Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting
Thursday 30 July 2020

Agenda and papers

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 30 July 2020, 09:00-11:30**
Venue: **WebEx and For Internal Staff Room 52, 1st Floor Grosvenor Wing**

Time	Item	Subject	Lead	Action	Format
1.0 OPENING ADMINISTRATION					
09:00	**1.1**	**Welcome and apologies**	**Chairman**	Note	Oral
	1.2	**Declarations of interest**	**All**	Assure	Oral
	1.3	**Minutes of meeting – 25 June 2020**	**Chairman**	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
09:05	**1.5**	**Chief Executive Officer's Report**	**Chief Executive**	Inform	Report
2.0 DIVERSITY, INCLUSION AND CULTURE					
09:15	**2.1**	**Diversity and Inclusion Report and Action Plan**	**Chief Executive / Acting Chief People Officer (Culture)**	Assure	Report
3.0 QUALITY AND PERFORMANCE					
09:30	**3.1**	**Quality and Safety Committee Report**	**Committee Chairman**	Assure	Report
09:40	**3.1.1**	***Safeguarding Adults Annual Report 2019/20***	**Acting Chief Nurse**	Assure	Report
	3.1.2	***Safeguarding Children Annual Report 2019/20***			
09:50	**3.2**	**Integrated Quality & Performance Report**	**Chief Operating Officer**	Assure	Report
10:05	**3.3**	**Cardiac Surgery Quarterly Update**	**Chief Medical Officer**	Assure	Report
10:20	**3.4**	**Complaints Annual Report 2019/20**	**Acting Chief Nurse**	Assure	Report
4.0 FINANCE					
10:30	**4.1**	**Finance and Investment Committee Report**	**Committee Chair**	Assure	Report
10:40	**4.2**	**Finance Report (Month 03)**	**Chief Finance Officer**	Update	Report
5.0 RISK, GOVERNANCE & COMPLIANCE					
10:50	**5.1**	**Audit Committee Report**	**Committee Chair**	Assure	Report
11:00	**5.2**	**Board Assurance Framework Q1 2020/21**	**Chief Corporate Affairs Officer**	Assure	Report
11:15	**5.3**	**Horizon Scanning Report:**			
	5.3.1	***Emerging Policy, Legislative, Regulatory and Governance Issues (Q1)***	**Chief Corporate Affairs Officer**	Note	Report
	5.3.2	***Local & Regional issues (Q1)***	**Chief Strategy Officer**	Note	Report
6.0 CLOSING ADMINISTRATION					
11:20	**6.1**	**Questions from Governors and the Public**	**Chairman**	Note	Oral
	6.2	**Any new risks or issues identified**	**All**	Note	
	6.3	**Any Other Business**		Note	
11:30	**CLOSE**				

Thursday, 24 September 2020, 09:00-11:00
WebEx and For Internal Staff Room 52, 1st Floor Grosvenor Wing

Trust Board
Purpose, Meetings and Membership

Trust Board Purpose:	The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Vice Chairman	NED
Elizabeth Bishop	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Prof. Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li	Associate Non-Executive Director	ANED
Tim Wright	Non-Executive Director	NED
Andrew Grimshaw	Chief Finance Officer and Deputy Chief Executive Officer	DCEO
Avey Bhatia	Chief Operating Officer	COO
Robert Bleasdale	Acting Chief Nurse & Director of Infection, Prevention & Control	ACN
Richard Jennings	Chief Medical Officer	CMO
In Attendance		
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Humaira Ashraf	Acting Chief People Officer (Culture & OD)	ACPO(C)
Elizabeth Nyawade	Acting Chief People Officer (Workforce)	ACPO(W)
Secretariat		
Tamara Croud	Head of Corporate Governance/Board Secretary	HOCG-BS
Apologies		
James Friend	Chief Transformation Officer	CTO
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 25 June 2020
Room 52, 1st Floor Grosvenor Wing, St George's Hospital, Tooting & WebEx

Name	Title	Initials
PRESENT ***(*attendees joining the meeting via videoconferencing)***		
Gillian Norton*	Chairman	Chairman
Jacqueline Totterdell*	Chief Executive Officer	CEO
Ann Beasley*	Non-Executive Director	NED
Elizabeth Bishop*	Non-Executive Director	NED
Stephen Collier*	Non-Executive Director	NED
Prof Jenny Higham*	Non-Executive Director	NED
Prof Parveen Kumar*	Non-Executive Director	NED
Dr Pui-Ling Li*	Associate Non-Executive Director	ANED
Tim Wright*	Non-Executive Director	NED
Avey Bhatia	Chief Operating Officer	COO
Robert Bleasdale	Acting Chief Nurse and Director of Infection Prevention & Control	ACN/DIPC
Dr Richard Jennings	Chief Medical Officer	CMO
Andrew Grimshaw*	Chief Finance Officer and Deputy Chief Executive Officer	CFO/DCEO
IN ATTENDANCE		
Stephen Jones*	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Elizabeth Nyawade	Acting Chief People Officer – Human Resources	ACPO-HR
Tom Shearer*	Deputy Chief Finance Officer	DCFO
SECRETARIAT		
Tamara Croud*	Head of Corporate Governance/Board Secretary	HCG
APOLOGIES		
James Friend	Chief Transformation Officer	CTO

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting and noted the apologies as set out above.	

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

		Action
1.2	**Declarations of Interest** The Trust Chairman reminded the Board of her conflict of interest in relation to her role as *'Chairman in Common'* across both St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust (ESTH). The Chairman also noted Elizabeth Bishop's conflict of interest as non-executive director at ESTH alongside her role at St George's, as authorised by the Board. The Board noted the interests as set out by the Chairman and that these had previously been authorised by the Board. Stephen Collier also reported a new interest in Healthcare Purchasing Alliance. This entity, HPA, undertook procurement activity for two large Private Medical Insurers (Aviva and Vitality, respectively insurer numbers 3 and 4 in the PMI sector). Although HPA did not itself engage with the Trust, its two shareholders did. The Board noted and authorised this conflict to exist.	
1.3	**Minutes of the meetings held on 28 May 2020** The minutes of the meeting held on 28 May 2020 were approved as an accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log and agreed to close those actions proposed for closure. It also noted the following updates: • Learning from Deaths Report (Action Item TB28.05.20/02): The CMO advised that the two patient deaths reported in the quarter four learning from deaths report were not related to the failures in the cardiology laboratories. The CMO also clarified that the deaths of the six mental health patients referenced in the report were not related to the patients' respective mental health conditions. • Guardian of Safe Working Hours Report (Action Item TB28.05.20/04): The CMO reported that Ann Beasley had been invited to the next virtual junior doctors forum. • Integrated Quality and Performance Report (Action Item TB28.05.20/01): The CN reported that the quality impact data related to the waiting list would be included in the next Integrated Quality and Performance Report.	
1.5	**Chief Executive's Officer (CEO) Report** The Board received the report from the CEO. The CEO conveyed the Trust's disappointment that the Trust was rated 209th out of 230 trusts on the Freedom to Speak Up Index and emphasised that the Trust needed to do more to develop an open culture where staff felt able to raise concerns without fear or detriment. The CCAO had taken on executive responsibility for the function which would strengthen the transparency and independence of the service. The Trust was now looking into how to increase the capacity and reach of the service and there was a programme of work being led by the CCAO to co-produce with staff the FTSU Strategy which would provide the framework for addressing the issues. The CEO highlighted the focus being given to improving diversity and inclusion across the Trust and noted that a	

		Action
	programme was being developed with a number of short, medium and long term actions. The Trust aimed to achieve a fundamental shift in its approach to diversity and inclusion and ensure staff felt that they were working in a genuinely inclusive and safe organisation with equality for all staff. Board members strongly concurred with the need to focus on diversity, inclusion and FTSU activities and the need to progress the Trust's cultural change programme. In relation to the recovery of services following the first wave of COVID-19, Stephen Collier queried the process for restarting elective activity safely. The COO reported that services were being restarted in order of clinical priority and aligned with both the Trust's clinical safety strategy and the wider approach being taken across the South West London system. The Trust had returned to its original intensive care unit bed base and redeployed staff were returning to their normal service areas. Neurosurgery, cardiac surgery and paediatric services had already restarted. The Board noted the report.	
2.0	**ANNUAL REPORT & ACCOUNTS 2019/20**	
2.1	**Audit Committee Report** Elizabeth Bishop, Chair of the Committee, provided an update on the meeting held on 11 June 2020. The Committee had received and endorsed the draft annual report, financial statements, quality report, and reports from the external auditors. The Trust had closed the financial year in line with the revised forecast and had received an unqualified audit opinion on the financial statements. The 'except for' audit opinion in relation to the Trust's use of resources was demonstrative of the improvement the Trust had made given that for the past four years the Trust had received an 'adverse' opinion. The Trust had also proceeded with the production of a full quality report for 2019/20 despite guidance from NHS England and NHS Improvement making certain aspects optional and deferring the deadline for submission until October 2020. In line with this guidance, the quality report had not undergone external audit assurance. In this absence of this, the Quality and Safety Committee had closely scrutinised and endorsed the report. The Audit Committee commended the 2019/20 annual report, financial statements and quality report and recommended that the Board approve the reports. The Committee also noted its thanks to all the teams involved in the production of the reports and seamless process, despite the challenges of the COVID-19 pandemic. The Board noted the report.	
2.2	**Annual Report & Accounts and Quality Account 2019/20** The Board noted and approved the 2019/20 annual report and financial statements as a true and fair view of the Trust's performance in 2019/20. The Board also approved the quality report for 2019/20.	

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

		Action
2.3	**Auditors Reports** The Board received and noted the external auditors' findings report, external auditors' opinion on the financial statements which would be presented to the Council of Governors and the Head of Internal Audit Opinion for 2019/20.	
2.4	**Letter of Representation** The Board received and approved the letter of representation and authorised the Trust Chairman and Chief Executive Officer to sign the letter on behalf of the Board.	
3.0	**NOVEL CORONAVIRUS (Covid-19)**	
3.1	**Update on Novel Coronavirus (Covid-19)** The Board was provided with an update on the Trust's management of and response to the Covid-19 pandemic. The following key points were reported: • The number of Covid-19 patients continued to fall in month. As at 16 June 2020 there were only two patients in the intensive treatment unit (ITU) and six adult inpatients on Covid-19 wards. The Trust was able to return to the original ITU bed base. The antibody testing initiative had been launched in May 2020 and was continuing and significant focus was currently being given to ensuring that all staff underwent a thorough risk assessment. • In response to a question from Tim Wright, the COO advised that the Trust was working on future surge plans. These would incorporate provisions for Winter, post-Covid peak increase in activity levels and any future peaks in Covid-19. The surge plans would address how the Trust maximised ITU and workforce models required to ensure that it remained flexible and agile, and able to respond to future peaks in demand on the Trust's services. These plans would fit into the wider South West London plans with a shared approach to planned care. • The system was taking a network approach to delivering patient care with work being carried out to deliver one list by speciality across South West London. The Trust's 52 week backlog was increasing as a result of the impact of COVID-19 with more patients waiting to access services. Only by working together collaboratively across the sector would services be maintained effectively. • In relation to the programme of staff risk assessments, Ann Beasley and other Board members reported that there was some disquiet among staff in relation to having to declare health issues to their line managers. The COO and ACPO(W) reported that the Trust had piloted the form with staff members and different staff groups before the full launch. The form stated that staff members could go directly to occupational health if they did not want to submit the form. **The Board agreed that the ACPO(W) would revisit the form to ensure that there was greater clarity that staff with concerns about revealing health conditions to their managers could contact occupational health directly.**	**ACPO(W)**

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

		Action
	• Elizabeth Bishop queried what steps the Trust was taking to encourage patients who needed care to come into the hospital on the elective pathways that had restarted following the peak of Covid-19 cases. The COO reported that some patients had refused to come into the hospital until the risk of contracting Covid-19 had declined. Some patients had asked for more details of the steps the Trust was taking to protect them from contracting Covid-19 as a result of visiting the site and these had been provided, and the Trust had a robust communication package available for booking staff. Where priority patients refused to come into the hospital, consultants had been ringing them directly to provide more information in order to allay their fears and concerns. This remained a challenge for the Trust and an area of ongoing focus given the Trust's commitment to ensuring safe patient care. This would also continue to impact on the referral to treatment performance given that the same rules applied and the clock kept ticking even if a patient refused to come into the hospital. The Trust had launched new patient leaflets and patient information which provided step by step guide by clinical pathway. The Board noted the report.	
4.0	**QUALITY AND PERFORMANCE**	
4.1	**Quality and Safety Committee Report** Professor Parveen Kumar, Chair of the Committee, presented the report of the meeting held on 23 June 2020, which set out the key matters raised and discussed. The Committee had held extensive discussions about Covid-19 and had highlighted the need for the Trust to focus on staff morale and wellbeing as the peak of Covid-19 cases reduced and the Trust restarted more services. The Committee was assured and pleased to learn of the good emergency department performance, with the Trust currently rated as one of the best performers nationally in relation to the four hour standard. The Trust was managing to keep its use of agency staff low. The Committee was also assured that there had been good progress on implementing the maternity improvement plan and, in relation to research, despite Covid-19 the work on implementing the research strategy had continued with good progress being made. Ann Beasley queried the key driver for the improvement in the maternity service in response to which the ACN reported that the team had come together effectively to focus on delivering effective patient centred services to patients during the Covid-19 pandemic. The team worked cohesively and demonstrated many of the behavioural milestones which were in the improvement plan. The Trust would now focus on building on this work to ensure that the good team working exhibited during the Covid-19 pandemic was sustained. The work would continue under the leadership of the substantive director of midwifery who would join the Trust in August 2020. **The Board agreed that data on maternal deaths and outcomes for Black, Asian and Minority Ethnic mothers would be presented to the Quality and Safety Committee.** The Board also noted the progress on developing an intensive care unit triage framework and process which the Ethics Committee would review and	**COO**

		Action
	provide comments on. The Board also thanked the Ethics Committee for its help and support to date in the development of this work. The Board noted the report.	
4.1.1	**Medicines Management (Bi-Annual Report)** The Board received, considered and noted the bi-annual report on medicines management which had been considered extensively at the Quality and Safely Committee, 23 June 2020.	
4.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 2 (May 2020), which had been scrutinised at both the Finance and Investment and the Quality and Safety Committees. Beyond the matters raised in the reports from the Board Committees and in the earlier update on Covid-19, the Board noted the following: • Focus continued on safely restarting the services which had been stopped due to the Covid-19 pandemic with particular attention being given to diagnostics and endoscopy. • The deterioration in the resuscitation training compliance was also being given particular focus. The performance for basic life training had reduced to 65% against the 95% target. It was evident that the social distancing measures and focus on managing the Covid-19 pandemic had impacted on the Trust's ability to deliver this training. This was a key priority for the Trust and a key action in the CQC improvement plan. Actions taken to improve performance included re-establishing resuscitation training and providing more online training opportunities. • The staff vacancy rate was recorded as 6.8%, a figure that was considerably lower than would have been expected, and the Board was made aware that some further validation work was being conducted to ensure that the employee and financial systems tallied accurately. • The ACN advised that the Trust was collecting patient feedback from virtual outpatient services. • The Trust had a significant number of category three patients waiting to gain access to services and, as such, the Trust may in some cases need to transfer these patients to other organisations to ensure they were treated in a timely way. This would impact on the Trust's financial performance and the Trust was working through how it could work within the system budget to ensure any lost activity and income could be appropriately offset. The Board received and noted the report.	
5.0	**WORKFORCE**	

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

		Action
5.1	**Workforce and Education Committee (WEC) Report** Stephen Collier, Chair of the Committee, provided an update on the meeting held on 11 June 2020. The Committee had restarted following a brief hiatus whilst the organisation focused on responding to the Covid-19 pandemic. The Committee's discussion were outlined in the report and the following key points were raised and noted by the Board: • The Trust Chairman highlighted the concerns around diversity and inclusion and asked about the Committee's engagement on diversity and inclusion issues. Stephen Collier advised that the Committee had been aware of the issues and had flagged the lack of progress being made in its reports to the Board. At the same time, he added that in retrospect the Committee could have been more forceful in its interrogation of and holding management to account for delivering the action plans. The Committee would reinvigorate its focus on this work and conduct greater scrutiny and oversight and ensure there was effective assurance around the steps being taken to improve diversity and inclusion going forwards. • Jenny Higham noted that it was import not to minimise the impact of Covid-19 on training for staff. Covid-19 would be present for some time and it was important that the Trust had a robust plan and programme of work to ensure education and research continued to be delivered. The CMO reported that care group leads were focused on supporting junior doctors and retaining talent in the organisation and robust plans would be developed to ensure they were effectively trained. **The Board agreed that the Workforce & Education Committee would take the lead on behalf of the Board in interrogating the plans for addressing the training needs of all staff.** The Board noted the report.	**WEC**
5.1.1	**Committee Annual Report, Proposed Workplan and Revised Terms of Reference** The Board received and considered the annual report from the Committee, agreed the changes to the terms of reference and endorsed the Committee's 2020-21 programme of work.	
5.2	**Freedom to Speak Up Guardian Report** The Board received the report from Freedom to Speak Up Guardian (FTSUG), Karen Richards-Wright. While engagement had increased and the number of cases was increasing year on year, more work was required to improve how managers addressed concerns when they were raised. The change in executive leadership of FTSU was already driving some key changes including increasing the resource to the function. The Board had an extensive discussion about the FTSU service and the broader culture of raising concerns, and the following points were raised and noted: • The Trust Chairman noted that the report was very comprehensive and expressed the Board's disappointment at the Trust's position on the	

		Action
	FTSU Index (209th of 230 trusts). The FTSUG reported that to improve the Trust's performance the Trust needed to do more work to train and develop both senior leaders' and middle managers' skills in employee relations, managing difficult issues, and improving the quality of line management. Many of the issues escalated to the FTSUG could have been avoided if managers were better equipped to manage conflict within their teams. • The CEO reported that the Trust was keen to support the FTSU function and would invest in increasing the resources in and support for the service. The Trust did have conflict resolution training in place for staff and work would be carried out to ensure that senior leaders were completing this training. The CEO also reinforced the commitment to use the framework in place to develop the Trust leaders including developing a Management Charter. • Parveen Kumar queried the degree to which the Trust was engaging with all staff including those working for third party suppliers such as Mitie who made up a significant proportion of the workforce. The FTSUG reported that she regularly engaged with Mitie staff and could confirm that they had not raised any concerns about staff morale. • The CCAO reported that it was important to reset the FTSU function, put in place the resource needed to support the Guardian, and develop a clear and ambitious strategy for improving the FTSU culture within the Trust and the plan was to bring this strategy to the Board in September. Work was being planned to broaden the network of champions and look at ways of improving engagement and responsiveness when concerns were raised. Culture and leadership were the key issues that need to be addressed to improve performance and engagement across the Trust. Alongside and distinct from the reporting of the FTSUG, it was important that the Board received assurance on how the Trust was responding to concerns and the issues raised by the Guardian and guidance from NHS England and NHS Improvement set out that this assurance should be provided by the executive lead for FTSU and this would be brought to the Board at future meetings. The Board noted that it was clear the Trust was not where it needed to be on FTSU and fully supported investing in and supporting the function to drive the necessary changes in order to create a culture of openness where staff felt safe to raise concerns and know that these issues would be addressed effectively.	
6.0	**FINANCE**	
6.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meeting held on 23 June 2020. The Committee welcomed the news that the emergency department had achieved 95% against the four-hour standard and was one of the highest performing Trusts against this standard in London and nationally. The Information Communication and Technology team were to be congratulated on the good work to improve virtual systems to allow staff to work remotely during the Covid-19 period. The Committee had also welcomed Andrew Asbury, the new Director of Estates and Facilities, to the	

		Action
	meeting and was assured that he understood the magnitude of the challenge and key risks. The Committee remained concerned about long-term financial planning in light of the uncertainty in the system which inhibited the Trust's ability to effectively drive efficiency and productivity. There was significant demand for capital funding across the Trust but there remained uncertainty about what capital the Trust would receive. The Board noted the report.	
7.0	**RISK, GOVERNANCE & COMPLIANCE**	
7.1	**Fit and Proper Person Test Process Procedures and Exception Reports** The Board received and noted the fit and proper person test assessment, and also noted that due to sickness absence it had not yet been possible to complete the returns for the Chief Transformation Officer. **The Board agreed that the fit and proper person information relating to senior leaders in acting up roles should be undertaken and the professional qualification of the CFO should be adequately referenced in the report.**	**ACPO(W)**
8.0	**CLOSING ADMINISTRATION**	
8.1	**Questions from the public** The Lead Governor, Richard Mycroft, reported that that the Council of Governors were concerned about the diversity and inclusion challenges which the Board had discussed and the Trust Chairman committed to providing an update to Council of Governors at its next meeting on 9 July 2020.	
8.2	**Any other risks or issues identified** There were no other risks or issues identified.	
8.3	**Any Other Business** There were no matters of any other business raised for discussion.	
Date of next meeting: Thursday, 30 July 2020, Room 52 and videoconference		

Trust Board Action Log Part 1 - July 2020						
Action Ref	**Section**	**Action**	**Due**	**Lead**	**Commentary**	**Status**
TB25/06/20/03	**Workforce and Education Committee (WEC) Report (June 2020)**	The Board agreed that the Workforce & Education Committee would take the lead on behalf of the Board in interrogating the plans for addressing the training needs of all staff.	30/07/2020	WEC	This action was moved to the WEC action log	**PROPOSED FOR CLOSURE**
TB28.05.20/01	**Integrated Quality and Performance Report (IQPR)**	The Board received and noted the report and it was agreed that the data on quality impact attributed to the waiting list be included in future IQPRs.	25/06/2020	ACN/CMO	ACN/CMO to provide a verbal update at the meeting.	**DUE**
TB25/06/20/04	**Fit and Proper Person Test Process Procedures and Exception Reports**	The Board agreed that the fit and proper person information relating to senior leaders in acting up roles should be undertaken and the profession qualification of the CFO should be adequately referenced in the report.	25/06/2020	ACPO(W)	ACPO(W) would provide a vebal update at the meeting.	**DUE**
TB25/06/20/01	**Update on Novel Coronavirus (Covid-19)**	The Board agreed that the ACPO(W) would revisit the COVID-19 Staff Risk Assessment form to ensure that there was clarity that staff with concerns about revealing health conditions to their managers could contact occupational health directly.	30/07/2020	ACPO(W)	ACPO(W) would provide a vebal update at the meeting.	**DUE**
TB30.01.20/05	**Patient Story: Sickle Cell Patients in the Emergency Department**	The Board thanked Ms Vitalis for sharing her story and agreed that a follow-up report would be presented to the Board setting out the actions that had been taken to ensure that her poor experiences would not be repeated either for herself or for others.	~~25/06/2020~~ 26/11/2020	ACN	**Not yest due** - Previous Update: The Trust had devised a programme of work which would be informed by a group including sickle cell patients and staff members. The programme was also part of the NHS Improvement/England Always Events initiative. The programme of work was put on hold as a result of the Covid-19 pandemic with patients shielding and staff remobilised to support other parts of the hospital during the peak of the health crisis. The Trust anticipates this would restart in September 2020. Accordingly the Board is asked to agree that the update be defered until the November 2020 meeting.	**OPEN/ DEFERRED**
TB28.05.20/03	**Learning from Deaths Quarter Four (2019/20)**	So far, no themes which provided cause for concern had been identified and an update would be provided in the next learning from deaths report.	24/09/2020	CMO	Not yet due	**NOT YET DUE**
TB25/06/20/02	**Quality & Safety Committee Board Report (June 2020)**	The Board agreed that data on maternal deaths and outcomes for Black, Asian, Minority and Ethnic mothers would be presented to a forthcoming Quality and Safety Committee.	31/08/2020	COO	Not yet due	**NOT YET DUE**

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 July 2020	**Agenda No.**	1.5
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	**Jacqueline Totterdell, Chief Executive**		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is asked to: • Note the update on key developments for the Trust since the last Board meeting; and • Note the use of the Trust Seal 2019/20 as set out in Appendix 1.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
NHS Oversight Framework Theme:	All		
Implications			
Risk:	As set out in the report		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	
Appendices	Appendix 1: Use of the Trust Seal 2019/20		

1

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Chief Executive's report to the Trust Board – July 2020

In this report, I have endeavoured to provide the Trust Board with an overview of key and emerging issues affecting staff, patients, and the communities we serve. As set out in my report, Covid-19 remains a very real and ever-present risk to both our patients and staff; and the key challenge for all healthcare providers is learning how to co-exist with the virus, whilst also providing safe and effective care for the many patients who depend on our services.

On a personal level, and like many staff, I am returning to the hospital after shielding for a prolonged period. In a letter to staff who have also been shielding, I made clear that Covid-19 has accelerated our ability – and willingness – as an organisation to enable staff to work in new and different ways, with location increasingly less of an issue (particularly for non-clinical staff).

I have also received a number of kind and positive messages from staff following my return to the hospital, and whilst virtual working can be positive, it has also been great this week to meet and talk to colleagues in person. I have worked in hospitals all of my working life, so it's great to be back in the building.

Key and emerging issues:

Our focus at present is on re-starting as much planned activity as we can, but in a safe, sustainable way. The number of Covid-19 positive patients under our care is now very small, but – like all hospitals – we must remain vigilant and ever ready for spikes in infection and increased demand on our services.

At present, 23 of our 29 operating theatres are operational. This is positive, but our operating capacity – and ability to treat surgical patients – is disproportionately affected because of the importance of following strict Covid-specific infection prevention and control processes. I am confident that capacity will increase week by week, but this remains a challenge, as does the increase in patients waiting more than a year for treatment as a result of the impact of Covid-19 on our waiting lists. We know that timely access to care is a key part of the quality of our services and we are working hard to ensure that patients receive the care they need in a timely way.

Elsewhere, I am pleased to say that our emergency care performance remains very strong – indeed among the best in London and across England. Between April and June, over 95% of patients visiting our Emergency Department (ED) were seen, treated and admitted and/or discharged within four hours. While initially the numbers of patients presenting at ED were lower as a result of COvid-19, given our previous challenges with ED performance this represents real progress, particularly as attendances are now increasing all the time (currently averaging 350 a day). As important, patient satisfaction remains high, with 90% of patients in June saying they would recommend the service to family and friends.

As well as keeping patients safe, we also need to ensure we are maintaining high standards of care. We have recently re-started our ward accreditation programme, which is a big step forward. We have also adapted the criteria for assessing wards to take into account Covid-19, with a particular focus on infection prevention and control protocols. As an organisation,

we are compliant with 62 of the 63 standards that make up the infection prevention and control board assurance framework – and the standard we are partially compliant with (Standard 10.2 – training around FFP3 reusable respirators) is one that many Trusts in the Capital are finding challenging to meet at present. We will continue to assess our compliance against these standards and will review this quarterly at our Patient Safety and Quality Group and provide regular updates to the Board.

Finally, I would like to say how pleased I am by the annual reports on adults and children's safeguarding and on complaints which are on the Board agenda for this meeting. Adult safeguarding training compliance has remained above the Trust target of 85% and we are now exceeding the 85% compliance rate for Prevent training and I am pleased to say that having previously had concerns about our performance in this area the report demonstrates the Board can take assurance about our performance in 2019/20. In relation to children's safeguarding, we have developed and implemented the Named Midwife for Safeguarding role over the past year. The Board can also take assurance that we are also discharging all of our statutory responsibilities under the Children's Act 2004. Training compliance at all levels is good – but we will continue to give this the focus it deserves as it is so important.

In relation to complaints, the annual report presented to Trust Board shows that 92% of complaints were responded to within 20 days in 2019/20, compared with just 62% in 2018/19. This is real, measurable progress, and I know how much time and energy has been put into refreshing our approach to this key aspect of improving patient care. Having improved the timeliness with which we respond to complaints, we are giving renewed focus to further improving the quality of our responses and, crucially, the processes by which we ensure there is learning from complaints – so that problems with care or patient experience and the issues that led to these are identified and improvements are made so that they do not reoccur.

National update:

The ongoing impact of, and recovery from, Covid-19 remains very much the focus at a national level – and not just in healthcare.

The past month has seen a further relaxation of the lockdown in England, and indeed across the rest of the UK – with the leisure and hospitality industries slowly re-starting, for example. Specific initiatives – such as Eat Out to Help Out – are designed to rebuild confidence, and make it easier for people to return to a more normal way of living. A series of additional measures have also been put in place to help people feel safe. For example, face coverings must be worn in shops from 24 July, a policy that has applied to hospitals and healthcare settings since 15 June. People who have been shielding (roughly 2.2 million people nationally) can also return to the workplace from 1 August provided their workplace is 'Covid-secure'.

In healthcare, the national challenge is the same as the local one – how to re-start planned and specialist activity in a way that is safe, and does not expose people unnecessarily to infection. We also know that some people will have suffered as a result of not accessing care – with Macmillan Cancer Support having already warned of a 'ticking time bomb' affecting cancer patients specifically. That is why we are working hard across the Trust, and with our partners across South West London, to re-start elective activity as soon as we can safely do

so – and our compliance with the infection prevention and control board assurance framework demonstrates the progress we are making in ensuring that where services are re-started we have the processes in place to deliver safe patient care.

Knowing when and how to re-start activity across different specialities is a delicate balancing act. Indeed, local outbreaks in Leicester and Blackburn provide proof, were it needed, that Covid-19 remains at ever-present threat. Outbreaks in hospital settings – widely reported in the media this month – also show the importance of vigilance, and strict adherence to infection prevention and control protocols. New regulations give local authorities the power to imposed local lockdowns in the event that local areas see spikes in infection rates and, with our partners in South West London and at a regional level, we closely developments in infection rates so that we can respond in an agile way across the system so that patients can receive timely and safe care.

Separately, the Government announced additional funding of £3 billion for the NHS in July to ensure the health service is ready and equipped for a possible second Covid-19 peak. This investment is of course welcome, and we await further detail about how the funds will be allocated, and the potential for improvements here at St George's. Our planning for winter and the possibility of a second Covid-19 peak is well underway at St George's, and we will bring our surge plans to the Board for review at the next meeting in September 2020.

The NHS in South West London:

Given the pace of change over recent months, it is worth taking stock and briefly reflecting on the changes that have been made in South West London, due in the main to Covid-19 and the need to keep patients and staff safe.

In a letter to council leaders and local scrutiny committees last week, Sarah Blow (Accountable Officer for the South West London Health and Care Partnership) set out in detail the many and varied ways in which service delivery had changed. For example, 80% of GP appointments in south west London are currently carried out virtually – either by phone, or video conferencing. We have come so far in such a short space of time, that it is easy to forget that such a radical change would have seemed borderline impossible less than six months ago. The way hospitals provide care is also very different – with virtual outpatient appointments quickly becoming the norm as well. Earlier this year, the Board agreed our new digital strategy, but in some respects we are far further forward in what has been delivered than we could ever have expected back in February. A number of urgent and emergency care services have also moved to a 'phone-first' model, with our neighbours at South West London and St George's using this successfully for mental patients in crisis.

Of course, these new and innovative ways of working have presented enormous challenges for everyone in recent months – but the gains and efficiencies we have made in some areas also show what it is possible when healthcare providers work collaboratively, and with the interests of the patients at heart.

On a related point, there has been a significant development in recent weeks, with confirmation that a new, £500 million hospital would be built in Sutton. This follows a public consultation that took place earlier this year. This is a welcome development for Epsom & St Helier NHS Trust, which will run the new site when it opens, currently scheduled for 2025.

The new build in Sutton will specialise in emergency care with six major services, including maternity, inpatient paediatric wards, critical care and an emergency department. As I referenced in my previous report, St George's responded to the consultation and supported the selection of Sutton as the site for the new hospital with certain caveats around investment in our emergency department and on cancer services in South West London.

In the shorter-term, we continue to work closely as 'one NHS' across south west London, with the joining up of resources and expertise necessitated by Covid-19 helping to accelerate our ability to work as a joined up system, rather than as individual providers. This month, for example, infection control leads across south west London have agreed a set of common principles that will help us manage the flow of patients in and out of our hospitals. We have also established consistent guidelines relating to self-isolation and testing for patients before and after elective procedures, which is also a positive step forward.

The changes we have seen across South West London in recent months signal important developments to the configuration and delivery of healthcare that are likely to endure. One aspect of this is the increasing focus on system-wide delivery and management of healthcare, greater collaboration between NHS providers and commissioners, and a move away from the previous focus on individual organisations. As set out in the horizon scanning paper, while the Government has signalled that it will introduce legislation to reform the NHS, until that legislation is in place there is an inherent tension between the increasing movement to across system working and the legislative framework that places legal responsibilities and accountability on individual Trusts. Of course, we are not alone in managing these tensions, and we are playing a very active role across South West London, working closely with our partner Trusts and the Integrated Care System.

Our staff:

Much of our focus this month has been on ensuring all staff – whatever their background, or role - complete risk-assessments. This is crucial, as the information provided in the risk-assessments enables us to take additional steps, if needed, to keep staff safe from Covid-19.

The Trust began the process of risk assessing all substantive staff on 2 June 2020. At the time of writing, our completion rate stands at 80.7%. This figure puts the Trust's completion rate in the top quartile (75% -100%) for NHS Trusts in the London region. For context, the average completion rate for Trust's in London is 56% and the national average sits at 43%.

The Trust's completion rate of risk assessments for staff from BAME backgrounds stands at 81.8%. The national average is 73% and the London average is 59%. Further information provided by NHS England and NHS Improvement shows that St George's is in the top 5 NHS Trusts in the London region, for completion of risk assessments for BAME staff.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Below is a table summarising the outcome of the risk assessments, and impact on staff roles as a result:

Combined remote working and non-patient facing work	155
Continue in role	6,409
Continue with restrictions	251
Other (Shielding, LTS)	163
Redeployed to less risk area	21
Remote working including home	256
Grand Total	**7,255**

We are also continuing to push forward with our diversity and inclusion agenda. As discussed at last month's Trust Board, it is critical that we measurable and impactful progress in this area – warm words are fine, but these will not deliver the real change that our staff want and need.

Concrete and measurable initiatives are crucial, and – as a positive example of this - we have this week introduced a new initiative that requires interview panels for all Agenda for Change band 8A roles to include a trained BAME recruitment representative. Nearly 50% of our staff are from a BAME background, but are under-represented at a senior level – and this initiative is one of many we are putting in place to help redress the balance.

Separately, we last month appointed Joseph Pavett-Downer as our new Head of Diversity and Inclusion. Joseph will bring a fresh impetus to our work in this area, and his knowledge of the organisation – having worked here for a number of years – will be incredibly helpful as he starts his role. Of course, he is only one person among 9,000 – and diversity and inclusion needs to be everyone's concern, and not just Joseph's.

Our diversity and inclusion agenda links to our wider work on organisational culture, which Humaira Ashraf, Acting Chief People Officer, is driving forward at present. We are establishing a series of projects and initiatives under the following headings:

Key Priority Projects

- Improving the career progression of BaME staff;
- Improving development opportunities and ensuring equal access to development for staff;
- Listening and responding to concerns raised by BaME staff.

Changing Behaviours and Attitudes

- Leadership commitment;
- Building awareness and understanding.

As part of this, over 3,000 senior staff have been asked to complete a leadership and culture survey this month, and we are approaching a number of stakeholders for their opinions and experiences of organisational culture at St George's as well. All Board members have now participated in interviews with the staff leading the cultural change programme and this will

feed into the proposals for how we establish the culture we want and need to see at the Trust.

This exploratory phase, which commenced before Covid-19 but was delayed as a consequence of the pandemic, will last approximately 6 months and will conclude in September, at which point we will take stock; listen to what our staff and stakeholders are telling us about organisational culture; and develop further interventions and initiatives to help us make St George's a better place to work, and be treated. At the next Board meeting in September, we will bring a substantive update on where we are and what the proposed next steps should be. The Board, of course, has a key role to play here given its role in establishing a positive culture. Unless we make real and rapid progress in improving our culture and addressing the issues around diversity and inclusion that have become apparent in recent months we will not realise the ambitions we set for the Trust in our clinical strategy – our people are key to everything we do, and this will be a core area of focus in the months ahead.

Use of the Trust Seal

Finally, it is good governance practice that the use of the Trust Seal is reported to the Board on an annual basis. Attached to this report is a report of its use in the financial year 2019/20. There have been no uses of the Trust seal in the first quarter of 2020/21.

Appendix 1: Use of the Trust Seal 2019/20: List of all uses (1 of 3)

Ref	Date	Title	Reason	Signatories	Witnesses
695	29 May 2019	Ambulatory Care Refurbishment Project	Expansion and relocation of the Ambulatory Care clinic Richmond Ward St James Wing. The construction dates ran from November - March 2018	Kevin Howell (DEF), Stephen Jones (DCA)*	Andrew Grimshaw (CFO), Jenni Doman (AD-EF), Joshua Roles (EA – Chair & CEO)
696	29 May 2019	Blood Transfusion Office Relocation	The project involved the fit-out of the building leased from NHS Blood Transfusion Service into office accommodation, providing over 100 desk spaces to accommodate the relocation of the Finance team from 120 the Broadway back to St George's site.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
697	29 May 2019	Moorfields Eye Hospital Refurbishment	Complete refurbishment of Trust space leased to Moorfield's Eye Hospital (Theatres and Duke Elder ward on 5th floor Lanesborough wing). The construction programme ran from February – December 2018.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
698	29 May 2019	CT Scanner (St James' Wing)	'JCT 2016 Design & Build contract' pertaining to the construction element of the CT scanner replacement in St James Wing ED. This included the construction, mechanical and electrical works and associated preliminaries; the contracted works being £60,050.00, and was delivered as a design and build turnkey solution by Siemens Health. The contract was administered by McNaughts.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
699	29 May 2019	Lanesborough HV/LV Generator Project	Replacement and upgrade of HV ring switches & distribution switchgear; replacement of HV-LV Transformers; replacement and upgrade of Standby Generator Sets; replacement and upgrade of LV main switch panels.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
700	24 April 2019	SWL + St George's MH Trust Willow Annex + Grosvenor Wing	To install and fit out an office block for 240 members of staff displaced by the demolition of Clare and Knightsbridge Wings. Failure to proceed would result in inadequate space for corporate offices (IT, Finance, procurement etc). The construction programme ran from January – March 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Stephen Jones (DCA), Joshua Roles (EA – Chair & CEO)
701	1 May 2019	Moorfields Second Deed of Variation Lease	Adjustment to the lease. As there has been considerable delays to the completion of the project (Duke Elder Eye Unit) which have resulted in operational performance and income being affected.	Jacqueline Totterdell (CEO), Andrew Grimshaw (CFO)	Joshua Roles (EA- Chair & CEO)
702	1 May 2019	Expansion of Emergency Department	Minor Works to increase the footprint of the existing seminar room, to include an adjacent office, and to supply new mechanical ventilation to support, to allow for teaching requirements in ED. The project was funded by SFT monies from SGUL and from a charitable gift. The construction programme ran from January – March 2018.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)

Appendix 1: Use of the Trust Seal 2019/20: List of all uses (2 of 3)

Ref	Date	Title	Reason	Signatories	Witnesses
703	29 May 2019	Trevor Howell Day Care Chemo Chair Extension	The existing oncology day case ward was not fit for purpose and was unable to manage the daily workflow. The scheme increased the space allocation for patients and the number of treatment chairs from 14 to 16. The construction dates ran from April – December 2016.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
704	29 May 2019	Mortuary Expansion Phase II	Phase Two of mortuary expansion project, undertaken following Human Tissue Authority (HTA) inspection and subsequent report in August 2015. Works provided new freezer space for long-term storage; greater than thirty-days, and contaminated community storage, as indicated in the proposed statutory requirements from the HTA in 2017. The construction programme ran from August-October 2016.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
705	29 May 2019	Bronte Annex Demolition and Associated Works	To isolate the remaining building services (eg water) and demolish Bronte Annexe. This building was deemed unfit for purpose. The demolition programme ran from November – December 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
706	29 May 2019	Packaged Sub-Station Installation Project Contract	The Project consisted of: • A new electrical sub-station and a new transformer externally by St. James Wing. • A new electrical HV/LV panel to provide additional electrical capacity for the Theatres refurbishment projects (Theatres 3 and 4, Theatres 7 and Theatres 1 and 2 (St. James Wing). • Retrospectively re-wiring past projects to ensure full compliance with HTMs. The construction programme ran from June- September 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
707	29 May 2019	Neuro Rehabilitation Unit: Transfer from Wolfson to Lanesborough Wing	Transfer of existing clinical service from Wolfson site in Wimbledon, following public consultation on service provision and subsequent sale of land. New clinical service provided on the St George's site in Lanesborough Wing, as well as the rehabilitation services at Queen Mary, Roehampton. The construction programme ran from December 2011 – March 2012.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
708	29 May 2019	Champneys Ward Upgrade	Part refurbishment of existing hospital ward accommodation to provide suitable clinical service provision for renal patient's services; including dialysis stations, following the CQC 2016 inspection. Works included new mechanical ventilation, flooring, lighting, ceilings, decoration and RO plant for dialysis. The construction programme ran from September - November 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)

Appendix 1: Use of the Trust Seal 2019/20: List of all uses (3 of 3)

Ref	Date	Title	Reason	Signatories	Witnesses
709	29 May 2019	Medical Physics Relocation Project	Strip out of Bed Management Team offices and creation of a Medical Physics workshop to replace accommodation vacated as a result of the plan to demolish Knightsbridge Wing. The construction programme ran from January – March 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
710	29 May 2019	Upgrade of Theatres 5 + 6	The project included a complete refurbishment of Theatres 5 and 6 in St. James Wing to bring them it up to current standards with individual Ultra Clean Ventilation in both Theatres and provide modern theatres with up-to-date technology. The construction dates ran from April to September 2016.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
711	29 May 2019	Surgical Assessment Unit (SAU)	The Nye Bevan Unit project was a project to deliver a new emergency surgical assessment facility on the ground floor of St James Wing co-located with the ED department. The new facility comprises eight short-stay beds, eight trolleys, two clinics and one minor treatment room. It required the relocation of the Chapel / Multifaith facility, Fracture clinic Admin, Audiology, Chest Clinic Consultants, QMR Medical Records and Quality team. The construction programme ran from October – June 2016.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
712	29 May 2019	Venous Access Project	The existing venous access room needed to be relocated urgently as part of the renal service relocation out of Knightsbridge Wing. The project involved conversion of a disused X-ray room in SJW X-ray to create a new venous access room with two patient bays and preparation area. The construction dares ran from November – February 2017	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
713	29 May 2019	Modular Office Accomodation	To install and fit out an office block for 240 members of staff displaced by the demolition of Clare and Knightsbridge Wings. Failure to proceed would result in inadequate space for corporate offices (IT, Finance, procurement etc). The construction programme ran from January – March 2017.	Jacqueline Totterdell (CEO), Kevin Howell (DEF)	Andrew Grimshaw (CFO), Joshua Roles (EA – Chair & CEO)
714	29 May 2019	Clinisys Laboratory Information Management SWL Pathology	Extending the scope of the existing contract to include other elements of IT provision for the service model – Clinical Portal and Integration engine.	Jacqueline Totterdell (CEO), Andrew Grimshaw (CFO)	Stephen Jones (DCA), Tim Planche (SWLP), Joshua Roles (EA – Chair & CEO)
715	29 May 2019	SWL Lift Deed of Surrender for St John's Therapy Centre	St George's no longer manage the podiatry services at St Johns. Lease is now managed between CHP and the service provider.	Jacqueline Totterdell (CEO), Stephen Jones (DCA)	Joshua Roles (EA – Chair & CEO)

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

2.1

Meeting Title:	Trust Board		
Date:	30 July 2020	**Agenda No**	**2.1**
Report Title:	Diversity and Inclusion (D&I) Action Plan Update		
Lead Director/ Manager:	Humaira Ashraf, Acting Chief People Officer, Culture and OD		
Report Author:	Humaira Ashraf, Acting Chief People Officer, Culture and OD		
Presented for:	Assurance/Update		
Executive Summary:	This reports provides the outline of the revised Diversity and Inclusion (D&I) Action Plan (refer to Appendix A). The plan has been drafted as a result of discussions at Executive Management team and Trust Management Group meetings and in response to issues raised by staff, specifically, from BAME backgrounds attending the listening events, D&I steering group meetings and on an individual basis to the Deputy Chief People Officers and to the Chief Executive Officer. The action plan will be delivered through a structured programme management approach. The specific actions have been grouped into two sections and five workstreams:- • Section One - D&I Key Priority Projects: Workstream: (a) Improving the career progression of BAME staff, (b) Improving development opportunities and ensuring equal access to development for staff, (c) Listening and responding to concerns raised by BAME staff. • Section Two - Changing Behaviours and Attitudes: Workstream: (d) Leadership Commitment, (e) Building awareness and understanding. Following agreement of the final draft of the action plan, key deliverables for each workstream will be identified, together with timescales and success measures refer to Appendix B for workstream template and Appendix D for WRES indicators. It is proposed that each workstream will be led by an Executive Sponsor and supported by a professional lead and project manager. Respective roles and responsibilities have been outlined in Appendix C. Parallel to the development of the revised action plan, a number of D&I activities continue to be delivered. An update on the progress of D&I activity is provided for information in the attached Appendix E.		
Recommendation:	The Board is asked to review the action plan and to note progress to date on the development of a detailed action plan and delivery of D&I activities as outlined in Appendix E.		
Supports			
Trust Strategic Objective:	Champion St Georges.		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Well led		

1

Implications			
Risk:	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity.		
Legal/Regulatory:	Equality Act 2010		
Resources:	As detailed in the report.		
Equality and Diversity:	The D&I Action Plan is designed to close the gap in workplace inequalities.		
Previously Considered by:	People Management Group	**Date**	22/07/2020
Appendices:	Appendix (A) - Revised D&I Action Plan; Appendix (B) - Workstream Deliverable Template; Appendix (C) - Workstream Roles and Responsibilities; Appendix (D) - WRES Indicators; Appendix (E) - D&I Activity Progress Report.		

Diversity and Inclusion Action Plan

1.0 PURPOSE

1.1 The purpose of this report is provide the Trust Board with an update on:

- The development of the revised Diversity and Inclusion (D&I) Action Plan;
- Progress to date on delivery of the action plan.

2.0 INTRODUCTION

2.1 The Trust is committed to building a workforce which is valued and whose diversity reflects the communities it serves, enabling it to deliver the best possible healthcare service to those communities.

Everyone who works in the Trust, or applies to work in the Trust, must be treated fairly and valued equally irrespective of age, disability, race, nationality, ethnic or national origin, gender, religion or belief; sexual orientation, marital status, pregnancy and maternity status, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership. These are known as ***protected characteristics.***

The Trust is committed to enabling everyone in the Trust to achieve his or her full potential in an environment characterised by dignity and mutual respect.

3.0 CONTEXT

3.1 Approximately 47% of our staff are from BAME backgrounds. The majority of these staff are in the lower banded grades, band 2 to band 5. The percentage of BAME staff in higher bands 8a and above, however, falls considerably.

3.2 Our Workforce Race Equality Statistics show:

- That White staff are 1.47 times more likely to be appointed from shortlisting than BAME staff;
- BAME staff are 2.54 times more likely to enter the formal disciplinary process than white staff;
- Our Staff Survey results for 2019 show that the Trust has a below average D&I score in comparison to an average score of 9.0 for similar Acute Trusts;
- Specifically the staff survey highlighted that the areas to address within the D&I agenda are in relation to:
    - Career progression
    - Experiences of discrimination at work from patients/service users
    - Experiences of discrimination at work from managers, team leaders or colleagues
    - The Trust making adequate adjustments to enable staff that identified as having a disability to carry out work.

4.0 THE DEVELOPMENT OF THE REVISED D&I ACTION PLAN

The attached action plan, Appendix (A), has been drafted as a result of discussions at Executive Management team and Trust Management Group meetings and in response to issues raised by staff, specifically, from BAME backgrounds attending the listening events, D&I steering group meetings and on an individual basis to the Deputy Chief People Officers and to the Chief Executive Officers. Many of the activities within the plan have a particular focus on combating discrimination experienced by our BAME workforce.

It is envisaged that over the coming weeks this plan will be further developed to include additional input from stakeholders around the Trust and will incorporate the D&I Network's own individual action plans. Thus, the action plan will include the actions that we are currently in the process of implementing and also actions that we are planning to undertake to support our staff that identify with the other workforce protected characteristics.

4.1 The action plan will be delivered through a structured programme management approach. The specific actions have been grouped into two sections and five workstreams:-

- Section One - D&I Key Priority Projects: Workstream: (a) Improving the career progression of BAME staff, (b) Improving development opportunities and ensuring equal access to development for staff, (c) Listening and responding to concerns raised by BAME staff;

- Section Two - Changing Behaviours and Attitudes: Workstream: (d) Leadership Commitment, (e) Building awareness and understanding.

4.2 Following agreement of the final draft of the action plan, key deliverables for each workstream will be identified, together with timescales and success measures, refer to Appendix B for workstream template and Appendix D for WRES indicators.

It is proposed that each workstream will be led by an Executive Sponsor and supported by a professional lead and project manager. Respective roles and responsibilities have been outlined in Appendix C.

5.0 PROGRESS ON D&I ACTION PLAN

Parallel to the development of the revised action plan, a number of D&I activities continue to be delivered. An update on the progress of D&I activity is provided for information in the attached Appendix E.

6.0 RECOMMENDATION

6.1 It is recommended that members of the Trust Board review the contents of the revised action plan and to note progress to date on the delivery of D&I activities as outlined in appendix E.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

APPENDIX (A)

REVISED DIVERSITY AND INCLUSION ACTION PLAN

5

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

REVISED DIVERSITY AND INCLUSION ACTION PLAN

Introduction

The Trust is committed to building a workforce which is valued and whose diversity reflects the communities it serves, enabling it to deliver the best possible healthcare service to those communities.

Everyone who works in the Trust, or applies to work in the Trust, must be treated fairly and valued equally irrespective of age, disability, race, nationality, ethnic or national origin, gender, religion or belief; sexual orientation, marital status, pregnancy and maternity status, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership. These are known as ***protected characteristics.***

The Trust is committed to enabling everyone in the Trust to achieve his or her full potential in an environment characterised by dignity and mutual respect.

The Development of The Revised D&I Action Plan

The attached action plan has been drafted as a result of discussions at Executive Management team and Trust Management Group meetings and in response to issues raised by staff, specifically, from BAME backgrounds attending the listening events, D&I steering group meetings and on an individual basis to the Deputy CPOs and to the CEO. Many of the activities within the plan have a particular focus on combating discrimination experienced by our BAME workforce.

It is envisaged that over the coming weeks this plan will be further developed to include additional input from stakeholders around the Trust and will incorporate the D&I Network's own individual action plans. Thus, the action plan will include the actions that we are currently in the process of implementing and also actions that we are planning to undertake for all other workforce protected characteristics.

Structure of the Revised Action Plan

Once agreed the action plan will be delivered through a structured programme management approach. The specific actions have been grouped into two sections and five workstreams, as outlined below. Key deliverables will be formulated for each workstream, along with actions, timescales and success measures, Appendix (B) provides an overview of the template that will be populated once the final draft of the action plan is agreed.

Section One - D&I Key Priority Projects: Workstream: (a) Improving the career progression of BAME staff, (b) Improving development opportunities and ensuring equal access to development for staff, (c) Listening and responding to concerns raised by BAME staff.

Section Two - Changing Behaviours and Attitudes: Workstream: (d) Leadership Commitment, (e) Building awareness and understanding.

Roles and Responsibilities

It is proposed that each workstream will be led by and Executive Sponsor (Lead) and supported by a professional lead and project manager. Appendix (C) provides an outline of the respective roles and responsibilities of Exec Lead, Professional Lead and Project Manager.

Targets and Success Measures

This action plan has been devised to address the challenge of achieving a real sustainable difference in closing the gap in workplace inequalities between BAME and white staff. How successful we are in meeting this challenge will be demonstrated via our progress as highlighted in the NHS Workforce Race Equality Standard (WRES). The WRES provides the Trust with a baseline to demonstrate progress against nine indicators of staff experience. Please refer to Appendix (D) for further information on the WRES indicators.

We will also develop targets and other success measures for other protected characteristics and for each of the projects within the workstream to ensure that implemented actions are having the desired impact, refer to Appendix (B).

Timescales – Colour Coded

SECTION ONE: DIVERSITY AND INCLUSION ACTION PLAN: KEY PRIORITY PROJECTS

WORKSTREAM: Improving the Career Progression of BAME Staff Objective: To develop and implement initiatives that will help to remove barriers to career progression and help increase the likelihood that BAME staff will be successful in securing senior level appointments within the Trust.				
Workstream Title & Executive Sponsor	**Actions and Activities**	**Professional Lead**	**Project Manager**	**When**
Improving the Career Progression of BAME Staff Executive Lead: Chief Strategy Officer	1) All recruitment panels for band 8a's above are ethnically balanced. • Approximately 30 BAME staff have been trained to sit as equal panel members on recruitment panels; • Process for ensuring that staff sit on recruitment panels has been defined; • Numbers of vacancies for band 8a and above for the month July have been identified.	ACPO(W)	D&I Lead & Recruitment	
	2) Identify the average number of band 7 and below recruitment panels per year and then review the feasibility of trained BAME staff supporting these panels.		D&I Lead	
	3) Train additional BAME staff to sit on recruitment panels	ACPO(W)	Head of Corp Trng	
	4) Develop an online unconscious bias training for recruiting managers	ACPO(C)	Head of Corp Trng	

	5) Make the online unconscious bias training Mandatory for all managers undertaking a recruitment process	ACPO(C)	Head of Corp Trng	
	6) Develop a proforma in line with positive action that managers complete to record a career conversation if a staff member from a BAME background is not successful at interview for a Band 8a or above role. - Develop supportive guidance material for managers coaching staff.	ACPO(C)	D&I Lead/Head of Corp Trng	
	7) Through the use of the performance appraisal process offer BAME staff career coaching and mentoring - Develop a list of internal career coaches/mentors - Create a communication and guidance plan to launch the offer to staff	ACPO(C)	OD Lead?/ Head of Corp Trng	
	8) Revise the Trust's recruitment and selection training programme to ensure that awareness of unconscious bias is a core part of the programme.	ACPO(C) / ACPO (W)	Head of Corp Training	
	9) Make D&I questions mandatory in all selection interviews and use the candidate's response as a criteria to make recruitment decisions.	ACPO(W)	D&I Lead	

9

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

SECTION ONE: DIVERSITY AND INCLUSION ACTION PLAN: KEY PRIORITY PROJECTS

WORKSTREAM: IMPROVING DEVELOPMENT OPPORTUNITIES & ENSURING EQUAL ACCESS TO DEVELOPMENT OPPORTUNITIES FOR ALL STAFF

Objectives: To ensure that development opportunities be made available for all staff so that they are able to reach their potential and that every staff member should have equal access to these opportunities regardless of ethnicity, background or circumstances.

Workstream Title & Executive Lead	Actions and Activities	Professional Lead	Project Manager	When
Improving development opportunities & ensuring equal access to development opportunities for all staff Executive Lead: Chief People Officer	1) Review all processes and procedures related to attendance and applications for training and development to ensure selection is equitable.	ACPO(C)	Education Centre Leads	
	2) Develop panel process for HEE CPD higher value development programmes	Head of Corporate Nursing/Head of Workforce	Head of Prof Dev	
	3) Develop and implement a development coaching and mentoring framework;	ACPO (C)	OD Lead	
	4) Clarify line managers expectations and responsibilities in relation to supporting their staff to develop meaningful personal development plan	ACPO(C)/ ACPO(W)	HRBPs Head of Corporate Training	
	5) Revise Performance Development Review Process to ensure that there is a structured	ACPO(C)	Head of	

	career development section in place - Develop guidance and training module for managers to conduct career planning discussions as part of the performance review discussion.		Corp Training OD Lead?	
	6) Develop succession planning process for the Trust - Trial the process	ACPO(C)/ ACPO(W)	HRBP/ OD Lead	
	7) Implement Succession planning process for the Trust	ACPO(C)/ ACPO(W)	HRBP/ OD Lead	
	8) Develop an Inclusive Talent Management Process that is integrated into the succession planning and performance development review process	ACPO(C)	OD Lead	
	9) Establish Inclusive Talent Management moderation processes and panels	ACPO(C)	HRBPs OD Lead	
	10) Develop and deliver a phased Inclusive Talent Management Implementation Plan	ACPO(C)	HRBPs OD Lead	

11

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

SECTION ONE: DIVERSITY AND INCLUSION ACTION PLAN: KEY PRIORITY PROJECTS

WORKSTREAM: LISTENING, SUPPORTING AND RESPONDING TO CONCERNS RAISED BY OUR BAME STAFF

Objective: To create an environment whereby staff feel safe and supported to raise concerns and to develop structured and effective processes to address problems and concerns as they are raised.

Workstream Title & Executive Lead	Actions and Activities	Professional Lead	Project Manager	When
Listening, Supporting and Responding to concerns raised by our BAME staff Exec Lead: Chief Corporate Affairs Officer	1) Offer the opportunity to raise concerns by a variety of means:- - Acting CPO structure; - FTSUG - HR other	CCAO	FTSUG D&I Lead	
	2) Communicate and review the grievance/raising concerns processes with BAME network colleagues	ACPO(W)	HR Lead	
	3) Work with BAME Network Chair to identify BAME staff raising issues 'hot spots' (an area where there are a number of issues being raised by BAME staff around discrimination and bullying and harassment)	ACPO(C) ACPO(W) CCAO	D&I Lead	
	4) In conjunction with key stakeholders (managers responsible for 'hot spot' areas devise an OD plan to identify, address and resolve issues as raised.	ACPO(C)	OD Lead	

	5) Review culture change diagnostic data and incorporate improvement actions	ACPO(C)	OD Lead	
	6) Follow up Gillian's and Jacqueline's communication piece with a lived experience story from BME staff members. - Bring out real examples of what has been said to them at SGH and how it feels.	BAME Network Chair/D&I Lead	Comms Lead	
	7) Provide structured support in the form of techniques, guidelines and where possible facilitation for Team leaders to have meaningful conversations about diversity and inclusion.	ACPO(C)	OD Lead	

13

SECTION TWO - DIVERSITY AND INCLUSION - CHANGING ATTITUDES & BEHAVIOUR

WORKSTREAM: LEADERSHIP COMMITMENT

Objective: To ensure that senior leadership have the capabilities to positively influence the development of an organisational culture that promotes inclusion and values diversity.

Workstream Title & Executive Lead	Actions and Activities	Professional Lead	Project Manager	When
Leadership Commitment Exec Lead: Chief Executive Officer	1) Executive Team and Board members to come up with one personal action which they will take to improve the working lives of the BAME workforce, e.g., I am being reversed mentored by a BAME colleague - Cascade this to all employees and include in appraisals. Everyone is asked, what have I done to improve D&I in the last year?	Chair/ CEO/ CCAO	ACPO(C)/ D&I Lead	
	2) D&I Networks, review and clarify Executive Sponsor role to ensure all networks receive focused support. - Specifically, support the implementation of network action plans	ACPO(C)	D&I Lead	
	3) Develop competency framework for senior managers, building in the capability to promote D&I as a core senior management competency.	ACPO(C)	OD Lead	
	4) The Advanced Leadership Programme aimed at Deputy General Managers and Service Managers to include the development of inclusive leadership capabilities.	ACPO(C)	Head of Corporate	

			Training	
	5) Commission Leadership Development programmes for other functional directorates and ensure that inclusive leadership capabilities are a core part of the programme.	ACPO(C)	Head of Corporate Training	
	6) Succession planning to include D&I as a gateway; cannot promote any individual if they don't have an excellent track record of promoting D&I	ACPO(C)	OD Lead	
	7) Division and Directorate level D&I action plans - What are we going to do as a division/directorate to improve diversity and inclusion within our function?	COO	D&I Lead	
	8) Benchmarking and continuous improvement: visiting other Trusts and different sectors around the country to see how they implement D&I	ACPO(C)	D&I Lead	
	9) To ensure that D&I features in our discussions and decision making processes we will:- - Wherever possible include D&I issues as a discussion agenda item; - Review our meetings in relation to how effective we were in considering D&I; - Include a section on our paper submission template that explicitly outlines the impact of decisions/plans on D&I	CCAO	D&I Lead	
	10) Agree as part of our Patient and staff story at Trust Board we will also consider a D&I staff or patient story. Consideration will be given to filming the story and subsequent discussion to go on the Trust intranet.	CCAO/D&I Lead	Comms Lead	
	11) Regular comms on D&I to all staff from the CEO/Chair/Exec team	D&I Lead	Comms Lead	
	12) Align the work with the culture change programme.	ACPO(C)	OD Lead	

15

	13) Use the WRES and survey data to make a simple scorecard to track progress at each Board meeting.			

SECTION TWO - DIVERSITY AND INCLUSION - CHANGING ATTITUDES & BEHAVIOUR

WORKSTREAM: BUILDING AWARENESS & UNDERSTANDING Objective: To develop an understanding of the barriers to inclusion and diversity and build an awareness of the role that inclusion and diversity play in organisational learning, innovation and performance.				
Workstream Title & Executive Lead	**Actions and Activities**	**Professional Lead**	**Project Manager**	**When**
Building Awareness & Understanding Exec Lead: Chief People Officer	1) Launch the 'Respect' Programme. - Set up a working group; - Scope out logistics, plan and resource - Develop communication plan with key stakeholders; - Deliver 'respect' programme; - Monitor and track progress.	ACPO (C)	Head of Corporate Training	
	2) Plan and deliver diversity and faith awareness and celebration events	D&I Lead	D&I Network Leads	
	3) Align the work with the culture change programme.	ACPO(C)	OD Lead	

17

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Appendix (B)

WORKSTREAM:

Executive Sponsor:
Professional Lead:

Deliverable	Actions	Project Manager	Timescales	Measure of Success
Dependencies:				
Risk and Issues:				

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Appendix (C)

Diversity & Inclusion Action Plan - Overview of Roles and Responsibilities

- The **Project Manager** is responsible for the overall completion of the agreed project deliverables, using agreed the project methodology. They will oversee and coordinate day to day activities and involvement of team members and external suppliers to ensure the project is delivered on time, within budget and to the required quality;

- The **Professional Lead** is a subject matter expert who ensures that the project deliverables will strategically achieve the desired outcomes, and in alignment with other projects. They advise and oversee the Project Manager in developing sound project documentation, provide coaching and support to complete all deliverables to the required level of quality, and act as an escalation and sign-off route for risks, issues and project changes;

- The **Executive Lead** is a senior/chief level sponsor and champion who supports adequate resourcing and alignment and recognition of projects across the Trust. They offer high-level oversight of the project and act as a final escalation point for risks, issues and changes.

Project Phase	Project Manager	Professional Lead	Executive Lead
Inception	• Prepare a project brief to clearly communicate the project's desired outcomes and deliverables • Identify measures for monitoring and evaluating project outcomes	• Ensure the that the stated project deliverables will achieve the desired measurable outcomes • Sign off the brief and communicate new projects to Executive Lead and other departments as required • Ensure strategic alignment with other projects in and outside of the department •	• Support the inception of projects that will meet the needs of the Trust • Ensure strategic alignment with other projects and programmes across the Trust • Sign off briefs that are of particular risk or expense to the Trust
Planning	• Develop a project plan (within a PID) to outline how the deliverables will be completed over time, including key stages, milestones and resources • Identify main risks and corresponding mitigation strategies, and build these into the project plan	• Advise on, contribute to and sign off the project plans and budgets (PIDs)	• Sign off project plans (PIDs) that are of particular risk or expense to the Trust

19

Implement-ation	• Complete all deliverables in the plan within agreed timescales, engaging and overseeing the work of any project team members • Resolve emerging issues and escalate significant issues and risks to the Professional Lead • Manage and monitor the project budget • Coordinate and chair project meetings as required • Report on progress as required to the Professional and Executive Leads	• Maintain an overview of the project ensuring the quality of the deliverables and process • Support and coach the project manager to prioritise, problem solve and make decisions • Sign off on necessary changes to the project that may affect quality of outcomes, timescales and budgets • Escalate significant issues/risks when necessary	• Champion the project across the Trust and ensure continued alignment and integration with other projects • Advise Professional Lead of external or internal changes that may impact the project
Integration and Evaluation	• Capture lessons learned to benefit future projects • Ensure an appropriate evaluation of the outcomes of the project • Integrate the project into BAU so that its benefits are sustainable	• Oversee evaluation of the outcomes and ensure that the benefits of the project can be demonstrated • Ensure sustainability of the project deliverables and outcomes	• Communicate outcomes and successes of the project to the wider organisation • Ensure that resulting changes of the project are integrated across the Trust

Outstanding care every time

APPENDIX (D)

Workforce Race Equality Standard (WRES) 2019

	Workforce indicators For each of these four workforce indicators, compare the data for white and BME staff
1	Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce disaggregated by: Non-clinical staff, clinical staff, of which - non-medical staff - medical and dental staff Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
2	Relative likelihood of staff being appointed from shortlisting across all posts. Note: This refers to both external and internal posts.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.
4	Relative likelihood of staff accessing non-mandatory training and CPD.
	National NHS staff survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.
	Board representation indicator For this indicator, compare the difference for white and BME staff
9	Percentage difference between the organisations' board membership and its overall workforce disaggregated: • By voting membership of the board • By executive membership of the board

21

Outstanding care every time

Appendix (E)

Diversity & Inclusion Activity - July Progress Update

Outstanding care every time

Diversity & Inclusion Activity - July Progress Update

1. RESPONSE FROM COMMS BULLETIN'S AND SENIOR LEADER BRIEFING'S ON D&I

1a) Medcard Division

Through the process of a series of discussions around D&I the divisional senior leaders and their respective teams have developed a list of values and behaviours that jointly demonstrate their commitment to creating an inclusive culture that values diversity. They have also devised an action plan to promote and support D&I in the workplace. Some the actions include:-

- being more aware of unconscious bias;
- taking out time to understand and celebrate cultural differences, through sharing information on religious and cultural holidays;
- Lunch and learn sessions

1b) STNC Division

The Division has introduced Divisional D&I Groups to oversee implementation of D&I action plans within the clinical areas. Representatives within the services areas will feed into this group. Other initiatives are as follows:-

- The Division is also implementing a Band 7 development day to which they have invited Joseph to present current position on D&I;
- ***Neuroscience (46% staff are BAME)*** are working with Claire Copland to set up a Schwartz round focused on the experience of BAME staff members;
    - A D&I notice board is being introduced to some wards, this will hopefully also promote internal support services, FTSUG, D&I Lead, LiA and Staff Support;
    - They have also introduced D&I working groups (all bands represented);
- ***Theatres & Anaes – (61% of staff are BAME).*** This team have recently experienced some inter-racial discrimination issues and have responded effectively and efficiently by putting a number of initiatives in place, for example:-
    - Confronted the conflict issues between staff members by providing constructive feedback and developmental support;
    - Held one focus group on race and discrimination and are planning to hold more later on this month;
    - Introduced D&I working group to include a range of staff.

<u>Next Steps For Theatres & Anaes</u>

- Interim Senior OD Lead (Daniel Scott) to work with General Manager and Clinical Leads to design and deliver OD interventions that will improve cross cultural awareness, communication and working practices.

1c) CWDT Division

There are a number of initiatives that are being implemented within this Division, however, one key project is outlined below as an example of how leaders are taking the whole subject of D&I seriously and driving excellent practice through engagement and good leadership:-

The project has been initiated by Charlotte Felix-Otoo and Sarah Cook both Speech and Language Therapist working within the ***Paediatric Speech and Language Therapy (only 20% BAME staff).*** A brief outline of the project is outlined below:-

- Establishment of a 'Supporting Ethnicity and Cultural Diversity in the Workplace' supervision session;
- Resources have been used to prompt discussion and raise awareness of issues around discrimination, for example, the resource offered in Gillian's and Jacqueline's communication bulletin was found to be really useful in understanding how to combat racism in the workplace;
- The team have developed an action plan that consists of activity around improving recruitment and development opportunities for BAME staff and keeping the focus on D&I issues.

Next Steps:

- Charlotte and Sarah will write up their project so that it can be used as a case study for possible review at the September Board meeting;
- They are also looking to create video footage of BAME staff talking about their experiences of racism to help people really understand the impact of discrimination on staff.

Sijo Francis, Clinical Director of Children's Services, is proactively looking at developing and delivering a range of interventions targeted at creating a culture of tolerance and inclusion. This team has a high level of multi-cultural, overseas Nurses and Doctors, for example, Indian, Fillipino, Irish and Spanish nurses and medical staff that are from Bagladesh, India, Europe and South Africa working along side British born white nurses and medics.

Sijo has provided some good examples of actions that have been taken to encourage all staff to behave in a way that is inclusive, however, there is a recognition that there is much still left to do to improve cross cultural communication.

Next Steps

- Interim Senior OD Lead (Daniel Scott) to work with Sijo to conduct a detail assessment on cross cultural challenges and develop a delivery plan for creating sustainable change;
- The development work in this clinical area will serve as a pilot site for delivery of development interventions for other service areas.

Outstanding care every time

2) D&I ACTION PLAN

The EMG have devised a detailed action plan which is structured around the five workstreams as outlined below. Against each workstream a few bullet points have been provided on what has been achieved this month and what is being planned for next month.

D&I Workstreams - Progress on Activity		
Workstream	**What has been achieved this month**	**What is planned for next month**
Improving the Career Progression of BAME staff.	All recruitment panels for band 8a and above will have a trained BAME representation sit on the panel.	To develop additional training to these panel members so that they feel confident and are able to contribute constructively as equal panel members.
	A detail project plan has been devised to ensure that there the Trust delivers on its commitment to have ethnically diverse recruitment panels.	To review the feasibility of implementing this process for band 7 recruitment panels.
		To attract and train additional BAME staff to sit on to recruitment panels.
		To design/procure an on-line recruitment and selection training (which includes unconscious bias) module and make it mandatory for all recruiting managers.
	Making D&I questions mandatory for selection interviews and use candidates response as a criteria for making decisions. (will be actioned by end of July).	
Improving development opportunities and ensuring equal access to development opportunities for staff.	Developed an equitable selection process for attendance on HEE CPD higher value development programmes.	To commence detail review of all processes related to staff selection and attendance on development programmes/courses to ensure that they are fair and equitable.

Listening, supporting and responding to concerns raised by our BAME staff.	Almost every directorate and division has had discussions around D&I either as part of their meetings or held listening events/focus group sessions. Some examples are provided in section (1) above.	The OD team are in the process of developing a resource pack and facilitator guide so that team leaders are supported to have meaningful and structured discussions around the topic of D&I.
	Cultural diagnostic interventions such as the Focus Groups and Leadership survey have been developed and launched. Questions around experiences of race and discrimination have been included in the diagnostic tools.	Synthesis of all diagnostic data will be commence and be concluded in August.
Leadership Commitment.	Leadership commitment and engagement has been demonstrated at every level within the organisation, some examples are provided in Section (1) above.	A process is to be developed whereby feedback and progress around D&I activity is co-ordinated and shared.
	EMG have been asked to consider making a pledge publically on how they will personally support the development of a culture that is inclusive and one that values diversity.	
	Discussions have taken place with the Kings Fund to include Inclusive Leadership Development as a core module on the Advanced Leadership Programme.	Approach, method of delivery including timescales for the programme to be agreed with Divisional Directors.
Building Awareness and Understanding.	LGBTQ+ Pride activities were well received. The network have also established a sub group to drive inclusivity for Gender Identity and Expression.	
	Women's menopause policy is being finalised.	A focus group is being held next month on experiences of menopause within the workplace.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

3.1

Meeting Title:	Trust Board		
Date:	23 July 2020	**Agenda No**	3.1.1
Report Title:	Annual Safeguarding Adults Report April 2019– March 2020		
Lead Director/ Manager:	Robert Bleasdale – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Bill Turner – Head of Safeguarding for Children and Adults		
Presented for:	Assurance		
Executive Summary:	The report highlights some of the key achievements of, and areas of challenge for, the Safeguarding Adults team over the previous financial year, as well as seeking to set out key future pressures, challenges and opportunities for the Adult Safeguarding Service at the Trust. There has been a welcome increase to the staffing establishment of the team during the reporting year. The work of the Adult Safeguarding Team covers four aspects , Safeguarding Adults, Learning Disabilities, Mental Capacity/ Deprivation of Liberty Safeguards and Prevent. Given the importance and diversity of the portfolios, separate annual reports for Learning Disabilities, MCA and DoLs and Safeguarding Children will be provided. The report provides quantitative data for the number of contacts received by the team during the year, and the number of safeguarding referrals made to local authorities. Further data regarding domestic abuse and the embedded youth workers is available in the Safeguarding Children's report. During the reporting year, the internal governance of Safeguarding has been continued to be delivered via the joint Children and Adults Safeguarding Committee, which remains an improved method of governance, with a more integrated, 'Think Family' approach. Designated CCG leads receive a standing invite to the Committee. The Trust Safeguarding Adults team has continued to participate as fully as possible in local Safeguarding Partnership work, and in the Regional Safeguarding Adult Provider Forum network. There are some challenges inherent in the Trust for example not being Executive members of the Safeguarding Adults Board covering the geographical area the Trust sits in (Wandsworth) which are detailed in the report. Safeguarding training compliance has remained above the trust target of 85% and during the current year. The team will further review the content to ensure this matches current practice. The Trust is now exceeding the 85% compliance rate for Prevent training and this is no longer an area for concern. A future area of pressure relates to the implementation of the new Intercollegiate Safeguarding Adults training guidance.		
Recommendation:	The Board is asked to receive and note this report.		
Supports			

Trust Strategic Objective:	Treat the patient – treat the person; Right care, right place, right time		
CQC Theme:	Safe / Caring / Well Led		
Single Oversight Framework Theme:			
Implications			
Risk:	The Annual Report identifies potential areas of risk		
Legal/Regulatory:	The Annual Report references the Trust's legal and regulatory duties in this area		
Resources:	The Annual Report references the currently available resources.		
Previously Considered by:	Patient Safety and Quality Group Quality & Safety Committee	**Date:**	15/07/2020 23/07/2020
Appendices:	Nil		

Safeguarding Adults – Annual Report 2019/20

1. Introduction

St George's University Hospitals NHS Foundation Trust has a commitment and responsibility to ensure that all patients receive safe, effective and dignified care. In particular, we have a duty under Care Quality Commission's 'Fundamental Standards' to ensure that those adults most at risk should "not suffer any form of abuse or improper treatment while receiving care. This includes: neglect, degrading treatment, unnecessary or disproportionate restraint and inappropriate limits on their freedom."

The Trust's ethical, clinical and legal duties, and referenced to the Trust Values, around Safeguarding Adults are clearly displayed on prominent area of the Trust's website, (copied below) and the visibility of internal and external communication in this area will be an area of focus in the current financial year, as part of the Trusts' wider development of our communication strategy.

https://www.stgeorges.nhs.uk/about/living-our-values/safeguarding-adults/

This report provides a summary of activity with regard to safeguarding adults' activity at the Trust and highlights how St George's responds to and reports on concerns and allegations of abuse and neglect and how we ensure that safeguarding is integral to everyday practice.

It is important to note that the Care Act 2014 sets out in primary legislation to which adult safeguarding duties apply; a key difference to safeguarding children is that there is *not* a universal definition. It is set out in full below.

In the context of the legislation, specific adult safeguarding duties apply to any adult who:

- **Has care and support needs,** and
  - *Is experiencing, or is at risk of, abuse or neglect, and*
  - *Is unable to protect themselves from either the risk of, or the experience of abuse or neglect, because of those needs.*

***Within** the scope of this definition are:*

- *All adults who meet the above criteria regardless of their mental capacity to make decisions about their own safety or other decisions relating to safeguarding processes and activities;*
- *Adults who manage their own care and support through personal or health budgets;*
- *Adults whose needs for care and support have not been assessed as eligible or which have been assessed as below the level of eligibility for support;*
- *Adults who fund their own care and support;*

This Annual Report specifically covers Safeguarding Adults activity at the Trust. This report does not cover Mental Capacity Act, Deprivation of Liberty Safeguards (which following the passage of the Mental Capacity (Amendment) Act in May 2019, will be replaced by the new Liberty Protection Safeguards regime).

The reporting year was a busy and pressured one for the Safeguarding Adults team at the Trust. Although there has been a levelling of the previous rise in the number of referrals to the team, the quantitative data does not reflect the significant complexity of the issues experienced by many of the patients referred to the team.

2. Safeguarding Structure and Policy

St George's utilises the Pan-London Adult Safeguarding Procedures which were published in January 2016 in an attempt to provide a consistent response from all agencies involved in adult safeguarding across London. An updated version of these procedures, following a consultation in which the Trust took part, was published in May 2019. Although the revision of these procedures was a substantial piece of work, the impact on the day to day work of the Safeguarding Adults team has been largely unchanged, and the team continues to focus on the safeguarding of adults at risk. At the same time, the team is often called upon to provide advice, support or guidance in relation to adults, who may have vulnerabilities, but who do not meet the 'Care Act criteria' for recognition as an adult at risk, and this 'welfare' workstream is an important element of the teams work.

