Trust Board - Part A May 2023

Committee Rooms A and B, Trinity Building, Springfield Hospital

11 May 2023 01:30 PM - 04:00 PM London Standard Time

Agenda Topic

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

AGENDA

Meeting	**Board of Directors**
Time of Meeting	**1.30pm to 4.00pm**
Date of Meeting	**Thursday 11th May 2023**
Location	**Conference Rooms A and B, Trinity Building, Springfield Hospital**

	PART A		**Format**	**Lead**	**Time**
1.	**PATIENT STORY**		**Paper**	**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**			
	2.3. Chair's action	**FE**			
	2.4. Minutes of the meeting held on 9th March 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**
	3.2. 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**	**14:30**
	4.3. Corporate Objectives 4.3.1. Corporate Objectives 2023-24 4.3.2. Q4 2022-23 Report	**FR**	**Paper**	**AS**	**14:40**
	BREAK				**14:50**
5.	**MAKING THE TRUST A GREAT PLACE TO WORK**				
	5.1 People Committee chair's report	**FR**	**Paper**	**SA**	**15:00**
6.	**ENSURING SUSTAINABILITY**				
	6.1. Finance and Performance Committee chair's report	**FR**	**Paper**	**VS**	**15:10**
	6.2. Monthly finance and savings reports	**FD**	**Paper**	**PM**	**15:20**
	6.3. Estates Modernisation Committee chair's report	**FR**	**Paper**	**JuA**	**15:30**
	6.4. Audit Committee chair's report	**FR**	**Paper**	**RF**	**15:40**
7.	**NOTIFIED QUESTIONS FROM THE PUBLIC AND STAFF**	**FD**	**Verbal**	**AB**	**15:50**
8.	**MEETING REVIEW**	**FD**	**Verbal**	**AB**	**15:55**
9.	**Next Trust Board business meeting in public –** 1.30pm on 13th July 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
Sola Afuape (SA)	Non-Executive Director
Vik Sagar (VS)	Non-Executive Director
Richard Flatman (RF)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Dr Billy Boland (BB)	Medical Director
Sharon Spain (SS)	Director of Nursing and Quality Standards
Philip Murray (PM)	Director of Finance and Performance
Jennifer Allan (JeA)	Chief Operating Officer
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:

Emma Whitaker (EW)	Deputy Director of Corporate Governance

Apologies:

*=non voting

Making life better together

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

Advanced Clinical Practitioners and the Community Transformation Programme

May 2023

Presentations:
Service user and carer: Ron and Pat

Attending from service:
Paula Robins, Head of Nursing and Quality

Introduction

This month's patient story is presented by Ron and his wife Pat, and focusses on their experience when trying to get support from mental health services, and of their experience of receiving input from an Advanced Clinical Practitioner (ACP) within the Community Service Line. Although Ron initially found it difficult to access support, once he started receiving input from the ACP his experience was more positive

The role of the ACP

The Multi-professional framework for Advanced Clinical Practice (ACP) was published in 2017 with a plan for implementation in 2020. The framework set out a new and bold vision in developing this critical workforce role in a consistent way to ensure safety, quality, and effectiveness. It has been developed for use across all settings including primary care, community care, acute, mental health and learning disabilities. This framework recognises that the health and care system rapidly evolve to deliver innovative models of care, health and care professionals have adapted, to meet the increasing demands of individuals, families, and communities.

The Community Service Line currently has 4 ACPs working across the 5 boroughs and a Physical Health ACP across the community service line and is keen to support the development of further roles. Funding has been sourced by HEE to support 12 ACP Trainees across our newly transforming community IRH Teams as part of our new Enhanced Response Service to take up the ACP Masters Programme within one of our identified universities commencing in September 2023/January 2024.

ACPs work inline with 4 pillars which are detailed in the framework. There are as follows:

Clinical Practice

- Demonstrate a critical understanding of their level of responsibility, working with complexity, risk, and uncertainty.
- Demonstrate critical reflection, openness to change
- Working with families, patients, carers, carrying out holistic assessments
- Providing Complex Assessments, Diagnosis, Treatment/interventions and Discharge
- Planning care, promoting a person centred approach, supporting recovery .
- Prescribed medicines, therapies, lifestyle advice

Leadership and Management

- Assess and address own learning needs, personal development plan.
- Self-directed learning
- Identify developmental needs for individuals and wider teams, supporting to address.
- Supporting Clinical Managers and ACDs to provide effective, quality focused and safe service delivery to improve patient outcomes and experience

Education

- Assess and address own learning needs, personal development plan and that of other junior staff.
- Self-directed learning
- Identify developmental needs for individuals and wider teams, supporting community service line training and development programmes.
- Acting as a role model for MDT and upskilling nurses within our community teams.

Research

- Adhere to good research practice guidance so that evidence-based strategies are developed and applied.
- Audit own and others clinical practice, acting on findings.
- Identify gaps in evidence base and application to practice, alerting appropriate organizations as to how this can be addressed.
- Identify needs for further research.
- Develop and implement robust governance systems.
- Share best practice findings through presentations, peer reviews etc.

Ron and Pat's story

Ron has a diagnosis of depression, and he became unwell in 2022 after stopping his Venlafaxine medication on the advice of his doctor due to concerns over side effects. Ron experienced real difficulty accessing services initially; his GP referred him to mental health services and after a while he received a telephone assessment by the Single Point of Access (SPA) team. This assessment concluded that Ron did not require secondary mental health services and he was discharged and redirected to primary care mental health services. Ron felt that he was being told that he was not unwell enough to be given support.

Ron went back to his GP and was then referred and assessed by a doctor in primary care mental health services, who referred him back to secondary mental health services. Ron felt like he was being passed around services, and that no one was really listening to him or to Pat.

The second referral resulted in Ron being visited at home by an ACP (Sarah). Both Ron and his wife Pat felt that this was a real turning point in his care and treatment. Sarah listened to their concerns and agreed that Ron needed support. Sarah reviewed Ron's medication and advised that his Mirtazapine be reduced to help his sleep, and discussed the option of Ron receiving support from the Home Treatment Team (HTT). After some consideration Ron did not feel this was necessary, Sarah therefore arranged for Ron to receive short term support from the Recovery and Support Team (RST). Sarah also gave Pat information about carer support that was available. Ron and Pat noted that Sarah provided them with a number that they could reach her on, they felt very reassured by this.

Following the home visit Sarah contacted Ron by telephone to see how he was getting on, and she noted that he was feeling much brighter in mood after her intervention, and his sleep had also improved. Ron was then under the care of the RST where he was seen by medical staff, things continued to get better for him, and he started feeling more positive. Ron's medication was further reviewed by the RST, and he was put back on his old medication. Ron has now been discharged from the RST, and he is currently waiting to receive Cognitive Behavioural Therapy (CBT) with Kingston iCope.

Although Ron experienced difficulty accessing services initially, he has nothing but praise for Sarah and the RST staff who helped him

Feedback from ACP Sarah

"I contacted Ron after he had been seen by PCMHT and then referred to us.

I assessed Ron at his home address with his wife Pat who is very involved in Ron's recovery.

I completed a comprehensive assessment and noted his views that he had dementia, had low mood and lack of sleep was impacting on his mental health.

I was able to diagnose his current mental health conditions and ascertain his level of risk and safety at home.

I suggested a reduction of mirtazapine to 30mgs to improve sleep with Rons consent. I offered HTT, as I was worried about Ron's risk of suicide, but Ron and Pat did not want this intervention and Pat was able to support Ron.

I followed up to see the response of the reduction of mirtazapine and made a referral to RST (IRH) for further intervention. I stayed connected to keep Ron updated as the referral was not very smooth"

Feedback from teams about working with ACPs

"ACP's in CMHT's are helpful as they are someone who the MDT we can speak with to discuss crisis issues that are not with a specific team. They can also help to manage complex situations if a crisis occurs, leaving the duty staff to continue with their work, so saving time for patients getting the care they require."

"Having an ACP work with the SPA team has been a great way of addressing limited doctors' availability by using their enhanced training to take on complex assessments.

The inclusion of an ACP within the team also led to overall service improvement by them supporting clinicians with assessments and reflection, providing training and upskilling physical health knowledge which is an important component of the initial assessment.

This has been especially noticed by the support our ACP provided to new nurses through mentorship and coworking."

Next steps and way forward

Access to services is the second highest category for complaints received across the Trust. Ron's experience clearly shows the value of the ACP once their input was requested however highlights the difficulty that patients can experience when initially referred to secondary mental health services.

Part of the Community Transformation programme includes improving the patient experience when it comes to access to services.

Six core principles of the community transformation include:

1. **Integrated Services** - Improved integration with voluntary, community and social enterprises (VCSE) partners, such as the peer support provision which has been sub-contracted to Mind in Kingston and Richmond….

Next steps and way forward continued

2. No wrong door: Increased referral routes to the SPAs include self referral online through the website and eRS for GPs .

3. Place based holistic support offer: includes peer support (from people with lived experience), welfare advice and employment support.

4. Single trusted assessments: Less duplication of assessments through risk and needs assessments and full assessments in the SPAs. No patient should receive two full assessments in the SPAs and IRHs.

5. New roles and skillsets: To help to overcome barriers to recruitment in some of the more traditional clinical roles. New roles include COMHAD Practitioners, SCM Practitioners, MHWP, peer support coordinators, welfare advice and ACPs.

6. Removing barriers between primary and secondary care: advice and guidance to GPs in the SPAs, PCN Mental health Practitioners working in GPs, inclusion of PCMHTs in DIAM and improved step down to primary care.

D.I.A.M

The Daily Interagency Allocations Meeting (DIAM) aims to streamline the process for new referrals in a holistic manner and allocate the correct treatment pathway. DIAM takes place with the SPAs and interfacing teams who present recommendations from trusted assessments and allocate treatment. Treatment may include IRH enhanced clinical pathways, peer support, welfare advice and employment support.

There is IRH representation at each DIAM and this is also attended by external partners who offer input and assist in decision making. DIAMS started in Sutton around a year ago, and have recently started taking place in Kingston and Richmond services. Feedback has been positive and there have been less instances of referrers being passed around services.

Feedback about the DIAM

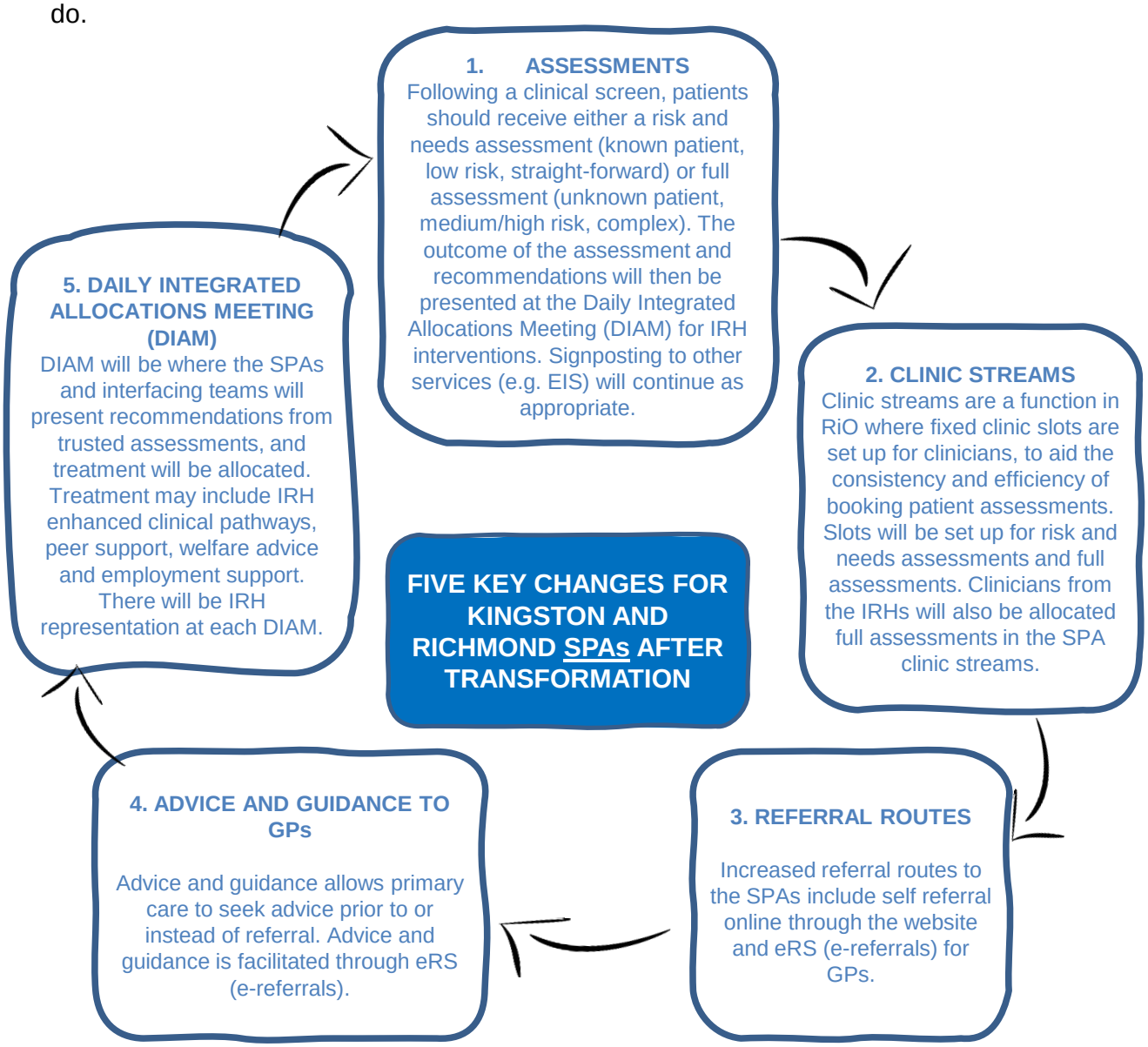
"Benefits we have seen include joint up thinking and decision making, improved relations between colleagues, reduction of back and forth between clinical teams which improves patient access into teams. It is also helpful to consider other interventions at an earlier point e.g., employment support, OT assessments, peer support"

"DIAM meetings are very helpful to deciding which pathways patients require treatment. As the meetings are interagency, we can ensure all patients are considered for peer support, need any welfare benefits and also employment support. Its also an opportunity for staff to contribute with helpful ideas which may have even not been considered in the community. It is very much a holistic approach. DIAM provides a space for all professions to be heard and make valuable contribution for care and treatment delivered in the community. I have really valued the meetings and feel they bring a more of a partnership working in the community."

"DIAM is going well, everyone is learning how to provide a succinct detailed assessment, to save on any follow up questions"

Key changes for Kingston and Richmond SPAs after transformation

The diagram below shows 5 key changes that are being implemented K&R SPA services to streamline and enhance the patient experience of accessing services. The transformation model has been developed and revised from the Sutton model which is already in place. We will continue to develop our community services to ensure that care is organised around the needs of patients and carers who are at the heart of all we do.



South West London and St George's Mental Health NHS Trust
Springfield University Hospital, 61 Glenburnie Road, London SW17 7DJ
Telephone: 020 3513 6000
Website: www.swlstg-nhs.uk

May 2023 Trust Board

APPENDIX TO PATIENT STORY

To accompany the Patient Story, additional information is being provided on patient experience, using data from the monthly patient family and friends test. The Patient Story enables in depth understanding of an individual experience, while the family and friends test provides feedback from an average of about 350 of this Trust's patients each month.

The NHS family and friends test has been in operation since 2013 and the same questions are used every month by all Trusts, allowing extensive comparison – the national data for mental health each month captures feedback from around 20,000 patients, or over 200,000 each year. Data from the test has been used in the Trust's Quality and Performance Report for some years. Unlike the annual Patient Survey, the cohort of respondents to the FFT is not controlled to be representative, so the data should be interpreted in that context. Month on month variations may be less instructive than consideration of data over a wider period, as provided in the Q&P report.

The Trust's position over the most recent nationally reported months is as follows:

	% positive SWLSTG	% negative SWLSTG	% net positive SWLSTG	% net positive English MH Trusts
December 2022	84.3	9.7	73.6	79.6
January 2023	87.1	6.6	80.5	80.6
February 2023	76.9	15.7	61.2	80.5

To provide triangulation, data from the national quarterly staff pulse survey (NQPS) is also provided on the 'advocacy' scores that covers answers to questions about *"Care of patients/service users is my organisation's top priority*" and "*if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."* The NQPS captures views from over 119,000 NHS staff in England per quarter.

	Advocacy score SWLSTG	Advocacy score English MH Trusts
Q4 2022/23	5.2	6.5
Q3 2022/23 [National staff survey]	6.7	6.9
Q2 2022/23	6.6	6.5

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

Board of Directors (Part A)

Draft minutes of the meeting held on Thursday 9th March 2023.

Present:

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

In attendance:

Guests for patient story (item 23/20)

Martin Haddon	Wandsworth Healthwatch

Apologies

Doreen McCollin (DM)	Non-Executive Director
Jennifer Allan (JeA)	Chief Operating Officer

Item		Action
23/20	**Patient story** Jupiter and Lavender Ward assisted by the "Movemakers" from the Involvement Peer Support Workers The Board heard from R, a patient on Jupiter Ward as well as Sarah and Ayesha, Peer Support Workers at the Trust, who shared their experience of the recent ward moves. Jupiter and Lavender Wards moved into the new state of the art Trinity Building. The story gives 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. The story highlighted the value of patient views in the Estates Modernisation Programme and the value of lived experience and the work of Peer Support Workers and Involvement Team in contributing to reviews of care environments, patient experience and engagement. It was noted how this emphasises the importance of coproduction and collaboration with patients and the Trust's lived experience workforce. The Board noted how the story demonstrated the value of peer-to-peer support, even during challenging situations like a ward move. The Integrated Programme Delivery Team can utilise this expertise again when Shaftesbury moves. There was a discussion about the issue of recurrent funding for peer support worker roles, It was agreed that the next Board should receive an update on the issue.	**SS**

AB thanked R for attending to provide his story and the Board wished him well for the rest of his recovery journey.

23/21 Apologies and welcome
Apologies were received.

23/22 Declarations of Interest
No new declarations were reported.

23/23 Chair's action
No Chair's action was taken.

23/24 Minutes of the last meeting
The minutes of the meeting held on 12th January 2023 were agreed as a correct record.

23/25 Action Tracker
The action tracker was noted.

23/26 Chair's report
AB thanked all staff for their dedication and commitment to their work.

The Board welcomed Richard Flatman's re-appointment.

It was noted that the substitute member on the Committees in Common will be Sola Afuape.

The Board noted the Chair's report.

23/27 Chief Executive's report
VF highlighted the following points:

- Junior Doctors industrial action on 13th to 15th March. VF assured the Board that preparations were comprehensive.
- Staff survey. The Trust's results showed improvement greater than the majority of mental health trusts. A full report would go to People Committee. The key themes identified from the results are health and wellbeing, learning and development and anti racism.
- Estates modernisation – the significance of the Trinity move was emphasised. Nonetheless the importance of ensuring a successful move into Shaftesbury later in 2023 will remain a top priority.
- 2023/24 objectives will come to the May meeting following further discussions.
- It is clear that DHSC and NHS England have a stronger focus on national financial issues for Trusts than has been the case for some time.
- The NHS is 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 the Trust's 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 issues remain the biggest risk to the quality of care and experience of staff. The Trust is developing workforce plans through March, with actions plans in April. These will come to People Committee in April.

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

23/28 Quality and Safety Assurance Committee chair's report

The following points were highlighted by DBo:

- 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 WODC / People committee foster understanding and governance of this priority area. There are also resource and financial implications Board will wish to hold in mind.
- QSAC continues to think about how to fulfil its terms of reference in relation to health inequalities and ensure it is embedded in its work following the expansion of its terms of reference. At the February meeting, it had worked through several examples that helped elucidate responsibilities when discussing 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 that the Trust holds as part of patient experience reporting that might enrich understanding and inform priorities in relation to health inequalities. DBo invited the Board to in due course 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.
- 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.

There was a discussion where it was noted that there is now a good body of data and analysis, but the emphasis going forward needs to be on the achievement of agreed improvements.

The Board considered the issue of productivity and noted the nationally expressed concern that the delivery of the mental health investment standard has not resulted in improved quality and financial outcomes.

Further points raised in discussion included.

- the importance of a trajectory to cease the use of out of area beds, as this is unaffordable – while acknowledging the patient safety issues that lead to the use of these beds.
- the need to improve communication with frontline teams about the value of KPIs.
- the potential value of wider engagement with patients and also the clinical community on risk appetite issues

The Board:

1. **Noted the QSAC Chair's report.**
2. **Received the approved minutes of the January QSAC meeting.**

23/29 Quality and performance report

JeA introduced the report. The following points were highlighted in discussion:

- The importance of progress in MAST performance

- ASD / ADHD waiting times. The multi-agency nature of the care model for these patients was noted. It was agreed that a report will go to QSAC providing a fuller picture and proposing a way forward. **JeA**
- Access to IAPT for people from black and ethnic minority communities. Further information on this will come to a future QSAC meeting.

The Board noted the Quality and Performance Report.

23/30 2022/23 Corporate Objectives – Q3 delivery

The Board received a report on the delivery of the 2022/23 corporate objectives in quarter 3. It was noted that the commentary on the "so what" in the cover report could be made more specific to quarterly delivery going forward. It was also noted that the report highlighted the breadth of the objectives that had been agreed for 2022/23 and that this can be a learning point when deciding on the 2023/24 objectives.

The Board noted the report.

23/31 Workforce and OD Committee chair's report

The Board received a verbal report from SA. Points highlighted in discussion included:

- The need for coordinated working by committee chairs and their executive leads when addressing issues that are cross cutting and require triangulation.
- Ongoing concerns around medical staffing in the Trust and the need for further assurance that mitigation of these risks is being successful.
- The value of comprehensive preparation for the impact of industrial action
- The high cost of agency premium fees – about £2 million per annum – and the need for a robust People plan including effective recruitment measures to be put in place as soon as possible.
- The importance of the new People Committee maintaining a focus on core issues – including recruitment and retention, MAST, statutory requirements and employee relations – while avoiding being diverted onto wider issues.

The Board:

1) **noted the WODC chair's report.**
2) **received the approved Committee minutes.**

23/32 **Equality and Diversity Committee chair's report**

The Board noted with considerable concern the collective grievance submitted by the Deaf staff network about BSL interpreters. KR assured the Board that a meeting with the network was scheduled for 20th March to discuss the issues. It was agreed that there was a need for a detailed plan with an agreed approach, with an aim to achieve resolution by the end of March. AB emphasised the need for urgency. It was agreed that the April People Committee would be advised about the resolution with an update to the May Board. **KR**

There was a discussion about the anti-racism agenda and it was acknowledged that progress requires the full support of the Board. VF assure the Board of her personal commitment to an anti-racism approach in everything that the Trust does and how she is always willing to have difficult conversations on the issues. SA highlighted the lessons to be learned from a recent employment tribunal case involving NHS England concerning whether certain management actions were racially motivated. A copy of the judgement has been circulated to the Board. DBo

asked for the Board pledges to be revisited, as part of the challenge posed at the December Board seminar.

Gender pay gap
AB highlighted that there had been no substantive progress over a period of 5 years and it was agreed that delivery and monitoring of an action plan to address this must be taken forward.

The Board noted the approved committee minutes.

23/33 Finance and Performance Committee chair's report
VS suggested the need for further consideration of the Board's risk appetite with specific reference to the issue of the use of private sector beds. Alongside this there was a discussion about delayed transfers of care, which SS emphasised to be a system wide issue. AB highlighted the importance of effective engagement with clinicians in addressing these issues. Reference was made to progress with transformation in acute and urgent care, notably the wards and the Home Treatment Teams. VF stated the need for pace and the importance of system wide working. It was agreed that there is a need to address clinical risk thresholds and risk appetite with a process to be agreed in which this will be considered with clinical leaders. A clear agreed approach will need to be considered through QSAC and onwards to Board. **BB/SS**

The Board noted the FPC chair's report, received the approved minutes and endorsed the modern slavery statement.

23/34 Estates Modernisation Committee chair's report
The Board received a report from JuA. There was a discussion about the importance of how each of the elements of the transformation programme fit together. It was agreed that the June Board seminar should focus on transformation issues.

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

23/35 Corporate Trustee business
Charitable Funds Committee chair's report
The Board noted the committee's discussions on the issues of the management fee and dormant funds. PM assured the Board that diligent checks are in place for restricted funds. It was agreed that the time was not right to take the 'Pennies from Heaven' initiative forward at this stage.

23/36 Meeting review
The Board recorded its formal and sincere thanks to Nicola Mladenovic for her service to the Trust over a number of years. This was her last attendance at the Board prior to her retirement.

It was noted that the framing of questions for the Board in committee chair's reports was valuable and should be continued as a practice.

23/37 Next meeting – The next Trust Board meeting in public will be held on Thursday 11th May 2023 at 1.30pm at Springfield Hospital

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

ACTION TRACKER – for May 2023 Board

BOARD OF DIRECTORS (Part A)

2.5

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
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)
09/03/2023	23/20	**Patient story**	Peer support workers – to report back on recurrent funding	**SS**	**11/05/2023**	Verbal update
09/03/2023	23/29	**Quality and performance report**	ADHD and ASD waiting lists. Report to go to QSAC with further detail and proposals	**JeA**	**11/05/2023**	Considered by May QSAC
09/03/2023	23/32	**EDC chair's report**	BSL interpreters – collective grievance. To be resolved by the end of March 2023. Report to go to People Committee	**KR**	**11/05/2023**	Verbal update
09/03/2023	23/33	**FPC chair's report**	There is a need to address clinical risk thresholds and risk appetite with a process to be agreed in which this will be considered with clinical leaders. A clear agreed approach will need to be considered through QSAC and onwards to Board.	**BB / SS**	**11/05/2023**	Verbal update
NOT DUE						
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**	**13/07/2023**	

1

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

ACTION TRACKER – for May 2023 Board

BOARD OF DIRECTORS (Part A)

2.5

			COMPLETED AT LAST MEETING			

2

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

C2.1

Meeting:	Trust Board – Part A
Date of meeting:	11th May 2023
Report title:	Chair's Report
Author:	Ann Beasley, Trust Chair
Purpose:	For report

Doreen McCollin

Doreen McCollin decided to step down from her role as a NED with effect from 31 March 2023, on health grounds.

Doreen joined the Trust in 2019. During that time, she has chaired both the Equality and Diversity Committee and the Charitable Funds Committee, in addition to membership of the Audit Committee and the Quality and Safety Assurance Committee. She has also acted as the NED lead for Infection Prevention and Control. Doreen has served the Trust during a remarkable period that has included the pandemic and a series of other serious challenges.

Doreen's contribution to the Trust has been sincerely appreciated and we wish her well in her future endeavours

NED recruitment

Following discussion, it has been agreed with NHS England that we will recruit to the NED vacancy as soon as possible. We are seeking to appoint a NED with senior level clinical and patient safety expertise in the Mental Health sector gained from medical, nursing, allied disciplines or social care experience. Experience in Quality Improvement and Innovation is desirable.

In order to improve Board governance it has also been agreed to advertise for up to two associate NEDs. We have not had any ANEDs for some time but it is now appropriate to return to this approach. We are seeking to appoint individuals with senior level experience in one of the following areas:

- strategic workforce development or finance gained in the private, commercial, public, voluntary, community or charity sectors
- clinical and patient safety expertise gained from medical, nursing, allied disciplines or social care experience

The advert will be published by NHS England shortly and the appointments are scheduled to take place by the summer.

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

C2.1

Committee membership

Following Doreen's departure, the following changes are proposed to Committee membership. These will be reviewed after the new NED joins the Board

- Chair of Charitable Funds – Juliet Armstrong
- Audit Committee member – Charlotte Clark
- QSAC member – Richard Flatman
-

Changes to the NED membership of the People Committee and the Charitable Funds Committee will be confirmed verbally at the meeting.

ICB chair

NHS England has announced the appointment of Mike Bell as the new independent chair for NHS South West London Integrated Care Board (ICB) from 1 May 2023. His new role sits alongside his current role as Chair of Lewisham and Greenwich NHS Trust in South East London, a position he has held since July 2022. He is an experienced NHS Chair with a long history of working in South West London, including 10 years as Chair of Croydon Health Services NHS Trust.

RECOMMENDATIONS

The Board is asked to

- Approve the proposed changes to committee membership
- Note the remainder of this report

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

Chief Executive's Board report Part A

May 2023

making life better together

making life better together

Suggested questions and points to have in mind

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

- How do we approach quality going forward, given the challenging context (not least finance, workforce and demand), and whilst recognising our stated risk appetite (appendix 1)
- How do we maintain staff engagement and recognise the hard work of staff in the context of continued demand and the most recent industrial action – with potentially further ballots and industrial action on the way (RCN and junior doctors)
- Today we are agreeing our delivery priorities. Through our corporate objectives, how do we keep true to these? Balancing managing the urgent and important alongside the delivery of longer-term transformational priorities?

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 - Friday 28 April (newsweaver.com)
- Chief Executive Update - 21 April (newsweaver.com)
- Chief Executive Update - 14 April (newsweaver.com)
- Chief Executive Update - 6 April (newsweaver.com)
- Chief Executive Update - 24 March (newsweaver.com)
- Chief Executive Update - 17 March (newsweaver.com)
- Chief Executive Update - 10 March (newsweaver.com)
- Chief Executive Update - 03 March (newsweaver.com)

making life better together

The external world: national context

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

There are a number of pressures and challenges that impact us and our ability to achieve our ambitions…

And there are a number of opportunities too…

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

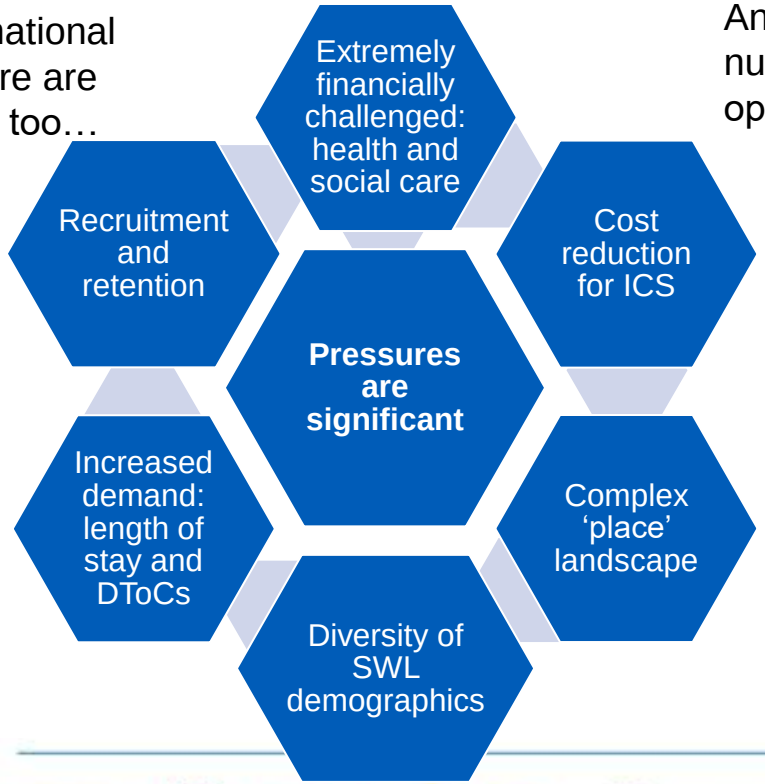
4

making life better together

The external world: South West London

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

Alongside the national challenges, there are local pressures too…



And there are a number of opportunities…

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

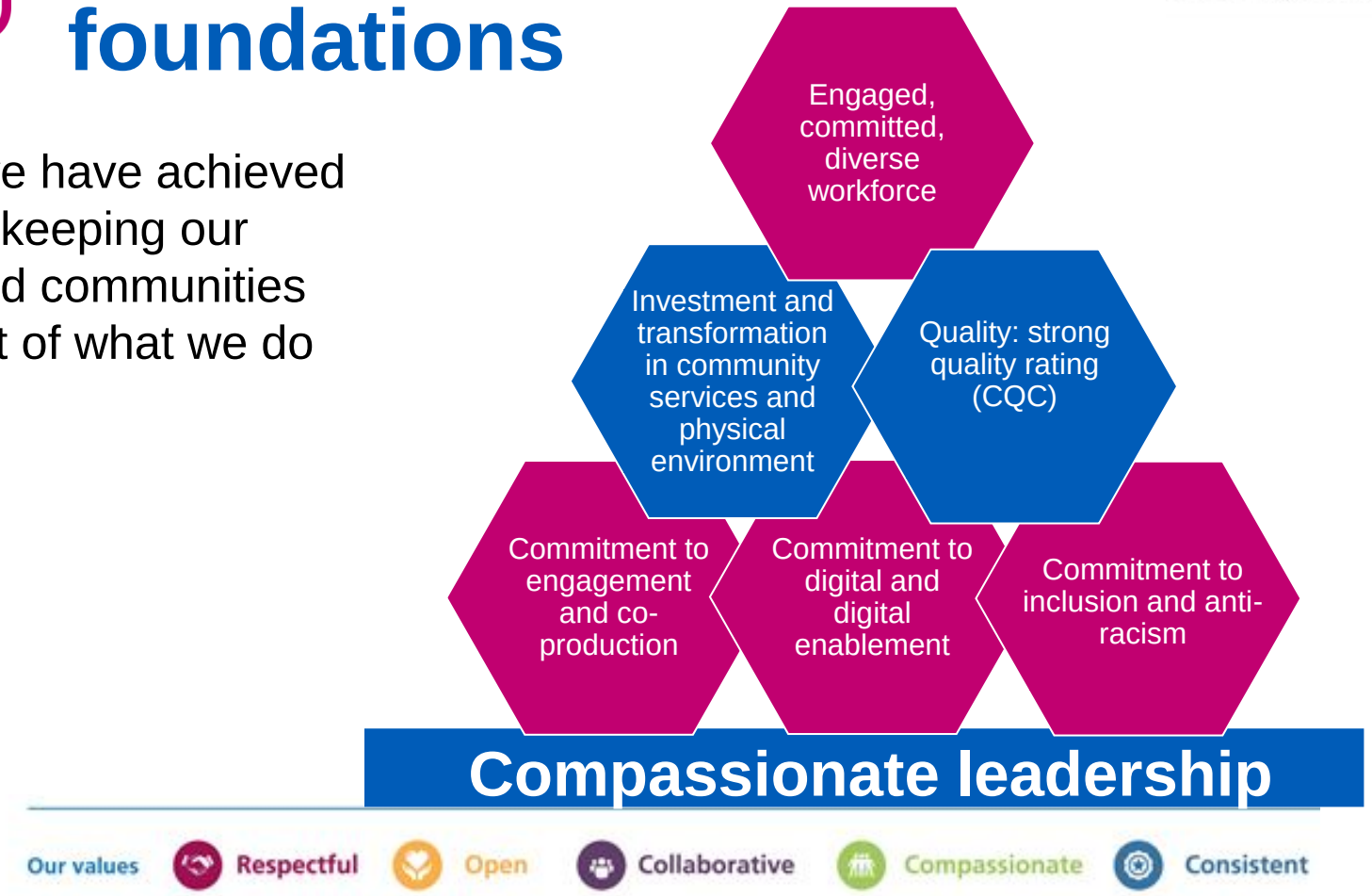
5

making life better together

Our Trust: strong foundations

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

Together we have achieved so much – keeping our patients and communities at the heart of what we do



6

making life better together

Demand and acuity

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

High demand across the system

- We continue to see demand pressures across the Trust, particularly in our Urgent Care pathway. 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 significant numbers of private beds to support flow.
- Recent periods of industrial action have impacted on the wider system and flow through both acute and mental health settings. Our staff worked collaboratively during the strikes, and many went above and beyond in supporting patients and colleagues. Thank you to all those who contributed so we could keep caring for our patients safely. No serious incidents related to the strikes were reported, but this placed additional pressure on our services.
- We are focused on working in partnership across our system to respond to these challenges. There are increasing numbers of patients whose transfer of care following inpatient treatment is delayed, and we are working with ICS and social care colleagues to address this.
- Through our service transformation work, we are aiming to reduce length of stay, avoid the need for crisis care and to enable people to stay well in the community:
  - We are working closely with Psychiatric Liaison services in our local EDs, and improving S136 pathways in collaboration with London Ambulance and the Met Police, as well as developing NHS111, press 2 for mental health.
  - 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, additional new roles in community teams, and enhanced admission and discharge processes on our wards.
- We have been working closely through our ICS to develop an insight informed campaign and training package to support people to access the right Mental Health support, including the crisis line, crisis cafes and talking therapies.

making life better together

Recruitment and retention

Supporting our workforce

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

- Our workforce remains our biggest asset and the most important part of us providing high quality care at SWLSTG – and this is our biggest challenge
- While we are seeing a gradual reduction of our vacancy rate (now 17.4%), increased demand, pressure in the system, including the recent strikes) and internal change is impacting on the experience of our colleagues, and ultimately turnover is being affected (now 17.2%)
- **Recruitment:** Following our focus on recruitment, our overall vacancy rate has reduced, 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.
- **Retention:** Despite high recruitment levels, turnover remains high – especially turnover of those who stay with us under 12 months. Our developing workforce plans, which will help up better understand hotspots, leadership and development programme and leadership framework will support this work
- **Staff survey:** Further analysis of the staff survey has been conducted and results are being shared with teams with listening events scheduled. A greater focus is being put on our quarterly 'people pulse' which will offer more 'live' understanding of people's experience of working here
- Celebration: Through MLBT, we continue to profile and celebrate exceptional people monthly. This month we were delighted that Pebbles was awarded the trainee Nursing Associate of the year. Pebbles started working with us in security, became and HCA and now a TNA. All within two years.
- Health and wellbeing: we continue to offer cost of living support to patients and staff, including money workshops for communities and staff

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

8

making life better together

Inclusion and active anti-racism

Inclusion and anti racism

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

- Our Anti-Racism steering group has developed a new active anti racism approach for the organisation
- In March we held our first Executive Advisory Group to support diversity in our decision making
- In March we began to advertise in our local communities for African and Caribbean families to be part of our home placement project
- In April we put a cross-orgnasiational call out for people to be part of our new anti-racism Action Learning Sets

Our first Executive Advisory Group Meeting!

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

9

making life better together

Investment in transformation

Transformation: People moves

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

- We were delighted to see CAMHS outpatients moving into Trinity in March 2023, which completes our people moves into Trinity. We recognized this move with a 'Goodbye to Harewood House' celebration
- We celebrated a successful temporary move into Livingstone House, ahead of a 15 month transformation at Barnes
- In June we will see Laurel and Rose wards move from Queen Mary's Hospital into Morrison, ahead of their moves into redeveloped Tolworth in 2026
- We expect formal handover of Shaftesbury in the summer. We will work with teams to develop move dates
- 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 communities, with summer celebrations at Springfield, Tolworth and at our community sites throughout July
- We continue to welcomed a series of visitors to Trinity, including Adrian James, Presnedent of RC Psyc, our local Healthwatches, the NHS London team, Julian Hartley, NHS Providers, CQC team and Ruth May, NHS Chief Nurse, Nicholas Serwatka

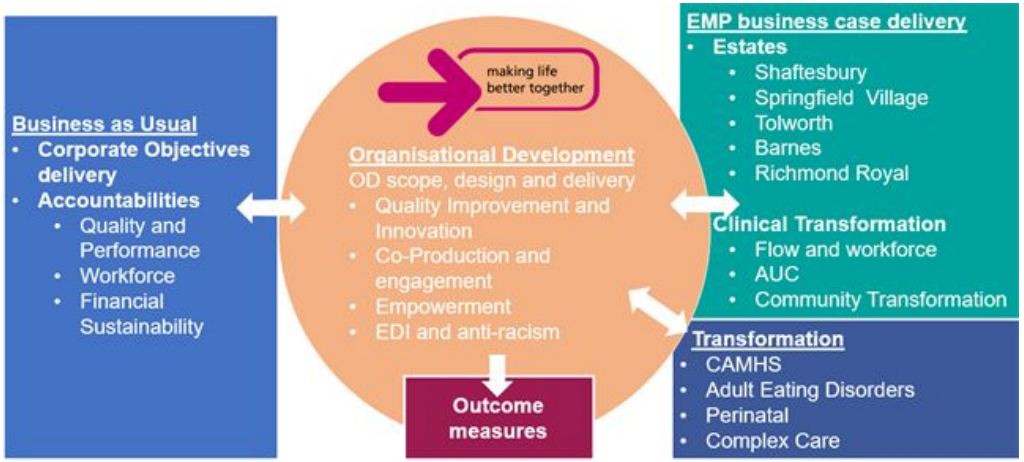
making life better together

Investment in transformation

Transforming: Our people and OD

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

- We are developing an Organisational Development framework to support us to 'turbo charge' the transformation work, identifying key areas of focus and activities to support cultural change in service of delivering transformation. This is part of the Integrated Programme and within Making Life Better Together.



- The framework will provide
  - A structure and approach for the provision of immediate, short term needs around leading and managing change to support individuals and teams already in the process
  - A medium to longer-term approach to the development of culture in support of transformation which ensures alignment of all current development activities, including the Trust's approach to leadership and management development (recognising that this is bigger than transformation).
  - Mechanisms and timescales for how to review and evaluate the impact of the OD work that is established through the OD framework.

Our values Respectful Open Collaborative Compassionate Consistent

11

making life better together

DRAFT: 2023/24 delivery priorities – the core 'what'

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

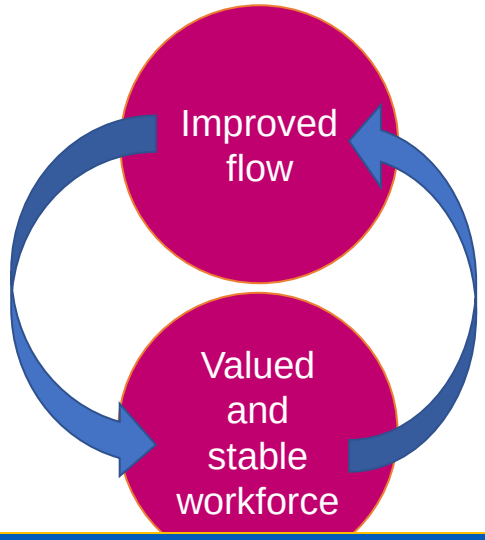
To be discussed at Board: We need to define the most important things for us to deliver in 23/24. These are proposed as improved flow and stable workforce:

Areas of work

Transformation
- Discharge challenge
- Complex emotional needs pathway
- Community enhanced response and interface teams
- Organisational development (MLBT)

Digital
- Clinical systems development

People
- Recruitment
- Retention
- Learning & development support



Measured by

Transformation
- Out of area placements
- Length of stay
- A&E presentations and admissions of known patients

Digital
- Productivity measure

People
- Vacancy rate
- Turnover rate (overall and within 12 months)

Agency levels

Delivering improved flow and stabilising and valuing our workforce will deliver:

Improved quality (and sustained CQC good)

Financial sustainability and the EMP business case

12

making life better together

Horizon Scanning

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

National publications and announcements

- **The Hewitt Review: an independent review of integrated care systems:** This review includes recommendations to uplift preventative healthcare budgets and acknowledges the mental health treatment backlog, lack of parity of esteem, and recommendation that the mental health investment standard is retained. The government are currently considering the recommendations of the review
- **Liberty protection safeguards:** The Government has delayed the implementation of the Liberty Protection Safeguards (LPS) beyond the life of this Parliament. The LPS, designed to replace the current 'Deprivation of Liberty standards' were part of the Mental Capacity (Amendment) Act in May 2019
- **NHS Resolution: Being fair 2 - Promoting a person-centred workplace that is compassionate, safe and fair:** This analysis highlights the connection between poor culture, staff wellbeing and safety. A proactive approach to ensuring the wellbeing of employees and a preventative approach to behaviours such as bullying, incivility and harassment will have the greatest impact on improving workforce challenges. The *Just and learning culture charter* has been updated.
- **Racism and Ethnic Inequality in a Time of Crisis** - Findings from the Evidence for Equality National Survey
- **NHS England delivery and continuous improvement review -** This recommends a national improvement board to agree a small number of shared national priorities; a single, shared 'NHS improvement approach' and a Leadership for Improvement programme.
- **A guide to good governance in the NHS - NHS Providers**
- **2023 to 2024 financial directions to NHS England**
- **Cyber security strategy for health and social care: 2023 to 2030**

making life better together

Horizon Scanning

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

National documents - Mental health

- Mental health policy in England - House of Commons Library (parliament.uk): Latest House of Commons Library briefing on Mental health policy (March 2023)
- Progress in improving mental health services in England – National Audit Office : "DHSC and NHSE made a series of clear commitments and plans to expand and improve mental health services, but … it is unclear how far the current commitments take the NHS towards its end goal, and what else is needed to achieve it. Staff shortages continue and data that would demonstrate the results of service developments are limited."
- NHS England » NHS England position on serenity integrated mentoring and similar models

System wide

- Joint Forward Plan - NHS South West London Integrated Care Board
- Adult social care system reform: next steps to put People at the Heart of Care: Government plans for adult social care system reform
- SEND review: right support, right place, right time - GOV.UK (www.gov.uk)

Patient opinion

- NHS England - Co-production: A literature review
- National Healthwatch Annual Report to parliament

Workforce

- NHS England Agency rules
- NHS Pension Scheme: McCloud remedy part 2: proposed changes to Scheme Regulations 2023
- Workforce Race Equality Standard (WRES) indicators for bank workers
- Case stories: Applying the freedom to speak up principles in practice

Trust review reports

- Greater Manchester NHSFT review
- Tees, Esk and Wear Valley NHSFT NHS England Report
- Reading the signals: the report of the independent investigation

making life better together

Horizon Scanning: Agency 'Break Glass' protocol

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

NHS England has published new agency rules for Trusts for 2023/24. These specify a number of requirements for Boards, set out below, with an emphasis on the 'break glass' override process. Trusts should not pay more than the NHS England price caps to secure an agency worker, except in exceptional patient safety circumstances, referred to as 'break glass'

- Overrides should be used within a robust escalation process sanctioned by the trust board. Trust boards have primary responsibility for monitoring the local impact of the agency rules and ensuring patient safety.
- All trust boards to ensure that they are following robust and effective processes for managing the implementation of the agency rules. NHS England expect:
    - accurate and timely reporting to NHS England: - data submitted monthly by agreed dates - submissions signed off by a voting board member
    - board accountability: one accountable officer in place for agency expenditure and compliance with the agency rules.
    - escalation process for sourcing agency staff which ensures: appropriate review of agency use taking into account safety, quality, and finances; appropriate use of the override mechanism; and appropriate use of escalation rates within framework agreements prior to engaging workers through high-cost, off-framework suppliers
    - regular internal review panels for monitoring trust overrides and reviewing agency rules monitoring data
    - regular board review of agency expenditure and overrides to ensure compliance with system agency ceiling.

NHS England will scrutinise any overrides. Inappropriate use and failure to make rapid improvements to workforce management may lead to regulatory action as appropriate.

A report on the break glass process will come to June QSAC. Regular reporting on agency issues will come through People Committee and FPC, as well as being addressed in the Quality and Performance report.

making life better together

Use of the Trust seal

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

The seal has been used to sign off the following transactions:

Date	Type	Signatories
12/04/2023	Licence for Alterations Alterations at the Wilson Hospital. Between NHS Property Services and SWLSTG.	Chief Executive Officer and Integrated Programme Director
25/04/2023	Renewal Lease For Laurel and Rose Wards to remain at QMH until 30 June 2023.	Chief Executive Officer and Executive Director of Finance

making life better together

Appendix 1: What is our approach to risk?

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

Our risk appetite: The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the public and strategic partners. **The Trust will not accept risks that materially result in a negative impact on patient safety**. The Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has a proportionate appetite for risks related to innovation. It is willing to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment."

ELEMENTS	
FINANCIAL AND VALUE FOR MONEY	
• Meeting statutory duties	MINIMAL / LOW
• To support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level	CAUTIOUS / MODERATE
• Investments that may grow the size of the organisation	CAUTIOUS / MODERATE
QUALITY INNOVATION AND OUTCOMES	
• Patient safety	AVOID / NONE
• May compromise the delivery of outcomes, does not compromise the quality of care	MINIMAL / LOW
• Innovation that does not compromise the quality of care or the delivery of outcomes	OPEN/ HIGH
COMPLIANCE AND REGULATORY	MINIMAL / LOW
REPUTATION	MINIMAL / LOW

Our values Respectful Open Collaborative Compassionate Consistent

17

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

Trinity Building
Springfield University Hospital
15 Springfield Drive
London
SW17 0YF

Licence number: 400052

Date of issue	**Version number**
1 April 2023	1

Miranda Carter
Director of Provider Development, NHS England

Version History

Version number	Date	Comments
1.0	31 March 2023	Licence Created

Contents

Section 1 – Integrated Care

IC1: Provision of Integrated care

1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS:
    i) is integrated with the provision of such services by others, and
    ii) is integrated with the provision of health-related services or social care services by others and
    iii) enables co-operation with other providers of health care services for the purposes of the NHS

    where this would achieve one or more of the objectives referred to in paragraph 2.
2. The objectives are:
    a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,
    b. reducing inequalities between persons with respect to their ability to access those services, and
    c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.
4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.

IC2: Personalised Care and Patient Choice

1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.
2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.
3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.
4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.
5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.
6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

Section 2 – Trusts Working in Systems

WS1: Cooperation

1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.
3. Without prejudice to the generality of paragraph 2, the Licensee shall:
   a. consistently co-operate with:
   - other providers of NHS services; and
   - other NHS bodies, including any Integrated Care Board of which it is a partner;
     i. as necessary and appropriate for the purposes of developing and delivering system plan(s).
     ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year
     iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans

   b. consistently co-operate with:
   - other providers of NHS services;
   - other NHS bodies, including any Integrated Care Board of which it is a partner; and
   - any relevant local authority in England
     i. as necessary and appropriate for the purposes of delivering NHS services.
     ii. as necessary and appropriate for the purposes of improving NHS services.
4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either:
   a. the Secretary of State for Health and Social Care; or
   b. NHS England.

For the purposes of this condition, cooperation is considered synonymous to collaboration.

WS2: The Triple Aim

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.
3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.
4. In this condition, “the triple aim” refers to the aim of achieving:
    a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)
    b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
    c. more sustainable and efficient use of resources by NHS bodies,

and “duty relating to the triple aim” means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.

WS3: Digital Transformation

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).
3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).

Section 3 – General Conditions

G1: Provision of information

1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.
2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.
3. The Licensee shall take all reasonable steps to ensure that information is:
    a. in the case of information or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested.
4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

G2: Publication of information

1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.
2. For the purposes of this Condition, “publish” includes making available to the public at large, to any section of the public or to particular individuals.

G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
    a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
    b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
    c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
    d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.

3. For the purposes of paragraph 2, a person is not fit and proper if that person is:
    a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or
    b. an organisation which is a body corporate, or a body corporate with a parent body corporate:
        i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
        ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;
        iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;

iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;
v. which passes any resolution for winding up;
vi. which becomes subject to an order of a Court for winding up; or
vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.

4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by the Care Quality Commission.

G4: NHS England guidance

1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.
2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.

G5: Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   a. the Conditions of this Licence,
   b. any requirements imposed on it under the NHS Acts, and
   c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   b. regular review of whether those processes and systems have been implemented and of their effectiveness.

G6: Registration with the Care Quality Commission

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.
2. The Licensee shall notify NHS England promptly of:
    a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or
    b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.
3. A notification given by the Licensee for the purposes of paragraph 2 shall:
    a. be made within 7 days of:
        i. the making of an application in the case of paragraph (a), or
        ii. becoming aware of the cancellation in the case of paragraph (b), and
    b. contain an explanation of the reasons (in so far as they are known to the Licensee) for:
        i. the making of an application in the case of paragraph (a), or
        ii. the cancellation in the case of paragraph (b).

G7: Patient eligibility and selection criteria

1. The Licensee shall:
    a. set transparent eligibility and selection criteria,
    b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and
    c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.
2. “Eligibility and selection criteria” means criteria for determining:
    a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and
    b. if the person is selected, the manner in which the services are provided to the person.

G8: Application of section 6 (Continuity of Service)

1. The Conditions in Section 6 shall apply:
    a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service,
    b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2,
    c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension),
    d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service),
    e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider.
2. A service is designated as a Commissioner Requested Service if:
    a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and
    b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either
    c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or
    d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4.
3. A notice in accordance with this paragraph is a notice:
    a. in writing,
    b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.

4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable.

5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either:

a. an instruction of the sort referred to in paragraph 7, or
b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.

7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service.

8. A service shall cease to be a Commissioner Requested Service if:

a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or
b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or
d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.

9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.

12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.

13. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

Section 4 – Trust Conditions

NHS1: Information to update the register

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall make available to NHS England written and electronic copies of the following documents:
    a. the current version of Licensee's constitution;
    b. the Licensee's most recently published annual accounts and any report of the auditor on them, and
    c. the Licensee's most recently published annual report,

and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.
3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.
4. The obligation in paragraph 3 shall not apply to:
    a. any document provided pursuant to paragraph 2;
    b. any document originating from NHS England; or
    c. any document required by law to be provided to NHS England by another person.
5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.
6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.

NHS2: Governance arrangements

1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
    a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
    b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
    c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
    d. comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
    a. effective board and committee structures;
    b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
    c. clear reporting lines and accountabilities throughout its organisation.
5. The Licensee shall establish and effectively implement systems and/or processes:
    a. to ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively;
    b. for timely and effective scrutiny and oversight by the Board of the Licensee’s operations;
    c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;

d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Section 5 – NHS Controlled Providers Conditions

CP1: Governance arrangements for NHS-controlled providers

1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
    a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
    b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
    c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
    d. comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
    a. effective board and committee structures;
    b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
    c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).
5. The Licensee shall establish and effectively implement systems and/or processes:
    a. to operate efficiently, economically and effectively;
    b. for timely and effective scrutiny and oversight by the Board of the Licensee’s operations;

c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;
d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within

the rest of the Licensee’s organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Section 6 – Continuity of Services

CoS 1: Continuing provision of Commissioner Requested services

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.
2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.
3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:

a. with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or
b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or
c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.

4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.
5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the

delivery or provision of that service in a manner which differs from the manner specified and described in:

a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or
b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or
c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

CoS 2: Restriction of the disposal of assets

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")
2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.
3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.
4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.
5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:
    a. with the consent in writing of NHS England, and
    b. in accordance with the paragraphs 6 to 8 of this Condition.
6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.
7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.
8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:
    a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:
        i. transactions of a specified description; or
        ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or
    b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.
9. In this Condition:

"disposal"	means any of the following:

	(a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;
"relevant asset"	means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
"relinquishment of control"	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding:

a. the manner in which asset registers should be established, maintained and updated, and
b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.

CoS 3: Standards of corporate governance, financial management and quality governance

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as:
   a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider,
   b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and
   c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.
2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:
   a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance;
   b. the Licensee’s ratings using the risk rating methodologies published by NHS England from time to time, and
   c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.

CoS 4: Undertaking from the ultimate controller

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"):

a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and

b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it;

b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

c. comply with any request which may be made by NHS England to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and
b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:
    a. a health service body, within the meaning of section 9 of the 2006 Act;
    b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;
    c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or
    d. a trustee of the Licensee and the Licensee is a charity.

CoS 5: Risk pool levy

1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.
2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.

CoS 6: Cooperation in the event of financial or quality stress

1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about:
    a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress
    b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or
    c. the ability of the Licensee to carry on as a going concern.
2. When this paragraph applies the Licensee shall:
    a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct;
    b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and
    c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee’s affairs, business and property.

CoS 7: Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
    a. “After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”
    b. “After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources”.
    c. “In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”.
4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.
5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.
6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have

the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;

"Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts;

"Required Resources" means such:

a. management resources including clinical leadership,
b. appropriate and accurate information pertinent to the governance of quality
c. financial resources and financial facilities,
d. personnel,
e. physical and other assets including rights, licences and consents relating to their use,
f. subcontracts , and
g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.

Section 7 – Costing Conditions

C1: Submission of costing information

1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall:
    a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information,
    b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.

2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.

3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors:
    a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and
    b. provides that information to NHS England in a timely manner.

4. Records required to be maintained by this Condition shall be kept for not less than six years.

5. In this Condition:

"the Approved Guidance"	means such guidance on the obtaining, recording and maintaining of information about costs and on

	the breaking down and allocation of costs published annually by NHS England.
“other relevant information”	means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information.

C2: Provision of costing and costing related information

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.
2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that:
    a. in the case of information (data) or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested;
3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

C3: Assuring the accuracy of pricing and costing information

1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.
2. This may include but is not limited to
    a. Regular assessments by the providers internal and/or external auditor
    b. specific work by NHS England or NHS England nominated representative on costing related issues and
    c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information.
    d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.

Section 8 – Pricing Conditions

P1: Compliance with the NHS payment scheme

1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.

Section 9 – Interpretation and Definitions

Condition D1: Interpretation and Definitions

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right hand column of the table.

“the 2006 Act”	the National Health Service Act 2006 c.41;
“the 2008 Act”	the Health and Social Care Act 2008 c.14;
“the 2009 Act”	the Health Act 2009 c.21;
“the 2012 Act”	the Health and Social Care Act 2012 c.7;
“the 2022 Act”	The Health and Care Act 2022;
“the Care Quality Commission”	the Care Quality Commission established under section 1 of the 2008 Act;
“Commissioner Requested Service”	a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition;
“Commissioners”	NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB;
“Director”	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, (ii) an NHS Trust or (iii) a company constituted under the Companies Act 2006;
“Governor”	a Governor of an NHS foundation trust;

“Hard to replace provider”	has the meaning given in condition G8 of the licence;
“Integrated Care Board”	a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act;
“the NHS Acts”	the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act;
NHS Controlled provider	An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where ‘control’ is defined on the basis of IFRS 10;
“NHS England”	the body named as NHS England in section 1 of the 2022 Act;
“NHS foundation trust”	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act;
“NHS Trust”	an NHS trust established under section 25 of the 2006 Act;
“Relevant bodies”	NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act;
“Trusts”	means NHS foundation trusts and NHS trusts.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.
3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.
4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

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

Meeting:	Trust Board
Date of meeting:	11th May 2023
Transparency:	Public
Committee Name	Quality and 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 lead 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 March and April meetings of QSAC:

1. Risk articulation, mitigation and management continues to be a key theme. QSAC will look to capture fuller information about quality and safety risk assurances discussed at other Committees.

2. Demand, resource and capacity continue to be the greatest and most persistent challenges that QSAC considers. The Committee will review progress with waiting list performance. We noted the pressures across Acute and Urgent care, including length of stay and the increased number of patients on 1:1 observations. We were assured that this was being addressed by focused work commenced under the 100 day discharge challenge.

3. We noted that for 2023/24 the Trust would be focusing on improvement in key areas of challenge, which were flow, operations and workforce.

Subject to the outcome of discussions at the 4th May QSAC it may also be necessary to bring an additional report to Board.

Areas of risk escalation to the Board:

- The context within which we work continues to be challenging and the quality position is stable, but not improving. Questions arise regarding increased risk, persistent 'wicked' problems, the balancing of multiple demands and priorities and potential choices for Board; see below for further discussion in the Quality and Performance item.

- Industrial action and the Trust's ability to ensure patient safety during periods of action remain a concern that the Committee is monitoring. The Committee is to receive a "lessons learned" presentation at its May meeting. The presentation was created following a lessons learned review after the first period of junior doctor strike action.

- Underperformance in MAST is an ongoing concern that QSAC will continue to monitor. It has been discussed with the Chair of the People committee. Board may wish to discuss further given the implications for all aspects of our work, especially patient safety and quality.

For each item discussed at the Committee there would be a statement against the three areas below:
1 Assurance Position ("What")
2 Evidenced by ("So What")
3 What next?

<u>Waiting List</u>
What: QSAC received an update from the Chief Operating Officer on the Trust waiting list, with the aim of transparency, reviewing the quality and risk implications of waiting times and understanding the framework within which those are being addressed. The update followed feedback from our service-user and carer attendees at QSAC who noted that waiting lists remained a relatively opaque area of our work to them and therefore potentially our community. The Committee is committed to transparency and co-production with service-users and carers, and those commitments informed the discussion.

So What: Waiting times have increased for a number of clinical services, reflecting challenges of capacity and demand within the system. Some services are under particular pressure, for example adult ADHD and ASD provision and CAMHS, with breaches being recorded in the Q&P report. Waiting times have significant implications for patients, their families and staff working in a context of limited resource and growing need. The Board should have an understanding of both the Trust's position and its plans with regard to waiting times.

The Committee noted that waiting list management processes are underpinned by and potentially enhanced via the Trust's digital programme. As such, there is a crucial intersection between progress in that digital programme and our capacity to understand, manage and communicate regarding waiting lists. QSAC was interested in how we might understand the trajectory regarding demand and capacity and our response, appreciating that these are complex issues influenced by a range of

variables, some of which are outside the Trust's control. The proposal is to review via metrics such as waiting time performance with a longer term ambition to embed an understanding of capacity and demand into the business planning process. QSAC noted the importance of understanding waiting times by protected characteristics, particularly ethnicity. The Committee was advised that would be part of the ongoing work in this domain.

