean patients can be treated locally.
- There may be workforce challenges but there may also be the opportunity for staff to be upskilled.

A23/8 **Medicines Optimisation Annual Report**

The Committee noted and accepted the report.
SS highlighted the following:

- There are currently two executive risks on the Trust risk register related to staff not following Medicines Health and regulatory patient safety alerts (valproate in women of childbearing age and the PREVENT program) (Score 12 Moderate – no change) and prescriptions for patients on clozapine being expired and not renewed leading to patients not receiving their medicines in a timely manner which could result in relapse (Score 9 Moderate – reduced).
- The report has identified one external delay related to the delivery of the upgrade to EPMA. A further delay has been identified on delivery of the medicine's safety dashboard due to lack of support from the app development team.
- Pharmacy have submitted requirements for Year 3 of community transformation to be included in the Trust bid however there is a risk that there will not be sufficient funding to support sufficient pharmacy staff in the 2 additional boroughs, Merton and Wandsworth.
- Deliverables for the year are on target.
- Pharmacy continues to oversee the Trust Electronic Prescribing and Medicines Administration (EPMA) system and have initiated a project to update to Version 8.2 – this should have been completed last year; however, the supplier has delayed the upgrade with no timeline for the upgrade.
- The quarterly controlled drugs audits have provided good assurance with the required standards, although there were some outliers that require improvement.
- The Trust is underspent on medicines against budget at year to date. Pharmacy have implemented several medicines optimisation workstreams to ensure cost effective use of medicines.
- There has been a successful move of the Pharmacy to Trinity.

- SS questioned the key challenge in respect of the lack of pharmacy post in the Community to ensure the safety of medicines.
- SS informed the meeting that this was due to lack of funding and is now only affecting 2 boroughs.

A23/9 **Safeguarding – Children**

The Committee accepted and noted the report.

TOW presented the PowerPoint presentation which was circulated:

- DH pointed out that Sutton Uplift have double the number than Wandsworth and asked if this can be looked into.
- TOW pointed out some staff may not be clear about what constitutes a safeguarding concern and informed the meeting that she is currently writing guidance for staff and that Sutton Uplift report quite a lot of historic abuse that may need to be recorded differently.

A23/10 **Safeguarding – Children**

The Committee accepted and noted the report.

FC highlighted the following:

- Safeguarding Children is one of the 11 Fundamental Standards of Care.
- There have been free training sessions for Children's sexual abuse for Trust staff
- Reports are now being broken down by ethnicity.
- The Trust is increasing DBS compliance.
- The Trust is sharing knowledge regarding intra-familial and inter-generation child sexual abuse.
- There has been an increase in Serious incidents s affecting children.
- Incident reporting and domestic abuse remains high.
- CC asked how long a member of staff can work without an up-to-date DBS check.
- FC informed the meeting that there is a clear policy where staff receive reminders and if they fail to respond this is escalated to SS and Safeguarding Lead.

A23/11 **Quality and Performance Report**

The Committee accepted and noted the report.

JeA highlighted the following:

- November/December and January is always a time of high pressure in the NHS also taking into consideration November and the industrial action.
- There is continued high pressure and demand which is being addressed through the Trusts Performance framework.
- There is pressure on the waiting times for ADHT services and there have been several breaches which will continue.
- IAAT has the same challenges.
- A focused report will come to QSAC in February regarding referrals and waiting list management .
- The CQC report for rehabilitation services and the safe move to Trinity should be noted as achievements.
- The Trust is in a difficult position with regard to medical staffing.
- There are wider workforce challenges.
- DH asked if the staff are consulted prior to Community Transformation changes and was concerned staff may be leaving as a result.
- JeA was not aware of any staff leaving and DH will follow up with JeA.

A23/12 **Quality Governance Group minutes**
The Committee received and noted the minutes.

A23/13 **Ethics Committee minutes**
The Committee received and noted the minutes
Chair will email an observation on the wording for review.

A23/14 **Matters for Escalation to the Board**
None raised by members and Chair will consider as she develops her next report.

A23/15 **Committee Workplan**
The Committee noted the Committee work plan. .

A23/16 **Meeting Review**

- It was requested that documents added in the meeting chat be circulated after each meeting **Action EH**
- DM questioned how Diversity and Inclusion issues will be reviewed in the reports & reports as well as connected to the Board's work.
- The Chair informed the meeting that she will be discussing that important question in a meeting with EHa, BB and SS and will feed back in due course.

A23/17 **Any Other Business – None**

A23/18 **Next Meeting**
The next meeting is on Monday, 6th February 2023 at 13:30 via MS Teams.

Trust

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

Quality and Performance Report

January 2023

Glossary

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

Contents

Part A: Executive Summary

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.

ELT has reviewed the report and the overall performance position is stable. The key issues identified are the high use of out of area beds and the under performance against MAST standards, with plans to address this in place for both areas, with improvement anticipated over the next 2-3 months.

The start of the year has seen a continuation of pressures across the system with high demand and staffing pressures across acute and local authority partners presenting a challenging context to deliver timely care. To date, while industrial action in the NHS has not had a direct impact to the Trust, we have continued our actions to support staff and patients who have experienced disruption in other sectors. The BMA's announcement of planned action by junior doctors in March will affect our services and we are now coordinating our plans to preserve service provision.

Pressures on adult acute beds have been significant and the number of patients in external beds has grown. This poses a significant financial pressure and can lead to a poor experience for service users and carers. Reducing the number of patients in out of area beds is a Trust priority and we are working towards a trajectory to eliminate their usage by 1 April. With continued high demand across the crisis pathway there is a balance of risk to consider which we will address with our senior clinical leaders. We are engaged in the 100 day discharge challenge set out by NHS England and working closely with partners in the ICB and social care to reduce the number of patients who remain in a MH bed while clinically ready for discharge.

We are progressing transformation programmes in Adult Community, Acute & Urgent care, and CAMHS Community. We continue to strive to embed co-production at all levels, ensure interdependencies across service lines are clearly addressed and outcomes well understood. We are exploring the most effective organisational development support we can offer to help teams embrace new ways of working at a time of continued busy operational demands and staffing constraints. The move of remaining clinical services into Trinity was completed in January with the re-location of adult outpatients.

There are improvements seen in a number of our quality of care indicators through the Fundamental Standards of Care programme, including better completion of risk assessments. The ongoing focus on this programme will be sustained as it is acknowledged that new ways of working take time to embed.

The focus of this report is January 2023 and our priority metrics to ensure patient safety and effective care, along with our integrated approach to quality, workforce and overall productivity and sustainability. This is supported by detailed executive review and discussion at the bi-monthly Service Line Review (SLR) meetings, which focus on key issues, actions and accountability to address these. Our operational performance sub-groups across Flow and Access support more detailed work to address the Trust risks relating to treatment waiting times such as process standardisation in waiting list management and lowering length of stay across inpatient areas and community caseloads.

The following areas of challenge and improvement in relation to priority performance metrics are noted in January 2023.

Clinical Quality Update:

- The CQC formally published their inspection report of Rehab services for Burntwood Villas and Phoenix ward in January 2023, which saw these services being re-rated as good in all domains. The Report highlighted the sustained improvements in clinical care and leadership.
- The report continues to see steady improvement in the Fundamental Standards of Care, although further work is being undertaken for the recording of therapeutic observations.
- A focused piece of work on Discharge Summaries has commenced, the guidance has been re issued across the clinical services which includes the automatic submission of the Discharge Summary to the GP via DocMan Connect in RiO.

Workforce Update:

- The level of vacancies have reduced, and work to ensure that proactive recruitment initiatives are in place to continue to fill vacant posts**.**
- Work continues to improve the MAST compliance rates as this area concern and focus and a paper on key next steps necessary is due for ELT w/c 6th March 2023. The Director of People & Director of Nursing with Service Lines are to develop improvement plans especially in relation to ABLS and PPI as these are directly related to patient safety.

Access Update:

- Adult ADHD/ASD services face significant demand and capacity pressures and long waits for this service continue to increase. There is regular scrutiny of the position and ongoing work to optimise capacity, while a clinically led proposal to commissioners will be submitted in March outlining the options to bridge the gap through either returning medical review work to primary care or limiting assessment capacity to match resources.
- The Trust incurred (59) 52 week breaches in January 2023 - (57) in the Adult ADHD service and (2) in Wandsworth Complex Needs (CNS). Longest waits are subject to weekly scrutiny and are also reviewed at monthly Access Meeting. ADHD cases are deemed to be of low risk but if there are other risk factors to consider this would be managed via the SPA's at point of referral.

- All four IAPT services are below their cumulative access requirements. The volume of waits over 30 weeks continues to rise as Step 3 vacancies continue; this is a challenge for IAPT services nationally. Internal modelling, benchmarking and national modelling tools all indicate services are under-established for the current IAPT access rates, despite internal efficiencies being delivered. Review of the resourcing position for 2023/24 against increased access requirements is under way.
- Work to address internal waits over 30 weeks is on-going. There is a new internal referral process to be piloted to ensure robust transfer of patients between and within teams and the standardisation of P&P pathways work also continues.
- Positive signs of reducing waits in Sutton adult community services have been seen following transformation, including reduced waits for assessment. We will continue to monitor the transformation programme outcomes at Place level as changes bed in.

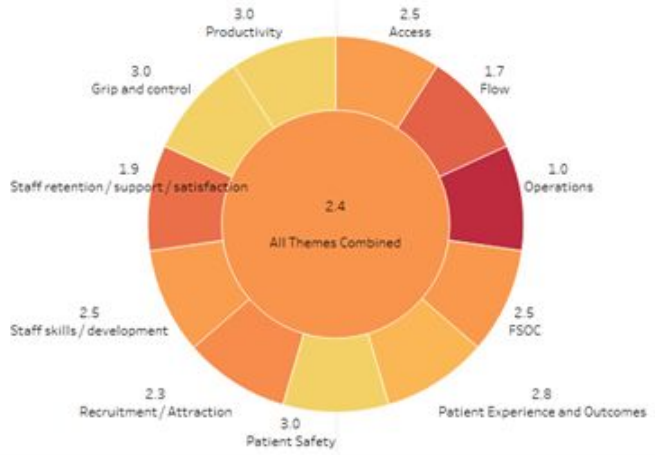
Flow, Patient Safety & Productivity Update:

- Crisis and acute inpatient services remain in a challenging position, with the need to balance demand, waiting times in crisis, and bed capacity. The Trust keeps patients in SWL wherever possible through block contracts for private acute and step-down hostel beds, the latter of which have been expanded in partnership with adult social care as a short term measure for winter. Further support to the pathway has been provided through a second tranche of ICS winter discharge funding.
- Improving LOS is a key priority for the acute service transformation programme, as the Trust benchmarks high compared to other London MH trusts following increase in LOS over the last year. There are high levels of delayed transfers of care, reflecting in part constraints in the wider system, with active exec escalation weekly. The transformation programme has been refreshed and relaunched and workstreams are now in progress to address crisis, inpatient improvements, and the national MH discharge challenge 10 key areas.
- Liaison services seeing patients in Emergency Departments within 1hr remains a concern; as do 12hr breaches in Emergency Depts, which attract significant system-wide attention. Services are looking at reshaping existing establishment. Winter funding has been allocated to additional Triage resources for the liaison teams with additional shifts now in place in all three Emergency Departments. Liaison and crisis services continue to support acute Trusts during LAS industrial action.

We are seeing indicators moving in the right direction in a number of areas, but the challenges of meeting significant increased demand and acuity in all services mean that improvement is slow. While progressing our transformation work in HR, Quality and Clinical services, we are also mindful of how to use digital workflows and best practice processes to support delivering sustainably excellent services in the future. Overall the Trust position is amber (see summary below) and the executive and Service Line leadership teams continue to work together to address our quality and performance challenges.

The Trust submitted a revised financial plan in June which showed a position of break-even for the year. To achieve this, the Trust needs to deliver a savings target of £12.4m. At Month 10, the Trust remains on its target trajectory and has delivered £11.2m of cumulative savings. Year to date 30% of savings are recurrent and this remains the area of concern as we move to year-end and plan for 2023/24.

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



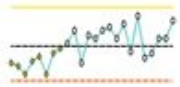
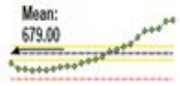
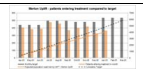
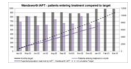
Summary Domain Performance:

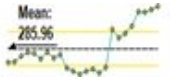
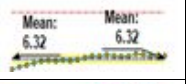
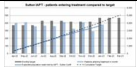
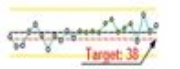
Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	3	12	18	45.5%
Quality	6	12	10	64.3%
Workforce	2	3	7	41.7%
Finance	0	3	0	100.0%
Total	**11**	**30**	**35**	**53.9%**

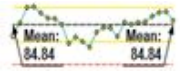
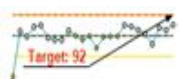
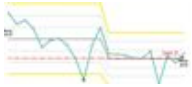
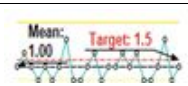
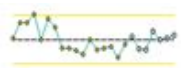
A table showing how many KPIs have full assurance, some assurance and no assurance, split by domain.

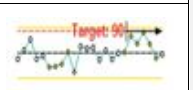
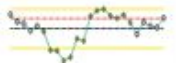
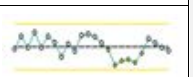
Donut Performance over-time (all themes combined):

Priority Metrics

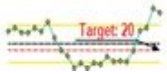
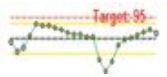
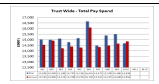
	Priority Metrics	Jan-23	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 9)	66.7	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 10)	37	= 0	→	✗	
	Access					
	No one is waiting more than 30 weeks for treatment - Number of breaches (including CAMHS Neuro, IAPT & Non-RTT teams) (see page 11)	1556	0	↗	✗	
	Access					
	Adult and Older People's CMHTs - Non-Urgent Referrals assessed within 28 days (%) (see page 13)	80.6	≥ 80.0	→	?	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 14)	42.9	≥ 95.0	↗	?	
	Access					
	Expected population need IAPT – Merton Uplift (see page 13)	4004	4794	-	-	
	Access					
	Expected population need IAPT – Richmond (page 13)	3841	4186	-	-	
	Access					
	Expected population need IAPT – Talk Wandsworth (see page13)	6917	8828	-	-	
	Access					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 16)	216	= 0	↗	✗	
	Flow					
	Time on caseload (days) (see page 15)	436.6	-	↘	-	
	Flow					

	Priority Metrics	Jan-23	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (see page 9)	78.1	≥ 95.0	↘	✗	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 10)	78.9	≥ 92.0	↘	✗	
	Access					
	Referral to treatment (RTT): 52 week breaches (see page 12)	59	= 0	↗	✗	
	Access					
	Internal waits for treatment of over 30 weeks (see page 12)	449	-	→	-	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 14)	6.6	≥ 10.0	↗	✗	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 15)	70.9	≥ 80.0	↘	?	
	Access					
	Expected population need IAPT Sutton Uplift (see page 13)	3711	4130	-	-	
	Access					
	Adult acute average length of stay (Excluding PICU) (see page 16)	49.3	≤ 38	↗	?	
	Flow					
	Delayed transfers of care (%) (see page17)	7.5	≤ 2.5	↗	✗	
	Flow					
	Data quality maturity index (DQMI) (%) (see page 17)	98	≥ 95.0	→	✓	
	Operations					

	Priority Metrics	Jan-23	Target	Trend	Assurance*	SPC Chart
Quality	Community risk assessments reviewed within the last 12 months (%) (see page 18)	91.7	≥ 95.0	↘	✗	
	Fundamental Standards of Care					
	Physical Health Assessment attempted within 48 hours of admission (%) (see page 19)	95.1	≥ 95.0	→	?	
	Fundamental Standards of Care					
	Cardiometabolic Assessments - Community and EIS (%) (see page 20)	85.9	≥ 75.0	↗	✓	
	Fundamental Standards of Care					
	Safe Staffing: requirements inc obs levels (see page 21)	82.9	-	→	-	
	Fundamental Standards of Care					
	Always Ready Audits Completed (%) (see page 21)	79.3	≥ 90.0	→	✗	
	Fundamental Standards of Care					
	Patient Friends and Family Test (%) (see page 23)	87	≥ 92.0	→	✗	
	Patient Experience and Outcomes					
	IAPT recovery rate - Merton Uplift (%) (see page 24)	45.2	≥ 52.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate – Richmond IAPT (%) (see page 24)	51.1	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	Patient Safety Incidents – Severe Harm (see page 25)	1	≤ 1.5	→	?	
	Patient Safety					
	Reducing restrictive practices – Prone Restraint (see page 26)	42	-	→	-	
	Patient Safety					
	Inpatient discharge letters sent within 24 hours (%) (see page 27)	74.6	≥ 90.0	↘	✗	
	Patient Safety					

	Priority Metrics	Jan-23	Target	Trend	Assurance*	SPC Chart
Quality	Inpatient Risk assessments completed within 48 hours of admission (%) (see page 18)	92.3	≥ 95.0	→	✗	
	Fundamental Standards of Care					
	Physical Health Assessment completed within 7 days of admission (%) (see page 19)	79.7	≥ 90.0	↗	✗	
	Fundamental Standards of Care					
	Safe Staffing: National Compliance - Inpatients (%) (see page 20)	129.5	≥ 95.0	→	✓	
	Fundamental Standards of Care					
	Always Ready Audit Compliance (%) (see page 22)	88.5	≥ 90.0	↘	✗	
	Fundamental Standards of Care					
	Complaints Answered Within 25 Days (%) (see page 22)	85.7	≥ 85.0	↗	?	
	Patient Experience and Outcomes					
	Emergency readmission within 30 days - Adult Acute & PICU (%) (see page 23)	7.5	≤ 8.5	→	✓	
	Patient Experience and Outcomes					
	IAPT recovery rate - Sutton Uplift (%) (see page 24)	46.6	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate - Talk Wandsworth (%) (see page 24)	51	≥ 50.0	→	✓	
	Patient Experience and Outcomes					
	Total number of restraints (physical restraints and rapid tranquilisation) (see page 26)	120	-	↘	-	
	Patient Safety					
	Death - Suspected suicide (see page 27)	5	-	→	-	
	Patient Safety					
	Follow up within 72 hours of discharge from inpatient services (%) (see page 28)	86	≥ 80.0	→	?	
	Patient Safety					

	Priority Metrics	Jan-23	Target	Trend	Assurance*	SPC Chart
Workforce	Vacancy Rate (%) (see page 29)	17.1	≤ 15	↘	✗	
	Recruitment/ Attraction					
	Time to Recruit (days) (see page 30)	45.7	≤ 49	↗	?	
	Recruitment/ Attraction					
	Temporary staffing - Acute and Urgent Care Service Line (%) (see page 31)	33.5	≤ 22	↗	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 1 (%) (see page 33)	91.2	≥ 95.0	↘	✗	
	Staff Skills/Development					
	Turnover (%) (see page 34)	18.4	≤ 15	↗	✗	
	Staff Retention/ Support / Satisfaction					
	Supervision (%) (see page 35)	83.3	≥ 85.0	→	?	
	Staff Retention/ Support / Satisfaction					
	Active ER cases (see page 36)	59	TBA	→	-	
	Staff Retention/ Support / Satisfaction					
	Staff FFT (recommend treatment) (%) (see page 37)	-	≥ 75.0	-	-	
	Staff Retention/ Support / Satisfaction					
Finance	% Forecast budget overspend (see page 38 (see)	0	≤ 0	→	?	
	Grip & Control					
	Cumulative CIP Delivery £000 (see page 39)	11,174	10,323	-	-	
	Grip & Control					
	Activity Vs WTE (see page 40)	11.7	-	→	-	
	Productivity					

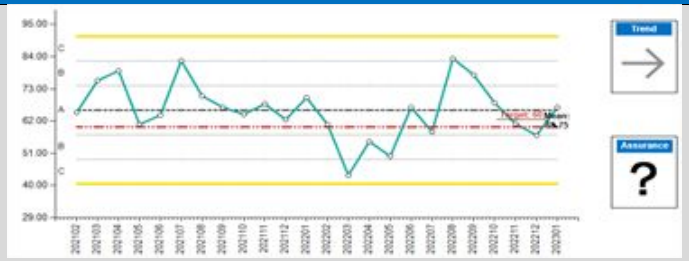
	Priority Metrics	Jan-23	Target	Trend	Assurance*	SPC Chart
Workforce	Vacancies in active recruitment (%) (see page 30)	60.3	≥ 90.0	↘	✗	
	Recruitment/ Attraction					
	Percentage of BAME staff - Band 8+ and Medical (see page 31)	31.5	≥ 50.0	↗	✗	
	Recruitment/ Attraction					
	Temporary staffing - Community Service Line (%) (see page 32)	20.2	≤ 22	↗	✓	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 2 (%) (see page 33)	85.9	≥ 85.0	↘	✓	
	Staff Skills/ Development					
	Staff Leaving within 12 months of appointment (%) (see page 34)	24.3	≤ 20	↗	?	
	Staff Retention/ Support / Satisfaction					
	PADR (%) (see page 35)	88.8	≥ 95.0	↗	✗	
	Staff Retention/ Support / Satisfaction					
	ER cases exceeding 90 days (see page 36)	36	-	→	-	
	Staff Retention/ Support / Satisfaction					
Finance	Agency as a % to NHSI Target (%) (see page 38)	112	≤ 100	→	?	
	Grip & Control					
	Pay Cost Vs Budget £000 (see page 39)	14,854	14,658	-	-	
	Grip & Control					
	Activity vs Caseload (see Page 40)	1.4	-	→	-	
	Productivity					
	Contract Activity – Local CCG Contract (%) (See page 41)	92	≥ 95.0	→	?	
	Productivity					

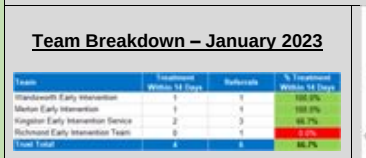
* This refers to assurance that the performance of a metric will consistently exceed the target

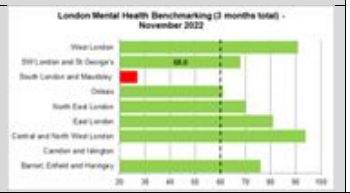
Operations Domain

Access

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







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

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

Underlying issues
- Inconsistent clinical oversight of waiting list and validation is not always completed promptly.
- Occasional insufficient awareness of processes for new staff.
- Some inpatient wards and adult assessment teams are slow to refer patients on to EI services once psychosis is identified making it much harder for them to meet the waiting time targets.
- RiO is not configured to allow the accurate recording of first episode of psychosis and provide a workflow; as a result, there is an administrative burden on teams to manually validate all waiters.
- There has been an unplanned gap in team leadership in Kingston & Richmond EIS contributing to insufficient oversight of recent performance.
- There were some administration issues which led to duplicate referrals being added to clinical record – such cases need to be removed.

Actions:
- Targeted training for SPA teams to continue in order to reinforce the importance of timely referrals to EIS.
- Trust to explore digital solution to initiate a prompt in Rio upon entry of diagnosis of psychosis.
- To maintain performance over 60% for all teams through core structures of daily huddles and use of dashboards by each EIS team.
- EIS teams to ensure robust referral checking systems are in place.

Access

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

Kingston Liaison Psychiatry

St Georges Liaison

St Helier Liaison

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

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

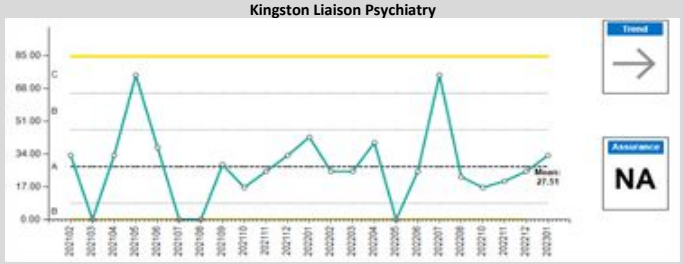
Underlying issue:
- High numbers of referrals in Kingston and St Georges in comparison to staff levels; unfilled posts; referrals during handovers or out of hours meaning the services are not always able to meet demand.
- Service users delayed at A&E are causing an increased workload for clinicians and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

Actions:
- 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 capacity and performance related at peak times.
- Establishment variation completed for additional Band 7 nurses (across all three A&E Departments) to work late shift for 6 months. Funder via winter scheme monies and will support with mental health triage and divert from Emergency Department when clinically appropriate.
- Clinical Service Lead to work with teams to build on the Triage Model implemented in December 2022.

Access

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

Kingston Liaison Psychiatry



St George's Liaison

St Helier Liaison

Background
Patients assessed at A&E by Liaison Psychiatry should not experience long waiting times if access to a bed is required.
What the charts tells us
The level of 12-hour breaches is relatively consistent across the three services with occasional variation.

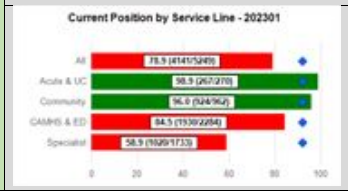
Underlying issue
- A lack of available adult acute beds will lead to an increase in waits over 12 hours.
- DTOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital and use of Winter surge beds.

Actions
- Breaches are discussed and escalated in a daily pathway meeting where patient clinical needs and risks are rated using a bed prioritisation scoring.
- The new Acute & Urgent Care Service Line management are to have discussions with liaison services in November 2021 as part of a review and update of action plans related to consistently underperforming metrics.
- The Trust has contract for use of 18 beds at Holybourne in Roehampton until the end of the financial year.
- Meeting took place to review use of trusted assessor framework to minimise need for admission.
- Recruitment of Consultant Psychiatrist to Kingston Liaison Psychiatry on short term contract; there is also ongoing recruitment process for substantive Consultant posts within the service.
- Trust recently reviewed the Trusted Assessors Framework which will prevent duplicate assessments pre-admission i.e. once assessed by liaison or HTT there should be no need for further assessment as long as all points of framework are covered.

Access

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

Current Position by Service Line - 202301



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

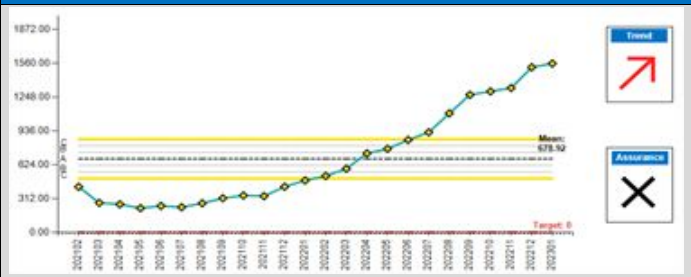
Including ADHD/ASD teams	78.9%
Excluding ADHD/ASD teams	89.7%

Background
The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to start of treatment (RTT) by a consultant led service.
What the chart tells us
Mean performance is below target and there has been a significant downturn trend in performance since April 2021. A change in process is required in order to improve performance.
Underlying issue
- **Adult ADHD:** There are known demand and capacity issues within the service; in January 2023, 62.8% (698/1111) of the 18-week breaches relate to this service (see below for further information).
- **CAMHS Tier 3:** Underinvestment in the Kingston & Richmond SPA. Onward referrals from the CAMHS Neurodevelopment team to Tier 3 for ADHD medication titration has led to increased wait times. These waits are linked to lower risk patients.
- **CAMHS SPA:** Tightening of the CAMHS Neurodevelopmental acceptance criteria has caused a backlog in the NDT screening within the SPA's (especially Kingston & Richmond SPA).

Actions
- **Trust:** The reporting of RTT by appointment type commenced on 1st July 2022 which provides more accurate waiting times and enables teams to have more control in determining when treatment has commenced.
- **CAMHS Tier 3:** The Trust has secured further investment to increase the capacity of the Kingston and Richmond CAMHS SPA and reduce the number of inappropriate referrals reaching the Tier 3 CAMHS service. Additional staff are being recruited to a number of Tier 3 services following further investment. Nurse prescriber in Merton (for ADHD medication) commenced in post on 7th July 2022.
- **CAMHS SPA:** NDT backlog clearance resource deployed in Kingston & Richmond SPA in October 2022 to assist with screening backlog. Review of NDT screening criteria and communication processes between NDT and SPAs to take place January 23.
- Therapy waiting cases are reviewed through 8 weekly review calls and all waiting patients are provided with a While you Wait support pack.
- **Adult ADHD:** See below.

Access

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



Service	Dec-22	Jan-23	+ / -
ADHD/ASD 30 week breaches	477	526	49
CAMHS Neuro Development	79	120	41
Merton Uplift	194	205	11
CAMHS Tier 3	28	34	6
CAMHS Tier 2	43	48	5
Adult Eating Disorders	15	18	3
Other	62	33	-29
Wandsworth Complex Needs	14	13	-1
Cognitive Stimulation Therapy	14	10	-4
Talk Wandsworth	341	337	-4
Sutton & Merton Complex Needs	41	31	-10
Sutton Uplift	116	83	-33
CAMHS SPA	108	69	-39
Total 30 week breaches	**1532**	**1559**	**27**

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.

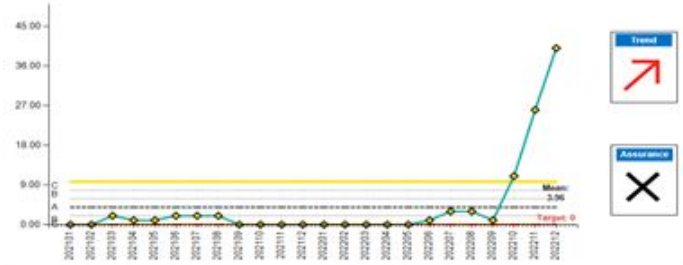
What the chart tells us
Following long-term poor performance, the trust was able to consistently improve but there has been further deterioration over recent months.

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 increase in 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.
- **IAPT:** The volume of waits over 30 weeks continues to rise as Step 3 vacancies continue; this is a challenge for IAPT services nationally. Internal modelling, benchmarking and national modelling tools all indicate services are under-established for the current IAPT access rates.
- Long waiters have been outsourced to 3rd party provider and there are concerns about capacity and performance and longer waits. The Trust believes this is common among many third party providers. Administration resources stretched and unable to get cover via Trust Bank.

Actions:
- **Adult ASD/ADHD**: **Waitlist initiative**: ADHD long waiters will be seen by a third-party using waiting list initiative monies with 176 clients having been transferred to Clinical Partners. These cases will need annual medication review to be booked once returned to service and will further impact on capacity this will start to take effect in January 2023. **Annual Medication Review**: To undertake annual medication reviews and support caseload management two non-medical prescribers have been recruited with a further post out for recruitment. The Trust is also to engage with local GPs on ADHD medication review pathway through the Integrated Care Board (ICB) in the near future, with the aim of freeing up capacity for ADHD diagnosis work.
- Improvement plan led by Clinical Manager to improve processes around referrals, cancellations and recording. The service is also undertaking work to optimise clinical capacity, which will involve a review of ADHD admin and clinical processes.
- IAPT: Recruitment to next round of trainees in March 2023 which aid planning and support for clinical capacity in service.
- **CAMHS SPA:** NDT backlog clearance resource deployed in Kingston & Richmond SPA in August 2022.
- **CAMHS Tier 3:** Psychiatry recruitment drive across community CAMHS T3.
- **Sutton & Merton Complex Needs (non-RTT):** Short & medium term action plan in place to recruit to new posts and address variation between borough CNS teams – reporting through to Trust-wide work on PD. Improved stepped care through community transformation. Recruitment and training of new Structured Clinical Management workers (x13 new posts into Community SL in Jan 2022, adding 6 more in 22/23)
- **IAPT**: Modelling information has been presented to ICB in the context of both current year in access and ability manage waits, and in advance of 23/24 spend planning. Revised local access targets with ICB now agreed to allow services to at least hold steady waiting times, if not decrease them.

Access

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



Team	Number of Breaches
Merton Adult ADHD	23
Sutton Adult ADHD	34
Wandsworth Complex Needs Service	2
Total	**59**

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

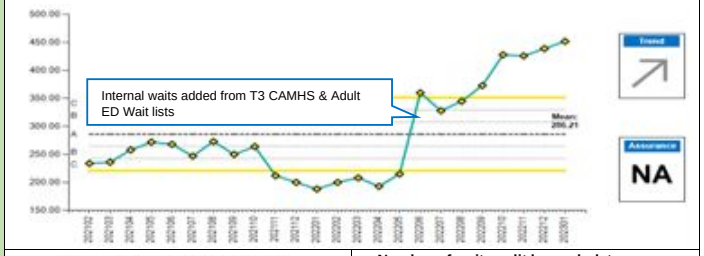
Underlying issues that prevent us from consistently reaching the target:

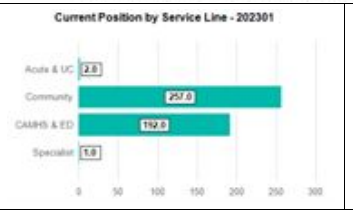
- There are known demand and capacity issues within adult ADHD services and there is a continued risk of further increase in 52 week breaches.
- Wait list is increasing making it difficult to offer appointments within the timeframe.
- Staff sickness within service has impacted on offer of appointments and resulted in some cancellations leading to appointments being re-booked after 52 weeks.
- Further service cancellations due to limited trainee availability and Consultants having to cover the wards at St George's Hospital. Appointment cancellations (by patient/or clinician) lead to increased waiting times within service due to lack of appointment availability.
- The levels of 52 breaches will continue to rise as once diagnosed cases remain on the adult caseload for long term for annual medication review. Overtime this will diminish assessment/diagnostic slots as clinicians will be required to complete more medication reviews.
- In November 2022, a local waiting list was identified in Wandsworth Complex Needs Service which included 4 patients who were not being tracked on RiO.

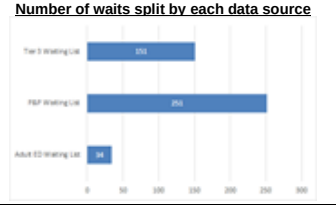
Actions:

- **ADHD:** Improvement plan led by Clinical Manager to improve processes around referrals, cancellations and contact options (i.e. use of e-consultation).
- The Trust is to engage with local GPs on ADHD medication review pathway through the Integrated Care Board (ICB) in the near future, with the aim of freeing up capacity for ADHD diagnosis work.
- Adult ADHD service and Performance Analyst are having weekly meetings to review 50 plus week waiters. The service waiting times are subject to scrutiny via the Internal Access meeting and 52 weeks breaches are now reported as a priority metric.
- To undertake annual medication reviews and support caseload management two non-medical prescribers have been recruited, these staff are now in post and completing their scope of practice. A further post is currently out for recruitment.
- RiO based waiting lists are being implemented across all services to ensure visibility of all patients waiting.

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







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

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

Underlying issues

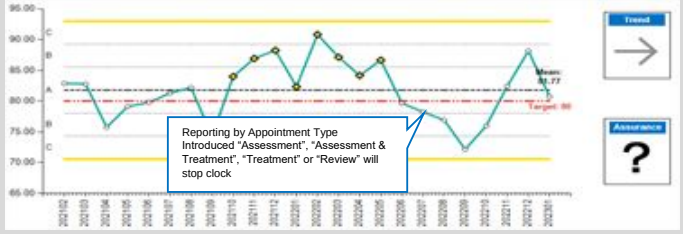
- Historically services have not been reviewing existing dashboards resulting in data quality issues.
- An ever-increasing demand for psychological input with demand exceeding capacity.
- Staff issues: early career posts remaining vacant for extended periods; preceptorship posts reducing in-service capacity; staff training (HEE community transformation programme) reducing capacity.
- Richmond Tier 3 CAMHS historically had a large backlog of young people waiting for therapies due to limited team capacity. Post new investment for Tier 3, Richmond CAMHS has struggled with recruitment more than other boroughs.

Actions

- Community: Improvement plan in place and discussed at April's Access Meeting. A recruitment drive is ongoing and a review of staff productivity is to be undertaken over the summer period. The service line is also Training non-P&P staff to deliver CBT which will increase capacity, this is a long-term measure with staff taking 2 years to complete training.
- Project underway to create a new Trustwide team to deliver DBT skills groups will increase capacity for this intervention.
- New Family Interventions in active recruitment for psychosis posts created in EIS teams will increase capacity for this intervention which accounts for most of the long waits in EIS.
- CAMHS: Recruitment on-going towards new investment across the Tier 3 teams in Merton, Sutton, Wandsworth, Kingston, and Richmond.

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

Access



Underperforming Teams

Team	Assessed Within 28 Days	Assessments	% Assessed Within 28 Days
Merton Adult Assessment Team	68	86	79.1%
Sutton PURS - Single Point of Access	49	63	77.8%
Merton Uplift PCRS	31	41	75.6%
Richmond SPA	34	45	75.6%
Merton Older People's CMHT	6	8	75.0%
Putney & Roehampton CMHT	6	9	66.7%
Dementia Clinical Nursing Service (DCNS)	4	7	57.1%
Twickenham RST	5	9	55.6%
North Kingston CMHT	5	10	50.0%
Carshalton & Wallington RH	4	9	44.4%
Central Wandsworth & West Battersea CMHT	2	6	33.3%
Sutton and Cheam RH	3	9	33.3%
Richmond RST	1	9	11.1%
Morden Recovery and Support Team	0	3	0.0%
Sutton PURS - Recovery Team	0	3	0.0%
Trust Total	418	528	80.6%

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

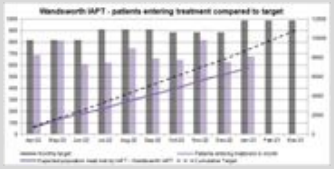
What the chart tells us
Mean performance is above target but there is some variation over the period. Last three months there has been deterioration.

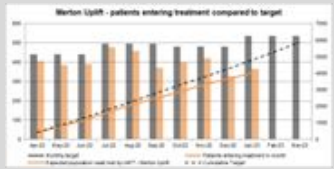
Underlying Issue
- Managerial gaps (Team Manager level) affecting coordination of service delivery and staffing team manager level.
- Limited clinical capacity due to sickness and difficulty filling locum positions has reduced assessment slots from consultants.
- Integrated Recovery Hub (IRH) in Sutton have lack of medical cover from late Q3. Shortage in workforce means current waits to assessment is 3 months.

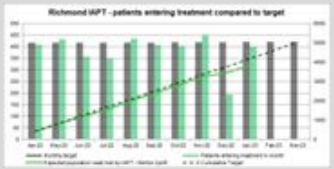
Actions
- The reporting of RTT & Access KPI's by appointment type commenced on 1st July 2022 this will provide more accurate waiting times and enable teams to have more control in determining when treatment has commenced.
- Additional communication on appointment type recording has been issued to assessment teams in Community Service Line. Teams have also been asked to progress amendments to appointments accordingly.
- Substantive team managers in place in both North Kingston and South Kingston and Advanced Clinical Practitioner to assist in coordinating non urgent assessment.
- Sutton: Sutton Primary Liaison and Recovery Service Single Point of Access team has a recovery plan in place and is currently working through their wait list backlog which is reducing.
- Locum consultant for IRH beginning in December to improve IRH Assessment waits.
- COO in conjunction with Community Service Line Management to lead review of appointment recording within SPA's.

Expected population need met by IAPT (numbers entering treatment)

Access







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

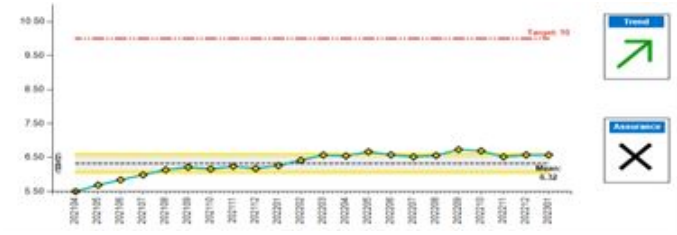
What the chart tells us
All four IAPT services are below their cumulative access requirements.

Underlying issues
- Insufficient referrals across all services.
- Services agreed with commissioners to focus on treating existing waiters.
- Continuing low conversion rates of referrals to access for Merton.
- The volume of waits over 30 weeks continues to rise as Step 3 vacancies continue; this is a challenge for IAPT services nationally. Internal modelling, benchmarking and national modelling tools all indicate services are under-established for the current IAPT access rates.).
- Staff absences due to long term sickness/unplanned leave can lead to lost triage slots.
- National lack of available of PWP trained clinicians contributing to high vacancy rates.
- Richmond Well-being Service has now been integrated into the Trust but there are some residual quality issues which are being worked through by Information Management Department and the IAPT Service.

Actions
- Revised local access targets with ICB now agreed to allow services to at least hold steady waiting times, if not decrease them.
- Revise Access plan for Richmond to chase any deficit accrued over the transfer from ELFT to the Trust.
- Operational Lead of IAPT to work with Merton Uplift on conversion rate improvement.
- Services continually review marketing plans; initiatives include face to face engagement, health and social care meetings and use of social media platforms.
- Continued close oversight of sub-contracted providers to ensure appropriate level of activity is being undertaken, and housekeeping (discharge management) is routinely performed in service.

Access

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



Perinatal Access: The metric is based on a rolling 12-month period. To be included in the numerator, the patient has to have been seen FTF or via e-consulation in the preceding 12 months. This is a count of distinct patients not referrals.

Measure	202203	202204	202205	202206	202207	202208	202209	202210	202211	202212	202301
Women accessing PMH services *	1,024	1,029	1,039	1,025	1,016	1,022	1,049	1,043	1,016	1,025	1,024
Estimated births	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595
Nationally Published Figures: Service use per birth (ONS)	6.6	6.5	6.7	6.6	6.5	6.6	6.7	6.7	6.5	6.6	6.6
Service use per birth (For Context Only)	7.7	7.7	7.8	7.7	7.7	7.7	7.9	7.9	7.7	7.7	7.7

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 below national requirement (target).