An important overall observation is that as the key legislation and Multiagency guidance relating to Safeguarding Adults is considerably more recent than that which relates to Safeguarding Children, there is very considerable variation both between and sometimes within local authorities as to how the procedures are applied. This is also reflected in the way that our local authority partners record data and information. This situation highlights the particular importance of effective partnership working in the Safeguarding Adults sector.

The current staff resources in the Adult Safeguarding team are:

Job Title	Band	WTE	Role comments
Head of Safeguarding – Adults & Children	8B	1 wte	The post holder is responsible for leading the Safeguarding Children and Safeguarding Adults function at the Trust, therefore approximately 0.5 of the post holder's time specifically relates to Safeguarding Children. The postholder works closely with Named and Designated professionals within the Trust, CCG and local authority to ensure the Trust fully discharges it's Safeguarding responsibilities. The postholder is extensively involved in partnership work, including but not confined to Safeguarding Adult Boards.
Lead Nurse – Safeguarding Adults	8A	1 wte	The postholder is the operational lead, and first point of contact for Safeguarding Adult issues at the Trust. On any given day this can involve responding to a number of contacts from Trust staff or elsewhere and often involves much more extensive involvement in specific cases. The postholder also supports partnership safeguarding activity locally (for example attending the Community Multiagency Risk Assessment Panel) and provides Adult Safeguarding training to staff groups when face to face training is specifically requested or needed. The postholder will also review Trust records in relation to specific patients when there is a requirement to do so.
Safeguarding Adults Clinical Advisor	6	1 wte (from 06/19)	The post provides key support within the Safeguarding Adults team, providing operational support for any incoming Safeguarding Adults concerns, follow up of cases and support to the training provision.
Safeguarding Administrator	3	1 wte	This is a business support post, providing administrative support to the Adult and Children's Safeguarding

Job Title	Band	WTE	Role comments
			team.
Lead Nurse: Learning Disabilities	7	1 wte	The postholder leads the Learning Disability Nursing service at St George's. This primarily involves providing a service to patients who have been admitted to the Hospital or who are attending the Trust as outpatients. The team provide direct support to patients, many of whom they know well, and provide support and advice to staff. The Band 7 postholder also leads the Trust's strategic work and partnership engagement regarding Learning Disability issues i.e. the local LEDER programme.
Learning Disabilities Nurse	6	2 wte (second post comme-nced 09/19	These post holders are experienced Learning Disability nurses who provide support to patients, and other learning disability related work, and are line managed by the Band 7 postholder. The expansion of the Learning Disability nursing team into 3 full time nurses (from September 2019) has been a very welcome and substantial addition to this effective team during the reporting year.
Mental Capacity Trust Lead	8a	1.0 wte (from 02/20)	This postholder commenced in February 2020, and has overall strategic leadership for Mental Capacity issues across the Trust, and supports the practitioner in post with operational issues.
Mental Capacity Act and DoLs Practitioner	7	1 wte	This postholder supports the Mental Capacity Lead. This post has a more operational focus, but is also concerned with training and service development

3. Safeguarding Alerts April 2019-March 2020

The Safeguarding Team collate data on all 'incoming' contacts to the team. In general these contacts are raised (on the phone, via email or in person) by a member of Trust staff to the Lead Nurse for Safeguarding Adults, although contacts/referrals are also made to the team by other agencies i.e. a Local Authority, or another NHS Trust (i.e. when a patient is admitted to the Trust and the Local Authority is already involved in a safeguarding matter, or whereby a patient is transferred between hospitals). Sometimes, matters are referred to the Team when another part of the Trust has been contacted (i.e. the complaints team) but the colleague feels there are potential Safeguarding issues to be explored.

The second row in the table indicates the number of Safeguarding Adult referrals made by the Trust to a Local Authority. In Safeguarding Adults, all such referrals have been completed by the Safeguarding Adults team. Whilst this represents a significant additional workload for the team (as opposed to asking clinical staff to undertake referrals) it means that a consistent referrals threshold can be applied, and there is a clear and positive impact on quality assurance as a result. We are also aware that asking ward based and clinical colleagues to complete referrals would represent a significant additional task for these teams. Compared to Safeguarding children's, where there is a normally very easy to identify referral process, 'intake' services for Safeguarding Adults teams differ significantly between local authorities, and this is an area in which the teams local/sector knowledge remains important, although is perhaps also an area which highlights the relatively low profile afforded to Safeguarding Adults (as opposed to Safeguarding Children) in the national policy agenda.

The involvement of the Safeguarding Adult Team following a contact varies considerably; in some cases brief advice only might be provided, to advise that Safeguarding procedures are not applicable in

the circumstances of the case (although in such cases colleagues are always advised to make contact again if the situation changes or they need further advice) or it might involve a considerable volume of activity such as direct and extensive patient and family contact, referral and liaison with partner agencies and extensive attendance representing the Trust at internal and external partnership meetings. Although there is no typical or average case, the level of activity normally sits somewhere between these two poles.

Please note that this information does not capture the considerable volume of referrals from the Trust to Local Authorities to adult social care when hospital discharge is required (although the Safeguarding team may become involved in some of the more complex cases in this category). The data in tables 2 and 3 relates to the first row of table 1 (contacts into the Safeguarding team) and the data in tables 4 and 5 relate to the second row of table 1 (external referrals from the Safeguarding team to a Local Authority).

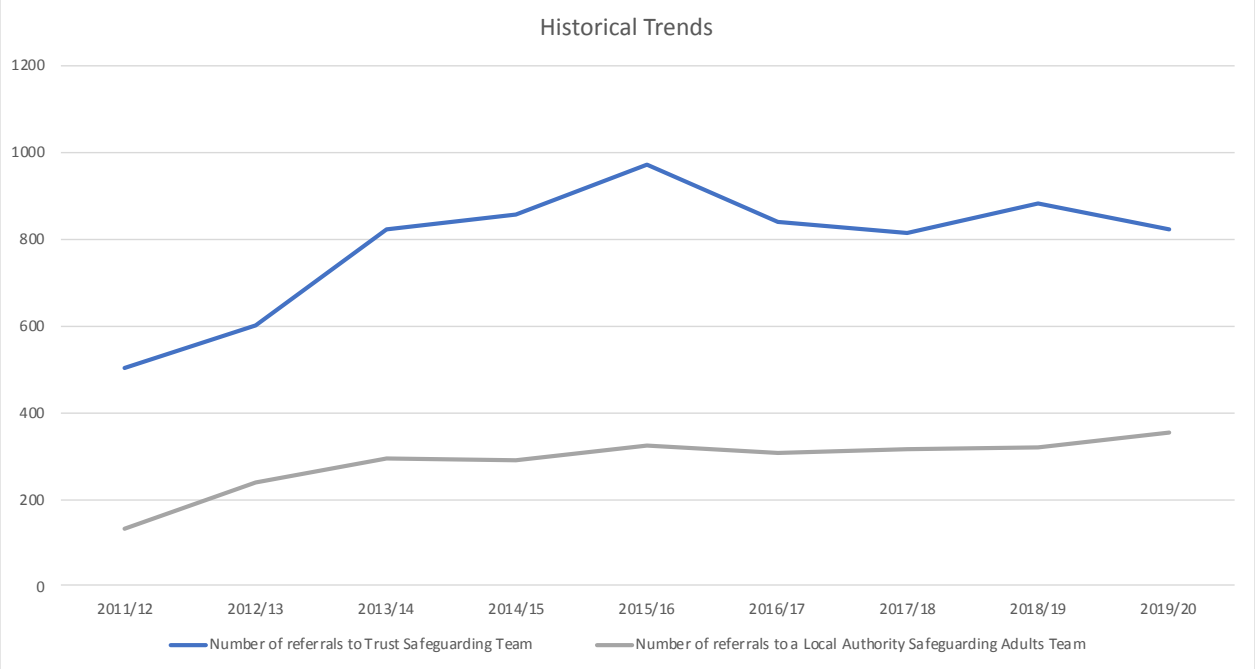
The second row records the number of external referrals i.e. the number of referrals made to a Local Authority Safeguarding Adult Team by the Trust Safeguarding Adult Team. Both Merton and Wandsworth have adult social work teams based at the hospital, although the team have links with the Safeguarding Teams in local authorities across South West London.

As will be seen from the data, the number of referrals 'out' is considerably smaller than the number of contacts 'in'. This reflects the considerable role the Trust Adult Safeguarding team play in providing advice, support, and working with colleagues to consider thresholds for intervention.

Table 1:

Number of contacts / referral by year:

Year	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Number of referrals (contacts) into the Safeguarding adults team	502	602	825	855	971	841	813	882	825
Number of formal safeguarding Referrals (to a local authority)	133	240	294	290	322	307	316	320	354



N.B the figures up to and including 2015/16 *included* referrals in relation to MCA/DoLS. Since 2016/17 MCA/DoLS figures have been recorded separately.

Table 2:

Number of Safeguarding Adult contacts (i.e. into the Trust Safeguarding Adult team) by primary presenting concern for 2018/19 and 2019/20

Category	2018/19	2019/20
Neglect	220	217
Physical	85	73
Emotional	43	49
Sexual	19	9
Financial	48	55
Domestic Violence	37 *	60*
Self-neglect	93	95
Discharge issues and concerns	50	37
Pressure Ulcer screening	78	52
Advice/Information exchange	194	140
Other	15	38

*- Please note that the Trust employs a Clinical Nurse Specialist for Domestic Violence (who also leads on Female Genital Mutilation response outside of maternity). The figure of 60 for domestic violence only refers to domestic violence cases in which a *Safeguarding Adult threshold (as defined by the Care Act 2014) was also met* (i.e. the patient concerned had an identified need under the Care Act). In such cases there is either close working between the relevant Trust Staff, or it is agreed who is the best placed colleague to lead on the case. The majority of the cases in which the CNS for Domestic Violence provides support, advice and intervention do **not** also involve the Safeguarding Adults team and it is important not to read the above data as suggesting that the Trust only became involved in 60 domestic violence cases in the reporting year.

Breakdown of incoming referrals by Local Authority.

As seen below the largest proportion of Safeguarding referrals at the Trust relate to Wandsworth. Both Merton and Wandsworth have a team of social workers located at the Hospital, who are able to undertake Safeguarding work alongside social care assessment and care management work. For any Safeguarding matter potentially related to the provision of patient care at the Trust, the London Borough of Wandsworth is the lead authority. Please note this data does **not** include referrals to Local Authorities under the Mental Capacity Act asking for the Deprivation of Liberty Safeguards to be applied.

Table 3:

Number of Safeguarding Adult contacts during the financial year 2018/19 and 2019/20 sorted by local authority.

Borough	2018/19	2019/20
Wandsworth	415	419
Merton	204	179
Lambeth	57	49
Croydon	28	36
Kingston	18	16
Sutton	34	18
Richmond	15	11
Surrey	24	27
Other	87	70

A further pressure area for the team during the reporting year, has been the number of s42 enquiries, these related to a concern raised about care at the Trust, and raised by, or referred to the Local Authority (i.e. London Borough of Wandsworth). Section 42 enquiries are formal, 'Safeguarding Adults' investigations, which are a locally authority led process legislated for by the Care Act 2014.

The basic tenant of the legislation related to s42 is set out below

Section 42 Care Act 2014: Enquiry by local authority
(1)This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—
(a)has needs for care and support (whether or not the authority is meeting any of those needs),
(b)is experiencing, or is at risk of, abuse or neglect, and
(c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it"

Section 42 of the Care Act establishes the process of local authority led 'Safeguarding Adults enquiry', which may be in relation to concerns about abuse or neglect within a vulnerable adult's family, within the community or within a health or care setting. The legislation does not set out a distinction between section 42 of the Care Act in relation to large hospitals, and other care and health providers, i.e. small domiciliary care agencies, and nor does it refer to how Safeguarding enquiries interact with Trust governance systems, clinical audit and complaints etc. There have been a number of occasions during the reporting year, in which the Local Authority (Wandsworth) and the Trust Safeguarding team have had a different understanding of the threshold for convening enquiries, when this relates to Trust care. This issue has also been referred to the CCG, and it is hoped the coming year will ensure better local guidance is developed (it is noted that other Trusts in London have experienced this problem in similar ways). It is perhaps something of a surprise that the London ADASS procedures, which are very lengthy, did not address this issue in more depth. It is noted elsewhere in this report that more strategic involvement in the local Safeguarding Board would be of assistance in resolving this issues.

During the reporting year, 27 referrals regarding care at the Trust were made to the London Borough of Wandsworth's Safeguarding Adults service, of which 10 resulted in formal section 42 enquiries being undertaken. The Trust Safeguarding Adults team were involved in all these cases, often playing a liaison role with clinical colleagues. Ensuring greater strategic oversight and joint working procedures in respect of these cases, including agreed thresholds, and ensuring congruence with Trust governance processes will be key to this work, as will continuing to develop a strong partnership with the Local Authority and the CCG. The Trust Safeguarding Committee will also provide in year governance and oversight of this area of work.

4. Patient Story (a vignette illustrated different aspects of Adult Safeguarding at the Trust)

Patient X was in their 40's and had multiple Sclerosis (MS.) The patient was a very proud and independent person who lives alone. They have 4 times a day package of care commissioned by the local authority. The patient was admitted to St Georges following a call from the carers to the GP as they were concerned about the patients' shortness of breath and fever. The GP recommended ringing an ambulance. London ambulance advised attendance at A&E. The patient was very reluctant to go to A&E but was persuaded in the end by the ambulance crew.

In A&E the patient was very angry at the carers for calling the ambulance, and made some specific allegations of neglect in respect of their care. In particular they alleged that the morning carers had left them in wet clothing, the lunchtime carer had not heated meal properly and that one of the carers had repeatedly shouted and swore at them, telling them to do as they were told.

The safeguarding lead received a referral from A&E and discussed the case with the duty social worker. Following admission to the ward they both met patient X the next day on the admissions ward to discuss the concerns. The patient was a bit calmer than in ED and felt that they had overreacted in what they said about the carers. The patient was angry at having to be admitted to hospital but now understood why they rang an ambulance. However, it was clear there were some issues around the support plan – and the needs had increased since the last review and the patient had also missed an appointment with the MS nurse which meant their medication hadn't been reviewed recently. As per "Making Safeguarding Personal" the social worker asked patient X what outcome they would like - did they want to continue with safeguarding enquiries? The patient said that they didn't want to pursue this process but did want to have the support plan reviewed and a discussion about the role of carers and how they communicated with them. The patient also wanted to explore the use of personal budget which could provide a more personalised approach to their care needs. The patient also had therapy and MS nurse review in order to optimise their functioning and symptom control prior to discharge. Patient X also agreed to an outpatients review with the MS nurse where future care and treatment options would be discussed (advanced care planning).

The patient was discharged home three days later with a planned community review by social worker with carers present in two days' time.

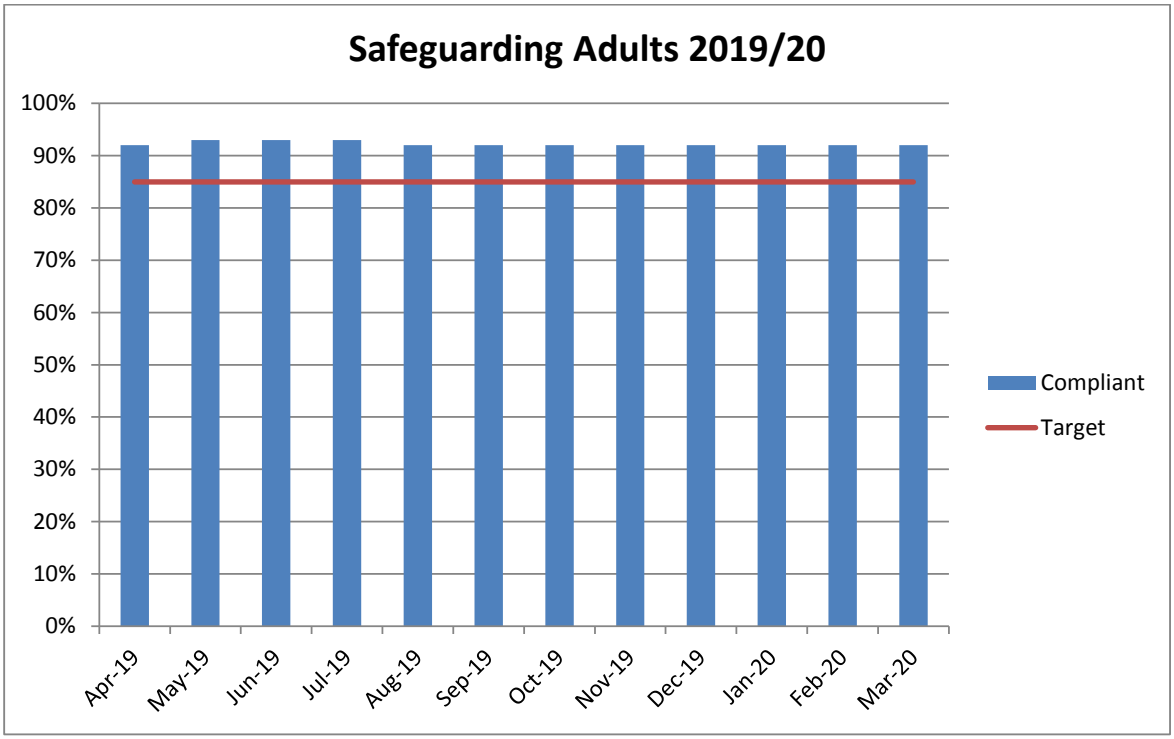
5. Training Compliance 2019/20

All staff working at St Georges University Hospital NHS FT are required to undertake level 1 Safeguarding Adults training. This training is delivered via the e-learning platform and requires users to complete the module and pass a short test after.

The training target for this mandatory training is 85% compliance. As is illustrated by the below, the Trust-wide level of Training compliance in Safeguarding Adults are good and have been consistently above the Trust target of 85% for the year.

Whilst the Safeguarding Team are pleased with the continuing strong levels of compliance

with Safeguarding Adults training amongst Trust staff, in the current year the team will be focusing on a strategy to develop training materials in line with current best practice and Intercollegiate Guidance, which seeks to move Safeguarding Adults training, across the NHS, onto a similar status to Safeguarding Children training. There are resourcing implications to this area of work, and close collaboration with the CCG and with regional provider colleagues will be important.



	April 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
%Compliant	92%	93%	93%	93%	92%	92%	92%	92%	92%	92%	92%	92%

6. Audit

During the reporting year, the Trust's Safeguarding Adults arrangements were the subject of an audit by 'tiaa', the Trust's external auditors. We were very pleased to share that the highest rating possible, 'substantial assurance' was awarded to the Trust's Safeguarding Adults function. The team and all relevant stakeholders were delighted that the Auditors rating as it reflects the hard work not only of the Safeguarding team, but also of all colleagues at St George's in ensuring that Safeguarding our most vulnerable patients, and their families, is a key priority for all at the Trust. The audit reported minor recommendations to be made, most of which were addressed by the time the report was finalised.

In the current year the Team will consider how to implement a further recommendation of the external audit, which is to consider how the Team is involved with, and disseminates, clinical audit work. Whilst the Trust's Safeguarding Children's Team is involved in regular audit activity, this has been more challenging for the Safeguarding Adults Team, as they have a smaller staffing establishment, although the members of the team regularly take part in multiagency case discussion and planning, which contains an element of live case audit and review.

Safeguarding also features as a key aspect of the St George's Ward Accreditation scheme, which is in itself a key part of the Trust's clinical governance arrangements. In the months April 2019 to July 2020

(NB this is a continuous process so not financial year data) the ward accreditation team audited inpatient wards and spoke to 196 members of staff about their understanding of aspects of safeguarding, this includes Children's and Adult Safeguarding, and a question on Female Genital Mutilation. Of these 196 staff 170 were able to articulate fully their actions in a given safeguarding scenario and the auditor was confident that a safe and appropriate response would be made in 'real life'. Where there were elements of an appropriate response but prompting was required and/or some aspects of the scenario were not fully articulated, but the auditor was assured of the individuals safe practice, the response as recorded as a 'partially answer'. This equates to 26 members of staff. In this reporting cycle no member of staff gave a response that suggested that they had no relevant knowledge in the area which would lead to a patient being unsafe.

The very welcome investment in the staffing establishment of the team will make more developed work in the area of Safeguarding Adults clinical audit possible.

7. Partnership Working and Priority Areas:

The Trust is actively involved in partnership safeguarding activity in relation to Safeguarding Adults, including Local Safeguarding Adult Boards, as well as Health Safeguarding Leads Partnership meetings. The Trust has recently offered to host a meeting of the SW London Safeguarding Adults Health Leads meeting, and will be exploring hosting this meeting on a permanent basis.

The lead nurse for adult safeguarding attends the monthly 'CMARAP' – Community Multiagency Risk Assessment Panel for adults at risk across Wandsworth. This is an opportunity for teams across Wandsworth to present complex cases to senior operational leads across social services, mental health, police, housing, acute health and fire with a view to mitigating risk. Themes include self-neglect, hoarding, disengagement from services, drug and alcohol use and housing issues. There have been a number of successful outcomes for clients through this process.

The Safeguarding Adult team is actively engaged in partnership working at a local level. Safeguarding is a continuum and our responsibility to ensure vulnerable adult patients are appropriately safeguarded does not begin and end with their attendance/admittance and discharged from hospital.

Furthermore the Safeguarding team seek to make long term contributions towards safeguarding outcomes wherever possible i.e. attending planning meetings with partners to plan long term care for specific patients, or with the Lead Nurse for Adult Safeguarding attending Wandsworth Community Multiagency Risk Assessment Panel which meets on a monthly basis to seek to mitigate risk on high risk vulnerable adults living in Wandsworth.

The Trust is a Member of Merton Safeguarding Adults' Board, whilst at the Richmond and Wandsworth Safeguarding Adult Boards; Health is represented by the CCG. The Trust reports through the Director of Quality and CCG Safeguarding Leads to this meeting. In the year ahead the Safeguarding team will continue to undertake work to ensure that our contribution to partnership safeguarding activity (i.e. Safeguarding Boards) is proportionate to the size of the team, is focused on improving safeguarding practice and outcomes across agencies, including our own, and makes a demonstrable difference to activity, whilst avoiding both duplication and ensuring that data collection is purposeful and strategic. The Safeguarding Team remain of the view that not being members of the Executive of the Safeguarding Adults Board of the area the Trust is situated in is a far from ideal position as the position, and impacts the ability of the Trust to be involved Strategically in Safeguarding issues locally. It also means that the Safeguarding team is less well cited on local developments relevant to safeguarding adults than we might otherwise be. Lastly, and perhaps most importantly, non membership of the Board has inhibited, at times, the ability of the team to form close working relationships with colleagues in key operational and strategic roles across agencies. This is being addressed through a meeting with the Director of Quality at the CCG to ensure two way communication and accurate reporting between services.

For example, as the Trust is situated in Wandsworth, Wandsworth Council is the lead agency in respect of s42 Safeguarding Adult enquiries undertaken under the provisions of the Care Act. The reporting

year has involved a number of case in which there have been different perceptions of 'threshold' and differential response to concerns between agencies. Whilst this remains an open workstream, it is the Team's view that partnership challenges would be best addressed via fuller participation in the Board.

In general, and as would be expected, the Trust has strongly developed partnership working arrangements, and regular contact at a range of levels with both Wandsworth and Merton Councils and Safeguarding Boards

It is notable however that both the Children and Adults Safeguarding Teams are increasingly asked to provide input in relation to a number of patients from a wider range of boroughs, specifically (but not exclusively) Kingston, Lambeth, Croydon and Surrey.

There are a number of specific areas of work undertaken by the Safeguarding Team which extend across both the Children's and Adults Safeguarding strands. The report will provide a brief commentary on each of these.

Domestic Violence:

- Please note that this year's Annual Safeguarding Children's Report includes data from the Trust Domestic Violence Service for the first time and interested parties may wish to refer to this report for further information.

- The Trust employs a Clinical Nurse Specialist for Domestic Violence and Female Genital Mutilation, who works in close partnership with a Senior Independent Domestic Violence Advisor who is an employee of Victim Support based on site at St George's. Both these staff members can be contacted by staff across the Trust, and work either directly with patients who may be experiencing domestic abuse, either during their time in hospital, or after they have been discharged, or provide advice and guidance to staff to support them in patient care in relation to domestic violence.

- The Independent Domestic Violence Advisor (who is not a Trust employee) is also able support to provide advice and support to staff experiencing domestic violence in their personal life.

- There is also a Clinical Midwife Specialist for Domestic Abuse works closely with the team when required, and who is able to case hold women experiencing significant domestic abuse.

- The Clinical Nurse Specialist for Domestic Violence has both an operational and strategic role in relation to domestic abuse and awareness of the role has increased across the Trust during the reporting year. The postholder is also involved in delivering the Trust's training offer but the team is considering ways of extending this.

- The Clinical Nurse Specialist is also the Trust's MARAC lead (Multiagency Risk Assessment Conference) and takes part in three local MARACs (each London Borough has its own MARAC). As an Acute Trust having contact with a very large number of patients this is a key part of the role, and a significant demand on the Clinical Nurse Specialist's time. Please see below for an explanation of MARAC:

- Each borough MARAC is essentially a multiagency body with set up with the purpose of increasing the safety, health and well-being of victims/survivors, adults and their children
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability, and
- Improve support for staff involved in high-risk domestic abuse cases *(taken from Richmond upon Thames MARAC website, June 2018)*

Prevent:

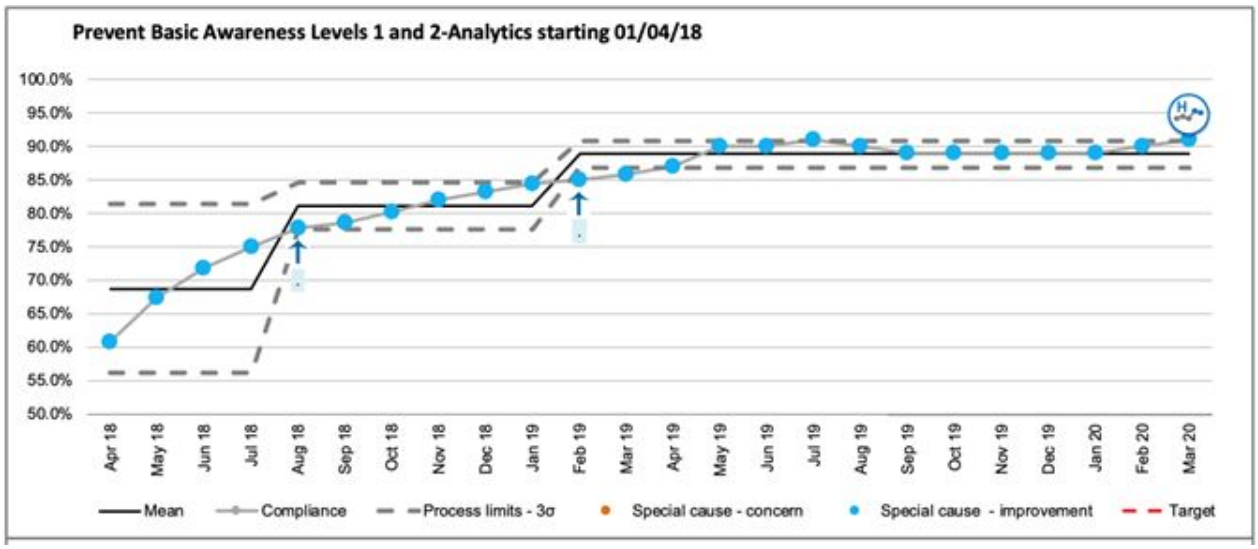
Prevent (short for 'Preventing Radicalisation' work conducted under the auspices of the Government's counter-terrorism strategy) work at the Trust encompasses both the Children's and Adults team and engagement with the NHS England Regional Prevent coordinator as well as local partnerships. During the reporting year, the volume of partnership activity in relation to Prevent declined considerably, as the London Regional Co-ordinator was deployed to other roles. However the Safeguarding Team are fully aware of their responsibilities in this area.

A key theme of Prevent work in the Trust is seeking to improve uptake of Prevent training, which is a statutory requirement. In May 2018 the Trust launched the Level 3 Prevent ELearning module – this has radically improved our compliance and we now comfortable exceed the 85% target.

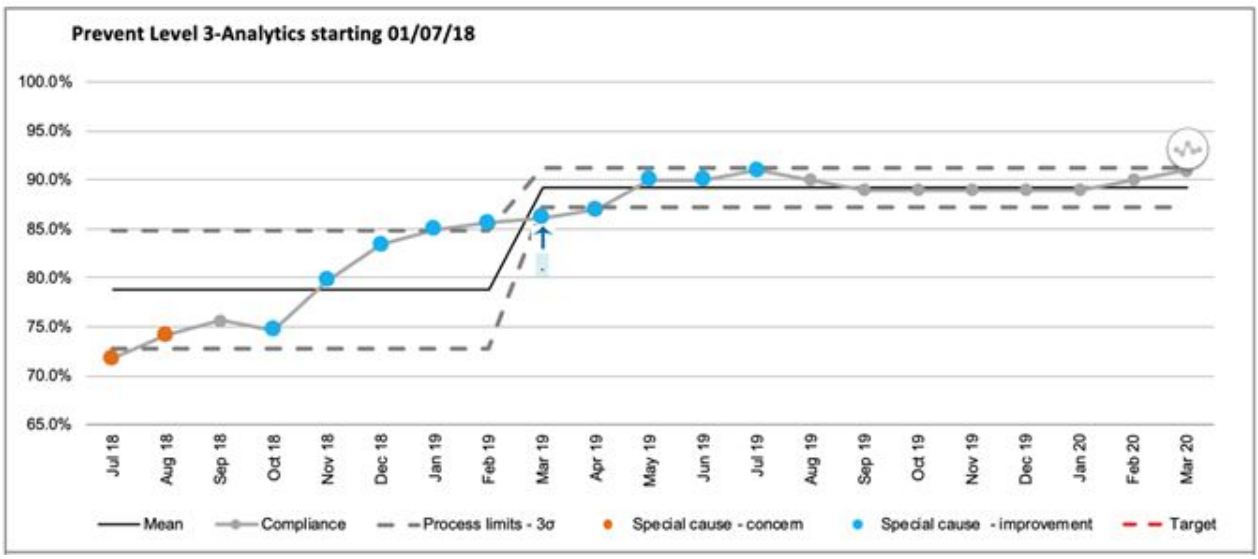
The Head of Safeguarding is the Trust Prevent lead and the contact person for referrals. As there is a general lack of published information regarding the role of Acute Trusts in the Prevent strategy, it is important for the Trust Lead to develop and maintain the existing working relationship with NHS England Regional Prevent Lead to ensure that we are up to date with any developments, as well as horizon scanning more generally.

The online training seeks to ensure that staff are aware that Prevent activity is not exclusive to adherents of any specific religion or ideology, and also highlights the growing importance of the far-right terrorist threat. The principal reference to the NHS in the Government's updated Counter Terrorism Strategy (Contest: Home Office (June 2018) refers in the main to Mental Health services but Prevent nonetheless remains an important area of the Trust's work.

The SPC graphs below show training compliance for Prevent Level 1, 2 and 3.



Summary: *Trending improvement*



Summary: SPC shows a stabilised position. Prevent Level 3 training and compliance as of March 2020 was 91%

Month Year	April 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
%Compliant	87%	90%	90%	91%	90%	89%	89%	89%	89%	89%	90%	91%

8. Safeguarding Adult Reviews:

No reviews relating to care at the Trust were published during the reporting year.

The Trust is an active participant in Safeguarding Adult Reviews (SAR). Whilst numbers are too small to establish a definitive hypothesis, there is a tendency for cases which are the subject of a SAR to come from a wider geographical area than solely from the Boards of which we are members, or the Local Authorities with whom we work closely with on a regular basis. It is likely this is linked to the Trust's status as a trauma and tertiary referral centre insofar as the Trust admits patients from a wider arena in respect of complex, challenging and serious medical presentations.

As with Serious Case Reviews in respect of children the team is seeking to develop a strategy to more effectively harness learning from reviews on a national level – this is more challenging as there is no central collation of SARs nationally. A project led by SCIE (Social Care Institute for Excellent) is apparently underway to address this deficit and we will follow developments closely. The Head of Safeguarding has recently completed training via the Wandsworth Safeguarding Adults Board in the 'Learning Together' model of Safeguarding Adult Review, which was pioneered by SCIE which sought to deploy a systemic learning model to review processes.

An area of work for future development relates to SARs published nationally which contain important learning for Acute Hospitals- there are often reviews published in other areas which may contain potentially important learning for Acute Trusts on a national basis.

The reporting year has seen relatively low levels of activity on the number of Safeguarding Adult Reviews in which the Trust has been involved with, although the team not infrequently receives requests for information related to reviews (responding to three from one Board alone in a short space of time).

Shortly after the end of the reporting year but included in this report to avoid further delay a Safeguarding Adults Review was published by Lewisham Safeguarding Adults Board about the care and support provided to a gentleman who passed away in January 2016 (he had been a recent patient at the Hospital before he sadly passed away (after leaving the Trust). Whilst some specific and unforeseeable circumstances led to this review being delayed, this matter does illustrate the chronic issue relating to the often lengthy gap between an incident and a review being published, which has a significant impact on organisational learning – particularly in large organisations where there is inevitably a frequent turnover of staff). An outcome of the review emphasised the importance of capacity assessments and risk assessments being undertaken.

A connected area is Domestic Homicide Reviews, in which the Trust also is frequently asked for information. The 'Health' component of DHRs is normally undertaken by CCGs which has had an impact on the quality of learning and engagement from the Trust due to an 'arm's length' approach being adopted, this needs to be balance with the often extreme challenges of a small team taking part in complex reviews from a time perspective. DHRs are generally convened by local Community Safety Partnerships of which provider Trusts are seldom members.

9. The wider picture

There is a large cohort of adult patients at the Trust who fall outside the fairly closely defined remit in the Care Act 2014 of adult safeguarding (see above). This is not to say that there are not a large number of patients at the Trust who would benefit from

additional support or intervention of one kind or another. One group in such a category are young people who present at the Hospital following injury incurred as a result of peer or peer violence. Another group 'missing' from Safeguarding Adults legislation are young people who, as children, were in the care of the local authority – i.e. 'care leavers' (whether or not they are formally receiving a leaving care service).

When considering the care and support needs of young people at the Trust, we work closely with the Redthread Youth Violence Intervention Programme. They have a co-located team of youth workers based in the Emergency Department who provide a high quality and responsive service to young people aged 11 to 24 who have experienced or are at risk of serious violence, domestic violence, sexual assault, or exploitation.

There are also significant areas of work and pressure within the Trust which impact patients who are defined as vulnerable adults within the Care Act, but which are indirectly, as opposed to directly linked to Safeguarding, such as issues around safe discharge and adult social care packages.

For the first time the Trust is providing data in respect of Redthread's work as part of our Safeguarding Children's Annual Report and interest parties may wish to refer to this report for more detail.

10. Key risks and challenges in relation to Adult Safeguarding at the Trust.

The key risk for the service which are being managed as follows:

Ensure that the small staff team is able to response to increasing demand due to the scope of adult safeguarding work being although well-defined inconsistently applied and thus generating high numbers of contacts.

Ensuring that we respond and engage efficiently with all local agencies / authorities across wide geographical area the Trust serves.

In December 2018 updated Intercollegiate Safeguarding Adults guidance was published which clarifies the expectations around Safeguarding Adult training and in particular sets out expectations regarding face to face as well as e-learning. In common with many other provider Trusts, we have identified that this represents a potentially significant pressure, as currently the Trust does not employ external trainers, and compliance with face to face learning is harder to achieve than with e-learning. The Trust is actively engaged with the Regional Adult Safeguarding Provider leads, and with a Health Education England initiative in order to work collectively to meet some of these challenges and updates will be provided to the trust Safeguarding meetings as this work progresses, to achieve the implementation of the new training framework in 2020.

The Mental Capacity (Amendment) Act 2019 is now law with replaces the current system of Deprivation of Liberty Safeguards (a system overseen and managed by Local Authorities) with the Liberty Protection Safeguards (which gives a greater role to the Trust in decision making around the Deprivation of Liberty). This remains an ongoing area of work for the Trust, Local Authorities and CCGs nationally, and importantly the provision of a new updated Code of Practice.

The provisions of the Homelessness Reduction Act 2017 requiring that the Trust offer a referral to any patient who is homeless, or threatened with homelessness within 56 days, to a local authority (of their choice) is now in force. Whilst this is not a Safeguarding Duty under the Care Act 2014, it is important to highlight that awareness of this duty across the Trust is not high, and there remains work to do to ensure that staff offer to refer patients falling into this category to the local authority to which they

are entitled, although it important to note that the Trust's role involves making a referral to a local authority housing department, and this does not guarantee a particular outcome in terms of housing.

11. Conclusion:

The Trust is compliant with its statutory and regulatory obligations regarding Safeguarding Adults, and has participated in the annual Safeguarding Adults self-assessment and assurance with the local authority.

The work of the Safeguarding Adults' team encompasses four strands, and all areas will need to be considered and addressed in the Service Development Plans for the team.

i) Operational safeguarding work; i.e. the provision of advice, active involvement in identified safeguarding cases (ranging for limited to extensive involvement) and the provision of Safeguarding Adults training.

ii) 'Strategic' safeguarding work: developing practice across the Trust to ensure that systems, processes and workplace culture create an environment in which Safeguarding matters can be identified, and when they are identified, effectively addressed. This involves developing internal and external working relationships, the review of available resources and ensuring that quality assurance mechanisms are agile and fit for purpose.

iii) Quality assurance and reporting: There are a considerable volume of reporting requirements in respect of the Safeguarding Adults team, including CCG and local Safeguarding Adult Boards as well as to NHS England and where required the CQC and through internal governance processes within the Trust.

iv) Partnership safeguarding activity: This involves 'formal' Safeguarding Partnerships at Local Safeguarding Adult Boards but also the development and maintenance of effective working relationships between organisations.

Particular areas of importance internally in the coming year will be more effective engagement with the discharge processes for vulnerable patients, and the identification of a budget for legal advice when needed by the team. These are joint aspirations held by both the Safeguarding Adults service and the Mental Capacity team. It will also be important to develop more locally informed, streamlined and outcome focused practice in relation to s42 enquiries convened in relation to care at the Trust.

During the reporting year, much work went into the Trust's updated Modern Slavery Statement, with input from a variety of stakeholders across the Trust. There were some delays to this process due to the Covid pandemic, although it is anticipated this Statement will also have been finalised by the time the present report has been presented to the Trust. Although tackling Modern Slavery is a Trust-wide responsibility it is unsurprisingly one in which the Adult Safeguarding team have a particular part to play; in the current year this will including ensuring that training materials are updated to include up to date best practice in this area, and engagement with partnership activity pertaining to Modern Slavery.

It is hoped that this report gives an indication of the depth and complexity of the work undertaken by the Safeguarding Adults team and provides assurance that there are appropriate structures and training in place to support safeguarding principles as defined in the Care Act, and as required to meet regulatory standards.

We are also keen to focus partnership working activity, within the available capacity of the team, into activity which has a clear focus on improving outcomes. The Team take part in a variety of London wide discussions with Safeguarding Adults colleagues in provider Trusts and seeking to capture best practice regionally will remain important themes in the coming year.

In summary, this was a busy and successful year for the Safeguarding Adults team at the Trust. It is clear both from patient impact and from feedback from partners that the team played an essential role in supporting some of the most vulnerable patients the Trust provides care for, and in combating abuse and neglect, and our contribution to local partnerships has been valued. Given the resent investment in the team, it is hoped that we can extend quality assurance work and follow up on cases, providing advice/support and signposting to the considerable group of patients who have additional vulnerabilities but do not meet a 'Care Act threshold' in terms of Safeguarding Adult legislation. The capacity and continued work of the team will be subject to ongoing review in the year ahead.

Meeting Title:	Trust Board		
Date:	30 July 2020	**Agenda No**	**3.1.2**
Report Title:	Annual Safeguarding Children's Report April 2019– March 2020		
Lead Director/ Manager:	Robert Bleasdale – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Bill Turner – Head of Safeguarding		
Presented for:	Assurance		
Executive Summary:	The annual safeguarding report details the systems and processes in place to safeguard children in acute and community services. The report demonstrates that the Trust is committed to the safeguarding of children and promoting their welfare in line with the statutory requirements of the Children's Act. The report provides further data regarding the important work of the Trust domestic abuse service and the embedded youth work team. The report highlights some of the key areas of work and areas of challenge for the Safeguarding Children's team over the previous financial year, as well as seeking to set out key future pressures, challenges and opportunities for the Safeguarding Children Service at the Trust. The report highlights a key in-year achievement in relation to the development and implementation of the Named Midwife for Safeguarding role. This report is focused on activity over the past financial year, but also references changes and developments to the Service which are either planned, or already underway. The key issues to note in the report are: • The Trust is discharging the required statutory responsibilities as outlined in the Children's Act 2004 • There are clear lines of accountability, responsibility and governance which have been strengthened by the full integration of acute and community safeguarding teams. • Training compliance at all levels is good but requires on going focus to maintain compliance in all areas. Training is available for all levels including the bespoke training package for level 3 in line with intercollegiate document. • The report details some of the continuing challenges around the provision of safeguarding supervision in an acute Trust setting and some of the work which has taken place in year to address this. • Partnership working in general remains a strength but there are some pressures and challenges that we continue to focus on. • The Trust has safeguarding policies, procedures and guidance documents which reflect best practice and Pan London Standards, although the current year will include further policy update and development. • The Trust has embedded the business as usual pilot of joining the Adult and Children's Safeguarding Committees together for better collaborative working and a 'Think Family approach'		

Recommendation:	The Board is asked to receive and note the report.		
Supports			
Trust Strategic Objective:	Treat the patient – treat the person; Right care, right place, right time		
CQC Theme:	Safe / Caring / Well Led		
Single Oversight Framework Theme:			
Implications			
Risk:	If proper systems and processes and governance not in place failure to meet statutory requirements and potentially put children at risk.		
Legal/Regulatory:	Compliance with: (i) Heath and Social Care Act 2008 (ii) Section 11 Children's Act 2004 (iii) Working Together 2018 (iv) Regulation 13: Safeguarding service users from abuse and improper treatment		
Resources:	No additional resources required or requested.		
Previously Considered by:	Patient Safety and Quality Group Quality & Safety Committee	**Date:**	15/07/2020 23/07/2020
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Safeguarding Children – Trust Annual Report 2019/20

1. Introduction

St George's University Hospitals NHS Foundation Trust, and all staff and volunteers working for the Trust have important and distinct ethical, legal and where applicable, regulatory duties to ensure that all children and young people receiving services from the Trust receive safe and dignified care, and that they are safeguarded from harm, abuse and neglect, including ensuring that appropriate action is taken when the Trust becomes aware of potential issues of concern which come to our attention, taking place outside of the Trust. The Trust Board has agreed a Safeguarding Children's Statement which is publicly available on the Trust website, and is appended at the end of this report. The statement can be accessed online at the following link and is appended at the end of this report.

https://www.stgeorges.nhs.uk/about/living-our-values/safeguarding-children/

This safeguarding duty may be enacted in the context of the administration of patient care directly, or by the Trust participating in multiagency safeguarding practice, such as sharing information with a local authority or attending a strategy meeting relating to a specific child. However, it is extremely important to note that the Trust's safeguarding duties also extend to children and young people who are **not** patients at the Trust (and who will not be physically seen by the staff member or clinical team providing treatment to the adult). These duties typically occur when the Trust receives information which might indicate that a child or children are potentially at risk of 'significant harm'.

Most commonly, this will occur when an Adult patient is receiving treatment at the Trust, and the consultation or treatment indicates that a referral to children's social care/support or advice from the Trust Safeguarding team might be needed (for example if an adult is presented at the Trust for issues related to domestic abuse, substance misuse or poor mental health). We refer to this as a 'Think Family' approach. These duties will apply whether or not the names and details of the children are known or not. It is important to reference this duty as it applies to all Trust staff including colleagues who seldom or never work with children as part of their day to day duties.

In essence, our Safeguarding duties as a Trust relate to all children, regardless of where or with whom they reside, and whether or not they have used any Trust services, and whoever at the Trust comes into contact with information which is relevant to Safeguarding a child.

In such cases, the Trust's duties principally relate to sharing information with relevant agencies, and participating in multiagency safeguarding processes, whereas in the cases of children who are inpatients or who receive direct and ongoing care from the Trust, we are likely to play a more active and substantial role in service provision.

The 'backbone'' of legislation relating to Safeguarding Children in the United Kingdom is the Children Act 1989, although there have been a number of important legislative and policy milestones since this time. In particular, the Act introduces the concept of 'significant harm' on which most statutory interventions and information sharing processes in relation to children, are based.

The key piece of Statutory Guidance relating to Safeguarding Children is *Working Together to Safeguard Children* (updated July 2018) and there is important regional guidance in the Pan London Child Protection Procedures (http://www.londoncp.co.uk/index.html).

During the reporting year, key tenets of the Children and Social Work Act 2017, came into force. Whilst this has not impacted day to day safeguarding practice at the Trust there has

been a substantial impact in respect of the transition to Safeguarding Children's Partnerships

The Pan London Child Protection Procedures, which all NHS Trusts are obliged to follow, are updated on a six monthly basis, and contain detailed information to guide operational responses to specific situations and concerns.

This report provides a summary of activity with regard to safeguarding children's activity at the Trust and highlights how St George's responds to and reports on concerns and allegations of abuse and neglect and how we ensure that safeguarding is integral to day to day clinical care and practice at George's.

2. Safeguarding Team Structure

The reporting year saw some significant changes in staffing in the Safeguarding Children's team at the Trust, and the during the early part of the reporting year there were some challenges due to vacant posts and sickness. The team has however been fully (and permanently) staffed since November 2019. A key staffing development during the year was the welcome introduction of the post of Named Midwife, Safeguarding Children. The postholder is a highly experienced Midwife with many years' experience at the Trust.

Job Title	Band	WTE	Role comments
Head of Safeguarding – Adults & Children	8B	1 wte	The post holder is responsible for leading the Safeguarding Children and Safeguarding Adults function at the Trust, therefore approximately 0.5 of the post holder's time specifically relates to Safeguarding Children. The postholder works closely with Named and Designated professionals within the Trust, CCG and local authority to ensure the Trust fully discharges its Safeguarding responsibilities. The postholder is extensively involved in partnership work, including but not confined to Safeguarding Children and Safeguarding Adult Boards.
Named Doctor – Safeguarding Children	Cons	0.3 wte	Responsible for clinical/medical advice on complex safeguarding cases across the Trust, working closely with the Head of Safeguarding and the Named Nurses in this respect, as well as acting as point of contact for Doctors with Safeguarding related query. At St George's the Named Doctor also leads a detailed programme of Safeguarding education/seminars (complementary to the Level 3 Safeguarding course) which is accessible to all doctors and nurses across the Trust. Like colleagues, the postholder is also extensively involved in partnership working.
Deputy Named Doctor – Safeguarding Children	SpR	0.1 wte	Deputises for the Named Doctor, and also participates in Safeguarding activity alongside colleagues from the Safeguarding team.
Named Nurse for Safeguarding Children (Acute Services)	8A	1 wte	Responsible for clinical advice and guidance to all Trust staff on Safeguarding matters, both on specific cases and operationally. Responsible for the Trust's Level 3 training offer in respect of Children's Safeguarding, and oversees the development in the Trust's safeguarding children's work and for overseeing the provision of Safeguarding supervision to Nursing and Therapy staff across the Trust. The postholder is extensively involved in partnership working.

Job Title	Band	WTE	Role comments
Clinical Nurse Specialist for Safeguarding Children	7	2 wte	The Clinical Nurse specialists provide advice and support to staff on all children's safeguarding issues and are a visible presence on wards (in the Emergency Department and Paediatric Wards). The Clinical Nurse Specialists are often involved in referrals to Local Authorities regarding safeguarding matters as well as taking part in case specific partnership meetings such as Strategy meetings and Child Protection conferences.
Clinical Nurse Specialist – Domestic Violence and FGM	7	1 wte	This post works across the Trust on Safeguarding activity which may relate to children or adults, but is managed within the Safeguarding Children's team to which most of the operational activity relates.
Safeguarding Administrator	3	1 wte	This post holder covers both the Children and Adults functions supporting the team with the considerable volume of administrative tasks associated with Safeguarding.
Named Nurse for Safeguarding Children (Community)	8A	0.6wte	The main focus of this role is acting as the Safeguarding Lead in respect of Community based services, although given the Trust's disinvestment from a number of community based services (specifically school nursing in September 2018) the postholder also provides much needed support to the Acute Team.
Paediatric Liaison Health Visitor/CNS Emergency Department Liaison, Safeguarding Children and Young people	7	1 wte	Liaison of information/notifications/referrals from the Emergency Department to School Nurses, Health Visitors and Local Authorities. Chairing the weekly safeguarding ED meeting, overseeing safeguarding practice within ED. Quality assurance of Safeguarding Practice within the ED department.
Administration (Paediatric Liaison and community services)	4	1.8 wte	These roles provide administrative support to the Liaison service and is responsible for data collection, and sending out the significant volume of information
Named Midwife for Safeguarding Children	8a	1.0 wte	Overall operational and strategic lead for Safeguarding within Maternity Services at St George's both across the Maternity Department and in respect of partnership working. The postholder is a member of the senior management team within the maternity department, but also as a line of accountability to the Head of Safeguarding.
Clinical Midwife Specialist *	7	1.0 wte	Provide specialist safeguarding support to maternity services.

It is also important to note that two voluntary sector services work within the Trust, and work closely with the Safeguarding Team, these being Redthread and the Independent Domestic Violence Advisor. Both these services are funded by MOPAC (Mayor's Office for Policing and Crime)

Independent Domestic Violence Advisor (Victim Support employee):
This member of staff works closely with the Clinical Midwife Specialist and provides bespoke support to patients who are affected by domestic violence, including after discharge. Redthread also have an Independent Domestic Violence Advisor (IDVA) who support domestic abuse victims and survivors under the age of 25.

***Redthread*:**

Redthread is a youth work charity providing support to young people with a range of vulnerabilities. Redthread have seven youth work staff, including a Team Leader, three youth workers, a young women's worker, and IDVA and a Programme Coordinator based in the Emergency Department. Redthread have a presence in London, Nottingham and Birmingham's Major Trauma Centres, Homerton University Hospital, Heartlands Hospital and UCLH. They are set to expand to three more London hospitals later this year. Whilst Redthread has developed a significant public profile in respect of their work in relation to knife crime, and this forms an important part of their work at the Trust, they work with young people aged 11-25 attending the Trust for any reason associated with youth violence including domestic violence, sexual violence, exploitation and non-weapon related assaults.

The team work proactively and flexibly with young people who have been admitted to Hospital, and seek to make use of the 'teachable moment' when a young person is hospitalised, to co-produce a longer term intervention with them.

Redthread's Youth Violence Intervention Programme is funded by The Mayor's Office of Policing and Crime, and a number of trusts and foundations. They also partner with SOLACE to provide a youth IDVA who works with young women affected by domestic violence, and a Comic Relief funded young women's worker who supports young women affected by gang activity. Over the past year, Redthread and the Trust Safeguarding team have continued to build on operational and strategic working. Redthread continue to actively contribute towards the Trust's multiagency Level III Safeguarding Training and the Trust Safeguarding team have an important role in supporting Redthread with staff recruitment.

It is noted that Redthread, beyond core clinical services, are the main agency providing services to young people over the age of 18 who with additional vulnerabilities who use Trust services as these young adults are over the age at which the Safeguarding Children's team work. The vast majority of these young adults, despite their vulnerabilities are not generally seen as meeting the threshold for a Local Authority Adult Safeguarding intervention. Whilst many young people using Trust services have additional vulnerabilities and needs, the vast majority of this cohort of young people will not meet the threshold for adult social care services. The contribution which Redthread is able to provide to this group of young adults is therefore particularly important, as they provide a service which is unlikely to be offered by any statutory services at this time.

Towards the end of the reporting year, Redthread staff, in common with all MOPAC funded hospital based youth services, were switched from co-location in the Emergency Department to remote working and a short summary of these changes is set out below. As of July 2020 plans for some Redthread staff to return to the St Georges' site are well underway.

Redthread response to Covid-19 at St. George's Hospital:
Redthread have worked intensively alongside clinicians and safeguarding leads within the Trust to develop and roll-out a remote youth work service, as the Covid 19 pandemic impacted their ability to have a physical presence in our hospitals across London and the Midlands. They have continued to take referrals remotely and have provided support to our NHS colleagues by adapting our service offer to be able to receive referrals and work in a virtual way. They have continued to work with young people, not only our existing cases but also by taking on new referrals from the hospitals in which we are based.

During the pandemic, Redthread have provided a remote youth work service for young people both in the hospital and in the community and have been able to offer support to young people virtually (via phone and video call) in the following areas:

- Safety planning for safe discharge from hospital
- Safeguarding young people within the multi-agency network
- Creating a clear support plan for each young person

- Ensuring each young person understand their treatment plan
- Supporting young people with their physical and emotional wellbeing
- Consistent support in relation to key areas including housing and ETE
- Advocating for young people with a wide range of statutory and voluntary agencies

Appended below are details of the referrals (from St Georges' staff) during the reporting year. This data illustrates the number of young people experiencing complex and challenging circumstances which both the Trust (principally but not exclusively the Emergency Department) and Rethread are responding to. One particular area of importance of Redthread's work is that they work to support a wide age range of young people (both children and young adults), age 12-25. Whereas children (under 18s) are eligible for support from children's social care services, the support to young adults from statutory agencies is far more restricted, and very few of the young adults referred to Redthread by the Trust will be eligible for support as adults, under the Care Act 2014. The gap in 'transition' services is as 'older young adult' become 'young adults' is a widespread area of concern across public services and the work undertaken by Redthread plays an important role in alleviating this gap for young people who are patients of the Trust.

Below follows a variety of quantitative information regarding referrals to Redthead from Trust services during the reporting year.

Referral reasons

Row Labels.	F	M	Total
"Honour" based violence	1		1
Child Criminal Exploitation		1	1
Child Sexual Exploitation	1		1
Affected by Gang Activity	3	6	9
Assault	74	357	431
Domestic Violence	35	16	51
Gang Affiliation	2	2	4
History of Assault	5	11	16
Risk of Harm	21	25	46
Sexual Violence	19	1	20
Other	4	5	9
Grand Total	**167**	**424**	**591**

Explanatory note. Numbers were the total is under 5 are not provided, and hence the exact number of referrals is not provided in this report. Of the sizeable number of 'assaults' referred to Redthread (431) approximately 22% were stabbings, 9% were assaults with a blunt object and the remainder assaults caused by body parts i.e. hands, fists or feet.

Redthread referrals broken down by age

Age on arrival

Row Lab	F	M	Not recorded	Total
11-13	16	23		39
14-16	30	94		124
17-19	48	120	4	172
20-22	42	103	1	146
23-25	30	78		108
>25	0	6		6
Grand Total	**166**	**424**	**6**	**595**

Redthread referrals broken down by Borough of residence

Borough	F	M	Grand Total
Wandsworth	64	104	168
Merton	36	83	119
Croydon	9	71	80
Lambeth	19	47	66
Other	39	116	155
Grand Total	**167**	**421**	**588**

3. Policies and Governance:

The Chief Executive has overall responsibility for the safeguarding of children and there is a clear line of accountability in place. The Chief Nurse and Director of Infection Prevention and Control, on behalf of the Chief Executive has the responsibility to ensure that our contribution towards safeguarding children and promoting their welfare is discharged effectively throughout the whole organisation and that St George's University Hospitals NHS Foundation Trust is represented in local safeguarding partnerships.

The Chief Nurse is responsible for;

Safeguarding children practice and assumes a strategic lead on all aspects of the Trust's contribution to safeguarding children
Ensuring the Trust is represented on Local Safeguarding Children's Partnerships
Ensuring that appropriate safeguarding processes are in place, including compliance with all legal, statutory and good practice requirements

The Trust has appropriate policies and procedures in place for safeguarding children which are available to all staff via the intranet on the Policy Hub. These policies and guidance are regularly reviewed to ensure that they are in date and updated as required in response to any national changes in requirements and legislation.

Ensuring that policies are not only compliant, and up to date, and most effectively support staff when dealing with practical safeguarding concerns, issues and challenges will be a key strategic priority for the new Named Nurse (Acute) in the coming six months (from the date of this report).

A key overall aim in reviewing the policies is to ensure that they effectively meet the needs of busy staff in pressured operational settings seeking guidance and support on what they need to do in potentially challenging or complex situations.

In January 2019 the Trust introduced an internal Joint Children's and Adults Safeguarding Committee (replacing the previous two, separate committees). Having a joint Committee is more congruent with the policy of 'think family' that the Safeguarding Team are keen to promote, but also means that a joint focus can be applied to relevant areas. Combining the Committees has also reduced the number of meetings which staff (particular those with

broad remits or who cover large operational areas) are expected to attend, which has had a positive overall impact on attendance. However, the Committee will consider safeguarding matters separately or on a combined basis, as appropriate.

Both the Designated Safeguarding Leads (Children and Adults) at local CCGs have a standing invite to the Committee (and are sent papers if they cannot attend) which ensures that they are able to maintain an overview of the Trust's Safeguarding work, and are able to pose any queries required, and this is an important part of our relationship with CCG colleagues

Staff in the Safeguarding Team hold regular operational meetings with the Emergency Department, the Neonatal Department and with Midwifery, and are able to attend specific staff meetings upon request. Some workstreams referred to in previous Annual Reports as under development are now 'business as usual' i.e the Chid Protection Information System has been implemented and embedded across all sites, whilst other IT projects were developed throughout the reporting year (i.e. the development of an electronic safeguarding referral form to notify local authorities of Safeguarding Concerns – making referrals given more timely and avoiding the use of handwritten referrals which are understandably no longer popular with Local Authority colleagues)

This Annual Report is updated on a biannual basis for the Safeguarding Children's Committee.

A weekly list continues to be compiled by the Clinical Nurse Specialists for Safeguarding Children of all children who are inpatients at the Trust with whom the Safeguarding Team is currently substantially involved and is circulated to the Chief Nurse and relevant nursing managers, as well as to the Head of Safeguarding and Named Doctor for Safeguarding Children. This list plays an important role in the operational assurance of safeguarding practice.

4. Referrals and activity:

There are a wide range of concerns 'behind' referrals – this is a non-exclusive list.

- Children attending A&E following self-harm
- Children admitted to hospital due to safeguarding concerns
- Alcohol / substance misuse
- Children attending following attempted suicide
- Physical injuries resultant from violence inflicted by other young people
- Attendances related to mental health
- Non-accidental injuries

The Trust now systematically records and securely stores all referrals made to a local authority children's services department. Beyond this, we are able to sort referrals by presenting concern and local authority area, providing a more nuanced and detailed picture highlighting specific issues related to safeguarding, or areas for wider review.

Following a review of the referral process the Safeguarding team have now instigated a central secure email to ensure that they receive all copies of referrals that are made to the children's team (the team are unable to quality assure and record any referrals which are not sent to them, and continued communication work is underway to ensure all staff are aware of the need to send copies of all children's social care referrals to the Safeguarding Team).

This will act as a useful exercise in mapping levels of activity, establishing patterns of referrals and concerns relevant to partnership safeguarding activity and will enable the Safeguarding Team to quality assure all referrals so we know that information is being

shared actively and proportionally with local authority partners. Currently approximately 80% of referrals to local authority children's social care departments originate from the Emergency Department. It is important to note that in the Emergency Department referrals to the Local Authority may essentially be notification (i.e. informing them of the nature of the admission and the source of concern following an ED attendance and subsequent discharge) referrals in relation to children or young people who are inpatients or outpatients are likely to be more detailed, and in general the Trust will expect to be part of the Safeguarding plan for as long as the child is a patient and where appropriate, beyond.

The majority of referrals from the Trust are from the Emergency Department, with whom the Safeguarding team holds regular operational meetings, and has an excellent working relationship. In the coming year it will be important to maintain these relationships whilst ensuring that the Safeguarding Team operates as a truly 'Trust wide' service. Internal safeguarding meetings benefit from the attendance of Wandsworth Children's Services (in respect of Wandsworth cases) and we are seeking to engage other local authorities in this process for their own cases.

The team has also contacted local Multiagency Safeguarding Hub (MASH) managers to request that they escalate any concerns they have about poor quality referrals to the Named Nurse for Safeguarding Children as an additional layer of quality assurance.

NB. The Children's Safeguarding Team can receive referrals in respect of domestic violence, which may or may not present alongside another safeguarding issue. The Lead Nurse works closely with the Clinical Nurse Specialist for Domestic Violence and reviews on a case by case basis who the most appropriate practitioner to respond to these referrals is.

April 2018 to March 2019 - Referrals to Local Authority Children's Social Services from St George's Emergency Department

		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
London Boroughs	Barking & Dagenham	1	1	0	0	2
	Barnet	1	0	0	0	1
	Bexley	0	0	0	0	0
	Brent	0	0	0	0	0
	Bromley	1	1	1	1	4
	Camden	0	1	0	1	2
	City of London	0	0	0	0	0
	Croydon	18	9	15	17	59
	Ealing	1	1	1	1	4
	Enfield	0	1	0	0	1
	Greenwich	0	0	0	0	0
	Hackney	0	0	0	0	0
	Hammersmith & Fulham	2	0	0	0	2
	Haringey	1	0	0	0	1
	Harrow	1	0	0	0	1
	Havering	1	1	0	0	2
	Hillingdon	0	1	0	0	1
	Hounslow	1	0	2	1	4
	Islington	0	0	0	0	0
	Kensington & Chelsea	1	0	0	1	2
	Kingston Upon Thames	3	4	4	4	15

		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
	Lambeth	16	12	13	15	56
	Lewisham	0	1	2	2	5
	Merton	52	48	34	39	173
	Newham	0	0	0	1	1
	Redbridge	0	0	0	2	2
	Richmond Upon Thames	10	2	2	2	16
	Southwark	1	2	1	0	4
	Sutton	7	3	2	6	18
	Tower Hamlets	0	0	0	1	1
	Waltham Forest	0	0	0	0	0
	Wandsworth	74	63	62	49	248
	Westminster	0	1	0	0	1
Other	Kent	0	0	3	0	3
	Surrey	6	3	9	9	27
	Sussex	2	2	2	1	7
	Other	3	5	6	5	18
TOTALS		**203**	**162**	**159**	**158**	**681**

April 2019 to March 2020 - Referrals to Local Authority Children's Social Services from St George's Emergency Department

		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
London Boroughs	**Barking & Dagenham**	**2**	**0**	**1**	**0**	**3**
	Barnet	**0**	**0**	**0**	**0**	**0**
	Bexley	**0**	**2**	**0**	**0**	**2**
	Brent	**0**	**0**	**0**	**0**	**0**
	Bromley	**1**	**0**	**1**	**1**	**3**
	Camden	**1**	**1**	**0**	**0**	**2**
	City of London	**0**	**0**	**0**	**0**	**0**
	Croydon	**10**	**15**	**10**	**13**	**48**
	Ealing	**0**	**0**	**0**	**1**	**1**
	Enfield	**0**	**1**	**0**	**0**	**1**
	Greenwich	**1**	**0**	**0**	**0**	**1**
	Hackney	**0**	**1**	**0**	**0**	**1**
	Hammersmith & Fulham	**0**	**0**	**1**	**1**	**2**
	Haringey	**0**	**0**	**0**	**0**	**0**
	Harrow	**0**	**0**	**0**	**0**	**0**
	Havering	**0**	**0**	**0**	**0**	**0**
	Hillingdon	**0**	**0**	**0**	**0**	**0**
	Hounslow	**0**	**1**	**0**	**2**	**3**
	Islington	**0**	**0**	**0**	**0**	**0**
	Kensington & Chelsea	**0**	**1**	**0**	**0**	**1**
	Kingston Upon Thames	**3**	**3**	**2**	**3**	**11**
	Lambeth	**10**	**18**	**10**	**6**	**44**
	Lewisham	**1**	**0**	**0**	**0**	**1**
	Merton	**46**	**52**	**31**	**37**	**166**

		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
	Newham	**0**	**1**	**0**	**0**	**1**
	Redbridge	**0**	**0**	**0**	**0**	**0**
	Richmond Upon Thames	**3**	**0**	**3**	**1**	**7**
	Southwark	**1**	**0**	**1**	**0**	**2**
	Sutton	**6**	**4**	**5**	**2**	**17**
	Tower Hamlets	**0**	**0**	**0**	**0**	**0**
	Waltham Forest	**0**	**1**	**1**	**0**	**2**
	Wandsworth	**56**	**52**	**34**	**46**	**188**
	Westminster	**1**	**0**	**1**	**0**	**2**
Other	**Kent**	**0**	**0**	**0**	**2**	**2**
	Surrey	**9**	**8**	**4**	**8**	**29**
	Sussex	**1**	**0**	**0**	**0**	**1**
	Other	**7**	**6**	**2**	**1**	**16**
TOTALS		**159**	**167**	**107**	**124**	**557**

It will be noted that there is an overall decline in referrals from the Emergency Department from 681 to 557, which is a reasonably substantial fall, and there is a notable decline in Wandsworth (from 248 to 188). This data will be reviewed internally and in the partnership, as well as in the context of overall ED attendance numbers. It is notable however that a key part of Safeguarding practice is not only knowing when a Safeguarding referral is required, but also when it is not required (and would represent an inappropriate statutory intervention) and part of the Safeguarding team's work includes advising on (and embedding practice) instances when a safeguarding referral is not required as well as when it is.

The range of presenting reasons why referrals to a Local Authority by own Emergency Department remains broad in scope:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Adult Alcohol/Drugs	10	14	2	7	33
Adult Assault	7	4	2	1	14
Adult Domestic Abuse	24	18	16	19	77
Adult FGM	0	1	0	0	1
Adult Medical Condition	1	1	0	0	2
Adult Mental Health	34	38	31	20	123
Adult Other	3	4	2	0	9
Adult Parental behaviour	0	3	2	0	5
Adult Sexual Abuse	0	2	2	0	4
Adult Total	**79**	**89**	**57**	**46**	**271**
Child Absconded	1	4	0	0	5
Child Adult Alcohol/Drugs	0	0	1	0	1
Child Alcohol/Drugs	3	5	7	6	21
Child Assault/Stabbed/Shot	25	29	13	22	89
Child Behavioural	2	1	0	4	7
Child Burn	1	0	0	0	1
Child County Lines	0	0	0	1	1

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Child Death	0	1	0	0	1
Child Death/Inury of Sibling	0	1	0	2	3
Child Delayed Attendance	2	1	1	0	4
Child Dog Bite	1	0	0	0	1
Child Domestic Abuse	2	2	2	6	12
Child Education	0	1	0	0	1
Child Fall From Height	1	2	0	1	4
Child LADO	2	0	0	0	2
Child Major Trauma	3	2	0	0	5
Child Mental Health	5	5	6	8	24
Child Missing	0	0	0	2	2
Child Nature of Injury	0	5	2	3	10
Child Neglect	7	0	0	0	7
Child Non-compliant with medication	0	0	0	1	1
Child Non accidental injury	0	0	1	2	3
Child Other	4	0	1	0	5
Child Parental Behaviour	4	4	2	5	15
Child Physical Abuse	2	1	1	2	6
Child Police Custody	3	4	1	2	10
Child Pregnancy	1	1	0	0	2
Child Risk to Self	1	0	0	0	1
Child Sexual Abuse	0	1	1	2	4
Child Sexual Assault	0	0	2	1	3
Child Social Reasons	0	1	1	0	2
Child Suicide Attempt	9	4	8	1	22
Child Unwitnessed Injury	1	2	0	0	3
Child Vulnerable	0	0	0	2	2
Child Young Carer	0	1	0	0	1
Child Total	**80**	**78**	**50**	**78**	**286**
Number of Referrals to CSS	**159**	**167**	**107**	**124**	**557**

5. Serious Case Reviews/Learning Review/Partnership Working specific to Children's Safeguarding

During the reporting year, a new national system relating to Serious Case Reviews has been implemented nationally, replacing 'Serious Case Reviews' with 'Child Safeguarding Practice Reviews, with a clearer distinction between 'local' and 'national' reviews. The actual process of taking part in a review, for the Trust or other partners, differs little. There is however, an increased level of accountability for Safeguarding partnerships in terms of communication and engagement with the National Panel (which reviews all local Reviews). During the reporting year, the Trust (along with local partners) took part in a regional engagement event related to an ongoing national review, which was experienced positively by local participants.

Only one Serious Case Review in which the Trust had been a participant was published during the reporting here. ('Child A', Wandsworth Safeguarding Children's Partnership

(WSCP)). There were no specific recommendations relating to care provided by the Trust, but an overall recommendation relating to Wandsworth Safeguarding Children's Partnership reviewing the effectiveness of alerting mechanisms between acute and community health providers. This specific area of work has been a close focus of the team in any event, throughout the reporting year.

During the reporting year, a number of Serious Case Reviews / Child Safeguarding Practice Reviews were initiated during the year and the coming (current at time of writing) year should see the publication of a number of reviews in which the Trust has been a participant. There are no current Reviews in which care provided by the Trust is a major line of inquiry.

There are also a small number of reviews which are essentially complete but where publication has been delayed due to specific events related to the specific circumstances of the case (i.e. a criminal trial or the need to support vulnerable individuals supported by events)

As is typical for a large Acute Trust, particularly for a tertiary referral centre, the Trust provides patient care services to children and young people who have been admitted to hospital as a result of injuries caused by deliberate harm or by an accident which has occurred in circumstances which indicate the need for a safeguarding intervention. The Trust also provides inpatient services to children and young people who have an illness or medical condition where the treatment profile is complicated by social factors. These circumstances mean that a relatively large number of children and young people whose circumstances lead to a Serious Case Review, are, or have been patients at the Trust. It also means there is a tendency for Serious Case Reviews to cover patients from a wider area than that to which the hospital also provide a District Hospital service.

Serious Case Reviews are formal, and often very detailed (anonymised) reports which are published by a Local Safeguarding Children's Board when a child has died or suffered serious harm and there is a concern about how agencies worked together to safeguard her or him. The intended purpose of Serious Case Reviews is for learning informing future practice to take place, as opposed to being an exercise in apportioning blame.

The formal guidance regarding Serious Case Reviews is copied below *(Working Together 2015)*

- The LSCB must undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006 set out the LSCB's function in undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

- A Serious Case Review must always be initiated when:
  a. Abuse or Neglect of a child is known or suspected; AND
  b. Either:
     i. The child has died; OR
     ii. The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board Partners or other relevant persons have worked together to safeguard the child.

- Thus cases meeting **either** of these criteria must always trigger a Serious Case Review:
  1. Abuse or Neglect of a child is known or suspected AND the child has died (including by suicide); OR
  2. Abuse or Neglect of a child is known or suspected AND the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. In this situation, unless it is clear that there are no concerns about inter-agency working, a Serious Case Review must be commissioned.

The Trust is currently participating in a number of Serious Case Reviews, although as stated the fact that the Trust is a participant in a review does not indicate that practice at the Trust is in itself the subject of review. The Head of Safeguarding at the Trust has also chaired a Serious Case Review on behalf of a Local Safeguarding Board, in response to a request to partner agencies for support with this role.

In order to best understand the nature of the Trust's involvement in Serious Case Reviews, it may be helpful to sub-divide reviews in which the Trust has an input into the following categories, although *it should be stressed that this is local guidance only, and is not part of the statutory guidance regarding Serious Case Reviews:*

Type A: Reviews in which services provided by the Trust, alongside other services, form part of the Serious Case Review (SCR) process and are the subject of review. This could include cases in which the Trust provides services prior to neglect or abuse being either identified or sufficiently addressed. One such review is currently in the process of being finalised, although the timing of publication is contingent on an ongoing criminal justice process.

Type B: Reviews relating to patients admitted to the Trust (potentially for considerable periods of time) *following* injuries or abuse sustained prior to admission, which subsequently become the subject of a Serious Case Review. The Trust is currently involved in two such reviews.

Type C: Reviews which take place relating to children who lived in an area which is served by a Local Safeguarding Board of which the Trust is a member (i.e. the London Borough of Wandsworth and the London Borough of Merton) and in which the Trust had no involvement, or minimal/historic involvement with the children and family in question. In these reviews the Trust might be asked to provide input in a 'partnership' capacity.

Due to reasons of confidentiality it is not possible within the context of this report to provide further information regarding any current serious case reviews in which the Trust is involved, and in terms of published reviews, the Trust is not always identified by name.

Local Safeguarding Children's Boards also make use of Learning Reviews, in which it is felt that the threshold for a Serious Case Review is not met, but in which partnership learning could usefully occur, and the Trust currently engages in these processes.

It should be noted that there may be Safeguarding related learning for the Trust in respect of Serious Case Reviews published at a national level, with which the Trust has not had any involvement. This is particularly so of Reviews in which the provision of acute hospital care was a component of services provided to the child, young person or to their family. Although the NSPCC maintain a national repository of Serious Case Reviews there is no fail safe mechanism for capturing all SCRs featuring acute trust services.

6. Training and Staff Knowledge

The Trust provides comprehensive training packages which are in line with the recommendations of the Safeguarding Children and Young People Intercollegiate Guidance (NB new version published January 2019).

As nearly all face to face Training is provided directly by members of the Trust Safeguarding Children's Team (unlike some Trust we do not use external trainers), and particularly during the earlier part of the reporting year, this was an area of some pressure.

Both our local Safeguarding Children's Partnerships (LSCP) provide Safeguarding Training and the Safeguarding team highlight the availability of this training to staff, although the training is generic and not designed with the specific needs of staff providing care in an inpatient setting in mind.

Staff are assessed on what level of training is required depending on which department they will be working in, however, all staff at the Trust (regardless of their role) are required to have Level 1 training. Level 1 training is part of MAST on line and is mandatory for all staff, while level 2 children's safeguarding training is available as both face to face sessions and e-learning. As well as core training the team also deliver bespoke training for staff groups as required.

The table below provide an outline of the areas covered within the Trust safeguarding Level 3 Safeguarding

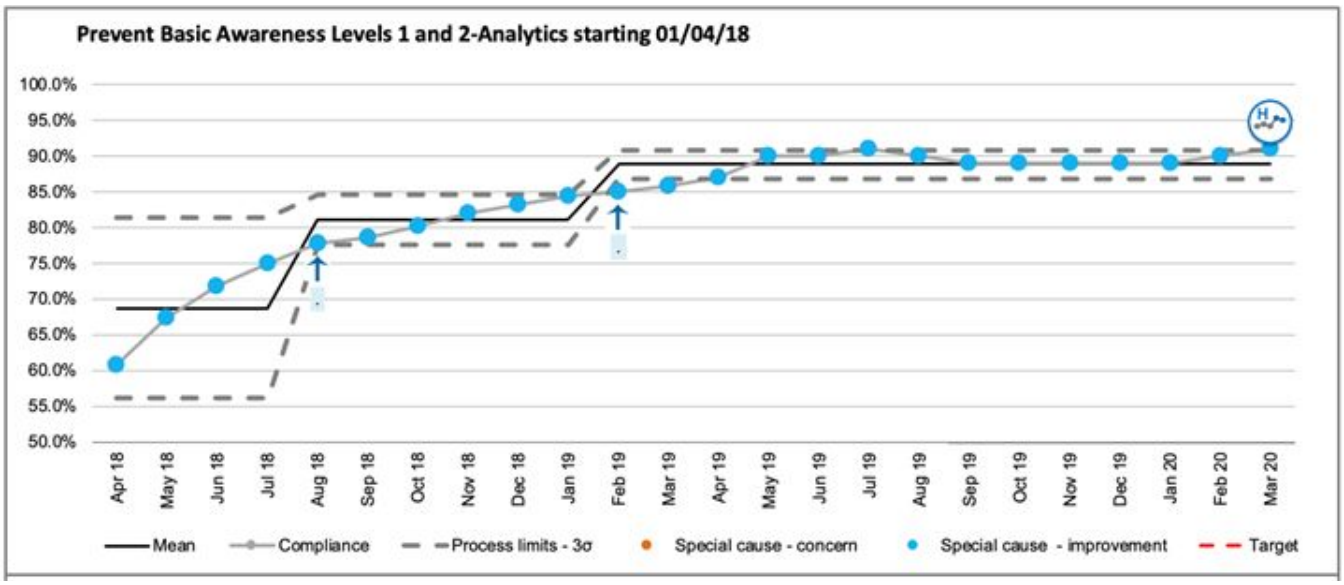
Training – topics covered	
Safeguarding policies, procedures and guidelines	Learning from Serious case reviews and individual management reviews
Signs of abuse	Role of the Local Authority Designated Officer
Child sexual exploitation (CSE) and Human Trafficking	Fabricated Induced illness
Record keeping	Domestic abuse
How to make a referral	PREVENT
Female Genital Mutilation (FGM)	Private fostering
Managing allegations against staff	Mental Health

During the reporting year, the Safeguarding Team have continued to provide the broader programme of training including Domestic Abuse and Child Sexual Exploitation. It will be noted that the Trust's compliance with Prevent training has very substantially improved – the availability of Prevent training as an E-learning exercise has been a key component in enabling this.

