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St George's University Hospitals NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday 24 September 2020, 09:00-11:50**
Venue: **MS Teams**

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 – 30 July 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, CULTURE AND WORKFORCE					
09:15	**2.1**	**Workforce and Education Committee Report**	**Committee Chair**	Assure	Report
09:25	**2.2**	**Culture Programme Update** *(Reviewed by Workforce & Education Committee)*	**Chief Executive/ Acting Chief People Officer (Culture)**	Assure	Report
09:35	**2.3**	**Diversity and Inclusion Report and Action Plan** *(Reviewed by Workforce & Education Committee)*	**Chief Executive/ Acting Chief People Officer (Culture)**	Assure	Report
09:45	**2.4**	**Freedom to Speak Up Vision and Strategy** *(Reviewed by Workforce & Education Committee)*	**Chief Corporate Affairs Officer / FTSU Guardian**	Approve	Report
09:55	**2.5**	**Guardian of Safe Working Hours Q1 Report** *(Reviewed by Workforce & Education Committee)*	**Guardian Of Safe Working/Chief Medical Officer**	Assure	Report
10:05	**2.6**	**Medical and Nursing Revalidation Reports** *(Reviewed by Workforce & Education Committee)*	**Chief Medical Officer/ Chief Nurse**	Approve	Report
3.0 QUALITY, SAFETY AND PERFORMANCE					
10:10	**3.1**	**Quality and Safety Committee Report**	**Committee Chairman**	Assure	Report
	3.1.1	***Learning from Deaths Q1 Report*** *(Reviewed by Quality & Safety Committee)*	**Chief Medical Officer**	Assure	Report
	3.1.2	***Mental Capacity Act and Deprivation of Liberty Safeguards Annual Report*** *(Reviewed by Quality & Safety Committee)*	**Chief Nurse & DIPC**	Assure	Report
	3.1.3	***Learning Disabilities Annual Report*** *(Reviewed by Quality & Safety Committee)*	**Chief Nurse & DPIC**	Assure	Report
	3.1.4	***Clinical Negligence Scheme for Trusts – Maternity Services*** *(Reviewed by Quality & Safety Committee)*	**Chief Medical Officer/ Chief Nurse**	Approve	Report
10:30	**3.2**	**Integrated Quality and Performance Report** *(Reviewed by Finance & Investment Committee and Quality & Safety Committee)*	**Chief Operating Officer**	Assure	Report

Time	Item	Subject	Lead	Action	Format
10:45	**3.3**	**COVID-19, Flu and Winter Plan 2020-21** *(Reviewed by Finance & Investment Committee and Quality & Safety Committee)*	**Chief Operating Officer**	Approve	Report
4.0 FINANCE					
11:00	**4.1**	**Finance and Investment Committee Report**	**Committee Chair**	Assure	Report
11:10	**4.2**	**Finance Report (Month 5)** *(Reviewed by Finance & Investment Committee)*	**Chief Finance Officer**	Update	Report
5.0 STRATEGY, RISK & COMPLIANCE					
11:20	**5.1**	**Corporate Objectives 2020/21**	**Chief Strategy Officer**	Assure	Report
11:30	**5.2**	**Board Assurance Framework Q2 2020/21**	**Chief Corporate Affairs Officer**	Assure	Report
6.0 CLOSING ADMINISTRATION					
11:40	**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	
11:50	**CLOSE**				

Thursday, 26 November 2020, 09:00-12:00
MS Teams

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St George's University Hospitals NHS Foundation Trust

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		
James Friend	Chief Transformation Officer	CTO
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		
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.*	

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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, 30 July 2020
Microsoft Office Teams

Name	Title	Initials
PRESENT		
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		
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Elizabeth Nyawade	Acting Chief People Officer – Workforce	ACPO-W
Humaria Ashraf	Acting Chief People Officer – Culture	ACPO-C
SECRETARIAT		
Tamara Croud	Head of Corporate Governance/Board Secretary	HCG
APOLOGIES		

		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 and warmly welcomed James Friend back following a period of absence.	

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		Action
1.2	**Declarations of Interest** There were no additional or new declarations of interest reported.	
1.3	**Minutes of the meetings held on 25 June 2020** The minutes of the meeting held on 25 June 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: • Data on quality impact attributed to waiting list (Action Item TB28.05.20/01): It was reported that a number of metrics had been identified to demonstrate quality impact on patients attributable to the waiting list and that these would feature in the Integrated Quality and Performance Report from September 2020. • Fit and Proper Person Test (Action Item TB25.06.20/04): The ACPO(W) reported that fit and proper person information relating to senior leaders in acting up roles would be undertaken and the professional qualification of the CFO was now complete and would be added. An updated Fit and Proper Person Test position would be brought back to the Board for completeness in September 2020. • Staff Risks Covid Assessments Form (Action Item TB25.06.20/01): The ACPO(W) reported that the COVID-19 Staff Risk Assessment form was revised to ensure there was clarity that staff who had concerns about revealing health conditions to their managers could contact occupational health directly.	
1.5	**Chief Executive's Officer (CEO) Report** The Board received the report from the CEO and the following points were noted: The Trust was focused on recovery following the initial phase of the Covid-19 pandemic. This involved stepping services that were paused back up and running, getting patients back into the hospital for the treatment needed, and working with system partners across south west London and beyond to ensure that patients received the right treatment at the right time. Linked to this, the Trust itself was getting back in a more normal rhythm, with more theatres opening up, CommCell restarting and the ward accreditation programme resuming. • The Trust was pleased that its Emergency Department (ED) performance against the 4-hour standard continued to be amongst the top performing trusts in London and across England. More patients were now attending the Trust's ED following a significant fall in the number of attendances at the height of the pandemic in the Spring. The Trust remained focused on ensuring the safety of patients attending ED and reassuring them that it was safe to come on site to seek the care they needed.	

		Action
	• The Trust was developing its Covid, Flu and Winter Plan which would be presented to the Board via Quality & Safety and Finance & Investment committees in September 2020. • 97.7% of Trust staff had completed the Covid-19 risk assessment to date, which put the Trust in the top quartile of Trusts in the London region. The Trust aimed to get to 100% and was working hard to achieve this. • The Trust was continuing to push forward with its diversity and inclusion agenda given the need to make measurable and impactful progress in this area. A new diversity and inclusion manager had been appointed. Key priority projects included improving the career progression of BAME staff, improving development opportunities for staff, and listening and responding to concerns raised by BAME staff. • The exploratory and diagnostic phase of the Trust's culture programme was well underway and was expected to conclude in late September 2020. An update on the programme would be brought to the Board at its meeting in September 2020, and the Board would subsequently be engaged in considering in detail the outcomes of the diagnostics phase. The Board noted the report and the use of the Trust seal for 2019/20.	
2.0	**DIVERSITY, INCLUSION & CULTURE**	
2.1	**Diversity and Inclusion Report and Action Plan** The Board received and discussed the Trust's new Diversity and Inclusion Action Plan, which had been developed to respond to feedback from staff across the Trust and to ensure measurable and impactful progress was made in this essential area. The plan included five workstreams, each of which had an identified executive lead with clear lines of responsibility and ownership. Project leads had been identified and next steps included developing clear metrics and measures of success and the timescales for delivery. These would be presented to the next Workforce and Education Committee. Senior leaders across the Trust had engaged well with this work and a number of local engagement events had already been held. The Trust would develop a facilitators guide and toolkit to support staff in conducting diversity and inclusion conversations with their teams. There were now BAME representatives on all interview panels for staff at Agenda for Change Band 8a and above and the Trust was ensuring that these representatives received appropriate training. Recruitment and selection training is being developed for managers which would include unconscious bias training. The following key points were raised and noted in discussion: • Elizabeth Bishop welcomed the action plan and commented that it would be useful to facilitate mock interviews for BAME staff in order to support and feedback when applying for senior roles. Further, it was suggested that local communities should be engaged to support the provision of coaching and mentoring. The ACPO(C) reported that across the Trust there were a number of people that would like to support the mentoring and coaching programme and the Trust wanted to develop a good structure around this to best use its resources. The Trust was working on delivering career coaching but would also consider including mock	