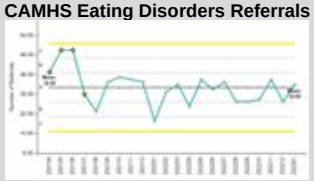
Underlying issue
- National target is based on predicted birth rate which is higher than the actual local birth rate.
- Number of referrals received progressing to assessment is too low in order to reach access requirements of 10% of PMH population.
- Limited financial investment will prevent expansion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

Actions
- Bank shifts added to capacity in order to increase new patient assessments and reduce waiting time, especially in Sutton & Merton.
- Health visitors and midwives attend some huddle meetings this will help increase referrals. This practice to be more standardised across all huddle meetings where possible.
- Ongoing development of maternal mental health service with review of additional capacity and impact on access, expectation for access rate of one percentage point increase from this service once live. Soft launch scheduled for January 2023.

Access

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

CAMHS Eating Disorders Referrals



Waiting for Treatment Summary January 2023

		00 - 01	01 - 02	02 - 03	06 - 07	07 - 08	13+	Total
Waited	Standard	1	1	1	1	2	0	7
	Urgent (7 Days)	0	1	3	0	0	0	4
Waiting	Standard	0	1	0	1	1	1	12
	Urgent (7 Days)	2	0	0	0	0	0	2

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

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

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

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

Access

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

Target ≥ 80%

Trend: ↘

Assurance: ?

Team Breakdown

Team	Assessed Within 8 Weeks	Assessments	% Assessed Within 8 Weeks
Wandsworth CAMHS Tier 3	13	14	92.9%
Sutton CAMHS Tier 3	13	15	86.7%
Merton CAMHS Tier 3	14	19	73.7%
Kingston CAMHS Tier 3	9	15	60.0%
Richmond CAMHS Tier 3	7	16	43.8%
Trust Total	56	79	70.9%

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

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

Underlying issue
- Most breaches relate to waits for ADHD medication and Psychiatry. As T3 CAMHS continues to assess more of the backlog of ADHD waiters this KPI will continue to deteriorate of until the backlogs are cleared.
- There are delays in ADHD medication due to the prioritisation of urgent referrals, screening forms being returned late, cancelling appointments and a small number of errors in recording.
- Kingston & Richmond Tier 3 services continue to struggle with assessment slot availability within the team, as resources are being focused on offering therapy slots for waiting patients.
- There has also been some pressure within psychiatry, such as loss of psychiatry time and increased urgent referrals and inpatient reviews.

Actions
- Psychiatry continues to prioritise higher risk referrals for appointments, meaning ADHD medication waiters (who are less risk) will continue to be reason for most 8-week breaches.
- Non-medical Prescriber post being advertised for Kingston and Richmond CAMHS to support the ADHD medication demand across both teams.
- Psychiatry recruitment drive across all community teams.

Flow

Time on caseload (Community & CAMHS & ED Service Lines Only)

No Target

Adult Community:

Trend: ↘

Assurance: NA

CAMHS & ED:

Trend: →

Assurance: NA

Background
To monitor caseloads and review duration on caseload between clinical services.

What the chart tells us
Community: Consistent downward trend on average time on caseload.
CAMHS & Eating Disorders: Consistent downward trend on average time on caseload.

Underlying issue
- **Community:** Some patients remain for long periods on caseload due to being prescribed Clozapine.
- Staff in the RSTs/CMHTs often focus on those patients presenting with significant risk (Amber/Red zoned) patients, and patients zoned as Green are not discussed regularly. This affects capacity and focus on discharge.
- GPs in some areas are still reluctant to accept patients on depot and therefore these patients remain on the RST/CMHT caseloads.
- Workforce challenges with high vacancy rates in all key clinical roles impacts on service delivery inclusive of clinical review, plan and discharge.
- **CAMHS:** In Kingston & Richmond there are cases having to be kept open in T3 due to long waits to be seen in Tier 2 Achieving for Children (a non Trust service).
- In Richmond Tier 3 the Psychiatry caseload has young people above 18 years of age that remain open until the Adult services have taken on the case (this is due to long waiting times in the Richmond Adult services for psychiatry).

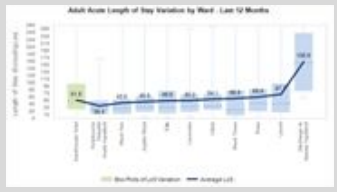
Actions
Community:
- As part of transformation of community services and the introduction of new roles and processes, the service line is reviewing the process of stepdown/discharge following recovery.
- Analysis undertaken to look at the teams with the longest average waiting times. This was reviewed in the January 2023 Trust Flow Meeting with actions agreed to address outlying teams.

CAMHS:
- A review of Tier 3 caseloads has been undertaken.
- The service is currently recruiting a transition coordinator position to assist with transition cases in Kingston & Richmond.

Flow

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

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



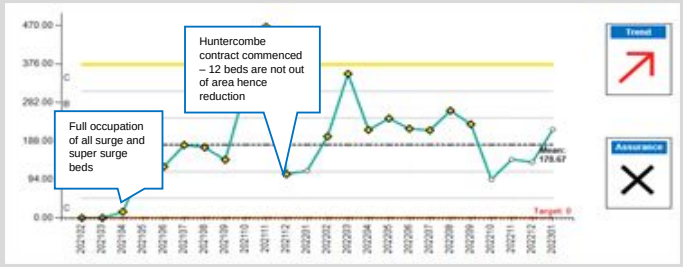
Background
Average length of stay is important as it informs future bed planning. This definition was agreed by the Bed Management Project Group and approved by Trust Executive. It includes out of area placements and excludes stays on PICU wards and leave.
What the chart tells us:
Trust average performance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

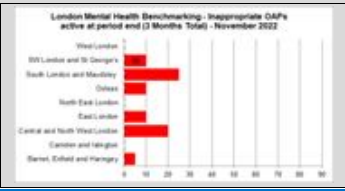
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds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

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

Flow

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





Background
The Five Year Forward View for Mental Health aims to end entirely the practice of sending people out of area due to local adult acute bed pressures by no later than 2020/21. The data includes 5 beds purchased at East London Foundation Trust that from April 2020 meet the DOH criteria, including continual record sharing, as appropriate. Typically, an inappropriate placement would relate to the patients admitted to the private sector. In this instance regular reviews and follow-ups are conducted by Trust staff to ensure the delivery of effective care.
What the chart tells us
- Statistically significant and sustained increase (deterioration) in recent months following a long period of good performance.

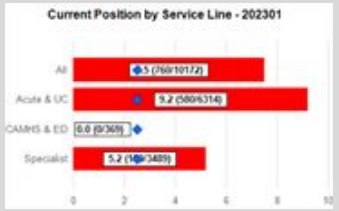
Underlying issue
- Performance is related to the demand for adult acute and PICU beds. High and continual occupancy rates that exceed 95% inevitably lead to the use of out of area beds at times of peak demand.
- DTOC patients impacting on flow and ability to create capacity despite block contract beds with Holybourne Hospital and use of Winter surge beds. The apparent correlation between external occupied bed days used and increased DtoC days is being explored.

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

Flow

Delayed transfers of care (%)

Target ≤ 2.5%



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

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

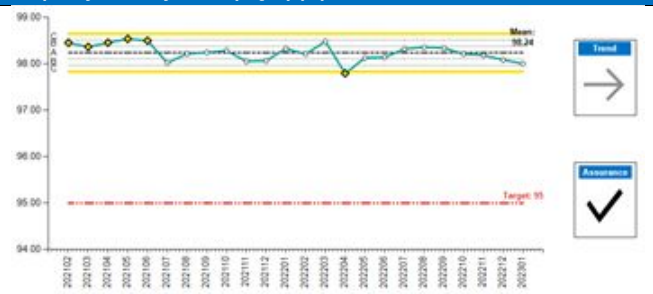
Underlying issue
- Improved identification of delays for non-medical reasons through use of an estimated discharge date.
- An increase in the proportion of more complex cases as bed numbers are reduced.
- Delays are often beyond the control of the Trust and reliant on LA engagement and resources.
- A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

Actions
- Escalation processes involving local authorities & CCG's is in place.
- The Creating Inpatient Capacity project is working to ensure use of estimated discharge dates, barriers to discharge and delayed patient processes work effectively. Standard operating procedure should improve flow through the system. Discharge and Choice policy has been circulated for review. Part of transformation programme is to reduce stay of complex cases and reduce stays on wards.
- Plan to develop pan borough DToC call and escalation framework (will need local authority engagement).
- Discharge and choice policy has been extended for 6 month period and a task and finish group (with representation from LA's) commenced in November 2022.
- Discharge and choice policy for review with LA stakeholders' task and finish group due to present to the February SOIM meeting (interface meeting with local authority directors).

Operations

Data quality maturity index (DQMI) (%)

Target ≥ 95%



DQMI Areas for Improvement – January 2023

DQMI Item	% Compliance
Primary reason for Referral	94.1%
Ethnicity Category Code	93.3%
Indirect Contact time (hour)	89.3%
Referral Closure Reason	89.3%
Ex British Armed Forces	87.3%

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

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

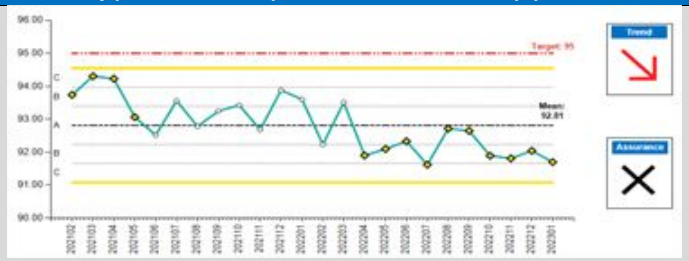
Underlying issues
- Trust consistently benchmarks well on this indicator when compared to other mental health Trusts.
- A small number of measures on the DQMI need improvement – these are listed in the summary table i.e. Ethnicity Category Code and Ex British Armed Forces.
- Lack of oversight at service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

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

Quality Domain

Fundamental Standards of Care

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



CPA Breakdown – January 2023

CPA	94.4%
Non-CPA	90.5%

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

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

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

Actions
- The Fundamental Standards of Care community campaign and dashboard was launched in July 2022 across Community Services.
- CAMHS Risk Assessment recording via IAPTus is now available via the FSoC Dashboard and will be reported in Quality and Performance as a separate risk metric in the coming months.
- New Clinical Risk Assessment policy has been approved at Trust Quality Governance Group. Evaluation of the pilot including the use of new safety formulation expected to be completed by Spring 2023.
- 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.

Fundamental Standards of Care

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

Compliance by Service Type – January 2023

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

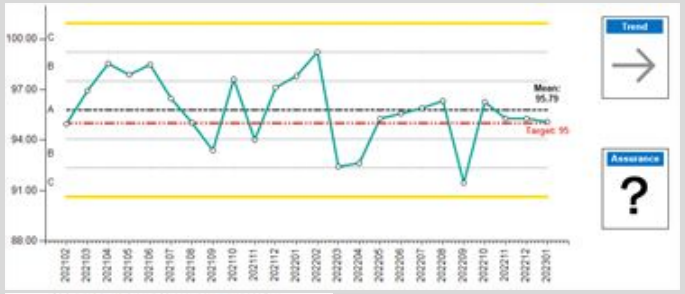
What the chart tells us
Downward (negative) trend in performance; target (which is above upper control limit) will not be met under current process.

Underlying Issues
- Risk assessments have been a priority focus for our clinical services, as part of the Fundamental Standards of Care, which is being monitored through the quality plan, there has been an improvement in the quality of the risk assessment.
- Impact of move to Trinity Building has impacted some ward areas and also affected monitoring/oversight from Matrons and Clinical Service leads.
- Liaison under performance linked to late completion of risk documentation in the Trust's clinical system.

Actions
- Amendment to reporting made following review with HTT, AUC Management and Performance & Information at end May in order to capture community risk assessments recorded in the 12 hours prior to assessment event. The change was implemented in order to align with actual clinical practice.
- Acute & Urgent Care: Improvement plans for Inpatient wards and Richmond Home Treatment Team and Kingston Liaison are addressing the issues of recording.
- Audits to be undertaken across all liaison services.

Fundamental Standards of Care

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



January 2023 (Underperforming wards)

Team	PHA Attempted Within 48 Hours	Admissions	% PHA Attempted Within 48 Hours
Ward Three	12	13	92.3%
Cirrus	9	10	90.0%
Ward One PICU	7	8	87.5%
Rose	7	8	87.5%
Aquarius	5	6	83.3%
Halswell	1	2	50.0%

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

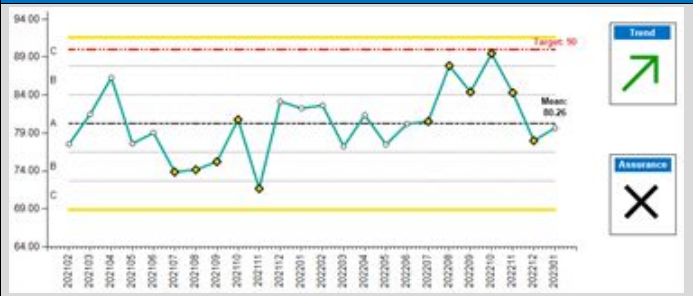
What the chart tells us
Historic under performance followed by recent sustained improvement above target.

Underlying issue
- Consistent under performance linked to an inadequate configuration of the clinical IT system to support workflows and a need to improve daily ward processes to ensure assessments are consistently completed.
- There are times where some wards have limited medical cover, and this can impact on performance.
- Some medical staff are poor at recording measurable information, preferring to only update clinical notes.

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

Fundamental Standards of Care

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



January 2023 (Underperforming wards)

Team	PHA Completed Within 7 Days	Admissions	% PHA Completed Within 7 Days
Ward One PICU	7	8	87.5%
Elks	6	7	85.7%
Ward Three	10	12	83.3%
Aquarius	4	5	80.0%
Lilacs	11	14	78.6%
Jupiter Ward	7	12	58.3%
Rose	4	8	50.0%
Laurel	3	8	37.5%

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.

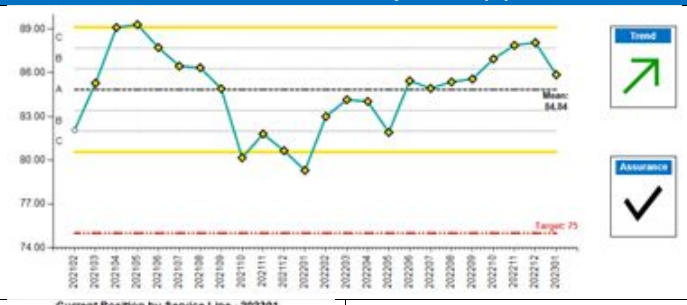
Underlying issue
- Consistent under performance linked to an inadequate configuration of the clinical IT system to support workflows and a need to improve daily ward processes such as handover to ensure assessments are consistently completed.
- A high number of patients initially refusing to undertake 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
- The Clinical Director for Acute and Urgent Care has communicated with all doctors who complete admission clerking, clarifying the correct process for completing and recording PHA on admission as well as handing over outstanding tasks. This will also be discussed at the medical out of hours group.
- The Clinical Director for Acute and Urgent Care has requested that Ward Consultants ensure that the Junior Doctors in their teams know how to use the dashboards and ensure that they are viewed daily to pick up when PHA forms have not been completed.
- Quality KPI monitoring process established with Clinical Service Lead's and Matrons on a weekly basis.
- Inpatient caseload dashboard is used daily in safe staffing meetings.

Fundamental Standards of Care

Cardio metabolic Assessments – Community and EIS (%)

Target ≥ 75%



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

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

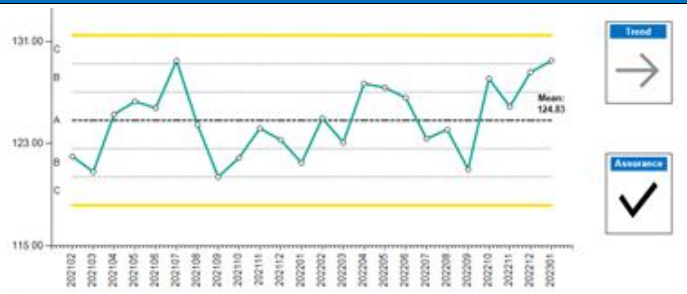
Underlying issue
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised. Trust clinical systems do not support workflow and performance is expected to dip in Q3 when annual re-reviews are required. Some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

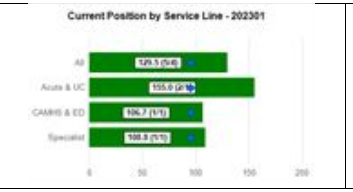
Actions
- Teams have access to shared care records that contain supporting information to simplify the data collection process.
- Acute: All wards using the inpatient caseload dashboard in handover.
- QI project being developed, led by Junior Doctors and enabled by QI team. Focus will be on improving physical health for inpatients, effective use of dashboards and streamlining admission process.
- Community: Assertive outreach approach for patients who have refused CMA over the last 12 months, including the offer of home visits.

Fundamental Standards of Care

Safe Staffing: national Compliance - Inpatients (%)

Target ≥ 95%





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

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

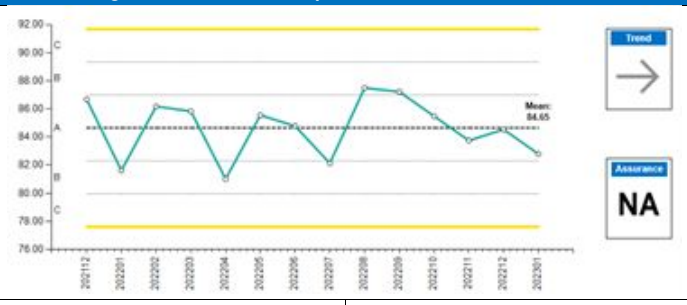
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.
- All wards were safely staffed in Specialist services.
- Downturn for CAMHS & ED service line linked to closure of Corner House there were no staffing issues perse.

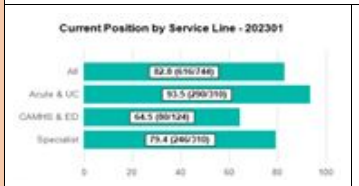
Actions
- Acute & Urgent Care: Focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.

Fundamental Standards of Care

Safe Staffing: baseline includes requirements related to observation levels

Target TBC





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

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

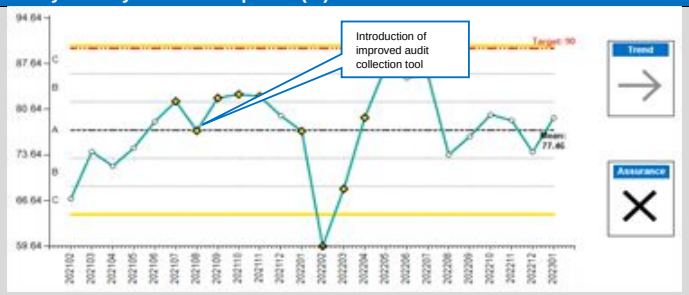
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.

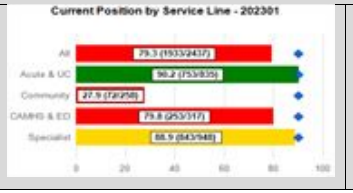
Actions
- Acute & Urgent Care: Focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.
- Training has been provided for Ward Managers & Team Leaders on the Fundamental Standards of Care Dashboard.
- Daily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

Fundamental Standards of Care

Always Ready Audits Completed (%)

Target ≥ 90%





Audit Volumes by Service Line:

Service Line	Audits Completed	Audits Required	% Audits Completed
Acute And Urgent Care	753	835	90.2%
Specialist Services	843	948	88.9%
CAMHS & ED	253	317	79.8%
Community (Adults)	72	258	27.9%
Other (i.e. inc Pharmacy)	12	79	15.2%
Trust Total	1933	2437	79.3%

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

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

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

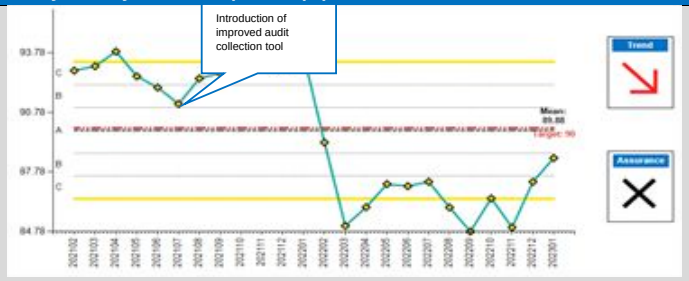
Underlying issue
- The Always Ready application improved and implemented in June 2021 before some staff had received training and a period of familiarisation.
- Some teams have required support and training with understanding and using the Always Ready Audit application and dashboard.
- Always Ready performance in the Community service line is of concern and DONQ has raised with Head of Nursing and Quality.
- Improvement in Acute & Urgent Care noted.

Action
- Service lines to agree the audit cycle (action plan template) in order to provide a standard feedback process for teams to review actions.
- In Acute & Urgent care Service Line dashboard training has been provided via Performance & Information Team.
- The acute service line carryout formal weekly meetings to review compliance and actions. Additional training for staff has been provided by Applications Development and Information Management.
- Updated training video on dashboard has been developed and deployed in order to support staff.

Fundamental Standards of Care

Always Ready Audit Compliance (%)

Target ≥ 90%



Audits of Concern:

Audit	% Compliance
Safety In Motion Audit	86.8%
Case Note Audit - Community	80.2%
Ward IT Equipment Audit	74.8%
Mental Health Crisis Line Triage Audit	69.7%
Flushing Audit	69.5%

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

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

Underlying issue

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

Action:

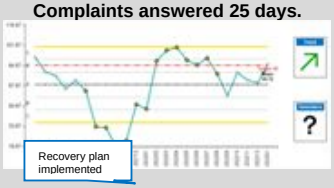
- Additional information of the quality of audits, themes and risks and any outlying areas will be provided next month.
- Always Ready dashboard has been developed to assist completion and improve performance. A Training video for use of new Always Ready Dashboard is also available on My Dashboards.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

Patient Experience and Outcomes

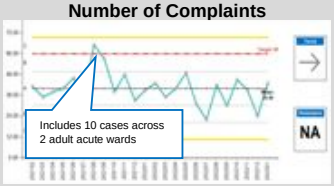
Complaints answered within 25 days (%)

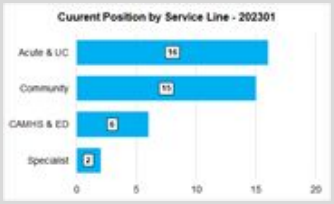
Target ≥ 85%

Complaints answered 25 days.



Number of Complaints





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

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

Underlying issue

- In January 12 out of 14 complaints were responded to within 25 working days, achieving the target of 85%.
- The team have returned to full complement, however delays in receiving information to conclude complaints has been a main contributor this month.

Actions:

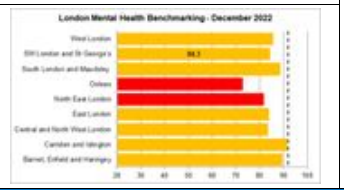
- Service Line learning events continue to increase and evolve, helping focus on learning from incidents, complaints, and good practice.
- Further work is on-going to build on the quality of responses, which has largely been successful.
- The Complaints Review Group (with Lived experience members) met in January and agreed a presentation to be delivered to staff on Compassionate Complaints handling.

Themes and Learning:

- In January there were 44 complaints received; this is an increase from those received in the previous month and above the average of 39 complaints a month.
- Acute & urgent Care: Poor communication with family and carer has been raised as a theme.

Patient Experience and Outcomes

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



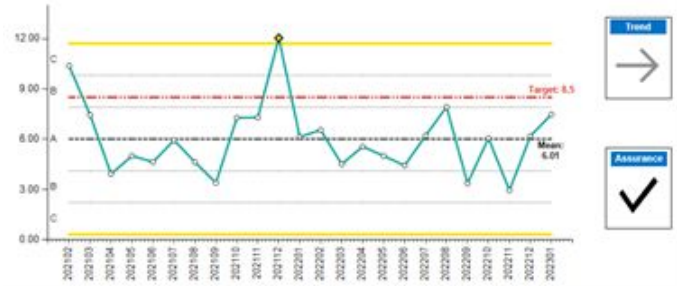
What the chart tells us:
Mean performance is consistently below target a change of process required.

Underlying issues:
- Information Management team are undertaking a review on the target thresholds.
- Challenges with engaging patients to complete at appropriate points in their pathway.
- Using the results in a meaningful way to identify and make improvements within the clinical services.
- In Acute and Urgent care most underperformance linked to liaison and Mental Health Crisis hub.

Actions:
- Community Service Line are promoting use of the FBL QR code for service users and carers (FBL first question is the FFT)
- IPO group has now amended the SMS algorithm for requesting FFT from patients to ensure it is fully representative and not disproportionately weighted to assessment teams, over treatment teams, but this will take time to stabilise in the results.
- Satisfaction levels within Specialist Services remain very high.

Patient Experience and Outcomes

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



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

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

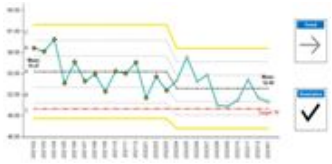
Underlying issue
- 8 emergency re-admissions reported in January 2023.

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

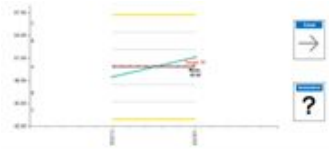
Patient Experience and Outcomes

IAPT recovery rate (%) — **Target ≥ 50%**

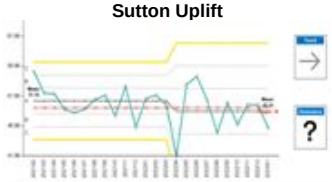
Talk Wandsworth



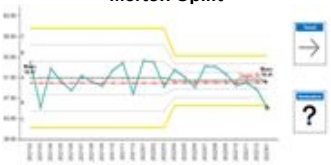
Richmond IAPT



Sutton Uplift



Merton Uplift



Background
Improving Access to Psychological Therapies (IAPT) is an NHS programme in England that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety.

What the chart tells us
Merton is below stretch target in 2021/22 but mean position is above national target. All other services are likely to exceed the target which is below the average performance. Monthly variation is expected.

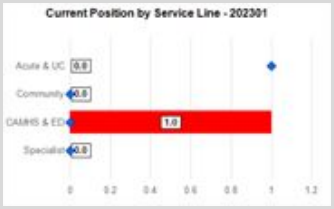
Underlying issues
- Clients who 'drop-out' and fail to attend appointments (DNA) may be discharged before they have 'recovered'. This can be more apparent with sub-contracted services.
- Routine audits have shown that some processes around discharging clients (who were unrecovered) are not always being followed.
- In Sutton Uplift there has been an increase in dropouts (before last session) and premature discharging of clients close to recovery.
- Richmond: Changes in recording processes following Silvercloud 2.0 roll out led to decline in recovery rate (clients who had not engaged were incorrectly being shown as completed).
- Richmond Well-being Service has now been integrated into the Trust but there remain some residual quality issues which are being worked through by Information Management Department and service.

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.
- Project for 2023 to be undertaken to draw comparison between 1:1 & Groups at step 3 for quality improvement with trainees.

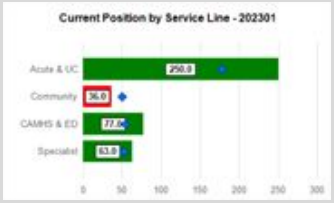
Patient Safety

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

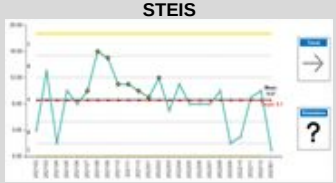
Patient Safety Incidents – Severe Harm



Patient Safety Incidents Reported



STEIS



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

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

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

Underlying Issue:
- In January 2023 there was 8 serious incidents where further Investigation/ Review has been requested to identify gaps in care and treatment. These include 4 Unexpected Death, and 4 Suspected Suicide.
- The total number of incidents reported in January increased as expected for this time of year.

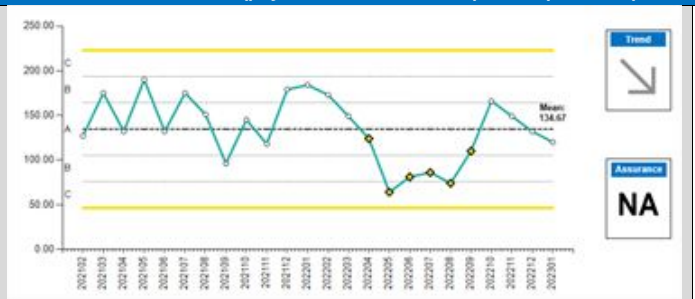
Actions:
- A number of teams are not routinely reporting Incidents on the Ulysses system, Heads of Nursing are following this up with their teams to improve incident reporting.
- A reminder of importance of recording patient safety incidents on Ulysses has been issued to service lines. This impacts the PSIs being reported to the NRLS.
- **Community Service Line:** It is now possible to identify teams who have not reported any or below 5 incidents across 2022, these teams will be targeted for training and awareness to improve under reporting.
- Outstanding RCAs and PIRs actions are now addressed through the Service Line Clinical Safety Meeting and monthly working group to review and close actions which will be addressed with Clinical Managers and CSLs.

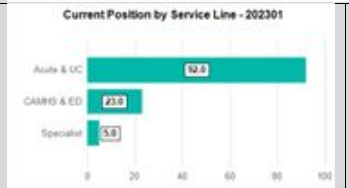
Themes & Learning:
- In January learning around gaps in documentation staff supervision and induction, observations the referral process and zoning was reported.

Patient Safety

Total number of restraints (physical restraints and rapid tranquilisation)

No Target





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

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

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

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

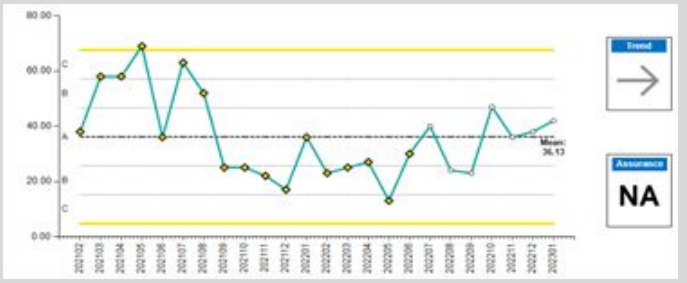
Actions
- Acute: The updated rapid Tranquilisation policy has been circulated and discussed with the teams
- Restrictive Practice Groups review data to understand issues and inform learning.
- Acute: Safety in Motion Interventions have been reintroduced and discussed with teams.

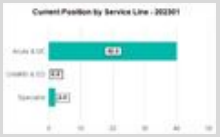
Themes and Learning:
- **Acute and Urgent Care:** The main for physical restraint continue to be administration of medication followed by harm to others and self.

Patient Safety

Reducing restrictive practices - Prone restraint

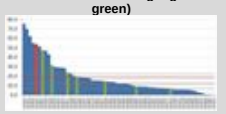
No Target





Number of Clients Prone Restrained – January 2023

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



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

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

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

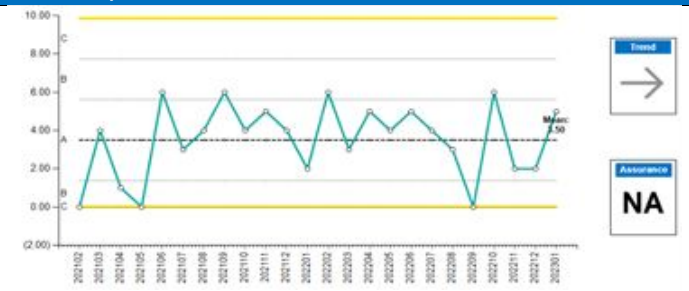
Actions:
- The deltoid technique is used where possible and prone restraint is used as a last resort.
- Staff are debriefed following an incident to review how the incident was managed and any alternative practices that should/could have been considered.
- The use of prone restraints is monitored monthly through the service lines local restrictive practice groups led by the Matron. A report is published monthly detailing all uses of restrictive practices for that month with clinical narratives attained from the clinical managers.

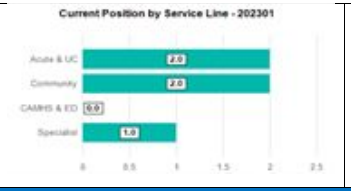
Themes and Learning:
- **Acute:** The use of restraint and rapid tranquilisation fluctuates month on month, the service line to continue the appropriate monitoring of the understanding of the reporting processed with respect to the RiO Restrictive Practice monitoring form and the Ulysses incident form.

Patient Safety

Death - Suspected suicide

No Target





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

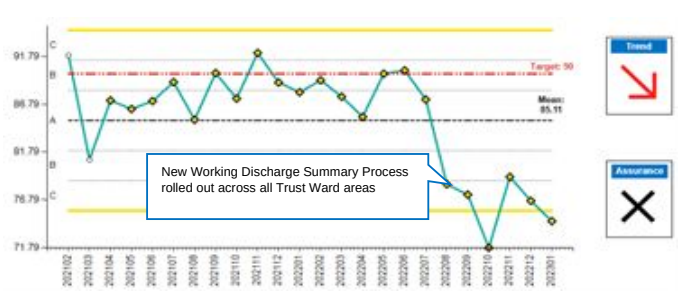
Underlying Issue:
- There were four suspected suicides reported in January 2023.
- The number of suicides being reported month to month continues to vary. This data was reviewed in the bi-monthly Mortality & Suicide Prevention Committee. The mean monthly average has increased from 2.9 (pre-April 2020) to 3.5 (post April 2020).

Actions:
- All such incidents will be subject to an investigation and are signed off by a Serious Incident panel chaired by Director of Nursing and Quality.
- The milestones from the Trust's Suicide Prevention Strategy will be monitored via the Mortality & Suicide Prevention Group.
- Mortality Committee received the thematic review of the last two years of community suicides. The presentation/report will be presented more widely highlighting the learning and recommendations from the review.
- Inpatient deaths, unexpected deaths with a focus on zoning and physical health, homicides involving trust patients and serious incidents that have occurred in the community assessment teams will be presented at future meetings.

Patient Safety

Inpatient discharge letters sent within 24 hours (%)

Target ≥ 90%



Letters sent within 24 hours – January

Compliant	Total Letters	%
88	118	74.6%

7 / 18 wards were 100% compliant

Letters sent within 7 days – January

Compliant	Total Letters	%
103	118	87.3%

10 / 18 wards were 100% compliant

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

What the chart tells us
Mean performance is below target and there is a downward trend ion performance. Significant deterioration in recent months with some recent improvement.

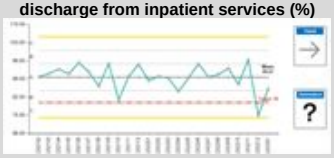
Underlying issue
- Main issue remains wards not complying with the new process in order to complete the discharge in RiO and submit the working discharge summary form within 24 hours.
- Communication between medical and nursing staff needs to be improved especially when specific actions I.e. (date/time of discharge) are completed on RiO.
- Need for a more streamlined discharge process this will be reviewed by Ward Flow Working Group.
- Technical issue linked to TTA's was picked up. In order to address an IT and Pharmacy working group (accessed via MS Teams) has been picked up so issues can now be addressed quickly.

Action
- The new process for Working Discharge Summary Completion was launched across all inpatient wards on the 1st August 2022. The new process includes the automatic submission of the Discharge Summary to the GP via DocMan Connect in RiO.
- Project Lead and Acute and Urgent Care Service Line have meet in order to bottom out where problems lie. This has resulted in an automated alert being issued via the generic ward email so ward staff are made aware that the discharge has been progressed and form needs issued to GP via Doc Man.
- Working Discharge Summary process has been taken into the Ward Flow Working Group. Plan is to have the Working Discharge status displayed (via dashboard) in nursing in real time.
- COO, Lead Consultant & Trust Admin Lead to undertook site visit (on Rose Ward) to discuss and review local practice.
- Training Induction for Junior Dr's has been reviewed and incorporates recent changes to discharge process in RiO.

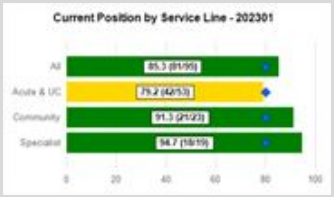
Patient Safety

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

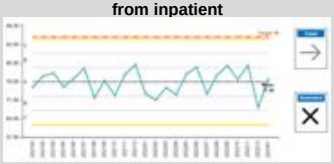
Discharge follow up within 72 hours of discharge from inpatient services (%)



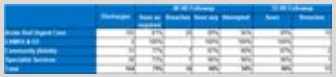
The Trust remains a high performer against the national 72 hour target of 80%.



Follow up within 48 Hours of discharge from inpatient



Follow-up summary including attempts – January 2023



48 hour follow up performance by service type – January 2023

Background
NHS data analysed by the Royal College of Psychiatry shows that patients are at most risk of suicide on second or third day post discharge from psychiatric hospitalisation.

What the chart tells
Mean performance is comfortably above target with target being met in 22/24 months over the period.

Underlying issues

72 Hour follow Up:

- The Trust consistently achieves the national 72 hour target from November 2022 this is the priority metric for follow up following discharge from inpatient services.
- The availability of patients impacted performance in December 2022.
- Inconsistent documentation of clinical record; appointments not recorded in diary or discharge planning form.

Action:

- Improvement meeting set up within Acute and Urgent care service lines for areas of concern.
- Reinforce use of Inpatient Discharge Follow Up Dashboard across the Trust especially in holiday periods when it may be more difficult to engage clients.
- Attempt summary has been amended and now incorporates the 72 Hours position.
- Acute: Learning across the service line on the SOP has been undertaken with focus on incident reporting and ensuring cases of no contact post are reported as missing person.

48 Hour Follow Up:

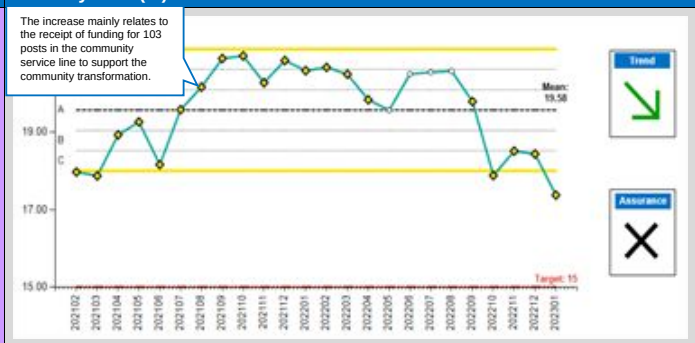
- High sickness and vacancy rate has meant reliance at times on agency staff who are less familiar with follow up processes.
- The Trust has a 48 follow up process in place in order to ensure clients are seen in a timely fashion post discharge.
- Whilst patients may not be seen, the Trust has assurance that attempts were made (see table) to contact. In January 2023 attempts to contact within 48 hours was at 94%.
- **7 day follow Up:** - There were 9 breaches reported for January 2023 of which 7 were subsequently contacted. There were two or more contact attempts for one of the cases, and the team had tried to contact the other client.

Workforce Domain

Recruitment / Attraction

Vacancy Rate (%)

Target ≤ 15%



Vacancies by Staff Group

Staff Group	Post FTE	Assign FTE	Vacant FTE	Vacancy Rate FTE
Add Prof Scientific and Technic	467.8	389.3	78.5	16.8%
Additional Clinical Services	701.1	565.1	135.8	19.4%
Administrative and Clerical	635.3	563.2	72	11.3%
Allied Health Professionals	163.2	132.1	30.9	18.9%
Estates and Ancillary	35	33.9	1	2.9%
Healthcare Scientists	1	0	1	100.0%
Medical and Dental	228.5	204.3	24	10.5%
Nursing and Midwifery Registered	882.5	691.8	190.7	21.6%
Total	**3114.4**	**2579.7**	**533.9**	**17.1%**

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 with recent performance decreasing (and positive downward trend); performance remains above target but is now below lower control limit.

Underlying issue:
- Some service leads have not proactively reviewed their vacancies and/or are not confirming all the position numbers where multiple roles can be included in a recruitment campaign, which results in an artificial higher vacancy rate. This despite monthly meetings set up with the services, with the HRBP's and the recruitment lead. Processes such as commissioning meetings being introduced at the beginning of a Recruitment campaign have been introduced as part of the incident, however it is clear that only certain departmental leads have oversight over posts to be included in bulk recruitment.
- CAMHS: The increase in vacancies is primarily due to new posts being established within CAMHS. Some of these are new posts in early help (Child Well-being Practitioners & Trailblazers). TAMHS service is under review to be reinstated. Higher Levels of Vacancy in CAMHS Eating Disorders due to increased investment. (Currently 30.8%) with 43.6 wte vacancies.
- The Trust turnover have increased steadily in 2021 into 2022, which impacts on the vacancy rates, in addition to the newly created roles. Work needs to be carried out to ensure that the number of new starters exceeds the number of leavers, as part of reviewing retention

Actions:
Vacancy rate is linked to turnover; retention strategies need to be developed.
- **Acute**; Plan for mass recruitment for band 5 and 3 is in progress with HR recruitment team, fortnightly meeting have taken place for the planning / implementing phase to progress through an assessment centre with a view to launch in April.
- **Community Transformation:** Review of core skill mix within the RSTs/CMHTs from band 5-7 as part of transformation of community services y2 programme.
- **Medical workforce strategy** range of actions in progress. Medical posts in Wandsworth and Richmond due to go back out to advert under general recruitment dept for the Trust – new adverts written. New specialist roles have been advertised as per skill mix review.
- **Monthly 'Deep-Dives'** with Service Leads included line by lines on current vacancies – this has already proven useful with several 'vacancies removed which should cleanse the data.
- Work is being carried out with Remedium looking to bring in Specialist (SAS) posts to the Trust.
- Review hard to recruit posts to developmental role in order to attract suitable candidates as career pathways to fill the vacancies.
- Communication Team is supporting with advertising via Social media on Facebook, Twitter, LinkedIn for targeted adverts and currently developing YouTube content.
- HRBPS, Recruitment and Service Leads are working together to identifying suitable strategies to assist recruitment within areas with high vacancy rates. HR will be supporting the organisation with a Workforce Planning programme of work that will focus on addressing the vacancy gap and growth of our future workforce to meet the future staff-shortages and patient acuity demands.