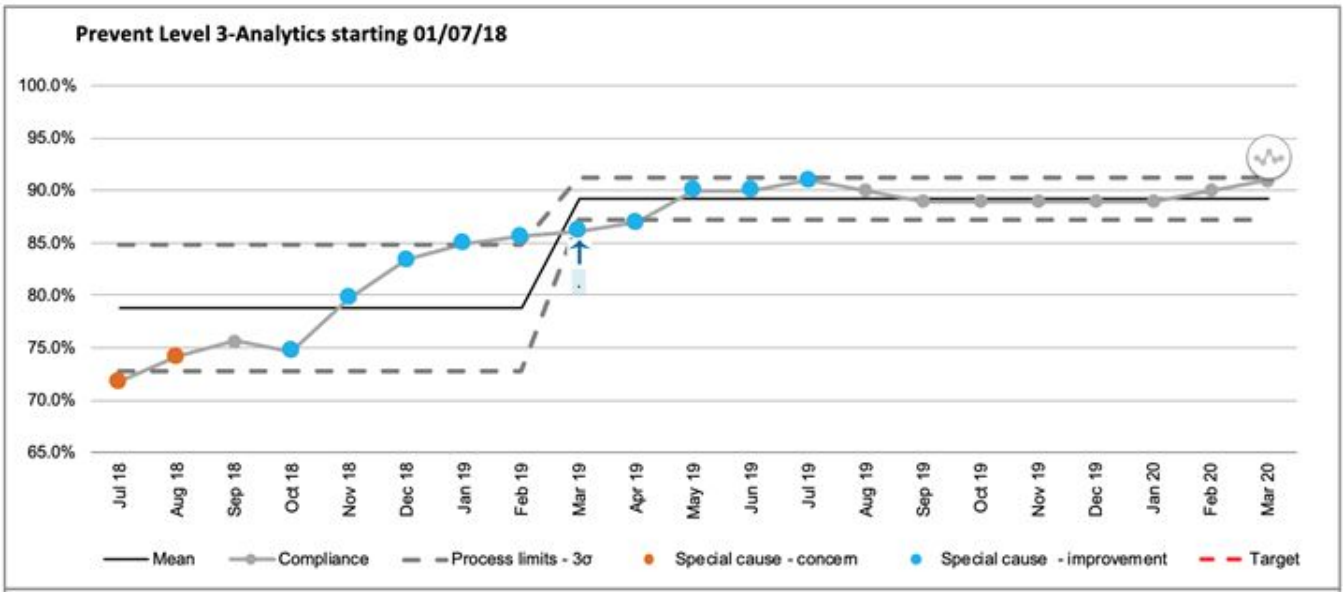
Please see the graphs below for performance on a month by month basis over the reporting year. Ensuring that sufficient Level 3 provision is offered, and that staff access training offered in a timely manner, remains the key training challenge for the Safeguarding Team

The compliance target is set at 85%.

Please note that the training figures update overnight via the Trust ARIS system so the figures in this report are only correct at the time of extraction.

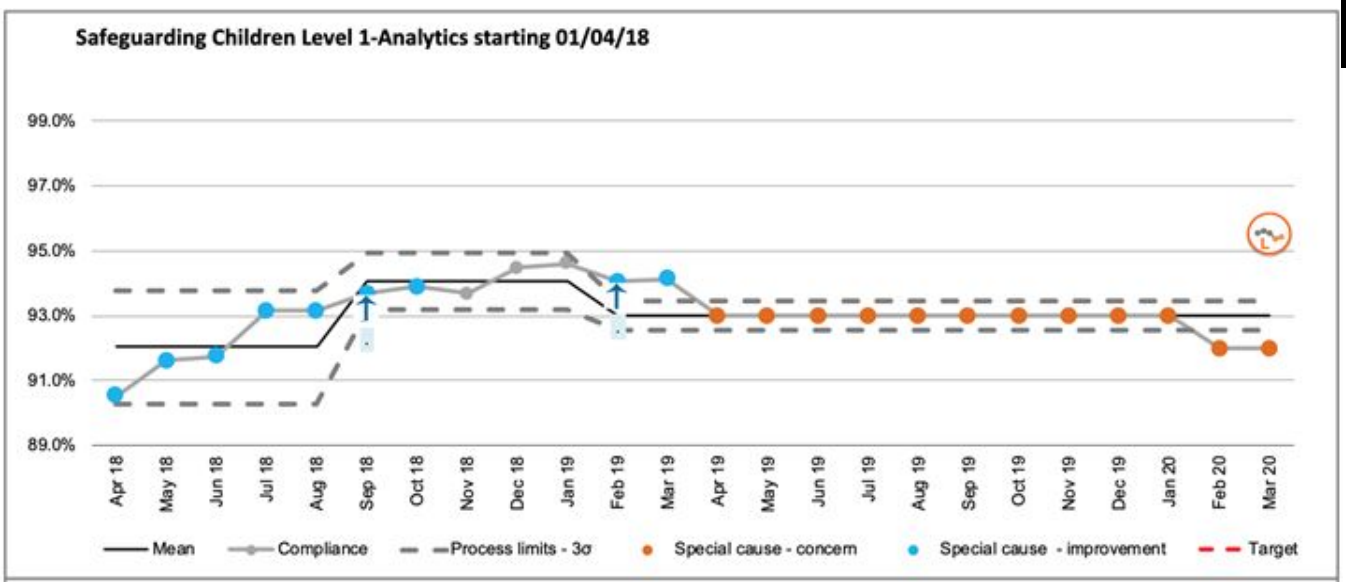


Summary: *trending improvement year on year can be seen in the SPC graph above, with current compliance sitting at 90%*

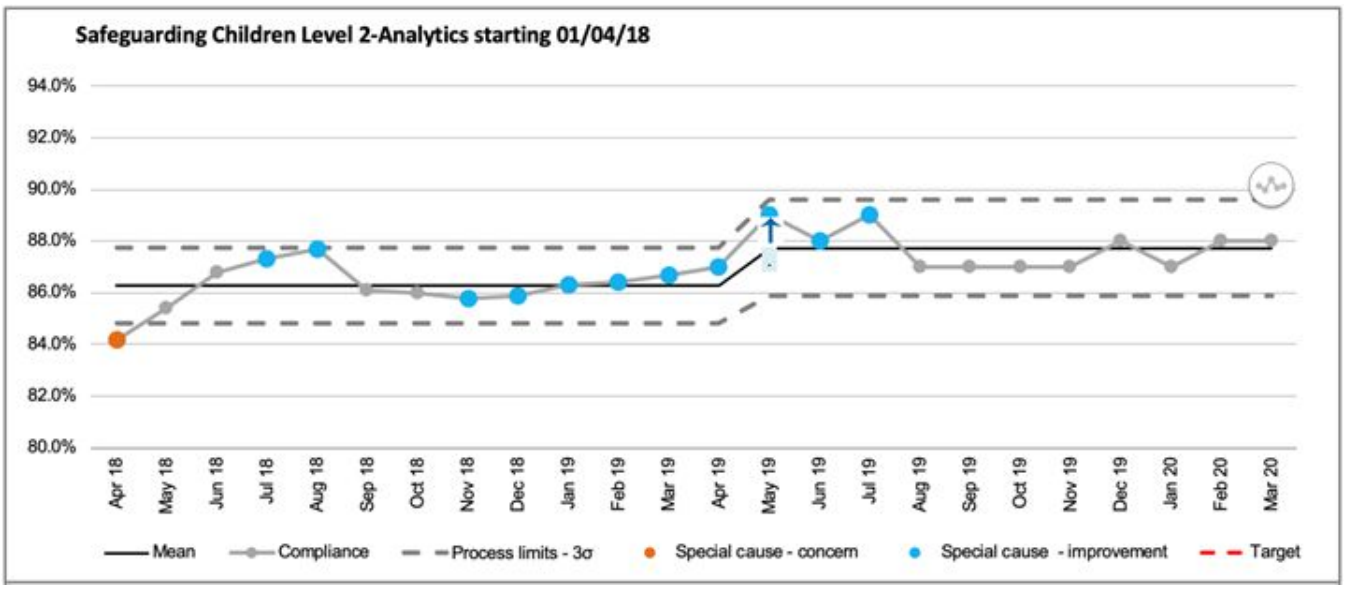


Summary: stabilised with 93% compliance achieved

St George's University Hospitals NHS
NHS Foundation Trust

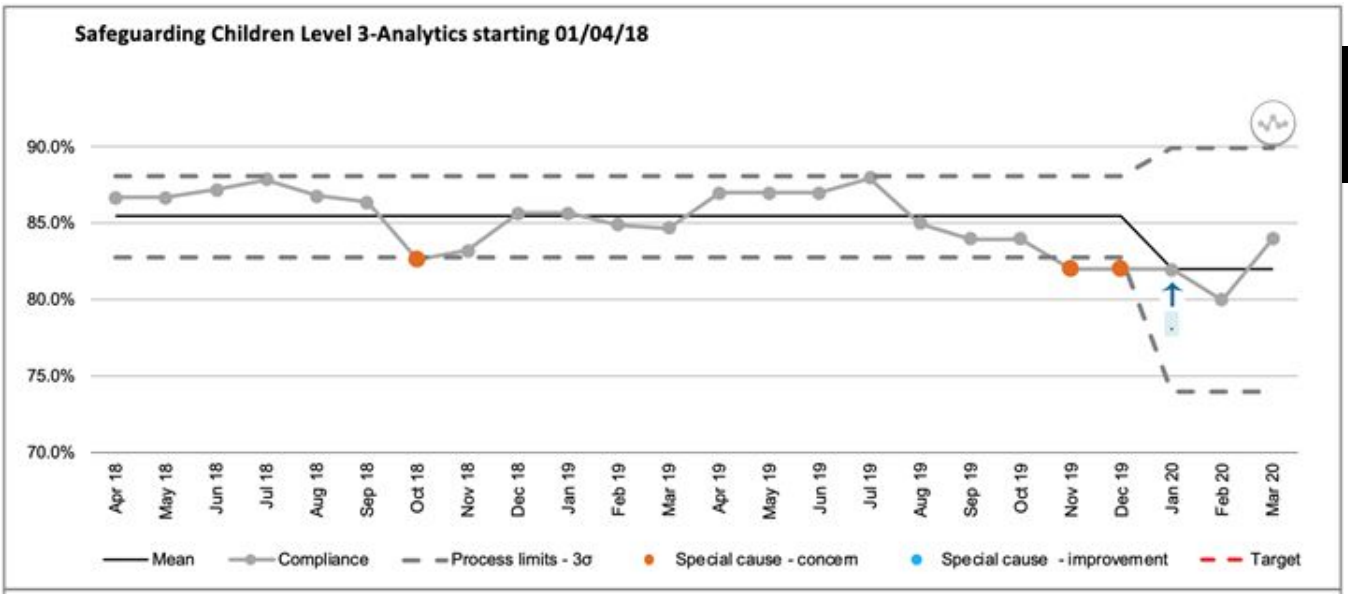


Summary: The SPC chart shows decline in compliance during the months of February and March 2020.



Summary: Stabilised trend for compliance.

St George's University Hospitals NHS
NHS Foundation Trust



Summary: The graph shows a special cause variance during the months of November and December 2019, this was due to staff shortages within the team, which impacted on their ability to deliver training at that point in time

In addition the community Named Nurse provides half day training sessions on FGM, CSE, DV and record keeping for all community practitioners.

In Maternity Level 3, is also a whole day session (7.5 hours) and staff have access to specialist topics e.g. FGM. Compliance is reported in the CWDT division data.

In the Acute services safeguarding children Level 3 has increased to a whole day session (7.5 hours) and incorporates specialist topics i.e. FGM, Child Sexual Exploitation (CSE) and raising an awareness of PREVENT.

Training compliance is monitored through the Trust Safeguarding Children's Committee which includes reviewing performance by Division, and an escalation process is undertaken in respect of any non-compliant staff. During the reporting year the team undertook considerable bespoke work with Departments and teams to deliver training with bespoke content in settings, and at times, which were most suitable to the needs to the staff group concerned.

7. Safeguarding Supervision:

The provision of a supportive and reflective space for staff to discuss safeguarding issues (whether related to specific cases or safeguarding issues more generally), including formulating plans, agreeing actions any considering the practical and emotional impact of challenging situations on practitioners is integral to an effective safeguarding system.

1. Supervision
Health professionals are in a good position to identify safeguarding concerns and the needs of individual children. Effective safeguarding supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect on their decisions and the impact of their decisions on children and their family *(Working Together Safeguard Children March 2015).*

The RCN guidance for Nurses, *Safeguarding Children And Young People* (2014) states that local arrangements for safeguarding supervision must be robust, meet the specific needs of staff and demonstrate the effective discharge of NHS Trust statutory duties to safeguard and promote the welfare of children and young people

The 4 main functions of supervision are;

· **Management**: Supervision allows the opportunity to review how specific cases are managed within the Trust and assessing risk; ensuring that staff are competent and accountable for safeguarding practice.
· **Mediation:** Escalating concerns within the Trust and with partner agencies.
· **Developmental:** CPD - Reviewing the safeguarding training needs of the practitioner.
· **Supportive:** This function allows practitioners a time for reflection focusing on the impact of decision making and emotional resilience.

A review of current supervision arrangements within the Trust has taken place. This identified the lack of sufficient qualified supervisors within the team along with the staffing issues within the team. The Trust only had two qualified supervisors in June 2019 increasing to 3 in August.

Two independent courses were commissioned from an external trainer to deliver safeguarding supervisor training for up to 10 in house staff per course to be funded by allocating 6 spaces for external candidates at a fee, making each course cost neutral. All staff are now undertaking supervised practice to gain competency to deliver this independently. This has been hindered by Covid as face to face supervision has been largely postponed. The Safeguarding Team remain committed to supporting all staff working with children and young people across the Trust and we are continuing remote group supervision according to staff availability as well as ad hoc supervision on a need or request basis while trying to maintain the regular sessions already organised with the practice educators for each department.

The Named Nurses continue to lead Safeguarding supervision activity and to liaise with staff in other Trusts to seek to harness available learning from colleagues on a regional and national basis via networks and forums. The team have also received a one day safeguarding supervision update workshop to update existing supervisors and provide a level four CPD update. Mechanisms have also been implemented to more effectively capture Safeguarding supervision as it occurs and we are working on identifying staff who have not had supervision for a sufficient period, this will then be liaised to their practice development lead and manager to ensure they are released from duty to attend.

This area of work is the single most significant, Trust-wide area of development for the Safeguarding Children's Team and work is continuing to develop this but has been hindered by Covid restrictions and redeployment of staff as well as staffing pressures. While the actual figures of supervision are yet to demonstrate the input towards supervision, the team are confident they will improve moving forward with the systems now initiated.

Now both the permanent Named Doctor and Named Nurse are in post safeguarding supervision of multidisciplinary teams for gastroenterology, respiratory, endocrine and Neurology have been started monthly for their complex cases, with a view to expanding the offer as the need is identified.

The development of the Trust's Supervision strategy will be a standing item on the Trust Safeguarding Committee agenda in 2020/21.

8. Partnership Working:

During the reporting year, key provisions of the Children and Social Work Act 2017 passed into law. These provisions abolished Local Safeguarding Children's Boards and replaced them with Local Safeguarding Children's Partnerships. The Act designated there 'statutory safeguarding partnerships' in each local authority area; namely the Local Authority, the Police and the CCG. Although in many areas, the newly renamed Partnerships continued along very similar to the Boards, in Wandsworth and Merton there was a significant change in that Health providers and Provider Trusts are no longer represented on the Partnership Executive and health is represented by the CCG. Although the general nature of engagement with Partnerships has remained similar throughout the reporting year, arguably the Trust has less influence as this work is now overseen by an Executive of which the Trust is not part. It also means that the nature of the relationship between Health providers and the CCG, in terms of Safeguarding, is of particularly crucial importance.

Local Authorities are particularly important safeguarding partners, who liaise with the Trust Safeguarding team on a daily basis. Overall, this has been a strong year for joint working with local authorities.

At the Trust, we are fully committed to partnership working at an Operational and Strategic level. The Safeguarding Team frequently participate in two specific types of meeting, although they also take part in many others (such as child protection conferences for children and young people who are inpatients or where the Trust has significant information or analysis to contribute to a multiagency plan), these are detailed below:

Discharge Planning Meeting: These meetings occur to plan the care upon discharge which is needed for an individual child, and may take place for a number of reasons, and may occur following a Strategy Meeting (see below). Discharge planning meetings take place for a wide range of reasons; for example to plan support for parent(s) who have complex or vulnerable circumstances and a child with additional needs, or to help plan the care for a child who is going to enter foster care. Discharge planning meetings should normally involve the parents or carers, and the local authority.

Strategy Meeting: This is a specific meeting between agencies, and chaired by the local authority, which occurs under the auspices of section 47 of the Children Act 1989, and occurs when a local authority is investigating whether a child may have suffered, or be likely to suffer 'significant harm'.

Strategy meetings can agree that a 'single agency' investigation is led by the Local Authority or a 'joint agency' investigation occurs which is a joint investigation by the Local Authority and the Police. Trust staff will often provide specific information to partners in a strategy meeting to information their investigation, such as helping to understand a child's specific medical presentation, or to consider the potential causation of an injury. Strategy meetings do *not* directly involve the child or their parents/carers.

Escalations: a developing area of work in relation to Safeguarding is ensuring that Local Safeguarding Board Escalation Policies are properly applied and understood. Escalation is essentially raising (generally at a more senior level within an agency) concerns about the response from another agency, and is most likely to occur within a Trust context when the Safeguarding Team, in consultation with treating clinicians do not feel that the response from a local authority children's social care department is proportionate to the level of safeguarding need in a specific case. Equally, the Safeguarding team are the point of contact in the Trust for any agency who wishes to discuss an individual case, or to discuss or review Safeguarding practice within the Trust – a wide range of issues fall into this category, for example asking for additional or more detailed information in relation to a referral, or a request that a child be admitted for a 'social admission' whilst a local authority

formulates and delivers a safeguarding plan (i.e. arranging a suitable placement for a child).

The Head of Safeguarding is always seeking to develop contacts in local boroughs so that there are clear routes for escalation in respect of such cases, when they do occur, although given the immense pressure on the housing market across London it seems unlikely this will be an area of work in which there are any obvious or easy solutions.

In respect of Policing, there are very substantial changes to the Metropolitan Police's response to Safeguarding in terms of the organisation of the Command dealing with Child Abuse, Domestic Violence and Sexual Offences. Whilst this should not have an impact on the day to day work of the Safeguarding Children's' team or of other Trust staff, it will be important to bear in mind when working with the Police on complex operational matters. The Head of Safeguarding will continue to monitor the potential impact of these developments at the Safeguarding Partnerships.

It is notable however that both the Children and Adults Safeguarding Teams are increasingly asked to provide input in relation to a number of patients from a wider range of boroughs, specifically (but not exclusively) Kingston, Lambeth, Croydon and Surrey. During the reporting year, the working relationship with Croydon Children's services improved, with far fewer escalations being needed, but the working relationship with Surrey County Council remains an area of focus.

Key activities during the reporting year has included a far more robust use of escalation strategies in instances when the Trust Safeguarding Team feels that appropriate Safeguarding action has not been undertaken by a Safeguarding partner. Normally this involves an escalation to a more senior level in a local authority, but has also involved a professional challenge to the Metropolitan Police on occasion. Often the Trust will request that a face to face meeting is convened to review the issues in a case, and in order to fully understanding the safeguarding risk and concerned. Although escalations (by the Named Nurse or the Head of Safeguarding) have involved a wide range of cases, there seems to be a substantial number involving the response of local authorities to older teenagers.

The Team is closely focused on ensuring that when required, that Local Authorities convened strategy meetings in respect of relevant cases; these should be hosted in hospital in respect of children who are inpatients, but the Trust is able to share information and take part in meetings following discharge as required.

9. Child Protection Medicals:

The Trust is responsible for conducting child protection medical examinations for children and young people from Wandsworth who may have experienced abuse or neglect. It is highly likely children for whom the local authority applies to Court for an Interim Care Order will have had a child protection medical, and the medical can be important in helping determine whether or not a police investigation should proceed alongside a local authority led intervention. Therefore, these examinations have both 'welfare' and a 'forensic' components and effective, child-centred partnership working are of key important in this regard, and sensitivity to a children's wellbeing is essential for all involved in the process (i.e. examining doctors and social workers who attend medicals alongside parents/carers).

A recent audit demonstrated that the Trust is responding promptly and effectively to requests for medical examinations from the Local Authority (referrals are made by Social Workers as part of a 'section 47 child protection investigation) however it highlighted the need for referrals for requests for child protection medicals to be made promptly (by Local Authorities) hand efficiently and responded to (by the Trust) in the most timely way possible. This important and

sensitive area of work will be an important area for continued review. Work planned for the coming year involves a more regular and comprehensive reporting system of performance in this area to the Trust Safeguarding Committee.

10. Liaison with the Local Authority Designated Officer:

The Head of Safeguarding and the Named Nurse for Safeguarding Children work closely with the Wandsworth Council 'LADO' (Local Authority Designated Officer). The Trust has a duty to report to the LADO any instances in which it is alleged that a person who works with children (as an employee or as a volunteer) has;

- behaved in a way that has harmed, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children,

Whilst the Trust has a duty to inform the LADO of relevant cases (or to seek their advice regarding a referral), the LADO has a duty to provide advice, and to co-ordinate an Allegations and Staff and Volunteers Meeting (ASV meeting), the Trust retains ownership of all HR processes and procedures in this area.

This duty applies to allegations relating to the workplace, or in the employee's/volunteer's personal life. In the former category it will generally be the Trust who refers to the LADO, and in the latter category, unless the employee informs their manager directly, the LADO is likely to refer to the Safeguarding Team at the Trust. This is a complex and sensitive area of the Trust's work, and involves close liaison between the Trust Human Resource department and the safeguarding team. The Safeguarding Team are confident that we are compliant with all processes in this area, but are working with the Human Resources department in order to further develop agreed processes to deal with any related issues as they might arise.

During the reporting year the LADO has, when required, made contact with the Safeguarding team at the Trust to notify us about relevant information or to seek information or clarification. It is hoped to continue to build on this positive and important working relationship in 2021/22.

11. Domestic Violence and Abuse

The Trust employs a Clinical Nurse Specialist for Domestic Violence and Female Genital Mutilation, who works in close partnership with the Independent Domestic Violence Advisor who is an employee of Victim Support based on site at St George's and with the Independent Violence Domestic Advisor employed by Redthread. The Maternity department also has a specialist Midwife for Domestic Violence who works closely with the team.

These staff members can be contacted by staff across the Trust, and work either directly with patients who may be experiencing domestic abuse, either during their time in hospital, or after they have been discharged, or provide advice and guidance to staff to support them in patient care in relation to domestic violence. The domestic violence team can and do provide care and support to staff who are experiencing domestic violence in their life outside the workplace.

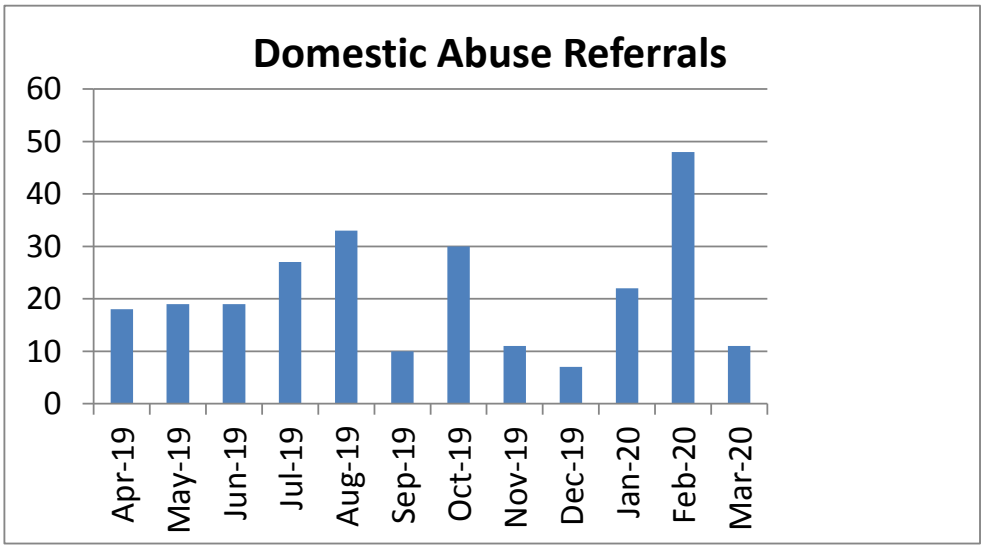
The Clinical Nurse Specialist has both an operational and strategic role, and the team are working to ensure that staff across the Trust are aware of the support and expertise the post holder can provide. The post holder is also involved in delivering the Trust's training offer but

the team is considering ways of extending this.

The Clinical Nurse Specialist is also the Trust's MARAC lead (Multiagency Risk Assessment Conference) and takes part in three local MARACs (which take place monthly) (each London Borough has its own MARAC). As an Acute Trust having contact with a very large number of patients this is a key part of the role, and a significant demand on the Clinical Nurse Specialist's time. [please see below for an explanation of MARAC]

Please see below data for referrals into the Trust Domestic Abuse team for the reporting year.

Month	Number of referrals to Trust Domestic Abuse team
April 2019	18
May 2019	19
June. 2019.	19
July 2019	27
August 2019.	33
October 2019	30
November 2019	11
December 2019.	7
January 2020	22
February 2020	48
March 2020	11



The table demonstrated both the volume of referrals to the team, and the fact that the monthly rate varies significantly from month to month (from a low of 7 to a peak of 48). There are no obvious trends identifiable by the Domestic Abuse team or in terms of Trust admissions data which would explain such wide fluctuation, and item in the coming year will continue to review this matter and raise in local partnerships as required.

Alongside the patient contact and support function, engagement with Borough MARAC (Multiagency Risk Assessment Conferences) is a key part of the teams role. MARAC is the multiagency forum (convened on a Local Authority basis) which oversees the support and risk planning for domestic abuse victim/survivors in the area. The Trust is a member of Wandsworth and Merton MARACs and provides information to Lambeth MARAC. Further, other Borough MARACs will contact the Trust when required. On a monthly basis a significant number of patients (and their children) known to the Trust, and the team further developed processes to monitor this information during the reporting year.

Please see text below for standard terms of reference of a Borough MARAC:

- Each borough MARAC is essentially a multiagency body which is set up with the purpose of increasing the safety, health and well-being of victims/survivors, adults and their children
- Determine whether the alleged perpetrator poses a significant risk to anyparticular individual or to the general community
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability, and
- Improve support for staff involved in high-risk domestic abuse cases *(taken from Richmond upon Thames MARAC website, June 2018)*

12 Prevent, Audit and CDOP (Child Death Overview Panel)

Prevent: All NHS Trusts are obliged to adhere to the Government's Prevent strategy. Whilst the Prevent Duty is relevant to both our children and adult safeguarding functions, fuller commentary regarding the Prevent Strategy at the Trust can be found in the Adult Safeguarding report. In brief, the key achievement in relation to Prevent during the financial year was increasing the Trust's compliance levels from a low level to compliance to a very healthy state, considerably above the agreed 85% target.

Audit: The Trust Safeguarding Children team have been involved in audit activity during the reporting year. During the reporting year the s11 process (multiagency audit and assurance activity as defined in the Children Act 2004), previously led by the Local Safeguarding Children's Boards and now by the Local Safeguarding Children's Partnerships did not occur, as the focus of the Partnership was absorbed in the transition from Boards to Partnerships. Both Partnerships have indicated that they wish to recommence s11 activity early in the current financial year. The Trust has previously engaged with s11 activity and will do so again once the activity resumes following this period of hiatus. The Safeguarding children's team have however been involved in multiagency case audit in reference to specific cases arranged separately by Wandsworth and Merton Safeguarding Partnerships. Separate to this the team have undertaken an audit of Safeguarding referrals (to local authorities) in the Emergency Department which highlighted a strong awareness of referral thresholds, and will be able to more compressively update this activity in the current year. Within maternity, audit took place in relation to the Trust's practice in relation to FGM (Female Genital Mutilation) which is feeding in to a multiagency piece of work in the current year, to be led by the Named Midwife for Safeguarding Children. The key area of focus has been the attention given to the provision, quality and assurance of Safeguarding Supervision (see specific section of this report).

Child Death Overview Panel: The reporting year involved a major change in the processes around the reporting and overview of all child deaths occurring at the Trust, pursuant to the Children and Social Work Act 2017 and Working Together 2018.. This is a separate, clinically led process at St George's, but it is inherent to the Child Death Overview Panel (CDOP) system that some of the deaths the CDOP process reviews will involve safeguarding issues.

The new legislation requires support to CDOPs at sector levels to ensure they meet the requirements of the revised statutory guidance. The new system also requires a four-part Child Death Review process following the death of a child or young person as below:
1. Immediate decision making and notification;
2. Investigation and information gathering;
3. Child Death Review Meeting; and
4. Independent Review by Child Death Review (CDR).

The Child Death Overview arrangements and how they have developed will be the subject of separate reports within Trust governances during the current year.

13: **The wider picture/contextual safeguarding**

It is important to reference in this report that the multiagency Safeguarding system which has developed since the advent of the Children Act 1989 is most evolved, adept and resilient to safeguard children who are at risk of, or who have experienced, abuse or neglect *within a family setting.* It is important to note key continuities and differences between harm and abuse within a family setting, and harm and abuse that children and young people (frequently, but far from exclusively, teenagers) may experience in community settings, away from home, such as Child Sexual Exploitation or Peer on Peer violence. In essence, and in common with all statutory agencies, our Safeguarding systems are built around addressing child protection issues occurring within a family setting, and there is a considerable process of service development and evolution required for us to be equally confident that we are equally as adept at addressing 'non-familial' child safeguarding issues. During the reporting year the Trust was involved in a number of partnership initiatives to develop services and responses in the CSE space.

The Safeguarding Team are frequently involved in responding to case of children and young people who have presented to the Emergency Department following a violent injury sustained outside a family setting, and the staff at the Trust remain alert to Child Sexual Exploitation, although it is important that the Safeguarding team collate and cascade information, research and training into areas in which the national learning profile is developing i.e. County Lines. It is important for the Trust to be mindful of the distinct role which Emergency Departments, and the accessible nature of the care which they provide, can have in relation to Contextual Safeguarding issues. During the reporting year staff at the Trust identified pertinent safeguarding issues in relation to a number of vulnerable young people and the Safeguarding team provided support to ensure that these were addressed as appropriate.

17. Key risks/challenges in respect of Children's Safeguarding include:

- Ensuring that the Safeguarding Training offer at the Trust is fully up to date with best practice (both face to face and training and eLearning) and as closely aligned with the nature and expectations of staff's role as it can be, and in accordance with Intercollegiate Guidance. Separately, and equally important a close focus on levels of staff compliance with training across the Trust. This work will take place in the

context of complaint and regular Safeguarding governance at the Trust.

Separately, consolidation and development of the Trust Safeguarding Supervision programme is a clear priority of the team, and updates will be provided to the Safeguarding Committee on a regular basis.

- The vital and relatively new role of the Named Midwife for Safeguarding Children needs to be further embedded, with reference to capturing and leading all safeguarding activity across the Maternity department, and for the postholder to become fully embedded in local strategic and operational partnership. This will include updating and realigning some reporting functions in the Maternity Department as well as the further development of some major process in the reporting year to develop the Trust's Maternity Safeguarding meeting, including ensuring that a consistent and meaningful dataset for the Maternity Safeguarding team can be produced.

  There has been a notable pattern during the year of some local authority case proceedings cases in the Family Court involving extensive requests for information and evidence from both the Trust Safeguarding team and to Trust staff more widely. The Adult Safeguarding team have also identified a more extensive need for bespoke legal support relevant to their area (given the pressure on, and specialism of the Trust's own legal services. It is likely that the Children's Safeguarding could also benefit from such provision).

  It is notable that the entitlement to support from local authorities for care leavers is not well known by staff across the Trust, and many care leavers may use Trust services without staff being aware, although care leavers, as young adults, do not come under the auspices of the Children Act 1989 in terms of the Trust's Safeguarding duties. During 2020/21 the team will seek to identify was in which staff awareness of the support and duties available to Care Leavers by local authorities can be better highlighted to Trust staff, who may be able to include such consideration in any care and treatment they may provide to young people who are Care Leave. (NB support for Care Leavers is one of the few areas in the broad safeguarding sphere in which are addressed directly in the NHS Long Term plan)

- Nationally and regionally (within London) there is an overall profile of rising levels of need and vulnerability amongst children and young people, and an increasing demand upon 'child protection' services, with the number of children coming into local authority care having rising almost every year since 2008. Although community based services will be a the 'forefront' of responding to this trend, there is likely to be a continuing impact on the work of the Safeguarding team at the Trust, and also on Trust services themselves (for example, when local authorities ask for a 'social admission' of a children whilst an appropriate plan is put into place).

- There is much publicised national and regional concern regarding levels of serious youth violence, which obviously has a direct impact Trust services, the Safeguarding team and our internal partners such as Rethread

18. Conclusion:

In essence the work of the Safeguarding Children' team encompasses four strands, and all areas will need to continue to be addressed and developed in the year ahead, which will need to take into account available resources.

i) Operational safeguarding work; i.e. the provision of advice, active involvement in identified safeguarding cases (ranging for limited to

extensive involvement) and the provision of Safeguarding Children's training.

ii) 'Strategic' safeguarding work: developing practice across the Trust to ensure that systems, processes and workplace culture create an environment in which Safeguarding matters can be identified, and when they are identified, effectively addressed. This involves developing internal and external working relationships, the review of available resources and ensuring that quality assurance mechanisms are agile and fit for purpose.

iii) Quality assurance and reporting: There are a considerable volume of reporting requirements in respect of the Safeguarding Children's team, including CCG and local Safeguarding Children Boards as well as to NHS England (who are sent quarterly figures on priority areas such as FGM and Prevent) and where required the CQC and through internal governance processes within the Trust.

iv) Partnership safeguarding activity: This involves 'formal' Safeguarding Partnerships at Local Safeguarding Children's Boards but also the development and maintenance of effective working relationships between organisations. As identified earlier in the report, the Trust would benefit from developing partnerships or closer working relationships with a wider range of local authorities specifically Lambeth, Surrey and Croydon.

It is hoped that this report gives an indication of the depth and complexity of the work undertaken by the Safeguarding Children's team, and provides assurance that there are appropriate structures and training in place to support high quality safeguarding practice across the Trust.

Inevitably an Annual Report involves looking back and reviewing the previous year, however the year ahead will involve the production and implementation of a Service Development plan, a review of training of the Trust's Safeguarding Children's Training needs and capacity, and the closer integration of Domestic Violence into both Children and Adults safeguarding work at the Trust.

St George's University Hospitals NHS
NHS Foundation Trust

Appendix:

Safeguarding children and young people statement (located at https://www.stgeorges.nhs.uk/about/living-our-values/safeguarding-children/)

St George's University Hospitals NHS Foundation Trust is fully committed to ensuring that all children and young people accessing acute and community services receive high quality care in a safe and secure environment. The Trust adheres to its statutory duties in line with Section 11 of the Children Act 2004 and the following safeguarding children arrangements are in place to support statutory duties:

- St George's University Hospitals NHS Foundation Trust meets the statutory requirements for safer recruitment with the Disclosure and Barring Service (DBS). All staff employed by the Trust will have a DBS check prior to employment and those working with children undergo an enhanced level of assessment.
- The Trust has Safeguarding Policies and Procedures in place which are up to date, reviewed regularly and approved by the Trust's Executive Lead for Safeguarding Children and Young People. All policies and procedures are accessible to staff via the Safeguarding Children page on the intranet.
- The Trust has a process to ensure children who are not brought to appointments are recognised and that decisions with regards to appropriate follow up are made taking into account the voice of the child and the impact on health and wellbeing.
- All staff members are required to undertake relevant safeguarding training; compliance is regularly reviewed via the training database and at the Trust Safeguarding Committee.. The Trust has a training strategy in place for the delivery of safeguarding training.
- The Trust is involved in both local Safeguarding Children's Partnerships (Wandsworth and Merton) and is committed to interagency working and positively supports opportunities to work with other agencies.
- The Trust has a Trust wide Safeguarding meeting and governance structure in place which has overall leadership from the Chief Nurse and Director of Infection Prevention and Control, who is the Executive Safeguarding Lead. The Safeguarding Team structure is as follows:
- The Trust Board takes accountability for Safeguarding Children and receives an annual report. The Safeguarding Committee (Children and Adults) reviews, scrutinised and oversees the Trust's safeguarding arrangements. The Trust will continue to review the arrangements in place and update in line with changing guidance and policy developments.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

3.2

Meeting Title:	**Trust Board**		
Date:	30 July 2020	**Agenda No**	**3.2**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	Avey Bhatia, Chief Operating Officer Rob Bleasdale, Chief Nursing Officer and Director of Infection Prevention & Control James Friend, Chief Transformation Officer		
Report Author:	Kaye Glover, Emma Hedges, Mable Wu		
Presented for:	Assurance		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, quality, patient access and performance. **Our Finance & Productivity** Activity levels continue to increase as the Trust continues to reopen services across all PODs. In June, 28 theatres were available - 23 of 29 operating theatres were operational at St George's with the independent sector providing the additional capacity. Outpatient activity continues to increase with 69% of all outpatient appointments occurring in virtual settings. June 2020 Emergency Department attendances are 23% below June 2019 activity; similarly, non-elective admissions are also 21% below the same period. **Our Patient Perspective** Programmes that were paused due to COVID-19 have restarted as staff have returned to post. Ward and departmental accreditation programme has restarted; the resuscitation training session frequencies have increased as the Resuscitation Team have returned from redeployment; the Falls prevention co-ordinator has resumed ward visits and has re-established regular education activities. Immediate action was taken in response to a Never Event in June and a serious incident investigation has commenced. The patient suffered no harm. Category 3 Pressure Ulcers remain above its long term mean though Category 2 Pressure Ulcers have dropped significantly from its peak in April 2020. The Emergency Department sustained its high performance with 90% of responders stating that they would recommend the service to family and friends. Inpatient FFT fell below its target of 95% achieving 93.6% for the first time in a year however a much smaller cohort is being surveyed as tablet computer use continues to be suspended. **Our Process Perspective** The Trust's Four Hour Operating Standard performance in June was 97.1% with emergency flow improving on a daily basis throughout the month. In June, London's performance was 93.3% with six trusts achieving the standard. St. George's NHS Trust was the second highest in London only being outperformed by Moorfields Eye Hospital. The Trust met four of the seven cancer standards for May 2020 and was non-compliant against the 31 day and 62 day standard. Fifteen cancer lists have been allocated to St George's at St Anthony's which will enable Priority 3 patients to be treated. It is anticipated that 62 day performance will fall further over the coming months because of shielding requirements and as the Priority 3 patients in the		

	backlog are treated. The Trust's six week diagnostic performance improved to 37.6% in June from 47.8% in May though the National Target is 1%. At time or writing, June regional figures have not been published however; London's May performance was 59.2%. May 2020's RTT performance was 63.8% against a National target of 92% with 274 patients waiting longer than 52 weeks. It is anticipated the number of 52 week breaches by the end of June will be circa 560. For comparison purposes, London's May 2020 RTT performance was 61.4%. **Our Workforce Perspective** In June, Trust level sickness rates have fallen significantly to 3.5% from its peak of 5.6% in April. This metric has returned to displaying common cause variation. The Trust will focus on Appraisals and Mandatory & Statutory Training (MAST) as staff return to post. The Trust's total pay for June was £0.3m favourable to a plan of £48.3m. Agency cost was also £0.51m favourable to a target of £1.25m.		
Recommendation	The Board is asked to note the report		
Supports			
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:			
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Equality and Diversity:			
Previously Considered by:	Trust Executive Finance & Investment Committee Quality & Safety Committee	**Date**	20/7/2020 23/7/2020 23/7/2020
Appendices:			

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

3.2

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 30 July 2020

Avey Bhatia, Chief Operating Officer
Rob Bleasdale, Chief Nursing Officer and Director of Infection Prevention & Control
James Friend, Chief Transformation Officer

17th July 2020

Our Outcomes

How Are We Doing?

June 2020

Daycase and Elective Surgery operations

Actual: 1,987

Target: 5,617

AMU bed occupancy at 12 Noon

Actual: 71% **Target:** 85%

Four Hour Emergency Standard

Actual: 97.1%

Plan: 95%

Whole Trust Inpatient Friends and Family Test

Actual 93.6%

Target 95%

Outpatient First Attendance

Actual 14,839

Plan 18,595

May 2020

Referral to Treatment Standard - Incomplete pathways

Actual: 63.8%

Target: 92%

Target for Daycase and Elective Surgery Operations and Outpatient First Attendance is based on pre COVID-19 SLA plan

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR PATIENT PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions G	Maternity	Patient Voice G
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR PEOPLE PERSPECTIVE	Workforce		Agency Use		Estates Health and Safety	

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Executive Summary – June 2020

Our Finance and Productivity Perspective

- COVID-19 continues to impact activity in June across all services though steady increases have been seen throughout the month. Elective and Outpatient activity were 61% and 23% lower than the same period last year.
- Similarly, Emergency Department attendances and Non-elective admissions were also 38% and 21% lower than the same month last year.
- The Trust continues to see outpatients in safe environments with 69% of all outpatient appointments being held in a virtual setting.
- Non-elective length of stay has reduced significantly compared to its April peak with services reviewing the configuration of yellow and amber pathways continuously to enable optimal patient flow and early discharge. Elective Length of Stay shows common cause variation.

Our Patient Perspective

- The number of Grade 3 pressure ulcers continues to show special cause variation with numbers being consistently above the mean since October 2019.
- The Trust lead for Trauma and the Trust lead for Learning from Deaths are working together to investigate an alert from the Trauma Audit & Research Network received in June.
- There was one Never Event reported in June.
- Emergency, Maternity (Postnatal) and Community services maintained their achievement of having 90% of patients recommending their services in the Friends and Family Test. The Outpatients and Inpatient department rates fell below target this month with a smaller cohort of patients being surveyed.

Our Process Perspective

- The Trust achieved the Four Hour Standard with a performance of 97.1% against a target of 95%. Both admitted and non-admitted pathway performance remained above the upper control limits allowing a positive flow of patients moving through the departments. In June, St. George's was second highest performer in London only to be exceeded by Moorfields Eye Hospital.
- In June, the Trust did not achieve the six week diagnostic standard with an adverse performance of 47.8%. Overall this was an improvement of 15.8% compared to May, where performance sat at 63.6%.
- In May, the Trust met four of the seven cancer standards and recovered its performance on the 14 day standard however the 62 day standard remained below target.
- Referral to Treatment performance continued to deteriorate throughout May 2020 down to 63.8%. The total number of reportable 52 week breaches through to the end of May 2020 was 274.

Our People Perspective

- Trust level sickness absence rate at 3.5% has reduced significantly again for the second consecutive month from a high of 5.6% at the height of COVID-19 pandemic.
- Agency spend is low across the Trust due to staff redeployment as a result of COVID-19. In June, the monthly agency spend target was £1.25m with actual agency spend of £0.74m resulting in a favourable £0.51m.
- With a reduction in COVID-19 pandemic related activities, the Trust is now focussing on completion of Appraisals and Mandatory & Statutory Training which were put on hold during that period

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions G	Maternity	Patient Voice G
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce		Agency Use		Estates Health and Safety	

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

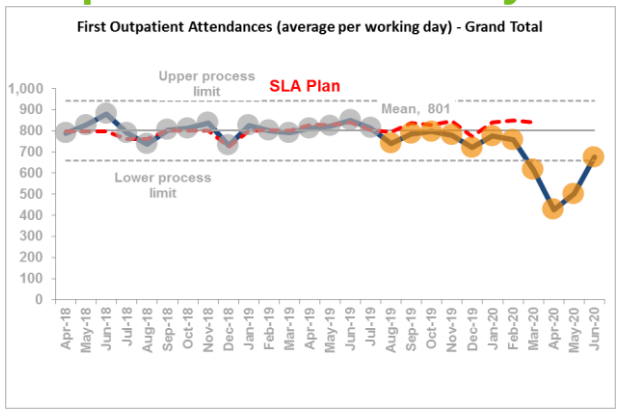
Activity against our Plan

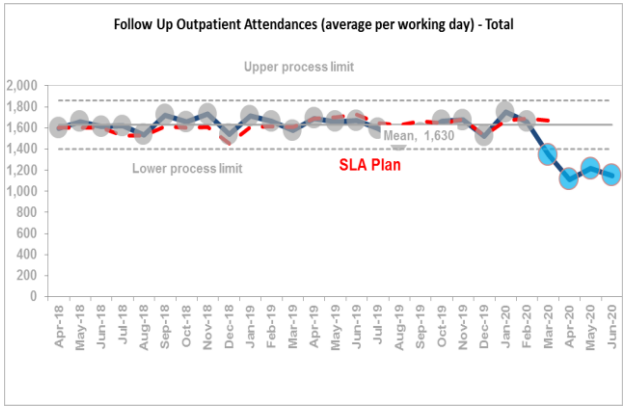
		Jun-19	Jun-20	Variance	Plan Jun-20	Variance	YTD 19/20	YTD 20/21	Variance	Plan YTD	Variance
ED	ED Attendances	14,285	8,827	-38.21%	14,299	-38.27%	42,889	22,146	-48.36%	43,373	-48.94%
Inpatient	Non Elective	3,837	3,034	-20.93%	3,891	-22.03%	12,047	7,918	-34.27%	11,811	-32.96%
	Elective & Daycase	5,141	1,987	-61.35%	5,617	-64.63%	15,143	4,405	-70.91%	15,698	-71.94%
Outpatient	OP Attendances	54,840	42,117	-23.20%	60,830	-30.76%	166,022	108,508	-34.64%	169,221	-35.88%

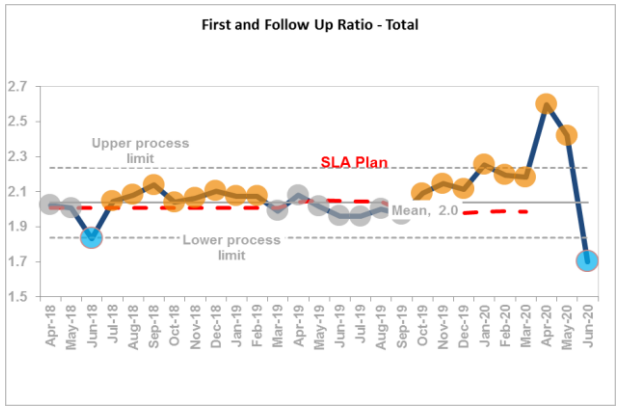
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

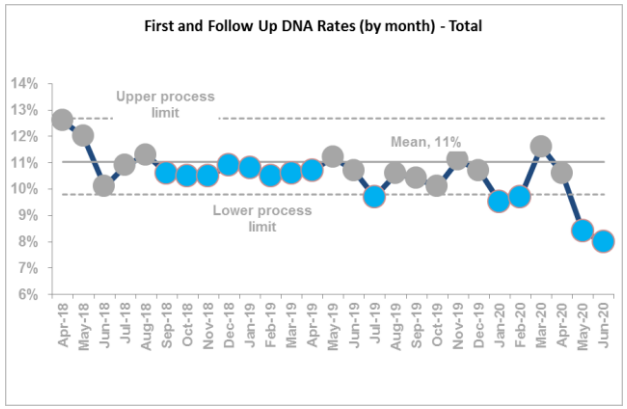
Note: Figures quoted are as at 08/07/2020, and do not include an estimate for activity not yet recorded (eg. un-cashed clinics).
Plan for 2020/21 is based on pre COVID-19 SLA plan

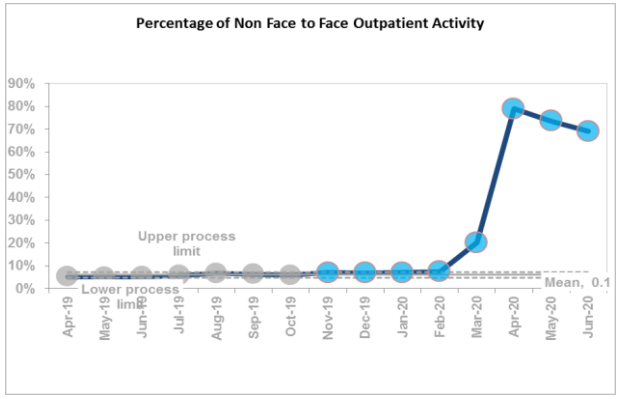
Outpatient Productivity











Actions and Quality Improvement Projects

A clinic activity work stream is in place to support the re-start and/or increase of face to face OP appointments, in line with service led clinical prioritisation. This work stream is led by the Corporate OP team, working closely with Infection Prevention & Control, Estates and Facilities and the Clinical services. This complex piece of work aims to deliver at pace, whilst ensuring the safety of all patients and staff.

Due to COVID-19, the majority of OP pathways are now virtual. Changes were made at pace to workforce, environment and technology resulting in delivery of a large proportion of the five year OP Strategy, within a matter of weeks. We are now in the process of fine tuning the processes and supporting technology to ensure the changes are sustainable whilst continuing to provide on the ground training to support staff.

- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

What the information tells us

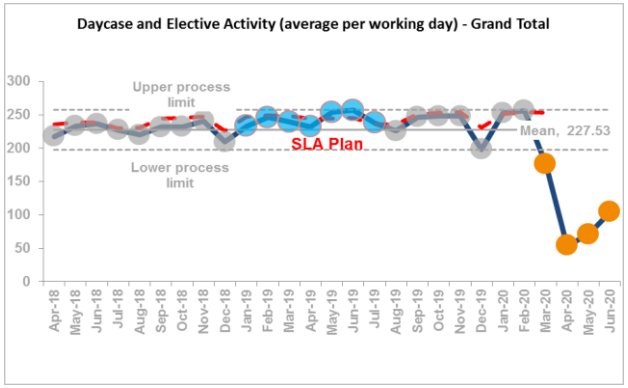
Outpatient first activity remains below the mean for the month of June however there has been a steady increase throughout the month, with an average 173 more patients a day compared to May. The number of attendances per day was 21% lower than the same period last year. All specialties are reporting activity in June below the lower control limit apart from Children's Services and Renal who display common cause variation. The steady increase seen throughout the month has been heavily impacted by new COVID-19 clinics under the treatment function code of Infectious Diseases.

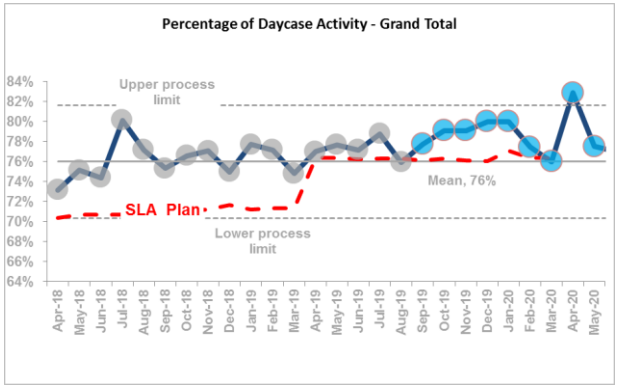
At Trust level, follow-up activity continues to perform below the lower control limits. Compared to the same month last year, activity per day is 31% lower. Renal, Specialty Medicine, Surgery and Women's Services remain with activity levels below the lower control limits.

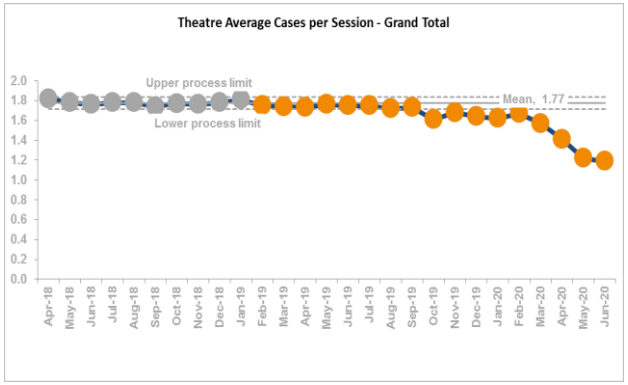
Although overall activity has dropped, continued improvement has been seen in the DNA rate in June reporting that 8% of patients did not attend their scheduled appointment. There is significant difference seen between the face to face and non face to face DNA rate, which is under review.

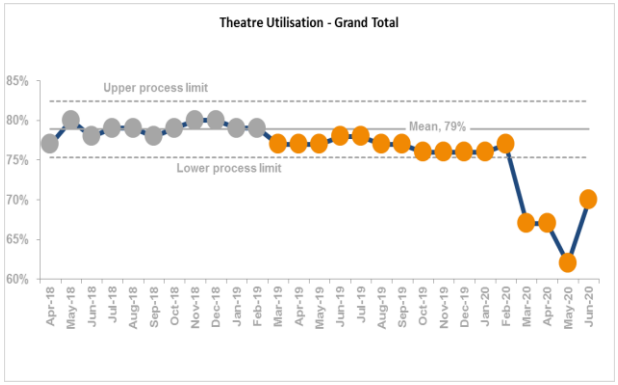
We continue to see the majority of our Outpatient appointments virtually, with 69% of patients seen in a virtual setting within June.

Elective Activity & Theatre Productivity









- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

Elective activity has seen a steady increase throughout June however activity levels remain below the lower control limits with a significant number of elective activity remaining cancelled. Compared to June last year there has been a 60% drop in elective activity. On average per working day this equates to approximately 152 treatments per day (this is not all theatre based activity).

The majority of services' activity remain below the lower control limits with Endoscopy showing the largest impact in terms of reduced activity compared to the same period last year. The Endoscopy service continues to maintain an emergency service until Priority 3 activity can commence. Both Neurology and Renal activity has increased and have returned to within the expected range between the upper and lower control limits.

Trust level theatre cases per session has fallen due to theatre process changes that have been implemented as a result of COVID-19. These processes are designed to keep staff and patients safe, however they do impact upon productivity. Theatre utilisation rates have seen a positive increase in June.

In the month of June 120 patients were treated in the Independent.

Actions and Quality Improvement Projects

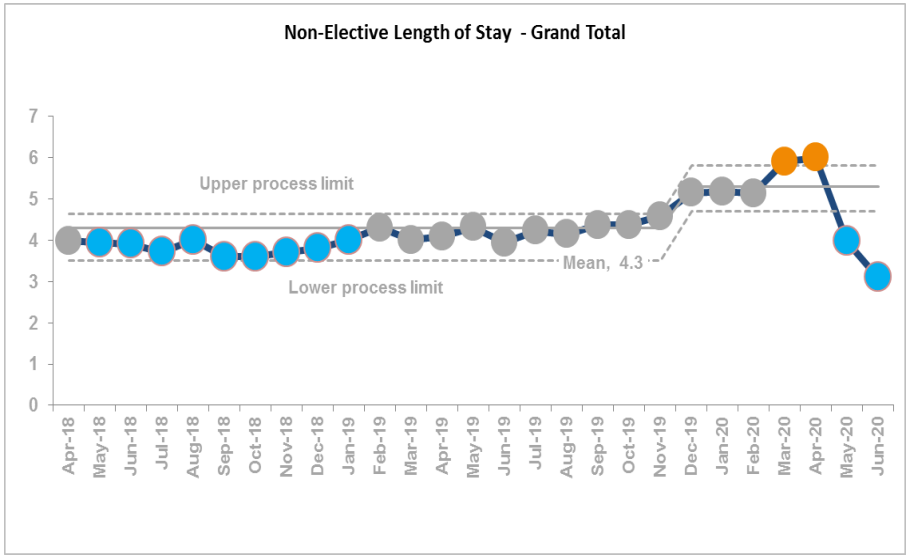
In March a minimal theatre schedule was implemented to offer only urgent and emergency treatments across all specialties. This was due to availability of kit and staff as well as safety for patients. This schedule has been under constant review and has been increased as the demands have changed.

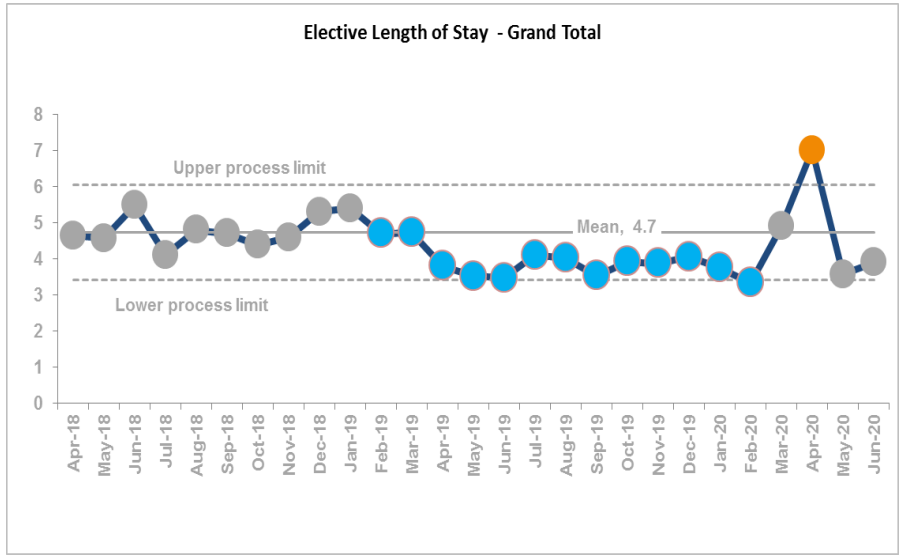
In May, 17 of 29 operating theatres were open, seven of which were for elective surgery. This has gradually increased in June to 23 of 29 operating theatres on site at St George's, but with the independent sector there are the 28 theatres available. Six theatres remain closed (five from early August) at St George's, due to new COVID-19, pathways requirements such as additional recovery space in Day Surgery Unit. Options are being worked up to manage these issues to see if all theatres can be reopened.

Robust list planning has recommenced and utilisation is improving.

The current capacity gap is being supported through capacity in the Independent Sector. The Trust has moved from using three theatres per working day in May to five theatres per working day in June.

Length of Stay





What the information tells us

Non-elective stay remains below the lower control limit for a consecutive month, reducing to an average of three days in the month of June. The number of non-elective admissions have increased by 16% compared to May however, compared to the same period last year the Trust continues to see a lower level of demand by approximately 21%. Within Acute Medicine the average length of stay has returned to within normal limits where activity within Emergency Short Stay admissions continue to increase to a position previously seen before COVID-19. Senior Health and Therapeutics length of stay, although remaining above the mean shows a consistent trend with previous months.

Elective length of stay has returned to within the upper and lower control control limits, with the number of elective procedures and ordinary elective admissions reducing by 61% compared to the same period last year.

Actions and Quality Improvement Projects

Teams are reviewing the configuration of yellow and amber pathways continuously to enable optimal patient flow and early discharge.

An acute post-COVD-19 clinic will be set up to enable earlier patient discharge for COVID-19 patients.

The Trust continues to meet with system partners daily to ensure patient discharges are not blocked. As lockdown eases, the discharge teams are focussing on maintaining the pressure and focus on ensuring patients are discharged in a timely manner.

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions G	Maternity	Patient Voice G
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency Use	Estates Health and Safety			

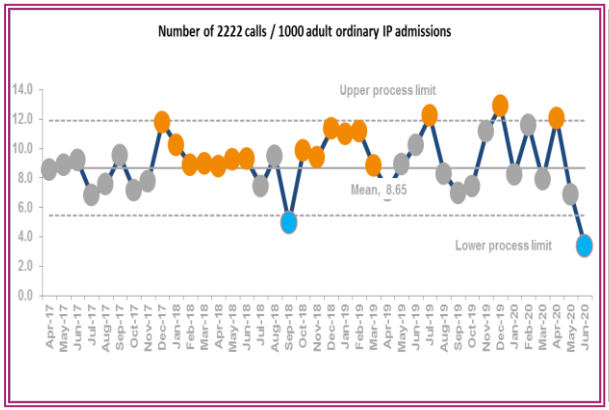
Key

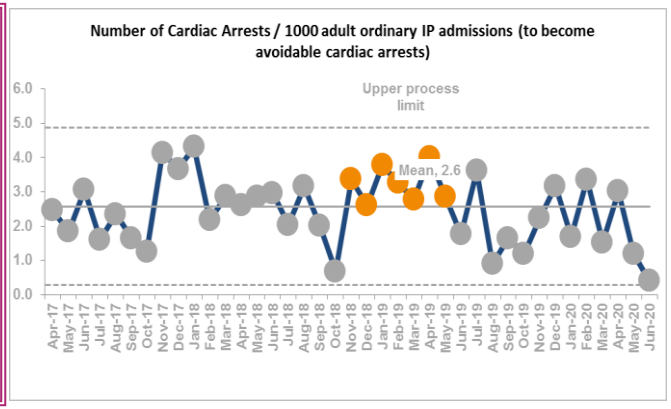
Current Month

A Previous Month

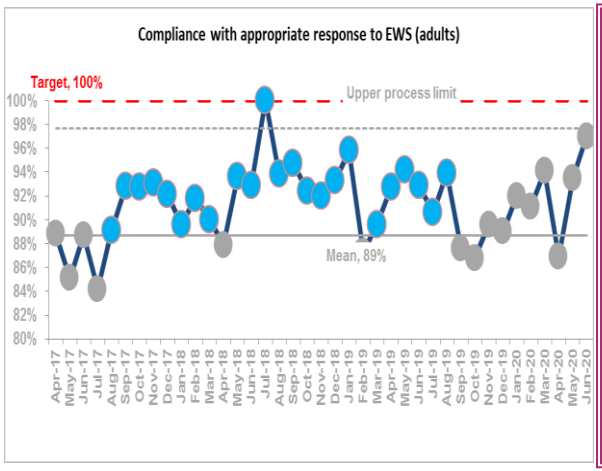
Scorecard RAG rating based on PreCOVID-19 plan

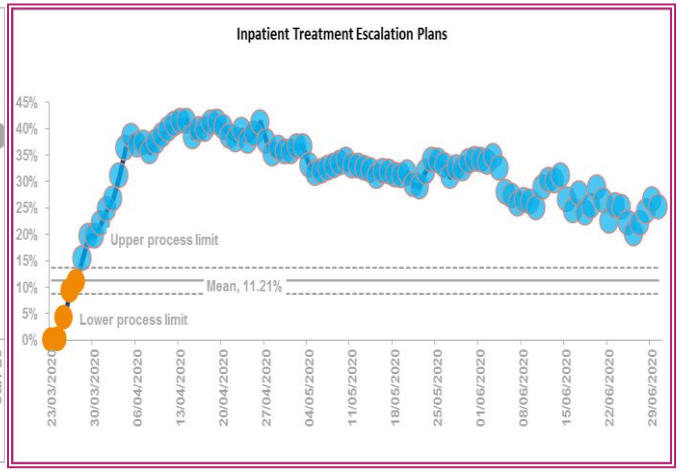
Quality Priorities – Treatment Escalation Plan





- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance





What the information tells us

The number of 2222 calls performance improved further this month showing special cause variation which may be indicative of the impact of the Critical care Outreach Team (CCOT)

Compliance with appropriate response to Early Warning Score (EWS) increased from 93.7% in May to 97% this month and continues to show common cause variation. The cohort of EWS patients is available in the Appendix.

As at 23 March 2020, the trust began collecting Treatment Escalation Plans data on all adult inpatients, this allows patients and staff to be aware of the limits of treatment in the event of the patient deterioration. Uptake on average for June was that 27% of all adult inpatients had a TEP.

Actions and Quality Improvement Projects

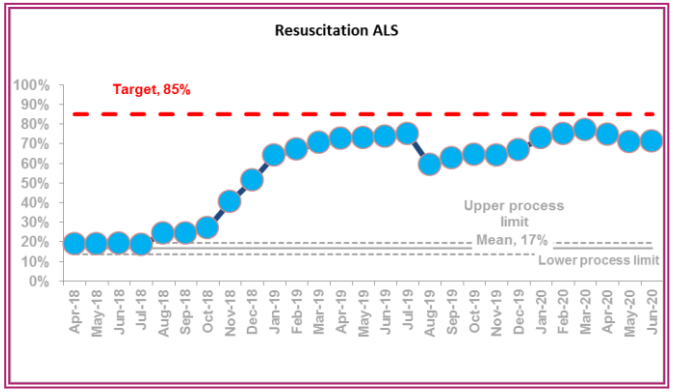
Treatment Escalation Plans (TEP) are now live in iClip supported by Trust wide communication to request TEPs are put in place for all adult inpatients within 24 hours of admission

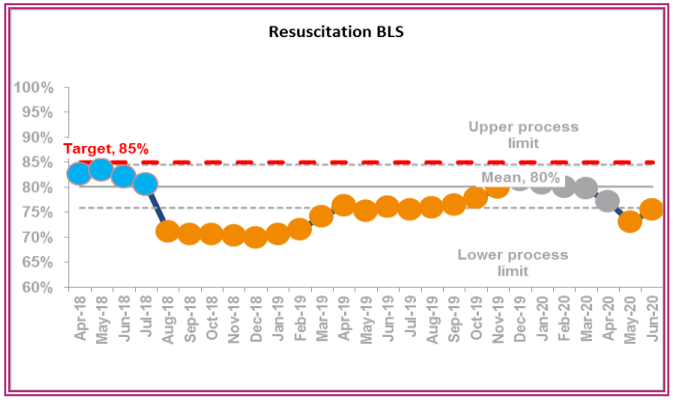
Engagement is undertaken with ward staff with low rates of completion

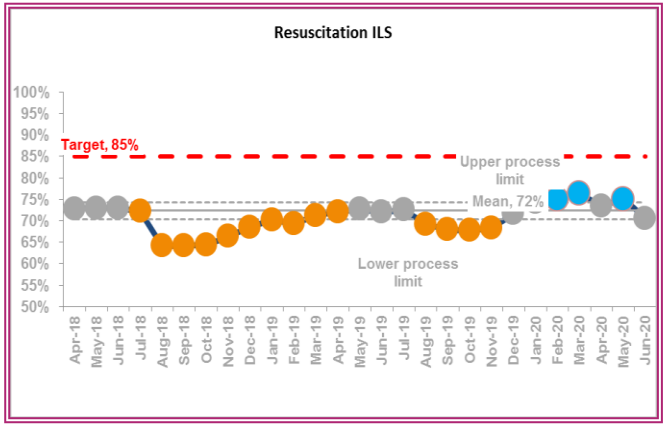
Between April – July 2020 a monthly point prevalence audit has been undertaken to examine the extent to which TEPs are restrictive or reflective of patients for full escalation

NEWS appropriate response audit now undertaken jointly by CCOT and ward sister to standardise the audit approach

Quality Priorities – Deteriorating Patients







What the information tells us

ALS (Advanced Life Support) training performance shows continued improved performance but has not met the 85% performance target.

BLS (Basic Life Support) training performance has made some improvement

ILS (Intermediate Life Support) decreased and is below the mean showing common cause variation.

- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

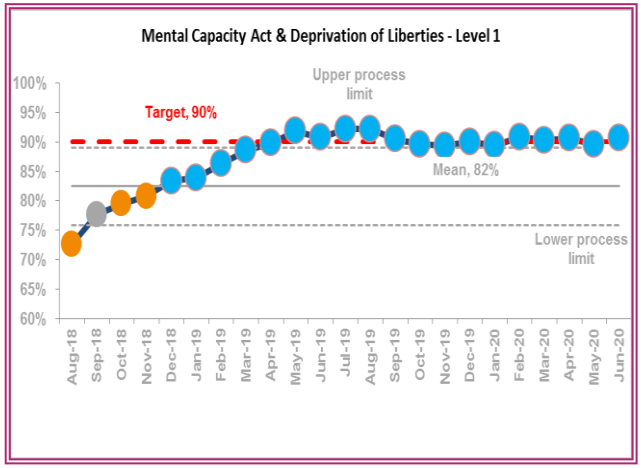
Actions and Quality Improvement Projects

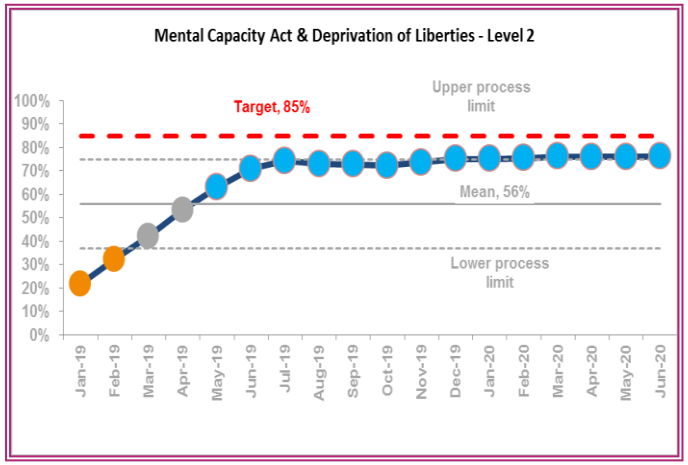
From mid-March 2020 the focussed provision of ALS and ILS training had been scaled back due to the need for the resuscitation training team members to return to practice in critical care.

Resuscitation Team have now returned from redeployment and training has restarted. Social distancing has been employed and so candidate numbers are reduced.

To increase access to training, an on-line BLS level 2 module with face to face assessment of CPR skills is in development and will be launched in August 2020. This on-line module will be available for staff already or about to become non-compliant. Undertaking this module will extend compliance for one year with the proviso that the member of staff attends ILS within that year. Staff requiring BLS as minimum requirement can also take Level 2 on-line module.

Quality Priorities – Mental Capacity Act & Deprivation of Liberties





What the information tells us

Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 remains within target

Level 2 training performance has plateaued. Overall level 2 compliance currently stands at 76%

Metrics taken from the ward accreditation system showing the number of staff interviewed and their level of knowledge was suspended due to COVID-19 and will shortly be resumed.

- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

Actions and Quality Improvement Projects

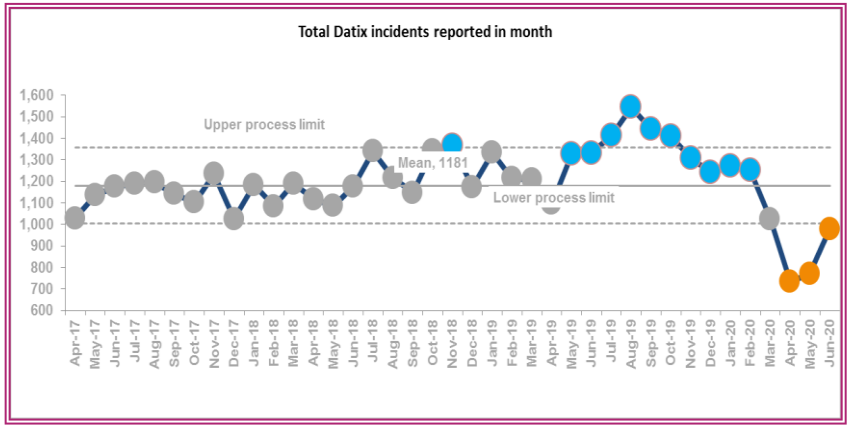
iClip MCA templates are now being built by IT and are expected to be ready for Test Domain 31 July 2020

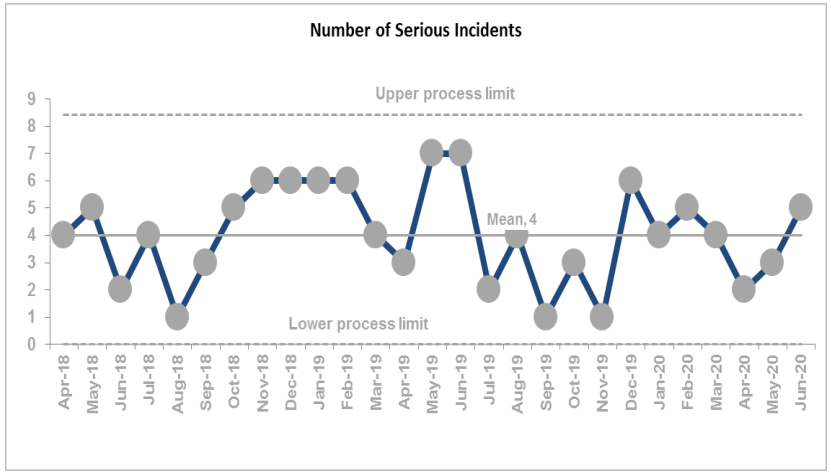
Quarterly staff knowledge audit remains delayed / currently suspended due to the potential impact of launching a trust wide questionnaire during COVID-19. Further planning underway to establish an appropriate timeframe. The aim of this audit, developed in partnership with South West London partners, is to enable the Trust to benchmark and review staff knowledge level against an expert agreed pass mark and in relation to other local healthcare organisations

An audit of consent including capacity, with deep dive component, is provisionally planned for Quarter 2 in conjunction with Medical Lead for Consent, Medical Records Lead and Audit Lead

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/ Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Total Datix incidents reported in month		1,332	1,413	1,544	1,442	1,410	1,309	1,241	1,271	1,252	1,026	734	770	979
Monthly percentage of Incidents of Low and No Harm		99.0%	97.0%	98.0%	97.0%	97.0%	96.0%	96.0%	96.0%	96.0%	93.0%	93.0%	94.0%	data one months in arrears
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%	100.0%	97.0%	93.0%	97.0%	97.0%	98.0%	86.0%	94.0%	82.0%	86.0%	84.0%	data two months in arrears	





What the information tells us

Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days

The number of adverse incidents reported in June 2020 remained lower than normal, but higher than that seen in April and May 2020

There was one Never Event in June 2020

- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

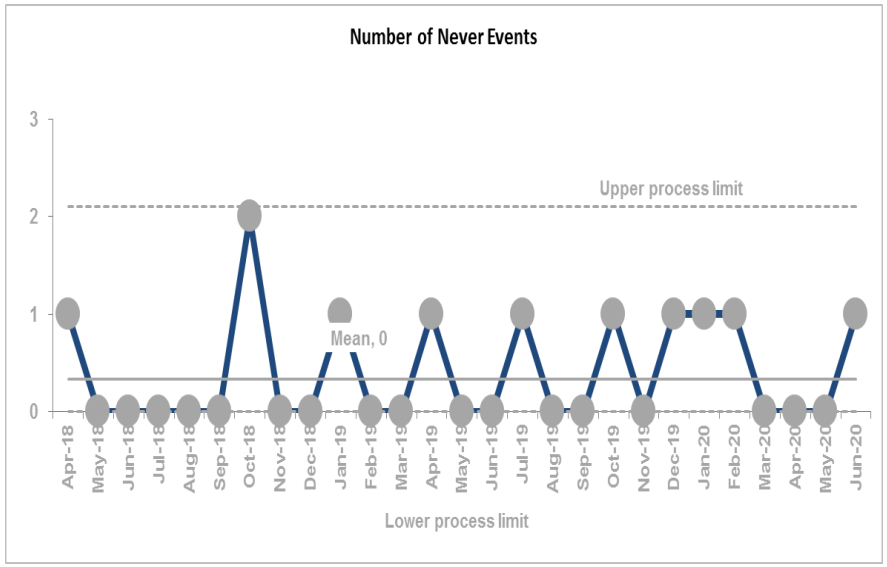
Actions and Quality Improvement Projects

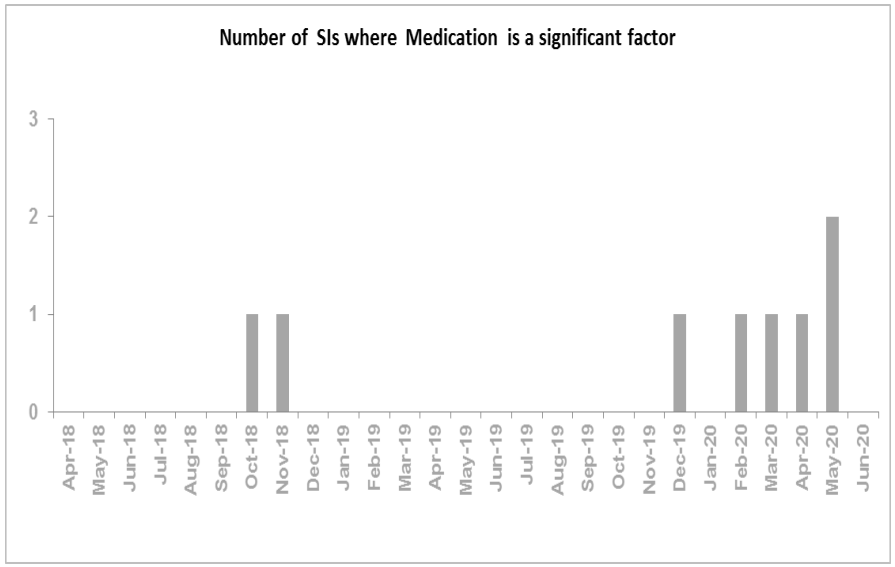
Never Event: Wrong site surgery (anaesthetic block) – patient suffered no harm as a result of the error.