		Action
	interviews as part of the plan. • Ann Beasley commented that the report was very thorough and asked that the Trust actively reflect the equality, diversity and inclusion impact in Board reports and draw out these issues in conversation. • In response to the need to make real and sustained progress in this area, the Workforce and Education Committee would convene additional meetings focused on diversity, inclusion and culture, and this would include monitoring progress against the action plan. The Committee would provide reports to the Board on these additional meetings, and the Board would receive full quarterly updates on progress against the diversity and inclusion plan. • Each Board member would be asked to make a pledge in relation to culture, diversity and inclusion actions which would be collated and shared with the Board. • Staff and patient stories could be used to relay the practical experience of staff and patients to the Board in relation to diversity and inclusion. It would be powerful for the Board to hear directly about the impact of the Trust's action plan. The CCAO reported that plans were underway to reintroduce the patient stories later in the year. • It was important that the diversity and inclusion plan covered all of the protected characteristics, although in light of recent staff feedback it was understandable why the focus was currently on the experience of BAME staff in relation to which the Trust needed to make substantial progress. • The Chairman asked how the frontline staff had received and perceived the programme of work and the wider focus on diversity and inclusion. It was reported that conversations were underway with some leaders taking a very responsive and proactive approach, but it was recognised that the Trust needed to support them with a facilitator guide. It was noted that a plan was being developed to reinstitute a regular staff pulse survey. • The staff networks, established earlier in the year, had been active participants in developing the plan. The Board noted the plan, progress made and next steps, and noted that an update on the diversity and inclusion action plan would be brought to the Board at its meeting in September 2020.	
3.0	**QUALITY AND PERFORMANCE**	
3.1	**Quality and Safety Committee Report** Professor Parveen Kumar, Chair of the Committee, presented the report of the meeting held on 23 July 2020, which set out the key matters raised and discussed. The Committee had reinstated its deep dive programme and at its July meeting had considered the systems in place to monitor and escalate mortality concerns and issues. The Committee noted that there were a number of systems in place to capture, track and investigate mortality concerns but recognised that more work was required to improve these systems. The Committee welcomed the good performance on complaints and	

		Action
	the positive working across South West London. The Committee recognised the challenges with the fit testing of masks and was assured on the Trust's plans to address the issues. The Committee was also assured that, with the exception of fit testing for masks, the Trust was compliant with the other 62 standards in relation to the Infection Prevention and Control Board Assurance Framework (IPC BAF). The Committee commended the IPC BAF which would be shared with the Care Quality Commission (CQC) and NHS England and NHS Improvement. The Trust had also made good progress on delivering against the CQC action plan with the exception of three actions which had been delayed. There had also been one Never Event which the Committee would consider in September 2020 as part of the monthly serious incident report. Ann Beasley queried the reasons why the three CQC actions (one pertaining to referral to treatment and diagnostics activity and two related to conducting audits in outpatients on environment and management of records) had not been progressed. It was reported that this was due to the operational pressures and changes implemented as a result of responding to the Covid-19 pandemic. The Trust had developed mitigation plans to ensure these could now be progressed as the Trust stepped services back up. The Trust was also conducting additional assurance work by examining the evidence to ensure this did not lead to any negative consequences for patients. Tim Wright asked for an update on finalising the Intensive Care Unit triage guidelines. It was noted that the guidelines had been reviewed by the Clinical Ethics Committee and there would be one final meeting to finalise the guidelines which would be shared with the Quality and Safety Committee. Parveen Kumar commented that in the event of future surges of Covid-19 it was important staff received sufficient training where they were redeployed to other areas. It was also noted that workforce was a key element of the Trust's Covid, Flu and Winter Plan which was currently being developed. The CMO reported that the Committee had held a very detailed discussion about never events. The Trust had recorded two wrong site surgeries in the current calendar year. Fortunately, there had been no harm to the patients involved, but the Trust was taking the issue extremely seriously and was identifying and sharing the learning from these. One of the key actions was that clinicians examine a patient's imaging immediately prior to the operation, and not only review the reports. Accordingly, a communication has been sent to staff to highlight this issue, raise awareness and share the learning from these incidents. The Committee noted the issues around fit testing of FPP3 masks, and that the Trust was actively engaging with NHS England to address these issues and proactively sourcing alternatives to ensure that staff were able to continue to work safely. The Board noted the report.	
3.1.1	**Safeguarding Adults Annual Report 2019-20** The Board considered the annual report on safeguarding adults 2019-20 which had previously been discussed at the Quality and Safety Committee. In year, the Trust had invested in additional capacity in the team. Work had	

		Action
	been conducted to improve governance and there was greater collaboration between the adults and children's safeguarding teams. The Trust was also working closely with its local partners. There had been over 800 contacts for the team and 300 referrals out of the team. The Trust had been an active participant in safeguarding adults' investigations but there were no identified learning points for the Trust to date, although these investigations were ongoing. The functions had been audited by the Trust's internal auditors and received 'substantial assurance'. The team would be working on improving relationships with the safeguarding adults' board and the Trust was working with external stakeholders to progress this. The team was also working on delivering training in innovative ways in light of Covid-19. Ann Beasley queried how the Trust was assured that it was reaching all the individuals that needed support from the service. The Trust had sought this assurance from the number of complaints but there were none in year. The Trust also monitored intelligence from section 42referrals to access if it was capturing the right patients. The Committee noted the report and commended the hard work of the team.	
3.1.2	**Safeguarding Children Annual Report 2019-20** The Board considered the annual report on safeguarding children 2019-20 which had previously been discussed at the Quality and Safety Committee. The Trust conducted annual and six monthly section 11 assurance and challenge sessions with local partners to assess how the Trust was meeting the requirements. The Trust also worked closely with its third sector party partners, such as RedThread, which supported the work of the team and the emergency pathway. There was a clear accountability framework which progressed through the organisation which included active involvement from representatives from the clinical commissioning group. The Named Nurse and Doctor chaired the London Safeguarding forums. Level 1 and 2 training had been good but there had been a decline in Level 3 training in recent months. The Trust had identified and targeted areas where there had been a notable decline in training and a virtual programme had been implemented resulting in improved performance. Only one review had been published during the year, and this had contained no learning points for the Trust. A number of reviews were ongoing. The Trust needed to do more around supervision, in particular in terms of case loads especially from the acute care perspective. The Board noted the report and reiterated its commendation of the hard work of the team as well as RedThread.	
3.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 3 (June 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 Committees, the Board noted the following: • The Trust remained focused on safely restarting the services which had been stopped due to the Covid-19 pandemic. • The Trust was facing a number of challenges getting elective activity	

		Action
	restarted following the initial Covid-19 surge and while there had been improvement, progress had been slow. The Trust was working with acute providers across the South West London to improve performance and increase productivity. The Trust was also working with the independent sector but activity had been low because of the challenges with provision of anaesthetic staff. • The Trust had opened more operating the theatres (25 of a total of 29) but needed to increase productivity in line with infection prevention and control pathways. • In month, the key hotspots included elective activity, theatre productivity, diagnostics waits and referral to treatment (RTT) performance. RTT performance had deteriorated in month moving from 68.3% in May to 55.6% in June against a London average of 61%. This would remain a challenge over the coming months. • The Trust's emergency department continued to perform well against the 4-hour standard which remained green in the balanced scorecard, and the Trust was among the highest performing Trusts in London and nationally for ED performance. • The changing infection prevention and control guidelines being issued system-wide remained a challenge. There was still clear anxiety among some patients about coming onto the hospital site. The booking teams, and the Trust as a whole, were doing significant work the encourage patients to come into hospital for their treatment. • The Trust was working with its partners in South West London to standardise infection prevention and control standards with lots of work around providing more patient information. • The Trust was concerned about the rise in the number of patients waiting 52 weeks or more for treatment, which had increased during the Covid-19 pandemic. The Trust had returned to managing the waiting list in the same way it had done pre-Covid, with priority being given to the most urgent cases. In May there were 274 52-week breaches which had increased to 554 breaches in June. The Trust had identified 200 patients from the 52 week waiting list to move to the independent sector or other acute partners to ensure these patients received care in a timely way. • The Trust was also focused on endoscopy and had successfully cleared the two-week referrals with more now coming into the Trust. The challenge would be to drive productivity through all the endoscopy suites. • August would be a challenging time, with staff typically taking annual leave, and the booking team was booking in more activity in September. • Stephen Collier queried the July position for driving theatre productivity and noted that the Trust's overall waiting list had not increased significantly. It was reported that in July productivity had improved but August was concerning because a significant number of staff were expected to take annual leave which would impact on activity levels (as was the pattern in recent years). The Trust had sought to balance the	

		Action
	need for staff to be able to take leave, particularly given the pressures on staff during the initial Covid-19 peak, with continuing to drive activity. The Trust was also reviewing its independent sector contracts to ensure that it maximised productivity. • All the workforce key performance indicators were showing improvements, with vacancy rates now below 10%. The Board received and noted the report.	
3.3	**Cardiac Surgery Quarterly Report** The Board received and noted the quarterly cardiac surgery report which had previously been considered at the Quality and Safety Committee. The Trust had put in place robust assurance mechanisms to monitor cardiac surgery outcomes. These remained within the expected limits as measured by the National Institute for Cardiovascular Research (NICOR) and the service remained out of 'alert'. In terms of activity, the Trust had stopped cardiac surgery during the peak of Covid-19 as a London-wide protocol for the treatment of cardiac surgery patient had been introduced, but the service had now resumed at the Trust. The Trust was also making good progress against the recommendations of and action plan from the Independent External Mortality Review, following the publication of its report in March 2020. Three specific actions remained ongoing, which related to the holding of formative individualised feedback sessions with identified clinical staff with representatives of the Review Panel and the CMO; fostering changing working relationships within and between cardiac surgery, cardiology and anaesthesia/intensive care teams; and ensuring continued robust consultant appraisal and job planning. While significant progress had been made, implementation of the full recommendations of the Review was a key priority both for the Trust and NHS England and NHS Improvement and the restrictions on the complexity of the operations undertaken by the service remained in place. The Trust continued to meet with and support bereaved families and the Trust continued to prioritise this despite the challenges with in-person meetings as a result of the Covid-19 restrictions. The Board noted the report.	
3.4	**Annual Complaints Report 2019-20** The Board received and noted the annual complaints report for 2019-20. The Trust's complaints performance had improved significantly and this had been sustained during the year as a result of focused activity and increases in resources allocated to managing complaints. Key actions which had led to the improvements included regular 'CommCell' meetings, supporting divisions with complex cases and increasing engagement. The key themes of complaints related to level of care, communication and clinical treatment. These were the same themes as reported in 2018-19. Overall, complaints performance was 92% against a performance target of 85%. This represented a significant improvement from 62% in 2018/19. The Board noted the report and commended the increased performance in complaints.	