Recruitment / Attraction

Vacancies in active recruitment (%)

Target ≥ 95%

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

- At present, not all positions numbers are included in recruitment campaigns where there is more than one post, resulting in an inaccurate view of roles progressed to recruitment. This is despite the recruitment team kindly asking hiring managers for all relevant position numbers in their commissioning meetings at the start of the recruitment campaign. More work has been carried out to meet with the Nursing Leads in each service line to link post numbers to adverts when bulk recruitment activity takes place.
- More in-depth conversations with services on future requirements will take place as part of the Commissioning meeting in order to progress recruitment at the point of new role creation.
- Residual data quality issues relating to staff not following prescribed recording processes. For example, recruiting to multiple posts but recorded against one position on IT systems.

Action:

- Service lines are now holding their managers account for their recruitment activities, ensuring progression as soon as they arise. This has also resulted in an increase in roles being progressed to recruitment.
- Service lines and HR staff have access to detailed automated dashboards to identify data quality issues and performance. Data is now refreshed on as weekly basis.
- Services continue to identify all post numbers on RRF so that all posts of that type are accounted for in recruitment process. The HRBP's and the recruitment lead are asking all managers to freeze / end any roles that are no longer active on their establishment. Monthly meeting with services are still showing that services are not proactively doing this, artificially inflating the vacancy rate.
- 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.

Recruitment / Attraction

Time to recruit

Target ≤ 49 days

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

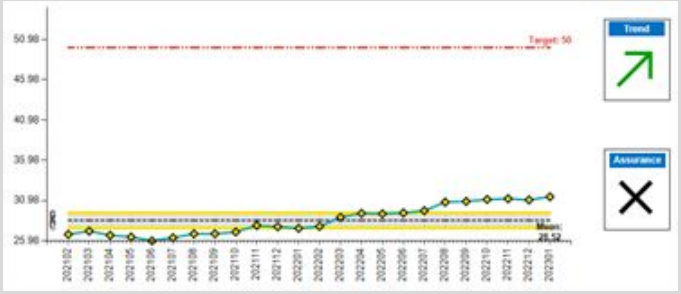
- Recruiting managers do not always pre-plan the recruitment activity, meaning there are delays in shortlisting, interview invites and offer completions following interviews. Start dates may have been agreed by the HR teams are not always notified. This issue should now be resolved as a result of the Commissioning meetings.
- Recruitment is reliant on external factors which are beyond the Trust's control such as response times of candidates, or newly qualified Nurses awaiting their pins.
- The time to shortlist and confirming interview outcome by hiring managers are outside of agreed KPI's and the time to send an offer by the recruitment team is outside KPI.

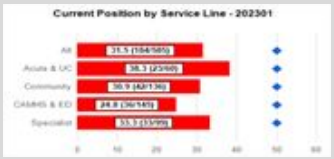
Actions:

- Acute: Recruitment planning meeting for Mass recruitment, ongoing review current vacancies status on Trac, line manager to adhere to shortlisting deadline to ensure all vacancies are aligned to all post out for advert
- The candidate pipeline has been reviewed in detail and new ways of working implemented. This has resulted in some checks coming through quicker than in past few months and where appropriate HR will work with the relevant Managers to start applicants at risk to accelerate the process.
- Recommendations remain for managers to pre-plan (proactive approach) their recruitment activity and flag up any challenges at the earliest possible to the recruitment team.

Recruitment / Attraction

Percentage of BAME staff - Band 8+ and Medical — Target ≥ 50%





Background:

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

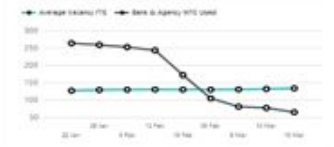
Underlying Issues:
- The Trust is currently undertaking a Leadership Gap Analysis. The first draft was presented to the ELT in July 2022. It highlights the good offer we have as an organisation in respect of leadership development, but we need to improve visibility, access and evaluation of outcomes.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

Actions:
- Diversity in Recruitment representatives are on interview panels for band 7 and above roles across the Trust.
- Specialist: Diversity and Inequalities forum is now in the early stages of introduction with a first meeting having taken place in June. As part of this initiative further EDI champions will be appointed to assist in promoting Equality and Diversity within the service line.
- Community: New borough based band 7 inequalities leads to be recruited as part of transformation.
- Specialist: One-day workshop entitled 'Managing racism in the workplace' has been commissioned and will be delivered in February 23. A further event on Opportunities for Black & ethnic Minority staff is also being planned and will be held in the coming months.

Recruitment / Attraction

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

Bank & Agency Usage



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

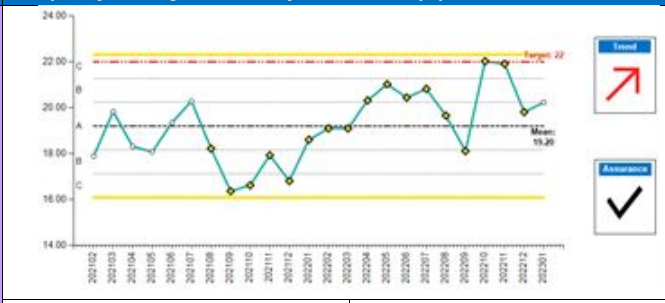
What Chart Tells Us:
There is a negative upward trend with mean performance above target (which is in line with lower control limit). A change of process is required.

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

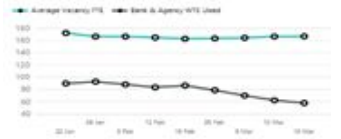
Actions:
- As part of the Recruitment Incident, long-term agency usage has been triangulated with vacancies with the aim of services releasing agency temps once the vacancy is filled. Stronger governance by way of TWR and TWE forms required for each long-term agency worker will be put in place as part of the Recruitment Incident.
- Service line is working with medical staffing to address vacancies and temporary fill rates.
- Human Resources Business Partners' (HRBP) are now meeting Service Lines regularly to review vacancies, sickness and agency usage in order to address areas with high agency usage.
- There will be improved processes within Dashboard to prompt and support Managers with sickness absence processes.
- Continued monitoring of temporary staffing costs in line with vacancies and requirements for additional staffing on the wards.
- Focus on recording, reviewing and following policy for observations at a ward level.

Recruitment / Attraction

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



Bank & Agency Usage



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

What Chart Tells Us:
Mean performance is consistently below target bit there is a negative upward trend in performance.

Underlying issues:

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

Actions:

- Continued focus on BAU recruitment actions and capitalizing on Community Transformation recruitment campaign.
- Follow up with Recruitment to address transaction process issues to expedite and streamline recruitment.
- Borough level vacancy reviews with head of recruitment and HRBP to confirm actions against all posts are completed.

Staff Skills / Development

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

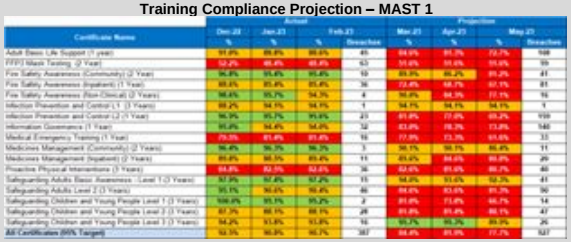
Statutory and Mandatory Training 1

Statutory and Mandatory Training 2

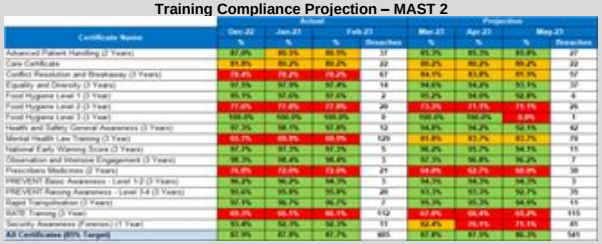
Current Position by Service Line - 202301

Current Position by Service Line - 202301

Training Compliance Projection – MAST 1



Training Compliance Projection – MAST 2



Background

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

What the chart tells us

MAST 1: Following period of improvement performance there is now a significant downward trend in performance.

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

Underlying issue

- Evidence shows that in higher performing areas managers proactively book staff onto courses and staff are able to cancel any MAST course within reason if their direct line manager is copied in the email sent to E&D.
- The training budget has not been adjusted to reflect the change in audiences for Advanced Patient Handling, Food Hygiene, or British Sign Language Training.
- Advanced Patient Handling is a new course that has replaced Patient Handling with Hoist. The Trust is unable to fund the full demand within the existing budget as the target audience is now 560 staff from the original 136 staff. Additional session now added to compass to accommodate 250 staff whose training would expire by June 2023.
- Significant amounts of staff sickness across the Trust resulted in cancelations and DNAs; high vacancy rates may prevent staff from being released for training.
- Current training capacity is not able to meet the demand for the Trust. For example, RATE Training only has staff volunteering to train others on this course and ABLs, MET, and PBLS has only one trainer. The Mental Health Law course has increased capacity to 150 to accommodate demand.

Actions

- Focused conversations in each SLR in regard to MAST 1 performance. Senior leadership have committed to daily dedicated focus. DoNQ to link with the new Head of L&D to review the process around MAST. The review for the L&D Provision, which will create a "MAST Grid" – that will reflect the training requirements for each job group, also start the conversations for a deeper Training Needs Analysis for individual service provisions and inform changes for any specific job roles which are not captured.
- Non-attendance is to be raised in staff supervision by the line managers.
- Health Education England have released one-off funding for the rest of this financial year for Health Care Support Worker development. A post has been put in place for 6 months to reduce the backlog in Care Certificate – now sitting in Nurse Education Team.
- In 2022/23 a MAST Steering Group is to be set up in order to formalise decision making with respect to MAST and training delivery.
- There are currently sufficient ABLS training courses following an increase in capacity to 4 days per week and courses are now planned up to 6 months in advance. Cancellations and
- There is a London-wide shortage of BSL interpreters and it has been difficult to book sufficient for all MAST training. Prebooking can only be made 4 weeks in advance.
- Review of classroom and e-learning performance to be undertaken in new year. This review will also incorporate a review of DNAs by MAST course.
- Further reviews recommended to compare DNAs for F2F versus Webinar / Online training to establish causality and propose change.
- A review is required of the training provisions extended to voluntary, honorary and contract staff to ensure all staff representing the Trust are included into our onboarding processes and practise.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%

London Benchmark – October 2022

Trust	Leavers	Turnover rate
Tavistock and Portman NHS Foundation Trust	145	22.5%
Central and North West London NHS Foundation Trust	1261	17.9%
South West London and St George's Mental Health NHS Trust	413	17.7%
North East London NHS Foundation Trust	1041	17.5%
West London NHS Trust	669	17.5%
Barnet, Enfield and Haringey Mental Health NHS Trust	529	17.2%
South London and Maudsley NHS Foundation Trust	827	16.5%
East London NHS Foundation Trust	979	16.2%
Oxleas NHS Foundation Trust	551	15.2%

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

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

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

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

Actions:
- People Directorate are reviewing retention, attraction and work force planning as part of a follow up task and finish project following the recruitment incident. The onboarding workstream, which forms part of the Recruitment incident has also focussed on the candidate experience as part of the onboarding process ensuring new starters receive their kit and id badge on their first day and attend a Trust welcome and induction within their first few weeks of joining.
- Human Resources Business partners engaged with On-Boarding Working Group lead by Chief Operating Officer with view to improving exit interview process.
- There are ongoing discussions with HR and Service lines regarding staff leaver discussions and interventions where possible to request staff to reconsider potential resignation decisions.
- New dashboard for exit interviews developed by Information Management which will enhance the organisational learning.

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.

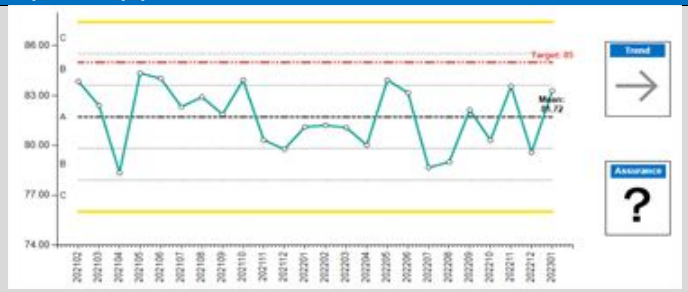
Underlying issue
- Whilst the Community service line have experienced significant workforce challenges, over 50% of the 'leavers within 1 year of starting' were Psychological Well Practitioners working for IAPT teams left to progress their career.
- Historically the Acute service line has had high turnover 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:
- Human Resources Business partners engaged with On-Boarding Working Group lead by Chief Operating Officer with view to improving exit interview process.
- **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.
- New dashboard for exit interviews developed by Information Management which will enhance the organisational learning.

Staff Retention/ Support / Satisfaction

Supervision (%)

Target ≥ 85%



Supervision by staff group / Corporate – January 2023

Clinical Staff	84.2%
Non-Clinical Staff (inclusive of Corporate)	76.5%
Corporate Services	80.7%

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

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

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

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

Staff Retention/ Support / Satisfaction

Appraisal (PADR) (%)

Target ≥ 95%

PADR by staff group / Corporate – January 2023

Clinical Staff	88.9%
Non-Clinical Staff (inclusive of Corporate)	88.7%
Corporate Services	90.6%

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

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

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

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

Staff Retention/ Support / Satisfaction

Active ER cases

Target TBA

Trend

Assurance: NA

Case Type Breakdown

Case Type	Employee Relation Cases	%
Appeal only	0	0.0%
Disciplinary	9	15.3%
Grievance	11	18.6%
Bullying & Harassment	2	3.4%
Performance	1	1.7%
Sickness Absence	36	61.0%
Total	**59**	
Employment Tribunal	15	

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

Factors Affecting Employee Relations Cases:

- At the end of January 2023, the ER team had 59 Open cases.
- There are 15 Employment Tribunal cases.

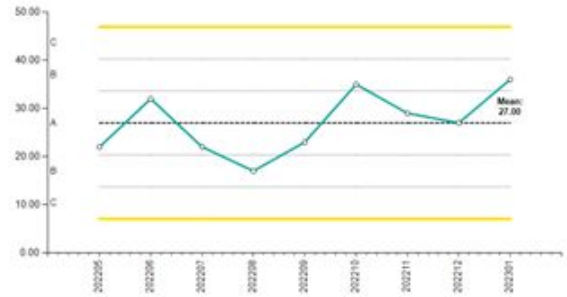
Actions:

- Informal resolution (mediation and facilitation pilot) is due to end with the service going live in December 2022.
- Acute & Urgent Care: Continued Monthly Training provided to managers in ER matters to prevent risk of claims.
- Coaching to Investigating officers to write robust investigation reports and present in formal hearings

Staff Retention/ Support / Satisfaction

ER Cases exceeding 90 days

Target TBA



Trend

Assurance: NA

What Chart Tells Us:
Low level variation with numbers over 90 days aligned to mean of 27 per month.

Underlying Issues:

- Current ER cases over 90 days are 36 which are being proactively managed.

Actions:

- As above.

Staff Retention/ Support / Satisfaction

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

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

Underlying Issues:

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

Actions:

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

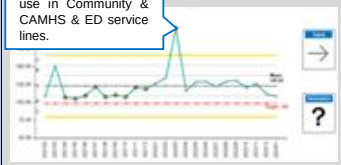
Finance Domain

Grip & Control

Agency spend as % to NHI target

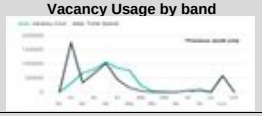
Target TBA

Increase in agency use in Community & CAMHS & ED service lines.



Vacancy Usage by Week

Vacancy Usage by band



Vacancy Spend – Indicative Numbers only.

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

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

Underlying issues:

- M10 spend was £918k; a £29k reduction compared to last month.
- Equates to 6.2% of pay costs; 7.2% cumulatively, 6.1% in 2021/22, London average 4.4%, NHSE target 3.7%.
- The skill mix breakdown of changes shows an increase in high-cost medical agency and a decrease in lower value agency.
- Highest areas of monthly spend include Medical £387k, Nursing £259k, and Scientific £104k. Challenge remains recruiting to community Consultant posts leading to service pressures and high-cost agency locums – a third of substantive consultant posts are vacant.
- The key pressure area remains the Community Service Line. £596k of the £918k total spend (65%)
- Financial incentives and flexibility afforded by agency working remain key barriers to transitioning staff to bank or permanent contracts.

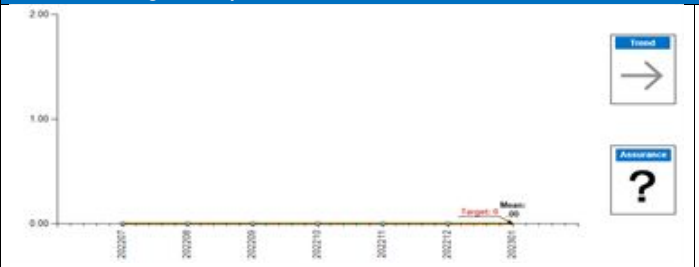
Actions:

- The reduction in agency expenditure remains a Trust priority with Service Lines asked to identify exit strategies for all agency staff and weekly monitoring of wte.
- The agency process was re-launched on 1 Feb 23 and includes tighter controls for agency approval.
- Weekly reporting of agency spend and numbers to Executive remains in place

Grip & Control

% Forecast budget overspend

Target TBC



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

Underlying Issues:

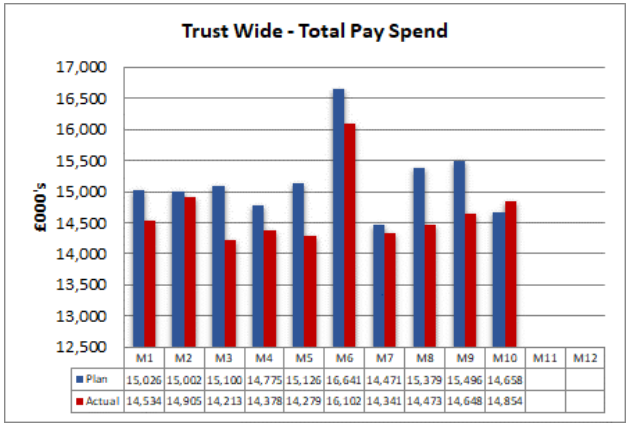
- Trust: The Trust is forecasting break-even overall currently.
- Acute: The projected overspend is due mainly to staffing pressures within inpatient services and high external bed usage.
- CAMHS & Specialist: Underspend linked to vacances in service lines.

Actions:

- Acute and Urgent Care: Pay overspends on wards due to observation levels; being addressed through FSOC and review of observations and engagement- fidelity to the trust policy and recruitment to vacancies.
- Overspends due to agency – addressed through review of agency and conversion to bank or FTC where possible. Line by line reviews with each service line in train.
- OOA beds addressed through LOS stay work and DTOC work programs.
- CAMHS & ED: Vacancies, agency are reviewed between the service line, HR and Finance. Additionally as above the establishment is being reviewed and validated.
- Specialist: A number of posts have closed and have no application or suitable candidates and are going back out to advert ASAP. Review of vacancies, agency use are being reviewed between the service line, HR and Finance.
- Specialist Service Line reviewing stretched target to include additional non-recurrent savings and NPSA activity on Seacole Ward & potentially develop NPSA income from Ruby ward, when it moves to the new Shaftesbury.

Pay Cost Vs Budget

Grip & Control



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Plan	15,026	15,002	15,100	14,775	15,126	16,641	14,471	15,379	15,496	14,658		
Actual	14,534	14,905	14,213	14,378	14,279	16,102	14,341	14,473	14,648	14,854		

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

Underlying Issues:
- An underspend is due to vacancies across the service line.
- Acute and Urgent Care: Overspend is mainly due to staffing and out of area bed placements which is unfunded aside from the acute bed contract with Holybourne.
- CAMHS & Eating Disorders: Vacancies in Nursing, Psychologists, Medical Consultants and Psychotherapists linked to underspend.
- Specialist: Vacancies in Nursing (Qualified) underspend offsetting a Nursing (Unqualified) £overspend, Psychologists £243k, AHPs £244k and Consultants £129k.

Actions:
- Acute and Urgent Care: Pay overspends on wards due to observation levels; being addressed through FSOC and review of observations and engagement- fidelity to the trust policy and recruitment to vacancies.
- CAMHS & ED: Vacancies, agency are reviewed between the service line, HR and Finance. Additionally as above the establishment is being reviewed and validated.
- Specialist: A number of posts have closed and have no application or suitable candidates and are going back out to advert ASAP. Review of vacancies, agency are being reviewed between the service line, HR and Finance.

Cumulative CIP Delivery — No Target

Grip & Control

What Chart Tells Us:
CIP Delivery position is slightly ahead of plan, £0.1m favourable YTD.

Underlying Issues:
- Recurrent Green savings represent 30% of the total CIP target. The Trust remains behind nationally reported averages of c50% recurrent. This is driving a high savings target for 2023/24.
- Following the in-month improvement within Community Adult (£1m of red/amber schemes turned green through non recurrent pay underspends) the Trust now has a delivery confidence of 103%.

Actions:

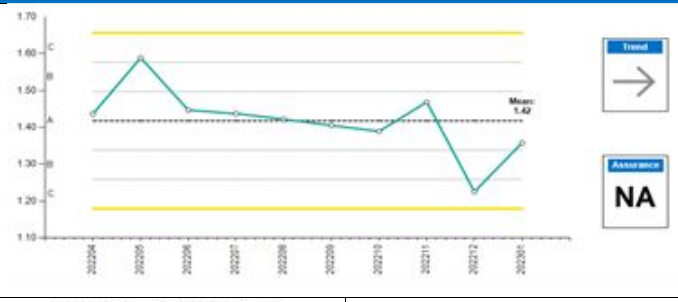
- Focus is centred on the 2023/24 CIP delivery plan, whilst ensuring green schemes continue to deliver for the last two months of the year as expected.
- Temporary staffing reductions and clinical efficiency are the key areas of under delivery and require further traction to support delivery.
- The focus moving forward will be in 3 key areas:
  - Reducing agency spend and the associated £2m cost premium
  - Reducing reliance upon external private beds
  - Productivity

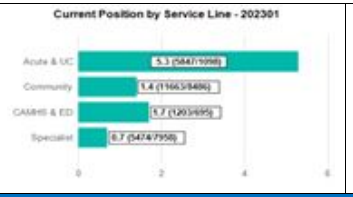
Commented [DG1]: Acute: CIPs identified are mainly non-recurrent pending the outcome of continued work:
Trial in Liaison to address performance
HTT impact of Coral Hub changes
Perinatal investment review

Activity vs Caseload (%)

No Target

Productivity





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

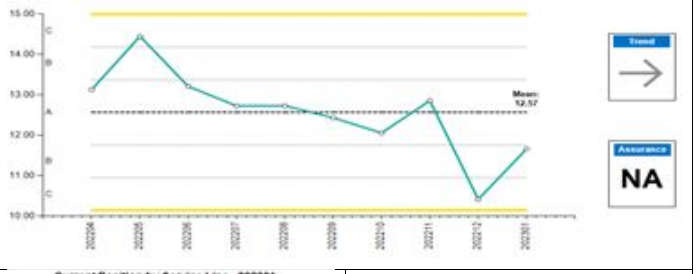
Underlying Issue
- New productivity measures have been introduced to reporting in September 2022.
- Variation in performance within services and poor administration leading to appointments not being booked or outcomed.
- Community: Complex clinical work requiring significant non patient facing care planning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

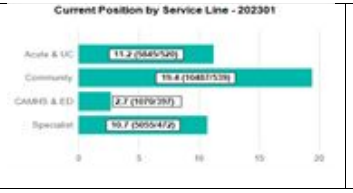
Actions
- Reports to support service lines with monitoring are being development.
- Community Service Line to target services with high levels of unoutcomed appointments in order to improve activity reporting.
- KPI document to be developed to assist with metric understanding.
- Specialist: Service variation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

Activity vs WTE

No Target

Productivity





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

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

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

Productivity

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

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

Underlying Issue
- New productivity measures have been introduced to reporting in September 2022.
- The Trust needs to have more focus on activity reporting and this will be reviewed at service line meetings. Current oversight is not routine.
- CAMHS: Richmond & Wandsworth looks like the main outliers against target with under-performance linked to SPA & liaison.
- In local Specialist Services recruitment and long term sickness impacting.

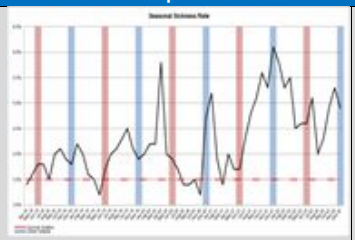
Actions
- Contracted activity reports to be issued to services pre submission to commissioner in order enable greater oversight on reporting.
- Productivity metrics are reviewed at the monthly Flow Meeting with greater emphasis on local contract performance in recent months.
- Reports to support service lines with this process need development.
- Contract schedule to commissioners is currently shared with service line management and Performance Analysts.
- Community Service Line to target services with high levels of unoutcomed appointments in order to improve activity reporting.
- CAMHS: SPA/Referral contacts have improved post the MHDS re-alignments have now actioned early February 2023. The underperforming SPA teams remain Kingston & Richmond SPA service which has been gradually recruiting towards new investment in 2022/23.
- Dashboard report to support contracted activity reporting has been developed and deployed by Information Management.

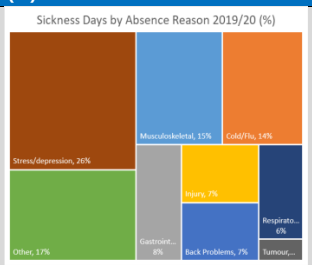
Non-Priority Metrics: reported by exception

Staff Retention/ Support / Satisfaction

Sickness Rate - reported month in arrears (%)

Target ≤ 3.5%





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

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

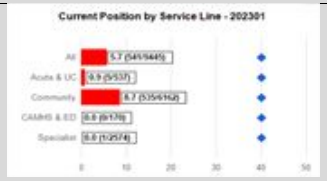
Underlying issue
- The spike in January 2021 relates to COVID and the effects on staff of the vaccine. For example, in Acute and Urgent Care there were 180 episodes of short term sickness, an increase of 16 from the previous month. Of this 180, 99 were related to COVID.
- A complex method of reporting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

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

Patient Experience & Outcomes

Paired Dialog Completed

Target ≥ 40%



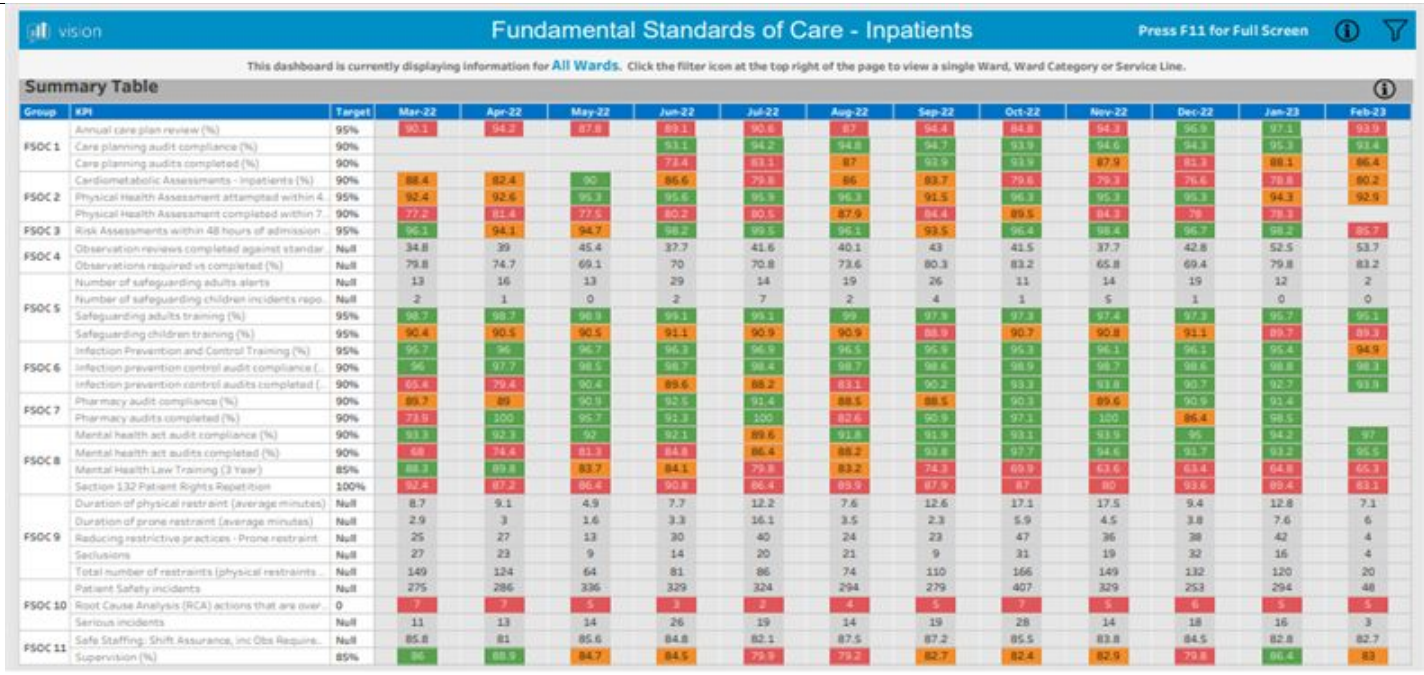
Background
DIALOG is an 11-question survey whereby people with a mental health illness are asked to rate their satisfaction and needs for care on 8 life domains and 3 treatment aspects. It is a tool that is completed by the service user and its content helps to highlight areas they may want support with.

What the chart tells us
Too early to draw conclusions as only available for last two months.

Underlying issue
- Reporting on paired dialog is new to the Trust and local practice is being embedded.
- Review of team inclusions for DIALOG is ongoing and is discussed at the Patient Experience & Outcomes Group.
- Trust is currently benchmarking well on Paired Prom measure – 6% compared to national average of 3% (based on November 2022).
- The Trust has been invited to showcase the work undertaken on the Mental Health Outcomes CQUIN at the National (NHS-E) outcomes CQUIN webinar.

Actions
- SOP for dialog use has been developed and issued to across the Trust.

Fundamental Standards of Care Dashboard – Inpatients



vision

Fundamental Standards of Care - Inpatients

Press F11 for Full Screen

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

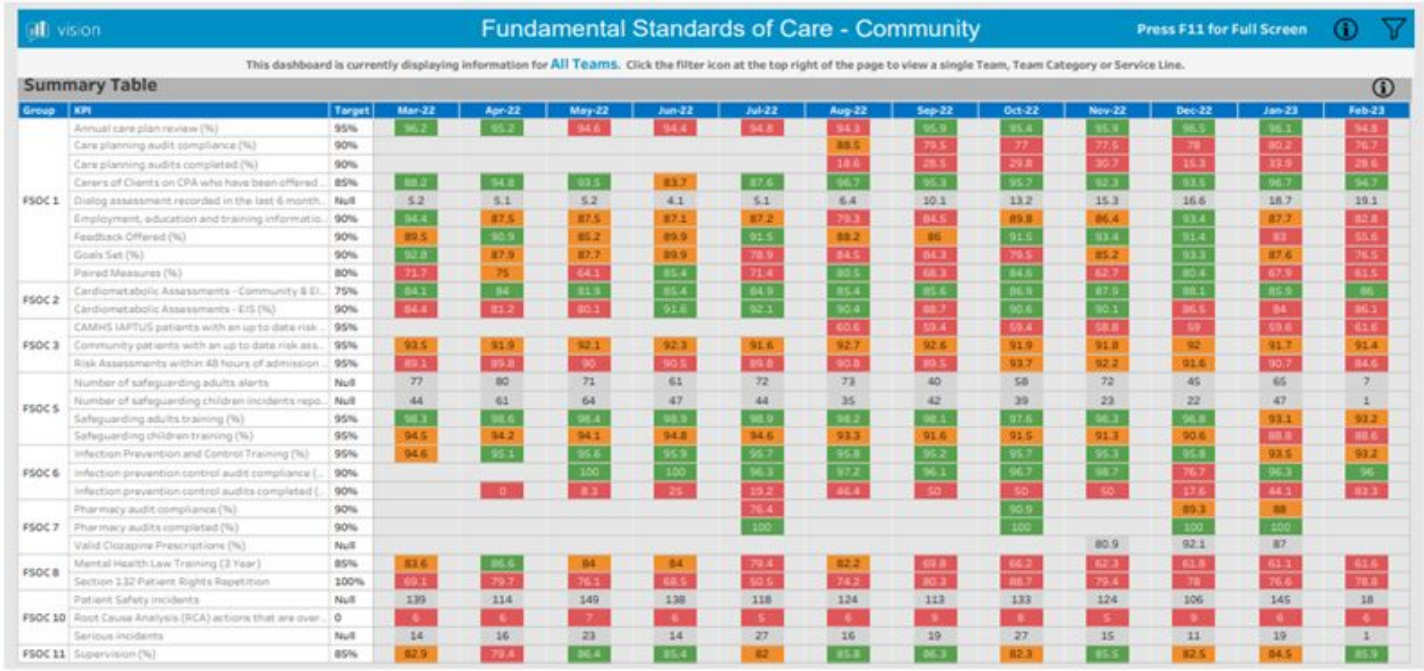
Summary Table

Group	KPI	Target	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
FSOC 1	Annual care plan review (%)	95%	90.1	94.2	87.8	89.1	90.6	87	94.4	84.8	94.3	96.9	97.1	93.9
	Care planning audit compliance (%)	90%				93.1	94.2	94.8	94.7	93.9	94.6	94.3	95.3	93.4
	Care planning audits completed (%)	90%				73.4	83.1	87	93.9	93.9	87.9	81.3	88.1	86.4
FSOC 2	Cardiometabolic Assessments - Inpatients (%)	90%	88.4	82.4	90	86.6	79.8	86	83.7	79.6	79.3	76.6	78.8	80.2
	Physical Health Assessment attempted within 4	95%	92.4	92.6	95.3	95.6	95.9	96.3	91.5	96.3	95.3	95.3	94.3	92.9
	Physical Health Assessment completed within 7	90%	77.2	81.4	77.5	80.2	80.5	87.9	84.4	89.5	84.3	78	78.3	
FSOC 3	Risk Assessments within 48 hours of admission	95%	96.1	94.1	94.7	98.2	99.5	96.1	93.5	96.4	98.4	96.7	98.2	85.7
FSOC 4	Observation reviews completed against standar	Null	34.8	39	45.4	37.7	41.6	40.1	43	41.5	37.7	42.8	52.5	53.7
	Observations required vs completed (%)	Null	79.8	74.7	69.1	70	70.8	73.6	80.3	83.2	65.8	69.4	79.8	83.2
FSOC 5	Number of safeguarding adults alerts	Null	13	16	13	29	14	19	26	11	14	19	12	2
	Number of safeguarding children incidents repo	Null	2	1	0	2	7	2	4	1	5	1	0	0
	Safeguarding adults training (%)	95%	98.7	98.7	98.9	99.1	95.1	99	97.9	97.3	97.4	97.3	95.7	95.1
	Safeguarding children training (%)	95%	90.4	90.5	90.5	91.1	90.9	90.9	88.9	90.7	90.8	91.1	89.7	89.3
FSOC 6	Infection Prevention and Control Training (%)	95%	95.7	96	96.7	96.3	96.9	96.5	95.9	95.3	96.1	96.1	95.4	94.9
	Infection prevention control audit compliance (	90%	96	97.7	98.5	98.7	98.4	98.7	98.6	98.9	98.7	98.6	98.8	98.3
	Infection prevention control audits completed (	90%	65.4	79.4	90.4	89.6	88.2	83.1	90.2	93.3	93.8	90.7	92.7	93.8
FSOC 7	Pharmacy audit compliance (%)	90%	89.7	89	90.9	92.5	91.4	88.5	88.5	90.3	89.6	90.9	91.4	
	Pharmacy audits completed (%)	90%	73.9	100	95.7	93.3	100	82.6	90.9	97.1	100	86.4	98.5	
FSOC 8	Mental health act audit compliance (%)	90%	93.3	92.3	92	92.1	89.6	91.8	91.9	93.1	93.9	95	94.2	97
	Mental health act audits completed (%)	90%	68	74.4	81.3	84.8	86.4	88.2	93.8	97.7	94.6	91.7	93.2	95.5
	Mental Health Law Training (3 Year)	85%	88.3	89.8	83.7	84.1	79.8	83.2	74.3	69.9	63.6	63.4	64.8	65.3
	Section 132 Patient Rights Repetition	100%	92.4	87.2	86.4	90.8	86.4	89.9	87.9	87	80	93.6	89.4	83.1
FSOC 9	Duration of physical restraint (average minutes)	Null	8.7	9.1	4.9	7.7	12.2	7.6	12.6	17.1	17.5	9.4	12.8	7.1
	Duration of prone restraint (average minutes)	Null	2.9	3	1.6	3.3	16.1	3.5	2.3	5.9	4.5	3.8	7.6	6
	Reducing restrictive practices - Prone restraint	Null	25	27	13	30	40	24	23	47	36	38	42	4
	Seclusions	Null	27	23	9	14	20	21	9	31	19	32	16	4
	Total number of restraints (physical restraints	Null	149	124	64	81	86	74	110	166	149	132	120	20
	Patient Safety incidents	Null	275	286	336	329	324	294	279	407	329	253	294	48
FSOC 10	Root Cause Analysis (RCA) actions that are over	0	7	7	5	3	2	4	5	7	5	6	5	5
	Serious incidents	Null	11	13	14	26	19	14	19	28	14	18	16	3
FSOC 11	Safe Staffing: Shift Assurance, inc Obs Require	Null	85.8	81	85.6	84.8	82.1	87.5	87.2	85.5	83.8	84.5	82.8	82.7
	Supervision (%)	85%	86	88.9	84.7	84.5	79.9	79.2	82.7	82.4	82.9	79.8	86.4	83

Comments

- The work on Fundamental standards of care continues to be led through the service line leadership team with great engagement from frontline staff. We have agreed a process for teams of concern to be escalated through the Service Line Reviews, triangulated with the SIREN and the quality metrics. The FSOC are also embedded into the new building inductions to support it being part of the new culture.
- Changes to be made to the dashboard to help easily identify outstanding actions from Incidents and Root Cause Analysis (RCAs), and Post Incident Reviews (PIR's).
- Action plan for each Service line on improving outstanding or unmanaged incidents.

Fundamental Standards of Care Dashboard – Community



vision

Fundamental Standards of Care - Community

Press F11 for Full Screen

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

Summary Table

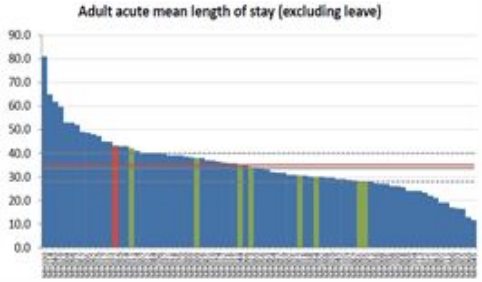
Group	KPI	Target	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
	Annual care plan review (%)	95%	96.2	95.2	94.6	94.4	94.8	94.3	95.9	95.4	95.9	96.5	96.1	94.8
	Care planning audit compliance (%)	90%						88.5	79.5	77	77.5	78	80.2	76.7
	Care planning audits completed (%)	90%						18.6	28.5	29.8	30.7	15.3	33.9	28.6
	Carers of Clients on CPA who have been offered ...	85%	88.2	94.8	93.5	83.7	87.6	96.7	95.3	95.7	92.3	93.5	96.7	94.7
FSOC 1	Dialog assessment recorded in the last 6 month...	Null	5.2	5.1	5.2	4.1	5.1	6.4	10.1	13.2	15.3	16.6	18.7	19.1
	Employment, education and training informatio...	90%	94.4	87.5	87.5	87.1	87.2	79.3	84.5	89.8	86.4	93.4	87.7	82.8
	Feedback Offered (%)	90%	89.5	90.9	85.2	89.9	91.5	88.2	86	91.5	93.4	91.4	83	55.6
	Goals Set (%)	90%	92.8	87.9	87.7	89.9	78.9	84.5	84.3	79.5	85.2	93.3	87.6	76.5
	Paired Measures (%)	80%	71.7	75	64.1	85.4	71.4	80.5	68.3	84.6	82.7	80.4	67.9	61.5
FSOC 2	Cardiometabolic Assessments - Community & El...	75%	84.1	84	81.9	85.4	84.9	85.4	85.6	86.9	87.9	88.1	85.9	86
	Cardiometabolic Assessments - EIS (%)	90%	84.4	81.2	80.1	91.6	92.1	90.4	88.7	90.6	90.1	86.5	84	86.1
FSOC 3	CAMHS IAPTUS patients with an up to date risk ...	95%						60.6	59.4	59.4	58.8	59	59.6	61.6
	Community patients with an up to date risk ass...	95%	93.5	91.9	92.1	92.3	91.6	92.7	92.6	91.9	91.8	92	91.7	91.4
	Risk Assessments within 48 hours of admission ...	95%	89.1	89.8	90	90.5	89.8	90.8	89.5	93.7	92.2	91.6	90.7	84.6
FSOC 5	Number of safeguarding adults alerts	Null	77	80	71	61	72	73	40	58	72	45	65	7
	Number of safeguarding children incidents repo...	Null	44	61	64	47	44	35	42	39	23	22	47	1
	Safeguarding adults training (%)	95%	98.1	98.6	98.4	98.9	98.9	98.2	98.1	97.6	96.3	96.8	93.1	93.2
	Safeguarding children training (%)	95%	94.5	94.2	94.1	94.8	94.6	93.3	91.6	91.5	91.3	90.6	88.8	88.6
FSOC 6	Infection Prevention and Control Training (%)	95%	94.6	95.1	95.6	95.9	95.7	95.8	95.2	95.7	95.3	95.8	93.5	93.2
	Infection prevention control audit compliance (...	90%			100	100	96.3	97.2	96.1	96.7	98.7	76.7	96.3	96
	Infection prevention control audits completed (	90%		0	8.3	25	19.2	46.4	50	50	50	17.6	44.1	83.3
FSOC 7	Pharmacy audit compliance (%)	90%					76.4			90.9		89.3	88	
	Pharmacy audits completed (%)	90%					100			100		100	100	
	Valid Clozapine Prescriptions (%)	Null									80.9	92.1	87	
FSOC 8	Mental Health Law Training (3 Year)	85%	83.6	86.6	84	84	79.4	82.2	69.8	66.2	62.3	61.8	61.1	61.6
	Section 132 Patient Rights Repetition	100%	69.1	79.7	76.1	68.5	50.6	74.2	80.3	88.7	79.4	78	76.6	78.8
FSOC 10	Patient Safety Incidents	Null	139	114	149	138	118	124	113	133	124	106	145	18
	Root Cause Analysis (RCA) actions that are over...	0	6	6	7	6	5	6	9	8	5	9	6	6
	Serious incidents	Null	14	16	23	14	27	16	19	27	15	11	19	1
FSOC 11	Supervision (%)	85%	82.9	79.4	86.4	85.4	82	85.8	86.3	82.3	85.5	82.5	84.5	85.9

Comments

- The work on Fundamental standards of care continues to be led through the service line leadership team with great engagement from frontline staff. We have agreed a process for teams of concern to be escalated through the Service Line Reviews, triangulated with the SIREN and the quality metrics. The FSOC are also embedded into the new building inductions to support it being part of the new culture.
- New Community Dashboard for Community Fundamental Standards of Care was launched on the 4th July 2022.
- Changes to be made to the dashboard to help easily identify outstanding actions from Incidents and Root Cause Analysis (RCAs), and Post Incident Reviews (PIR's).
- Action plan for each Service line on improving outstanding or unmanaged incidents.