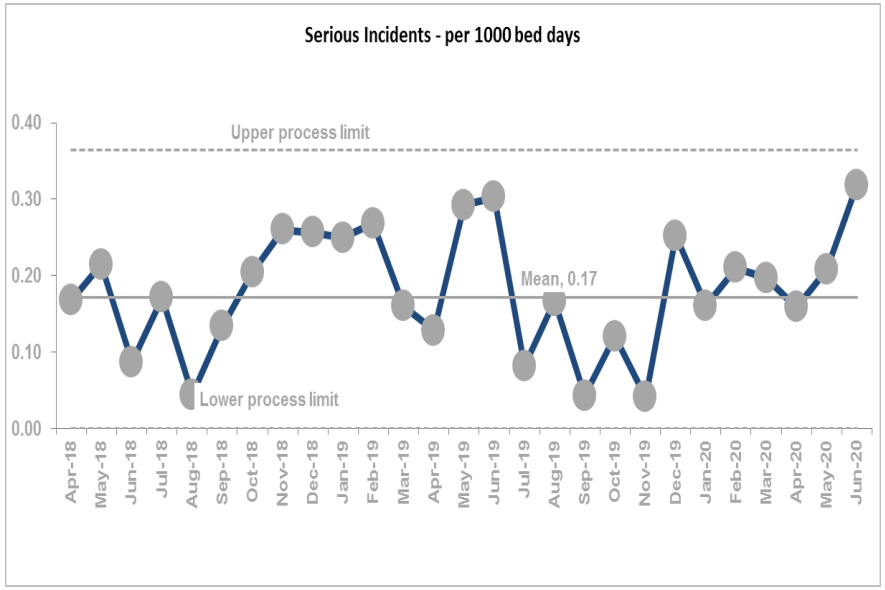
Immediate actions have been implemented and a serious incident investigation has commenced.

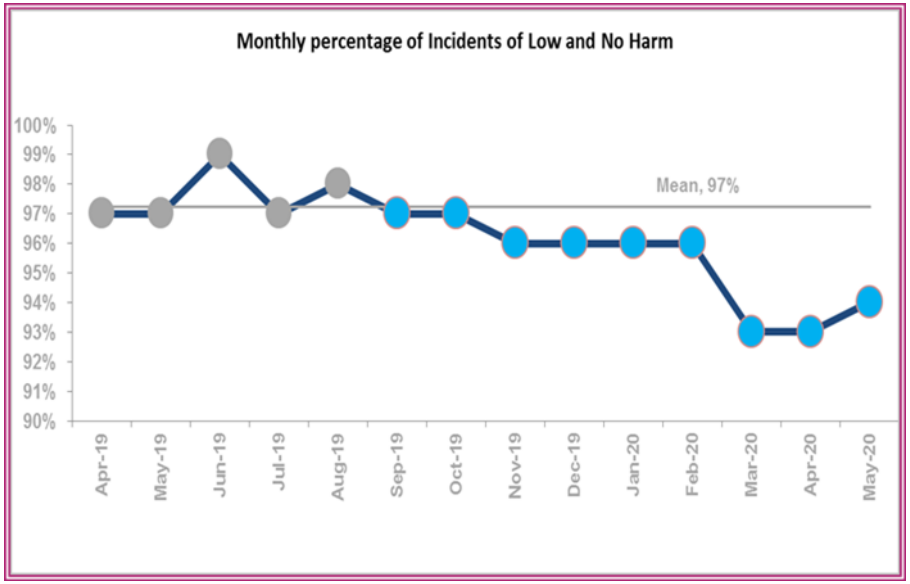
Quality Priorities – Learning from Incidents

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance



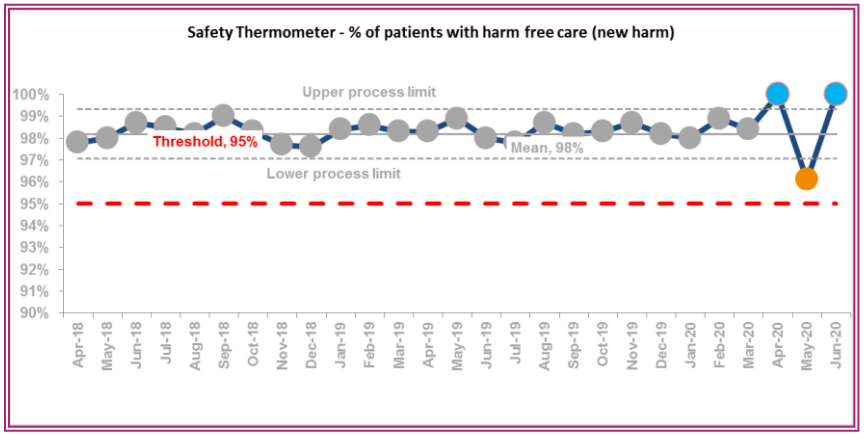


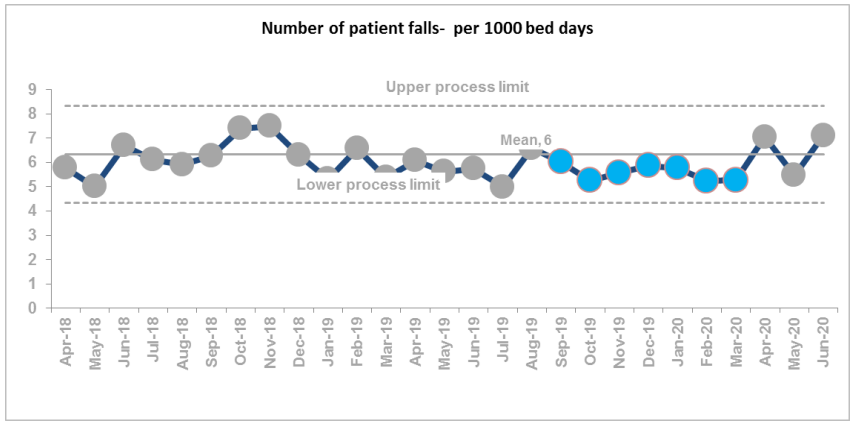


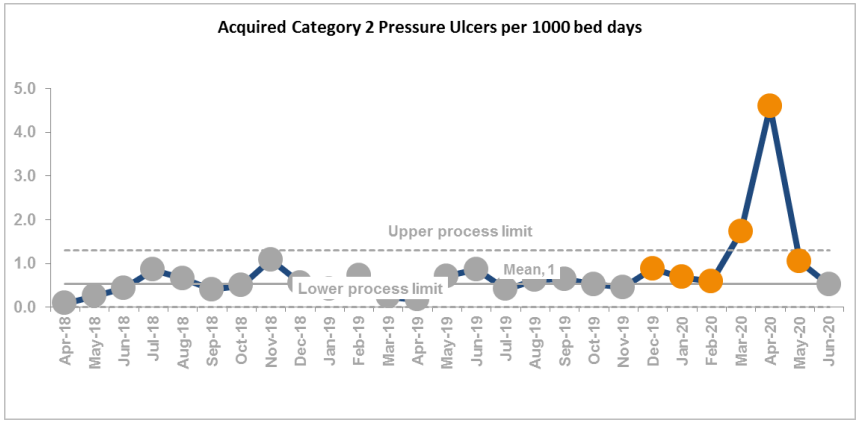


Data is 1 month in retrospect

Patient Safety







- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

What the information tells us

The Trust is meeting its VTE standards and is above the upper process control limit

Safety thermometer – percentage of patients with harm free care increased to 100%

The number of Category 3 Pressures ulcers show special cause variation, and Category 2 Pressure ulcers have this month returned to normal levels

The number of falls per 1000 bed days shows an improved position

Actions and Quality Improvement Projects

The Hospital Thrombosis Group (HTG) continues to monitor the Trust performance on VTE risk assessment. Results from Q4 for VTE risk assessment compliance were 95.5% and the HTG is awaiting 2020/21 Q1 results

All Category 3 and above pressure ulcers (PU) continue to be reviewed following Root Cause Analysis. This is reviewed at ward level with senior nursing input and an action plan agreed with the clinical areas

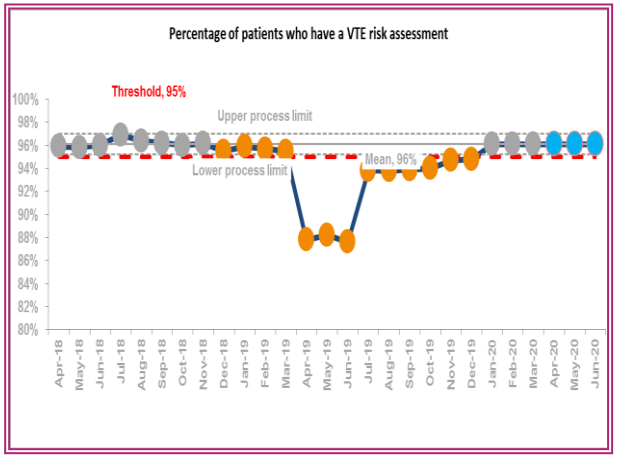
Pressure Ulcer Steering group was paused due to COVID-19 and will be reinstated in order to guide work with clinicians to reduce prevalence through audit and education

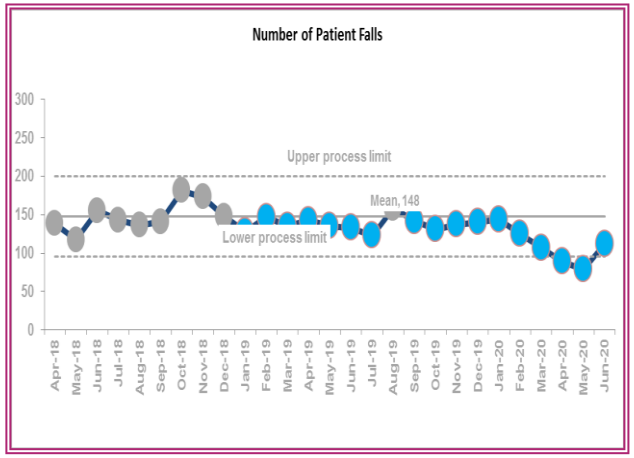
The Category 3 PU are within control limits and Category 2 PU are noticeably reduced for June. Following the return of Tissue Viability Nurses from ITU redeployment due to COVID-19 , pressure ulcer cases are now verified by the team

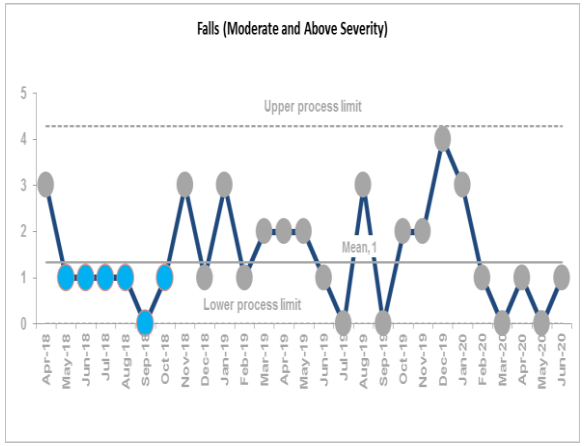
The Trust Falls prevention co-ordinator has resumed ward visits and has re-established regular education activities. Work has begun on improving functionality of falls risk assessments and care plans within the iClip platform which will improve compliance and better identification of patients at risk of falls at the start of their care episode

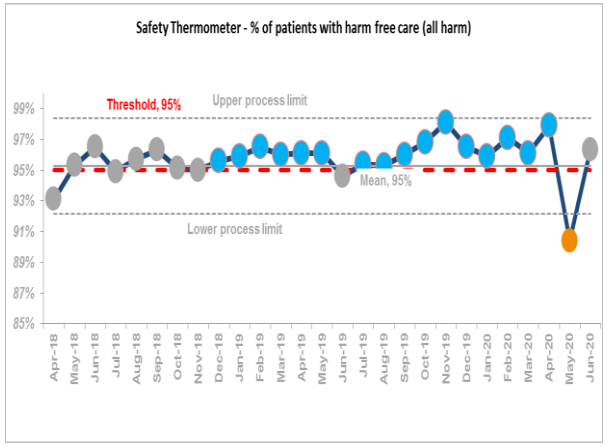
Patient Safety

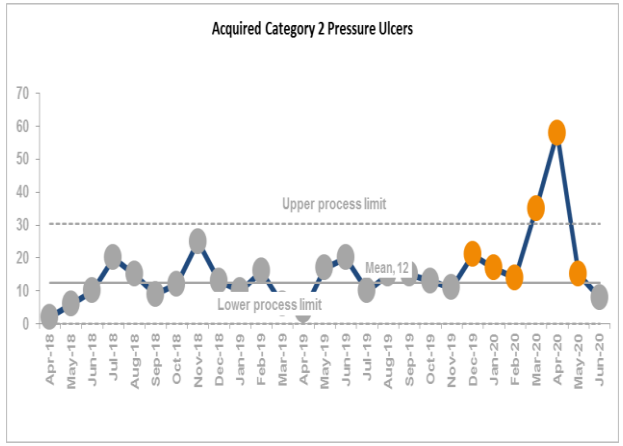
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

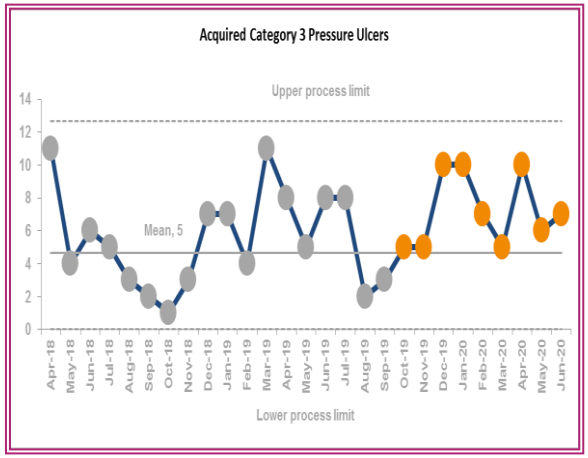






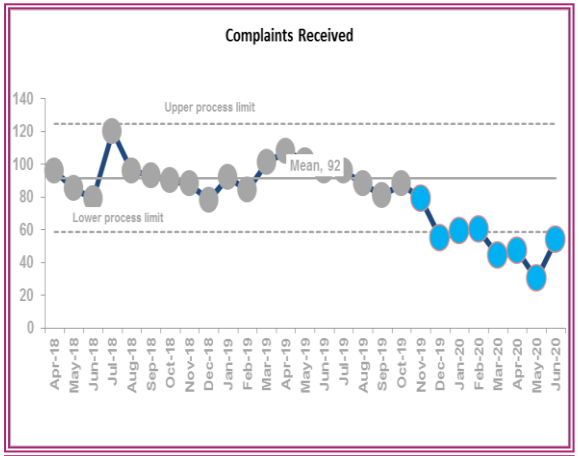


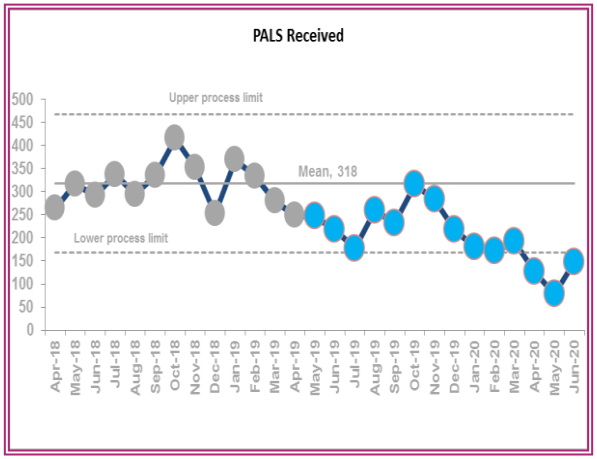


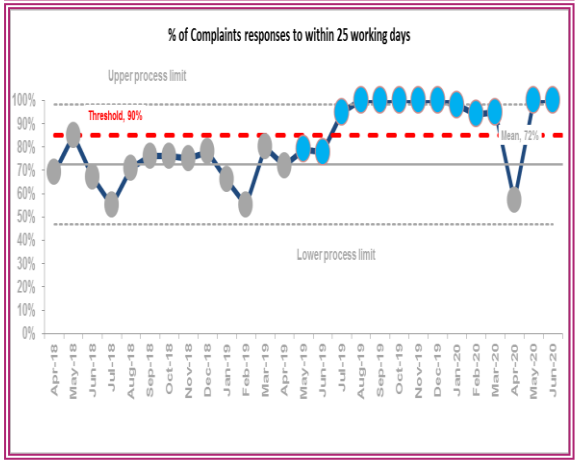


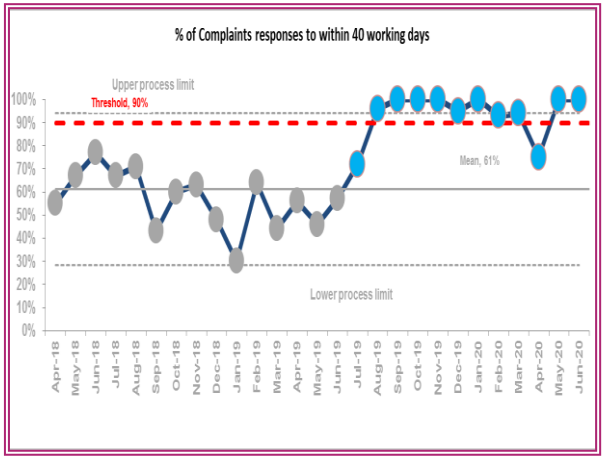
Complaints

Indicator Description	Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Complaints Received		96	96	88	81	88	79	55	59	60	44	47	30	54
% of Complaints responses to within 25 working days	85%	78%	95%	100%	100%	100%	100%	100%	98%	94%	95%	57%	100%	100%
% of Complaints responses to within 40 working days	90%	57%	72%	96%	100%	100%	100%	95%	100%	93%	94%	75.0%	100%	100%
% of Complaints responses to within 60 working days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0









- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

What the information tells us

The number of complaints received has increased but is still lower than expected

100% performance was seen across all complaint response categories for this reporting period

The number of PALS enquiries received has increased but is still lower than expected

Actions and Quality Improvement Projects

Daily complaints comcell continues to focus attention on timely investigation and response

Infection Control

Indicator Description	Threshold 2020-2021	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	1	0	1	0	1	0	0	0	0	0
Cdiff Hospital acquired infections	TBC	5	4	4	6	3	2	2	5	3	1	1	3	5	10
Cdiff Community Associated infections		1	1	1	0	1	2	0	0	0	2	0	0	1	
MSSA	25	1	0	3	2	2	3	5	6	3	2	3	0	2	5
E-Coli	60	5	7	7	8	6	4	9	5	7	4	4	8	3	15

What the information tells us

The Trust reported no MRSA incidents in June 2020. There is a zero target for 2020/21.

In June, there was a total of 6 Cdiff incidents, 5 Hospital Acquired and 1 Community associated.

The number of Ecoli and MSSA cases reported remains within control limits.

Actions and Quality Improvement Projects

The Trust continues with infection control measures with more emphasis on basic hand hygiene and has increased hand hygiene audits both by ward teams with cross audit by Infection Control Nurses for enhanced assurance

There is increased focus on cleanliness of the environment and cross audits planned both by the external provider and the Trust for enhanced assurance

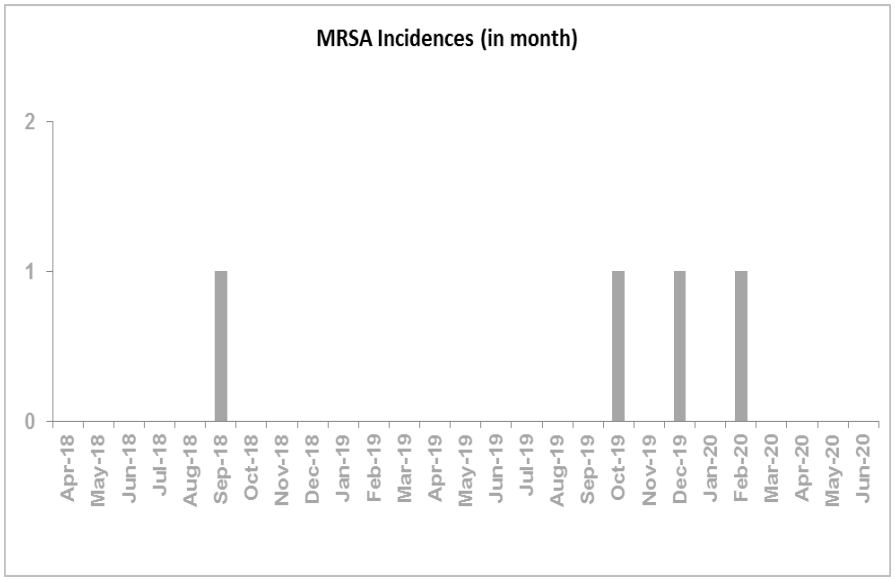
The ward and departmental accreditation programme was paused due to COVID-19. This has now recommenced and includes measures on infection control and cleaning standards

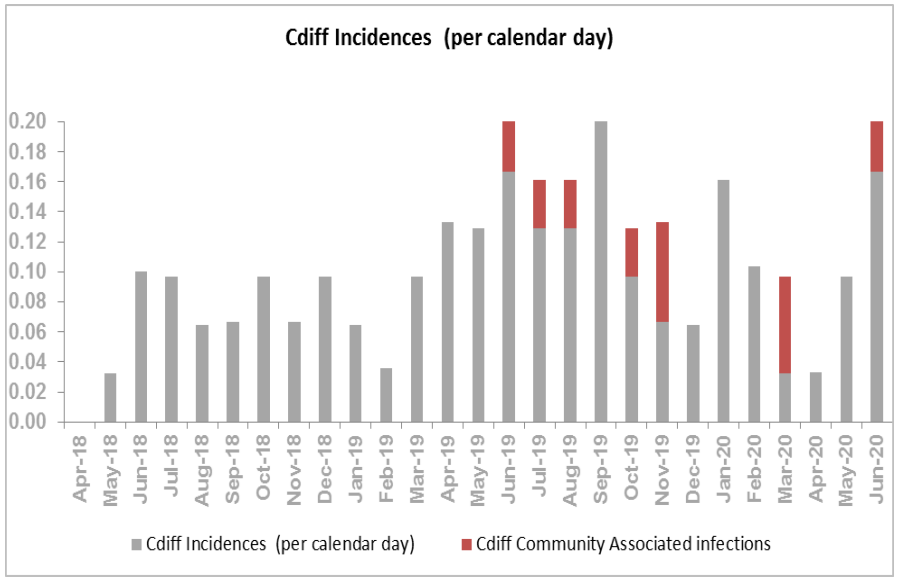
Areas where Hospital Acquired Infections have occurred continue to be placed under a higher frequency surveillance and audit programme

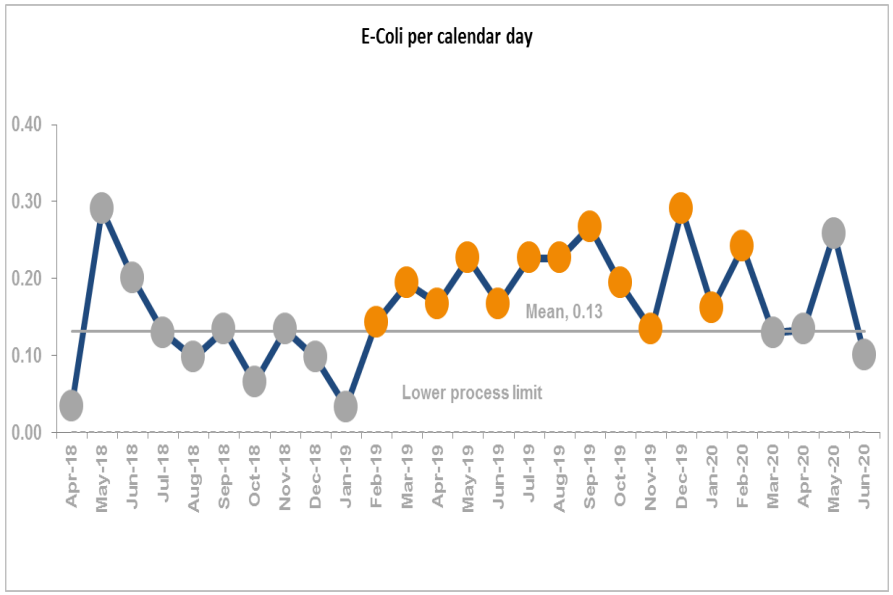
The Trust is liaising with the CCG to confirm the C-diff threshold for 2020-21. The Trust is awaiting confirmation of the target

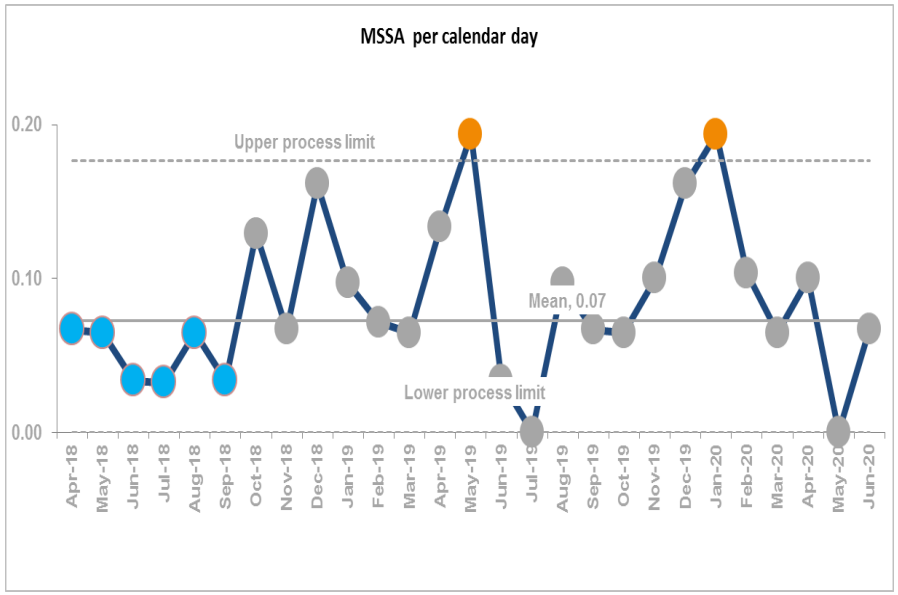
Infection Control

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance









3.2

Our Patient Perspective

Mortality and Readmissions

Indicator Description	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr 2019 to Mar 2020
Hospital Standardised Mortality Ratio (HSMR)	89.5	105.5	87.9	92.1	88.5	95	101.6	91.4	90.2	64.1	58.5	94.5
Hospital Standardised Mortality Ratio Weekend Emergency	73.5	113	77.2	93.8	107.3	80.6	100.1	87.6	112.3	68.4	80.8	95.1
Hospital Standardised Mortality Ratio Weekday Emergency	92.5	100.4	90.8	96.2	80.4	102.9	102.9	90.8	90.1	57.4	67.1	94.8

Indicator Description	Jun18-May19	Jul18-June19	Aug18 - Jul19	Sep18-Aug19	Oct18-Sep19	Nov18-Oct19	Dec18-Nov 19	Jan-19-Dec 19	Feb-19-Jan 20
Summary Hospital Mortality Indicator (SHMI)	0.81	0.83	0.83	0.83	0.85	0.85	0.85	0.86	0.88

Indicator Description	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	10.6%	9.9%	7.9%	10.9%	10.2%

Note: **HSMR data reflective of period Mar 2019 – Feb 2020 based on a monthly published position.**
SHMI data is based on a rolling 12 month period and reflective of period January 2019 to December 2020 published (May 2020).Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways.

What the information tells us

Both of the Trust-level mortality indicators (SHMI and HSMR) show our latest outcomes to be as expected.

30 day emergency readmission rates are above the upper control limit in May and June

Actions and Quality Improvement Projects

The Mortality Monitoring Committee (MMC) continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster.

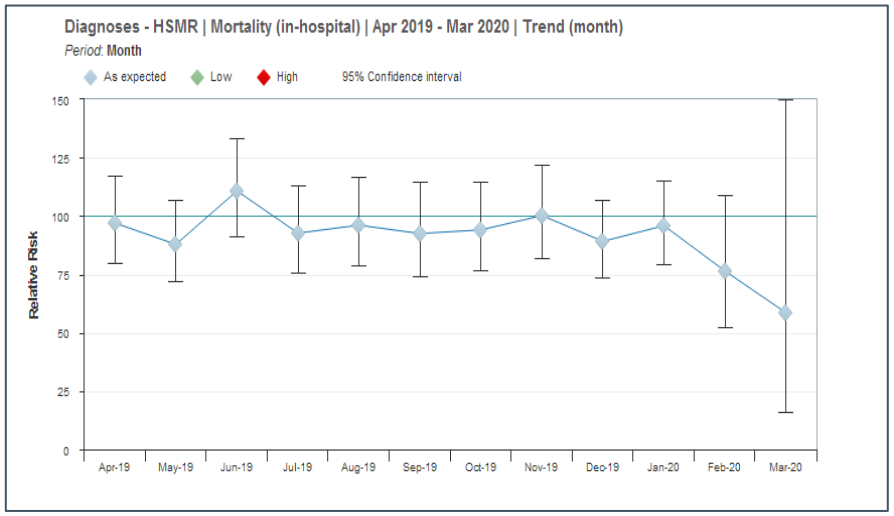
Investigations have recently been completed in the diagnosis group intracranial injury (December 2018 – November 2019) and for hip fracture (January 2019 – December 2019). These investigations were reported to the MMC in June and provided assurance that there were no systematic issues of clinical care observed in either patient group.

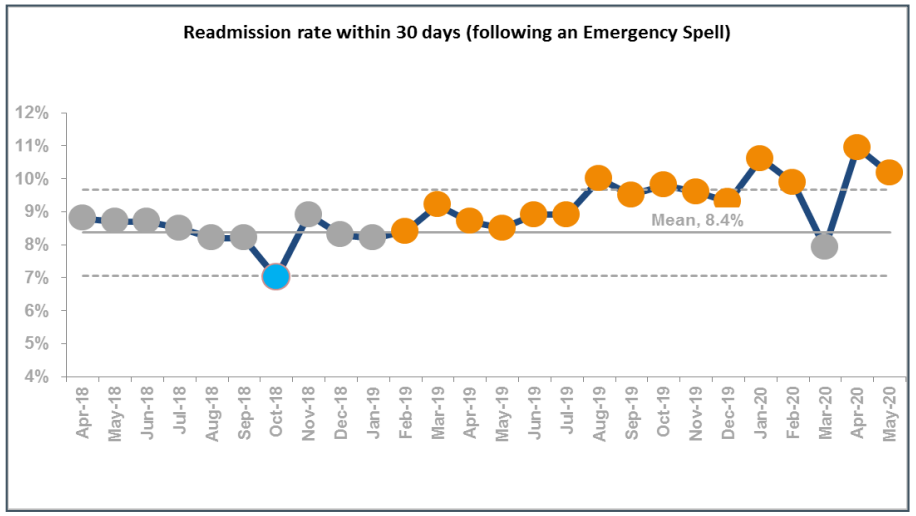
The committee noted that in June TARN (Trauma Audit & Research Network) has notified us of our negative outlier status for outcomes between July 2017 and June 2019. The Trust lead for Trauma and the Trust lead for Learning from Deaths are working together to investigate this alert.

Mortality and Readmissions (Hospital Standardized Mortality Rate)

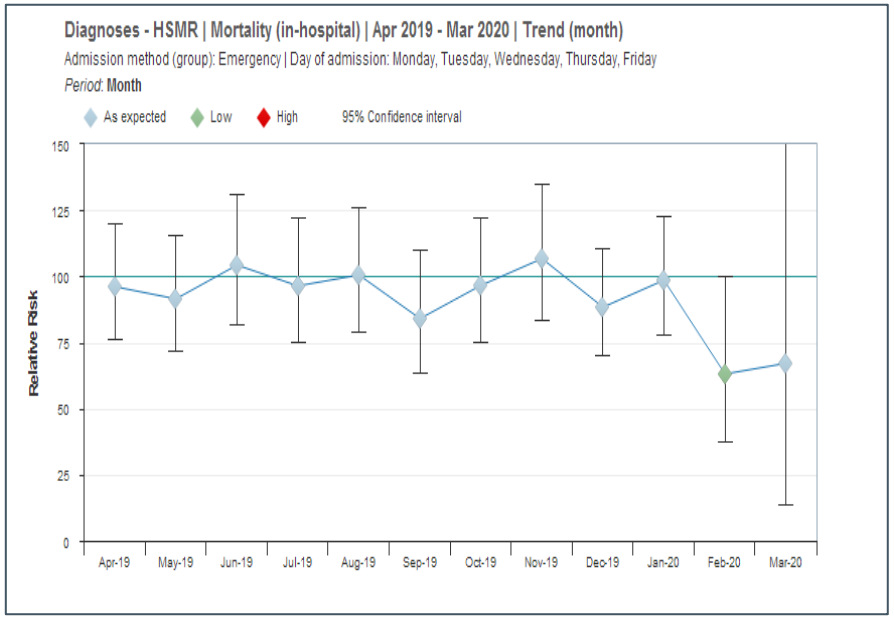
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

HSMR

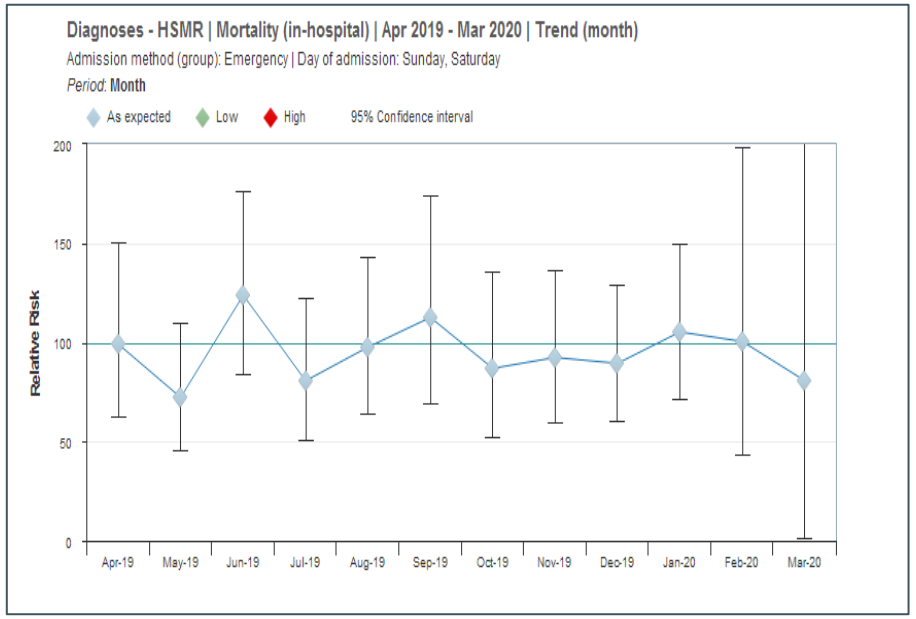




HSMR Weekday

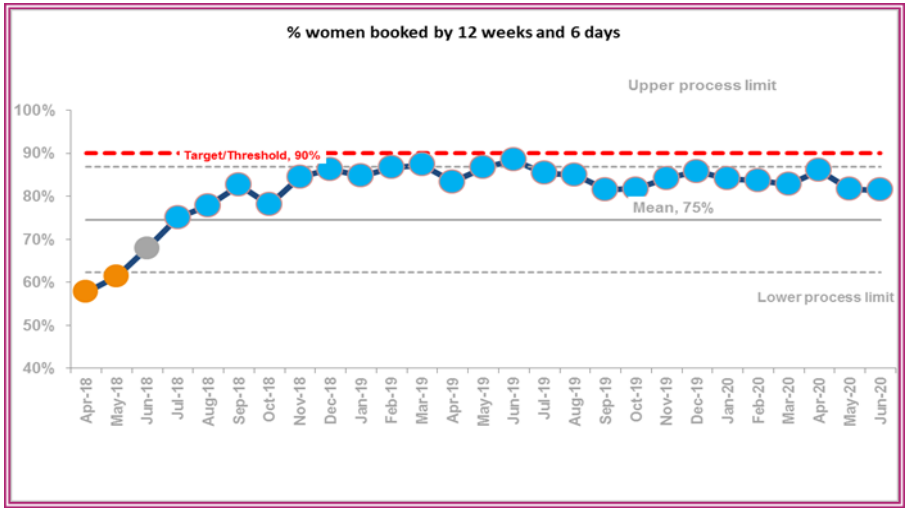


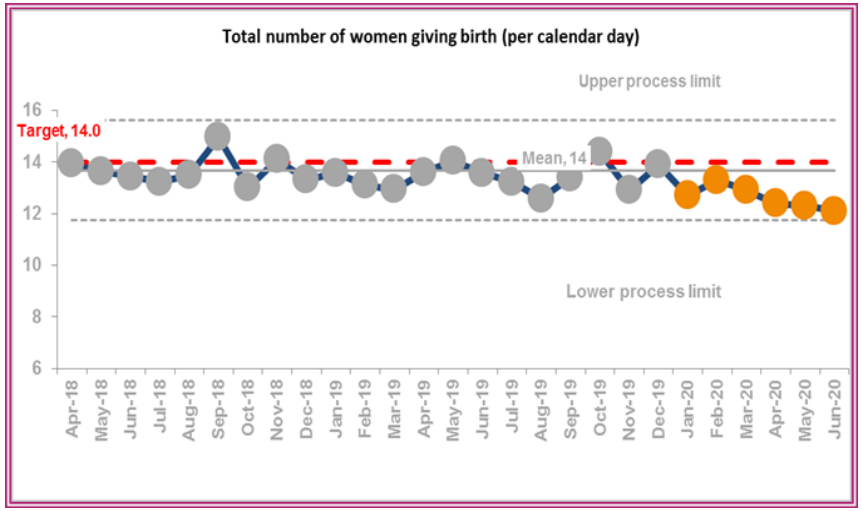
HSMR Weekend



Maternity

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance





What the information tells us

The overall birth rate continues to be low for June, similar to the pattern across London.

Carmen Suite was closed for five shifts during the month due to staff being redeployed to other areas of the unit to meet demand. The unit remained open to any woman currently in Labour on Carmen Suite, but was closed to new admissions. The number of women giving birth on Carmen Suite fell to 43 from 54

Stillbirths - Intrapartum rate was low but the <37 weeks rate is higher than normal. All of these cases are being investigated as per guidelines; however on initial analysis there does not appear to be any association with COVID-19 at this stage. A number of women were transferred with high risk pregnancies or foetal anomalies whose babies sadly died

Antenatal bookings - rates for booking by 9 weeks and 6 days and 12 weeks and 6 days remained stable. Analysis of the data suggests that if all of the women referred by 12 weeks and 6 days were seen within this time, we would achieve 90%. However further analysis of referrals is required, as there are a number of issues identified such as incorrect information on the referrals and women choosing dates outside of the booking range

Actions and Quality Improvement Projects

The establishment on Carmen Suite is currently under review to ensure open access on all shifts

The Antenatal booking office have identified a number of issues with the booking process leading to women being seen beyond 12+6 weeks of pregnancy. A 'deep dive' of issues will be conducted to see where these can be addressed and where feedback can be given to GPs and women regarding the importance of early booking. Staff in all the specialist teams will be included in this review which will be completed by the end of Quarter 2

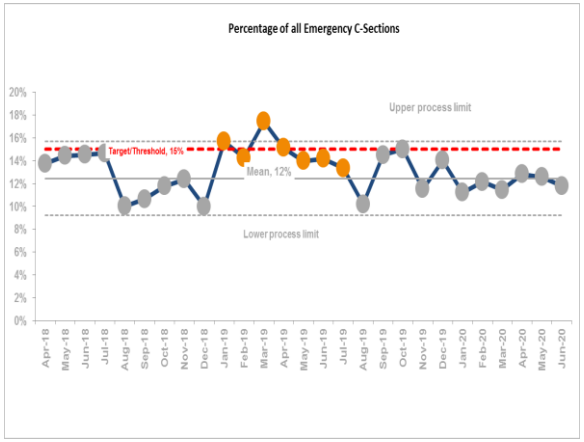
New visiting guidelines will be publicised to women

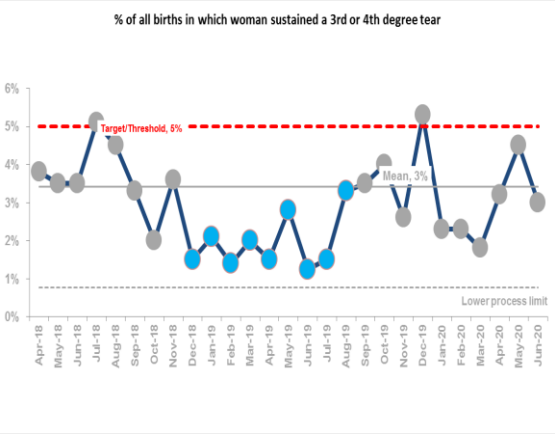
Maternity

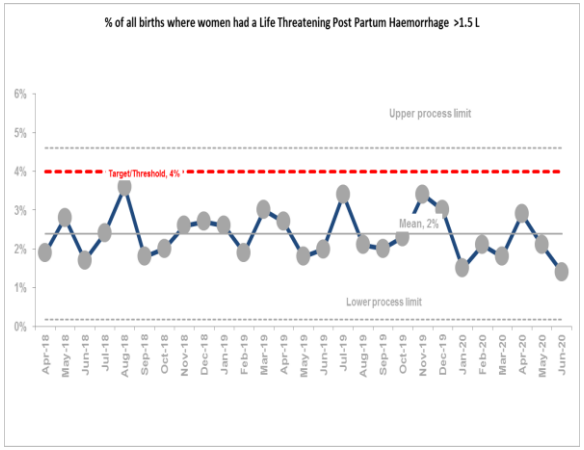
Definitions	Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Total number of women giving birth (per calendar day)	14 per day	13.6	13.2	12.6	13.4	14.4	12.9	14	13	13	13	12	12	12
% Time Carmen Suite closed	0%	6.7%	0.0%	4.8%	1.7%	19.4%	11.7%	8.1%	1.6%	22.5%	27.4%	10.0%	8.1%	8.3%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	1.2%	1.5%	3.3%	3.5%	4.0%	2.6%	5.3%	2.3%	2.3%	1.8%	3.2%	4.5%	3.0%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.0%	3.4%	2.1%	2.0%	2.3%	3.4%	3.0%	1.5%	2.1%	1.8%	2.9%	2.1%	1.4%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		14	10	9	10	7	14	11	12	11	13	9	9	15
Supernumerary Midwife in Labour Ward	>95%	98.3%	100.0%	96.8%	96.7%	96.8%	96.7%	96.8%	96.8%	94.8%	93.5%	100.0%	96.8%	96.7%
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	<2	2	0	0	0	0	0	3	0	0	0	0	0	4
Percentage of all Emergency C-Sections	15%	14.2%	13.4%	10.2%	14.5%	15.0%	11.5%	14.0%	11.2%	12.1%	11.4%	12.8%	12.6%	11.8%
% women booked by 12 weeks and 6 days	90%	88.4%	85.3%	84.9%	81.5%	81.7%	84.1%	85.7%	84.0%	83.6%	82.7%	86.0%	81.6%	81.4%

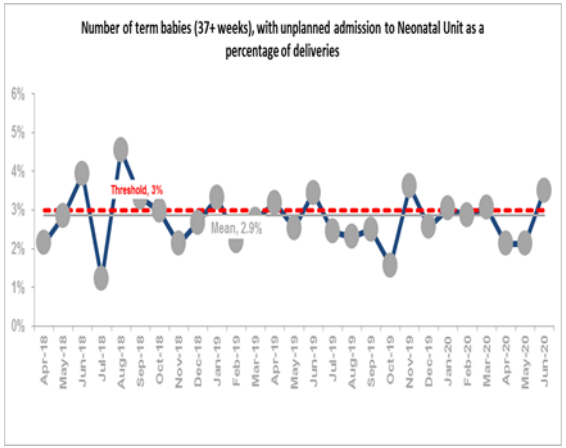
Maternity

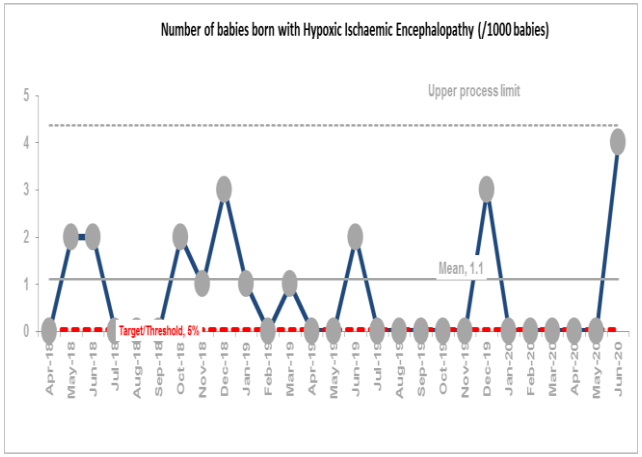
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance











3.2

Friends & Family Survey

Indicator Description	Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Emergency Department FFT - % positive responses	90%	83.3%	82.6%	82.7%	80.5%	81.5%	79.0%	80.3%	84.2%	86.2%	87.8%	93.9%	93.6%	90.0%
Inpatient FFT - % positive responses	95%	94.7%	96.9%	96.5%	96.6%	96.0%	96.5%	96.9%	96.8%	96.6%	97.2%	100.0%	97.2%	93.6%
Maternity FFT - Antenatal - % positive responses	90%	85.7%	100.0%		100.0%			100.0%	100.0%		100.0%	100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	97.9%	100.0%	95.2%	100.0%	100.0%	94.1%	100.0%	100.0%		100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	98.0%	100.0%	98.3%	95.2%	100.0%	97.3%	88.0%	90.7%	96.9%	100.0%		100.0%	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	90.0%	100.0%		100.0%	
Community FFT - % positive responses	90%	99.5%	96.4%	98.1%	98.8%	99.3%	98.1%	97.7%	100.0%	98.6%	100.0%		100.0%	100.0%
Outpatient FFT - % positive responses	90%	90.6%	90.9%	90.8%	90.1%	89.6%	90.7%	90.3%	89.9%	89.9%	91.7%	98.2%	89.9%	88.8%

What the information tells us

The cohort of patients surveyed continues to be low as a consequence of COVID-19

The percentage of positive responses across the Inpatients and Outpatients has decreased this month against the lower cohort of patients surveyed

Actions and Quality Improvement Projects

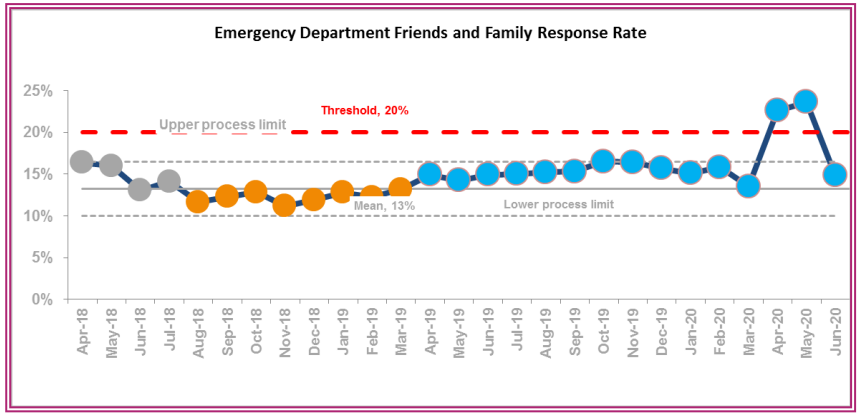
Changes in Friends and Family (FFT) guidance was due to be implemented in April 2020. The guidance encourages patients to provide feedback. throughout their care episode. In preparation for this and in line with guidance, the wording of the questions and changes to the Trust systems are being developed for launch at a future date to be confirmed.

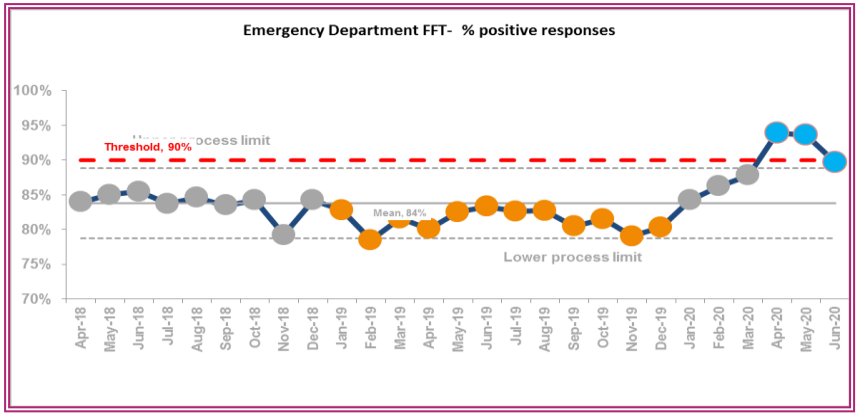
The FFT surveys completed on tablet computers continue to be suspended.

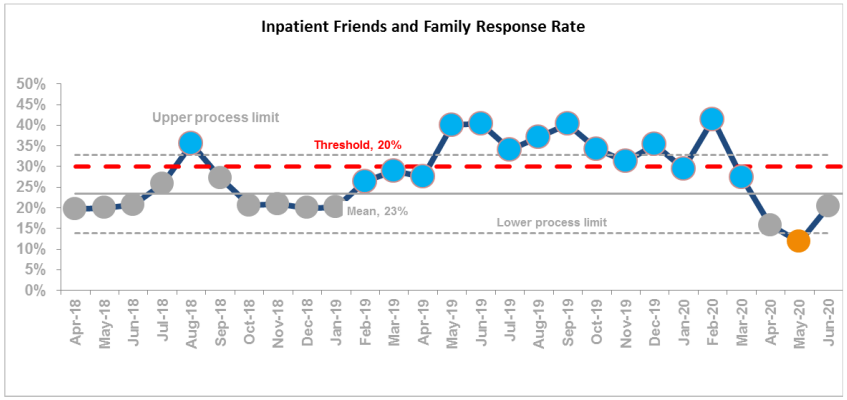
As services resume in line with the Clinical Safety Strategy plans are under development to safely capture patient feedback across all service areas. Future plans involve a move to text message for all areas (outpatients have restarted text messaging)

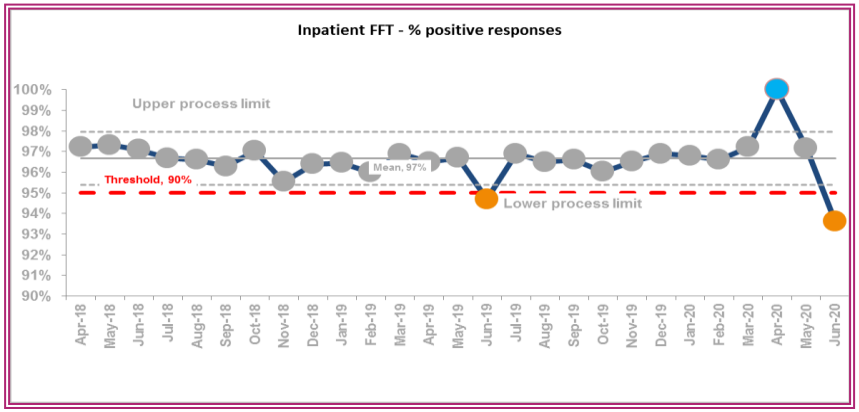
Friends and Family Test

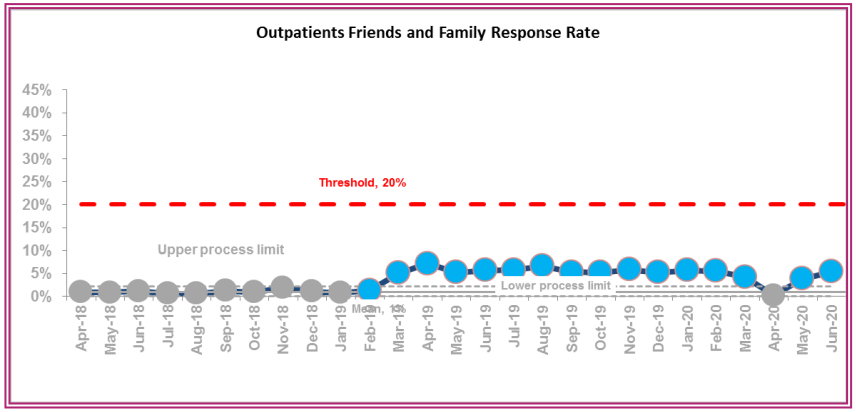
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

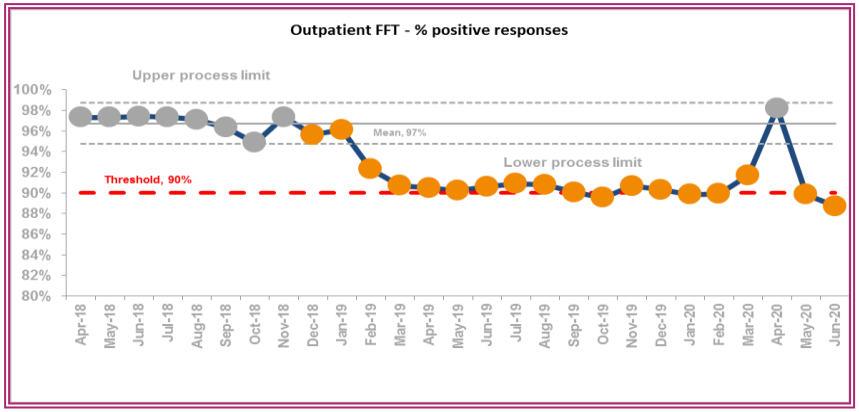










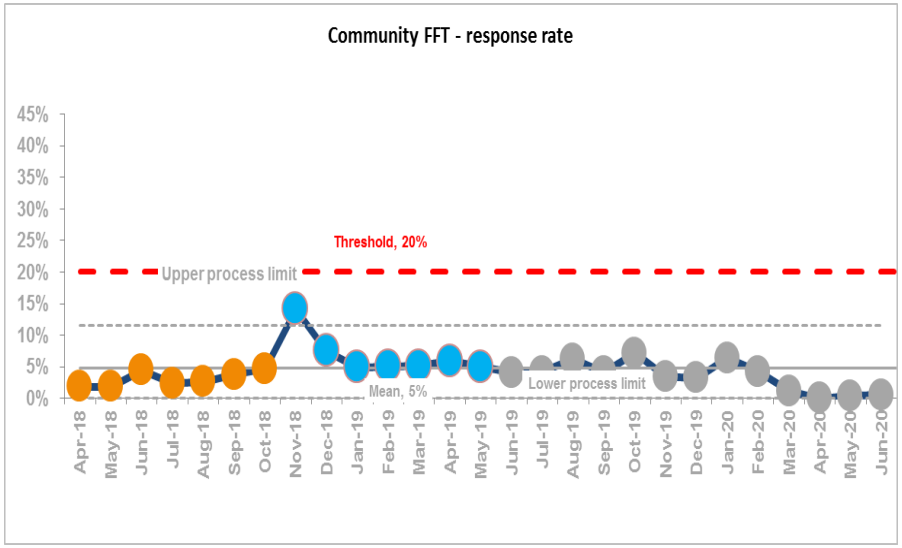


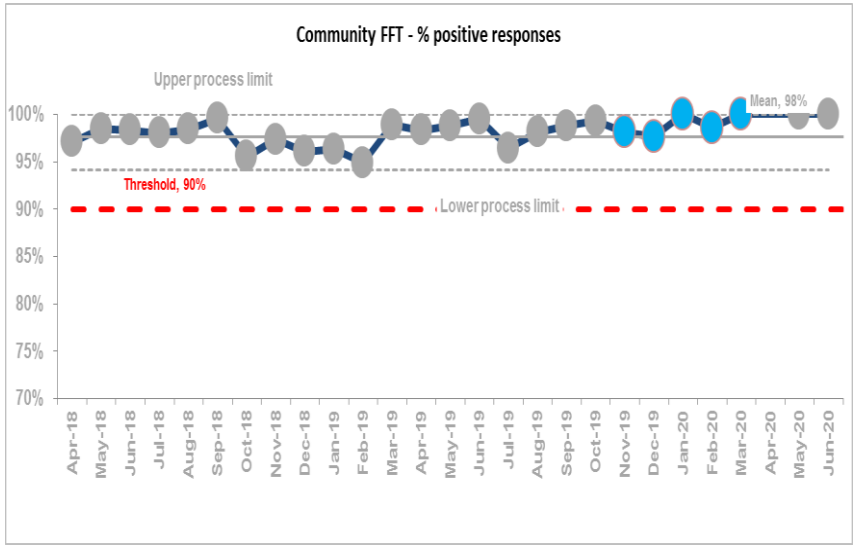
3.2

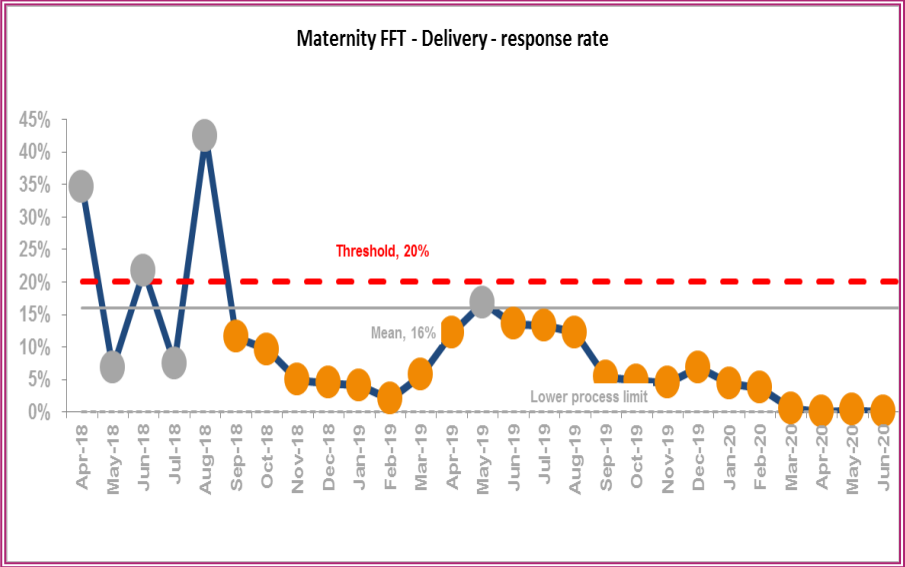
Our Patient Perspective

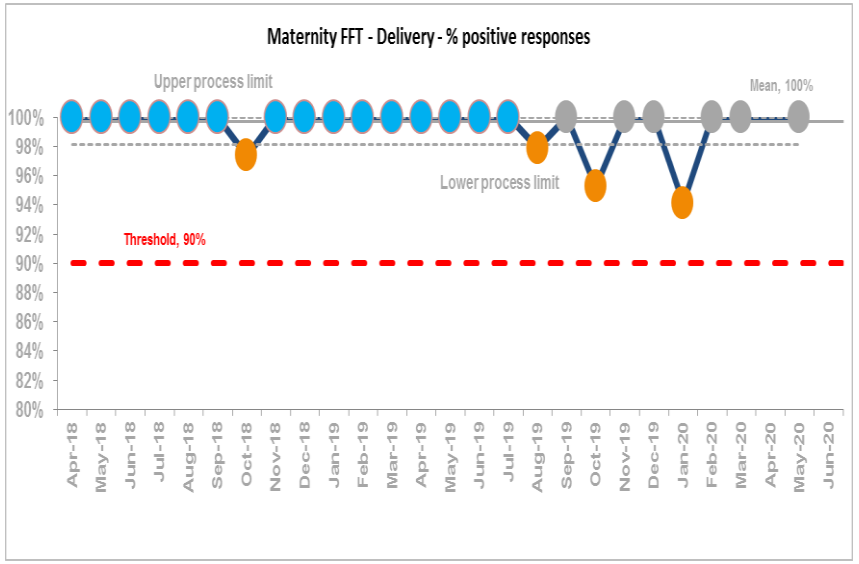
Friends and Family Test

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance









Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions G	Maternity	Patient Voice G
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce		Agency Use		Estates Health and Safety	

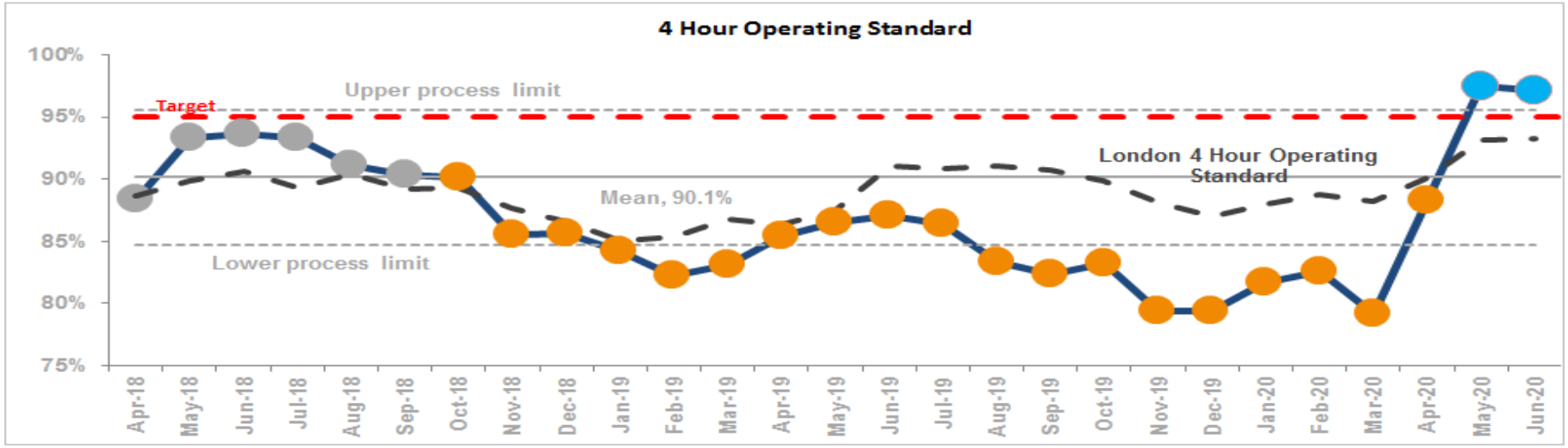
Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Emergency Flow



What the information tells us:
The number of patients attending our Emergency Department (ED) saw a steady daily increase throughout June, treating fifty more patients per day compared with May with performance being maintained against the Four Hour Standard for a consecutive month reporting 97.1% of patients waiting less more than 4 hours from arrival to either being discharged, admitted or transferred. Both admitted and non-admitted pathway performance remained above the upper control limits allowing a positive flow of patients moving through the departments.

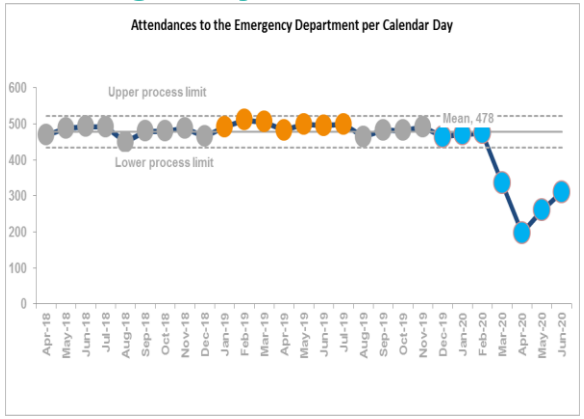
Although we have seen an increase throughout June in both walk in and ambulance arrivals to the Emergency Department, overall attendance numbers remain 38% lower than the same period last year.

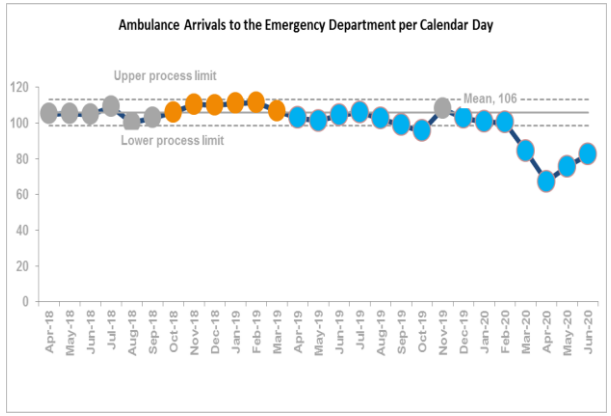
Due to COVID-19, bed occupancy for both Trust (general and acute beds) and the Acute Medical Unit (AMU) reduced during March and April to create bed capacity in response to an expected surge. General and acute bed availability has now started to slowly increase through June whilst admitting on average eighteen more non-elective patients per day. In line with the steady increase in non-elective admissions, the number of patients who have been in a hospital bed longer than 7, 14 and 21 days has also seen an increase however remains significantly below the lower control limits seeing a continued lower trend overall. Internal and external teams supporting our inpatients to return home and daily escalation calls to review patients that are medically optimised remains a focus.

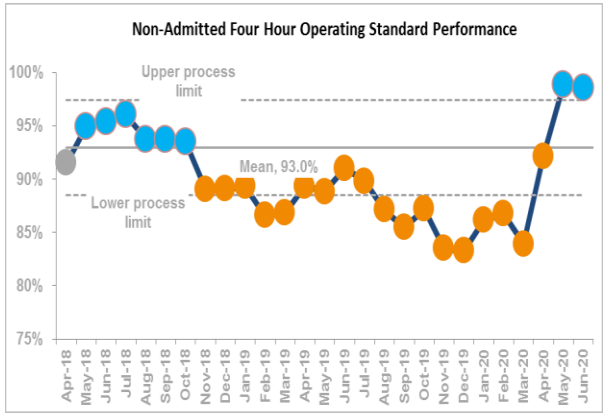
Actions and Quality Improvement Projects
Collaborative Working: Unscheduled care, safety & performance meetings have been established between ED & AMU senior teams three times a week to review breaches and identify solutions. This has been extended to Surgery and ICU and there is a flow & safety huddle to provide understanding of capacity & flow issues delivering solution the emergency care pathways throughout the Trust.
Next steps: Work with all Specialties and support services to deliver 95% and sustain improved Four Hour Standard performance.
Emergency Care Processes: Whilst the attendances have reduced the acuity is higher than normal due to COVID-19. ED has reconfigured their environment to deliver social distancing and meet Infection Prevention & Control (IPC) standards to protect patients and be able to flex capacity. AMU & NBU have changed working practices to accommodate a seated CDU to support flow from ED. Specialty pathways have been redesigned and implemented at pace to support the National Pandemic and challenge in acuity.
Urgent Care Centre (UCC) Waits and Direct Access: UCC direct pathways continue to ensure timely turnaround of non-COVID-19 patients, this has been cross Divisional joint working. All pathways are risk assessed and standard operating procedures are agreed.
Mental Health: Alternative mental health pathways have been put in place to support this patient cohort. There is a SWL Task & Finish group to focus on sustaining this improvement for the future led by South West London & St. George's Mental Health Trust.

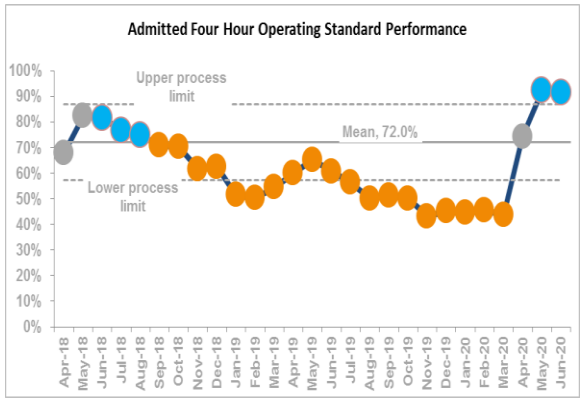
Emergency Flow

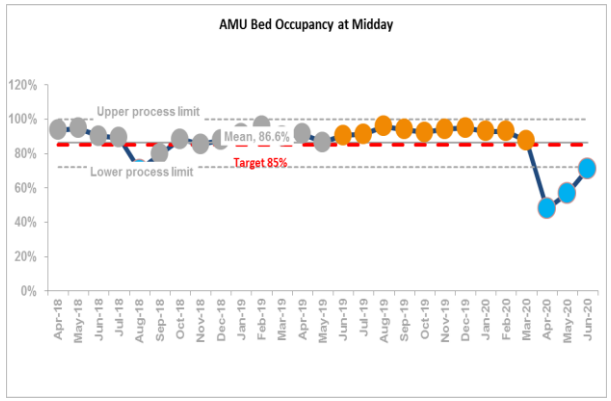
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

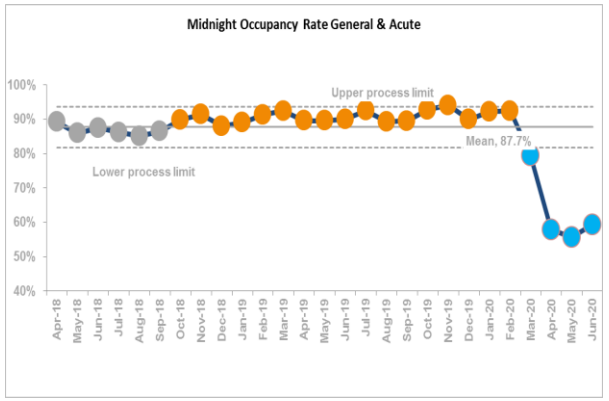


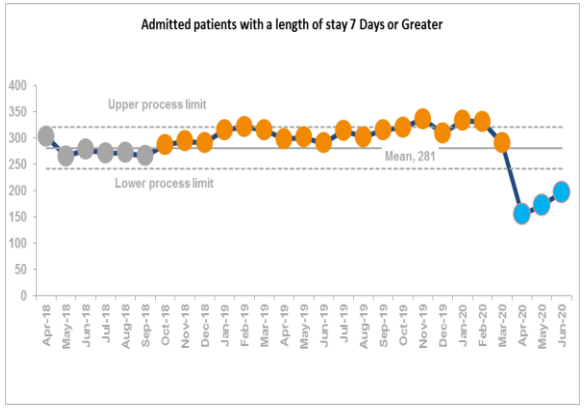


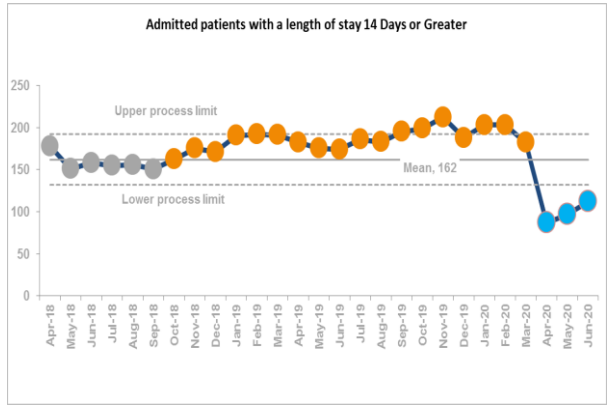


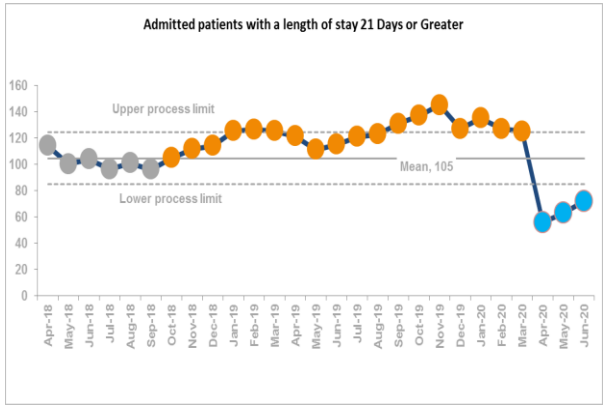






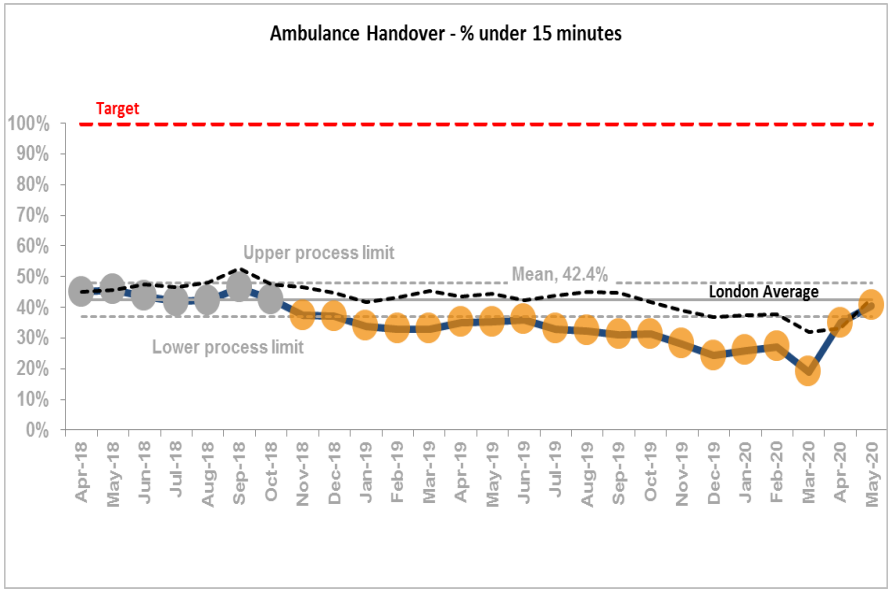


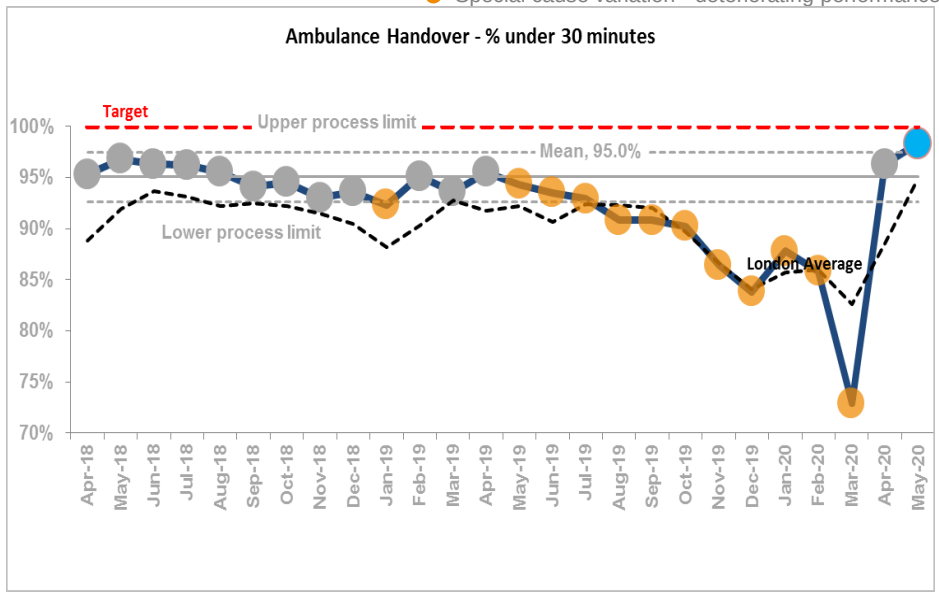


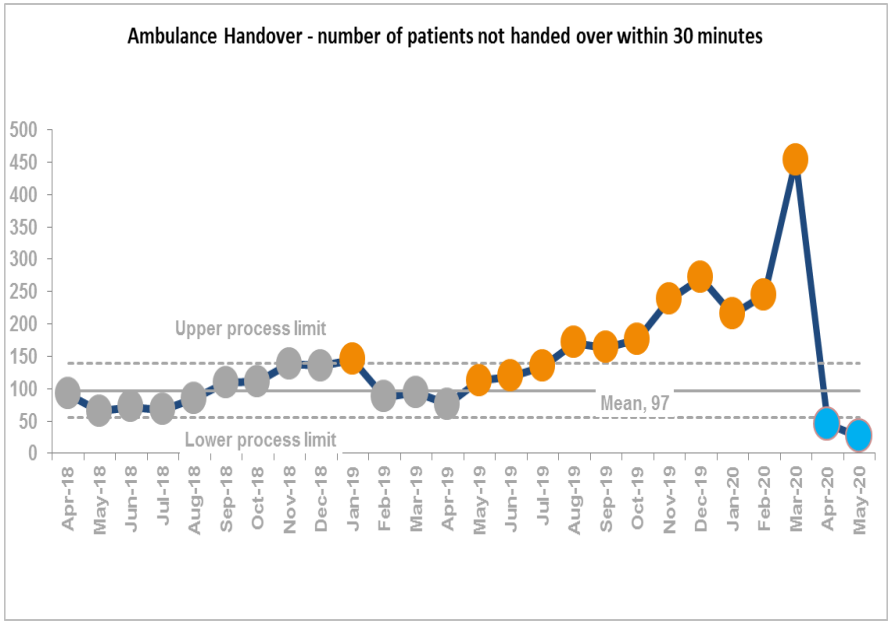


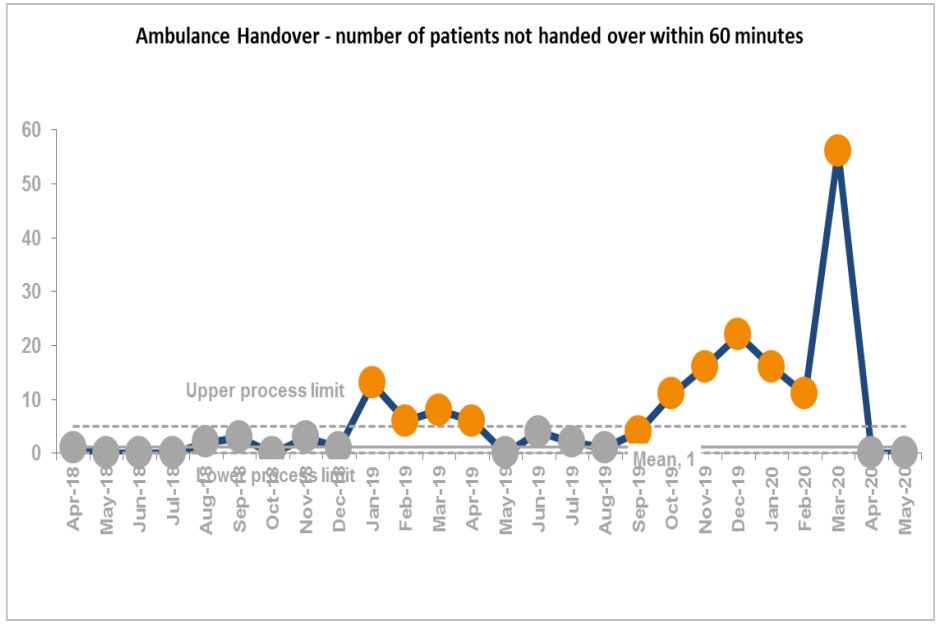
Emergency Flow

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance





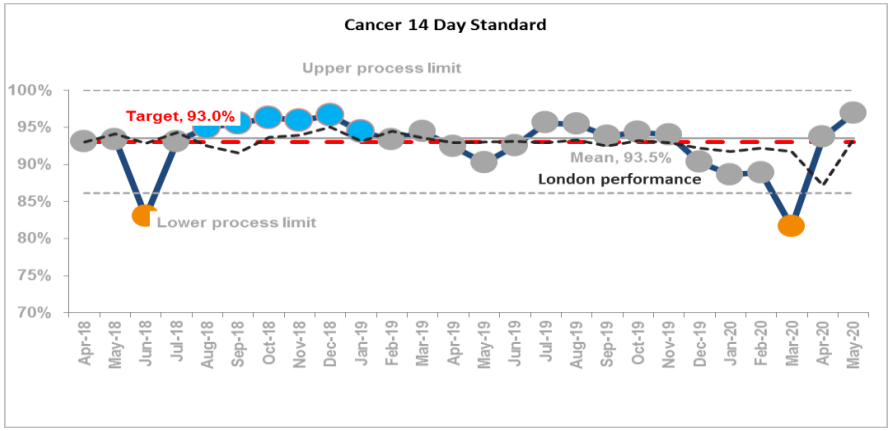


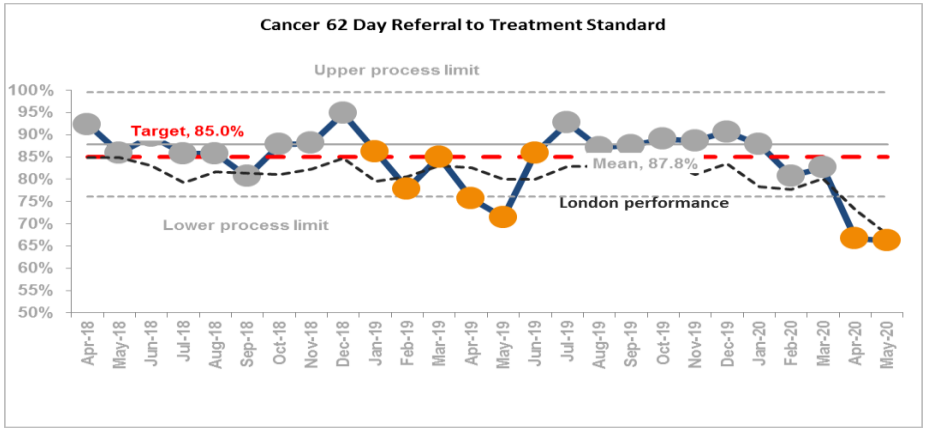


3.2

Our Process Perspective

Cancer





What the information tells us

The Trust met four of the seven cancer standards for the month of May and was non-compliant against the 31 day and 62 Day standards

Performance for the TWR 14 day standard for the month of May was at 96.9%. 814 patients seen in month which is an increase from 533 seen in April. Numbers have recovered to about 60% of the baseline

62 day performance was 66.2% and remains below the lower control limit. There were 37 treatments in May which is 55% of the normal baseline of 70 treatments. There were 15 breaches of the 62 Day standard. Five were clinically complicated, six are attributed to COVID-19 related delays and a further 4 were patient initiated due to COVID-19

Cancer 31 Day Diagnosis to Treatment performance was below the lower control limit, six tumour groups were non-compliant , all these breaches are attributed to treatment plans being agreed and then delayed by COVID-19 related constraints including theatre capacity at St George's and through the RMP hub process .