What next: The Chief Operating Officer will ensure that QSAC receives ongoing assurance of the intersection with, and impact of, the digital programme on the waiting times. QSAC will continue to review waiting times as part of its work, noting barriers and facilitators to progress.

Executive Risk Register

What: The Risk Register captures how risk is conceptualised, considered and mitigated at different levels within the Trust. QSAC values the document and continues to make suggestions regarding increasing the level and depth of analysis to support understanding of specific risks and seeking correlation with other sources of information. A recent example of QSAC's preferred approach was evident in discussion regarding the Trust's performance in responding to emergencies.

Following feedback, QSAC received the risk report using an amended template which aims to clarify the "What, So What and What Next", to enhance the level of analysis alongside process description and to encourage a more dynamic approach to risk. The Executive Risk Register is reviewed by the Committee at each meeting, following review by both QGG and ELT. The Committee noted that work was ongoing regarding the BAF within the Ulysses system.

So what: Understanding risk is fundamental to our collective understanding of, and choices in regard to, the quality and safety of our Services. It provides an invaluable source of data that, properly analysed and presented, can be used to triangulate with other sources of information. Attention to both what is recorded and what might be absent or perhaps less developed as a risk, matter in seeking assurance about the overall position and strategic decision-making by the Board.

Matters the Committee noted and discussed included:

- Several new risks, including those relating to the Smoke-Free Policy, in-patient food concerns and cyber security.
- The ongoing risk relating to emergency response times, noting the pressures that contribute to capacity to respond. The Committee heard that there was some focused work distinguishing between planned interventions and unanticipated emergencies.
- The rationale for several closed risks and understood that some would remain appropriately on more local risk registers.
- Progress in relation to outstanding risk reviews and actions.

QSAC sought and received assurance that the industrial action risk was being regularly reviewed and amended as needed, and noted the plans to prioritise patient safety during industrial action, whilst recognising in discussion that the risks were cumulative as strike action increased in frequency and duration. Specific assurance was sought regarding those staff required to cover for striking colleagues and the Committee were assured that attention to the ensuring staff are competent to provide safe care,

including in emergencies, had been considered within planning. QSAC considered that the increase in score for this risk is appropriate.

What next?
QSAC felt the template represented some progress in our approach to understanding quality, safety and experience risks, but that it did not convey how the principal risks were determined, where and why changes had been made. Furthermore, the mitigations were not consistently clearly linked to the risk as articulated and the scores remained static for long periods. The Committee noted and supported a comment from the Trust's internal auditors about limited change to risks on the register. QSAC looks forward to these elements of the register and process developing.

Following the discussion on industrial action, QSAC will receive an update at its May meeting, including an analysis of the lessons learned review.

QSAC requested further updates on specific work arising from some of the risks discussed, including the Smoking Policy and Emergency Responses. Those updates will be reported at future meetings.

Quality Matters

What: Quality Matters is an essential report that provides triangulation, prompts consideration of the relationship between strategic aims and operational practice. It reflects the 'Ward to Board' understanding of quality, safety and the patient experience. The Committee noted that the report is subject to review by the Director of Nursing and Quality to avoid duplication, enhance focus, articulate governance and discussion that has taken place at other committees and support assurance in respect of patient safety, serious incidents and quality of care.

So What: QSAC noted, as in the discussion of the risk register, the question of emergency responses arose. The issue reported concerned the recording of data. At its April meeting, the Deputy Director of Nursing reported on work to distinguish between emergency and planned situations and to enhance the capacity to record and report accurate data to the Committee at future meetings.

Matters that the Committee noted and discussed included:

- ongoing work around monitoring and reading of patient rights under the Mental Health Act. That has been an area of discussion and focus for some time and QSAC continues to take a close interest in progress.
- the publication of a final CQC report for Rehabilitation services in which all domains were rated as 'good'. The Committee congratulated all involved on their leadership, work and progress.
- 72-hour breaches. QSAC was advised that patients remained on Lotus ward for longer whilst they waited for an inpatient bed.

What next? QSAC will continue to review the areas that arose for discussion and consideration within the meeting e.g. emergency response times, reading of legal rights for patients and waiting times. The Committee will receive and triangulate the information contained within Quality Matters. The Committee looks forward to its development and to providing feedback on the new format when it comes to QSAC for review and discussion.

Quality and Performance Report

What: QSAC received the report, which seeks to describe the Trust's performance and progress across its functions. The Committee focuses on the metrics relating to quality, safety and experience. At both meetings, QSAC discussed the priorities arising from the report and the Executive analysis, noting especially the ongoing and increasing tensions created by increased demand, limited capacity and constrained resources. QSAC understands that the Trust will focus on improvement in three key areas, namely, i) flow; ii) operations; and iii) workforce.

So What: QSAC was advised that focus on the three key areas described above should improve performance in multiple areas due to the underpinning and foundational nature of each one. In March, QSAC noted that the Trust's position was 'stable but not improving' which is a matter of concern and prompted discussion. The Committee discussed the importance of prioritising areas for focus and developing an understanding of likely timelines for improvement, recognising that the context is changing, testing and uncertain. QSAC identified performance in out of area admissions, the use of private beds and our response to system pressures as particularly important, both from the perspective of the patient experience and because of the financial implications.

At its April meeting, QSAC received and reviewed the revised version of the Q&P report. The COO advised the Committee that the revised format aims to facilitate greater accountability; articulate and disseminate priorities and maintain focus on "wicked problems" e.g. patient flow. QSAC welcomed the new format and the rationale for the same.

Matters QSAC noted and discussed included:

- improvement in recruitment. The Committee was advised that the focus will now be on staff retention and developing leadership capacity and confidence. QSAC has been interested in the intersection between workforce and the quality and safety of care we provide.
- improvement in Physical Health monitoring and metrics. This has been an area of particular interest for QSAC for some time.
- MAST underperformance and the potential implications for quality and safety. The Committee was advised of the Trust's plans in place to address this area of practice.
- Out of area admissions and the ongoing monitoring by ELT.

What next? 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.

QSAC notes the specific requests from other committees e.g. from F&P Committee regarding out of area and use of private beds. Following the April meetings, QSAC has incorporated matters arising in other Committees into its action tracker. Those perspectives and inquiries will inform the Committee's approach to its work and especially the way in which it considers the Q&P report. Greater connection between Committees enables the Board to take a view on how it seeks to balance the competing demands on the Trust and makes strategic choices.

Patient Safety Incident Response Framework (PSIRF)

What: The PSIRF describes the new approach to developing and maintaining effective systems and processes for responding to patient safety incidents to support learning

improvement within the NHS. The Trust has established a PSRIF Implementation Group that reports into QSAC. That group oversees an implementation plan.

So What: The Committee noted the update report from the Implementation Group and was advised that progress reflects the timelines set out in the plan. Board accountability and training in relation to the PSIRF was also discussed at the Committee.

What Next: The Committee noted that key Trust staff have attended ICB-provided training. Board-level training has not yet taken place. QSAC was advised that training for its members was planned for July 2023. However, as QSAC does not meet in August, that will be a pressured agenda. The provision of timely training for both QSAC and Board was added to the Committee's action tracker whilst options are considered.

Integrated Health Inequalities and EDI Action Plan 2022/24

What: This report seeks to provide assurance on how the Trust meets its Public Sector Equality Duty via specific objectives against which progress will be monitored. As a public sector organisation, the Trust is required to produce and publish equality objectives at least once every four years and to demonstrate that these objectives advance equality for all protected characteristics and disadvantaged groups. The Trust is also required to implement the NHS mandatory standards and Frameworks including the new Patient and Carers Race Equality Framework (PCREF) as well as the Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES), and Medical Workforce Race Equality Standard (MWRES).

So what: The Board is accountable for the Trust's compliance with its duty under the Equality Act 2010. In 2022, work took place to integrate our approach to Health Inequalities and Equality, Diversity, and Inclusion into a single Action Plan. That action plan seeks to enable the Trust to understand and address existing and emerging inequalities, both in services and organisationally. The plan reflects the outcomes in EDI Strategy 2021-24 and our Anti-racism Framework. QSAC heard that the staff networks have been engaged in, and commented on, the action plan, including the proposed priorities. Trust services have developed local action plans to deliver against the equality objectives as set out in the plan and implementation is being supported by colleagues in the Health Inequalities and EDI teams.

QSAC welcomed the action plan and will continue to develop its approach to embedding consideration of EDI and health inequalities into reports, discussions and decisions.

What next: Regular assurance reports will go to QGG, ELT, People Committee, QSAC and the Board. The Committee noted that there are opportunities to support and make progress in improving equity in mental health care, treatment and services across SW London. QSAC considers that the action plan's success will depend on the extent to which the work and its objectives are understood, embedded and prioritised within both the Trust and via partnership working within the wider system. QSAC also highlighted the importance of the interface with the People Committee. The Chairs of those Committees will discuss that interface and its significance further.

Ethnicity and Mental Health Improvement Project (EMHIP)

What: The Committee received an update on EMHIP, noting that it is now in its second year.

So What: EMHIP is an innovative, important and complex project that involves partnerships and changing ways of thinking and working. It reflects the Trust's wider commitments to anti-racism, reducing health inequalities, improving quality years and EDI.

Matters QSAC noted and discussed included:

- the evaluation of the project by the ICB in Q3 of 2023/24;
- timelines for delivery of the project, anticipated and actual;
- planned quality assurance by the Trust's Research and Development;
- the intended development of a Health Inequalities action plan;
- the 2024 start date of work on Intervention 3 – reducing restrictive practice and coercion. The work will be led by the lived experience panel with multi-agency workshops to inform a training programme drawing on established training programmes, such as Safety in Motion. The project plan will be developed alongside the ICB, and will include risk mitigation.
- The importance of memoranda of understanding to facilitate effective partnership working.

What Next: The Committee discussed whether the launch date and timelines shown in the report were realistic considering the complexity and importance of the project. QSAC notes that the project has a high risk rating which it considers appropriate. The Committee will continue to monitor EMHIP and its progress, reporting to Board on barriers and facilitators. Specifically, QSAC sought information regarding how the project leads will report to the Committee regarding progress on the Health Inequalities action plan and looks forward to a response at its May meeting.

Appendices

Approved minutes of the meeting of 6th March 2023.

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

Quality and Safety Assurance Committee (Part A)

Draft Minutes of the MS Teams meeting held on Monday 6th March 2023

Present:

Professor Deborah Bowman (DBo)	Committee Chair – Non-Executive Director
Vanessa Ford	Chief Executive Officer
Prof Charlotte Clarke	Non-Executive Director
Billy Boland (BB)	Medical Director
Jennifer Allan (JeA)	Chief Operating Officer –
Sharon Spain (SS)	Director of Nursing & Quality
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
Jaydene Campbell (JC)	Lived Experience Representative
Ijeoma Ndubuisi (IN)	Lead Nurse Learning Disability & Autism
Ryan Taylor (RT)	Associate Director of Clinical Governance & Risk
Elaine Holder (EH)	Committee Governance Manager (Minutes)
Olan Adebayo	Health & Safety Manager

Apologies:

David Lee (DL)	Corporate Governance Director
Sofia Hussain (SH)	Lived Experience Representative
Doreen McCollin (DM)	Non-Executive Director

Item

A23/38 **Apologies**

Apologies were noted.

A23/39 **Declarations of Interest**

No new declarations of interest were reported.

A23/40 **Chair's Action**

Post-Board Development, SS/DB informed the meeting that QSAC reports and discussions will be framed differently going forward. DB informed the meeting that QSAC's role is to ensure all papers and conversations ultimately relate to Corporate Objectives and the BAF, focusing on assurance, strategic priorities and governance, which will inform reporting to Board and further discussion/decision-making.

There was a specific MAST training issue for Deaf colleagues that DB noted at EDC and has raised with SS for action as part of the wider focus on MAST training.

BB is offering the opportunity to take part in accredited quality training and the link is available for members. VF strongly advocates members taking this up.

JeA and team have completed work on the new look Q&P report. As the report changes members will continue to develop their understanding of reading and interpreting data

to inform the committee's work. JeA suggested training by Informatics – for the forward plan for May. **Action EH**

A23/41 **Minutes – minutes from the last meeting were agreed.**

A23/42 **Action Tracker**

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

VCY raised some questions regarding restrictive practices during and following the last meeting. Mike Hever and Emdad Haque have responded.

A23/43 **Q&P Report**

The Committee noted and accepted the report.

JeA highlighted the following:

- The Q&P report will be reshaped to become more concise and informative. This will be shared at May's QSAC meeting.
- Performance remains relatively stable.
- There is high usage of out-of-area beds in acute pathway which has been a concern for a while.
- There is ongoing under-performance on mandatory training - a plan has been put in place to address this issue.
- DH asked why safeguarding training is not mandatory. SS explained that there are different levels of training.
- SS informed the meeting that there is a long-standing issue dating from when the Trust shared the system with SLAM. There is also an issue with Compass which has been escalated to the People Director. It has been put on the risk register.
- DH asked the timescale for resolving this issue.
- SS informed the meeting that this will hopefully be resolved in 6 weeks.
- VF informed the meeting that ELT have highlighted this concern and will receive a paper at ELT to ensure there is a clear plan for resolution.
- RF asked why there is a decrease in assurance for the Always Ready audit compliance.
- SS informed the meeting that the Always Ready audits relate to care plans, infection control and risk assessments, with different ones for Community. There was an issue with the system and some of the questions for Community in respect of infection control are not appropriate, leading to the decrease in compliance.
- RT informed the meeting that this is part of BAU checks and controls.
- AB asked DB to share her comment with the Committee in respect of timelines for progress in the Q&P report.
- VF explained ELT feels that performance is stable but not improving which is a concern. ELT highlighted the need for improvement in respect of face-to-face MAST training as well as out-of-area admissions. ELT expects to see clear timelines by the next QSAC meeting. VF informed the meeting that a trajectory has been set in respect of out-of-area admissions.
- JeA informed the meeting that she will review Q&P actions with the service line teams and include consideration of timescales.

- JeA informed the meeting that the new Q&P will detail each committee's areas of concerns.

A23/44 **Waiting list update**

Committee accepted and noted the report.

JeA highlighted the following:

- JeA informed the meeting that waiting list management processes are being enhanced, and progress is being made with this through our digital programme.
- There are significant challenges with the process and waiting times.
- There is a gap in respect of demand and capacity.
- DH asked if the Richmond waiting list had anything to do with funding.
- JeA informed the meeting that there is historic low investment in mental health for Kingston and Richmond. JeA explained that future funding can be reallocated although this can be challenging.
- DH also commented that certain areas that have previously been mentioned by EMHIP do not get as much investment.
- JeA informed the meeting that that this can be reviewed by weighted population as well as ethnicity.
- DB asked what change has happened since discussion at ELT in respect of the Q&P report, if the timelines for work have been prioritised and how the actions address these points as well as considering culture.
- JeA informed the meeting that the paper was not changed. However, ELT acknowledge the 'so what, what next' being the need to understand waiting times by protected characteristics particularly ethnicity - this is an ongoing programme of work.
- JeA informed the meeting that a lot of the work is underway as part of the digital programme. The Trust's digital programmes are not as good as they should be and should be tracked via KPIs. JeA informed the meeting that this will part of the next steps.
- Trajectory for demand and capacity is difficult to track as this is constantly changing. There is ongoing continued investment for services therefore this should mean reducing waiting times. There is a mechanism to track this through business planning which will allow future work to review the results of investment for waiting lists.
- JeA informed the meeting that she has had conversations with Juliet Armstrong regarding standardisation and workforce planning which remains an issue. Benefits realisation and outcomes will need to be articulated and built into the 'what next'.
- CC asked if progress will be short-term or long-term.
- JeA suggested a high-level phasing may be helpful which is a programme within digital. The expectation is this will be delivered in 6-9 months (which would be the first phase). JeA will review the high-level plan for digital clerical admin which can be fed back to QSAC.
- DB noted that this is the clearest insight on waiting times for the last few years and wanted to acknowledge JeA's work in leading this work.
- JeA informed the meeting that the Trust is being more transparent in respect of waiting times.
- JeA informed the meeting that QSAC's role is to look at the quality and risk for waiting times as well as ensuring there is a framework to look at this which will

link back into the new Q&P framework. This may mean QSAC oversees the waiting times metrics which also interacts with the transformation programme.
- JeA will set out the impact of the digital programme on waiting times through EMC and then onwards to QSAC to give assurance.

A23/45 **Risk Register**

Committee accepted and noted the report.

RT highlighted the following:

- There has been feedback from the Trust Board meeting which RT is currently working on.
- There have been two new risks added: *Risk 2402 Smoke-Free Policy* which is under review, and *Risk 2401- Trinity - Cleaning provision and standards* which has now been resolved. There are ongoing issues with cleaning standards schedules, monitoring and accountability which is a wider Trust risk.
- *Risk 2048: Emergency response system – (medical or psychiatric emergency)* has been increased and there has a been a lot of work to understand what the problems are.
- Industrial action risk has been decreased and will be increased as necessary.
- *Risk 2267: CQC ratings - failure to maintain a CQC rating of 'good'* as the result of the outcome of the CQC inspection of the Acute Wards in August 2021 has been closed. ELT previously agreed that due to the work and assurance processes, this risk need not feature on the ERR, but remains on the Nursing and Quality risk register at a reduced level of 8 Amber.
- A new risk has been added by QGG in respect of the Trust's cyber risk.
- Risk 2398 was added by the services - *Staff shortages, for Twickenham RST*.
- Risk 2392 - *CAMHS - Inpatient food concerns* was added by QGG which has resulted in Sodexo being issued a formal improvement plan (Trust Wide) for food and cleaning.
- Risk 2391 was added in respect of the reduction in bed numbers from 33 to 15 and access to forensic Medium Secure Unit beds. The Service line expect this to be closed in the next two weeks.
- ELT noted and was pleased that the number of outstanding risk reviews and actions has considerably improved over recent months.
- Work continues around the exploration of managing the BAF within the Ulysses system, to enable both the BAF and ERR are managed and reported within the one digital system.
- DH asked how patients are supervised during smoking breaks and asked if the death of a patient form Lotus ward who left the ward for a break has appeared on the risk register.
- DH also commented on the quality of food and cleaning and who deals with these complaints.
- RT informed the meeting that there have been issues with the Sodexo contract for several years and the contract will be coming up for tender soon. RT informed the meeting that the service received so far will be considered.
- SS informed the meeting that she will update PQF regarding patients' smoking breaks and the cleaning contract.
- RF asked when the BAF will be put on Ulysses.
- RT will liaise with Ulysses and feedback to RF **Action RT**
- RF questioned *Risk 2408 Emergency Response* and new actions being developed. RF asked if next steps for can be fed back to QSAC. **Action RT**
- RF asked what the target scores for Training are (Risk 2287) which is important to QSAC. **Action RT**

- DB asked why the risk for industrial action was reduced and queried the timing.
- RT informed the meeting that this was reviewed at ELT in February with a view for this being increased if necessary.

A23/46 **Quality Matters**

Committee noted and accepted the report.

SS highlighted the following:

- SS informed the meeting that that she will be reviewing the Quality Matters report with RT as it may duplicate other reports. SS and RT will take the opportunity to ensure the report is more focused in respect of patient safety, serious incidents and quality of care whilst looking at 'what, so what and what next' as well as providing assurance that scrutiny has taken place at other committees.
- Serious incidents include a female patient from Lavender ward who died from health complications. The emergency response was good although there were issues with the radio system. A 33-year-old patient's death under the care of Lotus Ward may be linked to Section 17 leave and smoke break.
- Service lines have looked at managed incidents and RCAs.
- There was an issue about the data in respect of Emergency responses.
- 5 inquests were concluded and there were no CQC visits during January.
- There is ongoing work in respect of the monitoring and reading of rights.
- The final CQC report was published in January where the Trust's rating has moved back to 'good' for all domains.
- 72-hour breaches were discussed at ELT which understand that patients are being kept on Lotus ward longer whilst waiting for a bed.
- DH asked what quality feedback systems are held for sub-contractors.
- SS advised the meeting that the Trust has close links with Sodexo and security.
- CAB asked if patients on Lotus suite are sectioned. SS informed the meeting that patients on Lotus Ward are being assessed.

A23/47 **Quality Governance Group minutes**

The Committee received and noted the minutes.

A23/48 **Ethics Committee minutes**

The Committee received and noted the minutes.

A23/49 **Meeting Review**

The Chair asked Committee members to highlight any themes that arose for them during the meeting.

CAB commented that patients seemed less central to the discussion on waiting lists.

DH felt it was difficult to include patients in respect of seeking feedback on waiting times.

DH noted that themes recur in different meetings and at patient fora; these could all be condensed enabling QSAC to take an appropriately strategic focus.

RF felt the key theme was risk and that it would be useful to capture discussions and assurances as discussed at other committees.

CC felt the inclusion of high-level timelines would be useful and that graphs were not always clear.

A23/50 **Next Meeting - The next meeting is on Monday 3rd April at 13:30 via MS Teams**.

Trust

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

Quality and Performance Report

March 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 remains stable, in the context of significant performance deterioration across the NHS and industrial action impacting service delivery. The key issues identified are the ongoing flow constraints, with longer LOS leading to high use of out of area beds, and the high level of 52 week breaches in the adult ADHD screening service, due to an underlying demand and capacity mismatch. Our transformation work focuses on both community support and recovery for our patients to avoid crisis, and improvement to the acute inpatient and discharge pathways to support reducing LOS. We note some improvement in our vacancy rate, which is positive following HR recovery work, though retention is still a challenge, as is MAST compliance where a range of issues are being addressed. It is useful to note that the patient safety domain of performance remains stable and the Fundamental Standards of Care programme continues to focus work on our care quality priorities, with increased oversight in community services to support improvement.

There is continued significant pressure across the SWL system, with flow challenges in our services contributing to longer waits for patients in crisis and the need to work together with acute hospital partners to prioritise clinically and optimise patient safety across settings. Further periods of junior doctor strikes have been successfully managed internally, services maintained and no related patient safety incidents reported, and good coordination with the wider system in the context of severe pressures. Current levels of external bed use to support flow, and ongoing high usage of agency staff particularly in our community services, are of key concern due to the financial impact but equally their potentially negative impact on patient experience and the continuity of care close to home. Work is in progress to address these challenges, including participating in system working around discharge and workforce development.

The focus of this report is March 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. The SLRs in March piloted a new Live Dashboards approach to reviewing performance, which also enables immediate discussion and capture of top priorities for improvement and the associated actions, which are followed up through the meeting cycle. Teams of concern requiring support and Fundamental standards of care areas for improvement are also key focuses for the SLR meetings and the outputs inform discussion at Board committees and Board through the priority metrics and Q&P report commentary. This approach will be further enhanced within the Board committee and Board reports in 2023/24 to enable the most effective triangulation of information and action for the Trust.

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

Clinical Quality Update:

- The report continues to have ongoing focus on the Fundamental Standards of Care, although further work is being undertaken for the recording of therapeutic observations. Inpatient FSOC has maintained its position throughout the year but there is further work to be undertaken with Community services to support with improvement.

Workforce Update:

- The vacancy percentage has increased slightly to 17.8% in March, as the turnover rate exceeded the number of new recruits joining the Trust. The Recruitment Team continues to see record numbers of new starters, but the focus now needs to be on retention of these staff and the 12-week Retention Sprints work has commenced to focus on this.
- The turnover rate of those leaving within 12 months of joining remains a concern. A piece of work focussed on interventions to improve was received by the ELT in March and work has commenced. The areas of focus include, data analysis, reviewing current processes, understanding more about what makes colleagues stay and best practice learning.
- A paper was received by ELT on 9th March 2023 to understand in more detail what is driving the decrease in MAST compliance rates and focus on this action plan continues with weekly meetings held with Director of People and Director of Nursing . This relates to five key issues, including Subject Matter Expert Availability, Compass system and updates required, governance of the range and scope of MAST. An action plan is in place and weekly service line updates are being issued to the Director of Nursing and Director of People. MAST compliance is as a result beginning to improve but recognise this focus must continue to get us to expected compliance rates.
- The agency usage has further increased this month to 33.9%, which has led to an urgent project addressing NHSE Guidance which will be led by the People Director reporting into the People Committee and Finance Committee. This project will include stringent governance processes, a ban on Admin agency (with exception of IT) and creative ways to reduce the reliance on agency workers.
- PADR and Supervisions rates are lower than expected. Trust focus on PADR completion will commence in Q1 23/24 and as such it is expected that an increase back to normal target levels.

Access

- Adult ADHD/ASD services face significant demand and capacity pressures and long waits for this service continue to increase. A clinically led proposal to commissioners was submitted in March 2023 outlining the options to bridge the gap through either returning medication review work to primary care or limiting assessment capacity to match resources. While a sustainable solution is

designed by means of a working group between the Trust and ICS colleagues, the Trust is proposing to close to referrals for 6 month period as there is no prospect of offering assessment to patients referred at this time. We are liaising with ICS partners on this and communications will be issued in due course.

- The Trust incurred (132) 52 week breaches in March 2023 - (131) in the Adult ADHD service and (1) in Kingston CAMHS Tier 3 (linked to wait for medication commencement following long wait in CAMHS SPA screening and CAMHS Neurodevelopment pathway). Longest waits are subject to weekly scrutiny and are also reviewed at the 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 with access requirements in quarter being renegotiated. The volume of waits over 30 weeks continues to rise as Step 3 vacancies continue (although improving); 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. In this context, IAPT services continue to deliver good recovery rates and are also performing above the national average in terms of access for clients from BAME backgrounds.
- 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.

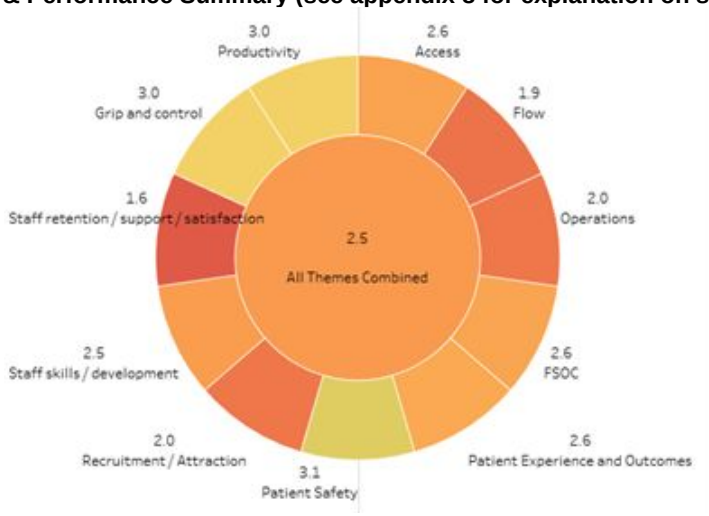
Flow, Patient Safety & Productivity Update:

- 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 extended by the Trust to support patient flow pending confirmation of ongoing 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. This work has been aligned with clinical system improvements to Rio to support an enhanced Discharge process which contributes to addressing the underperformance in transmitting discharge summaries to GPs within 24hrs.
- 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 junior doctor 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 needed to deliver a savings target of £12.4m. Actual delivery amounted to £12.5m, £0.1m ahead of plan. The key concern relating to in-year delivery was that only 30% of the target was delivered on a recurrent basis.

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

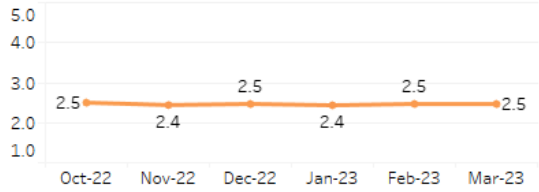


Summary Domain Performance:

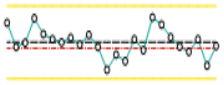
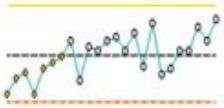
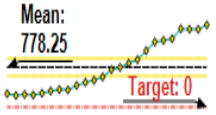
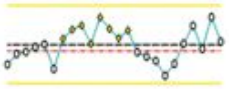
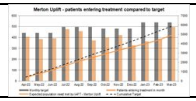
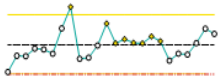
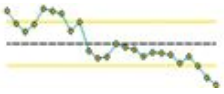
Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	5	12	17	50.0%
Quality	6	13	9	67.9%
Workforce	1	2	8	27.3%
Finance	0	3	0	100.0%
Total	**12**	**30**	**34**	**55.3%**

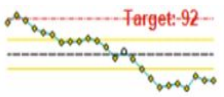
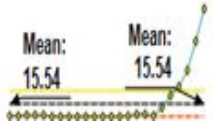
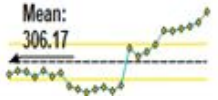
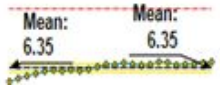
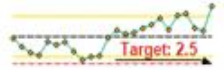
A table showing how many KPIs have full assurance, some assurance and no assurance, split by domain.

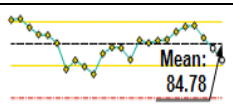
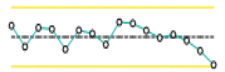
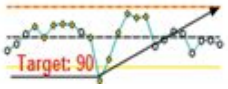
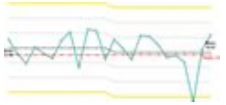
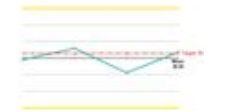
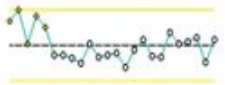
Donut Performance over-time (all themes combined):

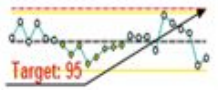
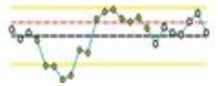
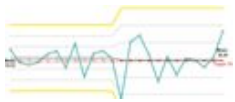
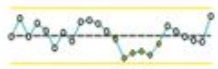


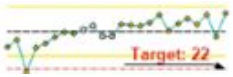
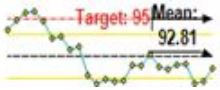
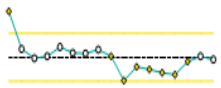
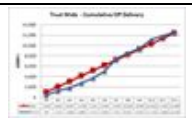
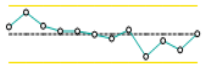
Priority Metrics

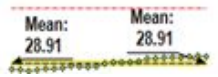
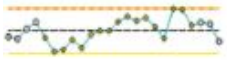
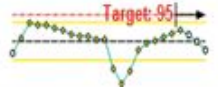
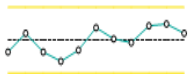
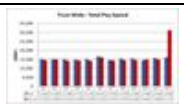
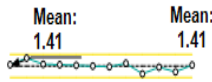
	Priority Metrics	Mar-23	Target	Trend	Assurance*	SPC Chart
Operations	1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) (see page 9)	61.5	≥ 60.0	→	?	
	Access					
	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (see page 10)	42	= 0	→	✗	
	Access					
	No one is waiting more than 30 weeks for treatment - Number of breaches (including CAMHS Neuro, IAPT & Non-RTT teams) (see page 11)	1602	0	↗	✗	
	Access					
	Adult and Older People's CMHTs - Non-Urgent Referrals assessed within 28 days (%) (see page 13)	83	≥ 80.0	→	?	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 14)	0	≥ 95.0	→	?	
	Access					
	Expected population need IAPT – Merton Uplift (see page 13)	4888	5868	-	-	
	Access					
	Expected population need IAPT – Richmond (page 13)	4656	5028	-	-	
	Access					
	Expected population need IAPT – Talk Wandsworth (see page 13)	8211	10806	-	-	
	Access					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 16)	280	= 0	→	✗	
	Flow					
	Time on caseload (days) (see page 15)	422.1	-	↘	-	
	Flow					

	Priority Metrics	Mar-23	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - Seen within 1 hour in A&E (%) (see page 9)	69	≥ 95.0	↘	✗	
	Access					
	Referral to treatment (RTT): Patients waiting less than 18 weeks for treatment at month end (%) (see page 10)	77.7	≥ 92.0	↘	✗	
	Access					
	Referral to treatment (RTT): 52 week breaches (see page 12)	133	= 0	↗	✗	
	Access					
	Internal waits for treatment of over 30 weeks (see page 12)	501	-	↗	-	
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 14)	6.7	≥ 10.0	↗	✗	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 15)	86.7	≥ 80.0	↘	?	
	Access					
	Expected population need IAPT Sutton Uplift (see page 13)	4502	5064	-	-	
	Access					
	Adult acute average length of stay (Excluding PICU) (see page 16)	52.8	≤ 38	→	?	
	Flow					
	Delayed transfers of care (%) (see page 17)	10.7	≤ 2.5	↗	✗	
	Flow					
	Data quality maturity index (DQMI) (%) (see page 17)	98	≥ 95.0	→	✓	
	Operations					

	Priority Metrics	Mar-23	Target	Trend	Assurance*	SPC Chart
Quality	Community risk assessments reviewed within the last 12 months (%) (see page 18)	91.6	≥ 95.0	↘	✗	
	Fundamental Standards of Care					
	Physical Health Assessment attempted within 48 hours of admission (%) (see page 19)	91.3	≥ 95.0	→	?	
	Fundamental Standards of Care					
	Cardiometabolic Assessments - Community and EIS (%) (see page 20)	81.8	≥ 75.0	↗	✓	
	Fundamental Standards of Care					
	Safe Staffing: requirements inc obs levels (see page 21)	77.3	-	→	-	
	Fundamental Standards of Care					
	Always Ready Audits Completed (%) (see page 21)	74.6	≥ 90.0	→	✗	
	Fundamental Standards of Care					
	Patient Friends and Family Test (%) (see page 23)	77.6	≥ 92.0	→	✗	
	Patient Experience and Outcomes					
	IAPT recovery rate - Merton Uplift (%) (see page 24)	53.4	≥ 52.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate – Richmond IAPT (%) (see page 24)	50.3	≥ 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)	40	-	→	-	
	Patient Safety					
	Inpatient discharge letters sent within 24 hours (%) (see page 27)	69.2	≥ 90.0	↘	✗	
	Patient Safety					

	Priority Metrics	Mar-23	Target	Trend	Assurance*	SPC Chart
Quality	Inpatient Risk assessments completed within 48 hours of admission (%) (see page 18)	**89.4**	≥ 95.0	→	✗	
	Fundamental Standards of Care					
	Physical Health Assessment completed within 7 days of admission (%) (see page 19)	84.1	≥ 90.0	→	?	
	Fundamental Standards of Care					
	Safe Staffing: National Compliance - Inpatients (%) (see page 20)	130.7	≥ 95.0	↗	✓	
	Fundamental Standards of Care					
	Always Ready Audit Compliance (%) (see page 22)	89	≥ 90.0	↘	✗	
	Fundamental Standards of Care					
	Complaints Answered Within 25 Days (%) (see page 22)	72.4	≥ 85.0	→	?	
	Patient Experience and Outcomes					
	Emergency readmission within 30 days - Adult Acute & PICU (%) (see page 23)	4.5	≤ 8.5	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate - Sutton Uplift (%) (see page 24)	56.1	≥ 50.0	→	?	
	Patient Experience and Outcomes					
	IAPT recovery rate - Talk Wandsworth (%) (see page 24)	52.9	≥ 50.0	→	✓	
	Patient Experience and Outcomes					
	Total number of restraints (physical restraints and rapid tranquilisation) (see page 26)	197	-	→	-	
	Patient Safety					
	Death - Suspected suicide (see page 27)	5	-	→	-	
	Patient Safety					
	Follow up within 72 hours of discharge from inpatient services (%) (see page 28)	87.4	≥ 80.0	→	?	
	Patient Safety					

	Priority Metrics	Mar-23	Target	Trend	Assurance*	SPC Chart
Workforce	Vacancy Rate (%) (see page 29)	17.8	≤ 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)	33.9	≤ 22	↗	✗	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 1 (%) (see page 33)	92.1	≥ 95.0	↘	✗	
	Staff Skills/Development					
	Turnover (%) (see page 34)	17.6	≤ 15	↗	✗	
	Staff Retention/ Support / Satisfaction					
	Supervision (%) (see page 35)	82.6	≥ 85.0	→	?	
	Staff Retention/ Support / Satisfaction					
	Active ER cases (see page 36)	62	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 page 38)	0	≤ 0	→	?	
	Grip & Control					
	Cumulative CIP Delivery £000 (see page 39)	12,524	12,387	-	-	
	Grip & Control					
	Activity Vs WTE (see page 40)	12.5	-	→	-	
	Productivity					

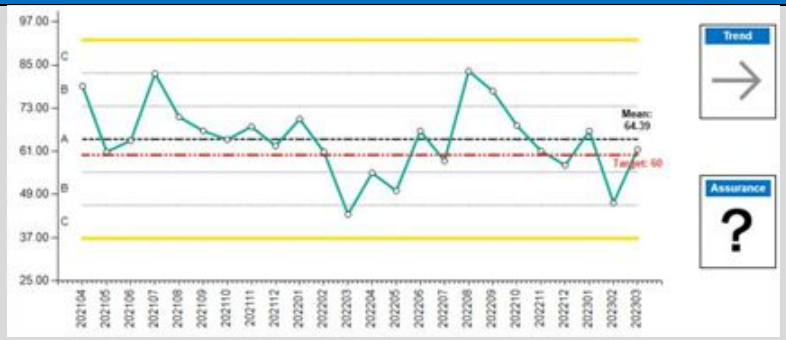
	Priority Metrics	Mar-23	Target	Trend	Assurance*	SPC Chart
Workforce	Vacancies in active recruitment (%) (see page 30)	58.6	≥ 90.0	↘	✗	
	Recruitment/ Attraction					
	Percentage of BAME staff - Band 8+ and Medical (see page 31)	31.5	≥ 50.0	↗	✗	
	Recruitment/ Attraction					
	Temporary staffing - Community Service Line (%) (see page 32)	17.7	≤ 22	↗	✓	
	Recruitment/ Attraction					
	Statutory and Mandatory Training: 2 (%) (see page 33)	88.8	≥ 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)	84.1	≥ 95.0	↗	✗	
	Staff Retention/ Support / Satisfaction					
	ER cases exceeding 90 days (see page 36)	32	-	→	-	
	Staff Retention/ Support / Satisfaction					
Finance	Agency as a % to NHSI Target (%) (see page 38)	88.4%	≤ 100	→	?	
	Grip & Control					
	Pay Cost Vs Budget £000 (see page 39)	31,137	16,083	-	-	
	Grip & Control					
	Activity vs Caseload (see Page 40)	1.4	-	→	-	
	Productivity					
	Contract Activity – Local CCG Contract (%) (See page 41)	93.3	≥ 95.0	→	?	
	Productivity					

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

Operations Domain

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

Access



Team Breakdown – March 2023

Team	Treatment Within 14 Days	Referrals	% Treatment Within 14 Days
Richmond Early Intervention Team	1	1	100.0%
Merton Early Intervention	2	2	100.0%
Sutton Early Intervention	2	2	100.0%
Wandsworth Early Intervention	2	4	50.0%
Kingston Early Intervention Service	1	4	25.0%
Trust Total	8	13	61.5%

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

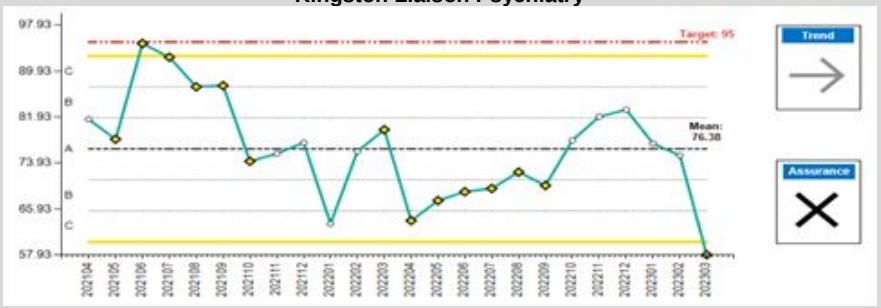
Underlying issues
- Staff vacancies and instabilities including team managers (e.g.: Wandsworth & Kingston EIS.).
- Inconsistent clinical oversight of waiting list and validation is not always completed promptly.
- Some inpatient wards and adult assessment teams are slow to refer patients on to EI services 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.

Actions:
- Targeted training for SPA teams to continue in order to reinforce the importance of timely referrals to EIS.
- Meeting was held in April 2023 with Applications Development and an early alert for referral to EIS has been developed. Alert system is currently being tested and is scheduled for roll out on 28th April 2023.
- 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.
- Community Service line to engage with acute services to improve processes for timely referrals to EIS.

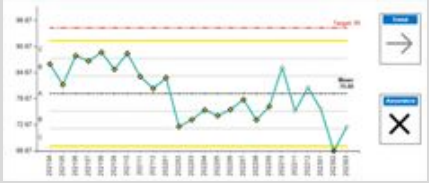
Liaison psychiatry - Seen within 1 hour in A&E (%) — Target ≥ 95%

Access

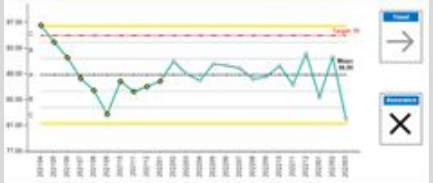
Kingston Liaison Psychiatry



St Georges Liaison



St Helier Liaison



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

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

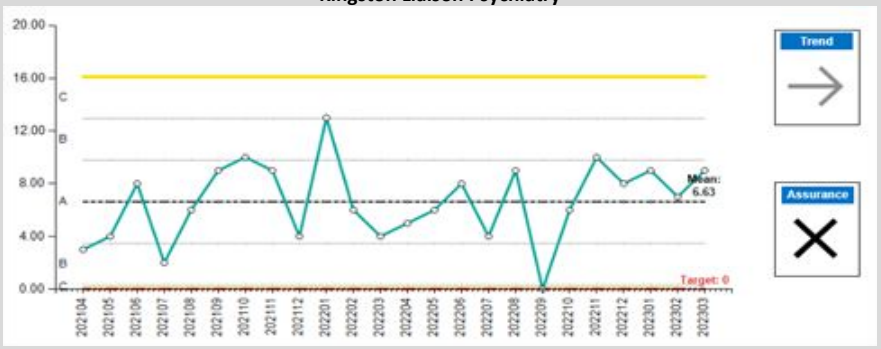
Underlying issue:
- The process of managing Emergency Referrals is impacted by many factors such as staffing shortages (including sickness and vacancy rate, cubicle space (St Georges), other activities such as handover and multiple referrals from both ED and wards.
- Impact of extended number of patients waiting for MH beds in general hospital requiring further reviews.
- Acute hospitals have been experiencing a high level of acuity and this has had an impact on referrals into liaison services.
- 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.
- Liaison services also see patients on acute hospital wards which also diminishes capacity.
- 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:
- Clinical Service Lead to work with teams to build on the Triage Model implemented in December 2022.
- Clinical Service Lead and Matron undertaking staffing review in regard to demand and capacity and CORE24 compliance. This is a longer term piece of work and will be trialled in Kingston Liaison initially.
- Shift patterns to be reviewed including overlapping shifts at St Helier to support handover, Kingston and St George's to consider shift pattern that covers peak referral times. Paper being drafted and consultation with staff to be progressed with support from HR.

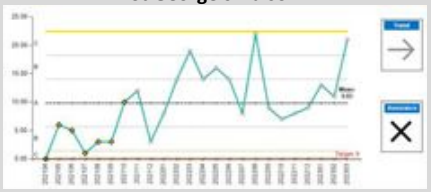
Liaison psychiatry - People waiting over 12 hours in A&E for a bed — Target = 0

Access

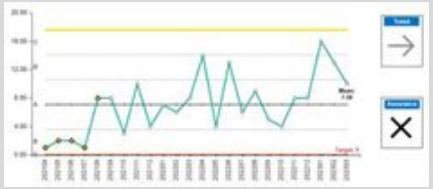
Kingston Liaison Psychiatry



St George's Liaison



St Helier Liaison



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

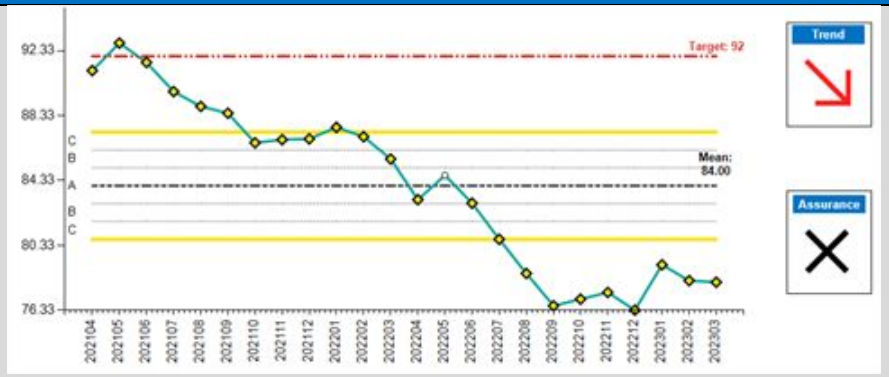
What the charts tells us
The level of 12-hour breaches is relatively consistent across the three services with occasional variation.

Underlying issue
- A lack of available adult acute beds will lead to an increase in waits over 12 hours.
- Increased LOS and 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.
- All patients requiring informal admission reviewed daily with support from team managers and consultants to ensure admission is clinically appropriate.
- The Trust has contract for use of 18 beds at Holybourne in Roehampton until the end of the financial year.
- 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.
- Matron working with Inpatient MDT to develop a new process of using Southcroft Lodge for step downs of those awaiting accommodation, hence improving flow of DTOC patients out of MH Inpatient services into a more suitable setting.
- Trust recently reviewed the Trusted Assessors Framework which will prevent duplicate assessments pre-admission i.e. once assessed by liaison or HTT there should be no need for further assessment as long as all points of framework are covered.

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

Access



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

Including ADHD/ASD teams	77.7%
Excluding ADHD/ASD teams	88.4%

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

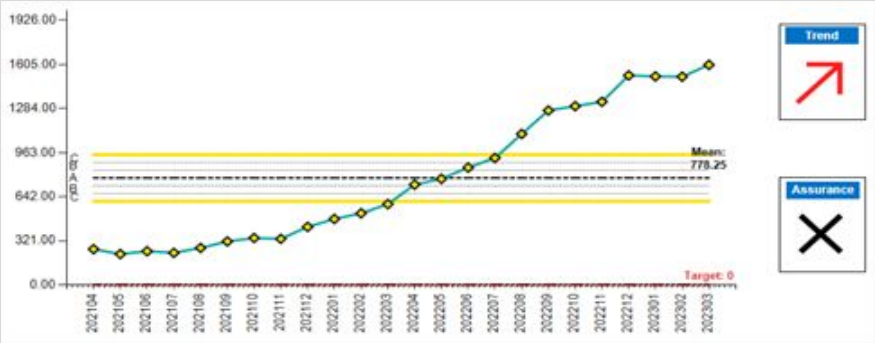
What the chart tells us
Mean performance is below target (which is above upper control limit) and there has been a significant downturn trend in performance since April 2021. A change in process is required in order to improve performance.

Underlying issue
- **Adult ADHD:** There are known demand and capacity issues within the service; in March 2023, 59.8% (840/1405) of the 18-week breaches relate to this service (see below for further information). Continued increase in caseload (for annual medication review) will impact on service assessment capacity.
- **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 CAMHS Tier 3 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 Management to review processes in SPA & NDT in order to streamline. SPA teams need to tighten administration on case closure (where forms sent to families are not returned).
- 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	Feb-23	Mar-23	+ / -
ADHD/ASD 30 week breaches	570	631	61
CAMHS Neuro Development	153	147	-6
Merton Uplift	204	240	36
CAMHS Tier 3	34	41	7
CAMHS Tier 2	61	54	-7
Adult Eating Disorders	21	31	10
Other	50	26	-24
Wandsworth Complex Needs	7	4	-3
Cognitive Stimulation Therapy	4	7	3
Talk Wandsworth	271	288	17
Sutton & Merton Complex Needs	25	25	0
Sutton Uplift	82	79	-3
CAMHS SPA	34	29	-5
Total 30 week breaches	**1516**	**1602**	**86**

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.

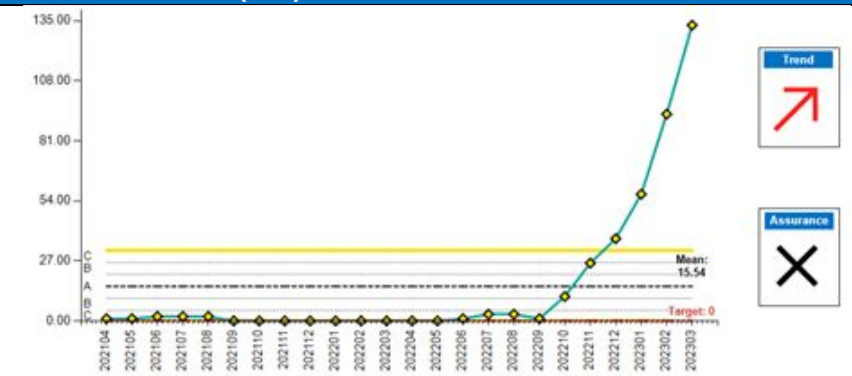
What the chart tells us
There is a consistent negative upward trend in 30 week breaches with performance above upper control limit since August 2022. A change in process is required.

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. The Trust is now incurring large numbers of 52-week breaches which will continue to rise (see below).
- **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.
- The Trust is proposing to close to referrals for 6 month period as there is no prospect of offering assessment to patients referred at this time. The Trust is liaising with ICS partners on this and communications will be issued in due course.
- **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.
- Nearly all vacancies have now been recruited in Step 2 and 3 with start dates for majority in April/May 2023.

Access

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



Team	Number of Breaches
Merton Adult ADHD	44
Sutton Adult ADHD	87
Kingston CAMHS Tier 3	1
Total	**132**

What the chart tells us:
Historic performance consistently met target; however recent months have seen significant increase in 52 week breaches with performance above upper control limit in last 4 months; a change in process is required.

Underlying issues that prevent us from consistently reaching the target:

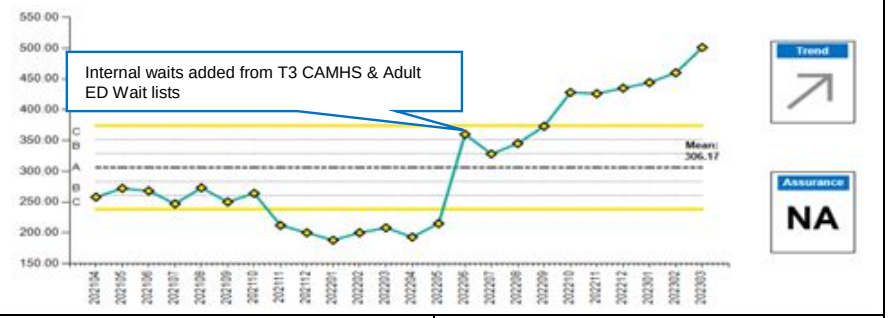
- Adult ADHD: There are known demand and capacity issues within adult ADHD services and there is a continued risk of further increase in 52 week breaches.
- The levels of 52 breaches will continue to rise as diagnosed cases remain on the adult caseload for annual medication review.
- Appointment cancellations (by patient/or clinician) can lead increased waiting times within service due to lack of appointment availability.
- CAMHS: Kingston CAMHS Tier 3 incurred one breach linked to case transferred to service from CAMHS NDT (non RTT service) post assessment; young person required medication titration for ADHD. Longest delay incurred SPA at Neuro Assessment and Treatment Stage where screening outcome is finalised.

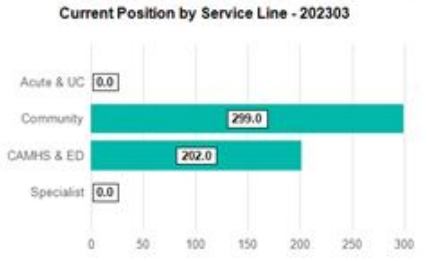
Actions:

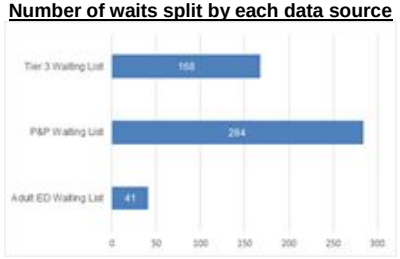
- **Adult ADHD:** A clinically led proposal to commissioners was submitted in March 2023 outlining the options to bridge the gap through either returning medication review work to primary care or limiting assessment capacity to match resources. While a sustainable solution is designed by means of a working group between the Trust and ICS colleague.
- The Trust is proposing to close to referrals for 6 month period as there is no prospect of offering assessment to patients referred at this time. The Trust is liaising with ICS partners on this and communications will be issued in due course.
- 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.
- **CAMHS:** New nurse prescriber to commence in post at end of May 2023 for Kingston & Richmond CAMHS Tier 3.
- **Trust:** RiO based waiting lists are being implemented across all services to ensure visibility of all patients waiting.

Access

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







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

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

Underlying issues

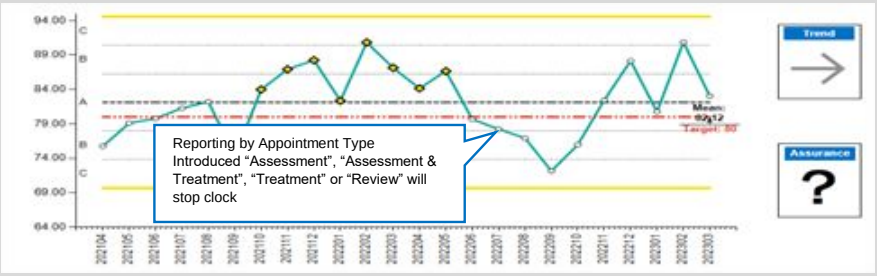
- Historically services have not been reviewing existing dashboards resulting in data quality issues.
- An ever-increasing demand for psychological input with demand exceeding capacity.
- Staff issues: early career posts remaining vacant for extended periods; preceptorship posts reducing in-service capacity; staff training (HEE community transformation programme) reducing capacity.
- New treatments (DBT skills groups) introduced as part of community transformation have been overwhelmed with referrals in Sutton and Merton.
- 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

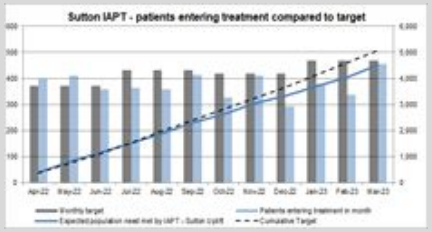
Team	Assessed Within 28 Days	Assessments	% Assessed Within 28 Days
Merton Uplift PCRS	23	29	79.3%
Merton Adult Assessment Team	58	74	78.4%
North Kingston CMHT	3	4	75.0%
Richmond SPA	25	34	73.5%
Dementia Clinical Nursing Service (DCNS)	9	13	69.2%
Putney & Roehampton CMHT	4	8	50.0%
Central Wandsworth & West Battersea CMHT	3	7	42.9%
South East Wandsworth CMHT	3	7	42.9%
Carshalton & Wallington IRH	3	22	13.6%

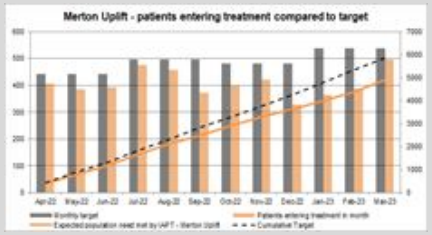
Background
The Trust is committed to ensure our service users have rapid access to Trust services as evidence suggests that this can lead to improved outcomes.
What the chart tells us
Mean performance is above target but there is some variation over the period. Last three months there has been deterioration.
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.

Expected population need met by IAPT (numbers entering treatment)

Access



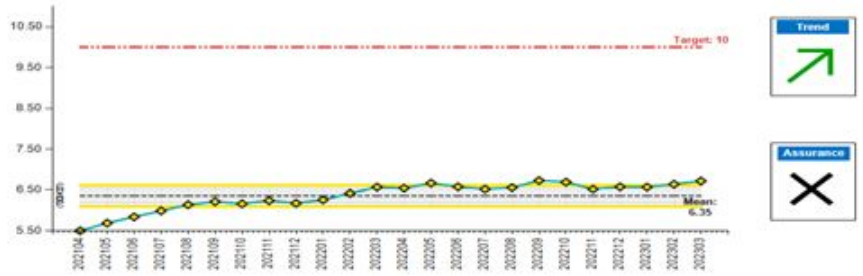


Background
Improving Access to Psychological Therapies (IAPT) is an NHS programme in England that offers interventions approved by NICE for treating people with depression or anxiety. In 2021/22 NHSE (agreed with Commissioners) have set a flat rate of cases entering treatment for each CCG area.
What the chart tells us
All four IAPT services are below their cumulative access requirements, but Sutton did meet its revised quarterly target.
Underlying issues
- Insufficient referrals across all services. Sutton Uplift is on course to meet the revised optimum efficiency target agreed with ICB for quarter 4.
- 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.
- 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.
- Merton Uplift service has increased the spread of assessment slots so more available in the afternoon and evening which are most popular.
- Talk Wandsworth expected to improve conversion rate by maximising use of Xyla; a 3 call system being trialled in Admin Team to ensure engagement is followed through and minimise drop outs.

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-consultation in the preceding 12 months. This is a count of distinct patients not referrals.

Measure	202205	202206	202207	202208	202209	202210	202211	202212	202301	202302	202303	202304
Women accessing PMH services *	1,039	1,025	1,016	1,022	1,049	1,043	1,016	1,025	1,024	1,035	1,047	1,004
Estimated births	15,595	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)	6.7	6.6	6.5	6.6	6.7	6.7	6.5	6.6	6.6	6.6	6.7	6.4
Service use per birth (For Context Only)	*7.8*	*7.7*	*7.7*	*7.7*	*7.9*	*7.9*	*7.7*	*7.7*	*7.7*	*7.8*	*7.9*	*7.6*

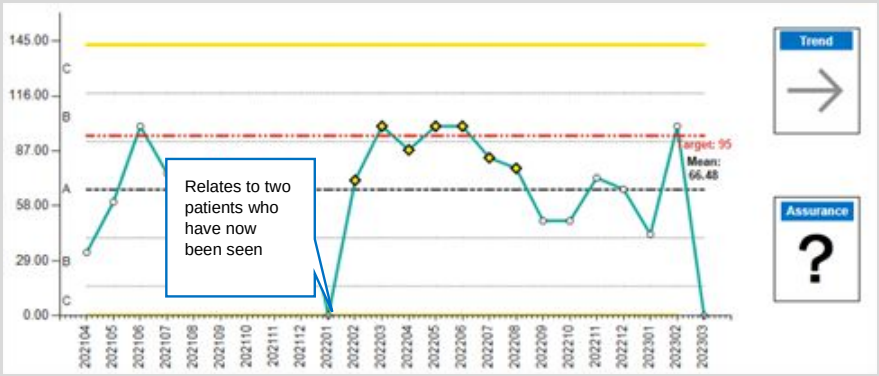
Background
Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of new and expectant mums and covers a wide range of conditions. The NHS Long Term Plan is for improved access to perinatal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

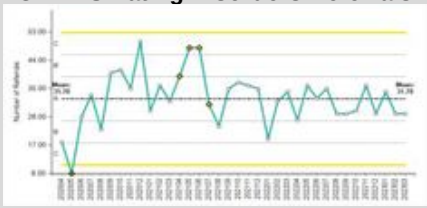
Underlying issue
- National target is based on predicted birth rate which is higher than the actual local birth rate.
- Number of referrals received progressing to assessment is too low in order to reach access requirements of 10% of PMH population.
- Limited financial investment will prevent expansion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

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.
- Development of Perinatal Trauma and Loss Service with review of additional capacity and impact on access, soft launch completed in Kingston Hospital and St Georges, aim to roll out to St Heliers end of April 2023.

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



CAMHS Eating Disorders Referrals



Waiting for Treatment Summary March 2023

		00 - 01	01 - 02	02 - 03	03 - 04	04 - 05	05 - 06	06 - 07	07 - 08	08 - 09	12+	Total
Waited	Standard	0	0	0	0	0	0	0	1	1	2	
	Urgent (7days)	0	1	1	1	0	0	1	0	0	0	4
Waiting	Standard	4	1	2	1	2	2	1	0	1	14	
	Urgent (7days)	1	0	0	1	1	0	0	0	1	4	

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 target 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 (n=2) in March 2023, 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
- The CAMHS Eating Disorders Service are continuing recruitment process.

Access

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

Team Breakdown

Team	Assessed Within 8 Weeks	Assessments	% Assessed Within 8 Weeks
Wandsworth CAMHS Tier 3	18	18	100.0%
Merton CAMHS Tier 3	13	15	86.7%
Richmond CAMHS Tier 3	11	13	84.6%
Sutton CAMHS Tier 3	16	19	84.2%
Kingston CAMHS Tier 3	14	18	77.8%

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 will be a further shortfall in non-medical prescriber resource due to expected vacancy.

