Trust Board - Part A July 2024

11 July 2024 10:45 AM - 01:30 PM London Standard Time

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

Agenda Topic — Page

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

AGENDA

Meeting	**Board of Directors – Part A**
Time of Meeting	**10:45am to 1:30pm**
Date of Meeting	**Thursday 11 July 2024**
Location	**Conference Room B, Trinity Building, Springfield Hospital**

	PART A		**Format**	**Lead**	**Time**
1.	**PATIENT STORY**		**Paper**	**AB**	**10:45**
2.	**STANDING ITEMS**			**AB**	**11:05**
	2.1. Apologies	**FN**			
	2.2. Declarations of interests and register https://swlstg.nhs.uk/our-board/	**FR**			
	2.3. Chair's actions	**FE**	**Paper**	**AB**	
	2.4. Minutes of the meeting held on 9 May 2024	**FA**	**Paper**	**AB**	
	2.5. Action tracker	**FE**	**Paper**	**AB**	
3.	**CHAIR'S and CHIEF EXECUTIVE'S REPORTS**				
	3.1. Chair's report	**FR**	**Paper**	**AB**	**11:10**
	3.2. Chief Executive's report	**FR**	**Paper**	**VF**	**11:15**
4.	**INCREASING QUALITY YEARS** **REDUCING INEQUALITIES**				
	4.1. Quality and Safety Assurance Committee chair's report	**FR**	**Paper**	**JW**	**11:40**
	4.2. Quality and Performance report May 2024	**FD**	**Paper**	**JeA**	**11:50**
	BREAK				**12:00**
5.	**REDUCING INEQUALITIES** **MAKING THE TRUST A GREAT PLACE TO WORK**				
	5.1 People Committee chair's report	**FR**	**Paper**	**SA**	**12:10**
6.	**ENSURING SUSTAINABILITY**				
	6.1. Audit Committee Chair's report	**FR**	**Paper**	**RF**	**12:20**
	6.2. Finance and Performance Committee chair's report	**FR**	**Paper**	**PM**	**12:30**
	6.3. Monthly finance and savings reports	**FD**	**Paper**	**PM**	**12:40**
	6.4. Modernisation Committee chair's report	**FR**	**Paper**	**JuA**	**12:50**
	6.5. Charitable Funds Committee chair's report	**FR**	**Paper**	**JuA**	**13:00**
7.	**NOTIFIED QUESTIONS FROM THE PUBLIC AND STAFF**	**FD**	**Verbal**	**AB**	**13:20**
8.	**MEETING REVIEW**	**FD**	**Verbal**	**AB**	**13:25**
9.	**Next Trust Board business meeting in public: 12 September 2024**, Conference Room B, Trinity Building, Springfield Hospital				

Attendees:

Ann Beasley (AB)	Chair
Sola Afuape (SA)	Non-Executive Director, Vice Chair
Richard Flatman (RF)	Non-Executive Director, Senior Independent Director
Juliet Armstrong (JuA)	Non-Executive Director
Jonathan Warren (JW)	Non-Executive Director
Humaira Ashraf (HA)*	Associate Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Dr Billy Boland (BB)	Chief Medical Officer
Sharon Spain (SS)	Chief Nursing Officer
Philip Murray (PM)	Chief Finance and Performance Officer
Jennifer Allan (JeA)	Chief Operating Officer
Amy Scammell (AS)*	Chief Strategy Officer
Katherine Robinson (KR)*	Chief People Officer
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

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

Trust Board
July 2024

Paper Reference:	
Report Title:	Jasmine Ward
Executive Summary:	The story this month is shared by IW, the husband of female patient R who has been receiving care and treatment in Jasmine older people's inpatient ward. The story highlights the experiences of R and her family of care provision experienced by carers and family members when their loved ones experience memory loss and cognitive decline. IW shares how he has been consulted and involved and the observations he has made of the older people's inpatient service. There will be an oral presentation from IW, R's husband. Senior staff from Jasmine Ward and the Specialist Service Line will also be in attendance.
Action Required:	The Board is asked to note this story relating to the Specialist Service Line – Cognition and Mental Health in Ageing (CMHA) – Jasmine Ward.
Link to Strategic Objectives:	The Trust launched its five-year Trust Strategy in 2018. The strategy 2018 – 2023 (now extended to 2025) includes four strategic ambitions: • **Increasing quality years -** Quality Improvement and Innovation • **Reducing inequalities -** Service users and carers co-production • **Making the Trust a great place to work -** Staff underpin all that we do • **Ensuring sustainability –** Transformation. These ambitions move the Trust to focus on outcomes, not processes and are held together by the mission – Making Life Better Together – which is at the centre of the Trust's work. This story links to all our strategic ambitions as the Trust recognises that the day-to-day activities and daily living skills provided to the older population, vastly contribute to extending quality of life. The views of our family members and carers around patients likes and interests, must be taken into account and that the valued support they provide to our patients is to be appreciated and recognised.
Risks:	Patient Safety is a domain of the Quality Strategy.
Quality Impact:	Patient Experience is a domain of the Quality Strategy. Listening to and learning from carers and family members informs our services and enables us to improve the experience for all who use our services.
Resource Implications:	IW's attendance in person has been facilitated through the Quality Governance Department.

Legal/Regulatory Implications:	None. Consent has been provided to use first names for IW and RW only during the meeting. Confidentiality has been maintained in the report.
Equalities Impact:	The Board is asked to note of important day to day service provision around therapeutic activities and safe staffing to enable continuity of care and activity programmes. This is part of the Trust's commitment to Increasing Quality Years and Reducing Health Inequalities for those who use our services.
Groups Consulted:	-IW, husband and carer of patient RW. -Jasmine Ward Manager and staff team, Lead Nurse, Senior Occupational Therapist and Clinical Manager. -Service Line Senior Leadership and Ward Consultant.
Author:	Brenda Ndiweni, Quality Governance Lead.
Owner:	Sharon Spain, Chief Nurse/Executive Director of Nursing and Quality Standards

Making life better together

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

Jasmine Ward - Cognition and Mental Health in Aging (CMHA)

July 2024

Background

This month's patient story to the Board is being presented by Mr IW and family who will share their experience of the Trust's Inpatient Older People's Service, Jasmine Ward and give some insight to the care and treatment his wife has received. Their story will highlight Collaboration with Families, Involvement and Communication about treatment interventions provided to loved ones.

South West London and St George's Mental Health Trust provide Older People's Services across the Trust boroughs of Wandsworth, Merton, Sutton, Kingston and Richmond, and Jasmine Ward is one of the two older people's inpatient service.

Cognition and Mental Health in Aging Services are predominantly known to maintain a focus on a lot of family involvement as part of care and treatment interventions for service users to work with, whilst on their journey to recovery. Family provide pivotal collateral information and advocate for the care of their loved ones.

Jasmine Ward

Jasmine Ward is a 16 bedded unit that offers care and treatment for male and female patients over 65 years of age. The service offers Inpatient care for older people with mental health problems, provides assessment and treatment of older people with a range of diagnoses, who require hospital care due to the severity of need.

Jasmine Ward provides services for patients who cannot be cared for in the community or other settings, due to the intensity and expertise of the care required. The ward operates 24 hours per day, 365 days per year.

Jasmine Ward admits patients informally or detained under the Mental Health Act . The recovery focus is cognitive functioning and/or promoting quality of life to achieve the best possible clinical and social outcomes for the individual.

Cognition and Mental Health in Ageing

Mental health plays a big part in our ability to enjoy life and services are provided to ensure it is not overlooked in older adults. Memory loss, cognitive decline, chronic pain and physical health issues, isolation and loneliness, financial concerns, loss of friends and loved ones, loss of independence, and other daily life stressors are some of the factors older adults often contend with at once.

- 59% of older adults are at high risk of social isolation.
- 22% will have mental health concerns.

Care Pathway

Jasmine Ward care pathway approach caters for all aspects of physical health, social care needs and risks which are jointly managed by an excellent multi-disciplinary team. This forms part of a planned and integrated holistic system approach to care. As a patient may not always be able to advocate for themselves, the whole care pathway approach maintains a standard requirement of the service working collaboratively with families.

This ensures that the patient journey from admission to discharge is achieved seamlessly and efficiently, within the care pathway. The collaboration with family should be initiated early in admission and maintained throughout the patient's inpatient stay.

Productive Healthy Ageing

Jasmine Ward provides assessment, treatment, intensive support and discharge planning recommendations for community support, residential or nursing home care or packages of care to meet the mental health needs of older people, as well as support their families.

The service offers an emphasis on supporting patients with productive healthy ageing and maintain more achievable therapeutic goals such as:-

- Social connectedness
- Family involvement
- Activities and daily living skills
- Meaning and purpose
- Physical health
- Resilience
- Addressing psychological factors

IW's Story - on behalf of his wife RW

My experience of Jasmine Ward has been since my wife was admitted. After the pandemic, we noticed that R's memory was not 100%, so we saw a local doctor.

He sent us to a clinic where they did tiny test and confirmed dementia, that was about 2 years ago. I was looking after R before and people were coming in from Tolworth, they were visiting weekly. Then I was not well and she was agitated and out of control. The ambulance people came and they were looking at me.

IW's Story - on behalf of his wife – continued

So they tested R for urine infection and said they still wanted her to go to Kingston hospital and take me as well so we were both checked us both over. R had ECG and x-ray done. She was very agitated and could not be controlled, and in her state she was in A&E from a Friday evening until a Sunday morning, when she eventually went to Jasmine.

Jasmine is very good, they do the best to look after the clients. Only thing at times, is activities. My wife has always been active. When she came over from Italy at the age of 12 years she used to go to her sister's café in Southwark Street. London. From 16 years onwards she was working there and has always been very, very active. Throughout her life R has enjoyed being in our own garden, going to garden centres and she loves roses and varieties of flowers. She likes walks at the Isabella Plantation at Richmond Park; we usually go there a lot. When we have travelled she likes the coast or the seaside abroad, places of interest, reading and writing. We have a lot if Italian friends and she enjoys get togethers with family and friends, she likes to mix with family, and we have lots of BBQs.

At times there is a lack of activities on Jasmines. I am sure they are short staffed at times and can not provide activities, but this would help.

IW's Story - on behalf of his wife – continued

I find staff are very attentive and they are very friendly, I can have a good laugh and joke with the staff; which I think is very important.

I get updated very well by the main consultant and two other doctors there who are very good. They keep me updated once a week or every 10 days.

Recently they even asked how I felt she was getting on which I felt was refreshing that they wanted my opinion. I explained her memory was still not so good with the progress of the Alzheimer's. They told me what they are doing with the medication and that they are hoping to take her out to the tiny restaurant on the hospital, where they take some of the clients for a coffee to see how they perform away from the ward.

By end of July and mid-August they think she may be ready to move to permanent residential care. I have been able to speak about my visiting as I think I was visiting too much, everyday, morning and afternoon. Now I visit Monday, Wednesday, Friday, depending on weekend may or may not visit.

The environment is okay, there are nice large gardens. Maybe they could look into clients having more flowers. At the moment there is only grass and hedges, more flowers would be good and doing gardening could be made an activity.

The dining room is clean and tidy, I have noticed the food is always hot, catering staff do a very good job.

Only other thing there was gentleman, a client, when they had laid the tables, he may open the sachets and move the cutlery.

A couple of clients have walked in and around dining room, I felt they may need their clothing changed as they were soiled and could be considered to not be around food.

Clothing gets mixed up. As a family we have labelled everything for R, but some of the clothes we find are not hers. Apart from that can't really complain and have no complaints.

A Look Back at the last 12 months on Jasmine Ward:

What Has Been Done

- Engagement and Observations
- Documentation and Record keeping.
- Improving staff skills on handover and communication using - SBARD (Situation, Background, Assessment, Recommendation, Decision), Zoning, Safety Huddles and Debrief.
- Staff engaging with patients on 1:1 basis on each shift.
- Learning from incidents and sharing learning across other services.
- Learning and development events.
- Triangle of Care and involving families.

A Look Back at the last 12 months on Jasmine Ward:

What Has Been Done - continued

- Physical Health Care.
- Activities of Daily living.
- Community meetings.
- Staff allocation and visibility in communal areas.
- Teamwork and freedom to speak up for patient safety.
- Recruitment into all vacant posts.
- Use of regular bank staff for continuity of care.
- Medicines Optimisation with pharmacy team.
- Clinical risk assessment and risk management.
- Collaborative Crisis Planning.
- Flexible visiting hours.

- Regular in-house training, reflective practice and psychology formulation sessions.
- OT team lead on gathering “This Is Me” documents to support patient centred care.
- OT team provide care home documents to support patients living with dementia, transition to new placements.
- Regular volunteer is in place and comes to the ward - providing musical entertainment.
- Pets As Therapy (PAT) dog visits and sessions.
- Linking with Hospital Rooms project for artwork and activities.
- Subscription the “Daily Sparkle” Reminiscence Newsletter which the patients very much enjoy. This is kindly paid for by charitable funds.
- Established links with Trust volunteer and engagement teams and facilitated short placement for a peer worker.

Next Steps and Way Forward

Jasmine ward will be part of:

- Culture of Care programme - focusing on ensuring a safe, therapeutic and equitable environment for people to be cared for and staff to work in.
- NHS Cognition and Mental Health in Ageing transformation – bringing about models of care that enhance integration, safe and effective care.
- Recruitment and retention drives.
- Ongoing refresher training and staff development.

Next Steps and Way Forward cont.

Dr Lola Velazquez Guerra, Clinical Director for the Specialist Service Line comment:

"We are extremely grateful to Mr IW for sharing with us the experience he and his family have had of our inpatient older people's service, Jasmine Ward. We are thankful for the positive feedback but also the areas where we can improve.

Therapeutic activities are an important part of maintaining quality of life for our older patients. We will continue to work on these areas, and the other areas highlighted to ensure that holistic care provision is maintained.

We will maintain an openness about any challenges the services may face around sustaining the improvements and collaborate and coproduce with families for ongoing feedback on key areas for improvement.

We will continue to monitor and review the systems in place through our service line leadership, to ensure that service delivery is aligned to promoting healthy ageing interventions.

remain open to further learning and actions will be monitored through the Quality Governance Group meetings".

Presentation:

Next of Kin: IW, husband of service user RW

Jasmine Ward (attending):
Hannah McCarthy, Ward Manager
Charles Rowling, Senior Occupational Therapist
Dr Julia Topp, Consultant Psychiatrist
Elizabeth Siaisiai, Lead Nurse
Adeshina Abdulsalam, Clinical Manager
Tracey Ugbele, Head of Nursing
Feizal Muhabally, Head of service Delivery
Lola Velazquez Guerra, Clinical Director

South West London and St George's Mental Health NHS Trust
Springfield University Hospital, 15 Springfield Drive, London SW17 0YF
Telephone: 020 3513 5000
Website: www.swlstg-nhs.uk

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Board of Directors (Part A)

Draft minutes of the meeting held on Thursday 9 May 2024, 10:45am to 1:30pm, Conference Room B, Trinity Building, Springfield Hospital.

Present:

Ann Beasley (AB)	Chair
Sola Afuape (SA)	Vice Chair and Non-Executive Director
Richard Flatman (RF)	SID and Non-Executive Director
Juliet Armstrong (JuA)	Non-Executive Director
Jonathan Warren (JW)	Non-Executive Director
Humaira Ashraf (HA)*	Associate Non-Executive Director
Vanessa Ford (VF)	Chief Executive Officer
Dr Billy Boland (BB)	Chief Medical Officer
Philip Murray (PM)	Chief Finance and Performance Officer
Sharon Spain (SS)	Chief Nurse
Jenna Khalfan (JK)*	Director of Communications and Stakeholder Engagement
Ian Garlington (IG)*	Integrated Programme Director
Amy Scammell (AS)*	Chief Strategy Officer
Katherine Robinson (KR)*	Chief People Officer

*Indicates non-voting member

In attendance:

S and K	Patient / Carer story
Jane Healey	Quality Governance Lead (Complaints)
Priya Samuel	Integrated Partnerships Manager
Val Crolle	Wellbeing Liaison for Primary Schools
Martin Haddon	Healthwatch Wandsworth
Dominic Sterling	Wandsworth Care Alliance
Suresh Desai	Staffside Representative (Unison)
Darren Blades	Wandsworth Community Empowerment Network
Malik Gul	Wandsworth Community Empowerment Network
Shariah Williams	Wandsworth Community Empowerment Network
Andy Glass (observing)	Corporate Governance Manager
Emma Whitaker	Deputy Director of Corporate Governance (Minutes)

Apologies

Jennifer Allan (JeA)	Chief Operating Officer
David Lee (DL)*	Director of Corporate Governance

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24/39 Patient / Carer story

SS introduced S and K, who had joined the Board to share their story. They had given clear feedback to the Trust around the challenges of communicating with carers and listening to what they were telling us. Their story had been powerful for SS to hear, and she felt that it would be good for the Board to hear from carers who were looking after people who were receiving care from our services.

S and K have an adult son named M, who received care from our services. M suffered from addictions and had a dual diagnosis. S and K stated that frequently these diagnoses were kept separate medically. M had to be admitted into hospital in December 2023. He had been in hospital previously in July 2023 and had received good treatment. S and K felt that M had been discharged prematurely from this stay. They added that he had been transferred to another ward just as he was getting better, as someone else had needed the bed on the ward.

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During his December stay, M had to repeat about his addictions to the doctors. S stated that M feels not worthy when he discusses his addictions. This time a doctor made a laminated A4 sheet about M's different addictions that he could keep with him. S stated that she thought it would be easier if she and K could speak to M's consultant every day. They understood in the first week on the ward M would be on crisis management medication. In the second week the medications felt heavier. S and K did not see a doctor but spoke to a helpful nurse, Sarah, who listened to them and took M off some of his medications. S and K asked to speak to the doctor. They instead spoke to another helpful nurse. They finally got a date to meet the doctor. They felt they would get the chance to discuss what M needed and to share the laminated sheet about his addictions. However, the meeting was changed to a discharge meeting rather than a carers' meeting, and the time was moved from 2pm to 3pm. S and K turned up at 3pm and asked to speak to the doctor. The room was packed with people and felt intimidating. M was also there. People talked at them and at M. He was discharged following the meeting. K added that he had been upset at the meeting. He had wanted to put his son in context. Things work best when doctors see the whole person. S and K had wanted to see the doctor on their own. It was sometimes difficult to say things in front of M. K felt he and S had not been treated properly and neither had M. They had been disappointed. There was no joined up thinking. M would benefit from treatment in hospital as he was not compliant whilst at home. They added that M had been released on depo but he was still not well.

Discussed:

The Chair thanked S and K for sharing their story. It was important for the Board to hear this story, especially as the Board had been discussing bed pressures earlier today. She noted that S and K had clearly had unsatisfactory involvement with us and had not been able to get their voices heard. We had not delivered the Triangle of Care as we wanted to do. We had not allowed S and K to speak about their son and she was sorry about that.

BB thanked S and K for sharing their story. He appreciated it was difficult when someone was in hospital to deal with addictions. He was sorry for what S, K and M had been through. He asked if S and K had a sense of why the team on the ward had behaved that way on the day of the discharge meeting. K responded that the staff had seemed rushed. He thought it was because of the pressure on beds. M had improved and that was enough. He felt they just wanted M out of hospital. S and K had been here before, with M getting stability but only superficially. They wanted someone to say this should not be going on, as the circle of coming back in to hospital was not good. He added that there seemed to have been the pressure of Christmas and the consultant being away ill.

SS raised that in the Kingston Carers' Group, a theme that came up often was Community. It was really important to look after people in the Community where possible and carers know the triggers, relapse signs, signs of non-compliance with medication and the signs of when people were deteriorating. SS had met with S and K and after this she spoke to the Community Service Line about the importance of hearing carers' voices. S added that it was important to make relationships with patients and carers. They would be grateful for someone talking to them. The consultant who rushes in and out had no relationship and this was not helpful.

VF raised that some people do need care and treatment in inpatient environments but patients get better in the Community. S and K were not just representing their story but the people in their community that cannot be heard. She was sorry for S and K's experience. There was work going on to ensure we do something different in Community Services. More peer support workers would be created, to enable more

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care in the community. She recognised there was a real issue around dual diagnosis especially as substance misuse services were not run by the Trust. Dual diagnosis treatment was something the system must do more about to create and support a culture of being clinically curious and treating the whole person.

The Chair added that it was important for the Board to hear this power of emotion and frustration, so when we had to make decisions about where we put our resources we had carer and patient voices in our heads to remember that on the other side of the resources were real people with real issues. She wished S, K and M all the best going forwards.

24/40 Apologies and welcome
Apologies were received as listed on page 1 of these minutes.

24/41 Declarations of Interest
No new declarations of interest were received.

24/42 Chair's Action
No Chair's Actions had been taken since the last meeting.

24/43 Minutes of the last meeting
The minutes of the meeting held on 14 March 2024 were approved as a correct record with the following amendments:

- Under the Chair's report, it should be recorded that the updated Remuneration Committee Terms of Reference had been agreed.
- Under the Modernisation Committee Chair's update it should say "there will be an extraordinary meeting on 2nd April" – not "there had been…".

Discussed:
JuA asked if it had not been discussed to think about bringing forward the Internal Audit for transformation from 2025/26, as stated in the Audit Committee minutes from the March Board, as by that point most of the transformation would be completed. RF confirmed that it had been discussed and it was decided the audit could remain where it was scheduled, as it would be to look at benefits realisation and there would not be any added value to bring the audit forward at the moment. The potential audit scope would be looked at within the audit planning and would look at areas of risk and assurance. JeA and IG would be having a conversation in the next week to look at the scope of a transformation post-project evaluation. It would not be an Internal Audit but it would be reviewed by Audit Committee for assurance. There would be an assurance plan to Modernisation Committee to show how the evaluation would fit together with any future Internal Audit.

24/44 Action Tracker
The action tracker was noted and updated as below:
23/45 – Service user and carer representation on the Board – This was an update as part of the Chair's report for today's meeting. SS was convening a working group with the involvement team and key members who already sit on Board committees. They were discussing the most effective way for us to hear the patient and carer voice through to the Board. A further update would come to the September Board.
23/39 – People Plan – The People Plan was now going to be presented at the July People Committee and would therefore come to the September Board.

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

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24/45 Chair's Report

Reported:

- There had been a successful recruitment round for a NED to Chair FPC and two Associate NEDs. All roles were currently going through reference and Fit and Proper Persons Checks. It was hoped they would be in place later this month and would attend the July Board. JuA was on standby to Chair May FPC. There were two excellent Associate NED candidates with a focus on Health Inequalities. One has expertise in race and faith, one in disabilities. These points of view would really help our Board. There may need to be some changes to how Board is run, as one Associate NED is deaf and we need to ensure they could participate fully.
- The Chair had been moved by the carer story today. There was an involvement quality report produced annually that focused on the voice of patients and carers. Challenges were raised to the Service Line teams, but it was not clear how best to check that these areas had then been addressed.

The Board noted the Chair's report.

24/46 Chief Executive Officer's Report

Reported:

- The CEO reflected that this had been a difficult month for mental health, with the publication of the reports from Nottingham and Greater Manchester. Looking at the media response to recent incidents e.g. the recent murder in Hainault, the immediate response was that that person must have had a mental health condition despite no evidence of this. It was like work to break down the stigmas around mental health was going backwards, at a time when we want people to step forward to seek treatment. What do we do with our communities to shift the dial on this? The Trust's work with Wandsworth Community Empowerment Network (WCEN) went some way, as did the new buildings, but those things did not do enough to welcome people in. This, together with the financial pressures of our SWL Integrated Care System (ICS) and its deficit position, with the acknowledgment that the way money has been spent historically, has meant 40% under investment in mental health. There needed to be significant changes to ensure we could continue to provide best care and treatment. Supporting care in the community to ensure those people get help they need was the best way forward. We as mental health leaders need to step into that space:
    - The Trust had launched a suicide prevention strategy that was co-produced with Hold the Hope.
    - The Trust recently held a Physical Healthcare Conference.
    - The Trust recently reset EMHIP at the recall conference last month where we were co-chairing. That was difficult for both us and WCEN, as was getting the balance right; as we need to hear voices that are difficult to hear and also put our energy into work that would make a difference to the communities we serve. Also PCREF must be co-produced; this would give a good platform to take the necessary next steps.
    - Other work was going on in the organisation around equality. Our Executive Advisory Group (EAG) has had a focus on race and racism, such as fair career progression for our BAME staff. How we reset our Trust Annual Priorities (Annual Delivery Plans) today was a reflection of the work of the Group. The next phase would be a further set of working groups and some high impact actions.
- The pressure across our adult patient journey from our Community Services into inpatient services was significant and patient experience was varied. Whilst we do our utmost to keep people safe, we had some particular challenges which affected our BAME patients disproportionately. Whilst the story we heard today was

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palpable, S and K had a voice and we have to hear the voices of those who do not.

Discussed:
Whether we were explicit enough about our outcomes and their quality.

Where in the Trust priorities sat the importance of listening, empathy and building relationships with our patients. VF responded that this was the bedrock of our values, which were co-created with service users and carers, who then helped us translate them into behaviours which were explicit about race and racism. We had also adjusted our standard job description templates in order to make this explicit.
The Board noted the Chief Executive's report.

24/47 Priorities 2023/2024 Q4 report
Reported:
- Some narrative had been included for progress around milestones and key metrics against the two most important priorities.
- Where there was full year data for the metrics this was included.
- This was the final paper for the 23/24 priorities.

The Board noted the Q4 update.

24/48 Priorities 2024/2025 – Annual Delivery Plans (ADPs)
Reported:
- Two ADPs had been agreed: Adult Patient Journey (APJ) and Making the Trust a Great Place to Work.
- Work proposed for the APJ included prevention of deterioration and a holistic supportive approach to prevent patients becoming unwell. Outcomes included how we used DIALOG+ as an outcome measure and how we bring this into our care.
- Quality and Health Inequalities had been embedded into the ADPs, as had elements around environment, partnerships, sustainability, and the Triangle of Care.
- There were some clear milestones and outlines, measures and metrics to assess delivery.
- The paper outlined our commitment to using Quality Improvement (QI) as a methodology and our ongoing Organisational Development journey.
- This paper had gone through EAG, ELT and all of the Board Committees.

Discussed:
That there had been a version of the paper that included measuring outcomes by protected characteristics. It was confirmed that not including this was an oversight and that work was underway for this to be included by Q2. There would be exception reporting if we could not present the outcomes in this way.
The Board unanimously approved the Annual Delivery Plans.

24/49 Annual Strategy Review
Reported:
- The September 2023 Board received a paper on the five year Trust ambitions. At that point the Board had agreed to extend the life of the strategy rather than creating a new one at that point.
- The strategy was extended by two years and it was thought that the best way to consider this again would be to produce an annual review. This was the review at the end of year one of the extension.

Discussed:
If there was a sense as to if, at the end of next year, there would be another extension or a new strategy; as this work would need to start this year. AS felt that it was best to

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extend the strategy for longer. Whilst developing a strategy would be a fantastic piece of work, the ambitions set in 2018 were still the right ones.
The Board unanimously approved the Annual Strategy Review.

24/50 Quality and Safety Assurance Committee (QSAC) Chair's report
Reported:

- Two significant quality reports had been published nationally:
  1. Greater Manchester – This report came as a result of the awful abuse shown on BBC Panorama. The review aimed to understand how the services allowed this to happen and how it went on for so long. It was predominantly around inpatient services. As a Committee QSAC received a formal report including a Trust self assessment against the review's recommendations. There were a number of areas where there were concerns in terms of quality: pressure on services, incidents of violence and aggression, observations and engagement, emergency responses for physical health emergencies, and staff and patient experience. The teams were working hard to address these concerns and QSAC were looking forward to next month, when Dr Justin Earl would be bringing his QI work, to really focus on these issues in order to really understand what we were trying to achieve, how we meet those aims and how we know these changes will lead to improvement.
  2. S48 emergency response Nottingham - This report came as a result of a murder. It focuses on Community Services, crisis services, IRTs and on a secure hospital. When we looked at our Community Services, we can identify a number of areas with concerns.
- QSAC had also received the latest CQC mental health Community Survey, which had some troubling responses from service users, particularly around treating patients with dignity and respect. Waiting times and how to keep patients safe whilst waiting was also a concern. We were in the process of a big transformation of our Community Services to address these concerns going forwards, using a QI approach. These were big areas of work and it was important that we hold our nerve and kept our focus, even when things were pressured, complex and difficult.

Discussed:
At the last Board development session, the Board talked about QI and our commitment to this methodology, with patients and carers at the heart of that.

That the Greater Manchester detailed response at QSAC had been very impressive.

The front sheet of the paper talked about observation records being falsified. SS clarified that this was not wide spread abuse. Some of the instances had been where people had documented an observation sometime after it had taken place, and times when the observation had not taken place at all and staff recorded that it had taken place. There were some concerns around compliance with observations and engagement and regular audits were taking place across inpatient services. We were really clear with staff that this practice was an unacceptable behaviour. This was a national issue – two months ago, 10 mental health Trust Chief Nurses held a whole day event at Springfield to discuss risks and this had come up as a concern across Trusts.

That on Board visits, sometimes staff talked about the acuity of patients being out of kilter for the ward. Was this something that QSAC was considering? SS confirmed that this was monitored and discussed at QSAC. We use Service Line Review meetings, triangulated with Quality Matters (QM) meetings. All Senior Clinical Leaders attend QM meetings. Staff were reporting in these meetings feeling that the wards were more acute now, with more detained patients, more incidents of violence and aggression,

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and more restraints. Work was ongoing to understand this further. There was a working group looking into violence and aggression, which was co-produced with our service users. QSAC also had conversations around the level of cover on each ward and in People Committee there were discussions around preceptorships and quality for Newly Qualified Nurses.

That some found it shocking that the Greater Manchester report showed Newly Qualified staff covering three wards. VF responded that she could honestly say that, at this Trust, there was never a time where there was not a Registered Nurse holding the keys to a ward.

Was there some complexity for physical health issues, to what degree had this increased and did we need a different response. Our society had increasing levels of morbidity which escalated into mental health, which means our staff had to respond to a higher level of physical healthcare. We also needed to hold the system to account to ensure that people got their physical health treatment before they came to us.

That people with a serious mental health issue still die on average 20 years younger than the national average. Having a mental health issue was a de facto Health Inequality.

Were we maximising digital support around observations. This was part of the Clinical Effectiveness work. Management kept trying to work through some of the technical issues and user non-engagement. There had recently been a London learning event which had showed lots of different ways of doing this. Looking at this further would be part of the work of the violence and aggression task and finish group.

The Board:

a. **noted the QSAC Chair's report.**
b. **received the approved Committee minutes.**

24/51 Quality and Performance Reports – February and March 2024

Reported:

- These reports had already been subject to Committee scrutiny.
- The current context we were working in made it more challenging to treat patients. Linking up facets of care was important, as was the impact on length of stay and the patient and carer experience.
- Currently performance was stable. Although we were not where we needed to be, in the context of the deteriorating national position and complex patients, it was good that we could maintain this performance.
- There were some areas where we had seen improvement and strong performance; e.g. talking therapies.
- We were having people proactively approaching us seeking employment which had not happened over recent years.
- There were a few areas of concern and continued focus, such as patient flow, helping people in crisis and better help in the community. If our patients were not being treated in the right place at the right time, they may not have the best outcomes. Another area of concern was waiting times, especially for ADHD and Neurodiversity services. The teams were continuing to work with system colleagues on this concern. ADHD waits were a national problem and NHS England (NHSE) were in the process of reviewing services and how they might be delivered differently.

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- SIREN was the internal alarm system the Trust used to review metrics and interventions of team managers, in order to understand which teams were in stress and / or needed more support to stop them going into crisis.

Discussed:
June QSAC would be receiving a report on how the Trust kept patients safe while waiting and a further breakdown of the waiting list data.

A proposed solution for ADHD waits was awaiting a response from the ICS. The waiting times were unacceptable to the Trust and had been long for almost two years. The Trust had spoken to system partners and suggested closing to new referrals, however they were keen we did not do this. We were therefore negotiating a position of shared care, whereby patients who needed an annual review would have this delivered by their GP. We so far had not been able to secure the financial envelope needed to support this shared care. The service now sent patients a letter on referral which was explicit and transparent about the waiting times, and advised them of their choice to go and see a private clinician if they wanted to do that. Even so, patients would still need an annual review after their initial assessments. The service commissioned was not equitable across the six SWL boroughs. Wandsworth did not have an assessment service open at the moment. We were negotiating to see if we could reuse private provision but that would mean that we would also need to accept the risk. There was a current national review because of the number of breaches across the country. It was a really difficult and unacceptable position. There was also a decision made not to prioritise Mental Health Investment Standard money for ADHD, and mortality and morbidity rates would not suggest this was where to spend funds most efficiently. We did not run a waiting list check like we did for CAMHS and other services as the risks were different. There was also a national supply issue for ADHD medications; there was a new risk on the Executive Risk Register to acknowledge this. This had impacted our ability to start patients on treatment. A decision had been made to prioritise those already on the medications rather than new patients.

How were we approaching the Dialog+ roll out; had we factored in the good learning from other processes and had the IT been properly tested. We had had patient and carers engagement early on in this roll out. We had consulted rather than coproduced in the past. There were 'train the trainers' in Community and Inpatient services. This would need to be properly embedded and needed time to do so.

The Board noted the Quality and Performance Reports.

24/52 People Committee Chair's Report

Report:

- The gender pay gap report went to People Committee prior to submission and publication.
- The workforce metrics show that turnover was reducing and vacancies were decreasing which was great improvement. However, some areas still had high vacancy rates and ELT were keeping an eye on these areas.
- Retention planning was underway. Some additional analysis in terms of impact on staff would be coming to a future Committee.

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- The Internal Audit report on sickness had been received. The Committee noted a couple of areas for improvement, e.g. around record keeping. A lot of the cases of sickness were around stress and MSK issues.
- MAST was a particular concern. It was recognised that MAST was an important part of enabling staff to do their jobs well.
- The Committee were going to receive a deep dive report on ER cases at the May Committee, in order to understand the context and ensure our approach to supporting staff through the ER process was done in a way that was reflective of our values.
- The Committee would be working with QSAC to monitor the experience of our staff with violence and aggression.
- The Committee were triangulating workforce data with data from Freedom to Speak Up (FTSU) cases, staff survey results and mitigations for MLBT.
- It was pleasing that the HR team were getting close to full complement, but they were picking up a significant amount of work so it was important that the Committee were sighted on morale and capacity.
- The Committee did some unpacking of the OD function and presented some helpful reflections for the OD team to take back, such as having a triaging system to ensure interventions were considered and targeted.

Discussed:
That now some of the HR metrics were improving and the People team were more stable, it would be good to start utilising the HR processes to support staff; e.g. PADRs and supervision. The People team had just run a series of webinars around holding a good PADR using coaching conversations, which had been well received.

What more could People Committee do to support staff in the organisation. We needed to tighten controls on vacancies and the use of agency staff. Whilst our agency staff usage had improved (from 21% to 14.5%), we were spending the most in agency costs in certain areas, such as medical staffing and in Community Services, connected to care coordination.
The Board noted the People Committee Chair's report.

24/53 Audit Committee Chair's Report
Reported:

- The Committee had received a positive Head of Internal Audit opinion. A couple of audit reports were still in draft but the Committee had received assurance from the Internal Auditors that they were unlikely to change the overall opinion.
- The sickness absence Internal Audit report gave partial assurance so it was discussed in-depth at Committee.
- External audits were going well.
- The BAF was reviewed and had been through an update but a later version was received this morning at Part B of the Board.
- The Committee received the asset valuations and impairments which would feed into the year end process. There was support from the external auditors on those valuations.
- The Annual Report and Accounts would need to be submitted by 11 June.

The Board:

a. **noted the Audit Committee Chair's report.**
b. **received the approved Committee minutes.**

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24/54 Finance and Performance Committee (FPC) Chair's report

The Board:

a. noted the FPC Chair's report.

b. received the approved Committee minutes.

24/55 Monthly Finance and Savings Reports

Reported:

- The accounts had been submitted on 26 April and reported delivery of a £1m surplus. This was a £47m deficit when the impairment transaction and asset valuation was included.
- The Trust hit its target for Capital spend, with an underspend of £19k.
- The Trust had a healthy cash balance and this would help to support the Tolworth building works.
- Agency use – last year the Trust had a much better performance (4.4%) than the year before (7%) which was a 3% points improvement. The national target this year was 2.9%; this was a stretch target because of the system deficit position. One of the key areas of focus for next year would be to recruit permanent people into the roles being filled by agency at the moment. We know this leads to better patient experience and quality of care.
- The Trust had spent £11m last year on out of area beds. ELT and FPC had debated whether the Trust should purchase more beds. It had been decided that the best approach was to keep developing and transforming Community Services as this would lead to better outcomes for our patients.
- The Cost Improvement Programmes (CIPs) target last year was £13m and we were forecasting that we would deliver on this. With hard work we managed to deliver our 62% recurrent savings target. Our target for this year was 80% recurrent.
- Next year's plan (2024/25) had been submitted in draft, forecasting a surplus of £0.5m, in the context of our system continuing to have a deficit. The ICS were still going through meetings with NHSE to review plans and NHSE may ask for another draft. There was a risk of Trusts having more scrutiny/control on them from NHSE if the plans were not in the right place.

The Board noted the finance and savings reports.

24/56 Charitable Funds Committee chair's report

Reported:

- Congratulations to Dave Moore from our Communications and Engagement team, who ran the London Marathon for the Trust Charity and raised £600.
- At the last Committee meeting there was discussion about fundraising. We were offering more opportunities for people to raise money for us. We were not able to recruit a substantive fundraising person but had some external interim support to help with a fundraising strategy.
- The Committee moved £18k of dormant unrestricted funds into a general fund to improve effectiveness in managing spend and making dormant funds available for use to patients and staff.
- The Committee tightened up financial controls and the approval matrix.

Discussed:

That, given the impact of the working environment on how staff feel, to what degree could we focus some of the Charity resources towards this. The Charity were doing lots and purchasing many things for staff wellbeing, but funds were not coming in e.g.

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donations. It was hoped by showcasing our funds it would encourage more people to get involved in fundraising. The Pennies From Heaven initiative would be restarted. The Committee had started to record the impact of funds spent to date.
The Board noted the Charitable Funds Committee chair's report.

24/57 Modernisation Committee Chair's report
Reported:

- There had been an update at the Part B today around Tolworth, Barnes and Richmond Royal.
- Despite lots of work, we had not yet moved the dial for length of stay or patient flow. The Committee reviewed a deep dive into the factors driving length of stay. The Committee were very impressed with this piece of work. It was holistic, had detailed analysis, it looked at how we record data, and how we interact with the wider SWL system. One of the key findings was around patients who were staying 90+ days and the impact on our mean length of stay. This piece of work helped shine a light on that cohort of patients and what more we can do to support them to leave our services and move on with recovery in the right place. There was a lot of analysis included on Community caseloads. The Committee were pleased to hear the level of engagement in this work to date. This would be key to take this work forward particularly for medical staff. Some more analysis needed to be done in some cases but most will move on to the work that sits under the Adult Patient Journey Annual Delivery Plan, which would combine current adult Inpatient and Community work. We would use QI methodology to move forward on the recommendations.
- The Committee received a very detailed programme update report. One of the things recommended was to introduce Health Inequalities data. It was fair to say that the Committee were at an early stage of reviewing that data and there was more to do to pull out the "so what". The Committee remained committed to ensuring that all transformation work was supporting Health Inequalities work, that we could measure this and would have the data to support this.

The Board:

a. **noted the Modernisation Committee Chair's report.**
b. **received the approved Committee minutes.**

24/58 Annual Delivery Plans (ADPs) – Quarter 3
The Board noted the Annual Delivery Plans Quarter 3 update.

24/59 Questions from the public and staff
The Board had received several questions in advance from the public. The questions and the answers were included in a table which was copied on page 12 of these minutes.

24/60 Meeting review
The QSAC minutes in the meeting papers pack were from the February meeting, which had already been circulated at a previous Board meeting. It was confirmed that this was an error rather than a change of practice or policy.

24/61 Next Public Board
Thursday 11 July 2024, 10:45am, Conference Room B, Trinity Building, Springfield Hospital.

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Question	Sender	Response
Within Vanessa Ford's CEO Report, she refers to the planned timetable for the implementation of the Patient and Carer Race Equality Framework (PCREF) launched by NHSE last November. Will Vanessa and the Board give an assurance that this important work will be co-produced in full consultation with service users, carers and local BME communities? [The NHSE website states "The anti-racism framework brings ground-breaking change to the sector, building on progress achieved locally, and promoting a whole new dimension of coproduction, where individuals and communities are at the heart of the design and implementation of the services they need."]	Darren Blades, WCEN	We have set up the internal governance structure and have completed the Part 1 self-assessment internally with staff and patient and carer representatives. The PCREF Task and Finish Group at SWLSTG was set up in Q1 2023/24 to oversee implementation of the PCREF framework, aiming to advance race equalities across all Trust mental health care pathways. The group has three Lived Experience Members, including one who is also an Ethnicity and Mental Health Improvement Project, Lived Experience Advisory Panel Member. Self-assessment against the six national organisational competencies has taken place to develop a coproduced action plan for improving these and other locally identified organisational competencies. Achieving progress within these competencies is central to the Terms of Reference of the new Framework for Developing Co-production and Involvement at SWLSTG (also co-produced with Lived Experience Network members and clinical staff teams), which is due for launch in early Summer 2024. Lived Experience representatives from PCREF will sit within the Lived Experience Forum (a Trust wide forum) enabling co-productive activity around PCREF to be identified, agreed, facilitated and evaluated within the Forum and strengthen links with the PCREF Task and Finish group. The new framework will support SWLSTG in meeting one of the core components of PCREF – the patient and carers feedback mechanism. We will be setting up a PCREF Steering Group with partners, including CEN, ICB, Public Health and the voluntary and community sector organisations, to lead the Part 2 and 3 self-assessment and implementation.
Within the Patient's Story reference is made to the Triangle of Care. Can the Board confirm if this is still something which is reported on via RiO and if so, do the stats provide evidence that the Triangle of Care is in fact being adhered to across the board?	Darren Blades, WCEN	The Triangle of Care is a therapeutic alliance between carers, service users and health professionals. It aims to promote safety and recovery and to sustain mental wellbeing by including and supporting carers. SWLSTG is proud to be a member of the Triangle of Care (TofC) scheme. To attain and retain membership SWLSTG has to measure itself across the six core standards of TofC and complete self assessments across all teams to monitor improvement / performance. We have just completed our self assessment process (we achieved 100% reporting across services) and our progress report has been submitted to Carers Trust for review (it will be available on our trust website once signed off / agreed by Carers Trust). This system of self-assessment provides the most valuable and up to date method of demonstrating / evidencing progress against our work with carers /TofC initiatives. The RiO electronic system is an important part of recording our contact with Carers and one of the standards we measure against. It is acknowledged by

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Question	Sender	Response
		all Trusts that use RiO that the system is not ideal in demonstrating all the qualitative work / contact with carers that staff undertake. We are currently doing some work with our Regional TofC group in agreeing a uniform approach to recording Carer contact on RiO and will be producing local guidelines for staff in how and where to record carer contact to ensure we can consistently demonstrate all the positive work we do.
At its January meeting the Board were told that the use of external beds had reached its highest ever level at 62 beds. I would like to ask whether that figure has since been exceeded, what is the latest daily figure and what was the average daily use of external beds for each of the 4 quarters of 2023/4.	Martin, Healthwatch Wandsworth	PM clarified that there are another set of beds included in the 62 figure, which are step down beds. He did not believe that the Trust had gone over 62 since that point in January. The averages as requested, broken down for each type of beds, will be attached to of the minutes of the meeting. *Post meeting note: the table can be found on page 15 of the minutes.*
I would also like to ask for some clarification of the apparent suggestion in the Report from the Finance and Performance Committee of a pause in monitoring of external bed usage.	Martin, Healthwatch Wandsworth	We definitely still are monitoring external/ private bed use. External/ private bed use is monitored daily, weekly and monthly. The point in the FPC report was that we are not going to monitor the original improvement trajectory of OBDs against the Cost Improvement Plan (CIP) while we implement further actions, then we will re-start the improvement monitoring in six month's time. This will not impact on quality, care or flow.

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

Data provided for 20234/2024 Financial Year		Financial Year / Financial Qtr											
		2023/2024											
		Q1			Q2			Q3			Q4		
Ward		**Avg OBDs per day**	**Occupied Bed Days**	**Days in period**	**Avg OBDs per day**	**Occupied Bed Days**	**Days in period**	**Avg OBDs per day**	**Occupied Bed Days**	**Days in period**	**Avg OBDs per day**	**Occupied Bed Days**	**Days in period**
Adult Acute	ELFT – Roman & Brick Lane Ward*	**3**	194	65	**3**	264	92	**2**	207	92	**2**	181	91
	Holybourne Hospital Acute Inpatient	**20**	1,831	91	**21**	1,954	92	**29**	2,645	92	**31**	2,837	91
	Out of Area Adult Acute	**7**	605	91	**2**	202	92	**3**	253	92	**3**	246	91
Hostel	SWL Acute Hostel	**1**	91	91	**1**	124	92	**10**	875	92	**12**	1,058	91
PICU	ELFT – Rosebank*	**2**	185	91	**2**	169	92	**2**	159	92	**2**	180	91
	Out of area PICU Female	**3**	233	91	**3**	272	92	**1**	119	92	**3**	298	91
	Out of Area PICU Male	**1**	75	91	**0**	22	92	**1**	126	92	**2**	145	91
	Grand Total	**35**	3,214	91	**33**	3,007	92	**48**	4,384	92	**54**	4,945	91

*NHS Provider

Notes:

1. ELFT Rosebank – SWL commissions its female PICU service from East London NHS Foundation Trust
2. ELFT Brick Lane – Service was not running until end April 2023 hence only 65 days in quarter.

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

ACTION TRACKER – for July 2024 Board

BOARD OF DIRECTORS (Part A)

Meeting	Ref.[i]	Minute Topic	Detail	Who	Due	Update
DUE						
NOT DUE						
11/05/2023	23/39	**People Committee Chair's report**	A detailed People Plan is due to go to the May People Committee.	**KR**	~~**23/05/2023 May 2024**~~ **September 2024**	It had been agreed to move the People plan to the July 2024 People Committee and so it would be reported to the September 2024 Board.
13/07/2023	23/45	**Quality and Safety Assurance Committee (QSAC) Chair's report** - **Service user and carer involvement**	AB to consider service user and carer representation on the Board more broadly in due course, informed by the government's response to the recommendations on this matter in the Rapid review into data on inpatient mental health settings.	**SS**	**September 2024**	Following the publication of the government's response to the rapid review into data on inpatient Mental Health settings, SS was convening a working group with the involvement team and key members who already sit on Board subcommittees. They were discussing the most effective way for us to hear the patient and carer voice through to the Board. A further update would come to the September Board.
COMPLETED SINCE LAST MEETING						

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Report Title:	Chair's report
Name of Meeting:	Trust Board – Part A
Date of Meeting:	11 July 2024
Author:	Ann Beasley, Trust Chair
Transparency:	Public

Purpose:	☒	**Approval**	☒	**Discussion**	☒	**Information**	☐	**Assurance**

What?	This is the Chair of the Trust Board's report to the July 2024 Board.
So What?	The report sets out information on: • Non-Executive Director (NED) and Associate NED (ANED) recruitment update. • Chief Operating Officer update. • System updates. • Board Activity. • Board Visits.
What Next?	The Board is asked to: 1) note and receive this report.
Appendices/Attachments:	

Strategic ambitions this paper supports *If this is not completed the paper will be returned*	☒	Increasing quality years	
	☒	Reducing inequalities	
	☒	Making the Trust a great place to work	
	☒	Ensuring sustainability	

IMPLICATIONS	
Equality analysis *[linking to EDI strategy]*	The new Leadership Competency Framework includes a number of measures around equality issues.
Health Inequalities	The new Leadership Competency Framework includes a number of measures around health inequalities issues. Two new Associate NEDs with focus on Health Inequalities joined our Board from June 2024. This will help us keep a focus on, and embed, Health Inequalities in our work as a Board and view all that we do through this important lens.
Service users/ carers	The Board visits programme is designed to ensure that Directors have regular direct contact with patient services and patient experience.

Estates	Board activity has included consideration of a number of commercial estates matters.
Financial	Recruitment for a NED to be the new Chair of the Finance and Performance Committee, with financial qualifications stated as desirable.
Legal	Advice has been sought on the implications of the merger of SGUL with City University, London, which has been reported previously.
Reputational	None specific.
Strategy	None specific.
Workforce	The NED and ANED recruitment has concluded successfully.
Sustainability e.g. Green Plan	None specific.
Other (specify):	None specific.

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CHAIR'S REPORT TO THE JULY 2024 BOARD

NEDs and ANEDs recruitment

We recently had three Board vacancies for Non-Executive Directors (NEDs) following term limits ending for Vik Sagar and Professor Charlotte Clark in April 2024, and following the departure of Professor Deborah Bowman in late 2023. Arrangements for a new University NED will be confirmed soon, taking into account the current merger process between SGUL and City University, London.

After a very competitive recruitment process, we managed to bring on Board some wonderful new NEDs, whom I would like to formally welcome:

Ebele Akojie has joined us in a NED role, taking on chairing Finance and Performance Committee. Ebele has significant strategic financial management, corporate finance, governance and risk management experience, with over 25 years' experience at Board level within the charity and housing regulated sector. She has held a number of Chief Financial Officer and Finance Director roles.

We also have two wonderful ANEDs who each come to us with a unique focus on Health Inequalities, which will help further our Board commitment to consider Health Inequalities in all that we do.

Dr Iram Sattar is an experienced NHS GP with a specialist interest and passion for mental health and addressing health inequalities. Her commitment extends beyond clinical practice; she serves as a trustee at three charities focused on addressing health inequalities in marginalised communities, particularly within the homelessness and women's rights sectors. Iram has dedicated over 15 years of her career to the charity sector. Iram's contributions were recognised with an MBE for services to the Health and Wellbeing of Vulnerable People in 2022. Iram understands the importance of high-quality disaggregated data to provide assurance and shape effective solutions. Iram recognises that spirituality is key to recovery, especially for Black, Asian and minoritised communities and advocates for faith and culturally sensitive health care, aiming to embed spiritual care within mainstream services.

James Watson-O'Neill has been Chief Executive at the deaf health charity SignHealth since 2016 and was awarded an OBE for services to deaf people in the Queen's New Year's Honours 2022. He has worked in the charity sector since 2001, including a variety of roles at Scope and the NSPCC. James is a qualified Non-Executive Director and has fifteen years' experience on boards of various charities, including the British Society of Mental Health and Deafness and he is currently a trustee of the Voluntary Organisations Disability Group, a membership body representing organisations within the voluntary sector who work alongside disabled people, particularly in social care. James co-chairs a cross-sector Civil Society working group focused on equity, diversity and inclusion, with a particular focus on anti-racism.

I am sure you will join me in making our new colleagues feel welcome. I look forward to working with them.

Chief Operating Officer update

Our Chief Operating Officer (COO), Jen Allen, is going off to pastures new, having secured a role as Executive Director of Operations at South East Coast Ambulance NHS Foundation Trust (SECAmb). The Board and I will truly miss her, as Jen has brought so much to the Board over her years with the Trust, although of course we are all delighted for her and her new opportunity, and wish her the best of luck.

Recruitment for a new COO has begun and the role is advertised on our public website.

System updates

I have been asked to include more information about what is going on in the wider system in my Board reports going forwards, so I will think about the best way to share these updates in future reports. One way will be that I will append to this report the most recent minutes from some of the system meetings I attend. I hope you will find them useful.

I would like to update you on the system financial position. SWL ICS was set a control total of £120m deficit by NHS England and in June submitted collective plans designed to deliver that target. As part of closing the final gap each Trust was asked to deliver a stretch target and as a result SWLStG was asked to find another £260k efficiency and to achieve a £760k overall surplus. We have agreed to do this to aid the system.

As a system we also have a challenge to reduce our reliance on agency staff and the national challenge is to get our usage down to no more than 2.9% of our total paybill. We have already made positive progress towards this target with a lot of hard work but we have more to do and it may be challenging.

Due to the resubmission of plans in June the end of May position is not wholly clear and June (M3) will provide us with a clearer picture – however not unsurprisingly pressures are already emerging across the system.

Board activity

The May Board part B discussions covered areas including the Board Assurance Framework (BAF), risk appetite, committee chairs' reports, and discussion around the SLP fitness for future review, and outcomes and benefits realisation with regard to our ongoing Estates Modernisation and Strategy work.

The June Board seminar received a presentation on our IT and digital strategy. We will be doing further work in this area at our October seminar, with a visit from NHS Providers.

Board Visits

The monthly Board visits programme is proceeding with valuable opportunities for Directors to hear regularly and directly from the frontline.

During May and June, the Board visited the following services:

Clinical services:

- Coral Mental Health Crisis Hub
- Halswell Ward
- Lavender Ward
- Ruby Ward
- Liaison Psychiatry - Kingston Hospital
- Richmond Adult single point of access
- Adult Eating Disorders Day Unit
- Bluebell Ward (Adult Deaf Ward)

- Laurel Ward
- Liaison Psychiatry - St George's Hospital
- Rough Sleeping and Mental Health Programme
- Forensic Outreach and Support Plus
- Wandsworth OP Functional RST, MAS

Corporate services:

- Strategy
- Communications and Engagement
- IT
- Estates
- Physical Health
- People (HR).

In future my report will detail some of the follow up actions that we have taken following our visits. This will also be reported to QSAC.

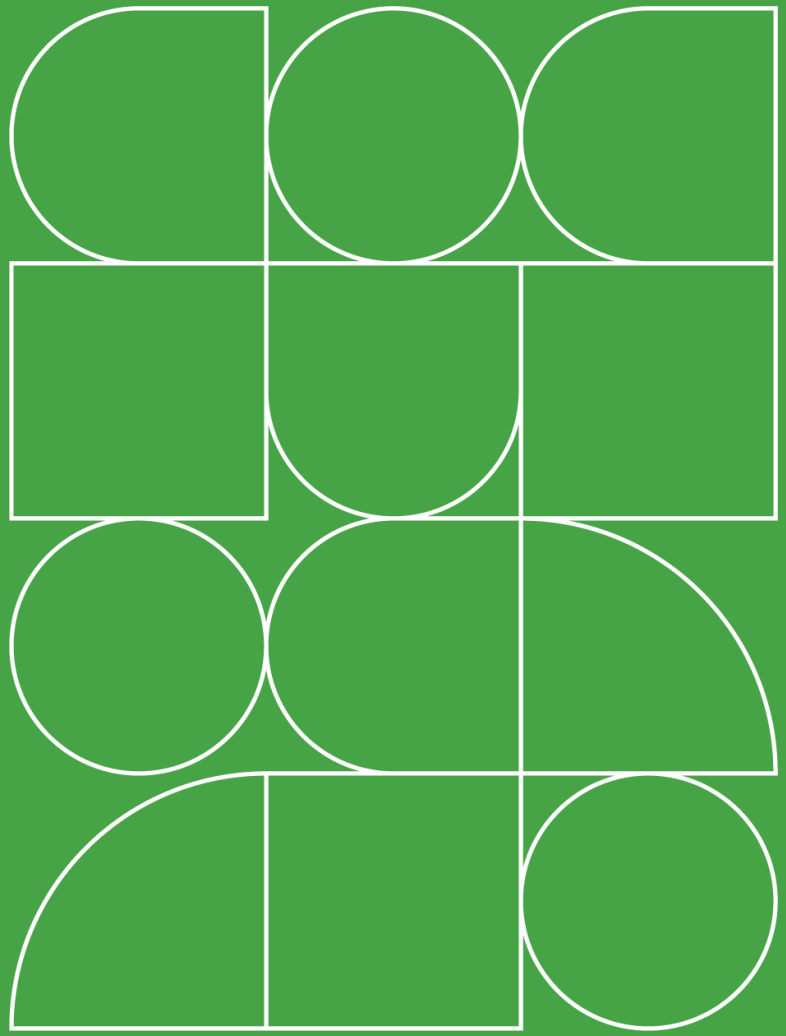
Recommendations

The Board is asked to:

1) note and receive the report.


Making Life
Better Together
NHS
South West London and
St George's Mental Health
NHS Trust
Vanessa Ford, Chief Executive
Board Report
Part A
July 2024
Respectful
Open
Collaborative
Compassionate
Consistent

Contents



Our Trust

Our staff, alongside our patients, are our main asset. Every week, I write to everyone with key messages and every two weeks I have an all staff Q&A. Alongside this I regularly visit our sites formally and informally.

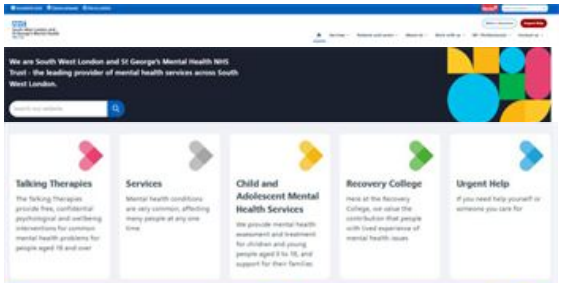
I always start with a thank you to our staff who put our patients first!