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		Action
4.0	**FINANCE**	
4.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meeting held on 23 July 2020. While the Committee had not reviewed the strategic risks in the Board Assurance Framework, it had held a deep around ICT risks. The Committee had agreed to close two highly scored functional risks, and its discussion had focused on the risks relating to cyber security, on which it asked that a cyber security dashboard be developed. Similarly, through the other papers on its agenda, the Committee considered the finance risks. Although currently the Trust was in a breakeven position, the Committee was concerned about the position over the second half of the year. The Trust had stacked up demand and it was anticipated that the Trust would be challenged on how it managed its activity and how it coped with the cost of trying to catch-up. There was also a more detailed conversation about capital and the Committee discussed options for delaying certain schemes in anticipation that the Trust may be left with a smaller capital budget. In relation to estates, the Committee considered the work ongoing to develop the Trust's Premises Assurance Model; the Committee noted the progress made and looked forward to its full implementation in the coming months. The Committee also reviewed a number of business cases. The Committee commended the procurement team on a good report and their hard work during the peak of the Covid-19 pandemic. In addition, the Committee considered an update on the non-emergency patient transport tender. Tim Wright added that the Committee had held a good discussion about the developing estates strategy and the many aspects the Trust needed to address as it sought to finalise this. There was a helpful discussion about the various strands of work involved and it was important that the Board engaged with and understood the full programme of work and the interdependencies involved. The focus was on shaping the strategy and looking at how to develop a tool which enabled full transparency on all aspects of the strategy. It was reported that updates on the development of the estates strategy would be provided to the Committee on a regular basis. The Board noted the report.	
4.2	**Finance Report M03** The Board received and noted the finance performance at month 3. The Trust, as with other NHS organisations, was being provided with support from NHS England and NHS Improvement (NHSE&I) to attain a balanced financial position each month. Expenditure on Covid-19 continued and was £3m in month and the Trust had received £3.6m income top-up. The Trust was still waiting for guidance on what the financial regime would be from month 6 onwards and it was anticipated that all Trusts would be expected to deliver productivity and efficiencies savings. The Trust was already looking at what efficiencies it could begin to deliver. The Chairman noted that this would be a challenge for the Trust, with staff required to manage future Covid-19 peaks as well as managing the resumption of services. The Board noted the report.	

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		Action
5.0	**RISK, GOVERNANCE & COMPLIANCE**	
5.1	**Audit Committee Report** Elizabeth Bishop, Chair of the Committee, provided an update on the meeting held on 13 July 2020. The Committee spent some time discussing the role of the newly-formed executive-led Risk and Assurance Group which, among other things, was responsible for overseeing the progress of internal audit reports and follow-up recommendations. The Committee welcomed the focus on this and indicated it would take a close interest in its impact. The internal audit report on the use of medical consultants received a limited assurance rating. The Committee noted that there was a lot of work needed in this area. The CMO reported that a review was already underway to address this and the Committee agreed that the CMO would provide a report on the review at its October 2020 meeting. The report on data security protection toolkit also received limited assurance from the internal auditors. The internal audit programme had been interrupted by the impact of Covid-19 and the Committee asked the internal auditors to review progress. The Committee received a preliminary paper on the new financial standard FRS-16 which would impact on the Trust's balance sheet. The Chairman queried the Committee's feel for the Trust's approach to risk, in light of the 'reasonable assurance' given in relation to the audit of risk management. The Committee Chair confirmed that the Committee did review the new Board Assurance Framework and progress on the Risk Management Strategy and this would be kept under review by the Committee. The CCAO noted the comments of the Care Quality Commission around risk management in its December 2019 inspection report and reflected that it was recognised that more work was required around the risk management strategy and on developing the Trust policy on risk, and that updates to both were planned later in the year. The Board noted the report.	
5.2	**Board Assurance Framework Quarter 1 2020/21** The Board received and noted the quarter one 2020/21 Board Assurance Framework (BAF). The new BAF had been populated setting out the controls, gaps in controls and assurances and actions to close these gaps, mitigations and assurance mechanisms linked through indicators in the IQPR and horizon scanning of emerging risk and future opportunity. The relevant BAF risks had been considered by the Workforce and Education Committee (Strategic Risks 8 and 9) and Quality and Safety Committee (Strategic Risks 1, 2 and 10) which reviewed and endorsed the risks scores and assurances for those risks allocated to them. The Finance and Investment Committee had not yet considered the risks allocated to it under the BAF (Strategic Risks 3, 5, 6 and 7) but had held broader discussions on risk and the BAF itself would be considered by the Committee before the next iteration of the BAF to the Board. As previously agreed by the Board, there was no stand alone strategic risk on Covid-19 but each risk area drew out the Covid-19 implications explicitly and a summary of the Covid-19 impact across all BAF risks was set out in the paper. The population of the BAF was completed in collaboration with the executive team and there would be internal scrutiny at the risk assurance group and also at each management sub-group.	

		Action
	Of the 10 strategic risks, seven were rated as partial assurance, two limited and one good assurance. Strategic Risk 1 was rated as 16 which reflected the progress made by the Trust in improving patient safety (as reflected in the Trust's removal from the quality special measures regime) balanced against the risks to patient safety as a result of Covid-19 infection and the knock-on impact on the delivery of other services for patients. Strategic Risk 8, in relation to culture, diversity and inclusion and raising concerns, had been reviewed in light of discussion at the Workforce and Education Committee and it was proposed that the risk score was increased to a score of 20 (4 consequence by 5 likelihood) to reflect there was no strong assurance currently in place. However, as the steps the Trust was taking to mitigate this risk started to have an impact, it was anticipated that the Board would be able to lower the risk score later in the year. In relation to Strategic Risk 4, which related to system working and was reserved to the Board, the risk had been proposed with a score of 8 (4 consequence by 2 likelihood) but in light of the sheer significance of cross-system wide developments, inherent tension between the statutory framework which placed sovereignty with individual organisations and system expectations around integrated, cross system working with pooled sovereignty, the CCAO suggested that the score felt low and that the Board may wish to consider raising this to a score of 12 (4 consequence by 3 likelihood). It was noted that Strategic Risk 5 (financial sustainability) was proposed as a maximum score of 25. When the planning guidance was issued later in the year plans, the level of risk could be reassessed. In the meantime, actions to mitigate this risk were being taken. Tim Wright noted that the uncertainties and the lack of control over external events would give rise to the Trust increasing the risk score for Strategic Risk 4. The Chairman commented that some of the corporate risks that sat below and informed the BAF needed further review. This was particularly the case in relation to those sitting under Strategic Risk 4, where risks on the HR risk register appeared to be scored lower than would have been expected. The CCAO agreed and advised that the Risk Assurance Group was responsible for reviewing corporate and divisional risks that informed the BAF and the Group would ensure these were reviewed prior to quarter 2. Elizabeth Bishop suggested that the BAF should contain in-year target risks for each Strategic Risk, which were both stretching but realistic. It was noted that the target risks on the BAF at present reflected the Board's agreed risk appetite statement, but the Executive would consider the development of in-year target risks. **The Board endorsed the risk scores considered by the Quality and Safety and Workforce and Education committees (1, 2, 8, 9 and 10) including the recommendation to increase the score for Strategic Risk 8 to a score of 20, agreed the proposed risks for those risks allocated to the Finance and Investment Committee (3, 5, 6 and 7), and further agreed that Strategic Risk 4, which was reserved to the Board, be increased to a score of 12.** **It was also agreed that the executive team would review the corporate risks which sat below and informed the BAF as well as consider the**	

		Action
	scoring of new in-year target risk scores for each Strategic Risk.	**CCAO**
5.3	**Horizon Scanning Report:**	
5.3.1	**Emerging Policy, Legislative, Regulatory and Governance Issues (Q1)** The Board received and noted the quarter one 2020/21 horizon scanning report on emerging policy, legislative, regulatory and governance issues. Of particular note for the Board were: • The health and care visa had a bearing on the Trust's workforce risks, strategic risk 9, this could potentially have significant impact on staffing in relation to the UK's exit from the European Union. • The establishment of the new observatory for diversity and inclusion issues given the Trust's focus on these issues. • The Public Health England report on the impact of Covid-19 on BAME groups in the context of the Trust's risk assessments of staff and staff health and wellbeing.	
5.3.2	**Local & Regional issues (Q1)** The Board received and noted the quarter one horizon scanning report on local and regional issues.	
6.0	**CLOSING ADMINISTRATION**	
6.1	**Questions from the public and Governors** There were no questions raised.	
6.2	**Any other risks or issues identified** There were no other risks or issues identified.	
6.3	**Any Other Business** There were no matters of any other business raised for discussion.	
Date of next meeting: Thursday 24 September 2020 2020, Microsoft Teams meetings		