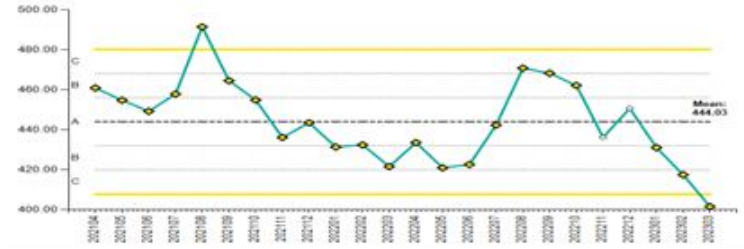
Actions
- Psychiatry continues to prioritise higher risk referrals for appointments, meaning ADHD medication waiters (who are of less risk) will continue to be reason for most 8-week breaches.
- Non-medical Prescriber post being advertised for Kingston and Richmond CAMHS to support the ADHD medication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

Flow

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

Adult Community:

CAMHS & ED:



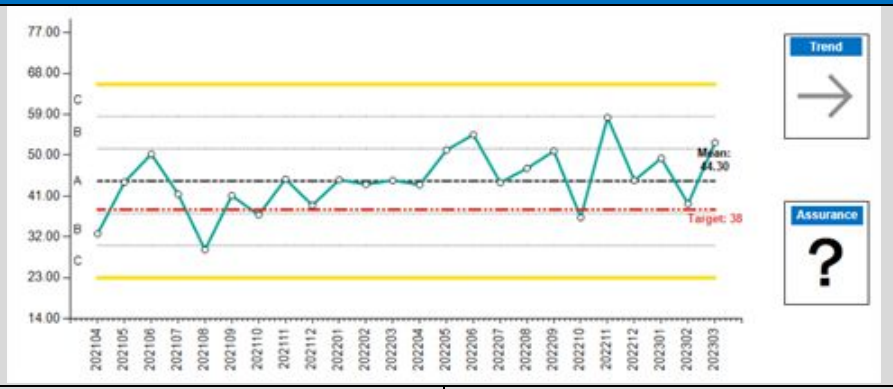
Background
To monitor caseloads and review duration on caseload between clinical services.
What the chart tells us
Community: Consistent downward trend on average time on caseload.
CAMHS & Eating Disorders: Consistent downward trend on average time on caseload.
Underlying issue
- **Community:** Some patients remain for long periods on caseload due to being prescribed Clozapine.
- Staff in the RSTs/CMHTs often focus on those patients presenting with significant risk (Amber/Red zoned) patients, and patients zoned as Green are not discussed regularly. This affects capacity and focus on discharge.
- GPs in some areas are still reluctant to accept patients on depot. Such cases have to 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
- A number of longer-term cases open in Merton and Richmond T3 Treatment Stage that are psychiatry medication cases. These need review and potential move to GP Shared Care pathways or closure.

Actions:
- **Community:** A QI workshop scheduled for 11th May is to map the underlying drivers and actions for two topics that are a priority across the secondary care teams on patient flow: 1) Overall time on caseload (and rate of discharge to primary care. 2) crisis presentations for patients known to our services. Action plan to be developed which will be managed through the Community Flow Group in 23/24.

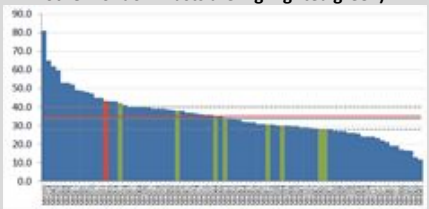
CAMHS:
- Weekly monitoring with regular audits of those with long LOS to ensure cases are on correct pathway.
- The service is currently recruiting a transition coordinator position to assist with transition cases in Kingston & Richmond.

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.

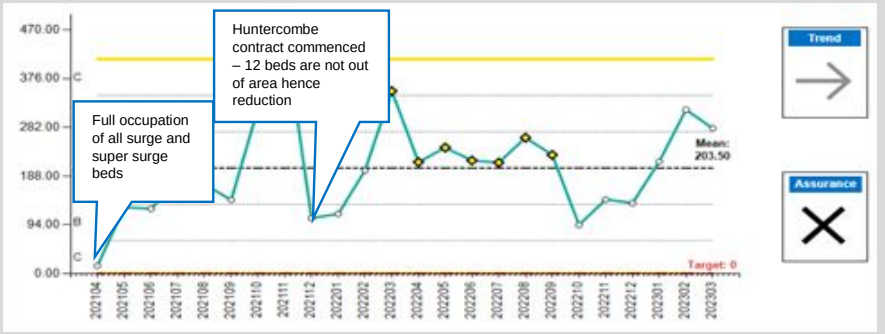
What the chart tells us:
Trust average performance exceeds the national average in 2020/21 (denoted as the target).

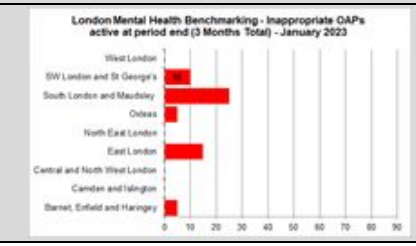
Underlying issue
- Trust has reduced short stay admissions – this has a consequence of overall increasing the average length of stay; there remains a need for Trust to focus reducing longer periods of admission related to patients with complex care needs which account for a larger proportion of beds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

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.
- Continuation of review of clear purpose for admission in line with 100-day challenge plan.
- 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.
- Design Implementation of EUPD/CEN pathway for inpatients.
- In-reach worker now working across all 8 adult acute ward.

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.
- Key to reduction in use of OOA provision is the work to decrease LOS and create capacity locally, alongside community transformation.
- The 100 day challenge plan should support reduction in LOS - workstream meetings set up for March to compile project plan.

Flow

Delayed transfers of care (%)

Target ≤ 2.5%

Trust DToC Days

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

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

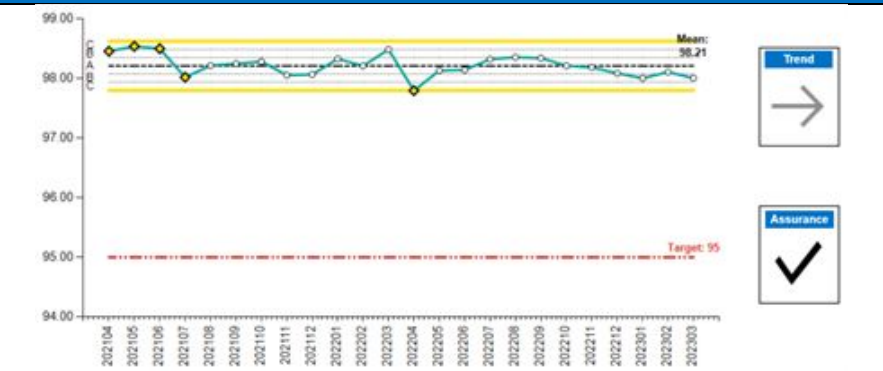
Underlying issue
- Improved identification of delays for non-medical reasons through use of an estimated discharge date.
- An increase in the proportion of more complex cases as bed numbers are reduced.
- Delays are often beyond the control of the Trust and reliant on LA engagement and resources.
- A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

Actions
- Escalation processes involving local authorities & CCG's is in place.
- The Creating Inpatient Capacity project is working to ensure use of estimated discharge dates, barriers to discharge and delayed patient processes work effectively. Standard operating procedure should improve flow through the system. Discharge and Choice policy has been circulated for review. Part of transformation programme is to reduce stay of complex cases and reduce stays on wards.
- Plan to develop pan borough DToC call and escalation framework (will need local authority engagement).
- Discharge and choice policy for review with LA stakeholders' task and finish group due to present to the April SOIM meeting.
- Focus on 100 day challenge plan to confirm details and timeline for each task and finish group within the plan.
- MADE event held on 5th April 2023 focus on B list (potential DToC'S) action plan in place.
- Specialist: Weekly DToC meetings implemented with all Borough attendance.

Operations

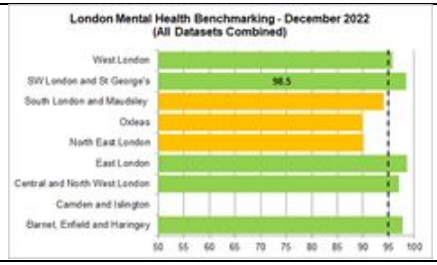
Data quality maturity index (DQMI) (%)

Target ≥ 95%



DQMI Areas for Improvement – March 2023

DQMI Item	% Compliance
Care Professional Service	94.7%
Ethnicity Category Code	92.9%
Primary reason for Referral	91.0%
Referral Closure Reason	90.6%
Indirect Contact time (hour)	89.4%
Ex British Armed Forces	86.0%



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.

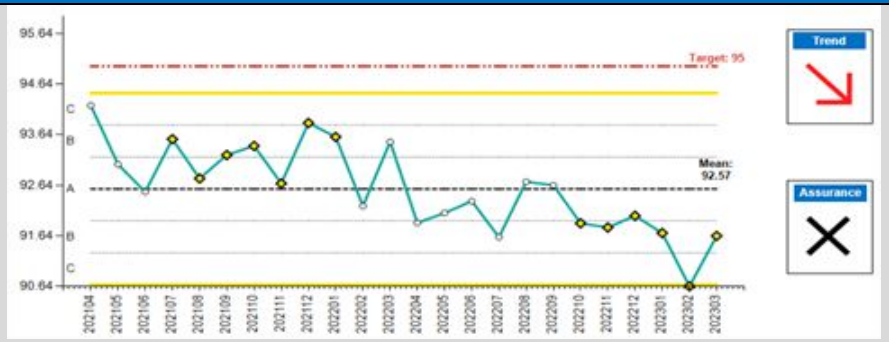
Underlying issues
- Trust consistently benchmarks well on this indicator when compared to other mental health Trusts.
- A small number of measures on the DQMI need improvement – these are listed in the summary table i.e. Ethnicity Category Code and Ex British Armed Forces.
- Lack of oversight at service 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 – March 2023

CPA	94.1%
Non-CPA	91.3%

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

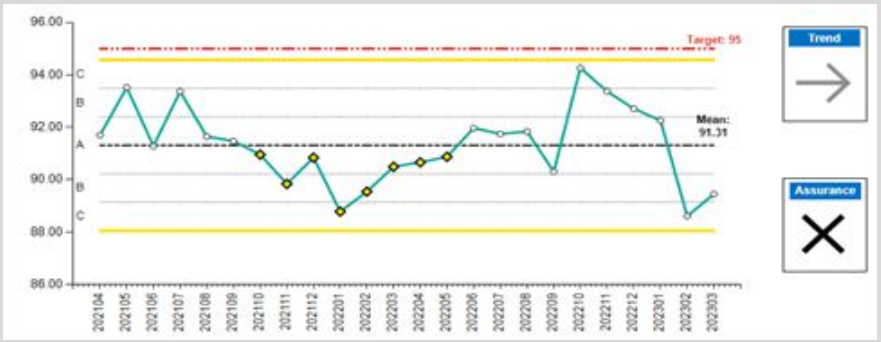
What the chart tells us
- Target is in line with upper control limit suggesting it is unlikely that the target will be met without a change in process.

Underlying issue
- Risk assessments are reviewed following a meaningful clinical contact and so this target is harder to achieve for the non-CPA cohort of patients who are seen infrequently and mainly by medical staff.
- In Community service there a number of medical posts not filed by substantive staff. High staff turnover resulting in some new staff being unaware of risk recording processes.
- 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.
- Community service line (which has most risk assessment missing/out of date cases) audited breaches in March 2023. The vast majority of such cases (87%) did have a risk assessment in place.
- 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.
- 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.
- Deputy Heads of Service Delivery and Service Improvement Lead are working to develop a single induction check list for new staff which include risk documentation completion.

Fundamental Standards of Care

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



Compliance by Service Type – March 2023

Event Type	RAin48HRs	Admissions/ Assessment	% RAin48Hrs
Admission	115	132	87.1%
HTT Assessment	236	251	94.0%
Liaison Asssessment	579	681	85.0%
Lotus assessment	109	109	100.0%
Grand Total	1,039	1,173	88.6%

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.

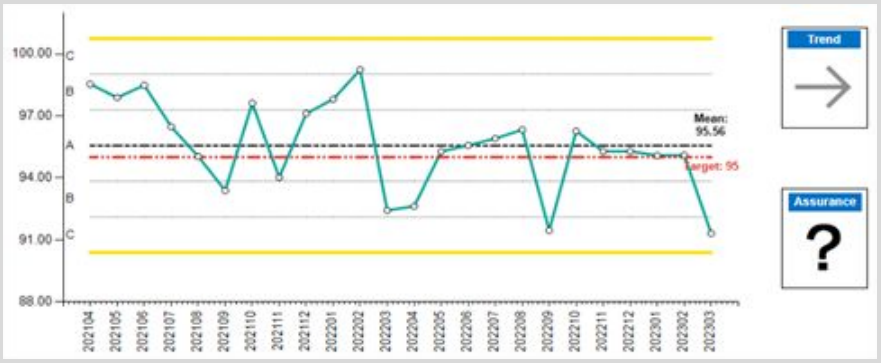
What the chart tells us
Downward (negative) trend in performance; target (which is above upper control limit) will not be met under current process.

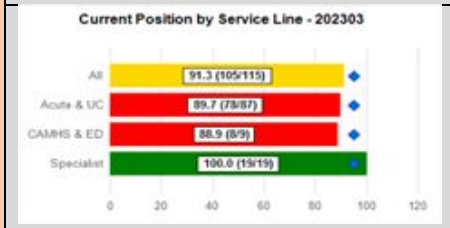
Underlying Issues
- Risk assessments have been a priority focus for our clinical services, as part of the Fundamental Standards of Care, which is being monitored through the quality plan, there has been an improvement in the quality of the risk assessment.
- Impact of move to Trinity Building has impacted some ward areas and also affected monitoring/oversight from Matrons and Clinical Service leads.
- Liaison Psychiatry: monthly audits from Kingston and St George's show that proportion of breaches relate to triage patients. The inclusion of risk assessment cases who are only triaged is subject to review by the Trust.

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.
- Liaison triage contacts inclusion to be reviewed with Performance & Information Team.
- Improvement plans in place for Lilacs and Lavender and Ward 1 & Jupiter being supported on a weekly basis to review their KPI's.
- Audits to be undertaken across all liaison services.

Fundamental Standards of Care

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





March 2023 (Underperforming wards)

Team	PHA Attempted Within 48 Hours	Admissions	% PHA Attempted Within 48 Hours
Rose	14	15	93.3%
Aquarius	5	6	83.3%
Lavender	9	11	81.8%
Ward Two	13	16	81.3%
Jupiter Ward	4	5	80.0%
Lilacs	7	9	77.8%

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.

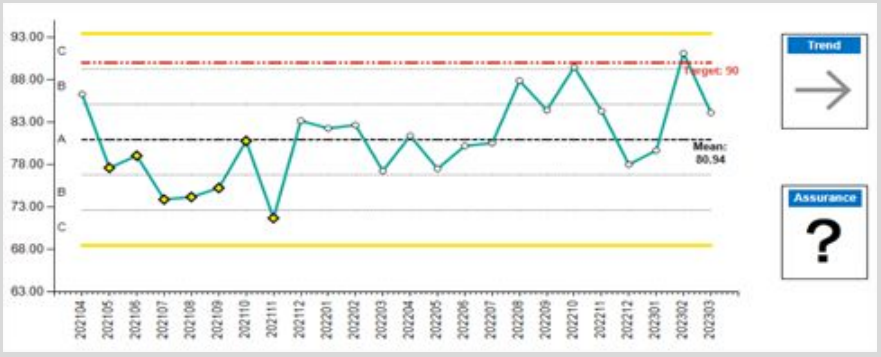
What the chart tells us
Historic under performance followed by recent sustained improvement above target.

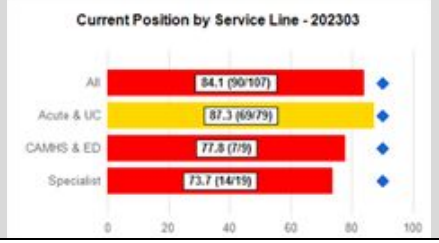
Underlying issue
- Consistent under performance linked to an inadequate configuration of the clinical IT system to support workflows and a need to improve daily ward processes to ensure assessments are consistently completed.
- There are times where some wards have limited medical cover, and this can 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%





March 2023 (Underperforming wards)

Team	PHA Completed Within 7 Days	Admissions	% PHA Completed Within 7 Days
Lavender	7	8	87.5%
Laurel	6	7	85.7%
Rose	11	13	84.6%
Jasmine Ward	5	6	83.3%
Ward Two	13	16	81.3%
Seacole (OCD/EDD)	3	4	75.0%
Crocus	3	4	75.0%
Ellis	8	11	72.7%
Aquarius	4	6	66.7%
Bluebell Old Church	2	3	66.7%
Halswell	0	1	0.0%

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

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

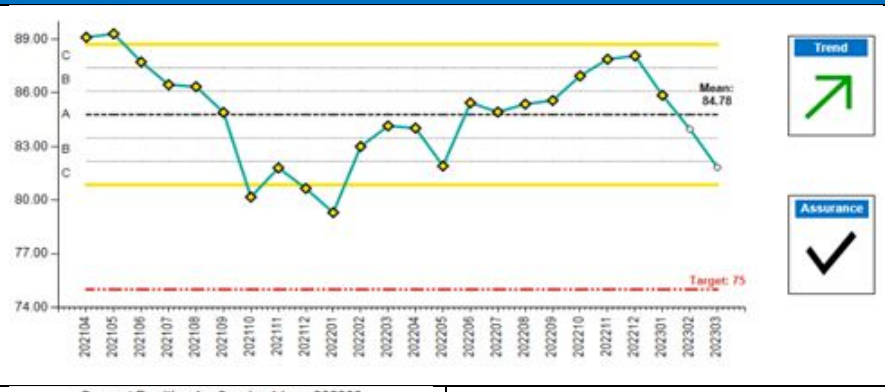
Underlying issue
- Consistent under performance linked to an inadequate configuration of the clinical IT system to support workflows and a need to improve daily ward processes such as handover to ensure assessments are consistently completed.
- A high number of patients initially refusing to undertake physical health checks (related to acuity) within the acute service line; medical staff are then reattempting the assessments and not recording the results in the appropriate measurable form, preferring to record in patient notes.
- Target met for first time over the reporting period the challenge is to maintain this over sustained period.

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

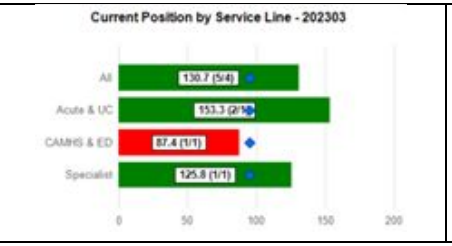
Underlying issue
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised. Trust clinical systems do not support workflow and performance is expected to dip in Q3 when annual re-reviews are required. Some 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.

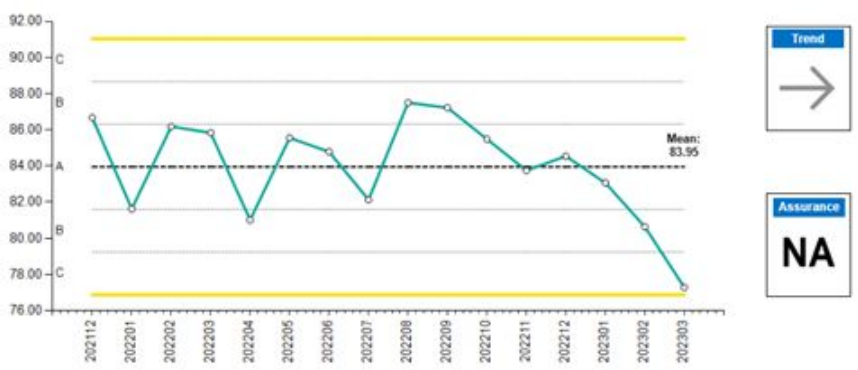
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.
- All wards were safely staffed in Specialist services.
- Downturn for CAMHS & ED service line linked to closure of Corner House there were no staffing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

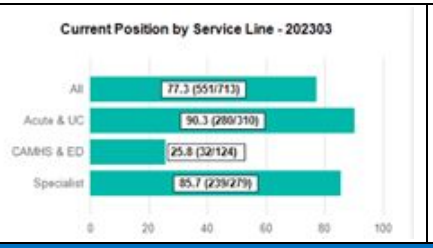
Actions
- Acute & Urgent Care: Focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.

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.

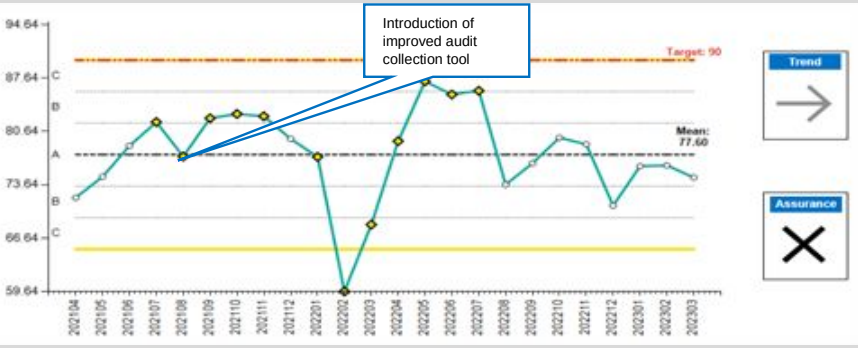
Underlying issue
- In Acute & Urgent care services all wards were safely staffed. Additional staff are required to manage to manage acuity/observations.

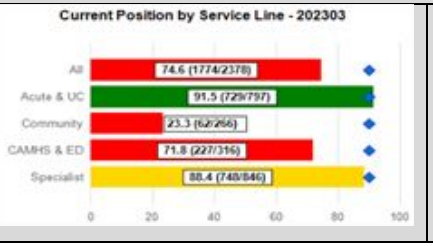
Actions
- Acute & Urgent Care: Focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.
- Training has been provided for Ward Managers & Team Leaders on the Fundamental Standards of Care Dashboard.
- Daily 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.
- Meeting with nominated ward lead to start planning the QI project on Therapeutic observation with an improvement trajectory to be provided in the next 2 months.

Fundamental Standards of Care

Always Ready Audits Completed (%)

Target ≥ 90%





Audit Volumes by Service Line:

Service Line	Audit Required	Audits Completed	% Audits Completed
Acute & Urgent Care	797	731	91.5%
Community	266	62	23.3%
CAMHS & ED	316	231	73.8%
Specialist	865	758	87.6%
Other	153	8	5.2%
Trust Total	2397	1790	74.4%

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.

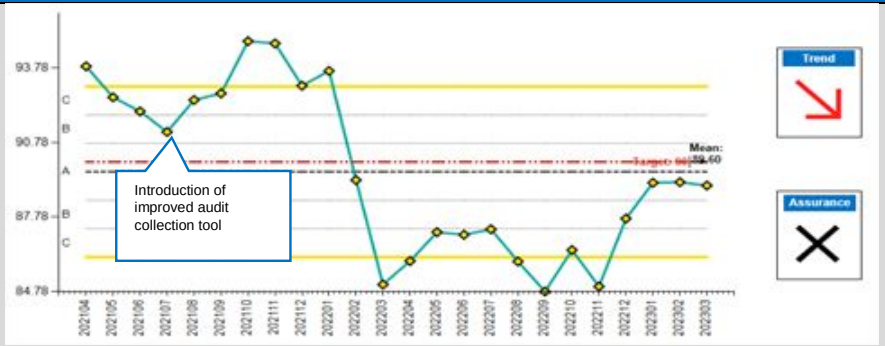
Underlying issue
- The Always Ready application improved and implemented in June 2021 before some staff had received training and a period of familiarisation.
- Some teams have required support and training with understanding and using the Always Ready Audit application and dashboard.
- Always Ready 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.
- A small number of teams are inaccurately required to undertake audits (i.e. on caseload audit); there have also been audit access issues. Service lines have raised with Applications and Development.

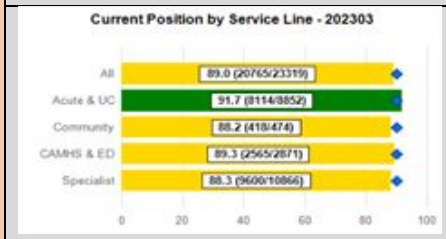
Action
- Service lines to agree the audit cycle (action plan template) in order to provide a standard feedback process for teams to review actions.
- In Acute & Urgent care Service Line dashboard training has been provided via Performance & Information Team.
- The acute service line carryout formal weekly 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
TMP Inpatient Audit	88.6%
Mental Healthn Crisis Line - Triage Audit	87.3%
Safety in Motion Audit	85.2%
Case Note Audit - Community	75.2%
Ward IT Equipment	75.2%
Flushing Audit	74.6%

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:

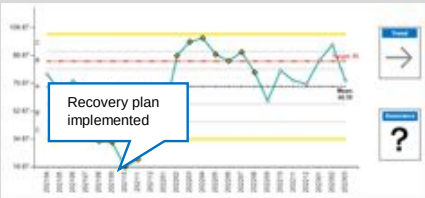
- Additional information of the quality of audits, themes and risks and any outlying areas will be provided next month.
- Always Ready dashboard has been developed to assist completion and improve performance. A Training video for use of new Always Ready Dashboard is also available on My Dashboards.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

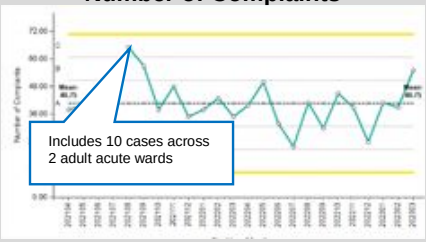
Complaints answered within 25 days (%)

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 March 72.4% of (21 out of 29) 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.
- Community Service Line: Patient Experience Action group is in place to review and complete all complaint actions within each Borough, gradual improvement seen over past 3 months.

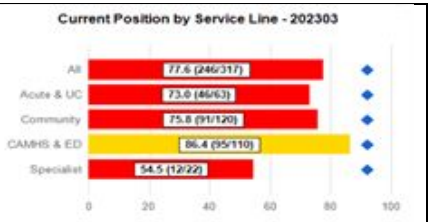
Themes and Learning:

- Acute & Urgent Care: Family and carers communication remains a theme – relaunch of Triangle of Care.
- Inadequate Support and Access to services are the top reported complaints this month. Acute & urgent Care: Poor communication with family and carer has been raised as a theme.
- Community Service Line: The Community Clinical Safety Group reviews complaint themes and identifies wider learning. This month theme focused on values and behaviours.

Patient Experience and Outcomes

Patient Friends and Family Test (%)

Target ≥ 92%



Background

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed.

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 and staff not actively seeking feedback.
- 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, home treatment and Mental Health Crisis hub.

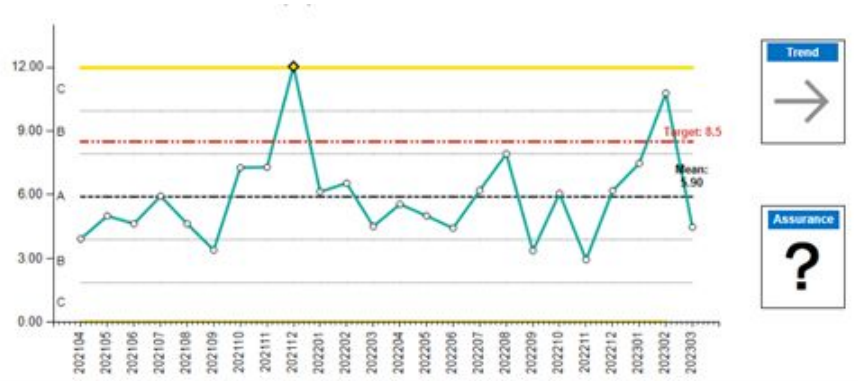
Actions:

- The longstanding issues with the FBL system (first question is the FFT) have now been resolved and in final testing and there will be a major re-launch throughout April 23.
- Community Service Line: Promoting use of the FBL QR code for service users and carers (FBL first question is the FFT).
- Governance Leads attending Community QGG to relaunch FFT.
- Head of Service Delivery met with Associate Director of Quality and Governance and agreed plan to help support with increasing feedback. There is now specific focus on certain teams within each borough.

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

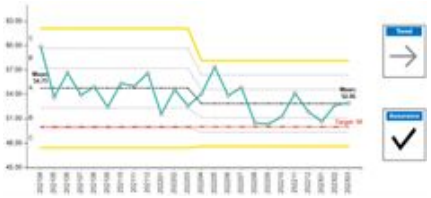
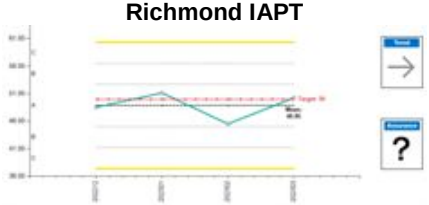
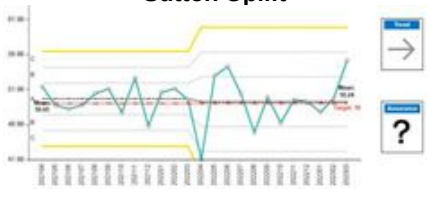
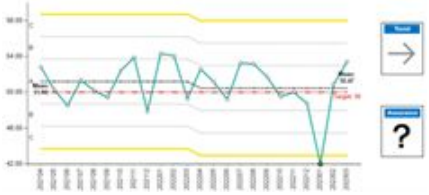
Mean position is below target indicating target will consistently be met but there will be occasional variation.

Underlying issue

- 5 emergency re-admissions reported in March 2023.

Actions

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

	IAPT recovery rate (%)		Target ≥ 50%
Patient Experience and Outcomes	**Talk Wandsworth** 	**Richmond IAPT** 	**Background** Improving Access to Psychological Therapies (IAPT) is an NHS programme in England that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety. **What the chart tells us** Merton is below stretch target in 2022/23 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 to implement recovery audits and training to be arranged with service. - 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.
	Sutton Uplift 	**Merton Uplift** 	

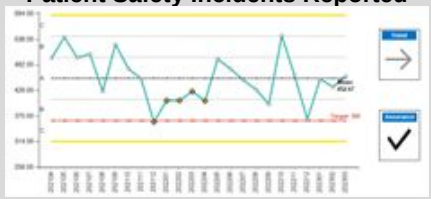
Patient Safety

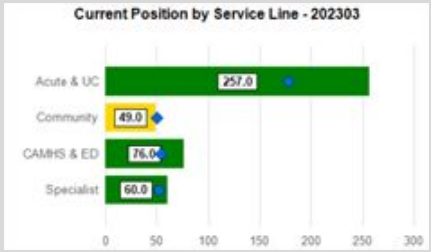
Patient safety incidents - Severe harm

Target ≤ 1.5%

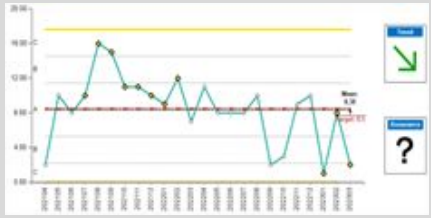
Patient Safety Incidents – Severe Harm

Patient Safety Incidents Reported

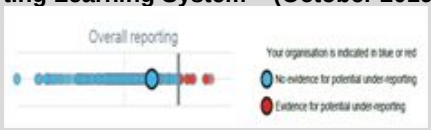




STEIS



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



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

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

Underlying Issue:
- In March 2023 there was 2 serious incidents where further Investigation/ Review has been requested to identify gaps in care and treatment. These include 1 Unexpected Death, and 1 Suspected Suicide.

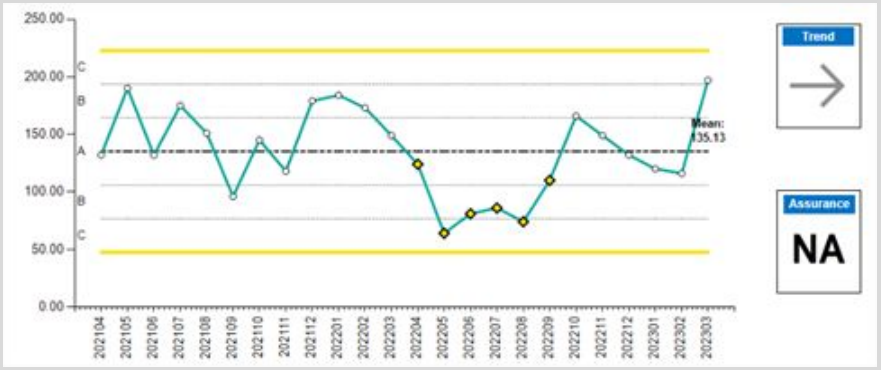
Actions:
- A reminder of importance of recording patient safety incidents on Ulysses has been issued to service lines. This impacts the PSIs being reported to the NRLS.
- **Community Service Line:** It is now possible to identify teams who have not reported any or below 5 incidents across 2022, these 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.
- The Trust is working towards the implementation of the Learning from Patient Safety Events (LFPSE) system as planned from 3rd April 2023. This system will replace the NRLS.

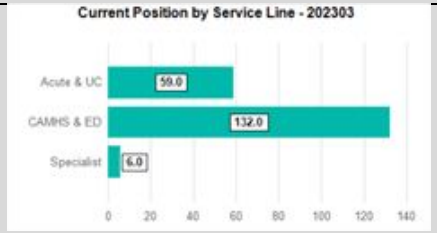
Themes & Learning:
- In March learning around communication with families, particularly when they raise concerns about a patient's presentation was identified.

Total number of restraints (physical restraints and rapid tranquilisation)

No Target

Patient Safety





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.

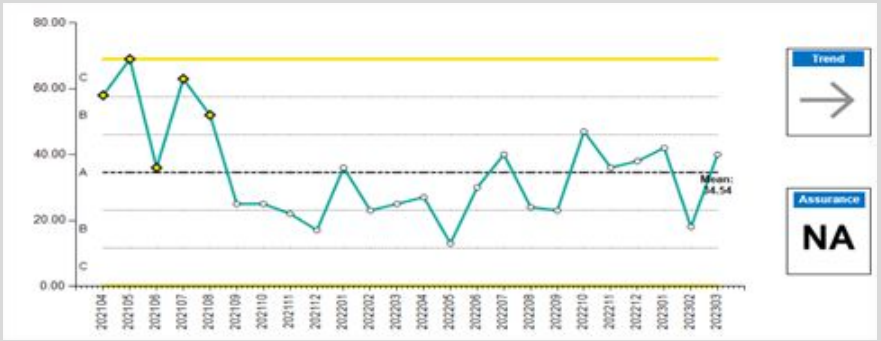
Actions
- Acute: The updated rapid tranquilisation policy has been circulated and discussed with the teams
- Restrictive Practice Groups review data to understand issues and inform learning.
- Acute: Safety in Motion Interventions have been reintroduced and discussed with teams.

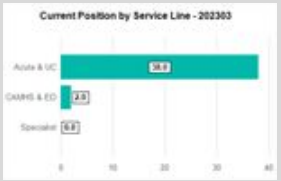
Themes and Learning:
- **Acute and Urgent Care:** The main for physical restraint continue to be administration of medication followed by harm to others and self.

Reducing restrictive practices - Prone restraint

No Target

Patient Safety

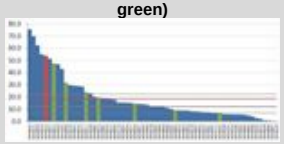




Number of Clients Prone Restrained – March 2023

Measure	Total
Number of Prone Restraints	40
Number of patients restrained more than once	8
Highest number of prone restraints	12

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.

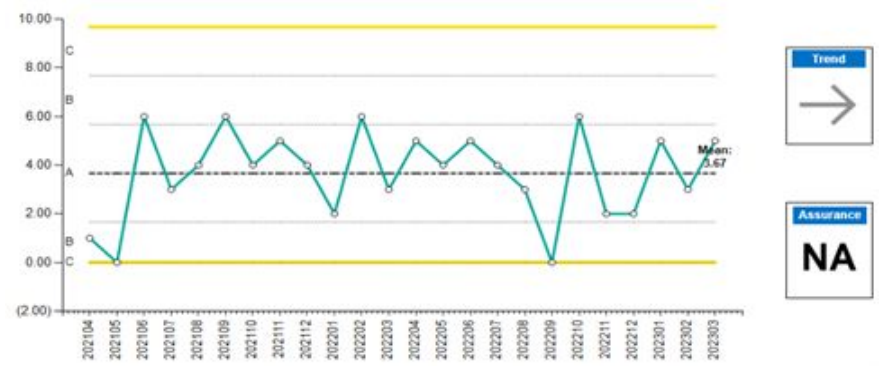
Actions:
- The deltoid technique is used where possible and prone restraint is used as a last resort.
- Staff are debriefed following an incident to review how the incident was managed and any alternative practices that should/could have been considered.
- The use of prone restraints is monitored monthly 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.
- Safety pod will be tested on Ward 1 for a month with a view to reduce use of prone restraint. Feedback for both patients and staff on use will also be sought.

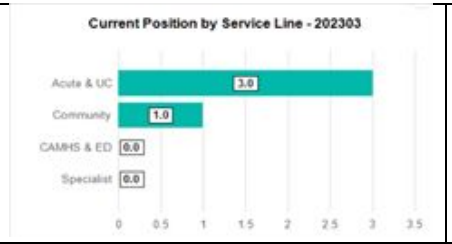
Themes and Learning:
- **Acute:** The use of restraint and rapid tranquilisation fluctuates month on month, the service line to continue the appropriate monitoring of the understanding of the reporting processed with respect to the RiO Restrictive Practice monitoring form and the Ulysses incident form.

Patient Safety

Death - Suspected suicide

No Target





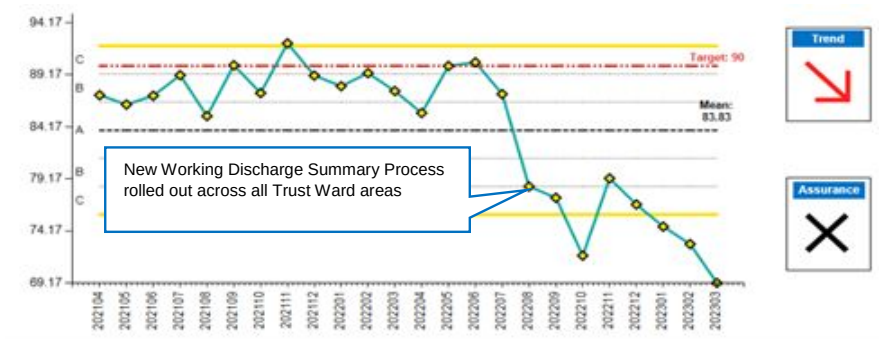
What the chart tells us
The number of suicides each month is subject to variation. Numbers reported are low.

Underlying Issue:
- There were five suspected suicides reported in March 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.
- Community Service Line: monitor deaths and SUI RCAs through the clinical safety group in the service line and continue to review SI's within local Quality Matters meeting.
- As part of the Trustwide Suicide Prevention and Community Quality Plan develop any learning and development into practice.

Inpatient discharge letters sent within 24 hours (%)

Target ≥ 90%



Letters sent within 24 hours – March

Compliant	Total Letters	%
83	120	69.2%

8 / 19 wards were 100% compliant

Letters sent within 7 days – March

Compliant	Total Letters	%
109	120	90.8%

14 / 19 wards were 100% compliant

Background
Discharge summaries are an important part of patient care and medical communication. It is an NHS requirement that GPs receive an electronic discharge letter within 24 hours of discharge.

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

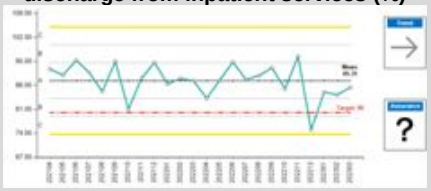
Underlying issue
- The administrative process is now more efficient, but this has exposed an underlying compliance issue with wards not completing the discharge in RiO and submitting the working discharge summary form within 24 hours.
- Need for a more streamlined discharge process in Rio to be explored via Clinical systems project.

Action:
- Plan in place to in order to amend Rio Working Discharge Summary Form in order to allow medical pre-sign off of discharge summary. This work will be prioritised by Applications Development and supported by transformation team.
- In line with 100 Day Challenge (Workstream 3): a working discharge document is being created to focus on step by step process of ensuring discharge plan is discussed early in episode to prevent delay and process will incorporate submission of discharge summary within 24 hours of discharge.
- Automated ward email alert generated so ward staff are made aware that the discharge has been progressed and the discharge summary finalised and transmitted.
- Working Discharge Summary status will be displayed (via dashboard) to ward team in real time.
- Training Induction for Junior Dr's has been reviewed and incorporates recent changes to discharge process in RiO.
- A new SOP and process for discharge, including the summary and its transmission, is being crafted as part of the acute transformation programme. This will include streamlining steps and extending the staff groups who can complete the process.

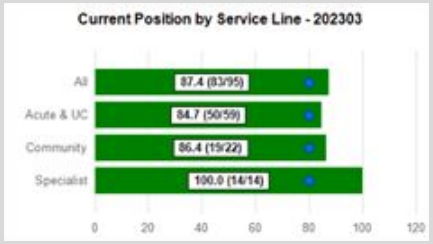
Patient Safety

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

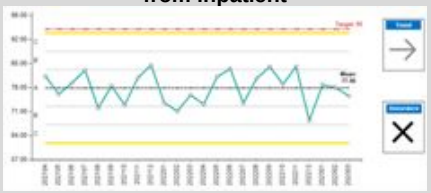
Discharge follow up within 72 hours of discharge from inpatient services (%)

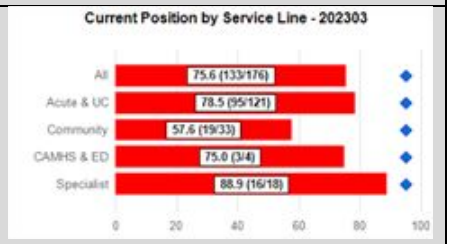


The Trust remains a high performer against the national 72 hour target of 80%.



Follow up within 48 Hours of discharge from inpatient





Follow-up summary including attempts – March 2023

48 hour follow up performance by service type – March 2023

Responsible Team Type	48 Hrs Seen	Discharges	%
Community	29	32	90.6%
Crocus	1	1	100.0%
HTT	31	31	100.0%
Ward	22	31	71.0%
Total	**83**	**95**	**87.4%**

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.
- By end of May 2023 all Acute and Urgent Care wards should have the inpatient caseload dashboard screens on display in nursing stations which provide visual reminder in real time on clients that require follow up.

48 Hour Follow Up:

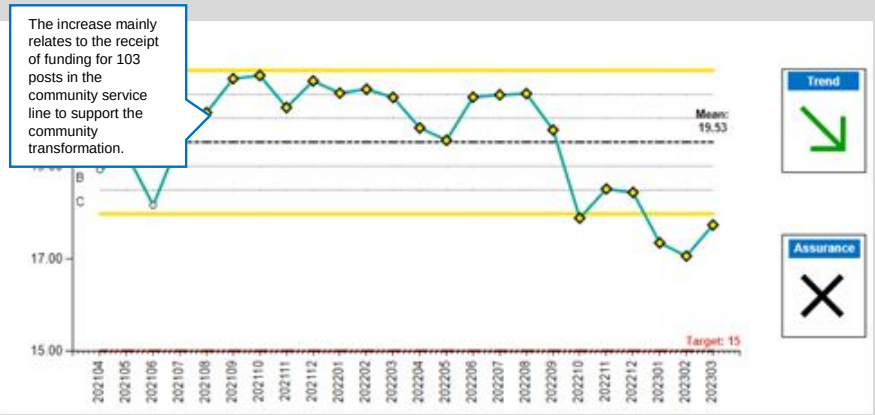
- High sickness and vacancy rate has meant reliance at times on agency staff who are less familiar with follow up processes.
- The Trust has a 48 follow up process in place in order to ensure clients are seen in a timely fashion post discharge.
- Whilst patients may not be seen, the Trust has assurance that attempts were made (see table) to contact. In March 2023 attempts to contact within 48 hours was at 90%.
- **7 day follow Up:** - There were 11 breaches reported for March 2023 of which 9 were subsequently contacted. The two remaining clients have yet to be contacted by the responsible teams.

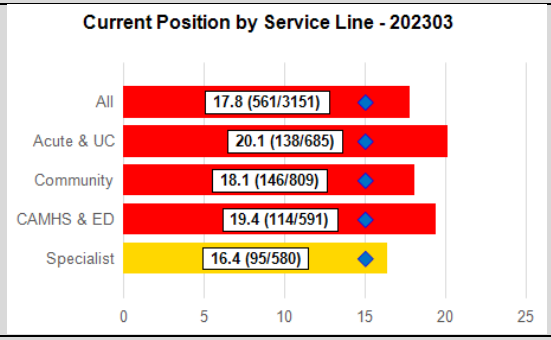
Workforce Domain

Recruitment / Attraction

Vacancy Rate (%)

Target ≤ 15%





Vacancies by Staff Group

Staff Group	Post Fte	Assign Fte	Vacant FTE	Vacancy Rate
Add Prof Scientific and Technic	475.1	397.8	77.4	16.3%
Additional Clinical Services	707	568.7	138.2	19.5%
Administrative and Clerical	647	564.3	82.6	12.8%
Allied Health Professionals	160.3	126.7	33.3	20.8%
Estates and Ancillary	35	33.9	1	2.9%
Healthcare Scientists	2	2	0	0.0%
Medical and Dental	239.5	209.7	29.6	12.4%
Nursing and Midwifery Registered	885.7	686.8	198.9	22.5%
Total	**3151.6**	**2589.9**	**561**	**17.8%**

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

Underlying issue:

- Each Service Line now has a designated People Delivery Partner with whom they are creating a workforce plan, and they will be working with the Head of Resourcing to ensure there is a continued focus on recruitment approaches.
- Community remains an area of challenge in terms of the level and extent of vacancies across all professions and are looking to create capacity within the team through the creation of new posts as part of transformation – this process will see a number of reconfigured posts. Specialist Services have managed to achieve success in recruiting with a vacancy rate of 14.6% and although several their roles are specialist which might be a reason for greater success as such roles are more in demand. The Trust are reviewing the success and will shared learning with other service lines.
- The Trust turnover has increased steadily over the last 2 years, which impacts on the vacancy rates, in addition to the newly created roles as in some months there are more staff leaving than being recruited. In March 2023 ELT received an outline of the work being undertaken over a 12 week period to target initiatives to improve this position.
- Continued review of the service lines establishments and their vacancies is required to ensure that we don't have inactive vacancies still listed, artificially pushing up the vacancy rate. HRBP's, Head of Resourcing and workforce information will meet with the services to review this.

Actions:

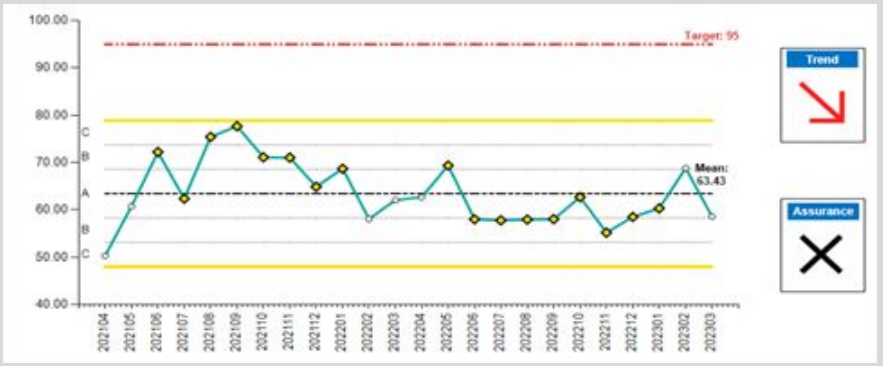
Community- there has been recent success in recruitment in Wandsworth and Sutton IAPT. Managers focussed on wellbeing conversations and staff development and current staff promote the teams as a good place to work in their network. Refreshed adverts for B7 roles with development to 8a to attract more Psychologists. Transformation: Review of core skill mix within the RSTs/CMHTs from band 5-7 as part of y2 programme.

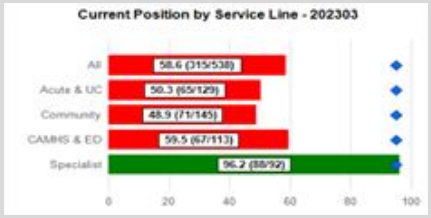
- A Trust wide mass recruitment day for permanent HCSW's posts is taking place on 28th April. Depending on the number of offers made, mass recruitment for this group may take place again in May to further close the vacancy gap for this staffing group.
- Direct Engagement recruitment days for NQN's are taking place throughout May. 116 NQN's have expressed an interest in joining the Trust as band 5 Staff Nurse. Total number of appointments will be known in early June.
- An attraction strategy for SWLSTG is required to understand current and future approaches in more detail; it is expected that this will be completed in Q1 of 2023/24.
- Work has commenced to look at career pathways for our hard to fill roles; to look at how we can make this more visible, where we lose colleagues on that journey and can ensure their career is visible and effective which will ultimately support retention of key skills.
- The Deputy Director of People is leading work on a workforce plan for SWLSTG, focussing on addressing the vacancy gaps both now and in the future, understanding potential growth or future skills required, and analysing current workforce trends.

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. 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 meetings in order to progress recruitment at the point of new role creation.
- AUC: Current vacancies for band 5 stand at 23, although there is a plan to have a rolling advert for AUC to carry out Mass recruitment this is currently on hold due to there are 49 nursing students who are due to qualified in September 2023 have expressed an interest to join AUC through Direct Employment. Therefore, the number of vacancies progressed to recruitment is less than what is actually happening, as these vacancies are held to NQN's.

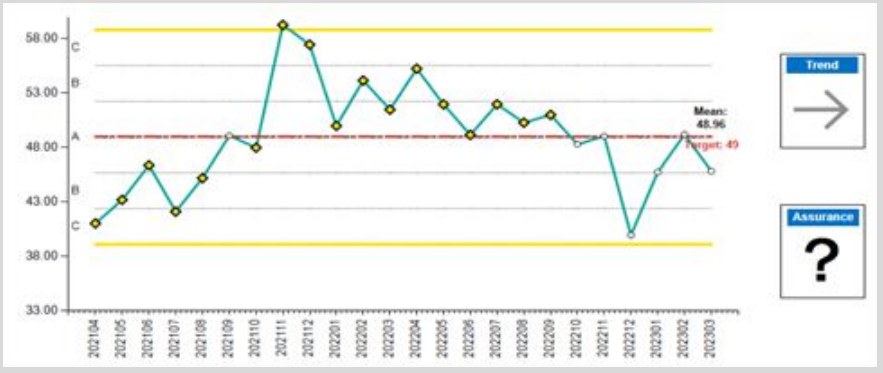
Action:

- People Delivery Partners and Head of Resourcing to focus on working with to ensure that our internal processes of linking posts to ads does not hinder us from being innovative and recruiting in a way that will meet our needs.
- Service lines/HR staff have access to detailed automated dashboards to identify data quality issues and performance. Data is now refreshed on as weekly basis.
- The recruitment pipeline reports are visible on Dashboards, 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



Directorate	Total Staff Recruited	T19 : Advertising start date to starting letter sent (Target:49) Denom	T19 : Advertising start date to starting letter sent (Target:49) Avg Wait (work days)	T01 : Duration of advertising (Target:14) Denom	T01 : Duration of advertising (Target:14) Avg Wait (work days)	T04a : Time to shortlist (Target:4) Denom	T04a : Time to shortlist (Target:4) Avg Wait (work days)	T05b : Time to update interview outcomes (Target:2) Denom	T05b : Time to update interview outcomes (Target:2) Avg Wait (work days)	T06 : Time to send conditional offer (Target:1) Denom	T06 : Time to send conditional offer (Target:1) Avg Wait (work days)	T11 : Conditional offer to Checks OK (Target:10) Denom	T11 : Conditional offer to Checks OK (Target:10) Avg Wait (work days)	T12 : Checks OK to starting letter sent (Target:2) Denom	T12 : Checks OK to starting letter sent (Target:2) Avg Wait (work days)	T26 : Starting letter sent to recruitment start date (No Target) Denom	T26 : Starting letter sent to recruitment start date (No Target) Avg Wait (work days)
Acute And Urgent Care	9	9	57.3	9	6.8	9	4.7	5	0.4	9	1.7	9	21.7	9	3.2	5	27.8
CAMHS & ED	13	13	27.3	11	6.0	9	12.0	6	2.7	13	0.3	13	19.4	13	0.2	12	25.2
Community (Adults)	29	28	55.3	24	9.8	28	8.1	26	3.3	29	1.0	29	24.2	28	1.5	28	23.9
Corporate	2	2	33.0	2	7.5	2	3.0	2	1.0	2	5.0	2	10.0	2	0.0	1	10.0
Specialist Services	2	2	94.5	2	9.0	2	10.0	2	22.5	2	1.0	2	10.5	2	0.0	2	20.5
Trust Total	52	51	45.7	45	8.2	47	8.9	41	3.7	52	1.0	52	20.5	51	1.3	48	23.1

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 in line with target indicating fairly frequent compliance but there will be occasional variation.

Underlying issues:

- The time to hire for specialist service is an outlier in March. Two internal candidates started in March, with significant delays from the hiring manager confirming the outcome to recruitment. In essence the internal candidate has been notified, but not recruitment. The time to hire for March for specialist services should be disregarded in terms of performance but highlights an issue with one hiring manager specifically.
- 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 that happen between a member of the recruitment team and the recruiting manager at the start of the campaign.
- 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.

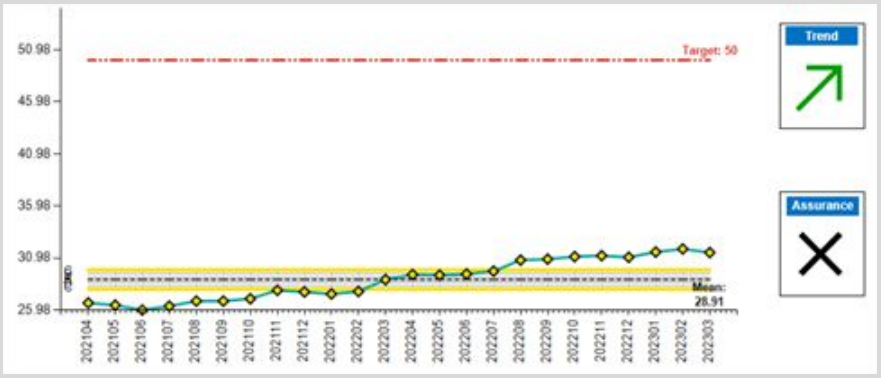
Actions:

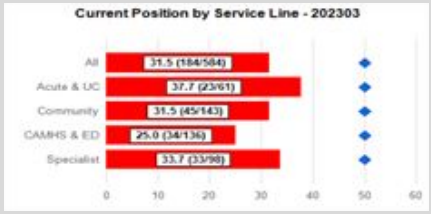
- Continued work on ensuring Commissioning Meetings are held with each recruiting manager which will map out the process and ensure key dates are agreed at the start.

Recruitment / Attraction

Percentage of BAME staff - Band 8+ and Medical

Target ≥ 50%





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

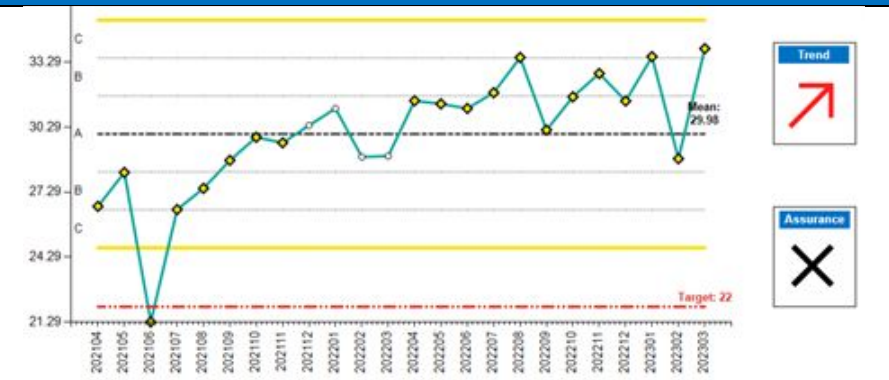
Underlying issues:
- The number of black, asian and minority ethnic colleagues being appointed at Band 8a is steadily increasing.
- The pace of change is slower than needed in order to meet target.

Actions:
- More work needs to be undertaken to understand where the blocks are in terms of our black, asian and ethnic minority staff progressing in the organisation. It is likely that this is at grades below 8a and the lack of career progression opportunities between bands 6-8a within certain clinical areas , which has been flagged as part of the workforce planning process. .
- Our anti racism programme has a workstream focussed on career development and has identified that a small pilot is required to understand what more can be done to enable greater career conversations and progression for colleagues keen to progress.
- 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.
- One-day workshop entitled 'Managing racism in the workplace' has been commissioned and will be delivered on 9th and 23rd May 2023.
- Community: New borough based band 7 inequalities leads to be recruited as part of transformation.
- Ensure all recruitments have a DIR rep on the panel. (Diversity in recruitment), especially for 8+ posts.
- CAMHS & ED: Service line has staff members on the HEE Ethnic Minority Psychological Professions Leadership Mentoring Scheme.

Recruitment / Attraction

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

Target ≤ 22%

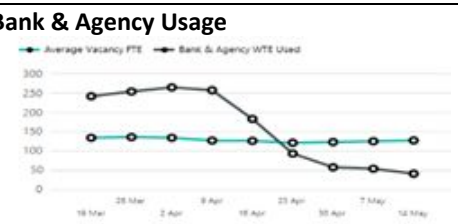


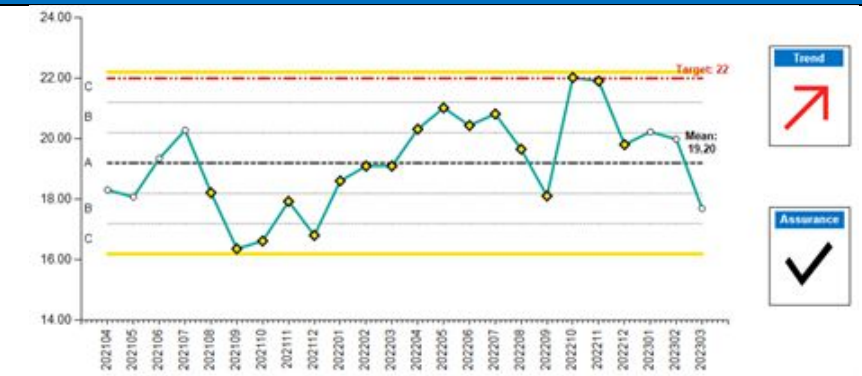
Background:
Trust analysis shows that agency staff often cost 25% more than those temporary staff source through the Trust bank. Based on its 2021/22 annual agency spend, the Trust could free up to £2.0m to reinvest in front line services or utilise to meet efficiency requirements by reducing reliance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

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

Underlying Issues:
- Agency spend is for mainly attributed to Medical, Nursing and Psychology expenditure.
- This % spending trend always happens during periods of reported high levels of unplanned absence, to cover vacancies and high levels of additional therapeutic observations for nursing due to the demand this activity places on Trust Bank. In addition to this, there is typically peaks in agency activity during months were there is a high annual leave take-up for example in March and August.

Actions:
- NHSE have published the latest Agency Guidance to outline steps NHS providers should take in order to meet the 3.7% agency target. An action plan is being drafted and People Delivery Partners will be working with Service Lines to implement, reporting into the People Committee and Finance Committee.
- 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. Robust governance by way of TWR and TWE forms required for each long-term agency worker have been put in place as part of the Recruitment Incident.
- A detailed plan in order to get each Service line to the targeted 3.5% agency spend will form part of the Workforce Planning process.