Cancer 62 Day Referral to Treatment Screening remains below target at 42.9%. There were four breaches (three related to patient initiated COVID-19 delay and the other due to patient complexity). The screening service is currently paused and there was a total of seven patients treated which is about 30% of the usual volume.

Actions and Quality Improvement Projects

All patients who require surgery within four weeks (Cat 1A/1B and 2) are being tracked on a separate Patient Tracking List (PTL) and having surgery at the Trust or St Anthony's from 8 June 2020. No patient in this priority group has waited more than 4 weeks for treatment.

15 cancer lists have been allocated to St George's at St Anthony's which will enable Priority 3 (can be treated within 10/12 weeks and nationally agreed to be on hold until recently) patients to be treated. It is anticipated that 62 day performance will fall further over the next months due to inbuilt delays due to shielding requirements and as the Priority 3 patients in the backlog are treated.

There are no cancer diagnostic delays, except for endoscopy and CT Colon services, or where the patient has delayed their own pathway.

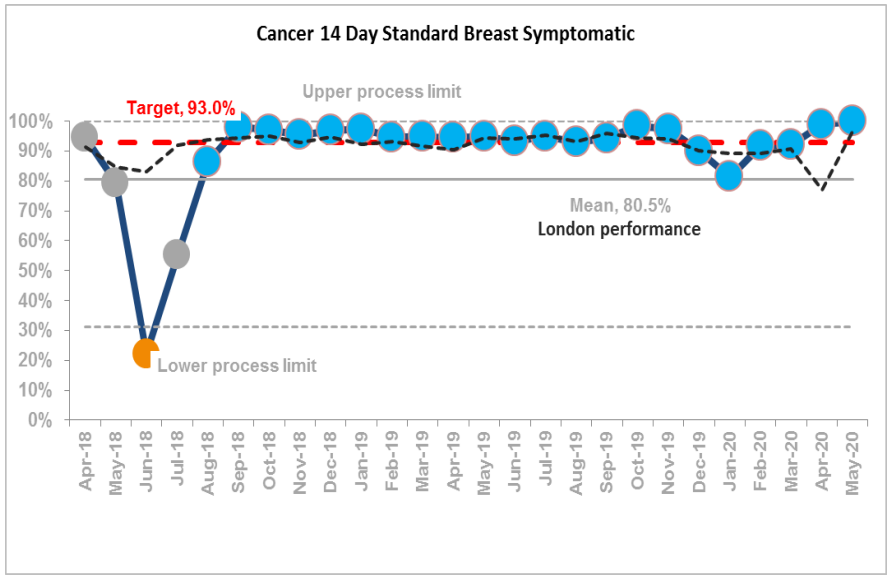
Endoscopy has restarted both in the IS sector (Parkside, St Anthony's), the Nelson QMH and at St George's from June 2020 and activity is increasing, with a weekly total of 228 slots available.

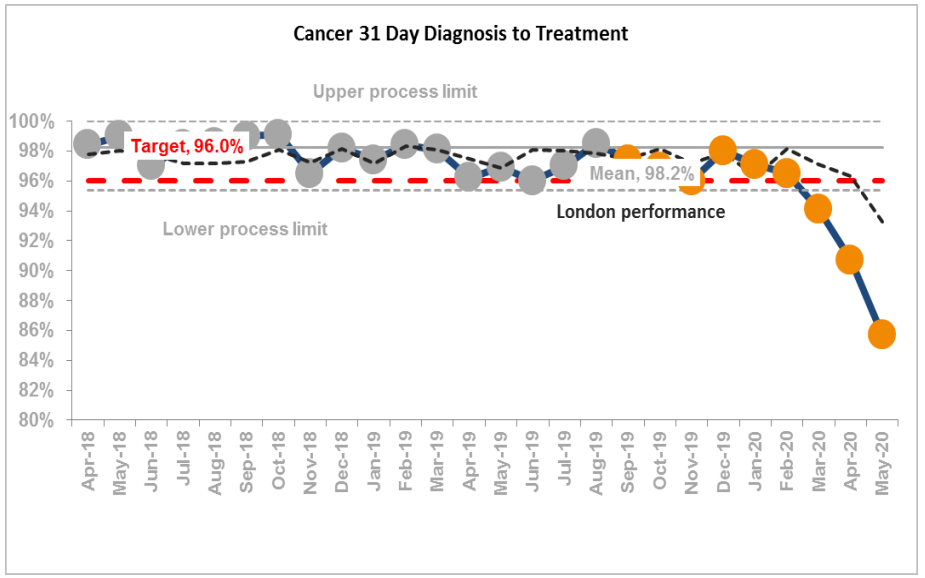
The Rapid Diagnostic Clinic will support the earlier diagnosis of cancer in patients who have a range of vague symptoms that are at risk of cancer. The target start date is August/September 2020

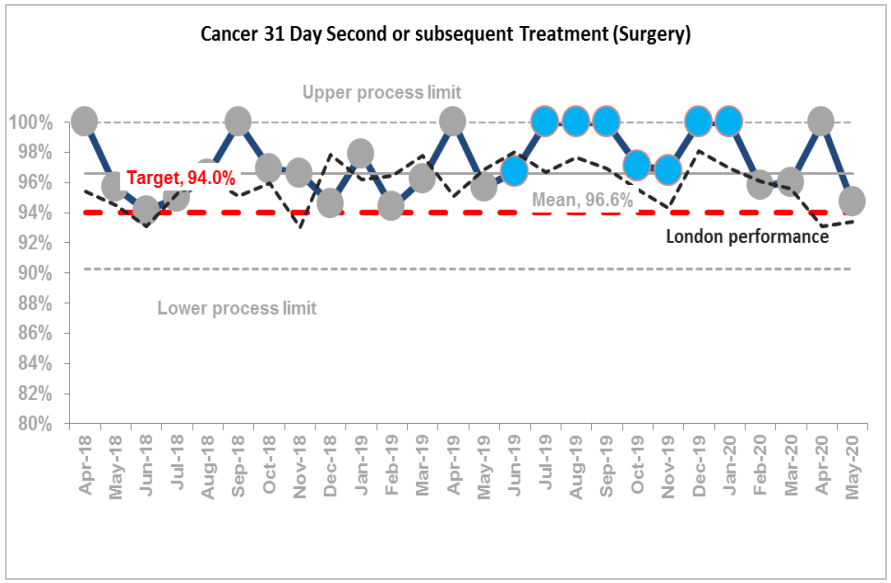
All patients who have had treatment or diagnostics plans delayed for more than 6 weeks are being clinically reviewed as part of safety netting and discussed by the MDT where appropriate.

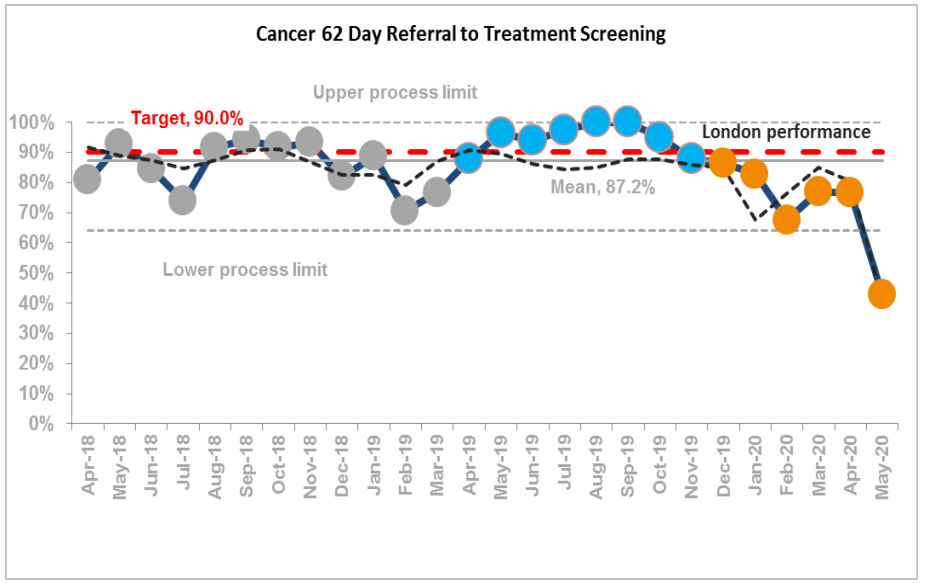
Cancer

Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance









Cancer

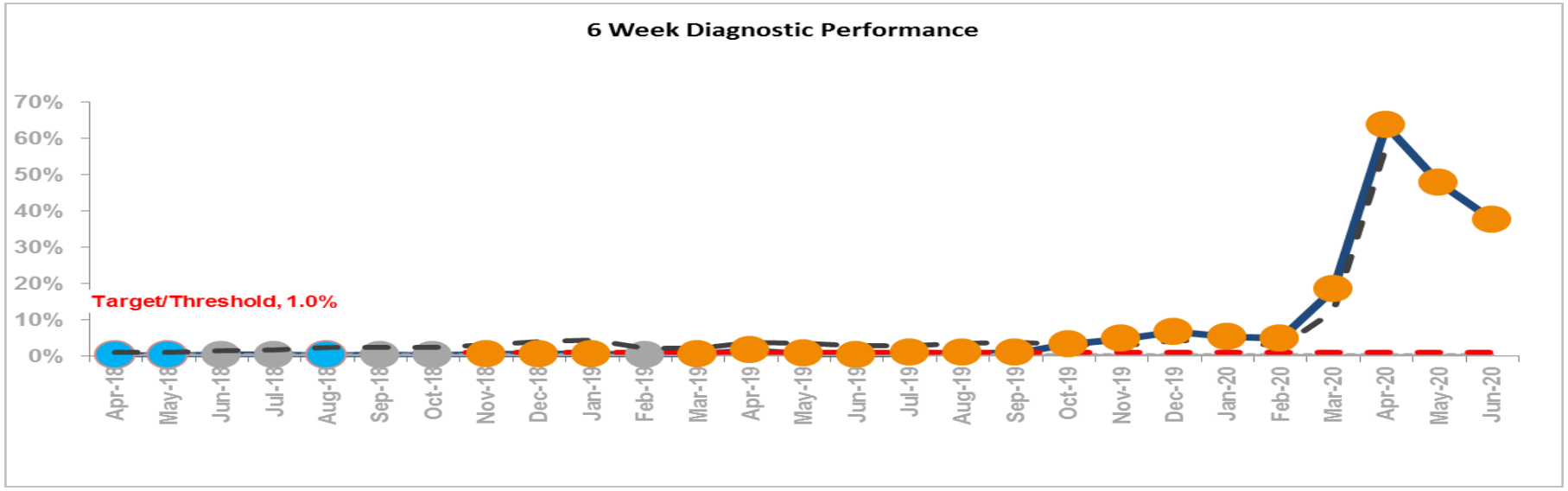
14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	No of Patients
Brain	93%	100.0%	-	100.0%	100.0%	-	-	-	100.0%	-	-	-	-	0
Breast	93%	96.9%	95.4%	94.9%	95.9%	100.0%	97.0%	95.6%	84.7%	95.6%	93.3%	97.5%	100.0%	176
Children's	93%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	85.7%	100.0%	100.0%	-	83.3%	6
Gynaecology	93%	78.0%	95.5%	97.2%	95.4%	97.6%	99.2%	99.0%	94.4%	95.9%	86.9%	93.0%	96.3%	80
Haematology	93%	96.0%	100.0%	100.0%	86.7%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	8
Head & Neck	93%	100.0%	98.9%	96.4%	96.6%	99.0%	96.6%	89.4%	95.2%	95.5%	90.8%	97.1%	100.0%	113
Lower Gastrointestinal	93%	87.9%	93.7%	93.1%	92.8%	89.7%	91.5%	80.3%	81.8%	69.9%	63.8%	86.8%	95.6%	90
Lung	93%	96.8%	95.7%	100.0%	97.1%	97.7%	100.0%	84.1%	80.6%	90.9%	85.7%	83.3%	90.9%	11
Skin	93%	94.8%	96.0%	98.0%	91.8%	95.9%	91.0%	94.8%	94.7%	93.3%	84.1%	93.2%	96.7%	214
Upper Gastrointestinal	93%	90.9%	95.1%	88.9%	87.2%	82.5%	88.1%	82.7%	75.3%	84.4%	75.5%	93.5%	98.4%	61
Urology	93%	92.1%	93.8%	93.0%	97.0%	88.4%	95.6%	92.9%	93.6%	93.6%	93.9%	94.0%	85.5%	55

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	No of Treatments
Brain	85%	-	-	-	-	-	-	-	-	-	-	-	100.0%	0.5
Breast	85%	87.5%	73.3%	88.6%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	58.8%	100.0%	100.0%	7
Children's	85%	-	-	100.0%	-	-	-	-	100.0%	100.0%	-	-	-	0
Gynaecology	85%	100.0%	100.0%	100.0%	100.0%	60.0%	100.0%	80.0%	66.7%	100.0%	100.0%	0.0%	50.0%	4
Haematology	85%	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	85.7%	66.7%	33.3%	100.0%	0.0%	0.5
Head & Neck	85%	28.6%	80.0%	80.0%	75.0%	76.5%	76.9%	68.2%	89.5%	73.7%	81.0%	50.0%	66.7%	3
Lower Gastrointestinal	85%	69.2%	83.3%	63.6%	90.0%	100.0%	87.5%	83.3%	60.0%	71.4%	75.0%	42.9%	50.0%	4
Lung	85%	100.0%	91.7%	89.5%	60.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	62.5%	0.0%	0.5
Skin	85%	95.7%	100.0%	100.0%	78.9%	100.0%	89.5%	100.0%	91.7%	100.0%	100.0%	52.9%	81.8%	5.5
Upper Gastrointestinal	85%	75.0%	100.0%	53.8%	66.7%	80.0%	50.0%	100.0%	0.0%	40.0%	-	0.0%	33.3%	3
Urology	85%	93.9%	100.0%	94.4%	100.0%	83.8%	87.8%	100.0%	85.0%	84.0%	81.5%	100.0%	64.3%	7
Other	85%	100.0%	-	-	-	100.0%	-	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	1

Diagnostics



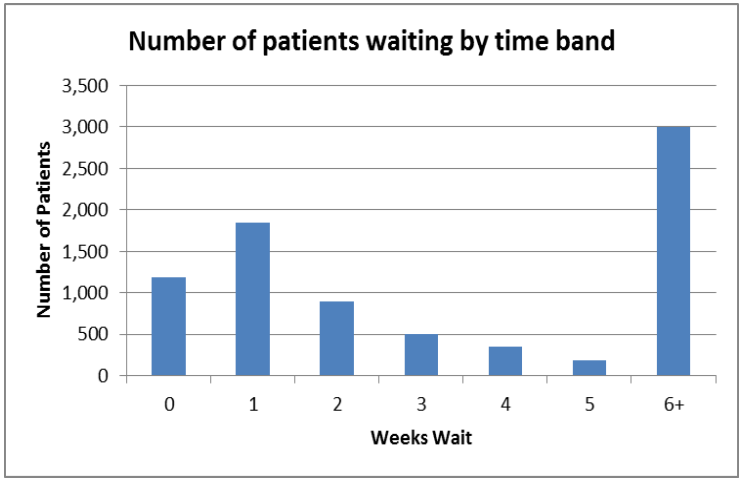
What the information tells us

In June, the Trust did not achieve the six week diagnostic standard with an adverse performance of 37.6%. The total number of patients waiting greater than six weeks was 3,000 of a total wait list of 7,969. Overall this was an improvement of 10% compared to May, where performance sat at 47.8% with a 20% increase in the total number of patients waiting.

In line with The Royal College of Radiologists national guidance, in relation to the recommended COVID-19 response, a significant number of routine diagnostics were postponed, increasing the waits across the majority of modalities.

All modalities, with the exception of Cystoscopy and Electrophysiology, have seen a performance improvement. The greatest improvement has been within Radiology Services (including MRI, Ultrasound and CT), with a significant reduction in the number of patients waiting over six weeks.

A weekly assurance review is being undertaken of any urgent referrals waiting > 6 weeks. All services are reporting that these are either patient choice, due to COVID-19, or triage and downgrading to routine by the Consultant. Of the patients waiting greater than 6 weeks, 6% of those are currently categorised as Urgent.



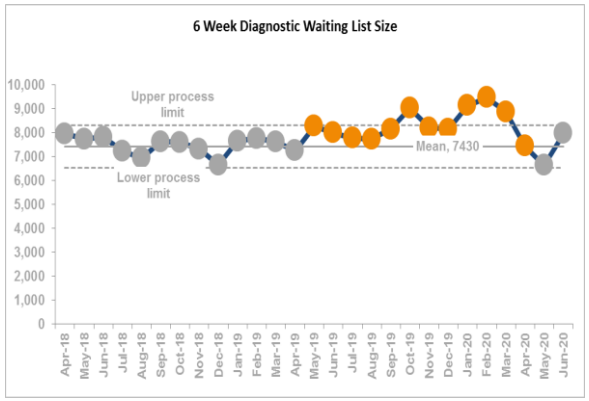
Actions and Quality Improvement Projects

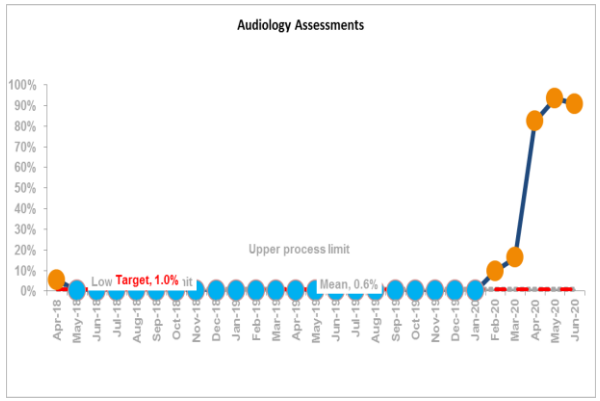
Risk assessments underway for modalities to restart routine work.

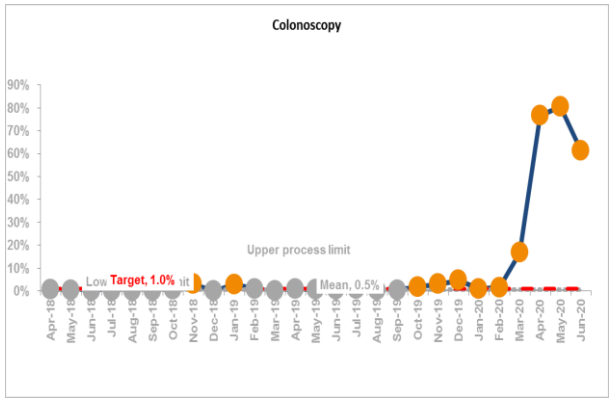
Weekly assurance review of all Urgent and Cancer diagnostic referrals

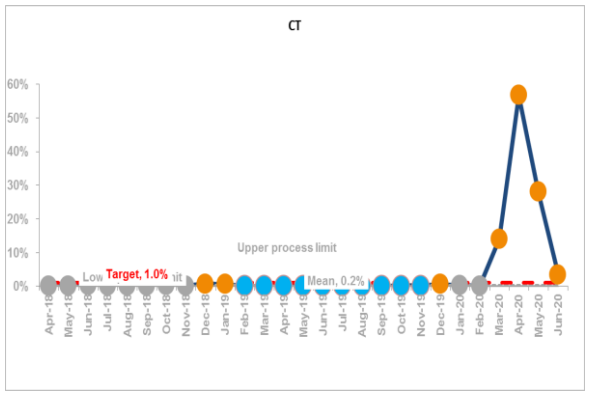
Diagnostics

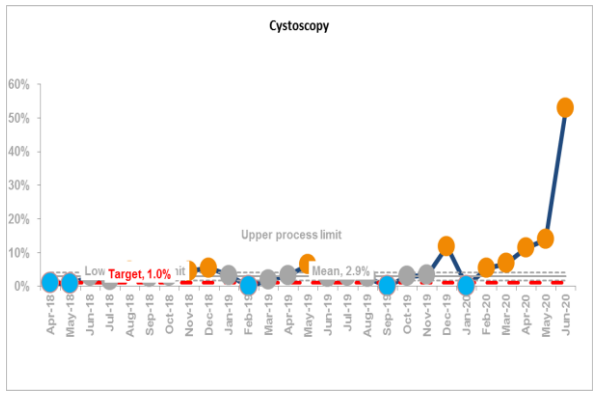
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

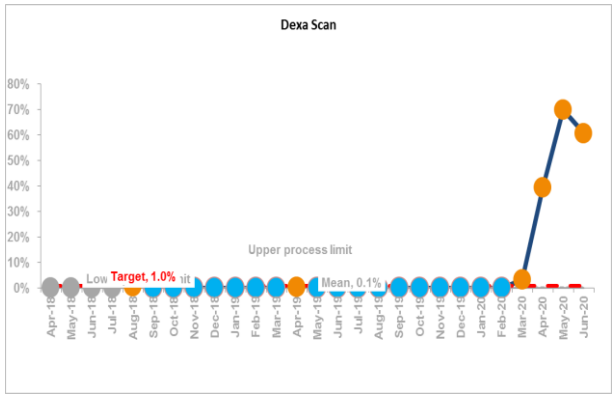


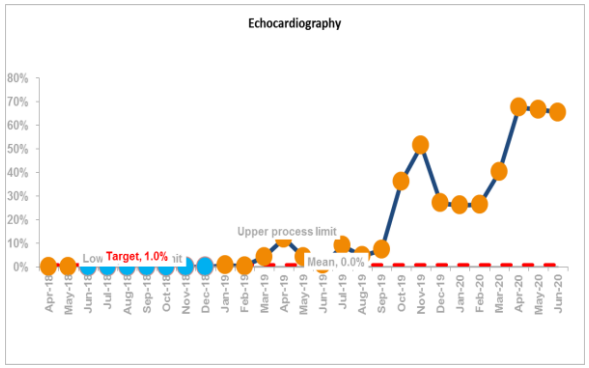


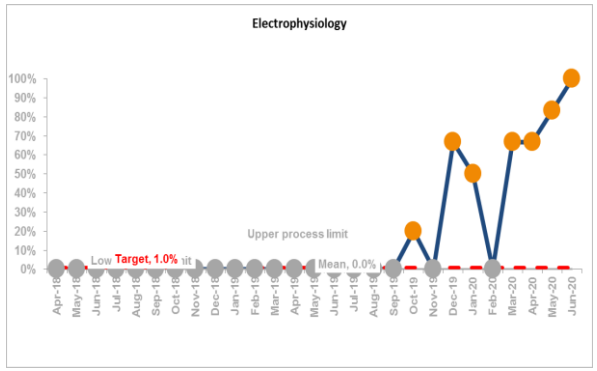


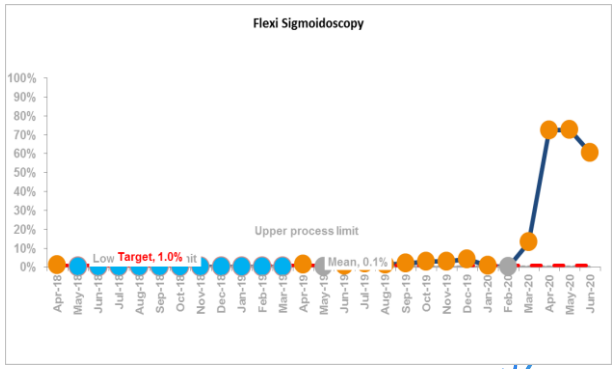






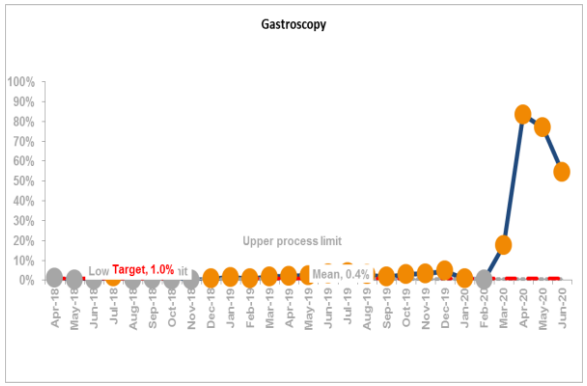


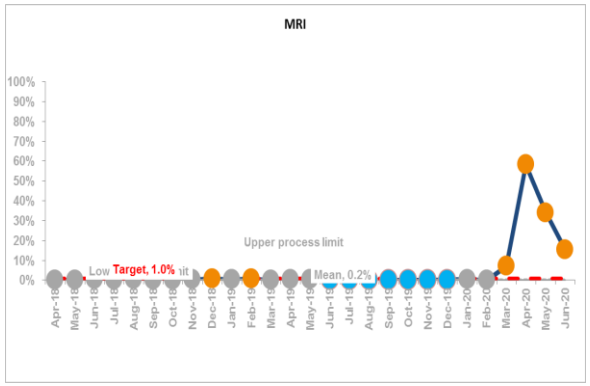


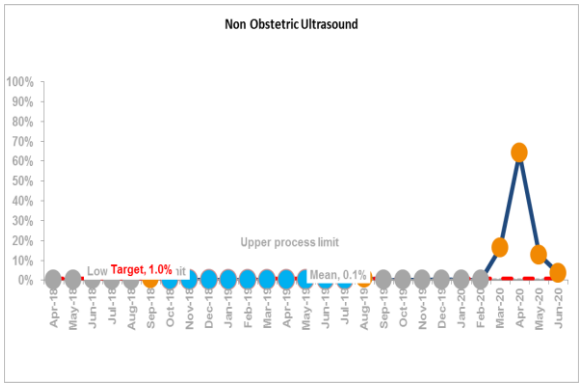


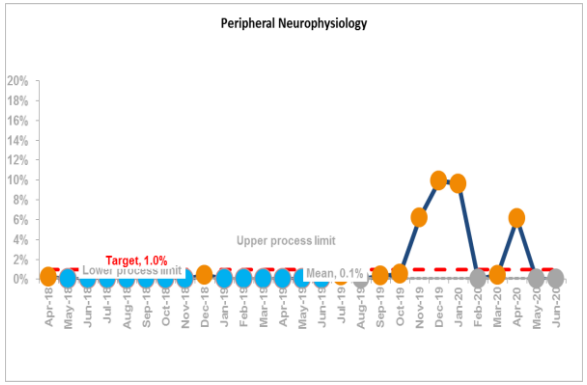
Diagnostics

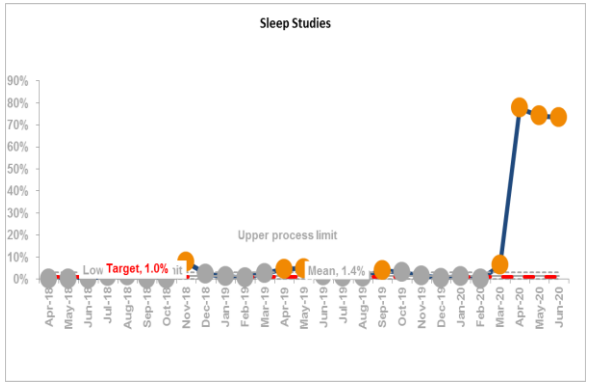
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

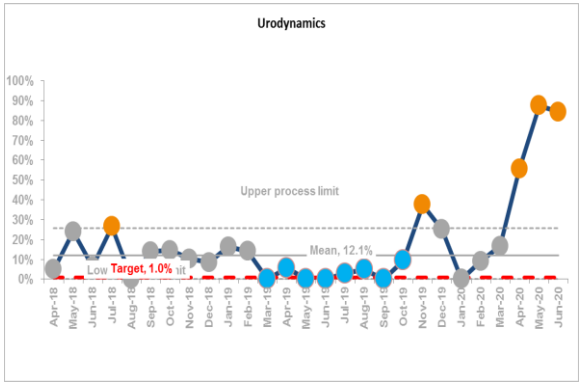








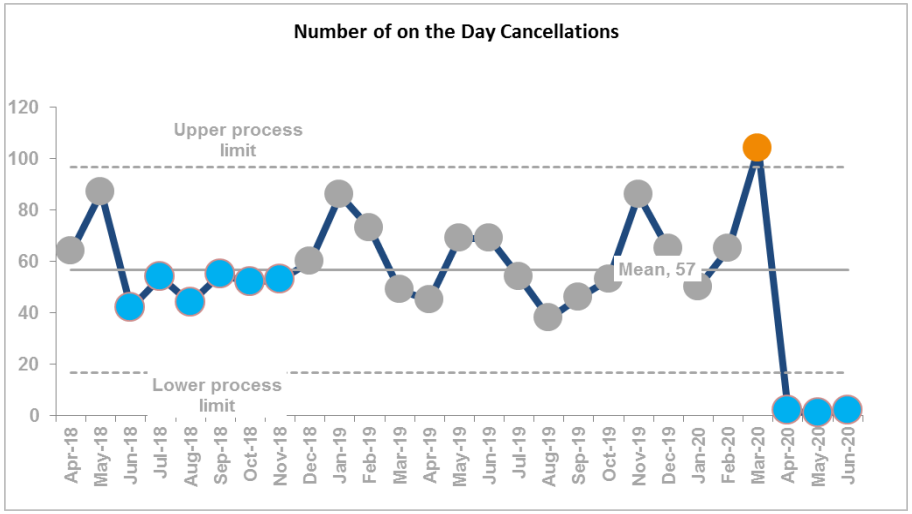


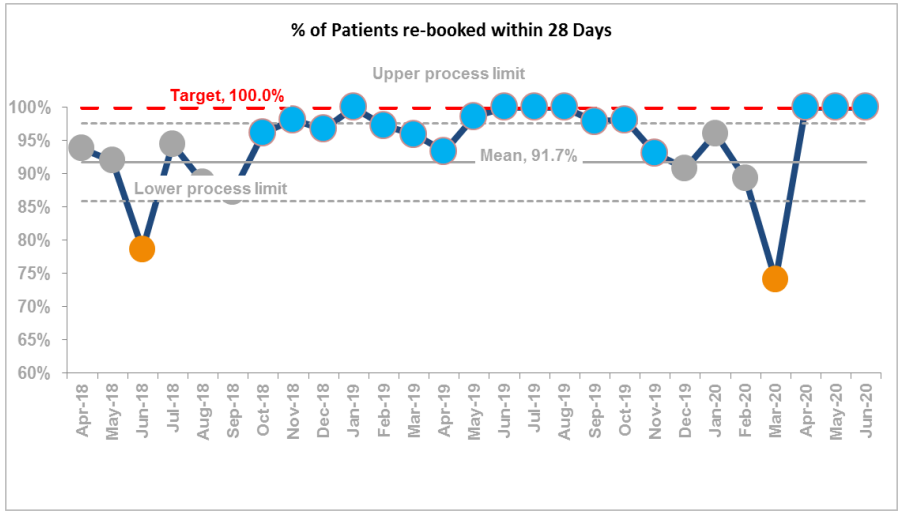


3.2

Our Process Perspective

On the Day Cancellations for Non Clinical Reasons





What the information tells us

Due to the fall in elective activity from March where all routine elective activity was cancelled, many patients continue to be informed of cancellation in advance of their procedure date.

In June, two patients were cancelled on the day due to an emergency case taking priority and an overrun of a theatre list. Both patients were re-booked within 28 days.

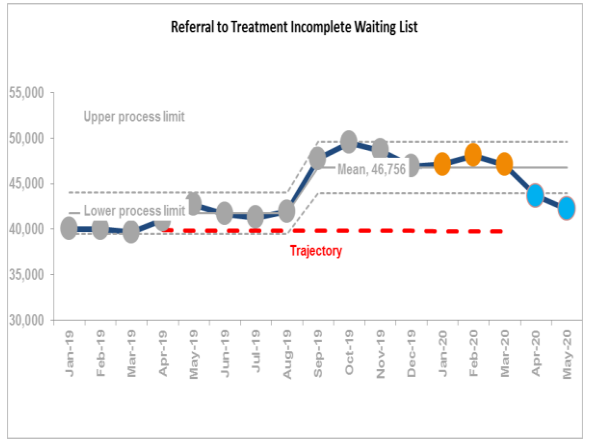
Actions and Quality Improvement Projects

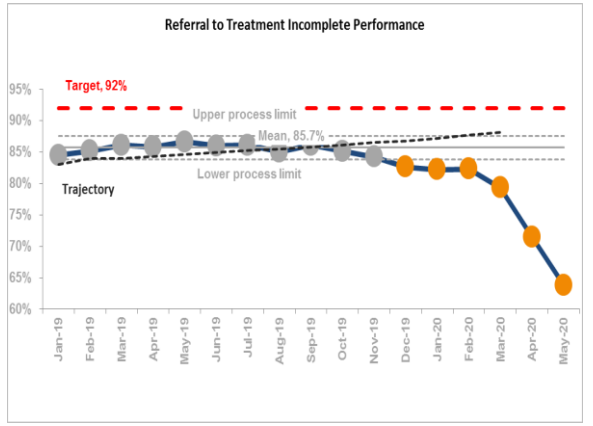
Theatre capacity is continuously reviewed to ensure that it meets the required demands and is maximising the use of staff, kit and theatres.

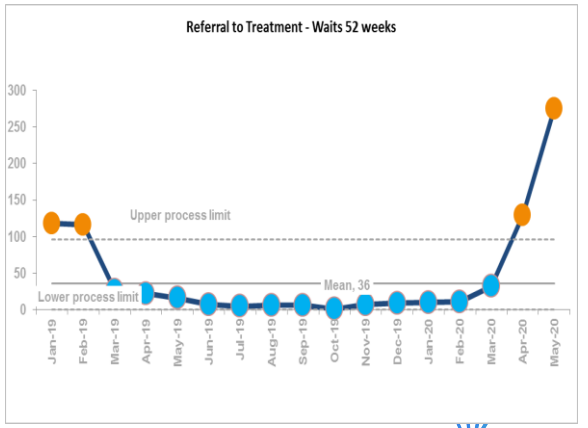
Clinical prioritisation occurs twice daily for urgent and emergency patients and weekly for urgent cancer cases.

Referral to Treatment — May 2020

Indicator Description	Target	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
RTT Trust Incomplete Performance	92%	86.6%	86.0%	86.1%	85.0%	86.1%	85.1%	84.2%	82.6%	82.2%	82.3%	79.3%	71.5%	63.8%
RTT Trust Incomplete Performance Trajectory for 19/20		84.6%	84.9%	85.3%	85.5%	85.8%	86.1%	86.5%	86.8%	87.2%	87.7%	88.1%		
RTT Total Incomplete Waiting Lize Size		42,671	41,658	41,259	41,945	47,714	49,495	48,640	46,918	47,089	48,061	47,048	43,643	42,196
RTT Total Incomplete Waiting Lize Size Trajectory		39,880	39,870	39,860	39,850	39,840	39,830	39,820	39,810	39,800	39,790	39,780		
Total waits greater than 18 weeks (inc 52Wk waiters)		5,717	5,820	5,739	6,305	6,651	7,353	7,701	8,183	8,382	8,498	9,755	12,440	15,268
Total waits greater than 18 weeks Trajectory		6,142	6,020	5,859	5,779	5,657	5,536	5,376	5,255	5,095	4,894	4,734		
Total waits greater than 52 weeks	0	16	7	5	6	6	1	7	9	10	11	32	129	274
Total waits greater than 52 weeks Trajectory		16	9	5	5	5	0	0	0	0	0	0		
RTT Incomplete Performance - Admitted		68.8%	68.7%	66.3%	63.7%	65.9%	65.3%	63.7%	61.4%	60.5%	61.9%	57.2%	49.0%	42.4%
Total waits greater than 18 weeks - Admitted		1,459	1,494	1,523	1,655	1,643	1,686	1,719	1,876	1,950	1,891	2,186	2,720	3,308
Total waits greater than 52 weeks - Admitted	0	8	4	1	2	4	0	2	5	2	3	20	88	190
RTT Incomplete Performance -Non Admitted		88.8%	88.3%	88.5%	87.6%	88.3%	87.3%	86.4%	85.0%	84.7%	84.7%	82.0%	74.6%	67.2%
Total waits greater than 18 weeks - Non Admitted		4,258	4,326	4,216	4,650	5,008	5,667	5,982	6,107	6,432	6,607	7,569	9,720	11,960
Total waits greater than 52 weeks - Non Admitted	0	8	3	4	4	2	1	5	4	8	8	12	41	84







What the information tells us

June month end performance will be submitted on 17 July 2020

In September 2019, Queen Mary Hospital's incomplete RTT performance was included resulting in an increase in total PTL size.

Performance continued to deteriorate throughout May 2020 down to 63.8% - June month end performance will be c.55.2%

The total number of reportable 52 week breaches through to the end of May 2020 was 274 - June month end will have c.560

The total incomplete RTT Patient Tracking List (PTL) size is 42,196 - a reduction of 1,447 from April 2020

Actions and Quality Improvement Projects

The Trust have now added a priority description field to the electronic To Come In (eTCI) form. All patients being listed for Surgery are given a priority description by the listing clinician as per Royal College of Surgeons (RCS) guidance. Patients with a high priority only were listed when capacity was constrained.

Patient priority descriptions for surgery will ensure the Trust's longest waiting patients are offered TCI dates. The majority of patients breaching 52 weeks are in Priority description 4 – patient can wait more than three months– from the point of clinical review, so these are now being booked for treatment.

Services with the biggest backlog of patients waiting for surgery have been clinically reviewed to identify patients suitable for transfer to other South West London (SWL) NHS Trusts / Private health care providers. This mainly relates to ENT and General Surgery.

All access and performance meetings have restarted.

The Trust expects its PTL size to increase in coming weeks and months as the number of new referrals into the Trust continues to increase. This will result in an improvement in incomplete RTT performance as

1. there will be more patients in the 0-18 weeks cohort
2. there will be fewer patients tipping into the backlog (18+ weeks); 20 July 2020 marks 18 weeks from lock down when referrals dropped

Referral to Treatment — May 2020

Specialty	Admitted		Non Admitted		Incomplete Pathway					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
General Surgery	389	32.4%	682	64.1%	563	508	1,071	61.1%	84	34
Urology	342	39.2%	1,567	78.7%	1,368	541	1,909	78.8%	34	13
Trauma & Orthopaedics	349	44.4%	1,732	70.4%	1,374	707	2,081	76.0%	35	8
Ear, Nose & Throat (ENT)	714	22.3%	2,089	75.0%	1,725	1,078	2,803	68.3%	172	52
Ophthalmology			549	66.7%	366	183	549	78.8%	2	0
Oral Surgery	5	80.0%	209	39.2%	86	128	214	50.8%	13	0
Neurosurgery	287	43.9%	2,322	56.9%	1,448	1,161	2,609	64.3%	59	7
Plastic Surgery	691	31.8%	544	73.9%	622	613	1,235	58.8%	105	53
General Medicine			20	1	14	6	20	75.0%	0	0
Gastroenterology	564	1	1,406	69.1%	1,411	559	1,970	75.4%	30	0
Cardiology	897	42.1%	2,626	64.7%	2,077	1,446	3,523	67.3%	101	19
Dermatology	4	50.0%	3,069	55.8%	1,713	1,360	3,073	68.2%	57	14
Respiratory Medicine	12	91.7%	1,533	77.7%	1,202	343	1,545	81.1%	7	1
Neurology	7	71.4%	2,115	76.4%	1,621	501	2,122	81.3%	9	0
Rheumatology	3	100.0%	1,114	58.4%	654	463	1,117	69.5%	17	1
Geriatric Medicine			52	82.7%	43	9	52	83.9%	0	0
Gynaecology	150	12.7%	2,287	71.1%	1,645	792	2,437	73.8%	51	4
Other	1,332	49.3%	12,534	66.5%	8,996	4,870	13,866	72.1%	240	68
Total	**5,746**	**42.4%**	**36,450**	**67.2%**	**26,928**	**15,268**	**42,196**	**71.5%**	**1,016**	**274**

There are a number of specialties reported under speciality ‘Other’. This follows guidance set out in the documentation, “Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care” – produced by NHS England.

Patients highlighted on the following slide have been grouped by Treatment Function Group (TFG). Where a service is listed on the following slide under the same speciality name as above – these are different patients. For example General Surgery on the following slide are Colorectal, Upper GI and Breast patients, General Surgery on this slide are purely General Surgery

The following slide outlines ‘Other’ specialties by treatment function group (TFG) and associated performance

Referral to Treatment (Other Specialties) — May 2020

Specialty	Admitted		Non Admitted		Incomplete Pathways					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
Audiology	0		2,358	57.1%	1,347	1,011	2,358	57.1%	20	2
Breast Surgery	52	51.9%	354	97.5%	372	34	406	91.6%	0	0
Cardiac Surgery	89	78.7%	31	83.9%	96	24	120	80.0%	0	0
Chest Medicine	0		1	100.0%	1	0	1	100.0%	0	0
Chiropody	1	0.0%	0		0	1	1	0.0%	0	0
Clinical Genetics	0		1,429	68.1%	973	456	1,429	68.1%	4	0
Clinical Haematology	97	100.0%	682	83.6%	667	112	779	85.6%	1	0
Clinical Infection Unit	0		55	80.0%	44	11	55	80.0%	0	0
Dental	102	24.5%	263	71.5%	213	152	365	58.4%	5	1
Dermatology	0		343	50.7%	174	169	343	50.7%	5	0
Diabetes/Endocrinology	2	0.0%	1,112	63.4%	705	409	1,114	63.3%	7	0
ENT	78	24.4%	204	74.5%	171	111	282	60.6%	15	13
Gastroenterology	0		308	61.4%	189	119	308	61.4%	8	0
General Surgery	151	32.5%	1,400	55.0%	819	732	1,551	52.8%	105	41
Gynaecology	0		145	99.3%	144	1	145	99.3%	0	0
Interventional Radiology	6	0.0%	21	28.6%	6	21	27	22.2%	2	1
Maxillofacial	240	50.8%	816	38.7%	438	618	1,056	41.5%	28	5
Oncology	1	100.0%	41	97.6%	41	1	42	97.6%	0	0
Paediatric Medicine	59	76.3%	1,202	81.0%	1,019	242	1,261	80.8%	0	0
Paediatric Surgery	207	52.7%	359	82.5%	405	161	566	71.6%	2	1
Pain Clinic	15	20.0%	480	74.0%	358	137	495	72.3%	19	0
Pathology	0		34	79.4%	27	7	34	79.4%	0	0
Plastic Surgery	28	35.7%	70	77.1%	64	34	98	65.3%	6	4
Radiology	9	11.1%	4	50.0%	3	10	13	23.1%	0	0
Renal Medicine	19	52.6%	262	85.5%	234	47	281	83.3%	0	0
Theatres	0		11	0.0%	0	11	11	0.0%	3	0
Thoracic Surgery	12	83.3%	70	84.3%	69	13	82	84.1%	0	0
Trauma & Orthopaedics	22	59.1%	21	57.1%	25	18	43	58.1%	1	0
Unassigned	0		1	100.0%	1	0	1	100.0%	0	0
Vascular Surgery	142	32.4%	457	75.5%	391	208	599	65.3%	9	0
Grand Total	**1,332**	**49.3%**	**12,534**	**66.5%**	8,996	4,870	13,866	64.9%	240	68

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions G	Maternity	Patient Voice G
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce		Agency Use		Estates Health and Safety	

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Workforce

Indicator Description	Target	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Trust Level Sickness Rate	3.2%	3.8%	3.8%	3.5%	3.4%	3.7%	3.8%	4.0%	3.9%	4.0%	5.1%	5.6%	4.1%	3.5%
Trust Vacancy Rate	10%	10.5%	11.9%	12.8%	12.8%	9.3%	9.9%	11.2%	10.8%	10.7%	10.6%	10.5%	6.8%	8.3%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.4%	17.5%	17.7%	17.7%	17.8%	17.6%	17.6%	17.4%	17.3%	16.9%	16.7%	16.1%	15.3%
Total Funded Establishment		9,251	9,365	9,432	9,534	9,280	9,294	9,403	9,383	9,369	9,369	9,373	9,098	9,289
IPR Appraisal Rate - Medical Staff	90%	84.5%	84.4%	85.7%	81.5%	83.9%	81.5%	83.6%	84.9%	81.7%	80.0%			
IPR Appraisal Rate - Non Medical Staff	90%	73.6%	73.3%	71.3%	70.4%	70.9%	72.3%	72.3%	72.0%	72.4%	69.6%	67.9%	67.6%	69.9%
Overall MAST Compliance %	85%	91.1%	91.2%	91.3%	90.6%	89.7%	89.7%	90.0%	89.7%	90.6%	90.7%	90.2%	89.7%	89.9%
Ward Staffing Unfilled Duty Hours	10%	6.1%	6.3%	5.4%	6.5%	6.1%	3.8%	5.3%	5.4%	6.2%	15.2%	17.4%	3.0%	1.6%

Note: Vacancy Rate at 6.8% in May is not a true reflection of the vacancy rate for the Trust. Reconciliation of the funded establishment figures on the ESR system and the General Ledger needs to be carried out. The funded establishment figure reported is down by circa 300 FTE in the month of May compared to April.

What the information tells us

Trust level sickness absence rate at 3.5% has reduced significantly again for the second consecutive month from a high of 5.6% at the height of COVID-19 pandemic and within common cause variation.

Appraisal rates for Non Medical staff increased to 69.9% in June against a target of 90%.

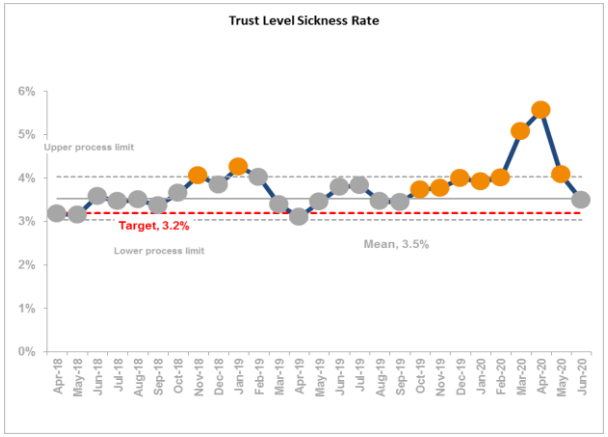
Appraisal rates for Medical staff has not been reported, due to the GMC pausing appraisal and revalidation activities until March 2021.

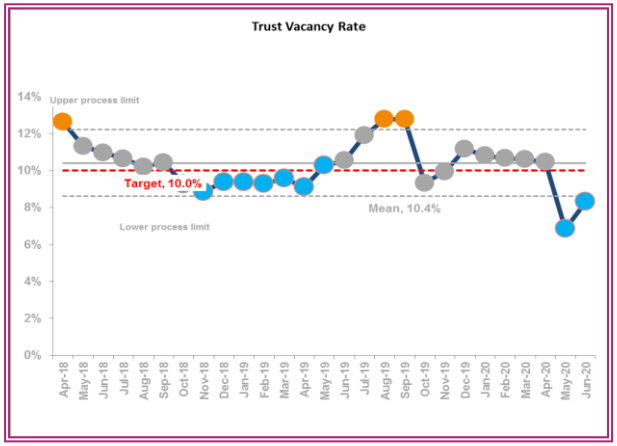
Vacancy Rate at 8.3% in June is below the set target of 10% - the Trust saw a rise in the number of new starters in the month of June. #

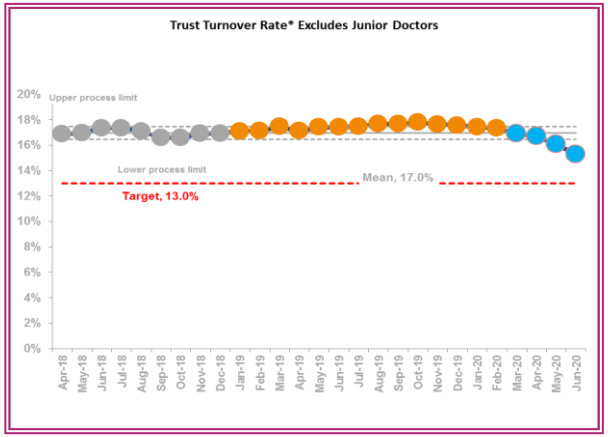
Actions and Quality Improvement Project
With a reduction in COVID-19 pandemic related activities, the Trust is now focussing on completion of Appraisals and MAST training. There are also discussions to commence medical staff appraisal completion.

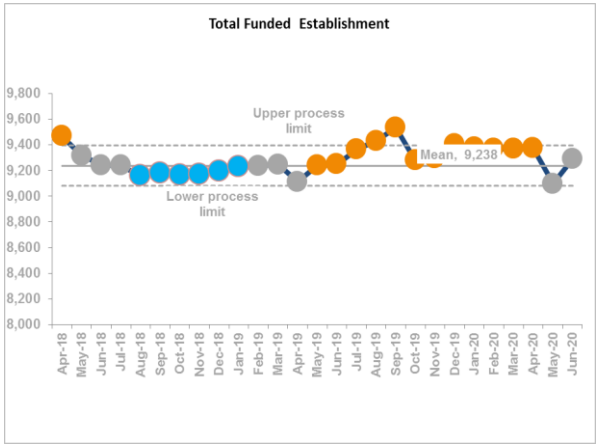
Workforce

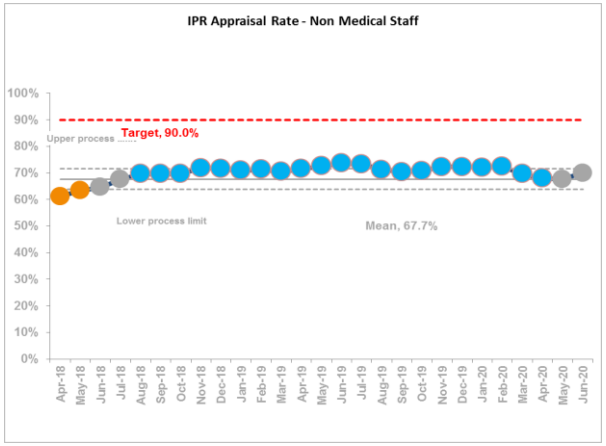
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

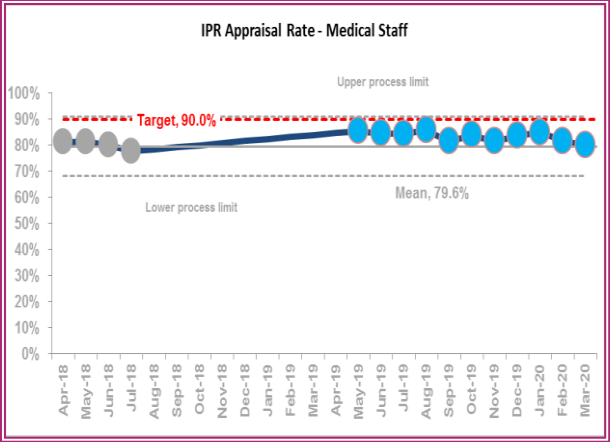








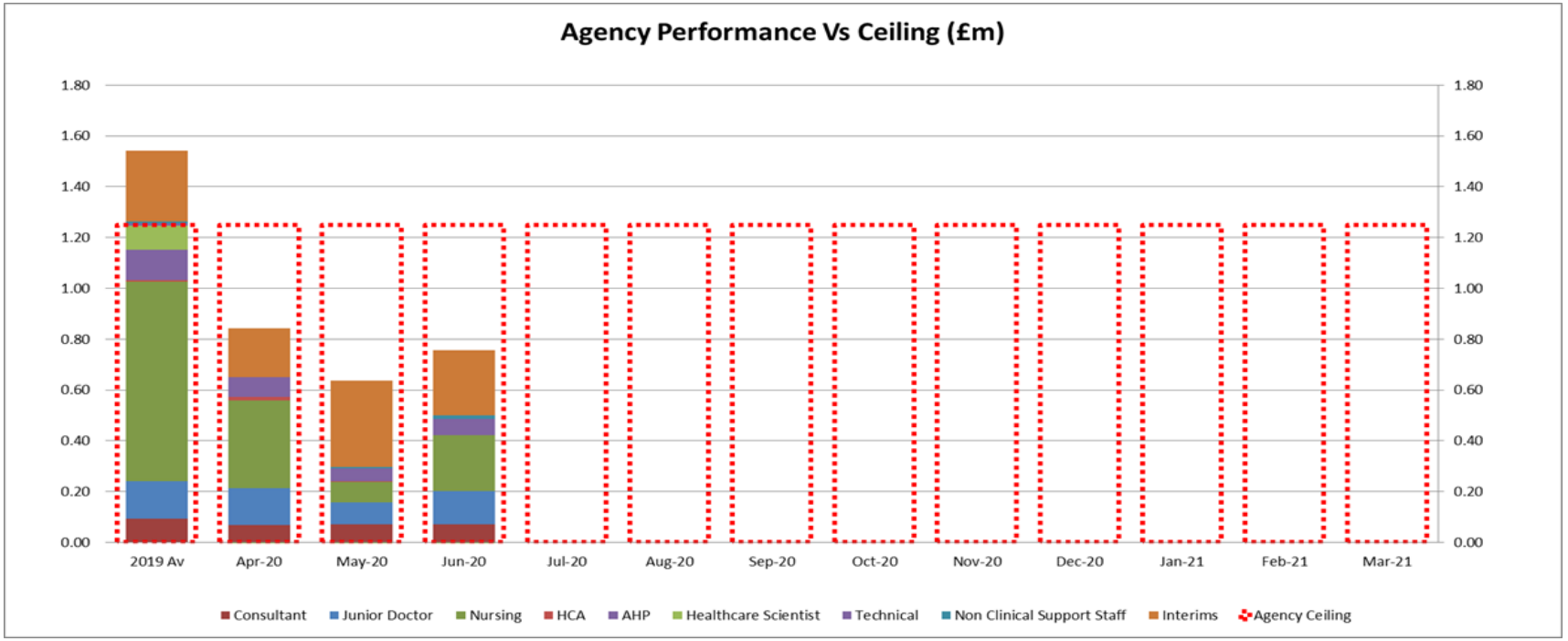




3.2

Our People Perspective

Agency use



The Trust's total pay for June was £47.94m. This is £0.31m favourable to a plan of £48.25m.

The Trust's 2020/21 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.

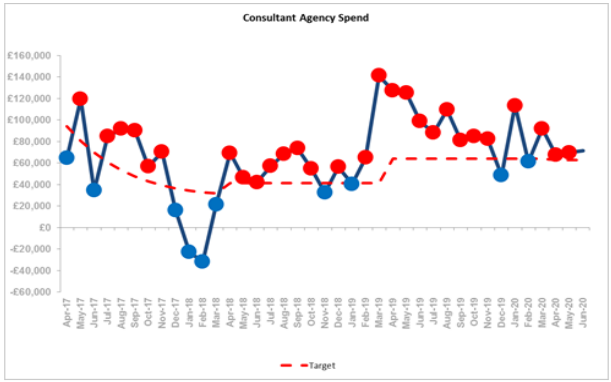
Agency cost was £0.74m or 1.6% of the total pay costs. For 2019/20, the average agency cost was 3.3% of total pay costs. For June, the monthly target set is £1.25m. The total agency cost is better than the target by £0.51m.

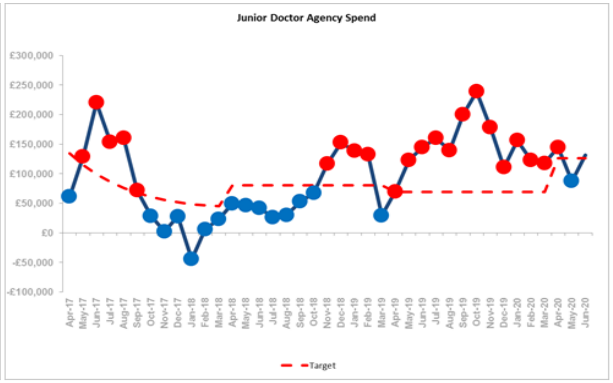
The biggest areas of overspend were Interims (£0.08m) and Consultant (£0.01m). The biggest areas of underspend were Nursing(£0.46m).

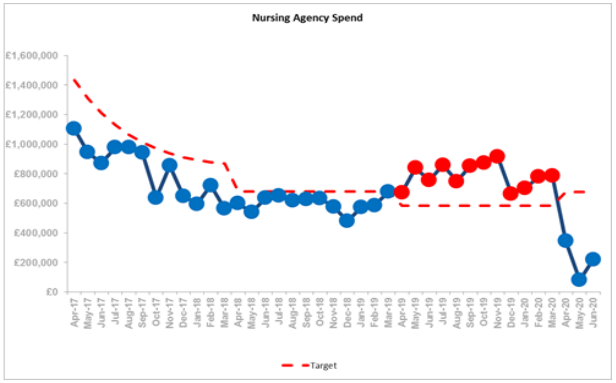
Agency spend is low across the Trust due to staff redeployment as a result of COVID-19.

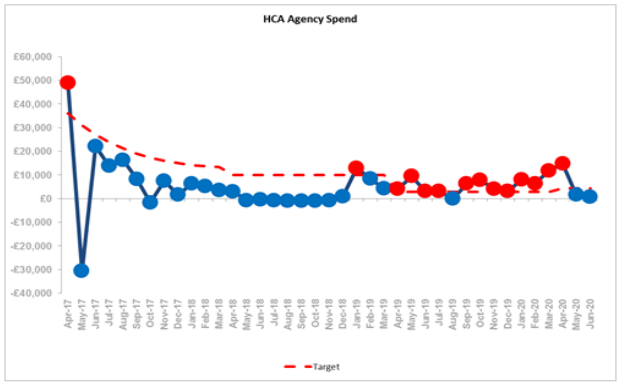
Agency use

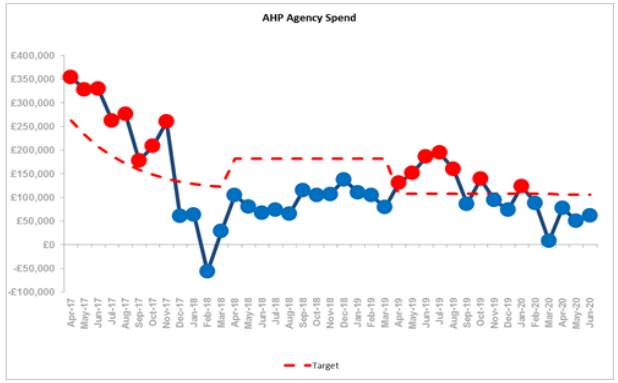
Below cap
Above cap

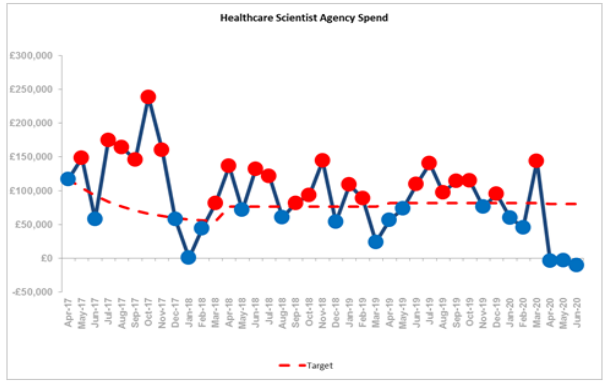


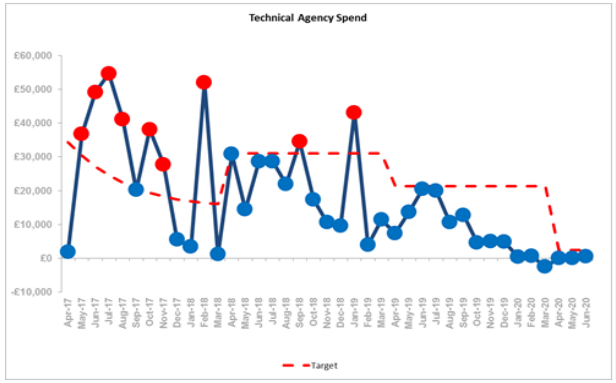


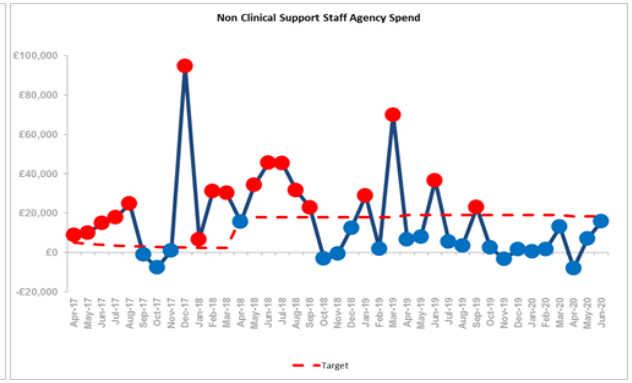


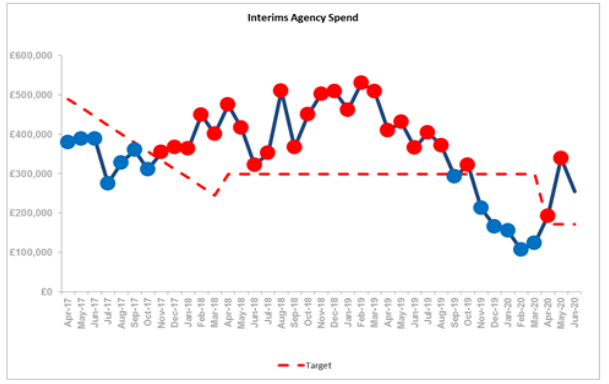






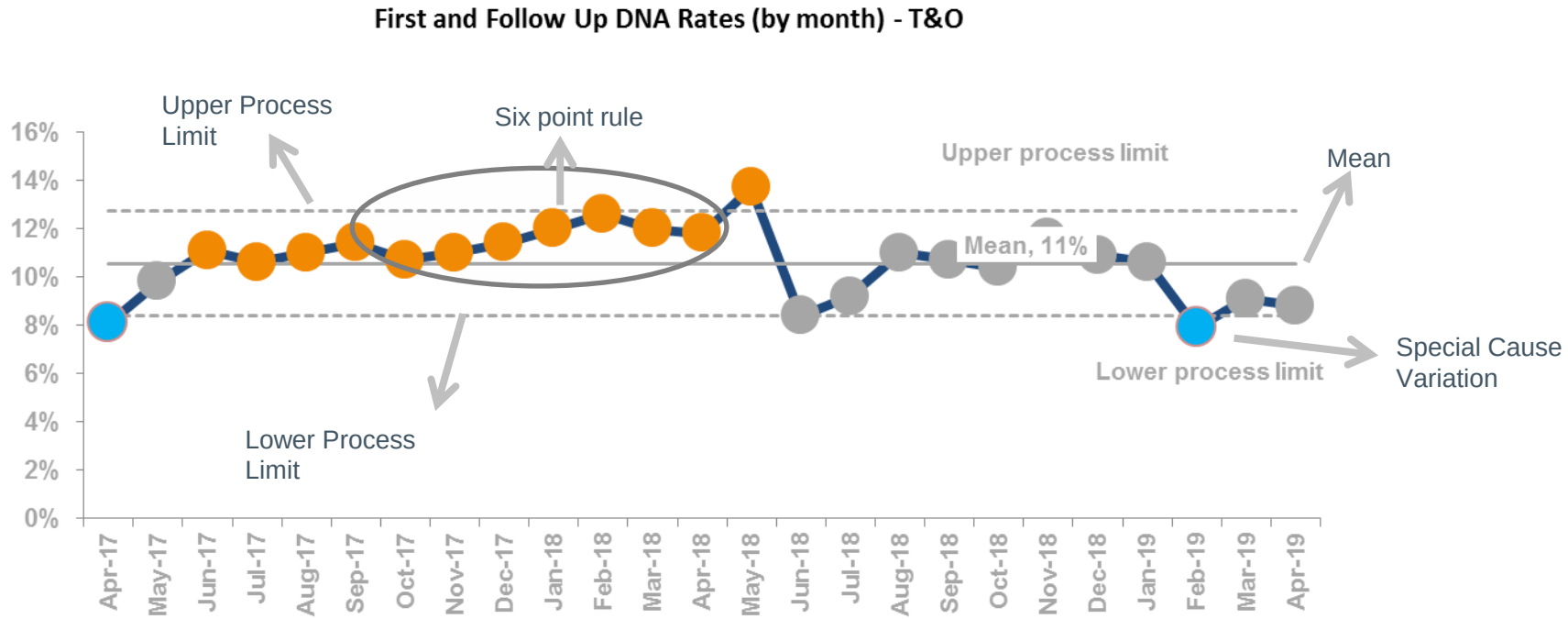






Appendix
Additional Information

Interpreting SPC (Statistical Process Control) Charts



SPC Chart – A time series graph to effectively monitor performance over time with three reference lines; Mean, Upper Process Limit and Lower Process Limit. The variance in the data determines the process limits. The charts can be used to identify unusual patterns in the data and special cause variation is the term used when a rule is triggered and advises the user how to react to different types of variation.

Special Cause Variation – A special cause variation in the chart will happen if;

- The performance falls above the upper control limit or below the lower control limit
- 6 or more consecutive points above or below the mean
- Any unusual trends within the control limits

Early Warning Score

Indicator Description	Threshold	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Compliance with appropriate response to EWS (Adults)	100%	92.9%	90.6%	93.9%	87.6%	86.8%	89.6%	89.0%	92.0%	91.1%	94.1%	86.9%	93.5%	97.0%
Number of EWS Patients (Adults)		393	448	360	380	356	534	420	400	460	289	290	403	474

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

3.3

Meeting Title:	**Trust Board**		
Date:	30 July 2020	**Agenda No**	**3.3**
Report Title:	**Cardiac Surgery Report – Quarter 1 2020/21**		
Lead Director	Richard Jennings, Chief Medical Officer		
Report Author(s):	Steve Livesey, Associate Medical Director for Cardiac Surgery Mark O'Donnell, Lead Cardiac Nurse – Governance & Mortality Kelly Davies, Head of Nursing – Cardiovascular Services		
Presented for:	Review and Assurance		
Executive Summary	Following the publication of the Independent Mortality Panel's Review and Independent Scrutiny Panel's Review on 26th March 2020 Trust Board reviewed the comprehensive sources of assurance that the cardiac surgery service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these reports had been or were being acted upon. Based on this assurance around safety and learning it was agreed at the Trust Board on 30 April 2020 that cardiac surgery reports would from now on be made quarterly to the Quality and Safety Committee (QSC) and then to Trust Board. This report is the report for Trust Board for Q1 2020/21 This paper provides the Trust Board with an update on the following: 1 The quality and safety of the service in Q1 2020/21 2 The actions that have been taken since the report to address the recommendations of the Independent Mortality Review and the Independent Scrutiny Panel 3 The communication and support being offered to the bereaved families of deceased patients 4 An update on liaison with HM Coroner 5 An update on the current previous and current arrangements at St George's for cardiac surgery in the light of the COVID-19 pandemic. 6 An update on the cardiac surgery networking discussions in South London 7 The arrangements in place for continuing internal and external assurance and oversight of the St George's cardiac surgery service.		
Recommendation:	The Trust Board is asked to note and discuss the updated information on safety assurance and other on-going actions.		
Supports			
CQC Theme:	Safe, Well Led		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Single Oversight Framework:	Quality of Care Leadership and Improvement Capability

Cardiac Surgery Report – Quarter 1 2020/21

1.0 Quality and Safety

Following the publication of the reports of the Independent Mortality Review Panel and the Independent Scrutiny Panel on 26th March 2020, the Trust Board reviewed the comprehensive sources of assurance that the cardiac surgery service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these two reports had been, or were being, acted upon. This section provides Trust Board with an update on the sources of assurance that the cardiac surgery service has remained safe through Quarter 1 (Q1) of 2020/21. This assurance is based on:

1) The patient safety outcomes in terms of mortality
2) The patient safety outcomes in terms of post-operative complications
3) The scrutiny by Quality and Safety Committee (QSC) of the investigation and learning of Serious Incidents or Adverse Incidents – one Serious Incident had already been declared in Q4 of 2019/20, but the investigation of that Serious Incident was completed in Q1 of 2020/21, and QSC reviewed the learning and resulting actions arising from that incident are reported here.

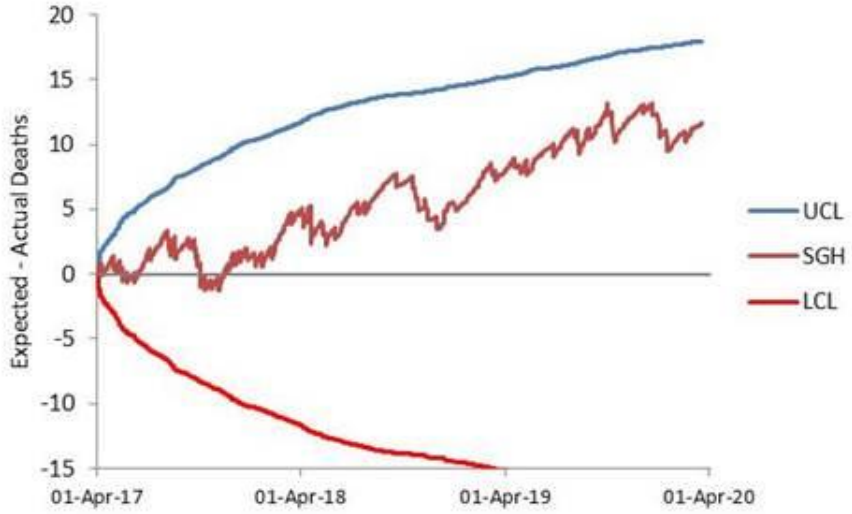
   There were no new Serious Incidents in cardiac surgery declared in Q1 of 2020/21.

1.1 Patient safety outcomes – mortality

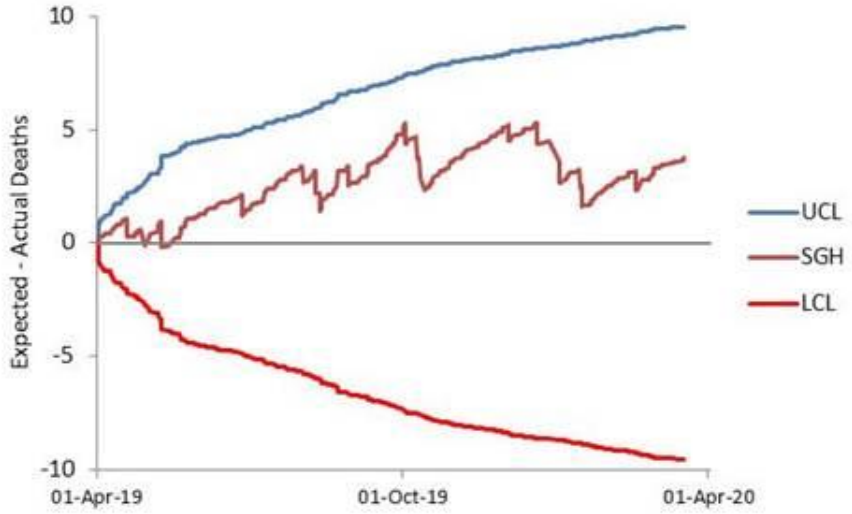
The trust monitors mortality in the cardiac surgery service, and the updated data, which is presented below, is an important part of the assurance that the service remains safe.