Trust Board Action Log Part 1 - September 2020						
Action Ref	**Section**	**Action**	**Due**	**Lead**	**Commentary**	**Status**
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	See agenda item 3.1.1	**PROPOSED FOR CLOSURE**
TB30.07.20/01	**Board Assurance Framework Quarter 1 2020/21**	It was also agreed that the executive team would review the corporate risks which sat below and informed the BAF as well as consider the scoring of new in-year target risk scores for each Strategic Risk.	24/09/2020	CCAO	See agenda item 5.2	**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~~ 24/09/2020	ACN/CMO	ACN/CMO to provide a verbal 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 yet 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 deferred until the November 2020 meeting.	**OPEN/DEFERRED**
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~~ 26/11/2020	COO	This item will be presented to the Quality & Safety Committee October and reported to Board in November 2020.	**OPEN/DEFERRED**

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2.1

Meeting Title:	Trust Board Meeting		
Date:	24 September 2020	**Agenda No.**	**2.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Humaira Ashraf, acting Chief People Officer Elizabeth Nyawade, acting Chief People Officer		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	• This paper sets out the key risks and issues reviewed by the Committee at its meeting on 13 August 2020 including commenting on assurance to the Board on key risks allocated to the Committee. No changes are proposed to the current risk ratings for Trust Risks SR8 and SR9. • The culture change programme which is being led by the Trust Chief Executive is moving from its Discovery phase, through the Planning phase and towards Implementation. The Committee noted the scale of the programme - and the risk that some elements might develop a well-intentioned momentum of their own and move ahead faster, with poor linkage to related workstreams or to the cohesive whole. An effectively-resourced programme management approach, which joins up all the critical components, is critical to the implementation of the culture change programme and this issue is being taken forward within the executive • It was not clear whether all staff who are presently shielding (currently c 125 in number) would be expected to return to work by a specific point in time, and further thought is being given to this complex issue and the need to balance staff wellbeing and health, against employer requirements. • The Trust has no central register of which staff are, at any one time, working from home. Whilst in individual teams this is being left to team managers to monitor, if this situation looks likely to continue for any length of time the Trust will need a more structured system to manage WFH, and to assess the productivity achieved. As a Committee we agreed that this was an issue to which we would return in October, as part of our review of whatever new normality the Trust and its staff are working within. • The Committee will be scheduling additional meetings to allow for greater focus on Deep Dive areas, and an Appendix to this Report summarises the assurance received at the first Deep Dive session of the Committee held on 16 September.		
Recommendation:	Receive this report		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		

1. Committee Chair's Overview

This was the first meeting of the Committee at which we had undertaken a scheduled Deep Dive review, and for good reason the area selected was the Trust's progress against the Workforce Race Equality Standard (WRES). This was an extremely useful exercise and enabled us to get sufficiently close to the detail to be able to give the Board a fully informed assurance on progress and on the critical next steps. This is set out below. Whilst the Deep Dive on WRES was extremely useful, it did demonstrate that additional time is needed to undertake these. As a consequence, we will be scheduling additional meetings of the Committee to allow us to focus in these on the Deep Dive activity. An Appendix to this Report summarises the assurance received at the first Deep Dive session of the Committee, held on 16 September.

We also received an update on progress being made on the Culture Change Programme which is being personally led by the Trust Chief Executive. What shone through in this report was that the programme of culture change is not a stand-alone activity. Rather it involves a number of discrete, but linked, initiatives which need to be advanced together as a cohesive whole, in order for the change in culture to be delivered. The range of initiatives is very broad and includes, for example, improving compliance with the WRES, improving our diversity and inclusion, resolving the challenges identified on Freedom to Speak Up, and a host of other initiatives.

Good progress has been made in the 'discovery' phase of the programme – even during the Covid disruption. This has involved a large number of people drawn from across the Trust, and has developed real traction. Work has since begun on using the information and data secured from that phase for the next steps of planning and implementation. However, some concern was expressed about the risk that individual elements within the wider culture programme are not moved forward in a co-ordinated fashion. Rather, that some elements develop a well-intentioned momentum of their own, and are moved ahead faster - but with poor linkage to related workstreams, or a cohesive whole. An effectively-resourced programme management approach, which joins up all the critical components is critical to the implementation of the culture change programme, and this issue is being taken forward within the executive.

2. Key points:-

Board Assurance

The Committee has two Trust-level risks[1] allocated to it as part of the Board Assurance Framework ('BAF').

The Committee concluded that there were no circumstances or matters of which it was aware that mandated a change to the existing risk ratings (currently: SR8, 20 ; SR9, 16). That said, the Committee noted continuing progress in a number of areas, but that these had not yet delivered a material change.

Theme 1 - Engagement

Strengthening culture, update – we were joined by Tom Kenward, Programme Director, who updated us on the work that had been undertaken in recent months on this programme, which was being sponsored and led by the Trust Chief Executive. Despite the impact of Covid, the programme has caught up with its timescale and the Discovery phase was now coming to an end and was on track to support the identification of priorities and supporting actions during the autumn. The Trust-wide sweep of the programme was reiterated, and the need for the various

[1] SR 8 – raising concerns, inclusive culture, diversity; SR9 – recruit, educate, develop and retain the right workforce and build leadership at all levels.

contributing components to be moved forward on a co-ordinated basis. There had been extensive activities undertaken since the report back we had in June, and Tom reminded us that over 600 Trust staff had been engaged directly in the Discovery Phase, in the collecting, collation and analysis of information that would inform the planning process within the Design Phase. This would run through to the end of the calendar year, and the Delivery Phase would begin in January next year. Tom briefed the Committee on some of the headline themes and findings beginning to emerge (and yet to be quantified), and how these would be taken forward. What was clear was that there was an apparent marked difference between the perspective of the Board and senior leaders, and that of the wider staff. The findings (once finalised) are to be shared with senior staff, and then the Board.

Dep Dive - WRES – We were joined by Joseph Pavett-Downer, the Trust's newly appointed Diversity and Inclusion Lead, who had prepared a review of the draft Report to NHSE/I on the Trust's progress against the Workforce Race Equality Standard (WRES). His key point was that the WRES is designed to close the gap in workplace race equalities, and that as a Trust with some 9,000 staff – almost 50% of whom are from BAME ethnic groups, this was mission-critical to us. We had a very full discussion on the content of the draft Report, and the presentation of the data. This showed generally good progress over the last three years - albeit with still a way to go and work still to be done. A number of issues around career progression and the use of the disciplinary process, which the Committee had previously explored in detail and supported policy changes proposed by the Trust's executive, were clear in the draft Report. An updated version of the Report will be included in the papers for the Board's September meeting, so I will not comment further here.

Diversity and Inclusion Update – Where the draft WRES Report provided a snapshot of the position at a point in time, the update we received from Humaira Ashraf on Diversity and Inclusion (D&I) set out progress by the Trust in implementing its D&I Action Plan. This had identified five key workstreams: career progression; development opportunities and access; responding to concerns; leadership; and awareness and understanding. We were briefed on progress on appointing Executive sponsors, operational leads, and project managers and the stage that the various actions within each workstream had reached.

Freedom to Speak Up (FSU) – the Committee received an update from Karyn Richards on progress over recent months, the levels of concerns being escalated and the issues arising during the Covid pandemic, and the proposed approach to creating and adopting a new FSU Policy (which was still being refined). The final draft of the new policy will be brought to the Board for review and endorsement. Karyn noted that there continues to be a marked increase in staff contacting the Guardian, and that for administrative staff the issues raised largely centre on management and on conflict within their teams. Doctors concerns centred on PPE. There had been a rise in collective (team) concerns, related to bullying and harassment, and unresolved conflict within a team. Whilst not easy messages to hear, the fact is that staff are using the Guardian on issues which convey a clear message to the Trust.

Surveys of staff had been paused as a result of the Covid pandemic and the Committee reviewed a proposal to re-initiate these on a phased basis. The proposal was to run the national Staff Survey undertaken by Picker between September and December, and then re-initiate the Staff Pulse, and the Friends and Family / place to work surveys on a quarterly basis after that, so from January next year. It was noted that as part of the culture programme Discovery work, some staff survey work had been undertaken and this provided insight on staff sentiment on a number of areas. The Committee recognised the logic of the proposal, endorsed the approach, and agreed that a step-back review of why, when and how the Trust was assessing staff feedback and sentiment would be helpful. This would be taken forward within the Strengthening Culture work.

Theme 2 – Leadership and Progression

Education Strategy, Implementation Plan 2020-21 - The Committee received an update on the implementation of the Trust's Education Strategy, and the way in which HEE allocated funding for non-medical staff of £1,000 each over three years will be used for staff CPD.