	Temporary staffing - Community Service Line (%)	Target ≤ 22%
Recruitment / Attraction		**Background:** Trust analysis shows that agency staff often cost 25% more than those temporary staff source through the Trust bank. Based on its 2021/22 annual agency spend, the Trust could free up to £2.0m to reinvest in front line services or utilise to meet efficiency requirements by reducing reliance on expensive external agencies. **What Chart Tells Us:** Mean performance is consistently below target but 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:** - NHSE have published the latest Agency Guidance to outline steps NHS providers should take in order to meet the 3.7% agency target. An action plan is being drafted and People Delivery Partners will be working with Service Lines to implement, reporting into the People Committee and Finance Committee. - Continued focus on BAU recruitment actions and capitalizing on Community Transformation recruitment campaign. - People Delivery Partner for Community now in place and working with the Head of Recruitment and the Service Line to ensure a more focussed approach in respect of how to reduce vacancies in Community. - Vacancy analysis by professional group and service with People Delivery Partner and HR Consultant to workout quick wins and a longer-term strategy.
	Bank & Agency Usage 	

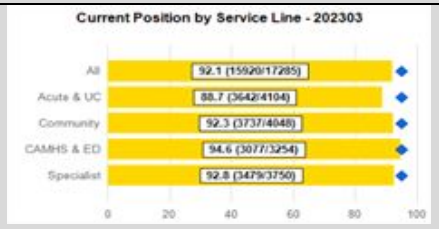
Statutory and Mandatory training 1 (%), Statutory and Mandatory training 2 (%) **Target ≥ 95%, Target ≥ 85%**

Staff Skills / Development

Statutory and Mandatory Training 1

Statutory and Mandatory Training 2

Current Position by Service Line - 202303



Current Position by Service Line - 202303

Training Compliance Projection – MAST 1

Certificate Name	Actual				Projection			
	Feb-23	Mar-23	Apr-23		May-23	Jun-23	Jul-23	
	%	%	%	Breaches	%	%	%	Breaches
Adult Basic Life Support (1 year)	81.1%	82.9%	82.6%	77	83.0%	78.1%	72.4%	122
FFP3 Mask Testing (2 Year)	54.5%	62.2%	62.1%	116	65.4%	63.4%	62.1%	116
Fire Safety Awareness (Community) (2	94.9%	93.9%	94.5%	74	89.8%	86.4%	82.7%	233
Fire Safety Awareness (Inpatient) (1 Year)	87.0%	87.3%	87.3%	83	81.1%	77.9%	69.6%	198
Fire Safety Awareness (Non-Clinical) (2	95.3%	95.3%	95.5%	33	91.8%	88.4%	85.5%	106
Infection Prevention and Control L1 (3	90.0%	90.6%	91.0%	44	90.8%	90.8%	90.6%	46
Infection Prevention and Control L2 (1 Year)	92.4%	92.7%	92.1%	179	83.0%	78.7%	70.3%	671
Information Governance (1 Year)	94.1%	93.9%	94.1%	161	87.4%	82.7%	76.8%	637
Medical Emergency Training (1 Year)	72.8%	70.0%	68.9%	76	66.0%	60.2%	57.4%	104
Medicines Management (Community) (2	89.6%	88.2%	88.1%	53	82.0%	78.4%	75.0%	111
Medicines Management (Inpatient) (2	90.9%	92.4%	92.5%	20	89.8%	86.4%	83.8%	43
Naso-gastric Intubation & Enteral Feeding	86.5%	84.6%	84.6%	4	84.6%	84.6%	84.6%	4
Proactive Physical Interventions (3 Years)	84.2%	83.2%	83.3%	88	84.8%	86.1%	85.9%	74
Safeguarding Adults Basic Awareness -	94.9%	95.4%	95.5%	124	94.1%	93.2%	92.0%	219
Safeguarding Adults Level 2 (3 Years)	89.5%	90.6%	91.1%	178	88.9%	87.2%	86.0%	281
Safeguarding Children and Young People	93.6%	93.3%	92.8%	41	87.7%	87.4%	85.4%	83
Safeguarding Children and Young People	83.6%	84.8%	84.4%	136	82.3%	81.6%	80.0%	174
Safeguarding Children and Young People	86.8%	86.6%	86.5%	151	88.5%	79.8%	75.2%	278
Safeguarding Children and Young People	70.0%	74.6%	74.6%	72	79.6%	79.6%	78.5%	61
All Certificates (95% Target)	89.5%	90.5%	90.5%	1710	87.0%	83.7%	80.3%	3561

Training Compliance Projection – MAST 2

Certificate Name	Actual				Projection			
	Feb-23	Mar-23	Apr-23		May-23	Jun-23	Jul-23	
	%	%	%	Breaches	%	%	%	Breaches
ABLS eLearning for Community and Allied	0.5%	1.3%	1.3%	622	1.9%	2.2%	2.4%	615
Advanced Patient Handling (2 Years)	76.0%	77.8%	78.4%	103	88.8%	88.2%	91.8%	91
Care Certificate	77.2%	75.0%	74.1%	82	75.0%	75.0%	75.0%	79
Conflict Resolution (3 Year)		71.6%						
Conflict Resolution and Breakaway (3	74.8%	76.7%	78.0%	366	79.2%	79.5%	78.5%	358
Equality and Diversity (3 Years)	95.9%	96.3%	96.1%	107	95.1%	94.4%	93.3%	183
Fire Safety (1 Year)		18.7%						
Food Hygiene Level 1 (3 Year)	97.1%	97.1%	97.1%	6	95.2%	93.8%	91.8%	17
Food Hygiene Level 2 (3 Year)	73.2%	76.5%	75.6%	38	73.7%	71.2%	69.2%	48
Food Hygiene Level 3 (3 Year)	100.0%	100.0%	66.7%	1	33.3%	33.3%	33.3%	2
Health and Safety General Awareness (3	95.9%	98.4%	96.0%	109	94.7%	93.7%	92.2%	214
Load Handling (2 Years)	81.4%	82.8%	81.9%	16	88.1%	73.8%	73.8%	11
Mental Health Law Training (3 Year)	84.7%	88.1%	88.3%	532	81.9%	84.1%	84.6%	269
National Early Warning Score (3 Years)	94.3%	95.2%	96.3%	20	94.6%	93.7%	92.6%	39
Observation and Intensive Engagement (3	97.1%	97.5%	97.7%	11	97.1%	95.7%	95.1%	24
Prescribers Medicines (2 Years)	61.0%	55.7%	53.4%	115	49.6%	48.2%	48.6%	132
PREVENT Basic Awareness - Level 1-2 (3	93.1%	93.6%	94.2%	42	94.2%	94.2%	94.2%	42
PREVENT Raising Awareness - Level 3-4	93.0%	93.7%	93.6%	128	92.8%	92.1%	91.5%	171
Rapid Tranquilisation (3 Years)	95.4%	96.1%	96.6%	19	95.9%	79.5%	77.7%	126
RATE Training (3 Year)	55.4%	57.9%	57.4%	583	59.5%	60.6%	59.6%	553
Resuscitation (1 Year)		65.8%						
Safeguarding Adults Level 3 (3 Years)		13.9%	15.2%	823	15.2%	15.2%	15.3%	823
Security Awareness (Forensic) (1 Year)	93.6%	92.9%	91.1%	15	84.0%	77.5%	71.6%	49
All Certificates (85% Target)	81.5%	75.3%	78.9%	3738	80.2%	79.4%	78.3%	3846

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

- The reasons for the compliance not being at the required level have been previously focussed on DNAs, and availability of courses.
- A more detailed piece of work by the Head of Learning & Development has established that the reasons potentially leading to a drop in compliance rates relate to the following challenges:
  - The system used to record MAST, Compass, requires a system upgrade and revised data to target MAST more effectively.
  - More availability for course booked over a longer period of time from the SMEs is needed.
  - Lack of dedicated admin support to manage bookings;
  - Governance of MAST programmes I.e. more added but not reviewed leading to increased courses required.
  - Capacity of service lines to release colleagues when vacancies are high in some areas; and availability of BSL interpreters.

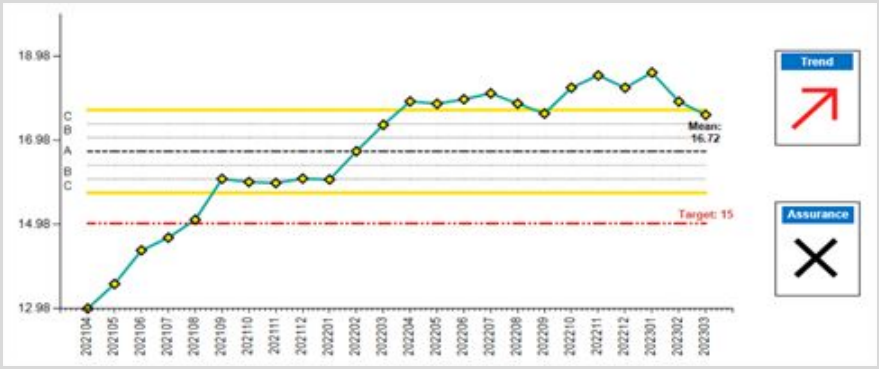
Actions

- The Director of People and Director of Nursing and Quality are receiving a weekly report on progress of the actions agreed to improve the position from the Head of Learning & Development.
- Service Lines asked to ensure there is a focussed approach to increasing their compliance rates. The Learning & Development Team have assigned one of the administrators to focus on this with each service line to ensure compliance rates improve.
- 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.
- 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.
- Annual PADR cycle set to commence in Q1 23/24 will also lead to improved compliance for staff as it's a PADR requirement.
- 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 – November 2022

Trust	Leavers	Turnover Rate
Tavistock and Portman NHS Foundation Trust	181	23.2%
Camden and Islington NHS Foundation Trust	440	19.0%
South West London and St George's Mental Health NHS Trust	479	18.5%
Central and North West London NHS Foundation Trust	1437	18.4%
West London NHS Trust	726	17.8%
Barnet, Enfield and Haringey Mental Health NHS Trust	586	17.2%
South London and Maudsley NHS Foundation Trust	912	16.8%
East London NHS Foundation Trust	1080	16.4%
Oxleas NHS Foundation Trust	632	15.5%
London Average		18.1%

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.

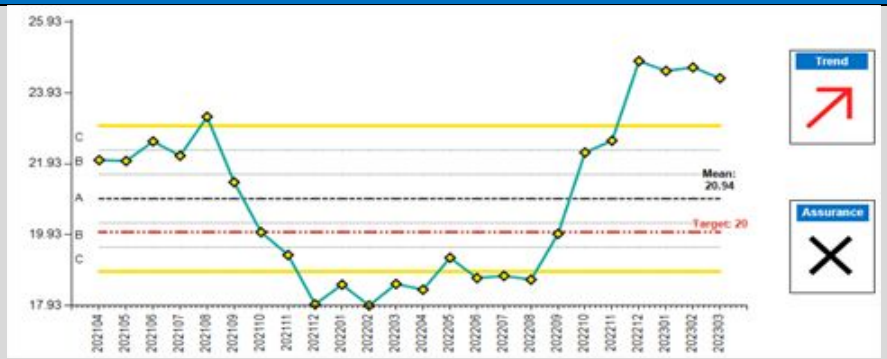
Underlying issue
- Turnover has steadily increased; likely impacted by the high vacancies in some teams and lack of career progression for those Additional Clinical Services Teams (unqualified Clinical roles), where staff are seeking opportunities outside of the organisation. this can particularly affect those with under 12 months if they arrive in a team with high vacancies and get enough support etc.
- Work to date has focussed on reviewing exit data only.

Actions:
- An outline proposal was shared with the ELT to undertake a focussed piece of work which has now commenced. The first step is to analysis the data more fully to understand the reasons for leaving, the hot spot areas; enabling a greater understand for all on what is driving this level of leavers and where they are going.
- A focus on this data is part of the Workforce planning process, involving a deep-dive into the reasons for people leaving in their first 12 months of service.
- It is also important to understand why colleagues stay and are we leveraging this enough in our communication, recruitment and engagement processes; and where retention is higher what can other services lines learn.
- Community Service Line: Listening sessions for all team, with closer involvement of PDP in high turnover areas and follow-up "you said, we did" communication.

Staff Retention/ Support / Satisfaction

Staff leaving within 12 months of appointment (%)

Target ≤ 20%



Background
Metric 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 was consistently above the target (poor performance) followed by period of improvement. Recent performance has shown an increase with last three months above target and upper control limit. A change in process is required.

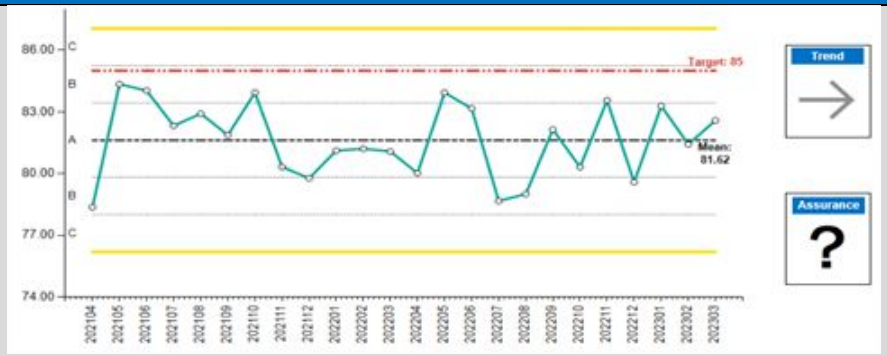
Underlying issue
- Community service line have experienced significant workforce challenges, over 50% of the 'leavers within 1 year of starting' were Psychological Well Practitioners working for IAPT teams left to progress their career.
- Historically the Acute service line has had high turnover as a 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:
- A focus on this data is part of the Workforce planning process, involving a deep-dive into the reasons for people leaving in their first 12 months of service.
- A 12 week Retention project will commence in April 2023 which will focus on the reasons people leave in order to stabilise the workforce.
- **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 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 – March 2023

Clinical Staff	83.4%
Non-Clinical Staff (inclusive of Corporate)	76.7%
Corporate Services	80.0%

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.

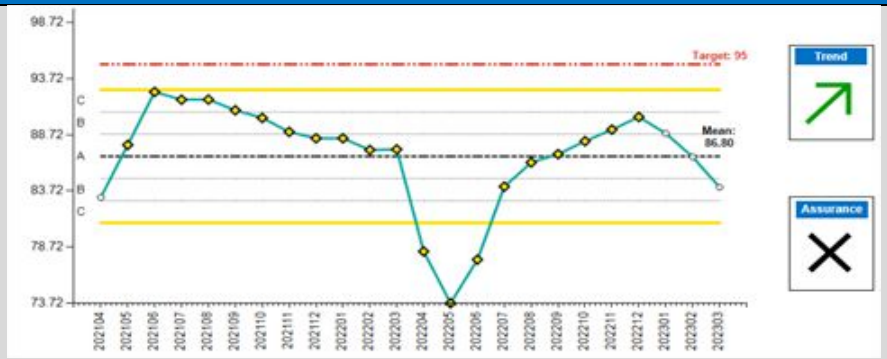
Underlying issue
- Trust is unable to consistently maintain performance on this metric.
- Supervision is below target overall for both clinical and non-clinical staff.
- Workload pressures, cancellations of meetings due to incidents on wards, high sickness levels in some areas (AUC) and high numbers 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 – March 2023

Clinical Staff	83.7%
Non-Clinical Staff (inclusive of Corporate)	86.4%
Corporate Services	88.1%

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 March and April 2023 as PADR's become out of date but an increase is normally seen in Q1.
- Incomplete paperwork on PADR can lead to delay in submission using our dashboard system.
- Performance was expected to deteriorate at year end and into early 23/24 as there was focussed work on the annual PADR completion in Q1 22/23. Performance is expected to improve by end of June 2023.

Actions
- 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 2023/24 as Trust managers are expected to complete in this period.
- In our Staff Survey 2022, some of our most improved questions are related to the appraisal process, however there is more to be done to ensure this is the experience for more staff and is included in our Staff Survey Recommendations for 2023/24.
- There will be focussed work on PADR compliance throughout Q1 23/24.

Staff Retention/ Support / Satisfaction

Active ER cases

Target TBA

Case Type Breakdown

Case Type	Employee Relation Cases	%
Dismissal Appeal	1	1.6%
Disciplinary	6	9.7%
Grievance	10	16.1%
Capability	0	0.0%
Probation	1	1.6%
Bullying & Harassment	1	1.6%
Capability/Performance	0	0.0%
Whistleblowing	1	1.6%
Sickness Absence	42	67.7%
Total	62	
Employment Tribunal	14	

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

Factors Affecting Employee Relations Cases:
- At the end of March 2023, the ER team had 62 open cases.
- Attendance management account for the greater proportion of cases.
- There were 14 Employment Tribunal cases and over the month of March this reduced down to 10 ET cases

Actions:
- The ER team are reviewing cases on a weekly basis to update the case entries, contacting managers to update attendance case entries and to examine cases which have reached a resolution and can be closed.
- Grievance cases are being reviewed for key lessons learnt.
- AUC establishing robust reporting framework with the new assigned line manager and Human Resources Business Partner (HRBP).
- AUC working with HRBP to access training related to ER to prevent risk of claims.
- AUC – training for band 6 who has responsibility in recording managing sickness with Band 7 TM at ER clinics.
- Specialist Services CSM's and HRBP review their cases monthly and closed 3 cases at their case meeting on 17th April reducing ER cases from 17 to 14.

Staff Retention/ Support / Satisfaction

ER Cases exceeding 90 days

Target TBA

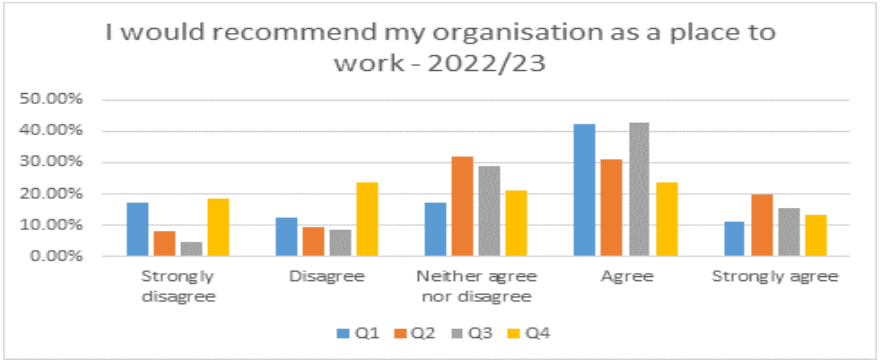
What Chart Tells Us:
Low level variation with numbers over 90 days aligned to mean of 28 per month.

Underlying Issues:
- Current ER cases over 90 days are 32 which are being proactively managed.
- The majority of the ER cases are related to absence management and where colleagues are in stage 2 attendance management and receiving a treatment plan or recovering from surgery, it is likely that the recovery period will extend beyond a 90 day time frame.
- Weekly review of cases by the ER team and follow up contact with managers.

Actions:
- An additional appointment to the ER team has been made at the end of March to support managers with their cases.
- The trends associated with ER queries are being analysed to see how these can be responded to more effectively and by the appropriate member of staff in HR.
- The stability of the ER team is key and recruitment to vacant posts is a priority as is consideration of our future model for ER.

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 seeing the % of people agreeing and strongly agreeing declining in each quarter.
- This question was also one that decreased between 2021 and 2022 staff survey results.
- Staff don't feel valued and recognised (2022 Staff Survey Results)

Actions:

- Part of work to be done with the 2022 staff survey results where we will explore why people don't want to recommend the organisation as place to work in
- Our People Programme priorities will allow us to use this data to further understand how we can encourage staff to become advocates of the services they provide to service users.

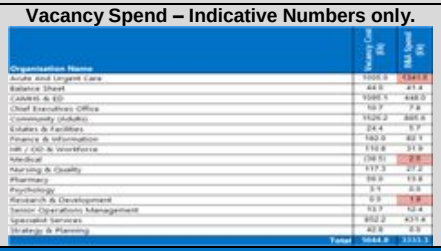
Finance Domain

Agency spend as % to NHI target

Target TBA

Grip & Control

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



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.

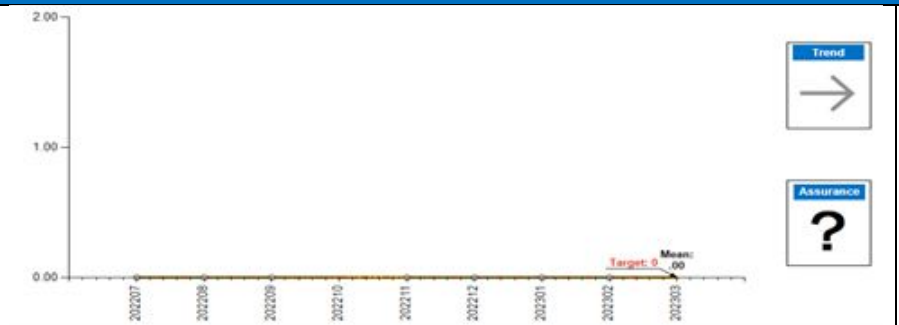
Underlying issues:
- Total Agency Spend was £12.3m which is £2.4m above target.
- Reduction in March 2023 the result of release of balance sheet.
- Agency equated to 6.4% of total spend, NHSE target = 3.6%
- 54% total expenditure within Community Service Line.
- Financial incentives and flexibility afforded by agency working remain key barriers to transitioning staff to bank or permanent contracts.

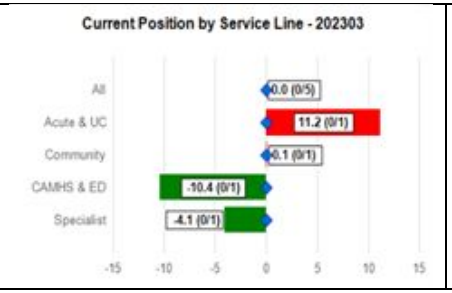
Actions:
- The reduction in agency expenditure remains a Trust priority with Service Lines asked to identify exit strategies for all agency staff.
- Weekly monitoring of wte to ELT; trend report of reasons also requested.
- Annual plan reduces agency to 3.7% of pay spend in M12, this is highly ambitious, pre covid levels were 5.5%.
- The challenge was discussed at ELT 20th April and actions agreed to gain firmer control of agency spend (reviewing process to NHSE requirements and adjusting as required and formalizing break glass process) and ensure workforce plans are finalised and incorporate the need to reduce agency.

% Forecast budget overspend

Target TBC

Grip & Control





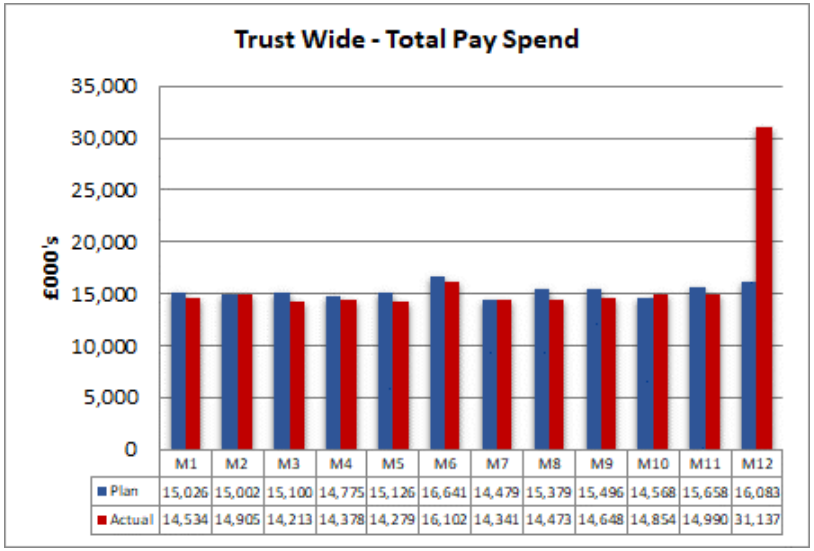
What Chart Tell us:
The chart indicates that Trust forecast is currently at break-even position.

Underlying Issues:
- Trust: The Trust achieved beak-even in line with plan for 22-23 before technical adjustments for impairments etc. Underlying issues remain over reliance on non recurrent savings, high agency usage, high external bed usage.

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. Out of area bed placements which are unfunded aside from the acute bed contract with Holybourne and a Trust wide approach being adopted to reduce demand for beds.
- Workforce plans being finalised to address agency, along with increased control mechanism.
- CIP plans being finalised for all services.

Grip & Control

Pay Cost Vs Budget



	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	14,479	15,379	15,496	14,568	15,658	16,083
Actual	14,534	14,905	14,213	14,378	14,279	16,102	14,341	14,473	14,648	14,854	14,990	31,137

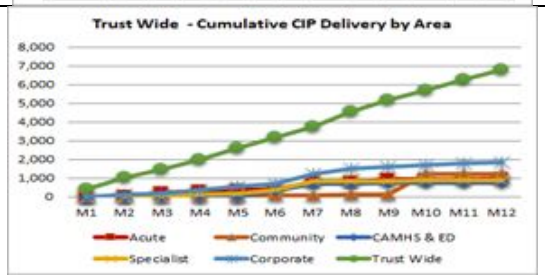
What the chart tells us:
Total Pay Spend in the Trust has consistently been below plan; however there has been a significant increase in March 2023.

Underlying Issues:
- An underspend is due to vacancies across the service lines.
- Spike in month 12 primarily caused by central superannuation adjustment (£7.0m) and provision for non-consolidated pay awards.
- Acute and Urgent Care: Overspend is mainly due to staffing.
- CAMHS & Eating Disorders: Increase in month 12 the result of accruals against additional monies received in month 12.
- Bank – 12/.2 and agency 6.4% of total pay bill. Trust is an outlier across London in terms of agency and bank usage.

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.
- Acute and Urgent Care: Review of impact on service delivery from safety perspective if agency that cannot be converted is removed from service line.
- 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.

Grip & Control

Cumulative CIP Delivery — No Target



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

Underlying Issues:
- The Trust delivered £0.1m more savings in 2022/23 than plan, however c70% of savings delivered were non-recurrent (nationally reported averages of c50%)
- CIP 2023/24 target is £13m, with 34% recurrent. Plan is due to be resubmitted and latest recurrent delivery estimated at c60%.
- Challenge remains to deliver against the new year plan and reduce reliance on non-recurrent schemes.
- If the plan is delivered the Trust will therefore not resolve the full underlying deficit in year and will go into 2024/25 with another challenging efficiency target.
- Both Clinical and Corporate service lines have a total target of 3.5% of budget, there are variations by service line within this.
- Weekly updates on the CIP plan are now required by the ICB

Actions:
- Revised plan to be approved for national submission 4th May 2023.
- Weekly CIP tracking to recommence.
- Paperwork for CIP schemes to be finalised
- Targets by service line to be input into budgets.

Productivity

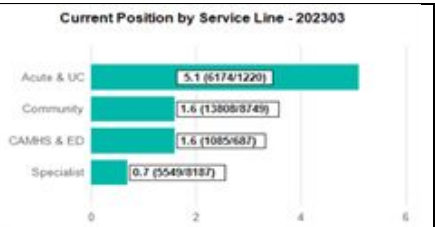
Activity vs Caseload (%)

No Target

Trend

Assurance

NA



What Chart Tells Us
There has low level of variation around the mean of 1.4.

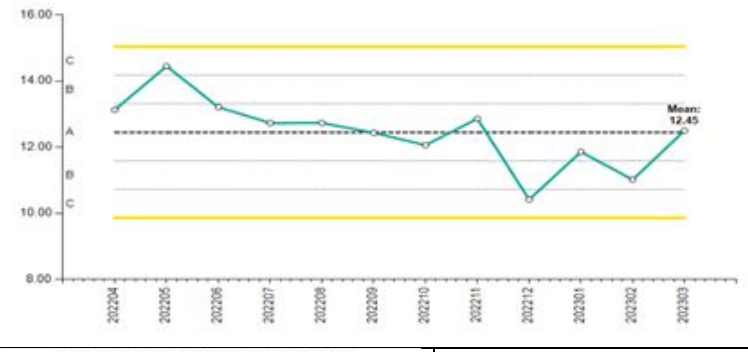
Underlying Issue
- New productivity measures have been introduced to reporting in September 2022.
- Variation in performance within services and poor administration leading to appointments not being booked or outcomed.
- Community: Complex clinical work requiring significant non patient facing care planning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

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.
- Community CAMHS services are now incorporated in reporting.

Productivity

Activity vs WTE

No Target



Trend

Assurance

NA

What Chart Tells:
There has low level of variation around the mean of 12.5.

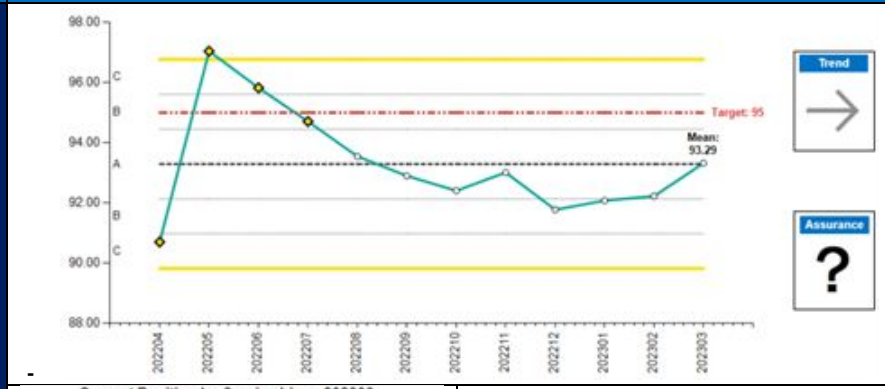
Underlying Issue
- New productivity measures have been introduced to reporting in September 2022.
- Variation in performance within services and in some area poor administration leading to appointments not being outcomed.
- New metric for service lines, there will be a period of adjustment as services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

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.
- Community CAMHS services are now incorporated in reporting.

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:

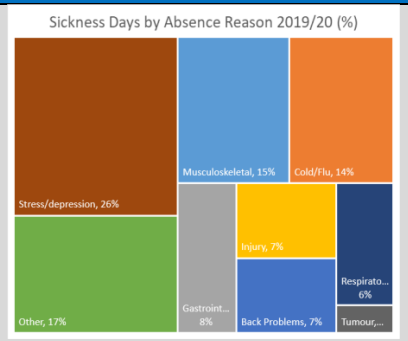
- Contracted activity reports to be issued to services pre submission to commissioner in order enable greater oversight on reporting.
- Productivity metrics are reviewed at the monthly Flow Meeting with greater emphasis on local contract performance in recent months.
- Reports to support service lines 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.
- Trust is currently finalising local activity plans for 23/24.

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.

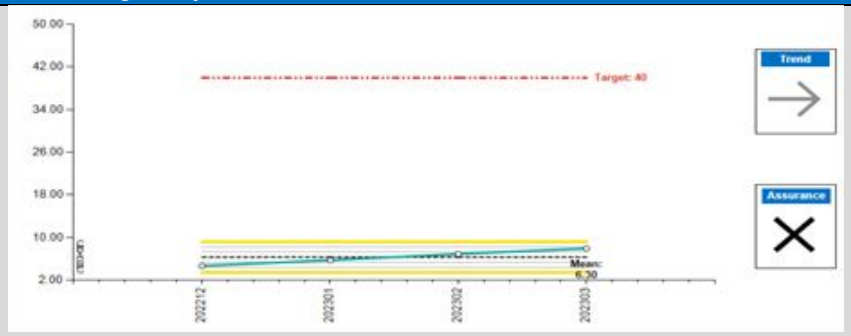
Underlying issue
- The spike in January 2021 relates to COVID and the effects on staff of the vaccine. For example, in Acute and Urgent Care there were 180 episodes of short term sickness, an increase of 16 from the previous month. Of this 180, 99 were related to COVID.
- A complex method of reporting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

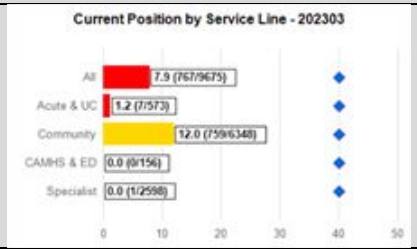
Actions
- New sickness reporting system which is scheduled for implementation in September 2022. New system will enable managers to better manage sickness absence with ongoing support from Employee Relations Team.
- The Trust is now overseeing all stage 2 sickness cases following handover from Capsticks 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.

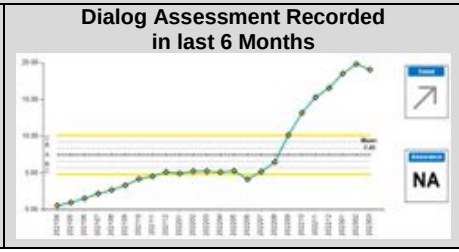
Patient Experience & Outcomes

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.
- From April 23 Paired Dialog completed will be reported as a priority metric.

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	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
FSOC 1	Annual care plan review (%)	95%	87.8	89.1	90.6	87	94.4	84.8	94.3	96.9	97.1	93.3	95
	Care planning audit compliance (%)	90%		93.1	94.2	94.8	94.7	93.9	94.6	94.6	95.1	95.5	93
	Care planning audits completed (%)	90%		73.4	83.1	87	93.9	93.9	87.9	80.4	87.5	91.7	91
FSOC 2	Cardiometabolic Assessments - Inpatients (%)	90%	90	86.6	79.8	86	83.7	79.6	79.3	76.6	78.8	78.1	83.7
	Physical Health Assessment attempted within 4...	95%	95.3	95.6	95.9	96.3	91.5	96.3	95.3	95.3	95.1	95.1	91.3
	Physical Health Assessment completed within 7...	90%	77.5	80.2	80.5	87.9	84.4	89.5	84.3	78	79.7	91.1	84.1
FSOC 3	Risk Assessments within 48 hours of admission	95%	94.7	98.2	99.5	96.1	93.5	96.4	98.4	96.7	97.7	97.9	97.8
FSOC 4	Observation reviews completed against standar...	Null	45.4	37.7	41.6	40.1	43	41.5	37.7	42.8	52.1	64.5	72
	Observations required vs completed (%)	Null	69.1	70	70.8	73.6	80.3	83.2	65.8	69.4	79.2	87.9	86.5
FSOC 5	Number of safeguarding adults alerts	Null	13	29	14	19	26	11	14	19	10	14	6
	Number of safeguarding children incidents repo...	Null	0	2	7	2	4	1	5	1	0	0	8
	Safeguarding adults training (%)	95%	98.9	99.1	99.1	99	97.9	97.3	97.4	97.3	95.7	96.1	95
	Safeguarding children training (%)	95%	90.5	91.1	90.9	90.9	88.9	90.7	90.8	91.1	89.7	89.8	89.2
FSOC 6	Infection Prevention and Control Training (%)	95%	96.7	96.3	96.9	96.5	95.9	95.3	96.1	96.1	95.4	95	93.7
	Infection prevention control audit compliance (...	90%	98.5	98.7	98.4	98.7	98.6	98.9	98.7	98.5	98.8	98.6	99
	Infection prevention control audits completed (...	90%	90.4	89.6	88.2	83.1	90.2	93.3	93.8	90.3	92.4	94.3	93.7
FSOC 7	Pharmacy audit compliance (%)	90%	90.9	92.5	91.4	88.5	88.5	90.3	89.6	91.4	91.5	91.3	88.3
	Pharmacy audits completed (%)	90%	95.7	91.3	100	82.6	90.9	97.1	100	85.7	100	100	95.5
FSOC 8	Mental health act audit compliance (%)	90%	92	92.1	89.6	91.8	91.9	93.1	93.9	94.9	94.5	95.9	94.6
	Mental health act audits completed (%)	90%	81.3	84.8	86.4	88.2	93.8	97.7	94.6	91.3	92.9	92.5	93.4
	Mental Health Law Training (3 Year)	85%	83.7	84.1	79.8	83.2	74.3	69.9	63.6	63.4	64.8	68	70.9
	Section 132 Patient Rights Repetition	100%	86.4	90.8	86.4	89.9	87.9	87	80	93.6	89.4	89.1	87.5
FSOC 9	Duration of physical restraint (average minutes)	Null	4.9	7.7	12.2	7.6	12.6	17.1	17.5	9.4	12.8	7	14.9
	Duration of prone restraint (average minutes)	Null	1.6	3.3	16.1	3.5	2.3	5.9	4.5	3.8	7.6	2.8	4
	Reducing restrictive practices - Prone restraint	Null	13	30	40	24	23	47	36	38	42	18	40
	Seclusions	Null	9	14	20	21	9	31	19	32	16	23	24
	Total number of restraints (physical restraints ...	Null	64	81	86	74	110	166	149	132	120	116	197
FSOC 10	Patient Safety incidents	Null	336	329	324	294	279	407	329	253	293	287	295
	Root Cause Analysis (RCA) actions that are over...	0	5	3	2	4	5	7	5	6	3	4	4
	Serious incidents	Null	14	26	19	14	19	28	14	18	15	8	6
FSOC 11	Safe Staffing: Shift Assurance, inc Obs Require...	Null	85.6	84.8	82.1	87.5	87.2	85.5	83.8	84.5	83.1	80.6	77.3
	Supervision (%)	85%	84.7	84.5	79.9	79.2	82.7	82.4	82.9	79.8	86.4	81.2	85.5

Comments

- Performance has been fairly consistent over the year with recent improvement on care planning noted. Improvement required in Safeguarding Children Training and in regard to MHA measures in particular Mental Health Law Training and Section 132 (reading of patient rights).
- 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

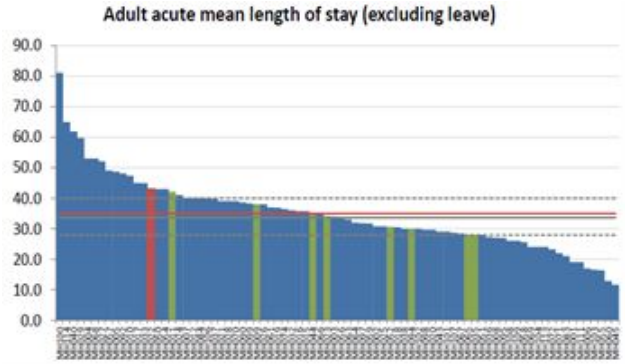
Group	KPI	Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
FSOC 1	Annual care plan review (%)	95%	94.6	94.4	94.8	94.3	95.9	95.4	95.9	96.5	96.3	95.4	93.8
	Care planning audit compliance (%)	90%				88.5	79.5	77	77.5	78	80.2	81.9	75.2
	Care planning audits completed (%)	90%				18.6	28.5	29.8	30.7	15.3	33.9	27.7	21.7
	Carers of Clients on CPA who have been offered ...	85%	93.5	83.7	87.6	96.7	95.3	95.7	92.3	93.5	96.7	94.7	91.4
	Dialog assessment recorded in the last 6 month...	Null	5.2	4.1	5.1	6.4	10.1	13.2	15.3	16.6	18.5	19.8	19.1
	Employment, education and training informatio...	90%	87.5	87.1	87.2	79.3	84.5	89.8	86.4	94.1	88.7	84.3	85.1
	Feedback Offered (%)	90%	85.2	89.9	91.5	88.2	86	91.5	93.4	91.5	88.5	77.4	83.8
	Goals Set (%)	90%	87.7	89.9	78.9	84.5	84.3	79.5	85.2	93.3	88	81.3	81
	Paired Measures (%)	80%	64.1	85.4	71.4	80.5	68.3	84.6	62.7	80.8	71.2	75.5	69
FSOC 2	Cardiometabolic Assessments - Community & EI...	75%	81.9	85.4	84.9	85.4	85.6	86.9	87.9	88.1	85.9	84	81.8
	Cardiometabolic Assessments - EIS (%)	90%	80.1	91.6	92.1	90.4	88.7	90.6	90.1	86.5	84	84.6	82.7
FSOC 3	CAMHS IAPTUS patients with an up to date risk ...	95%				60.6	59.4	59.4	58.8	59	59.6	65.7	73.5
	Community patients with an up to date risk ass...	95%	92.1	92.3	91.6	92.7	92.6	91.9	91.8	92	91.7	90.6	91.6
	Risk Assessments within 48 hours of admission ...	95%	90	90.5	89.8	90.8	89.5	93.7	92.2	91.6	90.8	86.2	87.4
FSOC 5	Number of safeguarding adults alerts	Null	71	61	72	73	40	58	72	44	66	45	55
	Number of safeguarding children incidents repo...	Null	64	47	44	35	42	39	23	22	47	27	25
	Safeguarding adults training (%)	95%	98.4	98.9	98.9	98.2	98.1	97.6	96.3	96.8	93.1	93.2	94.2
	Safeguarding children training (%)	95%	94.1	94.8	94.6	93.3	91.6	91.5	91.3	90.6	88.8	88.1	90
FSOC 6	Infection Prevention and Control Training (%)	95%	95.6	95.9	95.7	95.8	95.2	95.7	95.3	95.8	93.5	93.4	94
	Infection prevention control audit compliance (...	90%	100	100	96.3	97.2	96.1	96.7	98.7	76.7	96.3	98.1	97.8
	Infection prevention control audits completed (...	90%	8.3	25	19.2	46.4	50	50	50	17.6	44.1	71.4	60.7
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	82.9	97.6
FSOC 8	Mental Health Law Training (3 Year)	85%	84	84	79.4	82.2	69.8	66.2	62.3	61.8	61.1	67.7	72.3
	Section 132 Patient Rights Repetition	100%	76.1	68.5	50.5	74.2	80.3	88.7	79.4	78	76.6	73.3	71.6
FSOC 10	Patient Safety incidents	Null	149	138	118	124	113	133	124	106	151	134	155
	Root Cause Analysis (RCA) actions that are over...	0	7	6	5	6	9	8	5	9	6	7	6
	Serious incidents	Null	23	14	27	16	19	27	15	11	19	12	15
FSOC 11	Supervision (%)	85%	86.4	85.4	82	85.8	86.3	82.3	85.5	82.5	84.5	83.8	83.6

Comments

- There has been variation in performance over 12 month period; care planning measures need improvement (although annual CPA compliance has been above target in 6 out of last seven months). Risk assessment reporting has consistently been below target with CAMHS IAPTus being introduced in year now starting to improve. Compliance on Mental Health Law Training and Section 132 (reading of Patient Rights requires improvement).
- 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.

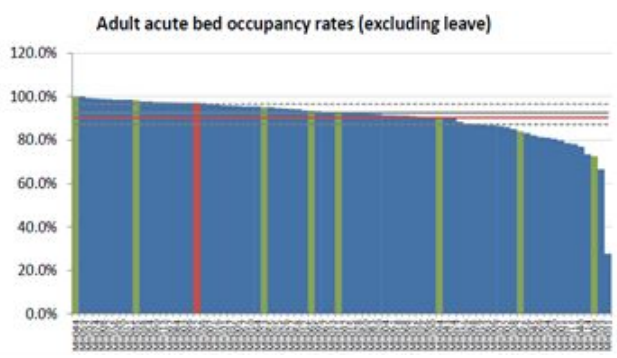
Appendix 1: Benchmarking

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.



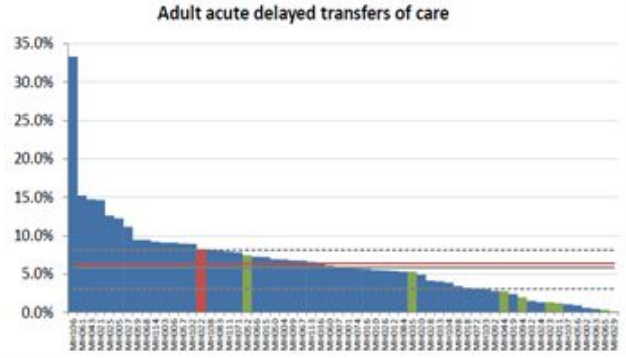
- **Adult acute average length of stay (days):**

2021/22		2022/23	
Trust	England	Mar-23	YTD
43.0	34.9	50.5	49.1



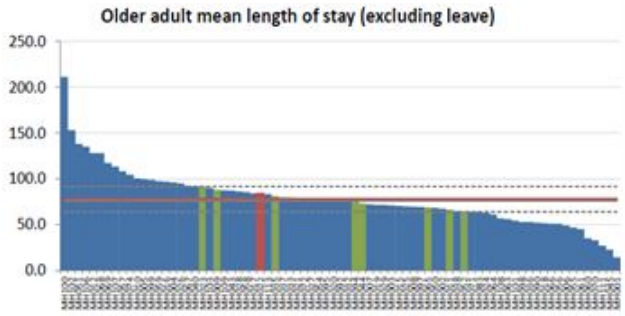
- **Adult acute bed occupancy rate (%):**

2021/22		2022/23	
Trust	England	Mar-23	YTD
97.1%	90.5%	99.0%	98.4%



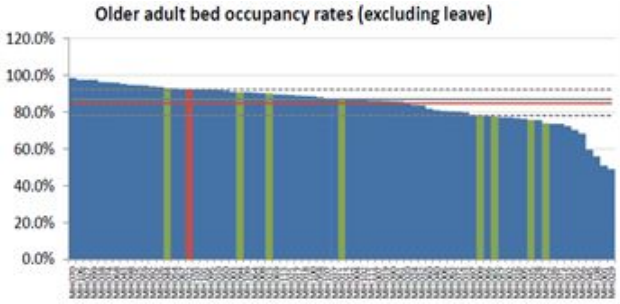
- **Adult acute delayed transfers of care (%):**

2021/22	
Trust	England
8.1%	6.4%



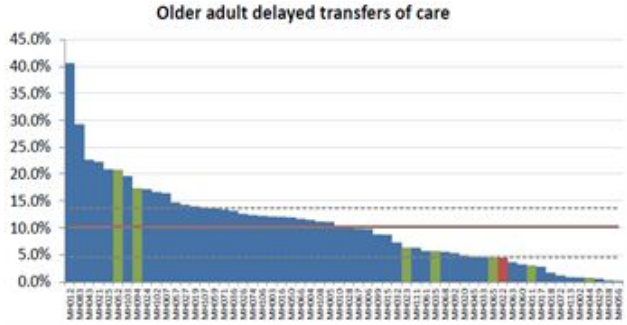
- **Older people's average length of stay (days):**

2021/22		2022/23	
Trust	England	Mar-23	YTD
84.0	78.5	95.5	97.4



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

2021/22		2022/23	
Trust	England	Mar-23	YTD
92.6%	84.8%	97.0%	91.4%



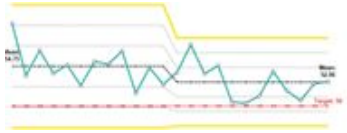
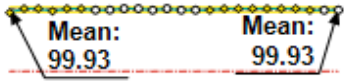
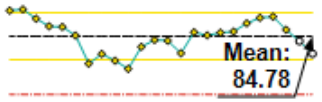
- **Older people's delayed transfers of care (%):**

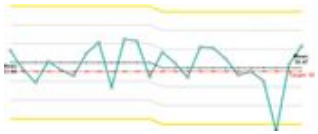
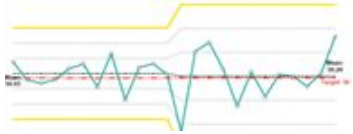
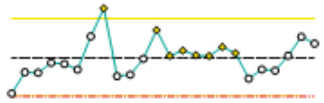
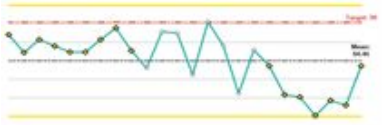
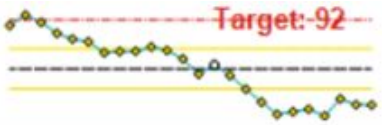
2021/22	
Trust	England
4.4%	10.3%

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.

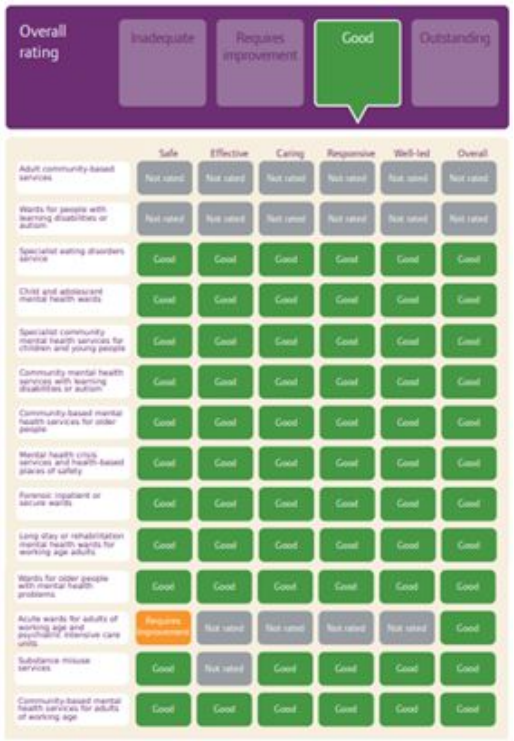
NHSI SOF Operational Performance Metrics	Mar-23	Target	Trend	Assurance on consistently meeting the target	SPC Chart	Comments
Data quality maturity index (DQMI) (%) see page 17	98	≥ 95.0	→	✓		Performance remains stable and consistently exceeds the target following the introduction revised administrative 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	52.9	≥ 50.0	→	✓		Performance is consistently above target for Talk Wandsworth.
IAPT/talking therapies - Waiting time to begin treatment within 6 weeks (%)	98.9	≥ 75.0	→	✓		Performance is consistently above target.
IAPT/talking therapies - Waiting time to begin treatment within 18 weeks (%)	99.9	≥ 95.0	↗	✓		Performance is consistently above target.
Cardiometabolic Assessments - Community & EIS (%) see page 20	81.8	≥ 75.0	↗	✓		Performance is consistently above target.
1st episode of psychosis - Treatment with a NICE recommended package within 2 weeks of referral (%) see page 9	61.5	≥ 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	53.4	≥ 50.0	→	?		Average performance for 2022/23 is currently above target.
IAPT recovery rate - Sutton Uplift (%) see page 24**Error! Bookmark not defined.**	56.1	≥ 50.0	→	?		Average performance for 2022/23 is currently above target.
Inappropriate out of area placement bed days - Adult Acute & PICU Ⓟ see page 16	280	= 0	→	X		The Trust has opened surge beds to help manage peak demand and keep out of area usage to minimum and has negotiated use of 18 beds at Holybourne unit in Roehampton for 22/23.
Cardiometabolic Assessments - Inpatients (%)	78.1	≥ 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	77.7	≥ 92.0	↘	X		There have been demand and capacity issues within adult ADHD services. Additional resources for non-medical prescribing have also been put in place.

Appendix 3: Effective: CQUIN key measures

Effective: CQUIN Key Measures	Target	Mar-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.	The Trust did not meet the target for the CQUIN, still at 36.4%. The Trust is not an outlier in this result and were the highest mental Health Trust in London.
Cirrhosis and fibrosis tests for alcohol dependent patients (%)	≥ 35.0	66		Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	The Trust achieved over the target at 66%. This will result in 100% payment
Routine outcome monitoring in CYP and perinatal mental health services (%)	≥ 40.0	24.4		Achieving 40% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measured at least twice	Partially achieved target at 24%
Routine outcome monitoring in community mental health services (%)	≥ 40.0	11.8		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.	Partially achieved target at 11.8% (this is over the lowest threshold for payment)
Use of anxiety disorder specific measures in IAPT (%)	≥ 65.0	72.3		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).	The Trust achieved over the target at 66%. This will result in 100% payment
Biopsychosocial assessments by MH liaison services (%)	≥ 80.0	86.6%		Achieving 80% of self-harm [1] referrals receiving a biopsychosocial assessment concordant with NICE guidelines	Currently achieved target at 86%, though there are a few more audits to be completed.
CAMHS Formulation (%)	≥ 80.0	-		Delivery of formulation or review within 6 weeks of admission, as part of a dynamic assessment process for admissions within Tier 4 CYPMH settings	Currently partially achieving target, there are a few more audits to be completed
CAMHS: Restrictive Practice (%)	≥ 80.0	76.5		Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings	Partially achieved target for Q4

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. ▪ There has been no CQC activity since the final report was received for the Rehab Core service. **Ratings on how Trust Scored for each core service:** 

Appendix A – Current regulation notices

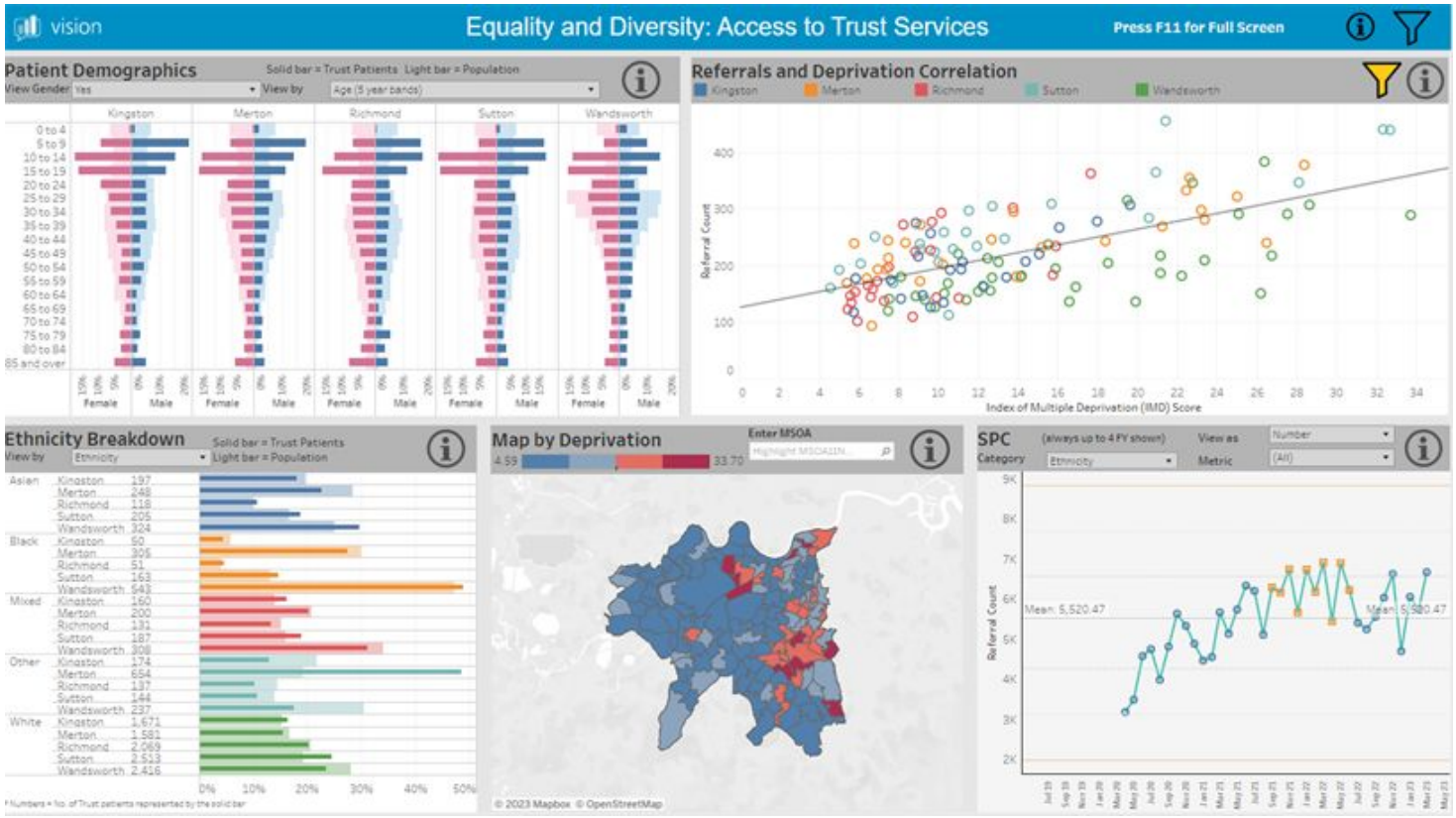
Regulation	Service	Issue
Regulation 12 HSCA (RA) Regulations 2014 **Safe care and treatment** Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Acute wards for adults of working age and psychiatric intensive care units	The trust 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	
January – March 2023						
14/02/2023	Aquarius	CAMHS & ED	MHV1-14443418241	13/03/2023	13/04/2023	
02/03/2023	Ruby Ward	Specialist S	MHV1-14638646931	22/03/2023	27/04/2023	
20/03/2023	Wisteria	CAMHS & ED	TBC	TBC	TBC	TBC

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.

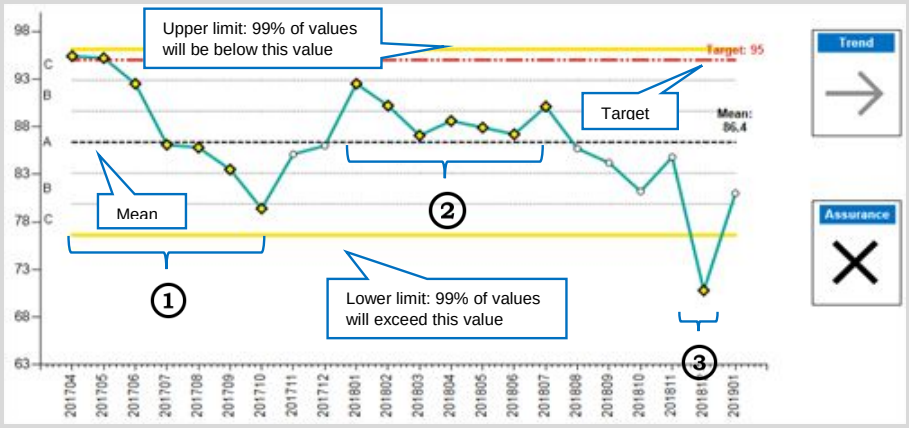
Appendix 7: Data quality assurance

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.

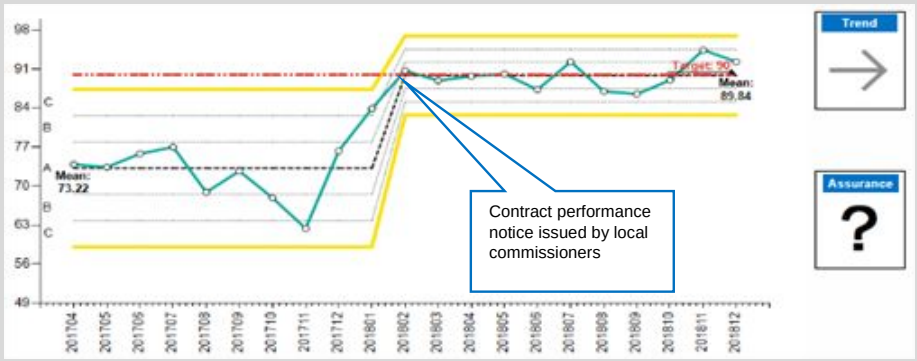
Appendix 8: Statistical Process Control (SPC) Charts & Performance Donut



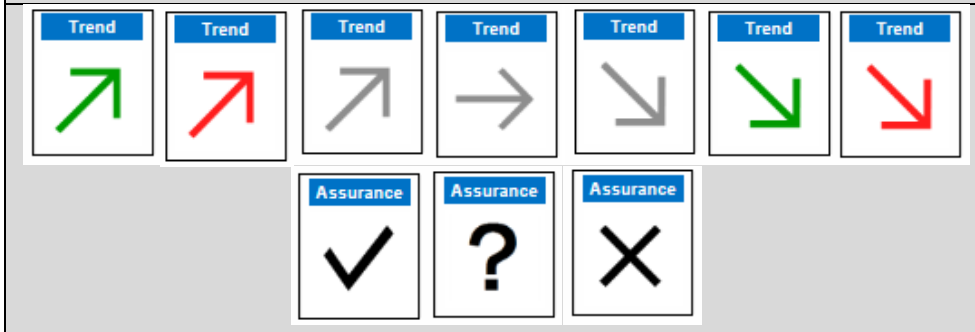
What is an SPC chart?
A Statistical Process Control (SPC) chart is a time series graph (we try to use 2 years) with three reference lines – the mean, upper and lower control limits. The limits help you understand the variability of the data. The variance of the data determines the process limits and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

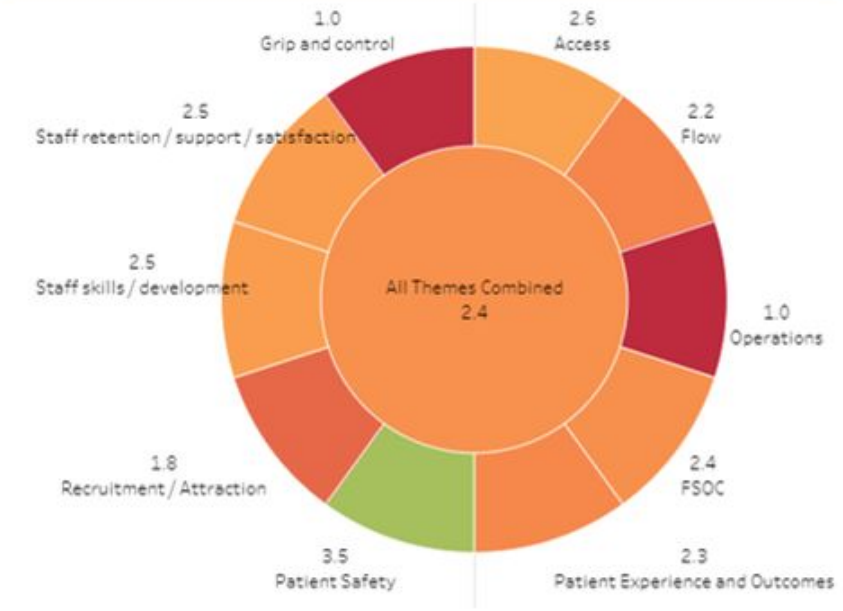


Use of icons to interpret charts
The Trend icon is shown as one of seven upward, horizontal or downward arrows depending on which direction the data is heading, coloured green, grey or red to indicate whether this is an improvement or deterioration in performance (or neutral where there is no target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

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

Trust Board – Part A 11 May 2023

Report Title:	2023/24 top priorities and corporate objectives
Author(s):	Amy Scammell, Director of Strategy, Transformation and Commercial Development
Executive Sponsor(s):	Amy Scammell, Director of Strategy, Transformation and Commercial Development
Transparency:	Public
Scrutiny Pathway	ELT 04.05.2023

Purpose:	☒	Approval	☐	Discussion	☐	Information	☐	Assurance
Additional information:	None							

What?	Each year, a set of organisational corporate objectives are developed to support delivery of the Trust Strategy. In developing these the Trust considers a number of key factors – delivery in the preceding year, existing pressures and challenges, our capacity and the external environment, for example. We aim, each year, to set ambitious yet realistic targets that will support the ongoing development of the Trust. As can be seen from the final 2022/23 corporate objective report, significant achievements were delivered and also some areas proved more complex than originally anticipated. Delivery was variable. We have developed our 2023/24 in an iterative manner through discussions across the Executive Leadership Team, within the Executive Advisory Group, in the Senior Leadership Forum and at Trust Board development sessions. We have considered our greatest challenges and the 'must do' work for 2023/24. We have agreed that our most important priorities are to (1) improve flow through our services (most specifically our adult acute pathway) and (2) value and stabilise our workforce. In this context, we recognise that whilst we want to progress strategic delivery through our existing corporate objective structure, we also need to identify and elevate a smaller set of work areas which will see us successfully address our challenges and deliver against these 'top priorities'. For 2023/24 we will therefore: 1. Retain the structure of our 6 corporate objective areas relating to quality, equality, diversity & inclusion (EDI), people, finances, transformation and partnership. We will align the first 4 areas directly to one strategic ambition with transformation and partnership acting as 'enablers' supporting all strategic ambitions. 2. Identify and elevate the areas of work within the corporate objectives which are critical for addressing our top priorities

around flow and people. We will robustly manage delivery of these core areas of work with specific targets and trajectories for improvement through the year.