The two Variable Life Adjusted Display (VLAD) plots below show the expected versus actual deaths for cardiac surgery at St George's over the period April 2017 to April 2020 and April 2019 to April 2020 respectively. Both the VLAD plots shows that mortality for cardiac surgery has been consistently lower than expected since March 2018.

Graph 1: VLAD plot April 2017 – April 2020



Graph 2: VLAD plot April 2019 – April 2020



As has been previously reported to the QSC, it should be noted that the trust remains out of alert in terms of its mortality as analysed by the National Institute for Cardiovascular Outcomes Research (NICOR), and this has been the case since the publication in October 2019 of the survival rate data for the period April 2015 – March 2018 that showed that the trust Cardiac Surgery Service as 'within limits' for this period.

The restriction on elective cardiac surgery at St George's to operations with a EuroSCORE II predicted risk of death of 5% or less, in place since 3rd December 2018, is still in place.

1.2 Post-operative complications in Q1 2020/21

The trust routinely tracks patient safety outcomes in terms of the significant commonly recognized complications of cardiac surgery, namely return to theatre, stroke, new haemofiltration and wound infection. In addition, the trust tracks the rate of healthcare acquired infections (HCAIs), which now includes COVID-19 infection.

The updated data is another important source of assurance that the cardiac surgery service remains safe.

St George's performed the last cardiac surgery operation, before London's arrangements for COVID-19 changed, on 17th March 2020. As part of London's response to the COVID-19 emergency, a Standard Operating Procedure (SOP) was agreed by the Pan-London Emergency Cardiac Surgery (PLECS) group, whereby all emergency and urgent cardiac surgery was performed at either Barts Health NHS Trust or Royal Brompton and Harefield NHS Foundation Trust.

The trust restarted emergency and urgent cardiac surgery on the St George's site on 2nd June 2020 – there were therefore only 16 instances of cardiac surgery performed in St George's in Quarter 1 2020/21. In these 16 cases in June 2020 there were no instances of patient death, return to theatre, stroke, new haemofiltration or wound infection. With regard to COVID-19 infection prevention and control measures, in accordance with the measures agreed at the PLECS group, these 16 patients were all shielded for fourteen days prior to their surgery, had tested swab negative for COVID-19 infection two days before surgery and were all telephoned at one week and at four weeks post-surgery to ask if they remained free of COVID symptoms. None of the 16 patients reported any symptoms of COVID-19 post-operatively.

1.3 Serious Incidents (SIs) and Adverse Incidents (AIs) that occurred, were declared or closed in Q1 2020/21

1.3.1 Serious Incidents (SIs)

A Serious Incident occurred in Quarter 4 of 2019/20 and was considered at the trust's SIDM on 16th March 2020 and was declared as an SI. The Serious Incident Root Cause Analysis (RCA) investigation for this incident was completed and discussed at SIDM in Quarter 1 2020/21.

The action plan formulated in response to this SI was reviewed at QSC on 23rd July 2020.

1.3.2 Adverse Incidents (AI)

There was one cardiac surgery post-operative death in Quarter 1 – the patient died 44 days after they underwent cardiac surgery, which was undertaken in Quarter 4 2019/20.

This death was considered at a Serious Incident Declaration Meeting (SIDM) in May 2020. It was agreed at this meeting that this incident did not meet the criteria to be declared a Serious Incident (SI). Instead, SIDM directed for an Adverse Incident (AI) investigation to be undertaken. This investigation is being completed and the AI report will be considered by SIDM within the next three weeks, and any learning and resulting actions will be considered at the next QSC.

2.0 Update on trust actions to address the recommendations of the NHSI commissioned Independent Mortality Review (Chaired by Mr Mike Lewis) and Independent Scrutiny Panel (Chaired by Sir Andrew Cash)

Following the publication of the two external reports on 26th March 2020, the Trust has continued to work towards meeting all the recommendations from the trust from both reports. The large majority of these recommendations have been met already, and the Quality and Safety Committee and the Trust Board received written assurance of this on 26th March 2020 and 23rd April respectively.

There are three specific actions for the trust that remain on-going.

In relation to the Independent Mortality Review's report recommendation 2 that "[e]*ach of the cardiac surgeons, the lead for cardiology, the lead for anaesthesia/ICU and the lead for perfusion should have an individualised feedback meeting with clinical representatives from the Independent Advisory and Mortality Review Panels…"* Dates for these meetings are now being provisionally arranged for August and September 2020.

In relation to the Independent Mortality Review's report recommendation 3 that "[*a] change of working relationships within and between cardiac surgery, cardiology and anaesthesia/intensive care teams should be fostered*", further work was delayed due to the publication of the reports coinciding with the initial response to Covid-19. This work will resume following the lifting of the COVID-19 restrictions. The Trust fully accepted the recommendation to have formal mentorships for new/locum consultants; this will be a part of any future recruitment processes. The trust previously engaged an external HR consultant to work with the cardiac surgery team in response to this recommendation, and it has been agreed that this external consultant will return to complete their work in Quarter 3 2020/21.

In relation to the Independent Scrutiny Panel's report recommendation 10 that "*[t]he Trust should continue to ensure robust consultant appraisal and job planning is in place for every consultant working in the Cardiac Surgical Unit*." This is being actioned.

3.0 The communication and support being offered to the bereaved families of deceased patients.

3.1 Meeting with bereaved families

After the trust wrote to all bereaved families to communicate the findings of the Independent Mortality Review Panel with regard to the care given to their deceased relatives (just before the publication of the report), a total of 42 families asked for meetings with the trust to discuss this further. Fourteen meetings have taken place so far. Of the remaining families, some expressed a preference for meeting in person rather than a virtual meeting. Meetings in person have not been possible so far due to COVID-19 restrictions, so we may need to re-offer these families a virtual option again, or identify a venue other than the hospital for face to face meetings.

Of the 14 meetings which have so far taken place (pre & post publication) the majority of families have told us that they find these meetings helpful.

4.0 Risk register

The table below shows the changes made to the main risks for cardiac surgery at St George's since the last report to Trust Board.

A risk rating of 1-3 is described as 'no risk', a risk rating of 4-7 is described as 'low risk', a risk rating of 8-9 is described as 'moderate', a risk rating of 10-14 is described as 'high' and a risk rating of 15 or more is described as 'extreme'.

Ref	Opened	Title	Risk level (current)	Rating (current)	Reasoning for change
CVT-1660	12/09/2018	Risk to patient safety within cardiac surgery	Moderate	8	This risk was reduced from 'high' to 'moderate' in June 2020. This change was made because of the collective assurance provided by the outcome data, including mortality, regarding safety within the Cardiac Surgery Service.
CVT-1642	29/08/2018	Reputational Impact of service challenges within Cardiac Surgery unit at St Georges	High	12	This has been reduced from 'extreme' to 'high' in June 2020. The risk was reviewed by the divisional triumvirate and the risk downgraded to high. This was because the Independent Mortality Review was published in the public domain in March 2020, and the attendant media attention has now occurred. Reputational risk remains, and part of this risk is that new or reopened Coroner's Inquests may have a reputational impact.
CVT-1661	12/09/2018	Strategic risk of loss of cardiac surgery service	Moderate	8	This risk was previously closed by the Directorate in April 2020 following the publication of the Independent Mortality Review's report in March 2020, as the

					Report did not recommend any discontinuation of the service. However, there is a clear pan-London plan for cardiac surgery, and networking discussions continue in South-London, and so this risk is now rated as 'moderate'.
CVT-1608	23/07/2018	Loss of income within the Cardiac Surgery service	Low	4	This risk has been reduced from 'moderate' to 'low' in June 2020. Following review from the divisional triumvirate the risk was reduced to 'low' as cardiac surgery income has been appropriately factored into the trust's projected financial performance for 2020/21.

5.0 Update on Coroner's inquests

The trust has liaised closely with HM Coroner throughout the time that the Independent Morality Review Panel has been carrying out their work. The Coroner has indicated to the trust and to NHSI (and we have accordingly shared this with bereaved families) that she may have to open or reopen a number of investigations and inquests. The trust continues to liaise with the Coroner.

The trust has advised all the bereaved families, in the letter that was sent to them just before the publication of the report, that it is possible that the Coroner may open or reopen and inquest into the death. The Coroner has advised the trust that her office will be in touch with families directly if this is the case.

6.0 Developing changes in the trust's cardiac surgery service in response to COVID-19

As noted above in section 1.2, St George's performed the last cardiac surgery operation, before London's arrangements for COVID-19 changed, on 17th March 2020. As part of London's response to the COVID-19 emergency, a Standard Operating Procedure (SOP) was agreed by the Pan-London Emergency Cardiac Surgery (PLECS) group, whereby all emergency and urgent cardiac surgery was performed at either Barts Health NHS Trust or Royal Brompton and Harefield NHS Foundation Trust.

The trust restarted emergency and urgent cardiac surgery on the St George's site on 2nd June 2020 – there were therefore only 16 instances of cardiac surgery performed in St George's in Quarter 1 2020/21.

As noted above in section 1.2, these patients were all shielded for fourteen days prior to their surgery, and had tested swab negative for COVID-19 infection two days prior to surgery.

Since 8th July the trust has been accepting other patients for cardiac surgery; these patients are also tested to ensure they are negative for COVID-19 ahead of surgery.

7.0 Developments towards networking cardiac surgery in South London

Throughout period of the COVID-19 emergency, the three lead surgeons from Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust and St George's have continued to meet regularly via a virtual platform and are committed to the principle of closer working for cardiac surgery across South London.

The three trusts have agreed a shared schedule of MDTs to which referring cardiologists can join via a virtual platform to refer patients. There are on-going discussions on how the three trusts can further unify governance processes for cardiac surgery in South London.

In recent months the three trusts have naturally been focussed on their individual responses to the COVID-19 emergency, but are now progressing to forward-looking discussions about cross-site working to further the overall goal of networking cardiac surgery in South London.

8.0 On-going external oversight of cardiac surgery at St George's

The NHSE/I London SGUH Programme Board meetings were originally designed in part to oversee the St George's response to the Independent Mortality Review; this oversight continues, but the focus of these meetings is now on issues around closer networking arrangements for cardiac surgery in South London.

The NHSE/I London Single Item Quality Surveillance meetings maintain regional oversight of the assurances that the service continues to provide safe, high quality care.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

3.4

Meeting Title:	**Trust Board**		
Date:	**30 July 2020**	**Agenda No**	**3.4**
Report Title:	**Complaints Annual Report 2019/20**		
Lead Director/ Manager:	**Robert Bleasdale, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	**Terence Joe, Head of Patient Experience and Partnership** **Alison Benincasa, Director of Quality Governance and Compliance**		
Presented for:	Assurance		
Executive Summary:	The Complaints Annual Report is a statutory requirement (Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) and covers the financial year 2019/20 and is attached as Appendix 1. The key findings were: • 956 complaints were received, which is a decrease of 13.7% (145) when compared to 2018/19 (1101). • 71% of complaints were acknowledged within three days in comparison to 2018/19 (82%). • The top three complaints subjects related to Clinical Treatment, Communication and Care, which was the same in 2018/19. • Overall complaints performance was 92% against the 85% performance target. A significant improvement from 62% in 2018/19. This is broken down further by working day response as follows: ➢ 25 working day: 93% against 85% target ➢ 40 working day: 84% against 90% target ➢ 60 working day: 100% against 100% target • 112 complaints were reopened compared to 2018/19 (108), an increase of 3.6%. • There were 7 requests for documentation from the Parliamentary Health Service Ombudsman's office (PHSO), the same as in 2018/19. Two final reports have been received and the two cases were partially upheld. One case is under investigation and the Trust is waiting to hear if the remaining four cases will be investigated • 498 compliments were received and logged, a decrease of 37.6% when compared with 2018/19 (798). • There were 4447 enquiries raised with the patient advisory and liaison service (PALS): a contact refers to any enquiry or request. This represents a decrease of 34% when compared to 2018/19 (6779). Of these contacts 2838 related to concerns (when a patient or relative raises a concern about the Trust and does not want to follow the formal		

	complaints procedure) which represents a decrease of 26% when compared to 2018/19 (3858). The top three themes for contacts related to appointments, care and communication.		
Recommendation:	The Board is asked to receive and note the report.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person		
CQC Theme:	Responsive		
Single Oversight Framework Theme:	1. Quality of care (safe, effective, caring, responsive) 2. Leadership and Improvement capability (well-led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16: Receiving and acting on complaints		
Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	Patient, Safety and Quality Group Quality and Safety Committee	**Date**	20/05/2020 23/07/2020
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1 Complaints Annual Report 2019 / 20		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Complaints Annual Report
1 April 2019 – 31 March 2020

Contents

Complaints Annual Report 1

Contents 2

1.0 Executive Summary 3

2.0 Purpose of the Report 4

3.0 Introduction 4

4.0 Accountability for complaints management within the Trust 6

5.0 Total complaints received in 2019/20 6

6.0 Complaint themes 9

7.1 Complaint Themes: Communication 11

7.2 Complaint Themes: Clinical Treatment 13

7.3 Complaint Themes: Care 13

7.4 Complaint Themes: Waiting Times 14

7.5 Complaint Themes: Attitude 14

8.0 Primary complaint subject by directorate 14

9.0 Complaints compliance and performance 15

10.1 Reopened Complaints 17

11.0 Parliamentary and Health Service Ombudsman (PHSO) Complaints 19

12.0 Positive feedback 20

13.0 Upheld Complaints 20

14.0 Training 21

15.0 Patient Advice and Liaison Service (PALS) 21

16.0 Looking Forward 23

1.0 Executive Summary

This is the executive summary of the complaints annual report for St George's University Hospitals NHS Foundation Trust. The report is for the period 1 April 2019 to 31 March 2020. In accordance with the NHS Complaints Regulations (2009) this report provides an analysis of the complaints received. It also includes an overview of PALS concerns and activity for the same period.

The key findings were:

- 956 complaints were received, which is a decrease of 13.7% (145) when compared to 2018/19 (1101)

- 71% of complaints were acknowledged within three days in comparison to 2018/19 (82%)

- The top three complaints subjects related to Clinical Treatment, Communication and Care, which was the same in 2018/19

- Overall complaints performance was 92% against the 85% performance target. A significant improvement from 62% in 2018/19. This is broken down further by working day response as follows:

    - 25 working day: 93% against 85% target
    - 40 working day: 84% against 90% target
    - 60 working day: 100% against 100% target

- 112 complaints were reopened compared to 2018/19 (108), an increase of 3.6%

- There were 7 requests for documentation from the Parliamentary Health Service Ombudsman's office (PHSO), the same as in 2018/19. Two final reports have been received and the two cases were partially upheld. One case is under investigation and the Trust is waiting to hear if the remaining four cases will be investigated

- 498 compliments were received and logged, a decrease of 37.6% when compared with 2018/19 (798)

- There were 4447 enquiries raised with the patient advisory and liaison service (PALS): a

contact refers to any enquiry or request. This represents a decrease of 34% when compared to 2018/19 (6779). Of these contacts 2838 related to concerns (when a patient or relative raises a concern about the Trust and does not want to follow the formal complaints procedure) which represents a decrease of 26% when compared to 2018/19 (3858). The top three themes for contacts related to appointments, care and communication.

- Examples of actions taken in response to the learning from our complaints were:
  - Clinical Treatment: Junior doctor training was provided on the management and documentation of potassium levels in response to poor communication
  - Communication: Staff were reminded to use a check list when taking a medication history to ensure all the required information is obtained
  - Care: The Cauda Equina Syndrome Pathway was reviewed to improve patient experience. The review focused on improving communication with patients and other hospitals as well as documentation.

2.0 Purpose of the Report

The Complaints Annual Report is a statutory requirement (Local Authority Social Services and National Health Service Complaints (England) Regulations 2009).

This purpose of the report is to provide:

- assurance the Trust is managing its formal complaints in accordance with the Trust complaints policy and procedure
- information relating to the complaints activity for the Trust with specific focus on each of the divisions
- Examples of where complaints have led to service improvement and shared learning Trust-wide.

3.0 Introduction

The Complaints Annual Report for St George's University Hospitals NHS Foundation Trust is for the period 1 April 2019 to 31 March 2020. The report provides an overview and analysis of the complaints received, the key identified themes and trends, compliance with performance targets, and the changes and impact on services in accordance with the NHS Complaints Regulations (2009). It also includes an overview of PALS enquiries and activity for the same period.

Complaints received provide much learning for the Trust on where and how we need to improve. The themes and trends identified from complaints in 2019/20, and previously in 2018/19, highlight the need to improve communication and information provided to patients, carers and families, improve communication on clinical treatment, improving waiting times and improving the care provided.

A key objective of the Trust, and one we need to do better at, is to learn, change, improve and evolve in response to complaints. The lessons learned and trends identified through monitoring data collected through complaints plays a key role in improving the quality of care received by patients and their experience and is a priority for the Trust reaching its vision of outstanding care every time.

The efficient and effective handling of complaints by the Trust matters to the people who have taken the time to raise their concerns with us. They deserve an appropriate apology for their experience alongside a recognition where substandard and inadequate care was provided and assurance that we will put actions in place to ensure other patients are not affected by a reoccurrence of the same concerns. This assurance comes through robust investigation with meaningful actions put in place.

Posters and leaflets are displayed around the Trust and there is information on the Trust website to ensure that patients are made more aware about their options and the process for raising a complaint. We view all types of patient feedback as positive and we are constantly looking at ways in which we encourage patients, carers and families to give their views.

Throughout 2019/20 the Trust continued to proactively manage complaints, improving the process and quality of the responses, and embedding the learning from complaints in to services and practice.

In July 2019 a daily ‘complaints huddle’ was established to focus on better management of complaints investigation to ensure complaint responses went out on time. In addition, the PALS and complaints service was restructured in December 2019 to include senior posts with enhanced skills in root cause analysis to provide support and coaching for divisional leads with investigations, complaint responses, and local resolution meetings.

From January 2020, in response to an internal audit assessment of learning from complaints, the Trust included a summary of the actions to be taken in the complaint response letter to put all the improvement actions together in a summary table for the complainant and support the monitoring and delivery of the improvement actions.

4.0 Accountability for complaints management within the Trust

The Board has corporate responsibility for the quality of care and the management and monitoring of complaints received by the Trust. The Chief Executive has delegated the responsibility for the management of complaints to the Chief Nurse and Director of Infection Prevention and Control. The Head of Patient Experience and Partnership, reporting to the Director of Quality Governance and Compliance, is responsible for the management of the complaint process to ensure:

- All complaints are investigated appropriately to the concerns raised
- All complainants receive a comprehensive written response, and / or a meeting if requested, to address the concerns
- Complaints are responded to within the set local standard response times
- When a complaint is referred to the PHSO, all enquiries are responded to promptly and openly

Each month the following information is reported through the Integrated Quality Performance Report to the Trust Board:

- Numbers of complaints received
- Number of complaints closed by working day response time and compliance with performance targets
- Number of complaints breaching the 6 month response timeframe
- The number of PALS contacts received

5.0 Total complaints received in 2019/20

During 2019/20 the Trust received 956 complaints which equates to an average of approximately 18 complaints received per week or 80 complaints per month. This shows a decrease of 13.7% (145) on the number of complaints received in 2018/19 (1101).

Table 1 below shows the 956 complaints received related to all attendances equates to a complaint versus attendance ratio of 0.09%. This figure equates to approximately 1.46% complaints as a percentage of inpatient activity (in 2018/19 these figures were 0.11% and 1.63% respectively).

Table 1: Complaints related to inpatient activity

Activity	18/19	19/20
Inpatient Emergency, Maternity, Other and Transfers	67569	65392
Elective, Day cases, Regular Attends	84940	88781
A&E Attends (including Streaming and EPU)	176483	171706
Outpatient Attends (New and Follow Ups)	680064	719699
Total attendances	**1009056**	**1045578**
Number of Complaints	**1101**	**956**
Complaints as % of all Attendances	**0.11**	**0.09**
Complaints as % of Inpatient Activity	**1.63**	**1.46**

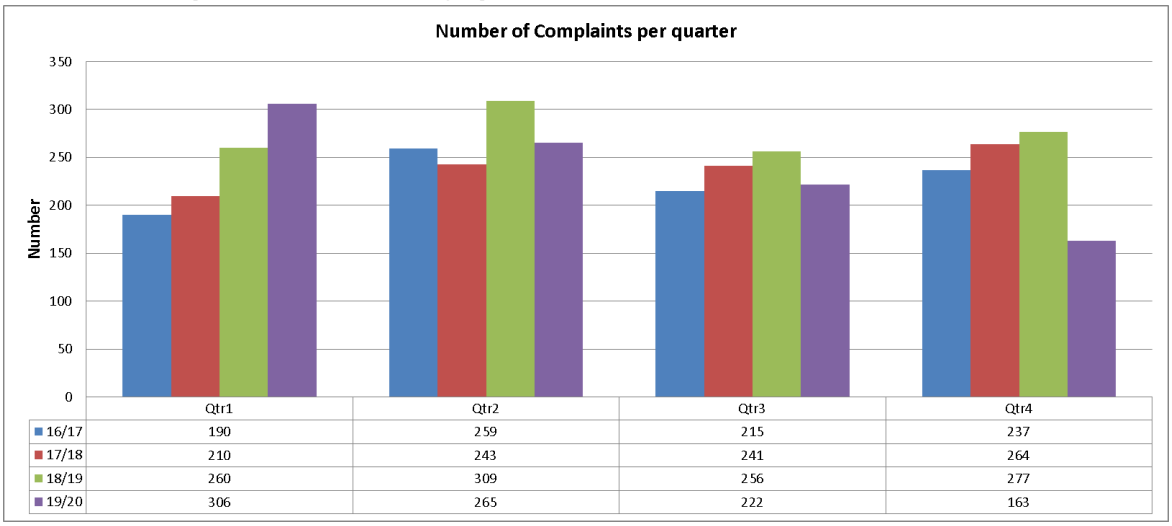
Table 2 below shows the number of complaints received and the method by which they were received. The majority of complaints were received by email.

Table 2: Complaints and mode of receipt

	Formal Complaint
E-mail	715
Received via Facebook	1
Received by letter	106
Complaint via MP	5
PALS Referral	71
Received in person	14
Received by telephone	22
Received on the ward	2
Totals:	936

Chart 1 below demonstrates the number of complaints received in each quarter from 2016 to 2020. There was a significant increase seen across quarter 1 in 2019/20. However, quarters 2 and 3 have seen a consistent decrease in the number of complaints received. It is noted that complaints received in quarter 4 was significantly decreased in comparison to previous years. An assumption can be made that Covid-19 impacted on the last 2 weeks of this quarter.

Chart 1: Complaints received by quarter



	Qtr1	Qtr2	Qtr3	Qtr4
16/17	190	259	215	237
17/18	210	243	241	264
18/19	260	309	256	277
19/20	306	265	222	163

Table 3 below shows a breakdown of complaints received by month and year for the years 2017/18, 2018/19 and 2019/20.

Table 3: Comparative monthly complaints totals 2017-2019

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
63	76	71	66	97	80	96	77	68	90	80	94	958

Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
96	84	79	120	96	93	90	88	78	92	84	101	1101

Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
108	102	96	96	88	81	88	79	55	59	60	44	956

Chart 2 below is a statistical process control (SPC) chart which enables a broader understanding of the differences and norms of complaints received during 2019/20. The monthly complaint rates are plotted within upper and lower process limits which measure whether variations on a monthly basis are stable and thereby predictable (common cause variation), or in contrast were unstable and thereby unpredictable (special cause variation). The table illustrates no noticeable deviations outside of the upper and lower process limits.

Chart 2: SPCC overview of complaints received

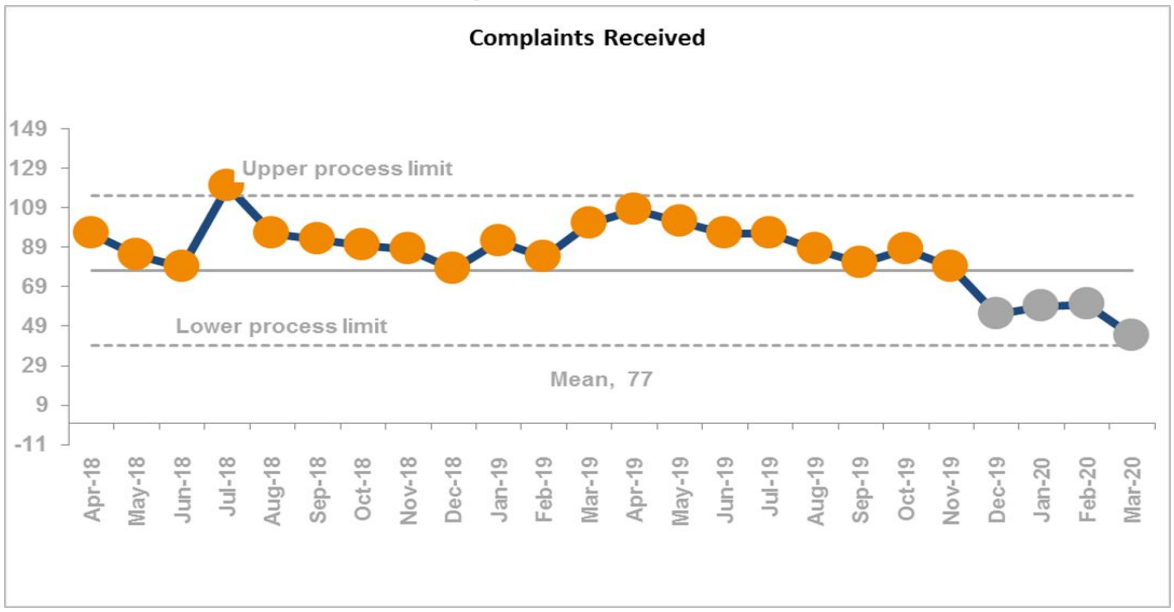


Table 4: Monthly complaints received as per SPC chart 2

Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
96	84	79	120	96	93	90	88	78	92	84	101	1101

Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
108	102	96	96	88	81	88	79	55	59	60	44	956

6.0 Complaint themes

The Department of Health (DH) classifies complaints in to 18 distinct categories by the subject of the complaint.

Each complaint may involve more than one issue depending on the nature and complexity of the complaint. By theming our complaints by subject it allows us to identify whether any trends are developing. Table 5 below identifies the top five themes and trends from our complaints by subject during each quarter of 2019/20. The data is related to the primary subject raised within each complaint.

Using the DH classifications, the five most commonly identified complaints were related to:

1. Communication / information to patients (written and oral)
2. Clinical Treatment
3. Care
4. Waiting Times
5. Attitude

Table 5: Complaints received quarterly by primary subject

Subject	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Total
Admission arrangements	0	0	2	0	**2**
Attitude	33	18	23	16	**90**
Cancellation	13	6	19	16	**54**
Cancellation of surgery	7	5	2	4	**18**
Care	37	34	33	19	**123**
Car Parking	5	0	0	0	**5**
Clinical treatment	55	64	54	44	**217**
Communication	103	87	52	23	**265**
Discrimination	0	0	2	0	**2**
Discharge arrangements	0	3	4	5	**12**
Hotel and site services	2	3	0	1	**6**
Request for Information	1	0	0	1	**2**
Other	7	10	2	9	**28**
Medical records	5	4	1	0	**10**
Transport arrangements	4	6	3	4	**17**
Transfer arrangements	0	0	1	1	**2**
Unhelpful	0	1	2	3	**6**
Waiting times	29	23	22	23	**97**
Totals:	**301**	**264**	**222**	**169**	**956**

The top three subjects of communication, clinical treatment and care were the same in 2018/19. Waiting times was a new subject included in the top five and staff attitude moved down to fifth place from fourth in 2018/19.

Table 6 below shows the top five primary subjects of complaints received by each of the Trust's directorates. It is not possible to indicate the total change compared to the previous fiscal year as there has been a change within the top 5 with complaints related to cancellation replaced by waiting times. There is a decrease of 17% (19) in the number of complaints related to attitude from 109 cases in 2018/19 to 90 cases in 2019/20. A decrease of 30.9% (55) was noted in complaints related to care from 178 cases in 2018/19 down to 123 cases in 2019/20. Complaints related to communication also saw a decrease of 6.4% (18) from 283 cases in 2018/19 down to 265 cases in 2019/20. These decreases are reflective of the 13% overall decrease in complaints received for 2019/20. The increase in the number of complaints related to clinical treatment might be considered significant against the 13% decrease in overall complaints. There are noted increases in complaints received for neurosciences (64%) acute medicine (54%) and surgery clinical (23%).

Table 6: Complaints by Primary Subject and Directorate

Directorates	Attitude	Care	Clinical treatment	Communication	Waiting times	Total for Top 5 Primary Subject
(MC) Emergency Department	13	22	28	10	5	**85**
(MC) Acute Medicine Clinical	4	18	17	14	0	**63**
(MC) Cardiology Clinical Academic Group	5	3	14	20	4	**50**
(CW) Children's	2	5	11	7	2	**32**
(CW) Community Services	2	4	4	6	4	**24**
Corporate Affairs	0	0	0	0	0	**1**
Corporate Nursing	2	0	0	0	0	**4**
(CW) Critical Care	1	2	2	0	0	**6**
(MC) Cardiac, Vascular, Thoracic Surgery	3	8	8	3	0	**25**
(CW) Diagnostics Clinical	9	3	7	12	0	**33**
Estates & Facilities	6	0	0	6	1	**40**
Finance	0	0	0	5	0	**8**
(SN) Neurosciences Clinical	6	10	23	36	11	**99**
Operations	0	0	0	1	0	**2**
(MC) Renal, Haematology, Palliative Care & Oncology	3	3	4	14	5	**33**
(MC) Specialist Medicine Clinical	6	3	10	19	5	**57**
(SN) Surgery Clinical (inc. Trauma and Orthopaedics)	11	20	58	59	39	**224**
South West London Pathology	0	0	1	2	1	**4**
(SN) Theatres Clinical	1	0	2	4	1	**9**
(CW) Therapeutics Clinical	9	1	5	22	11	**66**
(CW) Women's	7	21	23	25	8	**91**
	90	**123**	**217**	**265**	**97**	**956**

7.0 Analysis of the top five complaints subjects and examples of learning

Analysis of the top five subjects is included below with examples of actions taken in response to the learning from the concerns raised.

7.1 Complaint Themes: Communication

There were 265 complaints received where communication was recorded as the primary subject of concern and were related to a wide range of directorates and services. Surgery clinical directorate was noted to have the largest decrease of 27% (22) where communication was the primary subject. This is a significant improvement in relation to 2018/19 where surgery directorate was noted to have the largest increase. In contrast, there were increases within neurosciences and

renal, haematology, palliative care and oncology (RHPCO). It is encouraging to note decreases within cardiac, vascular and thoracic surgery and children's directorates.

An example of a complaint in surgery, neurosciences, cancer and theatres division and the actions taken:

Concern:	Actions Taken:
Concerns were raised in relation to the level of communication when taking a medication history	Review training and assessment requirements of staff members involved Ensure patients and relatives are involved at all stages of patient care including establishing medication history Use a check list when taking a medication history to ensure all the required information is obtained Repeat training logs to complete medication histories

An example of a complaint in medicines and cardiology division (where the complaint was resolved by speaking directly with the complainant and resolving the concerns raised and closing with a verbal resolution letter from the General Manager):

Concern:	Actions Taken:
Communication when discharged from ward as the patient considered the information was insufficient	Discharge summary sent to patient and GP and apology given for distress caused.

An example of a complaint in children, women's, diagnostics, therapies and critical care division:

Concern:	Actions Taken:
Insufficient information being provided by consultant	Further reflection and learning and discussion of the complaint and concerns raised at the team meeting and subsequently at annual appraisal for the consultants involved

7.2 Complaint Themes: Clinical Treatment

There were 217 complaints received where clinical treatment was recorded as the primary subject of concern. There are noted increases in, neurosciences (64%) acute medicine (54%) and surgery clinical (23%).

An example of a complaint in medicines and cardiology division and the action taken:

Concern:	Actions Taken:
Poor clinical observations	Junior doctor training provided on the management and documentation of the patient's potassium levels

7.3 Complaint Themes: Care

There were 123 complaints received where care was recorded as the primary subject of concern.* Comparison required

An example of a complaint in surgery, neurosciences, cancer and theatres division and the actions taken:

Concern:	Actions Taken:
Concerns were raised about insufficient information being provided by staff within plaster services	Plaster technicians reminded to explain to patients the process/steps to be taken before proceeding with any treatment or procedure. Information and appropriate leaflets provided on how the patient can look after their affected limbs or cast. Training provided to the plaster technician team and updates provided about roles and responsibilities to improve patient experience

An example of a complaint received in medicine and cardiology division and the actions taken:

Concern:	Actions Taken:
Concerns raised about the care received within the service	The Cauda Equina Syndrome Pathway was reviewed to improve patient experience. The review focused on improving communication with patients and other hospitals as well as the documentation provided.

7.4 Complaint Themes: Waiting Times

There were 97 complaints received where waiting times was recorded as the primary subject of concern.

An example of a complaint received in Children, Women's, Diagnostics, Therapies and Critical Care Division

Concern:	Actions Taken:
Concerns raised about waiting time for wheelchair and appropriateness of one provided.	All suppliers and manufacturers to only use our clients' individual reference numbers on the equipment packaging Reflection and learning on the order omission by the member of staff Re-assessment of patient's needs undertaken to improve future care

7.5 Complaint Themes: Attitude

There were 90 complaints received where attitude was recorded as the primary subject of concern. This represents a decrease of 3% (19) when compared with 2018/19.

In relation to staff attitude, staff are expected to read the complaint letter and are supported by their line manager to reflect by providing a reflective statement on how they could have responded differently. The reflection is further reviewed with the staff member to ensure learning has taken place. Where indicated, training on values based leadership and effective people management is provided. Customer service training is also provided monthly by PALS which can be accessed by all staff across the trust. Medical staff are required to discuss the complaint with their medical supervisor and agree a corresponding development plan and this is revisited annually as part of their appraisal.

In some cases staff attitude was investigated in line with the Trust policies and escalated to the Chief Nurse, Chief Medical Officer and/or Chief Operating Officer as appropriate.

8.0 Primary complaint subject by directorate

Table 7 below shows totals of the primary subjects identified during 2018/19 within each directorate.

Table 7: Total of the primary subjects identified during 2018/19 by directorate

Directorate	Admission arrangements	Attitude	Cancellation	Cancellation of surgery	Care	Car Parking	Clinical treatment	Communication	Discrimination	Discharge arrangements	Hotel and site services	Request for Information	Other	Medical records	Transport arrangements	Transfer arrangements	Unhelpful	Waiting times	Total
(MC) Emergency Department	1	13	0	0	22	0	28	10	0	1	1	0	2	2	0	0	0	5	85
(MC) Acute Medicine Clinical	0	4	0	0	18	1	17	14	0	3	0	0	3	2	1	0	0	0	63
(MC) Cardiology Clinical Academic Group	0	5	3	0	3	0	14	20	0	0	0	0	0	0	0	0	1	4	50
(CW) Childrens	0	2	4	0	5	0	11	7	0	1	0	0	0	0	0	0	0	2	32
(CW) Community Services	0	2	2	0	4	0	4	6	0	0	0	0	2	0	0	0	0	4	24
Corporate Affairs	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Corporate Nursing	0	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	4
(CW) Critical Care	0	1	0	0	2	0	2	0	0	0	0	0	1	0	0	0	0	0	6
(MC) Cardiac,Vascular, Thoracic Surgery	0	3	1	0	8	0	8	3	0	2	0	0	0	0	0	0	0	0	25
(CW) Diagnostics Clinical	0	9	0	0	3	0	7	12	0	0	0	0	2	0	0	0	0	0	33
Estates & Facilities	0	6	0	0	0	4	0	6	0	0	4	0	5	0	13	0	1	1	40
Finance	0	0	0	0	0	0	0	5	0	0	0	0	3	0	0	0	0	0	8
(SN) Neurosciences Clinical	0	6	3	2	10	0	23	36	1	2	0	0	1	0	2	2	0	11	99
Operations	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	2
(MC) Renal, Haematology, Palliative Care & Oncology	0	3	0	0	3	0	4	14	0	0	0	0	3	0	1	0	0	5	33
(MC) Specialist Medicine Clinical	1	6	10	1	3	0	10	19	0	0	0	0	1	1	0	0	0	5	57
(SN) Surgery Clinical (inc. Trauma and Orthopaedics)	0	11	20	11	20	0	58	59	0	1	1	0	2	2	0	0	0	39	224
South West London Pathology	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	1	4
(SN) Theatres Clinical	0	1	0	1	0	0	2	4	0	0	0	0	0	0	0	0	0	1	9
(CW) Therapeutics Clinical	0	9	10	0	1	0	5	22	1	2	0	1	1	2	0	0	1	11	66
(CW) Womens	0	7	1	3	21	0	23	25	0	0	0	0	1	1	0	0	1	8	91
Totals:	2	90	54	18	123	5	217	265	2	12	6	2	28	10	17	2	6	97	956

9.0 Complaints compliance and performance

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 set out the rights of complainants and the expectations on the Trust to investigate and respond in an appropriate and timely manner. Best practice is that each complainant is contacted to discuss their complaint and agree both the process of resolution and the timescale.

The NHS complaints regulations state that complaints should be acknowledged within 3 working days. In 2019/20 the Trust achieved 71% of complaints acknowledged within 3 working days, a decrease in performance when compared to 82% achieved in 2018/19. This is related to the team transitioning to a new structure. The new structure will be embedded in 2020 and it is anticipated that this performance target will be met.

For a number of years the Trust's complaints performance has remained below the Trust's internal targets with an average of 65% of complaints being responded to within 25 working days.

In July 2019 a new process was implemented supported by a daily Complaints Commcell; a thirty minute meeting. Commcell was led by the Chief Nurse alongside the Director of Quality Governance and Compliance, Head of Patient Experience and Partnership and including all the complaints officers. A clear message was signalled to the divisions at the beginning of the process that local performance targets would be achieved.

The purpose of the Commcell was to track each complaint due within the next two week period as it progressed from the investigation stage to response letter to ensure the complaint response was of high quality and sent within the agreed timescales. Complaints identified as at risk of breaching the expected timeframes were escalated to the divisional leads for further scrutiny and appropriate support from the complaints team.

This focussed approach yielded the following results:

- Complaints performance target (85%) met for Green complaints from July 2019 to March 2020
- Complaints performance target (90%) met for Amber complaints from August 2019 to March 2020
- Complaints performance target (100%) met for Red complaints throughout 2019/20
- Complaints performance target met for all responses from August 2019 to March 2020
- Reduction in the number of overdue complaints by 77%

Table 8 below identifies the proportion of complaints responded to within set performance target.

Table 8: Proportion of complaints responded to within set performance target

KPI	Category	Target	2018/19 performance	2019/20 performance full year
25 working days	Green	85%	68%	93%
40 working days	Amber	90%	55%	84%
60 working days	Red	95%	62%	100%

Table 9 below shows the further breakdown of performance by clinical group across the Trust.

Table 9: Complaints by care group and severity

	Green - 25 working days	Amber - 40 working days	Red - 60 working days	Total
Emergency Department Care Group	65	22	4	91
Anaesthetics, Acute Pain & Resuscitation Care Group	1	1	0	2
Audiology & ENT Care Group	44	6	1	51
Cardiology	35	12	2	49
Cardiac Surgery	4	3	1	8
Clinical Genetics Care Group	2	2	0	4
Chest Medicine Care Group	4	4	0	8
Clinical Infection Unit & Genito-Urinary Medicine Care Group	2	1	0	3
Community Services - Adult Services	21	1	0	22
Community Services - Childrens Services	1	0	0	1
Community Services - HMP Wandsworth Offender Healthcare	2	0	0	2
Corporate Affairs	0	1	0	1
Critical Care Care Group	2	1	1	4
Diabetes & Endocrinology Care Group	11	2	0	13
Estates & Facilities	37	1	1	39
Finance	7	1	0	8
Gastroenterology & Endoscopy Care Group	13	1	0	14
General Medicine	28	30	1	59
General Surgery Care Group	34	10	2	46
Imaging Care Group	25	3	0	28
Oral & Maxillofacial Surgery Care Group	9	2	0	11
Neonatal Care Group	0	1	0	1
Stroke Neuro-logy & -rehab Care Group	33	13	1	47
Neuro-surgery, -radiology & -pathology Care Group	37	12	1	50
Nursing	3	1	0	4
Obs & Gynae, & Fetal Medicine Care Group	62	27	2	91
Medical Oncology, Clinical Haematology, Renal & Palliative Care Group	24	10	1	35
Operations	2	0	0	2
Outpatients & Medical Records Care Group	42	2	0	44
Plastic Surgery Care Group	27	6	0	33
Paediatric Medicine & PICU Care Group	17	6	1	24
Paediatric Surgery Care Group	2	5	1	8
Rheumatology, Dermatology & Lymphoedema Care Group	15	3	1	19
South West London Pathology	2	1	0	3
Therapies Care Group	15	0	0	15
Thoracic Surgery	4	2	0	6
Inpatient & Day Case Theatres & Decontamination Care Group	3	1	0	4
Trauma & Orthopaedics Care Group	46	19	1	66
Urology Care Group	13	4	0	17
Vascular Surgery	1	10	0	11
Totals:	695	227	22	944

*Noted Datix pull through for reporting means figures do not total 956.

10.1 Reopened Complaints

The number of complaints that do not achieve resolution with the first response is used as a proxy measure for the quality of the complaint response. A complainant who does not feel listened to is unlikely to be satisfied with their response. 112 complaints were reopened during 2019/20 compared with 108 in 2018/19, an increase of 5 (3.6%). This demonstrates that significant improvement in meeting complaint response times marginally impacted on the quality of the complaint response.

A proportion of the complaints were unresolved due to questions arising from the information provided. In many of these cases local resolution meetings have taken place with key staff to discuss and address the on-going questions and concerns directly with the complainant.

Chart 3 below shows the number of reopened complaints received and primary subject quarterly for 2019. Since quarter 2 in 2019/20 the number of reopened complaints began to decrease to expected levels by quarter 4 in 2019/20.

Chart 3: Reopened complaints and primary subjects

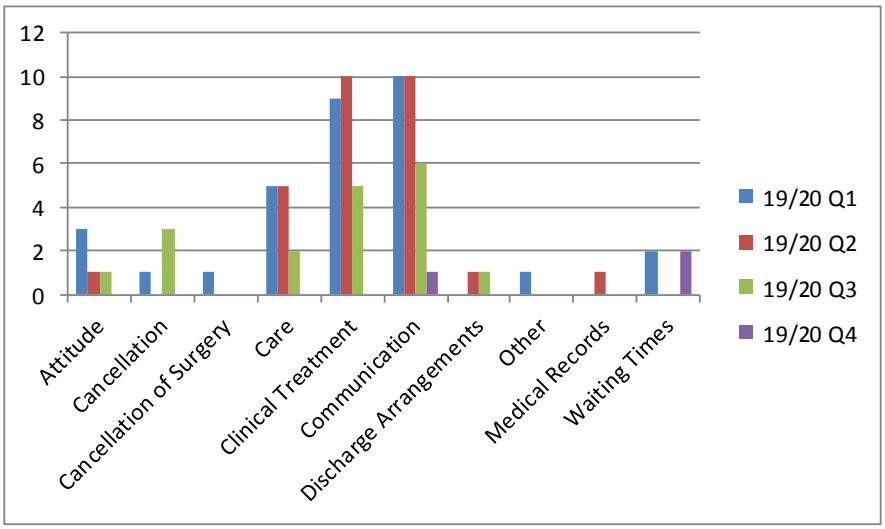


Table 10: Reopened complaints and primary subject

	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4
Attitude	3	1	1	0
Cancellation	1	0	3	0
Cancellation of Surgery	1	0	0	0
Care	5	5	2	0
Clinical Treatment	9	10	5	0
Communication	10	10	6	1
Discharge Arrangements	0	1	1	0
Other	1	0	0	0
Medical Records	0	1	0	0
Waiting Times	2	0	0	2
Totals	**32**	**28**	**18**	**3**

Table 11 below shows the primary themes identified with complaints which were reopened. It is evident that the key themes relate to clinical treatment, communication and care.

Table 11: Primary themes for reopened complaints

	Attitude	Cancellation	Cancellation of surgery	Care	Clinical treatment	Communication	Discharge arrangements	Other	Medical records	Waiting times	Total
(MC) Emergency Department Directorate	0	0	0	3	5	2	0	0	0	0	10
(MC) Acute Medicine Clinical Directorate	1	0	0	2	5	1	0	1	0	0	10
(MC) Cardiology Clinical Academic Group	1	0	0	1	2	3	0	0	1	0	8
(CW) Childrens Directorate	0	0	0	1	2	4	0	0	0	0	7
(CW) Community Services	1	0	0	0	0	1	0	0	0	1	3
Corporate Nursing Directorate	0	0	0	1	0	0	0	0	0	0	1
(MC) Cardiac,Vascular,Thoracic Surgery	0	0	0	1	1	0	1	0	0	0	3
(CW) Diagnostics Clinical Directorate	1	0	0	0	1	2	0	0	0	0	4
Estates & Facilities Directorate	0	0	0	0	0	2	0	0	0	0	2
(SN) Neurosciences Clinical Directorate	1	1	0	3	3	4	1	0	0	0	13
Operations Directorate	0	0	0	0	0	1	0	0	0	0	1
(MC) Renal, Haematology, Palliative Care & Oncology Directorate	0	0	0	0	0	1	0	2	0	0	3
(MC) Specialist Medicine Clinical Directorate	0	1	0	0	2	1	0	0	0	0	4
(SN) Surgery Clinical Directorate (inc. Trauma and Orthopaedics)	3	1	1	3	9	10	0	0	1	2	30
South West London Pathology	0	0	0	0	0	0	0	0	0	1	1
(SN) Theatres Clinical Directorate	0	0	0	0	2	0	0	0	0	0	2
(CW) Therapeutics Clinical Directorate	0	1	0	0	0	0	0	0	0	0	1
(CW) Womens Directorate	1	0	1	2	3	2	0	0	0	0	9
Totals:	9	4	2	17	35	34	2	3	2	4	112

11.0 Parliamentary and Health Service Ombudsman (PHSO) Complaints

Seven requests for documentation were received from the PHSO in 2019/20, the same as in 2018/19. The requests related to individual complaints about services in the Therapies Directorate, Specialist Medicine, Emergency Department, Acute Medicine, a joint complaint about a service in Specialist Medicine and the Complaints Department, and two complaints about a service in the

Children's Directorate (see table 12 below).

Two cases have been investigated and we have received the final reports from the PHSO. Both cases were partially upheld. Recommendations have been complied with and these cases are now closed.

One case is under investigation and the Trust is awaiting confirmation on whether the remaining four cases will be investigated.

Table 12 PHSO requests 2019/20 by Directorate

Case	Directorate	Outcome
547RR	Therapies Directorate	Under investigation
1018SS	Specialist Medicine	Case file requested
054TT	Emergency Department	Case file requested
003SS	Acute Medicine	Case file requested
811SS	Children's Directorate	Case file requested
956NN	Specialist Medicine / Complaints Department	Partially Upheld
161RR	Children's Directorate	Partially upheld

12.0 Positive feedback

In addition to complaints, staff in the Complaints and Improvements Department also log compliments and positive feedback from users of Trust services. This provides valuable insight into the things the Trust does well and identifies good practice from which lessons can be learnt. 498 good news/ thank you letters were received and logged centrally, a decrease of 37% (798) when compared with 2018/2019.

13.0 Upheld Complaints

It is a requirement of the complaints regulations that Trusts set out in their annual report the number of complaints which the Trust decided were upheld during the financial year. Historically, the Trust's position has been to determine that all complaints are 'upheld' on the basis that even if a complaint is considered by the Trust to be unjustified, the complainant was aggrieved enough by what happened for them to take the time to complain. This means it was not possible for the Trust to provide the number of upheld complaints.

In 2018/19 the Trust undertook to record the number of complaints that were upheld, not upheld and partially upheld. However, due to instability in the complaints team and changes in senior leadership this did not happen consistently. Consistent reporting will commence from April 2020 from Datix in line with the complaints procedure.

14.0 Training

Throughout 2019/20 the Complaints and Improvements and PALS teams have provided training sessions for staff on both directly handling complaints and concerns as they arise and on investigating complaints and providing written responses. All new staff to the Trust received a session about customer care and handling concerns on the frontline as part of the Corporate Trust induction (a total of 1848 staff across the staff groups in the table below).

Table 13: Number of staff attending Customer Care induction sessions

	2019									2020			Total
Professions	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Add Prof Scientific and Technic	14	3	13	21	11	19	14	12	6	4	3	7	127
Additional Clinical Services	23	22	28	32	28	39	25	33	26	36	47	44	383
Administrative and Clerical	36	42	33	39	32	60	24	46	32	33	17	10	404
Allied Health Professionals	4	5	11	11	13	25	19	11	4	17	10	5	135
Estates and Ancillary	2	2	3	2	1	2		4	4	4	2	3	29
Healthcare Scientists	1	1	1	5	5	2	5	5		5	5	1	36
Medical and Dental	14	13	15	20	19	24	14	15	23	12	20	10	199
Nursing and Midwifery Registered	32	23	43	33	26	98	96	61	21	38	28	36	535
Grand Total	**126**	**111**	**147**	**163**	**135**	**269**	**197**	**187**	**116**	**149**	**132**	**116**	**1848**

“Responding to Complaints” and “Effective Customer Care” training sessions are provided monthly in the Training and Development Department. 98 staff attended training for effective customer care in 2019/20 in comparison to 91 in 2018/19.

Additional bespoke training was also delivered to groups of staff and individuals where indicated and requested.

15.0 Patient Advice and Liaison Service (PALS)

The PALS team provided the following:

- Assistance to patients and their representatives with concerns and requests for information. (Examples are enquiries are patients being unable to contact outpatient departments,

patients concerned about waiting times for an operation and patients with transport queries)

- Act as a liaison between patients and services to offer suggestions for improvements drawing on the patient experience

- Deliver customer care training to staff in partnership with training and development and on a bespoke basis to wards and services Trust wide

- Raise the profile of PALS throughout the Trust by linking in with wards and departments and representing the service and views of patients on relevant committees
- Provide accessible information to patients, relatives, visitors and staff on the Trust's intranet and internet

The PALS values are to:

- offer on the spot resolution (where able)
- ensure patients receive appropriate information
- resolve patient concerns at an early stage
- provide a seamless service
- inform and educate staff
- monitor concerns and outcomes
- be a catalyst for service improvement and change

15.1 PALS Activity

A PALS ***contact*** refers to any enquiry or request. An example of this is where a patient wanting information about a service or a member of staff requested information on how to contact an external organisation. It also included expressions of thanks from patients and relatives. The number of PALS ***contacts*** was 4447 in 2019/20. This represents a decrease of 3.6% (6779) when compared to 2018/19.

A PALS ***concern*** refers to when a patient or relative raises a concern about the Trust and does not want to follow the formal complaints procedure. The number of PALS ***concerns*** raised was 2838 in 2019/20 which represents a decrease of 22% (3858) when compared with 2018/19.

16.0 Looking Forward

It is noted that at the close of 2019/20, Covid-19 was just starting to impact on the Trust and our patients' experience. There was a significant fall in the number of complaints received during the last month of quarter 4 and it is assumed that this is likely to continue into quarters 1 and 2 of 2020/21.

The PALS and Complaints service will need to adapt to find new and responsive ways of working with patients and families. In line with the new PALS and Complaints service structure, it is essential that coaching and training is provided to identified staff within the divisions. This will enhance the investigation and complaint response writing skills of those staff, reducing the disproportionate impact of complaints on Divisional Directors of Nursing and Governance and other senior staff. New training packages will be developed to incorporate root cause analysis, investigative skills and human factors (study of the physical and psychological behaviour of humans and how this impacts on their interaction and performance with specific environments, organisational culture or tasks) in partnership with corporate governance and risk teams by quarter three.

The Trust will continue to proactively manage complaints, improve the process and quality of the responses, and embed the learning from complaints in practice.

The Trust will also review the process for the complaints satisfaction survey with a view to increasing our feedback to facilitate further improvement where indicated.

The PALS and complaints team will work closely with the paediatric team to develop a child friendly complaints process by quarter four of 2020/21.

Given the increase in the number of complaints related to clinical treatment when compared with the decrease in overall complaints, a deep dive analysis will be undertaken to identify any opportunities for divisional and organisational learning in 2020.

PALS and complaints will work with the clinical audit team to identify areas where audit may be needed and establish an audit schedule.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

4.1

Meeting Title:	**Trust Board**		
Date:	30 July 2020	**Agenda No**	**4.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 23rd July 2020.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee – July 2020

The Committee met on 23 July. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on Larger Projects, the Emergency Floor Strategic Outline Case, Technical Releases, a Procurement Report and a Patient Transport Options Paper.

Committee members discussed the BAF risks on finance and ICT, although noting no change in overall risk scoring at present. The Committee continued to commend the achievement of the Emergency Flow 4 hour target and noted performance in Diagnostics, Cancer and RTT which have been affected to varying degrees by the COVID-19 pandemic. The Committee discussed current financial performance, cash management and capital expenditure, as the Trust reports the first quarter of the new financial year. **The Committee wishes to bring the following items to the Board's attention:**

1.1 Finance & ICT Risks – the Deputy Chief Financial Officer (DCFO) and the Chief Information Officer (CIO) gave updates on their respective BAF risks. Discussions on financial risk were covered through other agenda items, such as the M3 Report and Capital Plan Update. ICT discussions were based on the deep dive paper introduced. The Committee agreed with the decision to close two highly-scored functional risks and discussion focussed on cyber security.

1.2 Estates Report – the Director of Estates & Facilities (DE&F) introduced the paper on Estates. The Committee discussed the development of the Estates strategy and how it would need to be flexible based on current events.

1.3 Activity Performance – the Chief Operating Officer (COO) noted the gradual increase in elective and day case activity following the relaxation of COVID-19 restrictions. The Committee discussed how this could be further improved, for example through use of private sector capacity. The COO outlined the challenges in increasing activity and explained how these were being worked through and subject to ongoing focus.

1.4 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in May of 63.8% was below the previous month's value of 71.5%, and the number of 52 week waits of 274 was more than the previous month's 129. The size of the waiting list (including QMH patients) was 42,196 patients. The COO noted performance in July, where 554 52-week waits had been observed, a waiting list of 42,672 was recorded and the performance percentage was 55.7%, as elective activity slowly increases from the levels seen in the pandemic.

1.5 Diagnostics Performance – the COO noted the continued impact of the pause in all non-urgent diagnostics owing to COVID-19. Diagnostics performance did however improve in June, with 37.6% of patients having a Diagnostic wait of over 6 weeks compared with a last month's 47.8%.

1.6 Cancer Performance – the COO noted that the Trust met 4 of the 7 cancer targets in May, including the two-week target in Cancer performance. Performance was still challenged against the 62-day target, where patient choice and COVID related delays have impacted.

1.7 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 97.1% in June, with attendances 38% lower than the same period last year. The Committee commended this excellent performance.

1.8 Financial Performance& Forecast – the DCFO noted performance in month 3 of breakeven, following a £3.6m top-up accrual to offset the deficit position as per central guidance. He noted that £3.0m of COVID costs had been incurred, with a £3.4m shortfall in block income and £2.8m of underspends due to significantly reduced 'business as usual' activity owing to COVID (although this underspend has reduced in M3). He also noted that the cash balance at the end of June was £46.3m against a plan of £3.0m owing to receipts of both the April, May and June block values, and that capital expenditure was under plan by

£2.1m, with £3.8m COVID costs as yet unconfirmed by NHSI/E. The Committee welcomed the production of a bottom-up financial forecast by divisions to the end of the financial year.

1.9 Capital Update– the DCFO introduced the Committee to the paper providing an update on capital, noting schemes that could be paused in order to deliver a reduced programme of £41m in 2020/21. The committee discussed the input of the South West London Integrated Care System in the process of allocating capital.

1.10 Projects Update – the Director of Financial Planning (DFP) introduced the paper updating on some of the larger projects that the trust is working on at the moment.

1.11 Emergency Floor Strategic Outline Case – the DFP introduced the paper asking for approval to prepare the Outline Business Case for redesigning the Emergency Department. The Committee approved the case as a key strategic priority in the coming years.

1.12 Procurement Update & Patient Transport Tender – the Associate Director- Procurement (ADP) introduced papers on Procurement and the Patient Transport Tender. The former paper noted the work of the department at the height of the pandemic in sourcing PPE for staff. The latter paper noted the options available to the trust in retendering the contract to begin in April 2021. The Committee praised the work of the department and welcomed the tender update.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee for information and assurance.

Ann Beasley
Finance & Investment Committee Chair,
July 2020

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

4.2

Meeting Title:	**TRUST BOARD**		
Date:	**30th July 2020**	**Agenda No.**	**4.2**
Report Title:	**M3 Finance Report 2020/21**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer		
Report Author:	Tom Shearer, Deputy Chief Financial Officer Michael Armour, Financial Reporting		
Presented for:	Update		
Executive Summary:	The Trust has been requested to report a breakeven financial position at M3 by NHSE. This has been achieved through an income "top up" accrual to offset any deficit position, as per central guidance. The reported position at M3 includes £9.6m of COVID costs (£3.0m in-month) and £10.5m of Income Top Up (£3.6m in-month). The underlying position, therefore, is a £0.9m deficit to date (£0.6m deficit in-month). This is made up of £10.2m shortfall in block income vs Trust budgeted costs (£3.4m in-month), as set out in the Trusts interim plan for 20/21, offset by £9.6m (£2.8m in-month) of underspends due to significantly reduced BAU activity due to COVID.		
Recommendation:	The Board is asked to note the Trust's financial performance at M3.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Finance & Investment Committee	Date	23/07/2020
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

4.2

Financial Report Month 03 (June 2020)

Trust Board
30 July 2020

Chief Finance Officer

30th July 2020

Executive Summary

Month 03 Financial Position

- The Trust has been requested to report a breakeven financial position at M03 by NHSE&I. This has been achieved through an income “top up” accrual to offset the deficit position, as per central guidance.
- The in month reported position at M03 includes £3.0m of COVID costs and £3.6m of Income Top Up. The underlying position, therefore, is a £0.6m deficit.
- This £0.6m deficit is made up of £3.4m shortfall in block income vs Trust budgeted costs, as set out in the Trust’s interim plan for 20/21, offset by £2.9m of underspends and lower income due to significantly reduced BAU activity due to COVID.
- The Trust has received top up income covering the underlying deficit in full for M1, although the M2 payment was short by the value of bad debt provision included YTD (£0.4m). This is being queried with NHSI/E for resolution, and is accrued into the position as per national guidance.
- The Trust has spent £11.2m of capital at month 3, against a plan of £13.3m, including £3.8m associated with COVID 19. The £3.8m COVID costs are current reported as an overspend. The remaining capital spend is £5.9m underspent, against the plan.
- The Trusts cash balance at M3 was £46.3m. This is significantly higher than the £3m usually held by the Trust due to two months block payment being received in M1. The Trust is actively trying to ensure suppliers are paid in good time at the current time.

1. Month 03 Financial Performance

			Full Year Budget (£m)	M3 Budget (£m)	M3 Actual (£m)	M3 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding COVID and Income Top Up	**Income**	SLA Income	785.4	65.5	62.0	(3.5)	196.3	185.9	(10.4)
		Other Income	162.6	13.3	11.9	(1.4)	40.7	36.3	(4.3)
	Income Total		**948.0**	**78.7**	**73.9**	**(4.9)**	**237.0**	**222.3**	**(14.7)**
	Expenditure	Pay	(580.3)	(48.2)	(46.6)	1.6	(145.1)	(139.7)	5.4
		Non Pay	(328.6)	(27.2)	(24.6)	2.6	(82.1)	(73.8)	8.4
	Expenditure Total		**(908.9)**	**(75.5)**	**(71.2)**	**4.2**	**(227.2)**	**(213.4)**	**13.8**
	Post Ebitda		(39.1)	(3.3)	(3.3)	0.0	(9.8)	(9.8)	0.0
	Grand Total		**(0.0)**	**(0.0)**	**(0.6)**	**(0.6)**	**0.0**	**(0.9)**	**(0.9)**
COVID and Income Top Up	**COVID**	Pay	0.0	0.0	(1.3)	(1.3)	0.0	(5.3)	(5.3)
		Non Pay	0.0	0.0	(1.7)	(1.7)	0.0	(4.4)	(4.4)
	Total COVID		**0.0**	**0.0**	**(3.0)**	**(3.0)**	**0.0**	**(9.6)**	**(9.6)**
	Income Top Up	SLA Income	0.0	0.0	3.6	3.6	0.0	10.5	10.5
	Reported Position		**(0.0)**	**(0.0)**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**(0.0)**

Month 03 Financial Position

- Guidance from NHSE&I states that the Trust should report a breakeven position in June, which is achieved by an income top up accrual to balance the position.
- The tables above show the reported financial position excluding COVID costs and Income Top Up, and also show these exceptional items separately.
- The YTD financial impact of COVID on the Trust from additional expenditure is £9.6m.
- The income top up value is £10.5m, which brings the position to breakeven.
- Excluding COVID costs, and excluding the income top-up accrual, the Trust's YTD position would be £0.9m adverse to plan. This is due to the expected income 'Top Up' of £10.5m being offset by £9.6m of underspends and lower income as a result of not undertaking BAU activity because of COVID.

Financial Report Month 03 (June 2020)
St George's University Hospitals NHS Foundation Trust

Outstanding care every time

2. Balance Sheet as at June 2020

Statement of Financial Position	FY 19-20 Audited Mar-20 (£m)	M02 June-20 FY20-21 YTD Actual (£m)	Variance
Fixed assets	**426.9**	**431.3**	**4.4**
Stock	**11.9**	11.5	(0.4)
Debtors	**93.7**	87.0	(6.7)
Cash	**3.5**	46.3	42.8
Creditors	**(94.0)**	(151.9)	(57.9)
Capital creditors	**(22.5)**	(5.0)	17.5
PDC div creditor	**0.0**	0.0	0.0
Int payable creditor	**(0.1)**	(1.4)	(1.3)
Provisions< 1 year	**(0.3)**	(0.3)	0.0
Borrowings< 1 year	**(322.5)**	(321.6)	0.9
Net current assets/-liabilities	**(330.3)**	**(335.4)**	**(5.1)**
Provisions> 1 year	**(2.5)**	(2.9)	(0.4)
Borrowings> 1 year	**(69.9)**	(68.8)	1.1
Long-term liabilities	**(72.4)**	(71.7)	0.7
Net assets	**24.2**	**24.2**	**0.0**
Taxpayer's equity			
Public Dividend Capital	**135.7**	135.7	0.0
Retained Earnings	**(226.5)**	(226.6)	(0.1)
Revaluation Reserve	**113.8**	113.8	0.0
Other reserves	**1.2**	1.2	0.0
Total taxpayer's equity	**24.2**	**24.1**	**(0.1)**

M03 YTD Balance Sheet

Fixed assets increased by £4.4m since March-20. This includes the impact of depreciation and capital expenditure YTD.

Stock is £0.4m lower compared to year end Mar-20.

Debtors has reduced by £6.7m since March 2020.

The cash position is £42.8m higher than reported at year end in March-20. This is due to the block contract payment for July received in advance in June .

Cash resources are tightly managed monthly to meet the £3.0m minimum cash target at the end of the year.

Creditors are £57.9m higher than the figures reported at year end in March-20. This increase includes deferred income held on account to NHS England for the receipt of July-20 fund received in advance.

Capital creditors are £17.5m better than March-20. This is due to payment of year end capital invoices.

Department of Health (DoH) has confirmed the intention of converting £315m of both capital and revenue loan to PDC in 20/21. After conversion The Trust will be left with outstanding loans to DoH of £11.7m for capital and £10m revenue support.

Outstanding care every time

3. YTD Analysis of Cash Movement

Statement of Cash Flow	M03 YTD FY 20-21 Actual £m
Opening Cash balance	**3.4**
Income and expenditure deficit	(0.1)
Depreciation	6.9
Interest payable	3.1
PDC dividend	0.0
Other non-cash items	(0.1)
Operating surplus/(deficit)	**9.8**
Change in stock	0.4
Change in debtors	6.7
Change in creditors	58.2
Change in provisions	0.4
Net change in working capital	**65.7**
Capital spend (excl leases)	(11.3)
Capital Creditors	(17.5)
Capital donation	0.0
Interest paid	(3.2)
PDC dividend paid/refund	0.0
Interest Received	0.0
Net change in investing activities	**(32.0)**
PDC Capital Received	0.0
PDC Capital Paid	0.0
DH Loan Accrued Interest Reversal	0.0
Capital Loan repaid	(0.3)
Other Loans/ PFI /finance lease repayme	(0.3)
Net change in financing activities	**(0.6)**
Cash balance as at 30.06.2020	**46.3**

M03 FY20-21 YTD cash movement

The cumulative M03 20-21 I&E deficit is £0.1m. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).

Within the I&E deficit of £0.1m, depreciation (£6.9m) does not impact cash. The charges for interest payable (£3.1m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating surplus" of £9.8m.

Working capital is increased by £65.7m. There is no significant change in stock level. Increase in creditors is due to increase in deferred income.

DH capital loan of £0.3m was repaid in May-20. The remaining £0.3m payment made to other loans which includes London Energy Efficient Fund (LEEF), finance leases and PFI.

June-20 cash position

The Trust achieved a cash balance of £46.3m on 30th June 2020, £43.3m higher than the £3m minimum cash balance required by NHSI. This is due to the block contracts funding for July received in June 2020. This is to assist Trusts with issues that may arise from the impact of Covid.

Outstanding care every time

4. M03 Capital

- The table below shows capital spend year to date of £11.2m. This includes £3.8m of costs associated with COVID 19. This COVID capital spend currently stands as an overspend, although bids for funding have been submitted to NHSI/E.

- The capital plan is currently being worked through in detail as part of the South West London prioritisation work, before this is finalised, as SWL capital plans stand, materially higher than the centrally allocated CDEL.

TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	**Internal Budget £000**	M01	M02	M03	**M03 YTD budget £000**	M03 YTD exp £000	*M03 YTD var £000*
Infrastructure renewal	**11,600**	1,684	1,534	1,782	**5000**	5,000	*0*
P22	**10,000**	47	72	560	**2500**	679	*1,821*
Major projects	**14,400**	802	186	108	**1374**	1,096	*278*
IT	**6,500**	2,389	1,934	-900	**3423**	3,423	*0*
Medical equipment	**2,000**	224	233	198	**655**	655	*0*
Leases	**5,000**	904	-904	365	**365**	365	*0*
SWLP	**500**	0	108	(108)	**0**	0	*0*
Emergency Loan Funding	**0**	0	0	0	**0**	0	*0*
Total	**50,000**	6,050	3,163	2,005	**13,317**	11,218	*2,099*

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

5.1

Meeting Title:	**Trust Board**		
Date:	30 July 2020	**Agenda No**	**5.1**
Report Title:	**Audit Committee Report**		
Lead Director/ Manager:	Elizabeth Bishop, Chair of the Audit Committee		
Report Author:	Elizabeth Bishop, Chair of the Audit Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on 16 July 2020.		
Recommendation:	**The Board is asked to note the report and note that the key areas of risk related to the Use of Consultants, DSP Toolkit, Cyber Security and impact of International Financial Reporting Standards 16 (Leases) and be assured that the Committee keep these areas under review.**		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Audit Committee Report – July 2020

Matters for the Board's attention

The Audit Committee met on 16 July 2020 and agreed to bring the following matters to the attention of the Board.

1. Internal Auditors Reports

The Committee considered the following reports from internal auditors:

- Internal Auditors Progress Reports and Recommendation Tracker
- Use of Consultants (Limited Assurance)
- Staff Appraisals (Reasonable Assurance)
- DSP Toolkit (Limited Assurance)
- Cerner – EPMA Project (Reasonable Assurance)
- Risk Management (Reasonable Assurance)

The Committee was assured by the good progress made in completing internal audits in quarter 1 (2020/21) despite the Trust being heavily focused on managing the impact of Covid-19. The Committee were also reassured to learn that the new management governance forum, the Risk Assurance Group, was intending to be proactive in managing the progress of internal audits and the completion of audit recommendations and noted the importance of Executive leads progressing agreed recommendations in a timely way.

The Committee was pleased to note that three of the completed internal auditors received a 'reasonable assurance' rating.

The Committee discussed whether other management forums should also have a role in overseeing the delivery of internal audit recommendations, but agreed that it was important the new Risk and Assurance Group had an opportunity to demonstrate its impact in this area, and that this would be kept in view by the Committee. Individual audit reports, however, were already shared with other management groups to ensure that learning from internal audit findings were taken forward.

The Committee received reassurance that there was sufficient flexibility in the 2020/21 internal audit programme to respond to any arising risks. There were a number of outstanding internal recommendations from previous audits, particularly in relation to estates and ICT, but the internal auditors were able to provide reassurance that the organisation was focussed on completing these. The Committee challenged the management of the outstanding recommendations related to Consultant Job Planning and the impact this was having on the medical pay overspend. The Committee heard that consultant job plans had changed significantly to respond to patient need during the Covid-19 surge. The Trust was now focused on progressing effective consultant job planning and managing those areas which were within its control for example the number of supporting professional activities assigned to each care group. This work was being progressed and a paper setting out proposals for this had been considered by the Trust Management Group that week.

The Committee considered the limited assurance rating for the use of consultants and the management team advised that the areas of concerns raised in the internal auditors were valid and as such a review of the Trust's process for appointing consultants and making decisions about filling vacant posts was underway. The Committee was not assured that there was sufficient progress being made in this area and agreed to receive a detailed report once the review was completed.

The work around Data Security Protection Toolkit had been severely impacted by the Covid-19 pandemic with the ICT teams implementing solutions to support more staff working from home and conducting virtual patient appointments. The audit had been completed in February 2020 in preparation for the original submission of the Trust's self-assessment against the National Data Guardian's 10 data security standards at the end-March 2020. The timeframe for submission had been delayed as a result of Covid-19 until September 2020. The Committee also considered the Trust's annual progress report on completing the DSP toolkit and noted that 65% of the standards had been met and 77% of the evidence had been collected. The Committee noted the action plan to ensure that the Trust would be compliant with the 10 standards by the end-September. Key areas of focus included increasing the information governance training and ensuring there where robust systems in place to protect the Trust from cyber security threats. The Committee was not assured and asked the management team to take all actions to ensure that the Trust would be complaint by September 2020 and asked internal audit to revisit the report in the light of further action. The Committee also noted that the Trust was in the process of implementing Windows 10 which would provide additional security protection against cyber security threats. The Committee noted that the Finance and Investment Committee would regularly review a cyber security dashboard.

2. Internal Compliance and Assurance

2.1. Annual Compliance Reports

In addition to the annual report on DSP Toolkit compliance the Committee also received and noted the following reports which outlined the Trust's compliance and internal controls:

- Information Governance
- Risk Management Strategy and Policy
- Conflict of Interest
- Freedom to Speak Up
- Use of Trust Seal

The Committee welcomed the good progress made on improving the Trust's conflicts of interest declarations processes. Since implementing the new policy and the Declare system the Trust had achieved 44% compliance of decision makers make the relevant declarations. This compared well against other organisations and the Committee was assured by the additional work that would be undertaken to continue to achieve further improvement and the sound systems in place. The Committee also noted the systems and mechanisms in place to deliver an effective and independent freedom to speak up function. Recent changes to the Executive leadership of the function were noted as were the governance arrangements for reporting on concerns. It was also noted that in addition to the assurance the Audit Committee would continue to receive on the internal controls around the function, the Workforce and Education Committee would continue to receive the themes around issues that are raised so it could provide assurance to the Board in relation to the work on cultural change. The Committee also noted the interim changes proposed to the Risk Management Policy and that a comprehensive review was to be completed by the end of Quarter 3 (2020/21) which triangulated the feedback from the Care Quality Commission inspection report of December 2019, the output from the clinical governance phase three review and the findings from the internal audit review of risk management.

2.2. International Financial Reporting Standards 16 (Leases)

The Committee had previously reported to the Board that the Trust (along with all public bodies) would be required to transfer all operating leases to its balance sheet in line with IFRS 16 measurement model by April 2021. This new provision would materially impact on disclosure of the Trust's year-end statement of financial position. The Committee received and noted the action plan to fully implement IFRS16 by 1 April 2021. While the Committee

was reassured that the Trust had a plan in place it remained concerned about the complexity of transferring all operating leases and the risk to the Trust's financial position. The Committee asked for specific assurance to be addressed in a follow-up report and noted that it would maintain regular review of the Trust's progress on implementing IFRS 16.

2.3. Losses and Compensation and Debts Report (Bad Debts, Write-offs, Aged Debts)

The Committee considered the reports on losses and compensation and debts. The Committee noted and endorsed the proposal to write-off salary overpayments over 10 year old given that there was little chance to recoup these payments. The Committee heard that the management team planned to complete more proactive work managing salary overpayments and that the Committee would review this in due course.

2.4. Counter Fraud

The Committee also received the Counter Fraud report and there were no material matters of concern raised. The Trust remained vigilant in relation to key fraud risks especially those related to Covid-19 and continued to complete proactive work to increase awareness.

Recommendation

The Board is asked to note the report and note that the key areas of risk related to the Use of Consultants, DSP Toolkit, Cyber Security and impact of International Financial Reporting Standards 16 (Leases) and be assured that the Committee keep these areas under review.

Elizabeth Bishop
Audit Committee Chair, NED
July 2020

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 July 2020	**Agenda No**	**5.2**
Report Title:	**Board Assurance Framework (BAF) – Quarter 1 2020/21 Review**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Maria Prete, Risk Manager Alison Benincasa, Director of Quality Governance and Compliance		
Presented for:	**Approval**		
Executive Summary:	This paper sets out the Board Assurance Framework 2020/21 and provides a report of the strategic risk profile of the Trust. The Board approved the new Strategic Risks on the Board Assurance Framework (BAF) at its meeting in May 2020. The Board also agreed its risk appetite in relation to each of the new Strategic Risks and confirmed which risks would be reserved to the Board and which risks would be overseen by its Committees. In addition, the Board agreed a new structure of and approach to the BAF in order to draw out – for each of the Strategic Risks – the controls in place (and an assessment of their strength), the sources of assurance internally and externally (both positive and negative), the gaps in controls and assurance and the actions being taken to address the gaps, a set of key indicators for each risk, and an overview of emerging risks and opportunities. The BAF has been updated with the quarter 1 2020/21 assurance ratings and statements. The implications of Covid-19 for the Board Assurance Framework have been provided both as a high level overview and in details against each strategic risk. The appendix sets out the contributing risks from the corporate risk register as well as the methodology for scoring the BAF and descriptions of how the assurance ratings and control strengths are defined. **Quarter 1 Assurance ratings and risk scores:** Quarter 1 is the first assurance rating for the ten new strategic risks. Seven of the ten strategic risks have a 'partial' assurance rating, two have a 'limited' assurance rating and one has a 'good' assurance rating. There are seven extreme risks, one high risks and two moderate risks. **Strategic Risks reserved to the Board – SR4:** SR4 (system working) is reserved to the Board and the Board is asked to agree the assurance level of 'moderate' and a risk score of 8 (4x2).		
	The Board is asked: 1. For the strategic risk reserved to itself (SR4) to: • Agree the risk score and proposed assurance rating • Agree the proposed assurance statement 2. For the 9 risks assigned to its Committees to: • Approve the risk scores, assurance ratings and statements from the relevant Committee.		

5.2

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	As set out in the paper.		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Previously Considered by:	Workforce and Education Committee Quality and Safety Committee	**Date**	11.06.2020 23.07.2020
Appendices:	Full Board Assurance Framework Q1 2020/21		

5.2

Appendix 2 **Assurance ratings – definitions**

Significant Assurance	There are robust controls operating effectively to ensure that risks are managed and objectives achieved.
Partial Assurance	The controls are generally adequate and operating effectively but some improvements are required to ensure that risks are managed and objectives achieved.
Limited Assurance	The controls are generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and objectives achieved.
No Assurance	There is a fundamental breakdown or absence of controls requiring immediate action.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Board Assurance Framework 2020/21

Risk and Assurance Group
Quarter 1 report on full BAF

5.2

Stephen Jones
Chief Corporate Affairs Officer

Trust Board
30 July 2020

Executive Summary

The Board approved the new Strategic Risks on the Board Assurance Framework (BAF) at its meeting in May 2020. The Board also agreed its risk appetite in relation to each of the new Strategic Risks and confirmed which risks would be reserved to the Board and which risks would be overseen by its Committees. In addition, the Board agreed a new structure of and approach to the BAF in order to draw out – for each of the Strategic Risks – the controls in place (and an assessment of their strength), the sources of assurance internally and externally (both positive and negative), the gaps in controls and assurance and the actions being taken to address the gaps, a set of key indicators for each risk, and an overview of emerging risks and opportunities.