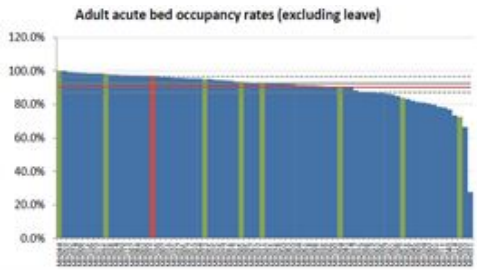
Appendix 1: Benchmarking

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



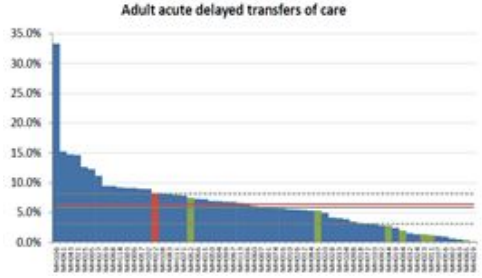
- **Adult acute average length of stay (days):**

2021/22		2022/23	
Trust	England	Jan-23	YTD
43.0	34.9	50.3	48.9



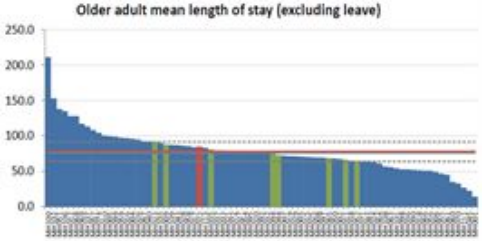
- **Adult acute bed occupancy rate (%):**

2021/22		2022/23	
Trust	England	Jan-23	YTD
97.1%	90.5%	98.8%	98.4%



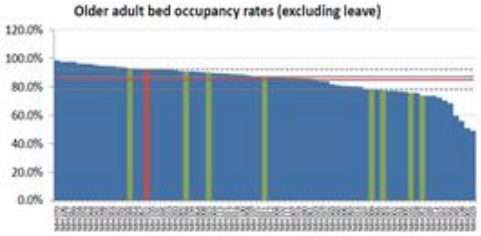
- **Adult acute delayed transfers of care (%):**

2021/22	
Trust	England
8.1%	6.4%



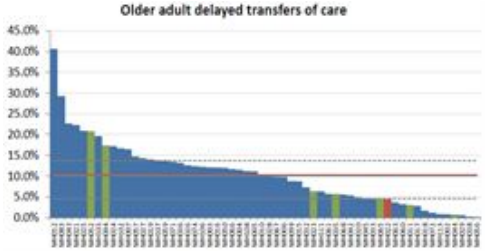
- **Older people's average length of stay (days):**

2021/22		2022/23	
Trust	England	Jan-23	YTD
84.0	78.5	97.9	97.6



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

2021/22		2022/23	
Trust	England	Jan-23	YTD
92.6%	84.8%	91.2%	90.2%



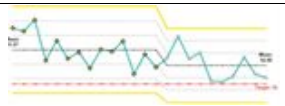
- **Older people's delayed transfers of care (%):**

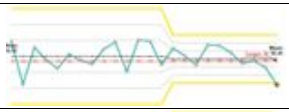
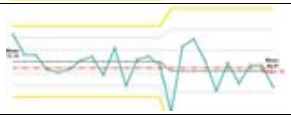
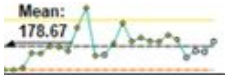
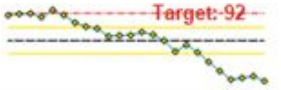
2021/22	
Trust	England
4.4%	10.3%

Appendix 2: NHSI Compliance Overview

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

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

NHSI SOF Operational Performance Metrics	Jan-23	Target	Trend	Assurance on consistently meeting the target	SPC Chart	Comments
Data quality maturity index (DQMI) (%) see page 17	98	≥ 95.0	→	✓		Performance remains stable and consistently exceeds the target following the introduction revised administrative processes to collect missing data. The Trust is reported by NHS Digital as being one of the highest performers in England.
IAPT recovery rate - Talk Wandsworth (%) see page 24	51	≥ 50.0	→	✓		Performance is consistently above target for Talk Wandsworth.
IAPT/talking therapies - Waiting time to begin treatment within 18 weeks (%)	99.9	≥ 95.0	→	✓		Performance is consistently above target.
IAPT/talking therapies - Waiting time to begin treatment within 6 weeks (%)	98.4	≥ 75.0	→	✓		Performance is consistently above target.
Cardiometabolic Assessments - Community & EIS (%) see page 20	85.9	≥ 75.0	↗	✓		Sustained improvement following the implementation of a recovery plan in January 2020. Data forms have been simplified and were introduced across the Trust in September 2020. Staff continue to be trained on the use of the new forms and guidance has been issued.
1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) see page 9	66.7	≥ 60.0	→	?		There was a period of deterioration in performance, mainly due to referrals from wards and assessment teams.

IAPT recovery rate - Merton Uplift (%) see page 24	45.2	≥ 50.0	→	?		Average performance for 2022/23 is currently above target.
IAPT recovery rate - Sutton Uplift (%) see page 24**Error! Bookmark not defined.**	46.6	≥ 50.0	→	?		Average performance for 2022/23 is currently below target.
Inappropriate out of area placement bed days - Adult Acute & PICU Ⓟ see page 16	216	= 0	↗	X		The Trust has opened surge beds to help manage peak demand and keep out of area usage to minimum and has negotiated a six month contract for use of 12 beds at Huntercombe unit which commenced on 29th November 2021.
Cardiometabolic Assessments - Inpatients (%)	78.8	≥ 90.0	↘	X		A task and finish group has reviewed the process for capturing physical health information on clinical systems. Clinical data collection forms have been simplified and were implemented across the Trust in Sept 20. Guidance has been issued to all staff.
Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) see page 10	78.8	≥ 92.0	↘	X		There have been demand and capacity issues within adult ADHD services. A wait list initiative targeted at longest waiters ran between March 2022 – July 2022 where 176 of longest waiters were transferred and seen by a third party provider. Additional resources for non-medical prescribing have also been put in place.

Appendix 3: Effective: CQUIN key measures

Overall Dashboard					
Effective: CQUIN Key Measures	**Target**	**Jan-23**	**YTD**	**Information**	**Outcome**
Flu vaccinations for frontline healthcare workers (%)	≥ 90.0	36		Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	Currently the Trust is at 36%, which is far below the minimum threshold of 70%. The Trust is not an outlier to other Trusts and was second best mental health in London at the end of Q3.
Cirrhosis and fibrosis tests for alcohol dependent patients (%)	≥ 35.0	N/A		Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	Q3 was achieved. There has been one case in January that needs to be audited to see if criteria has been met and achieved
Routine outcome monitoring in CYP and perinatal mental health services (%)	≥ 40.0	24.6		Achieving 40% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measured at least twice	Q3 was partially achieved. Currently partially achieving target.
Routine outcome monitoring in community mental health services (%)	≥ 40.0	9.5		Achieving 40% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice. To meet the requirements of this indicator, Patient Reported Outcome Measures (PROMs) data will need to be submitted (either in combination with Clinician Reported Outcome Measures (CROMs), or only PROMs) as part of the numerator for this CQUIN during the financial year.	Q3 was not achieved. The Trust is almost at the lowest threshold of achievement for this CQUIN and will be at achievement in February.
Use of anxiety disorder specific measures in IAPT (%)	≥ 65.0	67.8		Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).	Q3 was partially achieved. The CQUIN is back above the highest achievement and looks set to fully achieve for Q4
Biopsychosocial assessments by MH liaison services (%)	≥ 80.0	82		Achieving 80% of self-harm [1] referrals receiving a biopsychosocial assessment concordant with NICE guidelines	Q3 was fully Achieved. Audits are currently being sent to the team for completion
CAMHS Formulation (%)	≥ 80.0	75		Delivery of formulation or review within 6 weeks of admission, as part of a dynamic assessment process for admissions within Tier 4 CYPMH settings	Q3 was partially achieved. Currently have 7 admissions in January for auditing.
CAMHS: Restrictive Practice (%)	≥ 80.0	72.8		Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings	Q3 was partially achieved. There has been an improvement in results in January from end of Q3, the CQUIN looks to partially achieve Q4 targets.

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

Key points and underlying issues	Action taken
▪ The CQC undertook an inspection of our services in September 2019, with the Well-Led element in October 2019. ▪ The subsequent report concluded an overall rating of 'good' across all five domains. It was clear that the Trust had really strengthen its good rating, but not to the extent to achieve 'outstanding' at this time (see matrix below) ▪ The only areas that were deemed as 'requires improvement' were from the Specialist eating disorders service, which also resulted in requirement notices in respect of five regulates that were assessed as being breeched in this service ▪ As expected, the CQC focused heavily on physical health care plans; ligature audits, risk assessments, incident reporting and learning from incidents; staff morale, records of staff training and meetings, the quality of staff supervision, and are asking to see to see a number of types of documentation such as audits and records. ▪ The CQC noted many outstanding features, such as; o In our wards for older people with mental health problems, staff provided excellent support to families and carers, considered their needs and were proactive in involving them in their relative's care o Staff provided a very high standard of physical health care and treatment to patients. o The Trust's 'safety in motion programme' which works to reduce restrictive interventions shows that staff are committed to using the least restrictive practice and this was evident in the low usage of restraint, seclusion and rapid tranquilisation. o On Avalon Ward, the occupational therapist developed a 'Your Group, Your Say' workshop where patients could make suggestions for new ward groups and then vote on what activities they wanted. o The Trust had set up an expert panel to look at the experience of black, Asian and minority ethnic (BAME) patients who were over-represented in mental health services and less likely to use talking therapies. The panel was chaired by an academic expert in the field. The expert panel was committed to developing a work programme to make Trust services appropriate to BAME needs and ensure equitable, safe and effective mental health care. o The pharmacy team had written a successful business case for a project on medicines optimisation in care homes for people living with learning disabilities. This has received praise from GPs and other stakeholders across the five boroughs. o CQC also found our staff to be caring, compassionate and kind and the leadership of our wards and services is strong and is having a positive impact on patient care. Patients were positive about the care and treatment that they are receiving from us and Physical health care had improved - in particular NEWs escalation and Rapid Tranquillisation monitoring. They commended the model of care provided in Lotus Psychiatric Decision Unit - which is important as we are leading the way nationally in this area o They found strong evidence of good risk management, learning from incidents and teamwork	▪ During the inspection a number of immediate actions were taken to address the verbal feedback provided each day. Action plans were devised after receiving formal verbal feedback in September 2019 at the end of the inspection ▪ Upon receipt of the draft report in November 2019 the actions were initially reviewed with the Service Lines, through the CQC Actions Group, that also established actions that link with the supporting information pack provided by the CQC. ▪ The actions were formally agreed at QGG in January 2020 and presented to QSAC for assurance also in January 2020. ▪ The Trust received the final published report for the long stay or rehabilitation mental health wards for working age adults Inspection (which happened in October 2022) in January 2023. ▪ The Trust had sent the factual accuracy document to the CQC ahead of the deadline given by the CQC. ▪ The CQC upheld all of the factual accuracies given by the Trust, which were typographical in nature. ▪ The report confirms that the Core service have improved their ratings from requires improvement in Safe, Effective and Well-led to good, which has improved the overall rating to good. ▪ The core service have had the must do actions received in 2021 rescinded, which will be confirmed once the final report is received. This means that the Trust now only have 2 must do actions, where there were 15 at the beginning of 2022/23 year. ▪ The Trust did not receive any new must do actions and received 4 new should do actions, which the service line believe are fair to the feedback received. ▪ The new should do's are: - The service should ensure that the medicines trolley and fridge is cleaned and appropriately maintained on Phoenix Ward. - The service should ensure that patients' elevated NEWS2 vital signs are always escalated promptly and in line with trust policy. - The service should ensure that patient risk assessments are kept up to date and recorded on the electronic patient record. - The service should ensure that fire drills are carried out on Phoenix Ward more frequently. **Ratings on how Trust Scored for each core service:**

Appendix A – Current regulation notices

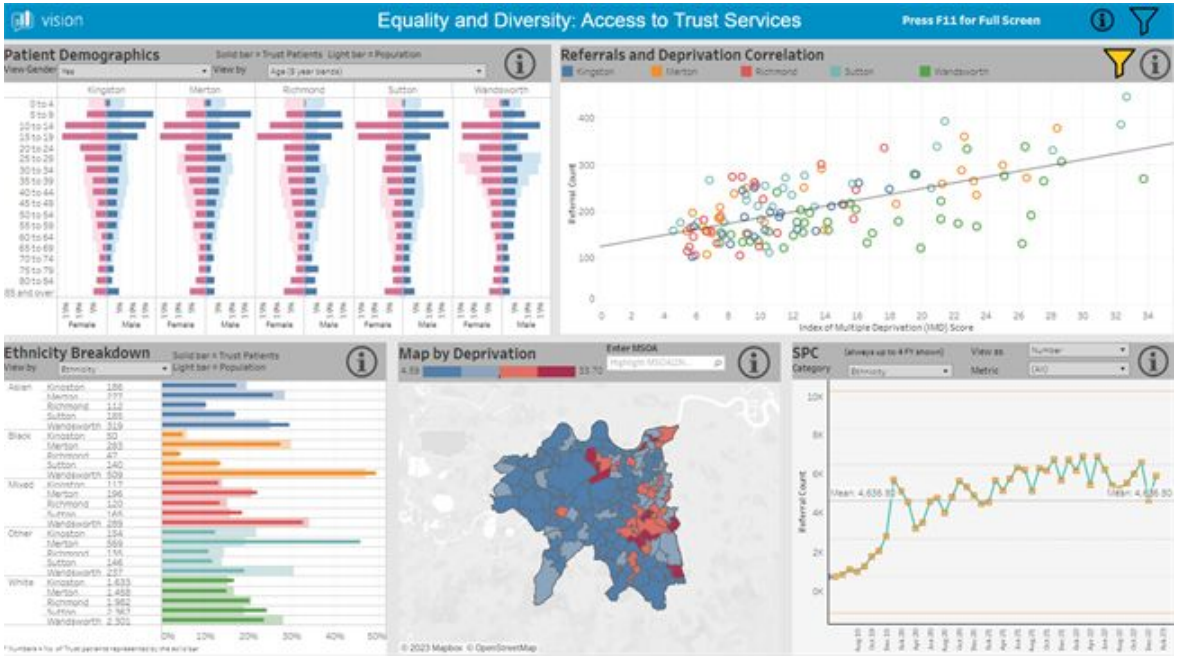
Regulation	Service	Issue
Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Acute wards for adults of working age and psychiatric intensive care units	The trust must ensure that there are appropriate and detailed plans in place to manage patients' physical health risks and that specialist advice is followed after a review of patients' needs. Regulation 12 (1)(b)
		The trust must ensure that staff do not complete intermittent observations at regular, predictable intervals. Regulation 12 (1)(b)

CQC MHA monitoring visits

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

Appendix 5: Equality Diversity Dashboard

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



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

Selected key themes by dashboard heading:

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

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

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

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

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

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

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

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

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

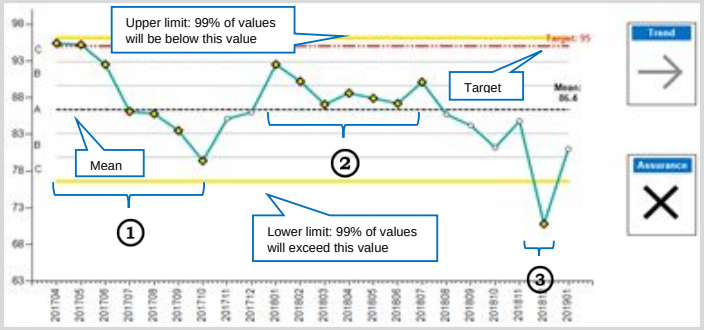
Appendix 7: Data quality assurance

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

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

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

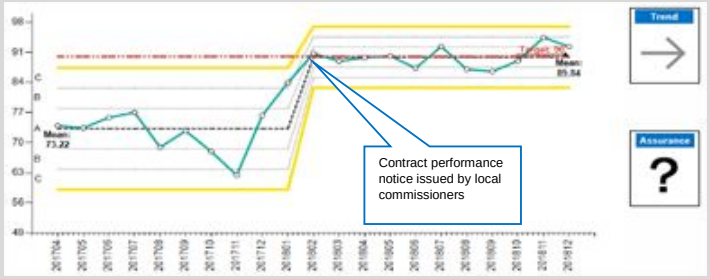
Appendix 8: Statistical Process Control (SPC) Charts & Performance Donut



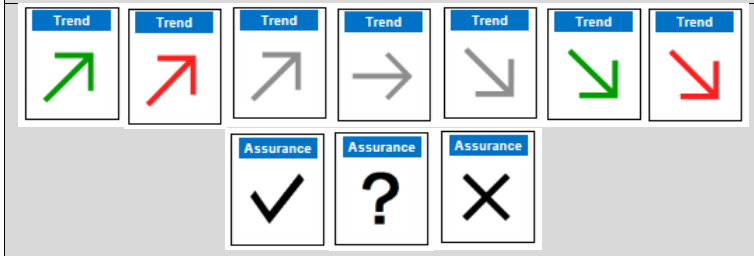
What is an SPC chart?
A Statistical Process Control (SPC) chart is a time series graph (we try to use 2 years) with three reference lines – the mean, upper and lower control limits. The limits help you understand the variability of the data. The variance of the data determines the process limits and you can expect 99% of data points to fall between them in normal circumstances.

Why we use SPC charts
They are used to distinguish between natural variation ('**common-cause**' and not caused by anything in particular) in performance and unusual patterns ('**special cause**', unexpected events) in the data which are unlikely to have occurred due to chance and require investigation. They also give us assurance on whether a target will reliably be met or whether we will never improve without doing things differently and show the impact of any changes made to improve performance.

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



Special-cause variation
These are statistically significant patterns in data which may require investigation and includes the following (as illustrated in the chart above):
Trend: 7 consecutive points trending up or trending down (a 0.8% chance of this happening naturally).
Zone A: 7 or more consecutive points on one side of the average (Zone A or beyond).
Beyond limits: beyond upper or lower control limit.
A full list of the statistical tests applied to determine special cause variation can be viewed under the charts in the Trust's SPC Suite (My Dashboards > Quality > SPC Reports > SPC Suite).
Use of a 'step-change' in SPC charts
Where performance has been permanently affected by a change in process (and the process change is known) then a **'step change'** should be applied to the SPC charts. For example, in the chart opposite the Trust was issued with a contract performance notice and the resulting improvement plan led to a change in process and improvement in performance. In these cases, the mean, upper and lower control limits are recalculated after the change in process.

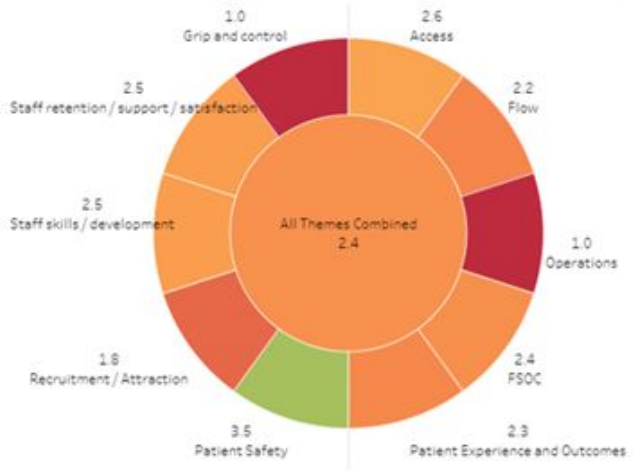


Use of icons to interpret charts
The Trend icon is shown as one of seven upward, horizontal or downward arrows depending on which direction the data is heading, coloured green, grey or red to indicate whether this is an improvement or deterioration in performance (or neutral where there is no target set); the icon is based on any trends identified involving any of the last **SIX** data points.
The Assurance icon
Assurance given: Target is in zone C or beyond (3+ standard deviations) and below the mean; reversed for when target goal is low and target is above the mean.
Questionable Assurance: Target is within zones A and B (1-2 standard deviations).
Assurance not given: Target is in zone C or beyond (3+ standard deviations) and above the mean; reversed for when target goal is low and target is below the mean.
If *Assurance is given* as above, but target has been missed in last 3 months then set to "*Questionable Assurance*" (and reversed for when assurance not given).
If "*Questionable Assurance*", however target has been hit for last 6 months and positive trend identified then set to "*Assurance Given*" (and vice versa for "*Assurance not given*").

Performance Donut Summary

Board Assurance Framework – Latest Risk

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



Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	4	16	21	48.8%
Quality	4	8	6	66.7%
Workforce	3	1	7	36.4%
Finance	0	0	2	0.0%
Total	**11**	**25**	**36**	**50.0%**

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

- Overall performance is measured on statistically significant improvement or deterioration and trends and follows NHSI best practice. This replaces performance based on year to date averages and in month performance that are affected by natural variation (RAG rating).
- The new methodology is based on the metrics' assurance on consistently meeting target and whether there is a positive or negative data trend – see appendix 7 for detailed explanation
- The metrics in each of the nine themes are given a score and the average is used to determine the colour rating (shown below).
- The middle section of the 'donut' represents the average score across all 9 themes.
- The table below shows the scores given to each pairing of the 'level of assurance' and 'trend'.
- The best ranking (a positive trend with a 'tick' for assurance) gives a score of 5, while the worst ranking (a negative trend with a 'cross' for assurance) gives a score of 1.

Possible Donut ranking: 5 = best, 1 = worst

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

RAG Rating:
Score
1.0 — 5.0

Meeting:	**Trust Board**
Date of Meeting:	**9th March 2023**
Report Title:	**2022/23 Corporate Objectives – Q3 delivery**
Author(s):	**Amy Scammell, Director of Strategy, Transformation and Commercial Development**
Executive Sponsor(s):	**Amy Scammell, Director of Strategy, Transformation and Commercial Development**
Purpose:	**For approval**
Scrutiny Pathway:	**Executive Leadership Team 19.01.23; Quality and Safety Committee 06.02.23; Estate Modernisation Committee 07.02.23; Workforce and Organisational Development Committee 23.01.23; Equality and Diversity Committee 16.02.23; Finance and Performance Committee 27.02.23.**
Transparency:	**Public**

Executive Summary

1. "The what" – our corporate objectives for 2022/23 and our performance to date

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

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

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

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

- (1) To improve the quality of our services through delivering a stepped change in fundamental standards of care and empowering service users and carers;
- (2) To deliver our integrated transformation programme providing state of the art mental health facilities, improving access and outcomes and reinvigorating working practices for staff and service users alike;
- (3) To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences;

- (4) To support our people to grow and develop our organisation to be the best we can be;
- (5) To proactively develop partnerships and act as a system leader driving strategic improvements to mental health of the SWL population;
- (6) To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL.

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

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

- Progress: Red – milestones off track and unrecoverable; amber – milestones partially on track with recovery planned and manageable; green – milestones all on track.
- Outcomes: Red – undelivered; amber – some improvements delivered but full delivery not achieved; green – metric/ target met in full. Outcomes will be assessed at year end but where data is available through the year (for example financial delivery) a indication of progress towards the outcome will be included.

In the Q1 report a progress RAG system only was used. In Q2 outcome data as included for objectives 1 and 4 to illustrate the position at M6.

1.7. This paper provides the Q3 2022/23 corporate objectives delivery update highlighting a summary of work completed and any outstanding elements. M9 data has been included in some areas. It should be noted that a data review of quality metrics previously reported in Q2 has been carried out and some amendments made due to a previously unnoticed reporting error. M9 data has been crossed checked for accuracy. Notes on future milestone risk have been included.

1.8. The ELT received this paper on 19.01.23 and discussed the volume of work that has been delivered. Changes to the external landscape and the ongoing pressure within services mean not all elements have been completed as expected. Some of these are outside of the Trust's control – EMP delays, system reset of EMHIP, approaches to provider collaborative working. ELT also reviewed delivery expectations of areas within the Trust's control and is working to ensure delivery by financial year end of any milestones or activities that are delayed. The paper has also been received by each committee of the Trust Board during February and March 2023 with feedback and assurance from those meetings flowing through those committee reports.

2. "The so what" – impact and considerations for the Trust

2.1. Corporate objectives remain an effective way of defining delivery requirements of the Trust on an annual basis. Variable delivery raises a number of issues for consideration as follows:

2.2. Impact: When setting the corporate objectives the Trust has tried to link outcomes to activities and milestones, however it is clear from the Q3 report that further work is needed to (a) ensure that activities and measures align (ie that the activities we undertake will genuinely deliver the desire outcome/ impact) and (b) further energy is needed in Q1 to ensure that all proposed measures are available and can be reported from Q1 onwards.

2.3. Breadth and scope of work: In addition, there is a need to consider the level and scale of ambition set in the corporate objectives each year. There is a balance to be held between

driving change forward and allowing space to act as contingency for areas of work that arise and require delivery in year.

2.4. Link to Trust Strategy: The work to review delivery of the Trust Strategy and progress against delivery of the strategic ambitions will be carried out in Q1 2023/24 (see CEO report update). Through this work we will review and assess corporate objective delivery over the past 5 years to identify material improvements made.

2.5. Visibility and ownership: There have been improvements through this year to increase the visibility of corporate objectives and to ensure that programmes of work link together. Further work is required on this for 2023/24 to best marshal capacity and to clarify ownership by groups and senior leaders in the organisation.

3. "The what next" – considerations for Q4 and 2023/24 corporate objective development

3.1. The ongoing delivery of the 2022/23 corporate objectives plays a part in the discussion of 2023/24 corporate objectives. Areas identified above are also being reflected upon.

3.2. The Q4 2022/23 corporate objectives report will include a full year 2022/23 assessment and be presented to ELT, committees of the Trust Board and the Trust Board during April and May 2023.

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

- Discuss the Q3 2022/23 delivery and key risks or issues to future delivery.
- Agree onwards submission to the Trust Board.

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

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

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

Appendices/Attachments: ***None***

Q2 2022/23 corporate objectives delivery

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

- Increase in % Alwaysready care planning and risk assessment audits completed (2021/22 average 85%; 2022/23 M6 87%; M9 86.5%; target 95%)
- Increase in % risk assessments reviewed within 48 hours (2021/22 average – 91%; 2022/23 M6 95%; M9 96%; target 95%)
- Increase in % risk assessments reviewed within last 12 months (2021/22 average – 93%; 2022/23 M6 93%; M9 93%: target 95%)
- Increase in % physical health assessments completed within 7 days of admission (2021/22 average 78.6%; 2022/23 M6 79.3%; M9 80.3%; target 95%)
- Increase in % of cardiometabolic assessments completed for community service users (2021/22 average 84.41%; 2022/23 M6 84%; M9 85.5%; target 95%)
- Reduction in Restrictive Practices (Total # Prone Restraints 2021/22 – 450; 2022/23 M6 157; M9 278. Total # Restraints – Physical & Rapid Tranquilisation 2021/22 – 2,245; 2022/23 M6 692; M9 1,215. Total # Seclusions 2021/22 – 379; 2022/23 M6 96; M9 178)
- Medicines optimisation guidance for service users and staff

Delivery priorities	Q3 2022/23 delivery summary	Q3 delivery rating	Plans for any outstanding Q3 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
Care planning and risk assessment • Revised standard operating procedures (SOPs) published and monitoring framework agreed (Q1) • Interventions identified to support improvements using a QI methodology, communications delivered for all staff and training cascaded around processes and standards (Q2) • Clinical audit governance developed and completion audits underway quarterly (Q2-Q4) • Patient experience outcomes triangulated with care planning and risk assessment initiatives (Q2-Q4) **Physical health assessment** • Revised standard operating procedures (SOPs) published and monitoring framework agreed (Q1) • Interventions identified to support improvements using a QI methodology,	**Care planning and risk assessment** • Audits remain underway. • Development of the Feedback Live! system has not yet been completed but existing data has been reviewed. This suggests that 71% of service users agree that they have care plans that address their needs. National guidance recommends that services should move from Risk Assessments to Safety Plans. 84% of service users agree that they feel safe on wards and 88% agree that Crisis Plans (Safety Plans) have been discussed with them. **Physical health assessment** • Good progress has been made to move forward with physical health despite delays in Q2. The co-produced physical health framework has been approved and allocated to		• The triangulation of patient experience data for all areas was planned to begin in Q3, this has been impacted on capacity to develop Feedback Live! This is now being addressed. • The Restrictive Practice Use of Force Policy audit will be completed by end Q4. • Medicines optimization framework, positive messaging and adverse affects work areas will all be completed by Q4.	Patient experience outcomes triangulation year end delivery may be impacted – information awaited.		Unlikely to meet restrictive practises reductions due to delays in moves.

communications delivered for all staff and training cascaded around processes and standards (Q2) • Clinical audit governance developed and completion audits underway quarterly (Q2-Q4) • Patient experience outcomes triangulated with physical health initiatives (Q2-Q4) **Restrictive practices** • Current safety in motion work reviewed, training delivered for Clinical Service Leads, safety in motion work relaunched, SOP for restrictive practices published and terms of reference for Restrictive Practice Group refreshed (Q1) • Restrictive Practice and Use of Force Policy updated and Restrictive Practice Monitoring Framework developed (Q1) • Quality monitoring of restrictive practises commenced (including oversight group) and support delivered for operational teams to implement safety in motion programme (Q2) • Use of Force Policy compliance audit completed (Q2) • Quarterly reporting on restrictive practices commenced (Q2-Q4) • Patient experience outcomes triangulated with restrictive practice initiatives (Q2-Q4) **Medicines optimisation** • Tools available to support adherence scoped and options paper on this	colleagues for delivery in the agreed timeframes. During Q3/4 the physical health team are working with Comms to launch the framework and raise awareness around the organisation. The physical health team are supporting specific projects. For example, work on Lotus to meet NICE guidance around HIV testing which has now been expanded to include routine physical health blood checks and screening for other blood borne diseases, and, a project in the Therapies Team around admission protocols and a review of the Physical Health Assessment (PHA) forms on RiO. • Audits remain underway. **Restrictive practices** • The compliance audit of the Use of Force policy remains incomplete due to external auditor sickness. Preliminary feedback is that there is a high degree of compliance but final audit results are awaited. • Patient data has not yet been collected or triangulated. The Involvement Team will be directly engaging with inpatient wards to support with Service User feedback following restraints and incidents – commencing Jan 2023. • Audits remain underway. **Medicines optimisation**					

discussed at Quality Governance Group (Q1) • Framework developed with service users to embed shared decision making around medicines (Q2) • Advice around positive messaging around medications developed for staff with training provided (Q3) • Guidance developed and training delivered for interventions when screening identified adverse effects of medication (Q3)	• The co-produced medicines optimisation framework was due for completion in Q2 andQ3, this remains underway. A number of workshops have been held with service users on the Lived Experience Members group to co-produce resources. Drafting is in progress with involvement of both staff and those with lived experience. • The medicines optimisation positive messaging advice document and the guidance around medication adverse effects have been developed and initially by the Drugs and therapeutics Committee (DTC). Final sign-off will be completed in Feb 2023 via DTC with implementation to follow, via ward managers, community medicines optimisation meetings and the doctors academic meeting.					

7

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

Outcomes/ Metrics:

- Services, staff and service users safely moved into new buildings.
- Waiting times in Sutton community SMI services reduced (average waiting time to start treatment – 2021/22 outturn TBC and 2022/23 M9 TBC; total waiters over 30 weeks – 2021/22 close 63; 2022/23 M9 – 46).
- Inpatient beddays used by Sutton residents reduced (2021/22 outturn TBC; 2022/23 M9 TBC)
- Longest lengths of stay reduced impacting positively on overall LoS (2021/22 outturn – 44 days; 2022/23 M9 – 44 days).
- Corporate and other staff safely relocated
- Positive feedback received on moves from staff
- Tolworth business case approved
- Estates Strategy approve – ***Complete***
- Digital delivery plan completed and digital strategy approved.

Delivery priorities	Q3 2022/23 delivery summary	Q32 delivery rating	Plans for any outstanding Q3 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
Overall • Peer review recommendations implemented (Q1) and Gateway 4 review completed (Q2) • Initial post-project evaluation on Phase 1 completed (Q4) **EMP** • Clinical and operational sign off completed for service moved (Q2) • Shaftesbury and Trinity soft landings completed (Q2) and services successfully operating from new buildings (Q3) • Retail units opened (Q2) • Remaining Springfield site elements closed – Fairways (Q2), Conference Centre and Car Park B (Q3), Restaurant, Main Building, Harewood House and Diamond Estate (Q4)	**Overall** • Due to delays in moving to Trinity & Shaftesbury, and with the Trust Board approval of Tolworth Full Business Case in early Q4, the programme refresh for Phase 2 will be completed in Q4. **EMP** • Trinity is open and successfully operating. Shaftesbury practical completion and handover is still planned for Q4 but learning from Trinity means the moves will happen in Q1 23/24 to allow for soft landings and familiarisation after handover. • A new managing agent has been appointed and is making good progress on negotiations with prospective tenants for the retail units including exchange of Heads of		**EMP** • Shaftesbury practical completion planned for Q4. • Car park B and the Conference centre remain open to continue meeting business needs with closure dates to be implemented in new due course. • A new managing agent for the retail units will support negotiations and contracting for tenants to take up units.	**Overall** • Due to dependencies on moves and requirement of 6 months bedding in, the post-project evaluation is now scheduled for Q2 23/24. **EMP** • Shaftesbury moves remain the key priority for 2022/23. • Barnes delivery in line with reprogramming progressing. • Retail unit provision and availability of		

• Phase 2a planning applications submitted by partners (Q1) • Estates Strategy approved (Q2) • Barnes plans progressed with planning application submitted and Barnes business case approved (Q1), planning application approved (Q2), business case confirmed (Q3) and services decanted from Barnes accommodation (Q3). **Clinical transformation** • Sutton community adult mental health model fully implemented (Q1) and evaluated using agreed metrics (Q2) • Kingston and Richmond community adult mental health models fully implemented (Q3) • Year 3 community mental health adult transformation funding bid submitted (Q4) • Redesigned rehabilitation, personality disorder and adult eating disorder models fully implemented (Q4) • Children and Young People's mental health transformation defined and planned (Q1) and underway with external stakeholder support (Q3) **People Readiness and Culture Change** • Relocation consultation outcome published for corporate and clinical support staff currently based at Springfield (Q1) and staff moved to new location (Q3) • Agile and change training for staff completed (Q1)	Terms. The first units are expected to open in May 23. • Negotiations have allowed extended use of Building 32 and Car Park B which are now scheduled to close in Q4 and Q1 23/24 respectively. • The Barnes Business Case has been approved by the Trust Board and submitted to NHSE with a decision expected in Q4. Construction work for the temporary decant option in Teddington has commenced and services expected to move in Q4 allowing construction on the Barnes site to commence. **Clinical transformation** • Initial data on the Sutton model has been reviewed and the ongoing reporting of transformation metrics is being aligned to work on the review of the Quality and Performance report at present. Further work to ensure positive impact is being carried out. • Implementation of new core model for Adult Community Mental Health in Kingston & Richmond is progressing and the integration of Richmond Wellbeing Service provision has been completed. Full delivery of the new model is expected now by end of Q4. • The bid for year 3 community transformation funding was submitted in Q3. • The initial phase of the CAMHS Transformation programme has been completed and a service improvement			food offer/s continue to be discussed. • Main Building, Harewood House and Diamond Estate on track for Q4 in line with contractual obligations for vacant possession to development partners. Contract negotiations have permitted extended operation of the restaurant for the benefit of the Trust. In addition, future years rental has given the Trust significant accounting treatment upside supporting the Tolworth FBC. **Clinical transformation** • Delivery of K&R models is being realigned to Q4 to fit with service changes and a phased approach to delivery. • Rehab pathway work has progressed but timescales will need to extend into 23/24. • AED progress is being made but full changes will not be seen until 23/24.		

• Staff moved from Acacia, Woodroffe (Q1), Building 30, Phoenix and Morrison (Q3) and Newton (Q4) • Effective consultation and engagement for all areas impacted by the transformation (Q4) **Digital** • Digital delivery plan, leadership and governance structure signed off (Q1) • EMP digital elements in place to support building moves (Q2) • Digital 22/23 plan fully delivered (Q4)	and design approach has been agreed for the next 12 months. **People Readiness and Culture Change** • Staff affected by the consultation have all moved their base location to Tolworth in Q3. • Delays with Trinity and Shaftesbury have had knock on impact to subsequent moves and these will take place in Q4. **Digital** • Work on this programme continues to progress with updates to EMC and consideration of 23/24 plan underway. Additional capacity for the Clinical Systems Project has been secured.			**Digital** • As flagged in the Q1 report, capacity pressures in Applications Development continue to impact on the wider (non-EMP) digital delivery. In addition, a focused approach around benefits realisation and change management/ user adoption remains required.		

10

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

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

Improvement in staff confidence in talking about race and ethnicity

Delivery priorities	Q3 2022/23 delivery summary	Q3 delivery rating	Plans for any outstanding Q3 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast
• EDI leadership roles recruited to and supporting structure agreed to drive delivery of EDI Strategy (Q1) • Standardised reporting and data capture agreed and embedded across all protected characteristics within the Trust for services and staff (Q4)	• Cultural capability work is linked to the EMHIP programme which is being reprogrammed. • The two anti-racism pilot interventions have been agreed as community-based recruitment and career coaching within an inpatient setting.		• The anti-racism pilots have plans for Q4 and into 2023/24. • Manualised dialogical cultural capability training will move to Q2 2023/24 and a revised project plan	• Anti-racism pilot evaluations will need to take place in 2023/24. • As noted cultural capability work will be delivered in 2023/24.		TBC – most data will not be available until Q4.

[1] For PP element on diversity and equality specifically Q15 (does your organization act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Baseline of 45.% in 2021), Q18 (I think that my organization respects individual differences (eg cultures, working styles, background, ideas, etc) Baseline of 67.1% in 2021) and Q7c (I receive the respect I deserve from my colleagues at work. Baseline of 75.6% in 2021).

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

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

• Refreshed action plan for workforce EDI actions agreed with Equality and Diversity Committee (Q1) and actions delivered (Q4) • Anti-racism leadership programme in place (Q1) and three small anti-racism pilots delivered and evaluated to support learning (Q2-4) • Cultural capability training development group, approach and action plan to leadership and supervision agreed, including organisational practice and service delivery level changes (Q1) • Manualised dialogical cultural capability training programme co-produced with BAME stakeholders, service users and EVOLVE (Q2), leadership and supervision action plan implemented (Q2), training piloted in Wandsworth (Q3) and evaluation of all elements completed (Q4) • EMHIP delivery agreed and underway and evaluation approach agreed (Q1) and evaluation of EMHIP hub and family placement scheme supported (Q3); EMHIP 2023/4 plan agreed (taking account of evaluation findings) (Q4) • Ethnicity audit approach agreed (Q1) and audit completed (Q3) • Medical Race Equality Standard (MRES) action plan developed (Q3) • EDI Strategy reviewed and full implementation plan agreed for 2023/24 (Q4)	• The EMHIP programme is being reset as previously reported. An implementation group is now in place to co-produce the project plan and work. The EMHIP evaluation framework has been agreed. Evaluation of the Wellbeing Hubs and the Crisis Family Placement Scheme will begin in April 2023. Quality assurance support for the evaluation will be provided through the Trust R&D team. • Ethnicity audit work has been reprogrammed to fit with external partners work. • Some aspects of MRES are in the Integrated EDI Action Plan for 2022/23, with development of reporting and action planning processes to follow.		for the whole project, including the project delivery model, outcomes, milestones and risks has been developed. • Internal data analysis for the ethnicity audit will begin in March 2023.	• EMHIP work reprogramming will continue to impact on EMHIP milestones. • The main ethnicity audit work will take place in 2023/24.		