3 May – Chief Executive update
10 May – Chief Executive update
17 May – Chief Executive update
24 May – Chief Executive update
31 May – Chief Executive update (anti-racism takeover)
7 June – Chief Executive update
14 June – Chief Executive update
21 June – Chief Executive update
28 June – Chief Executive update

Meeting Prince William

At Cheam Resource Centre

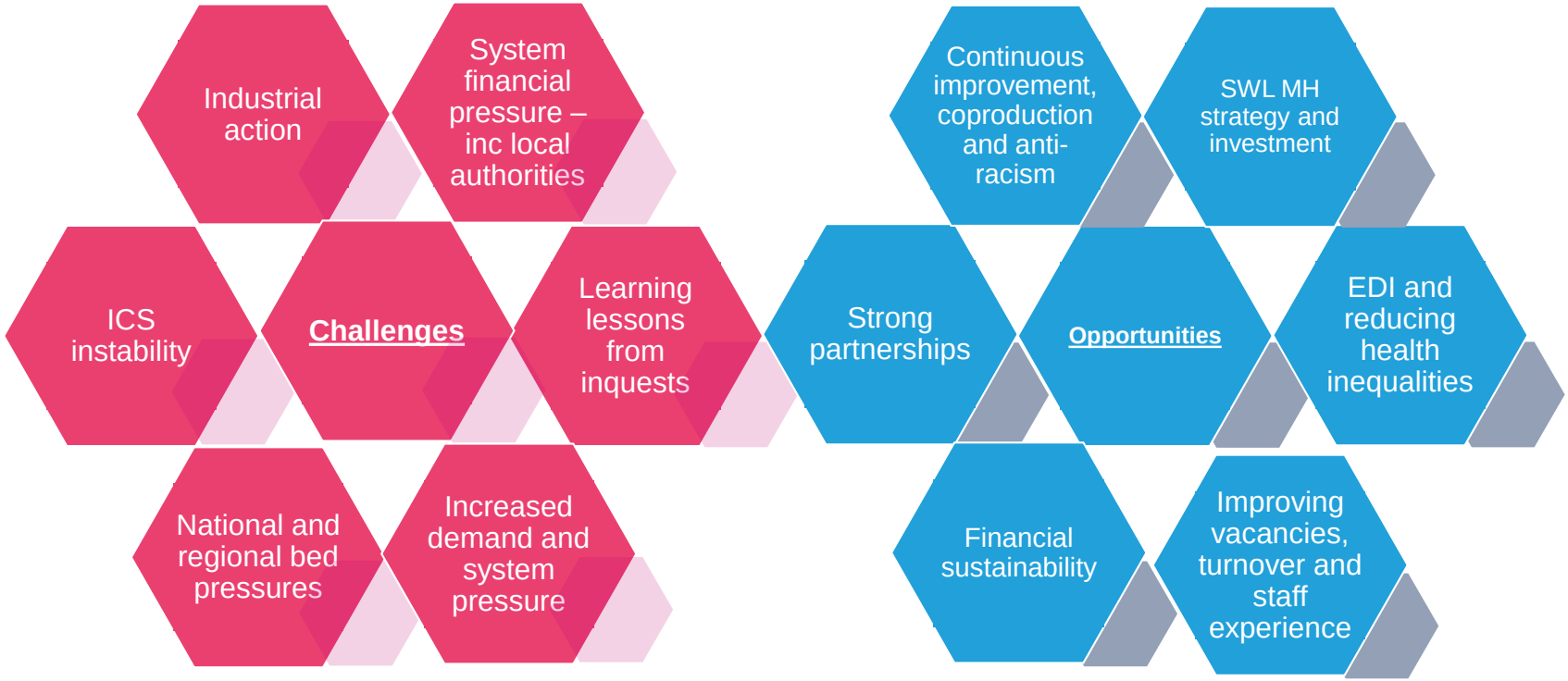
100 people at our first South West London Mental Health Conference



New website seeing double the number of visitors

Our context

There are a number of external pressures on our organisation and the NHS, and there are opportunities too!



4

Improving quality

Our thoughts are with the families of two patients who tragically died while being cared for by our services in 2018 and 2022. Following any serious incident like this, we thoroughly investigate and put in place immediate actions in response. In June we saw the outcome of the inquests into these patient deaths:

- The Assistant Coroner from Inner West London issued two Regulation 28 (Prevention of Future Death) reports in relation to a patient who had waited in Lotus in 2022 for a number of days before getting an inpatient bed. A few hours before they were able to move, a fire alarm went off in Lotus which allowed the patient to abscond and then die by suicide. The coroner noted their concern around our internal processed especially fire procedures and AWOL policies and also about bed management and capacity, noting that "*there is a genuine risk of future deaths directly connected to a shortage of mental health bed spaces in London unless further action is taken"*
- We had the outcome of an inquest by jury into the death of a patient after he was granted unescorted leave from ward 2 in 2018. He did not return, and his body was found 12 days later. The jury concluded that the decision to grant leave was inappropriate and contributed to his death. While we were not issued with a prevention of future death notice, there is clear learning for us, especially around leave documentation.

Next steps:

- Each of these cases has been thoroughly investigated and following the inquests our teams are working through the recommendations which will be taken through our Quality and Safety Committee
- Regarding bed capacity, we are working with the Integrated Care System on a joint response
- A review has been undertaken of the learning from previous Prevention of Future Death reports
- We are working positively and constructively with the London coroners to learn lessons and provide information

Annual delivery plans 2024/25

Each year we have set annual plans to support the delivery of the strategic ambitions. This year we are focussing in on our two biggest challenges.

Improved Patient Journey

Supporting annual deliver plan areas:

1. **Quality –** holistic care planning; DIALOG; PCREF; EMHIP
2. **Better Care –** acute, community, CAMHS transformation; core offer development. Digital
3. **Partnerships –** SLP; SWLMH Provider Collaborative

Great Place to Work

Supporting annual deliver plan areas:

4. **People –** Fair career progression; reducing violence and aggression; health and wellbeing; leadership and development; speaking up
5. **Better Environments** – Tolworth; Barnes; Richmond Royal; green programme; anchor and community
6. **Sustainability** – Shift to substantive workforce; increased productivity

Quality improvement, co-production and anti-racism as the enabler and approach for delivery

Did you know?

- **Average length of stay** – increased to 47.7 days. Led by those with the longest stays (90+ days)
- **Demand** – Increased between pre-Covid and now: 8% in acute, 40% in community
- **External beds** – increased and we are operating with two additional external wards
- **Health inequalities -** Disproportionate representation in the most restrictive settings for Black people
- **Experience** – improvements in FFT scores (86.5% positive)

- **Turnover** – reduction in turnover to 13.3%
- **Recruitment** - reduction in vacancy rate to 15.1%
- **Agency** – reduction in agency spend to 5%
- **Experience** – significant improvements in 5 of 9 staff survey areas.
- **Anti-racism**
  - Ethnic minorities report lack of fair career progression at every band
  - Plateau of progress in increasing Ethnic Minority leaders
  - Reports of microaggressions still prevalent

Adult Patient Journey

Our Improving the Adult Patient Journey programme is being evolved to integrate work across adult community, crisis and acute settings with a focus on the overall adult patient journey and supporting teams to work together. We will be taking a quality improvement approach to these changes and the voice of patients/carers and reducing health inequalities will be central to the development and delivery of the programme. The programme will hone our focus on the fundamental standards of care and recovery outcomes as the measures for our improvement work - care being purposeful, timely and least restrictive, avoiding crisis and recovery focused. Specifically, we will be looking at:

- **Discharge Challenge:** new purposeful admission programme and 3-month pilot of new Enhanced DTOC structure.
- **Length of Stay:** deep dive analysis into the drivers of length of stay. This will be used to inform next steps for the flow and clinical transformation plans with a particular focus on those people who stay the longest (90 days+).
- **Mental Health in ED:** Transformation of our Psychiatric Liaison team will continue and the Kingston extended triage trial remains in discussion, with a view to building on the feedback.
- **NHS 111/Section 136 South London hub:** will be further enhanced and developed
- **Care Planning:** Dialog+ Care planning will be adopted, enabling holistic, co-produced care plans to be put in place for our community patients which are focused on their recovery goals
- **Improved interfaces:** interfaces between services will be designed and our staff supported to work seamlessly to coordinate patient care and recovery

2023/24

Length of stay: 47.7↓ days vs 38 day end of year aim

Presenting in crisis: 1.5% ↔ vs 1.1% end of year aim

Inappropriate out of area: 427↓ bed days vs 0 end of year aim

Reduced delayed transfers of care: 12.9%↑

Friends and family test: 86.5% net↑ positive vs 81% end of year aim

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Intensive Support Intervention

The sustained pressure on our services, especially on adult acute beds, continues to take a toll on our patients, their carers, and our staff. In June we began a two-week Intensive Support Intervention to help patients who no longer need inpatient care, to recover at home or in the community, and to support our colleagues, especially in the acute and urgent care service.

The Intensive Support Intervention has received good support from ward teams, senior leads and broader service line colleagues and partners. The programme saw ward MDTs attended by senior clinical leads every day across acute wards with pre-briefings and post-attendance wash up meetings coordinating the process and taking feedback on escalation, issues and other improvements.

Reflection meetings and wash up meetings have been held with ward consultants and ward teams and with external partners. We also held specific wash up meetings on delayed transfer of care to help us capture feedback from the intervention.

During the two weeks of the intervention, 30 patients each week left restrictive inpatient care to receive support in the community. This is a positive position and we are looking for this to be sustained and built upon.

Next steps

- The themes will be drawn together with immediate actions already taken and short and longer term opportunities for improvement (using QI pilot) identified. These will be shared widely for input.
- A brief evaluation is planned and consideration will be given to whether to repeat the intervention to review changes made.

Reducing health inequalities

Our 2024/25 Annual Delivery Plan outline our commitments to reducing health inequalities. Our approach includes:

Next steps for EMHIP

- Implementing EMHIP interventions while also evaluating and strengthening our partnerships and co-production with patients and the community, utilising the Patient and Carer Race Equality Framework (PCREF) as a recommended framework.

Embedding health inequalities

- Embedding health inequalities through service line business planning with specific outcomes and milestones based on our 2024/25 priorities.
- Embedding reduction of health inequalities work into our transformation programmes.

Working in partnership

- VCSE mental health partners are helping us strengthen the third sector strategic involvement in mental health across SWL.
- An ICS-wide high-level group has been established to investigate data improvement and democratisation, focusing on addressing inequalities

Implementing PCREF

- Ongoing implementation of PCREF, supported by the Task and finish group

Great Place to Work

Our Great Place to Work programme will build on the positive work made as part of our Valued and Stable Workforce priority last year. By focussing on our people, and becoming a Great Place to Work, we know in turn our people will deliver the best care for our patients. We are taking a programme approach, with a focus on continuous improvement, co-production and anti-racism. The work will be delivered through five workstreams; attraction, leadership development, career development, HR service, and retention. These will be overseen by an EDI collaborative. Specifically we will be looking at:

- **Recruitment and career development:** Development of fair recruitment and fair career development programme and continued work to reduce our vacancy and agency rates, including developing community and local recruitment pathways.
- **Leadership Development:** Our Steps cohort 2 (targeted at Band 7/8a) has completed and arrangements are now in place to follow up with action learning sets from September for cohort 1 and 2. They will be facilitated by staff within the People Team rather than securing external support
- **Employment tribunals:** we continue to focus on our employment tribunal cases and learn lessons. We have work to reduce our case load even further.
- **Anti-racism:** Focussing on embedding valued into actions and our three high impact actions: fair recruitment, fair progression and the impact of racism (more on page 12)
- **Organisational Development:** the MLBT development centre continues to grow with targeted intensive support for a small number of teams, OD clinics, creation of internal facilitators and development day support

2023/24

Vacancy rate: 15.1%⬇ vs 15% end of year aim

Turnover rate: 13.3%⬇ vs 15% end of year aim

Turnover within 12 months: 24.4%⬇vs 15% end of year aim

Staff Survey advocacy score: 6.9⬆ vs 6.9 end of year aim

Sickness rates: 5%⬆ vs 3.5% aim for LDN MH trusts

Agency rate: 5%⬇ vs 3.6% end of year aim

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Anti-racism work of our Executive Advisory Group

- **Anti-racism values into actions:** On the 31 May, our EAG Co-Chairs (Noel and Ijeoma) and our Evolve Co-Chairs (Ranti and Jacquie) took over my Friday message to launch our new, co-produced, anti-racism values into actions. These have been embedded in job descriptions, adverts and appraisals.
- **Executive Advisory Group:** Our 5th Executive Advisory Group was in March. We held a follow up session to deep dive into fair career progression (which is one of the priorities coming out of the 2023 staff survey). We looked at the complexity of the problem and some of the solutions which will contribute to our plans in this area. Our next EAG will focus on health inequalities
- **High Impact Areas:** Through our response to WRES we are focusing on three 'high impact' areas: fair recruitment, fair progression and our response to racism.
- **Diversity in Decision Makers:** We are advertising for our next cohort of this successful programme
- **White Allies:** 12 senior leaders have graduated from the final London White Ally course.

Better Communities: Early works underway and Better Care celebration

Better Environments

- Preparations are underway for the autumn opening of Richmond CAMHS newly refurbished outpatient centre at the site of the former Richmond Royal Hospital.
- Early works are progressing well at Tolworth and Barnes Hospitals - old and unused buildings are being removed to make way for the development of brand-new facilities.
- Quarterly updates are shared with our communities in Richmond and Kingston.
- A monthly ‘construction look ahead’ is also shared with neighbouring residences at Tolworth, and a local working group between residents and partners is progressing at Barnes.

Tolworth Development

- The Greater London Authority announced a ‘call-in’ review of Barratt London’s proposed housing development at Springfield Hospital. If approved, this will unlock more than £50m in funding to support the full redevelopment of Tolworth Hospital.
- The proposal, which offers 50% affordable housing, was recommended for approval by local planning officers but was narrowly refused at Committee. We are supporting Barratt’s appeal.

Better Care

- In June, the Better Care programme marked the completion of the transformation of adult community mental health services. Over 50 partners, patients and staff from across South West London took part in a special celebration event at Springfield Hospital.

Better Communities

We celebrated Mental Health Awareness Week between 13 – 19 May 2024, with the theme this year being 'movement.' As such we developed a range of internal and external activities including:

- Maps of the first part of the new Springfield Park available in the entrance to the Trinity building or by downloading here. There is also a version for children available here. The map helps you discover everything the park has to offer, including the huge variety of plant and animal life that call the park home. This was launched on the first day of MHAW with a visit from our good friends Fircroft Primary School who joined us for a short talk, healthy snacks and then took to the park with maps and pencils in hand.
- To continue with the theme of movement we also promoted: Mental Health Staff Network webinar lead by exercise therapy colleagues; community spikeball and dodgeball games; Running Club taster session; Dr Bike bicycle servicing.
- In May and June we trained our latest cohort of Mental Health Champions through our innovative Mental Health First Aid England (MHFA) community programme. This takes the number of trained Champions to over 100. We will continue to run more training sessions culminating in a local trainer to embed the programme longer term.
- Our Trust Charity continues to develop and we now have three 'Challenges for Charity' to get involved with. This includes London to Brighton bike ride, Vitality London 10k run and a SkyDive. You can find out more (and sign up to these!) here.
- Our annual street party and roadshow dates have been agreed and materials / invitations have been shared with colleagues, service users, carers and residents.

People changes

Our leaders are crucial to the delivery of the best quality care to our patients and experience for our staff. Over the last month we have announced a number of changes.

- **Chief Operating Officer:** After 4 positive years, Jen Allan has announced that she will be moving on to take up a position at South East Coast Ambulance Service. Jen will leave in the autumn and we are actively recruiting for her successor.
- **Non-Executive Directors:** We have announced the recruitment of three new Non-Executive Directors. Welcome James, Iram and Ebele
- **Urgent and Acute Care (AUC)**: Mike Hever, Deputy Director of Nursing and Head of Nursing for AUC, is taking a fellowship secondment with the CQC for 9-month. We have advertised for both a Head of Nursing for AUC and a Deputy Director of Nursing both for 12-month secondments.
- **Community**: To reflect our focus on the Adult Patient Journey (APJ), Richard Morton's portfolio will be realigned to focus on the APJ programme as he continues in his role as Deputy Director of Operations. To pick up the operational leadership of the service line and to reflect the size and complexity of community services, we have repurposed a vacant role to create a standalone Head of Service Delivery for Community service for 12 months.
- **Estates and Facilities:** Ian Garlington, Better Communities Director will take on the leadership of the Estates and Facilities team. This will allow Philp Murray, Chief Finance Officer and Deputy Chief Executive, to maintain his focus on the considerable system financial challenges and our focus on digital improvement.

A number of these changes will mean opportunities for recruitment. We are committed to fair recruitment, fair progression and being actively anti racist. As such we are keen to invite applications from a wide variety of individuals with varied backgrounds.

Partnership working

We continue to work collaboratively with system partners.

In South West London (SWL) we are focused on 4 areas:

- Driving the delivery of the SWL Mental Health Strategy alongside colleagues from the SWL Integrated Care Board, local authorities, VCSE sector and other wider NHS providers. We oversee progress through the SWL Mental Health Partnership Delivery Group. Specific focus in 2024/25 is around defining core mental health offers for adults and children and young people.
- Developing our SWL Mental Health Provider Collaborative alongside South London and the Maudsley NHS Foundation Trust.
- Working with the SWL VCSE Alliance, to develop a strategic framework for joint working with the NHS.
- Continuing to support engagement and participation at place.

Across our South London Mental Health and Community Partnership (SLP) we are focused on:

- Exploring how to best evolve our commissioning hub functions to support our programmes of work.
- Delivering our CAMHS, adult eating disorders, perinatal and secure care provider collaboratives and our complex care programme.
- Considering the next steps for acute care work across the three trusts in light of successful work around NHS 111 and s.136.

Celebrating our teams

Kingston Care Home Liaison Team win RCPsych Team of the Year

Fircroft Primary celebrate MHAW at Springfield Park

Elisha Parkinson wins Student Nursing Times Award

Sutton Employment Service awarded 'Good' Quality Kite Mark

International Nurses' Day

Richmond CAMHS art exhibition

London Pride

Africa Unity

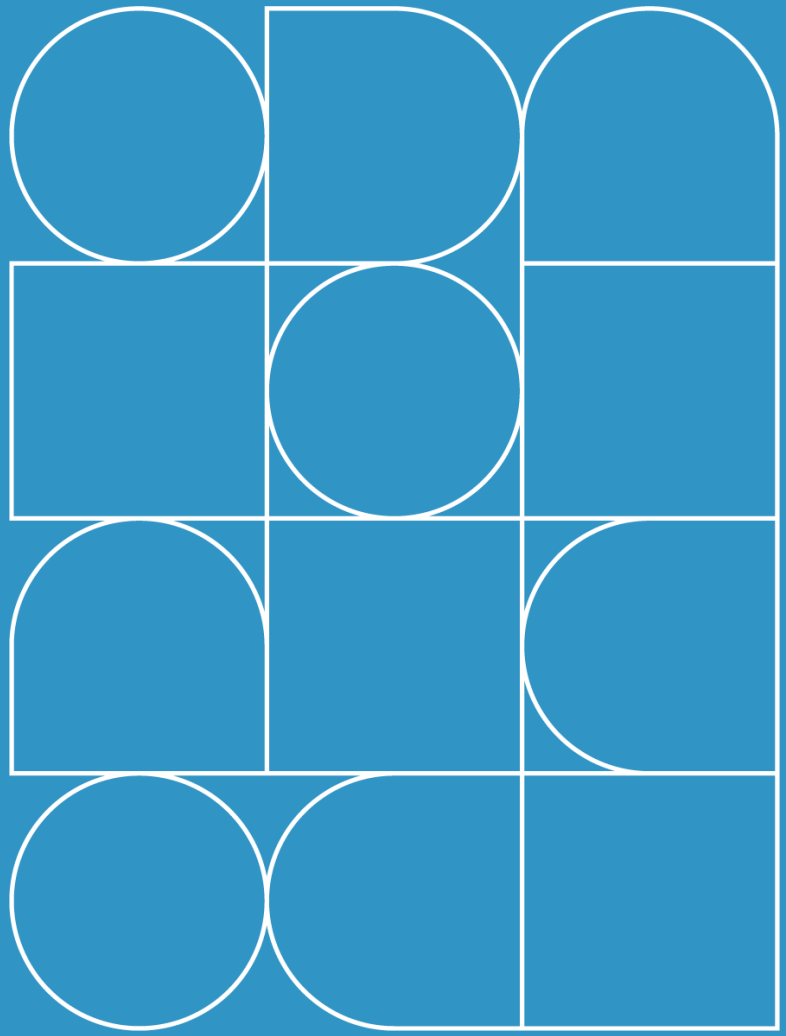
Exceptional People Award winners

Celebrating individual training successes

Kingston Community Services awarded Cancer Awareness grant

Questions and points to have in mind

1. Are we doing all we can to ensure that co-production, race equity and continuous improvement are embedded through our two key priorities (adult patient journey and great place to work) ?
2. Our teams have been working under sustained pressure for a considerable time. This continues to take a toll on our patients, their carers, and our staff. It also connects to our risk appetite. Are there further changes we need to make to recognise this pressure? And how as leaders, are we reflecting it?
3. How do we support, and get support, from our system and system partners around bed capacity given the outcome of our recent Prevention of Future Death report? Is there more we can do through our Adult Patient Journey to highlight the issue?
4. It is clear there is more we need to do to reduce health inequalities, especially race inequality. How can we make sure that we work with our community in partnership to address these challenges?



Appendix 1: Horizon Scanning

QUALITY

Lampard (Essex) inquiry: Government confirms scope of Essex mental health inquiry - GOV.UK (www.gov.uk) - Lampard Inquiry: terms of reference - GOV.UK (www.gov.uk)

NHS Constitution plans to strengthen privacy, dignity and safety - GOV.UK (www.gov.uk)

Duty of Candor review call for evidence: Government review to create a more open healthcare system - GOV.UK (www.gov.uk)

Causes of death to be scrutinised in revamp of death certificates - GOV.UK (www.gov.uk)

CQC admits it is failing to keep patients safe | News | Health Service Journal (hsj.co.uk)

Wide adoption of 'Martha's Rule' reflects trusts' commitment to safe, high quality care - NHS Providers

NHS England » Record numbers of women accessing perinatal mental health support

NHS England » NHS England appoints first medical director for mental health and neurodiversity

WORKFORCE

350 extra medical school places allocated in NHS training boost - GOV.UK (www.gov.uk)

Temporary NHS staff a 'lost voice' in crucial patient safety investigations (hssib.org.uk)

Low-income NHS staff paying the price for wage delays | News, Press release | News | UNISON National

ESTATES

Government failure to fix NHS buildings puts patients and staff at risk | News, Press release | News | UNISON National

DIGITAL

i.AI and NHS England sign Collaboration Charter to support the use of AI in the NHS - GOV.UK (www.gov.uk)

NHS England » Synnovis cyber attack – statement from NHS England

SUSTAINABILITY

New mental health currency unveiled | HFMA

Appendix 2: Use of the Trust seal

Date	Type	Signatories
02/05/2024	Deed of Variation Deed of Variation for Balham Health Centre. Between SWLStG and NHS Property Services.	Chief Executive Officer Better Communities Director
02/05/2024	Lease Lease of Tolworth Hospital UKPN Substation Between SWLStG and UKPN	Chief Executive Officer Better Communities Director
02/05/2024	Deed of Variation Deed of Variation for Plot D1, Springfield Hospital Between SWLStG and Barratt / Sainsbury's	Chief Executive Officer Better Communities Director
23/05/2024	Transfer Deed Transfer Deed for Substation 8, Springfield Hospital Between SWLStG and The Electricity Network	Chief Finance Officer Chief People Officer
27/06/2024	Deed of Variation Barnes Contract Deed of Variation Between SWLStG and the Secretary of State for Levelling Up, Housing and Communities	Chief Executive Officer Chief Finance Officer
27/06/2024	Section 106 Agreement Springfield Hospital planning application S106 Between SWLStG and City and Country	Chief Executive Officer Chief Finance Officer

Meeting:	Trust Board
Date of meeting:	11 July 2024
Transparency:	Public
Committee Name	Quality and Safety Assurance Committee (QSAC)
Committee Chair and Executive Report	Jonathan Warren and Sharon Spain

BAF and Corporate Objective for which the Committee is accountable:

QSAC has responsibility for the following BAF risks:

- A failure to effectively respond to quality and safety 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:

This report covers the QSAC meetings of May and June 2024.

1.1. Demand, resource and capacity (APJ), physical health and violence and aggression continue to be the biggest and most persistent challenges that QSAC considers.

1.2. QSAC supports the ongoing focus on improvement in key areas of challenge, namely flow, operations and workforce, recognising that each is inextricably linked to the quality of care we provide to patients. The Committee also supports the relaunch of the Funamental Standards of Care in order to bolster improvement in these challenging areas.

1.3. The Committee receives quarterly reports on the progress being made to reduce the use of prone restraint and for the future plans to lead to the elimination of this practice.

1.4. The Committee has asked to receive the planned review into the alarms in Shaftesbury building, which staff have reported are not appropriate.

1.5. The Committee raised concerns about handcuff use being needed for non-forensic patients and the impact this may have for untrained (non-forensic) staff. They hope to hear more about the matter in the next restrictive practice update.

Areas of Risk Escalation to the Board:

None.

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?

Executive Risk Register and Board Assurance Framework

What: The Executive Risk Register (ERR) demonstrates how risk is considered and mitigated at different levels within the Trust, and underpins the Board Assurance Framework (BAF). Each Committee monitors its specific risks as outlined in the BAF and the ERR is reviewed by QSAC on a regular basis. QSAC noted:

- Changes to the People BAF risk following an ELT deep dive;
- The national ADHD medication shortage has been added as a risk – to mitigate, medication was being prioritised where it was most needed.
- The Violence and Aggression (V&A) risk score had been increased following review.
- A new Mandatory and Statutory Training (MAST) risk had been added. Risk mitigations were in place.
- The medical workforce risk had been reviewed and it had been decided that, as it was sufficiently mitigated, it should be closed. ELT had discussed this and at this stage were content with the mitigations and improvements.
- The employment tribunals risk had been closed as the situation had improved.

So what: QSAC reviewed the mitigations. There was discussion around the MAST risk, as it had kept coming on and off the ERR periodically over the past few years. Committee noted that the level of risk had risen due to the deterioration around Physical Health which could be linked to resus and medical emergency training. Similarly with V&A, staff may not be trained in relative techniques. This would also be a key factor in a CQC well-led inspection. Once these things were triangulated, it had been agreed correct to add MAST to the ERR.

What next? QSAC continues to review the analysis of the risk register, both as a standalone document and in relation to other sources of data and information.

Committee were asked to ensure the risks have the right mitigations and progress was being made. However, there were a number of actions that were not complete and were past their due dates. It was important that the Committee received the latest update if mitigations and actions were completed. The Associate Director of Quality Governance and Risk said that he would feed this back to the risk owners. QSAC looked forward to receiving a more updated ERR.

Quality Matters

What: Quality Matters is an essential report that provides triangulation, prompts consideration of the relationship between strategic aims and operational practice and reflects the 'Floor to Board' understanding of quality, safety and the patient experience.

So What: The Committee noted the following:

- Strengthening of learning from incidents had been welcomed.Teams were using Quality Improvement and Innovation (QII) and Clinical Audit to enhance learning from incidents.
- The Clinical Directors have said that they had oversight of the concerns raised regarding Unmanaged Incidents. This was being worked through.
- 50% of complaints had been upheld/partially upheld. Complaints responses were now more compassionate. However, the team were still struggling to meet the 85% internal KPI for responding to complaints within 25 days.

The Committee discussed concerns regarding writing up of observations that had not happened or that the notes were not added at the time of the observation. They noted that ELT were supporting ward managers and promoting the culture on wards to identify and report this practice and to create a climate where it was not acceptable.

There was discussion around whether ethnicity could be captured by Feedback Live and how patients whose first language was not English were able to feed back.

What next? QSAC would look to receive updates on the issues around flow. There would be consideration on how to escalate this to QSAC to give an understanding of what this means for our patients; e.g. A&E waits, how long, impact, how many patients were at home with medical recommendations waiting; patients waiting in Lotus over appropriate timeframes.

There was recently a review of the three cases of physical healthcare incidents – this review would come to QSAC.

Quality and Performance Report

What: QSAC received the report and discussed priorities arising, noting that the Trust would be continuing the focus on improvement in key areas of challenge, which were flow, capacity and demand, physical health, and V&A.

So What: The Committee noted that:

- The Trust continued to deliver and maintain safe care during a challenging time.
- Teams were working hard on reducing Length of Stay (LoS) in the short term and were continuing to work in partnership with the Local Authorities, especially in supporting more complex patients to step down to sustainable and appropriate community settings. The Trust would be doing some more work on this at SWL level.
- There would be a stronger focus on a few areas: care planning, risk assessments and planning, including consideration of ethnicity.
- The closure of the CAMHS SLP beds meant that there were a number of complex CAMHS and ED patients in the Trust.
- There was continued focus on working with teams that were highlighted as concerns on SIREN and triangulating with other data; e.g. CQC Community Survey.
- There was now a Fundamental Standards of Care dashboard.
- There was good performance across a range of indicators, such as turnover, recruitment and retention, financial grip and control and productivity.

What next? QSAC will continue to monitor performance in specific areas, including assurance around restrictive practices, use of and compliance with observations, wait times, the efficacy of the emergency response procedures, and inappropriate behaviour of staff. July QSAC expects an update report for waiting list assurance.

The Chief Operating Officer would report back to QSAC on the data issues with the ethnicity breakdown and crisis line calls triaged data that were raised by Committee.

SWLStG Self Assessment Manchester Report

What: The Trust had completed a self-assessment against the recommendations within the recently published Manchester Report. There were seven areas and each one had been allocated to a key Executive, who was asked to look at areas of exception.

So What: The Committee discussed some key areas:

- The report suggested that Patients' and carers' voices needed to be strengthened and more empowered at Board level and on Committees across the organisation.
- Enhancing MDT leadership and holding each other to account.
- Increasing clinical input into some Board Committees.
- Continuing to drive equality, career progression, V&A and anti-racism.
- Change management and that the Trust were committed to using a QI approach.
- The staff survey showed that Corporate Services staff do not feel as valued by the Trust as other services.
- The Trust's role as commissioner and provider, the 'Fitness for the Future' review with SLP, and better partnership involvement.

What next?: The self-assessment recommendations would be absorbed into other ongoing pieces of work where appropriate and would be reported back to QSAC in the appropriate reports.

V&A report
What: QSAC had asked for an update on the cases of V&A across the Trust, as there had been a significant increase in incidents of V&A in the last year and QSAC were concerned about this. There had also been an increase in racially motivated and aggravated incidents.

So What: the Committee heard that, in response to the rise in cases, a new task and finish group, the Violence Reduction Group, had been established. There were plans to have Lived Experience Members and staff reps. on the Group.

What next?: the Committee suggested that some focus was needed in two areas: AUC cases and the fact that the vast majority of incidents were closed with no further action.

The Committee suggested that the standard letters to staff following an incident may be an irritation rather than helpful, and if there was a way to make these more personal.

Suicide Prevention Strategy
What: The Committee noted the Suicide Prevention Strategy. The Committee found the strategy document very moving, and thanked the Deputy Medical Director, Trust Lead for suicide prevention, and their colleagues for this work.

So what: the Committee were pleased to hear that the Strategy had been co-produced with the "Hold the Hope" group and with carers and patients; and that the strategy included the lens of neurodiversity and had been co-produced with people who were neurodiverse and their allies.

The Committee suggested that Health Inequalities should be more overt within the strategy. One of our Associate NEDs, Dr Iram Sittar, asked if there was any work around the suicide rates in specific ethnic groups. She highlighted that young Asian women were two to three times more likely to die by suicide than young White women. She would like to know if we had this trend in our communities or if we were different to the national average. The Committee heard that the strategy aimed to collect local data on ethnic groups and trends so some local prevalence data would be reviewed that could be mapped to national trends, and one of the strategy aims was to reach into difficult to reach communities.

What next?: There was an accompanying work plan for next year and this would be built on for the next two years with priorities against the strategy.

Annual CQC Community Patient Survey Six Monthly Report
What: the Committee reviewed the CQC survey and discussed that some of the results around medication, respecting privacy and compassion, not enough support whilst waiting, crisis care and the length of time to get through to the crisis team were troubling.

So what: The Committee heard that the Executive were keen to improve results for next year and to work on, and continue current work that was going on regarding, the gaps in care. The Executive was keen to proactively engage with patients to improve the response rate to the survey to get more representative results.

What next?: The Community Services Service Line would be doing a piece of work alongside the Nottingham review to triangulate both and to get an overall improvement plan. This would come back through QSAC in July with details of specific actions.

Patient and Carer Race Equality Framework (PCREF) update
What: The Committee will receive regular updates on the implementation and embedding of the quality elements of the the PCREF.

So what: The Committee heard that:

- The Trust were compliant with the framework and had joined the national network. The national team had been appreciative of our work. Someone from the NHS England team had invited us to present at a discussion of the national process one year on.
- The plan had been co-produced with service users and carers through a task and finish group.
- The roadmap to implementation was being socialised, and areas where the Trust needed to make improvement were being identified.
- There would be more work done over this year, to improve areas of disparity and outcomes of racialised groups in the community. The Trust were working closely with community partners and presenting the plan to different groups including the Mental Health Forum in Wandsworth; and helping ICB colleagues to include a PCREF element in funding outcomes.

What next?: The Committee suggested that, as language was important for this work, the name be changed locally from PCREF to Race Equity, as an acronym missed the point and ambitions. EMHIP discussions would be reported back to QSAC through the PCREF reporting cycle.

<u>QII Retrospective and Five Year Forward Delivery Plan</u>
What: The Committee received this report for Quality Improvement and Innovation (QII) and noted the plans to roll this out as the main QI tool across the Trust.

So What: A piece of work to understand this and develop a vision for going forwards had been undertaken, this had involved the Board. It would now be expanded with Lived Experience Members through the Lived Experience Forum.

What next?: The Committee noted that the QII delivery plan was a considerable shift and would involve moving resourcing around in the organisation. Resource discussions would need to be taken to FPC.

<u>Annual, six month and quarterly reports</u>
The following Annual Reports and six month reports were reviewed and accepted by the Committee:

- Annual CQC Community Patient Survey Six Monthly Report
- EPRR Annual Report
- Health and Safety Annual Report, including security
- Restrictive Practice quarterly update (Q3)
- Safer Staffing six month report
- Quality Improvement (QII) Annual Report
- Quality Account
- Always Ready Quarterly Report

Appendices

- Ratified minutes of the meetings of April and May 2024.

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

Quality and Safety Assurance Committee (QSAC) (Part A)

Minutes of the meeting held on Tuesday 9 April 2024, 10:00am – 12:00pm, Meeting Room 4, First Floor, Trinity Building.

Present:

Jonathan Warren (JW)	Committee Chair – Non-Executive Director
Ann Beasley (AB)	Trust Chair
Richard Flatman (RF)*	Non-Executive Director
Vanessa Ford (VF)	Chief Executive Officer
Sharon Spain (SS)	Chief Nurse

Attendees:

Carol-Anne Brennan (CAB)	Lived Experience Representative
Dr Victoria Hill (VH)	Clinical Director, Community (Working aged adult) Services
Richard Morton (RM)	Deputy Director of Operations, Adult Community Services
Shelia Nsoedo (SN)	Criminal Justice MH Liaison Nurse
Claire Reid (CR)	CQUIN, Quality Account and Compliance Manager (item 24/72 only)
Dr Iram Sattar (IS)*	General Practitioner (observing)
Ryan Taylor (RT)	Associate Director of Clinical Governance and Risk

Minutes:

Emma Whitaker (EW)	Deputy Director of Corporate Governance

Apologies:

Dr Billy Boland (BB)	Chief Medical Officer
Jennifer Allan (JeA)	Chief Operating Officer
David Lee (DL)	Director of Corporate Governance

**denotes online attendance*

Item		Action
A24/63	***Welcome and Apologies** Apologies were noted as above.	
A24/64	***Declarations of Interest** No new Declarations of Interest had been received since the last meeting. JW advised that he had reviewed of some of the teams in the Nottingham S48 inquiry on behalf of the CQC. The CQC were happy for him to discuss this work.	
A24/65	***Chair's action** No Chair's action had been taken since the last meeting.	
A24/66	***Minutes of the previous meeting** The minutes from the meeting of 5 March 2024 were agreed as a true and accurate record with no amendments.	
A24/67	***Action Tracker** The action tracker was noted and updated as below: It was agreed that if a due date was changed, the action should not be moved to the 'not due' section, but to remain in the 'due' section with the new due date.	

Item		Action
	A24/46 – Review of Action tracker – This had not yet been reviewed with DL and would be rolled over. **A24/48 – After incident learning** – There was a Learning and Improvement Group meeting later in April with this on the agenda, so that this paper should be ready for the May meeting. Action to remain open. **A24/23 – Diversity in Decision Making Reps** – this had been actioned and could be closed. **A24/29 – Single sex arrangements** – Action was ongoing. A number of Trusts had moved to single sex wards so it was timely to review the decision SWLStG had made as to whether to continue their current arrangement or not. There was a discussion around the view that some female patients preferred mixed wards as they found female only wards to be difficult. The decision had been reviewed when Trinity had been opened. The timing of a review would fit well with the timing of the single sex annual report. CAB said that, from her experience, she had been a patient on a small single sex ward which had been brilliant as there were not a lot of patients and staff were able to look after them. There had been no violence. She had also been a patient on a larger female only ward which had been like a school ground and there had been incidents of bullying. On a mixed ward, there was not as much female on female violence. CAB had also heard that men on mixed wards were less aggressive too. She asked that this work was done in co-production. **A24/34 – Clinical Effectiveness EIP –** JeA had met with the community team, alongside BB and Sean Whyte, Deputy Medical Director. There was a robust improvement plan in place and the most recent data had just been submitted. It was hoped to see significant improvement this year. There had been real focus on the improvement plan. There had been some significant sickness and vacancies which impacted on some of the work. Improvement work had not imbedded all the way through. The results of the national audit were awaited. This was being monitored through the Service Line reviews. JW raised that when QSAC had seen this in the Clinical Effectiveness report it was a real struggle. He asked if this had been a surprise to others. SS responded yes and that there had not been a focus on the EIP team's challenges. The reality was that in Service Line reviews there were only certain things that could be focussed on each time. VF raised that we were flagging that there was a team which was not NICE compliant for one of our most important client groups; how did we get assurance about this. SS responded that this was now being reviewed through Community Services Service Line reviews, and improvement should be seen through the monthly Q&P reports. It was noted that QSAC have asked for waiting list times with and without ADHD to ensure ADHD was not hiding any other issues. JeA was bringing a report to May QSAC on access. VF had asked for an internal audit of waiting times in the next six months.	
A24/68	***Executive Risk Register** The Committee noted and accepted the Executive Risk Register (ERR). **Reported:** • The PDF of the ERR had not been sent with the paper; RT gave apologies as this was an oversight. • There was a new risk around bed capacity for CAMHS and ED, with mitigations and controls in place listed. • No risks had been increased in month. • Closed risks: o **1820** – Lack of integrated electronic record across CAMHS and adult services o **2460** – Effective patient flow within the acute in-patient beds (demand and capacity).	

Item		Action
	• A new risk regarding the neurology backlog was taken to ELT. They were satisfied this was not an executive level risk. The Service Line would review to see if there needed to be on their Risk Register. • ELT's most recent focus had been around the acute care pathway risks. • Levels of incidents of violence and aggression (V&A) was a topic of conversation at ELT. A V&A reduction task and finish group had recently been established, which SS chaired and KR and Jenna Khalfan, Director of Communications, attended. The V&A risk level would also be reviewed within the next week. • There was a Physical Health review taking place in the next month. • The industrial action risk would be reviewed over the next week with KR. • Tolworth development risk - ELT felt this was risk rated correctly but needed actions to be reviewed in light of the recent planning application decision. This would be done over the next week. • Car parking – this would be reviewed as the current risk and actions were all about the physical aspects and did not capture the wider indirect consequences e.g. recruitment and retention. **Discussed:** That there was still a reference to alarms and had this not been resolved. RT responded that this remained a risk on the ERR and would be covered in the Quality Matters item on today's agenda. ELT had been looking at mortality rates for Acute and Urgent Care (AUC) and Physical Healthcare, to make sure things were in place and being done correctly, which was why there was an escalation to review physical healthcare. This would also be covered in the Q&P reports. A financial risk may be added to the ERR in light of the pressures within the system and any subsequent impact on the Trust should the system go into National Oversight Framework (NOF) rating 4. CAB raised the issue of increasing levels of V&A. Work on de-escalation had been done previously. She also asked if there would be strategies for patients on the ward so that they could try to de-escalate incidents themselves. RT responded that the new task and finish group would be working on establishing a reduction strategy. Preventing incidents by de-escalation would be a key part of this strategy. SS added that most of the increases had been on PICU and AUC. She had met with patients and they had said that there were many incidents which could and should have been de-escalated early on. VF added that wards were running at 115/120% occupancy and were using a high level of bank staff and had a high level of observations. Occupancy rates and the 'heat' wards were running on would be part of the review by the task and finish group. SS added that there was safety in motion and safety huddles as part of the work. It was noted that there were no concerns with the new wards; i.e. those that had moved into the Trinity, Storey and Shaftesbury buildings. The main concerns were with PICU and AUC at Tolworth. JW raised a concern that if the new wards had less incidents then both PICU and AUC rates may have gone up exceptionally. SS added that the report from the task and finish group would come to QSAC and to People Committee as it would cover both patients and staff. There was also a national violence reduction strategy which would be included in this work.	

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

Item		Action
A24/69	***Quality Matters** The Committee noted and discussed the Quality Matters report. **Reported:** • There were some significant concerns around Physical Healthcare, particularly in AUC, where there had been four patient deaths since January 2024. Two of these patients were in their 40s. This was unusual. The Physical Healthcare team had been asked to do a full review on these patients to see if there were any systemic problems. They had also worked on an action plan for inpatient wards, but there were concerns that this was not as robust as first thought as there remained concerns. The Trust had a CQC 'must do' in place for Physical Health escalations. • There were concerns around incidents of V&A in Ward 1 (PICU) as these were significantly high – there had been the same number of incidents on Ward 1 in the last three months as there had been over the whole of last year. There had been escalations to ELT from front line staff around concerns regarding staffing levels, safety, being listened to and leadership. Ward 1 had taken Learning Disability (LD)/ASD patients in the last three months which had had an impact on their resilience. SS had met with the team before Easter to discuss and there was now an improvement plan in place. The Service Line leadership team were working closely with the ward. In addition, to support the team, three beds had been closed as a short term measure, to new admissions. This reduced both the levels of observations required and the number of staff per shift; however the level of concern held by staff had not reduced. The reduction in beds was also a significant risk to other acute wards as it moved pressure to other areas. • Alarms: The alarms concerns had been reviewed by Mike Hever. All wards had a clear process to check alarms daily and a clear escalation process if alarms did not work. Our teams were not setting alarms back on to reset; they have all been trained on the new system but were still finding it hard to use . The next stage was trying to understand if there was a systemic issue across inpatient wards. Technical concerns were with Multitone, as the version which was requested for the new buildings had been complicated for staff to use. Multitone had not been responding as quickly as we would like to queries. • Emergency response data continued to be reviewed weekly at Quality Matters. When reporting DNAs previously to the Committee the data had seemed stark. RT had worked with the team to put this into context. There would be an internal response, then if needed the call would go out for a tier 1 response, which alerts other wards and security. There had been occasions when the other wards and/or security did not all respond. Most of the time there was a 75% response rate, sometimes 50%. All incidents requiring an emergency response were reviewed. Since 2021 there had not been any incidents with no response at all. • The report now included some learning from other organisation's inquests. **Discussed:** Whether anything more could be done to help Ward 1. SS responded that front line staff had not felt listened to when escalating concerns to leadership. It seemed also that the leadership was not working as well as it needed to be. Mike Hever, Deputy Chief nurse, was reviewing this with urgency. Why forensic services did not admit the LD/ASD patients. SS responded that the patients did not meet criteria for PICU. Ward 1 were asked if the patients were appropriate admissions at the time and they had thought that they were.	

Item		Action
	That Ward 1 had been working on culture change/quality improvement over a few years. There were some longstanding staff and very new staff and that combination was challenging. An Appreciative Inquiry had been commissioned, which would not be an immediate fix and it would be important to make sure the Inquiry was framed in a way to ensure our front line staff were heard and felt heard. There was a strong racial element to the work as well as the majority of staff on Ward 1 were BAME staff. That if staff had been trying to raise issues and had not been heard, what did that say about Trust systems. Would these be reviewed at some point to ensure they were robust. VF responded that the AI would include a systems review. It was fed back that the forensics team had fed back that the alarms are not liked. Staff who agreed to the alarm system were no longer in leadership roles and the new leaders say they do not like the alarms. The message was that the alarms were unsafe and staff could not work like that. Mike Hever had found them working and front line staff had said they felt safe. SS would be asking an external person to do an independent review. She would ensure that the review was signed off by leaders in the Forensic teams. Changing the system would be a huge cost. There was also the decision to make about what alarm system was put into the new buildings at Tolworth. JW raised that with the alarms causing anxiety, violence and aggression incidents increasing and physical response DNA rates not being where they should, was there anything missing across the whole of the response, which may not be clear when reviewing these areas in silo. SS responded that all wards must have someone on shift at all times who has been trained on and can undertake CPR. Sometimes CPR skills were not good at our staff do not get much practice. For emergency responses, we should define what would constitute success; e.g. 75% response rate. That the Physical Healthcare team do a full review of all cases needing an emergency response immediately afterwards. The Trust knew where things were working well and where they were not, and the areas needing extra support. The Physical Health team had been going to wards to undertake surprise Basic Life Support checks. CAB added that if a patient was hurt whilst at the Trust, the patient and carer community begin to not trust the staff. Also that if staff were unable to do Basic Life Support they should not be on the team. You cannot have staff going to emergencies who could not deal with it. The Committee liked the addition of the learning from other organisation's inquests. It seemed that one of the difficult issues across organisations that we also had here at the Trust was communicating with families and patient confidentiality. Last month the Trust received a Prevention of Future Deaths (PFD) notification from a coroner, around communication with family members, suggesting that when talking to a patient staff should be doing as much as they possibly could to engage with families. SS had met with Kingston carers and was hoping to have a Board patient story from one of the carers and how this felt for front line staff to hear. There had been work around the Triangle of Care. **Action:** An emergency response update to come to the May QSAC meeting.	**SS**

Item		Action
A24/70	***Quality and Performance (Q&P) Report** The Committee noted and accepted the Q&P report. **Reported:** • There was improvement around observations and compliance. There were still gaps being found through audits. • There were issues with CAMHS and ED beds due to closure across SLP beds. • ADHD waiting lists remain high. • Overall performance was RAG rated "amber" due to the continued pressures across AUC and neurodevelopmental waits for both adults and CAMHS services. • There had been an improvement in Friends and Family Test scores. • This month in the Community Services and CAMHS service line reviews there had been a focus on Fundamental Standards of Care (FSOC), as if these were done right we should see improved inpatient Length of Stay and caseloads. • There had been improvement in reduction in vacancy and turnover rates. • MAST compliance remained a concern. **Discussed:** RM reported that pressure continued across the AUC pathway. There had been some important reductions in use of out of area placements but demands remained significant and this remained a focus for the AUC and Community Service lines. Both were working closely on a day to day operational basis as well as planning for the next phase of the Adult Patient Journey transformation plan. The number of patients fit and ready for discharge remained high but had come down from over 40 to around 30, where the teams had been intensely working with system partners for a few weeks to move people out of hospital as quickly as possible. That despite the hard work the Trust were now out of benchmark for length of stay (ten days longer than a number of other areas). JeA, BB and teams had commissioned a piece of work to look at length of stay as it was a big patient quality issue as well as a financial and sustainability issue. AB raised that it was depressing to hear about the refocus on FSOC as it had previously been agreed that these were what we were going to focus on and somehow this had been lost. SS responded that this was an issue with the culture in the organisation. Since there had been refocus on FSOC, people were refusing to do them as they felt they were not part of their job. However it should be underpinning all jobs and then achieving KPIs/the dashboard should follow. The Executive had thought about this and discussed stripping the dashboard except for FSOC focussed KPIs to ensure focus from clinicians. RM added that in Community Services there had been some issues with KPIs. For example clinicians were saying they were recording risk assessments but the KPI was not correlating. They found out they were recording them in the wrong place. Better ways to collect information were being considered as part of the bigger programme to move away from CPAs to Dialog+. There were a high proportion of teams rated "red". SS responded that this was positive and a result of giving SIREN data a focus in Service Line reviews. Teams could change ratings if they did not think they should be rated "red". Through the Service Line reviews it transpired that some teams had not been flagged up as "red" and management thought they should be. RM added that SIREN should be treated with some caution as with any measure. If it was working well it was a valuable	

Item		Action
	triangulation tool. Kingston Adult Community teams were showing "green" despite some underlying challenges seen in other sources such as the staff survey. That Service Line reviews would be strengthened so that those teams who were of concern e.g. Ward 1 would be discussed as to how QI resourcing could be used to go into teams to do something different and make change happen. The next month the standard annual KPI document would come to QSAC. This would not reflect the conversation had today.	
A24/71	***Collecting and using clinical outcomes in CAMHS and adult community services** The Committee noted and discussed the clinical outcomes paper. • This work had been agreed a while ago and had been in place. This paper was a formality and would make this work transparent at all levels. • This paper had been through QGG and ELT, where the recommendations had been broadly accepted. • The paper sets out the current practices and any variation in practice. • The aim had been collecting clinical outcomes across CAMHS and adult services and embedding this in the Q&P framework. This had not been triangulated well with other KPIs that were looked at in the Q&P framework. QGG endorsed the core suggested set of KPIs that everyone across the Trust that could be used. • Dialog+ care planning was all about collaborative discussions with patient and carers. VH was the chair of the improving patient outcome group, which would reset its work plan. There would be some IT things needed and a cultural shift needed around our staff and our patients. **Discussed:** That this was a clinician led piece of work. The clinician view was that HONOS triangulated with the patient view and was important to capture. There had been agreement to continue with it alongside Dialog+. HONOS had been disentangled from clustering. There was a tracking process and the data for use of both systems came through in the Q&P report.	
A24/72	**CQR Report** The Committee noted the CQR Report**.** **Reported** • That eight teams had been reviewed out of a planned 12. Five had cancelled and these had been absorbed into visits for June, especially if the team had any areas that had scored "requires approvement" in the last visit. • Ward 1 and Mitcham IRH both scored "red" and this correlated with SIREN data. A few comments given at review were reflected in SIREN as well. • Under the "safe" domain five of the eight teams scored "requires improvement". A deep dive took place in these teams and it was found they should improve in terms of risk assessments, physical health assessments and training compliance. • Two teams had scored "requires improvement" in the "responsive" domain. A deep dive took place in these teams and it was found they should improve in terms of responsive feedback to service users, Feedback Live and complaint responses. • Care plans were reviewed and it was found that some had copy and pasting issues and needed improvement in updating risk assessments. • Positive areas from service users from some of the wards and Sutton older people Community Mental Health Team were that staff were caring, supportive and respectful.	

Item		Action
	Discussed: There was concern that some reviews were not undertaken due to staff sickness. This process was an important part of the Trust's assurance processes and needed to take place. It was asked if it was it realistic to do the other reviews in June and was there understanding as to why people were not being released to do the reviews. CR responded that many people were contacted to ask to be released to take part in these reviews. The push back was generally that there was clinical work to do. It had been harder in the last year to get reviewers and this might be a reflection on how people were feeling e.g. this was another thing to do. This was a shame as people who take part generally enjoyed doing it. Back fill was allowed. Often it was ward managers and staff at 8A and above who took part and these roles may not require backfill. Students had been used too. AB asked if this role needed to be within the JDs to reflect the 10% corporate good. VF suggested not at the moment, as with wards running at 110% clinical service leads were tied up with moving patients in and out of beds, observations, and dealing with violence and aggression. At the Board seminar there would be a conversation about QI and how to reinforce this. She added that there were still CQRs taking place, although not as many as we would want, and the process was not comfort seeking. It was disappointing to see five teams with "requires improvement" in the safe domain. It was asked if the reviewers were being hard in their judgement or did they really think things were not safe. SS responded that the themes were around patients not having risk assessments, MAST and physical health assessments. All three areas were known to have issues and were a focus. The safe domain was the hardest domain to maintain "good" in because of what gets measured. SS thanked CR for the amount of work put into this work as it was a phenomenal amount.	
A24/73	**Nottingham S48 report** The Committee noted the Nottingham S48 report. **Reported:** • Themes from this report were discussed in the Community Services strategic business review. The Clinical Service Line were keen to meet with JW around the report's recommendations. • The review recommendations from this report and the Edenfield report would be built into the Adult Patient Journey transformation and ADP.	
A24/74	**Mental Health Law report Q3** The Committee noted the Mental Health Law report Q3.	
A24/75	**Quality Governance Group minutes** The Committee noted and accepted the minutes**.**	
A24/76	**Agenda for the next meeting – May 2024** The Committee noted the agenda for the May meeting.	
A24/77	**Meeting Review: (a) Patient focus (b) Quality of challenge and (c) Health Inequalities focus** AB raised the QGG adopting the starred approach to not discussing papers. She was concerned there could get to point where no Committee discussed the paper. SS responded that it was not about not having the discussion. Each paper would have a clear purpose. Committee members read the papers, add comments, and so the papers were reviewed in advance and discussed within the Committees before QGG. SS would keep AB's point in mind.	

Item		Action
	AB had found the QGG minutes helpful in processing and reading the papers for QSAC. VF raised that Health Inequalities did not feature in the papers today and they were not cut by Health Inequalities data. She had given BB the challenge around this. AB had felt that the hybrid meeting had worked well. It worked well when there was the balance of the members in the room together. Presenters could make better use of their time by joining on screen. RF felt it had worked as JW had invited questions from those on the screen so he had not needed to put his e-hand up. VF asked if the Committee talked about the things most important to staff. SN responded yes and that the meeting had been a learning curve for her to improve practice. For example covering risk - one of the issues her team always had was that they were prioritising System 1 (their KPI) due to funding, rather than RiO so it felt that they were doing double the work. System 1 does not have a risk section so that ends up not being documented appropriately. VF raised that there was a similar issue in liaison psychology.	

A24/78	**Matters for Escalation for the Board**
	The following matters would be reported to the Board via the QSAC Chair's report:
	• The ERR key areas:
	  • Violence and Aggression
	  • Physical Health (following a review of the service)
	  • Industrial action
	  • Tolworth Development
	  • Car Parking (for indirect consequences e.g. recruitment and retention impact).
	• QSAC would look to receive updates on the issues in Ward 1, with the alarms and emergency responses, the outputs of the physical healthcare review, immediate learning after an incident and an emergency response update.
	• Q&P review especially around Length of Stay
	• Board visits report
	• That the following Annual Reports and six month reports were reviewed and accepted by the Committee:
	  • CQR report
	  • Mental Health Law report Q3
	  • Quality Priorities
	  • Always Ready
	  • CQUIN/Quality Accounts Q3
	  • Duty of Candour
	• Medicines Management six monthly update – and that it was agreed to receive this report annually only going forwards.	

A24/79	**Next meeting:** Tuesday 7 May 2024, 09:30am – 12:00pm, MS Teams. **Report deadline:** 5pm on the 30 April 2024.	

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

Quality and Safety Assurance Committee (QSAC) (Part A)

Minutes of the meeting held on Tuesday 7 May 2024, 09:30am – 12:00pm, MS Teams.

Present:

Jonathan Warren (JW)	Committee Chair – Non-Executive Director
Ann Beasley (AB)	Trust Chair
Richard Flatman (RF)	Non-Executive Director
Dr Billy Boland (BB)	Chief Medical Officer
Sharon Spain (SS)	Chief Nurse
Jennifer Allan (JeA)	Chief Operating Officer

Attendees:

Carol-Anne Brennan (CAB)	Lived Experience Representative
Shelia Nsoedo (SN)	Criminal Justice MH Liaison Nurse, Diversity in Decision Making (DiDM) Representative
Dr Iram Sattar (IS)	General Practitioner (observing)
Susie	SU/C Representative
Ryan Taylor (RT)	Associate Director of Clinical Governance and Risk
Justine Trippier (JT)	Joint Trust Lead for suicide prevention (item A24/91 only)
Dr Sean Whyte (SW)	Deputy Medical Director (item A24/91 only)

Minutes:

Emma Whitaker (EW)	Deputy Director of Corporate Governance

Apologies:

Vanessa Ford (VF)	Chief Executive Officer
Emdad Haque (EH)	Associate Director, Health Inequalities and EDI, and Trust PCREF Strategic Lead
David Lee (DL)	Director of Corporate Governance

Item		Action
A24/80	***Welcome and Apologies** Apologies were noted as listed above. The Chair welcomed Susie to her first meeting. Susie had joined QSAC as a new Lived Experience Member for the Committee.	
A24/81	***Declarations of Interest** No new declarations of interest had been received since the last meeting.	
A24/82	***Chair's action** No Chair's action had been taken since the last meeting.	
A24/83	***Minutes of the previous meeting** The minutes from the meeting of 9 April 2024 were agreed as a true and accurate record with the following amendments: • 'Matters to report to Board' section to be completed; • Next meeting date needed to be corrected to 7 May 2024; and • The attendance list needed to reference what the asterisks meant (they denoted online attendance).	
A24/84	***Action Tracker** The action tracker was noted and updated as below: **A24/69 – Emergency Response update –** There would be an update to QSAC in July. Action to remain open.	