The 2023/24 corporate objectives are:

1. To empower service users and carers to ensure their experience informs quality improvements in practice and services. Our focus is on the care planning and safety planning.
2. To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences. Our focus is on implementing the Patient and Carer Race Equality Framework (PCREF), delivering the Ethnicity and Mental Health Improvement Project (EMHIP) and embedding EDI and health inequalities in our services.
3. To support our people to grow and develop our organisation to be the best we can be. Our focus is on getting the HR basics right, recruitment, retention and leadership, learning and development.
4. To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL. Our focus is on reducing agency and external bed use and improving clinical and corporate efficiency.
5. To deliver our integrated transformation programme improving access and outcomes, reinvigorating working practices for staff and service users alike and providing state of the art mental health facilities. Our focus is on delivering clinical transformation elements and supporting change within the Trust.
6. To proactively develop partnerships and act as a system leader driving strategic improvements to mental health of the SWL population. Our focus is on mental health provider collaborative development and the SWL MH Strategy delivery.

For each corporate objective, key delivery items are outlined with the intended timescale for delivery. Key outcomes or metrics are included to enable monitoring of delivery of the objective. Baseline measures are included where these are available with some till requiring finalisation. Finally, our first four corporate objective are mapped directly to one of the Trust's four strategic ambitions – effectively acting as annual work programmes for that ambition. The remaining two areas – transformation and partnerships – are enablers for all strategic ambitions.

Within the corporate objectives there are 8 critical areas of work that will support the delivery of our top priorities of improved flow and a valued and stable workforce. These pieces of work are:

1. Complex Emotional Needs (CEN) pathway.
2. Discharge challenge work.
3. Community enhanced response service and interface team.
4. Organisational development framework.
5. Clinical systems development.
6. Recruitment.
7. Retention.
8. Leadership, learning and development.

The content of these areas and specific metrics, targets and delivery trajectories to meet the targets are included in the paper.

	Quarterly reports on progress have been made to ELT, committees and the Trust Board using the established RAG rating system 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 Reporting on the top priorities will focus on delivery against target with patient and staff experience as balancing measures. This reporting will have greater oversight on a monthly or bi-monthly basis via ELT or the Estate Modernisation Management Group (EMMG) and relevant Board committees.
So What?	Defining an annual set of priorities enables the Trust to direct attention, energy and capacity. The iterative process of development allows us to learn from preceding years and take into account views from across the Trust. The aim was to focus on fewer priorities enabling the ELT and leaders to direct their energy to work that will deliver the greatest impact. The identification of top priorities around flow and people for 2023/24 will support the Board and Board committees to focus directly on a small number of work programmes with specific metrics. Progress and delivery should be more clearly measurable. This also takes account of previously flagged issues around ensuring activities undertaken will genuinely deliver the desired outcome/ impact. This also enables the Trust to support senior leaders to step forward to deliver strategic pieces of work by more actively leading the work on the broader corporate objectives. Our plans to clearly communicate these areas and our focus will also improve visibility and understanding through the organisation. It should also be noted that targets are ambitious and the Trust will need to continue to support its people to make space to focus on delivery of change during 2023/34.
What Next?	The Board is asked to: • Approve the 2023/24 corporate objectives and top priorities and the associated work programmes, targets and outcomes. The ELT will progress the next steps to ensure clarity around final targets/ trajectories, communicate the work through the organisation in a clear and integrated manner and set up reporting and monitoring structures, building on those already in place around transformation, HR recovery, for example.

Any specific issues to note and/or for escalation:	N/A

Strategic ambitions this paper supports			
	☒	Increasing quality years	This paper supports all four strategic ambitions as it outlines priorities for 2023/24 all of which support delivery of the Trust Strategy.
	☒	Reducing inequalities	
	☒	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	
Equality analysis	Positive – Delivery of equality, diversity and inclusivity is everyone's business. EDI work begun in previous years will continue and develop in 2023/24 within a specific corporate objective aligned to the 'Reducing Inequalities' strategic ambition within the Trust Strategy.
Service users/ carers	Positive – Delivery of our corporate objectives and top priorities supports improving care for our service users and their carers. Impact of our work will be measured through service user and carer feedback and the Trust scores on the nationally recognised Friends and Family Test.
Estates:	Positive – Delivery of the Estate Modernisation Programme (EMP) remains a key organisational priority in 2023/24.
Financial:	Positive – Financial delivery will be a key focus in 2023/24 with a specific corporate objective aligned to the 'Ensuring Sustainability' strategic ambition within the Trust Strategy. Work described under the 'top priorities' element all contributes to improving efficiency and reducing financial pressure.
Legal:	N/A
Reputation:	Positive – Delivery of corporate objectives in 2023/24 will continue to support the Trust's reputation with stakeholders.
Strategy:	Positive – Corporate objectives continue to support delivery of the four strategic ambitions of the Trust Strategy. Work to progress delivery for the SWL MH Strategy in 2023/24 also adds renewed strategic focus.
Workforce:	Mixed – Workforce is arguably the greatest risk the Trust faces. Our people remain under pressure and we have challenges with recruitment and retention. Workforce has a specific corporate objective linked to the 'Making the Trust a Great Place to Work' strategic ambition within the Trust Strategy. The corporate objective focuses on continuing to develop our HR service and tackling core workforce issues. In addition, 'stabilising and valuing our workforce' is one of our two top priorities for 2023/24 with key targets.
Sustainability Eg. Green Plan.	Positive – Work around transformation, EMP and improved flow all contribute to delivering against the sustainability and green agenda within the NHS.
Other (specify):	None
Appendices/ Attachments:	N/A

2023/24 top priorities and corporate objectives

1. Introduction and this year's approach

1.1. Each year the Trust develops a set of annual priorities – corporate objectives – to support annual progress towards delivery of the Trust Strategy. These priorities act as an organisational programme of work defining the critical elements for delivery and targets to meet.

1.2. We take account of a number of considerations when setting our annual priorities including delivery in the preceding year, challenges being faced, the external context and environment, national targets and expectations, input from senior leaders, and our capacity, for example. For 2023/24 we are also reviewing our Trust Strategy and we are mindful of this work.

1.3. Drawing on learning from 2022/23, we have developed our priorities for 2023/24 in an iterative manner. We began this process in December 2022 and it has involved discussions across our Executive Leadership Team, with our Executive Advisory Group, in our April 2023 Senior Leadership session and in our Board development sessions. Our discussions have been mindful of the pressured context across the NHS and hinged around considering the balance of ambition and stretch with realistic delivery expectations. We have challenged ourselves to continue to focus on outcomes and clear measurement of delivery. We are committed to communicating the priorities as clearly as possible throughout the Trust once agreed, as well as raising the profile of delivery by ensuring monitoring and review features more clearly in our governance structure.

1.4. A key question that we have considered has been around our greatest challenges and the 'must do' work for 2023/24. We have agreed that our most important priorities are to (1) improve flow through our services (most specifically our adult acute pathway) and (2) value and stabilise our workforce. In this context, we recognise that whilst we want to progress strategic delivery through our existing corporate objective structure, we also need to identify and elevate a smaller set of work areas which will see us successfully address our challenges and deliver against these top priorities.

1.5. For 2023/24 we will therefore:

- Retain the structure of our 6 corporate objective areas relating to quality, equality, diversity & inclusion (EDI), people, finances, transformation and partnership. We will align the first 4 areas directly to one strategic ambition with transformation and partnership acting as 'enablers' supporting all strategic ambitions.
- Identify and elevate the areas of work within the corporate objectives which are critical for addressing our 'top' priorities around flow and people. We will robustly manage delivery of these core areas of work with specific targets and trajectories for improvement through the year.

1.6. The work needed to deliver on our top priorities is effectively a sub-set of the overall corporate objectives.

1.7. Our corporate objectives and their alignment to our strategic ambitions can be see in Figure 1 below:

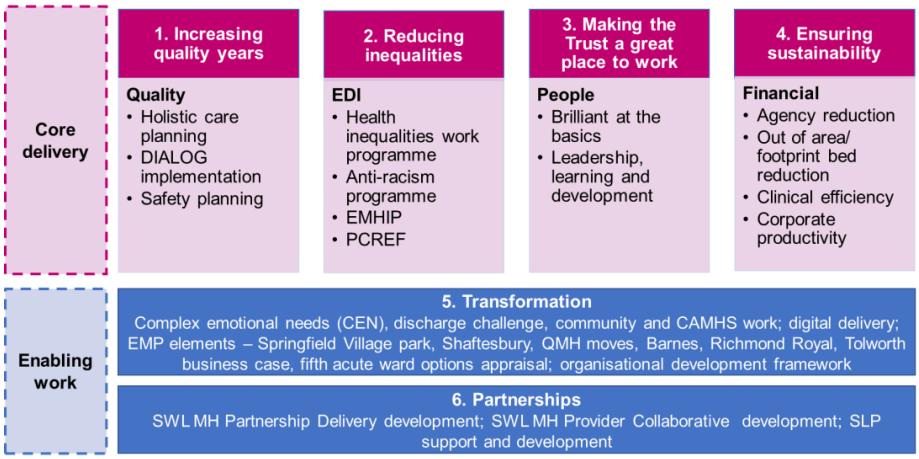


Figure 1: Our 2023/24 broader corporate objectives, aligned to our strategic ambitions

1.8. The specific top priorities work is highlighted in Figure 2 below:

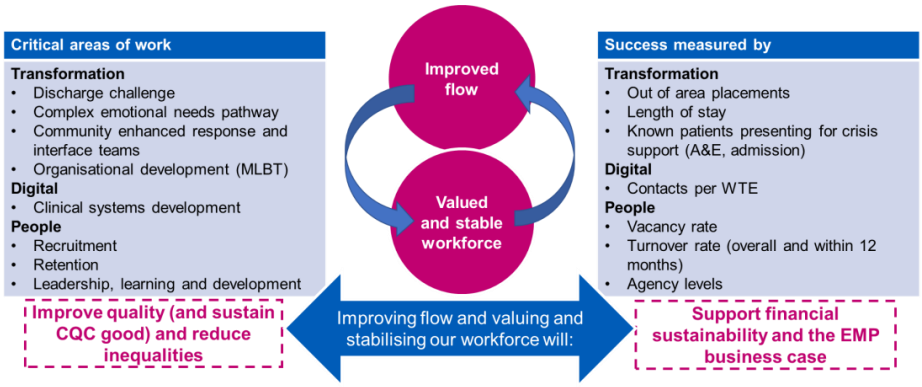


Figure 1: Our top priorities, work areas and measures of success

For the top priorities the key outcomes we want to achieve are reduced use of external bed, reduced length of stay, reduced numbers of patients known to the Trust presenting to crisis provision, improved productivity and reduced vacancy, turnover and agency levels. We will also measure patient and colleague experience with the aim of these improving.

1.9. The following sections of this paper provide the detail on the work programmes within the corporate objectives and top priorities.

2. 2023/24 corporate objectives

2.1. The draft proposed corporate objectives for 2023/24 are outlined in the table below. Each is mapped to a strategic ambition using the following key: I = Increasing quality years; R = Reducing inequalities; G = Great place to work; E = Ensuring sustainability. Red text indicates metrics that form part of the work around top priorities.

Corporate Objective	Delivery priorities	Outcome/ Metric	Strategic ambition*			
			I	R	G	E
1. To empower service users and carers to ensure their experience informs quality improvements in practice and services. **2023/24 key outcome: Successfully commenced holistic care planning, risk assessment and safety plans as part of changes to Care Programme Approach (CPA)**	**Embedding use of DIALOG/ holistic care planning, through co-production with service users and carers** • Set up work completed – Trust-wide project group and service user and carer co-production groups in place; SU and carer development needs identified; DIALOG+ care plan standard operating procedure (SOP) and care planning standards signed off; RiO changes developed and in testing – (Q1) • Care planning training package developed (Q2) and delivered (Q3) • Care planning process piloted (Q3) • OD support for key worker culture changes identified and case management and key worker SOP signed off (Q3) • Dashboard adjustments in place – aligning to measure care planning compliance and quality (Q3) • Key worker role and new case management process piloted (Q3) and then fully rolled out (Q4) **Implementation of safety planning in alignment with a change in risk assessment** • Delivery piloted (Q1) • Pilot evaluated and adaptations made to the framework (Q2) • Interfaces identified between safety planning framework and DIALOG use and agree implementation plan (Q2) • Safety planning implemented (Q3-Q4)	• Numbers of service users with a DIALOG in place - % of caseload • Numbers of service users with a DIALOG care plan - % of caseload • Increase in number of safety plans in place - % of caseload • Increase in % risk assessments reviewed within last 12 months • Increase in % Alwaysready care planning audits completed • FFT net positive score target 81% • Patient experience of changes monitored through FeedbackLive! and through Service User and Carer Group feedback (to be reported quarterly through narrative)				

2. To increase our inclusivity and improve equality and diversity becoming an organisation which values all contributions, voices and experiences
 	
2023/24 key outcome: Anti-racism outcomes delivered for staff and patients
	Delivery of the integrated EDI Action Plan, including producing resources, tools and capability to support delivery and refresh of the EDI strategy
	• Health Inequalities and EDI programmes developed with borough system partners and Inclusion Matters Group established (Q1)
	• Resource portal for managers delivered (Q1)
	• Diversity in Decision Making, Executive Advisory Group, and Staff Networks evaluated (Q2-Q4)
	• Anti-racism training and seminars for staff and managers delivered (Q2-Q4)
	• Leadership Development Seminars and resources focused on anti-racism and culture change delivered (Q2-Q4)
	• Renewed strategy signed off (Q4)
	
	Embedding EDI and health inequalities in service lines
	• EQIA guidance and template revised (Q1)
	• Outcome measures embedded and QI work in place across all service lines and analyse the impact on different groups (Q3)
		• Ethnicity dashboard developed
		• Increase in numbers of BAME staff at Band 8A and above
		• Numbers of racism complaints reported
		  ○ By patients
		  ○ By staff
		• Maintenance of improved staff survey results on EDI sections[1]
		• Improved MWRES, WRES[2] and WDES scores[3]				

[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, 47.6% in 2022), Q18 (2021)/Q20 (2022) (I think that my organization respects individual differences (eg cultures, working styles, background, ideas, etc) Baseline of 67.1% in 2021, 70.5% in 2022) and Q7c (I receive the respect I deserve from my colleagues at work. Baseline of 75.6% in 2021, 77.6% in 2022).

[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). 2022 data will be reviewed and included as a baseline when available. MWRES baselining will take place when 2022 data is available.

[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). 2022 data will be reviewed and included as a baseline when available.

	Deliver EMHIP and support the implementation of the Patient and Carers Race Equality Framework (PCREF) • Project plans agreed for all EMHIP key interventions (Q1) • Ethnicity dashboard completed and functional (Q1) • EMHIP interventions around reducing restrictive practice and cultural capability developed and delivered (Q1) • Patient and Carers Race Equality Framework (PCREF) work programme developed (Q1) • Patient diversity data including impact of services on access, experience and outcomes published (Q2) • EMHIP evaluation commissioned and completed (Q3-Q4)					
3. To support our people to grow and develop our organisation to be the best we can be **2023/24 key outcome: Stable HR function in place with solid improvements in recruitment, employee relations and health and wellbeing.**	**Implement the Leadership Framework and associated Leadership Development offer** • Leadership Development approach signed off and leadership development centres held to determine priorities (Q1) • Training needs analysis finalised (Q1) • Lunch & learn sessions (difficult conversations, flexible working, absentee management, etc.) delivered for frontline leaders (Q1-Q2) • Coaching and mentoring system established (Q2) • Training needs analysis findings implemented (Q2) • Talent strategy/ plan defined (Q3) • Key HR policies agreed (Q3) • Talent strategy/ plan implemented (Q4) • Succession planning development in progress (Q4) **Produce and deliver clear workforce plan for each service line aligning to overarching corporate priorities** • Detailed action plans designed and implemented (Q1-3) • Draft 2024/25 workforce plan in progress (Q3) and completed (Q4) **Produce focused programme of work to attract and retain our people** • Data analysis completed with recommendations for action (Q1) • Revised approach implemented and evaluated (Q2-Q4)	• Numbers of leaders accessing approach • Attendance rate of leadership offer sessions • Reduction in overall staff turnover and turnover of those with less than 12 months service with the Trust (tolerance of 15%) • Reduction in sickness absence rate • Reduction in vacancy rate (target of 15%) • Improvement in staff advocacy score in quarterly pulse staff survey and annual staff survey (targets 6.4 and 6.9 respectively) • Maintenance and stretch improvement in staff survey scores (health and safety climate, negative experiences and support for work-life balance				

	Development work to support future People Plan • Plan on a page drafted (Q1) and socialised across the Trust (Q2-Q3) • 2024/25 plan in progress: lessons learned and 2024/25 priorities set (Q4)	people promise elements[4]) and learning development (development people promise element[5]) • Qualitative feedback on leadership approach and offer gathered via feedback forms and reported quarterly via narrative update				
4. To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL **2023/4 key outcome: Review productivity overall programme governance including effective oversight and monitoring to deliver productivity and efficiency**	**Implement the agency reduction plan** • Existing process embedded and being used to monitor usage (Q1) • Processes reviewed to determine efficacy and monitoring in Q1 with plans for change implemented accordingly (Q2) • Processes reviewed quarterly and necessary changes implemented (Q3-Q4) **Implement Clinical Efficiency programme** • Clinical efficiency assessed by service lines and improvement plans, including use of digital tools, developed (Q1) • Service lines plans implemented and monitored (Q2-Q4) **Align transformation to deliver productivity to reduce the bed base** • Trajectory to deliver bed reduction by year-end agreed (Q1) **Introduce workflows to improve corporate productivity (e.g. HR)** • As-is scoped and opportunities for change identified (Q1) • Workflows amenable to change analysed and plans developed to implement (Q2) • Plans implemented (Q3-Q4)	• Reduction in agency spend in line with new national target (3.6% of pay bill) • Increase in activity per WTE (productivity metric) to wards 15 units per month				

[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, 55.4% in 2022). 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, 41.1% in 2022). 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, 54.1% in 2022).

[5] For PP element on development specifically Q20c (2021)/Q22c (2022) (I have opportunities to improve my knowledge and skills. Baseline 70.3% in 2021, 71.1% in 2022) and Q20d (2021)/Q22d (2022) (I feel supported to develop my potential. Baseline 54.4% in 2021, 56.5% in 2022).

5. To deliver our integrated transformation programme improving access and outcomes, reinvigorating working practices for staff and service users alike and providing state of the art mental health facilities. **2023/24 key outcome: Flow and outcomes improved across our services and Springfield Village now a reality**	**Integrated programme overall** • Principles and scope of future integrated programme agreed (Q1) • Refresh of governance and structure completed and in place (Q1) **Clinical transformation** • CEN pathway fully implemented (Q1) • Community enhanced response service and interface team delivered (Q1) • New community model fully implemented in Kingston and Richmond (Q3) and mobilisation underway for Wandsworth and Merton (Q4) • Discharge challenge workstreams mobilised (Q2) and impact being delivered (Q4) • System level work to enable individuals to return to their own accommodation post admission progressed (Q3) • Psychiatric Liaison work to reduce readmission and re-presentation finalised (Q2) and implemented (Q3-Q4) • CAMHS communications protocol published (Q2) and pathway improvements implemented to the NDT and emotional difficulties and complex needs pathways (Q3) **Digital** • Clinical systems cleaned-up and RiO useability and functionality improved (Q1) • Ward workflows implemented across all wards (Q1) • Digital skills programme rolled-out (Q2-Q3) • IAPTus useability improved (Q4) • Patient health records implemented (Q4) **Organisational development and change support** • OD framework in place (Q1) • Change support menu of options being accessed by staff (Q2) **EMP**	• Bed reductions to original 18 Holybourne and, then to 12. • Zero inappropriate out of area placements • Reduction in average Length of Stay (target 38 days) • Reduction in % of patients on caseload presenting to crisis services (target 1.1%) • Reduced DToCs • Waiting times in key areas reduced (community, CAMHS) • Number of patients waiting over 30 weeks for complex emotional needs or psychology and psychotherapy support reduced (targets of 20 and 400 respectively) • Reported positive staff engagement in transformation work					Enabling work supporting all strategic ambitions

	• QMH moves completed (Q1) • Springfield Village park open (Q2) • Shaftesbury building completed and services operating (Q3) • Barnes construction commenced (Q2) • Richmond Royal completed and services operating (Q3) • Fifth acute ward options appraisal completed (Q2) • Tolworth business case approved externally (Q2) and conditions precedent met (Q4) • Tolworth enabling works package (Q3) and main construction (Q4) commenced		
6. To proactively develop partnerships and act as a system leader driving strategic improvements to mental health of the SWL population **2023/24 key outcome: SWL MH Provider Collaborative in place with first phase of delegation completed and delivery of SWL MH Strategy underway**	**SWL** • SWL MH provider collaborative partnership delivery agreement in place (Q1) • SWL MH Partnership Delivery Group elements – planning, performance and oversight, sub-groups – in place and operating effectively (Q2) • SWL MH strategic financial and delivery review completed (Q3) • SWL MH Strategy year 1 delivery completed (Q4) **SLP** • Complex care delivery mechanisms updated to support phase 2 (Q1) • SLP business processes and structures refreshed (Q2) • Perinatal provider collaborative live (Q3) • CAMHS and AED cases for change agreed (Q4)	• SWL MH Strategy year 1 work delivered • SWL MH strategic financial and delivery review completed • Complex Care phase 2 year 1 delivered • Perinatal provider collaborative in place • CAMHS and Adult Eating Disorder cases for change agreed • SLP business support revised and processes amended	Enabling work supporting all strategic ambitions

3. 2023/24 top priorities

3.1. We have defined 8 critical areas of work as necessary to impact on our top priorities of improving flow and valuing and stabilising our workforce. These 8 areas are outlined below:

Area of work	Description	Monitoring and reporting arrangements
Transformation		
1. Complex Emotional Needs (CEN) pathway	A whole pathway improvement process, starting with providing dedicated resource in community services to deliver specific, clinically appropriate interventions to reduce escalation to crisis and/or an inpatient bed. For those in an acute setting, implementing a standardised 5–7-day admissions protocol to ensure they receive targeted interventions to help them recover and return to the community.	Part of Clinical Transformation programme and reported via the Estate Modernisation Management Group (EMMG) and Estate Modernisation Committee (EMC) (and any future revised integrated programme structure).
1. Discharge challenge	A national directive to reduce the number of delays to discharge from acute care in mental health services. Based on good practice and evidence, a set of 10 key interventions were proposed that would help drive improvements in flow and reduced delayed discharge for mental health providers. The Trust has grouped these interventions into four workstreams: 1. Purposeful admission: Ensuring all admissions have a purpose and that we reduce inappropriate admissions. 2. Impactful admission: Ensuring people are discharged once treatment is completed; introducing structured care pathways for first three days. 3. Facilitating discharge: Improving turnover/use of beds by introducing discharge by 11.00am and improving the overall discharge process. 4. Barriers to Discharge: B-list MADE events to address DToCs and facilitate discharges and producing resources to support overcoming barriers to discharge.	
2. Community enhanced response service and interface team	The enhanced response team will prevent admissions by managing risk and preventing crisis in the community and addressing know patients that go into crisis. The interfaces team will consist of designated staff to in-reach into inpatient wards and support to facilitate discharge. It will partner with the enhanced response team to supporting preventing admissions.	
3. Organisational development (MLBT)	Organisational development framework produced for the Trust with approaches in place to support teams to implement change.	Part of the Trust Making Life Better Together work and overseen directly by the Executive Leadership Team (ELT)

Digital		
4. Clinical systems development	An aspect of digital transformation where there are potential clinical efficiency benefits is the review and standardisation of our clinical systems – RiO and IAPTus. There are 3 phases to the work: • Phase 1 – Clean-up and improve useability of RiO • Phase 2 – Improve RiO functionality • Phase 3 – Improve useability of IAPTus system All phases aim to improve processes, use of form based data recording and release clinical and administrative time. The work will also support ongoing data quality improvements in reporting.	Overseen by Digital Oversight Group and reported via the EMMG and Estate Modernisation Committee (EMC) (and any future revised integrated programme structure).
People		
5. Recruitment **6. Retention** **7. Leadership, learning and development**	These areas of work are interlinked and comprise of a number of different elements: • Attraction strategy including community recruitment, work experience, new role development. • Development of flexible working. • Joint work with wider system partners around passporting, preceptorship and joint roles. • Development of career pathways. • Leadership development framework. • Improvements to processes and structures around recruitment, retention and learning and development.	Overseen through People Matters, ELT and the People Committee.

3.2. We will measure our success using a number of specific metrics – all of which form part of our existing reporting. We have set year end targets for delivery and in most cases a trajectory by which to chart progress throughout the year. Where trajectories are still required these will be finalised by 31.05.23.

Area of work	Measures of success	Baseline (31.03.23)	Target by 31.03.24	Trajectory
Transformation	Friends and family test (FFT) net positive score[6]	70.66	81 – national average 92 – stretch	Q1: 72; Q2: 75; Q3: 79

[6] The FFT net positive score is a national measure which is asks patients to tell us how likely they would be to recommend our trust as a place to be treated. There are four possible answers, extremely likely and likely (positive responses) and unlikely and extremely unlikely (negative responses). Organisations are told the percentage of respondents who expressed positive and negative answers – the net of these two positions is the Net Positive Score that is used for benchmarking purposes. E.g. if of 100 answers 80 were positive and 20 were negative the net positive score would be 60% (80%-20%).

• **Discharge challenge** • **CEN pathway** • **Community enhanced response and interface teams** • **Organisational development (MLBT)**	Additional beds used over EMP bed base and contracted Holybourne (18) and ELFT female PICU (5) beds[7]	14	0 – inappropriate OOA -6 (contracted bed reduction) – stretch	Requires further development
	Average length of stay[8]	44	38	Requires further development
	Patients on community caseload presenting to crisis services[9]	1.4%	1.1%	Q1: 1.4%; Q2: 1.25%; Q3: 1.25%
Digital • **Clinical systems development**	Activity per WTE – average number of community based clinical contacts per month[10]	12.45	15	N/A – further work will take place on productivity measures in year
People • **Recruitment** • **Retention** • **Leadership, learning and development**	Vacancy rate	17.8%	15%	Q1: 17%; Q2: 16.5%; Q3: 15.5%
	Turnover rate, overall	17.6%	15%	Q1: 17.5%; Q2: 17%; Q3: 16.5%
	Turnover rate within 12 months	24.3%	15%	Q1: 24%; Q2: 22%; Q3: 18.5%
	Quarterly pulse staff survey – staff advocacy score	5.2	6.4 (national MH average)	Q1: 5.7; Q2: 6, Q3 (NB no pulse in Q3 due to the national staff survey)
	Annual staff survey – staff advocacy score[11]	6.7	6.9 (national MH average)	N/A – only measured once a year
	Agency spend as % of pay bill[12]	7.1%	3.6%	Q1: 6.5%; Q2: 5.5%; Q3: 4.6%

[7] Further work will be carried out to translate the bed base utilisation into occupied beddays as the standard currency. Trajectory for the reduction of inappropriate out of area placements (bed use) is expected at EMMG on 23.05.23 and will confirmed at that point.

[8] This measure is targeting the average rolling annual length of stay (as opposed to the in month average LoS that is reported each month with the Trust Q&P report). The reason for this is that discharges of very long staying patients will skew LoS and thus taking a rolling annual average smooths such variances. It does however mean that where a month is high it forms a part of the average for the next year. Trajectory for the reduction of ALoS is expected at EMMG on 23.05.23 and will confirmed at that point.

[9] This metric takes snapshot of end of month adult (RiO) CPA community caseload and looks at the % were admitted to one of our beds or seen by psychiatric liaison. In March 10,870 were active and 163 were seen in those settings. Reducing the level of known patients presenting in a crisis setting is proposed as a marker of community services becoming more effective. Further work is proposed to determine expected impact.

[10] This metric takes all clinically initiated community based patient contacts (of any modality) and divides it by the Total Team WTE at month end (the WTE includes both clinical and non-clinical staff) to get a net productivity score. Data is available at a more granular level and further work is proposed to determine how to judge a meaningful impact. At present the target is the highest level achieved.

[11] These nationally defined scores are measured for all NHS organisations and are constructed from staff responses to the following questions: (1) Care of patients/ service users is my organisation's top priority, (2) I would recommend my organisation as a place to work and (3) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

[12] This metric is a nationally defined target within the NHS for 2023/24.

4. Next steps

4.1. The work on both corporate objectives and the top priorities will be reported quarterly to ELT, Board committees and the Trust Board in the standard reporting cycle.

4.2. The further work to define trajectories and consider what level of target can be considered meaningful in core areas will be completed during May 2023 as delivery proceeds.

4.3. This work will feed into the review of the Trust Strategy as this progress during Q1 and Q2 2023/24.

4.4. Finally, work to describe and communicate the corporate objectives and our top priorities will be undertaken to ensure clarity across the whole Trust. The Director of Strategy, Transformation and Commercial Development and the Director of Communications and Stakeholder Engagement will lead this work. This work has started at the senior leadership session in April 2023.

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

Trust Board – Part A 11 May 2023

Report Title:	2022/23 Corporate Objectives – Q4 Delivery
Author(s):	Leah O'Donovan, Deputy Director of Strategy & Transformation
Executive Sponsor(s):	Amy Scammell, Director of Strategy, Transformation and Commercial Development
Transparency:	Public
Scrutiny Pathway	ELT 12.04.23 People Committee 20.04.23 Finance & Performance Committee 27.04.23 Estates Modernisation Committee 02.05.23 Quality & Safety Assurance Committee 04.05.23

Purpose:	☒	Approval	☐	Discussion	☐	Information	☐	Assurance
Additional information:	None							

What?	Each year, a set of organisational corporate objectives are developed to support delivery of the Trust Strategy. The Trust Board approved the 2022/23 corporate objectives in May 2022. The 2022/23 corporate objectives were developed through an iterative process including discussions at the Executive Leadership Team, Board committees and the Trust Board between February and April 2022. Through these discussions, it was recognised that there was a need to pause some areas of delivery, creating space to focus on moving into the new Springfield buildings. In this context, the 2022/23 corporate objectives were: 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. For each objective, key delivery items were outlined with the intended timescale for delivery. Key outcomes or metrics were included to enable monitoring of delivery of the objective. Baseline measures were agreed

	where these were available. Finally, each corporate objective was mapped to support delivery of the Trust's four strategic ambitions. Quarterly reports on progress have been made to ELT, committees and the Trust Board. Revised RAG ratings have been used 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. From Q2 outcome data has been reported and in this final report year end delivery is also included. The ELT received this paper on 12.04.23 and discussed how to feed in 2022/23 delivery when considering setting 2023/24 priorities. The paper has since been received by each committee as noted above and final data has been included.
So What?	Progress across the majority of objectives is rated Amber. A summary of the delivery is as follows: 1. **Quality:** The key success here is the reduction in the he use of restrictive practices over 2022/23 improving care and experience for our service users. In addition, improvements have been seen in some elements of physical health assessment and risk assessment but not all. 2. **Integrated transformation programme:** The Trust successfully opened Trinity building and moved services and staff safely. The relocation of corporate teams to Tolworth was also delivered. The Tolworth business case has been approved by the Trust Board and is now in the external review process. The Sutton community transformation model has been embedded and outcomes are being measured. There is mixed delivery across wider transformation and digital initiatives. 3. **EDI:** Much work has progressed in this area including the refresh of the EDI Strategy Action Plan, our anti-racism programme and the support to EMHIP. However, the expected outcomes have not been delivered. Ongoing work is needed with external partners to implement changes. 4. **People:** Work has progressed to stabilise our HR service and vacancy rates are now reducing. Work is still required around other core workforce metrics. Staff survey feedback has been reviewed and included. 5. **Partnerships:** the SWL MH Strategy has been finalised and will be approved at the SWL ICB in May 2023. Work on the SWL MH Partnership Delivery Group structures and the SWL MH Provider Collaborative have progressed albeit at the slower pace than

	intended. The Trust continues to support SLP wide work. The focus on partnership working will continue, and likely expand, in 2023/24. 6. **Finance:** The Trust has made good progress delivering its CIP requirements for 2022/23 but in the main on a non-recurrent basis. Corporate objectives remain an effective way of defining delivery requirements of the Trust on an annual basis. As flagged in the Q3 report, variable delivery raises a number of issues for consideration as follows: • Impact: When setting the corporate objectives the Trust has tried to link outcomes to activities and milestones, however it is clear from the Q4 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. • 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. • Link to Trust Strategy: The work to review delivery of the Trust Strategy and progress against delivery of the strategic ambitions is now being planned and will be carried out in Q1 & Q2 2023/24. Through this work we will review and assess corporate objective delivery over the past 5 years to identify material improvements made. • 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. In addition, we will work to ensure that these priorities are appropriately described and communicated so that they are understood by all.
What Next?	Delivery against any outstanding 2022/23 corporate objectives has been considered in the development of the 2023/24 corporate objectives. The Board is asked to: • Note Q4 and year-end 2022/23 delivery
Any specific issues to note and/or for escalation:	None

Strategic ambitions this paper supports			
	☒	Increasing quality years	This paper supports all four strategic ambitions as it details delivery against
	☒	Reducing inequalities	

	☒	Making the Trust a great place to work	our 2022/23 corporate objectives, which are directly linked to delivery of our strategic ambitions.
	☒	Ensuring sustainability	

Implications	
Equality analysis	Positive – Delivery of equality, diversity and inclusivity is everyone's business. There has been 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.
Service users/ carers	Positive – Delivery of our corporate objectives supports improving care for our service users and their carers
Estates:	Positive – Delivery of the Estate Modernisation Programme (EMP) has been a key organisational priority in 2022/23.
Financial:	Positive – Financial delivery has been a key focus of 2022/23 in recognition of the exceptionally challenging landscape that the Trust is working in. Delivery has been pressured throughout the year.
Legal:	N/A
Reputation:	Positive – Delivery of corporate objectives in 2022/23 will continue to support the Trust's reputation with stakeholders.
Strategy:	Positive – Corporate objectives continue to support delivery of the four strategic ambitions of the Trust Strategy.
Workforce:	Mixed – The Trust workforce is under pressure and remains impacted by the legacy of Covid-19.. In addition, the Trust has experienced significant issues with delivery of the HR function. Due to this situation the 2022/23 people objective was moderate in ambition recognising the need to support our workforce and build a HR service that can support the Trust.
Sustainability Eg. Green Plan.	N/A
Other (specify):	None
Appendices/**Attachments**:	N/A

Q4 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%; M12 91% target 95%) ***– Increased level but target not met***
- Increase in % risk assessments reviewed within 48 hours (2021/22 average – 91%; 2022/23 M6 95%; M9 96%; M12 97% target 95%) ***– Increased level and target met***
- Increase in % risk assessments reviewed within last 12 months (2021/22 average – 93%; 2022/23 M6 93%; M9 93%: M12 91% target 95%) ***– Level not increased and target not met***
- Increase in % physical health assessments completed within 7 days of admission (2021/22 average 78.6%; 2022/23 M6 79.3%; M9 80.3%; M12 81% target 95%) ***– Increased level but target not met***
- Increase in % of cardiometabolic assessments completed for community service users (2021/22 average 84.41%; 2022/23 M6 84%; M9 85.5%; M12 82% target 95%) ***– Level not increased and target not met***
- Reduction in Restrictive Practices (Total # Prone Restraints 2021/22 – 450; 2022/23 M6 157; M9 278; M12 378. Total # Restraints – Physical & Rapid Tranquilisation 2021/22 – 2,245; 2022/23 M6 692; M9 1,215, M12 1,733. Total # Seclusions 2021/22 – 379; 2022/23 M6 96; M9 178, M12 241) **– Level reduced**
- Medicines optimisation guidance for service users and staff **– Drafted but not yet complete**

Delivery priorities	Q4 2022/23 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 22/23 delivery	Year-end delivery rating
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**	**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** • The physical health question in Feedback Live! has now been added,		• The triangulation of patient experience data for all areas was planned to begin in Q3, but has been impacted on by the capacity to develop Feedback Live! This was not completed by end of Q4 but has now been completed. • The Restrictive Practice Use of Force Policy audit was completed. • Medicines optimization framework, positive messaging and adverse affects work areas was completed in Q4. • Medicines Optimisation has completed its medicines optimisation positive	Feedback Live! questions are now online, enabling the triangulation of data to be completed.	

• 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 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)	to support collection of data on this element but this is not due to be online until Q1 2023/24. • Audits remain underway. **Restrictive practices** • The compliance audit of the Use of Force policy has been completed. There are plans to review and close compliance gaps • Patient data has not yet been collected or triangulated. Work is ongoing on Observation Qii, with ward attendances to collect experience feedback from service users on observations • Plans continue to provide peer support workers to support service users with post-incident debriefs. This is linked to EMHIP, which has delayed the start. Funding is being secured to support Involvement to provide the service with now a planned start in July 2023. • Audits remain underway. **Medicines optimisation** • The co-produced medicines optimisation framework was due for completion in Q2 and Q3 and remains in progress. As reported previously, 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.		messaging advice document and the guidance around medication adverse effects launched in April 2023, with messaging being shared in training.		

Medicines optimisation • Tools available to support adherence scoped and options paper on this 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 medicines optimisation positive messaging advice document and the guidance around medication adverse effects have been approved and signed off. They will be launched at the next Doctors' academic meeting and through ward managers and community medicines optimisation meetings.				

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 ***– met for services that have moved.***
- Waiting times in Sutton community SMI services reduced (average waiting time to start treatment – 2021/22 2.8 weeks and 2022/23 outturn 4.4 weeks; total waiters over 30 weeks – 2021/22 close 63; 2022/23 M9 – 46; M12 – 23) ***– not met for average waits; met for waiters over 30 weeks.***
- Inpatient beddays used by Sutton residents reduced (2021/22 outturn 11,211; 2022/23 outturn 11,607) ***– not met.***
- Longest lengths of stay reduced impacting positively on overall LoS (2021/22 outturn – 44 days; 2022/23 outturn – 44 days) ***– not met***.
- Corporate and other staff safely relocated ***– met.***
- Positive feedback received on moves from staff ***– mixed feedback with both positive elements and learning points identified.***
- Tolworth business case approved ***– approved by Trust Board and now in external review process.***
- Estates Strategy approved ***– met.***
- Digital delivery plan completed and digital strategy approved ***– partially met digital plan in place with digital strategy under development for Q1 2023/24***.

Delivery priorities	Q3 2022/23 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 22/23 delivery	Year-end delivery rating
Overall • Peer review recommendations implemented (Q1) and Gateway 4 review completed (Q2) • Initial post-project evaluation on Phase 1 completed (Q4) **EMP** • Clinical and operational sign off completed for service moved (Q2) • Shaftesbury and Trinity soft landings completed (Q2) and services successfully operating from new buildings (Q3) • Retail units opened (Q2) • Remaining Springfield site elements closed – Fairways (Q2), Conference Centre and Car Park B (Q3), Restaurant, Main Building, Harewood House and Diamond Estate (Q4) • Phase 2a planning applications submitted by partners (Q1)	**Overall** • The proposal for a revised programme structure and governance has been developed and is being finalised, ready to be re-launched in Q1 2023/24. **EMP** • Trinity is fully operational. • A few teams have been able to move into Shaftesbury early (Estates & Facilities and CAMHS team base) and the new car park is now open. Practical completion is estimated for the end of April 2023 with sufficient time for snagging and soft landings to follow. The building should be fully operational in summer 2023. • Discussions with Compass regarding the future retail catering provision and other retail commercial partners for the other retail units are ongoing. It is		**EMP** • The programme has successfully delivered a fully operational Trinity building, with plans for Shaftesbury to be fully operational in Q2 2023/24. Practical completion, snagging and soft landings will complete in Q1. • Retail units have not opened by year-end but plans are in place for opening by end of Q1 2023/24. • There have been delays to the Barnes plans approval process and temporary decant but both are due for Q1 2023/24. **Clinical Transformation**	• The re-launch of the programme is due for Q1 2023/24. • Outstanding work on Shaftesbury and moves is due for completion by Q2 2023/24. • The initial evaluation will take place in Q2 2023/24. • Kingston & Richmond transformed community model will be fully mobilised in Q1 2023/24.	

• Estates Strategy approved (Q2) • Barnes plans progressed with planning application submitted and Barnes business case approved (Q1), planning application approved (Q2), business case confirmed (Q3) and services decanted from Barnes accommodation (Q3). **Clinical transformation** • Sutton community adult mental health model fully implemented (Q1) and evaluated using agreed metrics (Q2) • Kingston and Richmond community adult mental health models fully implemented (Q3) • Year 3 community mental health adult transformation funding bid submitted (Q4) • Redesigned rehabilitation, personality disorder and adult eating disorder models fully implemented (Q4) • Children and Young People's mental health transformation defined and planned (Q1) and underway with external stakeholder support (Q3) **People Readiness and Culture Change** • Relocation consultation outcome published for corporate and clinical support staff currently based at Springfield (Q1) and staff moved to new location (Q3) • Agile and change training for staff completed (Q1) • Staff moved from Acacia, Woodroffe (Q1), Building 30, Phoenix and Morrison (Q3) and Newton (Q4)	anticipated that fit-out works will begin in late March 2023, opening by end of Q1 2023/24. • Car Park B has now closed. The Trust can continue to use Building 32 until at least January 2024, which will have a mixed tenure during this time. • NHSE and DHSC are reviewing the Barnes FBC with approval anticipated in late June 2023. The temporary relocation of Barnes teams took place the week of 14 April with all working from Teddington by 17 April. • As flagged in Q3, due to the dependencies on moves and requirement of six months' bedding-in prior to a review, the initial post-project evaluation is now scheduled for Q2 2023/24. After-action reviews have been conducted on all teams that have moved to collate immediate feedback and learning. • Contract negotiations have permitted extended operation of the restaurant for the benefit of the Trust. The Main Building, Harewood House and Diamond Estate have been vacated and are in the process of being decommissioned for handover. **Clinical transformation** • Sutton is now considered BAU. Conversations are taking place with Healthwatch to deliver a follow-up survey to assess the qualitative impact of transformation on service users.		• Sutton has successfully moved to BAU. • Kingston and Richmond began mobilising in April 2023 with both boroughs operating integrated meetings as of 17 April, with a soft launch approach. Internal mobilisation meetings continue to action service changes, including operational processes and onboarding of peer support. • Dedicated focus area work has also been completed in 2022/23. **PRCC** • All deliverables met or achieved **Digital** • This programme is now reporting through EMC and plans are in place for 2023/24		

• 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)	• Implementation of new core model for Adult Community Mental Health in Kingston & Richmond is progressing. • Rehab service is ready for move to BAU. Personality disorders work is continuing, with plans to focus on integrating Kingston and Richmond complex needs services. The pathway milestone has been met. Adult eating disorders is progressing for the end of 2023/24. • CAMHS phase 2 transformation programme commenced in Q4. **People Readiness and Culture Change** • All moves from Building 30, Phoenix and Morrison have now completed. • Newton staff moves are now complete. There will be a further set of moves when Shaftesbury is complete and refurbishment can take place in the old Hume ward in Newton for further teams to move in Q3 2023/24. • After-action moves are highlighting that teams were well-prepared and supported for moves. The refreshed programme proposes a wider scope for OD support to include clinical transformation. **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.				

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 **– not yet implemented**
- Improvement in scores in Staff Survey EDI sections (diversity and equality and inclusion people promise elements[1]) **– E&D score 2021 – 7.7; 2022 – 7.8; Inclusion score 2021 – 7.1; 2022 – 7.2 (and further detail on specific questions below) – all met**
- Improvement in Workforce Race Equality Standard (WRES) indicators[2] **- 2022 scores available in October 2023**
- Improvement in Workforce Disability Equality Standard indicators (WDES)[3] **– 2022 scores available in October 2023**
- Sustained improvement in Stonewall Index Score (total score for 2021: 70.5) **– no assessment was submitted for 2022 to enable time for work to embed**
- EMHIP evaluation completed **– not met.**
- Improvement in staff confidence in talking about race and ethnicity **– not measured yet**

Delivery priorities	Q4 2022/23 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 22/23 delivery	Year-end delivery rating
• 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) • Refreshed action plan for workforce EDI actions agreed with Equality and	Due to previously reported challenges in delivery the milestones due in Q4 have in the main not been achieved: • The cultural capability delivery timeline has shifted to 2023/24. An implementation group has been set up, which will carry out key engagement internally with those involved in EMHIP interventions 1, 2		• The EDI action plan has been refreshed. • The anti-racism pilots have not been delivered in 2022/23 but have been finalised in scope. These are planned for delivery in 2023/24.	• Cultural capability and manualised dialogical cultural capability training have plans for delivery by end of Q3 2023/24. • Anti-racism pilots will be delivered in 2023/24. • The ethnicity audit is due to complete by Q2 2023/24,	

[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, 47.6% in 2022), Q18 (2021)/Q20 (2022) (I think that my organization respects individual differences (eg cultures, working styles, background, ideas, etc) Baseline of 67.1% in 2021, 70.5% in 2022) and Q7c (I receive the respect I deserve from my colleagues at work. Baseline of 75.6% in 2021, 77.6% in 2022).

[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).

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)	and 3. Plans are also in place to recruit a training design expert to co-design the training module. • The manualised dialogical cultural capability training programme has a revised project plan in line with the cultural capability work, with a shift to delivery by Q3 of 2023/24. • The two anti-racism pilot interventions have been agreed as community-based recruitment, reducing restrictive practices and coercion and ensuring fair progression. Delivery will be in 2023/24. • The EMHIP evaluation has been delayed due to an unsuccessful search for an evaluation partner in March 2022. Plans are in place to seek an evaluation partner again in 2023/24 to deliver an evaluation by end of Q4 23/24. The framework has been agreed by the Delivery Group and the Trust's R&D team will help with quality assurance. The evaluation will cover the Wellbeing Hubs through the Trust's Adult Community teams and the Crisis Family Placement Scheme through the HTT and EMHIP programme. • The ethnicity audit is part of the EMHIP dashboard development, which is funded by the ICB. Partners are testing a trial version of the dashboard with a final produce due in Q2 2023/24. • Some aspects of MRES are in the Integrated EDI Action Plan for		• Cultural capability training will move to Q2 2023/24 and a revised project plan for the whole project, including the project delivery model, outcomes, milestones and risks has been developed. • The ethnicity audit is nearing completion with a trial version of the dashboard being tested by partners. This is expected to be ready for use in Q2 2023/24. • The EMHIP evaluation has not been delivered due to circumstances beyond the Trust's control. Plans are in place for 2023/24 for the interventions to be evaluated and R&D support is secured. • The completion of standardising reporting and data capture continues into 2023/24.	linked to the EMHIP dashboard delivery. • The EMHIP evaluation will be delivered in 2023/24 subject to finding a successful evaluation partner. • Standardising reporting and data capture will be delivered in 2023/24.	

	2022/23, with development of reporting and action planning processes to follow. • There are ongoing discussions about recording, reporting and monitoring of patient and staff demographic information as it relates to standardising and embedding reporting and data capture. Work in this area is ongoing. Diversity data will be reported as part of the annual report, public sector equality duty report and the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). • The EDI action plan has been refreshed and approved, including workforce actions. • EMHIP delivery plan has been agreed but did not take account of evaluation findings given this has not completed.				

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%; M12 17.41%) ***– Not met***
- Reduction in staff turnover for those with less than 12 months service (2022/23 M6 19.95%; M9 24.7%; M12 24.34%) ***– Not met***
- Reduction in sickness absence rate (2020/21 average 4.03%; 2021/22 average 4.97%; 2022/23 M6 5.09%; M8 5.05%; M11: in month 5.17%; rolling 12 months 4.87%) ***– Not met***
- Reduction in vacancy rate (2021/22 19.78%; 2022/23 M6 19.87%; M9 17.3%; M12 17.23%) ***– Met***
- Improvement in feedback around medical staffing, recruitment (both candidate and managers) and employee relations ***– Not yet measured***
- Monthly reduction in employee relations cases (baseline March 2022 81, March 2023 62) ***– Met***
- HR Recovery Plan delivered ***– Met***
- Leaders reporting improved skills ***– Not met***
- Improved HR & OD team staff survey results ***– partially met; improvement across 4 of 9 metrics***
- Substantive HR & OD team in place ***– Partially met***
- 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] ***–partially met (further details in the footnote)***

Delivery priorities	Q4 2022/23 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 22/23 delivery	Year-end delivery rating

• 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:
  ○ Reduction in agency spend achieved (Q4)
  ○ Effective high quality medical staffing, employee relations and recruitment service in place and able to support all Service Lines and corporate teams.
  ○ Rolling policy review and update programme in place.
	• Senior stakeholder engagement around the leadership framework has taken place and the leadership development offer is now being progressed through relevant governance.
	• In terms of specific HR recovery plan elements:
	  ○ Agency use has levelled out, impacted by recent industrial action. A new process for proactively managing requests for agency staffing is in place and is taking effect in some areas.
	  ○ Improvements have been seen in the Recruitment
			• Significant engagement has taken place on the Leadership Framework and Offer but this has not been delivered in-year.
			• Delivery of the policy framework and the policy review have not been met despite many attempts to do so.
			• Improvements have been seen across most of the HR recovery plan elements with significant progress to a stable HR function.
				• The Leadership Offer is planned for agreement in Q1 2023/24, with delivery commencing in Q2.
				• Following the identification of dedicated resource, a focused policy review will begin in May, for 12 weeks. The introduction of new policies will now be progressed in Q1 2023/24 with training delivered in Q2 2023/24.	

[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, 55.4% in 2022). 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, 41.1% in 2022). 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, 54.1% in 2022).

[5] For PP element on development specifically Q20c (2021)/Q22c (2022) (I have opportunities to improve my knowledge and skills. Baseline 70.3% in 2021, 71.1% in 2022) and Q20d (2021)/Q22d (2022) (I feel supported to develop my potential. Baseline 54.4% in 2021, 56.5% in 2022).

• 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)	service with permanently recruited staff in place. The next focus will be on improving the processes around experience and a more attractive 'pull' approach to attracting colleagues. ○ Improvements are also being seen in medical staffing responsiveness. Focused work has taken place on AAC panels, recruitment activity, rota management and general queries. Unfortunately, the candidate recruited to the Head of Medical Staffing post has withdrawn. Options on this are currently being worked through ○ ER cases remain challenged but some improvements have been made in identifying and progressing ER cases ○ Rolling policy review is behind schedule. A focused review will commence in April with a view to now deliver in Q1 2023/24. • There has been a decrease in the engagement score from 5.7 to 5.5 in the Staff Survey results. Pulse survey results are awaited. • The People Plan will now be smaller in scope, following Executive				

	discussions. This will be delivered in Q3/4 of 2023/24. • Work on OD and cultural development have progressed with an OD framework being developed in Q1 2023/24. In addition, support will be provided to teams to pilot different approaches.				

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 – ***Met*** • SWL MH provider collaborative, and team, in place ***– Partially met*** • Agreed MH budgets delegated ***– Partially met*** • SLP structures and delivery updated ***– Not met.*** • Place MH programmes developed ***– Not met.*** • SLL commitments delivered ***– Met.***					
Delivery priorities	**Q4 2022/23 delivery summary**	**Q4 delivery rating**	**Year-end delivery summary**	**Plans for any outstanding 22/23 delivery**	**Year-end delivery rating**
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 finalised and will be approved by the SWL ICB Board in May 2023. • SWL MHPC work remains underway with Complex Care Phase 2 delegation agreed. • SWL MH Partnership Delivery Group (PDG) continues to drive work forward and delivery agreement around MH has been drafted between the SWL MHPC and the SWL ICB. • SWL MHPC Programme Director started in post 09.01.23. • Existing SLP programmes have been reviewed and changes to leadership and structures are being developed. • South London Listens work continues with core elements delivered. **Places** • Kingston and Richmond MH place priorities agreed and further work to develop these programmes underway. Workshops to set Merton place MH		• SWL MH strategy has been a significant piece of work for 2022/23 that has taken much longer than anticipated. The Strategy is now under production and year 1 planning is underway. • The SWL MHPC work has been complex but has made progress with Complex Care Phase 2 delegation agreed and a pipeline of service areas agreed including perinatal as the next area. • Resourcing requirements for the SWL MH delivery work are under discussion.	Work will continue on SWL (system and place), SLL and SLP areas into 2023/24.	

• 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)	priorities are underway. Work is yet to start in Wandsworth.				

Objective 6: To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL. • Planned outturn met **– *met*** • CIP 2022/23 plans in place and delivering on four priority areas **– *Partially met.***					
Delivery priorities	**Q4 2022/23 delivery summary**	**Q4 delivery rating**	**Year-end delivery summary**	**Plans for any outstanding 22/23 delivery**	**Year-end delivery rating**
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 M11 was £300k below plan leaving cumulative position £0.5m over planned delivery (11.8m vs £11.3m target). £13.1m schemes now identified (£700k above target) and RAG rated giving us a 103% confidence (compares well to a 93% confidence at M11 in 2021/22). Issue remains that whilst £12.5m of the savings are rated green currently only c£3.7m is recurrent (30% of the target) which is no improvement over the position at the prior quarter's reporting (30%). • CIP has been fully delivered in 2022/23; however, there is a concern that only circa 30% is recurrent, but the 2022/23 control total is highly likely to be delivered. • The 2023/24 CIP plan is in place with minimal unidentified CIP of circa £1m. The plan was approved by FPC before 31.03.23. **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. • The Tolworth Business Case was approved by the Trust Board and,		• CIP plans have been successfully delivered 2022/23 and a plan produced for 2023/24 with minimal unidentified CIP. • The Tolworth business case has been successfully signed off by Trust and ICB governance and is now with NHSE and DHSC for final approval. • There have been delays to completing the provider collaborative due diligence so this remains outstanding for 2023/24. • The delivery of the budget planning module also remains outstanding and will move to 2023/24. • Strategic finance resource has not been recruited.	• Provider collaborative due diligence will be completed on an area by area basis reflecting the new approach to SWL MHPC development. • Delivery of the budget planning module will form part of BAU delivery in 2023/24.	

	following subsequent iteration, has now been approved by the ICB. The draft has been submitted to NHSE and DHSC. • Work to complete the provider collaborative financial due diligence is delays but underway. • As reported in Q3, there have been delays to implementing the budget planning module owing to staffing pressures. The module has been procured and this will now form part of BAU in line with 2023/24 objective delivery.				

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

Meeting:	Trust Board
Date of meeting:	11th May 2023
Transparency:	Public
Committee Name	People Committee
Committee Chair and Executive Report	Sola Afuape Katherine Robinson

BAF and Corporate Objective for which the committee is accountable:
People Committee has responsibility for the following BAF risks:

- Failure to have the right staff with the right skills at the right time.
- Failure to effectively respond to EDI issues facing the Trust.

People Committee is responsible for the following corporate objectives:

- To support our people to develop and grow and develop our organisation to be the best that we can be
- 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 March and April meetings of People Committee:

1. Reduction of agency spend.
2. Recruitment and Retention (especially in relation to the retention of younger staff / staff in non-qualified clinical roles).
3. Workforce Plans.

Areas of Risk Escalation to the Board:
The continued risk of the impact of potential industrial action, including staff health and wellbeing, and the appropriate training of staff taking on other roles in order to help during periods of industrial action. Although an area of risk, the Committee were assured that they had been sighted on any potential risks and the mitigations in place.

For each item discussed at the Committee there would be a statement against the 3 areas below:
Board Assurance Framework (BAF)
What: The Committee reviewed the People and EDI BAF.

So What: Key risks are around community-based recruitment, recruitment and retention and career pathways. Work was being prioritised in these three areas.

What next: The Committee asked for more work to be done around uptake of flexible working. There would be a paper coming to the Committee in the future around "Looking after our People". Please see below Quality Report section for actions around the three priority areas. As things improve, the Committee suggested scheduling reviews alongside some of these improvements and potentially reducing the risk score as a result. whilst recognising the BAF still has a way to go, the body of work is progressing, and is more comprehensive with the sprint element. Papers received by the Committee give the opportunity for rigorous oversight and assurance.

Making Life Better Together (MLBT)

What: The Committee received a report focused on the staff engagement aspects of the MLBT programme.

So What: Staff engagement had been high over the last year. The Committee noted improvements in areas of the Trust being inclusive and kind, and respectful of cultural differences, and that staff felt valued for their work.

What next: The Committee agreed with the staff engagement priorities for next year, such as a focus on Health and Wellbeing, and anti-stigma and anti-racism. Work would be needed around leading with compassion. It was asked that future iterations of this report include explicit commentary of the role of MLBT in building resilience and compassion in leaders.

Quality Report

What: The main areas of concern arising from the Quality Report in March and April were recruitment, Medical Staffing and Employee Relations (ER), although retention, MAST training rates, lack of career progression opportunities and the impact of potential industrial action were noted as areas of concern.

So What: The metric used to measure recruitment, from advert to offer letter, would be reviewed to see if it could be changed to from advert to time starting in post. Vacancy levels had continued to drop; however, April figures were starting to level out as there had been an increase in turnover rate, specifically those staff in their first year of service. The current data showed that a lot of staff who left the Trust were in non-qualified clinical roles, who could not access career opportunities or did not have a specified career pathway. ER cases had risen but the Committee were assured that this was due to the increase in the People Delivery Partners and their robust scrutiny of cases, and it was expected that this increase would level out as a result of this robust scrutiny going forwards.

What Next: There was a detailed action plan to address Mandatory and Statutory Training (MAST) completion rates. MAST was also added to the Committee forward plan, in order to ensure this piece of work was reviewed appropriately. Retention had

become a big area of focus in workforce priorities. There were some sprint actions that would take place from April to June to look at the reasons staff were leaving and to consider mitigations that could be put into place.

Agency Spend

What: Agency spend was discussed, as it is an important issue across the whole organisation. The Committee were assured that discussions were ongoing at ELT around this area of concern.

So what: The Trust had made some good progress in reducing agency usage, but had now plateaued and so needed some other initiatives to reduce its use further. The Committee were informed that there would be focused attention on some new initiatives such as creating a peripatetic bank post for patient observations, for teams where observations were more inevitable, to avoid last minute agency bookings; and on Community Services, which has more long-term agency staff in posts. It was noted that agency spend was different for each of the Trust's services, and so each service required a bespoke response. Some bespoke work was ongoing, such as work to understand the cause of the turnover of Band 3 staff as this had a knock-on effect on agency use. There was also discussion around increasing nursing input into the staff bank, to help with the support, training and wellbeing of bank staff.

What next: The Chair asked that future reporting to People Committee highlight where the hotspot areas were and interventions that were implemented; as well as progress updates and any lessons learned, if available. The Chair would also liaise with the Chair of the FPC in order to ensure that work was not duplicated and that finance was being considered appropriately by the work of the People Committee in this area.

Staff Survey

What: The People Committee were reviewing the staff survey results, action plans and subsequent implementation of actions, at each meeting.

So What: Last year it was agreed to focus work on three areas – Learning and Development, Ethnicity and Health and Wellbeing. The results do not suggest this should be changed in any way, especially because change takes time to embed. There may need to be some additional focused support in some hotspot teams and areas highlighted by the analysis, that happens alongside the work in the three areas.

What next: Communications and HR would be leading some focused conversations with leaders in each of those teams that were identified as hotspots, and hosting some listening events with those teams. Last year teams were asked to take one action that they felt they could change that could make a difference to their team. HR would be keeping this approach as it had worked well. For example, Pharmacy last year saw some challenging results. They held a listening event and put in place some thoughtful things around psychological safety. This year they saw real change in their staff survey results. HR were looking to share some of these positive stories to show teams that they can make a change at a small level. The Committee happily noted that events were being organised throughout all sites to meet staff to discuss the staff survey, what

the plan going forwards was and how staff would be better supported. This was to show action being done and that there was a plan in place taken from their survey feedback. The Committee looked forward to an update on this piece of work at a future meeting.