Workforce Update - Elizabeth Nyawade led a report to the Committee. The Staff Risk Assessment self-completion form had been amended, and had now been completed by some 94% of Trust staff. We received good assurance on the support and direction being provided to Trust staff working from home or shielding, and the work being done to support a phased return to working on-site at the Trust. It was not however clear whether all shielding staff (currently c 125 in number) would be expected to return to work by a specific point in time, and clearly further thought needs to be given to this complex issue and the need to balance staff wellbeing and health, against employer requirements. One factor that did emerge was that the Trust has no central register of which staff are, at any one time, working from home. Whilst in individual teams this is being left to team managers to monitor, if this situation looks likely to continue for any length of time the Trust will need a more structured system to manage WFH and to assess productivity achieved. As a Committee we agreed that this was an issue to which we would return in October, as part of our review of whatever new normality the Trust and its staff are working within.

We reviewed a number of other workforce metrics, noting good progress in reducing vacancies (now standing at 8.3%, and well below the 10% target maximum). Staff turnover had been reduced to 15.3%, the lowest level for some time and the trend appeared to be continuing down. Staff sickness absence stood at 3.5%, down from a Covid-driven peak of 5.6%. The decline in elective and other activity had led to a significant fall in the use of agency staff.

Assurance Review of Staff Appraisals – We reviewed a Report from tiaa, the Trust's internal auditor, on the way staff appraisals were undertaken. We noted the conclusion that there were reasonable controls in place over both the undertaking of appraisals and their reporting and accepted the conclusion of reasonable assurance. Three recommendations had been made, one relating to the policy document and two relating to the documentation of appraisals. Executive management reported that these were to be implemented, and we will monitor progress here against the timescale set and agreed.

Theme 3 - Workforce Planning and Strategy

NHS People Plan for 2020/21 - the Committee received a briefing on the NHS Plan, 20/21, released in July. This is being taken forward by the executive in the People Management Group, and we will receive an update on any changes proposed to our existing strategies and plans at our next meeting.

Implementation Plan for Trust's Workforce Strategy - Having at a previous meeting reviewed and endorsed the proposed implementation plan for the Trust's Workforce Strategy, it was good to receive an update on how the plan was being taken forward and the quarterly milestones that have been put in place as measures of achievement. It is too early in the process to look for completion of any items, but we received good assurance that a robust and auditable delivery process has been put in place.

Nursing and Midwifery, Establishment Review, 2019-20 - The Committee received a comprehensive report from Robert Bleasdale on the process adopted for re-setting the nursing establishment within the Trust, and a commentary from Steph Sweeny on the depth of the process and the result that it had generated. This was of a reduction of 4 WTEs on an establishment of 2,460 WTE nurses. Steph also outlined the way that Safe Staffing numbers had been derived from the review, and the specific planning priorities identified for inclusion

within the next establishment review. We took good assurance from the process used, and the level of support it had received from senior nursing leaders across the Trust. We noted that, as before, the nurse in charge on Day Shift was specifically not counted as part of the nursing workforce for the purpose of assessing nurse: patient ratios. This recognised the time demands of the managerial and leadership role being undertaken.

Theme 4 – Compliance.

Safe Working, Junior Doctors – we were joined by Dr Serena Haywood, our Guardian of Safe Working and received a very comprehensive report covering the first quarter (April to June) of the Trust year, the period in which the full impact of the Covid pandemic had been felt. There had been 54 exception reports, the majority of these driven by excess working hours. None of these had raised an Immediate Safety Concern. Comparison to prior quarters was in Serena's view not helpful or appropriate. It was noted that the Guardian had been asked to participate (as an informal representative of the Trainees' interest) in planning the Trust's response to the pandemic. Relations with divisional leads appeared open and proactive.

Monitoring Nursing and Midwifery Council (NMC) registration of SGH staff – The Committee received a comprehensive report setting out the measures to assure that nursing, midwifery and nursing associates working in the Trust were properly registered with the NMC. The assurance provided by this was high, and the timing was particularly helpful given the changes made by the NMC during the Covid pandemic (for example, the introduction of the NMC Temporary Register, and the temporary extension of revalidation deadlines).

Annual Medical Appraisal and Revalidation Report – The Trust's Responsible Office, Karen Daly, reported on how the Trust had managed medical appraisal and revalidation during the 2019-20 financial year, and how this had been paused during the Covid pandemic, and its proposals for returning to the normal revalidation cycle. We took assurance from the Reports' description of continued improvement in the Trust's medical appraisal processes and compliance achieved, though noted Karen's reflection that there was more work to be done.

MHPS – We received an update on progress on the updating of the Trust's Maintaining High Professional Standards policy, a final draft of which we anticipate reviewing at a future meeting.

Other – we sought and received assurance from Humaira and Elizabeth that neither was aware of any areas where there had been or was any non-compliances by the Trust.

Stephen J Collier

17 September 2020

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APPENDIX

REPORT BACK FROM COMMITTEE DEEP DIVE, 16 SEPTEMBER 2020

The Committee held its first stand-alone Deep Dive meeting on 16 September, with a detailed focus on Diversity and Inclusion and an update on the Culture Change Programme. In view of the proximity of that meeting to the deadline for issue of Board papers, it is being reported in summary form via this Appendix. Future reports from Deep-Dive sessions will be more comprehensive.

Diversity and Inclusion

This item was led by Humaira Ashraf and we were joined by Joseph Pavett-Downer, who between them provided a very comprehensive update of the current position and the proposed objectives. The nature of the reporting to the Committee was intended to provide assurance across three areas: planning process; delivery progress; and impact. This approach was very helpful and the Committee was provided with appropriate assurance that a clear process plan had been defined and agreed; that there was a clear, phased delivery plan which was now under way; and that an impact assessment had been designed and agreed which would evaluate the effect of the actions.

The Committee concluded that this tri-partite (Plan; Delivery; Impact) approach which had been developed within the HR Team was particularly helpful, and might well have an application in other areas. An extract of the Impact Tracker is attached below, for information. I apologise for the small font, but the intention is simply to show its structure rather than focus on detailed content.

Diversity and Inclusion Action Plan: Programme IMPACT Tracker

MEASURE	RELEVANT DELIVERABLES	BASELINE (Aug 20)	Q3 30/9/20	Q4 31/12/2020	Q1 31/03/2021	Q2 30/06/2021	Q3 30/09/2021	Q4 31/12/2021	TARGET (end 2021)	NOTES ON PROGRESS
SECTION ONE: Diversity & Inclusion Key Priority Projects										
WORKSTREAM 1: 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										
Proportion of leaders who identify as BAME at Band 8 (clinical and nonclinical combined)		47.3%							48%	does not include medical, ethnicity unknown is included as non BAME
Proportion of leaders who identify as BAME at Band 7 (clinical and nonclinical combined)		33.7%							42%	does not include medical, ethnicity unknown is included as non BAME
Proportion of leaders who identify as BAME at Band 8A and above (clinical and nonclinical combined)		24.5%							35%	does not include medical, ethnicity unknown is included as non BAME
Relative likelihood of appointment from shortlisting - for BAME identifying applicants (The % of all BAME job applicants who are appointed after interview.)		21.3%							35%	
Relative likelihood of appointment from shortlisting - for WHITE identifying applicants (The % of all WHITE job applicants who are appointed after interview.)		31.2%								
Relative likelihood of white staff being appointed from shortlisting compared to BAME staff (a comparison of the above two percentage figures: the WHITE % divided by the BAME %.)		1.47 (White applicants are 1.47 times more likely to be appointed than BAME applicants)							1.2	
Percentage of recruitment panels that have included a BAME representative		7 of 11 (64%)							95%	Since the process was mandated on 21/7/20. The 4 panels without a BAME rep are now being followed up to learn why and how to better ensure future compliance

Humaira drew attention to the scale and complexity of the D&I initiative, and confirmed that the appointment of a Programme Manager had been approved and an appointment was being progressed by the executive. Tom Kenward, who was facilitating the wider culture change programme, confirmed that the D&I implementation plan had been set and phased in a way that was consistent with the activities supporting wider culture change.

The Committee reviewed progress on two particular elements of the D&I programme: changes to recruitment practice; and the new 'Let's Talk About Race' training module. In relation to the former, the specific focus was for there to be a BAME representative as a full member of every

interview panel run within the Trust. The starting point was to initiate this with immediate effect for all appointments at Band 8a and above (estimated 35-40 posts per annum, likely to generate between 280 and 400 interviews) and rapidly roll this out to cover also Band 7 appointments (estimated 150 pa, generating 1200-1500 interviews). Training needs had been identified for BAME staff joining those panels, and critically also for all other panel members. Recent experience had emphasised the absolute need for such training and, based on the report received, the Committee endorsed this judgement. Appropriate training was well under way.

The Committee reviewed the new 'Let's Talk About Race' training module, and commended the decision of the executive not to use an existing off-the-shelf training package, but rather to develop its own bespoke programme. The contribution of Joseph Pavett-Downer and Daniel Scott to the development of this was noted, as was the interest in (and in one case adoption of) the programme by other public sector entities. The new module would be integrated into the Trust's core training suite. Progress on delivery, and impact, would be reviewed in future meetings of the Committee.