Item		Action
	A24/46 – Review of Action tracker – This had not yet been reviewed – to be changed to EW/ SS. Action to remain open. **A24/48 – After incident learning –** This was on the agenda for today's meeting. Action to be closed. **24/31 – Clinical Outcomes –** This had come to a previous QSAC. Action to be closed. **Discussed:** Susie and CAB were Patient Safety Partners (PSPs) as well as Lived Experience Members. They both attended a Patient Safety Learning Group. These were new roles as part of implementing the Patient and Carer Race Equality Framework (PCREF). Susie also attended external groups with peers from other organisations and the South West London Integrated Care Board (SWL ICB). They raised that they would need some more training for the PCREF and had not received it, despite repeated requests. RT explained that the Quality Governance team had been waiting for national training and / or ICB funding for training. They would continue to lobby nationally for this training but appreciated that they could not really wait any longer, and he would look to set up internal training for the current PSPs. **Agreed:** SS and RT to look to set up internal PCREF training for the current Patient Safety Partners.	**SS/RT**

A24/85	***Executive Risk Register**
	The Committee noted and accepted the Executive Risk Register (ERR).
	Reported:
	• As a result of the ELT deep dive this month, the following changes were made to the People risk:
	  ◦ A new Mandatory and Statutory Training (MAST) risk had been added. Risk mitigations were in place.
	  ◦ It was recognised that key HR policies were out of date and so this had been added as a new risk. There were clear plans and progress, and risk mitigations were in place.
	  ◦ Employee Relations (ER) files – the HR team were reviewing systems and processes following breaking of legacy arrangements with SLAM and the recent Internal Audit report.
	• Physical health risk mitigations were in place and physical health reviews were taking place.
	• A new risk had been added regarding the access policy.
	• The national ADHD medication shortage had been added as a risk – to mitigate, medication was being prioritised where it was most needed.
	• The Violence and Aggression (V&A) risk score had been increased following review.
	Discussed:
	AB raised that MAST had been an issue since she had joined the Board. She asked what had happened to make this a risk again. RT agreed that MAST had been on and off of the ERR periodically over the years. When the People risk was reviewed recently it was agreed this should go back on as the level of risk had risen due to the deterioration around Physical Health which could be linked to resus and medical emergency training. Similarly with V&A, staff may not be trained in relative techniques. This would also be a key factor in a CQC well led inspection. Once these things were triangulated, it was agreed correct to add MAST to the ERR. SS and KR would be meeting with the MAST team to work through complications. There was also difficulty with external training e.g. level 3 safeguarding training which is led by	

Item		Action
	the Local Authorities. It was confirmed that there were enough sessions available; the issue was how to access and complete these training courses easily. JW raised that the target for the physical healthcare assessments had not been met in at least two years. He suggested there was a need to do something different. SS responded that this would be part of the relaunch/reset of the Fundamental Standards of Care (FSOC). This was more of a data and practice issue than assessments not taking place. Staff were recording assessments into progress notes and then this was not being pulled through in the data. RF highlighted that the Committee were asked to ensure the risks have the right mitigations and progress was being made. However, there were a number of actions that were not complete and were past their due dates. It was important that the Committee received the latest update if mitigations and actions were completed. RT appreciated this and raised that there had been some updates to actions since this version of the report. He would feed this back to the risk owners.	
A24/86	***Quality Matters** The Committee noted and discussed the Quality Matters report. **Reported:** • This report had been through QGG and the monthly ELT where the Clinical Directors and Deputies attended. • Strengthening of learning from incidents had been welcomed. • Unmanaged incidents – the Clinical Directors had said they had oversight of the concerns raised. Feedback from teams was that as quick as incidents were closed, new ones were opening. This was being worked through. • Teams were using Quality Improvement and Innovation (QII) and Clinical Audit to enhance learning from incidents. • 50% of complaints were upheld/partially upheld. The team acknowledged that the response rates were still not where they would want them to be. **Discussed:** JW raised that it felt urgent to get the waiting list / access report and he welcomed seeing the report. He asked if there was a Trust policy that all patients on the waiting list would get some kind of contact. JeA apologised as the access paper was to come to this meeting, it would come to the June meeting and the Access update in general would come to the July meeting. CAMHS were now calling all patients waiting for assessments. The July paper would cover all actions taken to ensure that the access policy was being addressed across the organisation. There was an internal issue around the psychology wait in adults and a waiting list initiative was taking place. More detail around this would come to the July meeting. Assurance that Ward 1 immediate learning around observations and engagement, especially around compliance, were having an impact and whether it was time for something different to be tried. It was worrying that staff were saying they had undertaken an observation when they had not. In one of the early learnings it stated that a patient had tied a ligature during the time when it was recorded an observation had taken place. SS responded that there were still areas where there were compliance concerns. CSLs were still doing their walk arounds and were picking this up. Last month matrons had visited forensics and recognised there had been an issue with non-compliance with observations and creating records saying the observations had been done when they had not been done or had been recorded at a different time to the observation taking place. There were three forensic wards with these systemic issues. Where observations were not happening and records were not correct or missing, there would be a check on if any harm had been done. It was	

Item		Action
	very high on the agenda and a key focus across inpatient services alongside V&A. SS was linking with Chief Nurses across London. They reported a similar picture and the work and focus at the Trust was similar to what was happening in other organisations. Susie asked, if staff were saying they had done an observation and written it up, how had it come to light that they had not done it. SS responded that where records were checked and it was noted that observations had not been recorded or were recorded at the wrong time, they had checked CCTV footage and then confirmed that no observation had taken place. She added that the majority of our ward staff did the right thing all of the time. Most staff were doing their best for our patients. It was a small cohort of staff not doing observations and / or not recording them appropriately. She did not excuse the behaviour but wanted to give it perspective. There were many different reasons why a staff member may not act as we would expect, such as being frightened to say they had not done an observation or not documented it at the right time. BB reiterated that it was a really small number of staff that engaged in this sort of practice. ELT were supporting ward managers and promoting the culture on wards to identify and report this practice and to create a climate where it was not acceptable. The Trust had registered for the "culture of care" programme, as part of looking at other ways of tackling this as an organisation. Four of our inpatient wards were signed up and attended a launch meeting last week. SS and BB were the Executive sponsors of this work. The four wards would be using a QI approach to shift the culture. CAB asked what happened to staff who have been found to have made incorrect records and have missed observations – were they taken off clinical practice; were they retrained or would they stay on the wards? Did the Trust look at whether they were new or current staff? SS responded that there were a range of methods to use if staff were found to have missed or mis-recorded observations, such as using CCTV. It depended on the situation as to the next steps. Some staff were investigated, some were suspended; if it was the first time with mitigating circumstances there may be a lighter sanction. It was becoming clear across the organisation that this behaviour was unacceptable and the leadership would need to keep building on this. IS asked if ethnicity was recorded for Feedback Live responders, and if so was it proportionate to the ethnicity of our service users. She asked how patients and carers who do not read or write English were encouraged to feed back. She also asked if incidents were monitored by ethnicity. RT responded that there were annual and biannual reports which detailed incidents. Ethnicities linked to incidents were recorded in clinical records. Ethnicity was not collected for Feedback Live. IS responded that feedback from BAME patients was important as they may not want to bring up incidents of things such as racism and some cultures would maybe not trust that the feedback would be confidential, due to systemic and historical issues. RT advised that patients were provided guidance that if they had any additional concerns they could contact PALS. Peer support workers were on wards helping with collecting feedback. He would explore if Feedback Live could have the option of recording ethnicity.	

Item		Action
A24/87	***Quality and Performance (Q&P) Report** The Committee noted and accepted the Q&P report. **Reported:** • There remained areas of challenge - V&A, physical health, adult patient flow, the high demand for our services, constraints in supporting people to step down and sustaining them in the least restrictive environment. Some beds were closed and there were high numbers of patients in Holybourne. Teams were working hard on reducing these numbers in the short term and were continuing to work in partnership with the Local Authorities (LAs) even though this remained challenging, especially in supporting more complex patients step down to sustainable settings in the community. JeA would be doing some more work on this at SWL level. • There was now a stronger focus on FSOC as part of the APJ programme. There would be a push to reemphasise supporting staff to deliver FSOC. • There would be a stronger focus on a few areas: care planning, risk assessments and planning, including consideration of ethnicity. QSAC would be kept well sighted on this work. • The CAMHS SLP beds remained challenging. The closure of the beds meant that there were a number of complex CAMHS and ED patients in SWLSTG. • A more detailed update on access would be coming to Committee in due course. Challenges centred on adult ADHD assessment and some psychological therapies. Teams were ensuring compliance with the Access Policy and there would be an internal audit against the policy. • There was continued focus on working with teams that were highlighted as concerns on SIREN and triangulating with other data. SIREN brought together a lot of information e.g. supervision, complaints and incidents. It was reassuring to see areas of challenge in SIREN were where we would expect them. An area to reflect on with staff was whether there had been the improvements we want to see in some of those areas of challenge that have been concerns for a while; e.g. crisis services. There was huge pressure on the front line of our services. Lots of OD work was being done with these teams but it would take time to implement. Some areas of challenge were persisting over time; e.g. Community Services. **Discussed:** The CQC Community Patient Survey was on the agenda. BB highlighted that the Executive triangulated the data with the SIREN and Q&P reports. The FSOC dashboard had been included in this paper and inpatients had more 'green' areas than the Community**.** The APJ work would be discussed this coming week and this should improve quality. The crisis line calls triaged within 1 hour had a 95% target and in the most recent report the achieved figure seemed to have dropped to about 30%; should the Committee be concerned. JeA would look into this and would come back to confirm that there were no concerns. This had been reviewed previously. It was found to be related to data quality issues or handing patients over to another service. The number of calls would also be much lower now as the Trust were working with "111 press 2". A graph was provided with ethnicity breakdown for Merton. The bar for 'other' was high compared to the rest of the population. It was asked which ethnicities were included in that category. JeA did not know but said that she would find out; she apologised as IS had raised this query in March QSAC and had not yet had a response.	

Item		Action
	Action: JeA to find out which ethnicities were included in the 'other' category in the graph that showed the ethnicity breakdown for Merton in the Q&P report.	**JeA**

A24/88	***SWLStG Self Assessment Manchester Report**
	The Committee noted and discussed the SWLStG Self Assessment Manchester Report.
	Reported:
	• There were seven areas and each one had been allocated to a key Executive, who was asked to look at areas of exception. SS thanked RT and Executive colleagues for their hard work in pulling this together.
	• Quite a lot of sessions had taken place with staff involved and it had been taken through the Service Lines, in order to understand if there were particular gaps/areas that were relevant from the report, to focus on.
	• A further piece of work would look at whether there were any current pieces of work where these areas could already fit into, to avoid duplication.
	• Some key areas were discussed:
	  • Patients and carers voices needed to be strengthened and more empowered at Board level and on Committees across the organisation. There was a carer's story for Board this week.
	  • Enhancing MDT leadership and holding each other to account.
	  • Increasing clinical input into some Board Committees.
	  • Continuing to drive equality, career progression, V&A and anti-racism.
	  • Change management – and that the Trust were committed to using a QI approach.
	  • Corporate services – the staff survey showed that staff do not feel as valued as our other services.
	  • CQC – the Trust was very proud of its 'Good' status. This was only a snapshot in time and it was discussed if we were assured we were still in the 'Good' position, especially given the conversations QSAC had today around physical health and restrictive practices.
	  • The Trust's role as commissioner and provider, the 'Fitness for the Future' review with SLP, and better partnership involvement.
	Discussed:
	That this was a thorough piece of work and it was encouraging to see the level of thought that had gone into it and how it had been triangulated with other pieces of work.
	
	JW raised that a formal letter would be coming from NHSE wanting a response to this report, so it was good that this work had happened already. SS added that a lot of the gaps found would be captured through the APJ work.
	
	CAB thought it was a good report. It was hard for a patient or carer to take on a piece of work like this without being affected as a consequence. There was the need for more support to get people to come onboard for these pieces of work. She suggested that the difference that patients and carers have given to pieces of work should be communicated across the organisation as this would encourage people to come forward to do the work. SS would take this back to the teams.	

A24/89	***Immediate learning after an incident** The Committee noted the immediate learning after an incident report**.** **Reported** • Learning from incidents was undertaken for all areas of FSOC and monitored by QGG. Learning and improvements were shared via the Learning Group.	

Item		Action
	• In this report, QSAC had an example of a safeguarding case reviewed at the most recent group. • To review if the learning has made a difference, one or two cases would be re-reviewed in-month with a look back session. This was the first year of this process. External people have attended these sessions and there had been good feedback in how we were approaching this. • All key staff were members of the Learning Group. **Discussed:** JW raised that, apart from the retrospective audits, there did not seem to be any constant measures that were monitored for us to know we were making a difference with this learning. SS responded that the Learning Group did not set measures. RT would look at the annual reports for each area to ensure they were reviewing learning data, what had been done and if it had led to improvements.	
A24/90	***Violence and Aggression** The Committee noted the Violence and Aggression (V&A) report. **Reported:** • The cover paper had been updated post People Committee and ELT but the old cover had been included. It was noted that the new cover did not change the position. • There had been positive feedback from People Committee to the paper. • The Trust had seen a significant increase in incidents of V&A in the last year and were concerned about this. There had also been an increase in racially motivated and aggravated incidents. In response a new task and finish group, the Violence Reduction Group, had been established. The TOR of the Group was included for information. • The QII team were involved. They were assisting the Group in producing a project plan to cover the many facets of this work. • The task and finish group would be looking at the data going forward, how we use Statistical Process Control (SPC) to do this, and how we review if there had been any impact. SPC charts were helping the Group make progress already. **Discussed:** That it was good to see a group had been set up and would be reviewing the data; but what the Committee needed for assurance was to be updated when the Group had understood the data, and set specific actions with the intention of delivering specific outcomes. The QI methodology would help with this. That some focus was needed in two areas: that most of incidents were in AUC and that the vast majority were closed with no further action. That we hear that the new wards had improved the volume of incidents but the report suggested incidents had increased. This would imply that incidents had increased disproportionately on the wards that had not moved. This was coupled with the Deputy Director of Nursing's good news story around restraint. It was not clear what the Trust thought the problem was that they were trying to do something about. SS responded that incidents had not been triangulated across the wards that had moved and she would look to see this information was triangulated. The standard letters to staff may be an irritation rather than helpful. If staff were in two incidents and received two similar letters they may be unsatisfied. Was there an option to personalise the letter or make a phone call. SS responded that there had been a previous detailed piece of work around post incident support. As a result, staff did not receive just the standard letter. There was a set of principles around	

Item		Action
	calling the staff member and buddying them up on their return to work. The principles state clearly who was responsible in the service line for ensuring these things happened. There would be work to ensure these principles were strengthened and dovetailed into the work of the Violence Reduction Group. That there were plans to have Lived Experience Members and staff reps on the Group. There would also be a group of people established who can talk to staff and patients who have been involved in incidents, to glean first hand experiences as to what led to that assault. The next QSAC would receive a paper on QI within the organisation and would review the past five years and plans for the next five years. ELT were clear there would be a total quality management system in the organisation and this would involve a standard approach to improvement across the organisation. CAB was disappointed that incidents were increasing when a lot of work had gone on in this area. These incidents were being reported by patients over so many years and yet it felt as if things were going backwards. She was also disappointed to read the criminal data report for staff. She asked why we were not getting these things right. She asked that the wording in the standard letter that goes out to staff be checked as it was important that it was right, and also that reports to the Committee were checked before sending; e.g. *mens rea* was written as *mans rea* on page three. Susie raised that she was a member of the Complaints Review Group, who were looking at commissioning some staff training in more compassionate complaints handling. When we get complaints we must give a tailored response to let the person know we have listened and heard what they said, and we were replying to their concerns specifically. She suggested she ask for a similar piece of work around staff letters following incidents of V&A.	
A24/91	***Suicide Prevention Strategy** The Committee noted the Suicide Prevention Strategy. **Reported:** • This strategy covered the next five years. It reflected the national strategy, took into account partnerships across the ICB and had been fully co-produced with carers and patients. It built on the Trust's previous strategy, with those actions built into business as usual. • The strategy included the lens of neurodiversity and had been co-produced with people who were neurodiverse and their allies. • There was an accompanying work plan for next year and this would be built on for the next two years with priorities against the strategy. • JT had co-ordinated the strategy alongside the "Hold the Hope" group, which was why this strategy was so brilliant and different to what had been done before. **Discussed:** The Committee found the strategy document very moving. They thanked SW, JT and their colleagues for this work; it was very appreciated. IS asked if there was any work around the suicide rates in specific ethnic groups. She highlighted that young Asian women were two to three times more likely to die by suicide than young White women. She would like to know if we had this trend in our communities or if we were different to the national average. JT responded that she had just been on a national conference meeting and the data had been updated recently. Once this was shared it would be reviewed. The strategy aimed to collect local data on ethnic groups and trends so some local prevalence data would be reviewed that could be mapped to national trends. One of the strategy aims was to	

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	reach into difficult to reach communities. There would be Suicide Ambassador roles developed and specific staff to connect with marginalised groups, such as travelling communities, Asian communities, veterans and seafarers, etc. The Ambassadors would go out into communities and support breaking the stigma of suicide. BB added that the quarterly and annual mortality reports reported on the breakdown of suspected suicides by ethnicity and these reports come through QSAC. Last year's annual report had looked for emerging areas of concern in non-White populations. There was not an established trend in this area, so we did not think our BAME patient groups had more suspected suicides. He added that the Trust's overall numbers of suspected suicides annually were very small so it would be hard to report on any statistical difference. Whether Health Inequalities should be more overt in the strategy. There was work in the strategy in this area but it would be good if it was more overtly referred to, such as protected characteristics or groups targeted for specific work. It was wonderful that neurodiversity was included. A number of our inpatient deaths had been people with an element of neurodiversity in their presentation. We knew that nationally, people with Autism were seven to eight times more likely to die by suicide so it was important to have this focus in the strategy. BB added that people with neurodiversity should also be considered a group prone to Health Inequalities. Susie raised that BAME / non-white communities were included but there were also White ethnic minorities such as Irish and travellers who were not specifically included. The priority list was comprehensive but she did not see service men and women and veterans on that list. JT responded that veterans and service people were included within this work and this was continued work from the previous strategy.	
A24/92	***Annual Delivery Plans (ADPs) 2024/25** The Committee noted the ADPs for 2024/25. **Reported:** • This report had been through Part B of the Board and all of the Committees previously, prior to being finalised. • There would be focus on two main areas in the coming year: Adult Patient Journey (APJ) and Making the Trust a Great Place to Work. • QI methodology and the OD framework would be enablers and supporters of both ADPs. • The APJ ADP priorities included holistic care planning, Dialog+, PCREF and Health Inequalities, better care following the Acute, Community Services and CAMHS transformation work, including digital commitment; and partnerships - working through the complexities of SLP and the SWL Mental Health Provider Collaborative. • Making the Trust a Great Place to Work priorities included better environments, sustainability, fair career progression, and productivity; supported by QI, the OD framework and anti-racism work. **Discussed:** That the only objective around better environments was the Tolworth Full Business Case (FBC). Would there be any other objectives? It was clarified that the works at Barnes and Richmond Royal, the Anchor programme, and the Green programme work with communities would be underlying this ADP. The sign off of the FBC was the focus priority for the 24/25 year.	

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	Susie asked how better environments aligned with having less beds. She also raised a basement area that was a storage area but could have been used for beds, on the Springfield site. SS would look into the basement area as she was not aware of it. CAB raised that the V&A report showed that you could have the best building but if staff and patients were not happy the environment would be bad. We needed to get the basics right and to address the underlying issues. Less beds available in the Trust would put more people into Community Services, GPs and the voluntary sector. The outcomes of that needed careful review. BB described a recent ward visit where there was an incident with an agitated patient. These incidents were disturbing, took staff away from other patients, and were distressing for fellow patients. He was concerned as to what it must be like to witness that as a patient, and whether they would feel safe or not following an incident. He added that the bed stock was limited and was not able to be increased. Referrals were increasing year on year. The Trust had tried to accommodate additional capacity in places close to or in the local area, like Holybourne. These organisations would normally take patients with less acuity, leaving more complex and demanding patients staying in our environment. It was recognised that it was challenging to work in these difficult circumstances. CAB appreciated this and said that when the decision was made to reduce bed numbers, patients and carers raised that this would happen yet it went forward anyway. She knew it was not necessarily the Trust's decision but this was the consequence. Susie raised that even before the new buildings at Springfield there were cases of the Trust running out of beds. If there were less beds, we might have a patient travel a long way out of area to get a bed that will cause issues for patients and the staff as well.	
A24/93	***Annual CQC Community Patient Survey Six Monthly Report** The Committee noted the Annual CQC Community Patient Survey Six Monthly Report. **Reported:** • There had been an 18% response rate, which was below the national average of 20%. • The results were disappointing to the Trust. • It was difficult to completely compare this year's results with last year's, as the questions had been framed differently. • The areas where we have done better were care planning, supporting access and care, supporting other areas of your life; e.g. social, environment and community, feedback and checking how patients were with their medications. • The areas where our scores have decreased were medication, respecting privacy and compassion, not enough support whilst waiting, crisis care and the length of time to get through to the crisis team. • The Community Services Service Line would be doing a piece of work alongside the Nottingham review to triangulate both and to get an overall improvement plan. This would come back through QSAC in July. • As there were a lot of areas of priority, the key priorities for focus in year needed to be decided. The Service Line and SS were working with the Involvement Team to get a group of service users and carers to help decide the areas of focus. The other pieces of work would be picked up through the APJ ADP. **Discussed:** JW had found the survey results troubling, particularly around respect, dignity and family involvement. He was concerned when triangulating this with the Appreciative	

Item		Action
	Inquiry report from the Community Services Service Line, the staff survey results from the community teams, and some of the informal and anecdotal experiences e.g. board visits and Nottingham discussions. He asked if we were confident we were doing enough in these areas. SS responded that she would agree with feeling concerned. There had also been some worrying carer feedback about the interface in the community. From their initial self assessment against the Edenfield and Nottingham report, she felt that the Service Line would say they also feel very concerned about the gaps. The CQC survey response would come back to QSAC in July with details of specific actions. JeA added that a positive aspect was that the issues raised were largely things known about already and areas we knew we needed to work on or were working on currently. Good interactions with managers were integral to good interaction with patients. Workforce morale, integration and development was a really important area. There also needed to be a period of stability whilst we were implementing the transformation changes, to allow these to embed. We had to allow teams to stabilise and refocus on FSOC and working together as a team and always treating patients compassionately. JW asked if we were not surprised to be bottom for respect, dignity and compassion. JeA responded that it was concerning to be so far down in the scores but it was not a surprise. We knew there were gaps in care as we have lots of improvement work to do and embed, and needed to work on how we get staff to do this work in a more connected way. Patients reported a poor experience when they were passed between teams and that was a real concern at the moment. The ability of our staff to do this was impacted by the transformation changes, the amount of demand and the caseloads we see. There were a range of areas of concern driven by how to work with the workforce to get right leadership, connection as a team, integrating new roles and third sector providers to work in a more connected way with patients. Susie raised that some of the issues with dignity may due to staff not communicating well. She reported witnessing a patient on a ward where patients could come and go during the day. The patient wanted to get back on the ward after being out for a period of time. A member of staff who could operate the door did not speak to the patient when opening the door. Susie had found it shocking and upsetting to see. It was like this patient did not deserve to be spoken to. She added that if your attitude was more pleasant maybe you would find the workplace more pleasant to work in; and the same could work for patients. BB said that reading the results made him feel unwell. Some of the things patients reported were chilling. He and the Executive did not want the results to look like this next year. They wanted to change things and make a difference. He added that, not being dismissive of the results, there should be thinking about how best to make sense of this data, as the response rate was low. Things needed to be considered such as was this a representative sample, who were choosing to respond, etc. JK, SS and BB were looking at how to improve the response rate for the next survey, as this would give a clearer, more representative picture. The Executive was keen to proactively engage with patients to improve the response rate. The success of the increase in response rate for the staff survey was due to more engagement with staff. BB raised that we were a positive outlier in care planning relative to other organisations. Patients were saying we were doing a good job in this area. The Community Services Service Line had been asked to discuss and advise what they	

Item		Action
	should be doing to build on this good work for the areas where there were low scores. A nurse in BB's team had told him that he had gone to the Nottingham review session for Community Services, hosted by JW. He had said it was great and there had been positive leadership from his leaders. BB was very heartened to hear this feedback. The Friends and Family Test data had gradually improved across the organisation in the past year. That says we could make a difference on patient experience so should be able to make a difference in the CQC survey areas too. CAB thought that there had been a lot of changes in the Community over the past year and change affected staff and patients. The changes had been really difficult. In the Sutton local group a lot of complaints had come in. She hoped that, as things embedded, scores would improve. Susie raised about waiting times. She was involved in a forum for patients and carers in NHS Talking Therapies. They had come up with some ideas about checking on people whilst they were on a waiting list, such as a standard response by text or some form of contact so they knew they had not been forgotten. If possible there would be a way to tell how far someone had moved up the waiting list. This would help as it would away the loneliness and forgotten feelings patients may experience whilst waiting.	
A24/94	**Quality Governance Group minutes** The Committee noted and accepted the minutes**.**	
A24/95	**Quality Governance Group Terms of Reference (TOR)** The Committee noted and accepted the TOR**.**	
A24/96	**Agenda for the next meeting – June 2024** The Committee noted the agenda for the June meeting.	
A24/97	**Meeting Review: (a) Patient focus (b) Quality of challenge and (c) Health Inequalities focus** Susie said it had been a pleasure to meet new faces in her first QSAC meeting. She thanked all members for making her feel welcome. She had wondered how the meeting would be and she was not sure if she would speak but she had proved herself wrong! SS felt there had been good rigour today and there had been good and fair challenge. The patient voice had been heard. AB felt there had been some good challenge. She had been left with a feeling of discomfort on the position on a lot of things. She was not sure the things we need to do to get us on the right track had been identified. CAB felt it had been a good meeting, with a lot of discussion. She was pleased Susie was here. The Committee needed to keep an eye on levels of V&A especially as it had come up so many times in the past. We seem to make progress then get worse again. JW was grateful to have both Susie and CAB on the Committee and thanked all members for their input to the Committee.	
A24/98	**Matters for Escalation for the Board** The following matters would be reported to the Board via the QSAC Chair's report:	

Item		Action
	• Discussion on the ERR, especially around physical healthcare, MAST and outstanding / overdue actions. • QM discussion around observations and if the ethnicity of responders could be captured for Feedback Live, to see if there was underreporting from certain ethnic groups and what could be done to gather their feedback. • The positive feedback around the SWLStG Self Assessment following the Greater Manchester Report. • Immediate learning after an incident discussion around how to measure if learning was making a difference. • The concern around the increase in levels of incidents of V&A, the task and finish group and the request to have data showing incidents per wards, to see if the new environments were reducing incidents and understanding why the wards who had not moved had seen more incidents, if this was the case. • That the Committee had appreciated the excellent Suicide Prevention Strategy work and were pleased it had been co-produced. • That the ADPs had been noted and discussed. The patient representatives had raised concerns about the low bed numbers in the Trust. • The Committee had shared the Executive's disappointment in the results of the Annual CQC Community Patient Survey Six Monthly Report, and looked forward to seeing the action plan from the Community Services Service Line at its July meeting.	
A24/99	**Next meeting** The next meeting of QSAC would be held on: Tuesday 4 June 2024, 09:30 –12:00, MS Teams **Paper deadline:** Close of business 28 May 2024 **Late papers will not be accepted.**	

Trust

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

Quality and Performance Report

May 2024

Glossary

Term	Meaning	Term	Meaning
ALOS	Average length of stay	KPI	Key performance indicator
BAF	Board Assurance Framework	LOS	Length of stay
BCAG	Business Case Assurance Group	LFPSE	Learning from Patient Safety Events
CAMHS	Child and adolescent mental health services	NHS	National Health Service
CMA	Cardio-metabolic assessment	NHSE	National Health Service England
CQC	Care Quality Commission	PALS	Patient Advice and Liaison Service
CIP	Cost Improvement Programme	PPE	Personal protective equipment
CQUINS	Commissioning for quality and innovation	QII	Quality improvement and innovation
DNA	Did not attend	QSAC	Quality and Safety Assurance Committee
EDS	Eating disorder service	RTT	Referral to treatment
EC	Modernisation Committee	RIDDOR	Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations
F&P	Finance and Performance Committee	SIs	Significant incidents
FFT	Friends and family test	SLM	Service line management
FSOC	Fundamental Standards of Care	OF	Oversight Framework
GP	General practice	Trust	South West London and St George's Mental Health NHS Trust
HoNOS	Health of the Nation Outcome Score	WTE	Whole time equivalent
HTT	Home Treatment Team	YTD	Year to date
IPC	Infection Prevention and Control		

Contents

Part A: Executive Summary

What

The focus of this report is May 2024 and our priority metrics to ensure patient safety and effective care, along with our integrated approach to quality, workforce and overall productivity and sustainability. The quality and performance (Q&P) framework is supported by detailed executive review and discussion at the bi-monthly Service Line Review (SLR) meetings.

Overall performance remains Amber rated with consistent areas of challenge and achievement to previous months. The drivers of lower performance are access, flow and staff skills domains, reflecting high demand for services leading to long waiting lists (especially ADHD/ASD), significant ongoing demand and complexity of patients in the adult acute pathway along with constrained flow to discharge leading to long waits for care, extended lengths of stay and use of private beds, and ongoing challenges with MAST and supervision compliance across teams impacting workforce quality indicators.

We have seen continued stronger performance against patient safety metrics, and patient experience and outcomes indicators remain stable across a number of areas including Talking Therapies recovery rates, dementia diagnosis, and increasing collection of Dialog outcomes. Fundamental standards of care are being closely monitored, with some improvement in inpatient compliance but further work required in community.

Workforce pressures are of concern across the service lines, particularly in our wards and community teams, and we continue to monitor this closely through the SIREN tool. There are plans in place to support teams through our OD hub where we have seen longer term issues and where the staff survey results flagged specific concerns. Recruitment and retention indicators are improving but MAST compliance is not meeting standards and is an urgent issue in the context of ensuring staff are well equipped to manage complex physical health presentations and reduce violence & aggression within ward environments. Agency staffing is challenging to reduce given the level of complexity of patients within our services and ongoing medical / community staffing gaps.

The Trust plan for 2024/25 is £0.76m surplus for the year. To achieve this the Trust needs to deliver savings of £17.9m. In addition, the Trust is required to reduce agency spend to 2.9% of pay bill. There is £41.1m planned capital expenditure for the year, with two planned asset sales; this has reduced by £7m following the plan refresh for June resubmission. Loan repayments commence in 2024/25. At M2 the trust is on plan and showing a £100k YTD deficit; the underlying position has however deteriorated due to the increased use of external beds being offset by non-recurrent opportunities.

So What

The clinical and executive leadership teams are working together to address the significant challenges within our acute pathways. An “intensive support intervention” is in progress as the discharge levels remained low during May leading to higher waits for patients in crisis, with senior clinical support being offered on a daily basis to all acute ward MDT meetings. The themes, outcomes and next steps for piloting changes across acute, community, specialist and external areas of the pathway will be captured and actioned using a QI framework and linking to the Adult Patient Journey programme. This work is supported by the ongoing focus on FSOC and SIREN as our tools to understand and engage with teams about the quality of care and sustainability of our workforce.

We continue to work collaboratively with system partners including acute and Local Authority colleagues to deliver improvements to MH in ED pathways through piloting MH triage and rapid access clinics in acute hospitals, and through the complex care programme and SWL discharge meeting. Limited investment available from the system for MH and to support discharge has been directed to the acute pathway, including step-down hostel beds and interface workers to enhance flow, and to CAMHS Tier 3 services to support access, in line with the SWL MH Strategy.

Reduced turnover rates and improved recruitment are positive trends, although challenges in medical staffing especially in acute services remain and there is continued high use of additional staffing. We are reviewing Agency workers with each service line and developing plans for each post. However, there are considerable concerns at team level in a number of services, both practically in terms of high agency use and we are continuing to offer support through both the service line leadership and the OD hub, as well as to refresh our approach to MAST training, recognising the constantly increasing burden placed on staff. The Trust is in a relatively stable financial position in the context of significant deficits across SWL ICS. Flow pressures are driving considerable financial pressure in terms of external bed costs; the Trust has targeted a minimum of 70% recurrent savings plans for 2024/25 to support longer term financial sustainability and will need to address the flow issues along with above target agency ratios to secure a sustainable future financially.

What Next

Our Adult Patient Journey improvement programme has now started to bring together community and acute transformation work and to build the governance, resource and project scope that will deliver purposeful, timely, least restrictive and recovery focused care across the pathway. Supporting teams to work together to deliver more integrated care, embedding improvement in our business-as-usual frameworks, and focusing on the quality of care through FSOC will be key to the approach. Scope and engagement plans are being drawn up and we will be transitioning to the new programme in July 2024. Work on the Intensive Support Intervention on patient flow will be connected into the Adult Patient Journey scope.

Specialist service line are working together with CAMHS services to align approaches to the challenge of access to ADHD / ASD assessment for adults and children, and will be drawing up options for more innovative approaches as well as continuing to work with the ICS on sustainable pathways. We are also developing our partnership with Local Authorities and the Complex Care programme with a view to having more joint work on placement review and understanding the broader quality and financial implications of this patient group.

We will continue to enhance our workforce stability and morale, particularly looking at local recruitment, as part of our commitment to being an anchor institution, and on anti-racism and inclusivity in everything we do for and with our staff. We are reviewing mandatory training audiences to ensure the right focus, as well as promoting our leadership offer to ensure our staff are equipped and valued for their work. Our People Strategy is in development.

We are working to enhance our vacancy control process and alongside that our approach to agency staffing to ensure stability of workforce and with it a better experience overall for staff and patients alike. We are putting together a medical staffing proposal to address gaps and concerns in consultant and supporting medical roles, including consideration of new roles that can support our clinicians and patients.

Quality & Performance Summary (see appendix 3 for explanation on scoring)

Summary Domain Performance:

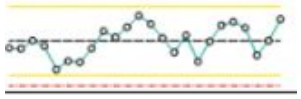
Domain	Full Assurance	Some Assurance	No Assurance	% Full/Some Assurance
Operations	2	13	16	48.4%
Quality	7	12	10	65.5%
Workforce	1	4	5	50.0%
Finance	1	2		100.0%
Total	11	31	31	57.5%

Donut Performance over-time (all themes combined):

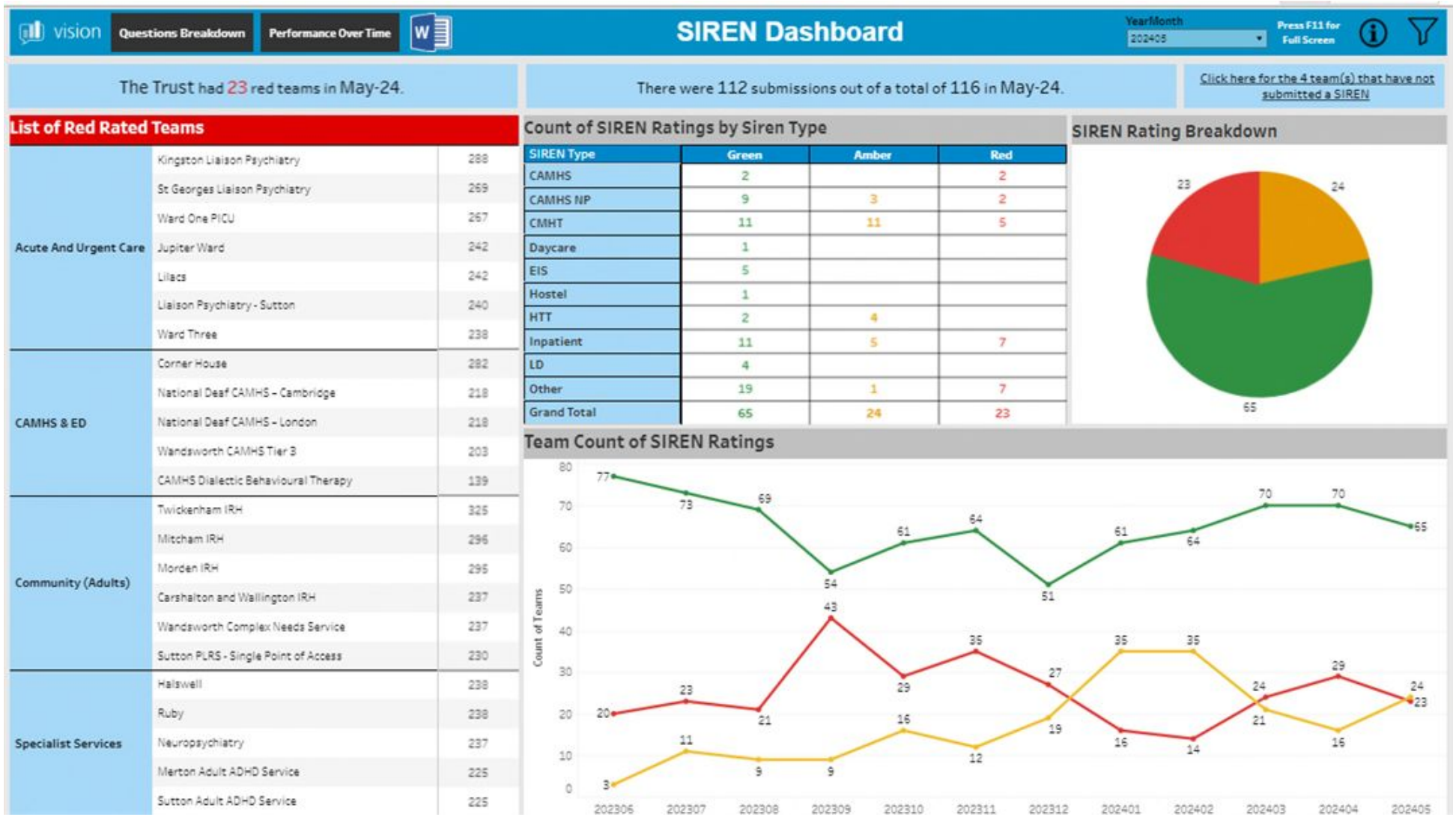
NHS: Oversight Framework

Theme	Metric		Previous (OF) Update	Latest Performance (OF)	Internal Trust Metric	Internal Trust Metric
Trust	S035a	Overall CQC Rating	3 - Good	3 - Good	N/A	N/A
	S059a	CQC Well led rating	3 - Good	3 - Good	N/A	N/A
Workforce	S067a	Leaver Rate	10.20% (May 23)	9.1% (Jan 24)	12.88% (May 24)	Staff Turnover
	S068a	Sickness Absence Rate	4.63% (May 23)	4.8% (Jan-24)	4.14% (Apr 24)	Yes
	S071a	BME senior staff %	15.20% (2022)	15.20% (2022)	32.3% (May 24)	Yes
	S071b	Female senior staff %	55.60% (May 23)	55.60% (May 23)	69.2% (May 24)	New metric for 24/25
Experience	S072a	Staff Survey fair career progression	47.60% (2022)	49.93% (2023)		N/a External Survey
	S121a	Staff Survey compassionate culture people promise sub-score (out of 10)	7.08 (2022)	7.24 (2023)		N/a External Survey
	S121b	Staff Survey Raising Concerns sub-score (out of 10)	6.49 (2022)	6.50 (2023)		N/a External Survey
	S133a	Staff Survey Compassionate theme score (out of 10)	7.34 (2022)	7.44 (2023)		N/a External Survey
	S063a	Staff Survey Bullying score (from managers)	11.50% (2022)	8.76% (2023)		N/a External Survey
	S063b	Staff Survey Bullying score (from colleagues)	16.40% (2022)	16.12% (2023)		N/a External Survey
	S063c	Staff Survey Bullying score (from patients/public)	27.10% (2022)	27.51% (2023)		N/a External Survey
	S069a	Staff Survey engagement theme score (out of 10)	6.99 (2022)	7.11 (2023)		N/a External Survey
Flow	S038a	Consistency of reporting patient safety incidents	50% (Apr-Sep 2022)	100% (Apr'23-May 2024)		Trust now automatically uploads reports to LFPSE so going forward reporting should be at 100%
	S125a	Adult Acute LoS over 60 days (%)	35% (May 23)	35% (May 23)	38% (May 24)	Metric for 24/25 now in place
	S125b	Older adult LoS over 90 days (%)	39% (May 23)	39% (May 23)	29% (May 24)	Metric for 24/25 now in place
	S086a	Inappropriate Out of Area placement bed days	1010 (May 23)	1010 (May 23)	385 (May 24)	Yes

South West London ICS Long Term Plan (LTP) Priority Metrics

ICS Long Term Plan Metrics	May-24	Target	SPC Chart	Comments
Number of children and young people accessing mental health services as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people with severe mental illness receiving a full annual health check and follow up intervention as a % of trajectory	-	-	-	Metric to be incorporated in future reports.
Number of people accessing Talking Therapies (Trust)	4,118	3,938		Trust is slightly above its cumulative access requirements for 2024/25.
Number of adults and older adults with severe mental health accessing community mental health services	11759	-		The Information Management Team have reviewed metric definition and issued guidance of team category inclusion. There is no target for this metric.
Inappropriate out of area placement bed days - Adult Acute & PICU	385	≤0		Trust continues to require use of out of area beds due to high demand. Trust has renegotiated use of beds at Holybourne, now has use of 30 beds which commenced on 1 December 2023 for a year to December 2024.

SIREN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Questions Breakdown
Performance Over Time
SIREN Dashboard
YearMonth
202405
Press F11 for Full Screen
The Trust had 23 red teams in May-24.
There were 112 submissions out of a total of 116 in May-24.
Click here for the 4 team(s) that have not submitted a SIREN
List of Red Rated Teams
Acute And Urgent Care
Kingston Liaison Psychiatry 269
St Georges Liaison Psychiatry 269
Ward One PICU 267
Jupiter Ward 242
Lilacs 242
Liaison Psychiatry - Sutton 240
Ward Three 238
CAMHS & ED
Corner House 282
National Deaf CAMHS - Cambridge 218
National Deaf CAMHS - London 218
Wandsworth CAMHS Tier 3 203
CAMHS Dialectic Behavioural Therapy 139
Community (Adults)
Twickenham IRH 325
Mitcham IRH 296
Morden IRH 295
Carshalton and Wallington IRH 237
Wandsworth Complex Needs Service 237
Sutton PLRS - Single Point of Access 230
Specialist Services
Halswell 238
Ruby 238
Neuropsychiatry 237
Merton Adult ADHD Service 225
Sutton Adult ADHD Service 225
Count of SIREN Ratings by Siren Type
SIREN Type | Green | Amber | Red
CAMHS | 2 | | 2
CAMHS NP | 9 | 3 | 2
CMHT | 11 | 11 | 5
Daycare | 1 | |
EIS | 5 | |
Hostel | 1 | |
HTT | 2 | 4 |
Inpatient | 11 | 5 | 7
LD | 4 | |
Other | 19 | 1 | 7
Grand Total | 65 | 24 | 23
SIREN Rating Breakdown
23
24
65
Team Count of SIREN Ratings
Count of Teams
202306 202307 202308 202309 202310 202311 202312 202401 202402 202403 202404 202405

SIREN – May 2024 Summary Commentary

SIREN continues to be used within team and service line meetings on a regular basis to support understanding and action on concerns. There has been a shift from red to amber rating of teams in May; also noted green SIREN levels have also reduced.

- **Community: (key link to caseload size, supervision, leadership gaps and staffing challenges)**

❑ Teams that have reported red SIREN results for 2+ months have been proactively reviewed, and include Centra Wandsworth & West Battersea, Wandsworth SPA, Richmond SPA and Twickenham IRH. Key themes driving concern include recruitment challenges associated with high agency usage, high team caseload, low supervision rates and high levels of stress.

❑ Wider service line actions to support teams include a new SLR performance framework for all boroughs bringing borough leadership team & the quartet together to review SIREN results and wider performance priorities including FSOC. The Community workforce plan 24/25 has a focus on recruitment challenges and improving the quality of supervision. Ideas on new retention initiatives are being reported into the wider retention group for the Trust.

Acute & Urgent Care: (key link to ongoing pressure on the crisis and acute pathway and leadership vacancies with liaison psychiatry)

❑ Ward 1 improvement plan is in place, focusing on three specific areas: physical health, observations, and medicine optimisation. Observation levels on the ward are reviewed daily and have reduced in line with the new zonal observation plan.

❑ Concerns remain around Liaison psychiatry; the teams have vacancies, including a team manager and a consultant psychiatrist post and temporary cover is being put in place. Additionally caseload levels and supervision are factors. This interacts with stress levels, workload, and morale with high demand within the ED environment to create long term challenges for these teams. Transformation work is ongoing and current focus is on improving digital systems and streamlining process, while the CSL is auditing caseloads and initiating improvement work in this area. The team are a priority for organisational development support.

❑ Common themes of concern in other red rated teams were vacancies, staff sickness, leadership changes/absence and supervision.

- **CAMHS & AED: (link to increased acuity within inpatient areas, and demand and vacancies within community)**

❑ National Deaf CAMHS team continues to experience high stress levels associated with increased demand, there has been an increase in sickness and supervision requires focus. Additional assessment capacity has been implemented and wait list protocol is in place to monitor waiters and ensure contact with local teams.

❑ Wandsworth Tier 3 has reduced psychiatry capacity following locum leaving and has impacted on team's ability to respond to psychiatric emergencies/medical management queries. Recruitment for replacement Psychiatrist is being progressed.

❑ In Corner House there have been increase stress levels and the Consultant role is vacant The model and consultant cover arrangements for Corner House are under review.

- **Specialist: (key link to ADHD assessment long waits)**

❑ Within ADHD wait list challenges and long-term sickness has impacted service efficiency. Non-Medical Prescribers have been recruited and bank administrative posts agreed in order to improve flow primary care. Discussions are ongoing to support the team and to progress more sustainable pathways.

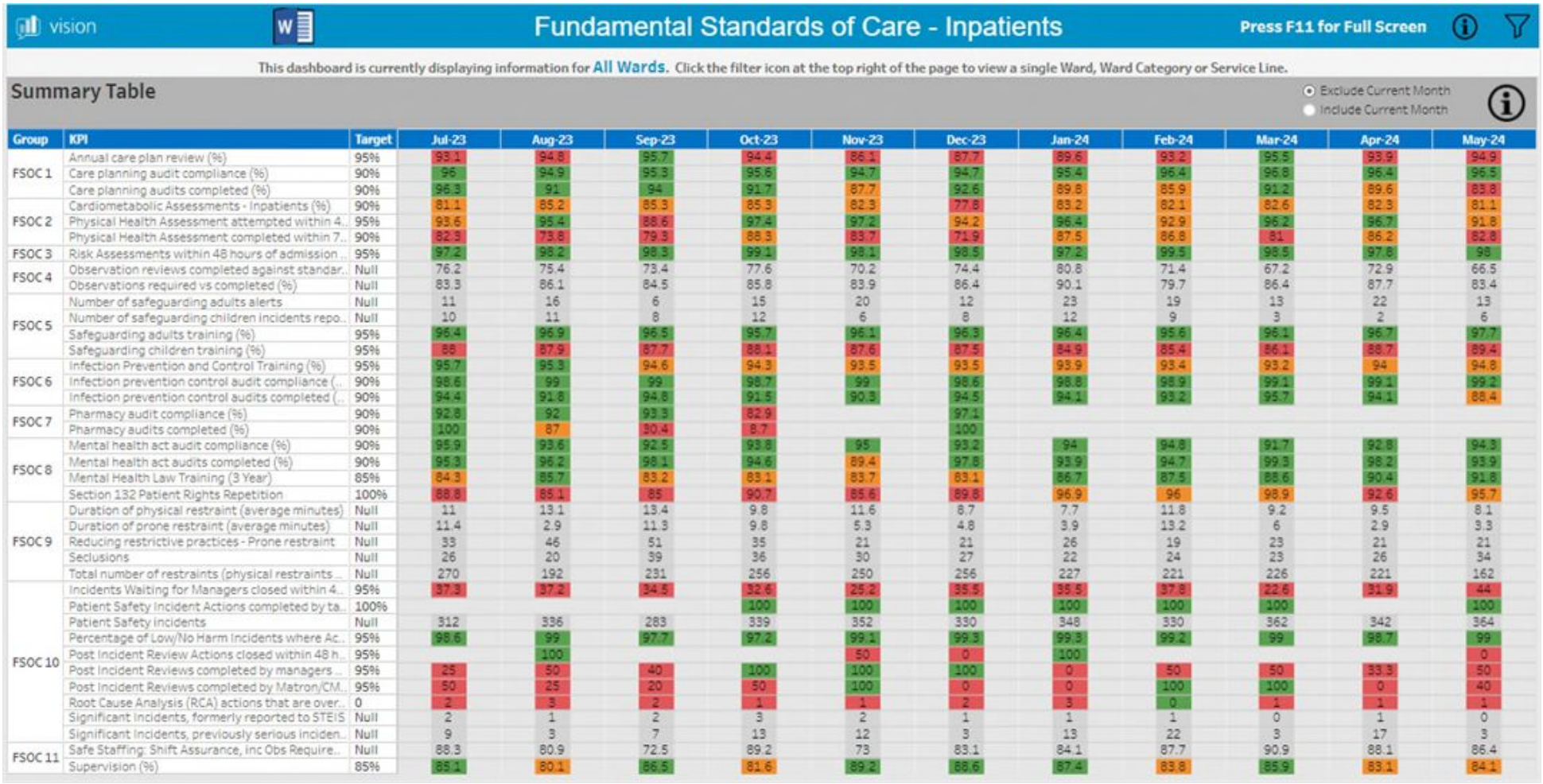
❑ Jasmines ward improvement plan continues to be embedded and improvement and learning is being supported by SL leadership team. CQR for quality check has been brought forward from September 2024. There is oversight of the SIREN around Jasmines ward.

❑ FOS are experiencing high demand in the context of ongoing difficulties with recruitment, staff sickness and IT issues with the service are being investigated. Senior management support in place.

❑ Forensics has two complex patients leading increased observation (care plans are in place) and ongoing concerns regarding the alarm system and a serious incident on Hume ward. The leadership team are working closely with Forensic wards to support them.

❑ Neuropsychiatry; Increased caseload and has new staff settling into roles and long waiting list. Clinical Manager is providing support and plan in place to manage long waiters.

Fundamental Standards of Care - Inpatients



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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

Exclude Current Month
Include Current Month

Group	KPI	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
FSOC 1	Annual care plan review (%)	95%	93.1	94.8	95.7	94.4	86.1	87.7	89.6	93.2	95.5	93.9	94.9
	Care planning audit compliance (%)	90%	96	94.9	95.3	95.6	94.7	94.7	95.4	96.4	96.8	96.4	96.5
	Care planning audits completed (%)	90%	96.3	91	94	91.7	87.7	92.6	89.8	85.9	91.2	89.6	83.8
FSOC 2	Cardiometabolic Assessments - Inpatients (%)	90%	81.1	85.2	85.3	85.3	82.3	77.8	83.2	82.1	82.6	82.3	81.1
	Physical Health Assessment attempted within 4..	95%	93.6	95.4	88.6	97.4	97.2	94.2	96.4	92.9	96.2	96.7	91.8
	Physical Health Assessment completed within 7..	90%	82.9	73.8	79.3	88.3	83.7	71.9	87.5	86.8	81	86.2	82.8
FSOC 3	Risk Assessments within 48 hours of admission ..	95%	97.2	98.2	98.3	99.1	98.1	98.5	97.2	99.5	98.5	97.8	98
FSOC 4	Observation reviews completed against standar..	Null	76.2	75.4	73.4	77.6	70.2	74.4	80.8	71.4	67.2	72.9	66.5
	Observations required vs completed (%)	Null	83.3	86.1	84.5	85.8	83.9	86.4	90.1	79.7	86.4	87.7	83.4
FSOC 5	Number of safeguarding adults alerts	Null	11	16	6	15	20	12	23	19	13	22	13
	Number of safeguarding children incidents repo..	Null	10	11	8	12	6	8	12	9	3	2	6
	Safeguarding adults training (%)	95%	96.4	96.9	96.5	95.7	96.1	96.3	96.4	95.6	96.1	96.7	97.7
	Safeguarding children training (%)	95%	88	87.9	87.7	88.1	87.6	87.5	84.9	85.4	86.1	88.7	89.4
FSOC 6	Infection Prevention and Control Training (%)	95%	95.7	95.3	94.6	94.3	93.5	93.5	93.9	93.4	93.2	94	94.8
	Infection prevention control audit compliance (..	90%	98.6	99	99	98.7	99	98.6	98.8	98.9	99.1	99.1	99.2
	Infection prevention control audits completed (..	90%	94.4	91.8	94.8	91.5	90.3	94.5	94.1	93.2	95.7	94.1	88.4
FSOC 7	Pharmacy audit compliance (%)	90%	92.8	92	93.3	82.9		97.1					
	Pharmacy audits completed (%)	90%	100	87	80.4	8.7		100					
FSOC 8	Mental health act audit compliance (%)	90%	95.9	93.6	92.5	93.8	95	93.2	94	94.8	91.7	92.8	94.3
	Mental health act audits completed (%)	90%	95.3	96.2	98.1	94.6	89.4	97.8	93.9	94.7	99.3	98.2	93.9
	Mental Health Law Training (3 Year)	85%	84.3	85.7	83.2	83.1	83.7	83.1	86.7	87.5	88.6	90.4	91.8
	Section 132 Patient Rights Repetition	100%	88.8	85.1	85	90.7	85.6	89.8	96.9	96	98.9	92.6	95.7
FSOC 9	Duration of physical restraint (average minutes)	Null	11	13.1	13.4	9.8	11.6	8.7	7.7	11.8	9.2	9.5	8.1
	Duration of prone restraint (average minutes)	Null	11.4	2.9	11.3	9.8	5.3	4.8	3.9	13.2	6	2.9	3.3
	Reducing restrictive practices - Prone restraint	Null	33	46	51	35	21	21	26	19	23	21	21
	Seclusions	Null	26	20	39	36	30	27	22	24	23	26	34
	Total number of restraints (physical restraints ..	Null	270	192	231	256	250	256	227	221	226	221	162
FSOC 10	Incidents Waiting for Managers closed within 4..	95%	37.3	37.2	34.5	32.6	25.2	35.5	35.5	37.8	22.6	31.9	44
	Patient Safety Incident Actions completed by ta..	100%				100	100	100	100	100	100		100
	Patient Safety Incidents	Null	312	336	283	339	352	330	348	330	362	342	364
	Percentage of Low/No Harm Incidents where Ac..	95%	98.6	99	97.7	97.2	99.1	99.3	99.3	99.2	99	98.7	99
	Post Incident Review Actions closed within 48 h..	95%		100			50	0	100				0
	Post Incident Reviews completed by managers ..	95%	25	50	40	100	100	100	0	50	50	33.3	50
	Post Incident Reviews completed by Matron/CM..	95%	50	25	20	50	100	0	0	100	100	0	40
	Root Cause Analysis (RCA) actions that are over..	0	2	3	2	1	1	2	3	0	1	1	1
	Significant Incidents, formerly reported to STEIS	Null	2	1	2	3	2	1	1	1	0	1	0
	Significant Incidents, previously serious inciden..	Null	9	3	7	13	12	3	13	22	3	17	3
FSOC 11	Safe Staffing: Shift Assurance, inc Obs Require..	Null	88.3	80.9	72.5	89.2	73	83.1	84.1	87.7	90.9	88.1	86.4
	Supervision (%)	85%	85.1	80.1	86.5	81.6	89.2	88.6	87.4	83.8	85.9	83.1	84.1

FSOC Service Line Feedback – Inpatient: Some improvement in training but care planning, physical health assessment and incident management need further focus.

Acute & Urgent Care:

- ❑ Quarterly KPI meetings have been taking place to go through each standard including care plan audit compliance. Care Plan Training implemented which will be relaunched in June after development of revised training package.
- ❑ FSoC: Compliance for Physical Health Assessment within 7 days is an area for improvement. Clinical Service Leads have communicated importance of physical health care plan completion and ensure staff follow induction checklist. Recent audit has shown improvement in addressing physical health including escalation to Physical Health where appropriate. Position on physical health to be re-audited within next 3 months.
- ❑ Observation audit: Overall improvement on daily reviews however in some ward areas i.e. Ward 2 & Lavender and Lotus further work is required. Clinical Service Lead addressing gaps with wards. Ward 1 has implemented zonal observation in June 2024 in an effort to reduce restrictive interventions and to better engage with patients.
- ❑ Section 132 Reading of Rights performance fluctuates and is an area of continued focus to ensure reading of rights is update to date.
- ❑ Training on safeguarding level 3 remains a challenge (due to availability and release of staff) although it has improved. Managers are being asked to closely monitor. Improvement noted in Mental Health Law Training and Safeguarding Adults.
- ❑ Timeliness of incident management remains a challenge for managers due completing priorities. Matrons are to provide assurance that incidents are discussed/addressed in their Governance meetings and support managers to complete.