Leadership Development Approach

What: There are three main areas that the Approach focuses on – Healthcare Leaders Framework, the Leadership Way (behaviours expected of leaders in the NHS as part of the People Promise) and Scope for Growth (a way of assessing and developing talent).

So What: The Trust would help assess Leadership and ensure there was appropriate development for our leaders recognsing the challenges they have and their key role in our organisaiton. As well as structured programmes this would be supported with staff having access to 360 degree assessments, mentoring /coaching, and self-assessment tools.

What next: The offer would be bought together and consideration would be given to how the Trust can allow people to develop a leadership career and how success could be measured. It is hoped that this would eventually be built into the PADR process for 2024/25.

Appendices

Minutes of the March 2023 meeting of the Workforce and OD Committee.

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

WORKFORCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Approved Minutes of the meeting held on **Tuesday 28 March 2023**, 15:00-17:00 via MS Teams.

Present:

Sola Afuape (SA)	Non–Executive Director (Chair)
Ann Beasley (AB)	Trust Chair (attended until 16:00)
Katherine Robinson (KR)	Director of People
Sharon Spain (SS)	Director of Nursing and Quality (attended until 16:00)

Attendees:

Emdad Haque (EH)	Associate Director of Health Inequalities and EDI (attended from 15:30)
Jenna Khalfan (JK)	Director of Communications and Stakeholder Engagement
Johnny Steyn (JS)	Joint Trust Employee Engagement Manager
Pam Warren (PW)	Deputy Director of People

Observers with speaking rights:

Jeremy Coutinho (JC)	Diversity in Decision Making Representative and Recovery College Manager
Nisha Proietti (NP)	Diversity in Decision Making Representative and Deputy Senior Employment Advisor, Sutton Uplift

Apologies:

Jen Allan (JeA)	Chief Operating Officer
Vanessa Ford (VF)	Chief Executive Officer
Jan Lonsdale (JL)	Head of Education and Development

Minutes:

Elaine Holder	Corporate Governance Manager (recording only)
Emma Whitaker	Deputy Director of Corporate Governance (minutes taken from recording only)

	Item	Action
1	**Standing Items**	
24/1	**Welcome and Apologies**	
	Apologies for absence were received and noted as recorded above. The Chair formally welcomed NP as the Committee's second Diversity in Decision Making Representative. It was noted that NP had a particular interest in Equality, Diversity and Inclusion, having recently been on the EDC Committee.	
24/2	**Declarations of Interest**	
	No new declarations were reported.	
24/3	**Chair's Actions**	
	No Chair's Actions have been taken since the last meeting.	

	Item	Action
24/4	**Minutes of the meeting held on 24 January 2023** The minutes of the meeting held on 24 January 2023 were approved as an accurate record with the following amendment: • Page 3 – "*Retention continues to increase, even though recruitment is increasing, unfortunately the numbers of staff exiting the Trust does not get the Trust ahead. Themes the Guardian Service are monitoring are, when staff are considering leaving, are being captured so this is worked through rather than receiving this information as part of an exit interview*". This was not a clear statement. It should state that, although SWLSTG are recruiting successfully, retention is decreasing, so the numbers are standing still. KR to provide a new form of words to explain this more clearly.	**KR**
24/5	**Action Tracker** The Committee received and noted the action tracker. The following updates were received: • **22/54 – Committee Forward Plan –** This item was on the agenda for this meeting. Action to be closed. • **22/86 - Staff survey –** This item was on the agenda for this meeting. Action to be closed. • **22/89 – Leadership and Development Report** – This was a piece of work looking at the Trust's Leadership and Development offer, where the deadline has had to be extended because staff were prioritising MAST and industrial action. Action to remain open. • **23/5 Lessons Learned Report** – This item of work follows on from the HR Recovery plan. The Chair did not want to lose the learning as there was significant impact on the organisation. KR and SS agreed to take the report back to ELT and check they are happy with it. Action to be closed. • **Action from FPC** – This was a specific ask of the Committee, to request a scoping of work and outputs, templates and timelines in terms of the impact on agency costs. It was noted that Community transformation was also running through EMMG. The work out of EMMG would sit with the workforce plans. KR would discuss this with the Chair outside of this meeting to ensure that this work meets the needs of the FPC but that there is also no overlap. This can be reported back to FPC. Anything outstanding would be taken as a Chair's Action and then reported back to the Board. Action to be closed.	
2	**Culture**	
24/6	**Director of People Report** The Committee received the new Director of People Report. This report helped to set more context for the Quality and Performance (Q&P) Report, as although the Q&P Report has more detail, its information was always a few months in arrears. The Director of People Report should give the Committee more opportunity to review the current status of, and to reflect upon, the Committee's critical areas of focus and key areas of risk.	

The Chair thanked KR for this report and stated that she found it helpful for setting context and felt it would help provide richer conversations about the Q&P report.

Reported:
KR highlighted the following points:

- The Report would have five key priority areas of focus:
  - Recruitment
  - Medical Staffing
  - Employee Relations (ER)
  - Retention
  - Mandatory and Statutory Training (MAST) compliance.
- The cover sheet to the Report summarised the current challenges and priorities.
- This Report was linked to the BAF.
- There would be two 'sprint' pieces of work, in 12-week sprints. Doing the work in this way would also allow release of resource.
- **Recruitment** – the overall vacancy rate had dropped, which was good news. An issue was that substantive recruits for key Medical Staffing HR roles had withdrawn after waiting for a couple of months. In one example the Trust that the candidate currently worked for had offered them an Assistant Director role in order to retain them. Fortunately there was some contingency in place.
- **ER** – the majority of cases were sickness based. Since introducing the more experienced Senior People Delivery Partners, there had been a spike in cases. This was thought to be because the Senior People Delivery Partners are uncovering more cases and progressing them. It was expected that the number of cases would start to drop-off after this initial spike.
- **MAST compliance** – a number of actions were being taken to manage the MAST compliance rates and a number of root cause issues were appearing. It was initially thought that the rates were due to DNA rates and capacity for courses; it was now thought to be a wider range of issues. KR had taken a paper to the Executive Directors to explain the issues and there was now a more robust approach to improve rates on an ongoing basis. The February 2023 Q&R report shows that rates were now on the right track and were improving.
- Industrial action – unfortunately there was going to be Junior Doctor's strike action during a peak period of annual leave.

Discussed:
The Committee was asked if they felt that the five priority areas were the right areas of focus, and if there was anything missing:

- Whether Recruitment should be changed to Recruitment and Retention, due to the aim being to increase substantive staff and keep them working in the Trust.
- Whether the metric to measure success in Recruitment - the time between the advert and the conditional offer – should be amended to time between the advert and the person starting with the Trust. KR stated that her team would manage this affectively, as it was important that the process ran well from advert to offer. There was a better handle on this now that there was a weekly

team meeting with the Resourcing and Onboarding team. There was a 'sprint' piece of work around Retention, and a paper had gone to the Executive.

- Whether agency spend should be a priority. KR stated that she had been very clear that this was an organisational issue. HR were supportive of this and were actively working with service lines, who were responsible for budget and agency spend. KR and the Director of Finance were working together to manage this. SS added that if the five areas of priority suggested by KR were well managed, this would have a positive impact on agency spend. The Nursing Directorate had been looking at how to make onboarding less 'clunky' and a better experience. Some of the newly appointed nursing staff reported having a positive experience. PW had agreed to support looking at some of these systems.

The Committee was also asked to support maintaining the internal focus on these areas. The Chair asked for more clarity on this point.

The Committee discussed that there seemed to be a lot of external meetings and was there a way of managing these down.

Agreed:
The Committee agreed the five key areas of focus.

The following actions were agreed by the Committee:

- KR to look at changing the metric to measure success in Recruitment - the time between the advert and the conditional offer – to the time between the advert and the person starting in post. **KR**
- In the next Director of People Report, KR to include information about the 'sprint' activities, and what Committee oversight should be to monitor these to ensure the outcomes are embedded and sustained. **KR**

24/7 Staff Survey Report and Analysis

The Committee noted the report. The Chair thanked JS and his team for the huge amount of work on the staff survey.

Report:

KR and JS highlighted the following:

- An initial high-level paper on the results had been taken to the Executive to review.
- A more high-level analysis and final report of the results would be going to the ELT the week commencing 2 April. This would come to the new People Committee for review and information in the April meeting. The Committee would be asked to ensure that people have viewed the survey results and to have a high-level conversation about them. The final report would include any areas that the Committee raised in today's meeting.
- The response rate is slightly better than past years but slightly lower than last year.
- Last year the Trust rated 6th lowest in Mental Health Trusts, and were now at 39th out of 51, which is a good improvement.
- There was a significant decrease in responses to only two questions.
- The result for "We are recognised and rewarded" was below average.

- The score for staff engagement remained the same as last year, which was good news.
- There was a pleasing increase in the score for "We have a voice that counts".
- The themes Learning and Development, EDI and Health and Wellbeing came up, as they did last year. JS and KR suggested the following recommendations:
    - That the Trust wanted leaders to have the confidence to support their teams, and that leaders were developed to have a career with the Trust. There will be a new Leadership Framework and development offer to support this.
    - That the Trust wanted to ensure that the anti-racism approach keeps being taken forward.
    - That the Trust wanted to support staff to stay working for the Trust for longer, and to support this, to renew focus on the 'not tolerated' approach to bullying and harassment.

Discussed:
The Chair asked if the paper coming to the April People Committee meeting could be clearer about any hot spots, and the different workforce elements that impact on the staff survey results.

The Chair picked up that the paper helped to pull out the differences between equality and inclusion. Whilst inclusion rates were better, it seemed that staff still felt a sense of inequity. The inclusion base activities were effective so if similar activities were applied to equalities the Trust should see improvement. The People Committee should help with this going forwards.

EH stated that there might be some 'quick wins'. For example, there could be a deep dive on staff experience of Bullying and Harassment. It was known that staff working in front line roles and bank staff have three times more negative experiences than white colleagues.

NP stated that, as deputy chair of the staff Mental Health network, she had seen improvement for black and ethnic minority staff, such as the Diversity in Decision Making role, and recruitment opportunities.

JC stated that, as a union representative, he initially felt disappointed to see stagnancy and minor improvements in the results; but that context was key here. Trusts had all had a difficult time and yet SWLSTG was improving compared to other Trusts. There had been a longstanding issue in the Trust with HR, with a big impact that other Trusts may not have seen. All of the work that is going on should have more of an impact going forwards.

JK raised that there had been changes and positive increases in scores around kindness, appreciation and respect for difference, which says something positive; however, the areas with decreases were worrying, such as advocacy scores, which were important questions in the staff survey. In context, though, the Trust had done reasonably well. There had been a conversation in the Executive Advisory Group about the early staff survey results and the Executive focused on some of the areas with decreased scores. There was disappointment about

the results and the perception of lack of progress. One of the key discussions was around importance of line managers and how this impacts staff feelings of worth, engagement, development and learning. Learning and Development and the leadership framework would be really important next year. Another of the key discussions was around how change takes time. These surveys come thick and fast and on reflection, staff could see that the Trust were making small and important changes in the areas of focus that were agreed last year. ELT agreed that it was of critical importance to maintain consistency in approach to these recommendations and not swap and change, as real positive changes are being made.

KR stated that, as well as HR recovery having an impact on the results, at the time that the survey was live, the Trust were moving into the new hospital buildings and some staff were moved to Tolworth. Last year, when action planning for this staff survey, ELT agreed that there would be three corporate areas to concentrate on and teams were asked to concentrate on one area that would really make a difference for them. This was a different approach than usual. It was recommended that the same approach is taken this year as well. The Chair asked if the April paper could address how the new People Committee could have oversight of this new approach and track its progress.

Agreed:
The following actions were agreed by the Committee:
The April People Committee paper to address how the new Committee could have oversight of the ELT's new approach to the staff survey and track its progress. **KR**

24/8 Making Life Better Together (MLBT) Update
The Committee noted the update report and JK highlighted the following:

- The Report reflected the Committee's request to have an increased focus on impact measures.
- The Report is focused on the staff engagement element of the MLBT programme of engagement work.
- Engagement with staff had been high over the last 12 months, with a large number of initiatives.
- To measure the impact of this element of the programme, outputs of the staff survey; feedback on events; campaign clicks; open rates for emails; and the large amount of qualitative feedback received about the work (over 300 comments/emails received) were used.
- This year, work had focused on putting in place some things that had not been in place before, such as the monthly exceptional people awards and long service awards; and picking up things that had fallen to the wayside, such as street parties.
- Improvements had been made in some of the key areas, such as that staff feel the organisation respects cultural differences, saying that the Trust are kind and inclusive, and people are recognised and valued for their work.
- A huge amount of work on recognition and appreciation had taken place and this was coming through in the staff survey results. It is hoped to get

improvement around staff engagement within the first 12 months of employment, which would hopefully have a positive impact on retention.

- A key area of work would be around people's understanding of and ability to access flexible working, as well as people's ability to speak out, and if they speak out, that they will be heard and it will not have any detrimental impact.
- Staff engagement priorities for next year were:
    - Values into behaviours
    - Health and Wellbeing
    - Recognition and Appreciation
    - EDI, anti-stigma and anti-racism
    - Everyone as Leaders.

Discussed:
The Committee were asked if they agreed that the staff engagement priorities for next year were the areas where MLTB may make a difference and improve staff survey metrics in these areas.

That Line Managers need development to lead in a compassionate way. This often comes up as a theme in ER cases and staff survey results. Some good work has been done in the wider NHS around leading with compassion and the Trust could tap into some of that. Resilience may be another area to focus on for Line Managers, as when things are hard it can be hard to lead compassionately. It was discussed that MLBT could build resilience into future works for managers and those with delivery roles. This work should link up with the People Board Assurance Framework (BAF). It was discussed how managers' views could be included in this work, such as focus groups and ongoing discussions. It was noted that one aim of MLBT was 'everybody as leaders' – so recognising everyone has a leadership role, so no specific work had been done with line managers. JK stated that it was something the Trust could look into, ensuring links between Communications and HR teams. Compassion and resilience were recognised as important. Previously, the Trust had run three sessions open to all staff, facilitated by the Kings Fund, on compassionate leadership. The sessions included resilience, compassion and responding effectively to bullying and harassment. JK agreed it would be something that could be ran again. EH suggested some work around how leaders/managers distribute leadership in teams, as some people think they have a natural ownership of leadership and they do not want to offer their teams the opportunity to lead. He felt that this could be woven into the Performance Appraisal and Development Review (PADR) model.

NP stated that her team across Merton, Sutton and Wandsworth are very interested in Mental Health First Aid (MHFA) training. JK responded that the Trust were hoping to be successful for a significant charity bid to support the Trust in conducting MHFA training for staff and communities. This feeds into the prevention agenda and shows how much the Trust values and invests in its staff.

EH stated that the Trust should think about how it becomes competitive. Understanding and looking after its people and providing all the tools and support needed to work well, gives the Trust a competitive advantage against similar providers and national organisations. It was noted that the current workforce was

quite young and if the Trust want to attract and retain the younger workforce it needs to consider what would attract them to the Trust and motivate them to stay in the organisation. Some of the activities ran by the Trust, including black history month black pride, were quite impressive. JK discussed that the two things other organisations that were regarded as good at staff inclusion and engagement had done were running campaigns around civility linked to compassion, recognition and appreciation – to communities, patients and each other; and joy at work - how can the Trust create joy at work. Part of what young people see in the post-Covid world was a job that they can feel joyful in.

The Chair asked that future iterations of this report include some explicit commentary on the role of MLBT in building resilience and compassion in leaders. It would also be helpful to have some manager's insight and feedback on culture, and any insights into what was working well elsewhere.

Agreed:
The Committee agreed the staff engagement priorities for next year.

3 Performance

24/9 Quality and Performance Report

The Committee noted the Quality and Performance Report.

Reported:
PW highlighted the following:

- Vacancy rate – since August 2022 the rate had moved down to 17.1%, showing that real progress had been made in attracting people to the Trust. There had been some increases to the establishment, e.g. some new roles had been created over the last few weeks. There were problems flagged in the process e.g. where managers are putting out bulk recruitment, those posts would show as active vacancies unless managers manually put in the individual job references.
- Turnover rate – There was concern about the turnover rate in the first 12 months of employment, which was 24.3%. The hotspots were in the younger demographic (20-30yrs) and predominantly in HCA and Health and Wellbeing practitioners roles. This indicates issues with career pathways and that staff do not stay in the Trust as there are no jobs for them to go into or no support mechanisms. More work would be needed about how to retain that group of people. Turnover in general was at 18.4%. As part of the workforce plans, each service line would be reviewed to address hot spots.
- Time to recruit is below seven weeks. The initial metric used – time from advert to offer – is an NHS standard metric, which is built into the Trac system so it can be benchmarked against other Trusts. There were a few processes within the full recruitment process which would build in delays, e.g. notice periods, PINs for student nurses.
- ER cases – there had been a steady progression from 59 to 74 cases. 67% of these cases were sickness cases. As KR flagged earlier, this demonstrates that the People Delivery staff are now able to progress these issues. Due to this it would be likely the case numbers would increase in the next couple of months and then should stabilise. It was noted that there were 14 ET cases at the moment, with two possibly coming off.

- Two areas of concern were ER cases and MAST and its impact on patient safety. In terms of ER cases, the HR Business Partners (HR BPs) had had some instability and there would need to be some time given for the new HR BPs to embed and get to know systems and services. Insight into 70% of the cases showed that they were cases that could be looked after by entry-level HR staff rather than experienced staff, as they were around "how do I operate a policy" or "how do I have a difficult conversation". There were a small number of complex grievance cases. It was noted that the team now had some good insight about what the future ER provision should look like.
- MAST – there had been a downturn as per the Director of People report. There were now action plans connected to MAST and a regular Friday meeting to keep track of progress against the action plans.
- Agency spend – it was worrying that agency spend was increasing, with particular hotspots in the community. There was an ongoing piece of work as part of the workforce plans, working with service lines to track against the target of 3.7%, which is the NHS national target. There would be a month by month plan on how to reduce agency usage. Some good work was already taking place; for example, an area of high spend was locum medics. The Trust had done some work with the Royal College of Psychiatry and as a result, 10 CVs would be coming forward for 18 of the assessed doctor roles.
- ER cases exceeding 90 days - the majority of cases were linked to sickness where treatment was ongoing and being monitored.

Discussed:
The Chair commented that the level of assurance had increased rapidly from where it was 6-9 months ago; e.g. approach, plans and strategy; all of which provided the Committee with greater confidence.

The Committee noted that the Finance and Performance Committee's critical areas of focus is agency spend, as the Trust is an outlier in the system and this had significant implications and impact on the Trust's ability to recruit to other areas. The Chair stated that it would be helpful to know that hotspots are being identified, and the Committee would also like to know how the hotspots are being prioritised.

The Committee noted the number of ER cases and discussed whether the sickness cases are related to work related stress. PW confirmed that the majority of sickness cases are cold and flu related, followed by stress. The data did not differentiate between work related stress and other factors. It was discussed that, if the HR support were unpicking some issues within the organisation, such as sickness ER cases, if there would be some value in having a deep dive, to understand this alongside triangulation with the staff survey results. This insight would be helpful when reviewing actions to mitigate risks in terms of the BAF.

The Chair requested clarity on the approach to the MAST training, recognising that in previous Committees, there had been debate on how a target of 100% achievement would be unrealistic. It was discussed that benchmarking was key in reviewing MAST figures. It would be helpful to see where the Trust sits with other Trusts and to discuss if the MAST target is realistic. There were a number

of reasons behind non-compliance that were being drilled into; some were systems related.

The Committee noted that the workforce plans will give detailed plans on agency spend against each professional area. The Chair noted that it would be helpful for the Committee to receive assurance as to what that means and when the Trust may reach its target.

The Committee were surprised to see the low rates of supervision, especially in non-clinical areas, as supervision is crucial.

The Committee noted that the metric 'time from advert to hire' was something that needed some thought but there was no system capability to do this at the moment. The HR team were currently doing some process mapping work to review how to measure recruitment. There had been a piece of work and some measures put into place, in terms of the transactional side of onboarding. On investigation, the induction is working, some issues were about equipment, security cards, and where staff need to go, so all stakeholders need to be in the room.

The Committee noted that there was work ongoing around exit interviews and creating a dashboard from this work. It was discussed if it was known where people were going to when they leave the Trust. IT was noted that the Q&P report said that 50% of turnover in the community teams were IAPT workers who had left for career development. Reason for leaving can be recorded on ESR but the data was not always accurate. Intelligence from managers and from exit interviews suggests that a majority of staff were leaving due to lack of career progression. The Trust was as a result, looking at having career pathways to support those in training. This work is also within the workforce plans.

4 Accountability

24/10 People BAF

The Committee noted the People BAF.

Reported:

The previous iterations of the BAF were operationally focused. This new People BAF was more strategic and covered a lot of the subjects discussed in today's meeting. The timeframes had been reviewed by ELT to ensure they were achievable.

The Trust risk register had a new risk around industrial action which was 'red'. This was not on the People BAF as this was not a workforce issue, however, if the industrial action continued for a long time that could create knock-on issues. The impact of other strike action (e.g. teaching staff) impacting on staff needed to also be monitored.

Discussed:

The Chair noted that out of 11 assurance areas, seven were red. She asked if the Executive members were happy that the actions attached to BAF would move these areas from red towards amber and green. KR stated that she was happy

with the actions, although industrial action might take staff out for a few days, for example. If the capacity in the team stays the same, the actions should progress well. This would be kept under review.

Concerns around lack of take up around flexible working were discussed. JC suggested the Freedom to Speak Up Guardian and the unions be asked to take this forward as a campaign. KR and JC would discuss this outside of the Committee.

Discussed:
The Committee were asked if they felt that all of the appropriate risks were included on the BAF and that the actions to mitigate the risks were appropriate.

Agreed:
Commentary to be added onto the BAF to show how the impact of the strikes had been considered for the next committee. **KR / SA**

24/11 People Matters Minutes
The Chair stated that she found these minutes useful to review and she asked that these continued to be bought to the People Committee.

5 Strategy

24/12 Workforce Planning Approach 2023/24
The Committee noted the Workforce Planning Approach 2023/24.

Reported:
KR highlighted the following:

- The Report was produced for information. Something more comprehensive would be coming to a future meeting.
- This was first year HR have joined with the process; in previous years the approach was decided by service lines. This has allowed for some triangulation of data into one central plan, such as issues out of Q&P report, recruitment and retention themes and agency spend.
- Workforce planning should take a five year view; that capability was being built into the organisation. The plan was aiming to include the understanding of the patient demographic and patient needs, and how needs were becoming more complex. There was also a piece of work to understand the finance. Staff had raised concerns around finance, such as if they recruit to all of their vacancies how can they achieve their CIP savings; so models must be financially sustainable.
- HR staff had spent time over the last 4-6 weeks with service line leads and leadership quartets, looking at understanding what workforce planning involved, considering future risks and opportunities, and posing some critical friend questions to challenging their thinking. The team then pulled together a comprehensive overview which contained a slide for each service line including data and challenges. The slide decks were taken to heads of service and nursing to socialise the packs with them, to ensure that timescales were workable. Over the next month a lot of detailed plans would be put into place, including timescales and trajectories. This work would be bought to the next Committee for its overview.

24/13 Q4 Corporate Objectives

This item was not discussed at this meeting, as there would be a Board seminar next week about next year's objectives. This item would come back to the April Committee.

6 Committee Governance

24/14 People Committee Workplan 2023/24

This Forward Plan was bought to each Committee for review and would go to the new People Committee from April for review and consideration of the objectives for year ahead. EDI would be more embedded in the work of the People Committee going forwards.

It was discussed that the Committee would like to have something on Staff Wellbeing sooner than July 2023 as members had been increasingly hearing about this. It would also be a good indication of how people were settling into the new hospital.

24/15 Matters to Report to the Board

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

24/16 Meeting Review

The Chair invited members and attendees to feed back on the meeting.

NP felt her first meeting had been great. She had a lot of questions and would like to join the meeting with KR and JS when they discuss onboarding. She had had some good feedback from some new starters in her team.

JC felt that presenting papers was getting more succinct which was helpful and enabled members and attendees to focus on the key points.

EH stated that it was a very well Chaired meeting with good timekeeping, and it had been an effective session.

PW stated that everyone had contributed and got involved, and the Chair had ensured everyone had space to contribute and challenge.

The Chair thanked KR, PW and team, as the quality of papers had improved, and the style and format lent itself to focus on critical issues.

The Chair would share with the Board the key discussions from the meeting:

- Recruitment and retention
- Some of the comments about the importance of MAST,
- Recognising that the strengthening of processes is happening and as a result there is better understanding of key measures and a greater insight for the Committee, as it would be able to focus on key areas and hotspots.

24/17 Date of Next Meeting

It was noted that the next Committee meeting will be the first meeting of the new People Committee, and would be held on 20 April 2023.

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

Meeting:	Trust Board
Date of meeting:	11 May 2023
Transparency:	Public
Committee Name:	Finance & Performance Committee
Committee Chair and Executive Report:	Vik Sagar (Committee Chair); Juliet Armstrong (Chair March Committee) 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 closed 2022/23 with an underlying deficit, the positive outcome on MHIS funding etc will improve the position to c£7m. Focus must be maintained to improve this position further.
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 is asked to ensure focus is maintained in this area. The saving is consistent with the expectation of the ICB following the work of PA consulting. Increased controls by the ICB are going to be imposed.

4. **Productivity** – work is on-going to improve productivity, changes to the reporting of key metrics with clear definitions of responsibility of oversight will help to gain traction. Each Board Committee will have oversight of their specific elements of the overall Quality & Performance Report.

5. **Culture –** Board is asked to discuss and consider how the Trust should invest and create an environment that enables space for leaders to identify process efficiencies and creates a culture of belief that they will be deliverable, leading to financial sustainability.

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 eradicate spot purchases by 1 April through change in clinical practice will not be achieved. It was noted that action was planned for April that was aimed at improving flow, getting patients into the most appropriate setting more quickly without recourse to further private capacity.
- **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 People Committee
- **Productivity** – limited assurance; it was recognised that this is a new metric and we are still seeking improved reporting via dashboards. Next step needs improved identification of drivers of opportunity and more consistent recording of data along with action to influence culture so that teams share best practice better, and re-quantification of the opportunity.

2022/23 M11/M12 Finance Report (including Savings update)

Full assurance provided, evidenced by financial position continuing to be on track against plan. Focus to remain on key drivers of the underlying position as described above. The Month 12 update provided assurance that the 'draft' accounts were submitted on time and delivered against the key financial targets. The annual accounts submission category split between income, pay and non-pay changed after the FPC report, with no overall impact on the bottom line. Delivery against the PSPP target was

not yet confirmed and unlikely to be achieved, further work is being done on this prior to 'final' accounts.

Annual Plan Submission

Full assurance provided by a well documented report highlighting key concerns, risk and changes since the report shared with the Trust Board in March. Plan was approved (delegated by Trust Board) for submission on 30 March.

Revised national guidance requires a further submission on 4 May. April FPC approved the proposed improvement, based on latest information, to the proportion of recurrent (now 62% previously 34%) vs non recurrent schemes (now 38% previously 62%).

The Trust could improve its position significantly, albeit non recurrently, if the Edward Wilson House sale were to be progressed by DHSC. Currently there is insufficient assurance that the sale will complete in 2023/24.

System position is required to improve by £12m. At the time of April FPC there remained a £2m gap and the Trust position remained breakeven. There was a risk that the Trust would be required to contribute to the gap up to a max of £250k. FPC Committee discussed whether it's delegated powers to approve the plan covered the potential £0.25m upside that may be required. It was concluded that on balance this was not a material movement and Committee could approve this, however, requested the DoF to seek "virtual" support from the wider Trust Board.

System deficit position will lead to increased financial controls for the Trust and continued pressure to improve the financial position to offset acute provider deficits.

Commercial Priorities Report

Fully assured - content noted with no significant matters of concern; committee noted the potential opportunity to support the financial position though recognised that capacity would be an issue.

Corporate Objectives 2022/23 Q4 Report

Fully assured – committee noted the volume of amber although recognised this had been trailed.

BAF

Assured – committee reviewed the latest version of the BAF and noted the updates since their last review; several suggestions were made to further improve the entry. Committee noted that due to the relative stability of the entries pertinent to their portfolio that updates would be taken quarterly excepting where material change occurred.

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 - Finance Report Part A 2022/23 M11 - cover and PowerPoint
Appendix 2 - Finance Report 2022/23M12 update - cover only
Appendix 3 - Planning Update 2023/24 (March Committee) - cover and PowerPoint
Appendix 4 - Planning Update 2023/24 (April Committee) – cover only
Appendix 5 - Corporate Objectives 2022/23 Q4 report

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

Report Title:	**Finance Report 2022/23 Month 11**
Meeting:	FPC
Date of Meeting:	30 March 2023
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Transparency:	Public
Scrutiny Pathway	Director review / ELT / FPC / Trust Board

Purpose:	☐	Approval	☒	Discussion	☒	Information	☒	Assurance
Additional information:								

What?	The purpose of the paper is to report on the financial position of the Trust and provide updates on the financial targets against which the Trust is performance monitored against. Key items to note are: ➢ **Year End Forecast** – broadly in line with plan at breakeven. ➢ **Cumulative position** – broadly in line with plan at £0.3m deficit. ➢ **In Month position** - the position for February, Month 11, is a £0.3m surplus. ➢ **Underlying Position** – remains at £1m deficit per month, c£12m per annum, the key drivers remain agency, external beds and non-recurrent delivery of savings. ➢ **Agency** – an increase of £0.1m compared to January spend, above budget, cumulatively 7.1% of pay bill, 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, costs increased again in February, the highest monthly spend to date. ➢ **Savings** – schemes have been identified to achieve the full £12.4m target. Year to date delivery is £11.8m, £0.5m ahead of plan. Recurrent Delivery is forecast at 30%, £3.7m. Nationally recurrent savings delivery is 50%. ➢ **Capital** – an underspend of £3.5m 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 (IFRS16) 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 £30.7m.
So What?	The report provides full assurance that the Trust is on track to achieve a breakeven position for the year, and sufficient progress

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

	is being made against all financial targets. 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. ➢ The key drivers of the underlying deficit remain external bed usage, agency costs and ability to deliver recurrent savings. Focus must therefore remain on these areas and traction to improve them achieved. ➢ 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. ➢ There are no exceptional part B 2022/23 items to bring to committee's attention. ➢ A planning paper will need to be submitted to FPC for approval but at this time there is minimal movement from that previously presented to committee. Separate papers have been considered by ELT on Leases and CIP planning and these will inform the final submission. The main outstanding item for plan submission is finalisation of contracts and agreement of MHIS and SDF funding.
What Next?	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. ➢ Prepare Final Plan submission and associated reports.
Any specific issues to note and/or for escalation:	1. Committee are asked to ensure that focus is maintained on reducing external beds, reducing agency and delivering recurrent savings.

Strategic ambitions this paper supports	☐	Increasing quality years	This paper supports by outlining how the Trust will achieve its financial goals, highlighting key cost drivers and their impact on underlying financial sustainability.
	☐	Reducing inequalities	
	☐	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	Outlined below are the key implications which may result from the proposals or information contained within this report
Equality analysis *[linking to EDI strategy]*	Positive impact – The Trust spends money to improve equality and diversity for patients and staff

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

Service users/ carers	Positive impact – Trust Funds are spent to get the best value to support our clinical services and patients
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
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Strategy:	Positive impact – The Trust has a good reputation for achieving financial targets
Workforce:	Positive impact – The Trust has a good reputation for achieving financial targets
Sustainability Eg. Green Plan.	Positive impact – The Trust knows its cost drivers and is taking positive action to ensure financial sustainability
Other (specify):	n/a

Appendices/Attachments:	One Power Point accompanies this cover sheet.

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

Finance Report 2022/23
11 Months to February 2023 – part A

Meeting	FPC
Date of Meeting	March 2023
Report Title	Finance Report 2022/23 – 11 Months to February 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

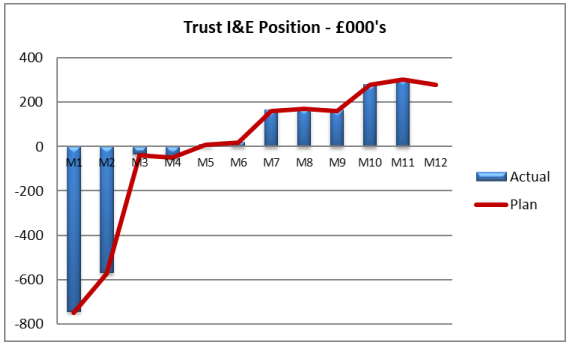
- In February, the Trust recorded a £0.3m surplus, marginally favourable to plan
- The cumulative deficit has now reduced to £0.3m, also marginally favourable to plan
- The expenditure position includes new year investments relating to MHIS and SDF. Unfunded pressures such as external bed usage and observation 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 Trust now expects to deliver the forecast position of break-even for year end. This is the result of non-recurrent measures and support being used to offset in-year underlying pressures e.g external bed usage, observation costs attached to high acuity patients, and high agency usage.
- The underlying position of the Trust remains one of concern and continues to run at a deficit approaching £1m per month

Financial Reports 2022/23	Current Month			YTD month 11			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	22.0	0.4	237.9	237.3	(0.6)	260.0	260.0	(0.0)
Pay	(15.7)	(15.0)	0.7	(167.2)	(161.7)	5.5	(183.3)	(177.6)	5.7
Non Pay	(4.3)	(5.4)	(1.1)	(55.5)	(60.8)	(5.3)	(59.9)	(65.6)	(5.8)
EBITDA	**1.7**	**1.6**	**(0.1)**	**15.2**	**14.7**	**(0.4)**	**16.8**	**16.7**	**(0.1)**
Cap Charges - Depreciation	(1.0)	(1.0)	0.0	(10.5)	(10.5)	(0.0)	(11.5)	(11.9)	(0.4)
Cap Charges - Interest & Div	(0.4)	(0.4)	(0.0)	(4.7)	(4.7)	(0.0)	(5.1)	(5.1)	0.0
Interest	(0.0)	0.1	0.1	(0.2)	0.2	0.5	(0.2)	0.3	0.5
Post EBITDA	(1.4)	(1.3)	0.1	(15.5)	(15.0)	0.5	(16.9)	(16.8)	0.1
Underlying Surplus / (Deficit)	**0.3**	**0.3**	**0.0**	**(0.3)**	**(0.3)**	**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**	**(0.3)**	**(0.3)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**

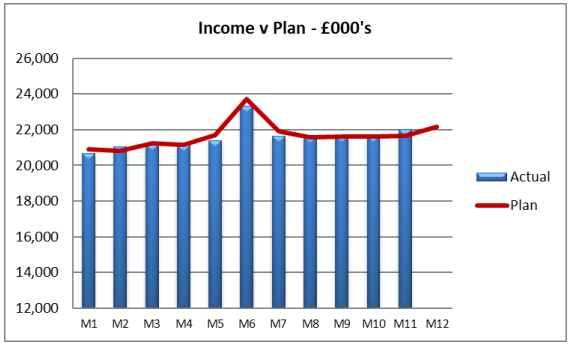
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

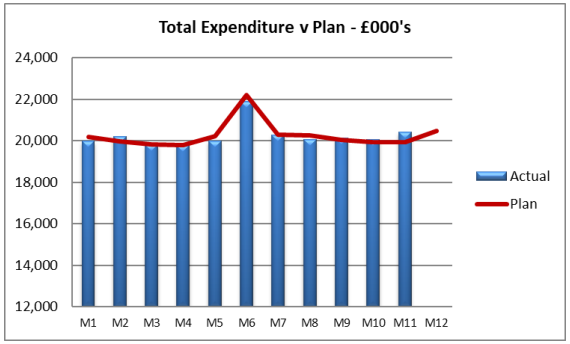
- Baseline surplus of £305k reported in month, £3k favourable to plan
- Cumulative deficit of £279k, £33k favourable to plan
- Deficit driven by external beds, Coral and Observation costs
- Significant risks to break-even position have now been mitigated non-recurrently



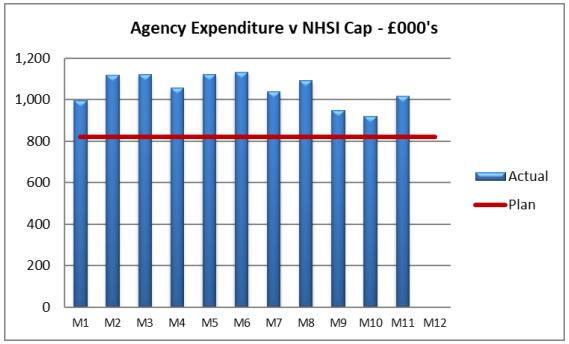
- Income received in month, £22.0m, £0.4m above plan
- In-month position reflective of additional education funding (£0.3m)
- Position also includes: additional SLP funding, Winter Pressure and Hostels monies partially offset by the NI reversal
- Additional funding negotiated in respect of Surge activity (£0.5m) and depreciation (£0.6m)



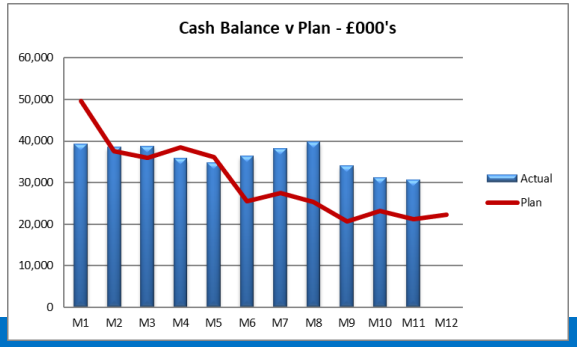
- Spend of £20.4m in month, £0.5m above plan
- External bed expenditure of £715k in month, £59k more than M10
- Significant External Bed pressure continues into M11, largely funded by investment slippage
- Position also reflective of additional digital therapy expenditure in-month (£111k)



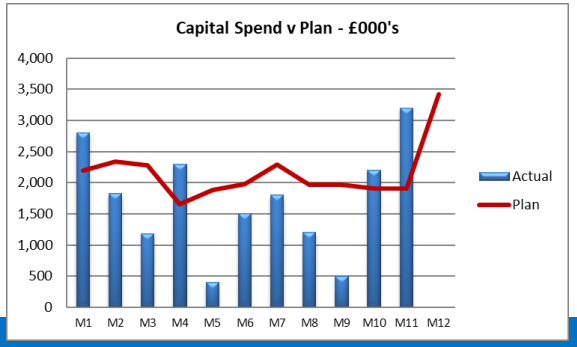
- Agency spend in month £1,017k, £179k above 2021/22 average spend
- £198k above plan
- Cumulatively, £2,536k above plan
- Community spend in M11 of £631k (62% of total)
- Cumulative Community spend now £6.1m (53% of total)
- Corporate spend further reduced to £32k in month



- Cash balance at end of February £30.1m
- £9.5m 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 £3.2m, £1.3m above plan
- Cumulative spend of £18.9m, £3.5m below plan
- Underspend found in EMP construction costs
- Forecast spend of £27.3m, £1.5m above plan but mitigated by additional funds negotiated
- Excludes leases, £15.4m, capitalised under IFRS 16



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

Income Position

- For Month 11 the Trust reported £22.0m of income, £0.4m above plan, and cumulatively £0.6m 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 now in line with plan
- 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 £0.4m favourable to plan due to additional salary replacement funding being received
- Other non-clinical income is £1.3m 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 11			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	179.7	179.7	(0.0)	196.5	196.8	0.2
Nhs England	1.7	1.7	0.0	18.3	18.3	(0.1)	20.0	19.9	(0.1)
Npsa Income	0.0	0.0	(0.0)	0.5	0.5	0.0	0.5	0.5	0.0
Provider Collaborative Income	1.8	1.8	0.0	19.0	19.0	0.0	20.7	20.7	0.0
Other Nhs Clinical Income	0.3	0.4	0.1	3.3	3.7	0.4	3.7	3.9	0.2
Nhs Clinical Income	**20.1**	**20.4**	**0.3**	**220.8**	**221.1**	**0.3**	**241.4**	**241.8**	**0.3**
Education & Training	0.7	0.9	0.2	7.4	7.7	0.4	8.0	9.0	0.9
Other Non Clinical Income	0.4	0.2	(0.2)	4.8	3.6	(1.3)	5.2	4.0	(1.2)
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**	**1.1**	**0.0**	**12.3**	**11.4**	**(0.9)**	**13.3**	**13.0**	**(0.3)**
Non NHS Clinical Income	0.5	0.5	0.1	4.9	4.8	(0.1)	5.3	5.2	(0.1)
Non Nhs Clinical Income	**0.5**	**0.5**	**0.1**	**4.9**	**4.8**	**(0.1)**	**5.3**	**5.2**	**(0.1)**
Income	**21.6**	**22.0**	**0.4**	**237.9**	**237.2**	**(0.6)**	**260.0**	**260.0**	**(0.0)**

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

Pay Position

- Pay amounted to £15.0m in February, £0.7m favourable to plan
- Medical Staff are now overspent by £1.0m due to continued and increased high agency and bank usage
- Despite continued acuity pressures, Nursing budgets are now showing a £0.4m underspend cumulatively
- Other Clinical Staff (principally Psychologists) have continued the trend reported in previous years and have returned a £6.5m cumulative underspend to date
- Non-Clinical staff are showing a £0.3m 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 11			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.4)	(2.6)	(0.2)	(26.3)	(27.4)	(1.0)	(29.1)	(30.2)	(1.1)
Nursing	(6.5)	(6.3)	0.1	(70.9)	(70.5)	0.4	(77.4)	(77.2)	0.2
Other Clinical	(4.1)	(3.4)	0.7	(41.1)	(34.6)	6.5	(45.1)	(38.2)	6.9
Non Clinical	(2.7)	(2.6)	0.1	(28.9)	(29.3)	(0.3)	(31.6)	(32.0)	(0.3)
Total Pay	**(15.7)**	**(15.0)**	**0.7**	**(167.2)**	**(161.7)**	**5.5**	**(183.3)**	**(177.6)**	**5.7**

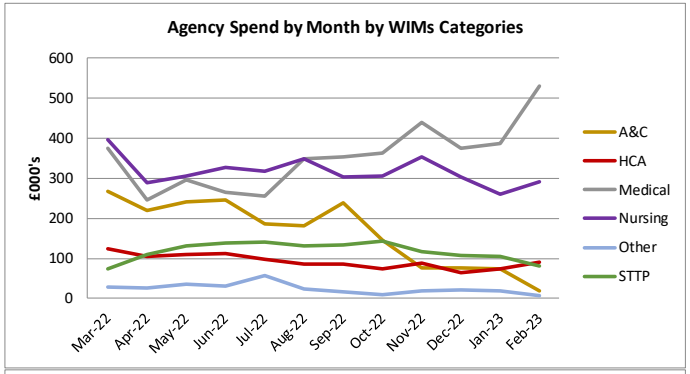
- Agency expenditure of £1.0m in February was £0.2m above both the Trust's plan and average 2021/22 monthly spend
- Bank expenditure was £1.7m, in line with plan. The cumulative position is now £1.4m above plan
- Permanent pay amounted to £12.3m in month. This was £0.8m favourable to plan due to continued vacancies and provision releases. Permanent pay is now £9.5m favourable to plan cumulatively with the underspend driven by Psychologist vacancies and provision releases

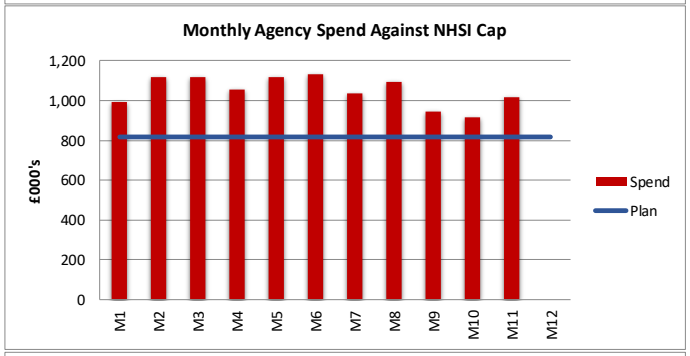
Financial Reports 2022/23	Current Month			YTD month 11			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(13.1)	(12.3)	0.8	(139.2)	(129.8)	9.5	(152.8)	(142.4)	10.4
Bank	(1.7)	(1.7)	0.0	(19.0)	(20.4)	(1.4)	(20.7)	(22.6)	(1.8)
Agency	(0.8)	(1.0)	(0.2)	(9.0)	(11.5)	(2.5)	(9.8)	(12.7)	(2.9)
Total Pay	**(15.7)**	**(15.0)**	**0.7**	**(167.2)**	**(161.7)**	**5.5**	**(183.3)**	**(177.6)**	**5.7**

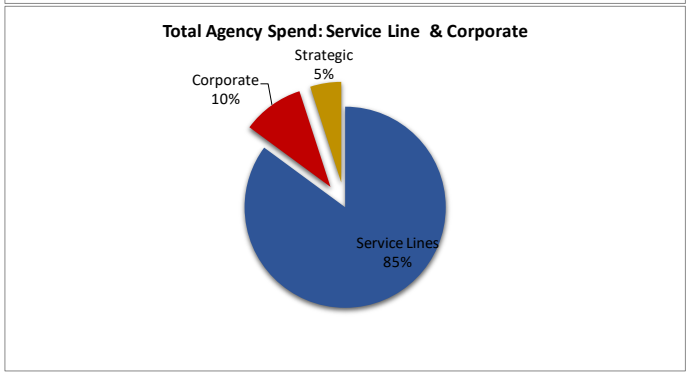
South West London and St George's Mental Health NHS Trust

Agency - in month and cumulative position

- Month 11 agency expenditure amounted to £1,017k
- Increase of £99k on Month 10 expenditure
- Equates to 6.8% of pay costs (7.1% cumulatively, 6.1% in 2021/22, London average 4.4%, NHSE target 3.7%)
- Highest areas of monthly spend: Medical £530k, Nursing £291k, and HCA £91k
- The increase in Medical Agency usage is notable. The M11 figure is £142k above M10 levels and the highest single monthly level recorded over the past 5 years. In M11 Medical accounted for 45% of all agency expenditure compared to 30% in April
- All other areas have shown reductions against average monthly spend incurred in Q1
- In total 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
- The key pressure area remains the Community Service Line; of the £1,017k total spend, £631k (62%) was incurred in Community. This represented an increase of £36k on January expenditure and £171k on April 2022 expenditure
- 85% of agency expenditure to date has been incurred within the Trust's 4 clinical service lines, with 10% relating to corporate areas, and 5% relating to agreed strategic investments
- Including strategic investments, cumulative Corporate expenditure has amounted to £1,721k for the first 11 months. This compares to £603k 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 £5.4m in month, a £1.1m overspend (cumulatively £5.3m overspent)
- External bed expenditure amounted to £0.7m in February, £0.4m above plan. This was the highest monthly spend of the year to date and increases the cumulative overspend to £2.6m
- Other costs are now cumulatively £2.6m 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 11			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)	(2.0)	(2.1)	(0.1)	(2.2)	(2.3)	(0.0)
Clinical Supplies & Servs Cost	(0.0)	(0.0)	(0.0)	(0.5)	(0.5)	(0.0)	(0.5)	(0.6)	(0.0)
Secondary Commisioning Costs	(2.3)	(2.6)	(0.3)	(29.7)	(32.3)	(2.6)	(32.2)	(35.0)	(2.8)
Other Costs	(1.8)	(2.6)	(0.8)	(23.2)	(25.8)	(2.6)	(24.9)	(27.9)	(2.9)
Contingency	0.1	0.1	0.0	(0.1)	(0.1)	(0.0)	0.0	0.0	0.0
Total Non Pay	**(4.3)**	**(5.4)**	**(1.1)**	**(55.5)**	**(60.8)**	**(5.3)**	**(59.9)**	**(65.6)**	**(5.8)**

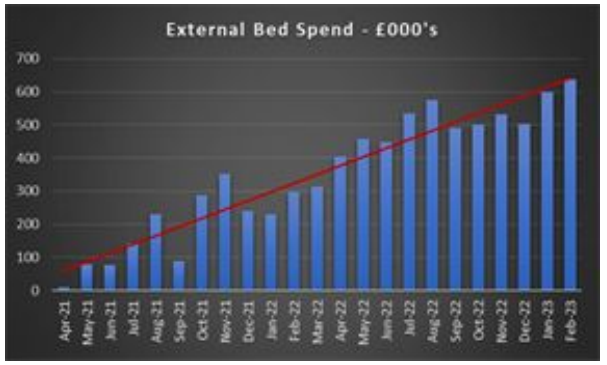
- Post EBITDA costs are now cumulatively £0.5m favourable to plan. This is as a result of the Trust capitalising interest payable in relation to the EMP loan alongside a favourable performance on Interest Receivable
- The increase in depreciation budgets since the start of the year reflects the impact 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

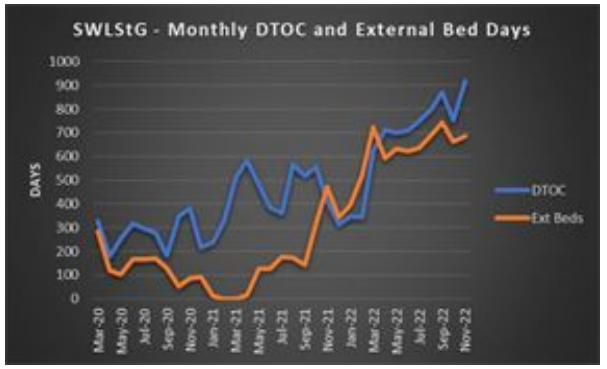
Financial Reports 2022/23	Current Month			YTD month 11			12 Mths to 31 March 2023		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Cap Charges - Depreciation	(1.0)	(1.0)	0.0	(10.5)	(10.5)	(0.0)	(11.5)	(11.9)	(0.4)
Cap Charges - Pdc Dividend	(0.4)	(0.4)	(0.0)	(4.7)	(4.7)	(0.0)	(5.1)	(5.1)	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest	(0.0)	0.1	0.1	(0.2)	0.2	0.5	(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**	**(15.5)**	**(15.0)**	**0.5**	**(16.9)**	**(16.8)**	**0.1**

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

External Beds, DTOCs and Acuity

- Over the past 23 months, spend on external beds has been on a steady upwards trajectory, increasing from £9k in April 2021 to £637k in February 2023. This is a major financial risk for the Trust.
- Expenditure in February was £637k , £37k above the January level, and remains significantly above the 2021/22 monthly average of £224k.
- Total spend to date in 2022/23 amounts to £5,684k. This gives an average monthly spend of £517k which is 231% above the 2021/22 average
- Of the total expenditure to M11 of £5,684k, the largest amount (£3,799k) is with Hollybourne (previously Huntercombe), for which the Trust has a contract for 18 beds. Additionally, the Trust has utilised "overflow" out of area beds at a cost of £1,606k. The Trust has also spent £196k on Male PICU capacity and spent £83k on Female PICU capacity (over and above the contracted ELFT beds)
- To M11, the Trust has also spent £350k on Discharge To Assess beds and £998k on hostel capacity. The break-even plan was predicated on no DTA usage from June and a maximum of 6 hostel beds being used. Usage above these levels presents a further financial risk
- Combined, the usage of external/hostel/DTA beds has resulted in a £2,734k overspend to date. This has been mitigated to date through the release of in year investment slippage
- The graph to the right shows a clear correlation between the increase in DTOCs and the number of external beds required. In March 2020 DTOC days equated to 328, by November 2022 this had increased to 917. During the same period, external bed usage increased from 284 to 621.
- Another major risk facing the Trust is the additional acuity of patients. A fair barometer of this is the number of observation hours used each month. This has increased from an average of 9,251 hours in 2019/20 to 18,969 hours in the first 8 months of 2022/23 demonstrating that in addition to the increased bed demands, patients in the beds are more severely ill.





NHS
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 £4.6m 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 £3.1m underspent due to continued recruitment slippages
- Community is cumulatively £0.3m underspent. This position improved marginally during the month as additional income offset increased agency and digital therapy expenditure
- Specialist Services is £1.3m 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 which have been partially offset by underspends in Strategy, Nursing, and Finance alongside other non-recurrent benefits and provision releases
- 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 one of break-even. Non-recurrent mitigations and support have been utilised to offset the significant pressures that the Trust has faced during the year

Financial Reports 2022/23	Current Month			YTD month 11			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)	(4.2)	(0.4)	(43.0)	(47.6)	(4.6)	(46.8)	(51.1)	(4.3)
Camhs & Ed	(2.6)	(2.3)	0.3	(27.6)	(24.5)	3.1	(30.3)	(27.2)	3.1
Community (Adults)	(3.8)	(3.8)	0.0	(42.5)	(42.2)	0.3	(46.3)	(46.3)	0.1
Specialist Services	(2.7)	(2.4)	0.3	(29.1)	(27.8)	1.3	(31.8)	(30.6)	1.1
Corporate	14.6	14.4	(0.2)	157.3	156.8	(0.5)	172.0	171.9	(0.1)
Capital Costs	(1.4)	(1.3)	0.1	(15.5)	(15.0)	0.5	(16.9)	(16.8)	0.1
Total	**0.3**	**0.3**	**0.0**	**(0.3)**	**(0.3)**	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**

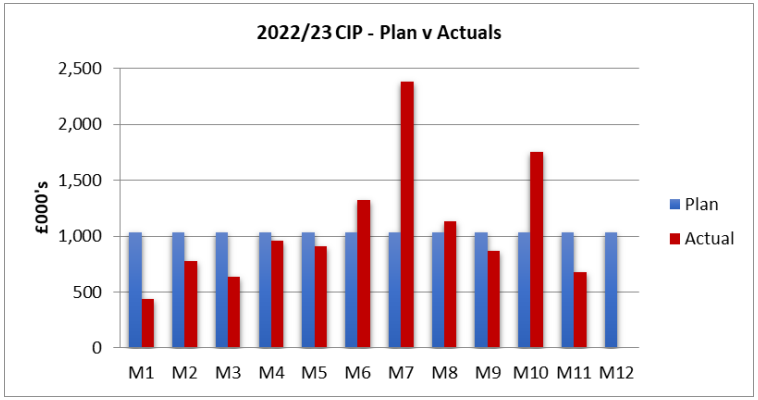
NHS
South West London and St George's Mental Health NHS Trust

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 over-recovery last month)
- This gives a 103% confidence level in delivery – the equivalent value for M11 last year was 93%
- In month delivery amounted to £0.7m against a target of £1.0m – a £0.3m shortfall
- Cumulative delivery now stands at £11.8m against a plan of £11.3m - £0.5m 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	3,742	0%	3,742
Green - Non-Rec	8,782	0%	8,782
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	2.7	(1.1)	18.8	15.3	3.5	21.9	23.2	(1.3)
Estates Maintenance	0.2	0.2	(0.1)	1.7	1.7	0.0	1.9	2.0	(0.1)
IT/Digital	0.2	0.2	(0.0)	1.8	1.9	(0.1)	2.0	2.0	0.0
Operational Total	1.9	3.2	(1.3)	22.4	18.9	3.5	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**	**3.2**	**(1.3)**	**37.8**	**34.3**	**3.5**	**41.2**	**44.2**	**(3.0)**

- Forecast spend for the year remains at £44.2m.
- The forecast includes £17.1m on leases which are shown on the balance sheet in line with the new IFRS 16 requirements. It 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.
- The forecast includes £1.3m of newly awarded national funding for capital schemes, the CRL will be adjusted.
- Capital expenditure for the month is £3.2m (£1.3m above plan); £34.3m cumulatively (£3.5m below plan)
- The Estates Modernisation Programme (EMP) is underspent by £3.5m 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. Contracts are in place and expenditure expected in March. 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

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

Statement of Financial Position

Statement of Financial Position (£m)	Plan as at end February 2023	Actuals as at end February 2023	Variance to YTD Plan
NON CURRENT ASSETS:			
Intangible assets	7.3	6.1	(1.2)
Plant, Property and Equipment	332.6	335.9	3.3
Receivables	26.7	26.7	0.0
Right of Use Asset	15.4	8.8	(6.6)
Total Non-Current Assets	**382.1**	**377.5**	**(4.5)**
Total Non-Current Assets Held for sale	**0.0**	**0.0**	**0.0**
CURRENT ASSETS:			
Inventories	0.2	0.2	0.0
Receivables due in less than 1 year	5.2	7.9	2.7
Other Financial Assets (Accrued Income)	1.6	2.1	0.6
Prepayments	0.0	1.4	1.4
Cash and Cash Equivalents	21.2	30.7	9.5
Total Current Assets	**28.2**	**42.3**	**14.2**
CURRENT LIABILITIES:			
Trade Payables	(35.8)	(10.9)	24.9
PDC Dividend Payable	(0.0)	(2.1)	(2.1)
Capital Payables	(11.1)	(11.9)	(0.8)
Provisions	(4.4)	(4.2)	0.2
Other Financial Liabilities (Accruals)	0.0	(32.1)	(32.1)
Deferred Revenue	(0.2)	(6.4)	(6.2)
Total amounts falling due within one year	**(51.5)**	**(67.6)**	**(16.2)**
NET CURRENT ASSETS/(LIABILITIES)	**(23.3)**	**(25.3)**	**(2.0)**
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)	(8.8)	6.6
Total amounts falling due after one year	**(121.5)**	**(115.0)**	**(0.1)**
TOTAL ASSETS EMPLOYED	**237.3**	**237.3**	**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	(0.3)	(0.3)	(0.0)
Revaluation Reserve	64.6	64.6	(0.0)
TOTAL TAXPAYERS EQUITY	**237.3**	**237.3**	**0.0**

- Current Receivables stand at £7.9m, £2.7m higher than plan, £1.7m from HEE and £1.1m relating to the EMP/car park leases, with prior year remaining £0.7m
- Cash is £30.7m, £9.5m 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.

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

Cash

All figures £k

	Plan as at end February 2023	Actuals as at end February 2023	Variance to plan
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)	5,113	4,619	(494)
Non Cash Adjustments			
Depreciation and Amortisation	10,553	10,538	(15)
Increase/(Decrease) in Working Capital	(2,767)	(728)	2,039
Net Cash Inflow/(Outflow) from Operating Activities	**12,888**	**13,614**	**726**
Cash Flows from Investing Activities			
Interest Received	11	629	618
(Payments) for Property, Plant and Equipment	(37,772)	(30,887)	6,885
Net Cash Inflow/(Outflow) from Investing Activities	**(37,761)**	**(30,257)**	**7,504**
Net Cash Inflow/(Outflow) before financing	**(24,873)**	**(16,643)**	**8,229**
Cash Flows from Financing Activities			
Interest element of finance lease	(715)	(583)	132
PDC dividend (paid)/refunded	(2,571)	(1,436)	1,135
Net Cash Inflow/(Outflow) from Financing Activities	**(3,286)**	**(2,019)**	**1,267**
Net Increase/(Decrease) In Cash And Cash Equivalents	**(28,159)**	**(18,663)**	**9,496**
Cash / Cash Equivalents at beginning of month	**49,403**	**49,403**	**0**
Cash / Cash Equivalents at end of month	**21,244**	**30,740**	**9,496**

- The cash balance at the end of the month was £30.7m compared with the plan of £21.2m.
- The increase of £9.5m relates to:
  - Capital spend +£6.9m
  - Movements in working capital, +£0.7m driven largely by late receipt of invoices
  - PDC Dividend +£1.1m
  - Other +0.8m
- 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

Report Title:	**Finance Report 2022/23 Month 12 Update**
Meeting:	FPC
Date of Meeting:	27 April 2023
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Transparency:	Public
Scrutiny Pathway	Director review / ELT / FPC / Trust Board

Purpose:	☐	Approval	☒	Discussion	☒	Information	☒ Assurance
Additional information:	The purpose of the paper is to report on the draft financial position of the Trust for 2022/23.						

What?	Key items to note are: ➢ **Submission** – draft annual accounts submission is 27 April. Audit will then take place with the intention of presenting Annual Accounts to Audit Committee on 13 June prior to Board approval. ➢ **I&E** – the expected position is an adjusted surplus of £41k, an allowable favourable variance against the breakeven plan. The overall position for the year is a £3.1m deficit due to market valuation impairments charged to the I&E. ➢ **Capital** - the position is £27.2m, an allowable favourable expected variance of £48k against CRL. The Trust is on track to achieve the CFL/EFL targets. ➢ **Cash** – the cash balance at 31 March 2023 was £20.9m with a further £1.7m sat in a solicitor commercial escrow account. ➢ **Savings** – the reported savings position is £12.5m, £0.1m more than plan. Of which £3.7m (30%) was delivered recurrently. This is in line with the previous forecast and less than the national 50% recurrent delivery. ➢ **BPPC** – the trust is currently below the 95% target of paying invoices within 30 days, further work is taking place. ➢ **Return on Assets Employed** – Trusts are required to generate a 3.5% return on assets employed, which is achieved through the payment of PDC. This is achieved. ➢ **Reports** – the normal suite of reports is not available due to the additional workload of annual accounts.
So What?	➢ The report provides full assurance that the Trust is on track to deliver its annual accounts on time and achieve key financial targets. There is a potential shortfall against the BPPC target, it is not unusual for Trust's to be below target. ➢ The key drivers of the underlying deficit remain external bed usage, agency costs and ability to deliver recurrent savings. Focus must therefore remain on these areas and traction to improve them achieved. ➢ The Trust currently has sufficient cash to manage its business and must not lose sight of the requirement to start

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

	repaying the loan in 2023/24, first repayment £10m.
What Next?	Actions have been identified as follows: ➢ Further review of invoices not paid within 30 days to see if they are legitimate exclusions from the target. ➢ Continued close working with KPMG to ensure audited accounts are ready to be presented to Audit Committee with no material movement to the draft submission. ➢ Focus on key drivers of the underlying deficit to improve run rates going forward.
Any specific issues to note and/or for escalation:	1. Note the unaudited financial position for the year 2. Committee are asked to ensure that focus is maintained on reducing external beds, reducing agency and delivering recurrent savings.