12

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

- Reduction in staff turnover (2020/21 average 14.17%; 2021/22 average 18.4%; 2022/23 M6 17.85%; M9 – 18.2%)
- Reduction in staff turnover for those with less than 12 months service (2022/23 M6 19.95%; M9 – 24.7%)
- Reduction in sickness absence rate (2020/21 average 4.03%; 2021/22 average 4.97%; 2022/23 M6 5.09%; M8 – 5.05%)
- Reduction in vacancy rate (2021/22 19.78%; 2022/23 M6 19.87%; M9 – 17.3%)
- Improvement in feedback around medical staffing, recruitment (both candidate and managers) and employee relations
- Monthly reduction in employee relations cases
- HR Recovery Plan delivered
- Leaders reporting improved skills
- Improved HR & OD team staff survey results
- Substantive HR & OD team in place
- Improvement in staff survey results related to health and wellbeing (health and safety climate, negative experiences and support for work-life balance people promise elements[4]) and learning development (development people promise element)[5]

Delivery priorities	Q3 2022/23 delivery summary	Q3 delivery rating	Plans for any outstanding Q3 delivery	Future quarters delivery at risk/ revised	Future quarters progress rating	Year end outcome forecast

• Leadership and development 2022/23 offering developed, agreed and communicated (Q1), underway (Q2) and evaluated (Q4)
• HR recovery governance reviewed and updated (Q2)
• HR recovery plan elements delivered:
  ○ Recruitment and retention plans in place for each service line (Q2) and reduction in medical and clinical vacancies plus reduction in agency spend achieved (Q4)
  ○ Recruitment and onboarding process reviewed and improvements implemented
	• As agreed in Q3 timescales around leadership development have been extended. Leadership development offer is continuing to progress, with plans to complete a Training Needs Analysis, along with the development of a Leadership Framework to set expectations for leaders in the organization.
	• In terms of specific HR recovery plan elements:
	  ○ Through the recruitment incident each Service Line has a clear plan in place for recruitment to vacancies with more strategic work to form
			• The review of core policies, together with an extension to our policy development framework to increase stakeholder engagement will be moved forward in Q4 now that additional resource has been secured.	• Original defined Q4 actions around policy review work, leadership development and cultural/ OD work will be reprogrammed into 2023/24 as necessary.
				• Progress on Q4 actions around vacancies and agency spend is being made.		

[4] For PP element on health and safety climate specifically Q11a (my organization takes positive action on health and wellbeing. Baseline of 56.4% in 2021). For the PP element on negative experiences specifically Q11c (During the last 12 months has you felt unwell as a result of work related stress? Baseline 43.4% in 2021). For the PP element on work-life balance Q6c (I achieve a good balance between my work and home life. Baseline 51.7% in 2021).

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

(Q2) with new onboarding and induction introduced (Q3) ○ Effective and high quality medical staffing, employee relations and recruitment service in place and able to support all Services Lines and corporate teams (Q4) ○ Policy development framework in place (Q1) with core policies agreed and implemented (Q3) and rolling policy review and update programme in place (Q4) • HR & OD disaggregation completed (first phase Q2 and second phase Q3) and substantive HR & OD function in place (Q4) • HR & OD team engagement scores increased in Pulse staff survey (Q2) and further increased in main staff survey (Q4) • People plan developed and agreed for 2023/24 (Q4) • Cultural practice and organisational development work delivered in key service areas and embedded as an approach across the Trust (Q4)	part of workforce planning in Q4. ○ New induction is in place, with evolving improvements based on continuous feedback. A report is planned for Q4 on progress. ○ Improvements beginning to be seen in key risk areas medical staffing, employee relations and recruitment and focus on these areas will continue. ○ Policy framework and policy review is behind schedule. Additional resource now in place to support work in Q4. • HR function now fully disaggregated. Additional investment has been agreed to bring in additional resource and support to continue stabilising the HR function. • Full staff survey results expected in Feb/Mar 2023 but the engagement score for the HR function has not improved. Discussions underway around how to follow this up. • Development work on People Plan underway.					

Objective 5: To proactively develop partnerships and act as a system leader to drive strategic improvements to mental health of the SWL population. • SWL MH Strategy in place • SWL MH provider collaborative, and team, in place • Agreed MH budgets delegated • SLP structures and delivery updated • Place MH programmes developed • SLL commitments delivered						
Delivery priorities	**Q3 2022/23 delivery summary**	**Q3 delivery rating**	**Plans for any outstanding Q3 delivery**	**Future quarters delivery at risk/ revised**	**Future quarters progress rating**	**Year end outcome forecast**
SWL ICS and SLP • Analytical and engagement work for SWL MH Strategy completed (Q1) and new SWL MH Strategy produced, approved and launched (Q2) • SWL MH provider collaborative (SWL MHPC) action plan and timetable and wider SLP plan developed; engagement work on MH PC development completed across SWL and across SLP (Q1) • Scope of SWL MH PC elements and potential clinical workstreams identified (and flagged for SLP connections) (Q2) and then confirmed (Q3) • Due diligence framework and approach confirmed for SWL MHPC areas defined as in scope for budget delegation (Q2) and due diligence review completed (Q3) • SWL MHPC resourcing requirements defined (Q2) and SWL MHPC team implemented (Q4) • SWL MH PC structure and governance drafted (Q3) and then set up and in place (Q4)	**SWL ICS and SLP** • SWL MH Strategy has been drafted and is now being iterated with input from partners. • SWL MHPC work remains underway and areas for progression are under discussion within SWL with place and ICB partners – these have been agreed with SLP partners. • Due diligence review is delayed but will progress in Q4 with Finance leadership. • SWL MH Partnership Delivery Group (PDG) continues to drive work forward and accountability agreement around MH to be developed in Q4 with the SWL ICB. • SWL MHPC Programme Director started in post 09.01.23. **Places** • Kingston and Richmond MH place priorities agreed and further work to develop these programmes underway.		• SWL MH strategy progression continues but is slow due to capacity pressures. • Confirmation of clinical areas in scope (with phasing) for the SWL MHPC will form part of work in Q4. • Resourcing requirements for the SWL MHPC requires ongoing discussion.	• All MHPC actions will take longer to complete and extend into 2023/24. Initial areas for delegation will be enacted. • The SWL MH Strategy approval routes awaited from the SWL ICB. • Place mental health programme development requires		

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

Objective 6: To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL. • Planned outturn met • CIP 2022/23 plans in place and delivering on four priority areas						
Delivery priorities	**Q3 2022/23 delivery summary**	**Q3 delivery rating**	**Plans for any outstanding Q3 delivery**	**Future quarters delivery at risk/ revised**	**Future quarters progress rating**	**Year end outcome forecast**
Internal delivery • Initial CIP plans in place, investment levels reviewed and non-recurrent CIP mitigation schemes agreed and enacted (Q1) • CIP plans implemented and CIP delivery underway (Q1-4) • CIP development for 2023/24 underway (Q3) and 2023/23 plan in place (Q4) **Strategic financial developments** • Structural deficit analysis completed identifying opening, changes and forecast outturn for 22/23 (Q1) • Undertake all cash flow and CDEL/ capital planning taking account of asset sales, loan and revenue requirements and stress test this (Q2) • Approve Tolworth business case and submit to NHSEI (Q3) • Support ICS colleagues to form financial governance structures for the SWL ICB and assess impact of IBC financial structures on Trust financial operations (Q1) • Implement strategic financial resourcing (Q1) and lead and complete SWL MH provider collaborative financial due diligence (Q3) • Implement budget planning module to support strategic financial planning (Q3)	**Internal delivery** • CIP delivery in M9 £100k below plan leaving cumulative position £0.1m over planned delivery (£9.4m vs £9.3m target). £13.1m schemes now identified (£700k above target) and RAG rated giving us a 97% confidence (compares well to a 76% confidence at M9 in 2021/22). Issue remains that whilst £11.4m of the savings are rated green currently only c£3.7m is recurrent (28% of those identified or 30% of the target) although it is recognised that this is a significant improvement over the position at the prior quarter's reporting (6%). • First workshop to develop 2023/24 CIP plans held before Christmas. **Strategic financial developments** • Revised JD for strategic financial support completed and work on the approach to MHPC due diligence worked up but not completed as yet. • Cash flow work completed as part of Tolworth Full Business Case. Discussions now taking place with ICB on managing CDEL cross-year impacts • Tolworth business case by Trust Board on 12.01.23.		• Tolworth business case approval now moving to external phase with ICB and NHSE. • Provider collaborative due diligence (and resourcing confirmation) to be completed in Q4. • Budget planning module to shift to after year-end to support completion of priority activities.	No actions flagged for progress risk but delivery risk will remain all year around the ability to meet our financial targets.		

	• Delays to implementation of budget planning module owing to staffing pressures; this will be deferred to after year-end.					

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

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE

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

Attendance list

Present:

Sola Afuape (SA)	Non–Executive Director (Chair)
Ann Beasley (AB)	Trust Chair
Doreen McCollin (DM)	Non–Executive Director
Katherine Robinson (KR)	Director of People
Sharon Spain (SS)	Director of Nursing (attended until item 22/88)
Jenna Khalfan (JK)	Director of Communications and Stakeholder Engagement
David Lee (DL)	Director of Corporate Governance

Attendees:

Pam Warren (PW)	Interim Human Resources Deputy Director
Mia Kruber (MK)	Joint Head of resourcing and On-Boarding
Anoushka Curtis-Vincent (A CV)	Senior HR Business Partner
Michelle Butler (MB)	Senior HR Business Partner
Jan Lonsdale (JL)	Education and Development
Johnny Steyn (JS)	Employee Engagement Manager
Nicola Mladenovic (NM)	Deputy Trust Secretary

Observer with speaking rights:

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

Apologies:

Trevor Procter (TP)	Management Accountant
Vanessa Ford (VF)	Chief Executive Officer
Vik Sagar (VS)	Non–Executive Director

Item		Action
22/80	**Welcome and Apologies** Apologies for absence were received and noted.	
22/81	**Declarations of Interest** No new declarations were reported.	
22/82	**Chair's Action** No Chair's Action has been taken.	
22/83	**Minutes of the previous meeting** SA thanked Elaine for attending the last meeting to type the minutes in the absence of Nicola. The minutes of the meeting held on 27th September 2022 were approved as an accurate record subject to the following amendments: - *The attendance is to be amended to reflect that KR did not attend the meeting*	

- *On page 2, 12th bullet point the action requested by the chair 'Chair requests next iteration to also include context in relation to National guidance, benchmarking, best practice' is to be moved to item 22/65 as this refers to the Leadership and Development Gap Analysis*
- *Item 22/66 on page 4, 1st bullet point is to be amended to be SP and not SA.*

22/84 Action Tracker and Matters Arising

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

- **22/28 Committee Annual Report** – SA has now sent the updates to KT and when NM receives this it can be closed.
- **22/46 – Workforce Update** – DL is to update the action. A lessons learnt report will come back to the committee and will incorporate a retrospective view of the current HR indicators to determine if they had been used in the previous period leading up to the breakdown HR issues would they have been robust enough to highlight the risk.
- **22/54 – Committee Forward Plan** - SA, DM, Emdad and Katherine met to agree how the workforce equality elements of EDC would be incorporated into WODC and when this was to be included in the revised Forward plan.
  Outstanding action is to establish when a report setting this out will come as planned to EDC and thereafter WODC.
- **22/63 – HR & OD Structure Transition and Budget review –** completed
- **22/65 – Leadership Gap Analysis** has been reported to ELT. Further work will take place and therefore has been push back to being reported in Q4. This is to be amended in the Forward Plan

22/85 Nurse Revalidation Annual Report

The Committee received the Nurse Revalidation Report. The following updates were highlighted by SS:

- This report has been through appropriate governance and been received at the Quality & Safety Assurance Committee (QSAC), which noted an assurance position based on a clear process being in place operating in conjunction with HR colleagues.
- All nurses holding a professional registration are required to undergo revalidation every three years.
- The revalidation covers a number of stages and there are rigorous steps to ensure if any person has not been revalidated that this will send a trigger to the Line Manager and Director of Nursing.
- Only one person was not revalidated and this was due to long term sickness following covid.

The Committee reflected that the current Cost of Living crisis could impact staff's ability to afford renewing registration, which was noted.

SS asked if the report is to come to this committee on an annual basis for noting as also this features workforce in addition to patient safety and quality. It was requested that future reports are to include ethnic profiling of the key areas such as lapses in registration and revalidation. **SS**

The Committee noted the report and agreed to receive the report with includes equality intelligence on an annual basis following assurance through QSAC.

22/86 Staff Survey Report and Progress Report

The Committee received the presentation. Johnny Steyn highlighted the following:

- The responses are lower than during the same period in previous years, which is a national trend.
- Reminders are being sent out by Picker on a weekly basis.
- ComplEAT lunches have taken place across most Trust sites and have been well received. Having the lunches has, in addition, enabled talks to include addressing a number of key workforce areas incl health/wellbeing, impact of the cost of living etc.
- At the vaccination clinics whilst waiting staff have been asked to complete the surveys on an iPad.
- The CEO weekly update has also supported widening communication. Updates on You Said, We Did have been included on the flyers as staff knowing the changes that have taken place is very powerful and attracts staff to feel empowered to complete the survey.
- Team Managers are being encouraged to walk around their services and to include this in their team meetings/handovers to promote and support staff complete the survey. Other support being encouraged is to give time in the shift or end the team meetings earlier to enable staff to access the survey also.

Through discussion it was raised that it was important to ensure inclusivity of staff working outside core shift patterns notably at weekends and night shifts and the benefits gained from staff knowing the extent of activities responding to what has been done following feedback from staff. It was raised that it would be helpful if managers knew the percentages of their team uptake so they could target those who had not completed the survey. However, some teams are quite small and drilling down into teams with less than 11 members of staff is not possible.

KR raised that staff have liked the ComplEAT lunches and requested that these are repeated.

Early insights from the embargoed report is due December/January thereafter the final report is to come to the March Committee.

The Committee noted the fall in response rates but was assured that a comprehensive engagement and communication is being undertaken and thanked those involved for their efforts.

22/87 Guardian Report

The Committee received the Guardian Report. The following points were highlighted by KR:

- LM was not in attendance but is expected to be a regular attender to the Committee to present his report.
- The number of cases remains steady and the majority relate to the management aspect, they might feel bullied and harassed. When this is explored further there seems to be a misunderstanding.
- KR reported that she meets with LM every 6 weeks and through these closer working links LM now raises queries with HR colleagues in order for a resolution to be achieved.
- LM has reported feeling supported in him being able to provide staff with updates.

KR

SA asked for the following in future reports:

- A cover sheet with executive summary setting out the key points and areas for assurance.
- Assurance that teams who have consistent not contacted the Guardian Service are fully engaged and supported and there is not a gap in the Trust being sighted on any workforce related well-being matters that might affect them.
- Trend analysis and benchmarking of Trust data with other comparable organisations.

The Committee noted the report and request for additional assurance.

22/88 Making Lives Better Together Report

The Committee received the report. JK provided an update:

- The MLBT priorities have been developed with the MLBT partnership group and this year fall into six categories:

- The MLBT workstreams will be taking forward key pieces of work; patient engagement, staff engagement and community engagement.
- **New initiatives for 2022/23:**
  Towards Anti-Racism: Creating a movement of active anti-racism in everything that we do, through a lens of equity and social justice
    - **Staff -Cost of living**: targeted support for those who need it most, including support to access local help, subsidised meals, car parking and hardship grants
    - **Long service awards** and **Exceptional People Awards**: this is for recognition for long service and exceptional performance
    - **Anti-Racism Hub**: resources, safe space and in-reach to support our goad of active-anti racism
    - **Diversity in Decision Making**: Cohort 2 started
    - **ComplEAT lunches**: Complete health, wellbeing and feedback support
    - **Patients -** Peer support workers working together with patients and carers seeking engagement and feedback about moving to the new buildings
    - Development of new carer- and patient-focused information for the new website (and associated resources) supporting self-care and self help
    - **Communities -** Mental health training and support for our brand new local communities at Springfield
- MLBT supports a range of interlinked work across the Trust that develops the culture and this is the conduit for culture change and working through the triangulation aspects. This is supported through the QI and HR Teams.

- Work has started on anti-racism and this will be led by the Anti-Racism committee.
- Further work will commence in evaluating the outcomes and evaluation measures. This will look at triangulating the key measures that are collected for internal measures, patient/carer measures and external measures.

The next steps will be to develop an Executive Advisory Group in Q4 next year. It was agreed that the next report update will clarify the role of the Committee in the governance arrangements, include the timelines for developing and implementing the evaluation and reporting using MLBT measures.

The Committee noted the report and progress to date.

22/89 Leadership & Development Report

The Committee received the presentation. JL provided an update:

- Review of the L&D Provision to provide assurance that this will deliver the required learning support to all SWLSTG colleagues to underpin the mental health work that makes life better together.
- During the SLaM and Trust split the L&D Team was depleted by three quarters and so it has taken some time to increase the team.
- Team Leader and Manager skills development round of courses have been delivered twice and now forms part of the managers' induction day.
- Supervision, PADR and mandatory and statutory training will also form part of the review support.

SA asked that the review includes how the revised training would be more interactive, creative and explore using a broader range of training approaches to also engage a younger and more diverse audience.

The Committee heard that the L&D Review will take place over a 12-week period and will commence in December. This will be reported to the Committee in March 2023. (**Action:** KR) **KR**

22/90 Quality & Performance Report

The Committee noted the report. PW highlighted the following key metrics in the September data:

- The vacancy rate was 19.9% in Sept, the target is 15%. The current position suggests that there is a reduction in vacancy rates to approximately 17% with confidence this will fall further.
- Time to recruit has increased to 60.5, the target is to be under 49.
- Temporary staffing is 30.2, the target should be less than 22.
- MAST compliance is 92.2% the target is 95%.
- Turnover rate is 17.6% and the target is to be less than 15%. Early signs in the October report is showing there is an increase in this area.
- Vacancies in active recruitment is 58% and the target should be higher than 90%.
- Percentage of BAME staff in band 8+ 30.4% and the target should be higher than 50%.

Through discussion a query was raised about the time to hire and the improvements that can be made. PW spoke about the improvements that will be implemented following the review and a number of KPIs have been put in place.

It was reported that there are incentives for temporary staff workers to commence substantive employment at the Trust. Nationally there are rates being capped for temporary staff and so this will support the conversion of staff joining the organisation. The agency cap for Trusts will also support as Trusts can't keep increasing their temporary staff usage.

To support maintaining training attendance the Recovery College operates an overbooking system to ensure that training courses remain full however the current COMPASS system needs to be amended to enable this functionality. JC to progress discussions about the Recovery college approach with HR.

The Committee noted the report and Committee receiving the Review report March 2023

22/91 People Scorecard

The Committee received a verbal update. The scorecard is still in development. A live snapshot from the Dashboards was presented to the Committee as a proposal as the future model. People data can be interrogated at a more granular team level and more closely identify and track trends over time. The RAG rating are to be reviewed and targets updated.

It was agreed that the scorecard should be defined and KR and SA to meet to agree the ask in advance of work undertaken to ensure full implementation at the first new People and Culture Committee **(Action**: KR/SA) **KR/SA**

The Committee noted the report.

22/92 Recruitment and Retention Progress Report

The Committee received the presentation. The following points were highlighted:

- An incident was initiated by the Executive Leadership Team and the 12-week incident period was 22 Aug – 14 November.
- There were 6 workstreams; on/off boarding, medical recruitment, temporary staffing, general recruitment and establishment cleansing.
- 152 actions came out of the workstreams. From 14th November most actions had been completed with the exception of some actions for the on/off boarding, appointment panels in medical recruitment, temporary worker process and prompt emails and some template adverts for other teams. These are to be concluded by the end of November.
- The final report is due to be received at ELT on 1st December.
- Qualitative and quantitative KPIs are in development to provide assurance on the outputs of the incident.
- Governance will be through the My Dashboard report and will form part of the People Matters agenda for scrutiny.
- Meetings have been held with service lines and services have committed to recruiting up to 197 posts by the end of November. Of these, 27 posts mainly in HR, have been reviewed and frozen. There have been 98 new substantive staff starters joining the Trust in October 2022. This resulted in the vacancy rate reducing to 17.9%.

SA asked for confirmation that the improvements achieved can be sustained and will the current action be sufficient to achieve a further downward trajectory. PW confirmed that mapping of processing has taken place and each manager is supported in their recruitment campaign to make sure the job description and other papers are in place. Maintaining a downward trajectory is key however knowing the

benchmarking of local organisations will help to understand if the Trust is within parameters or is an outlier.

The Committee noted the report.

22/93 Medical Staffing and Employee Relations Update

The Committee received a verbal update. The following points were highlighted:

- It was noted that Medical HR recruitment remains a significant risk. Medical HR Recruitment was moved into the main Recruitment Team to provide some mitigation. A review of the changed structure will be undertaken to understand and address any concerns raised by medical staff and to provide the committee that both functions are working effectively.
- There is now a vacancy for the role of Head of Medical HR and this will be recruited to shortly.
- Employee Relation cases have reduced from 79 to 47; sickness absence has reduced to 26, employment tribunals have increased slightly to 14.

Through discussion consideration was given to how the vacancies can be reduced further however PW confirmed that the Trust benchmarks within margins with other organisations as they report 15%.

The Committee was assured that there is continued good progress being made with Employee Relations.

The Committee noted the update.

22/94 HR Budget Update

The Committee received the report, KR highlighted the following:

- Plans to deliver a £124,469 CIP have now reduced this to £81,237
- The gap will be identified over time through non recurrent means
- There is an overspend in the service and this relates to laptops and more staff joining the team.
- Agency use has reduced by 7 and will continue to reduce further.

The Committee noted the report.

22/95 Policy Review Timetable

The Committee received a paper setting out the timeline to review and update current HR policies.

It was noted that this presented a significant undertaken given that the Trust was in the unusual position of having to review all policies at the same time. The policies had been categorised and prioritised to ensure that the Trust is compliant and to minimise The Committee noted that the review of policies which were currently non-compliant had been paused and those with immediate or imminent statutory requirements changes were prioritised.

The Committee noted the risk and the appropriate mitigation.

22/96 Workforce BAF

The Committee noted the report. KR highlighted the following:

- A revised reduced BAF is being produced with risks removed to the change in risk profile.
- The full impact of emerging critical risks such as the ballot outcome for industrial and on-going Cost of Living Crisis is still being determined and with regards to consequence of any industrial action, this is unlikely to occur until Jan/Feb.
- A BAF update will therefore come to the January committee.

SA noted the sustained improvement with addressing ER cases and reducing the backlog and asked if it should remain as one of the Committee three high priorities areas for scrutiny or should an alternative be identified. It was agreed that the priorities are to be refreshed by KR (**Action**: KR) **KR**

The Committee noted the report.

22/97 People Matters
The Committee noted the minute and noted discussion reflected current priorities.

22/98 Corporate Objectives Q2 Report
The Committee noted the report.

22/99 Committee Forward Plan
The Committee noted the report and reflected that the new People Committee will be launching in April 2023 and the forward plan will need to be updated **(Action**: SA, KR and NM to meet to update this) **SA, KR, NM**

22/100 Matters to Report to the Board
The Committee is to report a summary of items discussed to the Trust Board.

- Staff survey response, like other Trust, significantly lower than previous years for the same period but the committee is assured that all attempts at communication and engagement are comprehensive and will receive early indication of staff feedback in January.
- Guardian Report highlights main issues relate to 'management aspects' and that some departments consistently do not engage with the service. Both require further investigation and will be received at the next update
- Timings are such that September Q&P data was presented again. Assurance position therefore remains the same as last month. Vacancies steadily falling but still above target. A number of areas are for review or are paused as the HR function focuses on agreed priority areas. This is reflected in a number of KPI that
- The Committee is to review it's 3 priority areas (Recruitment and Retention, Medical Staffing and ER) given continued improvement in Employee Relations management. Recruitment Incident focused work is completed. The next few months recruiting and on-boarding staff must deliver effective impact at service line level to address operational challenges. This remains a high area of focused effort by the HR team.
- Medical staffing remains a significant concern with the Committee to provide sharp oversight of the introduction and implementation of the general and medical staffing merged functions
- Despite the challenges highlighted above progress made over a relatively short period of time is commendable with overall an enormous amount of work being undertaken by the HR team, who themselves are working with a number of constraints. Staff outside of the HR function in a number of settings widely report positively on the work ethic, effective leadership and valued based approach of HR colleagues which the Chair asks the Board to acknowledge.

22/101 Any Other Business

- A self-assessment has been carried out regarding the industrial action – biweekly meetings are being held with members of JCC. The UNISON staff ballot closes on 25th November.
- Cost of Living is an area where a confidential support line has been set up. Staff are contacting the support line with their own concerns and have raised issues regarding relocation concerns and pooling cars. An update will come to the next Committee.

22/102 Meeting Review

The Committee reflected on the meeting and considered that some elements could have had less time on the agenda to allow for wider discussions. Perhaps the minutes could have been considered outside of the meeting to save time at the meeting.

AB reflected that by not attending the Committee on a regular basis has demonstrated the amount of work that has been done in this area. AB asked for the invites for the rest of the year to be sent to her. NM has already forwarded the invites.

22/103 Date of Next Meeting

The next Committee assurance meeting will be held on 24th January 2023. 13 December 2023 will be a seminar meeting discussing the Trust's People Plan and strategy development

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

Meeting:	Board of Directors
Date of meeting:	9th March 2023
Transparency:	Public
Committee Name	Equality & Diversity Committee
Committee Chair and Executive Director	Doreen McCollin – Non-Executive Director Katherine Robinson – Director of People

BAF and Corporate Objective the committee is accountable for:

BAF Risk Description
A failure to effectively respond to equality and diversity issues facing the Trust

Corporate Objective:

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

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

1. This is the last separated committee meeting for EDC and future updates will come through the People Committee. Thanks were given to all attendees for their input during the time the Committee has been incepted.
2. The involvement of Staff Network chairs in future meetings is key and is an area for careful consideration.

Areas of Risk Escalation to the Board:

A collective grievance has been submitted due to a lack of response from the Learning Department in being able to provide BSL interpreters at all mandatory training courses.

Non-compliance in supporting Access to Work requests could impact the next steps in being awarded the next level in the Disability Confident Employer Scheme following independent assessment.

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

Item discussed:

Equality, Diversity and Inclusion Action Plan

- **Assurance Position:** Further work has progressed to be able to move the EDI agenda from a compliance aspect to now being one of a more inclusive and being more aligned with Trust values, priorities and objectives. All disparate actions have been brought together in one place.

- **Evidenced by:** Concise action plan whereby action leads have been identified.

- **What next?** Action leads to update at the new People Committee, the report is to be updated further and a new corporate objective to support health inequalities and EDI is proposed.

Staff Networks

- **Position Reported:** A collective grievance has been submitted due to a lack of response from the Learning Department in being able to provide BSL interpreters in all mandatory training courses. This could have long-term effects on staff retention and being able to provide a quality care to patients as this impacts on mandatory training. QSAC to pick up the training elements raised.
- Managers need to receive training in processing Access to Work requests from staff as this will have an impact in staff recruitment/retention as reasonable adjustments will not be made.

- **Evidenced by:**

- **What next?** Improvements will be monitored through routine Q&P progress reports. A new Equality Matters Group will start from April and staff network chairs will be members to ensure they remain involved.

Gender Pay Gap Report

- **Assurance Position:** The annual report is due to be published on 31st March 2023. This snap-shot date of reporting shows a 7.56% mean and 7.57% median. The 4 pay quartiles show a disproportionately high number of females in the lower pay quartile. The pay gap within the different pay scales shows there are small differences in the average hourly rates until Band 8d. The reasons for the gaps are primarily within Band 2, 6 to 8 and Band 8d.
- **Evidenced by the embedded report:** Gender Pay Gap Report

- **What next?** Further work will take place to improve the reporting and closer work will take place with the Womens' Staff Network to take this forward.
- A wider discussion is to take place to amend the report so that this is presented in a non-binary approach.
- Future reports are to include a 5 year 'look back' to see the improvements that have been made.

Anti-Racism Approach

- **Assurance Position:** The foundations are in place to further the Trust's position. There has been a significant commitment to becoming an anti-racist organisation, including the development of an anti-racism hub, training for the leadership and the investment in the White Allies programme.

- **Evidenced by:** ELT has received the initial report. The Committee is in agreement with the direction of travel.

- **What next?** Outcome measures are to be developed and expanded further. Full support of the Board is required to ensure this is brought into being 'business as usual'.

Corporate Objective Q3 Report

- **Assurance Position:** This is being reported as AMBER.

- **Evidenced by:** Cultural capability work is linked with the EMHIP programme.
- Two pilots are planned; *community based recruitment whereby it is a*nticipated that this will have a positive impact in being able to reduce the lengthy processes that are currently in place. The other pilot, linked with the anti-racism work, this is looking at *career development* as there are some posts where staff have been at the top of their banding for a considerable

time. Further support will be given to the manager to support them having better career coaching conversations.

What next? Future quarter reporting will receive evaluations from pilots and cultural capability work will continue into 2023/24 to ensure this is embedded across all protected characteristics.

Appendices

- Gender Pay Gap Report

Meeting:	EDC
Date of Meeting:	16th February 2023
Report Title:	Gender Pay Gap Report
Author(s):	Rob Bryan, Workforce Information
Executive Sponsor(s):	Katherine Robinson, Director of People
Purpose:	For information
Scrutiny Pathway:	ELT, EDC
Transparency:	Open

Executive Summary:

The Trust has a legal requirement to produce an annual gender pay gap report based on a snapshot date of the 31st March each year. This report must be submitted to the Government and published on the Trust's public website.

The gender pay gap as at the 31st March 2022 (the snapshot date for reporting) is 7.56% mean and 7.57% median. The 4 pay quartiles show a disproportionately high number of females in the Lower pay quartile.

The mean pay gap has increased by just under 2 percentage points since the previous year. Examination of the pay gap within the different pay scales shows that there are small differences in the average hourly rates until band 8d,

the reason for the pay gap result primarily within the Bands 2, 6 to 8 and Band 8d

The mean gender pay gap for bonuses is 35.21% and the median is 34.08%. This figure has seen a large increase of just over 25 percentage points (mean) since the previous year and a large increase in the median from 0% previous year. This is owing to small number of senior medics receiving national awards in year.

Recommendation:

The ELT is asked to: note and approve the report before it is published at the end of March 2023.

Corporate Risk		**Board Assurance Risk**	Retention of Staff: equality and diversity.

KEY IMPLICATIONS

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

Assurance/Governance:	This data is assured via the Electronic Staff Record (ESR) system for pay for male and female staff at a set point of time – 31 March 2022.
Clinical:	N/A
Equality & Diversity:	Monitoring and reporting gender pay gap differences promotes transparency and identifies where there may be particular reasons for differences which then allows plans to be developed to help address differences.
Estates:	N/A
Financial:	Reporting gender pay gap differences helps promote transparency and allows the Trust to make plans to address this.
Legal:	The Trust has a legal requirement to publish gender pay gap differences.
Quality:	There may be a link to improving quality with a perception of transparency and equity in pay for male and female staff.
QII:*	N/A
Reputation:	Having equality in pay for male and female staff will assist in promoting the reputation of the Trust.
Involvement (SUCFF):*	N/A
Strategy:	N/A
Workforce:	This paper relates to our statutory duty to report gender pay gap differences.
Other (specify):	

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

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

Gender Pay Gap Reporting 2021/22

1. What is the gender pay gap report?

Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between their male and female employees. There are two sets of regulations, but it is the second set which is relevant to the Trust as a public authority. Employers have up to 12 months to publish their gender pay gaps from the snapshot date of 31 March each year.

The results must be published on the employer's website and a government website. While employers may already be taking steps to improve gender equality and reduce or eliminate their gender pay gap, this process will support and encourage action. Whilst we are not obliged to publish a narrative accompanying the figures, we believe it is important do so to be transparent about the pay gap at the Trust and the steps we will be taking to address this gap.

Gender pay reporting is different to equal pay – equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may be several issues to deal with, and the process of analysing the individual calculations may help to identify what those issues are.

The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff.

Job evaluation (JE) enables jobs to be matched to national job profiles or allows trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

2. The gender pay gap indicators

An employer must publish six calculations showing their:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay, known as quartiles.

3. Approach

Our gender pay data has been obtained from our Electronic Staff Record System (ESR) for all staff employed and paid in March 2022.

The data and calculations have been derived from hourly rates of pay of:

- all employees (male/female) employed on the snapshot date (31 March 2022) – these are referred to as ‘relevant employees’
- all employees (male / female) who were paid their usual full pay in their pay period that included the snapshot date - these are referred to as ‘full-pay relevant employees’ (whether full time or part time they would have earned their usual pay in the pay period of the snapshot date.

The pay in consideration of the gender pay analysis is:

- basic pay
- allowances (such as payments for extra responsibilities, location-related payments, car allowances, recruitment or retention incentives)
- shift premium pay

Bonuses are considered separately and, as per national guidance, include any rewards related to:

- profit-sharing
- productivity
- performance
- incentive
- commission

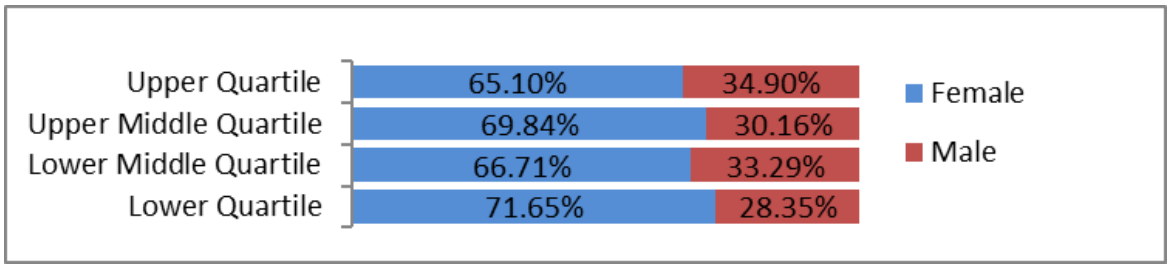
These are considered over a 12-month period to March 2022 as per guidance.

Background

This is the sixth gender pay gap report produced. Our last Gender Pay Gap report was in March 2022 based on snapshot data from 31st March 2021. The findings for the previous year were:

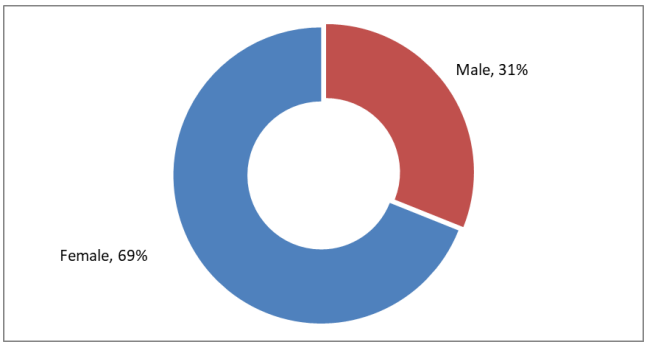
- our mean pay gap was 5.82%
- our median pay gap was 3.19%
- our mean bonus pay gap was 9.26%
- our median bonus pay gap was 0.00%

The total workforce was comprised of 68% female and 32% male. The pay quartile split was as follows:



Trust Gender Profile (based on headcount) March 2022

South West London & St George's Mental Health NHS Trust, as is typical of the NHS, has a higher proportion of females to males in its workforce – of the 2,879 staff counted as part of the gender pay gap reporting, 1,985 were female compared to 894 male.



Mean gender pay gap – 7.58%

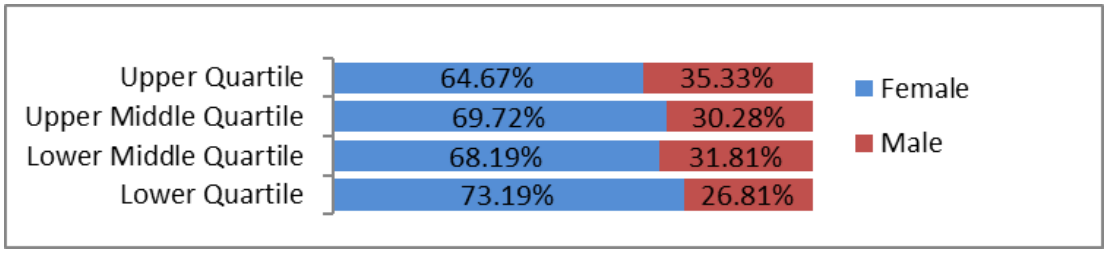
(2020/21 – 5.82%)

Median gender pay gap – 7.57%

(2020/21 – 3.19%)

The above figures show that the mean hourly pay for Male staff is £1.81 higher than that of Female staff, which is a gap of 7.58%. Male staff median pay is £1.64 higher than that of Female staff, which is a gap of 7.57%. For both mean pay and median pay there has been an increase in the gap in pay between male and female staff from the previous year.

Pay quartile split:



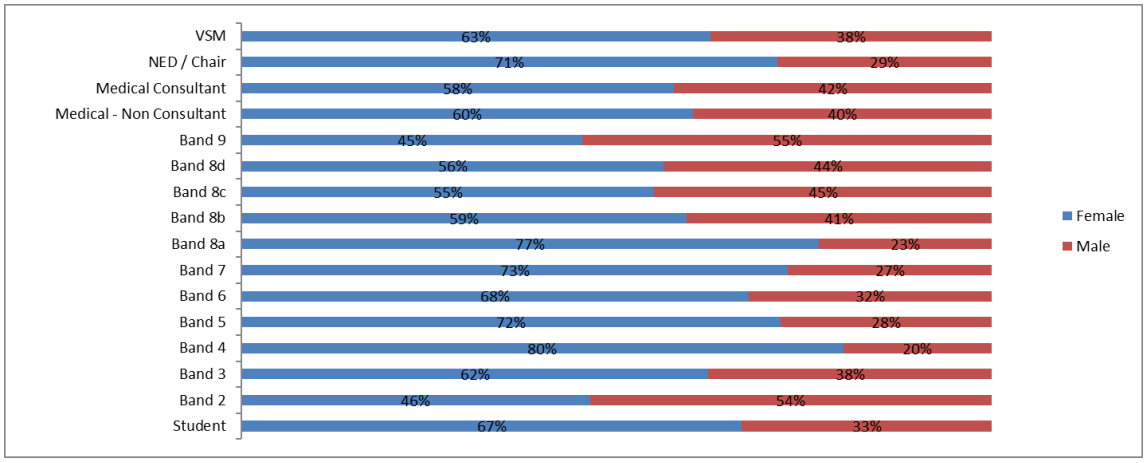
To determine the cause of the mean pay gap it is worthwhile examining the gender composition and pay gaps in each individual pay grade. This is shown in the following table, with the lower average pay by gender highlighted in red.

Band / Grade	No of Female Staff	No of Male staff	Female hourly rate	Male hourly rate	Difference	Gap	2020/21 Gap
Student	4	2	£11.25	£10.27	-£0.97	-9.47%	N/A
Band 2	13	15	£12.70	£13.25	£0.55	4.14%	4.96%
Band 3	326	198	£14.93	£15.22	£0.28	1.86%	2.37%
Band 4	316	78	£14.70	£15.19	£0.49	3.23%	1.83%
Band 5	314	123	£17.97	£18.62	£0.66	3.53%	4.26%
Band 6	325	156	£22.11	£22.88	£0.77	3.36%	3.38%
Band 7	287	107	£25.24	£26.03	£0.79	3.03%	2.86%
Band 8a	170	51	£28.34	£29.09	£0.76	2.60%	2.10%
Band 8b	51	35	£32.92	£33.52	£0.60	1.80%	0.01%
Band 8c	22	18	£38.69	£38.93	£0.24	0.62%	-2.86%
Band 8d	9	7	£44.31	£49.14	£4.83	9.83%	1.43%
Band 9	5	6	£57.83	£57.38	-£0.45	-0.79%	4.30%
Medical - Non Consultant	65	43	£29.86	£30.14	£0.28	0.94%	2.83%
Medical Consultant	68	50	£52.37	£53.99	£1.62	3.00%	0.44%
NED / Chair	5	2	£47.52	£48.15	£0.63	1.31%	1.26%
VSM	5	3	£66.57	£64.86	-£1.70	-2.63%	-5.50%

Negative values mean that the difference and the gap are favourable to Female staff

The largest pay gap across the bands and groups is for Band 8d pay which has risen from 1.43% in previous year to 9.83% this year. The largest positive pay gap is for VSM although it should be noted the number in this category are relatively small and the positive Gap has reduced for this group since last year.

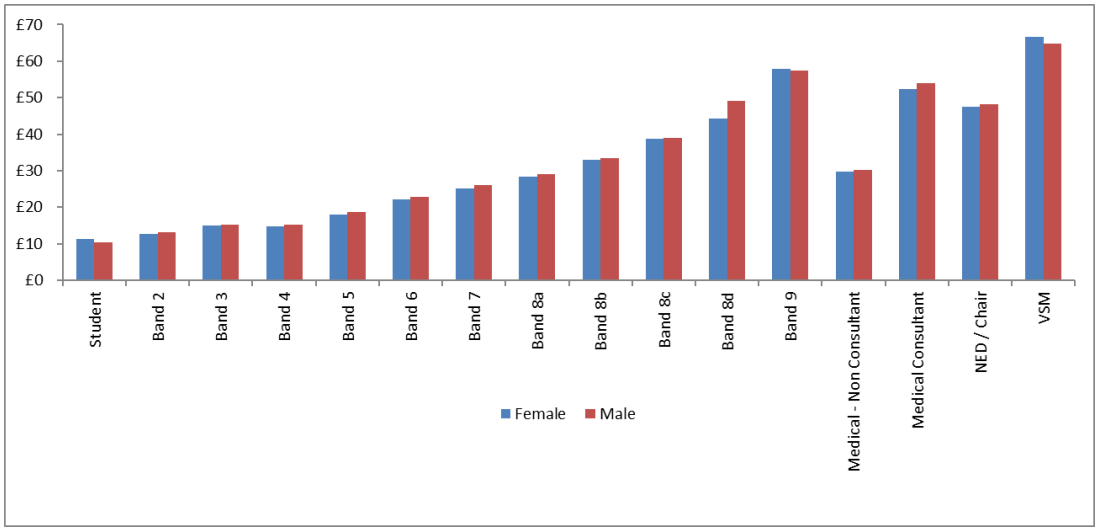
Gender split by band – based on headcount:



The mean gender pay gap has increased by just under 2 percentage points in the last year. The table above shows where the changes are in each grade – e.g. Band 8c pay gap increased from -2.86% in 2020/21 to 0.62% in 2021/22, Band 8d has increased from 1.43% in 2020/21 to 9.83% in 2021/22. Part of the reason we might see marked difference in Mean hourly rate within Bands 8a – 9 is that there are a relatively small number of staff in these bands compared to most others and there is only 1 final pay progression point within each of those bands at 6 years' experience.