CAMHS & Eating Disorders Service Line:

- ❑ Administrative questions on care plan audit leading to false negatives; issue has been raised with Digital Applications Team and currently awaiting resolution.
- ❑ Training: Safeguarding Children level 3 remains a concern although there has been improvement since February 2024. Service line continue to address training gaps and action update now required as part of Supervision.
- ❑ Incident closure by Managers within 48 hours is an area for improvement.

Specialist:

- ❑ Forensic Inpatient teams sustained good progress. Effective fortnightly FSOC review meeting with Ward Managers, Matron and Lead Nurse remains in place with Deputy Ward Managers more involved in the follow-up of any subsequent action plan.
- ❑ Training and incident management are areas for improvement. Service line are closely monitoring and an action plan is in place.
- ❑ On older adults ward, there is weekly follow up with Ward Managers on FSOC. Safeguarding training has been identified as a focus for the inpatient and community within older people's service and also across the across the service line.

Fundamental Standards of Care - 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

Exclude Current Month
Include Current Month

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FSOC 1	Annual care plan review (%)	95%	90.6	91.4	90.2	90.5	90.8	89.2	89.5	90.4	89.9	90.9	91.4
	Care planning audit compliance (%)	90%	80.7	79.9	83.7	80.4	80.8	85.5	83.2	85.3	87.5	89.6	89
	Care planning audits completed (%)	90%	34.5	38.1	35	30.8	30.3	25.5	32.1	36	33.1	35.3	27.6
	Carers of Clients on CPA who have been offered ..	85%	83.2	91.8	88.7	93.9	94.4	94.3	91.3	88.2	89.9	87.6	87.2
	Dialog assessment recorded in the last 6 month..	Null	22.1	23.8	25.1	27.2	33.1	33.4	36.2	36.6	36	36	35.2
	Employment, education and training informatio..	90%	82.6	82.9	80.6	75.8	79.9	73.4	68.4	71.3	73.3	72.6	71.4
	Feedback Offered (%)	90%	82.2	80.6	80	78	83.6	76	76.9	86.4	68.2	74.5	76.5
	Goals Set (%)	90%	82.9	78.7	77.1	71.7	79.1	70.9	76.6	75.6	78.3	72.5	72.9
	Paired Measures (%)	80%	72.9	78.3	67.1	64.4	82.9	62.8	69.4	65.9	63.8	73.2	67.7
FSOC 2	Cardiometabolic Assessments - Community & EI..	75%	83.3	84.8	84.7	84.6	84.1	85.1	84.7	84.6	84.3	83.3	83.4
	Cardiometabolic Assessments - EIS (%)	90%	84.7	82.6	81	81.6	85	88.4	85.3	89.5	92.6	92.8	94.9
FSOC 3	CAMHS IAPTUS patients with an up to date risk ..	95%	80	70.6	74.5	74.3	76.3	81.1	84.9	86.2	85.7	86	85.3
	Community patients with an up to date risk ass..	95%	92.1	92.5	92.5	92.5	91.8	91.1	91	90.7	91.9	92	93.3
	Risk Assessments within 48 hours of admission ..	95%	93.6	93.6	93.4	90.9	94.6	95.4	94.4	94.7	92.3	93.1	91.2
FSOC 5	Number of safeguarding adults alerts	Null	42	50	46	43	42	43	56	40	40	35	38
	Number of safeguarding children incidents repo..	Null	21	25	18	12	27	23	30	28	22	26	14
	Safeguarding adults training (%)	95%	95.8	95.9	95.8	96	94.7	94.6	94.8	94.8	93.4	94.3	93.3
	Safeguarding children training (%)	95%	86.3	86.2	84.7	86	83.9	83.7	82.9	83.5	83.9	84.4	84.6
FSOC 6	Infection Prevention and Control Training (%)	95%	94.4	93.7	93.4	92.5	91.5	90	90	90.1	89.8	90.7	90.8
	Infection prevention control audit compliance (..	90%	100	100	100	100	100	100	100	100	100	100	100
	Infection prevention control audits completed (..	90%	73.3	100	100	100	100	100	50	50	50	100	100
FSOC 7	Pharmacy audit compliance (%)	90%	88					85					
	Pharmacy audits completed (%)	90%	100					94.6					
FSOC 8	Valid Clozapine Prescriptions (%)	Null	97.9	96.3	99	96.9	97.5	95.8	98.9	98.4	93.8	97.9	98.2
	Mental Health Law Training (3 Year)	85%	86.5	88.4	86.5	86.3	86.6	84.7	86.7	87.2	86	87.9	88.9
	Section 132 Patient Rights Repetition	100%	76	79.1	69.1	68.5	79.9	88.2	84.9	87.5	81.8	87.6	73.6
FSOC 10	Incidents Waiting for Managers closed within 4..	95%	25	26.9	23.2	27.9	19	31.1	22.9	26.2	19.9	26.4	28.1
	Patient Safety Incident Actions completed by ta..	100%				100	100	100	100	100	100	100	100
	Patient Safety incidents	Null	104	137	110	142	167	130	158	152	111	111	122
	Percentage of Low/No Harm Incidents where Ac..	95%	91.9	94.9	91.3	92.7	89.7	90.4	89.7	90.8	91.3	93.4	91.6
	Post Incident Review Actions closed within 48 h..	95%					100	72.7	100		100		11.1
	Post Incident Reviews completed by managers ..	95%	87.5	66.7	66.7	70	75	60	42.9	40	71.4	44.4	33.3
	Post Incident Reviews completed by Matron/CM..	95%	58.3	62.5	100	33.3	44.4	20	27.3	62.5	73.9	37.5	0
	Root Cause Analysis (RCA) actions that are over..	0	5	5	4	4	0	1	3	2	0	0	
	Significant Incidents, formerly reported to STEIS	Null	3	0	2	1	0	0	0	0	0	1	0
	Significant Incidents, previously serious inciden..	Null	8	10	16	12	17	11	11	13	8	14	10
FSOC 11	Supervision (%)	85%	85	81.5	84.5	84.1	85.7	79.3	81.4	81.9	79.6	80	78.9

FSOC Service Line Feedback – Community: Overall the Community FSOC standards are of concern and improvements are being prioritised with teams.

Acute & Urgent Care:

- There has been steady improvement in meeting the set standards, training on safeguarding remains as a challenge. Managers are unable to book their staff to attend these training due to course availability but at the same time managers are being asked to closely monitor DNA's. SL continues to oversee FSOC closely with teams.
- An increased number of incidents not closed by managers within 48 hours mostly in liaison services. Clinical Service Leads are working with Team Managers to review FSoC Dashboards on a monthly basis and overseen by Deputy Head of Nursing and Matrons on quarterly basis.
- Supervision: There has been a significant deterioration in supervision in community teams. Team with outstanding supervision have been asked to prioritized and this will be overseen by Clinical Service Leads/Matrons.

Community:

Immediate:

- Key drivers for FSOC performance are inconsistent compliance with processes of documentation (e.g. risk assessment recorded in progress notes rather than on Rio forms) and staff vacancies in key roles (band 6 care coordinator, team manager and medical posts, including leadership roles such as ACD); and challenges with the Always Ready app for Community teams.
- Improvements have been seen in Merton on quality and safety.
- Community QGG key focus on FSOC for the next 3 months key areas are improving quality of risk assessments, crisis plans and care planning.
- Quartet, Community QGG and Team Leader Development Days have been used to undertake benchmarking discussions following the CQC findings in Nottinghamshire.
- The service line requires focus on Supervision. It is suspected that supervisions are taking place but not being recorded on the Supervision app. Improvement is expected May/June'24.

Medium term (may +):

- CSLs will work with Team Managers to audit 10 care plans, risk assessments and crisis plans per month for each IRH within their borough.
- Audits for care plans and crisis plans have been developed and manual audits commenced in May 2024. Service line has met with digital leads to develop a solution that is based on the Always Ready App to implement audit, focus group being arranged and new app in development.
- Physical health: 2 day physical health/ABLS practical training being led by Community physical health nurse lead for nurses and AHPs. Holistic hubs being rolled out across the service line to support the Physical health of our patients. QII project underway to support an improvement in our CMA compliance across EIS.
- 6+ leads per borough have been trained in CCST and will be providing bespoke risk training to staff across community from June 2024.

Improving practice:

- A new crisis plan SOP has developed and implemented.
- Community Strategic Review key priorities on delivering improvements on quality across the community with project plan developed around co-production with staff, carers and people with lived experience to enable engagement through quality improvements.

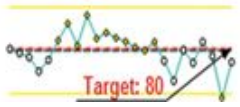
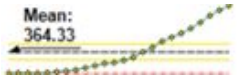
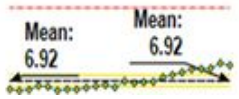
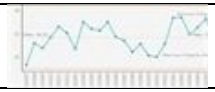
CAMHS & ED:

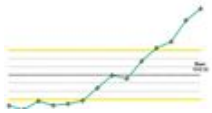
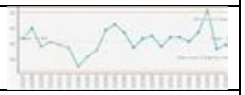
- Care plan audit compliance below target - this is being promoted and regularly discussed at the Community Cluster QGG. Reminders are sent to the teams. A working group is also in place who are developing a care planning audit tool.
- Risk assessments in IAPTUS are actively promoted and monitored. Improvement noted (although starting to plateau).
- Always ready audit compliance is breaching due to administrative questions "do you wish to opt out of this audit" and "are the RIO numbers provided correct" incorrectly flagging as a breach. Raised with App Dev awaiting resolution.
- Safeguarding children's training breaching, new starters gathering evidence and making use of compass resources for completion. Service line developing in house Safeguarding level 3 Training event to support improving position.
- Deaf CAMHS services- Improvement in training required. Matron is monitoring and plan in place for Safeguarding level 3 as above.

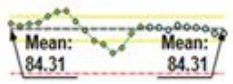
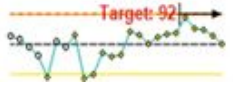
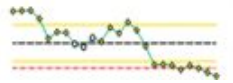
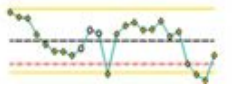
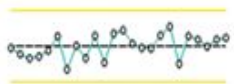
Specialist:

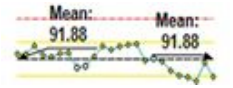
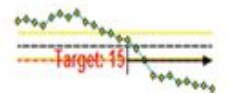
- CMHA and NDD are undertaking focused work on crisis / contingency plans to support compliance in care planning. Training levels are a concern in NDD/LD services and are a focus for the team leaders. Training levels are also a concern within NDD and an area of focus for the Team Leaders and Clinical Manager.
- Adult specialist (OCD/BDD, Neuropsychiatry and Deaf Community): Maintain steady position with weekly monitoring and FSOC review meeting in place. Action plan for training breaches also completed and being monitored by Clinical manager and clinical lead.
- FOS/Support plus areas for improvement are care plan audit completion. Good monitoring is in place though work needs to be done around covering this during annual leave and particularly acute periods as numbers are low. There have been improvements in risk assessment and 132 rights with good oversight.

Priority Metrics

	Priority Metrics	May-24	Target	Trend	Assurance*	SPC Chart
Operations	Adult and Older People's CMHTs – Non-urgent Referrals assessed within 28 days (%) (see page 16)	77.2	≥ 80.0	→	?	
	Access					
	Referral to treatment (RTT): 52 week breaches (see page 17)	1161	= 0	↗	X	
	Access					
	Access to Children and Young People's Mental Health Services (see page 19)	-	-	-	-	-
	Access					
	Perinatal: women accessing specialist PMH services as a proportion of births (see page 20)	7.6	≥ 10.0	↗	X	
	Access					
	CAMHS - Non-Urgent referrals assessed within 8 weeks (%) (see page 21)	67	≥ 80.0	→	?	
	Access					
	% Adult Acute LOS > 60 Days (see page 22)	38	-	-	-	
	Flow					
	Inappropriate out of area placement bed days - Adult Acute & PICU (see page 23)	385	≤ 0	→	X	
	Flow					

	Priority Metrics	May-24	Target	Trend	Assurance*	SPC Chart
Operations	Liaison psychiatry - People waiting over 12 hours in A&E for a bed (See page 17)	54	= 0	↗	X	
	Access					
	Expected population need Talking Therapies – Trust (see page for service breakdown 18)	2275	>=2032	↗	-	
	Access					
	Number of adults and older adults receiving 2+ contacts in new integrated model across the core and dedicated service provision (see page 19)	11801	-	↗	-	
	Access					
	CAMHS Eating Disorders - Non-Urgent referrals who begin treatment within 4 weeks (%) (see page 20)	100	≥ 95.0	↗	?	
	Access					
	Dementia diagnosis within 6 weeks of referral to a memory assessment service (%) (see page 21)	89.3	>= 85	→	?	
	Access					
	% Older Adults LOS > 90 Days (see page 22)	29.4	-	-	-	
	Flow					
	Delayed Transfer of Care (see page 23)	14.3	<= 2.5	↗	X	
	Flow					

	Priority Metrics	May-24	Target	Trend	Assurance*	SPC Chart
Quality	Cardiometabolic Assessments - Community and EIS (%) (see page 24) **Fundamental Standards of Care**	83.4	≥ 75.0	→	✓	
Quality	Patient Friends and Family Test (%) (see page 25) **Patient Experience and Outcomes**	85	≥ 92.0	↗	✗	
Quality	Death - Suspected suicide (see page 27) **Patient Safety**	4	-	→	-	
Workforce	Vacancy Rate (%) (see page 28) **Recruitment/ Attraction**	14.3	≤ 15	↘	?	
Workforce	Female senior staff (%) (see page 29) **Staff Skills/Development**	69.2%	-	-	-	-
Workforce	Statutory and Mandatory Training: 2 (%) (see page 30) **Staff Skills/ Development**	86	≥ 85.0	↘	?	
Workforce	Staff Sickness Rate (see page 32) **Staff Retention/ Support / Satisfaction**	4.1	<= 3.5	↗	✗	
Finance	% Forecast Overspend (See Page 33) **Grip & Control**	0	≤ 0	↘	?	
Finance	Activity vs WTE (Budgeted) (See Page 34) **Productivity**	20.8	-	→	-	

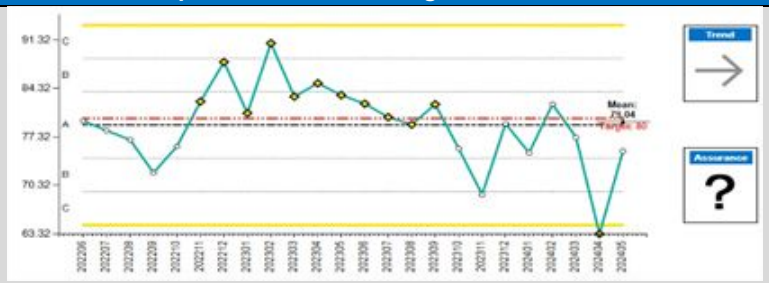
	Priority Metrics	May-24	Target	Trend	Assurance*	SPC Chart
Quality	Safe Staffing: National Compliance - Inpatients (%) (see page 24) **Fundamental Standards of Care**	138.9	≥ 95.0	↗	✓	
Quality	Talking Therapies recovery rate – Trust (%) (see page 26) **Patient Experience and Outcomes**	52.4	>= 50	→	?	
Workforce	Percentage of BAME staff - Band 8+ and Medical (see page 29) **Recruitment/ Attraction**	32.4	≥ 50.0	↗	✗	
Workforce	Statutory and Mandatory Training: 1 (%) (see page 30) **Staff Skills/ Development**	90.5	≥ 95.0	↘	✗	
Workforce	Turnover (%) (see page 31) **Staff Retention/ Support / Satisfaction**	12.9	≤ 15	↘	✓	
Finance	Agency spend as % to NHSE target (See Page 33) **Grip & Control**	161	<= 100	↗	?	

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

Operations Domain

Access

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



Team Breakdown (Services below target only) – May 2024

Team	Assessed Within 28 Days	Assessments	% Assessed Within 28 Days
Twickenham IRH	11	14	78.6%
Merton SPA - PCLS	97	124	78.2%
South Kingston IRH	5	7	71.4%
Mitcham IRH	8	12	66.7%
North Kingston IRH	8	12	66.7%
Sutton Primary Care Recovery Team	2	3	66.7%
North East Wandsworth IRH	4	6	66.7%
Richmond OP RST	11	17	64.7%
Wandsworth SPA	134	210	63.8%
Carshalton and Wallington IRH	4	7	57.1%
Central Wandsworth & West Battersea IRH	7	17	41.2%
Wimbledon IRH	1	4	25.0%
Trust Total	**588**	**762**	**77.2%**

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 just below target; there has been greater level of variation recent with 7 of last 8 months below target.

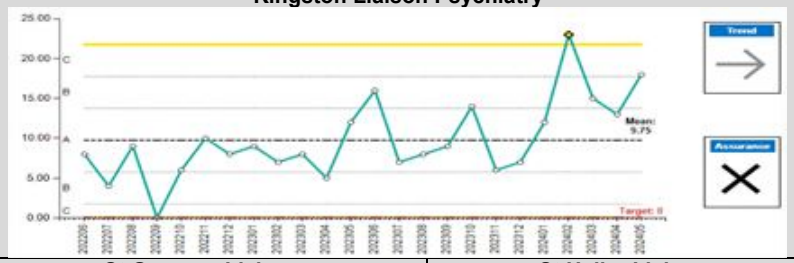
Underlying issues
- Staff compliance with process: assessment appointments are not always outcomed on Rio in a timely fashion.
- Staffing: Medical staffing challenges contributing to reduced medical appointments across SPA teams. High caseloads for doctors reducing capacity for offering new patient assessments. Challenges in recruiting sufficiently experienced non-medical roles into SPA teams.
- Processes in Wandsworth SPA: a practice development need is present to address variation in staffing structures and processes in Wandsworth SPA which is contributing to high caseloads and reduced patient flow through to treating teams. This includes patients remaining under WSPA for multiple assessments as routine practice.
- Recording approach for Risk & Needs Triage (new process introduced through Transformation) is not stopping the clock for a SPA assessment (i.e. an assessment, assessment and treatment or review appointment are required to stop the clock). Use of the Triage outcome is in line with current Rio Contact Recording guidance, but we need to re-visit whether it meets requirements for an assessment to be recorded.
- Integrated Recovery Hub (IRH) delays are often linked to delays carried over from the SPA.

Actions:
- Staffing levels have improved in Wandsworth SPA and successful appointment of SPA Consultant. Locum staff in place to cover workforce gaps in Wandsworth and are addressing backlog. An action plan is in development led by the Clinical Manager with service line leadership support.
- Sutton SPA- bank staff working out of hours to manage triage assessments.
- Speciality Locum doctor contract agreed for Richmond.
- Patients in Merton SPA now directly booked into appt assessment slots.
- ACPs, NMP and Pharmacists to continue to assist with assessments in all boroughs.
- Skill mix and workforce plan to assist in reducing doctors caseloads to free up more slots for assessment.

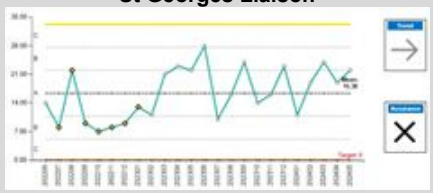
Access

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

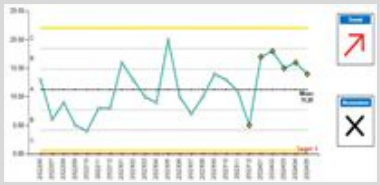
Kingston Liaison Psychiatry



St Georges Liaison



St Helier Liaison



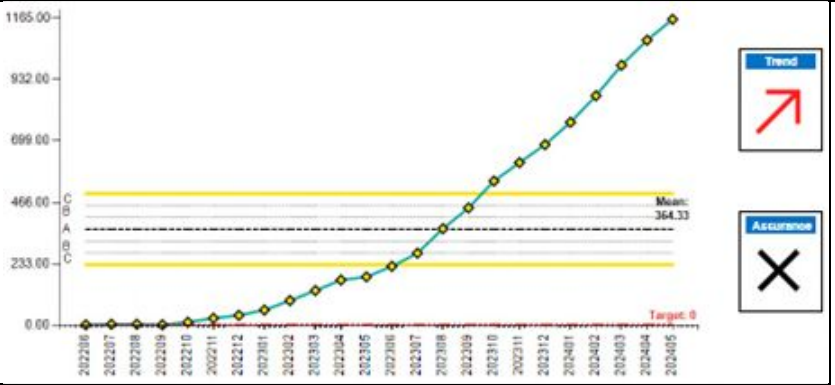
Background
Patients assessed at A&E by Liaison Psychiatry should not experience long waiting times if access to a bed is required.

What the charts tells us
The level of 12-hour breaches is increasing 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.

Actions
- Matron and CSL meeting with Associate Director of Transformation to discuss review method of providing assurance that patients are being reviewed at least once a day. Diary contact assurance is not reliable.
- Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds.
- New contract with Holybourne 30 beds commencing on 1 December 2023 for a year to December 2024. This means the block has increased from 18 – 30 beds.
- Length of Stay Improvement work being carried out by the Service Line and governed under the Programme Board Agenda and ongoing.
- Continue system meeting with acute hospitals and surge to prioritize patients across ED's for beds.
- The Trust is part of the SWL ICB Task & Finish Group which is looking at Mental Health in ED challenges and work out best options to support system pressure, flow and impact on existing resources.
- Business As Usual Digital project: Service Improvement lead setting dates for move to 'RiO Clinic' Model for better oversight of patients on Liaison caseload.

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



52 Week Breaches – May 2024

Team	52 Week Breaches	Max wait	Min wait
Sutton Adult ADHD Service	478	110	53
Richmond Adult ADHD Service	338	106	53
Merton Adult ADHD Service	317	104	53
Kingston CAMHS Tier 3	9	62	53
Merton CAMHS Tier 3	6	87	61
Adult Eating Disorders	5	72	53
Sutton CAMHS Tier 3	3	81	62
Wandsworth CAMHS Tier 3	2	64	61
Sutton CAMHS Referral	1	63	63
Richmond CAMHS Tier 3	1	55	55
Kingston CAMHS Referral	1	74	74

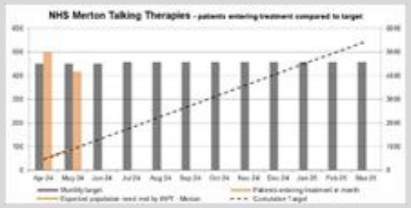
What the chart tells us:
Historic performance consistently met target; however recent months have seen significant increase in 52 week breaches with performance above upper control limit in last 7 months; a change in process is required.

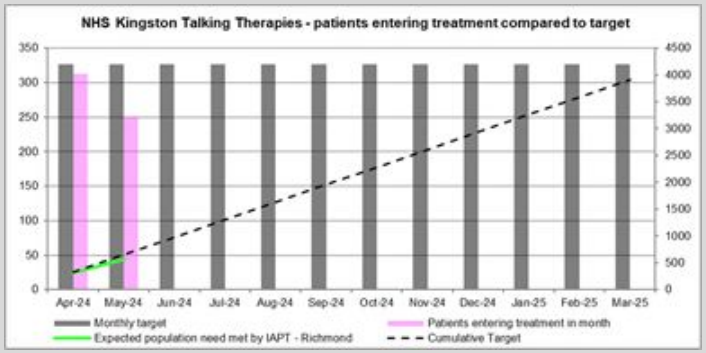
Underlying issues:
- Adult ADHD: There are known demand and capacity issues within adult ADHD services and there is a continued risk of further increase in 52 week breaches. Attempts to develop a locally Commissioned/Enhanced Service with GPs for shared care has not progressed and therefore the requirement of the ADHD service to offer annual specialist reviews (ASR) to patients treated with ADHD medication impacts the capacity of the service see new patients. The high conversion rate exacerbates the demand and capacity imbalance.
- CAMHS Tier 3: Most Breaches were linked to waits for ADHD medication commencement.
- Adult Eating Disorders service currently has 5 breaches - all patients are regularly reviewed whilst on therapy waitlist.
- CAMHS Complex Learning: One breach linked to demand and capacity issues.

Actions:
- Adult ADHD: An ICB led Task and Finish Group with SWLSTG and Primary Care representation commenced in July 23 has now concluded and a draft service specification for primary care was presented to ICB SMT in November 2023. Alternative models (that do not require GPs providing an enhanced service) are being considered, led by SWLSTG and ICB medical directors. No agreement has been reached regarding the discharge pathway.
- There remain patients at the top of the RTT waiting lists (90 weeks +) that require initiation of medication. These patients will remain on the waiting list in line with recent pharmacy guidance which stipulates service should not initiate medication for new patients unless they are high risk.
- Non-medical Prescribers have been recruited and are now operational supporting patient reviews and assessment.
- **CAMHS:** There is continued ADHD medication backlog clearance via Non Medical Prescriber Nurse in Kingston and Richmond.
- CAMHS exploring efficiencies in neuropathway including digitising of Connor's forms for ADHD screening.
- **Adult Eating Disorders (AED):** Pathway and process review being undertaken with clinical lead and ACD in order to maximise use of resource for treatment.
- New treatment groups (MANTRA) will now accept patients as patients drop out. Team exploring the same option for CBT/DBT group.
-

Expected population need met by Talking Therapies (numbers entering treatment)

Access





Background
Talking Therapies 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 local contract area.

What the chart tells us:
Four out of five Talking Therapies services are above their cumulative access requirements for 24/25. Kingston Talking Therapies is a new service for the Trust and access targets need confirmation.

Underlying issue:
- There is insufficient resource in Wandsworth, Merton, and Sutton and therefore meeting access requirements whilst maintaining (already long) stable waiting times, and achieving recovery rates, continues to be an ongoing challenge.
- Kingston Talking Therapies has come online for 24/25 target for service to be confirmed.

Actions:
- iPlato (3rd party provider) has proven to be very successful in increasing the numbers of referrals to achieve access (marketing).
- Service managers are monitoring referral numbers on a daily basis, and ensuring there are sufficient assessment slots available to meet access targets.
- Bookings are being closely monitored to ensure all assessment appointments are fully utilised and there is no wastage.
- Service managers are monitoring service capacity to ensure that clinicians are adhering to job plans.
- Excess referrals are being sent to sub providers (as these count towards our access), meaning talking therapies services can go above their capacity ceiling (at a cost)

Access to Children and Young People's Mental Health Services

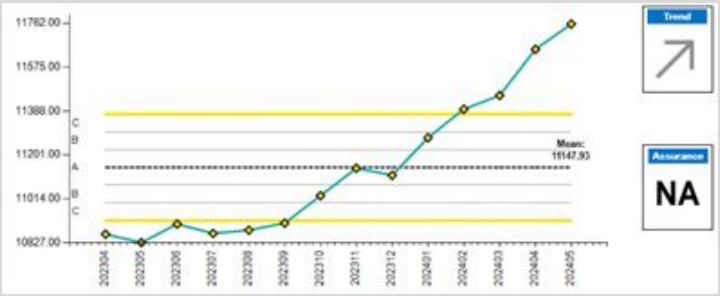
Access

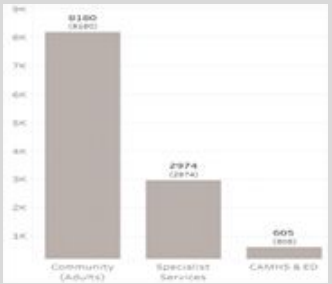
Background
A key operational priority for the NHS in 24/25 is improving access to mental health services so that children and young people receive the treatment they need.

Metric new for 24/25 and In development.

Number of adults and older adults receiving 2+ contacts in new integrated model across the core and dedicated service provision — No Target

Access





Background
A key operational priority for the NHS in 24/25 is improving access to mental health services so that adults and older people receive the treatment they need.

What the chart tells us the chart tells us
There is an upward trend number of adults and older people patients receiving 2+ contacts within the rolling 12 month period.

Underlying issue
- This measure aligns with the LTP ambition for increasing access to adult community MH services. The figures show a rolling 12 months, as per the national definition. The metric includes all services included in the national definition (MHS108).

Actions:
- Job planning and productivity focus to increase direct clinical care - job plans implemented for all clinical roles with activity tracked through supervision dashboard.
- Activity recording for VCSE peer support - discussions with VCSE partners in Q4 23/24 to adopt MHSDS reporting which is expected to drive a step change in contacts delivered.
- Specialist: This is a new KPI. It is anticipated that with the progression of the older adult transformation work - there will be increased access to services and increased activity for patients (upward trend send in CMHTs).
- Older People's Services: It is anticipated that with the progression of the older adult transformation work - there will be increased access to services and increased activity for patients (upward trend send in CMHTs)
- Trust: A KPI definition has been developed to support reporting and provide additional guidance.

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	202307	202308	202309	202310	202311	202312	202401	202402	202403	202404	202405
Women accessing PMH services *	1,065	1,072	1,075	1,104	1,119	1,137	1,156	1,159	1,163	1,197	1,182
Estimated births	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595	15,595
Nationally Published Figures: Service use per birth (ONS)	**6.8**	**6.9**	**6.9**	**7.1**	**7.2**	**7.3**	**7.4**	**7.4**	**7.5**	**7.7**	**7.6**
Service use per birth (For Context Only)	*8*	*8.1*	*8.1*	*8.3*	*8.4*	*8.6*	*8.7*	*8.7*	*8.8*	*9*	*8.9*

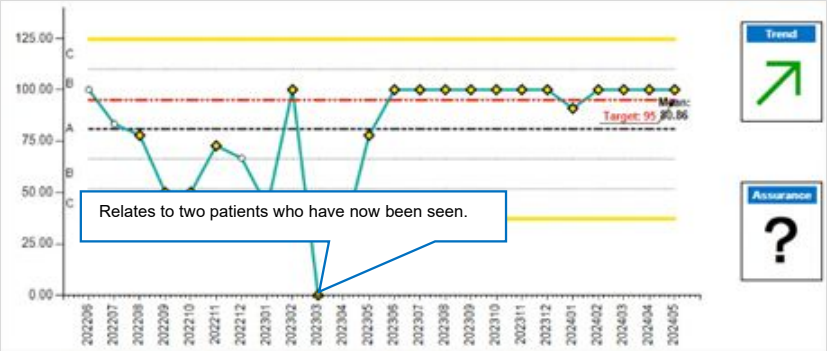
Background
Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of new and expectant mums and covers a wide range of conditions. The NHS Long Term Plan is for improved access to perinatal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

What the chart tells us
Although a slight upward trend is observed mean performance is below national requirement.

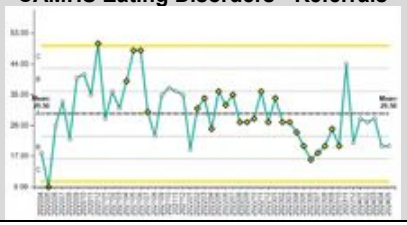
Underlying issue
- National target is based on predicted birth rate (2016 census data) which is higher than the actual local birth rate in 2022.
- Number of referrals received progressing to assessment is too low in order to reach access requirements of 10% of PMH population.
- High DNA rate.

Actions
- Ongoing development of Perinatal Trauma and Loss Service with review of additional capacity and impact on access. Service has now been rolled out across the three South West London.
- Peer Support Worker posts to be recruited into in October/November, with focus of roles on DNA project.
- Pilot for the Pre-conception Consultation Clinics are progressing well and with a new due to commence in Richmond in February 2024.
- Medical staffing model agreed. As a new post Royal College Psychiatry approval is required, job specification has been prepared and submitted.
- Initiation of QI project to address high DNA rates completed. First Plan, Do, Study Act (PDSA) cycle started in April 2024.

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



CAMHS Eating Disorders - Referrals



Waiting for Treatment Summary May - 2024

		00 - 01	01 - 02	03 - 04	Total
Waited	Standard	2	2	0	**4**
	Urgent (7days)	4	0	0	**4**
Waiting	Standard	0	1	1	**2**

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

What the chart tells us
Mean performance is below target however in more recent months performance has shown improvement with full compliance in eleven of the last twelve months.

Underlying issue
- The denominator for this KPI is low (n=4) in May 2024, 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
- More robust scrutiny of long waiters from service has led to improvement

Access

CAMHS Tier 3 - Non-Urgent referrals assessed within 8 weeks (%) — Target ≥ 80%

Team Breakdown – May 2024

Team	Assessed Within 8 Weeks	Assessments	% Assessed Within 8 Weeks
Wandsworth CAMHS Tier 3	17	20	85.0%
Sutton CAMHS Tier 3	19	24	79.2%
Merton CAMHS Tier 3	12	20	60.0%
Richmond CAMHS Tier 3	7	12	58.3%
Kingston CAMHS Tier 3	11	22	50.0%
Trust Total	**66**	**98**	67.3%

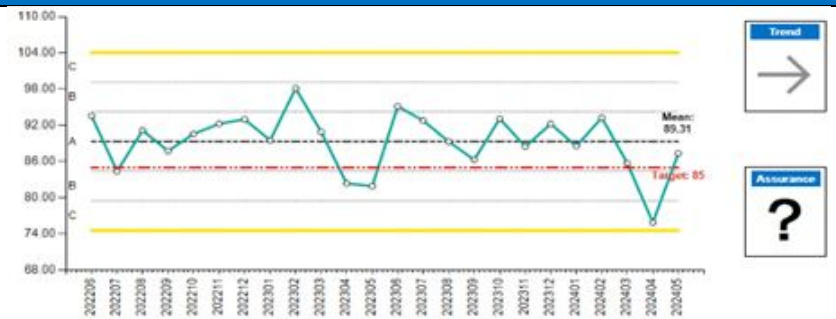
Background
To ensure that young people in need of care have prompt access to CAMHS services when there are concerns for welfare.

What the chart tells us
Mean performance is below target indicating compliance on occasion. Recent months have deteriorated with performance below mean in 4 of last 6 months.

Underlying issue
- Most breaches relate to waits for ADHD medication in community CAMHS i.e. 25 out of 32 in May 2024. 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.
- 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.

Actions:
- Non-medical Prescriber (NMP) and GP with special interest in ADHD are increasing assessment activity for long-term ADHD medication waiters (will continue to breach 8 week until backlog is cleared).
- Continue to recruit to T3 following investment to increase choice assessment resource.
- Seek solutions to supporting psychiatry related functions across community CAMHS (E.g. more Non-medical Prescriber).
- Pilot of GP Prescriber for ADHD medication in Richmond CAMHS Tier 3 to extend to Kingston CAMHS Tier 3 and Preceptorship ADHD nurse development to commence May 2024.
- Longer term plan to embed a preceptorship NMP role across all community CAMHS T3 teams.

Dementia diagnosis within 6 weeks of referral to a memory assessment service (%) — Target ≥ 85%



Team Breakdown – May 2024

Row Labels	Diagnosed within 6 weeks	Diagnosis required	%
Kingston Memory Service	6	8	75.0%
Memory Assessment Service Wandsworth	25	29	86.2%
Merton Memory Assessment Service	9	10	90.0%
Richmond Memory Assessment Service	19	23	82.6%
Sutton Memory Assessment Service	17	17	100.0%
Grand total	76	87	87.4%

What the chart tells us
Mean performance is comfortably above target indicating frequent compliance with occasional variation.

Underlying issue
- 11 breaches reported in May 2024
- Kingston and Richmond MAS below target in May 2024.
- Richmond MAS - patients cancellation lead to delay.
- Kingston MAS - contributory factors include: unplanned emergency leave by clinician and impact of appointments being rescheduled due to Tolworth hospital construction works.

Actions
- **Trust:** Work with local commissioners to increase referral activity where DDR rate is low- e.g. Kingston.
- Continued monitoring and additional support for teams where needed.

Adult Acute LOS > 60 Days (%)

Flow

Background:

New metric for 24/25 and will be fully reported in next month's report i.e. June 2024.

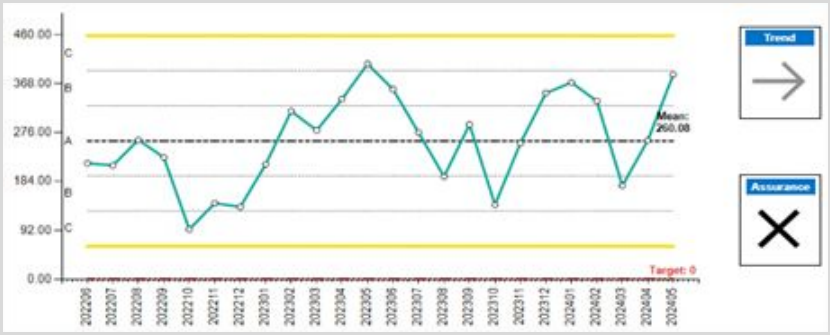
Older adult LoS > 90 days (%)

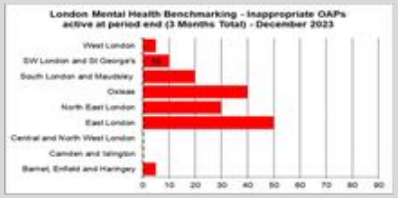
Flow

Metric new for 24/25 and will be fully reported on in next month's report i.e. June 2024.

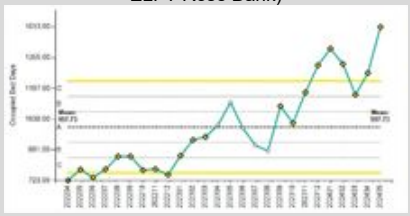
Inappropriate Out of area placement bed days - Adult Acute & PICU — Target = 0

Flow





Non Trust Bed Usage (inclusive Holybourne & ELFT Rose Bank)



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. 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.

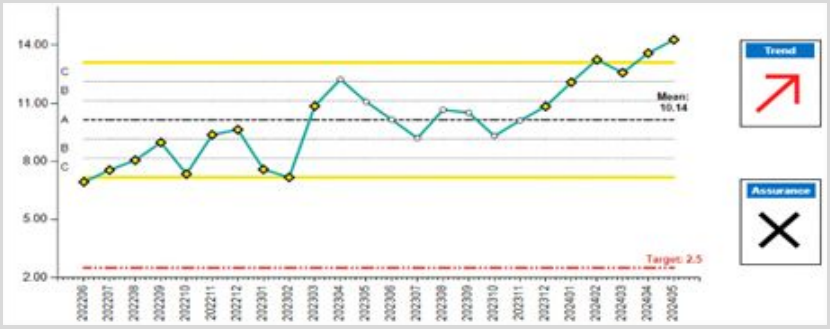
What the chart tells us
The levels of out of areas placements is subject to variation aligned to demand for beds (i.e. adult acute beds).

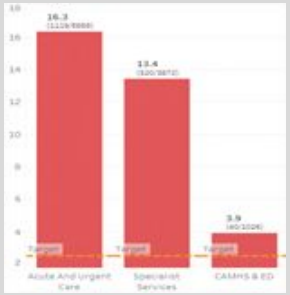
Underlying issue
- Performance is related to the demand for adult acute and PICU beds. High and continual occupancy rates that exceed 95% inevitably lead to the use of out of area beds at times of peak demand.
- DTOC patients impacting on flow and ability to create capacity despite block contract for 30 beds with Holybourne Hospital.
- Continued high demand across the crisis pathway and wider system; Ward 1 was closed to admissions for period in April 2024.

Actions
- New contract with Holybourne 30 beds commenced on 1 December 2023 for a year to December 2024.
- The number of inappropriate OAP bed days has reduced significantly due to the Trust consolidating its private bed usage to an in-area provider to enable better quality and flow oversight of patients outside trust beds.
- Trust has opened surge beds to help manage peak demand and keep placements to a minimum. 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 have commenced and implementation plan is in place.
- Monthly review of patients with LOS over 90 days undertaken by Associate Clinical Director and Head of Service Delivery.

Delayed Transfer of Care — Target ≤ 2.5%

Flow





Background:
A delayed transfer of care (DTOC) occurs when an inpatient 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.

What Chart Tells Us:
A sustained deterioration in performance, routinely above the target and significantly higher than historic levels. Two of last three months have above the upper control limit (special cause variation).

Underlying Issues:
- 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.
- Inconsistent engagement by community-based services with planning for discharge.

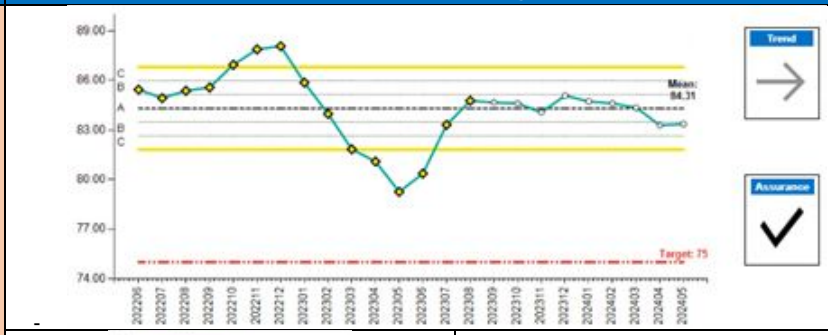
Actions:
- Escalation processes involving local authorities & CCG's is in place.
- Continued use of step down beds and B&B where appropriate to support early discharge.
- System wide escalations for those delayed due to non-trust issues - requires further work to embed robust escalation internally and externally.
- Acute and Urgent care: Monthly meetings with ward Consultants and Team Managers to review ward caseload and support with discharge planning of long stay /delayed patients.
- In reach from rehab team to identify patients who can move / might benefit from rehab intervention.
- Mini MADE events being held and revised scheduled to be implemented from February 2024.
- Plan to develop pan borough DToC call and escalation framework (will need local authority engagement).
- Focus on implementation plan and embedding practice from 100 day challenge.
- Continued focus for 90 day plus patients in monthly meetings with Associate Clinical Director and Head of Service Delivery.
- Specialist: Service line developing DToC reporting & escalation process for Rehab /complex care inpatient services.

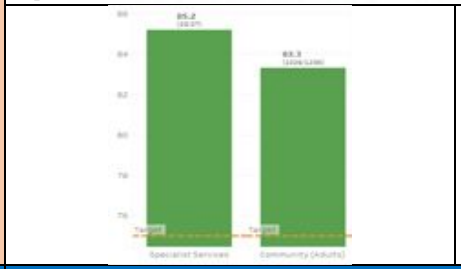
Quality Domain

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:
It is likely that the target will consistently be exceeded.

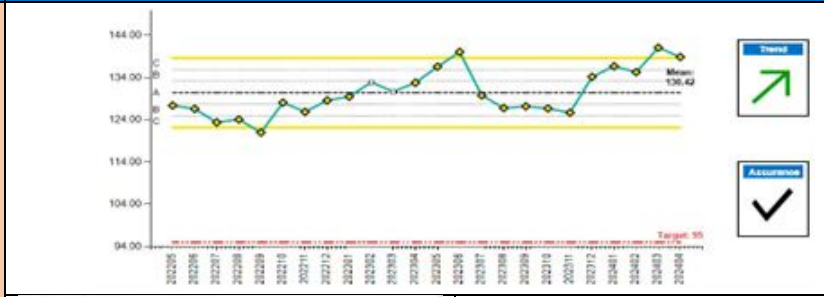
Underlying issue:
- Complex and time-consuming data recording across multiple forms.
- Processes are not routine, and performance tends to improve only when it is prioritised.
- Number of community patients have declined assessments. Attempts made to try and intensively engage patients to attend are not recorded within the system.
- Although this target appears to be met overall. The National Clinical Audit of Psychosis 2023 recorded that all 5 Borough's require a specific focus on physical health screening and interventions. Service line have completed the NCAP audit for 2024 with improvement in Kingston and Richmond EIS. A pre audit was completed for assurance purposed. All EIS teams are now above the 95%.
- Variable use of the Health Information Exchange (HIE).

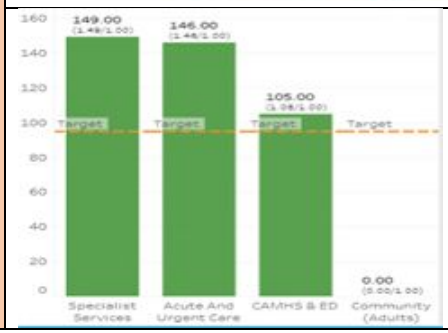
Actions:
- Community: Kingston & Richmond EIS improvement plans reviewed with updated actions. Clinical Manager to lead and embed within the team.
- Teams have access to shared care records that contain supporting information to simplify the data collection process.
- Weekly/twice weekly physical health clinics in all boroughs continue.
- Introduction of Holistic Hubs across all boroughs being rolled out to ensure when receiving one intervention physical health assessments and health promotion is provided as part of the offer/visit.
- Training in physical health being set up and will be offered across teams by Physical Health Advanced Clinical Practitioner.

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.

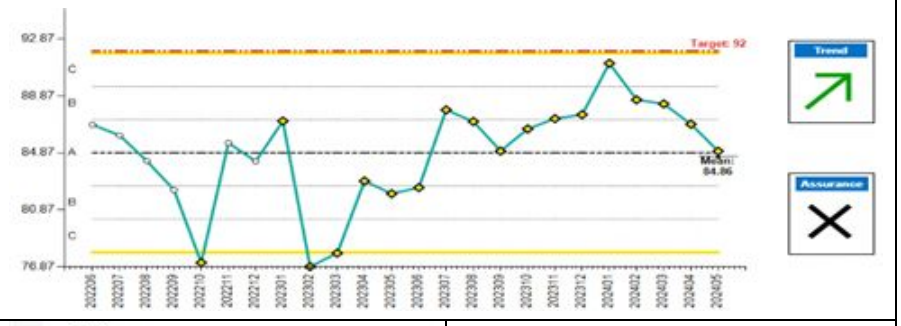
What the chart tells us:
Trust performance is consistently above target which is below lower control limit.

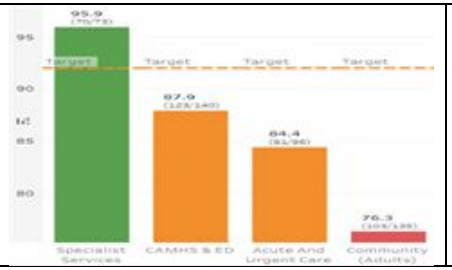
Underlying issue:
- Acute and urgent care: All wards were safely staffed in April 2024. Additional staffing is required to support constant or enhanced observations which is reviewed daily.
- CAMHS & ED: All ward areas were safely staffed; Corner House is minimally staffed due to very low occupancy and some team members are supporting other services. The Trust has also agreed a bespoke provision for a client; both Aquarius and Wisteria send staff to support. This is funded via the SLP.
- Specialist: No issues reported service line consistently exceeds target.

Actions:
- 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.
- Acute & Urgent Care: Continued focus on compliance with the observation and engagement policy to ensure that robust reviews are taking place in line with policy and recorded accurately.
- Weekly audit are completed by Clinical Service Leads on constant and enhanced observation, where complex cases are reviewed around the continuity of maintaining observation.
- The roster meeting is attended monthly by ward managers and CSLs and matrons reviewing roster completion and sign off fully.
- Training has been provided for Ward Managers & Team Leaders on the Fundamental Standards of Care Dashboard.

Patient Experience and Outcomes

Patient Friends and Family Test (%) — Target ≥ 85%





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. Performance in last 10 months has improved with position consistently above the mean although some decrease in recent months.

Underlying issues:

- 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.
- Acute and Urgent Care: Most under performance linked to crisis pathway (who may be less likely to complete questionnaires. Improvement noted in home treatment and perinatal services.
- Specialist Services: Accessibility concerns for the patient friends and family test have been raised to Governance Team especially for older adult.

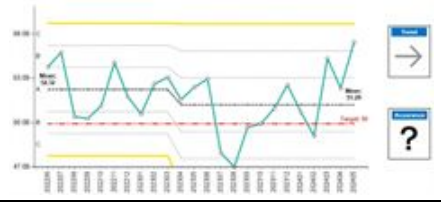
Actions:

- Feedback live has recently been relaunched as a platform for completing Friends and Family Test. First question on system is linked to the Friends and Family Test.
- Promoting use of the FBL QR code for service users and carers (FBL first question is now linked to FFT).
- Ongoing review within Improving Patient Outcomes (IPO) meeting and how we link FBL and FFT together.
- Community Service Line: Awareness and guidance provided to community service line through QGG and Team Leader Development Days, with key focus supporting improvements.
- Acute and Urgent Care: FBL will be an agenda item within Community Meetings to promote service user engagement. QR codes are displayed in ward areas and teams are giving out laminated cards with QR codes.
- CAMHS & ED: Service-related project in progress looking at ESQ response rates from children and families.

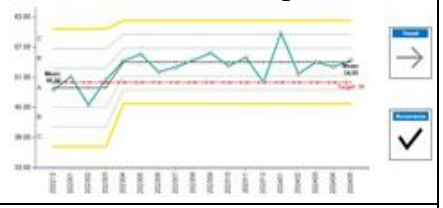
Talking Therapies recovery rate (%) — Target ≥ 50%

Patient Experience and Outcomes

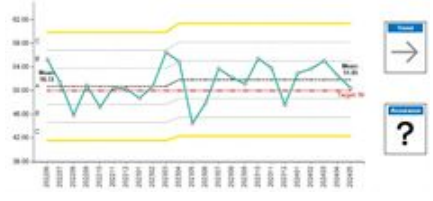
Talk Wandsworth



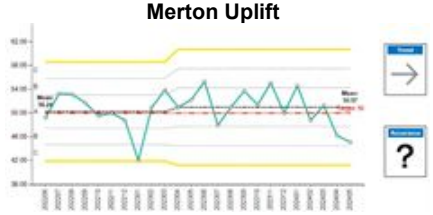
Richmond Well Being Service



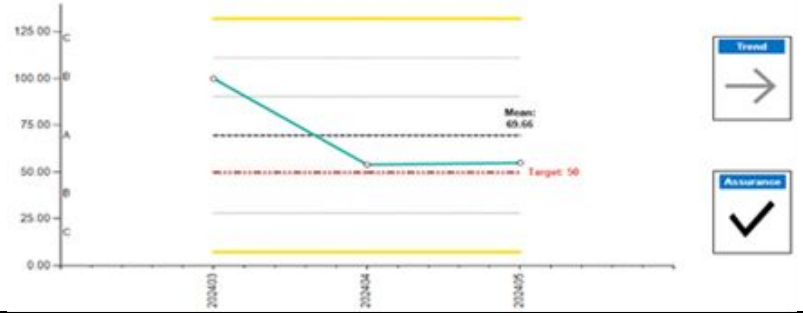
Sutton Uplift



Merton Uplift



Kingston

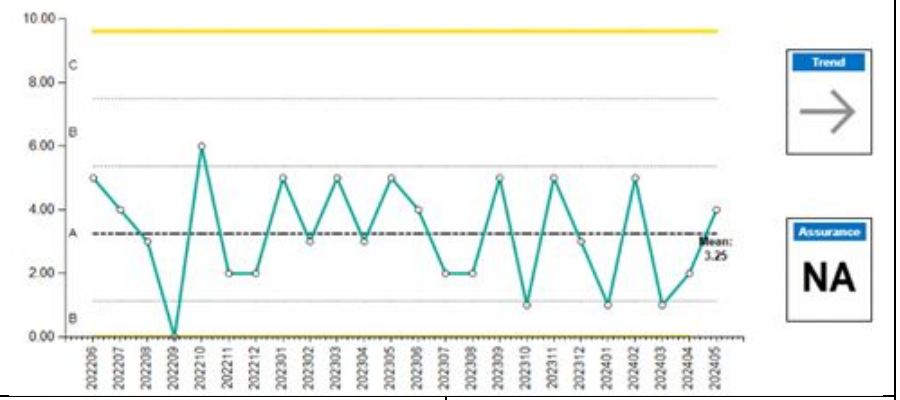
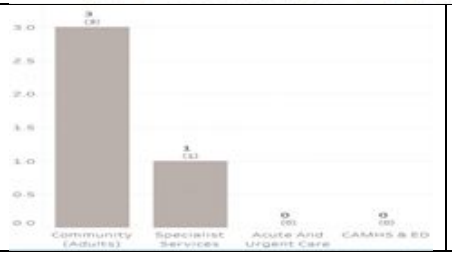


Background
Talking Therapies is an NHS programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety.

What the chart tells us
All Talking Therapies services except Merton are above 50% national target YTD; Monthly variation is expected.

Underlying issues
- Recovery rates are improving since the launch of the cross-borough recovery workgroup this summer.
- Audits indicate recovery deterioration is due to dropouts, and people declining treatment due to waiting times. Poorer recovery is also associated with missing or incorrect diagnostic labels, absence of repeat symptom measures, and lack of fidelity to treatment protocols.

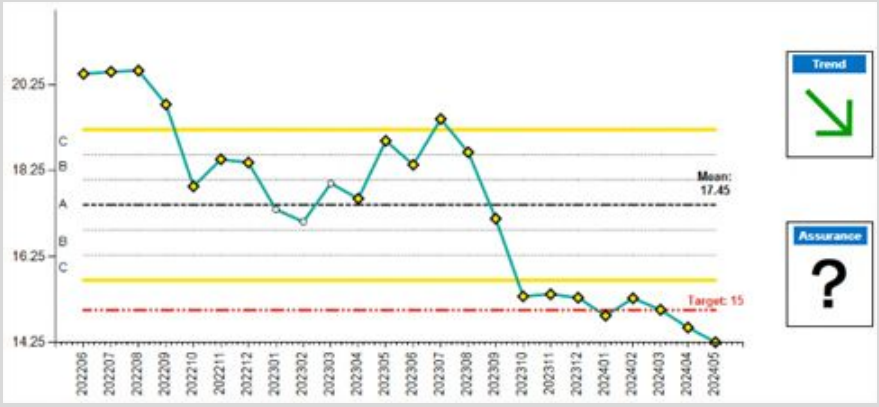
Actions:
- Service clinical leads are completing data quality checks in advance of the monthly recovery audits which then take place each month by 9th. Audit outcomes are investigated, and action plans implemented.
- Individual monthly recovery rates are now being shared with clinicians in supervision.
- The cross-borough recovery workgroup continues to meet monthly.
- Training has been delivered to support clinicians with treatment, focusing on ensuring accurate diagnostic assessment and routine ADSM completion.
- New "feedback call" stage between assessment and being placed on waiting list has been introduced - patients attend a structured treatment planning call to discuss treatment options, and requirements for engagement, to reduce dropout rates.
- Sharing of SilverCloud best practice has happened between services.

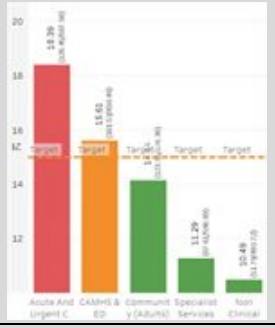
	Death - Suspected suicide	No Target
Patient Safety	 	**What the chart tells us** The number of suicides each month is low with common cause variation. **Underlying Issue:** - There was 4 suspected suicides reported in May 2024. **Actions:** - All such incidents will be subject to a review in line with the Patient Safety Incident Response Framework (PSIRF). - The Trusts Suicide Prevention Strategy is due to be reviewed and the Mortality & Suicide Prevention Group will monitor the content and completion of this. - The Annual NCISH report was reviewed in the Mortality & Suicide Prevention Group and key Clinical Messages will be shared in the monthly learning bulletin. - A one page document has been developed around Thematic Reviews to support those staff who are responsible for undertaking reviews and expectation on sharing these within the Mortality & Suicide Prevention Committee. - Community: Thematic review completed and presented at Mortality Committee with action plan. The service line has set up Special Interest Group in Suicide and Suicide Prevention to be rolled out across 2024 and will also address themes and how to improve risk assessments and practice.

Workforce Domain

Recruitment / Attraction

Vacancy Rate (%) — **Target ≤ 15%**





Benchmarking – NHS Digital Q4 22/23

Trust	%
North East London NHS Foundation Trust	20.9%
West London NHS Trust	17.3%
South West London and St George's Mental Health NHS Trust	17.2%
South London and Maudsley NHS Foundation Trust	16.3%
Oxleas NHS Foundation Trust	14.8%
Central and North West London NHS Foundation Trust	13.5%
Barnet, Enfield And Haringey Mental Health NHS Trust	12.9%
East London NHS Foundation Trust	8.1%
Camden and Islington NHS Foundation Trust	4.1%
London	13.9
National	11.3

Vacancies by Staff Group – May 2024

Staff Group	Post Fte	Assign Fte	Vacant FTE	Vacancy Rate FTE
Add Prof Scientific and Technic	526.7	437.5	89.2	16.9%
Additional Clinical Services	760.5	649.3	111.3	14.6%
Administrative and Clerical	670.0	615.3	54.7	8.2%
Allied Health Professionals	173.8	136.5	37.2	21.4%
Estates and Ancillary	38.0	34.4	3.5	9.2%
Healthcare Scientists	2.0	2.0	0.0	0.0%
Medical and Dental	243.1	216.2	26.9	11.1%
Nursing and Midwifery Registered	920.5	754.9	165.6	18.0%
Grand Total	3,334.5	2,846.1	488.4	14.6%

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, increase demands on existing staff and results in increased use of more expensive agency staff.

What the chart tells us
There is an overall downward trend in vacancy rate. Recent performance has improved and has been consistently below lower control limit for last five months with target being met in the last two months.