Strategic ambitions this paper supports	☐	Increasing quality years	This paper supports by outlining how the Trust will achieve its financial goals, highlighting key cost drivers and their impact on underlying financial sustainability.
	☐	Reducing inequalities	
	☐	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	Outlined below are the key implications which may result from the proposals or information contained within this report
Equality analysis *[linking to EDI strategy]*	Positive impact – The Trust spends money to improve equality and diversity for patients and staff
Service users/ carers	Positive impact – Trust Funds are spent to get the best value to support our clinical services and patients
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
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Strategy:	Positive impact – The Trust has a good reputation for achieving financial targets
Workforce:	Positive impact – The Trust has a good reputation for achieving financial targets
Sustainability Eg. Green Plan.	Positive impact – The Trust knows its cost drivers and is taking positive action to ensure financial sustainability

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

Other (specify):	n/a

Appendices/Attachments:	None

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

1. Executive Summary

This report is consistent with the 'key data' submission to NHSE of 19 April. This submission covers bottom line position for capital, cash position and a summarised I&E Position.

The Trust must submit a full set of accounts and supporting NHSE returns on 27 April, known as the 'draft annual accounts' submission. The bottom-line financial position for the Trust (capital, cash and I&E) must not materially change between 19 April and 27 April.

All information is subject to Audit.

This report provides an update on the draft year end position for 2022/23. The key message is that the Trust is on track to achieve all key financial targets for the year.

The normal suite of reports is not available due to the additional workload of year end accounts.

2. Full Year 2022/23 I&E Position

The Trust is reporting an adjusted position of £41k surplus and achieves the financial performance required against the breakeven plan.

The Trust has an overall deficit of £3,095k. However, depreciation on donated assets (£23k) and impairments due to market valuation (£3,111k) are recorded 'below the line' and not included in the underlying position against which the Trust is performance monitored. After adjusting for these the adjusted position is a £41k surplus.

The adjusted position (before impairments) is in total comparable to the forecast previously presented to committee and is shown in the table below.

All figures £m	FOT @ M11	Outturn	Movement
Income	260.0	275.2	15.2
Pay	-177.6	-192.9	-15.3
Non Pay	-65.6	-66.4	-0.8
EBITDA	**16.8**	**15.9**	**-0.9**
Cap Charge - Depreciation	-11.9	-12.4	-0.4
Cap Charge - Interest & Div	-5.1	-3.8	1.3
Interest	0.3	0.3	0.0
Post EBITDA	**-16.8**	**-15.8**	**0.9**
Underlying Surplus/Deficit	**0.0**	**0.0**	**0.0**
Impairment	0.0	3.1	3.1
Net Surplus/Deficit	**0.0**	**3.1**	**3.1**

Following confirmation of the accounting treatment of Trinity & Shaftsbury there was a improvement in the expected PDC position, this along with £15.2m additional income, are offset by additional expenditure. The key entries in March to get to this position were:

- **Pay award** – at the end of March guidance was received regarding accounting for the 2022/23 AfC non-consolidated pay offer. The cost, and therefore, additional income for SWLSTG has been estimated by NHSE as £5.3m. The estimate by NHSE was based on November data. The Trust estimate of the cost is £5.6m and guidance allows for expenditure to be accrued at a higher level than income. No revised guidance has been received following the rejection of the offer by RCN.

- **Central Superannuation Provision** – in line with previous years, Trusts are required to account for the additional expenditure arising from the 6.3% pension contributions paid by NHS England and the related income on a gross basis. The figure notified to the Trust and included in the accounts in both income and expenditure is £6.9m.
- **National Apprenticeship Levy Accounting** – in line with previous years, the Trust has adjusted the position at Month 12 to reflect the draw down during the year. This increases both income and expenditure by £0.5m.
- **Non Recurrent Support** – Income was received to support excess inflation (£0.5m), surge funding (£0.5m) and to support depreciation costs for nationally funded schemes (£0.6m)
- **Health Education England** - £0.3m additional income was received from Health Education England in "Q5". As HEE do not allow the deferral of income into 2023/24, and recognising the expectation that the Trust spends the money within the remit of HEE and had no time to do so within 2023/24, the income has been matched by equal and opposite expenditure provisions. This was the agreed approach with KPMG for 2021/22 accounts.
- **Ethnicity and Mental Health Improvement Project (EMHIP)** – the Trust received £0.8m income in March.
- **Ronald Gibson House Capital Grant** – the trust has provided for the full value of the capital grant that Treasury are being asked to waive, this is £1.1m more than the £1.7m provided in the 2021/22 accounts.

The position is subject to audit, where possible 'unusual/exceptional' entries were discussed with KPMG in advance to gain verbal support. Following the audit there will be a risk analysis review of entries on the balance sheet compared to known risks for 2023/24.

The Trust delivered £12.5m of savings against the target of £12.4m. Recurrent savings were 30% (£3.7m) of the total, Non recurrent were 70% (£8.8m). This is in line with forecast and below the national average of 50% recurrent.

The position against each of the savings schemes is shown below:

Ref.	Scheme	22/23 Target	YTD Actual	YTD Variance
1	Technical (NR)	4,050	4,596	547
2	Existing Establishment Vacancies (NR)	2,120	3,935	1,815
3	Slippage against new investment funds (NR): - 2022/23 £7m	1,700	1,700	0
4	- 2021/22 £2m	500	500	0
5	Clinical Efficiency	500	150	-350
6	Temporary staffing reductions	1,886	0	-1,886
7	Stretch target to 4.5%: Corporate	1,105	1,139	34
8	Site utilisation	200	167	-33
9	Drugs Management	200	256	56
10	Corporate Efficiency: HR	127	81	-46
Target		**12,387**	**12,524**	**136**

The position by service line is shown below:

Service Line SRO level	M12 YTD Plan £000's	M12 YTD Actuals £000's	Variance £000's
Acute and Urgent Care	970	970	0
CAMHS & ED	768	768	0
Community (Adults)	1,450	1,247	-204
Specialist Services	878	878	0
Nursing & Quality	232	232	0
Estates, Finance, Digital & Perf.	1,273	1,315	42
Strategy & Planning	58	58	0
H R / O D & Workforce	146	81	-65
Chief Executive, TSec & Comms	56	24	-32
Senior Operations Management	15	15	0
Medical	291	139	-152
Central & Technical	6,250	6,796	547
Totals	**12,387**	**12,524**	**136**

3. Full Year 2022/23 Capital Position

The Trust spent £27.2m on capital for the year. Expenditure is £48k less than the expected CRL for the year. Therefore, an allowable undershoot. The process for allocating CRL has changed for 2022/23 and therefore the CRL at draft submission is only £13.2m. Additional CRL are being allocated week commencing 15 May when the Trust is expecting a further £14.1m CRL to be allocated. Adjustments will also be made at this point to ensure EFL achievement for all Trusts.

Spend is £1.5m more than budget at the start of the year due to externally agreed funding for the 5th Tolworth Ward (£1.4m), Coral (£0.1m), Digital (£0.1m), Care Home (£0.1m) less £0.2m for Barnes which could not be spent as the scheme had not received national approval for 2022/23. Approval has been agreed for 2023/24.

NHS accounting rules require the Trust to breakeven against each subcomponent of CRL i.e. break even against National CRL (schemes awarded in year) and Local CRL. The Trust has a £44k undershoot against national CRL as the Coral scheme came in less than expected. The Trust has a marginal £4k underspend against local CRL however this masks a number of significant movements in year namely underspends against Tolworth and Richmond have enabled the additional expenditure on the retail units, refurbishment costs at Teddington, and the bringing forward of 2023/24 IT and estates bau schemes.

All figures £k	Original Plan	Adj	Expected CDEL	Actual	CDEL Variance
EMP Phase 1 (SPH)	9,287	-	9,287	12,707	(3,420)
EMP Phase 2 (TOL)	4,842	-	4,842	1,068	3,774
EMP Phase 2 (5th Ward national)	-	1,412	1,412	1,412	-
Barnes (national)	250	(250)	-	-	-
Teddington / Barnes	-	-	-	1,121	(1,121)
Richmond Royal	2,917	-	2,917	-	2,917
Other (Jup/Bluebell & PRCC)	1,727	-	1,727	2,158	(431)
Cost of Sales not yet completed	2,893	-	2,893	3,281	(388)
Total EMP	**21,916**	**1,162**	**23,078**	**21,747**	**1,331**
Estates Planned Schemes	1,885	-	1,885	2,947	(1,062)
IT Planned Schemes	1,992	-	1,992	2,256	(264)
Care Home (national)		75	75	75	-
Coral (national)		101	101	57	44
Digital (national)		119	119	119	-
Grand Total	**25,793**	**1,457**	**27,250**	**27,202**	**48**

National	250	1,457	1,707	1,663	44
Local	25,543	-	25,543	25,539	4
Grand Total	**25,793**	**1,457**	**27,250**	**27,202**	**48**

The Trust currently has an exceptionally high overshoot EFL of £20m. The EFL is the maximum financing required for the level of capital spend and makes no allowance for capital liabilities, creditors and accruals. Historically EFL limits have been adjusted based on need, and an adjustment is expected week beginning 15 May.

4. Assets Values, Purchase and Disposals

The District Valuer has performed a desktop valuation of Trust land and buildings. The valuation has reduced asset values by £6.0m, of which £2.8m reduced the revaluation reserve and £3.1m was a 'below the line' deficit to the I&E.

In 2021/22 at the Trust's request the District Valuer valued plots P&Q on the Springfield site at fair value under IFRS13. The rationale for this approach was approved by Audit Committee. As a result, asset values increased in 2021/22 by £16.9m. Therefore, a fair value approach has continued to be used in 2022/23. The DV has not confirmed an exact value but has confirmed that the fair value is not materially different from that in 2021/22 and would not be more. The accounts therefore reflect no change in the asset value. The Trust completed on the purchase of plot G (RGH) in February 2023 with a purchase price of £3.75m. This plot also forms part of the phase 2a sale. A fair value approach based on purchase price has been reflected in the accounts. These plots are part of the phase 2a sale which has exchanged and is due to complete in 2023/24. The fair value approach generates CDEL allocation on sale to support capital costs.

The Trust continues to provide for S106 future liabilities resulting from asset sales. However, indexation of the remaining outstanding S106 potential liability is now estimated at £7.4m.

Costs incurred in-year associated with future asset sales of Springfield and Barnes (£3.3m) are provided for within EMP capital costs. On completion these will reverse out generating a CDEL upside and will be netted off against sales receipts.

There has been no movement on the sale of Edward Wilson House which remains in the accounts with a NBV of £1.7m, and potential sales benefit of c£16m. The ICB has discussed the situation with National as the resulting benefit from the sale would be a non recurrent upside to both the Trust and System plans for 2023/24.

Accelerated depreciation has been applied to the modular build (building 30) at Springfield to reflect the need to remove it from Trust land in January 2025 at which point it will cease to have a value.

5. Cash as at 31 March and PSPP

The cash as at 31 March was £20.9m with a further £1.7m sat in a solicitor commercial escrow account pending confirmation of waiver of charge over the RGH property. This brings the total cash and cash equivalents reported in the accounts to £22.7m.

The Public Sector Payment Policy requires the Trust to pay 95% of debts within 30 days both in value and number.

At Month 8, based on value, only 8 of 35 London providers were achieving the target. The Trust position was 87.9% rank 24/35.

At the time of writing this report figures remain below target, at 91% by value (an improvement since M8 position), and 87% by number.

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

	2022/23	2022/23	2021/22	2021/22
	Number	£000s	Number	£000s
Percentage Paid Within Target	87%	91%	94%	97%
Target	95%	95%	95%	95%
	-8%	-4%	-1%	2%

The current position is being reviewed with particular focus on prepayments. The GAM allows adjustment where invoices are for prepayments, this is particularly relevant for the large number of complex care invoices processed by the Trust where the Trust is invoiced at the start of the month for that month's care. It is expected that figures will improve either for submission on 27 April or during the audit although it is not possible to say at this stage whether the target will be achieved.

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

Report Title:	**Planning Update**
Meeting:	FPC
Date of Meeting:	30 March 2023
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Transparency:	Public
Scrutiny Pathway	Director review / ELT / FPC / Trust Board

Purpose:	☒	Approval	☒	Discussion	☒	Information	☒	Assurance
Additional information:	The purpose of the paper is to report on the Trust's financial plan submission for 2023/24, submission due 30 March, and to seek approval for the submission.							

What?	Key items to note are: ➢ **I&E Planning –** no net impact from draft plan submission in February. Income and Expenditure plans are presented, in line with the agreed breakeven position before impairments. Impairments are estimated at £50m. There are significant risks associated with external bed usage, CIP delivery and agency costs. Risks are estimated at c£12m ➢ **CIP delivery** – currently £1.3m unidentified, balance allocated to services ➢ **External Beds** – plan includes 18 beds at Hollybourne and 6 hostel beds ➢ **Agency** – average as a % of paybill is 5.3% reducing run rate assumed achieving 3.7% target in M12 ➢ **Contracting –** MHIS and SDF income total agreed, usage to be confirmed when contracts signed, 31 March ➢ **Capital Planning** – The capital plan has been refined in line with ICB expectations. Plan includes Tolworth and Barnes development spend, and right of use assets. Since submission of the plan to ELT for review, the ICB has requested a £168k increase to the bau budget for 2024/25 which the Trust has agreed and enacted in the submission document. There has not been time to update this report for this change ➢ **Cash Flow** – minimum of 10 days operating expenditure maintained at all times ➢ **Balance Sheet** – increase in total assets employed generated by PDC for Barnes and 5th ward at Tolworth, and fair valuation of assets in year prior to sale. ➢ **WTE plans** – net reduction 56wte planned with increases resulting from new funding more than offsetting reduction if savings plans delivered.

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

So What?	Except for agency, the plan delivers the required financial targets. Agency is planned to reduce to 3.7% of pay spend in M12, this is highly ambitious, pre covid levels were 5.5%. The majority of savings schemes remain 'red' rag rated and progress is required. Contracting provides a £2.6m opportunity to depending on final contracting schemes agreed. External beds are currently above the planned levels and remain an area of significant financial risk. Whilst the cash plan indicates no cash concerns there are financial benefits of high cash balances and focus must be maintained on securing asset sales and the waiver of the RGH capital grant.
What Next?	Actions have been identified as follows: ➢ Finalise submission document to include the £168k capital 2024/25 increase as noted above. ➢ Review the likely completion date for Barnes, currently planned for 30 June but 30 September may be more realistic – this has no material change to the plan, minor cashflow movement only. ➢ Contracts to be finalised and financial impact on the plan confirmed ➢ Issue budget statements including the allocated CIP target ➢ Delivery plans need to be finalised, weekly CIP tracking to start from new year ➢ National submission of plan
Any specific issues to note and/or for escalation:	1. The financial plan needs to be approved. 2. Focus must be maintained on reducing run rate including agency, external beds and CIP delivery. 3. Contract finalisation has the potential to create a £2.6m upside, subject to pay award being fully funded, consideration is needed on how to apply this to the plan – reduction of CIP target, contingency or other.

Strategic ambitions this paper supports	☐	Increasing quality years	This paper supports by outlining how the Trust will achieve its financial goals, highlighting key cost drivers and their impact on underlying financial sustainability.
	☐	Reducing inequalities	
	☐	Making the Trust a great place to work	
	☒	Ensuring sustainability	

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

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

Equality analysis *[linking to EDI strategy]*	Positive impact – The Trust spends money to improve equality and diversity for patients and staff
Service users/ carers	Positive impact – Trust Funds are spent to get the best value to support our clinical services and patients
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
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Strategy:	Positive impact – The Trust has a good reputation for achieving financial targets
Workforce:	Positive impact – The Trust has a good reputation for achieving financial targets
Sustainability Eg. Green Plan.	Positive impact – The Trust knows its cost drivers and is taking positive action to ensure financial sustainability
Other (specify):	n/a

Appendices/Attachments:	One Power Point accompanies this cover sheet and word report.

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

1. Planning Update

The national submission of plans is due on 30 March. Approval is needed and January Board delegated approval of financial plans to the FPC.

The Contracting round has not yet completed and therefore working assumptions have been adopted where necessary to derive the plan submission.

2. Income & Expenditure Planning Update

Details of the I&E plan submission are provided. The key issues of note are:

- A break-even position (before impairments) is planned
- The position after impairments is estimated at £50m deficit due to the impairment of Trinity and Shaftsbury once reclassified as completed assets; this is schedule for end of Q1.
- There are significant financial risks associated with this plan including CIP delivery, external beds, agency costs, these are estimated at £12.2m
- The CIP target remains at £13m, as previously estimated. In addition, the Trust would need to continue to achieve £2.2m vacancy factor savings.
- Work to progress CIP development and devolvement to service lines has been progressed and unidentified stands at £1.2m. Significant progress is needed to move plans from red rag rating through to delivery. The annual plan submission assumes only 34% will be achieved recurrently, the Trust should aim to achieve a minimum of 50% recurrently.
- The plan already includes £2.3m release from the balance sheet and £1m from contract negotiations
- External beds are funded at an average of 18 in line with the existing Holybourne contract. The cost of external beds remains a significant financial risk.
- The Trust will not be able to achieve the targeted agency reduction to 3.7% of paybill. The plan is set with a gradual reduction and achieving an in month position of 3.7% of pay bill at Month 12. Detailed Delivery plans are needed to ensure that this is achievable. There is a risk that the plan will not be acceptable.
- Income and Expenditure includes an estimate for the transfer of Kingston IAPT, PCMHT and Substance Misuse contracts.
- Income and Expenditure include the agreed value for MHIS and SDF. Contracting needs to conclude to identify utilisation of these funds. Whilst in theory these should be cost neutral the following should be noted:
    - There is a potential £2.6m upside due to investment proposals including 'making good' investments that the Trust has made at risk in 2022/23.
    - Pay is currently set and funded at 2% increase for pay award. If awarded higher than 2% this will be funded centrally either by additional income or relaxing of activity and other targets; for Mental Health trusts this could be through MHIS funding therefore reducing the amount for new investment / pot
    - Risks have been submitted separately and are estimated at c£12m, broadly consistent with a £1m per month underlying deficit
- Whilst it is a financial plan, details of the wte impact are presented in the report. There is a net 56 wte reduction with investment more than offsetting CIP savings.

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

3. Capital Planning Update

The Trust must submit a draft 5 year capital plan, this adjusts years 2023/24 to 2026/27 from that submitted last year, and adds on another year. A draft was presented in the M9 finance suite of reports. Since then, the plan has been revised to reflect the recently approved MH UEC bid for the additional ward at Tolworth. Technical adjustments regarding treatment of asset sales and cost of sales have been made at the request of the ICB.

Of the £142m capital plan for the 5 years, £103.6m relates to Tolworth (£1.4m Tolworth costs are in 2022/23 following MH UEC bid approval), £11.1m Barnes, £3.5m for EMP related works e.g Richmond Royal, and the balance for business as usual capital.

The EMP team are concerned that the phasing of the Tolworth budget whilst broadly in line, with the FBC, may not be achievable and could lead to a significant unacceptable underspend in 2023/24. Work is progressing to determine a more realistic phasing and the ICB are aware of this potential significant rephasing (c£5-£8m) issue. EMC were minded to keep the phasing in line with the FBC however this requires a mitigating strategy to be agreed with the ICB.

Work is ongoing to prioritise the business as usual estates budget for 2023/24 to ensure best use of these limited funds.

Cash flow monitoring has been completed and a minimum cash level of 10 days operating expenditure is maintained throughout 2023/24. There is no change to planned asset sales which remain as previously stated. Asset sales create an opportunity to have higher interest receipts and reduced PDC payments and therefore should be closely monitored. Barnes PDC and fair valuation of assets in year increase the total assets employed by the Trust.

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

Financial Planning Update

Meeting	FPC
Date of Meeting	March 2023
Report Title	Financial Planning Update
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	Private
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

Progress since last month

- The purpose of this report is to updated FPC on the proposed final annual financial plan submission, due on the 30th March
- The format of the prior report has been retained and updated ensuring that the audit trail between opening position and final plan is maintained
- The overall position of break-even (after the £50m impairment) remains but there have been a number of other changes enacted:
  - At the time of the draft position, the base NHSE position, according to information received from the ICB, had increased by £0.9m. The Trust view was that this was unlikely and so an equal and opposite provision was made against this. Further clarification from NHSE has revealed this to be the case, so both are reversed
  - Close work with the ICB has enabled the agreement of additional SDF and MHIS investment. This amount equates to £10.0m and is reflected in equal and opposite expenditure increases. This has enabled the funding of Hollybourne beds to the 18 level and may provide some latitude to decrease the CIP level once investments are finally agreed
  - CIP planning has resulted in the split between income, pay and non-pay being revised
  - The Kingston IAPT transfer is now included, increasing both income and expenditure by £4.6m. The amount included is the Trust's reasonable assessment of the transfer and may be subject to some small movements
  - The potential 3-month delay in the receipt of £36m from London Square means that interest receivable will be £360k less than previously included. This is counter-balanced by an equal and opposite reduction in non-pay expenditure. The delay has also been reflected in the balance sheet and cash flow.
- The main movement in the capital plan relates to the inclusion of new and remeasured right of use assets

Detail	Income £000's	Pay £000's	Non-Pay £000's	Post EBITDA £000's	Total Position £000's
Draft Plan	**259,274**	**-177,748**	**-63,797**	**-67,729**	**-50,000**
Moves:					
NHSE	-892		892	0	**0**
SDF/MHIS	10,028	-3,576	-6,452	0	**0**
CIP Move	505	-2,745	2,240	0	**0**
Kingston IAPT	4,568	-510	-4,058	0	**0**
Asset Sale Delay	0	0	360	-360	**0**
Final Plan	**273,483**	**-184,579**	**-70,815**	**-68,089**	**-50,000**

	2023/24 £000's	2024/25 £000's	2025/26 £000's	2026/27 £000's	2027/28 £000's
M11 Planning report	**53,325**	**36,843**	**39,750**	**8,000**	**5,000**
Return of ICB Contingency	(2,023)		-	-	-
Trust share ICB demand > CRL	(350)	(317)	-	(133)	(265)
New Right of Use Assets	500	500	500	500	500
Capital b4 remeasurment	**51,452**	**37,026**	**40,250**	**8,367**	**5,235**
Remeasurment of ROU	7,000	3,620	2,500	1,000	3,000
Final capital plan	**58,452**	**40,646**	**42,750**	**9,367**	**8,235**

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

I&E Overview

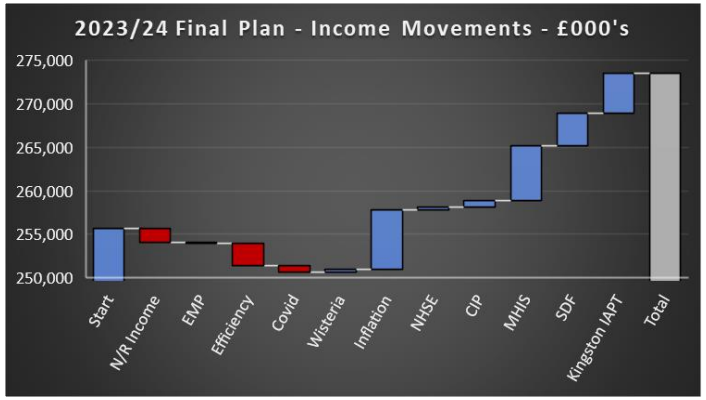
- Last year a deficit of £4.1m was reported in the April submission, reflective of financial risks and plans not being in place to address underlying deficits. This was not accepted by NHSE and following further work, an additional break-even submission was required in June
- The summary position for 2023/24, compared to the rollover position (i.e., budgets as they currently stand for 1st April), is shown in the table to the right. The deficit of £7.1m in the rollover position is comprised of non-recurring uncleared CIP balances..
- This year the Trust accepts that whilst savings plans are not yet fully completed, that it is reasonable to assume progress will continue to be made, and that therefore a break-even position should be submitted at both draft and final submission stages
- This strategic decision has been discussed with the ICB who are aware of the significant risks inherent within the plan (e.g. CIP achievement, external bed usage). Consequently, no pressure has been put on the Trust to improve its plan and the overall System position (at the time of writing a £150m deficit)
- The position includes an estimated £50m impairment in relation to Shaftsbury and Trinity. This value is subject to final confirmation by the District Valuer. The plan assumes the c£11m Barnes scheme will go live in Q1 2024/25 and therefore no impairment to 2023/24. The Trust is performance managed before impairments i.e. break-even.
- The key movements by subjective category are detailed in following slides.
- The proposed phasing of the plan shows monthly deficits of £200k in the first quarter. Following that small surpluses of approximately £50k a month during Qs 2-4
- The Q1 deficit relates to EMP: additional PDC and Depreciation costs will be incurred from Month 1 but additional savings from moving out of QMH will not be realised until Month 4
- The planned profile avoids the traditional "hockey stick" approach to planning. The two key areas that would impact on phasing relate to CIP achievement and external bed usage, however it is currently envisaged that:
  - Whilst recurring CIPs take time to work up, any slippage will be counter balanced by non-recurring and technical schemes
  - Higher than plan external bed usage will be offset by investment slippage (which will be greater during the early stages of the year)

Detail	Rollover £000's	23/24 £000's	Variance £000's
Clinical Income	242,819	261,900	**19,081**
Other Income	12,904	11,583	**-1,321**
Pay	-184,071	-184,579	**-508**
Non-Pay Expense	-63,097	-70,815	**-7,718**
Operating Surplus (Deficit)	**8,555**	**18,089**	**9,534**
Depreciation	-11,567	-11,207	**360**
PDC	-5,141	-7,593	**-2,452**
Interest Payable	-792	-762	**30**
Interest Receivable	1,833	1,473	**-360**
Surplus/Deficit	**-7,112**	**0**	**7,112**
Other:			
Impairment	0	-50,000	**-50,000**
Combined	**-7,112**	**-50,000**	**-42,888**

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

Income Movements

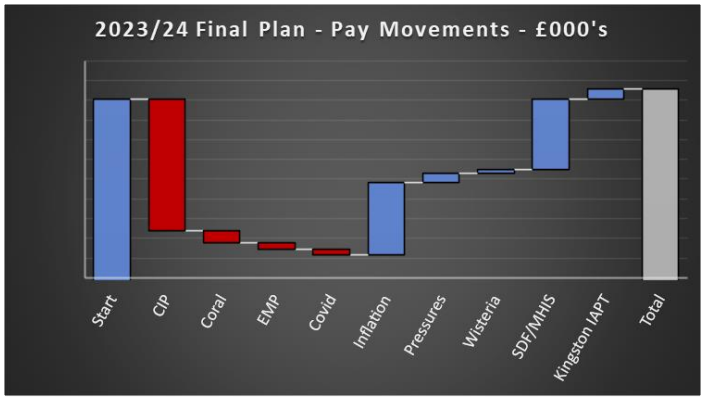
- The Trust's current rollover income position shows budgets of £255.7m. This will increase to £273.5m, an increase of £17.8m. The key elements of this move are:
  - The current budget position has non-recurrent income targets of £1.6m that need to be removed. Of this, £0.6m relates to income targets set, and achieved, that were part of the movement to overall balance for 2022/23. £1.0m relates to an income target (additional ICB/SLP income) that was not achieved
  - EMP will reduce income by approximately £0.1m (accommodation)
  - The national efficiency target of 1.1% will reduce income by £2.5m
  - The replacing of a fixed Covid payment of £2.1m by a 0.6% uplift to clinical income contracts (£1.4m) reduces income by £0.7m
  - The full year effect of the Wisteria business case increases income by £0.4m
  - Inflationary allowances (2.8% for clinical income, 2% for other income) provide an additional £6.8m. An additional £6.3m will be required if proposed 5% pay award is agreed
  - NHSE Mental Health contracts incorporate 2.05% growth, which will add £0.4m
  - £0.7m of additional income is identified as part of CIP planning
  - MHIS increases (after inflation is deducted) amount to £6.2m
  - SDF increases will provide an additional £3.8m of income
  - Both MHIS and SDF allocations are subject to change but movements at this point should not be material
  - The transfer of Kingston IAPT services to the Trust will generate a further £4.6m. Again, this is subject to some revision at the margins
- The key item excluded is the transfer of Complex Care Stage 2 monies. These relate to shared care arrangements and are estimated to be in the region of £16m



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

Pay Movements

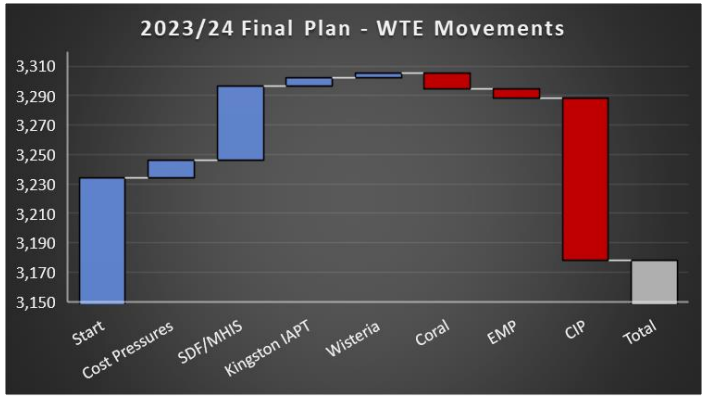
- Pay increases over the course of the year from £184.1m to £184.6m. This is a £0.5m increase which appears relatively flat and masks a number of movements:
  - Detailed work has been carried out on CIP modeling and shows a required £6.7m reduction
  - The full year impact of the Coral reconfiguration reduces expenditure by £0.6m
  - The full year impact of EMP changes (lines of sight, gender segregation, maintenance) reduces pay by £0.3m
  - £0.3m is also removed in relation to Covid expenditure
  - Pay inflation is currently modelled at 2% and adds £3.7m of expenditure. Intuitively, the 2% level seems low. However, NHSE has given categorical assurance that any settlement agreed above that level will be funded centrally either through additional income or the relaxing of activity and other targets. If the 5% proposed level for 2023/24 is agreed this will increase the pay bill by a further £5.6m
  - The potential downside for the Trust is that inflation currently forms part of required MHIS uplifts. It is therefore possible that an increased settlement could come all or partly out of MHIS allocations, therefore reducing the amount for new investment
  - Cost pressures funded as part of the budget setting round amount to £0.5m (see slide10)
  - The full year impact of the Wisteria business case adds £0.2m of pay expenditure
  - £3.6m of additional expenditure will be incurred in relation to SDF/MHIS investments
  - An additional £0.5m is incurred in relation to the part of the Kingston IAPT service (the PCMHT) that the Trust takes direct control of in April



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

Pay Movements - WTE

- Over the course of the year, budgeted WTEs are expected to fall by 56, from 3,234 to 3,178. The key drivers of this movement are:
  - Funded cost pressures (primarily in relation to Nursing Sustainability, see slide 12) will add 11 WTE
  - SDF/MHIS investments will add an additional 50 staff. This breaks down as: Community Transformation (21), Perinatal (11), CYP SPA (6) and CYP NDT Pathway (12)
  - The direct transfer of a small part of Kingston IAPT will add 6 staff. The transfer of remaining staff in April 2024 will add a further 42 WTE
  - The full year impact of the Wisteria investments adds a further 3 staff
  - The full year impact of the Coral reconfiguration will see staffing fall by 11
  - The impact of EMP results in inpatient and facility staffing changes and will see staffing reduced by a further 6
  - Finally, the required CIP of £6.7m will equate to a reduction of approximately 110 staff, although in practice much of this will be existing vacancies
- The above are based on movements from current budgeted WTE. Current actual WTEs (@ M11) amount to 3,120. The difference relates to vacancies that are causing the pay underspend that the Trust has been experiencing in-year
- It at first appears counter intuitive that the pay bill can increase whilst overall wte is reducing. The difference is inflation: without this a net reduction in pay expenditure of £3.2m would be recorded. This equates to 56 Band 6 wtes (the net reduction on overall workforce), which is in line with the Trust's current average salary



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

Agency Expenditure

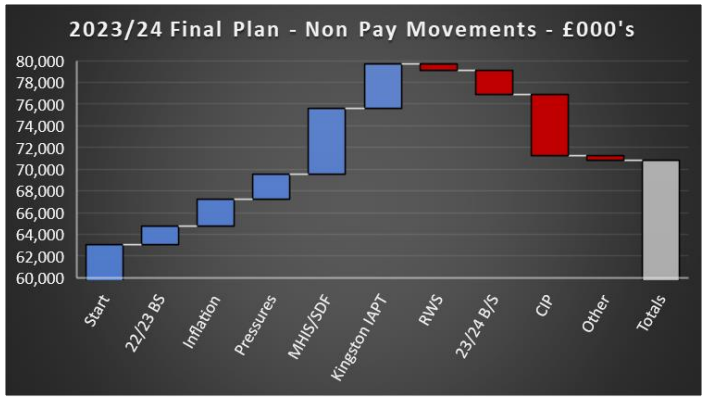
- NHSE have given Systems a target of reducing agency expenditure to 3.7% of total pay
- This is an unrealistic target for this Trust. Agency expenditure has run at an average of 7.2% to Month 10
- The approach adopted for both draft and final submissions has been to start at the current level of agency expenditure and gradually reduce this so that the exit run rate is at the prescribed NHSE level. Detailed delivery plans are needed to ensure that this is achievable
- Practically, this means that agency expenditure totals £9.9m for the year against a £6.9m target. This equates to a £3.0m adverse variance and average agency spend of 5.3%
- The best the Trust has achieved was 5.5% in 2020/21
- The percentage at the time of the draft submission was 5.5% and no adverse comment was received from NHSE
- The reduction relates to the pay bill increasing (MHIS/SDF and CIP changes) without a corresponding increase in agency expenditure
- We know now that the overall System agency figure for the draft submission amounted to 3.6% - within the overall 3.7% limit
- On the basis that other parts of the System have not moved adversely, the Trust final submission should also be acceptable
- If others have moved adversely and the System target is breached, the Trust may be asked to resubmit its agency plan

Year	Agency £000's	Pay £000's	Agency %
2015/16	15,748	116,267	13.5%
2016/17	15,120	119,195	12.7%
2017/18	7,954	121,351	6.6%
2018/19	7,228	127,053	5.7%
2019/20	8,135	142,310	5.7%
2020/21	8,856	159,658	5.5%
2021/22	10,054	171,284	5.9%
2022/23 - M11	11,548	161,716	7.1%

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

Non-Pay Movements

- Non-pay expenditure has increased by £7.4m, increasing from a rollover of £63.1m to £70.5m
- They key drivers of this movement follow:
  - The 2022/23 plan included a planned non recurrent balance sheet release of £1.7m which has depressed expenditure by the same amount and consequently increases 2023/24 expenditure
  - Inflationary increases amount to £2.5m. This excludes the energy and Sodexo increases which are separately accounted for within cost pressures. Where increases are known (e.g. ELFT Female PICU, CNST etc), these are included at that level. Other inflationary increases are calculated at 5.5% in line with NHSE guidance. The likely impact of the proposed pay awards on contracts with NHS providers will add £0.3m. For major non-NHS contracts (Sodexo, Hollybourne, Noonan) this could add a further £0.4m
  - Cost pressures (including energy and Sodexo) total £2.3m (see slide 12)
  - Increases associated with MHIS and SDF investments amount to £6.1m. This includes the funding of £1.1m of external beds to bring Hollybourne up to 18. This is a high figure but includes the potential contribution from investments that the Trust has asked to be funded out of MHIS that were effectively pump primed in 2022/23. If these bids are successful, this may afford some flexibility relating to CIP delivery
  - The cost pass through element of the Kingston IAPT transfer amounts to £4.1m
  - The contribution from the Richmond Wellbeing Service amounts to £0.5m and can be released into the position, therefore reducing expenditure
  - The plan for 2023/24 includes the release of £2.3m from the balance sheet (see CIP section, Month 8 Part B).
  - A reduction of £5.6m relates to the current CIP plan
  - Smaller adjustments net off to a £0.5m reduction. These soft FM changes resulting from EMP (the main movements are "below the line") and Covid



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

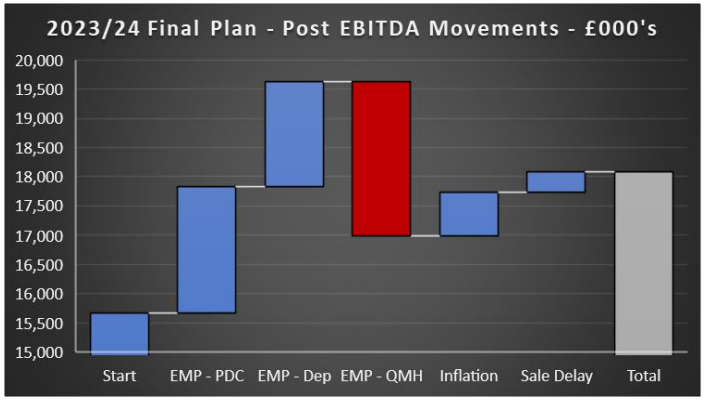
External Beds

- External bed usage remains a significant financial risk
- At the draft plan stage, the budget stood at £3.7m which would have enabled the purchasing of an average of 14 beds
- Following further progress on the contracting front, a further £1.1m has now been funded which will enable the block purchasing of 18 beds at Hollybourne for the whole of 2023/24
- There is no funding made available for external bed usage above this level. If usage replicated 2022/23 levels, this would present a risk of £1.6m
- The Trust will, of course, need to be open and explicit with the ICB that this is the proposed course of action. The Trust has, during 2022/23 used investment slippage to fund external beds. The ICB have yet to question this approach, albeit they are indicating that they would wish monthly updates on slippages during 2023/24
- 2023/24 investment proposals to the ICB would, if accepted, make good investments that the Trust has made at risk during 2022/23 (e.g. Community Transformation excess, CAMHS Tier 3). Were this funding to be approved there would be less investment slippage available to fund external beds so would not completely benefit the bottom line.
- However, If these investments are funded, this will provide an excess source of funds which could potentially be used to fund bed and acuity pressures and/or to reduce the overall CIP level
- Additionally, to external beds, the funding for 6 Hostel Beds (£0.9m) is also carried forward into the new financial year

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

Post EBITDA Movements

- There is a significant increase in post EBITDA costs which rise from £15.7m to £18.1m, a £2.4m increase
- They key components of this move are:
  - PDC associated with the EMP build adds £2.2m
  - A net depreciation increase, also EMP related, increases cost by £1.8m
  - The above items are still subject to the final impairment value being agreed
  - Savings on lease depreciation and interest through a reduced footprint at QMH save £2.6m
  - In line with national guidance, a 4% inflation provision is made at a cost of £0.7m
  - Reduced interest receivable, interest would have been maintained had it not been for the delay in the receipt of £36m from London Sq which will reduce the interest receivable figure by £0.4m
- As detailed on slide 3, the increased PDC and Depreciation are planned from April with the QMH savings materialising from 1st July, creating a phasing imbalance. Any delay in go live will generate technical savings.
- As also detailed on slide 4, provision in the plan is currently made for a £50m impairment on the Springfield Site. No impairment is planned relating to Barnes development.
- It is assumed that all asset sales in 2023/24 will be fair valued and therefore not generate a profit to I&E. Should the EWH sale complete in 2023/24 this could generate a £16m upside. NHS accounting rules have been amended such that asset sale profits benefit both the Trust and system position – treated above the line.



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

Cost Pressures

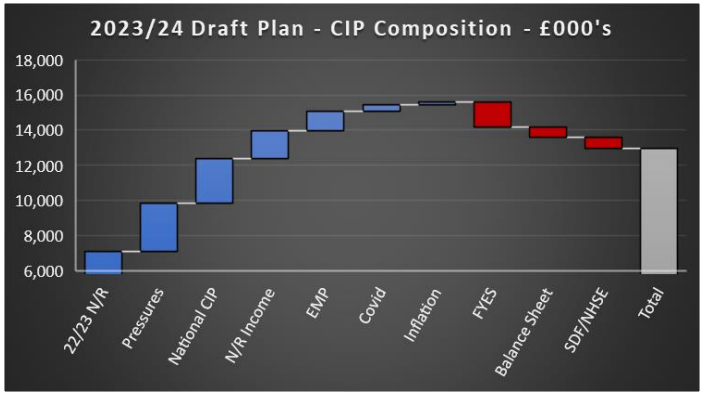
- As part of the budget setting process, the Trust goes through an annual cost pressure collation and prioritisation process
- The value of pressures initially submitted amounted to approximately £12.8m and amounted to 62 schemes
- The initial aim was to live within a £2.0m envelope
- The first prioritisation review was undertaken by the Chief Operating Officer and Director of Finance
- This initial prioritisation was subject to rigorous debate and challenge in ELT. A subsequent review was then undertaken by the COO, DoF, Nursing Director, and the Deputy Medical Director
- The table to the right shows the final agreed schedule. This amounts to £2.7m, some £0.7m above the initial envelope. This includes some slippage, with the full year value rising to £2.9m
- The key constraining factor this year was the weight of pressures that were unavoidable. For example, the energy and Sodexo pressures on their own amounted to £1.6m. A further £0.4m relate to costs that the Trust is already incurring
- This effectively left very little latitude in bringing the envelope down
- An improved position in relation to Covid income enabled this increase to be funded within the initial CIP envelope identified in Month 8 Part B report
- There are two further pressures that have been removed from the list as alternative funding streams have been identified:
  - Investment in the Nursing Development Team will come from additional Education placements income
  - The aim is to fund the Associate Director of EMI through EMHIP monies that the ICB are asking the Trust to carry forward

Pressure	2023/24 £000's	2024/25 £000's
Dietetics	42	56
Physiotherapy Assistant	28	38
Richmond Royal Security Cover	37	37
Utilities	1,029	1,029
Sodexo Contract Increase	528	528
Maintenance Contracts Increase	216	247
Maintenance Security Cover	30	30
Linen	74	74
Window Cleaning	20	20
Pest Control	26	26
Waste Management	48	48
Specialist Equipment	37	37
Apprenticeship Levy	60	60
Advertising	21	21
eRoster System	23	23
SGUL Recharge	36	36
Safer Staffing - Sustainability	222	382
Consulting Room Phone Licenses	3	3
Guess Wi-Fi Services	8	8
Microsoft Enterprise	69	69
Text Messaging	13	13
Middle Grade Cover: Lilacs and Ellis	103	138
Total	**2,673**	**2,923**

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

CIP Target

- Following the initial Month 8 Part B presentation, the CIP level for 2023/24 has now crystallised at the £13.0m level previously identified. They key components of the CIP are:
  - The level of non-recurring CIP from 2022/23, after playing in full year effects (mainly attributable to interest receivable) amounts to £7.1m
  - The agreed cost pressures detailed on slide 17 amount to £2.7m
  - The national CIP of 1.1% produces an efficiency requirement of £2.5m
  - £1.6m is removed from the income budget for non-recurring income that is no longer collectable
  - Increased costs associated with EMP amount to £1.1m. These will largely reverse in 2024/25 when the Trust fully vacates QMH
  - The net loss across Covid income and expenditure amounts to £0.4m
  - Inflationary pressures amount to £0.1m more than available funding
- The above pressures are then partially offset by the following mitigations:
  - The full year impacts of service changes/developments implemented in 2022/23 (Richmond Wellbeing, Coral reconfiguration, Wisteria) save £1.4m
  - The 2022/23 plan included a £1.7m balance sheet release, the 2023/24 plan includes £2.3m. Once the former is reversed and the latter is enacted, a net £0.6m benefit is derived
  - £0.6m contribution is taken into the position from NHSE growth and expected SDF monies
- Combined, the above amounts to a net £13.0m CIP target. This equates to 4.7% of turnover.
- In addition, the Trust must continue to deliver £2.2m recurrent savings through vacancies. Unless the Trust can identify £2.2m of posts to delete before 31 March this £2m will need to be added to the CIP target. Therefore, for monitoring purposes the CIP target is currently £15.2m.



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

2023/24 CIP Delivery Plan

- A savings plan update was presented to ELT on 8 March, with a £2m unidentified.
- Following ELT challenge the position was improved to £1.2m unidentified
- The key workstreams are:
  - Growth / Income Generation, £0.5m
  - Site Utilisation, £0.2m
  - Overseas Visitor Income, £0.2m
  - Workforce schemes, £6.2m
  - Contract negotiations, £1m – following contract finalization there may be opportunity to achieve more than £1m
  - Technical Savings, £3m
  - Non-Pay Savings, £0.3m
  - Corporate additional savings , £0.4m
- The plan submission has taken a prudent assumption for the recurrent / non recurrent split and assumes only 34% will be achieved recurrently. Analysis of the scheme indicate 50% recurrent should be achievable
- Weekly updates are required by the ICB and improved RAG ratings expected
- Allocation to service lines has been agreed and will be actioned as part of budget setting

	NPSA income	Private Patients	Grants / Commerical Income	Overheads Kingston Service Tfr	R&D	Site Utilisation	Challenging Decisions	Recurrent vacancy factor	NR Stretch vacancy factor	Clinical / Digital Efficiency	Prior Year Investment slippage	Workforce Planning	Operational control of pay spend	Sickness mgmt	Observations	Contract negotiation	Technical savings	Other non pay stretch	Corporate stretch	Total Target £k	% of budget
Executive Lead	JA	AS	AS	AS	BB	PM	PM	JA	JA	JA	JA	JA/KR	JA/KR	JA/KR	SS	PM	PM	PM	PM		
Operational Lead	FM/NW	NW	NW	NW	SW	RB	All OPs & Corp. HoSD	All HoSD	All HoSD	All HoSD	All HoSD	HoSD / HR	HoSD / HR	HoSD / HR	HoSD	ADC	DH	All	All		
Acute And Urgent Care						0	0	545	70	80			117	98	430			19		1,359	2.8%
Camhs & AED						0	0	416	50	55	340		72	38	3			13		987	3.0%
Community (Adults)						122	0	92	250	285	660		388	66				80		1,943	3.9%
Specialist Services	75					0	6	538	70	80			49	76	67			15		976	2.8%
Central		50				0	0	0	0			500	0	0				0		550	0.0%
Operations	**75**	**50**	**0**	**0**	**0**	**122**	**6**	**1,591**	**440**	**500**	**1,000**	**500**	**626**	**278**	**500**	**0**	**0**	**127**	**0**	**5,815**	**3.5%**
Medical						0	9	16	0				11	1				7	105	149	1.5%
Pharmacy						0	0	26	27				7	3				1	25	89	3.8%
Psychology						0	0	6	2				0	0				0	2	10	4.8%
Research & Development					100	0	0	0	0				0	0				0	3	103	37.8%
Nursing & Quality						0	0	91	26				3	8				13	58	199	3.7%
Chief Operating Officer						0	0	15	0				0	0				1	3	19	6.2%
Estates & Facilities				2		62	5	240	0				2	2				34	35	382	1.9%
Strategy & Planning			200	6		0	0	37	0				4	1				2	13	263	21.6%
Finance & Performance				50		0	207	41	5				26	11				39	115	494	4.6%
HR / O D & Workforce				18		0	25	0	0				70	5				22	41	181	4.7%
Chief Executives Office				2		0	0	40	0				2	0				5	5	54	11.3%
Communications				3		0	0	17	0				0	2				2	6	30	5.0%
Corporate	**0**	**0**	**200**	**80**	**100**	**62**	**246**	**529**	**60**	**0**	**0**	**0**	**125**	**33**	**0**	**0**	**0**	**126**	**412**	**1,973**	**3.5%**
Technical Savings																1000	3,000			4,000	
Total by scheme	**75**	**50**	**200**	**80**	**100**	**184**	**252**	**2,120**	**500**	**500**	**1,000**	**500**	**751**	**311**	**500**	**1,000**	**3,000**	**253**	**412**	**11,788**	
Total by workstream	**505**					**184**	**252**	**6,182**								**1,000**	**3,000**	**253**	**412**	**11,788**	**4.9%**
Target																				**12,974**	**5.4%**
GAP																				**1,187**	

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

Financial Risk

- The main planning return, albeit extremely detailed, does not contain a section on risk
- However, at the same time as the planning submission, the Trust is also required to submit a System triangulation return. The primary function of this return is to ensure that the interrelated income and expenditures between the Trust and ICB balance. The return, however, also includes a provider risk section.
- There are 5 pre-determined risk categories with 3 of them applying to this Trust: capacity, inflation, and CIP.
  - **Capacity –** Practically this relates to the external beds pressure that the Trust has faced this year. £1.6m has been entered – i.e. the difference between this year 2022/23 forecast spend and 2023/24 budget (see slide 10). A further £1.5m is added for acuity pressures
  - **Inflation –** Non-pay inflation is funded at 5.5% for next year. Currently inflation is running at almost 5% above this. Consequently, an additional 5% is included for non-pay which generates a further pressure of £1.9m. Pay inflation (above the 2% planning level) is excluded following NHSE assurances that anything above 2% would be funded. Further clarification is awaited on how the proposed 5% pay award will be funded but a further risk of £0.7m is included (see slide 9)
  - **CIP –** A risk level of 50% against CIP delivery is currently assumed, generating a pressure of £6.5m
- Combined these add up to a total risk level of £12.2m
- Whilst is can be difficult to accurately calculate risk at this stage of the planning process, the £12.2m feels a reasonable proxy for the underlying risk facing the Trust as it is in line with the £1m a month underlying deficit that the Trust has been recording during 2022/23
- This level of risk also reinforces the Trust view that, whilst a break-even position has been submitted, the plan will be extremely challenging to achieve
- The return also contains a mitigations section to reduce the level of risk. The Trust has not yet been asked to complete it and therefore has not done so and risk remains at £12.2m. This reinforces the challenge of delivering a break-even position and re-emphases the Trust would be unable to improve the position to assist the overall System position. The Trust is likely to be required to show an improved risk position before final submission.
- Cash Risks; cashflow modelling indicates that cash flow will not be an issue however there are a number of cash issues which require monitoring:
  - EWH sale (£16m) needs to complete in year. Previously discussed mitigated could be achieved by re-negotiating loan repayments.
  - There is a £1.7m risk associated with the capital grant waiver by Treasury
  - Barnes asset sale £4.5m has not yet been approved by DHSC, creating a further cash risk
- Phasing of Tolworth development costs has not been confirmed with the developer and costs may be significantly less in 23/24, creating a risk of a material CDEL underspend.

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

Contracting Update

- Regular contracting planning meetings have continued, both regular System wide (including SLAM) meetings and more local (and more detailed) meetings.
- MHIS totals have been agreed as well as indicative SDF totals. Alongside the Kingston IAPT transfer, this brings the total contract value with SWL ICB to £205.8m.
- The Trust has then matched its planned investments against appropriate income flows. There is one small issue where the ICB have highlighted that one proposed investment (in Dementia, £0.2m) is non-MHIS, however it should be possible to circumnavigate this through the reclassification of baseline expenditure.
- The **NHS Standard Contract** for 2023/24 was published by NHSE rather later than expected on 16th March 2023.
  - Contract representatives are drafting the contract schedules for inclusion and signature. This may now extend into early April.
  - Streamlining of contractual reporting processes has been agreed between the Trust and ICS. Its purpose is to remove unnecessary or obsolete reports from the monthly cycle, cut the reporting burden and align reporting to the Trust's standard format.
  - Alignment of KPIs has also been agreed, so that commissioners will receive the same performance reporting as the Trust Board.
- **Complex Care** sub-contracts are being refreshed and replaced with 3 year contracts, giving stability and a longer horizon for placement of patients with providers. Each patient also has an individual care plan which is agreed through the SPA prior to the placement.
- **Phase 2a of Complex Care** has been approved for mobilisation from April 2023. The contracting implications are currently unclear, concerning the volume of new contracts or contract variations which will be required for this phase. A first mobilisation meeting has been planned for 20th March between the Programme, the Trust and ICS leads.
- The **NHSE direct services** contract for 2022/23 has now been signed, following a protracted process to agree the correct financial totals. The new contract document for 2023/24 has not yet been received from NHSE and timings are being sought from NHSE.
- **Provider Collaborative** contracts are 3.5 years duration and remain in place, with annual contract variations. The SLP hub team is engaging directly with Lead Providers outside London (Surrey, Kent, Sussex) and involving the Trust in negotiating those contracts.
- **Overseas Visitors** cost recovery: The NHSE team has said that cost recovery will be via the main block contract, with no return to invoicing.
- **Primary Care Network (PCN)** contracts for Mental Health Practitioners are not yet in place in all boroughs and this will be an area of focus.
- The **Community Transformation Programme** roll out across boroughs has resulted in a number of new relationships with third sector and other partners. Each of these will require formal contracts, but currently are being agreed by temporary means such as email and letters.
- Work is underway to obtain additional contract manager resourcing for the newer areas above.

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

Capital Five Year Plan

- The Trust is required to submit a 5 year capital plan as part of the operating plan submission
- The plan has been agreed with the ICB who must manage its capital spend within the system CRL/CDEL allowance
- Tolworth costs remain in total in line with the FBC, with £1.4m rephased to 2022/23 reflecting national funding and £3m moved out to 2026/27 to reflect natural slippage of internal costs. The phasing across 2023/24 to 2025/26 is being reviewed by the EMP team as there is concern that £32.6m will not materialize in 2023/24 and would generate an unacceptable CDEL underspend. The ICB have been informed of this work.
- CDEL generated by reversing cost of sales have been excluded from the plan, at the request of the ICB, estimated at £1.6m in 23/24 and £4.9m in 25/26. This is likely to provide a CDEL upside in these years.
- The rules around brokering CDEL credits from asset sales between years have been relaxed and £30m has been moved from 2023/24 into 2024/25
- Frontline Digitalisation, bids for future years are not included in the plan
- The capital plan has been refined in the last month for the following:
  - Business as Usual capital; the figure for 2023/24 has been brought into line with the systems expectation, the figure for 2024/25 is £0.3m less than expected, outer years have been rounded down slightly from £5m to reflect the Trust's share of the system demand being greater than likely CDEL
  - An estimate of £0.5m per annum has been provided for new leases under IFRS16

	2023/24 £000's	2024/25 £000's	2025/26 £000's	2026/27 £000's	2027/28 £000's
M11 Planning report	**53,325**	**36,843**	**39,750**	**8,000**	**5,000**
Return of ICB Contingency	(2,023)		-	-	-
Trust share ICB demand > CRL	(350)	(317)	-	(133)	(265)
New Right of Use Assets	500	500	500	500	500
Capital b4 remeasurment	**51,452**	**37,026**	**40,250**	**8,367**	**5,235**
Remeasurment of ROU	7,000	3,620	2,500	1,000	3,000
Final capital plan	**58,452**	**40,646**	**42,750**	**9,367**	**8,235**

	Final Plan Submission March 2023				
All numbers £k	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Application					
EMP (Richmond Royal, Hume etc)	3,464	-	-	-	-
EMP Tolworth - local	32,605	31,523	34,750	3,000	-
EMP Tolworth - national	920	760	-	-	-
EMP Barnes	11,100	-	-	-	-
BAU Estates	1,440	2,280	2,500	2,367	2,235
BAU Digital	1,423	1,963	2,500	2,500	2,500
ROU new	500	500	500	500	500
Total CRL Required	**51,452**	**37,026**	**40,250**	**8,367**	**5,235**
Source					
CDEL generated by asset sales	25,850	30,000	26,700	-	-
Nat. CDEL STP Barnes	11,100	-	-	-	-
Nat. CDEL MH UEC Extra Ward	920	760	-	-	-
Nat. CDELROU	500	500	500	500	500
SWL CDEL	13,082	5,766	13,050	7,867	4,735
Total CRL Available	**51,452**	**37,026**	**40,250**	**8,367**	**5,235**

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

Right of Use Assets

- A Right of Use (ROU) Asset is defined as an asset not owned by an organisation but one that it controls and has right of use of.
- To date our ROU assets have only been leases for property.
- The value of a new, remeasured or transferred ROU assets score against national CDEL.
- As part of the draft annual plan submission the Trust was required to estimate the value of Right of Use Assets for 2023/24 to 2027/28.
- The value is calculated as broadly annual rent times by the number years in the lease. With some leases being 10 or 20 years this can be a material sum.
- It is anticipated that the numbers in the plan submission for ROU assets will inform CDEL values in 2023/24 and beyond.
- It is anticipated that this national CDEL will at some point transfer to ICB control, who will be expected to manage within the envelope given to them.
- The approach taken to determine the submission values has been to
  - Review existing leases and assume that they will be extended on same terms when the lease expires, plus 10% inflation
  - Adjust for likely transfer of leases for Kingston IAPT and Substance Misuse on their current terms plus 10% inflation, and assuming leases transfer on 31 March 2024
  - Adjust for QMH extension in 2023/24, assuming it is not agreed before 31 March
  - Include an estimate for new leases at £500k per annum, based on the approximate value for the Richmond Well Being Lease. For example, this allows for one new lease a year at £100k rental for a 5 year term.
  - Annual figure have been rounded up to the nearest £500k
- The detail has been reviewed by ELT and summary information is provided below.

£k	2023/24	2024/25	2025/26	2026/27	2027/28
Leases for transferred Service	4,290	0	0	0	605
Remeasurement / extension of existing leases	2,293	3,160	2,112	798	2,206
Allowance for new leases	500	500	500	500	500
Rounding	417	340	388	202	189
Total	**7,500**	**4,000**	**3,000**	**1,500**	**3,500**

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

Asset Sales

- As part of the 5 year capital plan the Trust must state its assumptions relating to asset sales. The following assumptions are assumed
- Fair Valuation of assets prior to sale is assumed, for all sales other than EWH, as this maximises the generation of CDEL credits.
- Disposals proceeds have not changed however opportunity to generate profit / increase CDEL using Fair Value has increased
- EWH is assumed to sell in 2023/24, it is unclear whether this asset can be fair valued. The figures below exclude the £8m contribution from DHSC share
- The rules around brokering CDEL credits from asset sales between years have been relaxed and £30m is moved in the plan from 2023/24 to future years
- Completion of phase 2a (London Square) has been moved to end of Q2 in the plan in line with an anticipated request from London Square, this reduces the level of interest receivable achievable in year

All numbers £k	**Completion**	**Disposal Proceeds**	**NBV on sale**	**Prior year Costs of Sale**	**Costs of Sale in year of sale**	**Profit / Loss**
Barnes	2023/24	4,500	3,896	604	-	-
EWH	2023/24	8,000	1,150	-	-	6,850
Phase 2a	2023/24	40,080	31,118	3,519	5,443	-
Phase 2b parcel 1	2023/24	19,000	19,000	4,856	-	-
Phase 2b parcel 2	2025/26	34,575	29,719			
		106,155	**84,883**	**8,979**	**5,443**	**6,850**

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

Cashflow

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Opening Balance	**26,148**	**21,459**	**18,737**	**23,776**	**27,366**	**24,899**	**46,780**	**48,800**	**46,211**	**55,558**	**56,194**	**51,017**	
Operating Income	22,852	22,852	22,852	22,872	22,872	22,872	22,942	22,942	22,941	22,981	22,980	22,998	274,956
Asset Sales	0	0	4,800	0	0	36,072	0	0	0	0	0	35,000	75,872
Deferred Receipt	0	0	0	0	0	0	0	0	10,676	0	0	0	10,676
PDC	1,073	780	353	541	932	660	1,410	1,442	1,387	1,064	1,011	1,367	12,020
Income	**23,925**	**23,632**	**28,005**	**23,413**	**23,804**	**59,604**	**24,352**	**24,384**	**35,004**	**24,045**	**23,991**	**59,365**	**373,524**
Revenue Expenditure	22,321	22,321	22,319	22,126	22,126	22,126	22,196	22,196	22,196	22,236	22,236	22,238	266,637
Capital Expenditure	4,001	3,647	1,850	2,362	3,249	3,647	3,404	3,774	3,806	3,613	3,867	3,779	41,000
PDC	0	0	0	0	0	3,792	0	0	0	0	0	3,801	7,593
Loan Interest/Repayment	0	0	0	0	0	5,180	0	0	0	0	0	5,175	10,355
Movements in Working Capital	2,292	386	(1,203)	(4,665)	896	2,978	(3,269)	1,003	(345)	(2,440)	3,065	13,460	12,158
Expenditure	**28,614**	**26,354**	**22,966**	**19,823**	**26,271**	**37,723**	**22,331**	**26,973**	**25,657**	**23,409**	**29,168**	**48,453**	**337,743**
Closing Balance	**21,459**	**18,737**	**23,776**	**27,366**	**24,899**	**46,780**	**48,800**	**46,211**	**55,558**	**56,194**	**51,017**	**61,929**	**35,781**
10 Days Operating Expenses	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	7,000	
Difference	14,459	11,737	16,776	20,366	17,899	39,780	41,800	39,211	48,558	49,194	44,017	54,929	

- The cashflow model is based on forecast closing cash for 2022/23 of £26.1m (cash = £30.7m at 28 February)
- The key movements on the cash flow for 2023/24 relate to:
  - Asset disposals - £75.9m comprising Barnes £4.8m, balance of Phase 1 (deposit received in 2021/22) £36.1m, deferred receipt relating to Springfield plots in 2020/21, Phase 2a Parcel 1 £19.0m and Edward House £16.0m
  - The PDC of £12.0m relates to the Barnes scheme £11.1m and £0.9m for the extra ward.
  - 2023/24 is the first year of the loan repayments £10.0m with £0.4m in interest payments, a further £6m is due in 2024/25 plus interest, again of £0.4m
  - Movements in working capital relate to quarterly invoices being paid and accruals crystallising into invoices. In addition, this also includes the risk of the escrow amount of £1.8m being repayable.
- The model indicates that the Trust will not have any cash problems in 2023/24 and will be able to maintain a minimum cash level of 10 days operating expenses at all times
- The Trust continues to build up cash to repay the loan.