The BAF has been updated with the quarter 1 2020/21 risk scores, assurance ratings and assurance statements. Each of the Strategic Risks set out in the paper have been approved by the relevant Executive lead(s) and endorsed by the Executive Management Team. Strategic Risks 1, 2 and 10 have been reviewed and approved by the Quality and Safety Committee at its meeting on 23 July 2020. Strategic Risks 8 and 9 were reviewed by the Workforce and Education Committee at its meeting on 11 June 2020. The Finance and Investment Committee has not yet reviewed the Strategic Risks assigned to it (SR 3, 5, 6 and 7) related to operational performance, finance, ICT and estates, but it did discuss both financial and ICT risks at its meeting on 23 July and the analysis of the risks presented in this paper reflect that discussion. Going forward FIC will review the BAF risks assigned to it prior to the Board's quarterly review of the BAF.

At its meeting in May 2020, the Board considered whether to include in the BAF a stand-alone Strategic Risk relating to COVID-19. While it recognised the significant impact of COVID-19 on the Trust, it agreed that COVID-19 had an impact across all elements of the BAF and, as such, it was important to be clear about the impact of COVID-19 on each Strategic Risk and to bring together at the start of the report a combined assessment of the impact of COVID-19 on the BAF. This analysis is set out in this report.

Quarter 1 Assurance rating and risk scores:
Quarter 1 is the first assurance rating for the ten new strategic risks: Seven of the ten strategic risks have a 'partial' assurance rating; two have a 'limited' assurance rating; and one has a 'good' assurance rating (see appendix for detail and annex for definitions).

Risk scores:
At its meeting in May 2020, the Board agreed a new approach to scoring the BAF, moving away from the BAF risk scores being defined by the highest related risk on the Corporate Risk Register (CRR) and enabling the Board to take a balanced position as to the risk score informed by both the risks on the CRR and its judgement on the level of risk to the delivery of the strategy. There are seven extreme risks, one high risk and 2 moderate risks. Two particular risk scores are worth highlighting:

- In relation to SR1 (patient safety) the risk score of 16 reflects the impact of COVID-19 on treatments times and the risks associated with COVID-19 infection.

Executive Summary

- In relation to SR 8 (culture), the Workforce and Education Committee agreed that the risk score of 12 on the equivalent risks on the 2019/20 BAF were too low and asked that the Executive consider an appropriate score in light of recent developments. The People Management Group considered the scoring of this risk at its meeting on 22 July and considered whether this should be scored at 16 or 20 (the latter consequence 4 and likelihood 5). Ultimately, it agreed to propose a score of 20 but noted that this was a finely balanced judgement. But in light of the weaknesses of the current controls, the fact that new actions currently being taken are yet to have a full impact, and the underlying importance of the culture change programme to the delivery of the strategy, which was still in its diagnosis phase, the Group considered a score of 20 to be, on balance, appropriate.

Strategic Risks reserved to the Board – SR4 (system working):
Strategic Risk 4 in relation to system working is reserved to the Board. The Board is asked to agree the assurance level for this risk of 'moderate' based on the assurances from report to the Board with specific reference to the SWL Integrated Care System's (ICS) five year plan which sets out how it will deliver the priorities within the NHS Long Term Plan. The Trust is a member of the SWL ICS and contributed to developing the five year plan. The risk relates to the Trust's ability (as part of the SWL ICS) to deliver the fundamental changes necessary to transform and integrate services and deliver the ambitions set out in the five year plan. The proposed risk score for this risk is 8 (a consequence score of 4 and a likelihood score of 2). This broadly corresponds with the risk score of 9 on the 2019/20 BAF relating to system working, though the Board will wish to consider this in light of the significance of the developments in terms of system working.

Recommendation:

The Board is asked:

1. For the strategic risk reserved to itself (SR4) to:
    - Agree the proposed risk score and assurance rating
    - Agree the proposed assurance statement

2. For the nine risks assigned to its assuring committees to:
    - Agree the proposed risk scores, assurance ratings and statements from the relevant assuring committee

Strategic Risks: High Level Summary – Assurance Rating and Risk Score

Strategic Objective	Risk Reference	2020/21 Strategic Risks	Assurance Rating	Risk Score
1. Treat the patient, treat the person	SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation	Partial	Extreme - 16
	SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	Partial	High - 12
2. Right care, right place, right time	SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives	Limited	Extreme - 20
	SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London	Partial	Moderate - 8
3. Balance the books, invest in our future	SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities	Partial	Extreme - 25
	SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds	Partial	Extreme - 20
4. Build a better St George's	SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure	Partial	Extreme - 20
5. Champion team St George's	SR8	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity	Limited	Extreme - 20
	SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels	Partial	Extreme - 16
6. Develop tomorrow's treatments today	SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.	Good	Moderate - 9

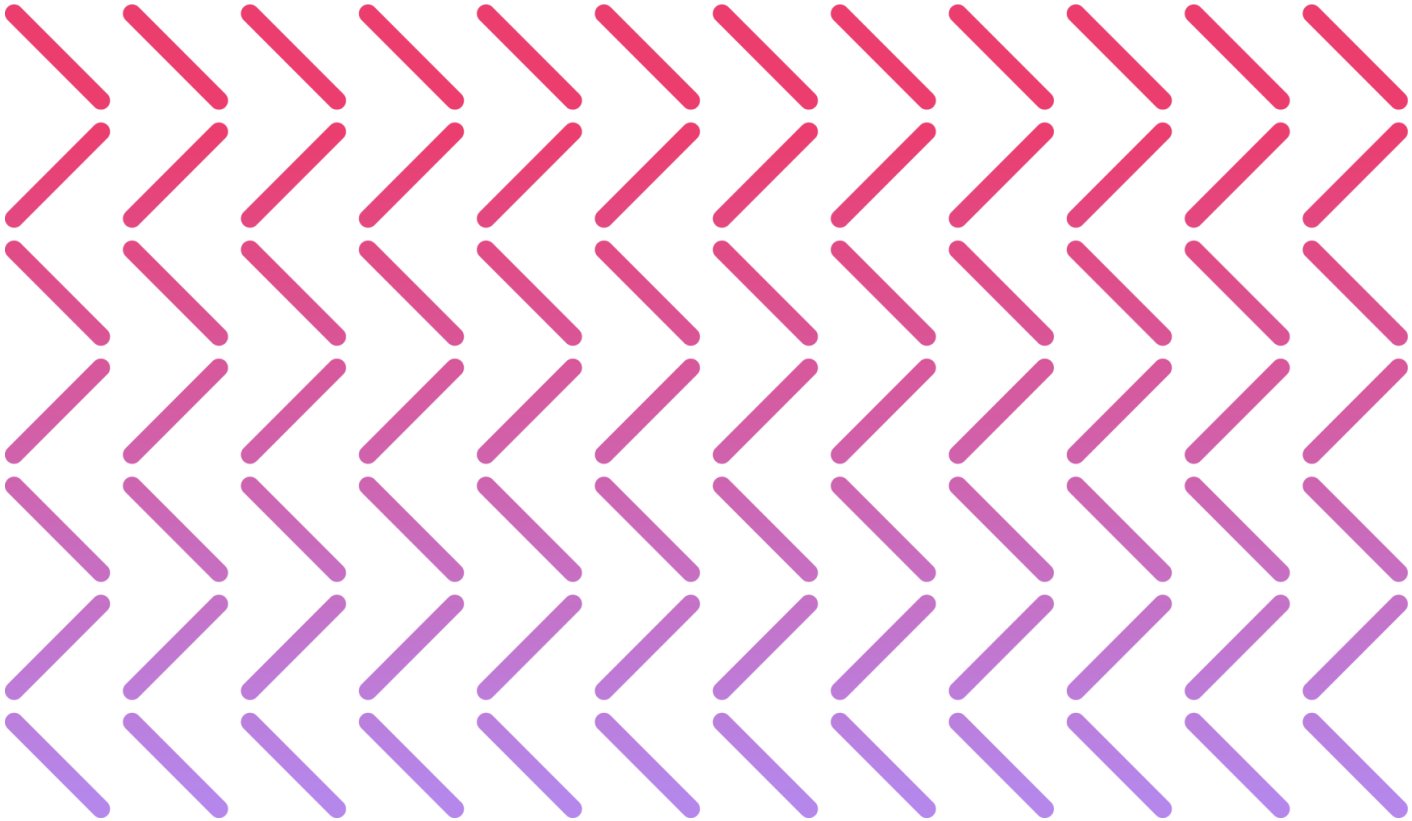
Covid-19: Implications for the Board Assurance Framework

Strategic Objective	Risk Reference	2020/21 Strategic Risks	Covid-19: Implications for the Board Assurance Framework
1. Treat the patient, treat the person	SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation	• Implemented a programme approach for rapid change to clinical pathways to protect patients and staff from infection whilst continuing to provide essential services • Patient Partnership and Experience Group members supported the development of messages to Loved Ones and were involved in the revised hospital visiting policy
	SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	• Temporary suspension of improvement work associated with the improvement actions from the 2019 CQC inspection and recommendations from the phase 1 and 2 external governance reviews. This work has now recommenced with revised dates • Development of the Clinical Safety Strategy to recommence elective services
2. Right care, right place, right time	SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives	• Reduced attendance was seen in the Emergency Department, a reduction was seen in the number of Two Week Rule referrals, reductions in first to follow-up in Outpatient Services although clinically required activity was undertaken on-sit or via virtual clinics , a minimal theatre list was maintained to respond to urgent and emergency treatments
	SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London	• Reduction in the scale and pace of delivery of the SW London Five Year Plan however, he collaborative approach adopted across SWL in the response to Covid-19 has accelerated cross boundary working and the integration and transformation of services • SW London Covid-19 Recovery Board established to collectively develop and implement a system wide Covid-19 recovery plan
3. Balance the books, invest in our future	SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities	• The Trust is block funded for M1-5, with "top-up" income received to cover any underlying deficit, on the condition the Trust is able to justify the financial position. Whilst this provides some short term mitigation to risk, this regime will not continue and therefore does not change the risk profile substantively
	SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds	• The Trust committed £8.6M of capital to directly respond to Covid-19 for which it has not received confirmation of funding from NHSE/I • COVID 19 has taken huge focus both internally and externally, meaning clarity on both capital and revenue funding regimes for the Trust remain uncertain
4. Build a better St George's	SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure	• Enhanced infrastructure requirements due to Covid-19 could create a wider gap between the condition of the existing estate and operational requirements • Some projects have been delayed due to Covid-19 (although others have been able to accelerate due to availability of spaces), longer term social distancing may also affect contractor timescales for delivery.
5. Champion team St George's	SR8	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity	• While in places it has fostered elements of a Team St George's spirit and staff network groups have continued to meet (and faith calendar days have been celebrated), it has also revealed issues relating to diversity and inclusion and willingness of staff to speak up • A number of engagement events have been paused (Go Engage pilot; TeamTalk
	SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels	• Staff were placed under intense pressure during the first surge, however the Trust was able to successfully redeploy staff and been able to reduce its agency spend during this period. Appraisal rates, however, have fallen and a number of education and training programmes have been delayed / deferred
6. Develop tomorrow's treatments today	SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.	• Most non-Covid-19 clinical research studies have been temporarily suspended since March 2020 and will re-start this month • The Trust has had the opportunity to participate in numerous Covid-19 clinical research studies and are currently first in the country for the number of active Covid-19 studies

Strategic Objective 1: Treat the Patient, Treat the Person
Strategic Risks SR1 and SR2

SR1:
Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality and learning across the organisation

SR2:
We are unable to provide outstanding care as a result of weaknesses in our clinical governance



Strategic Objective	Treat the patient, treat the person
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**

Risk Appetite / Tolerance	**LOW**	Patient safety is our highest priority and we have a **low appetite** for risks that impact on patient safety. Our appetite for risks affecting patient experience is also low, but is higher than for risks impacting on patient safety. If patient experience conflicts with patient safety, the safety of services will always be our highest priority.	**Assurance Committee**	**Quality and Safety Committee**
			Executive Lead(s)	Chief Nurse & DIPC Chief Medical Officer
			Date last Reviewed	23 July 2020

Current risk and assurance assessment

Improvements have been noted which saw the Trust formally removed from Quality Special Measures in March 2020 but the Trust still faces a number of challenges.

The Trust has key controls and sources of assurance in place, for example the process for the investigation and reporting of serious incidents which was rated by internal audit as providing substantial assurance and availability of Treatment Escalation Plans on clip which facilitates their promotion and auditability.

However, there are number of gaps in controls and sources of assurance, in particular the development of the year 1 implementation plan to drive the delivery of the quality priorities in the Quality and Safety Strategy and delivering the clinical standards for seven day services.

The current risk score of 16 (Extreme) highlights the level of risk the Trust is balancing with particular reference to infection control and avoidable harm across nine supporting risks (five of which relate to Covid-19).

The assurance strength is rated as partial to reflect the gaps in controls and the sources of assurance outlined above and overleaf which means there are weaknesses related to controlling this strategic risk.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	Extreme 16 = 4(C) x 4(L)	Partial	N/A	20 = 4(C) x 5(L)	6 = 3(C) x 2(L)
Q2					
Q3					
Q4					

Summary COVID-19 Impact

The Trust implemented a programme approach to facilitate rapid service change supported by a governance and risk assurance framework to safely stop services. The focus has now moved to phased recommencing of selected elective services directed by the recently developed Clinical Safety Strategy. Infection Prevention and Control guidance continues to be implemented and revised as and when required as directed by Public Health England.

The Trust has seen a reduction in the number of reported no and low harm incidents which correlates with the cessation of services e.g... endoscopy, on-site outpatients. The number of category 2 pressure ulcers has increased: due to the absence of validation of pressure ulcer category by the tissue viability nurses (both redeployed to critical care).

The Trust continued to investigate and report serious incidents and complaints. The number of declared serious incidents has not materially changed but the number of complaints has reduced by approximately 50%.

A number of meetings were suspended, including the Patient Partnership and Experience Group (PPEG). PPEG will hold a virtual meeting before the end of June 2020. PPEG members have been involved with developing the recently launched Messages to Loved Ones: an initiative where friends and relatives can send a message via email for delivery to the patient on the ward. PPEG members are also involved in discussions about the current visiting restrictions.

Strategic Objective	Treat the patient, treat the person
SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Quality and Safety Strategy in place and approved by the Trust Board (January 2020)	S				Trust removed from Quality Special Measures in March 2020 following improvements documented in CQC inspection report published in December 2019		X	X
					Treatment Escalation Plan (TEP) in place and implementation tracked in IQPR		X	
Serious Incident reporting and Investigation Policy including electronic incident reporting system (Datix) in place	S				Weekly review of serious incidents at serious incident declaration meeting and monthly report to PSQG and QSC (Note the Trust is currently awaiting the new Patient Safety Incident Reporting Framework)		X	X
					Internal Audit report including internal management action plan: rated substantial assurance		X	X
Complaints Policy in place	G				Quarterly complaints report to Patient Safety Quality Group identifying emerging themes and learning		X	X
					Internal Audit report including internal management action plan: rated reasonable assurance		X	X
					Friends and Family Test: provides a measure of how we learn from our complaints			
Infection Control Policy including Root Cause Analysis (RCA) for all C. Diff cases to ensure learning in place	S				Year end position for 2019/20: Hospital Acquired C.Diff - 43; MSSA - 37; and E-Coli - 74	X	X	
					May 2020: Hospital Acquired C.Diff -1; MSSA - 0; and E-Coli - 3	X	X	
					Infection control audit reports identifying emerging themes and improvement actions	X	X	
					Ward round monitoring to ascertain that infection control requirements are in place and followed and periods of increased Surveillance and Assessment (PISA)	X	X	
Early Warning Score training in place	G				EWS January 2020 audit :complete set of observations 75%; correctly scored 78%; Appropriate response 74%; Frequency 77%	X	X	
					Compliance with mandatory training – ALS BLS and ILS training are below 85% performance target	X	X	
					Critical Care Outreach team – funded establishment		X	

5.2

Strategic Objective	Treat the patient, treat the person
SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Gaps in resourcing of governance functions within the corporate and divisional teams impacting on learning across the organisation	Recruit to new positions as approved within the business plan Due date to be discussed with CQC	Sep 2020	
Implementation plan for Quality and Safety Strategy	Develop implementation plan and secure committee approval	July 2020	
Seven day clinical services standards (also see SR3)	Implementation of Divisional action plans to achieve seven day clinical service standards compliance	Sep 2020	
Critical Care Outreach team not recruited to full establishment	Critical Care recruitment plan to be reviewed and revised as partial recruitment only achieved due to Covid-19	July 2020	
Early Warning Score electronic devices not reliable due to IT issues as patient observations are not visible by the bedside. Lack of handheld devices to facilitate nurses' awareness of vital signs	Improve Early Warning Score electronic device availability in the wards through Wi-Fi and address cold spot	Jan 2021	
Learning from complaints - no standardised processes for distribution of key messages for learning	Deliver management action plan to standardise process for distributing key messages for learning from complaints throughout divisions	Aug 2020	
Friends and Family Test – patients not supported to respond due to impact of reduced footfall on site and removal of hand held devices due to infection control	Develop and implement alternative methods for patients to provide feedback	Aug 2020	
Electronic Sepsis screening tool for inpatients	Develop and roll out electronic screening tool on iClip	Aug 2020	

5.2

Strategic Objective	Treat the patient, treat the person
SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
All adult inpatients to have a Treatment Escalation Plan in place within 24 hours of admission					30% of all adult inpatients had a Treatment Escalation Plan in May 2020 which was above trajectory
Compliance with appropriate response to Early Warning Score (adult)					Compliance with Early Warning Score. January 2020 bi-annual audit: complete set of observations 75%; correctly scored 78%;Appropriate response 74%; Frequency 77%
Severity of reported incidents					Severity of adverse incidents – 93% No harm/ Low harm in April 2020
Number of declared serious incidents					4 serious incidents were declared in May 2020
Open serious incident investigations > 60 days					All serious incident investigations continue to be completed within the 60 day timeframe
Number of declared Never Events per month (0)					No Never Events were declared in May 2020
Infection Control (MRSA, C. Diff, MSSA, E-Coli)					Hospital Acquired C.Diff 3; MSSA 0; and E-Coli 8 reported in May 2020
Number of hospital acquired pressure ulcer category 3 and above					The number of category 3 pressures ulcers returned to normal levels this month
Safety Thermometer percentage of patients with Harm Free Care (new harm)					Safety thermometer– percentage of patients with harm free care fell to 96.1% and remains within target
Friends and Family Test					There was a reduced number of eligible responders across services. All services saw an increase in the number of positive responses apart from outpatients: the recommended rate reduced to 89.9% from 98.2% in April (against the target of 90%)

Emergent / future risks	Future opportunities
• Culture shift to embed quality improvement and learning does not happen, or does not happen quickly enough • Reputation of speciality services and impact on business • System working related to hospital specific clinical pathways may mean that we cannot manage our own activity • Impact of any future surge of Covid-19 on the Trust's ability to provide care to all patients in a timely way and on its capacity to learn from incidents • Unable to ensure effective patient engagement as a result of the impact of Covid-19 • Quality Improvement Academy does not have traction to effectively promote a culture of learning across the Trust	• We can utilise the data we hold related to our patients and the activity across our services to improve our learning in the organisation and how we plan and/ or deliver our services. We can also develop, adopt and promote key safety measurement principles and use culture metrics to better understand how safe our care is • The new National Patient Safety Incident Reporting Framework with its enhanced focus on learning will enable us to work together with our patients and their families to improve our investigation of incidents • Covid-19 provides opportunities to think differently about how we engage with patients, service users and their families

Strategic Objective	Treat the patient, treat the person							
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**							
Risk Appetite / Tolerance	**LOW**	We have a **low appetite** for risks that affect the robustness of our clinical governance structures, systems and processes as these can impact directly on the quality of care patients receive.	**Assurance Committee**	**Quality and Safety Committee**				
			Executive Lead(s)	Chief Nurse & DIPC Chief Medical Officer				
			Date last Reviewed	23 July 2020				
Current risk and assurance assessment	Improving clinical governance is a key priority in the Trust's Quality and safety Strategy 2019-24. The independent governance reviews undertaken in 2019 show that there is a need for significant strengthening of clinical governance. The Trust is in the process of implementing the recommendations from the reviews, but progress has been impacted by Covid-19. The Trust has taken a number of steps to strengthen the governance of its cardiac surgery service since the Trust received a NICOR alert in May 2017. Since the publication of NHS Improvement/ England independent mortality review report related to Cardiac Surgery the Trust has continued to engage with family members of the deceased patients. Duty of candour letters were sent to all family members and meetings have been held with some families. During March 2020 one cardiac operation was undertaken due to Covid-19. Update reports related to service improvements and continued governance protocols have moved to quarterly. The Trust has key controls and sources of assurance in place, for example the recently implemented Medical Examiner service which has reviewed of all Trust deaths in May 2020 and weekly care Group Leads meeting led by the Chief Medical Officer. There are number of gaps in controls and sources of assurance in particular the work to strengthen clinical governance as highlighted above by reducing variation in our processes for Mortality and Morbidity monitoring at care group level. The current risk score of 12 (High) highlights the level of risk the Trust is balancing across seven supporting risks including failure to act on diagnostic findings, to comply with the Mental Capacity Act and to improve clinical governance. The assurance strength is rated as partial to reflect the gaps in the controls and sources of assurance outlined and above overleaf which means there are weaknesses related to controlling this strategic risk.							
			Overall SR Rating – Quarterly Scores	**Period 2020/ 2021**	**Risk Score**	**Assurance Strength**	**Change** (last reporting period)	**Inherent Risk Score**	**Target Risk Score**
				Q1	**High – 12 4(C) x 3(L)**	**Partial**	**N/A**	**20 = 4(C) x 5(L)**	**6 = 3(C) x 2(L)**
				Q2					
				Q3					
				Q4					
			Summary COVID-19 Impact	The Trust implemented a programme approach to facilitate rapid service change supported by a governance and risk assurance framework to safely stop services. The focus has now moved to phased recommencing of selected elective services directed by the recently developed Clinical Safety Strategy underpinned by the Quality and Safety Strategy. Covid-19 has resulted in a temporary suspension of improvement work in particular relating to the Must and Should do actions within the Trust CQC action plan and the actions associated with the phase 1 and 2 governance reviews. The CNO and CMO have reviewed and revised the delivery dates for the improvement actions in the integrated clinical governance improvement plan. The delivery dates in the Trust wide CQC action plan for the Must and Should do actions have also been revised with the agreement of the CQC.				

Strategic Objective	Treat the patient, treat the person
SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Action plan to deliver improvements identified by the CQC	S				CQC inspection report December 2019: negative references to accuracy and safe storage of records and documentation of consent; positive references to services managing safety incidents well; and improved CQC rating for well led and a number of core services Trust exiting Quality Special Measures	X	X	X X X
Board agreement to invest in identified improvements to clinical governance	S				Phase 1 and phase 2 external governance reviews			X X
Improvement plan for Cardiac Surgery services	S				Independent external mortality review CQC inspection report December 2019: recognised improvements in Cardiac Surgery governance processes NICOR: The Trust is out of alert for cardiac surgery is within the expected mortality range	X	X	X X X
Risk management framework in place	P				CQC inspection report December 2019: negative references to documentation of risks on risk registers Internal audit report (internal management action plan in development)		X X	X X
Mental Capacity Act (MCA) and Liberty Protection Safeguards (LPS) strategy in place	S				MCA Steering Group reports to PSQG demonstrating progress against MCA strategy		X	
MCA level 1 and level 2 training programme in place	P				MCA level 1 and 2 training levels across all staff groups reported	X X	X X	
Medical Examiner System in place	S				Medical Examiner office reviewed all non-coronial inpatient deaths in May 2020		X	X
Mortality Monitoring Committee and Learning from Deaths lead in place	G				Learning from Deaths report including SHMI and sources of individual mortality alerts e.g.. NICOR		X	
Updated IT technical system to support eDischarge summary	P				Trust does not comply with NHS England Standard Contact for Discharge Summary			X

5.2

Strategic Objective	Treat the patient, treat the person
SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Gaps in resourcing of governance functions within the corporate and divisional teams impacting on learning across the organisation	Recruit to new positions as approved within the plan New due dates to be discussed with CQC	Sep 2020	
Delivery dates for agreed actions in the CQC action plan not achievable due to impact of Covid-19	Revise delivery dates for CQC Must and Should do actions and ensure delivery against the revised dates New due dates have been agreed with CQC	Jun 2020	Complete
MCA Steering Group to co-ordinate delivery of the MCA and LPS Strategy currently suspended	Agree membership for MCA Steering Group and re-start meetings Membership agreed. Group to restart meeting in September 2020	Jun 2020	Complete
MCA level 3 training module not developed	Develop and implement MCA level 3 training module. Level 3 / Champions programme delayed due to competing priorities / limited resource	Mar 2021	
No electronic templates for the recording of capacity assessment and best interest decisions on iClip	Implement the agreed templates for capacity assessment and best interest decisions within iClip	Oct 2020	
OrderComms catalogue not kept up to date therefore not all results are reported via Cerner	Update Cerner OrderComms catalogue	TBC	
eDischarge Summary Form not available on iClip	Finalise the eDischarge form to be included onto iClip	TBC	
No audit process for patient record documentation including consent	Develop and implement audit process No audit process for patient record documentation including consent and monitor resultant action plans	TBC	

5.2

Strategic Objective	Treat the patient, treat the person
SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Progress against phase 1 and phase 2 governance reviews					Learning from Deaths lead in place. Job descriptions for new roles drafted and agenda for change banding currently being finalised. New roles to be advertised by end June 2020.
Maintaining the SHIMI within the confidence level (<0.1)					SHMI 0.85
Open serious incident investigations > 60 days					All serious incident investigations continue to be completed within the 60 day timeframe
Readmission within 28 days (linked to failure in discharge planning)					7% readmission rate in March and April 2020 against a mean performance of 8.4%
Number of open actions on CQC Trust wide action plan (2 Must dos: 44 should dos)					46 open actions. Progress impacted by Covid-19
MCA level 1 and level 2 training performance					Level 1 MCA training compliance within target (90%), level 2 compliance is 76% in May 2020 against 85% target
Diagnostic indicators – DM01					May 2020 performance was 47.8% against the target threshold of 1%. However, this was an improvement from 63.6% in April

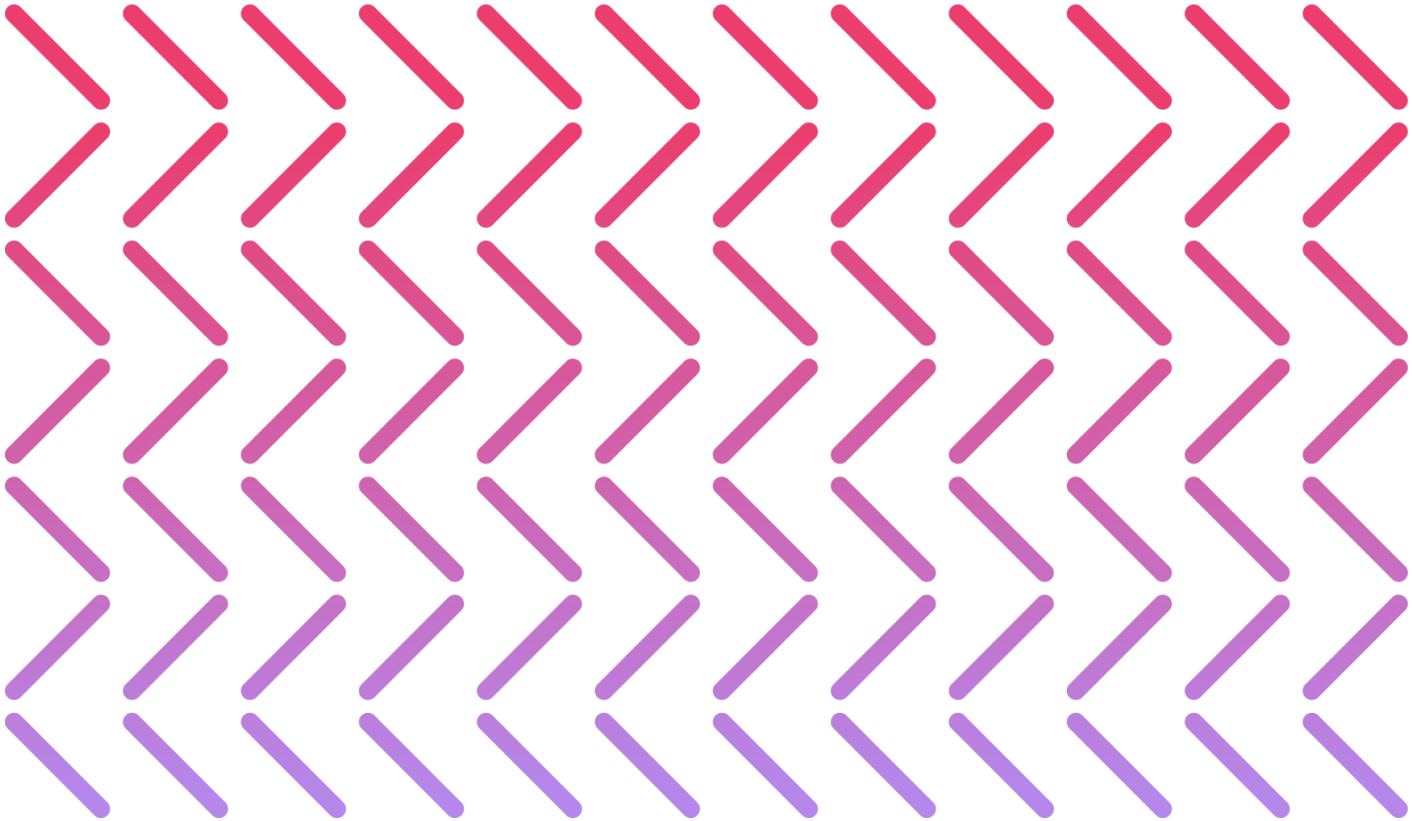
Emergent / future risks	Future opportunities
• A second wave of Covid-19 may impact on the delivery of improvement actions in the Trust CQC action plan and the Integrated Clinical Governance review action plan	• The phase 3 governance review, looking at ward to Board reporting and monitoring of quality and safety, will help to provide further clarification on reporting structures and further strengthen the Trust's reporting and accountability framework • IT developments to support new ways of working e.g... care group meetings and communication

5.2

Strategic Objective 2: Right Care, Right Place, Right Time
Strategic Risks SR3 and SR4

SR3:
Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

SR4:
As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London



Strategic Objective	Right care, right place, right time
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**

Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that impact on operational performance as this can impact on patient safety, but our appetite here is higher than for risks that directly affect the safety of our services	**Assurance Committee**	**Finance and Investment Committee**
			Executive Lead(s)	Chief Operating Officer
			Date last Reviewed	23 July 2020

Current risk and assurance assessment

Improvements have been made in our technology and the Trust has key controls and sources of assurance in place, for example the continued roll out of Windows10 and Microsoft teams has facilitated the provision of virtual clinical services and the video conferencing system for patients (Attend Anywhere) is now in use with supporting laptops, webcams and headsets installed.

However, there are a number of gaps in controls and sources of assurance as given the significant increase in the number of virtual users, the existing infrastructure now requires significant investment to ensure its stability and functionality.

In addition, although some progress has been made the Trust has not achieved the clinical standards for seven day services.

The assurance strength is rated as limited to reflect the impact of Covid-19 and the gaps in controls and the sources of assurance outlined above and overleaf which means there are weaknesses related to the control of this strategic risk.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	**Extreme – 20 5(c) x 4(L)**	**Limited**	N/A	**25 = 5(c) x 5(L)**	**6 = 3(c) x 2(L)**
Q2					
Q3					
Q4					

Summary COVID-19 Impact

The Trust has seen on average less than 200 patients attend the ED and the 4 hour operating standard for April was 88.3%, which was above the overall performance for London.

The Trust was below target for five out of the seven cancer standards. There has been a reduction in the number of TWR referrals. All cancer patients continue to be tracked and reviewed through MDTs and all TWR referrals are being triaged by consultants and where needed face to face appointments and diagnostics are continuing.

In outpatients all specialities have seen significant reductions in first and follow-up activity whilst the Trust reviewed and reprioritised activity in response to Covid-19. Clinically required activity was undertaken on-site or in virtual settings. There remains an element of catch up in terms of recording patient outcomes for virtual clinics. Elective activity has reduced with the exception of Haematology and Oncology. A minimal theatre schedule was implemented and offered only urgent and emergency treatments booked through a clinically led prioritisation process. As staff and capacity returned to anaesthetics and theatres more elective lists are starting to be run and is continually kept under review. As a result of all of the above bed occupancy has seen a reduction.

Strategic Objective	Right care, right place, right time
SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Clinical Safety Strategy	S				Clinically driven plan agreed at Operational Management Group and approved at Quality and Safety Committee		X	
Insourced company to manage adult and paediatric ECHO	R				Performance included in Integrated Quality and Performance Report (IQPR)		X	
Digital strategy - ICT Work plan aligned to Digital strategy	G				Annual penetration test last conducted Mar 2019 National "Cyber Essentials Plus" or equivalent becomes mandatory by April 2021 Information Governance Group		X	XX X
VDI	G				Improvement noticed by users Q4 of 2019/20 and reported to IGG but then Covid19 pandemic increased homeworking/remote working and further improvements are now necessary to meet the 'new normal'	XX		
Virtual clinics – video conferencing system with patients (Attend Anywhere) in use with supporting laptops, webcams and headsets installed; operational management by Corp OPD	R				Information Governance Group		X	
New workflow in iClip for Referral Assessment Service clinics as part of Covid19 changes	S				ICT Outpatient Project Steering Group and the Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of iCLIP clinic documentation for physical or virtual OPA available.	S				Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of Office365 and Microsoft Teams to support MDT cancer and orthopaedic meetings and further roll out in progress	S				ICT Covid-19 Service Management Report presented to IGG in April 2020		X	
ED rapid assessment and triage process in place	G				Clinical pathway and Standard Operating Procedure (SOP)	X		
Direct access pathways	G				Clinical Pathway and SOP	X		
Partnership working between ED and local Mental Health organisations to improve care and waiting time for patients attending the ED with mental health needs	R				Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	G				Clinical Pathway and SOP	X		

Strategic Objective	Right care, right place, right time
SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Seven day clinical services standards	Implementation of Divisional action plans to achieve seven day clinical service standards compliance	Sep 2020	
Availability of paediatric trained physiologist / ECHO technicians to carry out ECHO	Recruitment of vacant post within the new cardiac physiology structure	Nov 2020	
Cyber security	Implement recommendation to improve cyber security - 2020/21 Project Plan Recommended actions to improve cyber security are in place or being put in e.g.. Microsoft Win10 project, SQL2016 project. The network is segmented via VLAN, migration from N3 to HSCN was completed, password policy drafted. Forcepoint and IPS in place	Mar 2021	
ICT disaster recovery plan – require solution for 2nd data centre	ICT Project Plan in 2020/21 includes provision for second data centre	Mar 2021	
Outpatient virtual clinic, RAS and Attend Anywhere projects not fully implemented yet	Complete the ICT outpatient projects that are in flight	Sep 2020	
MDT teleconferencing for SWLP, equipment not yet provisioned; workflows changed due to Covid-19	ICT Project Plan 2020/21 to improve hardware and workflow for MDT teleconferencing.	Sep 2020	
Data warehouse capacity - not built to deal with current volume of data / continue use of paper based records. Cerner nightly extracts being terminated.	Project to improve data warehouse in capital plan for 20/21. Needs to also include replacement of nightly Cerner extracts for activity reporting	Mar 2021	
Multiple clinical systems which do not interoperate leading to fragmented clinical records (use of standalone systems not using patient MRN as single identifier)	Projects for Outpatients and Theatres in 2020/21 ICT Project plan	Dec 2020	
Clinical Decision Outcome Form (CDOF) not incorporated within iClip	Incorporate CDOF into iClip	Mar 2021	

5.2

Strategic Objective	Right care, right place, right time
SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
ED attendances					- 60.96% variance against the 20/21 year to date plan (pre-Covid-19 SLA plan) April 2020
Inpatient – non elective					- 40.16% variance against the 20/21 year to date plan (pre-Covid-19 SLA plan) April 2020
Inpatient – elective and day case					- 82.83% variance against the 20/21 year to date plan (pre-Covid-19 SLA plan) April 2020
Outpatient attendances					- 51.82% variance against the 20/21 year to date plan (pre-Covid-19 SLA plan) April 2020
RTT					TBC
6 week Diagnostic Performance					- 63.6% adverse performance against 1.0% performance target/threshold April 2020
ED 4hr operating standard					88.3% for April 2020, higher than the overall London performance
Cancer 14 Day Standard					81.6% for March 2020
Cancer 62 Day referral to Treatment Standard					82.6% for March 2020

Emergent / future risks	Future opportunities
Cerner nightly extracts being terminated so need to rebuild reporting in data warehouse to meet SUS/SLAM etc requirements	The restructure of the Genomics services will increase the demand on ECHO

Strategic Objective	Right care, right place, right time			
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**			
Risk Appetite / Tolerance	**MODERATE**	Because we recognise that significant changes are necessary across the South West London system, we have a moderate appetite for risks that impact on system transformation and cross-system working in order to facilitate changes that will improve care for patients across South West London.	**Assurance Committee**	**Trust Board**
			Executive Lead(s)	Suzanne Marsello
			Date last Reviewed	25 June 2020

Current risk and assurance assessment

The SWL Integrated Care System's five year plan sets out how it will deliver the priorities within the NHS Long Term Plan. The Trust is a member of the SWL ICS and contributed to developing the five year plan. The risk relates to the Trust's ability (as part of the SWL ICS) to deliver the fundamental changes necessary to transform and integrate services and deliver the ambitions set out in the five year plan. Also, as the Trust works towards working toward SWL system priorities there is a risk that these may not directly link with St George's.

The Trust is an active member of the various forums across the SWL ICS and has opportunity to influence the future direction which also provides opportunity for the Trust to better understand it's role in delivery. The Trust's CEO is a chair of the Acute Provider Collaborative which has a focus on developing standardised clinical pathways. The Trust is also represented on the SWL 'enabler' workstreams such as workforce, digital , estates and finance.

The Trust's workforce strategy which was approved by Trust Board in November 2019 will support the Trust to develop the future workforce models required to deliver the ambitions.

The management and clinical capacity within the Trust does pose a challenge going forward to enable sufficient engagement with the clinical priorities at SWL and Borough level.

Given the change in focus and priorities as part of the SWL Covid-19 Recovery Plan there is likely to be some impact on the programmes of work that were agreed and in progress as part of the SWL ICS and potentially the Acute Provider Collaborative and St George's role in these. Whilst the objectives of the new structure does reflect the need to progress with the ambitions of the SWL Five Year Plan it is inevitable that some of the earlier priorities will need to be reviewed particularly in terms of the pace and scale of delivery. (See further note on this in 'Summary of Covid-19 Impact).

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	**Moderate 8 = 4(c) x 2(L)**	**Partial**	N/A	16 = 4(c) x 4(L)	6 = 3(c) x 2(L)
Q2					
Q3					
Q4					

Summary COVID-19 Impact

- The SWL ICS response to and continue planning for Covid-19 will have an impact on the scale and pace of delivery of the priorities set out in the SWL five year plan and the Trust's contribution to these
- The SWL ICS has established a Covid-19 Recovery Board which will oversee development and delivery of the SWL ICS Covid-19 recovery plan. A plan is to not only ensure the system can continue to respond to the on-going threat of Covid-19 but to also start to make progress in deliver the priorities in the five year plan. However this may mean there are some things which may need to be reprioritised
- The Trust CEO is a member of the SWL ICS Covid-19 Recover Board and Steering Group and is the chair of the Acute Cell which leading a collaborative approach to the re-starting of services
- The collaborative approach adopted across SWL in the response to Covid-19 has accelerated cross boundary working and the integration and transformation of services.

Strategic Objective	Right care, right place, right time
SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
The SWL ICS Programme Board on which the Trust CEO is a member	R				• CEO representation on the Board • Quarterly SWL ICS Updates to Trust Board		X	X
The Trust is a member of the SWL Acute Provider Collaborative	R				• The APC is chaired by the Trust CEO and has a focus on clinical pathway standardisation		X	X
SWL Covid-19 Recovery Structure has been established	R				• Trust representation on key workstreams • CEO is a member of the Recovery Board and chair of the Elective Recovery Programme		X	X
SWL Clinical Senate - set the clinical priorities for SWL	R				• The Trust is represented on the Clinical Senate by the CMO		X	X
SWL ICS Five Year Plan - the Trust contributed to developing the five year plan which set the priorities for SWL	R				• The Trust is represented at all SWL Integrated Care System meetings • The SWL ICS and Acute Provider Collaborative Forums allow general oversight of commissioner and provider plans to develop relationships outside the sector • The Trust is an active contributor to the key 'enabling' workstreams across the SWL ICS e.g. Workforce, Digital, Finance		X	X
A Wandsworth and Merton Provider Partnership Board is in place	R				• The Trust is represented on this Board and is a forum for agreeing the approach to place based transformation		X	X
SWL Covid-19 Recovery Plan - driving greater collaboration	R				• The Trust CEO is a member of the SWL ICS Covid-19 Recovery Board , Steering Group and is chair of the Acute Cell		X	X
The Trust Workforce Strategy approved by Trust Board in November 2019 – a key driver being delivery of the SWL five year plan as well as the Trust's clinical strategy	R				• Implementation plans are in place and being delivered against		X	
Annual review of Trust Strategy	R				• The review of Trust strategy undertook in June confirmed that the priorities are still relevant taking account the changes in the external environment.		X	
Trust contribution to the Wandsworth and Merton Local Health and Care Plans	R				• The CSO is a member on both of the Borough Health and Care Partnership Boards • The CSO chairs the Wandsworth Borough Estates Strategy Working Group which will reflect any changes in clinical priorities		X	X

Strategic Objective	Right care, right place, right time
SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Limited clinical and management capacity within the Trust to engage with and deliver the clinical priorities for Wandsworth and Merton as set out in their respective Local Health and Care Plans	Both Wandsworth and Merton Health and Care Partnership Boards are to review the priorities in the LCHP in light of Covid-19 and this will provide an opportunity to re-assess the Trust's role in delivering these (The Trust is represented on both Boards) Future business planning activities to take account of the Trust's contribution to delivering the key priorities in the LHCP	TBC	
There is the potential for a gap in information sharing and oversight across the Trust with different Trust Executives representing the Trust on different SWL meetings	The Strategy Team is to develop a process to track Trust representation at key SWL meeting including identifying key priorities and potential implications for the Trust to ensure there is Trust wide oversight	Aug 2020	
With Covid-19 recovery being planned at SWL ICS level there is potential for Wandsworth and Merton Borough level priorities to be over-looked	Wandsworth and Merton Provider Board meetings which are attended by the Trust CEO are to identify any particular issues and so to act as the bridge between borough and system level planning	March 2021	
Trust's ability to fully utilise the space most effectively at QMH as part of the Covid-19 recovery response is constrained by financial agreements in place	The CFO to have discussions with the CCGs to agree principles as part of the wider QMH programme priorities	TBC	Not started

Strategic Objective	Right care, right place, right time
SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
A SWL Covi19 recovery plan in place					The Trust is represented on the SWL Recovery Board and associated workstreams leading the development of the Covid-19 recovery plan.
Clinical Safety Strategy in place and has identified revised clinical pathways across SWL					6 clinical networks have been established as part of the SWL recovery plan and additional clinical networks are currently being established
The number of clinical networks which are fully established for which SGUH is the lead provider					SGUH is the lead provider for ENT and Urology and these networks have been established. SGUH has also been identified as lead provider for Neurosciences and Cardiology which are currently being established
The number of key SWL meetings that have appropriate representation from SGUH					The CEO is a member of the SWL ICS Programme Board and SWL Recovery Board , chair of the Elective Recovery Programme and APC. Borough level meetings are represented by the Chief Strategy Officer. Future process to map attendance and outcomes of SGUH representative at key meetings is being developed during Q2
Delivery of Clinical Strategy implementation plans	n/a				Plans have been revised during Q2 to reflect any implications of Covid-19 and first progress report to Trust Board is due in September 2020
Delivery of Corporate Support Strategy implementations plans	n/a				Development of implementation plans was paused during Q1 due to Covid-19 and are being developed and approved during Q2. First progress report to Trust Board is due in September.

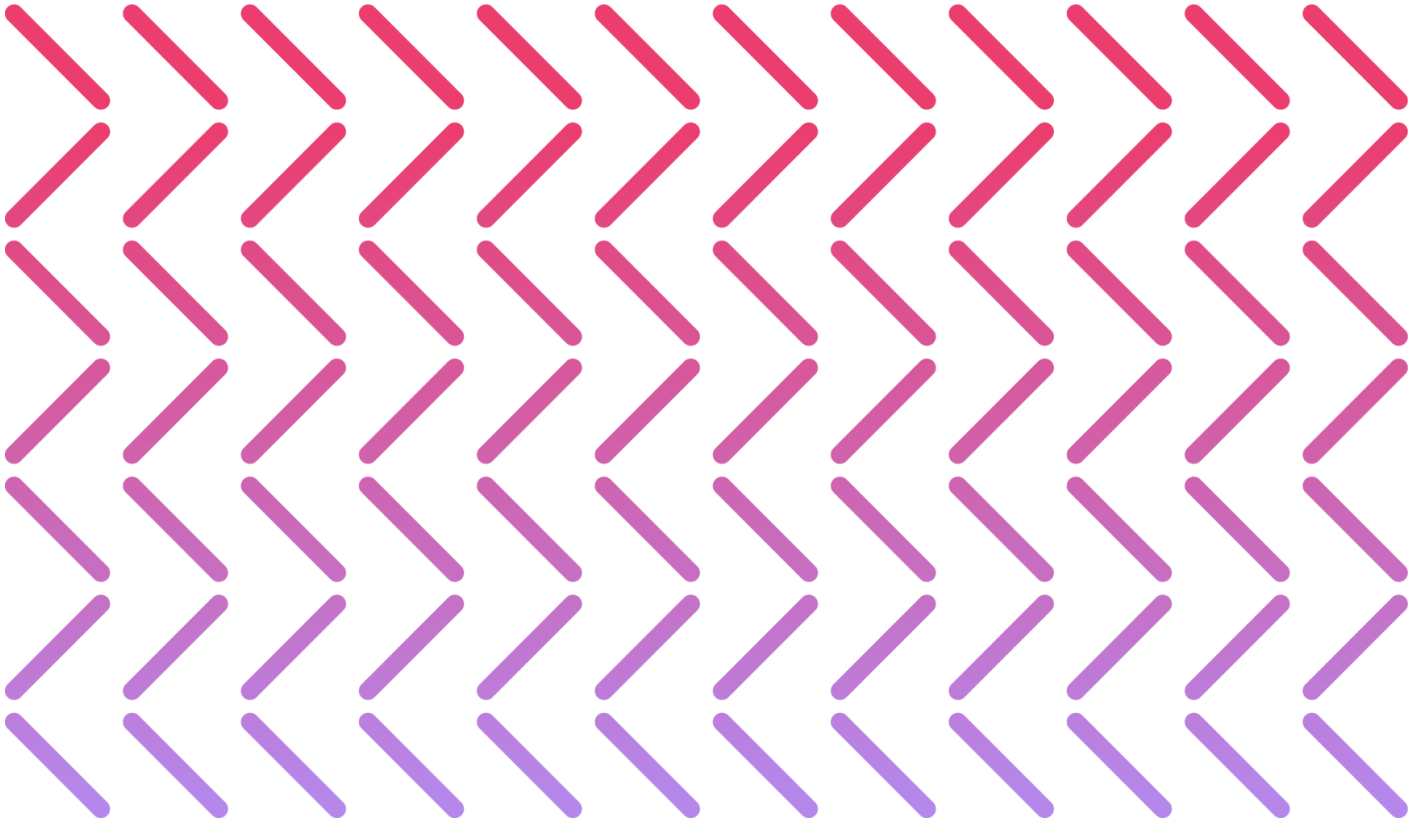
Emergent / future risks	Future opportunities
The continued focus on the response to Covid-19 for the foreseeable future and the threat of a second wave may put additional pressure on the clinical and management capacity within the Trust to focus on SWL five year plan priorities The outcome of the Improving Healthcare Together programme may present some risks to the Trust's ability to manage the potential increase in demand	The SWL Covid-19 Recovery Programme Board and associated recovery plan will provide an opportunity for enhanced collaborative working to achieve greater integration and transformation of services The outcome of the Improving Healthcare Together programme may provide an opportunity for greater collaboration between St George's, Epsom and St Helier and the Royal Marsden

5.2

Strategic Objective 3: Balance the books, invest in our future
Strategic Risks SR5 and SR6

SR5:
We do not achieve financial sustainability due to under-delivery of cost improvement plans and failure to realise wider efficiency opportunities

SR6:
We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds



Strategic Objective	Balance the books, invest in our future
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**

Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that will threaten the Trust's ability to deliver services within our financial resources	**Assurance Committee**	**Finance and Investment Committee**
			Executive Lead(s)	Chief Finance Officer
			Date last Reviewed	25 June 2020

Current risk and assurance assessment

- Financial planning in the NHS was postponed at the beginning of the pandemic, which included the requirement to develop a CIP plan in its traditional sense. This provides a risk to the organisation getting out of the 'rhythm' of delivering CIPs
- The Trust has continued pursuing delivery of CIPs with procurement, lead by the CFO and Director of Procurement.
- Divisional financial performance is being picked up through the Operational Management Group, through to Trust Management Group.
- Divisions are being met on a monthly basis by the Deputy CFO to review overspends, and underspends. Equal attention is being given to both as ensuring underspends on areas of lower activity due to the pandemic will form a material part of the financial recovery plan.
- A governance structure for financial performance review and escalation is currently under review, in response to the Trusts governance structure review.
- Financial performance of the Trust is being compared at South West London level through the CFO's, as well as at London level with the CFO network of tertiary Trusts in the region.
- A £42.7m planning gap currently remains due to shortfalls in block funding due to the national method for calculating this.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	**Extreme 25 = 5(c) x 5(L)**	Partial	N/A	**25= 5(c) x 5(L)**	**6 = 3(c) x 2(L)**
Q2					
Q3					
Q4					

Summary COVID-19 Impact

- **The COVID 19 pandemic resulted in usual financial governance arrangements being postponed (e.g. weekly Tuesday finance meetings)**
- **Temporary governance arrangements have been put in place to ensure that all spend above £50k related to COVID-19, and not within budgets is signed of by a member of the executive team and the CFO**
- **Monthly reporting will review spend to ensure costs are stepped down where expected, and cost increases due to COVID-19 are reasonable and justified**
- **The Trust has received indication that organisations will be funded at a level to break even if it can be evidenced that spend levels are reasonable**
- **The Trust has been instructed by NHSE to report a breakeven position for M1 2020/21**

5.2

Strategic Objective	Balance the books, invest in our future
SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Financial performance monitoring through SWL FAC to highlight areas for escalation and of discrepancy	L				SWL Monthly Finance Report			x
Monthly divisional finance meetings with in place with DCFO to discuss areas for escalation (underspends/overspends)	S				Monthly divisional finance reports	xx	xx	
Monthly reporting of financial issues through to OMG, TMG, FIC and Trust Board	S				Monthly Trust finance reports	xx	xx	
Monthly external review of Trust position by NHSE/I as part of monthly top-up payment review	S				Top up payment made to Trust		x	x

5.2

Strategic Objective	Balance the books, invest in our future
SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
South West London financial performance management structure in place to drive and ensure financial performance and best practise within sector	- Trust to lead development of financial governance with SWL ICS	Sept 20	
Baseline budgets that are out of date with current situation	- Financial forecast to be developed to drive improvement and efficiency within divisional positions	Aug 20	
Lack of consistent performance management within divisions, down to directorate and Care Group level	- DCFO to seek assurance of divisional financial governance arrangement, and intervene where necessary.	Sept 20	
No formal CIP plan of efficiency plan in place	- CIP/efficiency targets to be established alongside financial forecast	Oct 20	
Capacity plan not fully developed inline with new working environment post COVID	- Capacity plan to be agreed in line with financial forecasts and performance trajectories through OMG	Sept 20	
Lack of accountability within services for financial performance and delivery	- Finance to be included within objectives of all leadership posts with financial responsibility within the organisation	Nov 20	

Strategic Objective	Balance the books, invest in our future
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Financial balance achieved YTD					Financial balance reported at M3 due to expected “top-up” income
Financial balance forecast through to year end					Forecast complete, but awaiting confirmation of funding regime.
CIP/improvement plan to be agreed and delivered					CIP plan still a work in progress. More progress made in Procurement and Pharmacy
SWL plan to be developed to remain within control total					First draft SWL forecast due end of July. Funding regime to be confirmed.

Emergent / future risks	Future opportunities
- 20/21 spending enveloped expected to be received in the next month - Competing priorities within divisions meaning finance isn't prioritised	- 20/21 spending enveloped expected to be received in the next month - Financial improvement through further collaboration within the SWL Integrated Care System

5.2

Strategic Objective	Balance the books, invest in our future
SR6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**

Risk Appetite / Tolerance	**LOW**	Due to the importance of securing investment in the Trust's ageing estates infrastructure, we have a low appetite for risks that could impact on the availability of capital	**Assurance Committee**	**Finance and Investment Committee**
			Executive Lead(s)	Chief Finance Officer (CFO)
			Date last Reviewed	25 June 2020

Current risk and assurance assessment

- Capital Department Expenditure Limit (CDEL) set at SWL level c£40m below Trust individual plans
- Prioritisation completed at SWL level as part of planning process
- Trusts plans currently has ££24m funding gap between essential projects, and internally generated funds
- COVID capital bids submitted to NHSI for expenditure already incurred, and further expenditure required in future. 19/20 agreed and funded, but no confirmation on 20/21 items
- Alternative sources of funding to continue to be explored where feasible. (i.e. Leasing)
- Monthly reviews taking place with Deputy CFO to ensure urgent items to mitigate significant clinical risk are addressed, whilst considering the material financial risk to proceeding with the full programme

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	Extreme 20 = 4(c) x 5(L)	Partial	N/A	20 = 4(c) x 5(L)	6 = 3(c) x 2(L)
Q2					
Q3					
Q4					

Summary COVID-19 Impact

- The Trust has committed to material capital spend in response to the COVID 19 pandemic (£8.6m), for which it has not received confirmation of funding from NHSE/I
- Further spend is required to ensure activity can safely be stepped up inline with IPC standards. Detail of this is currently being worked through as part of the Operational Management Group
- It is likely that the national response to COVID-19 has committed significant capital; putting material strain on "business as usual" capital funding

5.2

Strategic Objective	Balance the books, invest in our future
SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly reporting to FIC and Trust Board on key areas of risk, both financially, and due to non-investment.	S				Monthly finance reports		x	
Weekly COVID Capital funding update and discussion at OMG, to review clinical urgency of requests.	S				Weekly update to OMG on status of COVID capital bids		x	
Evolution and development of capital prioritisation at SWL level through CFO meeting (FAC)	S				SWL Capital Plan report		x	

5.2

Strategic Objective	Balance the books, invest in our future
SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Confirmation of emergency financing to fund essential programme of capital works	Pursue emergency funding through the ICS through to NHSI/E London through CFO	Aug 20	
No alternative means of financing identified to fund programme	Alternative methods of financing current programme to be developed by DCFO	Aug 20	

5.2

Strategic Objective	Balance the books, invest in our future
SR6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**

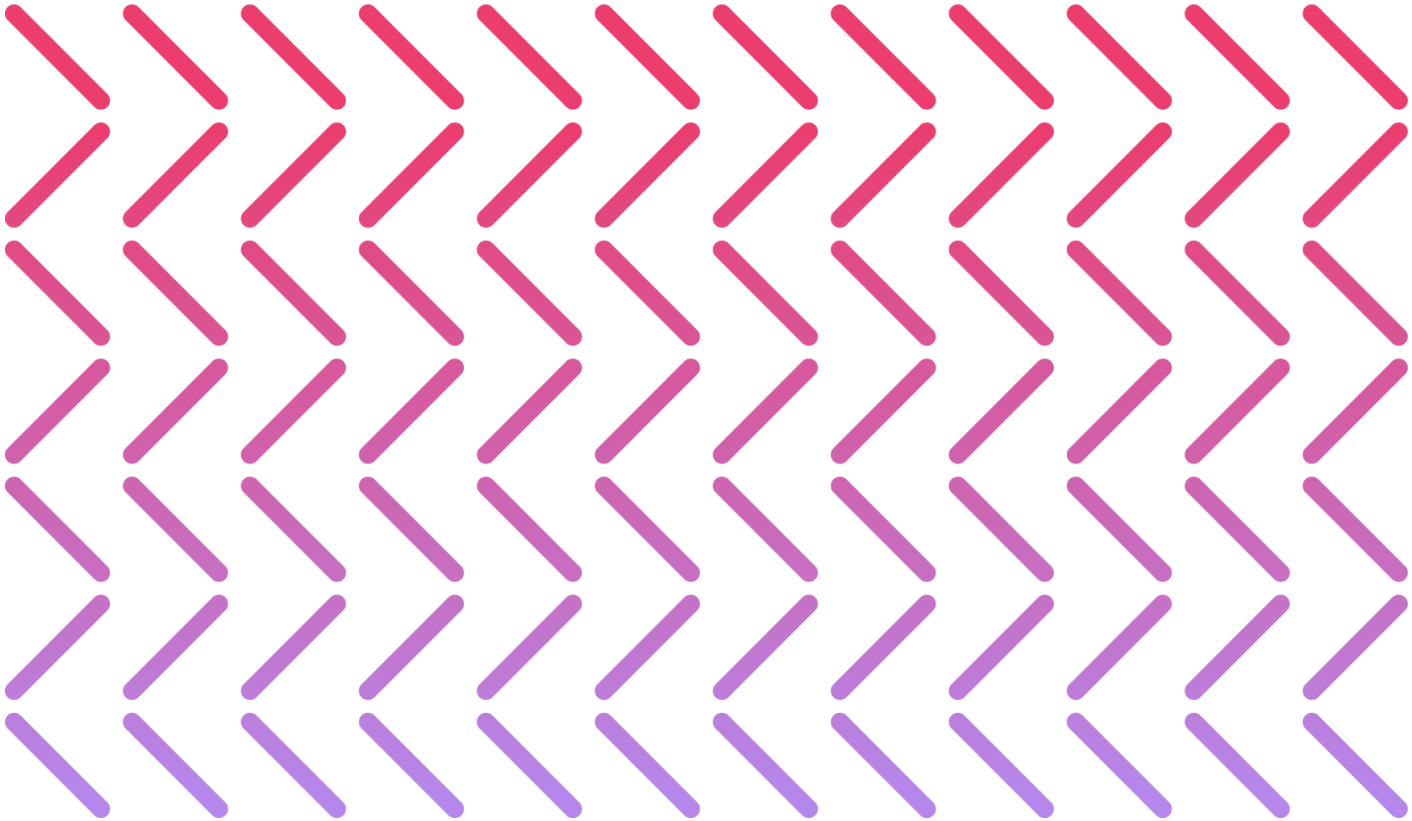
Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Funding confirmed for full capital programme					Discussions continue with SWL ICS and NHS London to confirm funding for full plan
Reduction of clinical risk resulting from old equipment estate infrastructure and IT					Additional risks emerging due to COVID. Spending continuing at risk to mitigate risks
Capital spend at full value of plan in 20/21					£9m of programme "paused" pending funding decision

Emergent / future risks	Future opportunities
- Further emergency capital works required above current plan due to unstable state of current estates and IT infrastructure - Further capital spend on COVID required to deal with second wave	- Emergency capital funding made available from NHSE/I - Further prioritisation within SWL to move money to address material and urgent risk at St George's

5.2

Strategic Objective 4: Build a better St George's
Strategic Risk SR7

SR7:
We are unable to provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure



Strategic Objective	Build a better St George's								
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**								
Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that affect the safety of our patients and staff	**Assurance Committee**	**Finance and Investment Committee**					
			Executive Lead(s)	Chief Finance Officer					
			Date last Reviewed	23 July 2020					
Current risk and assurance assessment	Our current risk assessments indicate that this is a High risk for the Trust. We are in the process of implementing enhanced assurance processes based upon the Premises Assurance Model and reviewing our risk management processes. As we implement the above, we will be better able to review the costs associated with resolving long standing condition issues. This will enable the Board to make informed decisions on the future investment needs and priorities. These priorities should also be informed by the agreement of a new Estate Strategy that is better informed by the Clinical Strategy, thereby supporting the transformation of services. We anticipate undertaking this assurance and strategy work over the next 6-9 months, with a risk reduction programme then taking 2-3 years to complete, subject to suitable investment.		**Overall SR Rating – Quarterly Scores**	**Period 2020/ 2021**	**Risk Score**	**Assurance Strength**	**Change (last reporting period)**	**Inherent Risk Score**	**Target Risk Score**
				Q1	**Extreme 20 = 4(c) x 5(L)**	Partial	N/A	**20 = 4(c) x 5(L)**	**6 = 3(c) x 2(L)**
				Q2					
				Q3					
				Q4					
			Summary COVID-19 Impact	The impact of future change and investment due to the long-term effects of Covid-19 needs to be carefully considered and coordinated so that this potential investment can be used to assist with the mitigation of this risk. It is important that planning for future Covid-19 projects consider condition issues of the estate. The impact of possible surges could limit the extent to which we can deliver improvement measures on the estate Enhanced infrastructure requirements due to Covid-19 could create a wider gap between the condition of the existing estate and operational requirements Some projects have been delayed due to Covid-19 (although others have been able to accelerate due to availability of spaces), longer term social distancing may also affect contractor timescales for delivery.				

5.2

Strategic Objective	Build a better St George's
SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Risk adjusted backlog maintenance programme informed by Authorised Engineer reports and independent condition surveys	S				Independent surveys and AE reports provide assurance on key issues Assurances are provides through safety working groups. PAM will provide enhanced assurance, this is currently being worked through. CQC report 2019 - technical assurance has been provided on the key areas of concern where reactive maintenance could potentially impact patient care		X X XX X	
Investment profile provides plans to manage backlog maintenance investment	L				The proposed capital report on expenditure to ensure that the risks associated with not delivering the plan through a lack of funding are understood and agreed.		X	
Governance systems in place to provide oversight on critical estates issues	R				Subject specific safety groups (e.g.. Ventilation, water etc) are now beginning to meet again to receive assurance reports. PAM provides assurance, although we need to enhance our data and systems capability to provide the right levels of assurance in an accurate manner.		XX XX	XX

5.2

Strategic Objective	Build a better St George's
SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
No centralised data management system in place to ensure all required information is available and coordinated	Data and Systems review within E&F to be undertaken	Jan 21	
Gaps in both capital requirements and available budget, together with a lack of long-term planning, makes effective use of capital difficult to plan	Coordination of all capital planning workstreams, in line with production of new estate strategy	Jan 21	
Governance groups are not aligned with new wider assurance arrangements	Groups restarting with reviews of ToRs being undertaken	Oct 20	
Current Estate Strategy is not aligned with Clinical Strategy	New estate strategy to be developed in line with other Trust strategies	Mar 21	

5.2

Strategic Objective	Build a better St George's
SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
% of reports on items of statutory compliance completed to required timescales					Reports are being produced, work is required on their collation and dissemination
% of backlog maintenance tasks (reactive / planned) undertaken in line with plan					Progress has been made on water and electrical backlog works, further work to be undertaken on fire and PPM compliance
Capital expenditure spend profile against agreed plan					Anticipated spend profile is behind target due to lack of certainty on budget
% of PAM compliance					PAM assessments being undertaken and reviewed, but trend analysis and management information not yet available, review underway in line with wider estate transformation

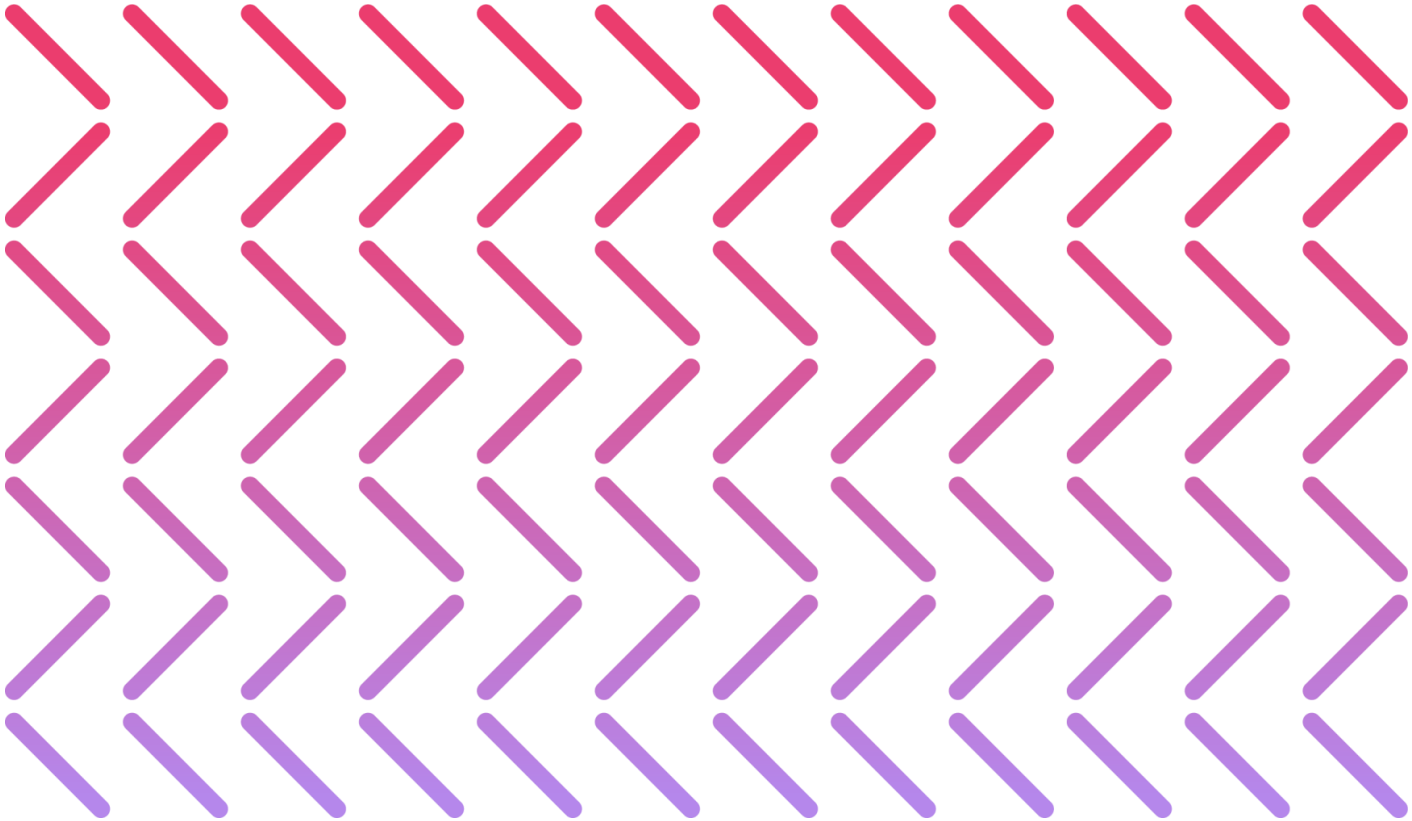
Emergent / future risks	Future opportunities
Impact of COVID on estate planning Lack of investment leads to further deterioration, therefore Trust is unable to deliver its wider strategic objectives Failure to produce / agree new estate strategy South West London health planning impact on estate planning Restructuring of teams temporarily affects ability to deliver services Continued focus on Tooting site is at the detriment to other locations	Estate aspects of the clinical strategy fully delivered More capital funding becomes available to improve future planning More effective organisational design improves service design Estate Strategy provides a framework for pursuing longer term redevelopment opportunities and additional capital sources Locations outside Tooting provide strategic advantage for transformation of services

5.2

Strategic Objective 5: Champion Team St George's
Strategic Risks SR8 and SR9

SR8:
Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity

SR 9:
We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels



Strategic Objective	Champion Team St George's			
SR8	**Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity**			
Risk Appetite / Tolerance	**LOW**	Due to concerns around bullying and harassment and the ability of staff to speak up without fear, we have a low appetite for risks that could impact on the culture of the Trust	**Assurance Committee**	**Workforce and Education Committee**
			Executive Lead(s)	Chief People Officer
			Date last Reviewed	11 June 2020

Current risk and assurance assessment

The Trust continues to face significant challenges in relation to diversity and inclusion, with staff feeling able to raise concerns without detriment, and in relation to its culture. The number of FTSU concerns have increased, which is positive, but the Trust ranks very low in the national FTSU Index, indicating it has a weaker FTSU culture than peer Trusts. COVID-19 has highlighted underlying challenges related to diversity and inclusion, and the Trust continues to face challenges in relation to its WRES position and performance in relation to both ethnicity and gender pay gaps. The Trust has key Board level controls in place via the approval of key strategies, but there are gaps in terms of implementation, part of which should be addressed through the appointment of a new D&I Lead in the coming weeks and months. A new FTSU Strategy and Vision is being prepared for Board consideration in September.

The highest rated supporting risk is effectiveness of staff engagement which scores as a 12 on the risk register, as does bullying and harassment. D&I and FTSU risks are scored at 9. Following a request from the Workforce and Education Committee, which considered that this risk score (based on the corresponding risks on the 2019/20 BAF) was too low, the Executive reviewed this risk score in light of recent developments and has proposed that it be raised to a score of 20. This reflects:

- The significant concerns that have emerged around D&I during COVID-19
- The lack of progress in implementing the D&I strategy
- The Trust's position on the FTSU Index (209 out of 230 Trusts)
- The weakness of the controls currently in place and the fact that the new controls being established are not yet embedded to provide effective assurance to the Board
- The fact that the culture change programme is currently in its diagnostic phase and is yet to define the culture we want and how we get there – and the significance of achieving cultural change to the delivery of the strategy.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	Extreme – 20 4(c) x 5(L)	Limited	N/A	16 = 4(c) x 5(L)	6 = 3(c) x 2(L)
Q2					
Q3					
Q4					

Summary COVID-19 Impact

COVID-19 has had a mixed impact on this risk. While in places it has fostered elements of a Team St George's spirit and staff network groups have continued to meet (and faith calendar days have been celebrated), it has also revealed issues relating to diversity and inclusion, willingness of staff to speak up. A number of engagement events have been paused (Go Engage pilot; TeamTalk).

Strategic Objective	Champion Team St George's
SR8	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce strategy in place and approved by the Trust Board (including culture change)	S				NHS Staff Survey shows that levels of bullying and harassment are not acceptable			x
Diversity and Inclusion Strategy in place and agreed by the Trust Board (Oct. 2018)	W				Number of concerns raised with FTSU Guardian has increased year-on-year		x	
Culture change programme established with clear timelines for delivery	S				Initial report of progress update of culture change the Board in February 2020		x	
Freedom to Speak Up function established with dedicated Guardian in place	R				Trust is rated 209 out of 230 Trusts in England on FTSU Index			x
Policy framework established (including E&D; Dignity at Work; Raising Concerns)	R				Ethnicity and gender pay gaps reported to Board		x	
Staff networks in place to support particular groups	R				Positive early engagement from staff in staff network groups		x	
Bullying and harassment helpline established supplemented by access to Staff Support	P				Key WRES scores lower than London and England average			x
Leadership and Management Development Programmes in place (paused during COVID-19 and challenges in organising new meetings	P				Likelihood of BAME staff entering formal disciplinary process 2.98 times higher		x	
Board visibility through Board visits and Chairman and CEO monthly TeamTalks	S					x		
Trust D&I lead recruited and in place	R							

Strategic Objective	Champion Team St George's
SR8	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
The Diversity and Inclusion plan not currently not in place	Develop and implement D&I implementation plan. A draft has been developed and is being considered by the Executive in July 2020.	July 2020	
No agreed plans to implement commitment to establish BAME representation on all Band 8A and above panels	Plan for inclusion of BAME staff on recruitment panels at Band 8a and above now implemented	July 2020	
The Trust does not have a Freedom to Speak Up Strategy and Vision	Develop FTSU Strategy and Vision	Sept 2020	
No centralised system for recording FTSU concerns raised with Guardian and Champions	Fully implement IT software package to record concerns	Jul 2020	
Bullying and Harassment (B&H) policy does not address latest best practice	Undertake full review of bullying and harassment policy	Aug 2020	
No established system to record the reporting of cases for bullying and harassment	System to record the reporting of cases for bullying and harassment developed	July 2020	
Go Engage system not yet fully live	Re-start Go Engage Pilot (previously deferred by COVID-19). The use of Go-engage is to be discussed at People Management Group in July 2020	Sep 2020	
Robust Diversity and Inclusion Strategy delivery plan	Revised delivery plan to assess robustness of plan and leadership committeemen	Oct 2020	
Updated Policy framework (inc. E&D; Dignity at Work; Raising Concerns)	Review of Dignity at work and raising concerns policies to ensure clarity and ease of usage	Sep 2020	

Strategic Objective	Champion Team St George's
SR8	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Number of Freedom to Speak Up concerns raised with Guardian					Q1 has seen a significant rise in the number of concerns raised with the FTSU Guardian (two thirds of total of 2019/20 cases)
Quarterly Friends and Family Staff Survey (via Go Engage)					Paused in Q1 2020/21 as a result of COVID-19
Number of BAME staff entering formal disciplinary processes					This continues to be significantly higher for BAME staff compared with white counterparts
Trust turnover rate					June 2020 turnover rate (excluding junior doctors) was 15.3% against a target of 13%

Emergent / future risks	Future opportunities
• Risk that the Trust is not seen to have taken decisive action to address serious concerns raised by BAME staff during listening events. • Risk of regression due to the impact of COVID-19 on staff well-being. • COVID-19 has led to the cancellation and / postponement of a range of training and development opportunities for staff, including management training • Delays to the full implementation of the IT system for managing FTSU cases	• Delivery of the culture change programme • Learning from Trust's with positive FTSU Index cultures being built into the development of the Trust's new vision and strategy for FTSU

5.2

Strategic Objective	Champion Team St George's							
SR9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels**							
Risk Appetite / Tolerance	**LOW**	Due to concerns regarding quality and diversity in our workforce, we have a low appetite for risks relating to workforce. However, in relation to developing future roles and recruitment and retention strategies our risk appetite is higher	**Assurance Committee**	**Workforce and Education Committee**				
			Executive Lead(s)	Chief People Officer				
			Date last Reviewed	11 June 2020				
Current risk and assurance assessment	Although COVID-19 has eased immediate challenges of recruitment and retention due to our ability to redeploy staff across the organisation, our vacancy rate remains above target as does our turnover rate. Training and developing our leaders remains a particular gap and this links to the cultural development work set out in Strategic Risk 8. Junior doctor supply continues to be an issue. We have not yet introduced fully the upgrade of Totara, which is expected later this month. When in place this will enable us to better track appraisals and put in place clearer talent management processes. There are a number of supporting risks scored at 16 on the risk register (recruitment and retention, Brexit, junior doctor vacancies, pensions) and one sored at 12 (organisational development). Appraisals is scored at 9 as is recognising good practice by our staff.		**Overall SR Rating – Quarterly Scores**	**Period 2020/ 2021**	**Risk Score**	**Assurance Strength**	**Change (last reporting period)**	**Inherent Risk Score**	**Target Risk Score**
				Q1	**Extreme 16 = 4(c) x 4(L)**	Partial	N/A	**16 = 4(c) x 4(L)**	**6 = 3(c) x 2(L)**
				Q2					
				Q3					
				Q4					
			Summary COVID-19 Impact	COVID-19 has placed staff under intense pressure during the first surge, however the Trust has been able to successfully redeploy staff meaning that it has been able to reduce its agency spend during this period. Appraisal rates, however, have fallen and a number of education and training programmes have been delayed / deferred due to the pandemic.					