This is part of the constant movement of the Trust staff profile, which remains fairly consistent. Additionally, for the size of Trust that SWLSTG is, changes in staff composition might have a greater impact on proportions than expected at a larger Trust.

The following graph shows the mean hourly rate for each grade by gender. It shows that they are more or less the same, with only noticeable differences occurring at the higher bands.



The above graph shows that the biggest gap in hourly mean pay is in Band 8d (favourable for Male Staff) and VSM Grades (favourable for Female Staff).

It is important to note to that across the Trust as a whole, discounting the Medical Trainee grades, VSMs, NEDs and Student grades (which don't have a notion of 'ceiling' steps within any of their grades) 31.94% of Male staff have reached the 'ceiling' in their band / grade and are paid max top point of scale whilst 28.64% of female staff have reached the top of grade. This will further impact the GPG as the steps within grades are now a high value.

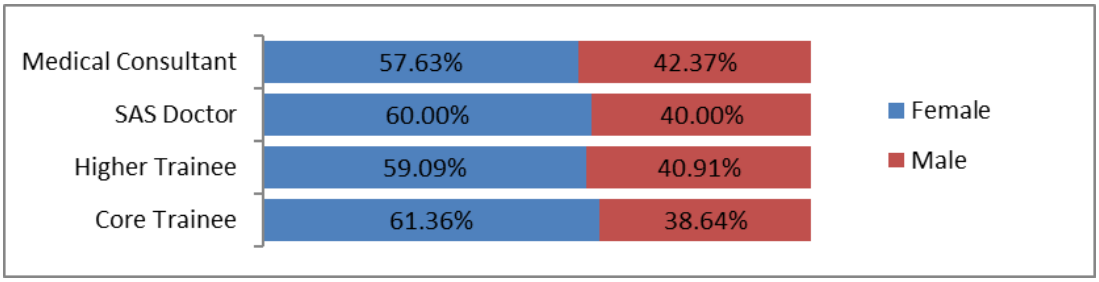
Medical Staff

Medical staff group comprises of all trainee to Consultant roles. The mean pay gap for Medical staff as a whole is 3.72% (up from 3.56% last year) – Male staff get paid on average £1.60 p/h more than female staff. The proportion of male to female staff is 41% and 59% respectively.

Band / Grade	No of Female Staff	No of Male staff	Female hourly rate	Male hourly rate	Difference	Gap	2020/21 Gap
Core Trainee	27	17	£26.43	£26.69	£0.25	0.95%	0.00%
Higher Trainee	26	18	£30.42	£30.98	£0.56	1.81%	3.10%
SAS Doctor	12	8	£36.33	£35.58	-£0.75	-2.10%	3.19%
Medical Consultant	68	50	£52.37	£53.99	£1.62	3.00%	0.44%

The mean pay gap for SAS Doctor grades is favorable to female staff and the mean pay gap for Higher Trainee grades has reduced since the previous year. However the mean pay gap for both Core Trainee and Medical Consultant grades has increased since the previous year.

Gender split by Medical Role – based on headcount



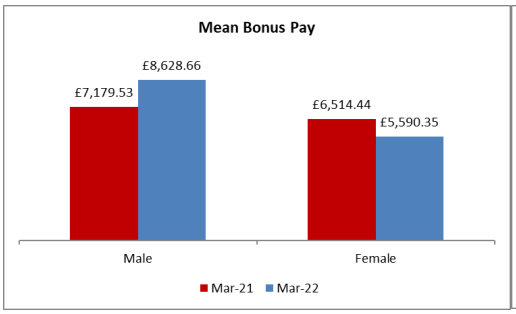
Median Pay Gap

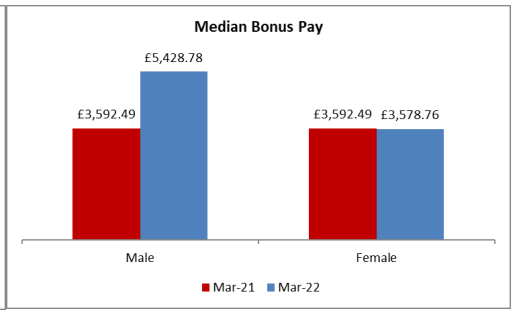
The median is based on the hourly rate that is in the middle figure when lined up from lowest to highest (if an odd number) or the mean of the 2 hourly rates in the middle when lined up from lowest to highest (if an even number).

	Female	Male
Lower Quartile	26.55%	21.59%
Lower Middle Quartile	24.74%	25.62%
Upper Middle Quartile	25.29%	24.38%
Upper Quartile	23.43%	28.41%

The highest concentration of males is in the Upper quartile, whereas this is where the lowest concentration of female staff sits. We can see that this disproportionately high number of males in the Upper Quartile is affecting where the median gap is as equity across the board would mean an equal split across all quartiles.

Bonuses





Mean gender pay gap – 35.21%

(2020/21 – 9.26%)

Median gender pay gap – 34.08%

(2020/21 – 0.00%)

In 2021/2022 the majority of Bonuses were paid in the form of Clinical Excellence Award or Distinction Awards to Medical Consultants however there were Bonus payments made for other reasons. In addition the Annual Local Clinical Excellence awards (LCEAs) which in previous years had been shared amongst the eligible Consultant workforce, received delayed payments for 2021/2022 LCEAs and as they were paid in May they were discounted from Bonus pay gap reporting. Due to the difference in reasons and timing of payments in 2021/22 compared to previous years' bonus payments impacts on ability to reflect comparisons between the 2 periods.

The mean gender pay gap for bonus pay has increased from the previous year as has the median gender pay gap for bonus pay and are now 35.21% and 34.08% respectively.

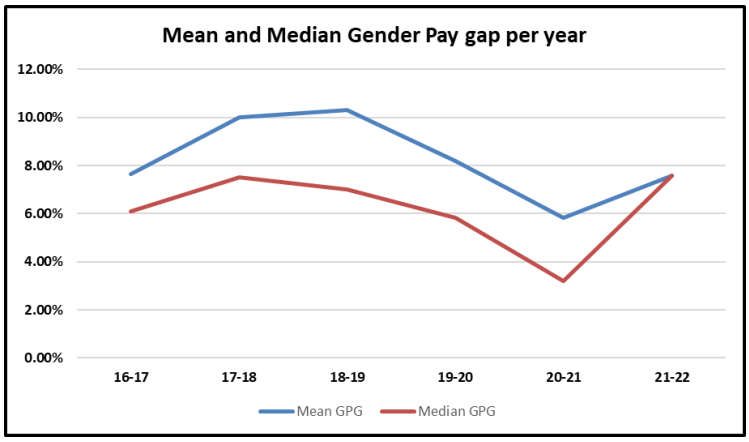
Bonus payments for CEA and Distinction awards are paid pro rata to part time staff however in Gender Pay Gap analysis there is no accounting for a particular rate of Bonus pay. A greater proportion of Female Consultants are part time compared to Male Consultants. Part time Female Consultants as a result receive a lower Bonus payment. If all eligible Medical Consultants were full time, the Mean Pay Gap would be 30.37% and the Median pay gap would be 40.67%. If payments for LCEAs had been made in year and included in the Bonus Gender pay gap report the Mean Pay Gap would be 23.31% and the Median pay gap would be 0.00%.

In addition the main reason for the increase for bonus payments relates to a male senior consultant who receives a CEA National Bronze Award. As there are a small number of staff receiving bonus payments (53 individuals in 2021/22) such a small change will impact the overall GPG.

Year on Year

With 6 years' worth of data, the figures for each metric over the years are presented here for reference.

Year	16-17	17-18	18-19	19-20	20-21	21-22
Mean GPG	7.64%	10.00%	10.32%	8.19%	5.82%	7.56%
Median GPG	6.09%	7.50%	7.01%	5.83%	3.19%	7.57%
Mean Bonus GPG	13.43%	4.99%	7.43%	11.46%	9.26%	35.21%
Median Bonus GPG	8.33%	5.36%	20.68%	5.56%	0.00%	34.08%
% males receiving bonus	3.07%	3.30%	5.18%	4.83%	4.38%	2.46%
% females receiving bonus	2.11%	1.94%	3.08%	2.86%	2.86%	1.56%



Comparison / Benchmarking

Following the 31st March 2023 deadline an analysis will be undertaken to compare SWLSTG Gender Pay Gap metrics against other NHS Trusts.

March 2022 comparison (March 2021 snapshot):

Of 226 NHS Trusts who published their return to the Government portal, SWLSTG had 17th lowest Mean GPG.

Comparison with other London MH NHS Trusts:

Employer Name	Mean Gender Pay Gap March 2018	Mean Gender Pay Gap March 2019	Mean Gender Pay Gap March 2020	Mean Gender Pay Gap March 2021	Difference / Movement 2020 to 2021
West London NHS Trust	4.30%	2.70%	DID NOT PUBLISH	0.60%	N/A
South West London & St George's Mental Health N H S Trust	10.00%	10.30%	8.20%	5.80%	-2.40%
South London And Maudsley Nhs Foundation Trust	10.10%	11.50%	10.70%	8.70%	-2.00%
East London NHS Foundation Trust	11.50%	DID NOT PUBLISH	12.00%	11.70%	-0.30%
Oxleas Nhs Foundation Trust	12.40%	13.10%	13.10%	11.00%	-2.10%
Camden and Islington NHS Foundation Trust	14.40%	DID NOT PUBLISH	12.90%	12.90%	0.00%
North East London NHS Foundation Trust	DID NOT PUBLISH	37.00%	36.90%	15.60%	-21.30%

Of the 220 NHS Trusts that reported, 35 did not pay any bonus (or at least did not pay any Male employees a bonus) and so did not report a Mean Bonus GPG. Of the 191 NHS Trusts that did, SWLSTG reported 34th lowest Mean Bonus GPG.

Conclusion & Next Steps

It should be noted that there have been small improvements in some areas, but there is still a higher proportion of males in the higher paid roles than females when comparing with the general Trust population. The following Action Plan has been developed in response and will be presented to the Equality and Diversity Committee.

- Continue to monitor and review the gender pay gap.
- Involve departments such as communications, recruitment, learning and development, and organisational development (OD) to help deliver the actions.

- Gather learning and good practice from other organisations that are leading the way.
- Share your report and proposed actions with all staff networks and staff-side.
- Communicate progress and achievements within and beyond the organisation by publishing the report.

Specific actions	**Lead**	**Date**
Encourage female medics to apply for the clinical excellence award.	Head of Medical Staffing	**Ongoing**
Continue to monitor and review recruitment and promotion policies to identify and remove any barriers for women as part of the Policy Review being undertaken by the HR & OD Team	Deputy Director of People	**Ongoing**
Review of progress against action plans from Gender Pay Gap for 2021, identifying lessons learned and progressing any outstanding pieces of work	AD of EDI and Health Inequalities	End May 2023
Working with the Women's Network identify policies or processes which may have an underlying impact on the gender pay gap. Hold focus groups/webinars to understand what might be causing barriers to progress.	Deputy Director of People, Head of Employee Relations, Senior People Delivery Partners, EDI team and Network leads	Review to be undertaken by end June 2022
Understand best practice at other Trusts and see whether these initiatives could support our work on the Gender Pay Gap	All	Ongoing

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

Equality & Diversity Committee

Minutes of the MS Teams meeting held on **Thursday 1st December 2022, 15:00-17:00**

Present:

Ann Beasley (AB)	Trust Chair
Deborah Bowman (DBo)	Non-Executive Director (joined the meeting at 22/76)

Attendees:

Jenna Khalfan (JK)	Director of Communications and Stakeholder Engagement
Vanessa Ford (VF	Chief Executive
Billy Boland (BB)	Medical Director
Katherine Robinson (KR)	Director of People
Ian Garlington (IG)	Integrated Programme Director
Andrew Francalanza (AF)	Equality & Diversity Inclusion HR Lead
Lenka Novakova (LN)	Deaf Staff Network - chair
Ashley Painter (AP)	DiverseAbility Staff Network
Eduard Margarit (EM)	LGBTQIA+ Staff Network – interim chair
Ranti Lawumi (RL)	Evolve Staff Network - chair
Jacqueline Ewers (JE)	Evolve Staff Network - deputy
Stephen Charlery (SC)	Mental Health Staff Network - chair
Nisha Proietti (NP)	Mental Health Staff Network – deputy and Diversity in Decision Making representative
Emily Downey (ED)	Women's Staff Network (interim co-chair)
Sarah Burrell (SB)	Service User and Carer representative
David Lee (DL)	Director of Corporate Governance

Apologies

Doreen McCollin (DMc)	Non-Executive Director (Committee Chair)
Nicola Mladenovic (NM)	Deputy Trust Secretary
David Heasman (DH)	Christian Staff Network - chair
Melena Blake (MB)	Service User and Carer representative
Emdad Haque (EH)	Associate Director – Equality, Diversity and Involvement

Item		Action
22/71	**Introduction and Apologies** Apologies were noted.	
22/72	**Chairs Action** No Chair's Action has been taken.	
22/73	**Minutes from the last meeting** The minutes from the 20th October 2022 were agreed to be an accurate reflection of the meeting.	
22/74	**Action Tracker** **Item 22/8 Staff demographics annual report –** this item will come to the February meeting **Item 22/44 Committee Forward Plan** – KR and DMc have discussed the workplan and this will come back to the February committee for consideration **Item 22/45 Deaf Staff Network** – update regarding the interpreter booking process. Initial discussions have taken place, there are some ideas to resolve the booking of interpreters for mandatory training and also a role to support the Training Department.	

	It was agreed that this action should remain on the tracker in order for an update to be provided at the February meeting,	
22/75	**Staff Network and Champions Updates** Deaf Staff Network Lenka provided an update on the Deaf Staff Network: During the year the following progress has been made: • Great progress has been made especially around interpreting. • Guidance has been published to support working with interpreting staff and this has been received especially within service line teams. • Progress has been made in interpreting the two weekly all staff meeting that is led by the Chief Executive. • Artwork has been co-produced and this will be displayed in the new buildings as well as signage to support deaf staff and service users accessing all Trust locations. • The Trust values and mission have now been BSL interpreted and drawn and this will be included in all materials. • Further work is progressing with the Learning and Development Team to make sure that a BSL interpreter is available for all training and not just mandatory training. This will also include progressing talks to have a centralised budget that would allow teams to access BSL. **Plans for the next year:** • The booking process including guidance is to be utilised by all teams. **Challenges** • BSL interpreters are to receive mandatory training as this is crucial in them undertaking their roles as are members of the team. • There is difficulty in booking interpreters especially as more face-to-face work is taking place and there are not enough interpreters to manage the ward even though Corner House is not open. The Committee asked the service to consider how the 'pool' of translators can be increased plus ensuring they are treated equally and how can we ensure that it is everyone's responsibility to make sure there is access to everyone. BB asked that all training should be accessible and not just mandatory training as the NHS Leadership Academy programme should be accessed for staff to progress through all available opportunities. Lenka updated the Committee on the steps taken in discussion with Health Education England to progress the possibility of co-designing specific bespoke training for professionals working in the NHS and also working with the NHS Leadership Academies to make this more accessible and inclusive. A deaf network has been set up to include deaf organisations based in London and south east England to work through how services can be provided for deaf people with mental health problems. The two meetings held have been very successful and a third meeting is planned in three months time. The session is looking at what is working well across teams in the country, terms of reference, best practice, sharing resources and expertise. It is hoped that this will be a national level meeting as there are more deaf staff working within the NHS.	

	Guidance has been created to support the accessibility and inclusivity in our meetings and as a rule this is as follows: 1. Mandatory attendance – BSL interpreter will be provided 2. Meeting where deaf staff are expected to attend – BSL interpreter will be provided 3. If a smaller meeting it will be best practice to have a BSL interpreter. The Committee asked for the next update to include the work that is progressing to train interpreters and what has worked well. In addition AB asked that the profile of the work that is underway in deaf services is shared and that opportunities for deaf staff to work in other teams is actively promoted.	
22/76	**Integrated Programme Presentation – equality impact assessment/approach** The Committee received the Integrated Programme Presentation. The following points were raised: - The programme does not just capture work in buildings but this is also focussing on people working within them including the opportunity to transform the way that we work within them. - The Integrated Programme sees Equality and Diversity as a continual process of quality improvement; it is not a one-off event. - For Tolworth, we undertook an EQIA to address any issues related to patients and staff with protected characteristics. Notably we identified a potential adverse impact on ethnic minority staff moving work base which is the subject of further monitoring. - The learning has been applied from the Springfield design to the Tolworth design. The protected characteristics, and reasonable adjustments are therefore as follows: o Disability: Individual assessments of workspaces being introduced in hot desk areas o Gender reassignment: Equality Act sex and gender reassignment provisions paper went to ELT. These patients and staff have access to gender neutral toilets, for example as well as gender neutral day rooms. o Religion: The multi-faith room size has increased from 22m2 (Trinity) to 36.87m2 (Tolworth) and is 14m2 larger. It also has two ablution rooms and carpeting as requested. o Age. Proximity of parking spaces for elderly and less mobile patients who may have dementia is being actioned. o Race: Sodexo have given assurance that any culturally specific dietary requirements will be met as per contract. It has also been agreed that patients and carers can bring in food for a limited period, subject to food hygiene requirements. o Pregnancy and maternity: a private space for breast-feeding has been provided at Trinity. o Sex: Gender segregated provision to be provided as call buttons have been changed from a female nurse symbol to a generic symbol to avoid traditional stereotypes. Any breaches will be operationally risk assessed o Sexual orientation: not an issue within the design of the building o Marriage and Civil Partnership: not an issue within the design of the building. - Within the new Trinity and Shaftesbury there is new signage to support visually impaired and those requiring hearing assistance. In addition there are BSL way finding signs and signage to kitchens and coffee stations.	

	- The art work in Trinity and Shaftesbury has been co-produced and includes art work from ethnically diverse artists who put marginalised people at the centre of their work. They worked directly with patients and staff to devise their designs. - A Leading People Through Change has been developed and module 3 has been developed in partnership with the Evolve Staff Network and this considers anti-racism and inclusion in the context of leading change. - As part of the Phase 2 Tolworth work an EQIA has been undertaken to determine the impact of the proposal on patients and staff. The impact on clinical care has been assessed as improved. However the staffing impact is scored as red and considers the turnover due to the loss of income for staff going to Tolworth and this is being picked up as part of the consultation. This affects approx. 200 staff and this is being worked through with the support of Human Resources. Through discussion learning from the Springfield Hospital development needs to be explored further to further consider supporting staff and patients with hidden disabilities as well as visible disabilities. Consideration should also be given if the building is to have a Pride flag put up and IG confirmed that a Pride zebra crossing is planned in the New Year. It was requested that more inclusivity around young people with mental health is an area for further consideration. The Committee noted the report and requested that the designs for Tolworth should actively celebrate everyone's differences.	
22/77	**EMHIP Update and EQIA Process** The Committee received the EMHIP Update and EQIA Process report. The following points were raised: • Significant progress is being made in the programme in particular the work of the wellbeing hubs and in developing the lived experience approach to some of the interventions • Work is progressing in designing how the interventions will be delivered and there has been a delay in co-producing the approach around the crisis family placement service. The delays have been supported by the partnership and the Trust is a provider of services but the project is being delivered by WCEN. • The annual Healing Our Broken Village was held last month and the involvement with EMHIP was celebrated. Through discussion VF confirmed that the ICS has made a commitment to invest £500,000 into a mental health improvement programme but this is not recurrent and there is a commitment to improve mental health and health inequalities in totality. In addition AB reported that the South West London Mental Health Strategy is a key aspect that needs to be firmly considered in all future discussions.	
22/78	**Corporate Objectives Q2** The Committee received the Corporate Objectives Q2 report. The following points were raised: • The corporate objectives have recently been received at the Board meeting held in November 2022 however this is an update on the Quarter 2 objectives	

	• The focus is to consider Objective 3 – To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions., voices and experiences
	  ○ The Associate Director of EDI has now commenced in post, Emdad Haque
	  ○ Good progress is being made in the anti-racism leadership programme; a steering group has been set up and has wide membership. The anti-racism approach is being worked through and this will set out the vision including the steps along the way to get to a position where we can say we are Anti-Racist.
	  ○ An approach has been agreed for the anti-racism work and the next Board Seminar will have a focussed session on this and will agree the work for the next six months.
	  ○ The work for EMHIP, previously discussed will continue.
	  ○ Work continues to develop the Medical Race Equality Standard and this will be further reported when information is available.
	
	The Committee noted the report.	

22/79	**Board Assurance Framework**
	The Committee received the Board Assurance Framework report.
	The following points were raised:
	
	• The Trust has identified sixteen controls that can mitigate the risk of *failure to effectively respond to equality and diversity issues facing the Trust* (Risk 1639)- and robustly addresses the gaps.
	  ○ Eleven key actions were developed to address the gaps in these control, three actions have been completed and eight remain ongoing. This is in part due to the changes that have taken place within the HR Team.
	  ○ The actions have been shared with the staff network leads for comment and agreement.
	• Delivery of statutory requirements relating to gender pay gap reporting, WRES, MRES, WDES are being monitored. The gender pay gap report will come to the February meeting.,
	• Now that the Assoc Director of EDI is in post the data will be further interrogated to see where further changes can be made. This will be particularly important when considering the Staff Survey outcomes.
	
	Through discussion it was agreed that the reporting aspect is to be changed as QSAC will receive the health inequalities elements and this committee going forward is to receive the workforce elements.
	
	The Committee noted the report.	

22/80	**People Matters minutes** The Committee received the People Matters minutes.	
22/81	**Committee Workplan** The workplan is to be revised in discussion with the Workforce & OD Committee.	
22/82	**Matters for the Board** A summary will come to the Board to include: • Details of the discussion for the Deaf Staff Network and key areas for progression. • Equality Impact Assessment for the Integrated Programme and further iterations are to include a more active stance on inclusion and diversity	

	• EMHIP Progress • Board Assurance Framework • Committee Forward Plan	
22/83	**Meeting Review** The Committee reflected on the meeting and noted that this was shorter than other meetings however the quality of papers allowed for a full discussion	
22/84	**Any Other Business** AB wished everyone attending a festive Christmas with family and friends. VF reported that the papers have been received for the completion of the new hospital and so services will start to move in and wards will spend their first Christmas in new surroundings.	
22/85	**Date of Next Meeting** The next meeting will be held on 16th February 2023 at 14:30-17:00 via Teams meeting	

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

Meeting:	Trust Board
Date of meeting:	9 March 2023
Transparency:	Public
Committee Name:	Finance & Performance Committee
Committee Chair and Executive Report:	Vik Sagar (Committee Chair) Philip Murray (Director of Finance and Performance)

BAF and Corporate Objective the committee is accountable for:

BAF Risk Description	
A failure to achieve financial targets	**Y**
A failure to have the right staff with the right skills at the right time	N
A failure to deliver transformed models of care, working practices and environments	N
A failure to effectively respond to equality and diversity issues facing the Trust	N
A failure to meet the increasing demand on services relating to acute care pathways	N

Corporate Objective	
Objective 1: To improve the quality of services through delivering a stepped change in fundamental standards of care and empowering service users and carers.	N
Objective 2: To deliver our integrated transformation programme providing state of the art mental health facilities, improving access and outcomes and reinvigorating working practices for staff and service users alike.	N
Objective 3: To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences.	N
Objective 4: To support our people to develop and grow and develop our organisation to be the best we can be.	N
Objective 5: To proactively develop partnerships and act as a system leader to drive strategic improvements to mental health of the SWL population.	N
Objective 6: To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL.	**Y**

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

1. **Underlying Deficit** – the Trust continues to operate with a c£12m underlying deficit
2. **External Beds** (currently c£6m pa) – a change in clinical practice is being adopted with the aim of removing the need for spot purchasing from April. To be owned by clinicians who will be more receptive to out of hospital options. Board

are asked to discuss their appetite for patients to be left in other parts of the system whilst the change in practice is embedded.

3. **Agency** (currently c7% of paybill, target 3.7%, agency premium £2m pa) – Successful delivery of savings schemes and agency as a percentage of paybill is dependent on success workforce planning. Board are asked to ensure focus is maintained in this area.

4. **Modern Slavery Statement** – FPC are commending the Modern Slavery Statement to Board for approval.

5. **Complex Care Business Case** – Board are asked to consider this business case within part B.

6. **Kingston PCMH transfer & IAPT/Substance Misuse head contract transfer** – Board are asked to consider these transfers within part B.

Areas of Risk Escalation to the Board:

No areas of risk escalated to Board – areas of existing risk remain and assurance rated as below.

For each item discussed at the Committee there is a statement against the assurance position, evidence and what next criteria below:

Performance reporting – Q&P Productivity Report

- **External Beds** - limited assurance, evidenced by actions discussed, trajectory to irradicate spot purchases by 1 April through change in clinical practice.
- **Agency usage** – limited assurance, evidenced by reassurance of weekly trackers in place, trajectory of the impact of QSAC review of effectiveness of observations and trajectory of the impact of workforce plans required from the Peoples Committee
- **Productivity** – limited assurance, evidence by improved reporting an dashboards, next step needs improved identification of drivers of opportunity, action to influence culture so that teams share best practice better, and re-quantification of the opportunity.

2022/23 M10 Finance Report (including Savings update)

Full assurance provided, evidenced by financial position continuing to be on track against plan both cumulative and against forecast. Focus to remain on key drivers of the underlying position as described above.

Annual Plan Submission

Full assurance provided by a well documented report highlighting key concerns and risk. Next steps, final submission due 30 March, approval delegated by Trust Board to March FPC. Detail to be discussed in Part B

Modern Slavery Statement

Full assurance provided, evidenced by no material changes to the current statement and evidence of review. Next step is for Trust Board approval.

Commercial Development – Kingston PCMH transfer & IAPT/substance misuse head contract transfer

Case supported with detail to be discussed in Part B

Commercial Development – Complex Care Business Case Case supported with detail to be presented in Part B
Commercial Priorities Report Fully assured - content noted with no matters of concern
Corporate Objectives 2022/23 Q3 Report Fully assured – content noted and commended to Board
Appendices All annual reports and other items that require to be in the full Board papers will be appended to the Committee Report **Appendix 1 - 2022/23 M10 Finance Report Part A** **Appendix 2 - 2022/23 M10 Savings Update** **Appendix 3 - Modern Slavery Statement** **Appendix 4 - Corporate Objectives 2022/23 Q3 report (agenda item 4.3)**

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

Finance & Performance Committee

Minutes of the Meeting held on Thursday 15 December 2022 at 14.00 by Microsoft Teams

Present:

Vik Sagar (VS)	Non-Executive Director (Chair)
Ann Beasley (AB)	Trust Board Chair
Juliet Armstrong (JuA)	Non-Executive Director
Sola Afuape (SA)	Non-Executive Director
Charlotte Clark (CC)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive (part)
Philip Murray (PM)	Director of Finance and Performance
Jen Allan (JeA)	Chief Operating Officer
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial Development
Billy Boland (BB)	Medical Director
David Lee	Director of Corporate Governance

Attendees:

Debbie Hollinghurst (DH)	Deputy Director of Finance
Dominique Zakkour (DZ)	Clinical Team Manager, CAMHS, NDT, DiDMR.
Dave Dowsett (DD) (for item 22/166)	Associate Director – Digital Services
Robin Bruce (RB) (for item 22/167)	Associate Director- Capital and Estates Management
Feizal Mohubally (FM) (for item 22/168)	Head of Service Delivery – Specialist Service Line
Clair Hartley (CH)	Committee Governance Manager (minutes)

Apologies:
None

Item		Action
22/157	**Apologies** None	
22/158	**Declarations of Interest** AB had been asked to chair the SW London Recovery and Sustainability Board.	
22/159	**Chairs Action** Chair had not taken any actions.	
22/160	**Minutes of the previous meeting and Matters Arising** The minutes of the meeting held on 28 November 2022 were agreed as a true and accurate record.	
22/161	**Action Tracker** The action tracker was noted.	
22/162	**Financial Report 2022/23 (Month 08 update) Part A** PM provided a verbal update and highlighted the following items:	

Item **Action**

- The Trust remains on plan at month 8, broadly through using the methods contained in the original plan that was submitted in June 2022. The position for Month 8 is a £0.2m surplus improving the cumulative position to £.1.0m deficit, broadly on plan. Whilst the position was on plan, it was underpinned by non-recurrent investment slippage and vacancies.
- The Trust continues to operate with agency costs higher than plan and additional controls are in place to reduce agency costs. In November the Trust spent £1.1m on agency, a £0.1m increase compared to October costs, and reflective of increased high-cost agency medics. Temporary bank costs also increased and were £1.8m in November. The Trust must continue to reduce agency costs in line with national focus to improve quality and reduce premium agency costs.

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

22/163 **Savings Report 2022/23 (Month 08 update)**

PM provided a verbal update and highlighted the following items:

- Corporate areas are approximately £0.1m ahead of plan although some areas remain behind target. Corporate recurrent savings total 45% which is appreciably more than the Trust total at 30%. The Trust remains behind nationally reported averages of c50% recurrent.
- Delivery in month - £1.1m against a target of £1.0m, £0.1m over achievement. Approximately half of the savings reported in month were recurrent.

The Committee **noted** the Savings report.

22/164 The Committee discussed the following issues

- The different incentives for delivering a surplus or breaking even.
- Planning for 2023/2024. – The Trust had started internal planning and submitted a paper through executive looking at cost pressures. A second stage of that process would go through in the next month. £2,000,000 of cypher cost pressures have been set and an excess of £12 million worth of cost pressure bids in. Those are unavoidable costs and are statutory/ mandatory. Executive colleagues have been asked to help with reprioritisation and to suggest a way forward. They were also, based on the current assumptions, starting to go through and chart out what the year-end position would look like and how that would impact on next year. It was expected that the CIP target would be about 13 million compared to this year's 12 and a half million.
- Update on Edward Wilson House – Three meetings had been held over the last two weeks. A new team was negotiating the issue and progress had been made.
- Medical staffing – According to news items some trusts are paying more than £5000 for a single shift for a doctor. About 3/4 of all trusts have paid more than £2000.00 for a single shift for a doctor. The Trust has not paid such high amounts, but the hourly rates are increasing. The ACD are

Item **Action**

working well to keep hourly rates down. The Trust had tried to forecast the likely agency costs and make provision for this.

- Although there were some anomalies in terms of excess medical costs and agency costs with the move to new facilities, the underlying trend was still coming down on the line-by-line review, so some of the controls were taking effect.
- Regarding KPMG, a full update would be received by the audit committee in a month, but it seemed that they were broadly in agreement with the Trust's treatment of PDC.

The Committee

- **Noted** the 2022/23 financial position and progress against mitigating actions to ensure financial targets were met.
- **Recommended** approval of the M9 year end-forecast to be submitted, breakeven against plan and with a £50m impairment deficit.
- **Noted** the key drivers of the underlying position, the impact on quality, and action required to improve the financial position including agency costs.
- **Noted** the draft £13m CIP target for 2023/24; and
- **Decided** to keep the forecast at Break-even against plan.

22/165 **Digital Services Review**.

PM and DD presented the report and covered the following topics-

- Digital Governance - The Trust has previously agreed the approach below for digital oversight – the COO will bring updates as to the progress of the digital through EMC with the DoF bringing BAU updates through FPC. The COO is the digital "customer" representing front line services responsible for identifying, specifying and managing digital projects that deliver improvements to services. The DoF is the digital "supplier" representing the IT function responsible for BAU IT functional delivery and provision of expertise and technical resource to projects. They would work in partnership with clear roles and processes to deliver improved services for patients.
- Financial Position – There had been an increase of £126k in the Digital Services budget between years incorporating £95k in pay awards and £31k non-pay which included an increase for year 3 of the Microsoft Enterprise contract and a reduction relating to the remaining balance of the 2022/23 CIP target. £200k of savings had been found recurrently from mobile phone charges through the development of a new contract. They were running very close to budget.
- Onboarding Staff – Several initiatives have been introduced to improve onboarding. Digital services are attending staff inductions to issue user equipment and to assist with system logons and access issues.
- Several KPIs have been introduced to measure customer satisfaction.
- Improvements have been made to the Solutions Architecture.
- Digital productivity improvements are under consideration.

Item		Action
	• The improvement of content and management of digital support for staff is planned. • A paper on the 18-month digital plan update was scheduled to be presented to EMC in the new year. The committee discussed the following issues: • The new structure was working well, and implementation was progressing. JeA said that she found it helpful to work more closely with the Clinical Digital leadership team and the Digital programme manager. • A corporate workflow workstream is chaired by DoF on behalf of corporate customers. DD works closely with PM and KR to ensure that corporate requirements are built into the program. • Model hospital data was paused during the pandemic. DH had collected data comparing the Trust to other trusts, particularly those leading in terms of digital and innovation, in terms of their budgets, and their spendings relative to their income or costs and would report as soon as the final report on Model Hospital benchmarks is published **Action** • Optimisation of licenses to ensure that are the Trust is only paying for modules that are being used is ensured by a robotic process which cancels licences which are not used for some time. Licence costs were kept to the minimum. • Digital services were working in collaboration with the ICB to assist them to take on their new digital services. • CC commented that the slide on customer satisfaction was not very useful, didn't contain sufficient information and was misleading and needed some revision. She offered to discuss this offline with DD. The committee discussed effective methods of measuring customer satisfaction. The severity of incidents and the effect on productivity should also be reflected. More qualitative information was required. • DD is to submit an update on digital benchmarks with the changes as discussed. **Action** The Committee noted the update.	**DH/ PM** **DD/ PM**
22/166	**Estates and Facilities Update** RB presented an update on Estates and Facilities. • Green plan was approved in September 2022. RB shared the objectives and action plan to improve energy efficiency and achieve BREEAM accreditation. Changes had been made to existing buildings to improve energy efficiency The new buildings were designed to a BREEAM excellent rating, thus the move into the new buildings would improve energy efficiency. • General performance – KPI's in all areas were exceeded consistently. The Trust continued to perform well against other Trusts in the area. Reactive maintenance was generally strong, issues are monitored and reported through H&S Committee. There was good staff retention and a well-established core team.	

Item		Action

- Risk – Backlog in maintenance of retained estate was not known. Survey had been commissioned but only looked at mandatory obligations. Insufficient infrastructure and funding to deliver net zero. EMP buildings – due to condensed handover, there was a lack of full understanding of systems, dealing with snags and defects in occupation – mitigated through customer care plan.
- Production of a heat decarbonisation plan (HDP) was in progress. Implementation of HDP would make the Trust eligible to access funds from different schemes. RB informed the committee of initiatives that had been introduced by other Trusts.
- Carbon Footprint (CF) – Supply chain accounts for 57% of Trust's CF of 35 000 tonnes. The Trust was working with suppliers to reduce their CF. The Trust provides supplier information to NHS England which is working with suppliers to reduce their CF.
- EMP readiness – Estates was working directly with EMP to ensure safe handover of facilities like CCTV, security access control and key management. Sodexo had been briefed on new buildings and was ready for transition.

The Committee discussed the update.

- More data was required about the KPI's. Information on backlogs on maintenance in the retained estate was required. More information was required about governance in making decisions on handling of risk. An update was to be submitted with this information **ACTION** — **RB/PM**

The Committee **noted** the report.

22/167 **Performance report**

JeA informed the committee that they were looking at the operational flow metrics, the finance grip and control and productivity metrics and using these as the key drivers of the trust flow group. They had decided to focus first on the community caseload length of stay productivity opportunity which the Flow Group had reviewed earlier in the week. They had agreed on a set of actions for adult community to optimize length of stay on caseload starting by looking at the outliers of caseload. They would start with patients who had been on the case load for more than five years and segmenting by diagnostic group and other possible causative factors. They would replicate that approach on the CAMS community caseload and the specialist caseloads. They would report back to the flow group in January with action sets for each of the community areas.

An analysis on inpatient length of stay by diagnostic group for adult CAMS and specialist wards was being conducted. They were also conducting a workshop on agency work, looking at how they could make agency work as productive as possible while staying within the budgeted cost.

The committee **noted** the report.

22/168 **Next meeting** – The next meeting would be held on **Thursday 26 January 2023** at **14h00** by Microsoft Teams.

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

Finance & Performance Committee

Minutes of the meeting held on Thursday 26 January 2023 at 14.00 by Microsoft Teams

Present:

Vik Sagar (VS)	Non-Executive Director (Chair)
Ann Beasley (AB)	Trust Board Chair (attended until 3pm and returned at 4pm)
Charlotte Clark (CC)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Philip Murray (PM)	Director of Finance and Performance
Jen Allan (JeA)	Chief Operating Officer
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial Development

Attendees:

Debbie Hollinghurst (DH)	Deputy Director of Finance
Nicola Mladenovic (NM)	Deputy Director of Corporate Governance

Apologies:

David Lee	Director of Corporate Governance
Billy Boland (BB)	Medical Director
Richard Flatman (RF)	Non-Executive Director
Juliet Armstrong (JuA)	Non-Executive Director
Sola Afuape (SA)	Non-Executive Director
Dominique Zakkour (DZ)	Clinical Team Manager, CAMHS, NDT, DiDMR.

Item		Action
23/1	**Apologies** None	
23/2	**Declarations of Interest** No new declarations were reported.	
23/3	**Chairs Action** No Chair's Action has been taken.	
23/4	**Minutes of the previous meeting and Matters Arising** The minutes of the meeting held on 15 December 2022 were agreed as being accurate.	
23/5	Action Tracker The action tracker and updated was noted and in particular the following: **Action Item – 22/111 - Supporting other staff with financial information**, PM confirmed he would continue to reach out to DZ to support her in her DIDM role when attending the committee. **Action Item 22/149-2 - Solvency Dashboard** Committee discussed the merits of alternative dashboards and agreed that given the current levels of cash in the trust no solvency dashboard was required. AB questioned whether this might be an issue regarding the Going Concern statement at year end. PM confirmed that in recent years NHS Going Concern has been based on the existence and continuation of contracts and whilst a solvency dashboard is useful, given the Trust is not expecting a deficit in 2022/23 or 2023/24	

Item		Action
	and the metrics are covered within the reporting, it was reasonable to pause the solvency dashboard reporting. **Action Item 22/151 - Investing Money with Higher Interest** PM advised Committee that National / Regional colleagues have not been able to provide guidance as to what is allowable and that he has approached the ICB Finance Director for support in determining the rules. It was noted however that any investment would need to generate a return greater than 3.5% due to the inclusion of current investments approaches being within the PDC calculation.	
23/6	**Productivity Report** The Committee received the Productivity Report and received an update from JeA. • An update has been shared with the SW London Sustainability Board at the ICB regarding the Trusts approach to productivity to develop three strands for workflow, clinical/digital efficiency and workforce: • **Enhancing Flow** for both in-patient and out-patients to enable patients to be supported to recover more quickly and step down the level of care sustainably. The primary gain it to be able to increase/decrease levels of activity to fit demand or to reduce additional resources (i.e agency, external beds). There are a range of metrics being looked at to include LoS, DTOC delays, caseloads, IP LoS and out of area placements and workstream initiatives • **Clinical/digital efficiency**. To enhance clinical efficiency through a range of improvements to systems and processes. Increased automation and/to eliminate waste. To increase productivity and to support the improvement of waiting times plus reducing the use of additional resources. Various workstreams will support this. • **Workforce efficiency**. To enhance the quality of care and contain/reduce costs through workforce improvement by also improving underlying workforce processes and developing more innovative ad sustainable roles/skill mix. The primary gains would be to reduce agency costs, reduce turnover/transaction costs and a more efficient skill mix. Various metrics will be considered and will cover workstream initiatives i.e agency control, corporate HR processes, on/off boarding, incentive schemes, focussing on hard to recruit posts. • The reporting and benefits realisation will continue to come through this Committee and other workstream productivity will come through SL Transformation Programme, Digital Programme, CIP Programme and workforce planning. More granular data will be available on the dashboards however it is understood further work is required on the detailed benefits definition and tracking. It was agreed that the productivity slides presented at the SW London Sustainability Board are to be shared with Committee members. The Committee requested further detail on the alignment of updates to include when this is coming to future committees. Additional information will also explain the underlying issues that have led to the increases eg increased agency /bank could be due to increased sickness. The Committee acknowledges that immediate improvements in productivity will not be seen as this will be seen over a gradual timeframe as changes are embedded. It was agreed that an updated plan detailing when deep dives into focussed areas will come to future Committee meetings. The plan is to come to the February	**NM** **PM/JeA**

Item		Action
	meeting. In addition a map of interdependencies detailing the productivity should be drafted to identify the reporting routes.	
	The Committee heard that there are increased costs connected to observations and this is significant. This is mainly around acuity and not that the risk appetite is decreasing. QSAC is asked to consider the quality issues in observations due to the restrictive practice and to provide an update to this Committee.	**SS/ QSAC**
23/7	**Financial Report 2022/23 (Month 09 update) Part A** PM provided an update and highlighted the following items: • The Committee reflected on the forecast M9 position and approved that the forecast should remain unchanged at break-even. • Agency costs per month have increased by 50% compared to pre-pandemic • External beds have increased 105% pre-pandemic. • Bed blocking has now increased to 177% pre-pandemic. • Savings are also improving. • Impairments – A paper has been received and approved by Audit Committee earlier in the week. The paper demonstrates that Trinity and Shaftsbury are linked for accounting purposes and that go live is after 31 March 2023. As a result there will be no impairment in 2022/23. The impairment will be below the line and impact in 2023/24. • The Barnes development was fully supported by the ICB; PM confirmed that he and Ian Garlington had attended the ICB Finance Committee earlier in the week. • Ronald Gibson House - It was confirmed that the Trust is still waiting to hear the outcome regarding the capital grant attached to RGH. The application remains at stage 3 out of a 5 stage process. PM believes that the summary paper is with Julian Kelly's office. In the meantime the Trust has paid £1.7m into an escrow account in order to complete on the sale which avoid the risk of a liquidated damages claims caused by delay in the transaction. The Committee **noted** the Part A Finance Report.	
23/8	**Savings Report 2022/23 (Month 09 update)** PM provided an update and highlighted the following items: • There have been in excess of £4m worth of vacancies this year. He felt it was improbable to either recruit to all of these vacancies or to fill these with agency staff as the number of people able to fill the posts are not around. Work is progressing to re-imagine services to work differently so the number of posts are not required. Work is progressing in Community Transformation and recruitment is being successful. At a recent meeting it was reported that overall vacancies are reducing as an overall reduction rather than singular teams. • There is new money coming with new posts as part of the mental health investment and other long term funding. It is anticipated that there will be approx. £3m of non-recurrent savings. • Agency costs for next year is to be no more than 3.7% as a percentage of paybill and this year it is 7.4% The Committee **noted** the Savings report.	