Culture Change Programme

Tom Kenward summarised the current state of the culture programme, and its shifting from Discovery to Planning. We were assured on the thought being applied to the planning process, to ensure the Implementation phase would deliver, with real impact. The appointment of a Programme Manger was noted. The Committee will receive a further report as the Programme finalises its planning for implementation.

Conclusion

The Committee concluded by thanking the executive team for the depth and clarity of the papers presented, and the thought that was being applied to ensuring effective implementation, with impact being tracked.

The use of a Deep Dive structure is clearly a mechanism that successfully enables the Committee to get into appropriate detail, whilst maintaining its assurance role. Further sessions are planned across future months.

SC – 17.9.20

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2.2

Meeting Title:	Trust Board		
Date:	24 September 2020	**Agenda No**	**2.2**
Report Title:	Strengthening St George's Culture		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive Officer Humaira Ashraf, Acting Chief People Officer (Culture)		
Report Author:	Tom Kenward, Programme Director Culture, Leadership & OD / Deputy CPO		
Presented for:	Update		
Executive Summary:	Diagnostics have now concluded and reports are presently being synthesised to then engage all Board and Staff groups in over the autumn, to generate together a prioritised action plan for 2021 and beyond.		
Recommendation:	The Board is asked to note update and raise any questions to assure of progress.		
Supports			
Trust Strategic Objective:	Champion Team St George's – significant shift in culture		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Well led		
Implications			
Risk:	Without this work, the core of the improvement agenda for St George's cannot be achieved. The work also contributes to one of the controls that we have in place for BAF strategic risk 8.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	Directly impacts across engagement of all staff		
Previously Considered by:	WEC Culture, Diversity and Inclusion Focused Meeting	**Date**	16/09/2020
Appendices:			

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St George's University Hospitals NHS Foundation Trust

2.2

Strengthening culture at St George's – recap, next steps, outline engagement plan

Trust Board

24th September 2020

Author: Tom Kenward, Programme Director, Culture, Leadership & OD

24 September 2020

Overview

- Recap on approach and progress
- Timeline to end of 2020
- Next phase of engagement
- Next steps

Why culture?

Culture drives behaviour and, ultimately, care.

We want a culture that models what we want everywhere in the Trust

More than anything, culture is about leadership > > >

> ***Our starting question is:*** *how do we ensure we have the leadership now and in the future that will nurture cultures which deliver high quality, continuously improving and compassionate care?*

Jacqueline Totterdell
Chief Executive Officer

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Broad vision of NHS I leadership and culture

10 Leadership behaviours		5 Cultural elements
Facilitating shared agreement about direction, priorities and objectives	Encouraging pride, positivity and identity in the team/organisation	**Vision and Values** Constant commitment to quality of care
Ensuring effective performance	Ensuring necessary resources are available and used well	**Goals and performance** Effective, efficient, high quality performance
Modelling support and compassion	Valuing diversity and fairness	**Support and compassion** Support, compassion and inclusion for all patients and staff
Enabling learning and innovation	Helping people to grow and lead	**Learning and innovation** Continuous learning, quality improvement and innovation
Building cohesive and effective team working	Building partnerships between teams, departments and organisations	**Team work** Enthusiastic cooperation, team working and support within and across organisations

Approach to date: understand and intervene in parallel

For culture change to succeed understanding, engagement and action are all needed. We are doing all at once:

1) Understanding and engagement have grown through the NHSI-designed diagnostic activities. At the same time..

2) Localised support in a few places has sought to help leaders develop culture now.

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Work done so far (by champions, core team and others)

- ‘Board’ interviews (NEDS, exec and divisional directors) **done**
- Leadership survey (500+ responses) **done**
- Over 30 focus groups across all sites **done**
- Leadership Workforce Analysis **done**
- Patient experience data collated **done**
- COVID debrief information collated **done**
- Three feedback pulse pilots **done**
- Divisional Triumvirate coaching and exec dev **ongoing**
- Analysis of datasets by champions **almost complete**
- Preparation of findings to present **in progress**
- Developing an engagement plan for co-design **in progress**

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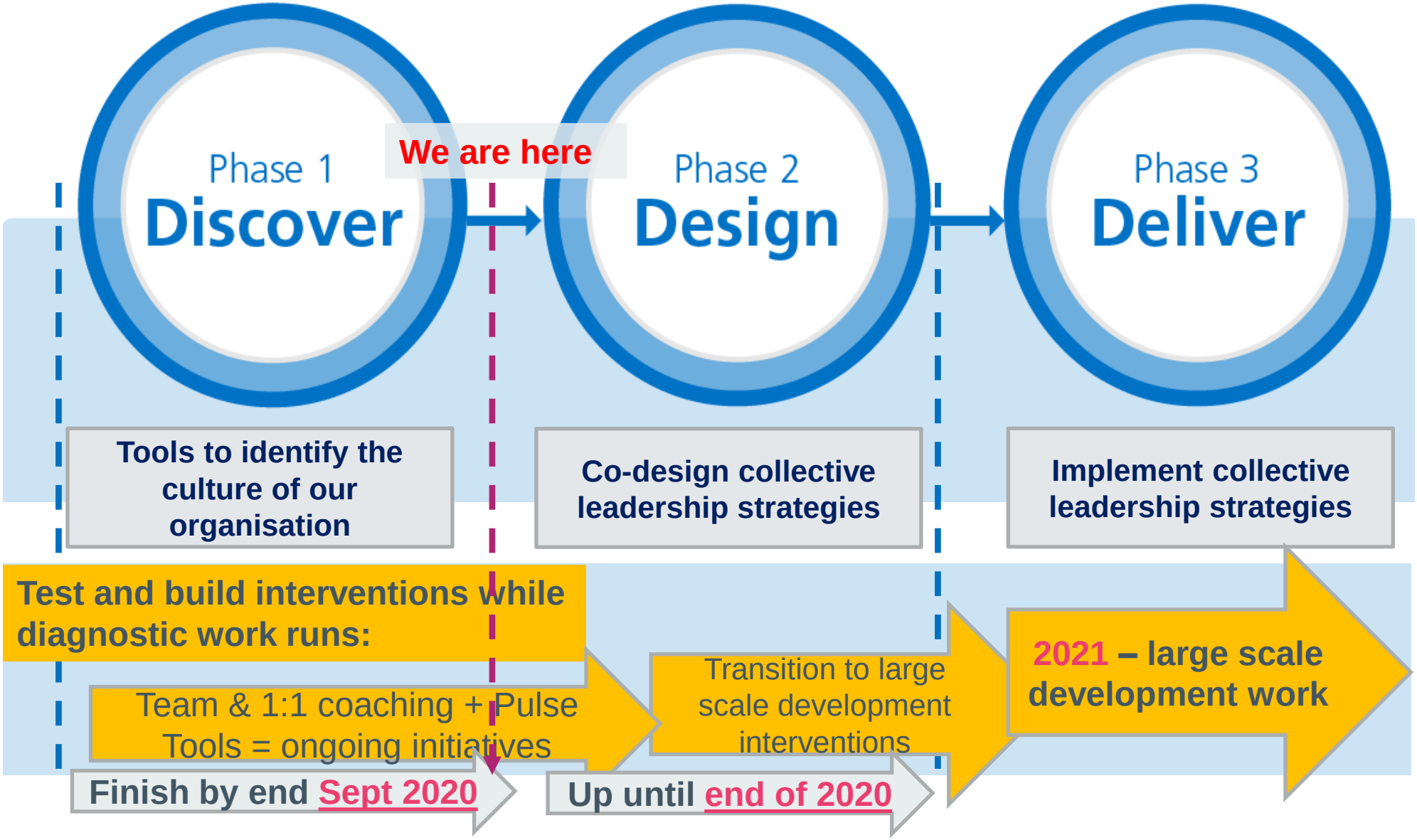
2.2