5.2

Strategic Objective	Champion Team St George's
SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce Strategy in place and approved by the Trust Board (Nov 2019)	S				Good performance in ward staffing unfilled duty hours – tracked in IQPR		X	
Education Strategy in place and approved by the Trust Board (Dec. 2019)	S				Reduction in use of agency staff – spend below cap in April 2020		X	
Recruitment strategy (review of rota, exploring alternative ways of working)	S				Workforce performance report to WEC		X	
Total funded establishment	S				MAST training performance consistently above target		X	
Workforce priority plan in place with an underpinning action plan	R				Successful nursing recruitment days – national award won in October 2019		X	
Advanced Clinical Practitioner Working Group established to work with HEE	R				Participation in NHSI regional retention scheme – reduction in nursing vacancies			X
Monthly qualified nursing and healthcare assistant open days	S				Guardian of Safe Working Hours Report		X	X
Appraisal training sessions / ad hoc training in place	P				June 2020 - Trust vacancy rate 8.3% against target of 10%		X	

5.2

Strategic Objective	Champion Team St George's
SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Board-level approved implementation plan for Workforce Strategy (via WEC)	Develop implementation plan and secure WEC approval Plan to be discussed at PMG and TMG in July and WEC in August 2020	Jun 2020	
Board-level approved implementation plan for Education Strategy (via WEC)	Develop implementation plan and secure WEC approval Plan to be discussed at PMG and TMG in July and WEC in August 2020	Jun 2020	
Leadership programmes yet to be fully defined and commissioned (in particular development of common understanding of line manager responsibilities, managing difficult conversations)	Commence Advanced Leadership and Management programme for staff in senior leadership roles; Deputy General Managers, Heads of Nursing, Clinical Directors and Care Group Leads.	TBC	
Appraisal rates are below target and appraisal quality is variable	Develop plan to address appraisal rates	TBC	
Junior doctor rota gaps as reported by Guardian of Safe Working	Development of plan to address rota gaps	TBC	
Performance and Development Review (Appraisal) guidance not in place	Develop performance and development review	Sep 2020	
Mentor training not provided to increase the availability of mentors for staff	Develop mentor training	Dec 2020	

Strategic Objective	Champion Team St George's
SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels

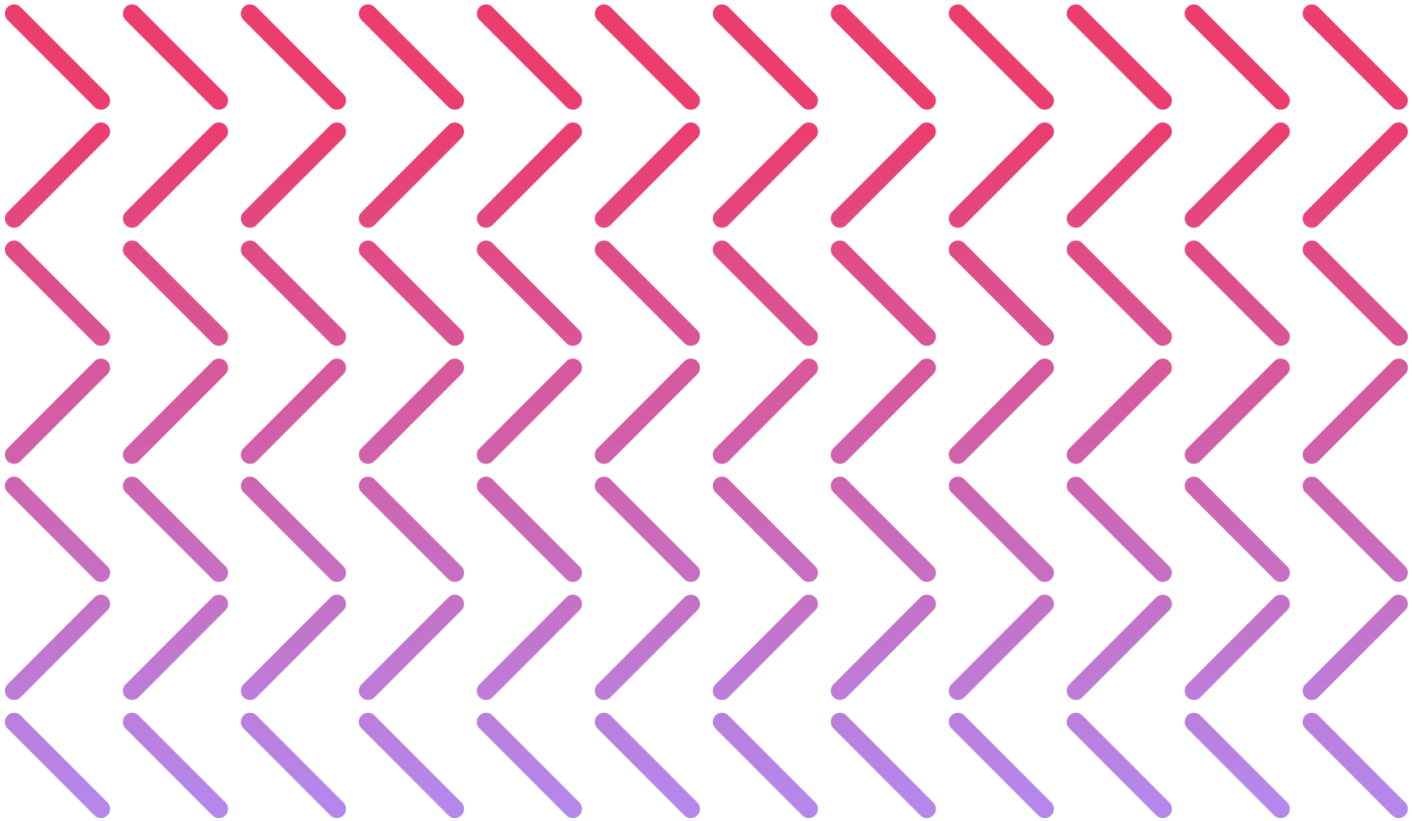
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Trust vacancy rate					Trust vacancy rate in June 2020 was 8.3% against a target of 10%
Turnover Rate					Trust turnover rate (excluding junior doctors) in June 2020 was 15.3% against a target of 13%
Sickness absence rates					Trust sickness absence rate of 3.5% in June 2020 compared with Trust target of 3.2%
Bank and agency rate					In June 2020, the Trust was well below its established monthly agency ceiling due to staff redeployment due to COVID-19
IPR appraisal rate medical staff					GMC paused appraisal completion rate due to COVID-19
IPR appraisal rate non-medical staff					Appraisal rates for non-medical staff in June 2020 were at 69.9% compared with Trust target of 90%. Target not met throughout 2019/20
MAST compliance percentage					June performance of 89.5% compared with Trust target of 85%

Emergent / future risks	Future opportunities
• Staff remote working requirements • Brexit – uncertainty over future reliance of supply of EU staff • Scaling back of HEE funding	• Further collaboration with SWL ICS and the Acute Provider Collaborative • NHS People Plan • Development of different roles • Links to University – opportunity to develop more 'in-house' training / courses with the university, cost effective, accredited • Apprenticeships

5.2

Strategic Objective 6: Develop tomorrow's treatments today
Strategic Risk SR10

SR10:
Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation



Strategic Objective	Develop tomorrow's treatments today
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**

Risk Appetite / Tolerance	**HIGH**	We have a high appetite for risks in this area in order to pursue research and innovation	**Assurance Committee**	**Quality and Safety Committee**
			Executive Lead(s)	Chief Medical Officer
			Date last Reviewed	23 July 2020

Current risk and assurance assessment

There has been a significant boost to the research profile in the Trust due to a 100% increase in patient recruitment to clinical trials over the previous three years. Although the Trust is currently highly active in Covid-19 research studies it has negatively impacted on the Trust's ability to implement the approved Research Strategy 2019-24 and secure additional funding and investment for research activities.

The Trust has a number of key controls and sources of assurance in place, for example regular research resource and portfolio review meetings with research teams and documented progress reports, and identified funding for the research portfolio.

However, there are number of gaps in sources of assurance in particular the formal approval of the strategy implementation plan.

The current risk score of 9 (Moderate) highlights the level of risk the Trust is balancing including the alignment of priorities between St George's and the University and the lack of investment. However, it is recognised that this risk score requires review and could be considered to have a risk score of 12 (High).

The assurance strength is now rated as good to reflect the sources of assurance and completed actions to address the previously identified gaps in controls. Governance and risk management arrangements provide a good level of assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented. Outcomes are generally achieved but with inconsistencies in some areas.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	Moderate – 9 = 3(c) x 3(L)	Good	N/A	16 = 4(c) x 4(L)	4= 3(C) x 2(L)
Q2					
Q3					
Q4					

Summary COVID-19 Impact

Most non-Covid-19 clinical research studies have been temporarily suspended since March 2020 and will re-start in July 2020.

The Trust has had the opportunity to participate in numerous Covid-19 clinical research studies and are currently first in the country for the number of active Covid-19 studies.

The development of the implementation to support the delivery of the new Research Strategy has been significantly impacted due to focus on Covid-19.

5.2

Strategic Objective	Develop tomorrow's treatments today
SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Research Strategy 2019-24 : approved by the Trust Board in December 2019	S				Increased numbers of clinical research studies led from St George's	X		
Partnership between St George's and St George's University London	G				Institute for Clinical Research fully functioning	X	X	
Key role in south London Clinical Research Network (chaired by CEO)	S				Leadership positions in the Clinical Research Network		X	X
Implementation of process of horizon scanning clinical studies, including 'easy win' studies to balance portfolio against lower recruiting more intensive studies	S				Increased patient recruitment for clinical trials	X	X	
Regular research resource and portfolio review meetings with research teams	S				Regular review meetings	X		
Joint Research and Enterprise Services review and ratify (with researchers) all study targets and resources required	S				Annual target setting process	X	X	X
Membership agreed for the Institute for Clinical Research steering committee	S				Steering Committee in place and reports to Patient Safety Quality Group and QSC	X	X	

5.2

Strategic Objective	Develop tomorrow's treatments today
SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Implementation plan for Research Strategy	Develop and deliver implementation plan to drive research strategy	September 2020	
Funding to implement 2019-24 research strategy not yet agreed	Seek funding to implement 2019-24 research strategy Initial £200K agreed	Completed	
Institute for Clinical Research steering committee not started	Set up meeting schedule for the Institute for Clinical Research committee Meeting schedule established	Completed	
Relatively low number of research projects and trial led by St George's and St George's University London	Formal establishment of four Clinical Academic Groups Four Clinical Academic Groups formally established	Completed	
Few clinical academics - Many areas of Trust activity are not reflected in St George's University London research	Seek investment to allow more clinical academic appointments	December 2021	
Poor research IT infrastructure	Seek investment /work with IT to set up research data warehouse	December 2021	
Protected research time for staff	Seek investment to allow more protected research time Initial £200K investment agreed	Completed	

5.2

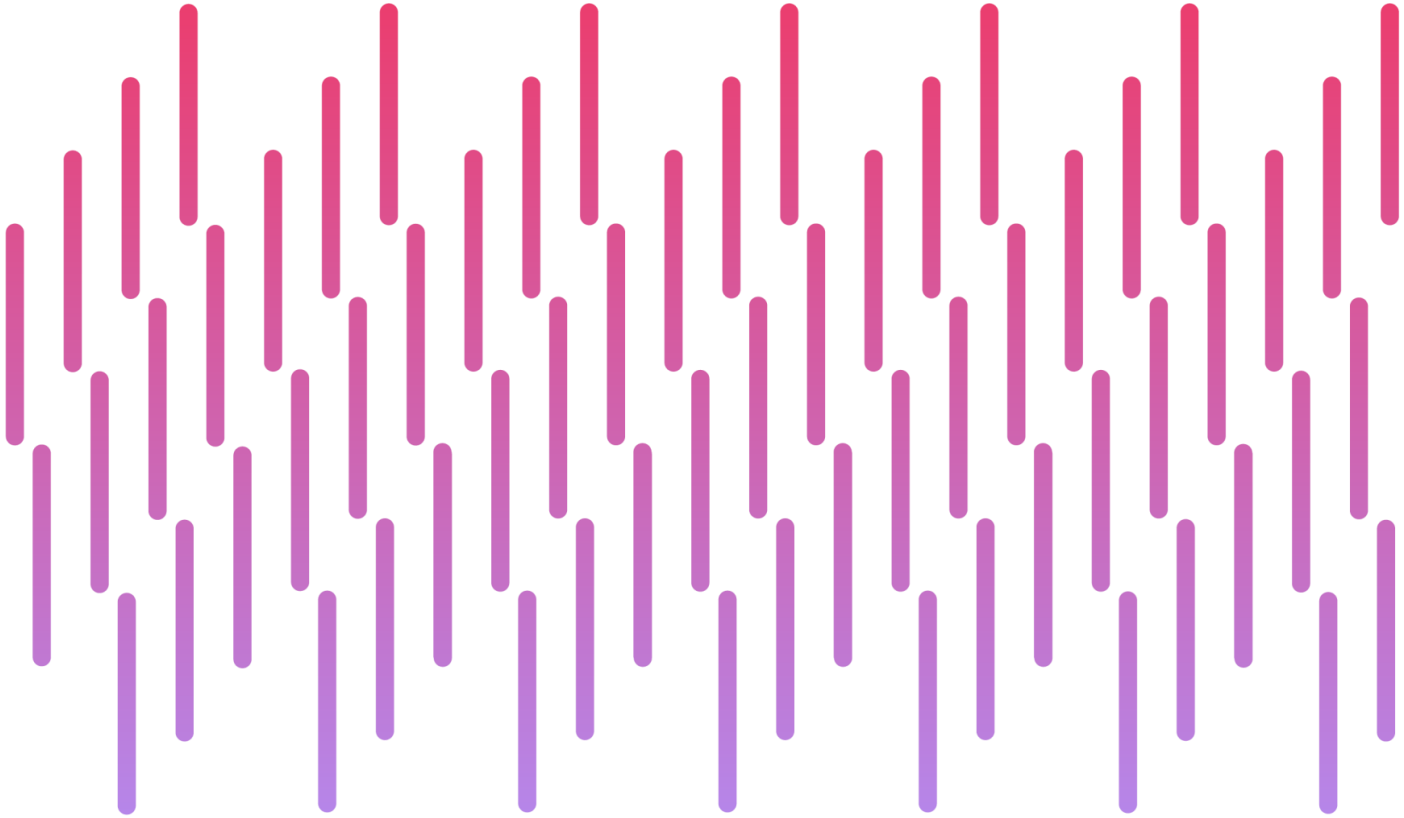
Strategic Objective	Develop tomorrow's treatments today
SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Percentage of patients recruitment in south London Clinical Research Network at St George's					17% (final figure, 2019/20) St George's is involved in research activities related to 17 Covid-19 research studies
Patient recruitment numbers					10,538 (final figure, 2019/20)
Number of clinical research studies led from St George's					58 (current St George's Trust/ University sponsored clinical research studies on National Institute for Health Research portfolio)

Emergent / future risks	Future opportunities
• Restrictions on funding/ investment to extend research activities • Inability to exploit research opportunities in full • Alignment of St George's and St George's University research priorities recognised as a risk in the Research Strategy • Reduced availability of National Institute for Health research funding	• National Institute for Health Research call for core Clinical Research Facility/ Biomedical Research Centre funding in 2021 • Opportunity for a greater research leadership role in SW London / partnership with other Acute Provider Collaborative Trusts • Build on current profile related to Covid-19 research activity/ studies • Develop closer collaboration between St George's and St George's University

5.2

Appendix 1: Individual risks contributing to strategic risks
Linked risks on the Corporate Risk Register



Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Q1 20/21
Strategic Risk 1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**			20	15
Learning from complaints	CN2009	Failure to learn from complaints	Dec 2019	15	12
Learning from incidents	CN1166	Failure to learn from incidents	Nov 2016	15	8
Deteriorating patients	MD1527	Staff fail to recognise, escalate and respond appropriately to the signs of a deteriorating patient. This may happen because the Early Warning Score is inaccurately recorded or the escalation process is not applied correctly leading to a delay in treatment being started and a poor outcome for the patient.	Dec 2016	20	8
Infection control	CN2050	C Diff; MRSA; MSSA; E.Coli	Mar 2020	12	12
Covid-19 - exposure	COVID-2051	Risk of exposure to Covid-19 virus	Feb 2020	20	20
Covid-19-wait too long (1)	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR3)	Apr 2020	20	16
Covid-19-wait too long (2)	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR3)	Apr 2020	20	20
Covid-19-Fit test	COVID-2106	Lack of fit test for FFP3 masks	Apr 2020	12	12
Covid-19-PPE	COVID-2107	Lack of PPE to effectively manage exposure to Covid-19 virus	Apr 2020	20	16
Strategic Risk 2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**			20	12
Cardiac surgery service – patient safety impact	CVT-1661	There is a risk that we may not make effective improvements to patient safety following the second NICOR mortality alert for cardiac surgery	Sep 2018	20	12
Learning from deaths	MD1119	Variation in practice in M&M / MDT meetings may mean we fail to learning from deaths and fail to make improvement actions to prevent harm to patients	Nov 2016	TBC	TBC
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	16	12
Mental capacity Act	CN751	Failure to comply with Mental Capacity Act (MCA)	Jun 2016	16	12
Discharge	MD2052	Non-compliance with the eDischarge Summary Standard	Mar 2020	16	TBC
Compliance with the CQC regulatory framework	CN-1179	Failure to comply with the CQC regulatory framework and deliver actions in response to CQC inspections may prevent the Trust achieving an improved rating at our next inspection	Jan 2017	20	12
Improving the quality of clinical governance following external reviews	CN-2056	There is a risk that we may not improve the quality of clinical governance following the external reviews of mortality monitoring & MDT and clinical governance in a timely manner which may have an adverse impact on patient care	Sep 2019	12	12
HealthCare Record (accuracy)	TBC	Healthcare Record (accuracy)	TBC	TBC	TBC

5.2

Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Q1 20/21
Strategic Risk 3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**			25	20
Covid-19-wait too long (1)	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR3)	Apr 2020	20	16
Covid-19-wait too long (2)	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR3)	Apr 2020	20	20
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	16	12
Diagnostics within 6 weeks	TBC		July 2020	TBC	TBC
Patient flow	TBC	Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission	TBC	TBC	TBC
Emergency care 4hr operating standard	ED-1514 ED-852	Failure to deliver and sustain the 95% Emergency Care Operating Standard	May 2014	20	12
Management of patient pathways (RTT)	TBC	Risk that patient pathways and waiting times are not accurately monitored or managed due to poor data quality and lack of management process	July 2020	TBC	TBC
7 day services	MD1118	Failure to be compliant with 4 of the Seven Day Services clinical standards	Nov 2016	12	12
Exposure to Cyber or Malware attack	CRR-0013	Infrastructure - Risk of potential successful malware / cyber attack due to weakness in the ICT infrastructure. This could lead to loss of data and operational disruption	Apr 2016	20	12
Network outage	CRR-1395	Infrastructure - Risk of further major network outages due to out-dated, unreliable, and prone to failure network, as a result of a lack of investment and maintenance in the Trust's ICT Network Infrastructure	Sec 2017	25	20
Fragmented Clinical Records	CRR-1398	Unavailability of all the correct and up to date clinical information at point of care due to fragmented patient records as a consequence of: Cerner implementation, multiple clinical system running in parallel but separate from Cerner,	Dec 2017	20	12
Telephony	CRR-1292	Infrastructure - Potential failure of the Trust's central telecoms system (ISDX) (1), radio tower system (DDI) (2), and/or VoIP platform (500 handsets) (3) due to aged telecoms infrastructure	Jul 2017	20	16
Clinical Decision Outcome Form	S2030	There is an on-going risk that patients on any elective pathway could be lost to follow up. This can be caused by the incorrect outcome being recorded on the Clinical Decision Outcome	Mar 2020	12	TBC
Data Warehouse/Information Management Fragmentation	CRR-1312	Information - Risk of poor daily operational performance reporting due to difficulties to retrieve data stored on multiple storage	Aug 2017	20	16
Virtual Desktop Infrastructure Sub-optimal	1717	There are a number of issues with the VDI infrastructure *insufficient licenses, insufficient compute power, and upgrade to Win10. Whilst some of these were addressed pre-Covid, the increase in home working and thus remote licenses, has meant that these all need to be improved again	July 2020	TBC	TBC
Paediatric ECHO delivery	CCAG - 1980	Inability of safely provide a paediatric ECHO service at St Georges Hospital	Nov 2019	20	16
ECHO Service Delivery	CCAG - 1950	Risk of delay in delivery of planned ECHOs in favour of delivering ECHO in patients who are on a 6 week diagnostic pathway, (DM01)	Oct 2019	20	16

Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Q1 20/21
Strategic Risk 4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**			16	8
Junior doctor vacancies	CRR 1684	Inability of the Trust to be able to fill Junior Doctor rota vacancies, due to shortage at national level, leading to rota gaps	Oct 2018	16	16
Recruitment and retention	CRR 0025	Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost.	Oct 2015	16	16
Lack of collaboration across SWL Acute Providers	STR1496	There is a risk that other Acute Provider Collaborative in SWL will pursue clinical/ commercial relationships with other tertiary NHS providers that pose a strategic threat to SGUH	Oct 2018	12	8
Strategic Risk 5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**			25	25
Managing an effective financial control environment	CRR-0028	Risk of not meeting statutory obligations, prevent fraud, mismanagement of funds or inappropriate decision making by Trust officers due to ineffective financial systems and processes	Oct 2016	20	20
Managing Income & Expenditure in line with budget	CRR-1411	Risk the Trust is not able to manage income and expenditure against agreed budgets to delivery the financial plan.	Dec 2017	25	25
Manage commercial relation with non-NHS organisations	Fin-1856	Risk that the Trust does not have sufficient capacity, or skills to manage commercial relationships with non-NHS organisations procuring services from the Trust.	May 2019	12	12
Future cash requirements are understood	CRR-1416	Risk that future cash requirements are not understood	Dec 2017	20	15
Processes to manage cash and working capital	CRR-1417	Risk that the Trust does not have up to date processes to manage cash and working capital	Dec 2017	20	12
Identifying and delivering CIPs	CRR-1865	Risk that the Trust doesn't have sufficient capacity and capability to deliver CIPs at the level required to hit the financial plan.	Apr 2019	20	20
Understanding cost structures	Fin-1372	A risk that we do not understand our current cost and performance baseline and structures, or benchmark ourselves against others in this area to identify efficiencies and improvements.	Nov 2017	15	9
Strategic Risk 6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**			20	20
Processes to deliver agreed investment	CRR-1415	Risk that the Trust does not have processes to deliver agreed investment	Dec 2017	16	15
Five year investment plan	CRR-1414	The Trusts deficit financial position doesn't currently provide sufficient internally generated capital to fund the required investment over a 5 year period. Alternative sources of financing have also yet to be identified in the absence of internally generated funds.	Dec 2017	20	16

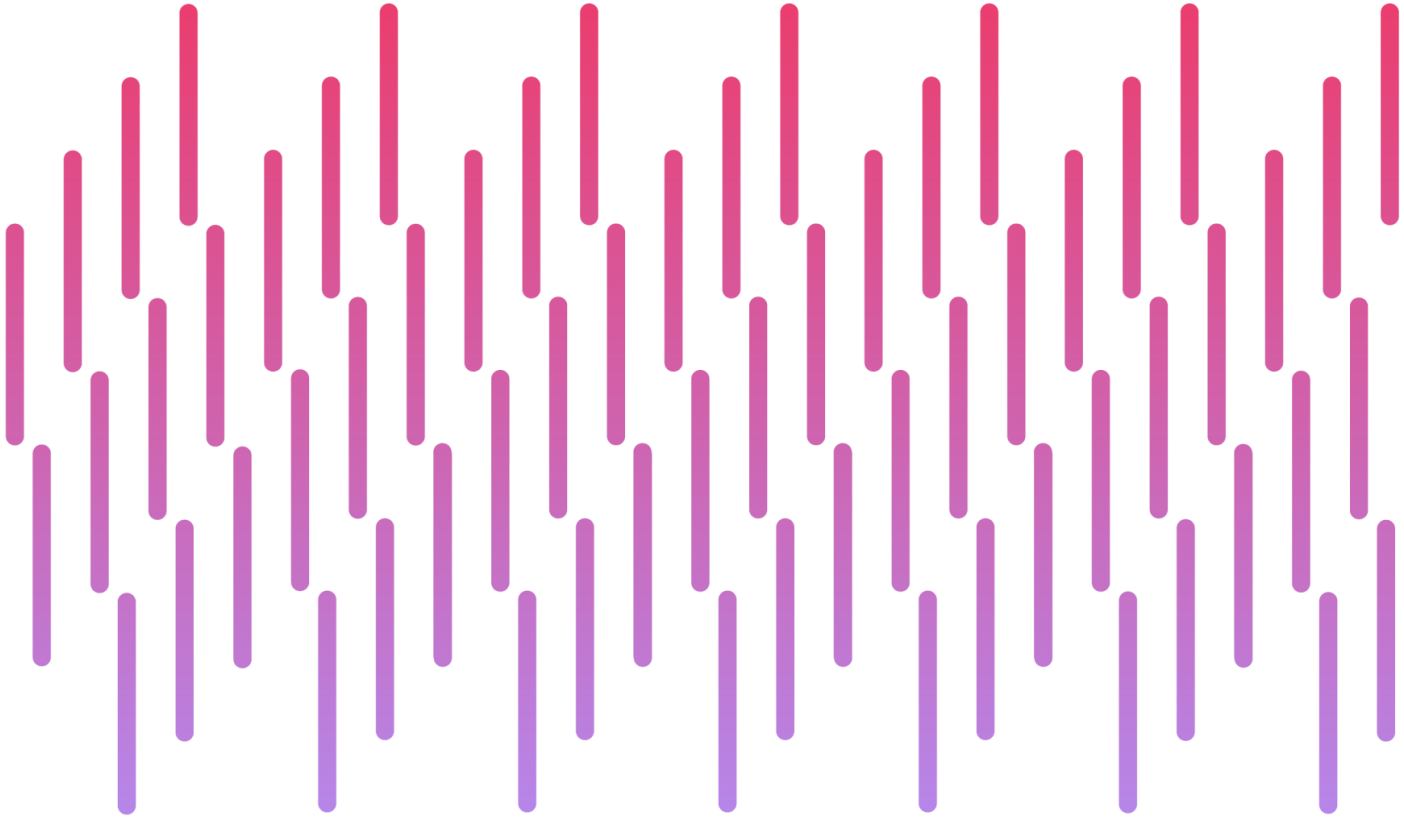
Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Q1 20/21
Strategic Risk 7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**			20	20
Inability to address infrastructure backlog maintenance to maintain safe site	CRR-0008	Inability to address infrastructure backlog maintenance to maintain safe site due to lack of capital	Jul 2016	**20**	**20**
Bacterial contamination of water supply	CRR-0016	Risk from exposure to potential pathogenic bacteria in water	May 2014	**20**	**20**
Risk of fire starting in Lanesborough Wing developing into a major fire	EF2036	Risk that an undetected and immediately extinguished fire could develop into a major fire resulting in area evacuation	Feb 2020	20	20
Electrical Infrastructure - Risk of non-compliance	CRR-1311	Risk of electrical non-compliance with Electricity at Work Regulations and BS7671 due to lack of regular testing	Aug 2017	16	16
Lack of UPS/IPS power supplies	EF2061	Lack of UPS/IPS power supplies	Mar 2020	**TBC**	**TBC**
Strategic Risk 8	**Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity**			**-15**	**12**
Raising Concerns	HR-1978	There is a risk that our staff a) don't know how to raise concerns at work b) don't know who to raise concerns with c) are not confident the concerns will be properly address and d) don't feel safe in raising concerns	Nov 2019	**12**	**9**
Diversity and Inclusion	HR-1967	There is a risk that we are unable to deliver our Diversity and Inclusion Strategy or that it does not have the required impact	Jul 2019	**9**	**9**
Bullying and Harassment	HR-881	There is a risk that our staff continue to report high levels of bullying and harassment compared with peers and that we have not taken adequate measures to address this	May 2010	**12**	**12**
Effective Engagement	HR-1364	There is a risk that we fail to effectively engagement with our staff	Apr 2016	**15**	**12**

Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Q1 20/21
Strategic Risk 9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels**			**16**	**16**
Recruitment and Retention	CRR-0025	There is a risk that we fail to recruit and retain sufficient and suitable workforce with the right skills to provide quality of care and service at appropriate cost	Jan 2015	**16**	**16**
High quality appraisals	HR-1363	Risk that we do not ensure all of our staff have a high quality appraisal.	Nov 2017	**9**	**9**
Recognise good practice	HR-1361	A risk that we do not recognise success or good practice amongst our workforce.	Nov 2017	**9**	**9**
Organisational Development	HR-1360	There is a risk that we do not ensure that our senior managers are developed to have the right leadership skills to be able to deliver our vision of outstanding care every time	Nov 2017	**12**	**12**
Junior Doctors vacancies	CRR-1684	There is a risk that we are unable to fill Junior Doctor rota vacancies, leading to rota gaps which may impact on patient safety	Oct 2018	**20**	**16**
Risk posed by a 'no deal' exit from the EU	CRR-1824	There is a risk that we are unable to retain our EU staff post EU exit	Apr 2019	**16**	**16**
Impact on pension tax on the NHS	CRR-1884	Pension tax impacting on the Trust. There are two elements to this risk. 1. Senior members of staff choose to leave the NHS as they have reached their Life Time Allowance (LTA) pension cap. 2. The impact of the annual allowance, where consultants are taking early retirement, reducing their hours, turning down additional work which is having an operation impact on the Trust. This leaves gaps in service cover	Jul 2019	**16**	**16**
Strategic Risk 10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**			**16**	**9**
Clinical Research recruitment reduction	MD-1132	Risk of Clinical Research recruitment reduction. could result in a significant shortfall in overall (CRN and Commercial) recruitment and therefore reduction in research funding and income	Nov 2016	**12**	**6**
The profile of research in SGHT being low	MD-1133	There is a risk that insufficient focus is given to research in SGHT. This could lead to a lack of investment in research, impacting on research delivery, income, reputation and ability to recruit and retain high calibre staff	Nov 2016	**12**	**9**
MHRA accreditation of the research department	MD-1405	There is a risk that the research department does not retain its MHRA accreditation due to poor infrastructure/ compliance	Dec 2017	**16**	**8**
Research partnership with St George's University	MD-1495	There is a risk that if research priorities are not aligned across SGUH and SGUL we will miss opportunities to translate academic research in to improved patient outcomes	Mar 2018	**12**	**9**

Appendix 2: Scoring the Board Assurance Framework
Risk Assessment & Assurance sources and descriptors



Outstanding care every time

Scoring the Board Assurance Framework

Risk Assessment and tracking of actions to address gaps in controls

Calculating Risk Scores

Risk Grading (Scoring)

CONSEQUENCE INDEX			LIKELIHOOD INDEX*		
5	Catastrophic	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure due to enforcement action; Total loss of public confidence	5	Almost Certain	No effective control; or ≥ 1 in 5 chance within 12 months
4	Major	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate	Moderate harm – medical treatment required up to 1 year; £100K - £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥ 1 in 100 chance within 12 months
2	Minor	Minor harm – first aid treatment required up to 1 month; £50K - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥ 1 in 1000 chance within 12 months
1	Insignificant	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Rare	Very good control; or <1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Risk scoring matrix

L/C	1	2	3	4	5
5					
4					
3					
2					
1					

Calculating Strength of Controls

Strength of controls

Control Strength	Description
Substantial	The identified control provides a strong mechanism for helping to control the risk
Reasonable	The identified control provides a reasonable mechanism for helping to control the risk
Partial	The identified control provides a partial mechanism for controlling the risk but there are weaknesses in this
Weak	The identified control does not provide an effective mechanism for controlling the risk

5.2

Scoring the Board Assurance Framework
Assurance sources and descriptors

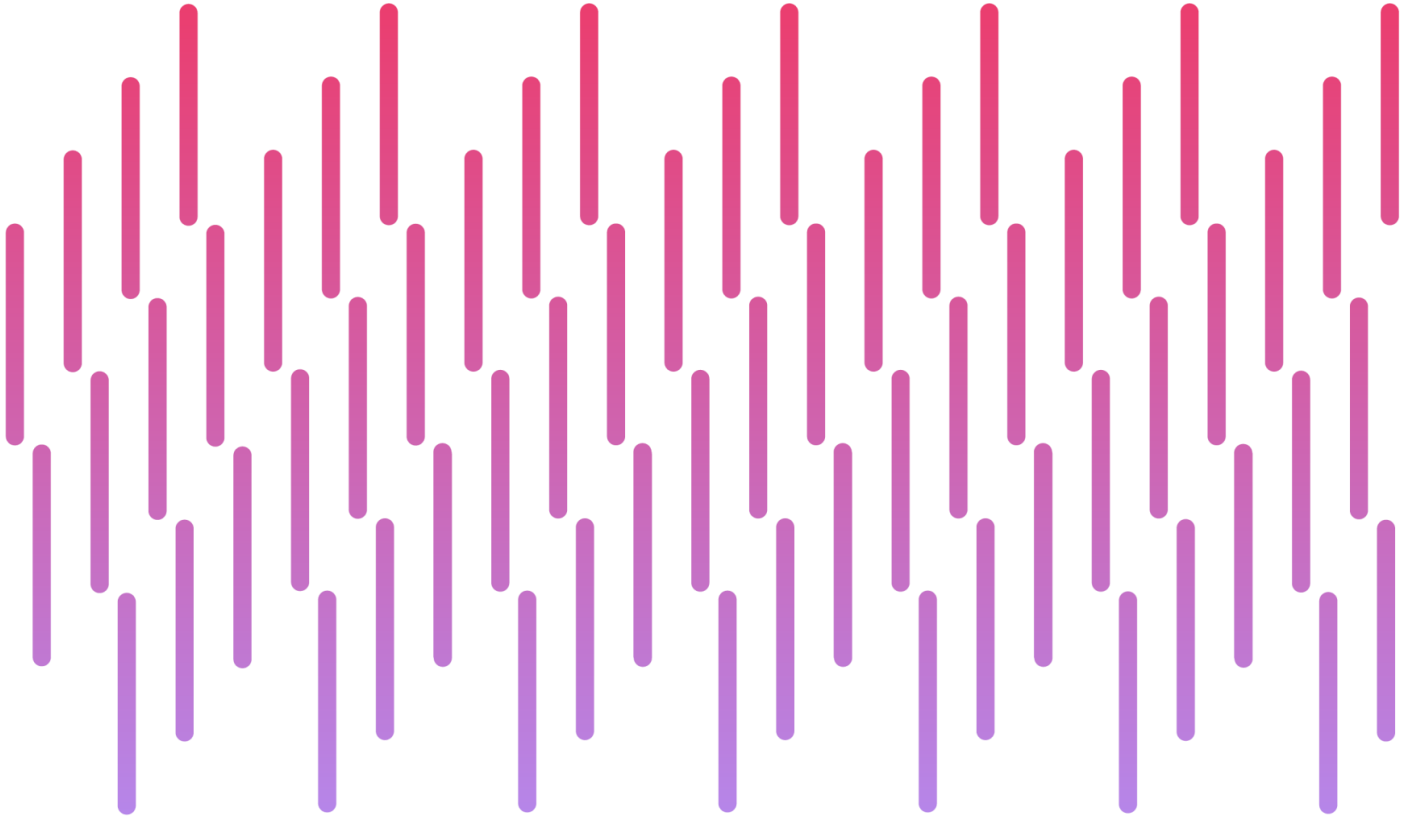
Sources of Assurance

Sources of Assurance			
Line of Assurance	**First Line Assurance**	**Second Line Assurance**	**Third Line Assurance**
Description	Care Group / Operational level	Corporate Level	Independent and external
Examples	Service delivery / day-to-day management Care Group level oversight Divisional level oversight	Board and Board Committee oversight Executive oversight Specialist support (e.g. finance, corporate governance)	Internal audit External audit Care Quality Commission NHSE&I Independent review Other independent challenge

Progress on actions to address gaps in control / assurance	
Delivered	
On track to deliver to agreed timescale	
Slippage against agreed timescales (non-material)	
Progress materially off track	
Action not delivered to agreed timescale	

Calculating Levels of Assurance

Assurance Levels	
Level of Assurance	**Description**
Substantial	Governance and risk management arrangements provide substantial assurance that the risks identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas
Good	Governance and risk management arrangements provide a good level of assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas
Reasonable	Governance and risk management arrangements provide reasonable assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance
Limited	Governance and risk management arrangements provide limited assurance that the risks identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance



Board Assurance Framework 2020/21
St George's University Hospitals NHS Foundation Trust

Outstanding care every time

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

5.3

Meeting Title:	**Trust Board**		
Date:	30 July 2020	**Agenda No**	5.3.1
Report Title:	**Horizon Scanning Report, Q1 2020/21: Emerging Policy, Legislative and Regulatory Issues**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Noting		
Executive Summary:	This report provides a quarterly update to the Trust Board on emerging political, legislative, policy and regulatory issues that have relevance to the Trust. This report focuses on key developments between April and July 2020, highlighting particular developments relating to: • The political and legislative environment; • The NHS policy and institutional landscape • System and professional regulation • Key appointments The report is intended to support the Board in providing a regular and systematic review of national political, policy and regulatory developments. It is distinct from the local and regional horizon scanning work which is reported in a separate report on the agenda. Previous reports on emerging political, legislative and regulatory issues were provided to the Board in July 2019, October 2019 and February 2020. Prior to submission to the Board, this paper will be turned into the usual slide deck, and will be supplemented with updates on developments in professional regulation and key inquiries.		
Recommendation:	The Board is asked to note the update.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-led		
NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)		
Implications			
Risk:	Horizon scanning is a key element in assisting the Board to understand emerging risks that could impact on the Trust's strategy and its operation.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Horizon Scanning report: Q1 2020/1

Emerging policy, political, legislative and regulatory issues

5.3

Stephen Jones
Chief Corporate Affairs Officer

30 July 2020

1. Purpose

The NHS Leadership Academy identifies three essential 'building blocks' in helping NHS boards to exercise their roles of formulating strategy, ensuring accountability and shaping a healthy culture effectively. Effective boards are informed by the external context within which they operate. They are informed by and shape the intelligence on understanding local needs, trends and comparative information on organisational performance, and give priority to engagement with stakeholders and opinion formers. This report provides the Board with a regular update on key developments in the Trust's external environment at the national level, particularly in relation to:

- **Political and legislative developments**: Current and emerging political and parliamentary developments at a national level with direct or indirect implications, or potential implications, for the Trust; key changes, or potential future changes, to primary legislation and regulations.
- **NHS policy and institutional landscape**: Changes and developments in relation to significant new national policy as determined by the central NHS organisations, and changes to the national architecture and structures of the NHS and those organisations with which the Trust interacts.
- **System and professional regulation**: Changes and prospective changes to the regulatory landscape, of both system regulators and relevant professional regulators with potential relevance to the Trust.
- **Reports and updates from key stakeholders**: Topical reports from key national bodies and other stakeholders of relevance to the Trust, and highlights of recent Board meetings of key system partners.
- **Current inquiries**: Summary of key inquiries that are underway.
- **Appointments**: Key appointments to national bodies and other key stakeholders.

This is the third such report to the Board and the format and issues will be kept under review to ensure the Board receives, through this report, a comprehensive quarterly update on key issues relating to these areas. It is distinct from the strategy horizon scanning report which focuses on regional and local issues.

2. Political and legislative developments

Legislative developments

- **NHS Funding Act 2020:** In the last horizon scanning report to the Board in February 2020, an update was provided on the ongoing Parliamentary consideration of the NHS Funding Bill. At that stage, the Bill was awaiting its Second Reading in the House of Lords. The Bill completed its Second Reading in the Lords on 26 February 2020 and, following the remaining stages of its Parliamentary passage, received Royal Assent on 16 March 2020. The NHS Funding Act 2020 places a legal duty on the Government to guarantee a minimum level of revenue spending for the NHS in England in each year from 2020/21 to 2023/24 inclusive. The amounts specified rise from £127.0 billion in 2020/21 to £148.5 billion in 2023/24. These figures compare with £120.1 billion in 2019/20. The Act places into law a funding settlement for NHS England first announced by the then Prime Minister, Theresa May, in June 2018. This formed the basis of the NHS *Long Term Plan*, published in January 2019. Legislation to enshrine the settlement in law was a commitment in both the Conservative Party 2019 general election manifesto and the Queen's Speech in December 2019. (Links to Strategic Risks 5 and 6 on the Board Assurance Framework on financial sustainability and capital. SR5 – financial sustainability currently scored at 25; SR6 – capital – currently scored at 20).

- **Medicines and Medical Devices Bill:** The February 2020 horizon scanning paper reported on the introduction of a new Medicines and Medical Devices Bill which has a stated aim of ensuring that the NHS and patients have access to the best innovative medicines, including by making it easier for hospitals to manufacture and trial innovative personalised and short-lived medicines, streamlining of the licencing and regulation of such medicines, and updating safety requirements. The Bill was introduced into Parliament on 13 February 2020, received its Second Reading in the House of Commons on 2 March and completed its Commons stages on 23 June 2020. It is due to received its Second Reading in the House of Lords on 27 July 2020. The changes to the regulatory framework on the management of medicines and medical devices have wider implications for the UK medical research sector, and consequently on the environment in which we have framed the Trust's research strategy 2020-24. (Links to Strategic Risk 10 on the Board Assurance Framework on research currently scored at 9).

2. Political and legislative developments

Legislative developments (continued):

- **NHS Long Term Plan Bill:** The Government announced in the Queen's Speech in December 2019 that it would bring forward legislation to help implement the NHS Long Term Plan. The Bill has not yet been published or introduced to Parliament. However, the Government stated that it was considering the recommendations from NHS England and NHS Improvement as to the requirements of new legislation to remove the barriers to delivery of the Plan and to better integration of services. The Board's Horizon Scanning Report of October 2019 set out the recommendations put forward by NHSE&I. The timing of any such legislation is likely to have been impacted by COVID-19. The Bill is expected to establish legislative provisions for the move towards greater system working. Until such legislation is in place, there remain inherent tensions between the move towards greater system working and effective pooling of sovereignty by NHS organisations in practice and the current legislative basis which places legal authority and responsibility on the Boards on individual NHS providers. (Links to Strategic Risk 4 on the Board Assurance Framework – system working – currently scored at 8).

Health and Social Care Select Committee Inquiries

Parliamentary Select Committees have met virtually during the pandemic, and the Health Select Committee are currently holding a number of inquiries of relevance to the Trust:

- Management of the Coronavirus Outbreak, opened on 3 March 2020: The inquiry is considering the management of the coronavirus epidemic by the Government and its agencies. MPs are looking at measures to safeguard public health, options for containing the virus and how well the NHS is dealing with the outbreak. Among the witnesses to the inquiry are: Professor Chris Whitty, Chief Medical Office for England, Sir Patrick Vallance, Government Chief Scientific Adviser, Sir Simon Stevens, Chief Executive of NHS England and NHS Improvement, and the Secretary of State for Health.

- Delivering Core NHS and Care Services during the Pandemic and Beyond, opened 22 April 2020: The inquiry seeks to better understand the impact the crisis has had on core NHS and care services during the pandemic and beyond. This includes how core services such as cancer have been delivered.

- Social Care: Funding and Workforce, opened 10 March 2020: seeks to establish how much extra money would need to be spent by government in each of the next five years to counteract the impact of a shortage of care on the NHS. Shortages in the social care workforce and what solutions need to be found to address changes in the years ahead will also be considered.

2. Political and legislative developments

UK withdrawal from the EU

- The United Kingdom left the European Union on 31 January 2020 and is now in a transition period until 31 December 2020 during which the UK remains subject to the EU's rules and a member of the Single Market. During the transition period, the health sector is not expected to experience significant change.
- Freedom of movement remains in place until the end of the transition period and the Trust can continue to recruit EU nationals as previously. However, the outcome of the ongoing negotiations between the UK and the EU on the shape of the future UK-EU relationship beyond the transition period, and any new UK immigration legislation, will shape the policy and regulatory environment in which the Trust recruits staff from overseas.
- Links in particular with Strategic Risk 9 (workforce) on the Board Assurance Framework, currently scored at 16.

3. NHS policy and institutional landscape

New powers for local authorities to contain COVID-19:

- On 17 July 2020, a new framework setting out how to manage COVID-19 outbreaks through the use of national and local expertise was published by the government. The COVID-19 contain framework is the blueprint for how NHS Test and Trace is working in partnership with local authorities, Public Health England, the NHS, other local business and community partners and the wider public to take action against outbreaks. New regulations came into effect on 18 July to give local and national government additional powers to stop local transmission of the virus. These will allow them to restrict local public gatherings and events, and close local businesses premises and outdoor spaces.

- Links to Strategic Risks 1 (patient safety), 3 (timeliness of care) and 4 (system working) on the Board Assurance Framework, rated as 16, 20 and 8 respectively.

Flu vaccination programme 2020/21:

- On 24 July 2020, the Department of Health and Social Care announced a major new flu vaccination programme. Under the plans, a significant new group will be eligible for the free flu vaccine as people aged 50 to 64 will be invited later in the season for a vaccination. A free flu vaccine will also be available to:
    - people who are on the shielded patient list and members of their household
    - all school year groups up to year 7
    - people aged over 65, pregnant women, those with pre-existing conditions including at-risk under 2s

- The DHSC has said that once vaccination of the most ‘at-risk’ groups is well underway, it will work with clinicians to decide when to open the programme to invite people aged 50 to 64, with further details to be announced. The NHS will contact people directly, including information about where to go to get the vaccine. The expanded flu vaccination programme is part of plans to ready the NHS – both for the risk of a second peak of coronavirus cases, and to relieve winter pressures on A&E and emergency care. Increased vaccinations is intended to help to reduce pressure on the NHS this winter.

- Links to Strategic Risks 1 (patient safety) and 3 (timeliness of care) currently rated as 16 and 20 respectively.

3. NHS policy and institutional landscape

Health and Care Visa:

- On 14 July 2020 the Home Secretary and Secretary of State for Health and Social Care announced that a new Health and Care Visa will be launched this Summer, creating a fast-track visa route for eligible health and care professionals to enter the UK and work in the NHS. Further details were also announced on how the exemption to the Immigration Health Surcharge will work for health and care staff, who will now be permanently exempt from this charge. The Health and Care Visa is said to be designed to make it easier and quicker for the best global health professionals to work in the NHS, for NHS commissioned service providers, and in eligible occupations in the social care sector. The legislation needed to open this new route was laid in Parliament earlier this month and health professionals will be able to apply from August. The new Visa is expected to come with a reduced visa application fee compared to that paid by other skilled workers, including exemption from the Immigration Health Surcharge.

- The Government has also announced that health and care professionals applying on this route can also expect a decision on whether they can work in the UK within three weeks, following biometric enrolment. As part of the launch of the Health and Care Visa, those who apply via the visa and their dependants will be exempt from the Immigration Health Surcharge. The new Health and Care Visa will apply to eligible roles within the health and care sector.

- Links to Strategic Risk 9 on the Board Assurance Framework (workforce), currently scored at 16.

Launch of NHS Race and Health Observatory

- On 30 May 2020, NHS England and the NHS Confederation launched a new centre to investigate the impact of race and ethnicity on people's health. The new NHS Race and Health Observatory, which will be hosted by the NHS Confederation, will identify and tackle the specific health challenges facing people from BAME backgrounds. The Observatory will provide analysis and policy recommendations to improve health outcomes for NHS patients, communities and staff.

4. System and professional regulation

NHS Debt "Write Off"

- On 2 April 2020, the Secretary of State for Health and Social Care announced that from 1 April 2020 over £13 billion of NHS debt would be "scrapped" as part of a wider package of NHS reforms. The changes were intended to provide financial support during the pandemic, as well as putting in place measures to support the Government's previously announced commitments to ensure the NHS becomes more financially sustainable. Under the new rules, in the event that hospitals need extra cash this will be given with equity, rather than needing to borrow from the Government and repay a loan. The debt to be written off at 31 March 2020 consists of a combination of interim revenue debt, which includes working capital loans and interim capital debt. Loans were frozen from 1 April when interest ceased, and loan principal and outstanding interest will be extinguished from balance sheets following a transaction during 2020/21 The "debt write off" is being achieved by converting the loans to equity (Public Dividend Capital). The loans that have been historically been issued as "Normal Course of Business" will be retained. The Government has also published a regional breakdown of the debt write off. Links to Strategic Risks 5 (financial sustainability) and 6 (capital) on the Board Assurance Framework, scored at 25 and 20 respectively.

NHS England and NHS Improvement Mandate 2020/21:

- On 26 March 2020, the Department of Health and Social Care published a new Mandate for NHS England and NHS Improvement for the financial year 2020/21. For 2020/21, the Mandate is brief which DHSC has said was to provide clarity for the system about the headline objectives that the Government needs NHS support to achieve during the pandemic. The intention is to replace this with a further mandate once Covid-19 has been effectively managed.

- The new Mandate sets five objectives for NHS England and NHS Improvement: (i) Support the Government to delay and mitigate the spread of Covid-19; (ii) Ensure progress towards the effective implementation of the NHS Long Term Plan and maintain and enhance public confidence in the NHS; (iii) With support from Government, help ensure delivery of wider priorities, including improving patient experience, cooperation with local government, and planning for life outside the EU once the transition period ends; (iv) Deliver the public health functions that the Secretary of State for Health and Social Care has delegated to NHS England; (v) Share all information with Government that is necessary to enable progress against this mandate to be effectively monitored, and to support the Secretary of State in fulfilling wider statutory functions, including in respect of Covid-19.

4. System and professional regulation

NMC register of nurses and midwives reaches highest levels

- A new report by the NMC published in early July 2020, highlighted that the NMC register was at a record high, with around 18,000 more nurses, midwives and nursing associates registered to work in the UK compared to a year ago. The rise is attributed to a combination of people joining and staying from the UK and from countries outside the European Economic Area (EEA).
- The latest figures highlight an increase to the permanent register of 9,012 (1.5%) nurses and midwives from the UK, and in England only, nursing associates. The number of people leaving the register from the UK has also fallen to a five-year low of 21,306 compared with a peak of 29,434 in 2016–2017. There has also been a big increase in the number of people from outside the EEA on the NMC's permanent register, rising by 11,008 (15%). This was driven by a 95% increase in the number of people joining for the first time (6,157 to 12,033). Meanwhile, the number of nursing and midwifery professionals from the EEA continues to decline, with the number this year reducing to 31,385, a 5% drop on the previous year.
- Links to Strategic Risk 9 on the Board Assurance Framework (workforce), currently scored at 16.

Nursing and Midwifery Council Strategy 2020-25

- On 29 April 2020, the Nursing and Midwifery Council (NMC) launched its new five-year strategy, 2020-25. The strategy is based on three key roles that underpin its core purpose: regulation, support, and influence.
- In terms of regulation, it reiterates the NMC's longstanding role in promoting and uphold high standards, maintaining the register of professionals eligible to practise, and stepping in to investigate on the rare occasions when care goes wrong. The strategy, however, places far greater emphasis on support and influence, including commitments to regulate the professions as progressively as possible and to support professionals to achieve and maintain high professional standards. It describes this as trying to get the balance right between investigating cases of poor practise and promoting excellent care. The strategy also emphasises the NMC's role in influencing the development of health and care policy at national and local level.
- Links to Strategic Risk 9 on the Board Assurance Framework (workforce), currently scored at 16.

4. System and professional regulation

Changes to General Medical Council regulatory requirements due to COVID-19

- **Changes to revalidation dates:** The General Medical Council (GMC) has confirmed that doctors' revalidation submission dates have been put back by up to 12 months due to the coronavirus pandemic. It means doctors with a revalidation date between 17 March 2020 and 16 March 2021 can have their revalidation delayed for up to a year. In response to feedback from responsible officers, the GMC has increased flexibility during the pandemic so responsible officers can make a revalidation recommendation at any point from now up to a doctor's new revalidation date. The GMC is writing to all doctors affected by the date changes with more information.

- **Assessments of doctors from overseas and resumption of fitness to practise cases:** The GMC has set out its plans for resuming Professional and Linguistic Assessment Board 2 (PLAB 2) tests for overseas doctors. From July, existing fitness to practise cases will also be restarted where possible with flexibility on timescales and in direct discussion with those involved. This follows the suspension of PLAB tests and changes to fitness to practise processes during the height of the COVID-19 pandemic.

- Links to Strategic Risk 9 on the Board Assurance Framework (workforce), currently scored at 16.

Regulation of Medical Associate Professions

- In July 2019, the Department of Health and Social Care (DHSC), with the support of the four UK governments, asked the GMC to regulate physician associates (PAs) and anaesthesia associates (AAs). Legislation to effect this commitment is anticipated in the second half of 2021.

- Once the GMC starts regulating MAPs, newly qualified PAs and AAs will have to join the GMC's register to be able to practise in the UK. Transitional arrangements will be in place for those who are already qualified and/or practising in the UK. Further information about these plans are likely to be published later this year. In the meantime, the GMC is seeking input from PAs and AAs as it designs its regulatory framework for these professions.

- Links to Strategic Risk 9 on the Board Assurance Framework (workforce), currently scored at 16.

4. System and professional regulation

Medical Licensing Assessment

- On 24 July 2020, it was announced that the UK's medical schools and parent universities have agreed to develop and deliver the Medical Licensing Assessment (MLA) that will be embedded within final exams for a UK medical degree. Their work will be overseen and regulated by the General Medical Council. To date UK medical schools have set their final exams independently in line with the GMC's *Outcomes for graduates*. A stated benefit of the MLA is that it would, for the first time, be possible to demonstrate that graduates from each medical school have met an agreed standard of proficiency and are well prepared to practise medicine as Foundation Year doctors. The MLA aims to provide assurance that anyone who obtains a UK medical degree has shown that they can meet a common and consistent threshold for safe practice before they are licensed to work in the UK.

- Under the agreement, the GMC will:
    - Define the range of professional skills, knowledge and behaviours a candidate needs to have achieved to be ready to practise medicine in the UK;
    - Approve procedures to compile test questions and papers, set standards and run exams;
    - Take corrective action if, through its quality assurance processes, it considers that standards are not met;
    - Be responsible for using information and data from the UK exams to apply a consistent approach to the assessment of international medical graduates.

- Under the agreement UK university medical schools will continue to develop and deliver their own curricula and prepare students for the MLA which will be regulated by the GMC.

- Links to Strategic Risk 9 on the Board Assurance Framework (workforce), currently scored at 16.

5. Reports and updates from key stakeholders

Public Health England report on the impact of COVID-19 on BAME groups

- On 16 June 2020, Public Health England (PHE) published a summary of stakeholder insights into factors affecting the impact of COVID-19 on black, Asian and minority ethnic (BAME) communities. PHE's research was commissioned by the Chief Medical Officer for England to understand the extent that ethnicity impacts upon risk and outcomes.

- The PHE review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19. The review found that the highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males). An analysis of survival among confirmed COVID-19 cases showed that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British. Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. This is the opposite of what is seen in previous years, when the all-cause mortality rates are lower in Asian and Black ethnic groups. Comparing to previous years, all-cause mortality was almost 4 times higher than expected among Black males for this period, almost 3 times higher in Asian males and almost 2 times higher in White males. Among females, deaths were almost 3 times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females. These analyses did not account for the effect of occupation, comorbidities or obesity.

- The main themes emerging from the stakeholder sessions were: (i) Longstanding inequalities had been exacerbated by COVID-19; (ii) Increased risk of exposure to and acquisition of COVID-19 among BAME communities; (iii) Increased risk of complications and death from COVID-19 among those of BAME origin; (iv) Concerns about Racism, discrimination, stigma, fear and trust.

- Links to Strategic Risks 8 (culture) and 9 (workforce) on the Board Assurance Framework, scored at 20 and 16 respectively.

6. Current inquiries

Independent Inquiry into Maternity Services at Shrewsbury and Telford NHS Trust

- An independent inquiry into maternity services at Shrewsbury and Telford NHS Trust was launched in 2017 at the request of the Secretary of State for Health and Social Care. The inquiry is looking into the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at the Trust. The review is being led by NHS Improvement and is being chaired by Donna Ockenden.

- Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors led to an extension to the scope of the original independent review. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be reviewed by the maternity review team to ensure rigour and application of good practice.

- On 10 July 2020, it was reported that as many as 1,500 cases could be reviewed by the inquiry. This followed the identification of hundred more cases of maternity care failings at the Trust which had been identified in a review of paper records dating between 2000 and 2011. The Trust is also facing a criminal investigation into the issues, with West Mercia Police having announced earlier this month that it would be looking to gather evidence in relation to both individuals and the organisation.

7. Recent appointments

Lead for London NHS COVID-19 Race Equality Programme – Yvonne Coghill

- On 9 June 2020, NHS England announced the appointment of its Director of Workforce and Race Equality, Yvonne Coghill, to lead a rapid programme of work to support black, Asian and minority ethnic (BAME) staff across London in response to the COVID-19 pandemic. Yvonne Coghill is scheduled to reire from the NHS after 43 years of service and will be replaced as Director of Workforce at NHS England by Habib Naqvi, currenty deputy director of the Workforce Race Equality Standard programme, on an interim basis pending a permanent appointment. The programme of work being led by Yvonne Coghill is of particular relevance to the Trust given both the diversity of our workforce (48% of our workforce are from a BAME background) and the concerns raised by our BAME staff during the pandemic which the Trust is addressing through its renewed work on diversity and inclusion and through its new BAME staff network.

Chair of the National Institute for Health and Care Excellence (NICE) – Sharmila Nebhrajani

- On 13 February 2020, the Secretary of State for Health and Social Care, Matt Hancock MP, announced that Sharmila Nebhrajani OBE had been appointed as the new Chair of NICE.

- The House of Commons Health and Social Care Select Committee conducted a pre-appointment hearing on 13 March 2020 and subsequently endorsed the appointment. Ms Nebhrajani was previously Chief Executive of Wilton Park, Chair of the Human Tissue Authority, Director of External Affairs of the Medical Research Council and Chief Executive of the Association of Medical Research Charities.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

5.3

Meeting Title:	Trust Board		
Date:	30 July 2020	**Agenda No**	**5.3.2**
Report Title:	**Horizon Scanning Q1, 2020-21 - Local & Regional Updates Report**		
Lead Director/ Manager:	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Laura Carberry, Strategy and Partnership Manager		
Presented for:	Update		
Executive Summary:	This Horizon Scanning Quarterly Report is intended for Trust Board; apprising the Board of the latest Local and Regional Updates, based on CCG Governing Body and Health and Wellbeing Board papers in south west London, and on current and future Clinical Tenders or Opportunities for St George's. It should be considered alongside the Corporate Office's Horizon Scanning Q1, 2020-21 Report on National Policy. Areas of interest/ particular relevance to the Trust, include: • the COVID-19 impact and plans for recovery and restart in SWL; • the establishment of SWLCCG; • the Improving Healthcare Together Programme; • a 'Cardiac Surgery at St George's' Report, and; and • the development of a Digital Strategy for SWL.		
Recommendation:	Trust Board is asked to note the latest Local and Regional Updates.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person; Right care, right place, right time; Balance the books, invest in our future; Build a better St. George's; Champion Team St. George's; Develop tomorrow's treatments today.		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring**: staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led**: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	Executive Management Team	**Date**	20 July 2020
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Horizon Scanning Q1, 2020- 21 – Local and Regional Updates

5.3

This Horizon Scanning Quarterly Report is intended for Trust Board; apprising the Board of the latest Local and Regional Updates, based on CCG Governing Body and Health and Wellbeing Board papers in south west London, and on current and future Clinical Tenders or Opportunities for St George's.

It should be considered alongside the Corporate Office's Horizon Scanning Q1, 2020-21 Report on National Policy.

Suzanne Marsello
Chief Strategy Officer

July 2020

CONTENTS

Contents	Slide No
Highlights	3
South West London CCG: Q1, 2020-21	
• Governing Body Meeting Papers Summary	4
• Board and Committee Structure	7
Health and Wellbeing Boards: Q1, 2020-21	
• Board Papers Summary	8
South West London and Surrey Heartlands CCGs	
• Improving Healthcare Together Programme	9
Current Opportunities for St George's	
• Clinical Tenders	10

HIGHLIGHTS

Below are the Common Themes or Headlines/ Highlights that are of particular relevance to the Trust.
NB: Areas covered in the Main Body of this Report are not fully replicated or summarised in this table.

Item	Notes	Likely to be of particular interest to…
COVID-19 impact and plans for recovery and restart.	CCG Governing Body, and Borough Committee, assessments of change for COVID-19 and plans for recovery and restart in SWL., covering the establishment of Gold Command, an Incident Control Room and Incident Control Cells (x8) and the impact on Models of Care, Staff and Ways of Working. Also discussed by the Finance Committee in relaton to the financial plan and position in SWL and the Primary Care Commissioning Committee in relation to Borough-level examples of practice/ response. Also covered in the Finance and Quality Reports to SWL CCG.	• Executive Management Team
Establishment of SWLCCG	In April 2020, the 6 CCGs established and formed SWLCCG; appointments to Board-level and Executive roles are approved/ confirmed and arrangements for the framework of Governance and Oversight, including the Board and Committee Structure (see Slide 8) and the CCG's Constitution, along with the documentation to support this, were reviewed and signed-off.	• Chief Strategy Officer • Deputy Chief Executive / Chief Finance Officer
Improving Healthcare Together Programme	Arrangements for a Committee in Common (CiC) covering the Improving Healthcare Together (IHT) 2020-2030 programme, including the Terms of Reference, were reviewed and signed-off. On 3 July 2020, the CiC for South West London and Surrey Heartlands approved the decision for Epsom and St Helier University Hospitals NHS Trust to be reconfigured, establishing a Major Acute Hospital at Sutton and an investment of £500m across the Trust. Actions to address the consultation feedback in relation to bed capacity, deprived communities and older residents, opportunities in Primary Care and transport and travel, were shared.	• Executive Management Team
Cardiac Surgery at St George's Report	SWL CCG received a report that: • confirmed the details of the Independent Mortality Review and the Independent Scrutiny Panel Report published recently; • advised that the Board of St George's had accepted the findings in full and that improvements, in line with the recommendations in the reports, were already in place or being progressed, and; • acknowledged that Cardiac Surgery data indicated that the latest Mortality Statistics were within normal range and no longer an outlier for the Trust.	• Chief Operating Officer
Digital Strategy	It was confirmed that the development of a Digital Strategy is planned; contributing to the COVID-19 planned recovery and restart.	• Deputy Chief Executive / Chief Finance Officer

SOUTH WEST LONDON CCG: Q1, 2020- 21

GOVERNING BODY MEETING PAPERS SUMMARY

Bi-Monthly Meetings

CCG Governing Body Meeting (May 2020)

- The Governing Body received a report on the **SWL CCG's response to COVID-19**. The report details the measures put in place to manage a Gold command structure, including the establishment of the Incident control room supported by the eight expert Incident Control Cells. The report provides details on each of the cells.
- The Governing Board received an update from each of the 6 **Borough Committee** Chairs. Each focused on the COVID-19 pandemic response of the borough and partners, detailing changes in remote working, redeployment of staff, training and changes to models of care provision.
- In March 2019, it was agreed by the Governing Bodies of the 6 CCGs in SWL (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth) to develop 'Moving Forward Together' proposals for a single SWLCCG.
- In April 2020, the 6 CCGs established and formed **SWLCCG; appointments to Board-level and Executive roles were approved/ confirmed** and **arrangements for the framework of Governance and Oversight, including the Board and Committee Structure (see Slide 8)** and the **CCG's Constitution,** along with the documentation to support this, were **reviewed and signed-off.**
- Appointments approved by the Governing Body for SWLCCG:
  - **Chair- Dr Andrew Murray**
  - **Deputy Chair- David Smith**; also Finance Lay Member
  - **Clinical Vice Chairs- Dr Naz Jivani**; also elected-GP lead for Kingston **and Dr Nicola Jones**; also elected-GP lead for Wandsworth
- Appointments confirmed as follows:
  - **Paul Gallagher**, Audit Lay Member
  - **Susan Gibbin**, Public Patient Engagement Lay Member
  - **Pippa Barber**, Registered Nurse Lay Member
  - **Les Ross**, Secondary Care Doctor Lay Member
  - **Agnelo Fernandez**, elected-GP lead for Croydon
  - **Vasa Gnanagragasam**, elected-GP lead for Merton
  - **Patrick Gibson**, elected-GP lead for Richmond
  - **Jeffery Croucher**, elected-GP lead for Sutton
- Executive Team established as follows:
  - **Sarah Blow**, Accountable Officer
  - **James Murray**, Chief Financial Officer
  - **Jonathan Bates**, Executive Director of System Planning, Performance and Delivery
  - **Karen Broughton**, Executive Director of Strategy and Transformation
  - **Charlotte Gawne**, Executive Director of Communications and Engagement
  - **Tonia Michaelides**, Locality Executive Director, Kingston and Richmond

5.3

4

SOUTH WEST LONDON CCG: Q1, 2020- 21

GOVERNING BODY MEETING PAPERS SUMMARY

- **James Blythe**, Locality Executive Director, Merton and Wandsworth
- **Lucie Waters**, Locality Executive Director, Sutton
- **Matthew Kershaw**, Place Based Leader, Croydon
- **Ben Luscombe**, Chief of Staff
- **Vacancy**, Chief Nurse & Executive Director of Quality

- Arrangements for the framework of Governance and Oversight, including the Board and Committee Structure (see Slide 8) and supporting Terms of Reference, were reviewed and signed-off:
  - **Audit Committee**, chaired by Paul Gallagher (Audit Lay Member);
  - **Finance Committee**, chaired by David Smith (Finance Lay Member);
  - **Primary Care Commissioning Committee**, chaired by Susan Gibbin (Public Patient Engagement Lay Member);
  - **Quality, Performance and Oversight Committee**, chaired by Pippa Barber, (Registered Nurse Lay Member), and;
  - **Remuneration Committee**, chaired by David Smith (Finance Lay Member).

  In addition the **6 Borough-level Committees** (also known as Localities or Place-Based) are confirmed formal Committees of the Governing Body.
- In addition, the **CCG's Constitution, Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions, Detailed Scheme of Delegation,** and **Template Accountability Agreement** were reviewed and signed-off.
- Arrangements for a **Committee in Common** covering the **Improving Healthcare Together (IHT) 2020-2030 programme**, including the Terms of Reference, were reviewed and signed-off.
- This acknowledges the agreement between the CCGs to collaborate on commissioning decisions and for decision-making to be delegated, from the Governing Bodies for South West London and Surrey Heartlands, on Epsom and St Helier University Hospitals NHS Trust's future and the Improving Healthcare Together (IHT) 2020-2030 programme without further Governing Body ratification.
- Committee in Common Meetings will be chaired by a 'Convener' and will, as far as possible, be in public.
- The Governing Body received a report from the chair of the **finance committee**. Governance items to note included approval of the Scheme of Delegation (SoD) and Standing Financial Instructions (SFI). Interim COVID-19 finance governance arrangements were set out, which supplement the CCG's SFI's and SoD. An update was provided on the current suspended planning round. The committee noted the degree to which decision making was occurring at the national level and the resultant level of uncertainty over the CCG's financial position.
- The Governing Body received an update from the **Primary Care Commissioning Committee**. Key issues highlighted was the Kingston and Richmond COVID-19 service delivery model and additional funding to support the Kingston Hot Hubs, Richmond GP Home Visiting Service and Merton's urgent GP home visiting service.

SOUTH WEST LONDON CCG: Q1, 2020- 21

GOVERNING BODY MEETING PAPERS SUMMARY

- The Governing Body received a **finance report**. This included a high level summary of the month 12 unaudited position. Details were provided on the interim governance arrangements related to COVID-19 expenditure. QIPP delivery for month 12 was also detailed.
- The Governing Body received a **quality report.** This included an update on changes to quality assurance oversight under COVID, including suspension of or changes to a number of areas of reporting/quality assurance relevant to the Trust. For instance, the Governing Body was asked to note that the Friends and Family Test has been suspended, and that changes have been made to the management of RRT, cancer, and ED performance standards. The quality report also highlighted key quality concerns in each of South West London's boroughs. The key issue relevant to the Trust was cardiac surgery (on which the Governing Body received a separate report).
- The Governing Body received an update on **cardiac surgery at St George's**. The report noted the recent publication of the Independent Mortality Review and the Independent Scrutiny Panel report. It noted that the St George's Trust Board had accepted the findings and recommendations of both reports in full, and that improvements had been made at the Trust, with the latest data showing the Trust no longer being an outlier for mortality in cardiac surgery.
- A number of questions from the public were responded to - including, of relevance to the Trust, the CCG confirming that a **South West London Digital Strategy** will be developed "in the coming months" as part of COVID recovery.

Board Papers can be found at: https://swlondonccg.nhs.uk/wp-content/uploads/2020/05/SWLCCG-Governing-Body-Papers-May-2020.pdf

SOUTH WEST LONDON CCG: Q1, 2020- 21

BOARD AND COMMITTEE STRUCTURE

Key:
Key Accountability
Key Relationship
Borough Level
Statutory Committee

SWL CCG MEMBERSHIP

Overall accountability for CCG functions.
The CCG reserves & delegates certain powers under the Scheme of Reservation and Delegation (SORD).
Frequency: x 1 AGM meeting; x 1 annual members meeting (locality membership meetings in addition and determined locally)

SWL CCG GOVERNING BODY
Chair: ANDREW MURRAY
Exec Leads: SARAH BLOW, JAMES MURRAY

Makes decisions on behalf of the CCG as delegated by the SORO to deliver the CCG's legal duties and long term sustainability.
Frequency: x 12 PA (6 formal GBs and 6 GB Seminars)

MERTON PRIMARY CARE MANAGEMENT GROUP
MERTON BOROUGH COMMITTEE

WANDSWORTH PRIMARY CARE MANAGEMENT GROUP
WANDSWORTH BOROUGH COMMITTEE

KINGSTON PRIMARY CARE MANAGEMENT GROUP
KINGSTON BOROUGH COMMITTEE

RICHMOND PRIMARY CARE MANAGEMENT GROUP
RICHMOND BOROUGH COMMITTEE

CROYDON PRIMARY CARE MANAGEMENT GROUP
CROYDON BOROUGH COMMITTEE

SUTTON PRIMARY CARE MANAGEMENT GROUP
SUTTON BOROUGH COMMITTEE

The PCMG's will ensure the aspects of primary care commissioning are undertaken effectively and in line with national regulation and local strategy.

Each local borough will have delegated power to make commissioning decisions on behalf of the GB, which are safe, timely, personalised, recovery focussed and sustainable. Decisions will meet the needs for and on behalf of the local population within the allocated resource.

AUDIT COMMITTEE
Chair: PAUL GALLAGHER
Exec Lead: JAMES MURRAY

Reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities that support the achievement of the CCGs objectives
Frequency: x 6 PA minimum

PRIMARY CARE COMMISSIONING COMMITTEE
Chair: SUSAN GIBBIN
Exec Lead: JONATHAN BATES

To exercise primary care co-commissioning functions delegated by NHSE to the CCG: GMS, PMS and APMS contracts . Also ratify new LIS; whether to establish new GP practices or approving practice mergers; or discretionary payments (all on recommendation from Borough Committee)
Frequency: x 6 PA in public

REMUNERATION COMMITTEE
Chair: DAVID SMITH
Exec Lead: KAREN BROUGHTON

Makes recommendations to GB to ensure appropriate remuneration, allowances and terms of service for the CCG chair, AO, VSM Pay Framework posts, GB clinical posts and clinical lead corporate roles; having proper regard to the CCG's circumstances & performance, the provisions of any national agreements and NHS E&I guidance
Frequency: x 1 PA minimum

FINANCE COMMITTEE
Chair: DAVID SMITH
Exec Lead: JAMES MURRAY

Ensures that a robust finance strategy is in place and oversees the system of financial management.
Frequency: Monthly (x 10 PA minimum)

QUALITY, PERFORMANCE & OVERSIGHT COMMITTEE
Chair: PIPPA BARBER
Exec Lead: JONATHAN BATES

Will ensure & oversee that a robust system of quality, oversight and performance is in place across SWL
Frequency: x 6 PA minimum

LOCALITY COMMITTEE INPUT x 6

PATIENT & PUBLIC REFERENCE GROUP
Chair: SUSAN GIBBIN
Exec Lead: CHARLOTTE GAWNE

Ensures the needs, aspirations & experiences of patients & the public influence discussions & decisions of the CCG at SWL level. To act as a champion for patients and public, ensuring the perspective of local people is considered in the business of the CCG.
Frequency: x 6 PA (rota ting across all boroughs)

LOCALITY COMMUNITY ENGAGEMENT REF GROUP x 6

INFORMATION GOVERNANCE STEERING GROUP
Chair: BEN LUSCOMBE

The IGSG is responsible for overseeing and delivering the CCGs statutory responsibilities for all aspects of Information Governance within the CCG. This includes setting robust & effective policies, procedures, systems and strategies for the SWL CCG.
Frequency: x 6 PA minimum

5.3

HEALTH AND WELLBEING BOARDS: Q1, 2020- 21

BOARD PAPERS SUMMARY

Quarterly Meetings

Croydon HWB

- Meetings scheduled for Q1 were either cancelled or postponed; DONM: 21 October 2020.

Board Papers can be found at:
https://democracy.croydon.gov.uk/ieListMeetings.aspx?CommitteeId=172&utm_source=mod-gov&utm_medium=taxonomy&utm_campaign=%20committee-calendar-healthwellbeing

Kingston HWB

- Meetings scheduled for Q1 were cancelled ; DONM: 3 September 2020.

Board Papers can be found at:
https://moderngov.kingston.gov.uk/ieListMeetings.aspx?CId=488&Year=0

Merton HWB (June 2020)

- The agenda covered the COVID-19 impact on Merton, Merton Care Home Support Plan (overview of response, key learning and future work), Merton Community Response Hub Mobilisation and a Merton Voluntary Sector Update *(NB: Minutes not published yet)*.
- DONM: 29 September 2020.

  - Board Papers can be found at:
  https://democracy.merton.gov.uk/ieListMeetings.aspx?CId=184&Year=0

Richmond HWB

- No Meetings scheduled for Q1; DONM: 16 July 2020.

Board Papers can be found at:
https://cabnet.richmond.gov.uk/ieListMeetings.aspx?CommitteeId=643

Sutton HWB

- Meetings scheduled for Q1 were cancelled ; DONM: 20 July 2020.

Board Papers can be found at:
https://moderngov.sutton.gov.uk/ieListMeetings.aspx?CommitteeId=471

Wandsworth HWB (June 2020)

- Received an update on COVID-19.
- Was asked to agree a changed set of priorities for the short to medium term, in light of COVID, which would "supersede" current work priorities and associated work programmes in the published Wandsworth Health and Care Plan
- These priorities would be: Community, Social and Primary Care integration; Hospital discharge; Care homes; Health Inequalities; Immunisations; Children's Community Services; Voluntary sector partnership working; Public, staff engagement, consultation and co-production; Safeguarding. It was proposed that delivery progress relating to all these areas will be reported back to the HWB at future meetings.
- DONM: 24 September 2020.

Board Papers can be found at:
https://democracy.wandsworth.gov.uk/ieListMeetings.aspx?CId=508&Year=0

5.3

SOUTH WEST LONDON AND SURREY HEARTLANDS CCGs

IMPROVING HEALTHCARE TOGETHER PROGRAMME

The Committee in Common (CiC) between SWL CCG and Surrey Heartlands CCG met on the 3rd July to make a decisions on the £500 million investment option for delivering a new clinical model in following a 12 week public consultation earlier in the year.

The CiC approved the preferred option of £500m investment for Epsom and St Helier hospitals (ESTH) and a brand new specialist hospital in Sutton.

The decision will see a brand new, emergency care hospital built in Sutton to treat the sickest patients and modernise ESTH. This means people can get the care they need in refurbished buildings locally, with a brand new specialist hospital nearby if they need it.

The IHT Programme Board have set out a range of measures to address issues around transport and travel, bed numbers and services for older residents and more deprived communities, which were raised during the recent public consultation were also announced, including:

- **extending the H1 Epsom and St Helier hospital bus route** into Merton and further south into Surrey beyond Epsom and increasing the frequency between the three hospital sites;
- **reviewing car parking on all three sites** to make sure there is enough for patients, visitors, and staff;
- **increased bed capacity to care for an extra 1,300 inpatients a year**, plus advances in technology, treatment and closer working with community services so fewer patients will need an overnight stay and will get home sooner, and;
- **exploring opportunities for primary care services** at ESTH, and expanding child and adolescent mental health services on the St Helier site.

They advise that under the proposals, around 85% of current services will remain at Epsom and St Helier, with six major services being brought together in the new specialist emergency care hospital, including A&E, critical care, and emergency surgery.

The Trust formally responded to the consultation exercise in support of the preferred option. Separately renal specialist across St George's and ESTH also provided a joint response outlining proposals for improvements to patient care through consolidating specialist renal services in one facility.

ESTH will now start to develop the Outline Business Case for this proposal.

CURRENT OPPORTUNITIES FOR ST GEORGE'S

CLINICAL TENDERS

There are no new clinical tender opportunities currently open nor future opportunities that have been notified to the Trust at present. It is likely that any planned procurements may have been paused during Covid-19.

Genomic Medicines Alliance Services (GMSA) - Joint Bid St George's and Guys and St Thomas'

Discussions are ongoing between the Trust and Guys and St Thomas' (GSTT) on the development of a GMSA across South London and South East England. Joint bids were due to be submitted to NHSE in March 2020, and while the formal deadline was delayed due to COVID 19, most regions submitted draft bids for informal feedback. The Trust's region did not submit a bid during this period because the Trust and GSTT could not agree on key governance and leadership arrangements for the GMSA. NHSE have now agreed to meet with the Trust and GSTT regularly to help develop a joint bid. The Trust and GSTT have agreed to put together a joint group to develop the bid. The deputy CE is the executive lead for this work.