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

Item		Action
23/9	**Committee Workplan** The Committee **noted** the committee workplan. The next meeting is to have Productivity at the start of the agenda.	
23/10	**Review BAF Risks** The BAF risks have been discussed at the Audit Committee. The risk remains the same at 16. Additional controls that are being implemented include the system setting up a Recovery Group, appointment of external consultants to assist in productivity pathways. The risks focuses more on acute healthcare rather than mental health.	
23/11	**Matters for the Board of Directors** A summary of the meeting points will be reported to the Board.	
23/12	**Meeting Review** The Committee had a rich discussion on the priorities that are needed to support discussions for 2023/4. The Productivity Report was well received. Long term investment is to be considered to support the long term sustainability of the organisation. The Committee is to look at a longer term picture of over 3 years as break-even might need to be worked towards in later years and other financial priorities of loans are a big factor to be borne in mind.	
23/13	**Next Meeting** – The next meeting would be held on **Thursday 27 February 2023** at **14:00** by Microsoft Teams.	

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

Meeting:	Trust Board
Date of Meeting:	9 March 2023
Report Title:	Part A - Finance Update 2022/23 Month 10
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

Executive Summary

What - the key items to note are:

- **Report Scrutiny –** The finance reports for month 10 were discussed at FPC and show no material change in the financial position; there was an increase in external bed costs offset by increased release of provisions.
- **In Month position** - the position for January for Month 10 is a £0.3m surplus.
- **Cumulative position** – broadly in line with plan at £0.6m deficit, c£1.6m of in year provision built into this position needed to achieve the year end forecast.
- **Year End Forecast** – broadly in line with plan at breakeven.
- **Underlying Position** – remains at £1m deficit per month, c£12m per annum, the £0.2m benefit, reported in M9, following the transfer of the Richmond Well Being Service is offset by increasing external bed costs.
- **Agency** – a marginal in month reduction in spend, still above budget and spend needs to halve to achieve the target of agency spend not exceeding 3.7% of the Trust pay bill. Trust remains an outlier across London.
- **External Beds** – Expenditure on external beds was on a steady upward trajectory from April 2021 to August 2022, remained relatively steady September to December, January costs of £0.6m was a significant increase and the highest monthly spend to date.
- **Savings** – schemes have been identified to achieve the full £12.4m target. Year to date delivery is £11.2m, £0.9m ahead of plan. Recurrent Delivery is forecast at 30%, £3.7m. Nationally recurrent savings delivery is 50%.
- **Capital** – an underspend of £4.7m ytd, and £3.0m forecast over spend for the year. The forecast overspend is due to additional funding agreed in month for Tolworth (£1.4m in year), and Right of Use assets estimated £1.7m more than initial budget. Additional CDEL is planned to cover the £3m overspend. The Trust is on track to report marginally under CDEL at year end as required.
- **Cash** – the cash balance is £31.3m.

So what - the key items to note are:

- the Trust is likely to achieve breakeven for 2022/23 as required, it has not achieved this as planned at the start of the year. This means that the Trust is entering 2023/24 with an underlying deficit of c£12m.

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

- The key drivers of the underlying deficit remain external bed usage, agency costs and ability to deliver recurrent savings.
- The Trust is on track to achieve the CFL/EFL targets.
- The Trust currently has sufficient cash to manage its business and must not lose sight of the requirement to start repaying the loan in 2023/24.

Next Steps – Actions have been identified as follows:

- Continued monitoring and reporting of the financial position for 2023/24 to final accounts submission.
- Focus on key drivers of the underlying deficit to improve run rates going forward.

Questions or Asks for Committee

1. **Underlying Deficit** – the Trust continues to operate with a c£12m underlying deficit
2. **External Beds** (currently c£6m pa) – a change in clinical practice is being adopted with the aim of removing the need for spot purchasing from April. To be owned by clinicians who will be more receptive to out of hospital options. Board are asked to discuss their appetite for patients to be left in other parts of the system whilst the change in practice is embedded.
3. **Agency (currently c7% of paybill, target 3.7%, agency premium £2m pa) –** Successful delivery of savings schemes and agency as a percentage of paybill is dependent on success workforce planning. Board are asked to ensure focus is maintained in this area.

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

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

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

Assurance/Governance:	Positive impact – This paper provides update to the financial targets against which the Trust is performance monitored against
Clinical:	Positive impact – Trust Funds are spent to get the best value to support our clinical services and patients
Equality & Diversity:	Positive impact – The Trust spends money to improve equality and diversity for patients and staff.
Estates:	Positive impact – The Trust is investing in its Estate to provide modern mental health facilities
Financial:	Positive impact - Provides information on the delivery of key financial targets

Legal:	Positive impact - Provides information on the statutory requirement of achieving break even
Quality:	Positive impact – Trust funds are spent providing good quality services to our patients whilst achieving financial targets
QII:*	n/a
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Involvement (SUCFF):*	n/a
Strategy:	Positive impact – Underlying financial sustainability is a key part of the Trust's strategy
Workforce:	Positive impact – Trust funds supports the employment of a secure permanent and stable workforce, the report provides information on the cost of agency
Other (specify):	n/a

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

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

Finance Report 2022/23
10 Months to January 2023 – part A

Meeting	FPC
Date of Meeting	February 2023
Report Title	Finance Report 2022/23 – 10 Months to January 2023 – part A
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Director of Finance & Performance
Purpose	For Information
Scrutiny Path	Director review/ELT/FPC/Trust Board
Transparency	Public
Recommendation	None
The Board is asked to	Discuss and Note

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

Executive Summary

This report provides an update on :

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

Overall – I & E Position

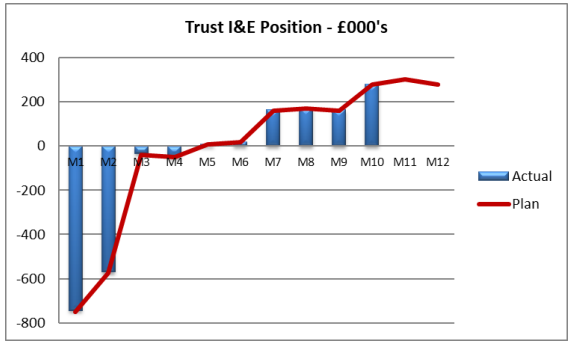
- In January, the Trust recorded a £0.3m surplus, marginally favourable to plan
- The cumulative deficit has reduced to £0.6m, also marginally favourable to plan
- The position fully reflects income flows agreed with South West London and other ICBs as part of 2022/23 contracting
- The expenditure position includes new year investments relating to MHIS and SDF. Unfunded pressures such as external bed usage and observation costs contribute to the current deficit
- The cumulative position fully reflects the impacts of the NI increase reversal along with additional agreed Winter Pressures, Better Care Fund, and SLP monies
- The forecast outturn is break-even in line with plan and requires a continued improvement in run rate during the remainder of the year. There remain significant risks associated with this – in particular, external bed usage increased during January and remains at extremely high levels

Financial Reports 2022/23	Current Month			YTD month 10			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	21.6	21.6	(0.0)	216.2	215.2	(1.0)	260.0	259.5	(0.4)
Pay	(14.6)	(14.9)	(0.3)	(151.6)	(146.7)	4.9	(183.3)	(177.5)	5.8
Non Pay	(5.4)	(5.2)	0.2	(51.2)	(55.4)	(4.2)	(59.8)	(65.2)	(5.4)
EBITDA	**1.7**	**1.6**	**(0.1)**	**13.5**	**13.1**	**(0.4)**	**16.8**	**16.7**	**(0.1)**
Cap Charges - Depreciation	(1.0)	(1.0)	(0.0)	(9.6)	(9.6)	(0.0)	(11.5)	(11.9)	(0.4)
Cap Charges - Interest & Div	(0.4)	(0.4)	(0.0)	(4.3)	(4.3)	(0.0)	(5.1)	(5.1)	0.0
Interest	(0.0)	0.1	0.1	(0.2)	0.2	0.4	(0.2)	0.3	0.5
Post EBITDA	(1.4)	(1.3)	0.1	(14.1)	(13.7)	0.4	(16.9)	(16.8)	0.1
Underlying Surplus / (Deficit)	**0.3**	**0.3**	**0.0**	**(0.6)**	**(0.6)**	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus / (Deficit)	**0.3**	**0.3**	**0.0**	**(0.6)**	**(0.6)**	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**

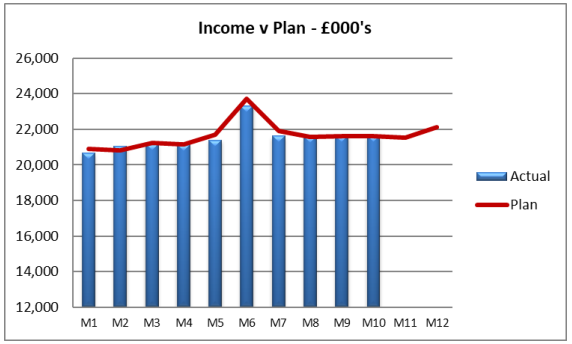
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

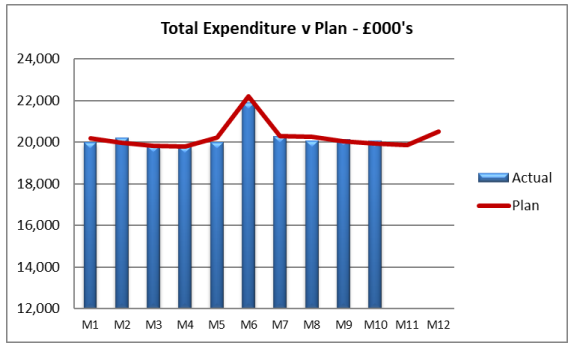
- Baseline surplus of £282k reported in month, £5k favourable to plan
- Cumulative deficit of £585k, £31k favourable to plan
- Deficit driven by external beds, Coral and Observation costs
- Profile reflects plan break-even submission to NHSE/I
- Significant risks to break-even position



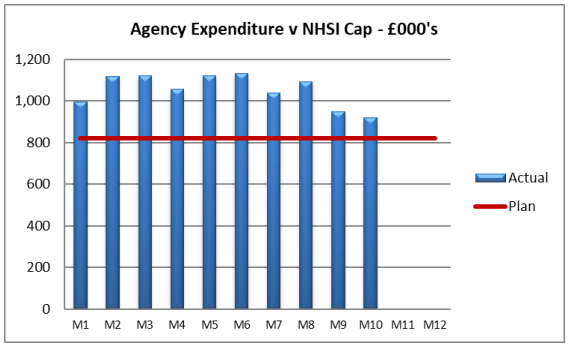
- Income received in month, £21.6m, in line with plan
- Reflects reduced funding in respect of NI reversal (£0.1m in month)
- Reflects SLP funding of legacy pressures (£0.2m in-month)
- Additional £0.2m awarded for Winter Pressures
- Includes £0.1m release against £0.4m hostel allocation



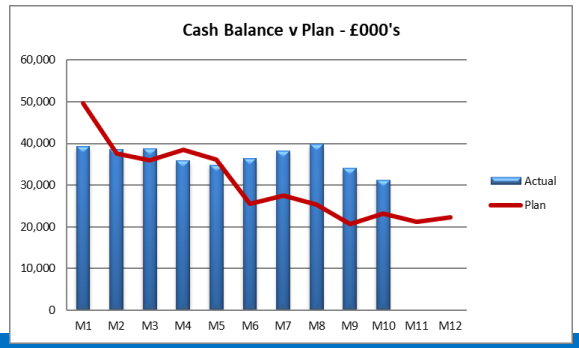
- Spend of £20.0m in month, in line with plan
- External bed expenditure of £656k in month, £88k more than M9
- Significant External Bed pressure continues into M11, currently funded by slippage
- Changes in expenditure patterns due to EMP and Richmond Wellbeing reflected in position



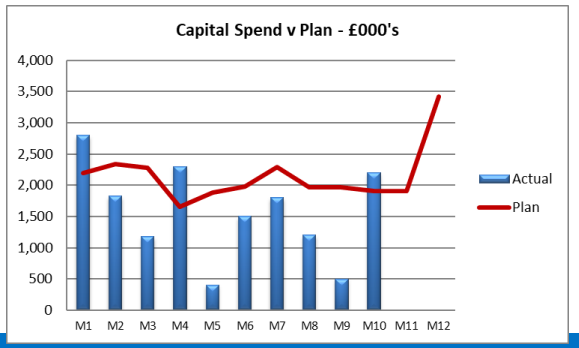
- Agency spend in month £918k, £82k above 2021/22 average spend
- £99k above plan
- Cumulatively, £2,338k above plan
- Community spend in M10 of £596k (65% of total)
- Cumulative Community spend now £5.5m (52% of total)
- Corporate spend reduced to £48k in-month



- Cash balance at end of January £31.3m
- £8.1m favourable to plan
- Key drivers are capital underspends, creditors, and receipts
- Cash balances required for loan repayment
- Loan repayments of £99m commence in 2023/24



- In month capital spend of £2.2m, £0.3m above plan
- Cumulative spend of £15.7m, £4.7m below plan
- Underspend found in EMP construction costs
- Forecast spend of £27.1m, £1.3m above plan but mitigated by additional funds negotiated
- Position excludes leases, £15.4m, capitalised under IFRS 16



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

Income Position

- For Month 10 the Trust reported £21.6m of income in line with plan, and cumulatively £1.0m adverse to plan
- All income budgets and actuals are fully reflective of the additional pay award funding received and subsequent reductions in relation to the NI increase reversal
- Local Contracts are £0.2m adverse to plan. This is a phasing issue and will equalise over the remainder of the year
- NHSE income is, following the resolution of the £2.8m funding error, showing a small adverse variance (£0.1m)
- NPSA income is now showing a balanced position
- Education income is £0.2m favourable to plan due to additional salary replacement funding being received
- Other non-clinical income is £1.1m behind plan as planned income flows associated with complex care have yet to materialise. This is partially offset by an over-recovery on other NHS income as additional income from the SLP has been agreed
- Non-NHS Clinical Income is £0.1m adverse to plan as a result of reduced salary recharges. This, however, is balanced by reduced pay expenditure
- Provider Collaborative and Merit Award income are all in line with plan

Financial Reports 2022/23	Current Month			YTD month 10			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	16.3	16.5	0.2	163.5	163.2	(0.2)	196.5	196.8	0.3
Nhs England	1.7	1.7	(0.0)	16.7	16.6	(0.1)	20.0	19.9	(0.1)
Npsa Income	0.0	(0.0)	(0.0)	0.4	0.5	0.0	0.5	0.5	0.0
Provider Collaborative Income	1.8	1.8	0.0	17.2	17.2	0.0	20.4	20.4	0.0
Other Nhs Clinical Income	0.3	0.5	0.1	2.9	3.2	0.3	3.9	3.8	(0.2)
Nhs Clinical Income	**20.1**	**20.3**	**0.2**	**200.7**	**200.7**	**0.0**	**241.4**	**241.4**	**(0.0)**
Education & Training	0.7	0.6	(0.1)	6.7	6.8	0.2	8.0	9.5	1.5
Other Non Clinical Income	0.4	0.3	(0.1)	4.4	3.4	(1.1)	5.2	3.8	(1.4)
Merit Award Income	0.0	0.0	0.0	0.1	0.1	0.0	0.1	0.1	0.0
Non Clinical Income	**1.1**	**0.9**	**(0.2)**	**11.2**	**10.3**	**(0.9)**	**13.3**	**13.4**	**0.1**
Non NHS Clinical Income	0.4	0.3	(0.1)	4.4	4.3	(0.1)	5.2	4.8	(0.5)
Non Nhs Clinical Income	**0.4**	**0.3**	**(0.1)**	**4.4**	**4.3**	**(0.1)**	**5.2**	**4.8**	**(0.5)**
Income	**21.6**	**21.6**	**(0.0)**	**216.2**	**215.2**	**(1.0)**	**259.9**	**259.5**	**(0.4)**

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

Pay Position

- Pay amounted to £14.9m in January, £0.3m adverse to plan
- Medical Staff are now overspent by £0.8m due to continued and increased high agency and bank usage
- Despite continued acuity pressures, Nursing budgets are now showing a £0.3m underspend cumulatively
- Other Clinical Staff (principally Psychologists) have continued the trend reported in previous years and have returned a £5.8m cumulative underspend to date
- Non-Clinical staff are showing a £0.4m adverse variance due to agency usage
- Both budgets and actuals are reflective of the reversal of the NI increase

Financial Reports 2022/23	Current Month			YTD month 10			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.3)	(2.5)	(0.2)	(23.9)	(24.7)	(0.8)	(29.1)	(30.2)	(1.1)
Nursing	(6.3)	(6.4)	(0.0)	(64.5)	(64.2)	0.3	(77.4)	(77.2)	0.2
Other Clinical	(3.4)	(3.3)	0.2	(37.0)	(31.2)	5.8	(45.1)	(37.8)	7.3
Non Clinical	(2.5)	(2.7)	(0.2)	(26.2)	(26.6)	(0.4)	(31.6)	(32.3)	(0.6)
Total Pay	**(14.6)**	**(14.9)**	**(0.3)**	**(151.6)**	**(146.7)**	**4.9**	**(183.3)**	**(177.5)**	**5.8**

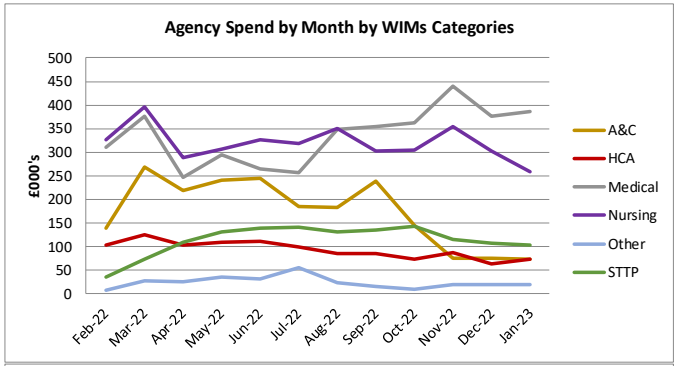
- Agency expenditure of £0.9m in January was £0.1m above both the Trust's plan and average 2021/22 monthly spend
- Bank expenditure was £2.1m, £0.4m adverse to plan. The cumulative position is now £1.4m above plan
- Permanent pay amounted to £11.8m in month. This was £0.2m favourable to plan due to continued vacancies and provision releases. Permanent pay is now £8.6m favourable to plan cumulatively with the underspend driven by Psychologist vacancies and provision releases

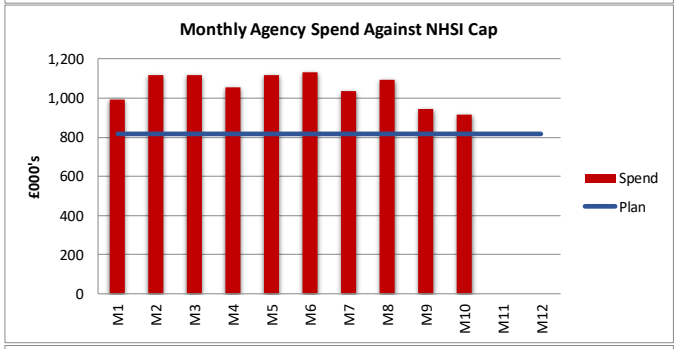
Financial Reports 2022/23	Current Month			YTD month 10			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(12.0)	(11.8)	0.2	(126.1)	(117.5)	8.6	(152.7)	(142.4)	10.4
Bank	(1.7)	(2.1)	(0.4)	(17.3)	(18.7)	(1.4)	(20.7)	(22.6)	(1.8)
Agency	(0.8)	(0.9)	(0.1)	(8.2)	(10.5)	(2.3)	(9.8)	(12.6)	(2.8)
Total Pay	**(14.6)**	**(14.9)**	**(0.3)**	**(151.6)**	**(146.7)**	**4.9**	**(183.3)**	**(177.5)**	**5.8**

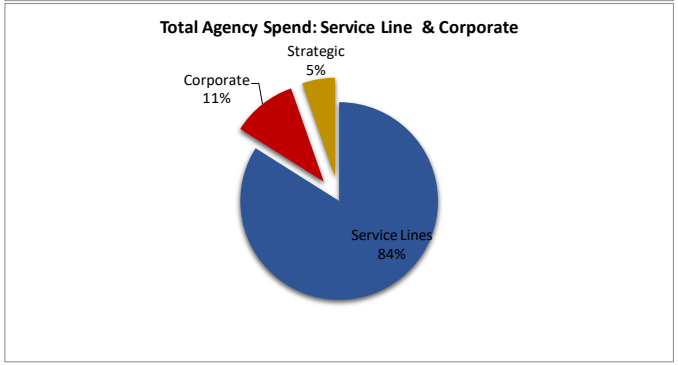
South West London and St George's Mental Health NHS Trust

Agency - in month and cumulative position

- Month 10 agency expenditure amounted to £918k
- Decrease on Month 9 expenditure of £29k, lowest monthly spend of the year to date, second successive monthly reduction
- Equates to 6.2% of pay costs (7.2% cumulatively, 6.1% in 2021/22, London average 4.4%, NHSE target 3.7%)
- Highest areas of monthly spend: Medical £387k, Nursing £259k, and Scientific £104k.
- Above the current plan by £99k in month
- The reduction in agency expenditure remains a Trust priority with Service Lines asked to identify exit strategies for all agency staff and weekly monitoring of headcount introduced
- The key pressure area remains the Community Service Line; of the £918k total spend, £596k (65%) was incurred in Community. This represented an increase of £29k on December expenditure
- 84% of agency expenditure to date has been incurred within the Trust's 4 clinical service lines, with 11% relating to corporate areas, and 5% relating to agreed strategic investments
- Including strategic investments, cumulative Corporate expenditure has amounted to £1,689k for the first 10 months. This compares to £515k for the same period in 2021/22







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

Non-Pay & Post EBITDA

- Non-Pay expenditure amounted to £5.2m in month, a £0.2m underspend (cumulatively £4.2m overspent)
- In-month positive movement reflective of clearance of Community Service Line CIP
- External bed expenditure amounted to £0.7m in January, £0.4m above plan.
- Other costs are now cumulatively £1.9m overspent. This is spread across several areas including: soft FM costs, estates maintenance, and property rentals
- 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 (£5.2m) cumulatively

Financial Reports 2022/23	Current Month			YTD month 10			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Drug Costs	(0.2)	(0.2)	(0.0)	(1.9)	(1.9)	(0.1)	(2.2)	(2.3)	(0.1)
Clinical Supplies & Servs Cost	(0.0)	(0.1)	(0.0)	(0.4)	(0.5)	(0.0)	(0.5)	(0.6)	(0.0)
Secondary Commisioning Costs	(2.3)	(2.5)	(0.2)	(27.5)	(29.7)	(2.3)	(32.2)	(35.0)	(2.8)
Other Costs	(2.9)	(2.5)	0.5	(21.3)	(23.1)	(1.9)	(24.9)	(27.4)	(2.5)
Contingency	0.1	0.1	(0.0)	(0.2)	(0.2)	(0.0)	0.0	0.0	0.0
Total Non Pay	**(5.4)**	**(5.2)**	**0.2**	**(51.2)**	**(55.4)**	**(4.2)**	**(59.8)**	**(65.2)**	**(5.4)**

- Post EBITDA costs are now cumulatively £0.4m favourable to plan. This is as a result of the Trust capitalising interest payable in relation to the EMP loan alongside a favourable performance on Interest Receivable
- The increase in depreciation budgets reflect the impact of IFRS 16 (detailed above). The adverse forecast variances relates to delays in moving services from QMH.
- Impairments associated following the completion of the two new hospital builds at Springfield are expected to impact next year.

Financial Reports 2022/23	Current Month			YTD month 10			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)	(9.6)	(9.6)	(0.0)	(11.5)	(11.9)	(0.4)
Cap Charges - Pdc Dividend	(0.4)	(0.4)	(0.0)	(4.3)	(4.3)	(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	(0.0)	0.1	0.1	(0.2)	0.2	0.4	(0.2)	0.3	0.5
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Post EBITDA	**(1.4)**	**(1.3)**	**0.1**	**(14.1)**	**(13.7)**	**0.4**	**(16.9)**	**(16.8)**	**0.1**

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

Service Line Positions

- Whilst the overall position is on track, there remains significant variance in terms of Service Line financial performance
- Acute Care is £4.2m cumulatively overspent as a result of acuity and external bed pressures. These are ongoing pressures that require continued and increasing central actions to mitigate
- CAMHS & ED is £2.8m underspent due to continued recruitment slippages
- Community is cumulatively £0.2m underspent. This is reducing due to additional agency expenditure
- Specialist Services is £1.0m underspent as vacancies continue to outweigh acuity issues in the Older Peoples wards
- The Corporate deficit is principally caused by adverse positions within the Estates and HR functions. The positive in-month movement is largely reflective of additional provisions released in-month to cover the external bed pressures
- The cost of capital position is expected to make a £0.1m surplus overall, with interest receivable offsetting the additional QMH costs.
- The forecast for the year remains break-even. There is risk in achieving this position as a continued improved profile is required during the remainder Q4 to offset H1 deficits alongside the emergence of additional pressures and continued capacity pressures

Financial Reports 2022/23	Current Month			YTD month 10			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)	(4.5)	(0.7)	(39.2)	(43.4)	(4.2)	(46.8)	(51.1)	(4.3)
Camhs & Ed	(2.7)	(2.4)	0.3	(25.0)	(22.2)	2.8	(30.3)	(27.2)	3.1
Community (Adults)	(3.9)	(3.9)	(0.0)	(38.7)	(38.4)	0.2	(46.3)	(46.3)	0.1
Specialist Services	(2.7)	(2.5)	0.2	(26.4)	(25.3)	1.0	(31.7)	(30.6)	1.1
Corporate	14.8	15.0	0.2	142.7	142.4	(0.2)	172.0	171.9	(0.1)
Capital Costs	(1.4)	(1.3)	0.1	(14.1)	(13.7)	0.4	(16.9)	(16.8)	0.1
Total	**0.3**	**0.3**	**0.0**	**(0.6)**	**(0.6)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**

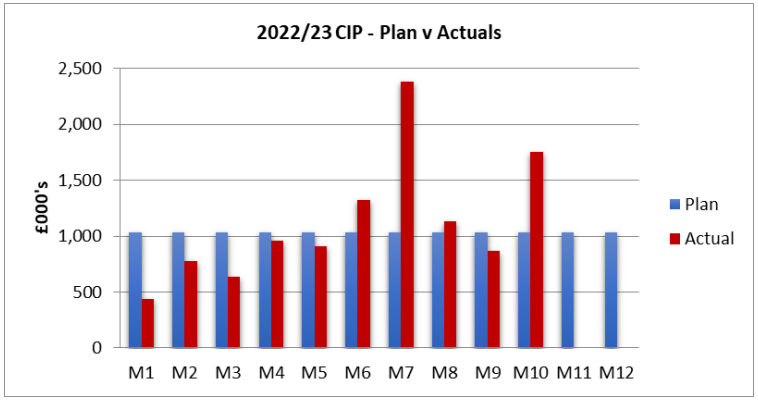
South West London and St George's Mental Health NHS Trust

Savings

- The Trust has a recurrent savings target of £12.4m (4.5%) to achieve the planned break-even position for 2022/23
- The savings target is phased equally across the year with a greater proportion of non-recurring schemes being achieved earlier in the year
- Schemes have been identified to deliver the full target of £12.4m. The current level of identification means a theoretical over-delivery of £0.7m is possible.
- Once risk adjusted expected delivery falls to £12.7m, leaving a £0.3m over-recovery (£0.3m shortfall last month)
- This gives a 103% confidence level in delivery – the equivalent value for M10 last year was 91%
- In month delivery amounted to £1.8m against a target of £1.0m – a £0.7m positive in month.
- Cumulative delivery now stands at £11.2m against a plan of £10.3m - £0.9m positive
- Despite positive movements during the month, a significant majority of savings delivered to date remain non-recurrent
- The challenge facing the Trust is to reduce the reliance on non-recurrent schemes and reduce the potential opening deficit for 2023/24

Status	2022/23 £000's	Risk Level %	Expected £000's
Green - Rec	3,715	0%	3,715
Green - Non-Rec	8,808	0%	8,808
Amber	334	50%	167
Red	234	75%	58
Unidentified	-704	100%	0
Total	**12,387**	**103%**	**12,749**

Gap	**362**



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

Capital

	Month			YTD			Annual		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Schemes									
EMP	1.6	1.9	(0.3)	17.2	12.6	4.6	21.9	23.1	(1.2)
Estates Maintenance	0.2	0.1	0.1	1.6	1.4	0.1	1.9	2.1	(0.2)
IT/Digital	0.2	0.2	(0.0)	1.7	1.7	(0.0)	2.0	2.0	0.0
Operational Total	1.9	2.2	(0.3)	20.5	15.7	4.7	25.8	27.1	(1.3)
Leases	0.0	0.0	0.0	15.4	15.4	0.0	15.4	17.1	(1.7)
Total Capital Expenditure	**1.9**	**2.2**	**(0.3)**	**35.9**	**31.1**	**4.7**	**41.2**	**44.2**	**(3.0)**

- Forecast spend for the year has increased from £42.8m last month to £44.2m. The £1.4m increase relates to the development of Tolworth and the successful award of additional funding to support the scheme
- The forecast includes £17.1m on leases which are shown on the balance sheet in line with the new IFRS 16 requirements. The forecast includes £0.6m for the lease transfer from ELFT associated with the Trust taking on the service provision of the Richmond Well Being service in December and the impact of extending the lease for QMH, which if enacted in year would add a further £1.1m The CRL will be adjusted by National.
- Capital expenditure for the month is £2.25m (£0.3m above plan); £31.1m cumulatively (£4.7m below plan)
- The Estates Modernisation Programme (EMP) is underspent by £4.6m year to date due to the continued delay in construction and handover of the buildings at Springfield, along with pausing works at Tolworth whilst awaiting DHSE approval. Design and preparatory works will now be progressed in line with additional funding. Estates and IT are broadly on plan
- The Trust has not received formal confirmation of its CRL target and EFL target for the financial year. The Trust is forecasting to achieve both targets

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

Statement of Financial Position

Statement of Financial Position (£m)	Plan as at end January 2023	Actuals as at end January 2023	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	7.3	6.2	(1.1)
Plant, Property and Equipment	331.6	333.1	1.5
Receivables	26.7	26.7	0.0
Right of Use Asset	15.4	12.8	(2.6)
Total Non-Current Assets	**381.1**	**378.9**	**(2.2)**
Total Non-Current Assets Held for sale	**0.0**	**0.0**	**0.0**
CURRENT ASSETS:			
Inventories	0.2	0.2	0.0
Receivables due in less than 1 year	4.6	3.9	(0.7)
Other Financial Assets (Accrued Income)	0.9	2.2	1.3
Prepayments	0.0	1.8	1.8
Cash and Cash Equivalents	23.2	31.3	8.1
Total Current Assets	**28.9**	**39.4**	**10.5**
CURRENT LIABILITIES:			
Trade Payables	(35.3)	(41.4)	(6.1)
PDC Dividend Payable	(0.0)	(1.7)	(1.7)
Capital Payables	(11.6)	(13.4)	(1.8)
Provisions	(4.4)	(4.2)	0.2
Other Financial Liabilities (Accruals)	0.0	0.0	0.0
Deferred Revenue	(0.2)	(5.8)	(5.6)
Total amounts falling due within one year	**(51.5)**	**(66.5)**	**(15.0)**
NET CURRENT ASSETS/(LIABILITIES)	**(22.6)**	**(27.1)**	**(4.5)**
NON CURRENT LIABILITIES:			
Provision for Liabilities and Charges	(1.5)	(1.7)	(0.1)
Capital Payables	(5.2)	(5.2)	0.0
Borrowings	(99.4)	(99.4)	0.0
Lease Liability	(15.4)	(8.6)	6.8
Total amounts falling due after one year	**(121.5)**	**(114.8)**	**(0.1)**
TOTAL ASSETS EMPLOYED	**237.0**	**237.0**	**0.0**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	142.3	142.3	(0.0)
Retained Earnings (accumulated losses)	30.6	30.6	0.0
Retained Surplus(Deficit) in year	(0.6)	(0.6)	(0.0)
Revaluation Reserve	64.6	64.6	(0.0)
TOTAL TAXPAYERS EQUITY	**237.0**	**237.0**	**0.0**

- Current Receivables stand at £3.9m, £0.7m lower than plan, with prior year reducing to £0.7m
- Cash is £31.3m, £8.1m more than plan, see next slide.
- There are no further loan drawdowns due, with the loan remaining at £99.4m. There are no repayments of the principal required in 2022/23.

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

Cash

All figures £k

	Plan as at end January 2023	Actuals as at end January 2023	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	4,318	4,256	(62)
Non Cash Adjustments			
Depreciation and Amortisation	9,611	9,580	(31)
Interest Received	(10)	(523)	(513)
Interest Paid	0	(185)	(185)
(Increase)/Decrease in Inventories	0	0	0
Increase/(Decrease) in Working Capital	(1,075)	703	1,778
Net Cash Inflow/(Outflow) from Operating Activities	**12,844**	**13,831**	**987**
Cash Flows from Investing Activities			
Interest Received	10	522	512
(Payments) for Property, Plant and Equipment	(35,861)	(30,862)	4,999
Proceeds from sales of property, plant and equipment	0	0	0
Net Cash Inflow/(Outflow) from Investing Activities	**(35,851)**	**(30,340)**	**5,511**
Net Cash Inflow/(Outflow) before financing	**(23,007)**	**(16,509)**	**6,498**
Cash Flows from Financing Activities			
Interest element of finance lease	(650)	(185)	465
PDC dividend (paid)/refunded	(2,571)	(1,436)	1,135
Net Cash Inflow/(Outflow) from Financing Activities	**(3,221)**	**(1,621)**	**1,600**
Net Increase/(Decrease) In Cash And Cash Equivalents	**(26,228)**	**(18,131)**	**8,098**
Cash / Cash Equivalents Opening	**49,403**	**49,403**	**0**
Cash / Cash Equivalents at end of month	**23,175**	**31,272**	**8,098**

- The cash balance at the end of the month was £31.3m compared with the plan of £23.2m.
- The increase of £8.1m relates to:
- Capital spend, +£5.0m (of which £3.4m relates to the Care Home purchase provided for in 21/22 and not yet completed, along with other capital underspends)
- Movements in working capital, +£1.0m driven largely by late receipt of invoices
- There are no further loan drawn downs due, with the full loan now drawn down to the value of £99.4m. There are no repayments of the principal required in 2022/23.

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

Meeting:	Trust Board
Date of Meeting:	9 March 2023
Report Title:	Savings Update 2022/23 M10
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Author:	Debbie Hollinghurst, Deputy Director of Finance
Purpose:	For discussion and note
Scrutiny Pathway:	Director review / ELT / FPC
Transparency:	Public

Executive Summary

What - the key items to note are:

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

Following the in-month improvement within Community Adult (£1m of red/amber schemes turned green through non recurrent pay underspends) the Trust now has a delivery confidence of 103%.

So What – the key items to note are:

Recurrent savings represent 30% of the total CIP delivery, which is lower than the nationally reported average of c50%. This is driving a high savings target for 2023/24.

Next Steps

Focus must be centred on the 2023/24 CIP delivery plan, whilst ensuring green schemes continue to deliver for the last two months of the year as expected.

Questions or Asks for the committee

Committee is asked to note the delivery confidence and the need to focus on delivery and identification of recurrent savings in preparation for 2023/24.

Appendices/Attachments:

A 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 – Provides effective estates utilisation
Financial:	Positive impact - Provides information on the delivery of key financial targets through CIP delivery
Legal:	Positive impact - Provides information on the statutory requirement of achieving break even
Quality:	Positive impact – Trust funds are spent providing good quality services to our patients whilst achieving financial targets
QII:*	Positive impact – Provides quality improvements and eliminates waste
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Involvement (SUCFF):*	Positive Impact - feedback from service users is important for recognising areas for improvement
Strategy:	Positive impact – Underlying financial sustainability is a key part of the Trust's strategy
Workforce:	Positive impact – Trust funds supports the employment of a secure permanent and stable workforce
Other (specify):	n/a

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

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

Trustwide Progress 2022/23 Savings Update M10

Meeting	ELT
Date of Meeting	February 2023
Report Title	Trustwide Progress 2022/23 - Savings Update M10
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Director of Finance & Performance
Purpose	For Information
Scrutiny Path	ELT/FPC/Trust Board
Transparency	Public
Recommendation	None
The Board is asked to	Discuss and note

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

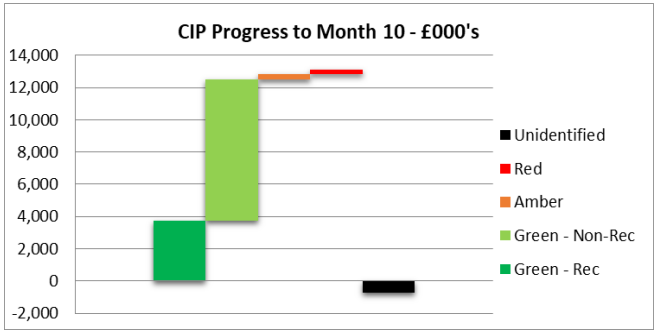
Executive Summary

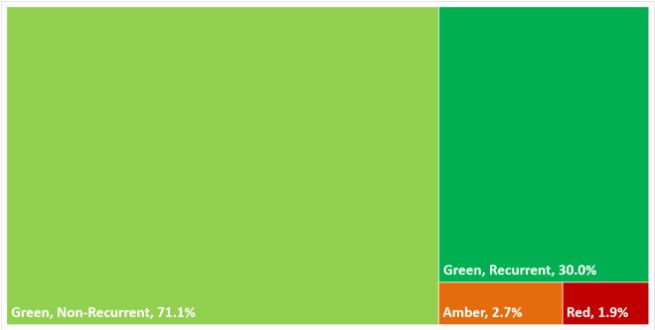
South West London and St George's Mental Health NHS Trust

Current Status

- The full year savings target has been achieved subject to Green rated schemes continuing to deliver in the remaining two months of the year
- Overall Green schemes have increased from 92% to 101% (£12.5m vs target of £12.4m) as previously Amber/Red rated schemes have turned Green
- Recurrent savings (Green) remain at £3.7m (30%)
- Non-recurrent saving schemes (including technical schemes, investment slippage, and some Service Line plans) now total £8.8m (£7.7m last month)
- The Trust will open 2023/24 with an underlying deficit, currently £8.8m, due to the CIP recurrent delivery shortfall.
- The challenge for the Trust therefore remains to convert non recurrent schemes to recurrent and identify new recurrent schemes.
- Focus is on the 2023/24 CIP delivery plan, an update on this is provided in the Part B Finance Report within the planning section.

Status	2022/23 £000's	2022/23 %
Green - Rec	3,715	30%
Green - Non-Rec	8,808	71%
Amber	334	3%
Red	234	2%
Unidentified	-704	-6%
Total	**12,387**	**100%**

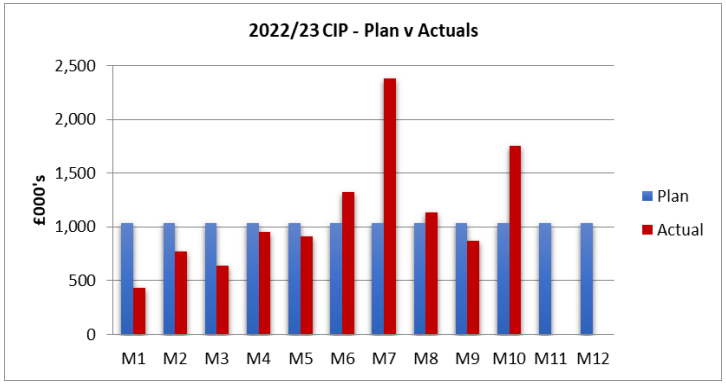




South West London and St George's Mental Health NHS Trust

Month 10 Delivery

- In month, £1.7m of CIPs were delivered, £0.7m over achievement against a plan of £1.0m
- The Community Service Line reported £1.1m savings in month to meet the year-to-date target
- Of in-month delivery, 100% was non recurrent. The challenge remains to increase recurrent delivery
- Cumulative savings now total £11.2m, £0.9m ahead of plan and with sufficient 'Green' schemes to ensure full year delivery of the £12.3m requirement
- All clinical services lines are currently ahead of plan, although these current over performances will equalise over the remainder of the year
- Corporate areas remain broadly balanced with positive positions in Finance/Estates, Nursing and Strategy partially offset by underperformance in Medical, CEO and HR
- Central and Technical Schemes remain £0.5m ahead of plan largely due to capitalising loan interest payments.