Where we are in the process

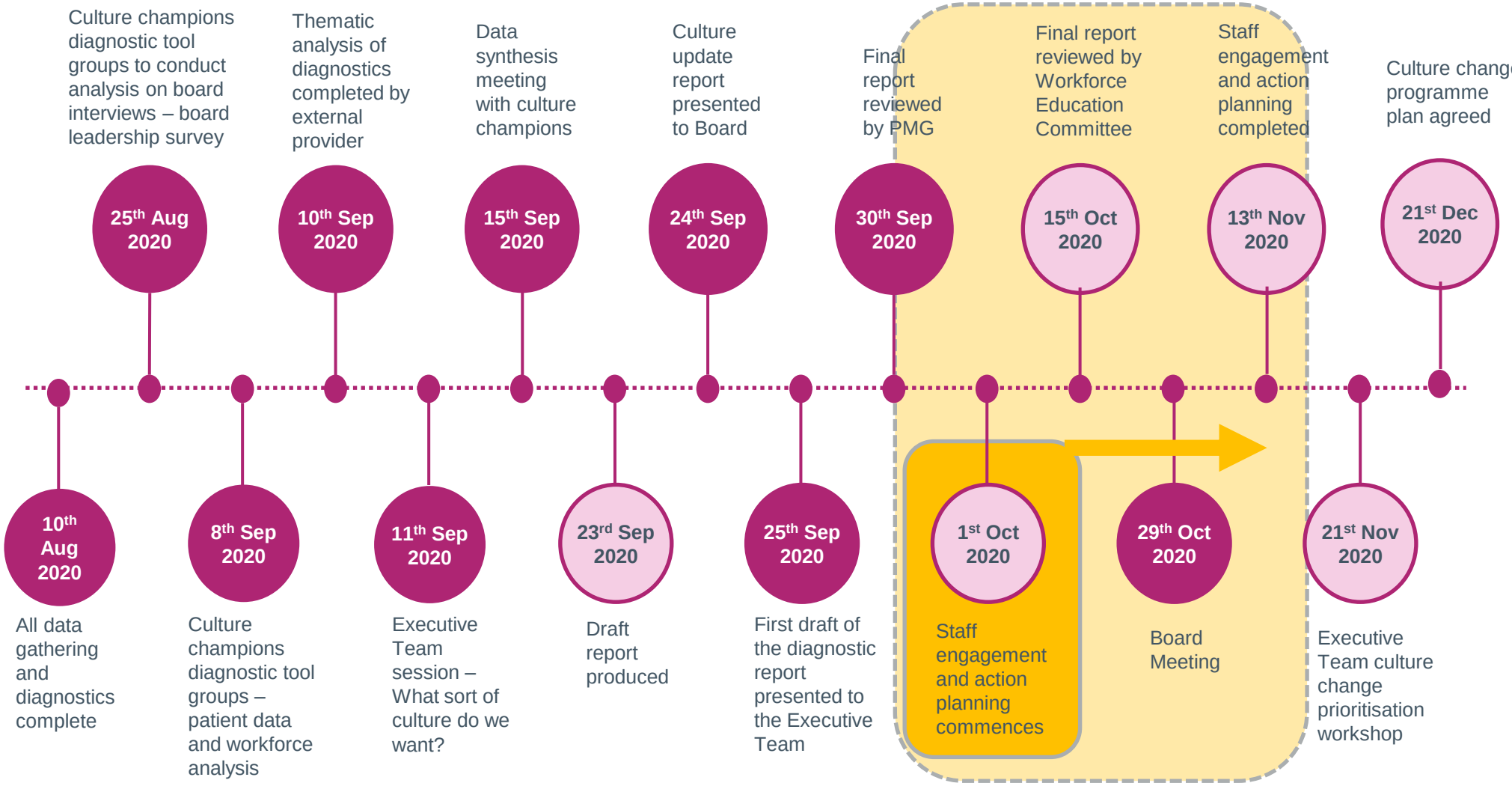


Where to from here – Phase 2, Co-design

Firm date

Proposed date

8



Who, how, when?

- Identify key forums to access: EMG, OMG, PMG, Senior Leaders, Junior Docs, Consultants, Care Group Leads and Clinical Directors, Matrons and Nurses, DMBs, Council of Governors, Staff Networks x 4 (via Chairs), QI, Ops and corporate services. WEC and Full Trust Board. Who else?

- Agree and schedule access from 1st October – 13th November (6 weeks)

- Present findings in these forums, with champions, and gather responses. Most if not all of these sessions will be **virtual**, to be as COVID-safe as possible. By using **MS Teams** we can also invite conversations afterwards, to draw out further thoughts in writing.

Next steps

- Exec to attend session on 25/9 to learn about the findings of the diagnostics, so they are informed before findings go to other groups.

- As we head into a pressurised Autumn/Winter period, staff will need support to prioritise attendance in these engagement sessions alongside the priorities of the other two objectives of Care and Collaborate.

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St George's University Hospitals NHS Foundation Trust

Thank you

St George's University Hospitals NHS Foundation Trust

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SW17 0QT

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2.3

Meeting Title:	Trust Board		
Date:	24th September 2020	**Agenda No**	**2.3**
Report Title:	Diversity and Inclusion Action Plan		
Lead Director/ Manager:	Humaira Ashraf, Acting Chief People Officer (Culture)		
Report Author:	Daniel Scott, Senior Organisational Development Lead (interim) Joseph Pavett-Downer, Workforce Diversity and Inclusion Lead		
Presented for:	Assurance		
Executive Summary:	This paper outlines the purpose and structure of the recently developed organisational Diversity and Inclusion (D&I) Action Plan. It also describes the accompanying Delivery and Impact Tracker which supports the Action Plan to be delivered, monitored and evaluated using a controlled Programme Management approach. The latest monthly D&I Action Plan update is provided in the power point slide deck as Appendix B and additional information on training for BAME Recruitment Representatives is provided as Appendix A.		
Recommendation:	The Board is asked to review and to note progress to date on the development of the D&I action plan and progress made on the delivery of D&I activities.		
Supports			
Trust Strategic Objective:	Champion St Georges.		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Well led		
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:			
Resources:			
Equality and Diversity:	The D&I Action Plan is designed to close the gap in workplace inequalities.		
Previously Considered by:	WEC Culture, Diversity and Inclusion Focused Meeting	**Date**	16/09/2020
Appendices:	Appendix (A) - 'BAME' Recruitment Panel Representative Process and Training Update. Appendix (B) - D&I Action Plan Progress Report.		

Diversity & Inclusion Action Plan
Trust Board Meeting, September 2020

1.0 PURPOSE

1.1 The *Diversity and Inclusion (D&I) Action Plan* sets out the organisation's commitment to tackling discrimination and building an inclusive organisational culture, and presents the range of planned deliverables between August 2020 (when it was launched) until the end of 2021.

1.2 This paper outlines the purpose and structure of the *D&I Action Plan*. It also introduces the *Delivery and Impact Tracker* that accompanies the Action Plan to ensure its timely delivery and to demonstrate its progress toward achievement of the deliverables/outcomes and their specific targets. More detail on the Tracker is included below.

1.3 To offer a more detail on specific projects within our D&I programme, Appendix A outlines the recent BAME Recruitment Representative training course that is currently being delivered, and Appendix B (attached separately) is the latest monthly D&I Action Plan Progress Report for August 2020.

2.0 DEVELOPMENT OF THE D&I ACTION PLAN

2.1 The D&I Action Plan has been developed following 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 Acting CPOs and to the CEO. Many of the activities within the plan have a particular focus on combating discrimination experienced by our BAME workforce.

2.2 This action plan is a ***'living document'.*** It will be further developed and refined over its implementation period to:-

- reflect and integrate lessons learned and through continued input from stakeholders Trust-wide, for example, our staff side representatives;
- incorporate the D&I Networks' own individual action plans;
- incorporate the London Race Equality Workforce Strategy Recommendations;

The measures and targets in particular are currently being further refined to ensure they are both meaningful and appropriately ambitious.

2.3 While there is currently an appropriate focus on tackling discrimination and bias against our BAME staff, the *D&I Action Plan* will expand over time to include actions that will undertake for all other workforce protected characteristics (beyond race and ethnicity).

2.4 The *D&I Action Plan* will be delivered through a structured Programme Management approach. Roles of the Project Manager, the Professional Lead, and the Executive Lead are outlined for each stage of project management at the end of the Action Plan document.

The actions have been grouped into 3 sections and 9 workstreams, as outlined below:

Section One - D&I Key Priority Projects:

- Workstream 1: Improving the career progression of BAME staff

- Workstream 2: Improving development opportunities and ensuring equal access to development for staff;

- Workstream 3: Listening and responding to concerns raised by BAME staff.

Section Two - Changing Behaviours and Attitudes:

- Workstream 4: Leadership Commitment;

- Workstream 5: Building awareness and understanding.

Section Three - Staff Support Networks (detail to be developed with input from the networks):

- Workstream 6: BAME Staff Network;

- Workstream 7: LGBTQ+ Staff Network;

- Workstream 8: Disability & Wellness Staff Network;

- Workstream 9: Women Staff Network.

2.5 The *Delivery and Impact Tracker* consists of 2 main parts:

The **DELIVERY TRACKER** monitors progress and completion of individual actions (tangible outputs) that will lead to achievement of each deliverable in the action plan:

- All actions are listed under their respective deliverable (or outcome), workstream, and section;
- A RAG rating is applied against each action, where GREEN indicates on track for delivery on time and to quality, AMBER indicates a risk of delay to delivery, and RED means that delivery is overdue (or experiencing issues that will lead to delay);

- A narrative (PowerPoint) monthly report on the Delivery Tracker accompanies this document to explain delays in delivery, to escalate risks as necessary, to highlight key achievements/successes and to outline priorities for the upcoming month (see Appendix B, attached separately, for an example)

The **IMPACT TRACKER** monitors the wider effect that the delivery of actions is having on a range of organisational measures of D&I over time, against a baseline measure and a target:

- We are currently working to identify/refine the most appropriate measures that will demonstrate movement and progress in the form of a user-friendly dashboard ;

- All of the WRES indicators are included as well as other measurable sources of data;

- Measures will be updated on a quarterly basis (or annually for staff survey results) and a target figure has been included as an aspirational point to meet for each measure, by the end of 2021;

- A narrative report on the impact tracker will also be provided on a monthly basis.