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

Balance Sheet

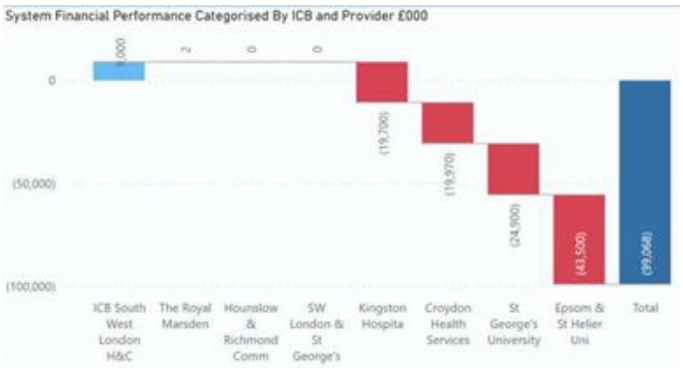
Statement of Financial Position (£m)	Opening Balance - Apr 2023 Forecast	Closing Balance - Mar 2024	Movement
NON CURRENT ASSETS:			
Intangible assets	6.2	6.2	0.0
Plant, Property and Equipment	334.0	326.4	(7.6)
Receivables (due in more than 1 year)	26.7	16.0	(10.7)
Right of Use Asset	0.0	0.0	0.0
Total Non-Current Assets	**366.9**	**348.6**	**(18.3)**
CURRENT ASSETS:			
Inventories	0.2	0.2	0.0
Receivables (due in less than 1 year):	7.9	6.8	(1.1)
Other Financial Assets	3.5	2.2	(1.3)
Cash and Cash Equivalents	26.1	61.9	35.8
Total Current Assets	**37.7**	**71.1**	**33.4**
CURRENT LIABILITIES:			
Payables	(26.7)	(34.5)	(7.8)
Provisions	(4.2)	(4.2)	0.0
Borrowings (due in less than 1 year)	(10.0)	(6.0)	4.0
Other Financial Liabilities (Accruals)	(32.3)	(16.5)	15.8
Deferred Revenue	(6.4)	(6.4)	0.0
Total amounts falling due within one year	**(79.7)**	**(67.6)**	**12.0**
NET CURRENT ASSETS/(LIABILITIES)	**(41.9)**	**3.5**	**45.4**
NON CURRENT LIABILITIES:			
Provision for Liabilities and Charges	(6.8)	(6.8)	0.0
Borrowings	(89.4)	(83.4)	6.0
Lease Liability	0.0	0.0	0.0
Total amounts falling due after one year	**(96.2)**	**(90.2)**	**6.0**
TOTAL ASSETS EMPLOYED	**228.8**	**261.9**	**33.1**
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	143.9	156.0	12.0
Retained Earnings	30.6	51.6	21.1
Revaluation Reserve	54.3	54.3	0.0
TOTAL TAXPAYERS EQUITY	**228.8**	**261.9**	**33.1**

- The opening balances are based on the forecast March 2023 position
- The main movements are:
  - Property, Plant and Equipment
    - Capital spend £58k
    - Impairment - £50k
    - Depreciation - £11k
    - Asset Sales - £5k
  - Receivables due in more than one year £10.7m deferred receipt from Springfield disposal in 2020/21
  - Cash – see previous slide
  - Loan – overall £10.0m capital repayment in 2023/24 – see current and non current liabilities
  - Public Dividend capital - £12.0m for Barnes scheme and extra ward
  - Retained earnings due to fair value valuations in 2023/24

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

Report Title:	**Plan Update 2023/24**
Meeting:	FPC
Date of Meeting:	27 April 2023
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Director of Finance & Performance
Transparency:	Public
Scrutiny Pathway	Director review / ELT / FPC / Trust Board

Purpose:	☒	Approval	☒	Discussion	☒	Information	☒	Assurance
Additional information:	The purpose of the paper is to update committee on the national requirement to resubmit the 2023/24 annual plan and the proposed changes to the plan.							

What?	Key items to note are: ➢ As previously reported, and approved by FPC, the Trust submitted a final 'break-even' annual plan for 2023/24 on 30 March. ➢ SWL ICB submitted a plan with a £99m deficit.  ➢ Concern regarding the national position has led to significant challenge of system plans, with all systems going through a challenge meeting, and then a subsequent meeting with the national Finance Director. ➢ As a result of these meetings the SWL ICB have been challenged to improve their plan by a minimum of £10m, have this will be achieved has not yet been confirmed – discussions are very live. ➢ All Trusts and Systems are required to resubmit Final plans on 4 May.
So What?	➢ To date the Trust has held firm that the only improvement would be if the sale of Edward Wilson House could be 'unblocked' nationally enabling a profit of c£14m to be achieved. This was discussed by the ICB at the meeting with the National DOF. ➢ The Trust March plan included only c30% recurrent savings, against a 2022/23 national average of 50%, and indication

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

	that the national planned average for 2023/24 is closer to 60%. The Trust is expected to improve the proportion of recurrent vs non-recurrent CIPS for the May submission. ➢ MHIS negotiations are nearing completion and the result is a benefit of c£4m, of which £1m was anticipated within the plan. By including the additional c£3m, and a few other minor changes, in the savings plan, the value of recurrent schemes is 62%. The Executive are minded to amend the plan accordingly and without reducing service line targets. This would create an element of over programming to offset risk, whilst maintaining focus on the need to deliver savings. A breakdown of the movements is provided in this report. ➢ No other changes to the plan are recommended. ➢ The focus on improving the SWL system position will lead to increased controls on the Trust e.g tender waivers are likely to require system approval. There will also be the need to continue to demonstrate that all grip and control measures have been implemented.
What Next?	Actions have been identified as follows: ➢ Await national/system guidance as to whether EWH sale should be included in the plan. ➢ Resubmit the plan by 4 May to reflect the improved recurrent/non recurrent split of savings. ➢ Review 'grip and control' actions and HFMA sustainability actions.
Any specific issues to note and/or for escalation:	1. Committee are asked to approve the resubmission.

Strategic ambitions this paper supports	☐	Increasing quality years	This paper supports by outlining how the Trust will achieve its financial goals, highlighting key cost drivers and their impact on underlying financial sustainability.
	☐	Reducing inequalities	
	☐	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	Outlined below are the key implications which may result from the proposals or information contained within this report
Equality analysis *[linking to EDI strategy]*	Positive impact – The Trust spends money to improve equality and diversity for patients and staff
Service users/ carers	Positive impact – Trust Funds are spent to get the best value to support our clinical services and patients
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

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

Legal:	Positive impact - Provides information on the statutory requirement of achieving break even
Reputation:	Positive impact – The Trust has a good reputation for achieving financial targets
Strategy:	Positive impact – The Trust has a good reputation for achieving financial targets
Workforce:	Positive impact – The Trust has a good reputation for achieving financial targets
Sustainability Eg. Green Plan.	Positive impact – The Trust knows its cost drivers and is taking positive action to ensure financial sustainability
Other (specify):	n/a

Appendices/Attachments:	None

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

Savings Plan Movements Since March Submission

		March 2023 Submission			April changes			May 2023 Submission			
Ref	Workstream	Recurrent Total	Non -Recurrent Total	Total	Recurrent Total	Non -Recurrent Total	Total	Recurrent Total	Non -Recurrent Total	Total	Comments
a (iii)	NPSA income	73	2	75	-38	38	0	35	40	75	Change based on latest info from the service line
a (iii)	Private Patients	0	50	50	0	0	0	0	50	50	
a (iii)	Grants / Commercial Income	200	0	200	0	0	0	200	0	200	
a (iii)	Overhead contribution (Kingston)	80	0	80	0	0	0	80	0	80	
a (iii)	R&D	0	100	100	0	0	0	0	100	100	
a (iv)	Site Utilisation	184	0	184	0	0	0	184	0	184	
c	Challenging Decisions	0	252	252	0	-200	-200	0	52	52	Removed £0.2m overseas visitors in line with latest national guidance
d (ii)	Recurrent vacancy factor	2,120	0	2,120	0	0	0	2,120	0	2,120	
d (ii)	NR Stretch vacancy factor	0	500	500	0	0	0	0	500	500	
d (ii)	Clinical / Digital Efficiency	500	0	500	0	0	0	500	0	500	
d (ii)	Prior Year Investment Slippage	0	1,000	1,000	0	0	0	0	1,000	1,000	
d (ii)	Workforce Planning	0	500	500	0	0	0	0	500	500	
d (ii)	Operational control of pay spend	300	451	751	0	0	0	300	451	751	
d (ii)	Sickness management	311	0	311	0	0	0	311	0	311	
d (ii)	Observations	0	500	500	0	0	0	0	500	500	
e	Contract negotiation	0	1,000	1,000	4,000	-1,000	3,000	4,000	0	4,000	Improved position based on final MHIS allocation
f	Technical savings	0	3,000	3,000	0	0	0	0	3,000	3,000	
g	Other non pay stretch	125	128	253	0	0	0	125	128	253	
h	Corporate stretch	206	206	412	0	0	0	206	206	412	
	Retail units	0	0	0	10	0	10	10	0	10	Based on the most optimistic information from EMP
i	Unidentified	269	918	1,187	-269	-918	-1,187	0	0	0	MHIS negotiations has moved the Trust into overprogramming
	Overprogramming	0	0	0	0	-1,623	-1,623	0	-1,623	-1,623	Balancing figure - level of over programming
	Total	4,368	8,607	12,975	3,703	- 3,703	-	8,071	4,904	12,975	
	% split	34%	66%					62%	38%		

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

Finance & Performance Committee

27 April 2023

Report Title:	2022/23 Corporate Objectives – Q4 Delivery
Author(s):	Leah O'Donovan, Deputy Director of Strategy & Transformation
Executive Sponsor(s):	Amy Scammell, Director of Strategy, Transformation and Commercial Development
Transparency:	Public
Scrutiny Pathway	ELT 12.04.23 People Committee 20.04.23

Purpose:	☒	Approval	☐	Discussion	☐	Information	☐	Assurance
Additional information:	None							

What?	Each year, a set of organisational corporate objectives are developed to support delivery of the Trust Strategy. The Trust Board approved the 2022/23 corporate objectives in May 2022 The 2022/23 corporate objectives were developed through an iterative process including discussions at the Executive Leadership Team, Board sub-committees and the Trust Board between February and April 2022. Through these discussions, it was recognised that there was a need to pause some areas of delivery, creating space to focus on moving into the new Springfield buildings. These areas for 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. 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.

	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 to support delivery of the Trust's four strategic ambitions. Quarterly reports on progress are made to ELT, sub-committees and the Trust Board. Revised RAG ratings are 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 was included for objectives 1 and 4 to illustrate the position at M6 and for Q3, M9; this is being updated for Q4 to M12 (data will be added as it becomes available). The ELT received this paper on 12.04.23 and discussed how to feed in 2022/23 delivery when considering setting 2023/24 priorities. ELT noted that data will be added to the report as it becomes available and recommended the paper be sent onwards to each Board committee.
So What?	Progress across the majority of objectives is rated Amber. A summary of the delivery is as follows: 1. **Quality:** The key success here is the reduction in the he use of restrictive practices over 2022/23 improving care and experience for our service users. In addition, improvements have been seen in some elements of physical health assessment and risk assessment but not all. 2. **Integrated transformation programme:** The Trust successfully opened Trinity building and moved services and staff safely. The relocation of corporate teams to Tolworth was also delivered. The Tolworth business case has been approved by the Trust Board and is now in the external review process. The Sutton community transformation model has been embedded and outcomes are being measured. There is mixed delivery across wider transformation and digital initiatives. 3. **EDI:** Much work has progressed in this area including the refresh of the EDI Strategy Action Plan, our anti-racism programme and the support to EMHIP. However, the expected outcomes have not been delivered. Ongoing work is needed with external partners to implement changes. 4. **People:** Work has progressed to stabilise our HR service and vacancy rates are now reducing. Work is still required around other core workforce metrics. Staff survey feedback is being analysed at present.

	5. **Partnerships:** the SWL MH Strategy is in final version and will be approved at the SWL ICB in May 2023. Work on the SWL MH Partnership Delivery Group structures and the SWL MH Provider Collaborative have progressed albeit at the slower pace than intended. The Trust continues to support SLP wide work. The focus on partnership working will continue, and likely expand, in 2023/24. 6. **Finance:** The Trust has made good progress delivering its CIP requirements for 2022/23 but in the main on a non-recurrent basis. Corporate objectives remain an effective way of defining delivery requirements of the Trust on an annual basis. As flagged in the Q3 report, variable delivery raises a number of issues for consideration as follows: • Impact: When setting the corporate objectives the Trust has tried to link outcomes to activities and milestones, however it is clear from the Q4 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. • 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. • Link to Trust Strategy: The work to review delivery of the Trust Strategy and progress against delivery of the strategic ambitions is now being planned and will be carried out in Q1 & Q2 2023/24. Through this work we will review and assess corporate objective delivery over the past 5 years to identify material improvements made. • 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. In addition, we will work to ensure that these priorities are appropriately described and communicated so that they are understood by all.
What Next?	Delivery against any outstanding 2022/23 corporate objectives is being considered in the development of the 2023/24 corporate objectives. The Committee is asked to: • Discuss the Q4 and year-end 2022/23 delivery • Agree onwards submission to the Trust Board
Any specific issues to note and/or for escalation:	None

Strategic ambitions this paper supports			
	☒	Increasing quality years	This paper supports all four strategic ambitions as it details delivery against our 2022/23 corporate objectives, which are directly linked to delivery of our strategic ambitions.
	☒	Reducing inequalities	
	☒	Making the Trust a great place to work	
	☒	Ensuring sustainability	

Implications	
Equality analysis	Positive – Delivery of equality, diversity and inclusivity is everyone's business. There has been 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.
Service users/ carers	Positive – Delivery of our corporate objectives supports improving care for our service users and their carers
Estates:	Positive – Delivery of the Estate Modernisation Programme (EMP) has been a key organisational priority in 2022/23.
Financial:	Positive – Financial delivery has been a key focus of 2022/23 in recognition of the exceptionally challenging landscape that the Trust is working in. Delivery has been pressured throughout the year.
Legal:	N/A
Reputation:	Positive – Delivery of corporate objectives in 2022/23 will continue to support the Trust's reputation with stakeholders.
Strategy:	Positive – Corporate objectives continue to support delivery of the four strategic ambitions of the Trust Strategy.
Workforce:	Mixed – The Trust workforce is under pressure and remains impacted by the legacy of Covid-19.. In addition, the Trust has experienced significant issues with delivery of the HR function. Due to this situation the 2022/23 people objective was moderate in ambition recognising the need to support our workforce and build a HR service that can support the Trust.
Sustainability Eg. Green Plan.	N/A
Other (specify):	None
Appendices/Attachments:	N/A

Q4 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%; M12 91% target 95%) ***– Increased level but target not met***
- Increase in % risk assessments reviewed within 48 hours (2021/22 average – 91%; 2022/23 M6 95%; M9 96%; M12 97% target 95%) ***– Increased level and target met***
- Increase in % risk assessments reviewed within last 12 months (2021/22 average – 93%; 2022/23 M6 93%; M9 93%: M12 91% target 95%) ***– Level not increased and target not met***
- Increase in % physical health assessments completed within 7 days of admission (2021/22 average 78.6%; 2022/23 M6 79.3%; M9 80.3%; M12 81% target 95%) ***– Increased level but target not met***
- Increase in % of cardiometabolic assessments completed for community service users (2021/22 average 84.41%; 2022/23 M6 84%; M9 85.5%; M12 82% target 95%) ***– Level not increased and target not met***
- Reduction in Restrictive Practices (Total # Prone Restraints 2021/22 – 450; 2022/23 M6 157; M9 278; M12 378. Total # Restraints – Physical & Rapid Tranquilisation 2021/22 – 2,245; 2022/23 M6 692; M9 1,215, M12 1,733. Total # Seclusions 2021/22 – 379; 2022/23 M6 96; M9 178, M12 241) **– Level reduced**
- Medicines optimisation guidance for service users and staff **– Drafted but not yet complete**

Delivery priorities	Q4 2022/23 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 22/23 delivery	Year-end delivery rating
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**	**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** • The physical health question in Feedback Live! has now been added,		• The triangulation of patient experience data for all areas was planned to begin in Q3, but has been impacted on by the capacity to develop Feedback Live! This was not completed by end of Q4 but is planned to be online early in Q1 2023/24 • The Restrictive Practice Use of Force Policy audit was completed. • Medicines optimization framework, positive messaging and adverse affects work areas will all be completed by Q4. • Medicines Optimisation has completed its medicines	It is expected that the new Feedback Live! questions will be online by the end of April 2023, enabling the triangulation of data to be completed.	

• 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 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)	to support collection of data on this element but this is not due to be online until Q1 2023/24. • Audits remain underway. **Restrictive practices** • The compliance audit of the Use of Force policy has been completed. There are plans to review and close compliance gaps • Patient data has not yet been collected or triangulated. Work is ongoing on Observation Qii, with ward attendances to collect experience feedback from service users on observations • From April 2023, peer support workers will also support service users with post-incident debriefs • Audits remain underway. **Medicines optimisation** • The co-produced medicines optimisation framework was due for completion in Q2 and Q3 and remains in progress. As reported previously, 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 approved and signed off. They will be launched in April 2023 at the Doctors' academic		optimisation positive messaging advice document and the guidance around medication adverse effects and these are due to be launched in April 2023.		

Medicines optimisation • Tools available to support adherence scoped and options paper on this 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)	meeting and through ward managers and community medicines optimisation meetings.				

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 ***– met for services that have moved.***
- Waiting times in Sutton community SMI services reduced (average waiting time to start treatment – 2021/22 outturn TBC and 2022/23 outturn TBC; total waiters over 30 weeks – 2021/22 close 63; 2022/23 M9 – 46; M12 TBC) ***– outcome awaited.***
- Inpatient beddays used by Sutton residents reduced (2021/22 outturn TBC; 2022/23 outturn TBC) ***– outcome awaited.***
- Longest lengths of stay reduced impacting positively on overall LoS (2021/22 outturn – 44 days; 2022/23 outturn – 44 days) ***– outcome awaited***.
- Corporate and other staff safely relocated ***– met.***
- Positive feedback received on moves from staff ***– mixed feedback with both positive elements and learning points identified.***
- Tolworth business case approved ***– approved by Trust Board and now in external review process.***
- Estates Strategy approved ***– met.***
- Digital delivery plan completed and digital strategy approved ***– partially met digital plan in place with digital strategy under development for Q1 2023/24***.

Delivery priorities	Q3 2022/23 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 22/23 delivery	Year-end delivery rating
Overall • Peer review recommendations implemented (Q1) and Gateway 4 review completed (Q2) • Initial post-project evaluation on Phase 1 completed (Q4) **EMP** • Clinical and operational sign off completed for service moved (Q2) • Shaftesbury and Trinity soft landings completed (Q2) and services successfully operating from new buildings (Q3) • Retail units opened (Q2) • Remaining Springfield site elements closed – Fairways (Q2), Conference Centre and Car Park B (Q3), Restaurant, Main Building, Harewood House and Diamond Estate (Q4) • Phase 2a planning applications submitted by partners (Q1)	**Overall** • The proposal for a revised programme structure and governance has been finalised and is progressing through governance in April 2023, ready to be re-launched in Q1 2023/24. **EMP** • Trinity is fully operational. • A few teams have been able to move into Shaftesbury early (Estates & Facilities and CAMHS team base) and the new car park is now open. Practical completion is estimated for the end of April 2023 with sufficient time for snagging and soft landings to follow. The building should be fully operational in summer 2023. • Discussions with Compass regarding the future retail catering provision and other retail commercial partners for the other retail units are ongoing. It is		**EMP** • The programme has successfully delivered a fully operational Trinity building, with plans for Shaftesbury to be fully operational in Q2 2023/24. Practical completion, snagging and soft landings will complete in Q1. • Retail units have not opened by year-end but plans are in place for opening by end of Q1 2023/24. • There have been delays to the Barnes plans approval process and temporary decant but both are due for Q1 2023/24. **Clinical Transformation**	• The re-launch of the programme is due for Q1 2023/24. • Outstanding work on Shaftesbury and moves is due for completion by Q2 2023/24. • The initial evaluation will take place in Q2 2023/24. • Kingston & Richmond transformed community model will be fully mobilised in Q1 2023/24.	

• Estates Strategy approved (Q2) • Barnes plans progressed with planning application submitted and Barnes business case approved (Q1), planning application approved (Q2), business case confirmed (Q3) and services decanted from Barnes accommodation (Q3). **Clinical transformation** • Sutton community adult mental health model fully implemented (Q1) and evaluated using agreed metrics (Q2) • Kingston and Richmond community adult mental health models fully implemented (Q3) • Year 3 community mental health adult transformation funding bid submitted (Q4) • Redesigned rehabilitation, personality disorder and adult eating disorder models fully implemented (Q4) • Children and Young People's mental health transformation defined and planned (Q1) and underway with external stakeholder support (Q3) **People Readiness and Culture Change** • Relocation consultation outcome published for corporate and clinical support staff currently based at Springfield (Q1) and staff moved to new location (Q3) • Agile and change training for staff completed (Q1) • Staff moved from Acacia, Woodroffe (Q1), Building 30, Phoenix and Morrison (Q3) and Newton (Q4)	anticipated that fit-out works will begin in late March 2023, opening by end of Q1 2023/24. • Car Park B has now closed. City & Country have agreed that the Trust can continue to use Building 32 until at least January 2024, which will have a mixed tenure during this time. • NHSE and DHSC are reviewing the Barnes FBC with approval anticipated in late June 2023. Decant dates for the temporary relocation of Barnes teams to Teddington has been confirmed for 15 April 2023. • As flagged in Q3, due to the dependencies on moves and requirement of six months' bedding-in priori to a review, the initial post-project evaluation is now scheduled for Q2 2023/24. After-action reviews have been conducted on all teams that have moved to collate immediate feedback and learning. • Contract negotiations have permitted extended operation of the restaurant for the benefit of the Trust. The Main Building, Harewood House and Diamond Estate have been vacated and are in the process of being decommissioned for handover. **Clinical transformation** • Sutton is now considered BAU. Conversations are taking place with Healthwatch to deliver a follow-up survey to assess the qualitative impact of transformation on service users.		• Sutton has successfully moved to BAU. • Kingston and Richmond are on track to fully mobilise in April 2023, which is a slight delay but indicates the large amount of work delivered in 2022/23 and learning from the Sutton delivery in year 1. • Dedicated focus area work has also been completed in 2022/23. **PRCC** • All deliverables met or achieved **Digital** • This programme is now reporting through EMC and plans are in place for 2023/24		

• 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)	• Implementation of new core model for Adult Community Mental Health in Kingston & Richmond is progressing but the timeline for full implementation is now April 2023. • Rehab service is ready for move to BAU in April 2023. Personality disorders work is continuing, with plans to focus on integrating Kingston and Richmond CNS services. The pathway milestone has been met. Adult eating disorders is progressing for the end of 2023/24. • CAMHS phase 2 transformation programme commenced in Q4. **People Readiness and Culture Change** • All moves from Building 30, Phoenix and Morrison have now completed. • Newton staff moves are now complete. There will be a further set of moves when Shaftesbury is complete and refurbishment can take place in the old Hume ward in Newton for further teams to move in Q3 2023/24. • After-action moves are highlighting that teams were well-prepared and supported for moves. The refreshed programme proposes a wider scope for OD support to include clinical transformation. **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.				

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 **– TBC**
- Improvement in scores in Staff Survey EDI sections (diversity and equality and inclusion people promise elements[1])**– E&D score 2021 – 7.7; 2022 – 7.8 Inclusion score 2021 – 7.1; 2022 – 7.2**
- Improvement in Workforce Race Equality Standard (WRES) indicators[2] **- 2022 scores available in October 2023**
- Improvement in Workforce Disability Equality Standard indicators (WDES)[3] **– 2022 scores available in October 2023**
- Sustained improvement in Stonewall Index Score (total score for 2021: 70.5) **– no score has been submitted for 2022**
- EMHIP evaluation completed **– not met.**
- Improvement in staff confidence in talking about race and ethnicity **– TBC**

Delivery priorities	Q4 2022/23 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 22/23 delivery	Year-end delivery rating
• 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) • Refreshed action plan for workforce EDI actions agreed with Equality and	Due to previously reported challenges in delivery the milestones due in Q4 have in the main not been achieved: • The cultural capability delivery timeline has shifted to 2023/24. An implementation group has been set up, which will carry out key engagement internally with those involved in EMHIP interventions 1, 2		• The EDI action plan has been refreshed. • The anti-racism pilots have not been delivered in 2022/23 but have been finalised in scope. These are planned for delivery in 2023/24.	• Cultural capability and manualised dialogical cultural capability training have plans for delivery by end of Q3 2023/24. • Anti-racism pilots will be delivered in 2023/24. • The ethnicity audit is due to complete by Q2 2023/24,	

[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).

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)	and 3. Plans are also in place to recruit a training design expert to co-design the training module. • The manualised dialogical cultural capability training programme has a revised project plan in line with the cultural capability work, with a shift to delivery by Q3 of 2023/24. • The two anti-racism pilot interventions have been agreed as community-based recruitment, reducing restrictive practices and coercion and ensuring fair progression. Delivery will be in 2023/24. • The EMHIP evaluation has been delayed due to an unsuccessful search for an evaluation partner in March 2022. Plans are in place to seek an evaluation partner again in 2023/24 to deliver an evaluation by end of Q4 23/24. The framework has been agreed by the Delivery Group and the Trust's R&D team will help with quality assurance. The evaluation will cover the Wellbeing Hubs through the Trust's Adult Community teams and the Crisis Family Placement Scheme through the HTT and EMHIP programme. • The ethnicity audit is part of the EMHIP dashboard development, which is funded by the ICB. Partners are testing a trial version of the dashboard with a final produce due in Q2 2023/24. • Some aspects of MRES are in the Integrated EDI Action Plan for		• Manualised dialogical cultural capability training will move to Q2 2023/24 and a revised project plan for the whole project, including the project delivery model, outcomes, milestones and risks has been developed. • The ethnicity audit is nearing completion with a trial version of the dashboard being tested by partners. This is expected to be ready for use in Q2 2023/24. • Cultural capability has not been delivered but plans are now in place for delivery in 2023/24. • Manualised dialogical cultural capability training has not been delivered and will shift to 2023/24. • The EMHIP evaluation has not been delivered due to circumstances beyond the Trust's control. Plans are in place for 2023/24 for the interventions to be evaluated and R&D support is secured. • The completion of standardising reporting and data capture continues into 2023/24.	linked to the EMHIP dashboard delivery. • The EMHIP evaluation will be delivered in 2023/24 subject to finding a successful evaluation partner. • Standardising reporting and data capture will be delivered in 2023/24.	

	2022/23, with development of reporting and action planning processes to follow. • There are ongoing discussions about recording, reporting and monitoring of patient and staff demographic information as it relates to standardising and embedding reporting and data capture. Work in this area is ongoing. Diversity data will be reported as part of the annual report, public sector equality duty report and the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). • The EDI action plan has been refreshed and approved, including workforce actions. • EMHIP delivery plan has been agreed but did not take account of evaluation findings given this has not completed.				

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%; M12 17.41%) ***– TBC***
- Reduction in staff turnover for those with less than 12 months service (2022/23 M6 19.95%; M9 24.7%; M12 24.34%) ***– Not met***
- Reduction in sickness absence rate (2020/21 average 4.03%; 2021/22 average 4.97%; 2022/23 M6 5.09%; M8 5.05%; M11: in month 5.17%; rolling 12 months 4.87%) ***– Not met***
- Reduction in vacancy rate (2021/22 19.78%; 2022/23 M6 19.87%; M9 17.3%; M12 17.23%) ***– Met***
- Improvement in feedback around medical staffing, recruitment (both candidate and managers) and employee relations ***– TBC***
- Monthly reduction in employee relations cases ***– TBC***
- HR Recovery Plan delivered ***– Met***
- Leaders reporting improved skills ***– Not met***
- Improved HR & OD team staff survey results ***– TBC***
- Substantive HR & OD team in place ***– Partially met***
- 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] ***– TBC***

Delivery priorities	Q4 2022/23 delivery summary	Q4 delivery rating	Year-end delivery summary	Plans for any outstanding 22/23 delivery	Year-end delivery rating

• 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:
  ○ Reduction in agency spend achieved (Q4)
  ○ Effective high quality medical staffing, employee relations and recruitment service in place and able to support all Service Lines and corporate teams.
  ○ Rolling policy review and update programme in place.
	• Senior stakeholder engagement around the leadership framework has taken place and the leadership development offer is now being progressed through relevant governance.
	• In terms of specific HR recovery plan elements:
	  ○ Agency use has levelled out, impacted by recent industrial action. A new process for proactively managing requests for agency staffing is in place and is taking effect in some areas.
	  ○ Improvements have been seen in the Recruitment
			• Significant engagement has taken place on the Leadership Framework and Offer but this has not been delivered in-year.
			• Delivery of the policy framework and the policy review have not been met despite many attempts to do so.
			• Improvements have been seen across most of the HR recovery plan elements with significant progress to a stable HR function.
				• The Leadership Offer is planned for agreement in Q1 2023/24, with delivery commencing in Q2.
				• Following the identification of dedicated resource, a focused policy review will begin in April, for 12 weeks. The introduction of new policies will now be progressed in Q1 2023/24 with training delivered in Q2 2023/24.	

[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).

• 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)	service with permanently recruited staff in place. The next focus will be on improving the processes around experience and a more attractive 'pull' approach to attracting colleagues. ○ Improvements are also being seen in medical staffing responsiveness. Focused work has taken place on AAC panels, recruitment activity, rota management and general queries. Unfortunately, the candidate recruited to the Head of Medical Staffing post has withdrawn. Options on this are currently being worked through ○ ER cases remain challenged but some improvements have been made in identifying and progressing ER cases ○ Rolling policy review is behind schedule. A focused review will commence in April with a view to now deliver in Q1 2023/24. • There has been a decrease in the engagement score from 5.7 to 5.5 in the Staff Survey results. Pulse survey results are awaited. • The People Plan will now be smaller in scope, following Executive discussions. A first draft will				

	commence through governance in April 2023. • Discussions to meet the cultural practice and organisational development work have been led by the CEO, Director of Transformation and the Director of People, and a specification has been drawn up. This will outline a two-year programme of OD initiatives to enhance our culture as we look to deliver a range of service transformation throughout teams				

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 – ***Partially met (final draft complete)*** • SWL MH provider collaborative, and team, in place ***– Partially met*** • Agreed MH budgets delegated ***– Partially met*** • SLP structures and delivery updated ***– Not met.*** • Place MH programmes developed ***– Not met.*** • SLL commitments delivered ***– Met.***					
Delivery priorities	**Q4 2022/23 delivery summary**	**Q4 delivery rating**	**Year-end delivery summary**	**Plans for any outstanding 22/23 delivery**	**Year-end delivery rating**
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 is in final draft and is being reviewed by the SWL ICB Senior Management Team in late April 2023 and will be approved by the SWL ICB Board in May 2023. • SWL MHPC work remains underway with Complex Care Phase 2 delegation agreed and budget due to be delegated. • SWL MH Partnership Delivery Group (PDG) continues to drive work forward and delivery agreement around MH has been drafted between the SWL MHPC and the SWL ICB. • SWL MHPC Programme Director started in post 09.01.23. • Existing SLP programmes have been reviewed and changes to leadership and structures are being developed. • South London Listens work continues with core elements delivered. **Places** • Kingston and Richmond MH place priorities agreed and further work to		• SWL MH strategy has been a significant piece of work for 2022/23 that has taken much longer than anticipated. The Strategy is now under production and year 1 planning is underway. • The SWL MHPC work has been complex but has made progress with Complex Care Phase 2 delegation agreed and a pipeline of service areas agreed including perinatal as the next area. • Resourcing requirements for the SWL MHPC requires ongoing discussion and will likely be impacted by ICB restructuring in 2023/24.	Work will continue on SWL (system and place), SLL and SLP areas into 2023/24.	

• 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)	develop these programmes underway. Workshops to set Merton place MH priorities are underway. Work is yet to start in Wandsworth.				

Objective 6: To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL. • Planned outturn met **– *TBC*** • CIP 2022/23 plans in place and delivering on four priority areas **– *Partially met.***					
Delivery priorities	**Q4 2022/23 delivery summary**	**Q4 delivery rating**	**Year-end delivery summary**	**Plans for any outstanding 22/23 delivery**	**Year-end delivery rating**
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 M11 was £300k below plan leaving cumulative position £0.5m over planned delivery (11.8m vs £11.3m target). £13.1m schemes now identified (£700k above target) and RAG rated giving us a 103% confidence (compares well to a 93% confidence at M11 in 2021/22). Issue remains that whilst £12.5m of the savings are rated green currently only c£3.7m is recurrent (30% of the target) which is no improvement over the position at the prior quarter's reporting (30%). • CIP has been fully delivered in 2022/23; however, there is a concern that only circa 30% is recurrent, but the 2022/23 control total is highly likely to be delivered. • The 2023/24 CIP plan is in place with minimal unidentified CIP of circa £1m. The plan was approved by FPC before 31.03.23. **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. • The Tolworth Business Case was approved by the Trust Board and,		• CIP plans have been successfully delivered 2022/23 and a plan produced for 2023/24 with minimal unidentified CIP. • The Tolworth business case has been successfully signed off by Trust and ICB governance and is now with NHSE and DHSC for final approval. • There have been delays to completing the provider collaborative due diligence so this remains outstanding for 2023/24. • The delivery of the budget planning module also remains outstanding and will move to 2023/24. • Strategic finance resource has not been recruited.	• Provider collaborative due diligence will be completed on an area by area basis reflecting the new approach to SWL MHPC development. • Delivery of the budget planning module will form part of BAU delivery in 2023/24.	

	following subsequent iteration, has now been approved by the ICB. The draft has been submitted to NHSE and DHSC. • Work to complete the provider collaborative financial due diligence is delays but underway. • As reported in Q3, there have been delays to implementing the budget planning module owing to staffing pressures. The module has been procured and this will now form part of BAU in line with 2023/24 objective delivery.				

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

Meeting:	Estates Modernisation Committee meeting
Date of meeting:	7th March 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. What should the balance be on working to improve current BAU HR challenges vs. developing the more strategic approach to OD and culture change? The committee discussed what it could expect to see on future plans for OD and culture change over the next few months, and was minded that there is still much to do to drive BAU HR initiatives and address more immediate workforce challenges.

2. The Board is asked to note that the committee discussed the importance of clear visibility of the sequence of financial and legal transactions that are coming up linked to, for example Tolworth and Barnes, and requested a summary of these

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 remains 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).

- **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 (dedicated operational senior leadership group)
  - Estates Modernisation Management Group (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 as well as the April Board seminar. 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, but now requires ministerial sign-off for the STP monies which are being used to fund.

- **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.
- Integrated Programme quality and performance metrics will be reported from June 2023, with collection starting from April data.

Item discussed- Finance Report (Month 10)

- **Assurance Position**

The Integrated programme finances are being well managed overall and risks appropriately understood. The M10 position is a cumulative £4.7m underspend, mainly due to slippages with the overall Tolworth timetable and Richmond Royal re-development.

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- CAMHS Community Transformation Programme update

- **Assurance Position**

The committee received an update on the programme for Phase 2 (Dec 22 – Dec 23) which focusses on 4 core areas i) clarifying pathways ii) aligning to Place iii) improving transitions and iv) enabling activities e.g. communication protocols with schools, social care and primary care. Key risks were highlighted, as was the importance of the work given high waiting lists particularly for Autism Spectrum Disorder (ASD) and Attention deficit hyperactivity disorder (ADHD) pathways.

- **Evidenced by**

  - Presentation report
  - EMMG discussion

What next?

- No major action, other than continued management and reporting. Further updates are already part of the EMC workplan.

Item discussed- Digital Oversight Group update

- **Assurance Position**

The committee is assured that escalations associated with the Trust's digital plan are coming to EMMG and there is strong focus on digital skills and training. A focus on encouragement for the development of digital skills as well as reducing digital inequality is being taken, together with highlighting the importance of digital skills to deliver the best care with enhanced quality and efficiency.

- **Evidenced by**

  - Digital Oversight Group report

What next?

- 5 year Digital strategy to come to a later EMC
- Update on Digital skills and training in May.

Item discussed- Integrated Programme Board Assurance Framework (BAF) risk review

- **Assurance Position**

The committee noted the more concise-format BAF position for the Integrated report and is assured key risks are being appropriately managed. The committee queried if there is sufficient focus on the mid-long term organisational development approach and outcomes, however.

- **Evidenced by**

  - BAF report

What next?

- Review BAF again in next quarter.

Appendices
None.

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

Meeting:	Estates Modernisation Committee meeting
Date of meeting:	4th April 2023
Transparency:	Public
Committee Name	Estates Modernisation Committee (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. To note the work continuing to prepare for a safe and high experience move into the new facilities at Morrison & Shaftesbury

Areas of Risk Escalation to the Board:

- Assurance around community transformation acknowledging the level of complexity and how it is being managed across boroughs whilst maintaining BAU. The trajectory of outcomes will become clearer in due course.

- A critical enabler is moving away from programmes working in silos to understanding the interdependencies and using matrix working for greater effectiveness which will involve developing a different skill set. Also the importance of organisational development support to achieve this. To be discussed further at Board seminar.

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 remains good assurance on the post-implementation situation in the new Trinity/Tolworth/Newton & CAMHS (Trinity & Shaftesbury) buildings. Further assurance is required to confirm the timetable of the move to the new Shaftesbury Building from STEP/SRM (developers).

- **Evidenced by**

  - Trinity 'after action' reviews and distillation of learnings for the future
  - Tolworth 'after action' reviews and distillation of learnings for the future
  - Newton 'after action' reviews and distillation of learnings for the future
  - Shaftesbury (part) 'after action' (CAMHS) reviews and distillation of learnings for the future
  - Master dashboard and detailed move Gantt-charts
  - Trinity building snagging lists reviewed by COODIG (dedicated operational senior leadership group)
  - Estates Modernisation Management Group (EMMG) papers

What next?

- Integrated Programme Phase 2 review will incorporate more work on creating a culture of joint-working in the new space
- Post-move survey
- 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 be further developed at the April Board seminar.

DHSC approval of the Barnes business case has been secured and the Memorandum of Understanding (MOU) is in place; planning permission is expected to be presented to planning committee in May '23.

- **Evidenced by**

  - Master dashboard
  - EMMG papers
  - BAF
  - MOU
  - Integrated Programme quarterly risk report

What next?

- Phase 2 Integrated Programme review of governance, scope and reporting will come continue to develop, noting the focus on the remaining moves for QMH & Shaftesbury
- The final scope of what EMC and the People Committee will cover is part of the Phase 2 Integrated Programme review.
- Integrated Programme quality and performance metrics will be reported from June 2023, with collection starting from April data.

Item discussed- Finance Report (Month 11)

- **Assurance Position**

The Integrated programme finances are being well managed overall and risks appropriately understood. The M11 position is a continuation of the trend underspend, mainly due to slippages with the overall Tolworth timetable and Richmond Royal re-development.

Continuing discussion on Edward Wilson House maintains as much pressure as possible from our Trust position and the progress through to discharge of the grant continues.

Draw down of the Barnes STP fund following (external) approval of the FBC is being designed with colleagues.

Phase 1 remains within the DHSC and Treasury approved fixed price of £155.2m.

- **Evidenced by**

  - Finance reports
  - Finance returns to centre.

What next?

  - No major action, other than continued management and reporting.

Item discussed- Community Transformation Deep Dive

- **Assurance Position**

  - Key headlines are that the community transformation has been delivered into BAU for Sutton, with Kingston and Richmond in progress and by Q1 24/25 will have been implemented across all boroughs.

  - Workforce is a key part of the transformation with many new roles created which has supported recruitment and retention but has brought challenges which are being worked through.

  - As the transformation has progressed, it has been clear that resources and processes were needed to reduce the demand on crisis services which has resulted in the creation of an enhanced response service.

- **Evidenced by**

- Deep dive presentation report
- EMMG discussion

What next?

- There is a symbiotic relationship between inpatient and community pathways. It is a priority over the next few months to ensure community and acute transformation programmes are more aligned so changes in community will have more direct impact on flow.

- The community transformation team is working closely with AUC to start to draw out the potential trajectories. There is a national conference in May and will hear about other experiences.

Item discussed- Integrated Programme Refresh

- **Assurance Position**

  - Note that transformation principles will be discussed at the next Trust Board seminar including governance, resourcing and positioning to align with Trust priorities. This will provide direction from June 2023 onwards.

  - Note the overall (revised) vision of programme needs to be clarified, and what that means for the individual workstreams and who is involved at each level of staff to ensure the level of change is appropriate. Considering the scope over the next couple of months is very important.

- **Evidenced by**

  - Board seminar itinerary
  - Trust priorities

What next?

- Some work is driven by internal and external factors. Some activities can be delivered outside of the Integrated Programme. Once the scope is confirmed, the programme structure and resourcing can be agreed.

Appendices

All annual reports and other items that require to be in the full Board papers will be appended to the Committee Report

- None

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

Meeting:	Trust Board
Date of meeting:	11 May 2023
Transparency:	Public
Committee Name:	Audit Committee
Committee Chair and Executive Report:	Richard Flatman (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	N
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.	N

Whilst the committee is not responsible for the delivery of the above objectives or managing the BAF risks its work supports them all through ensuring appropriate controls and oversight are in place and operating effectively.

Key Questions or Areas of Focus for the Board following the Committee:
The Board Assurance Framework was not reviewed by Committee as expected in March. There was however a detailed discussion about the BAF and the Committee's recommendations are included in the BAF report that appears separately on the Board agenda.

The internal audit review of risk management (see below) found there to be a sound governance structure around the BAF and risk management and confirmed that the structure is operating as intended.

Areas of Risk Escalation to the Board:

No specific items of risk were identified for escalation to Board.

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

External Audit

The Committee received an update on the progress against the external plan, highlighting that good progress had been made and no areas of significant control deficiencies or other issues had been identified that needed to be brought to committee's attention. It was noted that there had been delays at the interim audit and that KPMG believed that the audit was sufficiently progressed to avoid impacting the final audit completion. It was noted that there are no audit issues expected that require KPMG technical support. It was concluded that the issues experienced during last year's audit should not be repeated.

Value for Money (VfM) assessment is in progress with no issues raised to date.

Reasonable Assurance

Evidenced by – Progress against interim audit and VFM risk assessment with no matters requiring escalation.

What next? The final audit is scheduled to complete in May and report to Audit Committee 13 June 2023. An extraordinary Trust Board is scheduled to take place immediately after Audit Committee to approve the annual accounts.

Internal Audit

The Committee received the Draft Head of Internal Audit Opinion for 2022/23 and the Trust has been provided with a level 2 (out of 4) opinion. This is a positive opinion with most organisations receiving either a level 2 or 3.

The Committee received the following audits:

- Location Visits – partial assurance - Committee was disappointed to note that evidence suggests that care plans and crisis plans are inconsistently applied across teams and that elements required in accordance with agreed policy were absent in several cases. Work is required to bring care plans and crisis plans to the required standard and keep patients safe.
- IT Project Management – reasonable assurance
- Risk Management – reasonable assurance
- Clinical Audit – partial assurance – Committee expressed concern that it did not have oversight of the clinical audit programme and that that the process did not seem to be working effectively. At the time of the audit only 5 audits (less than 10%) had been completed with no nationally mandated audits covered. In 21/22 only 25% of audits were completed.

Assurance Map
Assurance mapping is a means to align assurance received with respect to key risks in an organisation. Committee received the first draft of the Assurance Map, was pleased with the progress made and discussed how the map could be aligned to Committee responsibilities. To date the map contains certain elements of the Trust's lines of defence in delivering effective risk management and control and now requires input from the Trust to move it further forward. The intention is to bring this to Board at the earliest opportunity.

Financial sustainability assessment
Committee received benchmarking information on the recent Financial Sustainability Assessment which supported the Trust's view of the work needed around improving culture and understanding of financial issues.

Data Security and Protection (DSP) Toolkit

Committee received benchmarking information on the Data Security and Protection Toolkit. Committee noted the report and stated its expectation that the Trust would improve its rating to moderate this year (last year the Trust received limited assurance rating).

Reasonable Assurance

Evidenced by – positive assurance opinions for the internal audits completed so far. Three audits were outstanding at the time of writing the opinion, with a positive draft Head of Internal Audit opinion.

What next? Whilst the annual opinion needs to be finalised following the final review of the last three audits, it is not expected that the overall opinion level will change.

The Location Visit audit was referred back to QSAC for further review of the actions required and a report back on the progress against actions.

Process to ensure clinical audit oversight to be agreed. Report was referred back to QSAC and ELT for consideration of how this could be achieved.

DSP Toolkit completion/submission by agreed deadline.

Counter Fraud
The Committee received a Counter Fraud Update report and noted the three new referrals in the month all related to agency staff. Committee noted the progress against the national return due in May and that it was expected to be rated Green. Lastly the national fraud initiative outputs were discussed and Committee noted the low levels of issues requiring further investigation.

Reasonable Assurance

Evidenced by – progress and oversight to date.

What next – Consideration needed as to whether a deep dive in agency should be included in the plan for 2023/24.

Annual Accounts update.
The Committee received an update and the following were discussed:

Going Concern – Committee reviewed the evidence and supported the preparation of accounts on a going concern basis, noting that final approval for this would need to be given in June.

Bad Debt Methodology – The methodology for providing for bad debts for 2022/23 was agreed; it remains unchanged from that adopted in 2021/22.

Accounting Policies – Accounting policies have now been published by NHSE and are consistent with those approved by Audit Committee.

Impairments – Committee reviewed and approved the approach to impairments. Assets have been reviewed and no impairments are required as a result of management action. The District Valuer report has been received and has been reviewed by the Finance Department with no material impact anticipated. Impairments due to market conditions are reported below the line.

Significant Assurance

Evidenced by – support from external audit to planned approaches and no identified gaps in control.

What next? Draft accounts submission deadline is 27 April.

Appendices

Appendix 1 - Minutes from January 2023.

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

Audit Committee

Approved minutes of the meeting held via video-conference on Tuesday 24th January 2023, 13:30-15:30

Present:

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

Attendees:

Philip Murray (PM)	Director of Finance & Performance
Debbie Hollinghurst (DH)	Deputy Director of Finance
Joanna Lees (JL)	External Audit – KPMG
Loyiso Xego (LX)	External Audit – KPMG
Sharonjeet Kaur (SK)	Internal Audit – RSM
Heather Greenhowe (HG)	Internal Audit – RSM
Nicola Mladenovic (NM)	Deputy Director of Corporate Governance (Minutes)

Apologies

Vanessa Ford (VF)	Chief Executive
David Lee (DL)	Director of Corporate Governance
Komal Taragi (KT)	External Audit – KPMG
Clive Makombera (CM)	Internal Audit – RSM

Item **Action**

23/1 Welcome and Apologies
Apologies for absence were received and noted as above.

23/2 Declarations of Interest
No additional declarations of interest were reported for noting.

23/3 Chair's Action
Chair's Action has been taken on 6th January 2023 in respect of signing off the final report Events After the Reporting Period and agreeing the tender waiver for retail unit leases as part of the business plan. In addition RF and PM have liaised regarding counter fraud issues and agreeing additional audit days.

23/4 Minutes of the previous meeting
The minutes of the previous meeting held on 25th October 2022 were approved as an accurate record.

23/5 Action Tracker/Matters Arising
The Committee received the action tracker and noted the following:

22/98 – Internal Audit. Data security and protection toolkit – the audit has been completed and RSM are checking against the progress against the action plan. It was agreed to keep this on the action tracker until this was completed.

22/109 - Detailed Scheme of Delegation – the approval levels were amended as the initial report contained an error. This has now been completed and is consistent with previous versions of the DSoD and SFIs.

23/6 External Audit
The Committee received the draft indicative Audit Plan for 31st March 2023 audit and the following points were highlighted by Joanne at KPMG.

- The audit covers the financial statements audit, the risk assessment for the value for money aspect will come to the next meeting for review.
- The risks continue to be reviewed and this is the reason for the indicative position until the accounts are produced due to the conditions to ISA 315.
- Some risks identified relate to fraud risk – expenditure recognition, valuation of land/buildings, management override of controls and revenue recognition. These risks are important due to the change in the financial landscape in the NHS nationally where most organisations will be forecasting a deficit at year-end.
- IFRS 16 is an audit risk and this comes into effect from 1st April 2023.
- There is no change to the materiality, this has been calculated on the same basis as the previous year. This will be revisited at year-end.
- There are two revisions to the International Auditing Standards; ISA 315 - identifying and assessing the risks of material misstatement. This will mean a change to the way the audit is carried out and will result in earlier work as part of the planning phase. The audit will be undertaken in May. The other change is to ISA 240 – the auditors responsibilities relating to fraud. The auditor is now required to investigate further and undertake more detailed procedures. The Audit Opinion is now longer and will include responses to fraud.
- KPMG confirmed their independence as being an external auditor.

Through discussion clarification was asked regarding ISA 315 and the interrogation of the IT system. JL confirmed that more inquiries will be performed with walk throughs of the IT system including overarching controls, change management and access.

In the Land and Buildings risk assessment PM confirmed that the district valuer had assessed the new buildings however based on the PDC paper the valuation will not be used this financial year but this will be used in Q1 2023/24. Further detail regarding this is included in the accounts update in management judgements.

JL confirmed that although the plan is indicative it will only come back to the Committee should there be significant changes to the risks or materiality calculations.

The Committee noted that in terms of the Quality Account this would not be subject to audit as in the past two years.

The Committee approved the Audit Plan subject to any final changes and agreed that if there are any changes to risk that this would come back to the March Committee.

23/7 Internal Audit

The Committee received the Internal Audit Plan 2023/24 and the Progress Report and highlighted the following:

Draft Audit Plan:

- In order to develop the proposed plan meetings were held with Executive Directors to understand the key issues or to be informed of areas to focus on for the future year as well as considering the BAF. The final Audit Plan will be brought to the March Committee.

Through discussion it was confirmed that the draft Audit Plan has received scrutiny at the Executive Team and the presented version has been agreed to come to the Committee. VS confirmed that the main items being focussed on include agency usage, external beds and CIPs mirror the discussions being held at the Finance & Performance Committee.

It was requested that the Trusts approach to productivity versus other Trusts is an area to be added to the Plan. This will assist the Trust in future discussions with NHSE regarding productivity.

After the plan is agreed specific audits will be fully worked up with the relevant Executive Directors.

RSM

The Committee requested to see the Assurance Map at the March committee.

Progress Report:

- Good progress is being made against the plan in terms of delivery.
- Since the last meeting the Financial Sustainability (HFMA review) has been finalised and risk management report has been issued in draft today. In total three reports have been issued in draft; location visits and IT project management. Two audits are in progress, one is nearing completion and one for workforce is commencing this month. These conclude the audits for 2022/23.
- There are eight actions overdue (six medium and two low), updates have been received from the management to confirm these are in progress. Revised dates have been agreed for the actions relating to the DSP toolkit.

The Head of Audit opinion will be coming to the March meeting as well as the updates on the final audits. The Chair of the committee requested that a no surprises update is shared and it was agreed that updates on the audits would be circulated as soon as they are finished rather than to wait and update at the March meeting.

The Committee noted and approved the following papers:

- The Progress Report.
- The Internal Plan – the final version will come to the March Committee.

The Committee was broadly content with the direction of travel and looked forward to the final version in March.

23/8 Counter Fraud

The Committee received the update on the Counter Fraud progress report and the following points were highlighted:

- An International Fraud Awareness week was held in November 2022. Ten remote awareness sessions were held focussing on cyber, recruitment and finance. In addition an interactive recruitment training session was held covering identity documents, qualifications and references to support knowing if the documents were forged. Attendance to the sessions was not mandatory and a total of four staff attended, this uptake was low despite additional communication being sent out to publicise the event. Going forward operational pressures and the scheduling of these events will need to have careful consideration.
- An annual Fraud Forum was hosted by RSM for over 50 LCFS staff to attend from across London and the south east. This is a great opportunity for

organisations to work collaboratively across partner agencies, to network and the key speaker at this event was the CEO for Counterfeit Authority.

- The field work in respect of the Fraud and Bribery Risk Assessment has been completed.
- Fieldwork for the recruitment counter fraud proactive review has started.
- The draft workplan for 2023/24 is being drafted and will come to the March meeting.
- Data for the annual self-assessment is being collated ready for the May submission.
- No new referrals have been received since September 2022 however this could be due to work pressures whilst planning moves/moving into the new Trinity Building and departmental changes. This area needs to be kept under review.
- Two counter fraud cases from the previous internal audit provider, TIAA are still on-going.
- Emerging risks continue to be cyber and mandate fraud.

Fraud and Bribery Risk Assessment
This assessment has been carried out to support the Trust to identify and understand the fraud and bribery risks with a view to facilitating some proactive counter fraud resources in these areas. Key findings from the review:

- Recruitment – this is a moderate risk due to gaps in control; there are gaps in processes. This area will be the subject of the next audit.
- Cyber Fraud – this area will always be one of the highest risks to organisations even though the Trust has an extensive set of controls there will always be continued prevalence of targeting public facing bodies.
- Declarations of interest – this was previously reviewed as part of the Association of British Pharmaceutical Industry data and some instances of none reporting was highlighted where hospitality had been accepted.

It is recommended that one risk is to be reported on the risk register as an overarching fraud risk.

Through discussion it was agreed that the Gifts and Hospitality Register needs to be brought to each meeting, even if this is blank. Currently this is reported on a six-monthly basis. The workplan is to be updated and a report is to come to the March meeting. **(Action)** **DL**

The Committee noted the Fraud Risk Assessment and approved the workplan areas.

23/9 Annual Accounts Progress Update
The Committee received the Annual Accounts Progress Update. The following points were highlighted:

- *Accounting Policies* – allowable adaptations to accounting policies in line with the Group Accounting Manual (GAM) and consistent with previous years are recommended. This includes the approach to asset valuation, uncertainty of reporting – whereby a desktop valuation has been carried out by the District Valuer, adoption of modern equivalent asset valuation, segment reporting as 80% of income comes from the SW London ICB and the Trust has an income of £260m.
- *Management Judgement* – Shaftesbury & Trinity
  A paper presented in October 2022, outlined the considerations for the 2022/23 Public Dividend Capital (PDC) payment calculation. The Finance

Team have discussed the paper with KPMG and reflected on recent building slippage.

A meeting took place with KPMG on 7 December where the options available to the Trust were discussed. KPMG confirmed that the GAM is silent in respect of PDC calculations when EMP PDC relief stops mid-year and that management judgement therefore needs to be applied. Whilst Trinity has been handed over it is not fully operational. Shaftsbury is not scheduled to be handed over until April. . Management judgement is therefore that they are treated as a joint asset and will not be fully operational at year end therefore they will be accounted for as an asset under construction. **The Committee approved this.** It is to be noted however that the Secretary of State has the right to review the PDC calculation and this might be changed at their request.

- *Charitable Funds* – it is proposed to not consolidate the charitable funds into the Trust accounts on the grounds of materiality. **The Committee approved this** . The administration fees have changed from £7k to £13k. It is proposed to maintain the administration charge at £10k, however Committee were asked if they would be minded to reduce the charge for 2022/23 in light of the conscious decision by the Trust to pause fundraising events in year. **The Committee approved this request and agreed that the amount of discount should be at the discretion of the DoF and the charge should not exceed the amount of income for the Charitable Funds for the year**

The Committee agreed the following:

- The accounting amendment in policies.
- The management judgement for Trinity and Shaftesbury buildings.
- Charitable Fund administration fee is be discounted and adjusted for 2022/23 and will thereafter be £10k per annum.

The Committee noted the report.

23/10 Debtors Report

The Committee received the Debtors Report and the following point was highlighted:

- A stable position is being reported. The total debt outstanding is £4.3m of which £4.0m is over £20k, meaning there is £0.3m of debtors each under £20k.
- Debtors over £20k have increased by £1.96m since September 2022. The increase relates to debts up to 3 months, with debts older than 3 months remaining constant at £0.7m.
- A vacancy in the Credit Controller post has temporarily slowed down the debt recovery. The post is now due to be filled.

The Committee noted the report.

23/11 Waivers Report

The Committee received and noted the Waivers Report.

Since the last report there have been four tender waivers (£429k) and seven quotation waivers (£222k).

23/12 Losses and Special Payments

The Committee received the Losses and Special Payments report. The following points were highlighted:

During the period, 1 April to 31 December 2022 the overview of losses and special payments totalled 61 losses with a value of £40,134, with 26 instances and £28,015 including a tribunal claim (25 instances and £4,782 excluding the claim) of those occurring between 1 October to 31 December 2022.

The Committee noted the report and approved the tribunal claim.

23/13 Board Assurance Framework

The Committee received the Board Assurance Framework and the following highlights were reported by PM:

- Risk of "*a failure to effectively position the organisation within the external environment*" has now been scored at 10 for two consecutive quarters and it is proposed that this is moved from the BAF to be added onto the Executive Risk Register. **The Committee approved this request.**
- The finance risk has been updated following some changes; the HFMA Sustainability audit has been completed and the outcomes provide further assurance. The underlying underfunding in the NHSE contract has been resolved removing a significant gap in assurance. Additionally the concern regarding 22/23 funding and target uncertainty has not crystallised, the ICB has instigated a Recovery Board and this is chaired by our Chair, Ann Beasley that met for the first time in December and the ICB is seeking external support for the system to help build a recovery plan.
- The EDI risk has been updated and several controls have been put in place to mitigate *"the risk of failure to effectively respond to equality and diversity issues facing the Trust".*

The Committee approved the recommendations and approved the removal of the "*failure to effectively position the organisation within the external environment"* **to be placed on the Executive Risk Register.**

Through discussion it was noted that although the BAF has five risk areas these are sizeable risks for the organisation.

For onward reporting at the Board the Committee asked for the cover sheet to be updated post-Audit Committee. On reflection the chair asked that this update is to consist of only 3 pages; coversheet, the headlines page detailing the risk description with score and then some information on the assurance perspective that the Board should focus on. **(Action**) **DL**

The Committee approved the BAF.

23/14 NHS Code of Governance

The Committee received and noted the NHS Code of Governance.

From April 2023 the Code of Governance will need to be adopted. The Committee requested that an update is to come to the October committee. It was agreed that DL would undertake the review. This is to be added to the workplan. **(Action)** **DL**

23/15 Committee Workplan

The Committee received and noted the workplan. NM confirmed that additional points raised in the meeting will be added; Gifts and Hospitality Report and NHS Code of Governance review.

23/16 QSAC minutes

The Committee received and noted the meeting notes from QSAC for 3rd October and 7th November 2022.

23/17 EMC Minutes
The Committee received and noted the meeting notes from EMC for 1st November 2022.

23/18 Matters to Report to the Board
The following items are to be reported to the Board:

- External Audit Plan
- Reporting requirements relating to VFM and Quality Accounts
- Review of the draft Internal Audit Plan
- Reference the progress of the Assurance Map
- Progress on the Financial Sustainability audit and the actions
- Fraud and bribery risk assessment
- EARP reporting – nothing to report as of 6th January 2023
- Review of the management judgement for Trinity and Shaftesbury buildings
- BAF
- NHS Code of Governance

The May meeting to approve the Accounts is originally on 18th May 2023 however JL requested that this is amended to reflect the 30th June submission deadline as this will involve a change in audit reporting. NM to look at suitable dates. **(Action)** **NM**

23/19 Meeting Review
The Committee reviewed the meeting and noted that the order of the meeting was amended to support PM to be able to attend another meeting.

23/20 Date of Next Meeting
The next meeting is scheduled to take place on 23rd March 2023