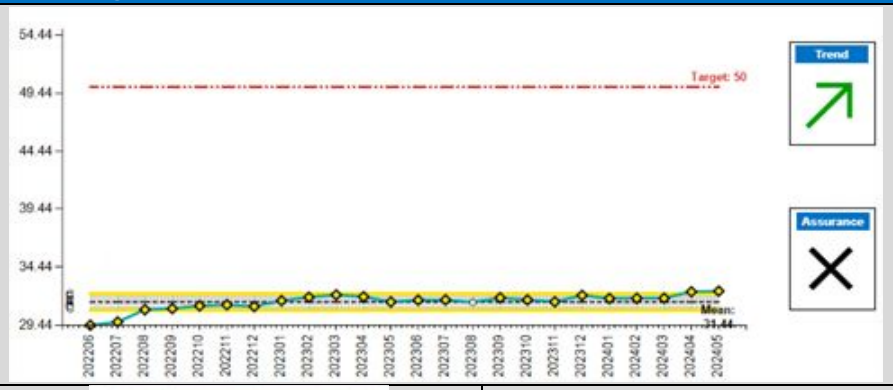
Underlying issue:
- Each Service Line has created a workforce plan to ensure there is a continued focus on recruitment, including bank and agency conversions into vacant positions.
- Even with this positive shift in the number of applicants and recent successes from mass recruitment campaigns there are still some professions which are continually providing difficult to recruit to. These are areas where we will need to think about alternatives in support whilst we carry vacancies to ensure we reduce the pressure for those in the team and retain them.
- Community: Recent increase linked to new posts being added to the establishment.
- Specialist: Roles in NDD require a specialist skill set which reduces the pool of candidates.
- Vacancies exist in teams where by the funding is fixed term making it more challenging to recruit (Post Diagnostic Support Team).

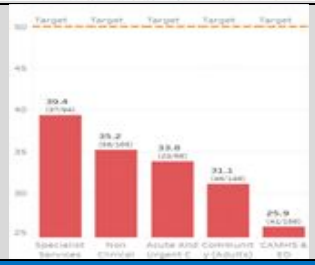
Actions:
- Recruitment Annual Timetable: A detailed recruitment activity timetable for the year is in place and outlines key dates for mass recruitment, recruitment fairs and open days, which has been operationalised via the recruitment delivery group. It focuses on building recruitment opportunities and ensure Trust-wide mass recruitment campaigns are scheduled effectively to meet the organisational need.
- Recruitment Delivery Group: Has been operationalised with stakeholders across the services to ensure detailed planning and approach is planned for each recruitment campaign and input to what might be needed in the future months is highlighted.
- Funds from our Strategic investment funds have been provided to develop some specific initiatives around Community Services; predominantly focused on medical staff.
- The Trust is currently recruiting resources to support Apprenticeships which has also been funded through our strategic investment fund.
- Workforce planning conversations produced a number of initiatives to support recruitment and attraction for each professional group. Focus on building links with universities, flexible working, staff survey, embedding new roles and health & wellbeing. Professional Leads to lead Trust-wide initiatives.
- Community: HRBP continues to work with borough leads to address low % for jobs in active recruitment.
- Review of core skill mix within the RSTs/CMHTs from band 5-7 as part of transformation of community services y2 programme.
- Acute & Urgent Care: Plan for mass recruitment for Nursing Associate to be discussed with Trust wide group on how to progress with recruitment on current vacancies.

Recruitment / Attraction

Percentage of BAME staff - Band 8+ and Medical

Target ≥ 50%





What Chart Tells Us:
Mean position is below target indicating target position seems to have plateaued in recent months following period of improvement.

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:
- Talent Strategy being developed, with a strong lens in terms of career progression and commitment to Black, Asian and Minority Ethnic Groups.
- Reviewing Recruitment & Selection Training for all recruiting managers to be launched in January 2024.
- Further analysis around appointments at senior bands to commence in new year.
- The action plan in response to the WRES is being built this year in partnership with our Evolve network. Our response to how we affect career development is featuring in this plan. The action plan is due to be published in Jan 2023.
- Action plan was agreed in March 2024 training is live now. The Trust is developing and EDI Dashboard for People Committee.
- Human Resources Department have launched training on bias within interviews for recruitment managers commencing in March 2024 to start our focussed work around fair recruitment and improved career development specifically focused at our Black, Asian and minority ethnic staff.
- Community: Borough based CSL's to become the EDI leads for their respective areas.
- CAMHS & ED: The CAMHS 24/25 workforce plan includes an action to increase BAME staff representation at Band 7 and above, through career pathways and DIR reps included on recruitment panels.

% Female Senior Staff

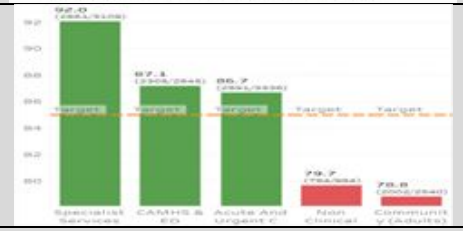
Metric new for 24/25 and In development.

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



Training Compliance Projection – MAST 1

Certificate Name	Actual				Projection			
	Apr-24	May-24	Jun-24		Jul-24	Aug-24	Sep-24	
	%	%	%	Breaches	%	%	%	Breaches
ABLS eLearning for Community and Allied	76.2%	68.8%	69.4%	408	69.1%	66.5%	63.2%	509
Adult Basic Life Support (ABLS)	86.8%	84.9%	84.6%	69	82.6%	77.8%	70.4%	136
Advanced Patient Handling (APH)	85.7%	87.3%	81.4%	102	83.6%	82.9%	81.8%	103
Conflict Resolution and Breakaway	88.9%	91.9%	91.7%	124	83.5%	83.3%	82.0%	316
Equality, Diversity and Human Rights -	98.4%	98.2%	98.3%	50	94.3%	92.5%	90.3%	292
Fire Safety Awareness (Community)	95.5%	96.2%	96.2%	54	92.9%	90.6%	87.7%	182
Fire Safety Awareness (Inpatient)	74.2%	76.7%	76.8%	160	82.9%	81.3%	79.2%	146
Fire Safety Awareness (Non-Clinical)	95.6%	96.0%	95.9%	32	92.0%	89.9%	86.2%	112
Health and Safety General Awareness	97.3%	97.3%	97.2%	80	92.5%	90.0%	88.2%	354
Infection Prevention and Control - Level 1	94.9%	96.6%	96.4%	19	94.5%	94.1%	93.7%	34
Infection Prevention and Control - Level 2	91.7%	91.8%	91.8%	197	81.9%	74.2%	65.1%	865
Information Governance	92.1%	93.8%	93.8%	182	85.0%	77.6%	68.9%	935
Medical Emergency Training (Medics)	55.9%	61.9%	62.4%	44	73.1%	73.1%	73.1%	32
Medical Emergency Training (Nurses)	82.9%	91.0%	90.8%	29	86.6%	83.2%	77.3%	73
Moving and Handling - Level 1		73.6%	74.7%	600	73.7%	73.7%	73.7%	643
Preventing Radicalisation - Awareness of	93.8%	94.2%	93.9%	126	86.4%	83.5%	81.4%	407
Preventing Radicalisation - Basic Prevent	98.0%	98.5%	98.4%	13	96.5%	96.5%	96.5%	29
Safeguarding Adults - Level 1	94.8%	94.5%	94.5%	161	89.4%	86.9%	84.9%	455
Safeguarding Adults - Level 2	95.1%	95.2%	95.1%	104	92.3%	91.1%	90.0%	220
Safeguarding Adults - Level 3	80.5%	81.3%	81.3%	169	71.4%	71.4%	71.4%	305
Safeguarding Children - Level 1	94.9%	95.5%	94.8%	34	91.9%	91.0%	89.6%	70
Safeguarding Children - Level 2	91.8%	92.2%	92.1%	69	88.5%	87.3%	85.4%	136
Safeguarding Children - Level 3	77.3%	77.9%	77.9%	258	76.4%	75.4%	74.8%	317
Safeguarding Children - Level 3 (CAMHS)	83.1%	81.2%	80.7%	57	79.3%	78.0%	77.4%	69
All Certificates (95% Target)	91.6%	90.5%	90.5%	3141	85.9%	83.4%	80.5%	6740

Training Compliance Projection – MAST 2

Certificate Name	Actual				Projection			
	Apr-24	May-24	Jun-24		Jul-24	Aug-24	Sep-24	
	%	%	%	Breaches	%	%	%	Breaches
Care Certificate Programme (CCP)	84.8%	86.2%	85.8%	46	83.7%	83.7%	83.7%	56
Collaborative Clinical Safety Training	65.9%	67.2%	67.5%	468	68.3%	68.0%	68.2%	469
Cyber Security - Stay Safe Online		85.5%	86.1%	402	84.2%	84.2%	84.2%	475
Essentials of Patient Safety - Level 1 (All	77.1%	85.4%	86.2%	371	84.0%	84.0%	84.0%	448
Essentials of Patient Safety - Level 1	60.5%	69.7%	69.7%	60	68.3%	68.3%	68.3%	65
Food Hygiene - Level 2	94.7%	95.3%	95.3%	6	91.7%	90.9%	89.4%	14
Food Hygiene - Level 3	100.0%	100.0%	100.0%	0	100.0%	100.0%	100.0%	0
Medicines Management (Community)	88.5%	87.8%	88.1%	55	81.2%	77.9%	74.9%	120
Medicines Management (Inpatient)	94.8%	96.9%	96.5%	10	91.8%	90.4%	85.7%	42
Mental Health Law	88.7%	89.6%	89.6%	188	88.6%	87.9%	87.3%	240
National Early Warning Score (NEWS) 2	98.8%	98.6%	98.4%	9	96.4%	95.6%	94.7%	31
Observation and Intensive Engagement	99.6%	99.6%	99.2%	4	94.7%	89.4%	82.6%	92
Oliver McGowan Mandatory Training on					38.6%	38.6%	38.6%	1845
Prescribers' Medicines	71.1%	69.6%	69.9%	74	67.3%	64.5%	61.8%	96
Proactive Physical Interventions (PPI)	93.0%	93.7%	93.9%	33	90.1%	90.7%	90.7%	53
Rapid Tranquilisation	96.9%	97.5%	97.5%	14	92.5%	90.7%	89.1%	62
All Certificates (85% Target)	83.2%	86.0%	86.3%	1740	75.7%	75.1%	74.5%	4108

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.

Following review MAST 1 requirements are now aligned with the Core Skills Competency Framework (CSCF), all other mandatory training is MAST 2.

Four new MAST requirements have been added in the past quarter as follows: -

- Cyber Security – recommended from a recent audit and agreed at Audit Committee
- Oliver McGowan Training – all health and care providers registered with the CQC can meet the legislative requirement introduced by the Health & Care Act 2022 to ensure staff receive training on learning disability and autism, appropriate to their roll.
- Patient Safety Training: Essentials of Patient Safety Level 1 will be going live on the MAST dashboards as of 18 April 2024, after a 3 month introductory period which began in January 2024, and is required to be completed by all staff. This is an eLearning package which is completed through Compass, along with additional eLearning required for board members and senior leaders.

These have all be added into MAST 2.

- Moving and Handling Level 1 (MAST1) – CSTF course which is required for all staff.

What the chart tells us

MAST 1: MAST 1 levels remain below target with recent months deteriorating.
MAST 2: Performance for MAST 2 has improved this month and now above target.

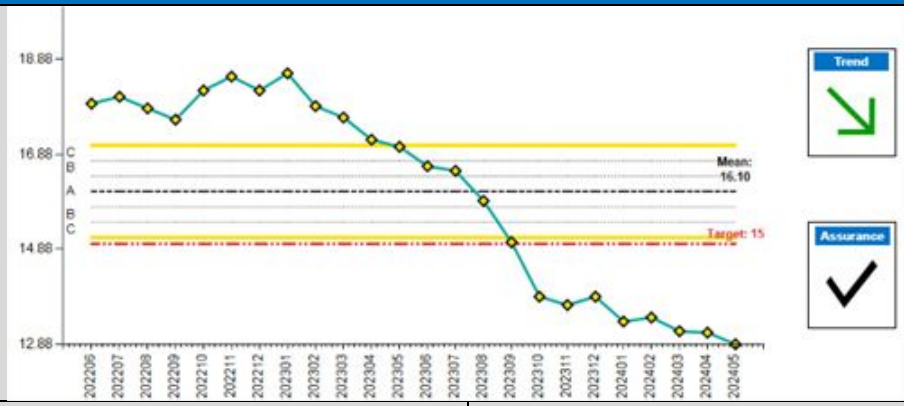
Underlying Issues and mitigations:

- MAST 1 and MAST 2 courses were not being reported on Dashboard against correct categories, a number of courses needed to be re-categorised to ensure correct reporting on dashboard. This work is currently being progressed and we have noticed a reduction in some compliance – which is also linked to the point below.
- The audiences have had to be updated; this is a complex process with subject matter experts Learning & Development, & Informatics working collaboratively to resolve. The process for audience reviews has also been under review, significantly impacting this work.
- Collaborative Clinical Safety Training (CCST) previously (RATE) Training has had high breaches owing to capacity with no available trainers. Service lines have now identified trainers to deliver this training so performance is expected to improve.
- Cyber security as recommended from a recent audit committee commenced reporting from May 2024.
- Work is being undertaken to align all MAST 1 courses with the Core Skills Training Framework (CSTF), once achieved, this should help streamline the verification of training which has previously been completed at other Trusts.
- MAST compliance will be displayed in each staff members' supervision record and will be RAG rated. Supervision App has been updated, the supervisor and supervisee must complete a text input box to agree upon a MAST compliance plan. A direct link to the supervisee's MAST compliance/report has also been added to the app.
- Work is taking place to review the integration of MAST subjects with the Corporate Welcome Day, to help ensure that new staff complete MAST as soon as possible. The next subject to be integrated, is anticipated to be Conflict Resolution Training, but there is ongoing work with the Patient Safety and Physical Health teams to explore further options.

Staff Retention/ Support / Satisfaction

Turnover Rate (%)

Target ≤ 15%



Annual Turnover FTE – February 2023 – February 2024

Organisation name	Leavers	Turnover Rate
Oxleas NHS Foundation Trust	605.5	14.7%
South London and Maudsley NHS Foundation Trust	773.9	14.2%
East London NHS Foundation Trust	939.2	14.1%
North East London NHS Foundation Trust	723.5	11.1%
Barnet, Enfield and Haringey Mental Health NHS Trust	935.8	30.3%
Camden and Islington NHS Foundation Trust	407.6	17.4%
Central and North West London NHS Foundation Trust	1056.8	13.7%
Tavistock and Portman NHS Foundation Trust	114.1	16.9%
West London NHS Trust	563.3	13.3%
South West London and St George's Mental Health NHS Trust	375.1	14.6%
London Average	**649.5**	**16.0%**
National	**552**	**12.6%**

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

Turnover continues on downward trend with last eight months below target and lower.

Underlying issue

- Suggested reasons for leaving is cost of living, career progression however the data from exit interviews is limited (only 197 responses in the past two years).
- Analysis to understand key hot spots, shows that 20% of AHPs are leaving within 12 months and nurses at 18%. HR colleagues are working with professional leads to understand what more can be done to reduce turnover in these areas.
- In last 6 months there have been 39 exit interviews completed. Although a low response rate 38% felt the Trust acted fairly with respect to career and promotion opportunities. 48.6% believe there was something the Trust could have done to make them stay in their current role. Positive feedback received, with 85.7% saying they believe Trust offers opportunities to work flexible. 61.1% believe they have been able to make improvements in their team and department. The top 3 reasons for leaving were 1) lack of training and development and opportunities for career progression 2) promotion 3) retirement.
- Increased support to develop our managers is key knowing that often individuals experience at work is how they are managed by their line manager.

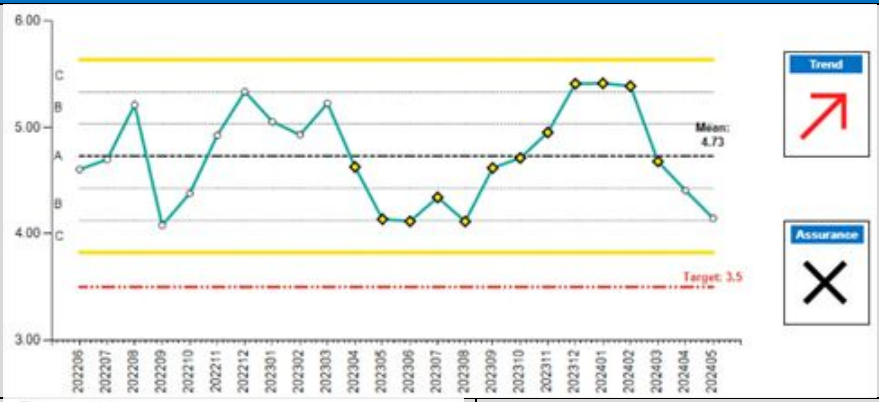
Actions:

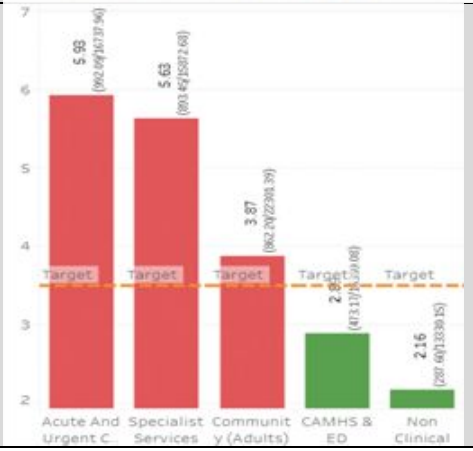
- Exit Interview process has been updated and has gone live. Response rates have slightly improved but remain low. Issue to be discussed at Retention Programme Board.
- The Trust is currently undertaking a deep dive into the ethnicity data behind our turnover.
- A comprehensive package of work to support retention is in place and has been discussed with People Matters and People Committee, focussed in three areas: my start, my development and my future. These three themes have been used to categorise the different initiatives.
- In addition to the Retention programme, we must ensure all take responsibility within the organisation to engage with colleagues, understand any concerns which might be leading to people thinking of leaving and also ensure that those who have recently joined are supported.
- The Trust is currently analysing and sharing the results of the national staff survey which 64% of our staff responded too; increases in engagement and advocacy scores noted.
- The Trust is working to develop key themes (from the staff survey) and is working with service lines/teams on simple actions for managers to take.
- Following review it appears the increase in % staff leaving within 12 months has been impacted by a drop in overall leavers from the Trust. The amount of staff leaving within 12 months is reducing.
- National evidence around retention suggests that the key lever to improving retention (through the research done by the vanguard Trusts) is in creating greater flexibility for staff. This could include a variety of options i.e. agile working, self-rostering, etc. A working group looking at this specific issue is live and hoping to set up a series of pilots. The need for greater flexibility is also referenced in our staff survey responses this year.
- CAMHS & ED: Stay conversations successfully embedded within service line. Some of the key positive themes emerging are that new colleagues feel supported by local teams, corporate induction well received, training offer is viewed as good and challenges identified around issues with IT on-boarding, space is a big issue, need to identify Trust brand. Presentation of stay conversation implementation plan to be shared with service line champions on retention programme project board in June for roll out across Trust.

Staff Retention/ Support / Satisfaction

Staff Sickness Rate

Target ≤ 3.5





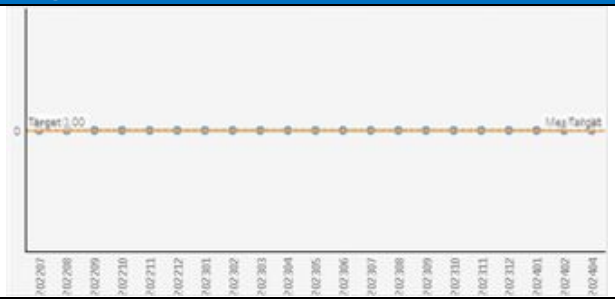
Background:
Looking after the health and wellbeing of staff directly contributes to the delivery of quality patient care. Poor employee health has high and far-reaching costs and ultimately patients. The Trust is concerned about the well-being of Trust employees and wishes to support staff in improving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

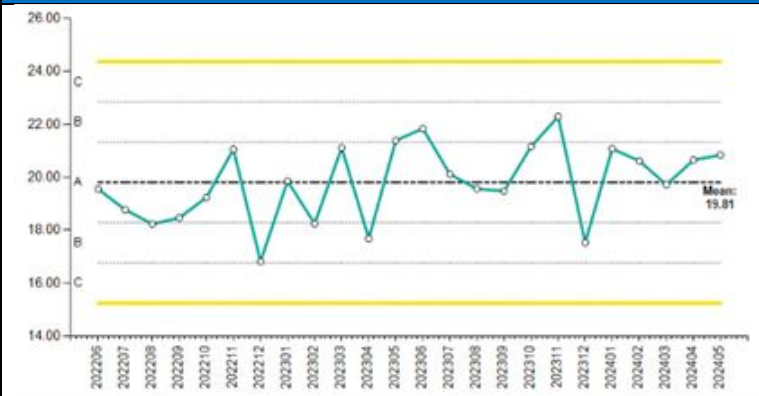
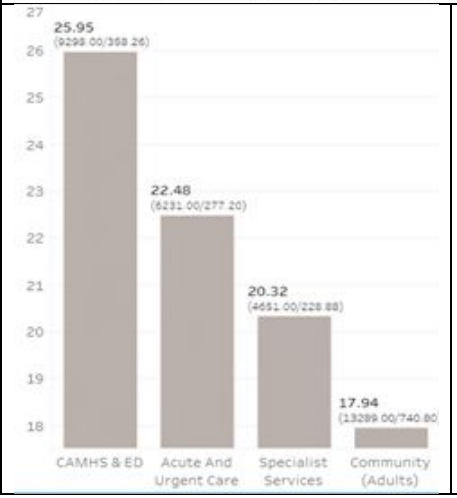
What Chart Tells Us:
Performance follows seasonal trends, but the Trust is consistently above target.

Underlying issue:
- The ER team is now reporting sickness from ESR and this has brought up a significant number of new cases mostly long term in nature.
- There are now 57 Sickness cases (down from 90 last month) of which 63% is of formal ER casework. The bulk of these cases continue to impact Acute, Community and Specialist.
- Long term sickness cases have reduced further reduced in May. The drop is attributable to continued effective case management by ER together with collaboration with the relevant service line managers. ER continue to work through these cases to ensure a plan is in place to support the manager and staff member involved.
- Targeted training is required to support managers with longer term case management.

Actions:
- The Sickness Policy and associated documents is currently under review prior to sharing with stakeholders in advance of consultation.
- The Trust is to run bespoke sickness absence refresher workshops with Managers via our legal team.
- Sickness training has been delivered as part of Ward Managers training days recently with good engagement.
- Regular/monthly sickness case surgeries for managers being rolled out to all service lines to support cases which need more support or are otherwise complex.
- Line Managers to ensure sickness data entry are accurate to prevent any payroll issues.
- Managers are being reminded at monthly ER surgeries to close off sickness episodes at the point of return, undertake Return to Work meetings, ensure sickness certification is continuous during any episode.

Finance Domain

	% 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:** - The Trust achieved its target of 62% recurrent savings in 2023/24; an 80% recurrent target has been set for 2024/25. - Full forecast reporting will commence from month 3. - Cumulative spend equates to 4.1% of Trust pay bill, above NHS target of 2.9%. - Trajectory is needed on productivity savings. - External beds pressures continue creating a financial risk. - Acute & Urgent Care: The projected overspend continues to be due to staffing pressures within inpatient services and high external bed usage. **Actions:** - Work with ICB to identify remaining Agency control gaps or collaborative actions to reduce agency spend. - Acute: Pay overspends on wards are mainly due to observation levels, although this is reduced. This continues to be addressed through FSOC and review of observations and engagement- fidelity to the trust policy and recruitment to vacancies with continued good impact in month on most wards. Our approach to HCA agency is currently being considered in this context. - Overspends due to agency – addressed through review of agency, discussion with individuals to convert to bank or FTC where appropriate and work with medical staffing. - External beds addressed through LoS stay work and DToC work programs and focus on flow in the context of continued high demand and proposed new contract to reduce bed day costs. - As start of 2024/25 the Trust need to reframe its approach to agency control and refocus on recruitment efforts. The national target of agency to pay-bill ratio reduces to 2.9%; the trust did not achieve the 2023/24 target of 3.6%.
	Agency spend as % to NHSE target	**Target ≤ 100%**
Grip & Control		What Chart Tells Us: Mean performance is above target indicating occasional compliance with some variation in performance. **Underlying Issue:** - M2 agency spend of £0.76m; £0.29m above plan. Cumulative spend of £1.4m, £0.5m above plan. Cumulative spend equates to 4.1% of Trust pay bill, above NHS target of 2.9%. - ICB approval now required for non-clinical posts. - Community: 63% of cumulative expenditure within Community Service Line linked to Agency Spend. - Vacancies and difficulties recruiting in particular nurses and doctors (inc. Consultant post leading to service pressures and high-cost agency locums), and operational pressures. - Acute & Urgent Care: Medical agency cost pressures – some vacancies remain in the service line; there is limited applications for posts despite continued recruitment. Agency is used where bank is not able to provide for additional shifts to maintain safe staffing E.g. for observations or specialing offsite. **Actions:** - The reduction in agency expenditure remains a Trust priority with Service Lines asked to identify exit strategies for all agency staff. Discussions with agency staff taking place to attempt convert to bank or a perm/fixed term contract. - From 1st July 2024 all Trusts required to (i) End the use of off-frame agency staff. (ii) Remove usage of estates and admin agency staff (unless covered by exemptions). - Community: Agency trajectory was reviewed - more positive end of year picture projected, mainly through expected reduction in medical staffing. - Vacancy control panels and tighter processes around use of agency (e.g.: agency employment into 80% of a vacant post). - Acute & Urgent Care: Continued recruitment to medical posts and review of recruitment/ retention schemes for these posts. - CAMHS & ED: Service line continue to review "Top 10" Agency workers by cost at the CAMHS Workforce meeting and a trajectory for each. - Specialist: Agency usage continues to be tracked through the monthly Specialist Workforce meeting and Operational Finance Management Group.

	Activity vs WTE (Budgeted)	Target TBC
Productivity		
		

Background:
This KPI's is looking at the numbers of assigned/budgeted WTE against the number of contacts recorded in the relevant month. This is a measure of productivity for review at team/service line level.

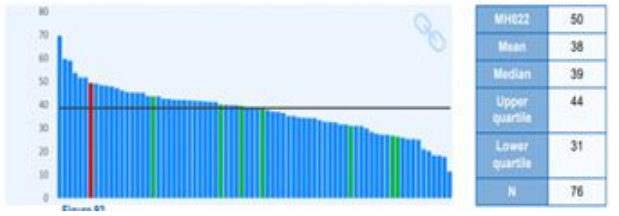
What Chart Tells Us:
Low level variation around the mean. Current months position above the mean value.

Issue:
- Activity is not always recorded in client diary (RiO) or clinical contacts section in IAPTus.

Actions:
- Contact recording SOPs are in place for RiO and CYP IAPTus.
- Training on importance of recording contacts.
- Community: Job planning for nursing staff being rolled across service line in February 2024.
- CAMHS & ED: Job plans are being implemented and progressed and regularly discussed with staff in supervision.

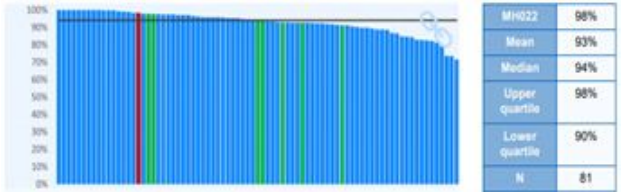
Appendix 1: Benchmarking

The NHS Benchmarking Network's 2022/23 Inpatient and Community Mental Health Benchmarking Report was issued in November 2023 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.



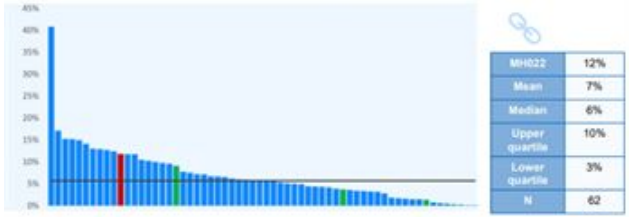
- **Adult acute average length of stay (days):**

2022/23		2024/25	
Trust	England	May-24	YTD
50.0	38.0	52.0	57.2



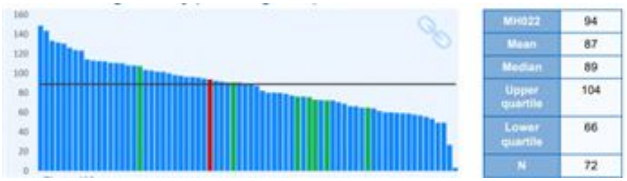
- **Adult acute bed occupancy rate (%):**

2022/23		2024/25	
Trust	England	May-24	YTD
98.0%	93.0%	99.5%	99.4%



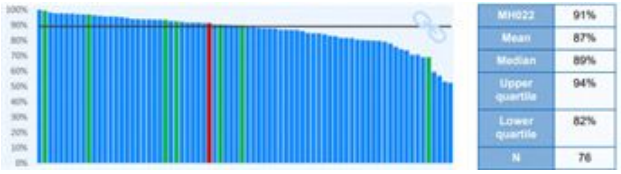
- **Adult acute delayed transfers of care (%):**

2022/23	
Trust	England
12.0%	7.0%



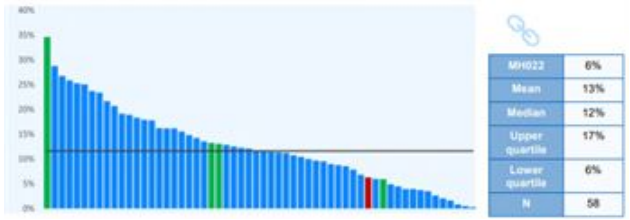
- **Older people's average length of stay (days):**

2022/23		2024/25	
Trust	England	May-24	YTD
94.0	87.0	66.90	87.4



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

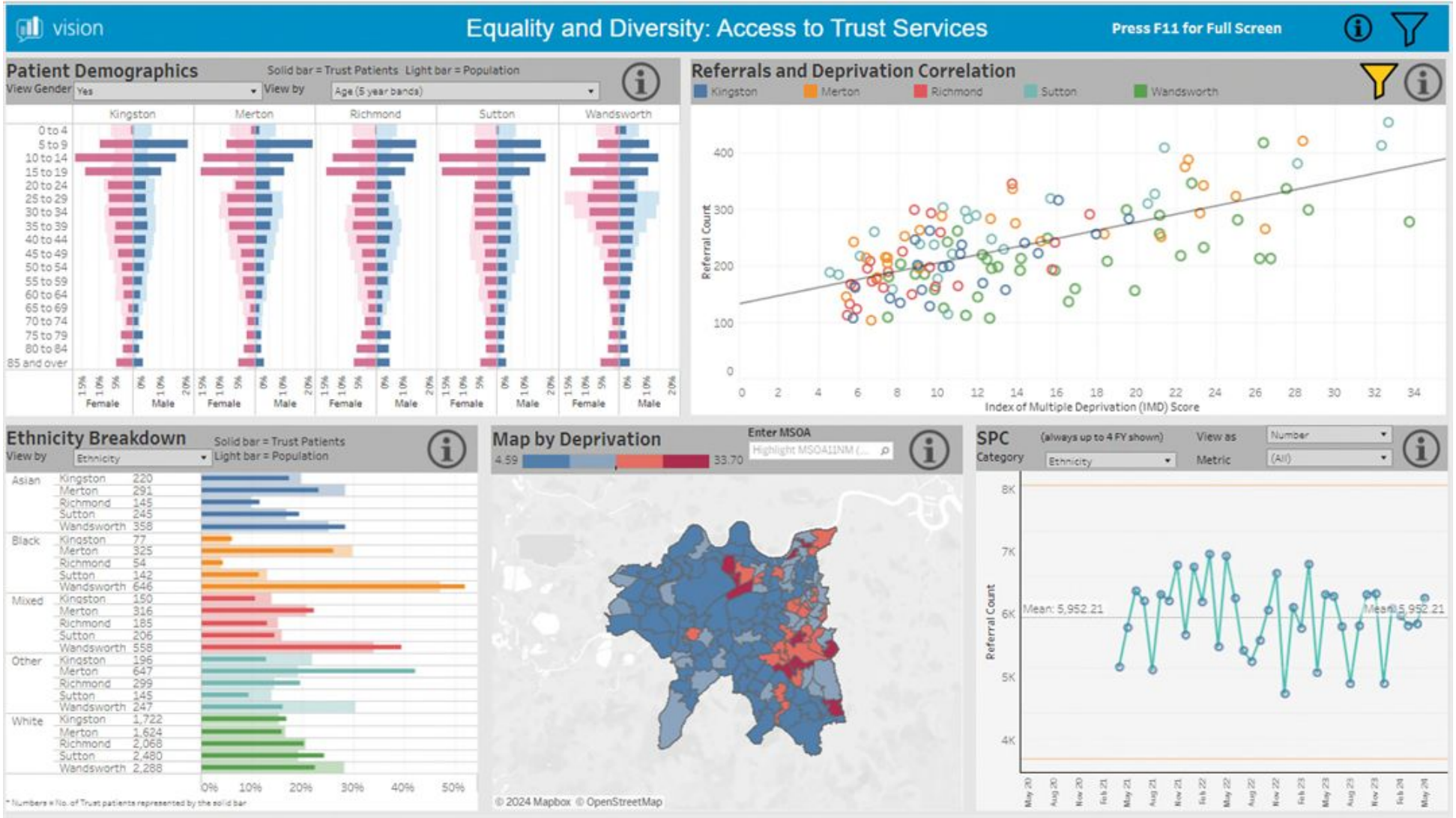
2022/23		2024/25	
Trust	England	May-24	YTD
91.0%	87.0%	91.7%	87.0%



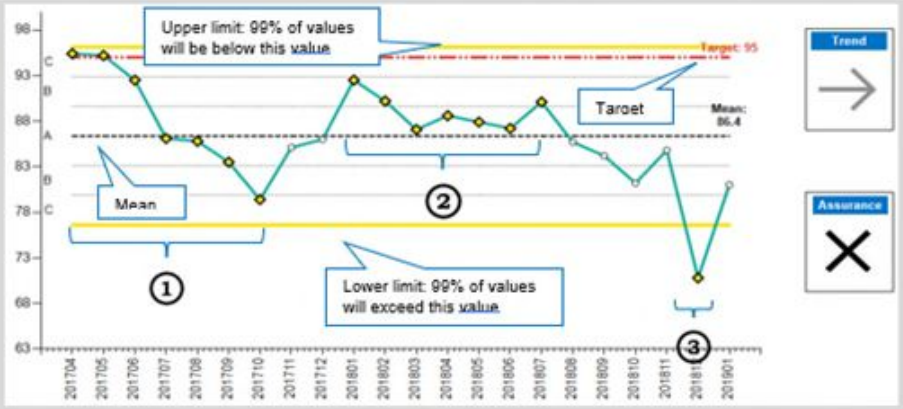
- **Older people's delayed transfers of care (%):**

2022/23	
Trust	England
6.0%	10.3%

Appendix 2: Equalities Dashboard



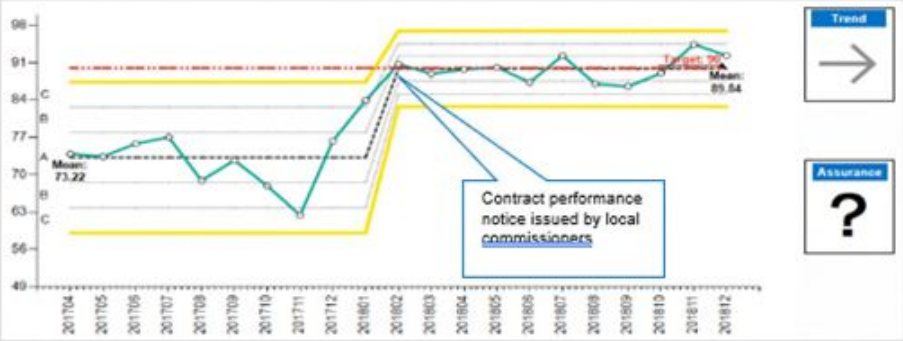
Appendix 3: Statistical Process Control (SPC) Charts & Performance Donut



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

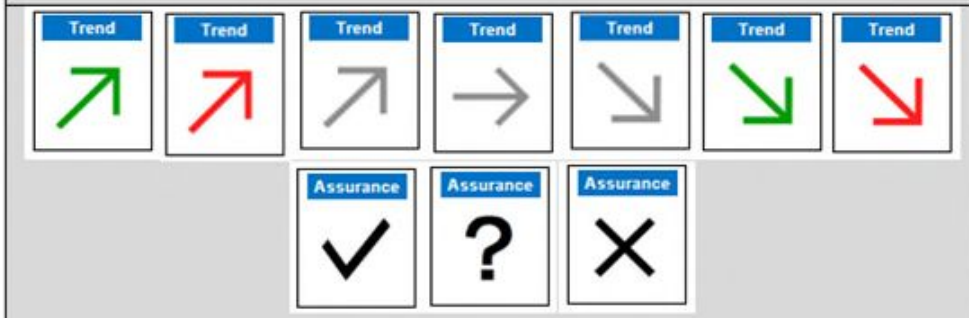
Why we use SPC charts
They are used to distinguish between natural variation ('**common-cause**' and not caused by anything in particular) in performance and unusual patterns ('**special cause**', unexpected events) in the data which are unlikely to have occurred due to chance and require investigation.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

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



Special-cause variation
These are statistically significant patterns in data which may require investigation and includes the following (as illustrated in the chart above):
Trend: 7 consecutive points trending up or trending down (a 0.8% chance of this happening naturally).
Zone A: 7 or more consecutive points on one side of the average (Zone A or beyond).
Beyond limits: beyond upper or lower control limit.
A full list of the statistical tests applied to determine special cause variation can be viewed under the charts in the Trust's SPC Suite (My Dashboards > Quality > SPC Reports > SPC Suite).

Use of a 'step-change' in SPC charts
Where performance has been permanently affected by a change in process (and the process change is known) then a **'step change'** should be applied to the SPC charts. For example, in the chart opposite the Trust was issued with a contract performance notice and the resulting improvement plan led to a change in process and improvement in performance. In these cases, the mean, upper and lower control limits are recalculated after the change in process.



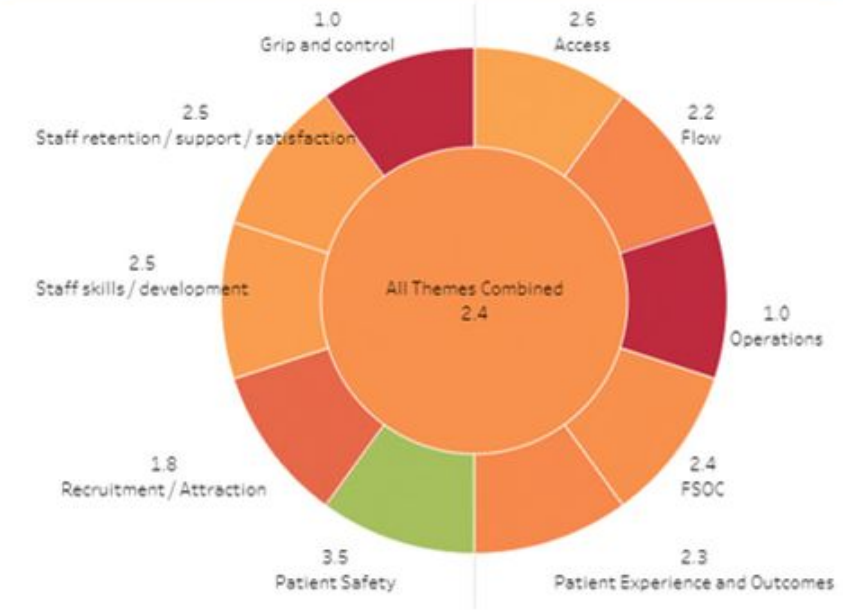
Use of icons to interpret charts
The Trend icon is shown as one of seven upward, horizontal or downward arrows depending on which direction the data is heading, coloured green, grey or red to indicate whether this is an improvement or deterioration in performance (or neutral where there is no target set); the icon is based on any trends identified involving any of the last **SIX** data points.

The Assurance icon
Assurance given: Target is in zone C or beyond (3+ standard deviations) and below the mean; reversed for when target goal is low and target is above the mean.
Questionable Assurance: Target is within zones A and B (1-2 standard deviations).
Assurance not given: Target is in zone C or beyond (3+ standard deviations) and above the mean; reversed for when target goal is low and target is below the mean.
If *Assurance is given* as above, but target has been missed in last 3 months then set to "*Questionable Assurance*" (and reversed for when assurance not given).
If "*Questionable Assurance*", however target has been hit for last 6 months and positive trend identified then set to "*Assurance Given*" (and vice versa for "*Assurance not given*").

Performance Donut Summary

Board Assurance Framework – Latest Risk

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



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

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

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

Possible Donut ranking: 5 = best, 1 = worst

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

RAG Rating:

Score 1.0 — 5.0

Meeting:	Trust Board
Date of meeting:	11th July 2024
Transparency:	Public
Committee Name:	People Committee
Committee Chair and Executive Lead:	Sola Afuape and Katherine Robinson

BAF and Corporate Objective for which the Committee is accountable:

People Committee is responsible for the following corporate objectives:

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

Achieving effective workforce and workflow continue to be the Committee's two main drivers for consideration of assurance as aligned to the key organisational priorities for improvement.

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

The following are the key themes that informed and reflect the discussion at the May and June meetings of People Committee:

1. There was a part B in May, which undertook a deep dive into employee relations. The Committee noted subsequent to that, that the Chief Nurse was undertaking work with HR to investigate the causes of increased disciplinary cases.
2. Mandatory and Statutory Training (MAST) was noted as of limited assurance and an area for continued focus and oversight. Some assurance had been provided that the matter was sighted at Executive level and that the Trust was working through the complexities, had identified key priority areas for focused improvements, and were working to establish the appropriate audience profiles for the different training areas.
3. A detailed discussion about representation of different ethnic groups and other characteristics throughout the organisation, outlining what is required in order to better understand the impact that this has on the culture of the Trust and inclusive opportunities and experience of all Trust staff. Progress in EDI and representation at senior leadership level were noted as key areas for on-going monitoring.
4. The workforce position continued to improve, but key areas of focus remained: talent, workforce development and leadership.
5. Assurance was received related to ongoing engagement with and listening to staff. It was recommended that maintaining participation in the Pulse Survey was important.
6. The Committee noted and queried the lack of patient safety cases in the Freedom to Speak Up (FTSU) report. The cases were largely workforce related and were being addressed through improved workforce arrangements, to reduce the number of workforce related cases going to FTSU.
7. The Committee continues to press for clearer evidence of outcomes in the WRES and EDI action plans that will demonstrate a shift in progress; and raised the matter of the

introduction of a 'comply or explain' approach in the recruitment process to address potential bias.

Areas of Risk Escalation to the Board:
There were no matters for escalation to the Board.

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?

Violence and Aggression Report

What: This report looked at the recent increase in incidents of Violence and Aggression involving both patients and staff. The Committee heard that there was an overall increase in incidents of violence and aggression in the last six months, and a 40% increase on the previous financial year.

So what: A Prevention and Reduction of Violence and Aggression Group had been set up to look at the issue in relation to both staff and patients.

Attempts to resolve incidents of violence against staff using the criminal justice route were frequently being closed. In most cases, this was either because staff did not want to pursue the case, or the patient lacked the capacity for this route to be appropriate.

What next: A further piece of work is required to consider what targets would be needed for reduction.

The next iteration of the Violence and Aggression report should include:

- Triangulation with data from the Executive Advisory Group (EAG) and staff networks.
- Strengthened EDI data to identify any ethnic disparities in staff incidents.
- Clarifications around messaging within the Trust.

Future reporting to outline how other areas, such as OD, MLBT and the Quality Team, were working effectively to maximise impact.

Making Lives Better Together (MLBT) Report

What: This report was about the newest iteration of the MLBT framework, part of the Trust's strategic objective to make the Trust a great place to work.

So what: The framework was originally aimed at trying to change cultural patterns within the Trust, and was brought to Committee in 2023. The current iteration established an MLBT centre in order to operationalise the findings from the framework and bring them into the organisation and address the cultural patterns the Trust wanted to change.

The OD work is intended to focus on the identified culture priorities; make things simpler and improve clarity. It will contribute to psychological safety, improved governance structures and attention to relationships when completing tasks.

What next: The next iteration will evaluate effectiveness and use case studies to ensure that all actions are relevant.

Staff Networks Report

What: The Staff Networks report to Committee on a quarterly basis, providing an update on the recent activities of the networks and recommendations of actions asked of the Committee, to provide oversight.

So What: The Staff Networks report position for 2023-24 and would be included in this year's annual report. It was noted the staff networks won at the Staff Quality Awards. The People Committee noted the valuable work the networks undertook on behalf of staff and the Trust.

What Next: The Staff networks' recommended actions from October 2023 People Committee to be reported in the Chair's report to the October 2024 Board.

Chief People Officer Report
What: The Committee receives this report for oversight of the monthly People function and broader key workforce related matters.

So what: A programme of update of HR policies is underway. It was noted those that remain outstanding would be reported as completed by September 2024. Changes have been made to the Supervision app to prompt line managers to chase up MAST compliance. A recent visit by Board members to Corporate Services had resulted in positive feedback.

What next: An update/evaluation of the approach to training managers in regard to HR policies would come back to September Committee.

Executive Risk Register
What: The Committee receives this paper each month, in order to receive assurance on the key risks.

So what: Reductions of the ratings of risks 2384 (industrial action) and 1804 (consultant vacancies) were being proposed.

HR policy development was not on track. There was a concentrated timetable shared with Committee.

Concerns were raised over the absence of controls in respect of Risk 2499 (MAST), given that significant numbers of staff were not compliant. There were actions being undertaken to improve compliance and user experience. This remained an area of limited assurance given Executive oversight and MAST improvement initiatives.

The industrial action risk score had been kept at the same level pending the decision of junior doctors. This score would remain the same now we know there would be more strikes. The risk had been amended to reflect the impact of strikes on other staff groups.

The Medical Workforce risk was lowered slightly because the overall vacancy rates had fallen below 10%.

What next: Risks are to be reviewed at ELT.

Tolworth Hospital transformation would have an impact on recruitment and retention at the Tolworth and Springfield sites and will be a focus for future

Future MAST reporting to Committee will focus on high-risk areas within the Trust and progress with the three core areas of ABLS, PPI and Safeguarding.

All out of date risks were to be reviewed for the next report.

Q4 Corporate Objectives Report
What: This paper provides a quarterly update to the Committee of progress on the Annual Delivery Plans (ADPs) that support the achievement of the Trust's strategy.

So what: EDI and Health Inequalities and People actions were rated Amber at year end, with some evidence of delivery and further upcoming work planned. It was noted that the rating

reflected activities undertaken and completed rather than outcomes achieved. Delays in the workforce related element of the EMHIP programme was noted.

What Next: Consideration is to be given to whether staff networks and EAG could have an additional space to talk to People Committee about workforce and EDI issues, possibly through staff stories.

People Committee Quality and Performance Report
What: This monthly report provides key updates on workforce data, to ensure the Committee is sighted on and receives assurance on improvements and areas of concern.

So what: The Trust was maintaining improvements in vacancy and turnover rates; Operations reported early evidence of this beginning to impact on the frontline and the Committee note some evidence in the KPIs metrics. Significant work had been done in the area of onboarding and the experience of staff but attention was needed as performance was dipping. Medical and temporary staffing required further work to improve the position and progress to the next iteration of reduction.

Turnover is currently 12.9%, the lowest since 2018, and below the system average.

What next: Triangulation of this work with the Finance and Performance Committee (FPC) was needed to align with improved financial performance.

Areas for focused improvements are MAST, temporary staffing and supervision.

ER and SIREN were reported as correlating reinforcing confidence in the reported position and triangulation across data sets.

EDI Enabling Strategy Action Plan (Q4) and Dashboard
What: The report updated Committee on the integrated HIEDI Action Plan and the EDI Dashboard.

So what: The report focussed mainly on areas where there was a high level of disparity, such as staff turnover, and turnover within 12 months. Staff leaving the organisation within 12 months were disproportionately from a BAME background and from younger age groups.

What next: Linking the plan to the analysis of staff survey data to provide a fuller, triangulated picture.

People Committee Quality and Performance Report
What: This monthly report provides key updates on workforce data, to ensure the Committee is sighted on and receives assurance on improvements and areas of concern.

So what: Problems with security badges had been resolved, leading to improvements in KPIs relating to the onboarding process.

Vacancies were below the 15% target, but there was an additional CIP target of 13%. The Trust needed to do additional work to see if vacancies had reduced further.

Time to recruit was now below the below the target. The latest figures showed around 105 newly qualified nurses had been recruited.

The Trust had a long-term goal to ensure there were more staff from BAME background in roles at Band 8a and above. The planned work on career development could address this.

MAST compliance continues to be a challenge. Work is ongoing to improve compliance in the key areas of Adult Basic Life Support (ABLS), Patient and Public Involvement (PPI) and safeguarding.

What next: A paper on timeframes for improving MAST compliance is expected to be submitted to Committee in June or July 2024.

The Committee requested greater assurance around the causes of the lower level of career progression for BAME staff requesting a more forensic look at vacancies and action on talent management.

EDI Enabling Strategy Action Plan (Q4) and Dashboard
What: The report updated Committee on the integrated HIEDI Action Plan and the EDI Dashboard.

So What: The action plan was a smarter document than 2023-24 as it acknowledged that other action plans were addressing some points.

There were some highlighted areas for 2024-25 as some outputs were still not delivered. Some actions had been moved to other areas e.g., Quality.

The most important aspect was the work was being done with staff networks on outcomes, such as trying to reduce disparities between white and BAME colleagues.

What next: The Committee provided a clear steer for assurance; data in the action plan broken down by specific ethnic group, rather than just including BAME staff more generally. Similarly gender and disability. The next iteration of the action plan would outline the workforce equality profile across the key workforce pathways i.e. recruitment, career progression; so the Committee can receive oversight of the areas of disparities at key pinch points in those pathways.

The action plan to demonstrate quantitative outcomes, points of progression and greater assurance of improvements in lived experience of our staff.

Workforce Race Equality Standard (WRES) Action Plan
What: the Committee received an update on the action plan, agreed in collaboration with the Evolve staff network, to improve the Trust's performance in line with the WRES indicators.

So What: The three main areas of focus were:

- Fair recruitment
- Fair career progression
- Fair connections – e.g., some staff have no access to a computer during worktime and therefore may miss opportunities others can access.

The aim was to create tangible actions, while also ensuring that these were different from previous approaches.

Microaggressions were a particular concern throughout the Trust; it had even been argued that such behaviours were in fact macro rather than micro in their effect. Bullying and harassment in some areas had improved but a gap still persisted between different groups.

What next: The Trust needs to consider how to clarify the metrics and outcomes in the action plan, and how to gain additional assurance from lived experiences of our staff.

A review of BAME staff who have remained at the top of a Band for significant periods of time would take place to target interventions to address these disparities. A positive action proposal to introduce a "comply or explain" approach, with a note explaining the appointing decision to the CEO every time a BAME person deemed appointable at interview was not offered a high-level role, e.g. in Band 8 and above.

The Ethnicity pay gap report, when received, is to include progress made in relation to the items raised within the paper.

People Board Assurance Framework (BAF)
What: This report gives Committee a monthly update on the key workforce risks in the Trust.

So what: There were questions over how management of the risks in the BAF was triangulated with the ADPs and other workstreams. This had led to a full rewrite in June, resulting in a new high level BAF with five key themes of work.

What next: The Committee requested a regular update on the strategic risk position on MAST and the delivery of the Talent approach, to include details of the strategic risks around L&D staffing capacity issues and the mitigations for these.

Equalities, Diversity and Inclusion (EDI) BAF
What: This monthly report provides an update on the key EDI risks in the Trust.

So what: Assurance was sought and received that the Trust remained compliant with its statutory obligations and Public Sector Equality Duty. The team is reviewing areas where there are gaps in address key EDI risks and will from July bring EDI risks to the People Committee and Health Inequalities risks to QSAC.

Five key risk areas were set out for assurance to the Committee and are reported to ELT.

What next: Consideration is being given to how scoring can be smarter based on risk appetite, and alignment with the Quality and People BAFs.

The separation of the BAFs into one for EDI and one for Health Inequalities was flagged as important for allowing Committee to focus on the areas relevant to workforce. The Chair will continue to liaise with the QSAC Chair as to where the two areas overlap and what this means for future reports, providing oversight across both areas, to Board.

Pulse Survey and Staff Survey – six-month update
What: This report gave an update on data from the quarterly Pulse Survey and the annual Staff survey.

So what: Nationally, there is a low rate of response, and less than 8% of Trust staff completed the survey. With the caveat of this low response rate it was noted that results suggested the Trust was on the right track with its action planning, and should retain its focus on the key priority areas of career progression, health and wellbeing and violence and aggression.

Survey fatigue was an issue, so there was a reluctance to push too hard for higher levels of participation in case this discouraged staff from completing the annual staff survey.

The Annual Staff Survey results have been analysed, the results communicated and identified key themes shared.

Messaging and communications had been centred to progressing a more focused engagement response with teams with results above certain organisational averages specifically identified to received details of their focus areas for change e.g., stress and anxiety and flexible working.

Five teams had significantly below-average experience. More specific support was being offered via the OD hub, with self-assessment, to clarify the precise support needed.

What next: It was suggested that a participation rate of 10% should be sought for the Pulse Survey in Q3.

Triangulation of this, the Staff survey data and the Friends and Family test with that of the Community survey to understand the wider context for patients' views of care at the Trust and will include

Freedom to Speak Up (FTSU) Guardian Paper
What: This report provides an update to Committee on the cases Trust staff have taken to the FTSU Guardian.

So what: There was a decrease in cases from six last month.

There were 11 cases overall in the year to date, with none related to patient care or rated red.

Fears of reprisal, fear of not being listened to, and impartial support were among the main reasons for engaging the Guardian.

Some staff had approached the Guardian as they felt they were unable to approach HR, with often their issues being more workforce-related. This is to be addressed through improvements as the HR function changes became embedded.

What next: The lack of patient safety cases was identified as a potential concern. This has been referred to Quality colleagues to consider.

Gender Pay Gap Report
What: The Gender pay gap report comes to Committee annually, and helps to inform our EDI work.

So what: The gender pay gap had increased 0.05% overall, and bonuses had reduced by 8%. The Trust were benchmarking well but there were some areas where action was needed.

There had been a commitment last year to work with the Women's network, which is being progressed.

There seemed to be a pattern of people taking career gaps and perhaps not progressing. There had been conscious support and encouragement for female staff to apply to the medical Clinical Excellence Awards, as men are currently over-represented.

What next: Once the data had been submitted work would start on the action plan, taking a deep dive approach into one or two actions

Appropriate gender and ethnicity balance were to be considered for leadership development courses, in order assist this under represented group access more senior roles.

Wellbeing Guardian report
What: the Committee receives this report to monitor and gain assurance around staff wellbeing. The health and wellbeing of staff is especially important to the Trust as it supports the health and wellbeing of patients, helps make the Trust a great place to work, and supports retention.

So what: A self-assessment was carried out six months' ago. This led to detailed work which pulled together the current wellbeing offer and included a plan about how to address the gaps.

There have been significant increases in staff accessing the support options in the health and wellbeing offer.

There have been focussed campaigns, such as Beyond Bullying, Towards Civility and Respect training, and campaigns around Stress and Burnout and Violence and Aggression.

What next: A fuller report would come to Committee in January 2025. The Occupational Health report would be rescheduled to come back to the Committee in due course.

Appendices
The May 2024 Committee minutes.

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

PEOPLE COMMITTEE

Minutes of the meeting held on **Tuesday 28th May**, 14:30-17:00 via MS Teams.

Present:

Sola Afuape (SA)	Non-Executive Director (Chair)
Ann Beasley (AB)	Trust Chair (until 15:25)
Humaira Ashraf (HA)	Associate Non–Executive Director
Jenna Khalfan (JK)	Director of Communications
Katherine Robinson (KR)	Chief People Officer
Sharon Spain (SS)	Chief Nurse

Attendees:

Emdad Haque (EH)	Associate Director of Health Inequalities and EDI
Mia Kruber (MK)	Head of Resourcing and Onboarding till 16:15
Emma Whitaker (EW)	Deputy Director of Corporate Governance

Apologies:

Jen Allan (JeA)	Chief Operating Officer
David Lee (DL)	Director of Corporate Governance
Vanessa Ford (VF)	Chief Executive
Lincoln Murray (LM)	Operations Manager and Guardian
Nisha Proietti (NP)	Diversity in Decision Making Representative and Deputy Senior Employment Advisor, Sutton Uplift
Jonathan Warren (JW)	Non-Executive Director
Pamela Warren (PW)	Deputy Director of People

Minutes:

Andy Glass (AG)	Corporate Governance Manager

	Item	Action
1	**Standing Items**	
24/88	**Welcome and Apologies** Apologies were noted as above.	
24/89	**Declarations of Interest** No new declarations were received.	
24/90	**Quorum** The Chair confirmed that the meeting was quorate.	
24/91	**Chair's Actions** No Chair's Actions had been taken since the last meeting. However, the Committee noted that future work around Violence and Aggression would be overseen by QSAC, while Mandatory and Statutory Training (MAST) would be in the remit of People Committee. People Committee would also retain oversight of Equality, Diversity and Inclusion (EDI) and Health Inequalities work. Despite this demarcation, People Committee may still need to discuss Violence and Aggression. Similarly, QSAC may also need to discuss issues such as workforce. Action: JW and SA to reflect on the split or work areas between People Committee and QSAC.	**JW/SA**

24/92 Minutes of the last meeting

The minutes of the meeting held on 23rd April 2024 were accepted as a true record of the meeting, subject to some grammatical corrections to be provided to AG. **SA**

24/93 Action Tracker

The Committee received and noted the action tracker.