Service Line SRO level	M10 YTD Plan £000's	M10 YTD Actuals £000's	Variance £000's
Acute and Urgent Care	808	946	138
CAMHS & ED	640	740	100
Community (Adults)	1,209	1,218	10
Specialist Services	732	868	137
Nursing & Quality	194	232	39
Estates, Finance, Digital & Perf.	1,061	1,166	105
Strategy & Planning	48	58	9
H R / O D & Workforce	122	68	-54
Chief Executive, TSec & Comms	47	20	-27
Senior Operations Management	12	15	2
Medical	242	129	-113
Central & Technical	5,208	5,712	504
Totals	**10,323**	**11,174**	**851**

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

Movements in Month

- No new schemes were identified in-month, however Green balances increased by £1.076m and Amber and Red balances falling by £92k and £985k respectively

- There was one movement in month: Community reported £1.1m of non-recurrent pay underspends

	Green R £000's	Green NR £000's	Amber £000's	Red £000's	Unidentified £000's	Total £000's
RAG Status M10 Report	3,715	8,808	334	234	-704	12,387
RAG Status M9 Report	3,715	7,732	426	1,218	-704	12,387
Movement	**0**	**1,076**	**-92**	**-985**	**0**	**0**
Caused by:						
Community - non-recurrent pay underspends		1,076	-92	-985		0
Total	**0**	**1,076**	**-92**	**-985**	**0**	**0**

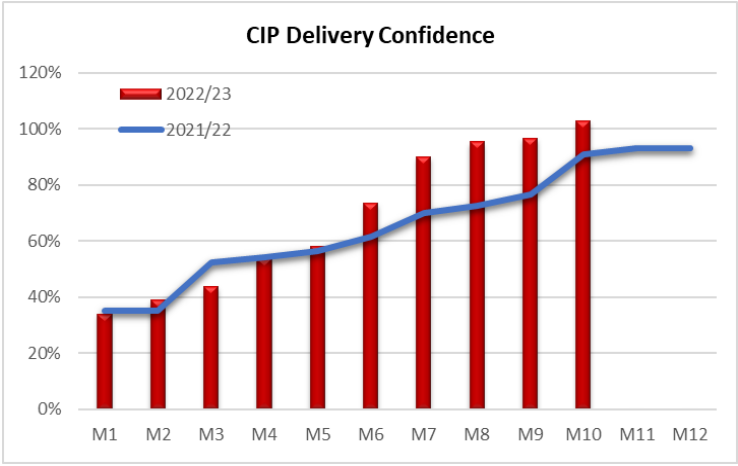
NHS
South West London and St George's Mental Health NHS Trust

Risk and Delivery Confidence

- Total CIP identification stands at £13.1m
- As they are unlikely to deliver in full, Amber schemes and Red schemes are assigned risk levels of 50% and 75% respectively
- Risk assessed delivery is now £12.7m, £0.3m above target, a £0.7m improvement compared to last month (£12m)
- Delivery confidence stands at 103%, compared to 97% last month (91% at M10 last year)
- Recurrent savings identified to date remain at £3.7m (30%).
- Whilst non-recurrent savings support the plan delivery in year, the risk of financial sustainability in future years remains high. The pressure to find further recurrent savings therefore remains a high priority.

Status	2022/23 £000's	Risk Level %	Expected £000's
Green - Rec	3,715	0%	3,715
Green - Non-Rec	8,808	0%	8,808
Amber	334	50%	167
Red	234	75%	58
Unidentified	-704	100%	0
Total	**12,387**	**103%**	**12,749**

Gap	**362**



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

CIP Delivery by Theme - £'000

Ref.	Scheme	22/23 Target	YTD Plan	YTD Actual	YTD Variance	Narrative
1	Technical (NR)	4,050	3,375	3,952	578	Non-recurrent release of balance sheet reserves and capitalisation of loan interest payments
2	Existing Establishment Vacancies (NR)	2,120	1,766	3,919	2,152	High level of long-term vacancies identified on a non-recurrent basis; £1m underspend FYE in Community Adults. Allocating posts to recurrent savings where clinically safe to do so, is proving challenging.
3	Slippage against new investment funds	1,700	1,417	1,360	-57	Slippage of 25% in recruitment and mobilisation of services; 2022/23 £7m, 2021/22 £2m. Variance due to profiling, forecast expected to deliver to plan.
4		500	417	400	-17	
5	Clinical Efficiency	500	417	126	-291	Minimal non pay savings in AUC and Specialist identified to date. Workstream will be carried forward to next year with a focus on workforce redesign (skill mix) and monitoring and capturing increasing productivity rather than re-investing it.
6	Temporary staffing reductions	1,886	1,572	0	-1,572	TWR/E agency process re-launched 1 Feb 23 and enacted greater controls to reduce spend including recruitment to 80% cover as opposed to 100% to save the 20% premium (for non-inpatient areas). Exceptions to be approved at VCP. Weekly ELT agency wte report to include booking reason e.g. sickness cover, vacancy etc to aid understanding of the key drivers of this spend. Costs remain high following a reduction in lower paid staff and an increase in medical staff.
7	Stretch target to 4.5%: Corporate	1,105	921	992	71	Medical and Estates continue to have unidentified CIPs which is offset by the overperformance in Finance.
8	Site utilisation	200	166	139	-27	Recurrent rent avoidance savings in CECS of £167k. Review of existing leases and activity by site ongoing; notice has been provided on vacant rooms identified however this could result in additional void costs if the space is not re-utilised within the wider system.
9	Drugs Management	200	167	218	51	Improvements in drug management driven and supported by Pharmacy team that have worked closely with services promoting best practice, reducing waste, ensuring prescribing is appropriate and optimising cost-effective medicines.
10	Corporate Efficiency: HR	127	106	68	-38	Savings from non-pay following review of the new structure and shortfall to be met from vacancy management.
Target		**12,387**	**10,323**	**11,174**	**851**	

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

Corporate Savings – Target £2.1m

- Corporate overall delivery remains at 90%; there was no further delivery reported in month
- Medical and Estate & Facilities directorates still have unidentified savings, offset by over delivery in Finance
- Recurrent Green savings total 46% of the total CIP target; 16% more than the Trust average of 30%.
- To achieve target a further £206k needs to be delivered.
- Focus is needed on turning non recurrent schemes recurrent and identifying new recurrent schemes for 2023/24.

Service Line RAG	Target £000's	Green Recurrent £000's	Green Non-Rec £000's	Amber £000's	Red £000's	Unidentified £000's	Over Delivery £000's
Chief Operating Officer	15	15	0	0	0	0	0
Nursing & Quality	232	0	232	0	0	0	0
Medical Directorate	291	50	89	0	0	152	0
Strategy & Planning	58	58	0	0	0	0	0
H R / O D & Workforce	146	81	0	65	0	0	0
Estates & Facilities	831	0	351	213	17	250	0
Finance & Performance	442	720	245	19	18	0	560
Chief Executives Office /Tsec	32	0	0	32	0	0	0
Communications	24	24	0	0	0	0	0
Totals	**2,071**	**948**	**917**	**329**	**36**	**401**	**560**

Totals - prior month	**2,071**	**948**	**917**	**329**	**36**	**401**	**560**
Movement	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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

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

Area	Big Ticket Scheme	SRO Lead	Service	Description	Risk Rating	Plan £000's
Corporate	Existing Establishment Vacancies	COO	Chief Executives Office /Tsec	Target allocation	Amber	32
Corporate	Existing Establishment Vacancies	COO	Chief Operating Officer	DOO Band 4 Post Reduction	Green	15
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Communications	Communications Non-Pay	Green	24
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Contracts	Additional interest received in-year	Green	14
Corporate	Existing Establishment Vacancies	COO	Digital Services	Target allocation	Amber	19
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Digital Services	Mobile phones	Green	200
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Digital Services	Phone Line Credits (BT)	Green	24
Corporate	Temporary staffing reductions	DoF / CPO	Digital Services	Target allocation	Red	18
Corporate	Existing Establishment Vacancies	COO	Estates & Facilities	Target allocation	Amber	23
Corporate	Existing Establishment Vacancies	COO	Estates & Facilities	KAP - Vacancies - Managers	Green	92
Corporate	Existing Establishment Vacancies	COO	Estates & Facilities	KAP - Vacancies - A&C	Green	52
Corporate	Existing Establishment Vacancies	COO	Estates & Facilities	KAU - Vacancies	Green	35
Corporate	Existing Establishment Vacancies	COO	Estates & Facilities	KAU - Minor Works Mgr (extra 50% to Capital)	Green	38
Corporate	Site utilisation	DoF / IPD	Estates & Facilities	Target allocation	Amber	190
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Estates & Facilities	Royal Borough of Kingston - Rates adjustment	Green	123
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Estates & Facilities	KAP - Service Contracts U/spend	Green	11
Corporate	Temporary staffing reductions	DoF / CPO	Estates & Facilities	Target allocation	Red	17
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Finance & Procurement	FPC Reassessment Refund	Green	136
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Finance & Procurement	Injury Cost Recovery Scheme	Green	46
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Finance & Procurement	Additional interest received in-year	Green	520
Corporate	21/22 c/fwd. scheme - Corporate Efficiency (HR)	CPO	H R / O D & Workforce	Target allocation	Amber	46
Corporate	21/22 c/fwd. scheme - Corporate Efficiency (HR)	CPO	H R / O D & Workforce	HR non-pay underspend	Green	81
Corporate	Temporary staffing reductions	CPO	H R / O D & Workforce	Target allocation	Amber	19
Corporate	Existing Establishment Vacancies	COO	Nursing & Quality	Governance Directorate pay underspends	Green	30
Corporate	Existing Establishment Vacancies	COO	Nursing & Quality	Therapies Directorate pay underspends	Green	68
Corporate	Existing Establishment Vacancies	COO	Nursing & Quality	Nursing Directorate pay underspends	Green	95
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Nursing & Quality	Governance Directorate non-pay underspends	Green	13
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Nursing & Quality	Therapies Directorate non-pay underspends	Green	7
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Nursing & Quality	Governance Directorate income over-achieveme	Green	2
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Nursing & Quality	Nursing Directorate income over-achievement	Green	14
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Nursing & Quality	Nursing Directorate non-pay underspends	Green	3
Corporate	Existing Establishment Vacancies	COO	Performance & Information	Performance & Information pay underspend	Green	25

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

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

Area	Big Ticket Scheme	SRO Lead	Service	Description	Risk Rating	Plan £000's
Corporate	Drugs Management	MD / COO	Pharmacy	Community Drugs	Green	50
Corporate	Existing Establishment Vacancies	COO	Pharmacy	Pharmacy Non Recurrent Pay Savings Band 5	Green	40
Corporate	Existing Establishment Vacancies	COO	Pharmacy	Pharmacy Non Recurrent Pay Savings Band 8	Green	40
Corporate	Existing Establishment Vacancies	COO	Psychology	Psychology A&C Band 4 underspend	Green	9
Corporate	Existing Establishment Vacancies	COO	Strategy & Planning	Strategy Establishment Review	Green	56
Corporate	Stretch target to 4.5% (Schemes to be identified)	DoF	Strategy & Planning	Strategy Non Pay review	Green	2
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Acute and Urgent Care	Female PICU - Non-Pay	Green	83
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Acute and Urgent Care	Perinatal - Non-Pay	Green	42
Operations	Existing Establishment Vacancies	COO	Acute and Urgent Care	Perinatal - Pay	Green	14
Operations	Existing Establishment Vacancies	COO	Acute and Urgent Care	HTT pay underspends	Green	214
Operations	Existing Establishment Vacancies	COO	Acute and Urgent Care	Liaison pay underspends	Green	476
Operations	Existing Establishment Vacancies	COO	Acute and Urgent Care	Other AUC pay underspends	Green	140
Operations	Existing Establishment Vacancies	COO	Camhs & ED	Vacancies CAMHS Community	Green	363
Operations	Existing Establishment Vacancies	COO	Camhs & ED	Vacancies CAMHS Specialist	Green	210
Operations	Existing Establishment Vacancies	COO	Camhs & ED	Vacancies ED	Green	28
Operations	Site utilisation	DoF / IPD	Camhs & ED	CECS - Accommodation	Green	167
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Community (Adults)	Target allocation	Red	198
Operations	Drugs Management	MD / COO	Community (Adults)	Community Drugs	Green	171
Operations	Existing Establishment Vacancies	COO	Community (Adults)	Community pay underspends	Green	1,076
Operations	Site utilisation	DoF / IPD	Community (Adults)	Target allocation	Amber	6
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Specialist Services	Adult Specialist Non-Pay	Green	7
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Specialist Services	Adult Specialist Overheads	Green	16
Operations	21/22 c/fwd. scheme - Clinical Efficiency	COO	Specialist Services	Forensic Community Travel	Green	2
Operations	Drugs Management	MD / COO	Specialist Services	Specialist Drugs - recurrent	Green	5
Operations	Drugs Management	MD / COO	Specialist Services	Specialist Drugs - non recurrent	Green	30
Operations	Existing Establishment Vacancies	COO	Specialist Services	Cognition Vacancies	Green	184
Operations	Existing Establishment Vacancies	COO	Specialist Services	NDD Vacancies	Green	80
Operations	Existing Establishment Vacancies	COO	Specialist Services	Adult Specialist Vacancies	Green	172
Operations	Existing Establishment Vacancies	COO	Specialist Services	Forensic Inpatient Vacancies	Green	228
Operations	Existing Establishment Vacancies	COO	Specialist Services	Forensic Community vacancies	Green	155
Trustwide	Slippage against 2021/22 Investment funds	DoF	Central	Slippage against 2021/22 Investment funds	Green	500
Trustwide	Slippage against 2022/23 Investment funds	DoF	Central	Slippage against 2022/23 Investment funds	Green	1,700

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

Appendix A – 2022/23 Full List of Schemes (3)

Area	Big Ticket Scheme	SRO Lead	Service	Description	Risk Rating	Plan £000's
Trustwide	Technical NR	DoF	Technical Savings - NR	Balance sheet release - Income	Green	1,172
Trustwide	Technical NR	DoF	Technical Savings - NR	Balance sheet release - Pay	Green	1,144
Trustwide	Technical NR	DoF	Technical Savings - NR	Balance sheet release - Non-Pay	Green	1,856
Trustwide	Technical NR	DoF	Technical Savings - NR	Complex Care inflation	Green	69
Trustwide	Technical NR	DoF	Technical Savings - NR	Loan repayment saving	Green	355

Total Identified (Green, Amber, Red)	**13,091**
Target	**12,387**
Unidentified	**-704**

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

Meeting:	Trust Board
Date of Meeting:	9 March 2023
Report Title:	Modern Slavery Statement
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
	Martin Kelly, Head of Procurement
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Purpose:	For agreement
Scrutiny Pathway:	Director Review/ELT/ FPC/Trust Board
Transparency:	Public

1. Executive Summary

What - The Modern Slavery Act 2015 makes provision about slavery, servitude and forced or compulsory labour as well as about human trafficking. Whilst not all the Act is directly relevant to business, section 54 "Transparency of Supply Chain" requires organisations that carry on business within the UK providing goods and services to report annually on the steps that they have taken, within that financial year, to ensure that slavery and human trafficking are not taking place in their own business or supply chain.

The existing statement was approved by Trust Board in May 2022, who requested that the statement is reviewed annually.

This report shows the existing statement with recommended changes tracked.

So What - Although publication in the Slavery Statement Registry (operated by the Home Office) is currently voluntary the government does intend to legislate for mandatory reporting under planned changes to the regime; it is considered good practice to make and publish an annual statement.

Next steps – publish the updated statement on the Trust website

Questions or Asks for the committee

- Committee is asked to: **approve the Modern Slavery Statement**

Appendices/Attachments:
None

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

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:	Positive impact – This paper provides update to Trust's approach to its duties under the Modern Slavery Act
Clinical:	Positive impact – Through being seen as an ethical employer we should attract the best staff who will deliver the best clinical outcomes
Equality & Diversity:	Positive impact – The Trust through taking these actions will positively support equality and diversity
Estates:	Positive impact – The Trust is investing in its Estate to provide modern mental health facilities and through these actions is assured on the ethics of the programmes
Financial:	Neutral impact – No direct impact upon the Trust finances
Legal:	Positive impact - Provides information on the statutory requirement of the Modern Slavery Act
Quality:	Positive impact – Through ensuring that we comply with the law both our own services and those of our supply chain should be of the best available quality affordable to us
QII:*	n/a
Reputation:	Positive impact – The Trust will be seen to be operating ethically and within the law.
Involvement (SUCFF):*	n/a
Strategy:	Positive impact – supports our strategy of being seen as a great place to work
Workforce:	Positive impact – Through these endeavours we will be seen as an ethical employer
Other (specify):	n/a

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

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

South West London and St George's Mental Health NHS Trust – Modern Slavery Statement Dated ~~XXX~~April 2023

Although not currently mandated to publish a modern slavery statement, SWLSTG seeks to adopt good practice and in line with its Trust values will take all reasonable steps to avoid involvement in slavery and human trafficking and to raise awareness of such practices to help combat them. We are committed to ensuring that all of our employees are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that an individual may be or is at risk of modern slavery/human trafficking.

We are committed to ensuring that no modern slavery or human trafficking takes place with our knowledge in any part of our business or our supply chain. This statement sets out actions taken by SWLSTG to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

Trust Structure and Principle Activities

Organisational Structure and Supply Chains

We are a leading provider of mental health services across south west London and a beacon of excellence for many of our national mental health services.

We serve 1.1 million people across the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth and employ more than 3~~2~~,000 staff who provide care and treatment to about 20,000 people from south west London and beyond at any given moment.

We have a long history of innovation that has helped to redefine the mental health landscape in the UK. We have more than 100 clinical teams across the Trust, working to make sure that high quality patient centred care is our key priority. The emphasis of our services is on recovery which means helping people to get on with their lives and to focus on the things that are important to them.

Our Trust headquarters are in the impressive grounds of Springfield University Hospital in Tooting, with major inpatient services provided from Tolworth hospital in Kingston, and Queen Mary's hospital in Roehampton. We also operate in many other community locations in London and the south east.

We provide community and outpatient services in each of the boroughs we serve and provide many national services such as those for people with eating disorders and OCD as well as national deaf services.

Our staff are among some of the most advanced and experienced practitioners in their fields and we are proud of the positive impact our mental health services have for both patients and the wider community. We invest in research, innovation and training in mental health and are connected to a number of academic and research organisations.

Our clinical expertise has led us to develop and contribute to ground-breaking national policies. We also regularly receive visitors to transfer knowledge and share good practice. From community outreach to informing government policy, we are working with you and for you to provide the best in mental health care.

As a teaching trust, we also provide education, training and research in partnership with a number of universities as listed below.

St George's University of London

Kingston University

London South Bank University

Health Education England affiliated Universities

The Trust has an Estates Modernisation Programme (EMP), one key part of the Trust's Integrated Programme, which is investing in our services, people and our environments, including new and refurbished mental health facilities across Kingston, Richmond and Wandsworth.

EMP is delivering new mental health facilities at Springfield alongside main contractor Sir Robert McAlpine and master developer Springfield and Tolworth Estates Partnership (STEP) as part of a new 'Springfield Village'. As part of this, works have been progressing at pace on the development of two new facilities, Trinity and Shaftesbury buildings at Springfield University Hospital. Some services are already being delivered from these new buildings with final completion scheduled in 2023~~Set to be delivered in 2022~~, these will help us to deliver the most modern mental healthcare in the country.

Alongside this new and refurbished facilities are planned at Barnes Hospital and Richmond Royal in Richmond and Tolworth Hospital in Kingston.

The Programme represents major innovation and investment in our local communities - by 2025 it will help transform mental health services in south west London.

The Trust's income earnings in ~~2020/21~~2021/22 were £~~220m~~250m and expenditure £~~216~~247m. Of the latter supplies and services were £~~8~~7m, purchased healthcare £~~12~~21m, premises £15m, and drugs £~~2~~3m. Capital spend covered the following main area EMP £~~55~~69m, technology £~~3~~4m, maintenance £1m and ward and other refurbishments £~~4~~3m.

We procure goods and services from a range of providers. Contracts vary from small one-off purchases to large service contracts and covers several category areas including but not limited to stationery and office equipment, medical consumables and medical devices, estates and facilities, medicine management and outsourced services.

To obtain these goods and services we work with local, national and occasionally international suppliers. A key part of our purchasing activity is linked with stakeholders such as NHS Supply Chain, Crown Commercial Service, NHS London Procurement Partnership, London University Purchasing Consortium. All of whom have commitments against modern slavery and responsible procurement. We maintain collaborative opportunities ~~collaborate~~ through the South London Partnership with Oxleas NHS Foundation Trust and South London and Maudsley NHS Foundation Trust (SLaM) and ~~via the latter linked in with Guys' and St Thomas's NHS Foundation Trust)~~ ~~and~~ through our links with the SW London Procurement Partnership. We are engaged with the work of ~~support the collaborative work of~~ NHS England's Central Commercial Function ~~Improvement~~ which is committed to the NHS Sustainability Agenda.

Through the Trust's membership of the London Universities Purchasing Consortium (LUPC) ~~and our Head of Procurement's position on their executive committee,~~ the Trust is affiliated to

Electronics Watch. Electronics Watch has worked to remediate forced overtime and recruitment fees in several manufacturing centres and the UK Government's 2020 Modern Slavery Statement highlighted the work they do with Electronics Watch to tackle modern slavery in their ICT hardware and electronics supply chains. LUPC partners also include the Business, Human Rights and Environment Research Group (BHRE), University of Greenwich.

Where possible the Trust aims to ensure that spend is carried out using a purchase order subject to the applicable Standard NHS Terms and Conditions for the Supply of Goods and Services. The Applicable Contract Terms Policy applies to any NHS organisation and states that where an NHS body issues a PO the standard Terms & Conditions apply.

Section 10 (Warranties) of those standard terms and conditions state the following:

10 Warranties

10.1 The Supplier warrants and undertakes that:

10.1.21 it shall: (i) comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and (ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains;

10.1.22 it shall at all times conduct its business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this Clause 10.1.22 and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy;

In addition, the NHS Standard Contract has been updated in 2022 to strengthen its position on Modern Slavery, extending requirements and the option to terminate for breaches of social and labour laws.

Organisational policies in relation to slavery and human trafficking

The Trust has internal policies and procedures in place in relation to the potential for modern slavery or human trafficking. This includes Safeguarding Adults at Risk and the Procurement Policy.

All staff have access to the Trust Safeguarding Adults Service for support and guidance when they are concerned about modern day slavery or trafficking. The Trust has a Whistle-Blowing Policy which details how staff can raise any concerns that they may have confidentially. This can be through an email inbox, or through a conversation with the Freedom to Speak Up Guardian, who will provide support to the individual raising a concern. Staff are provided with this information at corporate induction.

Trust activities and policies are required to have an Equality Impact Assessment (EQIA) completed and its Mandatory and Statutory Training (MAST) requires of all staff to have undertaken at least basic level safeguarding training with more in-depth training required for those in specific positions within the trust.

Assessing and managing risk and due diligence processes in relation to slavery and human trafficking

We use the stakeholders explained above to help minimise modern slavery or human trafficking in our supply chains or in any part of our business. In sourcing its larger procurement, such as through tendering, the Trust now includes social value as part of its evaluation process, using a minimum overall weighting of 10% for the total procurement.~~modern slavery issues in its documentation and/or in interviewing bidders where appropriate~~. The public sector framework suppliers we use have additionally been required to address such matters when applying to join frameworks.

The Trust reviews its Modern Slavery and Human Trafficking Statement on a regular basis and presents it at the Board of Directors meeting in Public. This demonstrates a public commitment, ensures visibility and encourages reporting standards.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain:

The Trust adheres to the National NHS Employment Checks / Standards (this includes employees UK address, right to work in the UK and suitable references).

The Trust has systems to encourage the reporting of concerns and the protection of whistle-blowers including the engagement of an independent Guardian Service.

Many of our purchases utilise existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of Contract, these all have the requirement for suppliers to have suitable anti-slavery and human trafficking policies and processes in place. Where suitable frameworks exist, we use them in preference to tendering.

The Trust upholds professional codes of conduct and practice relating to procurement and supply, has been awarded Level 1 under the Skills Development Network Towards Excellence Framework, including through our Head of Procurement's membership of the Chartered Institute of Procurement and Supply (CIPS).

Effective action taken to address modern slavery - Performance Indicators

The Trust is committed to social and environmental responsibility and has zero tolerance for Modern Slavery and Human Trafficking. Any identified concerns regarding Modern Slavery and Human Trafficking are escalated as part of the organisational safeguarding process.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance.

A Freedom to Speak Up Report is regularly submitted to the Board of Directors which includes an overview of the number of concerns raised by staff and the category that they fall into.

Through the Trust's Safeguarding Practices any concerns that staff have for our patients, in this respect, will be the subject of our internal clinical incident reporting processes. Quarterly safeguarding updates are taken to the Trust's Quality and Safety Advisory Committee (QSAC).

Training on modern slavery and trafficking

Safeguarding training is mandatory for all staff and includes information on trafficking and modern-day slavery in order to promote the knowledge and understanding of escalating concerns via the Home Office national referral mechanism/duty to notify process.

The Trust has used training resources available through the London Universities Purchasing Consortium and the Business, Human Rights and Environment Research Group (BHRE), University of Greenwich. The Head of Procurement holds Chartered Procurement and Supply Chain Professional status which includes an annual requirement to take an Ethical Procurement training session and test.

Conclusion

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and applies to South West London and St George's Mental Health NHS Trust.

Meeting:	Estates Modernisation Committee meeting
Date of meeting:	7th February 2023
Transparency:	Public
Committee Name	Estates Modernisation Meeting (EMC)
Committee Chair and Executive Report	Juliet Armstrong (Chair) Ian Garlington (Executive)

BAF and Corporate Objective the committee is accountable for:

BAF Risk Description
A failure to deliver transformed models of care, working practices and environments

Corporate Objective:

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

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

1. There is a significant amount of transformation still for the Integrated Programme. A planned refresh of the programme brand and scope is presently in play, with the express intention of ensuring a line of sight to the elements of clinical transformation and transformation OD required to deliver those elements. The significant delivery of the infrastructure will also remain a priority.

The Board is asked to note the planned refresh and monitor its roll-out to ensure effective and inclusive reporting.

2. There is also significant transformation taking place outside of the Integrated Programme.

The Board is asked to reflect on the aggregate level of change, consider any implications on the overall pace of change and what this means for the Trust's corporate objectives for 23/24.

Areas of Risk Escalation to the Board:

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

Item discussed- Move readiness/post-implementation review

- **Assurance Position**

There is good assurance on the post-implementation situation in the new Trinity Building. Further assurance is required to confirm the timetable of the move to the new Shaftesbury Building from STEP/SRM (developers). There is also assurance that other moves within Springfield are being appropriately managed, including from a patient and staff perspective.

- **Evidenced by**

  - Trinity 'after action' reviews and distillation of learnings for the future
  - Tolworth 'after action' reviews and distillation of learnings for the future
  - Some feedback from patients and 'movemakers'
  - Master dashboard and detailed move Gantt-charts
  - Trinity building snagging lists reviewed by COODIG
  - EMMG papers

What next?

- Integrated Programme Phase 2 review will incorporate more work on creating a culture of joint-working in the new space
- 3 month post-move survey to be reported at June EMC
- QSAC will now review any BAU safety or quality issues within the Trinity building

Item discussed- Integrated Programme progress

- **Assurance Position**

The individual parts of the Integrated programme are being well managed overall and risks appropriately understood, with good learnings from Phase 1 (Springfield).

Programme governance, scope and reporting is being reviewed for Phase 2 and this will come to the April EMC meeting. This will include more on the culture and organisational development aspects, where assurance there is clarity on the outcomes and longer-term approach of this work is weaker.

Since Board approval of Phase 2 Tolworth and also Barnes Full Business Cases (FBCs), meetings are taking place with key stakeholders in NHSE, DHSC and the council as appropriate, so these can continue through their governance routes towards a decision. Note that the Phase 2 Tolworth FBC will need to now go to the Treasury, as it is considered being a 'new' FBC, and possibly the Cabinet Office. The Barnes FBC was approved by the ICB Finance Committee.

- **Evidenced by**

  - Master dashboard
  - EMMG papers
  - BAF
  - Integrated Programme quarterly risk report

What next?

- Phase 2 Integrated Programme review of governance, scope and reporting will come to the April EMC
- The new People Committee (to be launched in April) will need to manage any interdependencies with the People Readiness and Culture Change parts of the Integrated programme. The exact scope of what EMC and the People Committee will cover is part of the Phase 2 Integrated Programme review.

Item discussed- Finance Report (Month 9)

- **Assurance Position**

The Integrated programme finances are being well managed overall and risks appropriately understood. The M9 position is a cumulative £5m underspend, mainly due to slippages with the overall Tolworth timetable and Richmond Royal re-development.

The 4 year capital plan was approved.

Phase 1 remains within the DHSC and Treasury approved fixed price of £155.2m.

- **Evidenced by**

  - Finance reports

What next?

- No major action, other than continued management and reporting.

Item discussed- Clinical Transformation (CT) updates on Acute and Urgent Care (AUC) , Perinatal and Rehab transformation

- **Assurance Position**

Each area now has updated workstreams and plans and either already have or are in the process of defining outcomes in each of the i) improving access, ii) preventing crisis, iii) recovery and iv) experience domains. Work on AUC in particular is strongly driven to reduce length of stay (LOS).

The committee reflected on the amount of transformation, how it all ‘fits together’ and the role of leaders to support transformation and innovation, including how it is seen more as BAU rather than something ‘extra’. The collective impact on staff was also highlighted – in corporate as well as clinical areas.

This will need to inform corporate objectives for 23/24. The importance of really bringing the changes to life – for patients and staff – was also highlighted.

- **Evidenced by**

  - Presentation reports for each transformation
  - Outcome measures for each transformation (where available)

What next?

- Highlight broader transformation questions to Board, as above
- No major action, other than continued management and reporting. Further updates are already part of the EMC workplan.

Item discussed- Communications and Engagement Deep Dive

- **Assurance Position**

There is good assurance that the communications and engagement on the Integrated Programme are being well managed. The original aims and objectives set in Feb 2022 have largely been delivered and a significant amount of learning has taken place to inform the Phase 2 approach. The key learnings have been around messaging continuity and consistency, project changes particularly when move dates change, and the challenges of communication with front-line staff, which can put an over-reliance on digital communication.

The committee reflected on the high quality content produced to date, the importance of leader's communications (which the communication team sometimes had to pick up) and the on-going importance role of 'story tellers' within the organisation who are trusted by their peers.

- **Evidenced by**

  - Comms and engagement plan update
  - Update on measures

What next?

- Obtain more feedback from people (did they feel involved, get what they needed? etc)

Appendices

All annual reports and other items that require to be in the full Board papers will be appended to the Committee Report

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

Meeting:	Trust Board
Date of meeting:	Thursday 9th March 2023
Transparency:	Public
Committee Name	Charitable Funds Committee
Committee Chair and Executive Report	Doreen McCollin and Ian Garlington

BAF and Corporate Objective the committee is accountable for:
Delete those not applicable

BAF Risk Description
A failure to achieve financial targets
A failure to have the right staff with the right skills at the right time
A failure to deliver transformed models of care, working practices and environments
A failure to effectively respond to equality and diversity issues facing the Trust
A failure to meet the increasing demand on services relating to acute care pathways

Corporate Objective:

- **Objective 1:** To improve the quality of services through delivering a stepped change in fundamental standards of care and empowering service users and carers.
- **Objective 2:** To deliver our integrated transformation programme providing state of the art mental health facilities, improving access and outcomes and reinvigorating working practices for staff and service users alike.
- **Objective 3**: To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences.
- **Objective 4:** To support our people to develop and grow and develop our organisation to be the best we can be.
- **Objective 5:** To proactively develop partnerships and act as a system leader to drive strategic improvements to mental health of the SWL population.
- **Objective 6:** To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL.

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

1. The reduced sum available in the Charitable Funds budget
2. The reduction in the administrative charge from the Trust to the charity
3. The various schemes being considered to raise funds for the charity

Areas of Risk Escalation to the Board:

High numbers of dormant funds without plans for use.
Reduce reputation risks for the Trust?

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

Charitable Funds Finance Report year to date

The Committee noted that there is a balance of £89,384 as at 31 December 2022. The majority, £41,744, of this relates to unrestricted funds and £47,640 relates to restricted funds. Since April 2022, the Charity has received £33,245 of which £29,021 was a League of Friends donation relating to Surbiton and Tolworth, £709 related to investment income and £3,515 came from direct donations. This was offset by expenditure of £17,049. The majority, £7,407, was on patients' comforts, £5,000 relating to Hospital Rooms, £2,722 on staff other, £1,056 on patients' furniture, £656 on patients' social groups/functions and £208 bank charges. This results in a net inflow of £16,196.

So What: The £29k received from the Friends of Tolworth & Kingston has been put in a separate restricted fund.

The Committee also noted the 2021/22 Charitable Funds Annual Accounts and Annual Report was uploaded to the Charity Commission website prior to the 31st January 2023 deadline.

What Next? The administration charge previously set for the last few years at £10,000 is to be reduced to £5,000 as the Trust made a conscious decision to reduce fundraising whilst the Estates Redevelopment was being prioritised. This has been discussed at the Audit Committee. It is hoped that with robust fundraising that the charge will revert to £10k in 2023/24.

The Committee also noted and approved the moving of the Charity's holdings in the Global Equity Fund to CCLA's ethical fund in line with the investment policy.

Charity Working Group update

The Committee notes the increased work that is taking place and heard about the following pieces of work:

- NHS Charities Together for £30k to fund a Development Officer to be dedicated support in raising income for the fund.
- £54k from the Sir Captain Tom Moore Fund for a mental health first aid training course, this will support the reducing stigma of mental health and will support the wider community to include non-clinical staff, people from our new residential estate.
- The Hospital Rooms work continues and will move ahead in discussions regarding the Tolworth redevelopment.
- Possible commercialisation of the Hospital Rooms art is being considered. This could generate additional income.
- Some small fund-raising ideas are being considered; Pennies from Heaven, Cash 4 Coins to donate of foreign currency. A 5k organised Fun Run is being progressed and also an option to open up the park space for Park Run.
- Other electronic forms of donating are being worked on to include digital screens, Click Here to Donate and contactless 'tap to donate' stations.

So What: The Committee heard that there are a number of dormant funds whereby the

plans for fund use is not known in either restricted on unrestricted accounts. This should be considered sensitively as this could have reputational concerns as this was awarded following a successful bid or was donated with a view that it was used to benefit staff and patients.

What Next? The Committee would like to thank the team involved in supporting the fundraising that has taken place as their commitment and enthusiasm has been pivotal in the work that has been achieved so far.

Appendices

Minutes for the meeting held on 31st October 2022

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

CHARITABLE FUNDS COMMITTEE

Draft minutes of the meeting of the Charitable Funds Committee held online on 31 October 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
Philip Murray (PM)	Director of Finance and Performance
Attendees:	
Clair Hartley	Corporate Governance Manager (minutes)
Apologies	
Sharon Spain (SS)	Director of Nursing and Quality Standards

No.	Details	Actions
C22/22	**Apologies** Apologies were noted.	
C22/23	**Declarations of interest** None.	
C22/24	**Chair's Action** None to report.	
C22/25	**Minutes of the last meeting** The minutes of the meeting held on 16th June 2022 were agreed as a correct record subject to the following amendment. C22/17.3 – First word in paragraph '**I'** should be '**IG'.**	

C22/26	**Action Tracker** IG advised that a Patron had not been identified due to work on the charity being in a holding pattern. **IG** would report on progress at next meeting. The remaining items on the action tracker were on the agenda.	**IG**
C22/27	**Charitable Funds Annual Report and Accounts** PM presented the Annual report. 1 The accounts were reviewed by Audit Committee who noted a couple of minor corrections to narrative which have been updated in this version. A copy of the draft Annual Report had been shared with AB who had confirmed that her signature could be added to the relevant pages of the report once approved. Some changes were to be made to the report submitted to CFC: • Specific dates of NED, Jean Dainith's tenure were to be provided. • Words 'patient' and 'service user' were used interchangeably. Word patient was to be used consistently. • On Page 5 – what we have achieved- refers to spend on patients, should be changed to spend on patients and staff. • On Page 5 – what we have achieved- states that contribution of £5000 to Hospital Rooms was included, this should be changed to excluded. PM pointed out the following • Overall funds had dropped by circa 20,000 from £94,000 down to £73,000 at the end of March in the unrestricted funds section. • Cash received from NHS charities at last balance sheet end were used to settle the creditors that were linked to the same project, resulting in cash balances being depleted by £134,000. • Creditors at year end reduced by £114,000. • There was a massive reduction in the inflow of funds during the year. • Griffin Stone Moscrop & Co conducted an independent review and gave the charity a clean bill of health and charged £2000 which appeared to be the going rate for an independent examination. The issue of the Staff salary recharges of £10 000 was raised and whether this could be reconsidered and reversed. Unfortunately, it could not be reversed as the accounts had already been finalised. Introduction of the Pennies from Heaven initiative might lead to further charges for administration. The committee discussed the cost of Trust staff doing work for the Charity. The Committee required some assurance that the amount charged was proportionate to the actual time and costs incurred and that it was similar to that charged by other charities. The Committee discussed use of the Charity's funds. The Charity should not spend its money on items which the Trust should provide for example furniture and items for patients' everyday living needs. They needed clarity on what the Charity funds should be used for versus what the NHS should provide. It was	

	decided that IG would investigate this and report back at the next meeting. **ACTION** The Committee discussed the Pennies from Heaven initiative. • Whether this was the right time to introduce it considering the cost-of-living crisis? Asking staff for money might be perceived negatively. • Whether the campaign could be targeted at certain staff groups or the corporate team? • That it should be clear that the money would not be squandered or used for administrative fees • That the money should go towards a particular campaign or be used to support members of staff who were struggling with the cost of living, It was decided that the MLBT group should be used as a sounding board. JK would ask the group for their opinions at their meeting on 7 December. **ACTION** If the soundings were reasonable, IG would prepare a paper for ELT about the Pennies for Heaven Initiative as discussed. **ACTION** PM referred to an idea he had seen for donations by scanning a QR code. JK said that the new buildings would have digital screens in the communal areas with a QR code to donate. After discussion the Committee recommended to the Trust Board the approval of the 2021/22 Charitable Funds Accounts, including the Independent Examiner's Report.	**IG** **JK** **IG**
C22/28	**Charitable Funds Finance Report year to date**	
	PM presented the report and emphasised the following issues: • There was a balance of £67,109 as at 30 September 2022. £48,490 of this related to unrestricted funds. • Since April 2022, the Charity has received £3,648 of which £500 related to investment income and £3,148 came from direct donations. This was offset by expenditure of £9,456. This resulted in a net outflow of £5,808. • The figures up to the end of September did not include the £29k received from the League of Friends of Tolworth & Kingston. These funds were received in October and would be put into a separate restricted fund and reported as part of the next financial report update • Work on identifying the dormant funds had not progressed as quickly as previously envisaged due to staff sickness and some resignations. Old documents pertaining to charitable funds had been found and were being reviewed. A recommendation would be made to the next Committee meeting on the use of these funds. The Committee discussed the report. • It was noted that not much fundraising had been done during the year because of the concentration on getting the new build done.	

	• JuA referred to a precedent of a charity with millions of unspent funds where they couldn't find the paperwork. The Charity Commission said that if they were unable to find out the reason for the donations after a period of time, despite reasonable endeavours, they could use the money. It should be confirmed whether specific time periods were referred to. The money could be used to buy things for the wards. PM said that he would look at case law on the subject. **ACTION** • The amount of £29 thousand received from the League of Friends was queried as a larger sum was expected. IG explained that the League had split the funds with another beneficiary. • PM referred to the £15 000 annual grant expected from Momark. They had not received the grant in 2022. This money could help to provide some the things that JuA had referred to that could be bought for the wards. **IG** said that he would discuss that with his team. **ACTION** The Committee **NOTED** the fund balances as at 30 September 2022. **NOTED** the ongoing work in identifying the restricted funds, dormant funds and authorised signatories.	**PM** **IG**
C22/29	**Working Group Update** IG presented the report and emphasised the following: • Although the Charity had been in a holding pattern, they had been working with Comms on rebranding of the charity Graphic earlier in the year. It was running on the CAF donate site in a shell format. Once it was upgraded, the branding would be done properly, and it would be linked to the new website. • AB had written to the Friends of Surbiton and Tolworth to thank them for the £29 000,00 donation. In accordance with their request that the donation be used to support the memory clinic at Tolworth, the working group were involved in projects to improve the clinic. • An amount of £149 000 had been received from NHS Charities Together, £108 000 had been spent. The balance of £40 000 had to be spent by March 2023. The core team was following up with project leads to close out projects. A report had been submitted to NHS Charities Together on Phase 1 and 2. • The NHS Charities Together Development Grant Programme bid is to be submitted by 30th December 2022. • A bid for a stage 3 bid for £55,000 funding via the NHS Charities Together was also being developed. JK explained that the Stage 3 Covid Recovery Grants were intended to support the long-term health and recovery of NHS staff, patients, community and volunteers impacted by Covid-19. It was intended that the funding be used to roll out a programme of mental health first aid and suicide prevention training in Springfield Village. It could also support the development of a Be Well hub. This would link in with South London Listens. They were thinking of a project to create a village environment where people who	

	lived in the local community were trained and supported around mental health and wellbeing. • Hospital Rooms was concluding work on site and the working group had talked to the team about their involvement in Stage 2. • Hospital Rooms offered to donate a light box installation by Yinka Ilori. JuA asked how Hospital Rooms work at Springfield could be maximised and whether an art therapy angle could be introduced as they had the paintings on site and whether the project was being publicised. • Jua asked whether the Board had approved the investment policy. PM replied that they would have to wait until the minutes had been formally approved before they could move the funds around. • The Committee discussed ideas to maximise the impact of the art created by Hospital Rooms. The Committee **NOTED** the update.	
C22/30	**Momark annual report and accounts**	
	The Committee **noted** the Momark annual report and accounts.	
C22/31	**Legal update**	
	The Committee **noted** the following: • briefing note on changes to the Charities Act 2022' • High Court interpretation of 'responsible investment' in judgment.	
C22/32	**Meeting Review**	
	DM thanked the Committee for the richness of the discussions. JuA commented that it was a very good meeting and that although the charity had been paused, a lot of good work had been done, which could be picked up when work started again. There had been some good conversations, especially around the pennies from heaven.	
C22/33	**Next meeting** The next meeting would be held on 6 February 2023.	