26/105(ii) HR Function KPIs – To discuss implementing KPIs to measure HR function. Detailed indicators were now available online, so this action was to be **closed**.

26/103(i-iii), 24/12, 24/37 - various EDI actions – these were all contained within the plan, which was on the agenda. Actions to be **closed**.

24/13 Fair Recruitment - LM, MK and KR to discuss creating a report for Committee on the use of Diversity in Recruitment (DIR) representatives and on recent interview panels, and the profile of new recruits. Extra time was needed to convene a discussion before this could be progressed. KR would bring this back to Committee in July, and invite the DIR reps.

24/37 EDI Action Plan - Ethnicity pay gap papers to be submitted to April Committee. These would be submitted in July 2024, once the Workforce Race Equality Standard (WRES) conversations had been finalised. The current focus was on WRES, because of its statutory completion date. There was a plan to create high impact actions for the Ethnicity pay gap, as there are for WRES.

24/58 WRES – multiple actions were now **closed**.

24/60 EDI BAF – this was on the Committee agenda and so was now **closed**.

24/76 Chief People Officer Report (CPO) – there were multiple actions, most of which were closed. The inclusion of Leadership Development statistics in future CPO reports would begin from the June Committee now that all programmes were live. Equality analysis would include not just ethnicity but broader information.

Initial analysis of onboarding meetings showed positive data so far; these would be incorporated into the CPO or another suitable report in future.

24/94 Chief People Officer Report.

The Committee received and noted the report.

Reported:

- Previous CPO reports had had an operational focus on recruitment and retention, owing to HR emerging from recovery. These subjects were now covered in the Quality and Performance (Q&P) report, so the new CPO report was focussed on areas not otherwise reported.
- ER process and operation was more under control than was previously the case. There were still outstanding cases, but there had been a reduction in the number of tribunals and greater proactivity around staff sickness.
- Vacancies continued to reduce, especially medical vacancies. Five new medical staff had been recruited to the Community service line. These changes may result from improvements in staff experience, organisational reputation and the Trust's estate, although there was no direct evidence that these were the reasons. Fewer vacancies were also thought to reduce turnover within teams.

- The HR policy review was ongoing. The recruitment policy had been updated in order to ensure statutory compliance, but still did not reflect some of the Trust's ambitions around fair recruitment. A further review in December 2024 would reimagine the current practice into a fair recruitment process.
- Strategic Investment Funding had been used to recruit an apprenticeship manager, who was currently reporting on the apprenticeship position and next steps. The Trust was not currently spending all of its apprenticeship levy. There were plans to support partner organisations by transferring part of levy. The Trust was currently using too many suppliers.
- Agency usage remained a key concern. Progress had plateaued at around 4.9% of the total pay bill, and how to reduce this would be discussed at ELT in June 2024. A cessation of agency use for Health Care Assistant (HCA) vacancies was under discussion.
- The Trust's approach to identifying and managing talent was becoming increasingly important. The NHS Scope For Growth model was being used to progress this work. Deputy directors had been through Healthcare Leaders 360 training and had independent coaching. The conversations had been assessed against the Scope For Growth model. This work was to be embedded in the organisation in the coming months.

Discussed:

There was positive feedback on the more strategic focus of the report. The importance of including talent management was recognised. The Trust was also to define the various elements of this, such as succession planning, career progression including leadership and technical skills, and recognising high performance and potential.

The Trust had been talking about ceasing agency usage for HCAs for some months, and was satisfied that there were sufficient numbers of HCAs working at the Trust, although agency usage was still required in respect of registered nurses. The stoppage of agency usage in respect of HCAs was being implemented throughout the ICS.

It was suggested that the apprenticeship review being submitted to the Committee should cover new roles and supporting the Trust's digital strategy. A new SWL apprenticeship hub was under development, and would feed into this.

2 Performance

24/95 People Committee Q&P Report

The Committee received and noted the report.

Reported:

- Problems with security badges had been resolved, leading to improvements in KPIs relating to the onboarding process.
- Vacancies were below the 15% target, but there was an additional CIP target of 13%. The Trust needed to do additional work to see if vacancies had reduced further.
- Time to recruit was now below the below 4-9 week target. The latest figures showed around 105 newly qualified nurses (NQNs) had been recruited.
- There was more work to be done in reducing vacancies in the Community service line. Legacy Mentors needed to be recruited to Community to support NQNs in this service line.
- The PADR rate had reduced, as expected for the time of year.
- The Trust had delivered some training on how to hold an effective PADR. This would be repeated as part of the career progression work.
- Sickness was slightly over target, but the Trust was not a significant outlier.
- The Trust had a long-term goal to ensure there were more BAME colleagues in Bands 8a and above. This was currently not showing any signs of changing. It was

thought that the planned work of career development could address this, as there appeared to be an issue with BAME staff moving through bands 5-7.

- MAST compliance continued to be a challenge. More needed to be done to understand the required audiences, but different views on this in different parts of the Trust had hampered progress. This work was focusing on the core areas of Adult Basic Life Support (ABSL), Patient and Public Involvement (PPI) and safeguarding. Once this was resolved, compliance was expected to improve.

Discussed:
There was a concern over the impact of MAST Training on Operations. The work described above was aimed at to targeting training on the core MAST areas so that the training would ultimately only given to those staff that required it. This was still being worked through. MAST 1 represented the core skills framework. Joe Purvis was involved in discussions around training audiences. The Q&P report showed which staff were included in MAST 1 audiences according to their teams; it was not possible to display this information according to job title because required participation was based on the service line.

The Trust was progressing this work in stages. As the current (95%) target was high, there was a need to examine the issue through a quality and safety lens. A paper on the issue would be submitted to ELT in June 2024.

It was discussed that the issue of low numbers of BAME staff in Bands 8a and above could result from problems in progression beyond these bands. EH would cover this in item 24/96 (EDI action plan) – this would also cover the interventions around this issue.

There was a discussion of the impact of workforce risks on patient flow, with staffing numbers cited as an issue. There was a broader issue around discharging patients and how the Trust could support other organisations to improve their staffing. Skills and development was seen as the key issue in career progression, and the main driver for staff leaving the Trust.

SS had attended a Royal College of Nursing (RCN) meeting on staff training, and noted that new diagnoses meant that cases were becoming more complex. Staff resilience was therefore important, especially for newly qualified staff.

It was understood that the Trust having a more stable workforce was important for improving patient outcomes. Anecdotally the staff experience seemed to have improved, but there was a challenge in how to demonstrate this. There was a question on how to more clearly link this to patient outcomes.

There was a link with MAST compliance, as recruitment and retention played a role in ensuring it was possible for teams to release staff to complete training courses.

There has been a focus on teams with a red rating in SIREN, but there may also be a value in looking at green-rated teams and ensuring they were not moving towards a red rating.

On Temporary Staffing, the largest category was “Unknown Team”. KR would look at this.

Agreed:
MAST was highlighted as an important area, with a paper on timeframes for improving compliance expected to be submitted to Committee in June or July 2024. The core areas were ABLS, PPI and safeguarding.

The Committee needed greater assurance around the causes of the lower level of career progression for BAME staff.

The Trust needed to think about how it was looking at vacancies and talent and how it could reach its desired position on these.

Action – KR to clarify the 'unknown team' category in the Temporary Staffing information in the Q&P report. **KR**

The Committee acknowledged the progress made on recruitment in the last year.

24/96 EDI Enabling Strategy Action Plan(Q4) and Dashboard

The Committee received and noted the report.

Reported:

- More work was needed around presenting data on BAME staff groups, and this would be presented in a fuller report.
- There was a plan to tie in ethnicity data with disability data.
- The action plan was a smarter document than 2023-24 as it acknowledged that other action plans were addressing some points.
- There were some mandatory drivers that input into the action plan. Currently these included WRES and WDES, and would soon include Bank WRES and MRES.
- The Patient Carer Race Equality Framework (PCREF) had a workforce element, so is included in the plan although it would primarily be overseen by Quality Committee as it had a Quality remit.
- There were some highlighted areas for 2024-25 as some outputs were still not delivered. Some actions had been moved to other areas e.g., Quality.
- Work was ongoing with staff groups on the Stonewall and disability actions.
- An important aspect was the work being done with staff networks on outcomes, such as trying to reduce disparities between white and BAME colleagues.

Discussed:

It was suggested that the data in the action plan should show the breakdown of individual roles, and show these by specific ethnic groups. Gender and disability should also be included, as these staff groups were also identifying career progression as a reason for leaving. The Part B discussion had given some insight into the experiences of staff from different ethnic groups.

The next iteration of the action plan should outline the workforce equality scrutiny pathway.

The action plan was inconsistent in articulating outcomes, with some being based on corporate objectives, and others on aspirations. It needed to be clearer on showing quantitative outcomes and points of progression, and greater assurance around EDI lived experience needed to be incorporated.

The Making Life Better Together (MLBT) programme was fundamental to changing culture and was linked to this work.

There was a discussion of the use in the report of the term "Black or Minoritised Ethnic" as opposed to "Black and Minority Ethnic". This had been derived from discussions with the Evolve staff network, who had stated that "Black and Minority Ethnic" was othering. The Committee acknowledged this.

The percentage of BAME staff above Band 8a was not the only metric in the dashboard but one that was highlighted to give a snapshot. There were other metrics that measured experience.

Agreed:

Action - SA/HA/KR to work through assurance elements of the EDI action plan for clearer oversight, and share findings with EH. **SA/HA/KR**

Action – the EDI enabling strategy should pick up other protected characteristics, to move toward greater intersectionality. **EH**

Action – EH to submit the next iteration of the EDI action plan and Dashboard to Committee. This is to include breakdowns of the data by individual ethnic group, gender and disability. **EH**

Action - JK would pick up a conversation with the Evolve network to clarify their endorsement of the term “Black and Minoritised Ethnic”, and report back to the Committee. **JK**

24/97 WRES High Impact Actions

The Committee noted the paper.

Reported:

- KR had met with Evolve to discuss what further actions were needed in response to the WRES action plan. The Executive Advisory Group (EAG) had input into this.
- Fair recruitment and career progression were priority areas.
- Instead of basing the actions on the WRES indicators, the Trust had focussed on what was driving inequity.
- There were some parts of the report where language had been corrected.
- The three main areas of focus were:
    - Fair recruitment
    - Fair career progression
    - Fair connections – e.g., some staff have no access to a computer during worktime and therefore may miss opportunities others can access.
- The aim was to create tangible actions, while also ensuring that these were different from previous approaches.
- Barriers to progression had been a key consideration.
- Clarity was needed on what fair progression meant, as this was different for different people and not necessarily about promotion.
- How to move talent around the organisation was a challenge, as staff were often put off by the risk of new positions not being the right fit.
- Microaggressions were a particular concern throughout the Trust; it had even been argued that such behaviours were in fact macro rather than micro in their effect.
- The plan in the paper contained short-, medium-, and long-term actions.
- The Trust needed to reimagine its recruitment processes and systems in order to make meaningful changes.
- There was a need to change the narrative around what it means to be racist. Gross misconduct rules discouraged staff from identifying their own behaviour and views as racist. A high bar for defining racist behaviour was meaning that some complaints were not being upheld.
- Three high impact actions had been shared with Evolve for comment. The main areas of involvement for Evolve would be in the conversation around resetting the understanding of racism and reimagining the recruitment process.

Discussed:

SA recounted an experience from another organisation she was supporting with their EDI work where a black senior nurse was being supported by two colleagues to enter into a senior role. A colleague who was not from a BAME background had an issue with this progression, and also wished to apply for the role. This colleague launched a “campaign of attack” on the person, through verbal and physical interactions and

through interactions with other colleagues. The person raised the issue with her employer over 9-10 months, but the other individual kept countering her comments. By the time she wanted to apply, the role was no longer available. This was put forward as a real-life example of microaggressions having a macro effect, and served to underscore the fact that this piece of work represented a radical change of direction for the Trust, which needed to be approached boldly.

It was noted that the presentation had succeeded in presenting some complex areas in a simpler way. The fair recruitment and fair career progression were clear goals and could be included in the staff survey.

The fair connections and language element was a very full work area, and in particular the piece around microaggressions represented a massive cultural shift. It was noted that language could be separate from microaggressions, which could also include non-verbal behaviours. This should therefore be split out into separate sections.

It was noted also that in the wider system, those with powers to sanction and reward staff were predominantly white, and that this had an impact on the culture. People Committee needed to acknowledge this.

There was a need to understand where Occupational Development (OD) fit in and how to understand some of the insights they might be able to offer. Within the People Team, OD were building a workplan for various workstreams, including career development – Adele Kendrick was leading, and had already begun having the necessary conversations.

There was a discussion about the overlap with existing work the Trust was doing around anti-racism, WDES, and how to craft a narrative around the different elements and obtain the necessary assurance. There was a potential scope for parallel conversations and intersectional insights, and to be informed by more disadvantaged groups. All staff networks were to be included in this discussion, with each network supporting its own members and looking at what barriers they face. The careers event had been attended by various organisations that were trying to help people with various protected characteristics to gain employment; a workshop was being held to understand the barriers people were facing in this regard. The Gender pay-gap report was also showing that career progression was a key issue in that area. Metrics, outcomes, and staff experiences were important in gaining assurance on these issues.

There was a need to consider representation throughout the whole organisation, including the leadership.

The actions had historically been focussed on WRES and WDES as usual, but the action plan had become an evolving process rather than a periodic report, which could make lived experience easier to include. The WRES areas provided a road map but not outcome. This was because the outcomes largely sat elsewhere, for example in the People Plan.

Compliance and assurance were both important, but lived experience was essential for triangulation of these.

Agreed:
Action – KR to consider how to clarify the metrics, and outcomes in the action plan, and how to gain additional assurance from lived staff experiences. **KR**

Chair's report to Board would include Committee noting importance of representation at senior leadership level. **SA**

3. Accountability

24/98 Executive Risk Register (ERR)

The Committee received and noted the register.

Reported:

- There had recently been a reduction from four risks to two.
- Risk 1804 (medical vacancies) had been closed, as new recruitment had reduced below the upper threshold of 13%.
- Risk 2438 (case management) was unchanged.
- Risk 2441 (Employment Tribunals) was closed.
- A new risk (2503) was added, relating to missing medical staffing files. However, all but one had been retrieved, so removal of the risk was under consideration.

Discussed:

Risk 2499 (MAST compliance) was missing from the register.

There was a discussion over whether risk 2384 (industrial action) should be reinstated. It was understood that Speciality and Specialist (SAS) doctors had not agreed a pay deal and therefore might go on strike.

Risk levels and calibration were discussed. The work of ELT and Audit Committee (which SA would now be joining) was seen as sufficient assurance in regard to this.

Violence and aggression and agency spend required scrutiny across the committees.

Agreed:

Action - KR to add in risk 2499 (MAST compliance) to the ERR or BAF as appropriate. **KR**

Action – KR to consider whether risk 2384 (industrial action) needed to be added in light of the potential action by SAS doctors. **KR**

Action - EW to speak to Richard Flatman about the need to scrutinise violence and aggression and agency spend holistically across the committees. **EW**

Action – KR to consider the impact of mitigations when updating the ERR. **KR**

Committee had received the report and were sufficiently assured.

24/99 People Board Assurance Framework (BAF)

The Committee received and noted the register.

Reported:

- There had been questions over how to triangulate management of the risks in the BAF with Annual Delivery Plans (ADPs) and other workstreams. This had led to a full rewrite of the BAF.
- The new BAF was high level, with five key themes of work. Feedback was welcomed on the new iteration.

Discussed:

The more streamlined and high level BAF made correlation with the ERR clearer. Risk ratings were possibly also improving.

The capacity of the People Team was a limiting factor is delivering the mitigations.

EDI and Quality risks were incorporated for triangulation, but they were referenced rather than repeated. It was necessary to retain oversight of issues that could fall through the cracks.

24/100 EDI BAF

The Committee received and noted the register.

Reported:

- This was the latest iteration of the Health Inequalities and EDI (HIEDI) BAF.
- Gaps had been identified and assurance was given to Committee that the Trust remained compliant with its statutory obligations.
- Five areas were included for assurance to Committee to manage risk score five and ensure a proper process was in place to prevent patients, carers and colleagues from being disadvantaged and disproportionately impacted by policy interventions.

Discussed:

This was a more refined BAF than had been the case previously.

It was clarified that a gap identified in the Trust's ability to report against EDI compliance was related to the Health Inequalities statement and referred to areas which had not previously been required to be reported. It was not workforce related and did not relate to key workforce EDI legal requirements.

4. Culture

24/101 Pulse Survey and Staff Survey – 6 Month Progress Update

The Committee received and noted the report.

Reported:

<u>Pulse Survey</u>

- There was a low rate of response nationally, and less than 8% of staff at the Trust had completed the survey. In general, the higher the rate of completion the better the reported experiences.
- This quarter saw better results than Q1 due to increased engagement.
- Participation was just above the national average, but full comparisons would not be available until the end of the quarter.
- The results suggested the Trust was on the right track with its action planning, but should not divert its focus from the key priorities of career progression, health and wellbeing and violence and aggression.
- Survey fatigue was an issue, so there was a reluctance to push too hard for high levels of participation in case this discouraged staff from completing the annual staff survey, which was a more important source of data for the Trust.

<u>Staff survey</u>

- The Trust had analysed the results, communicated with staff and identified key themes. This had raised awareness of the survey compared to last year.
- There had been personalised results tailored to individual teams.
- Communication had been enhanced to reduce the frustration of staff who complete the survey and then hear nothing between surveys. Monthly webinars were being held to explain to staff what actions had been undertaken.
- Messaging and communications had been centred on one of the three key themes e.g., health and wellbeing work.
- It was acknowledged that there was little time before the next survey to make considerable progress.
- Much of the groundwork was already done e.g., the violence and aggression work using QI methodology.
- Work had been done to engage teams. For example, given teams with results above certain organisational averages had been given opportunities to look at what needs to change e.g., stress and anxiety and flexible working.

- Five teams had significantly below-average experience. More specific support was being offered via the OD hub, with self-assessment to clarify the precise support needed.

Discussed:
Regarding Pulse, survey fatigue was acknowledged, but it was an important tool to check the Trust was on track. It was suggested that a participation rate of 10% was sought for Q3. The generic nature of the Pulse survey meant that it could not be targeted for demographic information.

The Staff Survey gave insight, but the Trust was not using the data as well as it could. Triangulation was needed with the recent Community Survey that showed patients did not feel that they were treated with compassion, dignity and respect. Clinical areas in the Staff Survey were generally good, so it would appear there was a discrepancy somewhere. The friends and family test should also be added into this work.

Agreed:
Action – JK to triangulate Community and Staff surveys to understand that discrepancy around patients' views of care at the Trust, and include the Friends and Family Test. **JK**

On the Pulse Survey, the Committee encouraged JK to persevere and report if greater participation was achieved in the next 6-12 months.

24/102 FTSU Guardian Paper

The Committee noted the paper.

Reported:
- There was a decrease in cases from six last month.
- There were 11 cases overall year to date, with none on patient care or rated red.
- Fears of reprisal, fear of not being listened to, and impartial support were among the main reasons for engaging the Guardian.

Discussed:
KR meets LM every six weeks. Business partners were now in place which meant LM could contact the People Team directly.

Some staff had approached the Guardian as they felt they were unable to approach HR, although their issues may be more workforce-related. It was hoped that this would improve as HR changes became embedded.

DL had previously noted that an earlier increase in Guardian cases had indicated people were comfortable speaking up. The lack of patient safety cases may be a concern, but quality colleagues would look at this.

Agreed:
Action - SS to consider the absence of patient safety cases with the Guardian as part of quality work. **SS**

5. Strategy

No update.

6. Key Matters to Report to the Board or other Committees

24/103
- The ER deep-dive in part B. The Committee were mindful that SS was doing work with HR on increased disciplinary cases.
- MAST was noted as area of continued oversight. Some assurance had been provided that the matter was sighted at Executive level and that the Trust was working through the complexities, identifying key priority areas and working through who the audiences should be.
- EDI and representation at Executive level were key themes.

- The workforce function position continued to improve, but key areas of focus remained: talent, workforce development and leadership.
- Assurance was received around ongoing engagement with and listening to staff. It was recommended that maintaining participation in the Pulse Survey was important.
- The FTSU report contained no patient safety cases. Improved workforce arrangements could reduce the number of cases that were going to FTSU. However, it was important not to lose sight of the FTSU work.

7. Meeting Review

24/104
- The meeting ran five minutes over and had no break.
- There were some high-quality reports, representing much hard work.

8. For Information Items

24/105 People Matters Group Minutes
The Committee noted the Minutes.

9. Forward plan and draft agenda items for next meeting

24/106 Committee Forward Plan
No update.

People Committee Acronyms List

BAF	Board Assurance Framework
DiDM	Diversity in Decision Making
EAG	Employee Advisory Group
EDI	Equalities, Diversity and Inclusion
ELT	Executive Leadership Team
ER	Employee Relations
ERR	Executive Risk Register
FPC	Finance and Performance Committee
HRBP	HR Business Partners
ICB	Integrated Care Board
ICS	Integrated Care System
KPI	Key Performance Indicator
LDA	Learning Disability and Autism
LMC	Local Medical Committee
LNC	Local Negotiating Committee
MAST	Mandatory and Statutory Training
NHSE	NHS England
OD	Organisational Development
OH	Occupational Health
OHW	Occupational Health Works (current trust OH provider)
ORAF	Operational Resilience Assurance Forum
PSED	Public Sector Equality Duty
PSIF	Patient Safety Incident Framework
QSAC	Quality and Safety Assurance Committee
RAG rated	Red, Amber, Green rated (usually used on action plans and the BAF)
SLaM	South London and the Maudsley NHS Trust

TOR	Terms of Reference
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Meeting:	Trust Board
Date of meeting:	11 July 2024
Transparency:	Public
Committee Name:	Audit Committee
Committee Chair and Executive Lead:	Richard Flatman (Committee Chair) Philip Murray (Chief Finance and Performance Officer)

BAF and Corporate Objective for which the Committee is accountable:

Audit Committee is not responsible for the delivery of the Corporate Objectives or managing BAF risks. Its work supports them all through ensuring appropriate controls and oversight are in place in the Trust and that they are operating effectively. The internal audit review of risk management (undertaken in 2022-23) found there to be a sound governance structure around the BAF and risk management and confirmed that the structure is operating as intended.

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

This report relates to the June 2024 meeting, which focused on the scrutiny of the Annual Accounts, Annual Report and Quality Account.

1. Chair's action: online approval of Counter Fraud Functional Standard Return (CFFSR) 2023-24, which was rated green and submitted in advance of the deadline.
2. The draft Annual Accounts were scrutinised and recommended to Board.
3. The Letter of Representation was scrutinised and recommended to Board.
4. The draft Quality Accounts were scrutinised and recommended to Board.
5. Approval of the reappointment of GSM as independent examiner for the Trust's Charitable Funds.
6. Review of the Annual Review of the Effectiveness of Internal Audit and Assurance Map. The Map was now ready to be moved to business as usual.
7. The write-off of three inter-NHS debts.

Areas of Risk Escalation to the Board:

None.

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?

Annual Accounts Update including Going Concern

What: Committee noted that nothing had been identified that would affect the Trust's ability to prepare its accounts on a Going Concern Basis. At this point, there were no Events After the Reporting Period. The Committee noted the request to write-off three inter-NHS debts and the reasons for that request; their combined value was £33,774.

KPMG, the Trust's external auditors, were comfortable that the Trust was operating as a going concern.

So What: Committee briefly discussed the paper and requests. Committee approved the basis for the accounts, agreed the write-off of the three NHS Debts and approved the reappointment of GSM as independent examiner for the Trust's Charitable Funds.

Annual Accounts 2023/24
What: The CFO took the committee through the draft accounts and explained the material year-on-year movements and any items of significance.

It was noted that the accounts contained a positive narrative about the Trust's financial position, an important milestone had been reached, as some years ago the Trust's income had been around £180m, and there had been an aspiration to increase this to £300m. Now this had been achieved, there was some discussion of the next income target.

So What: The draft Annual Accounts had been scrutinised and some clarifications and additional explanations sought which the CFO addressed.

What next: Committee commended to Board to approve the accounts on the basis that there are some elements of audit testing work requiring completion. If no material adjustments are required, authority for approval was delegated to the Chair of the Board, CEO and Chief Finance and Performance Officer. If material adjustments were required, then the Committee Chair and also the Board would have to approve these.

Committee formally thanked the Finance Team, especially the Chief Finance and Performance Officer, Deputy Director of Finance and Head of Financial Services, for their hard work, both on a well-prepared set of accounts and on the work that contributed to a smooth audit.

Letter of Representation
What: Each year the Board has to provide a management letter of representation to the external auditors concerning these matters where assurance cannot be gained through the traditional review of the primary accounts and statements.

So What: The letter proposed by KPMG was standard in nature with no additional or uncommon representations required. The Executive confirmed that to their knowledge there were no reasons why the letter should not be approved.

What Next: Committee recommended the draft letter to the Board for approval.

External Audit Opinion and update

What: KPMG presented their draft audit opinion and ISA 260 report. Although their work was not complete, they expected to be able to give clean opinions in all areas. No unadjusted misstatements were reported and only one minor control improvement had been identified.

So What: KPMG commended the trust on its engagement and their support to the audit, KPMG were not expecting issues within their remaining work.

What: Committee thanked KPMG and noted their opinion and report was very positive.

Draft Annual Report 2023/24 (Incl. Annual Governance Statement)
What: The Committee received and scrutinised the Draft Annual Report, which comes to Committee annually. Committee formally thanked the Director of Communications and Engagement and other colleagues who contributed to creating the draft Annual Report.

So what: Committee suggested there could be more detail around how the Trust was using funds to address racism and health inequalities. It was suggested that the report could reflect that the Trust had noted this point and would do more in the coming year. There was an aspiration to be able to talk about this issue in the AGM in September 2024.

There was a discussion around accessibility. There was usually a summary of the overview for the AGM. It was suggested that a 1-2 page easy-read version and a video could also be created.

There was a request to emphasise the role of staff and patients in influencing decision making.

KPMG had reviewed the Annual Report from an external audit point of view and there was nothing they had wanted to highlight to Committee.

What next: Committee agreed to recommend that Board approve the Annual Report subject to any material amendments.

Draft Quality Account 2023/24
What: the Committee receives the draft Quality Account annually. Committee formally thanked the Chief Nurse and other colleagues who contributed to creating the Quality Account.

So What: the Committee discussed how to include more of our equalities work and patient experience. This would allow the public to understand how quality was being impacted in real terms.

There was a discussion around feedback from stakeholders, and whether there were any additional stakeholders the Trust would like to include next year.

There was a discussion of whether NEDs should be invited to CQRs, with consideration that a more extensive involvement than the standard Board visits could compromise assurance.

What next: The Committee recommended to Board the approval of the Quality Accounts subject to any material amendments.

Head of Internal Audit Opinion (HIAO)
What: the Committee received the HIAO annually as part of the Annual Accounts and Annual Report process. The Trust remained at level two (positive) for internal controls.

So What: the Committee noted:

- an overdue IT project management action from the previous year related to issues with identifying funding for a training element for the digital team. This had now been identified and the evidence was to be sent to internal audit.
- temporary staffing and sickness absence internal audit had achieved partial assurance. These items fell under the remit of People Committee, so needed to be explicit in the People Committee Chair's report to Board.

What next: The Committee was comfortable with the HIAO and that it represented reasonable progress; level two was same level as last year's rating. RSM stated that some organisations were falling into level three, so this was a both positive opinion and a strong result.

Internal Audit Progress Report
What: the Committee received and noted the Internal Audit Progress Report.

So what: the Internal Audit reports on Risk Management and Bed Management and Discharge both showed reasonable assurance.

The Committee noted there had been a delay on a cyber action within the report. This had been due to the £1m implementation cost. An alternative solution had been found that would deliver the required outcome for £600k over three years. This would be implemented by the end of July 2024.

What next: the Committee approved the replacement of the Location Visits Review with the Physical Health Assessments Review in the audit plan.

Committee Chair will discuss the risk appetite scores with the Chief Strategy Officer and potentially RSM, in order to make the process of deciding and updating the appetite score more robust, for it to be used effectively to support Board decision making and allocation of resources.

RSM would bring back the Bed Management Report to July Committee, incorporating cross-referencing from the Better Communities Programme Director in relation to the Adult Patient Journey workstream.
Appendices The March 2024 Committee minutes.

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

Audit Committee

Minutes of the meeting held via MS Teams on Thursday 21 March 2024, 14:00-16:30.

Present:

Richard Flatman (RF)	Non-Executive Director (Chair)
Sola Afuape (SA)	Non-Executive Director
Philip Murray (PM)	Chief Finance and Performance Officer

Attendees:

Katherine Robinson (KR)	Chief People Officer (item 24/123 only)
David Lee (DL)	Director of Corporate Governance
Debbie Hollinghurst (DH)	Deputy Director of Finance
Heather Greenhowe (HG)	Internal Audit – RSM
Sharonjeet Kaur (SK)	Internal Audit – RSM
Mohammed Naeem (MN)	Internal Audit – RSM
Joanne Lees (JL)	External Audit – KPMG
Eric Sibisi (ES)	External Audit - KPMG

Apologies:

Vik Sagar (VS)	Non-Executive Director
Charlotte Clark (CC)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
Clive Makombera (CM)	Internal Audit – RSM

Minutes:

Emma Whitaker	Deputy Director of Corporate Governance (from recording)

Item **Action**

Standing Items

24/116 Welcome and apologies

Apologies for absence were noted as listed above.

The Chair noted that VS and CC had sent apologies and this was to have been the last Audit Committee meeting for both of them, as they were stepping down from their Board roles. The Committee thanked both VS and CC for their contributions to Audit Committee over many years.

The Committee noted that DL was working on new NED appointments to ensure the Committee was quorate going forwards.

24/117 Declarations of interest

SA declared she was now Vice Chair of the Croydon Health Services NHS Trust Board.

24/118 Chair's action

The CPS had recently agreed that a long standing fraud case should proceed to court. This meant more counter fraud days were required to enable court attendance. Another five days had been approved.

RF reported that he had completed his mandatory training since the last meeting. He raised that all Committee members must complete their IG training by 31 March 2024.

Item		Action

The draft Data Security and Protection Toolkit (DPST) deadline was 31 March 2024. RSM would then audit for formal submission by 30 June 2024.

24/119 Minutes of the previous meeting held on 18 January 2024

The Committee approved the minutes with the following changes:

- VS may not have been in the meeting; also he should have been under 'present' rather than 'attendee'. **AG**
- Page 5 – sentence 'this will be updated to clarify with sufficient assurance' should be changed to: 'this will be updated to clarify whether sufficient assurance is available'. **AG**
- Page 5 – sentence starting PC/CM should be amended to read: 'PC/CM will consider this again following receipt of the additional evidence in relation to the five areas where more assurance is sought. It is thought the reasonable assurance is in place in areas of greatest risk'. **AG**
- Page 8 stated that a going concern paper was not a mandatory requirement – the Chair asked if this was correct. It was clarified that this was correct. Every auditor had a duty to ensure the accounts were prepared as a going concern, but NHS Trusts were not required to put a paper on going concern through Audit Committee. It was considered best practice to do so, however, and so Audit Committee would continue to receive a paper. A paper on going concern was on the agenda for today's meeting.

24/120 Action Tracker

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

24/8(iv) - Clinical audit programme: SK updated that she created contact between Berkshire and BB's team in SWLStG. The meeting had taken place and outcomes and impact were being chased up.

24/79 – Oversight Framework (OF) and Planning Guidance: PM updated that the formal OF for 23/24 and the 24/25 Planning Guidance had still not been published. The Planning Guidance was expected by end of next week. A refresh paper of the OF from the draft model that was shared with Trusts would be going through ELT next week with the caveat that some of the metrics cannot be updated yet as it cannot be ascertained where the data in the Framework had come from.

24/98(iv) – assurance map: There were five areas with blue grids which meant there was evidence of internal assurance but third party external assurance had not been received. PM updated that following the last Committee meeting there was now only one area which could not be 'turned off' as a blue grid (contract management). Reflection was needed about how to get extra external assurance in this area. This might be added to the RSM audit programme in order to get this assurance. SK would update the map and bring to the June Committee meeting with a view of taking it onward to the Board for information.

24/107 – salary overpayments: SA asked for an update as date was 'TBC'. PM and KR had taken a paper through ELT where it was proposed to take a harder view with repeat offenders held to account between PM and JeA. This process was agreed and now an operational protocol was needed. SA asked if for further assurance a brief operational protocol could be reviewed at People Committee. RF would be in attendance as FTSU Guardian so the loop could be closed. The policy would need to be put into place to start from May 2024.

24/97(ii) - Internal audit plan – the plan for 24/25 was approved at last meeting and had been updated to reflect the last time the areas had been internally audited. Action to be closed.

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SA asked about the scope for other NED Chair involvement in planning the internal audit plan. RF and PM clarified that the plan was pulled together over a period of time by the auditors with careful input from the Executives and review by ELT. Audits were decided based on the areas of biggest risk. The plan iterates through the year. This was in line with RSM's other clients. It would be reviewed at Audit Committee regularly and it had NED members. Each audit would have an individual scope which would include NED input as relevant. RF noted that Juliet Armstrong had raised a point at the last Board meeting that the EMP audit was scheduled for 2026/27 and was that the right time for the audit, given that much of the work will probably be complete by then. It would be as the audit's focus was about benefits realisation. SA asked if NED Chairs could be invited to the Audit Committee where the plan was being agreed. She agreed Chairs should be involved in individual scoping. RF agreed with both these points.

EXTERNAL AUDIT

24/121 External Audit Progress

The Committee received and noted the paper.

Reported:

- KPMG confirmed their independence as the Trust's external auditors.
- The draft materiality calculation would be revisited at year end. There were no additional risk factors built into the calculation.
- Significant risks identified were consistent with the early reflections document brought to the last Committee: management override of controls; the valuation of land and buildings; and fraudulent expenditure recognition, focusing on those areas that management had the ability to manipulate, e.g. accruals and provisions.
- The value for money risk assessment was included. No significant weaknesses had been identified.
- The new accounting standards were included for information.

Discussed:

The auditors met with the Finance team three weeks ago. KPMG reported at that point that there were no emerging concerns.

There was a consultation out on the what the asset valuation rules might look like going forward, which if the proposals came to pass it would affect the Trust. This would be picked up in the valuation paper later in the meeting. System-wide there may be some issues regarding how PFI was accounted for.

INTERNAL AUDIT

24/122 Head of Internal Audit Opinion

The Committee received and noted the draft Opinion.

Reported:

- Overall the Opinion was a positive opinion (level 2).
- The two partial audit reports were pulled out (sickness and temporary staffing).
- The 23/24 work had been done. Draft reports for two audits would be released next week but were unlikely to impact on the overall opinion.

Discussed:

Page 3 stated "We would expect the Trust to consider in the formulation of the AGS the internal control weaknesses identified within our partial assurance opinions summarised above, along with the actions being taken to address the issues identified." – this would be picked up in the Annual Governance Statement.

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Item		Action

24/123 Internal Audit Progress Report inc. tracker assurance map/outstanding internal audit actions

The Committee received and noted the Internal Audit Progress Report.

Reported:

- Since the last meeting the sickness absence audit was released. The finding was 'partial assurance'.
- Sample testing took place in terms of return to work forms, etc. Managers said things were in place but documentation was lacking.
- Sickness absence was reported but there could be improved reporting at divisional level.
- The remaining audits on the plan were risk management and discharges. These were being quality checked and draft reports would be issued next week. This would conclude the 23-24 plan.
- Follow up – open actions – there were nine in progress but there had been updates from management. There were a large number of actions due 31 March, the internal auditors were working to get updates and close those actions where they could.
- Emerging risk radar - fraud risks for the Trust were similar to those seen elsewhere: financial challenge, digital and workforce.

Discussed:

KR attended the Committee to give assurance on the actions taken following receipt of the sickness absence report. There was a lack of consistency for responsibility and ownership within sickness absence. Key documents needed to be updated to reflect current processes. It had been suggested to use some of the technical skills training to include managing sickness absence and required documents. Managers needed to get and store FIT notes and HR needed to understand their responsibilities within the process. Sickness absence does get reported to some Committees but had been removed from the Q&P report when that was refreshed. This information would likely be incorporated within the Service Lines workforce reports which were being refreshed currently. This item was on the agenda for People Committee next week.

RF asked if the system did not allow the FIT notes to be captured or were none of those checks being done. KR responded that the checks were being done as an employee would not get paid if the FIT note was not received. The issue was where they were stored and having consistency around this. Internal Auditors had suggested they were stored on Health Roster but the Trust did not have the facility to do this.

SA responded that there were some actions for People Committee, such as looking at KPIs and MAST; and sense checking compliance with policies. She was mindful that there were a number of different things being managed and that a lot of the improvements would be sequential e.g. with the HR team new structure in place and embedded in a few months' time. She would update via the People Committee Chair's report to Board on what that change looked like for the Committee. RF agreed this would be helpful and would also be helpful for the Temporary Staffing audit.

SA asked SK what other agencies were doing differently. SK said nothing, and added that she had had follow up talks with HR staff and there were already changes taking place which would likely move the score.

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RF raised that there was a 'red' HR action on page 12 of the report, which stated that it had been agreed not to pursue plan on a page and instead a complete People strategy would be published by end 2024. He asked KR for an update. KR updated that it was decided that, when priorities were reset, and the team were stabilised, a People Strategy could be developed rather than a plan on a page. This would be delivered in Q1 2024-25. SK would continue to work with KR and the team to close off this action.

SK confirmed that with the nine open actions the Trust were on track. The "not due" actions due 31 March needed to be managed. SK had a colleague chasing the actions at the moment. RF suggested the Executive focus on these actions and give an update for the June Audit Committee.

RF raised RSM's system to track actions; he asked if the Trust used this system to update actions or if it was worth exploring. PM responded that there was a formal charter about how the Trust worked with Internal Audit and how actions were updated. This was within the audit plan. The Trust would be happy to look into a digital solution where staff could update the actions onto a system as it was a labour intensive process at the moment.

Counter Fraud

24/124 Review Counter Fraud and Security Progress Report

The Committee received and noted the Counter Fraud (CF) Progress Report, including the proposed Functional Standard Return (CFFSR) annual submission, and the CF annual work plan.

Reported:

- The CF team had delivered Cyber training which had 11 Trust attendees.
- The team had worked with the Trust L&D team to improve its presence and were now attending the fortnightly face to face Trust induction. They attended their first meeting yesterday and spoke to 23 staff. By joining each induction they would have trained around 280 staff in the year.
- The proactive review into agency staffing had begun.
- Two new referrals had been received since last meeting but both were closed as they were not suitable for investigation. There was one ongoing case.
- The CFFSR submission would be made by end May. The 1b rating from last year RAG rated 'amber' was now 'green' now there was a nominated CF champion. The Trust were confident they were fully compliant in all 12 areas. Conflicts of Interest was rated 'amber' as there were low levels of engagement, with a view to improve these numbers to get to 'green' next year.
- The CF work plan was risk based. It was proposed to undertake three proactive reviews. Two will be joint with internal audit and one will be an independent conflict of interest review. The timings could be flexible apart from the procurement exercise because that was run by the Counter Fraud Authority during set dates.

Discussed:

SA raised that for the size of our organisation, the amount of cases and the types of issues seemed reasonable. She asked how this related to other organisations. HG felt referrals were in line with other organisations, although she would like to see more referrals next year.

RF asked if there was more the Trust could do to enable engagement with the survey. HG responded that it was not a concern, as sometimes staff have survey

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fatigue. They had 80 clients and only 12 approximately have had responses from over 50 staff. There would be continued push to get more responses.

RF asked if there was an overall rating for the CFFSR. HG clarified that the Trust would be rated 'green' overall.

PM raised the low levels of declarations from staff and how some staff were not declaring where appropriate, as was evident by the annual Pharmaceutical return.

Payroll would be covered in the key financial controls audit.

Cyber security had been reviewed by Internal Audit in 23-24 year and there was a long wall review. The DPST also had penetration tests. The Audit Committee would receive the updated combined action plan for both of these areas. A business case had recently been through the business case assurance process and triple lock regarding investment areas that were required from both action plans and best practice from other Trusts.

Agreed:

- For the proposed CFFSR annual submission to be submitted as in the pack by 31st May 2024.
- The proposed CF work plan for 24-25.

24/125 National Fraud Initiatives

The Committee received and noted the National Fraud Initiatives.

Internal Governance

24/126 Board Assurance Framework (BAF) and Executive Risk Register (ERR)

The Committee received and noted the BAF and ERR.

Reported:

- All risks in the BAF had been updated, and the BAF included new risk appetite commentary. There was a graphical presentation around current, tolerable and optimal risk positions, which could be read across to BAF scores.
- The Trust had continued high levels of external bed use, length of stay, delayed transfers of care, and vacancies in Community Services. These all impacted on and were reflected in the BAF risks.
- Attempts to reduce the size of the BAF had not worked.
- The annual risk management framework would be reporting soon and would have recommendations for the format of the BAF going forwards.

Discussed:

That the document demonstrated good understanding of the Trust's risk position.

Whether to use a risk appetite score or just a commentary. Unless there was a scoring system, it would be hard to measure the current exposure tolerance. RF would like some guidance on how this was done elsewhere from RSM following the risk management audit report. SK added that this was picked up in the audit report and would be bought back to the July meeting for discussion.

The risk appetite commentary was helpful to the Committee and helped demonstrate that the process was working.

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24/127 Annual Accounts update

The Committee received and noted the Annual Accounts update.

Reported:

- There were several items of note:
  - Asset lives – Building 32 and IT. Building 32's asset life was extended for a few years but would now be shortened only to end June 2024. This would be a higher depreciation charge but it was taken account for in the profit and loss account. Some of the Trust's digital assets no longer had the life ascribed to them so IT would like to reduce to suggested shorter life for these assets.
  - The continued approval of the approach to non-NHS bad debt provision. Private sector debt over a year old would be provided for at 100% and other debt particularly Local Authority and salary overpayments less than a year old would have a spot decision made as to if they should be provided for. The Trust were not allowed to provide for NHS bad debt.
  - The potential changes to asset valuation which were out to consultation. The proposals would prevent assets being rebuilt on different locations. If this change was approved it would increase the Trust asset values and therefore increase revenue impact by increasing depreciation and the public dividend capital return that would be applicable to it. The new valuation would be in place from April 2025 although it may take longer to implement. This would potentially have a significant impact on the Trust accounts.

Discussed:

That the frequency and valuation of desktop valuation could be changed to evaluation every five years, either by indexation, desktop, etc. as per the asset valuation consultation. PM confirmed this. He explained that the Trust had historically undertaken a full valuation every fifth year with a desktop valuation in the interim years, with exceptions; e.g. a full on-site valuation of the new assets was completed last year, although ultimately they did not go live. The district valuer then updated that on-site valuation through a desktop valuation going into this year. The Trust and KPMG would contribute to the consultation. KPMG were involved in the discussions as part of the wider audit network on the possible implications on both the preparation of the accounts and also the impact on the audit.

Agreed:

- The continuation of the approach to non-NHS bad debt provision.
- Adoption of the changed asset lives for IT and Building 32 and the consequential change in valuation approach.

24/128 Accounts Policy

The Committee received and noted the Accounts Policy.

Reported:

- The new NHSE accounting policies had now been received. This paper highlighted the areas of change since the prior year and where updates would be needed. There were no major changes for the Committee to be made aware of.
- The Trust would put a specific note into the accounts to signpost the change in valuation approach for Barnes and 2B 1 plot.

Agreed:

The adoption of the new NHSE accounting policies.

Item		Action

24/129 Going Concern

The Committee received and noted the Going Concern.

Reported:

- The finance team felt the Trust should still consider itself a Going Concern. Very little had changed over the past year to impact this and the Trust were forecasting a small surplus before impairments with a strong cash surplus.

Agreed:

The Committee supported the Going Concern basis.

24/130 Valuation and Impairments

The Committee received and noted the valuation and impairments.

Reported:

- This was the Trust's biggest area of risk in the audit of the annual accounts.
- The draft District Valuer's report was received but it would need to wait for the March index before being included.
- There were areas where additional disclosure notes were needed:
  - Should valuation go from MEA to fair value which changes value of assets (Where land is deemed surplus to requirements the district valuer values it at 0. If there was a change in approach on a site (Barnes, parcel 2B 1) the land then becomes recategorised as surplus).
  - That, having done a site by site review, the team would propose that for Barnes and Parcel 2B 1 move away from MEA to fair value.
  - 2B 2 would not be changed away from MEA as the Trust were using some of it e.g. Morrison is on this parcel of land.
  - IT and Building 32 would be an accelerated depreciation transaction, due to change of asset life, not an impairment transaction.
- The Trust were looking to value Barnes mid-year as it may have been sold in year but it was not sold; therefore it was being valued as at 31 March.
- KPMG were generally satisfied with the approach to the GAM but this would be an ongoing conversation.

Discussed:

That the approach to the GAM had been approved in January's meeting and this had not changed since the January meeting.

If anything changes in terms of valuation between March and June, the next Committee meeting, the Chair asked for members to be informed outside of the meeting dates as it could have a material impact on the accounts.

24/131 Debtors Report

The Committee received and noted the report. There had been a large increase in debt but this was all current debt.

24/132 Losses Report

The Committee received and noted the report.

24/133 Waivers Report

The Committee received and noted the report.

Discussed:

There were two instances where threshold was breached as the Trust did not go out to tender. In one there were quotations received and the tender then came out higher; it was not felt that there would be significant value added in going back out to the market and doing a full tender. The second was for welfare advice provision from CAB Wandsworth. This was a joint decision with the system (ICS) on who could reasonably provide the service.

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SA asked what the prescribing observatory for mental health membership item was. PM clarified it was the Royal College of Psychiatrists' data benchmarking, oversight and analysis. This was the annual renewal of membership because this benchmarking and analysis could not be received from anywhere else but from the Royal College.

24/134 Gifts and Hospitality Registers

The Committee received and noted the registers.

Discussed:

The new process was beginning to move in the right direction but there was still concern that declarations were not being made. This was now a regular report in the Audit Committee workplan and would be monitored accordingly.

Committee Governance and Reporting

24/135 Matters to report to the Board

The Committee agreed that the following should be reported to the Board:

- The approval of the external audit plan.
- The draft head of internal audit opinion.
- The internal audit progress report, including the Partial Assurance rating on the sickness absence audit.
- The approval of the counter fraud plan and the CFFSR.
- The BAF.
- The approval of the bad debt provision methodology.
- The approval of the accounting policies.
- The approval of the going concern basis.
- The agreement to the ongoing asset valuation and impairment.

24/136 Review of Committee forward plan

The Committee noted the forward plan.

24/137 Agenda for the June Committee

- Annual account update and draft annual accounts were the same item. This would be amended.

24/138 Information items

These items were noted with no comments:

- Minutes of the Quality and Safety Assurance Committee
- Minutes of the Modernisation Committee.

24/139 Date of Next Meeting

Thursday 11 June 2024, 14:00 -16:30, MS Teams.

Meeting:	Trust Board
Date of meeting:	11 July 2024
Transparency:	Public
Committee Name	Finance and Performance Committee
Committee Chair and Executive Report	Juliet Armstrong (Committee Chair) Philip Murray (Chief Finance and Performance Officer)

BAF and Corporate Objective the committee is accountable for:

BAF Risk Description
A failure to achieve financial targets
Corporate Objective
Objective 6: To continue to work towards financial sustainability supporting best value and efficiency in health and care in SWL.

Key Questions or Areas of Focus for the Board following the Committee:
The following are themes that informed and reflect the discussion at the May and June meetings of Finance and Performance Committee (FPC):

1. We welcomed our new NED, Ebele Akojie, to her first meeting. Ebele would be Chairing the Committee going forwards;
2. We reviewed our BAF;
3. The annual accounts have now been submitted. The Committee thanked the team for their hard work on this;
4. Delayed Transfers of Care (DTOC) were reviewed to understand the key reasons and trends, and next steps, much of which will come into the Adult Patient Journey (APJ);
5. The Committee reviewed the status of two key tenders (Soft FM and Security);
6. The Committee supported the Forensic Intellectual and Neurodevelopmental Disabilities (FIND) Business Case.

Areas of Risk Escalation to the Board:
The ongoing financial risk with regards to the SLP CAMHS and Eating Disorders work and the pressures caused by increasing DTOC and external bed usage.

<u>Partnership working update</u>
What: the Committee receives a regular partnership update in order to keep the finances across our partnerships under review, and ensure we mitigate any impact they may have on our finances.

So What: the Committee heard that the Trust is continuing to think about aligning SLP internally as well as how to have the right oversight; leadership work with external

partners is ongoing and realistic pace needed to be considered for all of the partnership work.

What next: the Trust would continue to work towards obtaining lead provider arrangements for SWL MH Collaborative. The Committee noted that there may be financial implications with the ongoing work that the SLP Committee in Common and Portfolio Board is doing in respect of CAMHS and Eating Disorders services.

FIND Business Case

What: Following analysis of the impact of FIND teams elsewhere in the SLP footprint, the business case sought approval to accept SLP funding to establish a local team.

So What: The additional funds are part of the SLP forensic savings and seek to level up services in SWL. Oak Ward was created on the premise of being able to support patients to move on into the community and also our existing community step-down facilities are not well connected.

What next: Committee supported the case and gave approval to proceed subject to the agreement by the remaining SLP partners to invest in the service.

Quality and Performance Report

What: The Committee regularly receives and reviews this report for assurance.

So What: The Committee noted the report; overall position is stable and focus remains on incremental sustainable improvements. Positively, Length of Stay is reduced but is still above target; however, the Trust is less of an outlier, possibly as other Trust positions are deteriorating.

Discharge numbers had increased for the two weeks of the Intensive Support Intervention work (ISI) which means the intervention is making a difference. Hopefully learning through the Adult Patient Journey would continue.

What next: the Committee would continue to monitor the discharge numbers to see if the ISI work becomes embedded.

Finance Update

What: A revised plan has been submitted of £0.8 surplus, as agreed by Board. The five-year capital plan increased by £35.1m to £181m to reflect the costs of Tolworth. The Trust's underlying stability and position was discussed and ability to deliver mitigating actions if required.

So What: It was noted that any surpluses we make would undermine the Mental Health Investment Standard (MHIS) to a degree.

What Next: Reintroduction of a brief system update into finance reports was agreed. A MTFM was felt to be required.

BAF review *What*: The Committee reviewed its Board Assurance Framework (BAF) risk and mitigations. *So what*: work had been undertaken to ensure culture had been referenced within the BAF risk. The risk score was discussed and left as-is for now, particularly in the light of the system deficit position. *What next*: the Committee would continue to review the BAF and score every quarter, unless a reason for review arises. Delayed Transfers of Care (DTOCs) *What*: Committee received a detailed look at DTOC that provided both a Borough-based and Health Inequalities viewpoint. *So What*: This analysis identified that in terms of volumes of DTOC Merton was a particular outlier when weighted for population size. Equally Wandsworth was an outlier when ethnicity was considered with a far great black representation than the underlying population would suggest. In addition we identified some pricing anomalies regarding male PICU. *What Next*: Whilst Merton being an outlier was not a surprise, the findings in respect to both Male PICU costs and Wandsworth diversity were and these areas require further work.
Items for note None.
Appendices May Confirmed Minutes Months 1 and 2 Finance and Savings Reports

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

Finance and Performance Committee (FPC)

Minutes of the meeting held on Thursday 30th May 14:00 -16:30 by Microsoft Teams

Present:

Juliet Armstrong (JuA)	Non-Executive Director (Chair)
Jen Allan (JeA)	Chief Operating Officer
Philip Murray (PM)	Chief Finance and Performance Officer
Vanessa Ford (VF)	Chief Executive Officer
Amy Scammell (AS)	Chief Strategy Officer
Billy Boland (BB)	Chief Medical Officer

In attendance:

Debbie Hollinghurst (DH)	Deputy Director of Finance
Ashley Painter (AP)	DiDM Representative
Ebele Akojie (EA)	Non -Executive Director
Ann Beasley (AB)	Board Chair (until 15:00)

Apologies:

David Lee (DL)	Director of Corporate Governance

24/62	**Apologies** Apologies were as listed above. JuA welcomed EA to the Trust and to her first committee meeting. EA will be chairing the committee meetings going forward.	
24/63	**Declarations of Interest** No new declarations were reported.	
24/64	**Chair's Action** There were no chair's actions for this meeting.	
24/65	**Minutes of the previous meeting and Matters Arising** Minutes of the previous meeting on 25th April were accepted as an accurate record of the meeting.	
24/66	**Action Tracker** The action tracker was updated. Action – Meet to start discussions on the committee forward workplan. Action - Check the Action Tracker is updated with actions from the previous minutes. Action - Check dates when complex care and partnership working papers can come to FPC. Action - E-mail latest paper on Strategy, Commercial and Transformation priorities, to include points on health inequalities.	**PM/EA/ JuA** **EW** **AS** **AS**
STRATEGY		
24/67	**SLP Forensic Intellectual and Neurodevelopmental Disabilities (FIND) Business Case** **Reported** • The Trust already has a Forensic Learning Disability team that works across SLP. Work was commissioned to evaluate the current SLP FIND team and further develop it. • This was clinically led and recommendation was made to develop three individual Trust teams across SLP. The main difference being the new team will take on case management and case coordination.	

	• The Oak Unit was set up within out Trust with the intention to include a community service model which fits into this pathway. • The proposed staffing level has been based on the North London and Oxleas Trust models. • This business case has been approved by Oxleas Trust. Committee has been asked to approve this so that investment can be made. • This workstream will be funded through SLP savings for Forensic Services and will not create an additional financial pressure on us **Discussed** • Any additional costs will be funded by SLP. • There are no other projects in comparison to this that could have received this funding. • The current step-down facility is not very well connected. • The leasing of extra premises to house the extra staff was discussed – FM informed that existing office space within Trust Estate will be explored first – the business case includes premises costs should additional be required. • JuA questioned if the areas of benefit have been quantified. • FM informed the main benefit is quality of life for patients and having step down at the right time without the need to use private provision therefore giving financial savings. JuA asked if benefits could be quantified further in future • The effect of this project in respect of the SLP was questioned. • PM informed this investment will enhance Community Support to ensure patients from SW can leave Oak Ward and go back into the Community with a level of support rather than having a longer length of stay which will then reduce the number of DTOC patients. **Agreed** **The Committee were supportive of the Business case and gave approval.**	
24/68	**Finance and Savings Report M01** **Reported** • Due to the delayed planning guidance, there have been no National reporting requirements for M01. • The Trust is reporting on target and have delivered savings to the level required, although this is through non recurrent means.. • There is ongoing work with service lines to identify more recurrent savings. • The 2 main underlying cost drivers remain external bed and agency costs. Agency spend has reduced and is now at a ratio of 4% of pay bill, although it is noted that the Trusts pay bill has increased. This remains higher than the NHSE target. • A draft plan was submitted during March with the agreed £0.25m surplus. This was revised in May to the agreed £0.5m surplus. • The ICB May submission was not acceptable to NHSE who imposed a £120m deficit control total on the ICB. The shortfall to achieve this has been pro-rated across all providers based on declared underlying deficit positions which means the Trust has been asked to deliver a total surplus of £760k. Committee debated whether further increasing the Trust's planned surplus would undermine the MHIS and system's stated aim of increasing investment in MH. This was acknowledged however in the round it was felt that conceding this relatively small amount would overall be more beneficial and that in the wider context it would be hard to avoid. • The plan will be resubmitted on 11th June and any changes to the control total will be agreed with the Trust Chair if needed	

	• The extra surplus funds will need to come from additional CIP savings or the balance sheet. • Going forward the Trust will be monitored against CIPs, therefore the Trust will need to ensure these can be met. • PM informed that the ICB also have to reduce their capital plan by £10m and discussions as to how this will be achieved are ongoing. • The Trust is hoping planning permission for the extra residential plots at Springfield will be approved which will help in respect of the Tolworth Business case. Delays in the business case may support the system need to reduce capital spend in year, however this must not impact on the overall CDEL for Tolworth. If we offer up to £10m capital from our EMP capital plan, this should be returned to us by the system later on. • PM informed the Joint Investment Committee (NHSE and DOH) have reaffirmed their support in respect of the Tolworth Business Case with a condition precedent linked to the planning approvals being in place at Springfield. It was noted that the Greater London Authority (GLA) have now 'called in' the planning appeal • It was also noted that the Audit is progressing well • The case will now be subject to Treasury scrutiny; it was noted that the impending general election would mean this would be held in abeyance until the new government had formed. **Agreed** • The Committee were supportive of increasing CIPs by £260k to support System as well as reviewing the phasing of CIPs in the plan. • Committee were supportive of adjusting the capital plan submission given the Tolworth delays and recognised that further work was needed prior to finalising the figures. • Committee approved the plan resubmission on the above basis, subject to any changes being agreed with the Trust Chair before resubmission • Committee noted M01 update.	
REPORTING AND PLANNING		
24/69	**Quality and Performance Report** **Reported** • During April, the Trust remains in a a stable position. This report uses the new Q&P metric framework put in place for 24/25. • There are still challenges with flow, access and workforce although there is improvement in turnover and vacancy rates. • OD and Leadership work is ongoing. • The Adult Patient Journey (APJ) work is ongoing through the Transformation Programme • Clinical efficiency Programme is looking to produce cash savings. • Agency and flow work is also ongoing. • Long length of stay is very costly for the Trust and it is recognised that super stranded patients need to be the focus. We will start reporting on >60 and >90 days LOS • Activity versus WTE (whole time equivalent) continues to be positive but this is still challenging for workforce in respect of financial stability. • Trajectory for external bed usage will be reviewed by the APJ (team and be brought back to FPC in October - Action - Ask Adult Patient Journey team when external beds trajectory will be updated (Jen)	**JA**

	• All the Trust KPIs that drive productivity remain flat. • Average time on caseload is below the lower confidence level which has been caused by patients having been discharged who had been on the caseload for a long time – this is part of Community Services ongoing work. • 'Hostel plus' and work with Local Authorities will need to progress before any impact is seen in respect of DTOC and length of stay. • DNA rates have come down, with the exception of a few teams who have problems with long waiting lists e.g. ADHD There are ongoing workstreams to target these areas including waiting list evaluation. **Discussed** • How can efficiency and costs be discussed with staff in a positive way. • Open conversations and transparency is key – clinical leaders are working in respect of this. • JuA pointed out that some of the actions in the Q&P report for the Flow KPIs are more statements without review dates • The agreed approach is to support existing clinical teams to see more patients which include reviewing long term vacancies to see if these roles are actually still required. **Agreed** • A deep dive paper in respect of DTOC and long length of stay will be brought to June FPC to include private bed costs and support services. • A paper in respect of Assurance for Agency costs will come from People Committee for noting by Committee during July meeting. Actions and dates in the Q&P report to be made clearer.	
24/70	**BAF Review** The Committee noted the paper. **Reported** • The two Tolworth Business risks are being partially managed. • There is also partial assurance in respect of agency, recruitment, and retention. • Does the Trust need a target BAF risk in respect of Finance – PM noted that this was 12 and was within the wider BAF entry. • PM had included the Trust's underlying culture as a risk. • AS highlighted that the BAF format is being reviewed and so once this is done it may be a good point to revisit the risk appetite statement **Agreed** • Committee confirmed that quarterly oversight of the BAF remained appropriate and that the overall score of 16 should remain, particularly in the light of the system deficit position .	
COMMITTEE GOVERNANCE AND REPORTING		
24/71	**Committee Workplan -** this will be reviewed by PM/JA and EA before the June meeting.	
24/72	**Matters for the Board** • The Committee approved the FIND business case. Part A • Agreed extra surplus to help system £260k giving total surplus of £760k – Part B • Agreed rephasing of the capital plan to reflect Tolworth slippage and to support system's £10m allocation reduction - Part B • BAF has been reviewed and the score of 16 was discussed and agreed.	

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24/73	**Meeting** • PM will meet with EA outside of the meeting to understand NHS jargon etc. • EA felt the papers were thorough and well written. • The lighter agenda meant there was more time for more full and fluid conversation – this will hopefully be the case going forward. • Starred item agenda was discussed and maybe be used in the future. • It would have been helpful to have notification in advance of those leaving the meeting early to help with agenda management	
24/74	**Next meeting –** Thursday 27th June 2024 14:00-16:30 via MS Teams	

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Report Title:	**Finance report 2024/25 Month 1**
Name of Meeting:	Trust Board
Date of Meeting:	11 July 2024
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Chief Finance & Performance Officer
Transparency:	Public
Scrutiny Pathway:	Direct review / ELT / FPC (30 May) / Trust Board (11 July)

Purpose:	☒ **Approval**	☒ **Discussion**	☒ **Information**	☒ **Assurance**
Additional information:	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.			

What?	Key items to note are: ➢ **Month 1 Position** – The Trust is reporting break-even in line with plan. ➢ **Agency** – April costs were £0.6m, 4.0% of paybill and were £0.1m less than the 23/24 monthly average. ➢ **External Beds** – Costs of £1.1m in month were an increase on March but marginally less than reported in December, January and February. £0.3m overspend in month. ➢ **Savings** – in month delivery of £1.5m achieved through technical savings and assumed release of Month 1 pay underspends. ➢ **Capital** – overspend of £1.3m in month due to earlier than planned costs on EMP related schemes. ➢ **Cash** – the cash balance is £56.3m, loan repayments commence in 2024/25.
So What?	The report provides partial assurance that the Trust can achieve its revenue and capital target for the year. The Executive Team reviewed and supported the items FPC were asked to approve/note below. ➢ **External Beds** – A plan is in place and ELT remain confident given time this will deliver and focus must be maintained on the actions and service lines support to deliver them. ➢ **Agency** – Further improved oversight arrangements are being introduced as part of improved system oversight and because the Trust is not achieving the national requirement of agency spend not exceeding 2.9% of pay bill.

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	Other Key items to note are: ➢ **2024/25 Planning** – the full plan submission on 2 May has not yet received national approval.
What Next?	Actions have been identified as follows: ➢ Enhanced agency and recruitment controls to be embedded. ➢ Focus is needed on 2024/25 CIP delivery, including external beds. Schemes to be identified for the full savings target, and PIDS written up. CIP identification needed from services lines from month 2. ➢ Finance Department primary focus remains the 2023/24 annual accounts final submission.
Any specific issues to note and/or for escalation:	1. All committees are asked to ensure that focus is maintained on improving the underlying deficit through reducing external beds, reducing agency and delivering recurrent savings.
Appendices/Attachments:	One Power Point accompanies this cover sheet.

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	*Outline below 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
Health Inequalities	Positive impact – Trust Funds are spent to reduce health inequalities within the population we serve
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
Reputational:	Positive impact – The Trust has a good reputation for achieving financial targets

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Strategy:	Positive impact – The Trust has a good reputation for achieving financial targets. The report provides updates on the financial sustainability ambition and achievement of the financial plan.
Workforce:	Positive impact – The Trust provides information on temporary worker spend and achievement of NHSE targets in this area.
Sustainability e.g. Green Plan:	Positive impact – The Trust knows its cost drivers and is taking positive action to ensure financial sustainability.
Other (specify):	This report relates to the Finance risk on the BAF and risks 1027/1770/993 in the risk register.

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Finance Report 2024/25
1 Month to April 2024

Meeting	Trust Board
Date of Meeting	July 2024
Report Title	Finance Report 2024/25 – 1 Month to April 2024
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Chief Finance & Performance Officer
Purpose	For Information
Scrutiny Path	Director review/ELT/FPC/Trust Board
Transparency	Public
Recommendation	None
The Board is asked to	Discuss and Note

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Overall – I & E Position

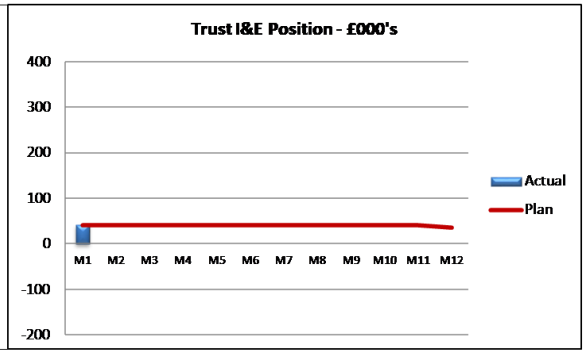
- In April, the Trust delivered a break even position in line with plan, the plan has not yet been approved by NHSE.
- The Trust is forecasting a £0.5m surplus in line with plan. Whilst there are risks against this position it is reasonable to assume mitigating action will be taken if the risks materialize.
- This position is before impairments and profit on asset sales. There are not plans for either element this year
- The majority of the cost improvement targets sit in non pay awaiting identification of budget reductions.
- Costs associated with external bed pressures remain significant, and continued diligence and continued strong financial control is required.

Financial Reports 2024/25	Current Month			YTD month 1			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	25.3	25.7	0.4	25.3	25.7	0.4	302.5	302.5	0.0
Pay	(16.7)	(16.5)	0.2	(16.7)	(16.5)	0.2	(197.8)	(197.8)	0.0
Non Pay	(7.3)	(8.1)	(0.8)	(7.3)	(8.1)	(0.8)	(89.1)	(89.1)	0.0
EBITDA	**1.3**	**1.1**	**(0.2)**	**1.3**	**1.1**	**(0.2)**	**15.6**	**15.6**	**0.0**
Cap Charges - Depreciation	(0.9)	(0.9)	0.0	(0.9)	(0.9)	0.0	(10.8)	(10.8)	0.0
Cap Charges - Interest & Div	(0.4)	(0.4)	0.0	(0.4)	(0.4)	0.0	(5.0)	(5.0)	0.0
Interest	0.1	0.2	0.2	0.1	0.2	0.2	0.6	0.6	0.0
Post EBITDA	(1.3)	(1.1)	0.2	(1.3)	(1.1)	0.2	(15.1)	(15.1)	0.0
Underlying Surplus / (Deficit)	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.5**	**0.5**	**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)	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.5**	**0.5**	**0.0**

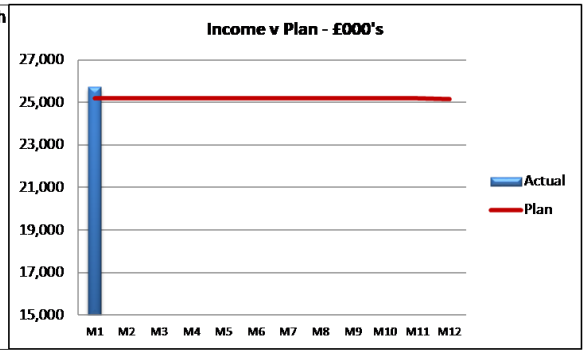
South West London and St George's Mental Health NHS Trust

Key Finance Metrics

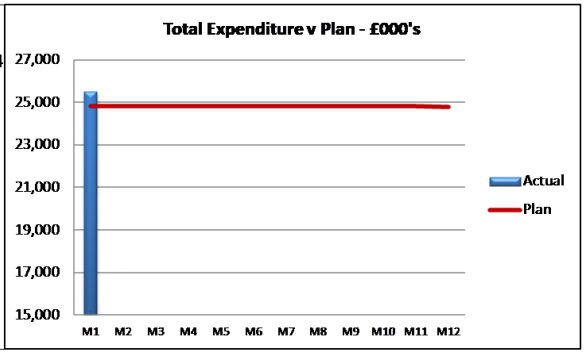
* Base surplus of £42k reported in month, in line with plan
* Profile reflects plan £0.5m surplus submission to NHSE
* Significant risks to planned surplus
* External Bed pressures and agency costs remain key drivers of underlying deficit position



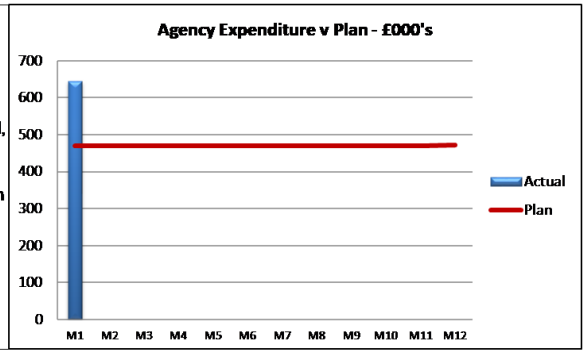
* Income received in month £25.7m, £0.5m better than plan
* Plan excludes additional MHIS funding for the year as not yet confirmed
* Actual position reflects additional funding for DTOC and EPOC in month.



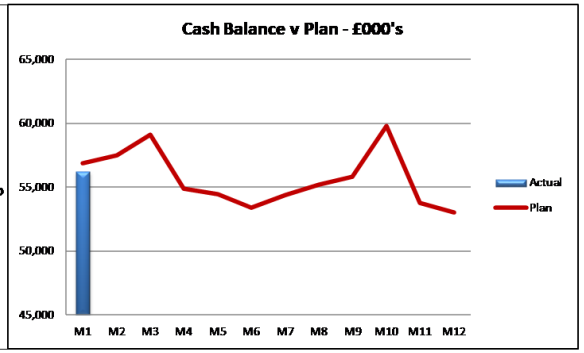
* Spend of £25.5m, £0.7m adverse to plan
* Provision made for 23/24 consultant pay award as per plan
* External bed expenditure of £1.1m in month , £0.1m above 23/24 monthly average.
* Significant External bed pressures continues into M2.



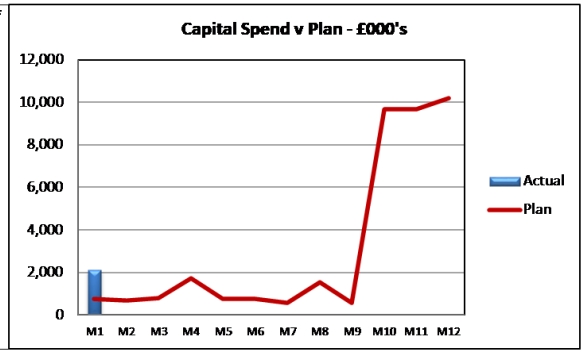
* Spend in month £0.6m 25.5m, £0.7m adverse to plan
* £0.1m better than 2023/24 average spend
* Equates to 4% of pay bill, 1.1% above NHSE target of 2.9%
* 43% of monthly spend on Medical, 32% on nursing.
* Community Service line spend amount to 54%



* Cash balance £56.3m, £0.6m adverse to plan
* Loan balance of £99m, repayments to commence in 24/25
* Movement in cash during the year due to asset sales, deferred receipts, loan repayments, and EMP phase 2 capital spend.



* In month capital spend of £2.1m
* Adverse to plan due to phasing of EMP expenditure rather than unplanned costs for the year
* Forecast spend for theyear £37.7m
* Spike in Q4 the result of uncertainty over timings in spend on the Tolworth and Barnes redevelopment.



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Income Position

- Income is £0.4m favourable to plan
- Local contract income is £0.1m ahead of plan. This positive position is caused by additional funding for delayed transfer of care and is offset by expenditure.
- Other NHS Clinical Income is £0.3m ahead of plan. This additional income is due to extended packages of care funded by the SLP and offset by additional expenditure. due to additional allocations received.
- All other categories of income are in line with plan.

Financial Reports 2024/25	Current Month			YTD month 1			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	19.2	19.3	0.1	19.2	19.3	0.1	230.5	230.5	0.0
Nhs England	1.9	1.8	(0.0)	1.9	1.8	(0.0)	22.3	22.3	0.0
Npsa Income	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.4	0.0
Provider Collaborative Income	2.6	2.6	(0.0)	2.6	2.6	(0.0)	29.8	29.8	0.0
Other Nhs Clinical Income	0.3	0.5	0.3	0.3	0.5	0.3	3.0	3.0	0.0
Nhs Clinical Income	**23.9**	**24.3**	**0.3**	**23.9**	**24.3**	**0.3**	**286.0**	**286.0**	**0.0**
Education & Training	0.7	0.7	0.0	0.7	0.7	0.0	8.1	8.1	0.0
Other Non Clinical Income	0.2	0.2	0.0	0.2	0.2	0.0	2.1	2.1	0.0
Merit Award Income	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.1	0.1	0.0
Non Clinical Income	**0.9**	**1.0**	**0.1**	**0.9**	**1.0**	**0.1**	**10.4**	**10.4**	**0.0**
Non NHS Clinical Income	0.5	0.5	0.0	0.5	0.5	0.0	6.1	6.1	0.0
Non Nhs Clinical Income	**0.5**	**0.5**	**0.0**	**0.5**	**0.5**	**0.0**	**6.1**	**6.1**	**0.0**
Income	**25.3**	**25.7**	**0.4**	**25.3**	**25.7**	**0.4**	**302.5**	**302.5**	**0.0**

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Pay Position

- Pay amounted to £16.5m in-month, a marginal underspend of £0.2m.
- Medical Staff are £0.1m underspent due to vacancies. The medical staffing budget has not yet been uplifted for the Consultant pay award agreed in March and due to be paid, with arrears, in May.
- Nursing budgets are overspent by £0.5m partly due to acuity pressures on the wards but also offset by £0.3m additional funding for extended packages of care.
- The underspend of £0.6m on Other Clinical staff primarily consists of Psychologist vacancies and continues the trend seen in previous years

Financial Reports 2024/25	Current Month			YTD month 1			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.5)	(2.4)	0.1	(2.5)	(2.4)	0.1	(30.9)	(30.9)	0.0
Nursing	(6.6)	(7.2)	(0.5)	(6.6)	(7.2)	(0.5)	(78.8)	(78.8)	0.0
Other Clinical	(4.6)	(3.9)	0.6	(4.6)	(3.9)	0.6	(52.7)	(52.7)	0.0
Non Clinical	(3.0)	(3.0)	(0.0)	(3.0)	(3.0)	(0.0)	(35.4)	(35.4)	0.0
Total Pay	**(16.7)**	**(16.5)**	**0.2**	**(16.7)**	**(16.5)**	**0.2**	**(197.8)**	**(197.8)**	**0.0**

- Spend on agency staffing is £0.6m adverse – further detail is provided on the next slide.
- Bank is £1.6m adverse to plan with the overspend being driven by the Nursing overspends detailed above
- Permanent staffing is showing a £2.5m underspend

Financial Reports 2024/25	Current Month			YTD month 1			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(16.3)	(13.9)	2.5	(16.3)	(13.9)	2.5	(193.3)	(193.3)	0.0
Bank	(0.4)	(2.0)	(1.6)	(0.4)	(2.0)	(1.6)	(4.3)	(4.3)	0.0
Agency	(0.0)	(0.6)	(0.6)	(0.0)	(0.6)	(0.6)	(0.2)	(0.2)	0.0
Total Pay	**(16.7)**	**(16.5)**	**0.2**	**(16.7)**	**(16.5)**	**0.2**	**(197.8)**	**(197.8)**	**0.0**

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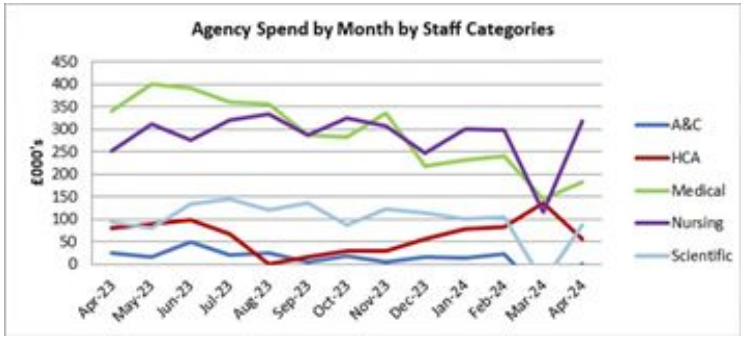
Agency - in month and cumulative position

- Expenditure is £0.6m and amounts to 4.0% of the pay bill. It is £0.6m above plan and the NHSE target of being 2.9% of pay expenditure
- In 2022/23 Trust agency expenditure was £12.3m (monthly average of £1,023k) 7.1% of total pay costs
- In 2023/24 Trust agency expenditure was £9.1m (monthly average of £758k) 4.5% of total pay costs
- Expenditure in April was below 2023/24 levels and £150k less than expenditure this time last year (April 2023)
- Of April expenditure, Nursing was the highest at £0.3m. Medical spend amounted to £0.2m with the next highest being Scientific at £0.1m
- The Community Service Line remains the highest user of agency staffing. Expenditure of £0.4m equates to 54% of the Trust total
- The Trust is implementing stronger controls to improve retention, reduce vacancies and reduce agency usage and costs, whilst recognising the need to maintain and deliver safe services.



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Non-Pay & Post EBITDA

- Non-Pay budgets overspent by £0.8m in the month driven by external bed usage.

Financial Reports 2024/25	Current Month			YTD month 1			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Drug Costs	(0.2)	(0.2)	0.0	(0.2)	(0.2)	0.0	(2.4)	(2.4)	0.0
Clinical Supplies & Servs Cost	(0.1)	(0.0)	0.0	(0.1)	(0.0)	0.0	(0.6)	(0.6)	0.0
Secondary Commisioning Costs	(4.1)	(4.9)	(0.7)	(4.1)	(4.9)	(0.7)	(57.0)	(57.0)	0.0
Other Costs	(2.9)	(3.0)	(0.0)	(2.9)	(3.0)	(0.0)	(29.0)	(29.0)	0.0
Contingency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Pay	**(7.3)**	**(8.1)**	**(0.8)**	**(7.3)**	**(8.1)**	**(0.8)**	**(89.1)**	**(89.1)**	**0.0**

- Post EBITDA costs are now £0.2m favourable to plan due to higher than planned interest receivable on cash balances
- The depreciation and PDC budgets are being reviewed following the completion of 2023/24 accounts
- There are no planned impairments for the year. As in previous years market valuation impairments will be calculated at year end following the review by the district valuation office. The Trust is not performance managed against impairments of this nature.
- There are no planned profits from asset sales.

Financial Reports 2024/25	Current Month			YTD month 1			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Cap Charges - Depreciation	(0.9)	(0.9)	0.0	(0.9)	(0.9)	0.0	(10.8)	(10.8)	0.0
Cap Charges - Pdc Dividend	(0.4)	(0.4)	0.0	(0.4)	(0.4)	0.0	(5.0)	(5.0)	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest	0.1	0.2	0.2	0.1	0.2	0.2	0.6	0.6	0.0
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Post EBITDA	**(1.3)**	**(1.1)**	**0.2**	**(1.3)**	**(1.1)**	**0.2**	**(15.1)**	**(15.1)**	**0.0**

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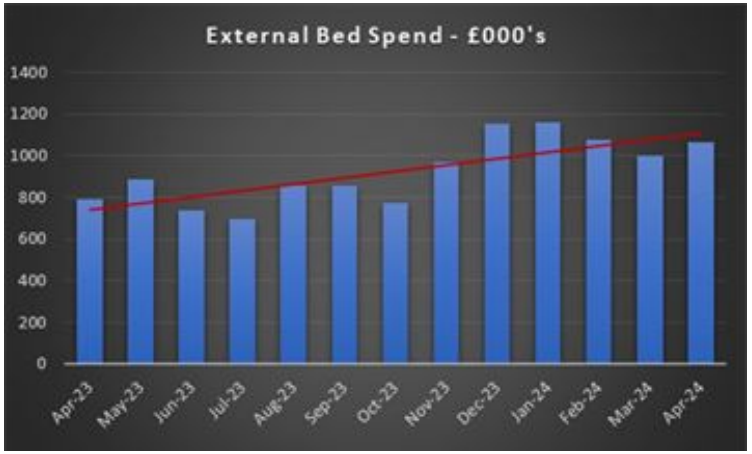
External Beds

- Expenditure of £1.1m remains at the high levels experienced in the latter months of 2023/24.
- External bed usage remains the key cost driver of the Trusts underlying deficit position.
- This analysis of external beds incorporates unplanned external bed usage as well as contracted beds at Holybourne and ELFT (both Female PICU and Acute)
- Significant external bed costs incurred in 2022/23 continued into 2023/24, and now continue into 2024/25
- This was £0.1m above the monthly average for 2023/24, £0.3m overspend in month.
  - Additional bed costs were funded primarily by investment slippage in both 2022/23 and 2023/24, funding for 2024/25 is not yet confirmed.
  - Of the cumulative expenditure: £0.7m was at Holybourne, £0.3m was spent on Female PICU and the balance of £0.1m was spent on other acute beds, and Male PICU beds
  - The current budgetary base is 30 Holybourne beds, 0 additional Acute beds, 3 female PICU beds, 0 male PICU beds. However, April usage was significantly above these levels, resulting in a £0.3k overspend in month
  - Early indications are that the high usage has continued into May and the split of external bed usage has changed meaning more expensive PICU beds have been used. This is likely to result in a higher overspend for the month of May compared to April.



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Service Line Positions

- Whilst the overall position remains on plan, there is significant variation in Service Line performance
- Acute Care is now £0.4m overspent driven by external bed pressures.
- CAMHS & ED is £0.2m underspent due to continued recruitment slippages
- Community is £0.1m underspent due to recruitment slippages
- Specialist and Corporate are in line with plan.
- Capital costs are £0.2m favourable due to additional interest receivable.
- The forecast for the year is for a £0.5m surplus. There are no planned impairments/profit on sale of assets. As detailed previously, the Trust is managed on the pre-impairment/profit on sale position

Financial Reports 2024/25	Current Month			YTD month 1			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Acute And Urgent Care	(4.3)	(4.7)	(0.4)	(4.3)	(4.7)	(0.4)	(50.9)	(50.9)	0.0
Camhs & Ed	(2.8)	(2.7)	0.2	(2.8)	(2.7)	0.2	(33.8)	(33.8)	0.0
Community (Adults)	(4.7)	(4.6)	0.1	(4.7)	(4.6)	0.1	(52.5)	(52.5)	0.0
Specialist Services	(2.8)	(2.8)	0.0	(2.8)	(2.8)	0.0	(33.1)	(33.1)	0.0
Corporate	15.6	15.6	0.0	15.6	15.6	0.0	182.6	182.6	0.0
Capital Costs	(1.0)	(0.8)	0.2	(1.0)	(0.8)	0.2	(11.7)	(11.7)	0.0
Total	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.5**	**0.5**	**0.0**

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Savings – YTD Position

- **Target £18m,** £15.1m identified; Fully Developed £2.4m (14%), Plans in Progress £5.7m (32%), Opportunity £7m (40%)
- **Unidentified** - £2.5m (14%)
- **Overprogramming** of £1.2m built into local targets
- **Month 1 Delivery** – £1.5m delivered in line with plan, over delivery on technical and pay underspends offsetting operational slippage – typically service line savings are 'declared' one month in arrears
- **Delivery Confidence** – 85% similar to this time last year
- **Recurrent Target £12.4m (70%)** – increase of 8% compared to the 2023/24 delivered position (62%)

Efficiency progress - SWLSG (£k)	Total			
	Pay	Non pay	Income	Total
Fully developed	-	2,405	-	2,405
Plans in progress	5,644	-	85	5,729
Opportunity	444	6,604	5	7,053
Unidentified	2,004	494	-	2,498
Total	8,092	9,503	90	17,685

Service Line	Total Target £k	M1 Plan	M1 Actuals	M1 Variance
Acute And Urgent Care	2,213	184	0	184
Camhs & AED	1,757	146	0	146
Community (Adults)	2,666	222	0	222
Specialist Services	1,853	154	0	154
Operations	8,489	707	0	707
Corporate	2,389	199	0	199
Undeclared vacancy underspends			422	-422
Technical Savings	8,007	664	1,049	-384
Overprogramming	-1,200	-100		-100
Scheme Total	17,685	1,471	1,471	0

	Trust Wide Scheme £k	Plan	Recurrent	Non-Recurrent	M1 Plan	M1 Actuals	M1 Variance
Enhanced Flow	Bed reduction	500	500	0	42	0	42
	Observations	120	120	0	10	0	10
Productivity	Clinical / Digital Efficiency	500	500	0	42	0	42
Workforce Scheme	Recurrent vacancy factor	2,660	2,660	0	222	422	-200
	NR Stretch vacancy factor	918	0	918	77	0	77
	Workforce Planning	500	500	0	42	0	42
	Operational control of spend	751	751	0	63	0	63
	Sickness mgmt.	311	311	0	26	0	26
Other Schemes	Private Patients	50	50	0	4	0	4
	Retail units	35	35	0	3	0	3
Technical	Technical Savings	8,007	5,685	2,322	667	1,049	-382
Local Schemes	Local Schemes	2,035	1,264	771	167	0	167
Unidentified	Unidentified	2,498	0	2,498	208	0	208
	Overprogramming	-1,200	0	-1,200	-100	0	-100
	Scheme Total	17,685	12,376	5,309	1,471	1,471	0
	Recurrent / Non-recurrent %		70%	30%			

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Capital

	Month			YTD			Annual		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Schemes									
EMP	0.4	1.8	(1.4)	0.4	1.8	(1.4)	32.7	32.7	0.0
Estates Maintenance	0.1	0.0	0.1	0.1	0.0	0.1	2.2	2.2	0.0
IT/Digital	0.2	0.2	(0.1)	0.2	0.2	(0.1)	2.2	2.2	0.0
Operational Total	0.7	2.1	(1.3)	0.7	2.1	(1.3)	37.2	37.2	0.0
Leases	0.0	0.0	0.0	0.0	0.0	0.0	10.9	10.9	0.0
Total Capital Expenditure	**0.7**	**2.1**	**(1.3)**	**0.7**	**2.1**	**(1.3)**	**48.1**	**48.1**	**0.0**

- The capital plan is £48.1m, predominantly Phase 2 EMP £20.9m, Barnes £9.3m and £2.5m for other EMP schemes. Estates and IT make up the remainder, split £2.2m each respectively. Of the total spend for 2024/25 £10.1m is funded by national Public Dividend Capital, with the balance funded through Trust funds including prior year asset sales.

- The plan includes £0.5m relating to new leases that are expected to materialise in 2024/25 and £10.4m of leases due for renewal during the year, including the Kingston leases relating to the absorption of new services from 1 April.

- Capital expenditure for the month is £2.1m (£1.3m more than plan) due to earlier than planned enabling works at Tolworth. Estates and IT are broadly on plan.

- The forecast position assumes the approval of the EMP phase 2 (Tolworth) business case and no material planning delays.

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Report Title:	**Finance report 2024/25 Month 2**
Name of Meeting:	Trust Board
Date of Meeting:	July 2024
Author(s):	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor(s):	Philip Murray, Chief Finance & Performance Officer
Transparency:	Public
Scrutiny Pathway:	Direct review / ELT / FPC (27 June) / Trust Board (11 July)

Purpose:	☒	**Approval**	☒	**Discussion**	☒	**Information**	☒	**Assurance**
Additional information:	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.							

What?	Key items to note are: ➢ **Month 2 Position** – The Trust is reporting a £0.1m deficit in line with plan. ➢ **Forecast** - The forecast is £0.7m net surplus in line with plan, detailed forecasting is completed from Q2. This is the position the Trust is monitored against by NHSE after adjusting for depreciation on donated assets. ➢ **Agency** – May costs were £0.8m, 4.3% of paybill, highest reported spend since August 2023. ➢ **External Beds** – Costs of £1.3m in month were an increase on April, and highest monthly cost to date. ➢ **Savings** – ytd delivery of £2.6m, Service Lines beginning to report savings. ➢ **Capital** – spend to date is £4.9m in line with plan. ➢ **Cash** – the cash balance is £55.4m, loan repayments commence in 2024/25. Balance Sheet and Cashflow reporting will commence from M3 in line with national reporting requirements. ➢ **PSPP –** above target both by value and by number.
So What?	The report provides partial assurance that the Trust can achieve its revenue and capital target for the year. The Executive Team reviewed and supported the items FPC were asked to approve/note below. ➢ **External Beds** – A plan is in place and ELT remain confident given time this will deliver and focus must be maintained on the actions and service lines support to deliver them. During June an

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	intensive support process is in place to help patients who no longer need inpatient care to recover at home or in the community. This work will help to inform the 'Adult Patient Journey' Programme launching in July and the forecast of future bed trajectories. ➢ **Agency** – Further improved oversight arrangements have been introduced as part of improved system oversight and because the Trust is not achieving the national requirement of agency spend not exceeding 2.9% of pay bill.
What Next?	Actions have been identified as follows: ➢ Enhanced agency and recruitment controls to be embedded. ➢ Focus is needed on 2024/25 CIP delivery, including external beds. Schemes to be identified for the full savings target, and PIDS written up.
Any specific issues to note and/or for escalation:	1. All committees are asked to ensure that focus is maintained on improving the underlying deficit through reducing external beds, reducing agency and delivering recurrent savings.
Appendices/Attachments:	One Power Point accompanies this cover sheet.

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	*Outline below 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
Health Inequalities	Positive impact – Trust Funds are spent to reduce health inequalities within the population we serve
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

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Reputational:	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. The report provides updates on the financial sustainability ambition and achievement of the financial plan.
Workforce:	Positive impact – The Trust provides information on temporary worker spend and achievement of NHSE targets in this area.
Sustainability e.g. Green Plan:	Positive impact – The Trust knows its cost drivers and is taking positive action to ensure financial sustainability.
Other (specify):	This report relates to the Finance risk on the BAF and risks 1027/1770/993 in the risk register.

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Finance Report 2024/25
2 Months to May 2024

Meeting	Trust Board
Date of Meeting	July 2024
Report Title	Finance Report 2024/25 – 2 Months to May 2024
Author	Debbie Hollinghurst, Deputy Director of Finance
Executive Sponsor	Philip Murray, Chief Finance & Performance Officer
Purpose	For Information
Scrutiny Path	Director review/ELT/FPC/Trust Board
Transparency	Public
Recommendation	None
The Board is asked to	Discuss and Note

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Overall – I & E Position

- The Trust has now submitted a revised plan. This increases the surplus for the year from £0.5m to £0.7m (£0.8m after normalisation adjustments) and contributes to an overall improved position for the SWL system
- The position both for May and cumulatively are in line with the revised plan submission (a £0.1m deficit)
- Despite emerging challenges (principally external bed usage) the forecast position for the year remains £0.7m surplus
- This position is before impairments and profit on asset sales, neither of which are planned for this year
- The majority of the cost improvement targets sit in non pay awaiting identification of budget reductions
- Costs associated with external bed pressures remain significant, and continued diligence and continued strong financial control is required to ensure that this expenditure is both minimised and mitigated

Financial Reports 2024/25	Current Month			YTD month 2			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Income	26.1	26.7	0.5	51.5	52.4	0.9	305.7	305.7	0.0
Pay	(17.9)	(17.7)	0.3	(34.6)	(34.2)	0.5	(207.9)	(207.9)	0.0
Non Pay	(7.1)	(8.0)	(0.9)	(14.4)	(16.1)	(1.7)	(81.6)	(81.6)	0.0
EBITDA	**1.1**	**1.0**	**(0.2)**	**2.4**	**2.1**	**(0.3)**	**16.1**	**16.1**	**0.0**
Cap Charges - Depreciation	(0.9)	(0.9)	(0.0)	(1.8)	(1.8)	(0.0)	(11.5)	(11.5)	0.0
Cap Charges - Interest & Div	(0.3)	(0.3)	0.0	(0.7)	(0.7)	0.0	(4.5)	(4.5)	0.0
Interest	0.0	0.2	0.2	0.1	0.4	0.3	0.6	0.6	0.0
Post EBITDA	(1.2)	(1.1)	0.2	(2.5)	(2.2)	0.3	(15.4)	(15.4)	0.0
Underlying Surplus / (Deficit)	**(0.1)**	**(0.1)**	**0.0**	**(0.1)**	**(0.1)**	**0.0**	**0.7**	**0.7**	**0.0**
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus / (Deficit)	**(0.1)**	**(0.1)**	**0.0**	**(0.1)**	**(0.1)**	**0.0**	**0.7**	**0.7**	**0.0**

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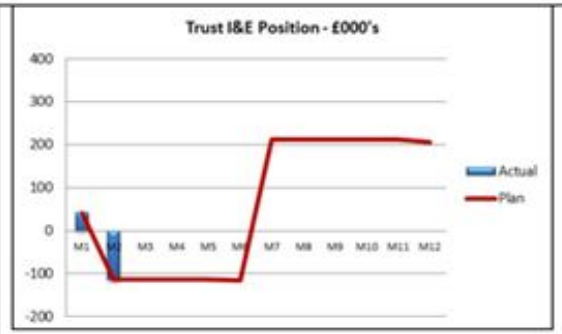
Key Finance Metrics

- Both in month and cumulatively positions are in line with the revised plan submission (a £0.1m deficit)
- Revised plan submitted to NHSE in June
- Phasing reflects revised plan
- Significant risks to planned surplus



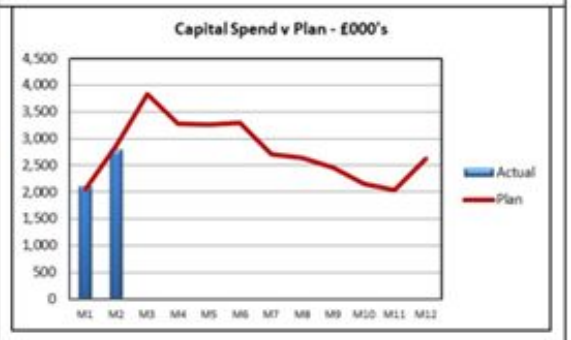
- £26.7m recorded in Month, £0.5m ahead of plan
- Position now reflects full inflationary funding
- £0.2m of MHIS shown in Month, balance not included pending final agreement
- No additional SDF funding shown
- Cumulative position incorporates £0.6m of EPOC income and £0.2m in relation to hostels

- Spend of £25.7m, £0.1m adverse to plan
- External bed expenditure of £1.3m in month is the highest monthly spend on record
- Monthly and cumulative overspend on external beds of £0.5m and £0.8m, respectively funded from slippage and reserve issues
- High external bed usage continues in June

- Agency spend in month £0.8m, highest reported since August 2023
- £0.3m above plan
- £0.1m increase on M1
- Equates to 4.1% of pay bill, 1.2% above NHSE target of 2.9%
- 43% of monthly spend on Nursing, 36% on Medical
- Community Service Line spend amounts to 59% of cumulative spend

- Cash balance at end of May £55.4m
- £0.2m adverse to plan of £55.6m
- The variance is made up of working capital (+£2.2m), capital spend (-£1.9m), PDC funding (-£0.8m), and interest receivable/payable (+£0.3m)

- Cumulative capital spend of £4.9m.
- There are no variances to plan as June resubmission required for the plan to match April and May actual
- The outstanding balance on the loan remains £99.4m



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Income Position

- Income is £0.9m favourable to plan
- Local contract income is £0.3m ahead of plan. This positive position is caused by additional funding for delayed transfer of care and the recognition of a small element of MHIS anticipated income not yet formally agreed. Both are offset by additional expenditure
- Provider Collaborative income is now £0.1m behind plan as AED inflow income remains below budgeted levels
- Other NHS Clinical Income is £0.2m ahead of plan. This additional income is due to extended packages of care funded by the SLP and offset by additional expenditure. This area also features the release of deferred income to offset the AED shortfall highlighted above
- Other Non-Clinical Income is now ahead of plan by £0.4m. This is driven by non-recurrent flows in relation to a utilities rebate
- All other categories of income are in line with plan.

Financial Reports 2024/25	Current Month			YTD month 2			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Local Contracts	19.8	20.1	0.3	39.0	39.4	0.3	234.2	234.2	0.0
Nhs England	1.9	1.9	0.0	3.7	3.7	0.0	22.4	22.4	0.0
Npsa Income	0.1	0.0	(0.0)	0.1	0.1	(0.0)	0.5	0.5	0.0
Provider Collaborative Income	2.2	2.2	(0.0)	4.8	4.8	(0.1)	27.9	27.9	0.0
Other Nhs Clinical Income	0.4	0.3	(0.1)	0.7	0.9	0.2	3.9	3.9	0.0
Nhs Clinical Income	**24.4**	**24.6**	**0.2**	**48.3**	**48.8**	**0.5**	**288.9**	**288.9**	**0.0**
Education & Training	0.7	0.7	(0.0)	1.5	1.5	0.0	8.5	8.5	0.0
Other Non Clinical Income	0.5	0.9	0.4	0.7	1.1	0.4	2.5	2.5	0.0
Merit Award Income	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.1	0.1	0.0
Non Clinical Income	**1.2**	**1.6**	**0.4**	**2.1**	**2.6**	**0.4**	**11.1**	**11.1**	**0.0**
Non NHS Clinical Income	0.5	0.5	(0.0)	1.0	1.0	0.0	5.7	5.7	0.0
Non Nhs Clinical Income	**0.5**	**0.5**	**(0.0)**	**1.0**	**1.0**	**0.0**	**5.7**	**5.7**	**0.0**
Income	**26.1**	**26.7**	**0.5**	**51.5**	**52.4**	**0.9**	**305.7**	**305.7**	**0.0**

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Pay Position

- Pay amounted to £17.7m in-month, an underspend of £0.3m which brings the cumulative position to £0.5m underspent
- Pay was £1.2m higher than in Month 1, principally the result of the inclusion of pay award costs (both paid and accrued) following national guidance to include in Month 2 reporting
- Medical Staff are £0.2m underspent due to vacancies. The budget and actuals are both reflective of the Consultant Pay Award, implemented in May
- Nursing budgets are overspent by £1.0m driven by acuity pressures on the wards and offset by £0.6m additional funding for extended packages of care.
- The underspend of £1.3m on Other Clinical staff primarily consists of Psychologist vacancies and continues the trend seen in previous years

Financial Reports 2024/25	Current Month			YTD month 2			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Medical	(2.9)	(2.7)	0.1	(5.4)	(5.2)	0.2	(32.5)	(32.5)	0.0
Nursing	(7.1)	(7.6)	(0.5)	(13.8)	(14.8)	(1.0)	(82.0)	(82.0)	0.0
Other Clinical	(4.8)	(4.1)	0.6	(9.4)	(8.1)	1.3	(56.5)	(56.5)	0.0
Non Clinical	(3.2)	(3.2)	0.0	(6.1)	(6.1)	(0.0)	(36.9)	(36.9)	0.0
Total Pay	**(17.9)**	**(17.7)**	**0.3**	**(34.6)**	**(34.2)**	**0.5**	**(207.9)**	**(207.9)**	**0.0**

- Spend on agency staffing is £0.5m adverse – further detail is provided on the next 3 slides
- Bank spend is broadly in line with plan
- Permanent staffing is showing a £0.9m underspend, driven by Psychologist vacancies

Financial Reports 2024/25	Current Month			YTD month 2			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Permanent	(15.3)	(14.7)	0.6	(29.4)	(28.5)	0.9	(203.6)	(203.6)	0.0
Bank	(2.1)	(2.2)	(0.1)	(4.3)	(4.2)	0.0	(4.1)	(4.1)	0.0
Agency	(0.5)	(0.8)	(0.3)	(0.9)	(1.4)	(0.5)	(0.2)	(0.2)	0.0
Total Pay	**(17.9)**	**(17.7)**	**0.3**	**(34.6)**	**(34.2)**	**0.5**	**(207.9)**	**(207.9)**	**0.0**

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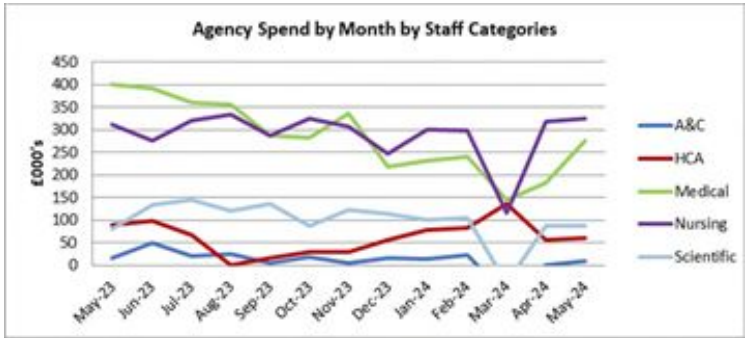
Agency - in month and cumulative position

- Agency expenditure in May was £760k (May 2023 £901k) and was marginally above 2023/24 average (£758k).
- It was the highest monthly spend recorded since August 2023
- May expenditure was £0.3m above plan, and amounted to 4.3% of the paybill (NHSE target = 2.9%)
- Of May expenditure, Nursing was the highest at £325k. Medical spend amounted to £276k with the next highest being Scientific at £88k. Each of these categories recorded increases over April expenditure
- Cumulative spend is £1.4m and is £0.5m above plan. Cumulative expenditure amounts to 4.1% of the paybill, again above target
- Of cumulative expenditure, Nursing is the largest element, amounting to £642k (46%). Medical amounted to £459k (33%) with the next highest being STTPs (scientific staff) at £177k (13%).
- The Community Service Line remains the highest user of agency staffing. Cumulative expenditure of £0.9m equates to 63% of the Trust total
- From July all Trusts are required (a) to end the use of off-framework agency staff and (b) to remove the usage of estates and admin agency staff (unless covered by exemptions). In May, the Trust used no off-framework agency but did report £9k of A&C staffing. However, post reporting it has been identified that this £9k is miscoded contractual expense rather than agency.



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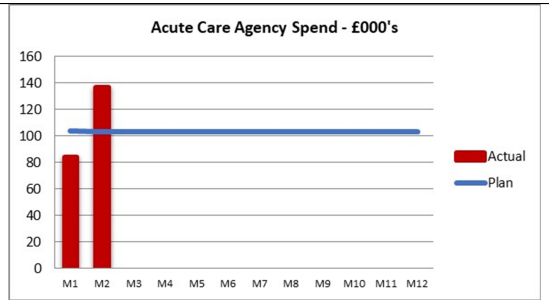
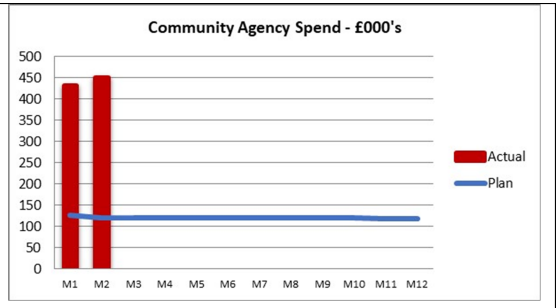
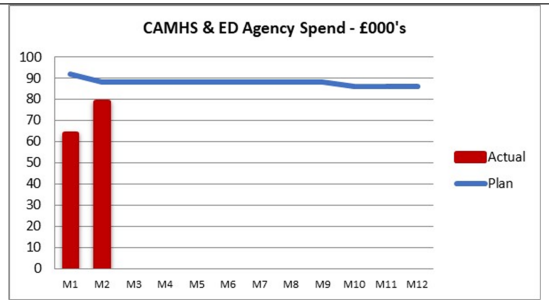
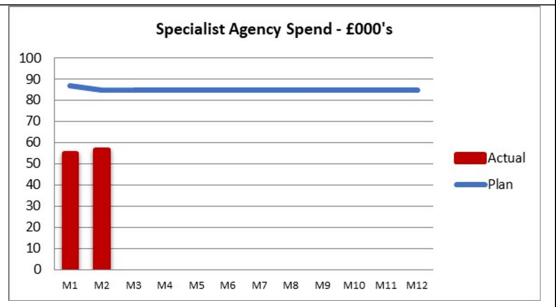
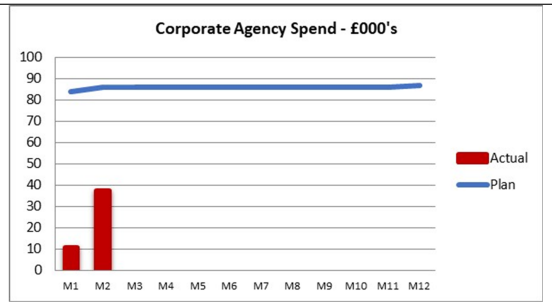
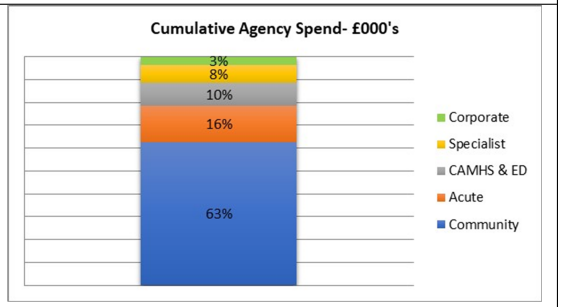
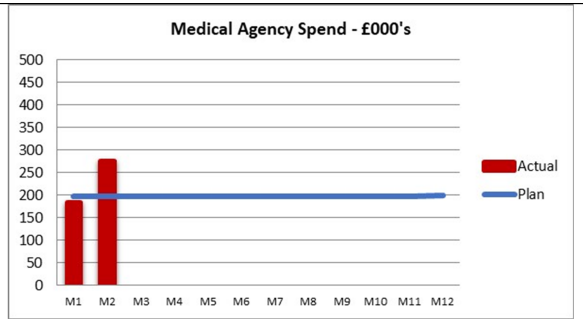
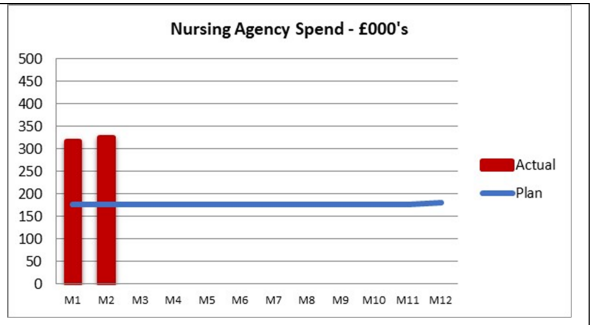
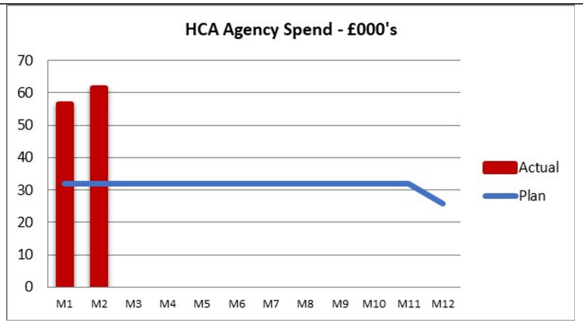
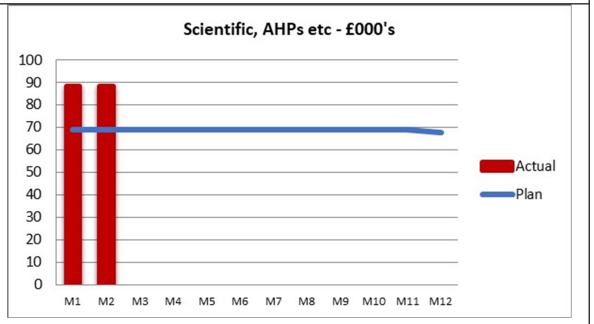
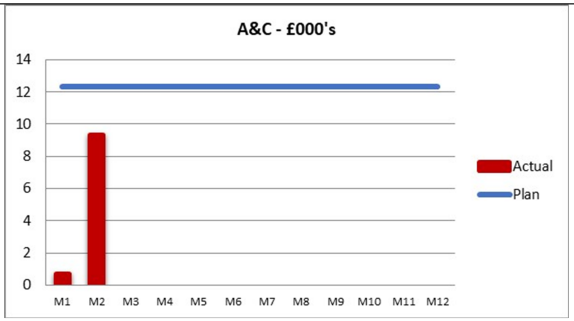
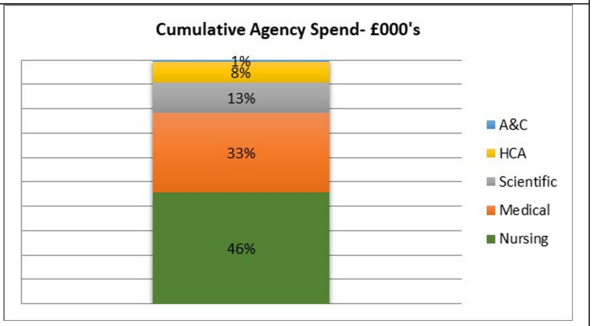
Agency – Service Line Positions

• In month spend of £137k • £34k above plan • £53k above M1 spend • Cumulative spend of £221k, £14k above target • Largest type of spend: Medical (£99k) followed by HCA (£74k), and Nursing (£48k) • £140k of total spend on wards, with £81k in Liaison Services • Highest area of spend: Liaison Psych - Kingston (£45k)		• In month spend of £451k • £330k above plan • £24k above M1 spend • Cumulative spend £883k. £636k above plan • Largest type of spend: Nursing (£491k), followed by Medical (£316k), and Scientific (£76k) • Highest areas of spend: Putney & Roehampton IRH (£88k) Twickenham Int Rec Hub IRH (£69k) and Central Wandsworth & West Battersea IRH (£60k)	
• In month spend of £79k • £9k below plan • £15k above M1 spend • Cumulative spend of £142k, £38k below plan • Largest spends: Scientific (£72k), Nursing (£48k) Medical (£14k), HCAs (£8k) • £123k of spend in community, £19k on wards • Highest area of spend: Camhs - Emergency Care Service (£19k)		• In month spend of £57k • £28k below plan • £4k below M1 spend • Cumulative spend of £112k • Largest spend: Nursing (£56k), HCA (£36k) Scientific (£20k) • £75k of spend in community settings, £37k in wards • Highest single area of spend: Sutton & Merton MHLD (£21k)	
• Spend of £37k in month • £71k below target • £27k above M1 spend • Cumulative spend of £48k with Medical (£28k), Pharmacy (£10k), HR (£9k)(miscode to be moved in M3) and Finance & Information (£1k) • Largest area of spend: Medical (£28k) relating to junior doctor spend held centrally		• Largest area of cumulative spend = Community (63%) • CAMHS ED – 10%, Acute = 16% • Specialist = 8%, Corporate = 3% • Service line and Corporate split = 97/3. Last year amounted to 96/4	

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

Agency – By Staff Group

• In month spend of £276k • £79k above plan • £93k above M1 spend • Cumulative spend of £459k, £65k above target • £58k of total spend on wards, with £331k in Community settings and £42k in HTTs/Liaison • Highest area of spend: Putney & Roehampton IRH (£69k)		• In month spend of £325k • £149k above plan • £8k above M1 spend • Cumulative spend £642k. £291k above plan • £593k of spend in Community settings, £9k on wards, and £40k within HTTs/Liaison • Highest area of spend: Mitcham IRH (£40k)	
• In month spend of £62k • £30k above plan • £5k increase on M1 spend • Cumulative spend of £118k, £54k above plan • Totality of spend on wards • Highest area of spend: Ward 1 (Male P.I.C.U.) (£23k)		• In month spend of £88k • £19k above plan • £1k below M1 spend • Cumulative spend of £177k, £39k above plan • £164k of spend in Community, £10k in Pharmacy, and £3k in wards • Highest single area of spend: Talk Wandsworth (£31k)	
• Spend of £9k in month • £3k below target • £8k above M1 spend • Cumulative spend of £10k, £15k below target • Largest area of spend: Education & Development (£9k) – miscode, not agency, to be corrected in M3.		• Largest area of cumulative spend = Nursing (46%) • Medical = 33% • Scientific = 13%, HCA = 8%, A&C = 1% • Clinical/Non-Clinical split = 99/1, last year amounted to 97/3	

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

Non-Pay & Post EBITDA

- Non-Pay budgets overspent by £0.9m in the month and are cumulatively £1.7m overspent
- The Secondary Commissioning overspend is driven by extremely high external bed usage in the two months to date
- Other costs are now overspent by £0.5m. They key driver of this overspend is uncleared CIP balances. This will change over time as CIPs are identified and enacted
- Other budgets remain broadly in balance

Financial Reports 2024/25	Current Month			YTD month 2			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Drug Costs	(0.2)	(0.2)	0.0	(0.4)	(0.4)	0.0	(2.3)	(2.3)	0.0
Clinical Supplies & Servs Cost	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	0.0	(0.6)	(0.6)	0.0
Secondary Commisioning Costs	(4.8)	(5.4)	(0.6)	(9.0)	(10.2)	(1.2)	(53.8)	(53.8)	0.0
Other Costs	(2.0)	(2.4)	(0.3)	(5.0)	(5.5)	(0.5)	(25.0)	(25.0)	0.0
Contingency	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Pay	**(7.1)**	**(8.0)**	**(0.9)**	**(14.4)**	**(16.1)**	**(1.7)**	**(81.6)**	**(81.6)**	**0.0**

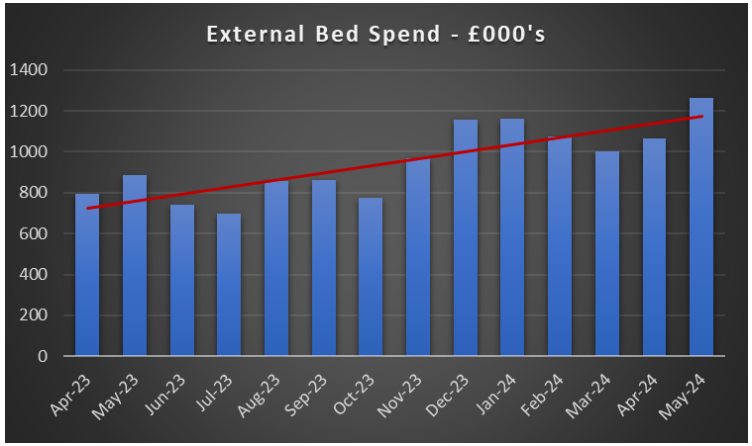
- Post EBITDA costs are now £0.3m favourable to plan due to higher than planned interest receivable on cash balances
- The review of PDC and depreciation budgets (and the impact of IFRS 16) has now been completed with required changes made and reflected in budgets
- There are no planned impairments for the year. As in previous years market valuation impairments will be calculated at year end following the review by the district valuation office. The Trust is not performance managed against impairments of this nature.
- There are no planned profits from asset sales.

Financial Reports 2024/25	Current Month			YTD month 2			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Cap Charges - Depreciation	(0.9)	(0.9)	(0.0)	(1.8)	(1.8)	(0.0)	(11.5)	(11.5)	0.0
Cap Charges - Pdc Dividend	(0.3)	(0.3)	0.0	(0.7)	(0.7)	0.0	(4.5)	(4.5)	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest	0.0	0.2	0.2	0.1	0.4	0.3	0.6	0.6	0.0
Profit / (Loss) On Asset Disps	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Post EBITDA	**(1.2)**	**(1.1)**	**0.2**	**(2.5)**	**(2.2)**	**0.3**	**(15.4)**	**(15.4)**	**0.0**

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

External Beds

- May expenditure of £1.3m was the highest experienced by the Trust to date, above 2023/24 peak levels and £0.4m higher than May 2023
- External bed usage remains the key cost driver of the Trusts underlying deficit position.
- This analysis of external beds incorporates unplanned external bed usage as well as contracted beds at Holybourne and ELFT (both Acute and Female PICU)
- Significant external bed costs incurred in 2022/23 continued into 2023/24, and have further increased in the early part of 2024/25
- Expenditure of £1.3m was £0.35m above the monthly average for 2023/24 and amounted to a £0.5m overspend in month
  - Additional bed costs were funded primarily by investment slippage in both 2022/23 and 2023/24, funding for 2024/25 is not yet confirmed. The overspend to date is effectively being covered by pay underspends, a small assumption regarding MHIS funding and reserve releases
  - Of the cumulative expenditure: £1.5m was at Holybourne, £0.6m was spent on Female PICU, £0.2m on Male PICU, and £0.1m on other Acute beds
  - The current budgetary base is 30 Holybourne beds, 0 additional Acute beds, 3 female PICU beds, 0 male PICU beds, totalling 33 beds. Actual usage averaged some 50 beds each day in May, 17 beds above plan and resulting in the £0.5m overspend
  - The cumulative overspend now stands at £0.8m
  - Early indications are again that extremely high usage has continued into June and a significant budgetary pressure will again be experienced in Month 3
  - The Trust has been given notice in relation to its use of Female PICU beds at ELFT from 31 July, which is likely to lead to a higher average unit cost paid after that date, an additional financial pressure



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

Service Line Positions

- All budgetary positions are reflective of CIP targets, devolved in Month 1
- Whilst the overall position remains on plan, there is significant variation in Service Line performance
- Acute Care is now £1.3m overspent driven by external bed pressures and uncleared CIP balances
- CAMHS & ED is £0.4m underspent due to continued recruitment slippages
- Community is now in a position of break-even
- Specialist Services are in line with plan
- Corporate costs are £0.5m favourable to plan due to income over-recoveries and reserves releases to cover external bed usage
- Capital costs are £0.3m favourable due to additional interest receivable.
- The forecast for the year is for a £0.7m surplus (£0.8m after normalisation adjustments). There are no planned impairments/profit on sale of assets. As detailed previously, the Trust is managed on the pre-impairment/profit on sale position

Financial Reports 2024/25	Current Month			YTD month 2			12 Mths to 31 March 2025		
	Budget	Actual	(Adv)/ Fav'ble	Budget	Actual	(Adv)/ Fav'ble	Budget	F/Cast	(Adv)/ Fav'ble
Acute And Urgent Care	(4.4)	(5.2)	(0.8)	(8.6)	(9.9)	(1.3)	(51.5)	(51.5)	0.0
Camhs & Ed	(2.9)	(2.7)	0.2	(5.8)	(5.4)	0.4	(34.1)	(34.1)	0.0
Community (Adults)	(4.8)	(4.9)	(0.0)	(9.5)	(9.5)	0.0	(56.8)	(56.8)	0.0
Specialist Services	(2.9)	(2.9)	(0.0)	(5.7)	(5.7)	0.0	(33.8)	(33.8)	0.0
Corporate	16.1	16.7	0.6	32.0	32.6	0.5	192.3	192.3	0.0
Capital Costs	(1.2)	(1.1)	0.2	(2.5)	(2.2)	0.3	(15.4)	(15.4)	0.0
Total	**(0.1)**	**(0.1)**	**0.0**	**(0.1)**	**(0.1)**	**0.0**	**0.7**	**0.7**	**0.0**

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

Savings – YTD Position

- **Target £18m -** £16m schemes identified; £1.2m (7%) overprogramming; £2.4m Green (13%), £5.7m Amber (32%), Red £7.9m (44%).
- **Net Unidentified** after overprogramming adjustment which is built into local targets is £1.8m (10%)
- **Delivery Confidence** – £7.2m (40%), value comparable to this time last year, % confidence has deteriorated due to larger target.
- **YTD Delivery** – £2.7m delivered in line with plan, over delivery on technical savings e.g. interest receivable, offsetting operational slippage – typically service line savings are 'declared' one month in arrears
- **Recurrent Target £12.5m (70%)** – increase of 8% compared to the 2023/24 delivered position (62%) . Reporting of actuals to commence in future months

Status	£000s	%	Risk Level	Expected
Fully Developed	2,406	13%	0%	2,406
Plans In progress	5,729	32%	50%	2,865
Opportunity	7,912	44%	75%	1,978
Unidentified	3,098	17%	100%	-
Overprogramming	- 1,200	-7%		
Total	17,945	100%	40%	7,249

Gap / Risk	10,697

	Trust Wide Scheme £k	Plan	Recurrent	Non-Recurrent	YTD Plan	YTD Actuals	YTD Variance
Enhanced Flow	Bed reduction	500	500	0	167	0	-167
	Observations	133	133	0	22	0	-22
Productivity	Clinical / Digital Efficiency	500	500	0	83	0	-83
Workforce Scheme	Recurrent vacancy factor	2,660	2,660	0	585	183	-402
	NR Stretch vacancy factor	918	0	918	100	280	180
	Workforce Planning	500	500	0	83	1	-82
	Operational control of spend	751	751	0	125	0	-125
	Sickness mgmt.	311	311	0	52	0	-52
Income Schemes	Private Patients	50	50	0	8	0	-8
	Retail units	35	35	0	6	0	-6
Technical	Technical Savings	8,267	2,600	5,667	1,073	2,165	1,092
Local Schemes	Local Schemes	4,520	4,520	0	581	57	-525
Other Adjustments	Overprogramming	-1,200	0	-1,200	-200	0	200
	Scheme Total	17,945	12,560	5,385	2,686	2,686	- 0
	Recurrent / Non-recurrent %		70%	30%			

Service Line	Plan £k	YTD Plan	YTD Actuals	YTD Variance
Acute And Urgent Care	2,213	369	95	-274
Camhs & AED	1,757	293	6	-287
Community (Adults)	2,666	444	293	-151
Specialist Services	1,853	309	0	-309
Operations	8,489	1,415	394	-1,021
Corporate	2,389	398	62	-336
Technical Savings	8,267	1,073	2,165	1,092
Undeclared vacancy underspends	0	0	65	65
Overprogramming	-1,200	-200		200
Scheme Total	17,945	2,686	2,686	-0

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	4.1	2.7	1.4	4.5	4.5	0.0	28.2	28.2	0.0
Estates Maintenance	(0.1)	0.0	(0.1)	0.1	0.1	0.0	2.2	2.2	0.0
IT/Digital	0.2	0.1	0.1	0.3	0.3	0.0	2.2	2.2	0.0
Operational Total	4.2	2.8	1.3	4.9	4.9	0.0	32.7	32.7	0.0
Leases	0.0	0.0	0.0	0.0	0.0	0.0	8.4	8.4	0.0
Total Capital Expenditure	**4.2**	**2.8**	**1.3**	**4.9**	**4.9**	**0.0**	**41.1**	**41.1**	**0.0**

- The operational plan of £41.1m is consistent with the June plan submission and consists of £28.2 for EMP of which Phase 2 is £16.5m, Barnes £9.3m and £2.5m for other EMP schemes. Estates and IT make up the remainder, split £2.2m each respectively. Of the total spend for 2024/25 £10.1m is funded by national Public Dividend Capital, with the balance funded through Trust funds including prior year asset sales.

- The plan also includes £0.5m relating to new leases that may materialise in 2024/25 and £7.9m of leases due for renewal during the year, including the Kingston leases relating to the absorption of new services from 1 April, due to be signed in July 2024.

- Capital expenditure for the month is £2.8m. Cumulative spend is £4.9m with all categories reported in line with plan.

- The forecast position assumes the approval of the EMP phase 2 (Tolworth) business case and no material planning delays.

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

Public Sector Payment Policy (PSPP)

- The Better Payment Practice Code requires all Trusts to pay 95% of invoices within 30 days. The metric is calculated based on the number of invoices and the value of invoices.
- In 2022/23 the 'by number' value fell below target and whilst the Trust benchmarked well compared to other Trusts it recognized the need to improve.
- In 2023/24 the Trust exceeded the target 'by value' of invoices with actual delivery at 96.5% and achieved 94.5% 'by number' of invoices. Whilst this was 0.5% short of the target of 95%, it was a significant improvement from the 2022/23 position of 88.7%.
- The 2023/24 values have been agreed and audited as part of the financial statements audit, which was completed well ahead of the timeline from the previous year, due to the robustness of the improved process.
- At M2, the Trust achieved the target for both cumulative % 'by value' (96.5%) and % 'by number' (97.0%).
- There is no automatic way of reporting against local SMEs. A snapshot in M10 identified that 94% 'by value' were being paid within 30 days. Recent process changes are likely to have improved this ratio.

	% Value	% Number
2022/23 Full Year	95.4%	88.7%
2023/24 Full Year	96.5%	94.5%
2024/25 - M1	95.9%	97.0%
2024/25 - M2	97.1%	97.1%
2024/25 - Cumulative	96.5%	97.0%

Meeting:	Trust Board
Date of meeting:	11th July 2024
Transparency:	Public
Committee Name	Modernisation Committee (MC) – 7th May meeting
Committee Chair and Executive Report	Juliet Armstrong (Chair) Ian Garlington (Executive)

BAF and Annual Delivery Plan the committee is accountable for:

BAF Risk Description 1347
A failure to deliver transformed models of care, working practices and environments within available resources

Annual Delivery Plan Enabling/supporting areas of work:

- To deliver our Better Care programme enabling service users to experience care as close to home as possible with a focus on recovery and outcomes
- To create Better Environments providing state of the art mental health facilities, improving access to outcomes and reinvigorating working practices for staff and service users alike.

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

The Board to note:

- **Drivers for long lengths of stay in inpatient beds and on community caseloads**:
  - The Committee commended the recent detailed work done to determine the factors driving the adult acute length of stay and community caseloads. The factors are multi-factorial for both but highlighted the high number of long stay patients in the acute inpatient services with a LOS of 90 plus days and this will be a key focus for the recommendations.
  - The Committee noted the engagement of staff in this work as well as the ongoing need for high engagement, particularly from medical colleagues and lived experience network. The recommendations will be incorporated into the new Adult Patient Journey (APJ) programme, to be launched soon.
- **Q4 annual delivery plans report and 2024/25 priorities**: The Committee noted the Q4 Annual Delivery Plans report and 24/25 Priorities for transformation, recognising much work had been delivered in 23/24.

Areas of Risk Escalation to the Board:

- None

Item discussed- Better Care : Identifying our drivers of long lengths of stay in inpatient beds and on community caseloads

Assurance Position

Good assurance was provided on this recent piece of analysis work, noting:

- The engagement with the acute and urgent care service line and Consultant body as well as Community Leadership and Clinical Management within the Community Service line
- The analysis presented, including data from other trusts and data over previous years
- The results of analysis and supporting data and evidence (or lack of) highlighting the following drivers for inpatients i) high numbers of long stay patients with LOS > 90 days ii) low number of short stay patients compared to other Mental Health Trusts iii) delays along our care pathways iv) variations in data reporting and use of definitions
- Over half of long stay inpatients (LOS > 90 days) were clinically ready for discharge with top 3 reasons for waits being i) for supported accommodation ii) for other NHS care iii) for a care package in their own home
- The community work has multiple reasons for size and time on caseload, including recruitment challenges, wait times for psychological therapies, variable discharge planning
- The importance of taking a full view along the entire patient journey and continuing to improve linkages between adult and urgent care and community teams and pathways.

Evidenced by

Papers presented to MC.

What next?

- Continue communication and engagement of the findings and recommendations
- Continue with some analysis and also benchmarking from other South London Partnership (SLP) Trusts, particularly how they are managing patient complexities and access to rehab services
- Incorporate recommendations into the APJ work being mobilised.

Item discussed- Q4 annual delivery plans report and 24/25 priorities

Assurance Position

Good assurance was provided and the following noted:

- A significant amount of work had been completed during 23/24, with the majority of metrics meeting or exceeding targets
- Much of the focus for next year will be the new APJ programme which is one of the top two priorities for the Trust in 24/25.

Evidenced by

Papers presented to MC

What next?

- Review progress quarterly

Appendices

All annual reports and other items that require to be in the full Board papers will be appended to the Committee Report

- Minutes of the 7th May 2024 MC meeting (Part A)
- Annual Report of MC

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

MODERNISATION COMMITTEE – BUSINESS MEETING PART A (PUBLIC)

Minutes of the meeting held on Tuesday 7th May 2024 at 2.30pm, via MS Teams

Present:	
Juliet Armstrong (JuA)	Non-Executive Director (MC Chair)
Jennifer Allan (JA)	Chief Operating Officer
Humaira Ashraf (HA)	Associate Non-Executive Director (Deputy MC Chair)
Ann Beasley (AB)	Trust Chair
Ian Garlington (IG)	Integrated Programme Director
Jenna Khalfan (JK)	Director of Communications & Stakeholder Engagement
Philip Murray (PM)	Chief Finance Officer & Deputy CEO
Amy Scammell (AS)	Director of Strategy, Transformation and Commercial Development
Attendees:	
Jermaine John (JJ)	Better Communities, Project Support Officer (minutes)
Stephen Reid (SR)	Diversity in Decision Making Representative
Toyin Oshodi (TO)	Diversity in Decision Making Representative
Apologies:	
Sola Afuape (SA)	Non-Executive Director (MC NED observer)
Billy Boland (BB)	Chief Medical Officer
Emily Downey (ED)	Integrated Programme Delivery Manager
Richard Flatman (RF)	Non-Executive Director
Vanessa Ford (VF)	Chief Executive
David Lee (DL)	Director of Corporate Governance
Katherine Robinson (KR)	Chief People Officer
Sharon Spain (SS)	Chief Nurse

Item		Action
24/59	**Apologies** The apologies for absence were noted. JuA chaired the meeting	
24/60	**Declarations of Interest** There were no formal declarations of interest reported for part A.	
24/61	**Chair's Actions** The Chair took no action on behalf of the Committee outside of the meeting for part A.	
24/62	**Minutes of the meeting held 5th March 2024 (Part A)** The minutes of the meeting held on Tuesday 5th March 2024 (Part A) were approved as an accurate record.	
24/63	**Action Tracker and Matters Arising (Part A)** Updates are included on the action tracker.	
24/64	**MC Workplan for 24/25** The Committee noted the draft MC workplan for 2024/25.	

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Item		Action

24/65 Identifying Drivers of Long Lengths of Stay in Inpatient Beds and Community Caseloads

The Committee noted the report regarding long lengths of stay (LOS) in inpatient beds and on community caseloads. JuA noted that the length of stay drivers was a thorough piece of work, very impressed with holistic nature in-which the analysis was completed. JA thanked Ranjan Kale, Ryan Baulk, Charlotte Harrison, Richard Morton, and colleagues within the transformation team who worked on the document.

JA provided the following key points:

- there are two aspects to this piece of work in terms of both Acute and Community length of stay. One is the context which enabled an understanding of the broader picture of length of stay. The second aspect is around staff engagement, recognising there is a broader topic about engaging with patients, carers, families in transformation work moving forward. The Committee noted the importance of enhancing engagement with staff in the Adult Patient Journey (APJ) work.

- There has been engagement with the Acute and Urgent Care service line and the consultant body. There has also been some engagement within the Community Leadership and Clinical Management within the Community service line.

- One of the key findings is that there is a requirement to focus on the patients with a long length of stay greater than 90 days, sometimes known as 'stranded patients'. There is a disproportionately high number of patients who stay longer than 3 months within the acute service line, which is a long time to be on an acute ward. Some patients stay much longer than this.

- There are patients in acute service cohort who are clinically ready for discharge and there are complexities with their discharge, but also patients who have not recovered which will also need to be reviewed. This is a key priority and will shape the APJ scoping works going forward.

- JA reported that there are fewer shorter stay patients due to the Lotus Patient Day Unit (PDU) model to support patients in crisis It has been identified that there is a degree of cumulative delay and procedures being carried out slower. JA noted that there is additional methodology that can be implemented into these processes. This work is currently ongoing.

- Being purposeful for admissions is an important principle for the APJ. This should be is agreed in co-production with the patient and the responsible consultant under Mental Health Law, where relevant, and being rigorous in the data and definitions, in conjunction with our medical workforce. This is being discussed at the Trustwide Medical Advisory Committee (MAC) including the discussion around median lengths of stay. This provides the understanding that the long length of stay is really the key problem here.

Item **Action**

JA referred to the key drivers via the LOS benchmarking presentation.

- Following the review of the Community caseload which sets out the key drivers, there is quite a broad area for further work in the Community and workforce. There is also a degree of embedding and sustaining within the workforce.
- . Care planning needs to be clear about the purpose of secondary community mental health care upfront and agree this with the patient, agree when care will end and ensure that GPs are willing to support patients at the end of care.

- There are also improvements that can be made to the effectiveness of the acute pathway e.g. not allowing issues to elongate due to DNAs

- System procedures are another key driver. This is to ensure that the primary care interface and zoning is effective with the nature of activity delivered, face to face or virtual with the use of primary care mental health teams.

- JA noted that the final key driver, primary care pathways from a community aspect of APJ and the interface, is critical to primary care and the system. There is currently work taking place to review the primary care network mental health workers and the joint care pathways.

The above points will be incorporated into the APJ programme The following key points were raised in discussion:

- HA noted that the mean length of stay is higher than other trusts, even though the number of admissions has reduced, with the number of beds increased. JA confirmed that the reason that the Trust's mean is considerably higher than other trusts is because patients with very long lengths of stay in the data set is driving the average mean up, but not the median. The benchmarking data does not factor in that the Trust has commissioned an additional 30 plus beds from the private sector. The number of funded NHS beds in south west London per head of population is low.

- HA clarified when compared to previous years and other trusts, does the Trust have patients with more clinical needs than other trusts? JA stated there is a hypothesis that is currently being explored.

- In addition, JA noted one of the aspects of the long length of stay review is working further with the South London Partnership (SLP) to see if there are ways that they are managing patient complexities, particularly around access to rehab. One of the key factors is that there is very poor access to rehab services in south west London; a number of Rehab services were decommissioned. There are a few boroughs who are struggling much more than they were in previous years, particularly Sutton and Merton

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Item	Action

- HA asked is there a hypothesis that we are more risk averse? This is a strongly debated topic currently amongst clinicians and the Executive. The Trust has a low re-admission rate compared to other Trusts which implies overall we do not discharge too early, although some consultants may feel under pressure to discharge given demand. HA noted that NHS England (NHSE) have discussed that all trusts must review this clinical risk aspect.

- JA restated that this is why it is important to engage with the medical leadership, particularly around risk management.

- JuA reported that 58% of service users had a blank diagnosis code. In terms of the cohort of service users who are the longest stayers, most have schizophrenia. JuA asked JA, is there a concern that there are quite a high number of patients with a blank diagnosis code and are there any initiatives around what more the Trust could do for service users who have schizophrenia? The LOS work highlights there is a requirement to review/focus on the schizophrenia treatment pathway.

- JA noted that there are concerns raised around the lack of diagnosis codes. This is due to a technical issue with the inpatient diagnosis coding. The backlog is currently being worked through. Unfortunately, this has caused an impact but not long term.

- In terms of community, there is concern that the diagnosis coding has not been the focus. Ian Petch, Head of Psychological Therapies, is currently working with the Clinical Directors and the teams to try and improve the rate of diagnosis coding in the Community.

- JA noted the schizophrenia work links with the rehab work. Charlotte Harrison, (rehab lead) and colleagues across the community teams/specialist services have a specific focus on rehab. This may be a driver for the schizophrenia cohort.

- JuA asked how we could maximise the chances of a successful process. JA confirmed that there will be a combination of consolidation and engagement with teams. There is an urgent requirement to allow colleagues to consolidate and implement the changes that have either been made or have just commenced, particularly around the crisis and psychiatric liaison services, the discharge planning pathways in acute and the new roles in Community. It is important to bring teams together and overcome the interfaces, and to use Quality Improvement (QI) There will also be an opportunity through the Dialog Plus care planning work to strengthen engagement and clarity of responsibilities. The above will be integrated into the APJ programme.

- The updated APJ Programme will be reviewed at the Better Communities Transformation Group meeting (BCTG) and then at the next Modernisation Committee (MC) taking place Tuesday 2nd July 2024.

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Item	Action

24/66 Q4 Annual Delivery Plans Report

The Committee received and noted the Q4 Annual Delivery Plans Report. AS updated on the following key points:

- An enormous amount of work has been produced within the MC and the BCTG in the past year. The report includes the year end outturn and to flag any pieces of work that will move forward for 24/25, regardless of where those might sit within the organisation.

- The Committee noted that the discussions and conversations around the priorities have now been consolidated and reviewed, including the work that had been drafted for 24/25 priorities. One of the two top priorities for the organisation is Adult Patient Journey which JA is leading on. This will be reviewed at the Board of Directors meeting taking place on Thursday 9th May 2024.

- Once reviewed and approved, the aim is to report back every quarter through the MC structure.

The following key points were raised in discussion:

- JuA thanked AS, noting that the majority of metrics across all the priority areas have exceeded their targets.

- JuA noted that there is an additional KPI around percentage of service users with a LOS greater than 90 days, and asked AS if there were any additional KPIs that have arisen out of LOS drivers. It was noted that there was no average length of stay listed on the metrics, only greater than 90 days. JuA suggested that the median length of stay should be tracked.

- AS stated that this is due to the committee timings (BCTG and MC) the reports were presented prior to the finalisation of the Trust Board papers. The updated paper will be reviewed at the Trust Board on Thursday 9th May 2024. AS noted that JA has been reviewing the 90 day/average length of stay and refining the targets and the metrics.

- JA noted there was a particular proposal around replacing the average length of stay with the over 90 day length of stay. It is important to review this metric, in line with the length of stay analysis work.

- The committee noted the Q4 delivery and the good delivery around the transformation priorities.

24/67 2024/25 Priorities

The Committee received and noted the 2024/25 Priorities and that they will be reviewed and agreed at the Board of Directors meeting taking place on Thursday 9th May 2024. Paper to be reviewed at the next MC meeting.

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Item	Action

24/68 Messages to Trust Board (Part A)

JuA confirmed the key messages for the Trust Board (Part A) from the Committee are:

- The Committee commended the recent detailed work done to determine the factors driving the adult acute length of stay and community caseloads. The factors are multi-factorial for both but highlighted the high number of long stay patients in the acute inpatient services with a LOS of 90 plus days and this will be a key focus for the recommendations.

- The Committee noted the engagement of staff in this work as well as the ongoing need for high engagement, particularly from medical colleagues and lived experience network. The recommendations will be incorporated into the new Adult Patient Journey programme, to be launched soon.

- The Committee noted the Q4 Annual Delivery Plans report and 24/25 Priorities for transformation, recognising much work had been delivered in 23/24.

24/69 Next meeting

The next business meeting will be held at 2.30pm on 2nd July 2024 via MS Teams.

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ANNUAL REPORT
MODERNISATION COMMITTEE for the FINANCIAL YEAR 23/24

1. Introduction

1.1. Committee Establishment

The Modernisation Committee (the Committee) is an established committee of the Board of Directors. The name of the Committee was updated from the Estates Modernisation Committee to Modernisation Committee in September 2023.

1.2. Committee Purpose & Duties

During 23/24 the Committee was charged with ensuring there were robust processes in place to manage and deliver aspects of the Trust's Better Communities Programme that are essential to the delivery of the Tolworth Business Case namely:

- **Better Environments** including Shaftesbury, the Tolworth Business Case, fifth ward options appraisal, Springfield Village, Richmond Royal, Barnes and EMP finances.
- **Better Care** including acute & urgent care and community transformation, complex emotional needs pathway related transformation.
- **Better Digital and Better Communications** for the above areas.

Areas overseen included:
- Receiving progress updates on the Better Communities Programme, and taking assurance from the Better Communities Transformation Group (BCCTG)
- Reviewing risks and risk management, financial reports, stakeholder engagement and any changes to the business case
- Receiving summaries of reports from the Independent Certifier and Trust representative relating to the quality of the construction and progress of the work and;
- All disclosures relevant to its Terms of Reference.

The Committee has overall responsibility for providing the Board of Directors (the Board) with a means of independent professional advice and to secure the attendance of outsiders with relevant experience and expertise as it considers necessary.

The Committee is authorised by the Board in the following areas:
- To investigate any activity within its Terms of Reference; and
- To seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

1.3. Terms of Reference

The Committee Terms of Reference were updated and agreed by the Trust Board of Directors in September 2023. The full details of the Committee's duties are outlined in the Terms of Reference in Appendix 1 (March-September 2023) and Appendix 2 (October 2023 to present).

A full review of the Committee workplan and the meetings that report into the Committee has been undertaken in order to support good governance.

2. Membership & Meeting Attendance

The Committee is chaired by a non-executive director and has as other members:

- Trust Board Chair
- Chief Executive (also BCTG Chair and SRO of the Better Communities Programme)
- Two additional non-executive directors
- Better Communities Director
- Chief Finance Officer
- Chief Operating Officer
- Chief Nurse

There is wide representation due to the scope of the Better Communities Programme and attendees invited include the Audit Committee Chair, Chief Strategy Officer, Director of Communications and Stakeholder Engagement, Director of Corporate Governance and two Diversity in Decision Making (DIDM) representatives. The Terms of Reference shows the full make-up of the Committee. From time-to-time external advisers have attended.

The Committee has really benefitted from the attendance of now two DIDM representatives and thanks them in particular for their contribution and challenge.

During the period the Committee met 8 times and the attendance is set out below in **Table 1**. As per the recommendation in the previous annual report, the Committee reduced frequency from monthly to bi-monthly which happened from September 2023 as the Phase 1 (Springfield) moves had been delivered with the completion of Shaftesbury.

Table 1 - Members and Meeting Attendance - 01 April 2023 to 31 March 2024.

MC Attendance 2023/24				Business	Business	Business	Business	Business	Business	Business	Business
ToR Role to Sep23	**ToR Role from Oct23**	**Title**	**Name**	**04/04/2023**	**02/05/2023**	**06/06/2023**	**04/07/2023**	**05/09/2023**	**07/11/2023**	**09/01/2024**	**05/03/2024**
MC Chair	MC Chair	Non-Executive Director	Juliet Armstrong	x	x	x	x	x	x	x	apols
Executive Lead	Executive Lead	Integrated Programme Director	Ian Garlington	apols	x	x	apols	x	x	x	x
Member	Ex officio	Trust Chair	Ann Beasley	x	x	x	x	x	x	x	x
Member	Member	Non-Executive Director (NED member for EMC)	Vik Sagar	apols	x	x	x	x	apols	apols	apols
Member	Member	Non-Executive Director (NED observer for EMC)	Sola Afuape	apols	apols	apols	apols	apols	apols	apols	apols
Member	Member	Non-Executive Director	Doreen McCollin								
Member	Member	Non-Executive Director	Deborah Bowman	apols	apols	apols	apols	apols			
Member	Member	Non-Executive Director	Charlotte Clark	apols	apols	apols	apols				
Member	Member	Non-Executive Director	Jonathan Warren					x	apols	apols	apols
Member	Member	Non-Executive Director	Humaira Ashraf						x	x	x
Ex officio	Ex officio	Chief Executive	Vanessa Ford	x	x	x	apols	x	x	x	apols
Member	Member	Chief Finance Officer	Philip Murray	x	x	x	x	apols	x	x	x
Member	Member	Chief Nurse	Sharon Spain	apols	apols	apols	apols	apols	apols	apols	apols
Member	Member	Chief Operating Officer	Jennifer Allan	apols	x	x	apols	apols	x	x	x
Member	Attendee	Chief Strategy Officer	Amy Scammell	x	apols	x	x	x	x	x	apols
Member	Attendee	Director of Communications & Stakeholder Engagement	Jenna Khalfan	x	x	x	x	x	x	apols	x
Attendee	Attendee	Audit Committee Chair	Richard Flatman	apols	apols	apols	apols	apols	apols	x	apols
Attendee	n/a	Chief People Officer	Katherine Robinson	x	x	x	x	x	x		x
Attendee	n/a	Chief Medical Officer	Billy Boland	apols	apols	apols	apols	apols			
Attendee	Attendee	Director of Corporate Governance	David Lee	apols	apols	x	x	x	x	x	x
Attendee	Attendee	Diversity in Decision Making Representative	Stephen Reid	x	x	x	x	x	apols	x	apols
Attendee	Attendee	Diversity in Decision Making Representative	Toyin Oshodi						x	x	apols
n/a	n/a	Associate Director Integrated Programme	Anna Barnes	x	x	x	x	apols	x	x	
Minute Taker	Minute Taker	Integrated Programme Delivery Manager	Emily Downey	x	x	apols	x	x	x	x	x

Key
x = present / apols = apologies
no longer part of the Committee / left the Trust

3. Committee Work & Activities

3.1. Annual Review - 01 April 2023 to 31 March 2024

The Committee conducted work in line with its purpose, recognising the complex and challenging overall environment that the Better Communities Programme is delivering within, including an increase in mental health demand and acuity that puts additional pressure on staff.

Notably the Committee:

- Oversaw regular **dashboard/project highlight, change control and finance reporting** for the Better Communities Programme.
- Regularly reviewed the **BAF and undertook quarterly risk reviews.**
- Ensured there was clear **assurance** including viewing the **Shaftesbury handover documentation and Tolworth Stage 4 Design**. However, there were no internal or external independent reviews conducted during the period.
- Approved quarterly delivery updates on **Corporate Objectives/Annual Delivery Plans** for submission to Trust Board.
- Approved **updated Terms of Reference** and programme documentation for the **Integrated Programme Refresh** covering the programme delivery framework and programme scope definition packs.
- Received regular deep dives on **Clinical Transformation** including Acute & Urgent Care, Community and CAMHS.
- Received regular deep dives on **Digital**, including Digital Strategy and leadership.
- Received regular updates on **Estates Modernisation** including Springfield Village, Barnes, Richmond Royal and Tolworth.
- Received regular reports on **move readiness and post-implementation**, including lessons learned to inform later moves.
- Received regular reports on **benefits tracking** for Phase 1 Springfield.

The items featured on the Committee's agenda during the period are included in **Table 2.**

Table 2: Committee Activity - 01 April 2023 to 31 March 2024 (all meetings held remotely)

Date	Format	Key topics
04-Apr-23	Business	Move Readiness/Post-implementation Review; Dashboard; Change Control, Finance Report; Community Transformation Deep Dive; Integrated Programme Refresh Update; Property Transactions; NHS Net Zero Building Standard; Workforce Planning 2023/24 Approach
02-May-23	Business	**Part A:** CAMHS Deep Dive; Evolving our Q&P Framework for 2023/24 **Part B:** Move Readiness/Post-implementation Review; Dashboard; Change Control, Finance Report; Quarterly Risk Review inc. BAF; Q4 Corporate Objectives Update; Update on Tolworth FBC; Summer Street Party/NHS 75; Update on Digital Strategy & Leadership Proposals
06-Jun-23	Business	**Part A:** Acute & Urgent Care Transformation Deep Dive **Part B:** Move Readiness/Post-implementation Review; Dashboard; Change Control, Finance Report; Fit-out and service for Chapel Square Unit 2 Commercial Restaurant; Quarterly Benefits Tracking

04-Jul-23	Business	**Part A:** Integrated Programme Refresh; Risk & Transfer Process to BAU; Digital Strategy Refresh; Green Plan Implementation Quarterly Review; Springfield Stakeholder Visits Update **Part B:** Move Readiness/Post-implementation Review; Dashboard; Change Control, Finance Report; Integrated Programme BAF Risk Review
August 23	N/A	No meeting
05-Sep-23	Business	**Part A:** Community Transformation Deep Dive; 2023/24 Corporate Objectives - Q1 Delivery; Committee Annual Report; EMC Terms of Reference Review; Formal Closedown of PRCC; KPI Report for EMC **Part B:** Move Readiness/Post-implementation Review; Dashboard; Change Control, Finance Report; Shaftesbury Sign-off Assurance Position; Phase 2 Tolworth Early Works; Retail Units Update; Barnes & Richmond Royal Update; Quarterly Risk Review; Note from Legal Compensation Meeting 16.08.23
07-Nov-23	Business	**Part A:** Acute & Urgent Care - Updated Impact Modelling; Shaftesbury Post-Implementation Review; Park Update; 2023/24 Annual Delivery Plans - Q2 Delivery **Part B:** Finance Report; Change Control; Programme Summary Reporting; Refreshed Programme Documentation; Shaftesbury Handover Documentation; Quarterly Benefits Tracking; BAF Review
09-Jan-24	Business	**Part A:** Tolworth Stage 4 Design Assurance; Digital Strategy Refresh Implementation Plan and Better Digital Scope Definition Pack **Part B:** Finance Report; Change Control; Update on Oak Unit Refurbishment Costs; Programme Summary Reporting; Quarterly Risk Review inc. BAF; Phase 1 Contingency Report; Retail Leases - Landlord Responsibilities
05-Mar-24	Business	**Part A:** Programme BAF Risk Review; Community Transformation Deep Dive, Acute & Urgent Care Transformation Deep Dive; 2023/24 Annual Delivery Plans - Q3 Delivery **Part B:** Finance Report; Change Control; Programme Summary Reporting; Shaftesbury Post Move Review

3.2. Forward Planning - April 2024 to March 2025

The Committee has developed a forward workplan for 2024/25. Deep dives will continue every six months for key programmes of work: Adult Patient Journey (APJ), Digital, Springfield Village & Park, Barnes & Richmond Royal and Tolworth. The focus on APJ will be particularly important as it is a key enabler in improving the patient experience, flow and reducing the current need for expenditure on private beds.

Quarterly updates will continue for the Risk Review, however Benefits Tracking is currently paused due to resourcing issues. Reviewing the Programme BAF is a standing item for every meeting.

Plan-related items will focus on overall programme summary reporting, financial review, change control, as well as BCTG updates. There are several assurance reviews due such as Gateway Review reports, Lessons Learned from AUC & Community Transformation and Post Project Evaluation (Phase 1).

Annual reviews of the transformation impact on health inequalities and how transformation is being embedded into the organisation are also scheduled.

The current forward workplan is detailed below in **Table 3**:

Table 3: Forward workplan 2024/25

Items	Frequency	Executive Lead	Part A/B	BCTG 26-Mar-24 Extraordinary MC 2-Apr-24	BCTG 23-Apr-24 MC 07-May-24	BCTG 18-Jun-24 MC 02-Jul-24	BCTG 27-Aug-24 MC 03-Sep-24	BCTG 22-Oct-24 MC 05-Nov-24	BCTG 17-Dec-24 MC 07-Jan-25	BCTG 25-Feb-25 MC 04-Mar-25
Standing Items										
Apologies	BM	JuA	A	√	√	√	√	√	√	√
Declarations of Interests	BM	JuA	A	√	√	√	√	√	√	√
Chair's Action	BM	JuA	A		√	√	√	√	√	√
Previous Minutes	BM	JuA	A&B		√	√	√	√	√	√
Action Tracker & Matters Arising	BM	JuA	A		√	√	√	√	√	√
Committee Workplan	BM	JuA/IG	A		√	√	√	√	√	√
Board Assurance Framework - Better Communities Programme BAF Risk Review	BM	IG	B		√	√	√	√	√	√
Plan Related Items										
Better Communities Programme Reporting	BM	IG	B		√	√	√	√	√	√
Better Communities: Change Control Register	BM	IG	B		√	√	√	√	√	√
Better Environments: Monthly Finance Report	BM	IG	B		√	√	√	√	√	√
Gateway 3 Report "Investment Decision" (Phase 2)	AR	IG	B		√					
Gateway 5 Report "Benefits Evaluation" (Phase 1)	AR	IG	B					√		
Post Project Evaluation - 6 months (Phase 1)	AR	IG	A					√		
Tolworth FBC Approval	AR	IG	B	√						
Inpatient LOS and Community Caseload Analysis	AR	JA	B		√					
Tolworth Review within Corporate Services and Clinical Support Team	AR	KR	A			√				
AUC & Community Transformation Lessons Learned Report	AR	JA	TBC				√			
Tolworth 5th Ward Options Appraisal (TBC)	AR	TBC	B							
Better Communities: Review of Benefits Approach (TBC)	AR	IG	A							
Presentations										
Adult Patient Journey Deep Dive	BA	AS	A			√			√	
Digital Strategy & Programme Deep Dive	BA	JA	A			√			√	
Springfield Village and Park Update	AR	IG	B		√			√		
Barnes & Richmond Royal Update	AR	IG	B			√			√	
Tolworth Update	AR	IG	B				√			√
Regular Reviews										
Risk Review	AR	IG	B		√		√		√	
Benefits Tracking (TBC)	BA	IG	B							
Better Communities: Annual Review - Reflection of Transformation impact on Health Inequalities	A	IG	A					√		
Better Communities: Annual Review on how transformation capability is being embedded into the organisation	A	IG	B						√	
Closing Items										
Better Communities Transformation Group Minutes	BM	IG	B		√	√	√	√	√	√
Messages to the Trust Board	BM	JuA	A&B	√	√	√	√	√	√	√
Meeting Review	BM	JuA	A&B		√	√	√	√	√	√
Site Visits/Principals Meetings										
for CEO/EMC Chair/Sir Robert McAlpine - TBC	AR	VF								
Committee Governance & Reporting										
Annual Delivery Plans - TBC	Q	AS	A		√					
MC Workplan 2025/26	A	JuA/IG	A							√
Committee Annual Report	A	JuA	A			√				
MC Terms of Reference Review	BI	DL	A				√			

KEY

A=ANNUALLY; M=MONTHLY; Q=QUARTERLY; BA=BI-ANNUALLY; AR=AS REQUIRED; BM=BI-MONTHLY

4. Assurance & Position Statement

The position on key items and the Committee's opinion and assurance is set out below for the period 2023/24:

Item	Committee's opinion	Key assurance
Construction Development Agreement (CDA) control/management	Good assurance on changes to and compliance with the CDA, including notice of satisfaction from the Independent Certifier (Kier) on Shaftesbury Handover. Change requests have been well managed.	• EMC/MC change control reports • Assurance on relevant documentation required through CDA for the handover of Shaftesbury • Assurance and input from Trust's external advisors (Gardiner and Theobold and Kier)
Status of the programme – Phase 1	**Better Environments (EMP)** There was safe opening of the Shaftesbury Building during 23/24 after a reported delay. This is testament to the huge effort and commitment by all staff and the committee thanked and congratulated them! The retail unit leases are being well managed. Springfield Park is being created for social value, with governance to ensure this. Learnings from the moves to date have been captured and staff and patients have been engaged in the pre-and post move process well. Themes have been summarised. **Better Care (AUC Transformation and Community Transformation)** Assurance has been provided through deep dives and regular reporting. Green shoots have been experienced for those boroughs which have already taken on the new Community Transformation model, although there have been on-going challenges with recruitment and embedding of new community roles. Despite a significant amount of work, including implementation of NHS exemplar initiatives to improve flow in the adult Acute and Urgent Care (AUC) pathway, length of stay (LOS) remained higher than target and an outlier when benchmarked against other Trusts. The committee has reflected that without all this work though, LOS would probably have been even higher given demand and patient acuity challenges.	• Pre and post move reports for the Shaftesbury Buildings, including lessons learned • Updates on the retail units including our obligations as a landlord • Social Value Vehicle proposal for Springfield Park • MC/EMC reports, including Finance reports • BCTG/EMMG reports • Community Transformation deep dives • AUC Transformation deep dives • CAMHS deep dives (descoped in the programme refresh) • Q&P reporting

	Further work will be taken forward next year, including to integrate the community and AUC streams through an Adult Patient Journey programme and to review step down facilities to support discharge. There is limited assurance that the LOS target can be met as at the end of 23/24. **Better Digital** There is assurance that we have a robust digital strategy in place for 23-28 and that plans are in place to strengthen digital skills and literacy within the Trust, as well as to enhance digital leadership within the service lines. **Programme scope and governance** The Programme refresh (highlighted in the previous annual report) was completed during the year to strengthen and review aspects of the programme including reporting and resourcing. The programme changed its name to Better Communities and this committee became the Modernisation Committee with more focussed remit as a result. Risks are being managed effectively. There is a process to track the original FBC benefits and each of the programmes have clear outcomes. Outcome trajectories are in place for Better Care. There is limited assurance that there is a robust, statistically valid approach to benefits tracking. This will be reviewed during 23/24.	• Digital strategy document • Updates on the digital strategy including leadership proposals • Integrated programme refresh documents and revised TORs for all aspects of the programme • Regular risk reviews, including review of BAF • High transparency of key risks, including escalation updates • Quarterly benefits reviews and reviews of outcomes (using a consistent approach covering access, recovery, crisis and experience) during deep-dives.
Status of the programme – Phase 2 including Barnes	The Committee had good assurance on the Tolworth plans and updating of the Tolworth FBC, as requested by DHSC and HM Treasury. Assurance was also received on the engagement process to review the Stage 4 RIBA designs by teams at Tolworth. The committee was very disappointed to hear that despite recommendation by the officers to approve a planning application by Barratt for plots XYZ at Springfield, this was refused by Wandsworth Council on 19 March 24. An appeals process is underway. This will now create a delay to the Tolworth FBC approval process and	• Tolworth timetable updates • Tolworth FBC updates • Tolworth Stage 4 Design engagement paper • Appeals options paper, including advice from Barratts external planning and legal advisers.

	construction, as the funding of Tolworth is dependent upon sales proceeds from plots XYZ. The Committee received updates on the status of Barnes Hospital construction including on the delays. A new contractor has now been put in place. The Barnes STP funding deadline has been extended to 24/25. There is limited assurance on the final completion date. Barnes FBC gained ministerial approval during the year. There have been further significant delays to the Richmond Royal construction timetable and there is limited assurance on the final completion date. Both the Barnes and Richmond Royal delays have been outside the Trust's control and have been mitigated through e.g. the renting (at peppercorn rent) of the Teddington site for Barnes staff.	• Barnes update papers • Richmond Royal update papers
Programme finances	As at the end of 23/24, the programme was £25m underspent, mainly due to the delays to Tolworth, Barnes and Richmond Royal. Overall Phase 1 was £3.3m overspent, and had 3 significant provisions i) £500k Phase 1 final account ii) £600k has been set aside based upon a new VAT ruling regarding car parking (Northumbria case) and iii) £600k net balance sheet release not actioned. The latter can be carried over to Phase 2 The programme can still be financed through a mix of Treasury Loan, land receipts and Trust cash. The position on Edward Wilson House remained unchanged (expected sale receipt £16.2m) although all stakeholders are aware including NHSE. The change waiver situation for Ronald Gibson House was resolved during the year	• Regular Finance reports
Alignment with Trust strategy and annual objectives	There is good assurance of this with quarterly reviews of the annual objectives linked to the Programme	• Quarterly annual objective reviews

External stakeholder engagement and communication	The approach and plans are sufficiently robust and comprehensive to support the current phase of engagement and communication	• MC/EMC reports • BCTG/EMMG reports • Integrated comms plan • Feedback from key stakeholder events
Key partner relationships	There are effective relationships with key partners for Phase 1 and for Tolworth.	• MC/EMC reports • BCTG/EMMG reports • Meetings with senior representatives from STEP/Sir Robert McAlpine
Co-production and EDI	There is reasonable assurance of sufficient participation of patients, carers and staff in design and decisions, although this is often more information, consultation and engagement, as opposed to co-design and co-production EDI and health inequality metrics are included in the Quality and Performance Report for the committee, although more narrative is required on the 'so what' and 'what next'. Two Diversity In Decision Making champions sits on the committee which helps to ensure we are considering EDI aspects	• Ladder of co-production updates in EMC reports • Q&P reports

5. Review of recommendations from the previous annual report

The following were recommendations in the 22/23 Committee annual report:

1) The Committee should review the frequency of EMC meetings after the Shaftesbury moves have been completed with a view to reducing to every two months.

2) The terms of reference should be reviewed to align with the refreshed programme governance arrangements, ensuring there is sufficient clinical “voice” from attendees given the increasing focus of clinical transformation within the Integrated Programme.

The first recommendation was implemented from September 2023 when the frequency was reduced to bi-monthly.

The second recommendation was approved in September 2023 with an updated Terms of Reference agreed reflecting the governance changes from the Integrated Programme into Better Communities. The Chief Nurse remained a member of the Committee, and although the Chief Medical Officer was removed as attendee, there was increased attendance of clinical directors presenting their deep dives at regular intervals.

6. Proposed recommendations to be addressed in 24/25

- Due to the focus on APJ, a NED with clinical experience should regularly attend the committee
- Continue to focus on learnings to date to inform future work
- Ensure there is sufficient focus on the impact of transformation on staff
- Mature the reporting of EDI and health inequality data, and how the programmes will support the reduction of health inequalities.

Appendix 1: Terms of Reference in place from October 2021 to September 2023

Committee	Estates Modernisation Committee
Strategic ambitions	**Increasing quality years** **Reducing inequalities** **Making the Trust a great place to work** **Ensuring sustainability**
Chair	Non-executive director
Executive Lead	Integrated Programme Director
Secretary	Integrated Programme Delivery Team
Members* **Only Executive Directors who are SROs within the Integrated Programme are members of EMC.*	Non-executive director (Committee Chair) Trust Board Chair Two Non-Executive Directors Director of Finance and Performance Chief Operating Officer Integrated Programme Director Director of Strategy, Transformation and Commercial Development Director of Communications and Stakeholder Engagement Director of Nursing and Quality Standards
Ex officio	Chief Executive
Attendees	Audit Committee Chair Medical Director Director of Workforce and Organisational Development Director of Corporate Governance Diversity in Decision Making Representative Service User/Carer/Staff representatives (as required) External advisors (as required) The Committee may invite any other Trust representative and/or external professional advisors as it deems necessary from time to time.
Frequency	At least every two months
Quorum	Three members who must include one Non-Executive Director or the Chair; the EMP Senior Responsible Officer or the Programme Director, plus one other director. Where an executive director is not able to attend the meeting they must send a deputy who is authorised to make decisions on their behalf.

Purpose

To provide the Board with assurance that there are robust processes in place to manage and deliver the Trust's Integrated Programme, which includes the Estates Modernisation Programme (EMP), Clinical Transformation (CT) and People Readiness and Culture Change

(PRCC) programmes. Also in scope is Integrated Communications and Stakeholder Engagement associated with the Integrated Programme.

Duties

To provide assurance to the Board that the Trust's Integrated Programme is being delivered within the defined parameters of time and cost and to the required quality and specification, through:

i. Receiving monthly monitoring and control reports from the Estates Modernisation Management Group (EMMG) that cover the EMP, CT and PRCC programmes that cover, by exception, the delivery of the agreed key workstreams, milestones and deliverables.

ii. Receiving updates and assurance from the Finance and Performance Committee (for the community transformation part of CT delivery), from the Quality Safety and Assurance Committee (for Clinical Transformation clinical and quality elements) and the Workforce and Organisational Development Committee (for People Readiness and Culture Change) relating to specific deliverables that are more suitable for those committees given their remits. These deliverables will be identified in advance by the SROs and Integrated Programme Director. It will remain the remit of the Estates Modernisation Committee to hold the overall status of the Integrated Programme together.

iii. The committee agenda will also cover core programme governance matters including risk management and the programme risk register (including alignment and review of the BAF); financial reports; stakeholder engagement and the business case.

iv. Having oversight of the programme plan and key milestones of the Integrated Programme (including EMP, CT, PRCC and Integrated Communications and Stakeholder Engagement), escalating any issues to the Board as necessary.

v. Ensuring there is an effective risk management system with associated mitigations in place for the Integrated Programme, and that regular reports on the risks and issues are effectively acted upon. The committee will receive escalations around identified material risks, with associated recommendations (costed where appropriate) and will consider how to effectively resolve these.

vi. Regularly reviewing the financial performance and financial plans for the Integrated Programme, ensuring that the Board is made aware of any financial risks or issues outside the agreed portfolio that impact estates modernisation.

vii. Regularly reviewing the alignment of the Integrated Programme with the Trust strategy and annual objectives.

viii. Consideration of regular gateway reviews and other internal and external assurance activities.

ix. Receiving summaries of the reports from the Independent Certifier, Quantity Surveyors and other external assurance parties appointed to conduct independent reviews.

x. Conduct ‘deep dives’ into subject matter per the agreed Committee workplan or request ad-hoc ‘deep dives’ based on emerging risk or issue severity.

xi. Providing assurance on the Integrated Programme delivery to the Trust Audit Committee as required for a sub-committee of the Trust Board.

To oversee and support the resourcing of the Integrated Programme to deliver it successfully within its agreed scope, time, cost and quality parameters.

To agree additional cost within the Committee’s delegation of authority for any recommended change requests from EMMG and/or make recommendations to the Board if above the Committee’s delegation of authority (unless that is sufficiently covered under Authority).

Current Estates/Facilities Management performance and issues escalated to a Committee level will be reviewed by the Finance and Performance Committee.

Authority

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

Operation

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

Reporting

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

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

Appendix 2: Terms of Reference in place from October 2023 to present

Committee	Modernisation Committee
Strategic ambitions	**Increasing quality years** **Reducing inequalities** **Making the Trust a great place to work** **Ensuring sustainability**
Chair	Non-executive director
Executive Lead	Better Communities Programme Director
Secretary	Better Communities Programme Delivery Team
Members	Non-executive director (Committee Chair) Two additional Non-Executive Directors Integrated Programme Director Director of Finance and Performance Chief Operating Officer Director of Nursing and Quality Standards
Ex officio	Trust Board Chair Chief Executive (SRO for the Programme)
Attendees	Audit Committee Chair Director of Strategy, Transformation and Commercial Development Director of Communications and Stakeholder Engagement Director of Corporate Governance Diversity in Decision Making Representatives The Committee may invite any other Trust representative and/or external professional advisors as it deems necessary from time to time.
Frequency	At least every two months
Quorum	Three members who must include one Non-Executive Director or the Committee Chair; the Programme Director or the SRO, plus one other director. Where an executive director is not able to attend the meeting they must send a deputy who is authorised to make decisions on their behalf.

Purpose

To provide the Board with assurance that there are robust processes in place to manage and deliver aspects of the Trust's Better Communities programme (subsequently referenced as "the programme") that are essential ("in scope") to the delivery of the Tolworth Business case namely

- **Estates Modernisation Programme (now called Better Environments)** including Shaftesbury, the Tolworth Business Case, fifth ward options appraisal, Springfield Village, Richmond Royal, Barnes and estates modernisation programme finances
- **Clinical transformation (now called Better Care)** : acute & urgent care and community transformation; complex emotional needs pathway related transformation
- **Digital (now called Better Digital), communications and stakeholder engagement** for the in scope areas

Duties

To provide assurance to the Board that the in scope aspects of the Better Communities programme are being delivered within the defined parameters of time and cost and to the required specifications, through:

xii. Receiving monthly monitoring and control reports from the Better Communities Management Group (BCMG) including reports on the delivery of the agreed key workstreams, milestones and deliverables

xiii. Receiving updates and assurance as appropriate from the Finance and Performance Committee, the Quality Safety and Assurance Committee and the People Committee relating to specific programme deliverables that are more suitable for those committees given their remits. These deliverables will be identified in advance by the BCMG. It will remain the remit of this Committee to secure assurance on the overall status of all in scope aspects of the programme.

xiv. The Committee agenda will also cover core in scope programme governance matters including risk management and the programme risk register (including alignment and review of the BAF); financial reports; stakeholder engagement and the business case.

xv. Having oversight of the programme plan, benefits realisation plan and key milestones of all in scope aspects of the programme, escalating issues to the Board as necessary, to include assurance on the management of all key interdependencies.

xvi. Ensuring there is an effective risk management system with associated mitigations in place for in scope aspects of the programme, and that regular reports on the risks and issues are effectively acted upon. The Committee will receive escalations around identified material risks, with associated recommendations (costed where appropriate) and will consider how to effectively resolve these.

xvii. Regularly reviewing the financial performance and financial plans for the in scope aspects of the programme, ensuring that the Board is made aware of any material financial risks.

xviii. Regularly reviewing the alignment of the in scope aspects of the programme with the Trust strategy and annual objectives, including health inequalities and equality, diversity and inclusion.

xix. Providing assurance that there is a continued unrelenting focus on the delivery of the benefits to patients, carers, staff and local communities as set out in the programme, in line with Trust values

xx. Consideration of regular internal and external assurance activities.

xxi. Conducting ‘deep dives’ into subject matter per the agreed Committee workplan or request ad-hoc ‘deep dives’ based on emerging risk or issue severity.

xxii. Providing assurance on in scope aspects of programme delivery to the Trust Audit Committee as required.

xxiii. Providing oversight on the transition of change to business as usual

To oversee and support the resourcing of the in scope aspects of the programme to deliver it successfully within its agreed scope, time, cost and quality parameters, in line with the benefits realisation plan.

To agree additional cost within the Committee's delegation of authority for any recommended change requests from BCMG and/or make recommendations to the Board if above the Committee's delegation of authority (unless that is sufficiently covered under Authority).

Authority

The Committee has been established to make relevant recommendations to the Board and must act within its delegated authority as set out in the Standing Orders and Standing Financial Instructions.

Operation

The agenda will be divided into part A and part B sections so as to ensure appropriate scrutiny, with the proviso that commercially sensitive matters are discussed in part B.

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

Reporting

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

The Committee will conduct an annual self-assessment and review of its terms of reference and present this to the Board.

Once the Board has approved the Committee's terms of reference any future material change must be presented to the Board for approval.

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

Meeting:	Trust Board
Date of meeting:	11 July 2024
Transparency:	Public
Committee Name	Charitable Funds Committee (CFC) – June meeting
Committee Chair and Executive Report	Juliet Armstrong (Chair) Ian Garlington (Better Communities Director)

BAF and Corporate Objective the committee is accountable for:

The committee does not support the corporate objectives directly but indirectly contributes towards:

Corporate Objective:

- **Objective 3:** To support our people to grow and develop our organisation to be the best we can be

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

The following are themes that informed and reflect the discussion at the June meeting of Charitable Funds Committee (CPC):

1. ***Finance update:*** the fund balance to March 24 (unaudited) is £107.8k, a reduction of £15k since the last report; an overall net funds inflow during the prior year of £19,928 was noted.
2. ***Fundraising***; An interim Fundraising team is now in place. A small team of experienced NHS charity fundraising consultants are working to an agreed brief over the next few months. There is also a plan to change the fundraising and donations platform to Just Giving. This follows a recommendation from the interim fundraising team and will allow fundraisers to set up their own fundraising pages (not possible currently via CAF Donate)
3. ***Staff microdonations;*** Microhive (formerly Pennies from Heaven) is to be rolled out to all staff. Following engagement of the Executive Advisory Board and some final testing and wider communications, this will start from July 24 allowing a purely voluntary way for staff to donate "pennies" of their pay to the Trust charity.

Areas of Risk Escalation to the Board:

- None

Item discussed- Charitable Funds finance report:

Assurance Position

There is good assurance on the fund balances and also on the stronger controls in place to manage expenditure. Funds (e.g. at ward level) with large balances are reviewed and there is active contact with fund owners.
The ethical fund over the period December 2023 and March 2024 increased by 3.3% to £40, 542.

Evidenced by

- Finance report

What next?

- Update on performance of Ethical Fund, including benchmarking with other types of savings vehicles/funds
- Invite our Independent Examiner (Griffin Stone Moscrop and Co) to the next Committee meeting to discuss the charity accounts
- Review latest accounts from Momark at the next Committee meeting.

Item discussed- Charity working group update

Assurance Position
An interim fundraising consultant team is in place with a clear brief. They have been focussed on short-term practical fundraising and communication opportunities including how we maximise the investment already made such as in the London to Brighton Cycle event. They will be invited to the next committee meeting to provide an update.

It has not been possible to complete the review of specific policies and the governing documents of the charity, and this will be carried forward.

The committee was pleased to hear the progress of Microhive and how this will provide a purely voluntary way for staff to donate pennies to the charity via payroll from July.

The committee discussed whether a Diversity in Decision Making or other staff or lived experience representative should join the committee and this will be further explored.

The committee thanked Trust staff who continue to progress the work of the charity, on top of busy jobs.

Evidenced by

- Good assurance provided by the Report

What next?

- Progress with fundraising plan with interim consultants
- Progress possible opportunities with employer partners to support the charity.

Appendices
All annual reports and other items that require to be in the full Board papers will be appended to the Committee Report

- Minutes