3.0 PROGRESS TO DATE ON THE DELIVERY OF THE D&I ACTION PLAN

3.1 An overview of the progress to date on the delivery of the D&I Action Plan is provided in the power point slide deck as appendix (B).

3.2 In addition to the overview, Appendix (A) provides a detailed update on 'BAME' Recruitment Panel Representative Process and Training.

3.3 Next month is also Black History Month and our BAME Network colleagues are currently working hard to ensure that we fully celebrate black history by organising events whilst adhering to social distancing and infection control guidelines.

Author: **Daniel Scott, Senior OD Lead**
Date: **16th September 2020**

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APPENDIX A

‘BAME’ Recruitment Panel Representative Process and Training Update

1. Outline of the Process

Since mandated on 21st July 2020, 15 of the 16 interviews held across the organisation have had a trained BAME recruitment representatives present. This equates to **94%** of Band 8A and above interviews.

The process is embedding well with a small number of emerging themes/actions that need to be considered:

- Develop ‘What to expect’ guide for the interview chair, outlining the role of the rep and what information the rep requires to support them in being part of the interview process
- Lack of notice for reps being called to support interviews
- Clarity around roles and responsibilities of the recruitment team in the process
- Reducing discrimination and bias at shortlisting/selection – particularly with regards to acting up or informal internal arrangements
- Strong, collective needs to modernise language, particularly around use of ‘BAME’. Recruitment Inclusion Specialists seems to be the preferred term amongst participants and network members.
- Some previously trained reps have not been part of an interview panel and therefore are not confident being an active part of the interview

2. Current Position on Training Session

Confirmed training dates: September 9th, 22nd, 23rd, October 2nd, 23rd (more dates are in demand and being scheduled for later in the year).

By the end of November, providing we have 100% attendance at each session, we will have trained 100 Black, Asian and ME recruitment representatives. This increase in resource will enable us to proceed with mandating this process for interviews for all bands 7 and above (currently it is mandated for band 8A and above).

The pilot session ran on 9th September was attended by 18 of the 20 confirmed attendees and was extremely well received. The session was rated, on average, 4.53 out of 5, with comments such as:

- *‘Highly recommended, left with a better understanding of trust objectives’*
- *‘Exceeded my expectations’*
- *‘Very impressed by the facilitator and the D&I Workforce Lead, would recommend to my peers’*
- *‘The course met all of the learning objectives and more’*
- *‘Very interactive, realistic and well run’*
- *‘It is great that the trust has finally recognised there is scope for change’*

3. Training Programme Objectives

By participating in this workshop, delegates will be able to:

- Describe the importance of and urgent need for better BAME representation in our leadership
- Identify the purpose of your role and what being a BAME recruitment rep involves
- Recognise discrimination and bias and describe how they might surface in a recruitment process
- List your duties as a BAME recruitment representative at different stages of the recruitment process
- Identify potential challenges you may encounter and choose how to best try and respond to them

4. Training Programme - Outline of Content

The Case for Change	• Statistics about our workforce and its composition of ethnicities per band • Staff survey results and differences in perception of access to career opportunities • Statistics about recruitment – shortlisting vs. appointment for White vs. BAME people • The impact of under representation – on the workforce and patient care • How we are tackling BAME under-representation more widely
Your Overall Role	• BAME representation in a panel is crucial – why? • Your role, in a nutshell • How the process of joining a panel will work, and what is your required commitment? • Future plans - Representation for all roles 8A and above will be mandatory, but encouraged for all recruitment panels
Discrimination and Bias	• The equality act, 2010 and the range of protected characteristics • Types of discrimination and what they can look like in recruitment • Types of bias and what they can look like in recruitment
The Recruitment Process and Your Role	• Overview of key stages in a standard recruitment process and what to expect at each stage • What specific discrimination and/or bias should we be looking for at each stage? • Before the interview, during the interview, following the interview
Overcoming Potential Challenges	• What, when and who might you need to challenge? • How to challenge well - having a tricky but non-confrontational conversation • Some scenarios • What if I don't feel heard or included? Who will support me? Escalating concern
Close	• Summary and wrap up • Committing to action • Further learning and training

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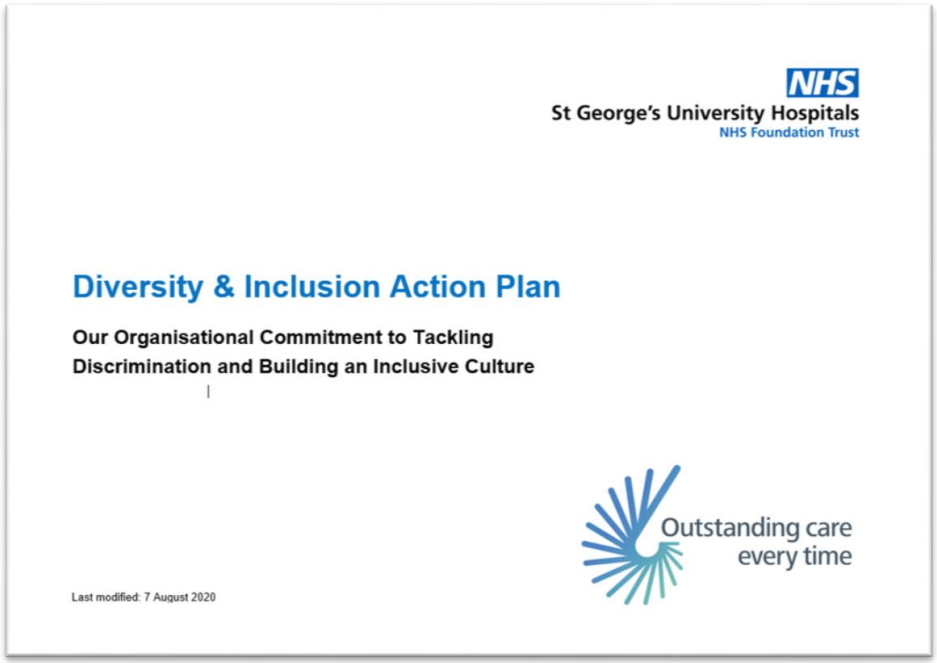
Trust Board – 24th September 2020

Appendix (B) - D&I Action Plan Progress Report

September 2020



Main achievements and successes this month

Launch of the 'Let's Talk about Race and Inclusion' Toolkit

- This internally developed toolkit has been launched 19 August 2020 and has been circulated widely across the Trust.

- The toolkit was developed in consultation with the BAME network and other stakeholders. Detailed comments were received from teams including QI/Transformation and Pharmacy who had already held similar conversations or were in the process of preparing a team conversation of this kind.

- A number of teams have expressed their gratitude for the guidance and their intentions to organise and conduct such team conversations shortly.
    - Sussex Police have seen the toolkit and extended their praise, asking our permission to use the it in creating their own, and committing to crediting St George's for the resource: *"It is a fantastic product and so well constructed… It really is a very impressive and well considered product, as so professionally published – which must make it more accessible and engaging for your colleagues to use."*
    - Senior Finance staff also offered feedback: *"..this toolkit has been really helpful in starting conversations on race and inclusion within the department, and has received good feedback in finance"*
    - *"…first and foremost, I think this is a really helpful tool for having these kinds of conversations and I wish we had it sooner… thanks to all that worked to put this together"* (from the Pharmacy team)

- The volunteer D&I lead in Pharmacy has conducted another local D&I event using the toolkit, with positive outcomes. Facilitated by internal facilitators from the team, and with about 30 colleagues in attendance, a rich exchange of personal stories around racism took place, and the team has built momentum for further events to take place.

- While we are confident that other team discussions will be taking place, we are not always able to find out by who and when. Despite our efforts to find out, we need leaders to let us know where and when such events take place, as they learn about them.

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Main achievements and successes this month

BAME Recruitment Representative Training

- A new half day training workshop has been designed for existing and new reps to build their competence and confidence in participating on recruitment panels.
- Three workshops are booked for 9, 21 and 22 September, and there has been a good response in terms of registrations, with 48 of 60 places already taken up.

2020 WRES Return

- WRES report was reviewed by PMG and WEC and submitted on time to NHS England.

BAME Recruitment Panel Representation

- A process is now in place to ensure that one BAME rep is included in all recruitment panels for posts at Band 8A and above. We are following up with any panels which didn't have a BAME rep to understand why and to ensure the process is robust.
- We are now scoping how to extend this to include Band 7 recruitments.

Leadership Development Training

- A 5 module programme with the King's Fund has been confirmed and will include a new module on Inclusive Leadership

Interview Training

- Face to face training has resumed (following a Covid-19 related break) on 'Preparing for Interviews' and 'Interviewing with Impact'

New Guidance for giving feedback to unsuccessful BAME interviewees

- New guidance (as an e-learning module and pdf reference) have been produced for recruitment panel chairs who are now required to offer any unsuccessful internal BAME applicants interviewed a career coaching discussion.
- The process for ensuring that this target group is routinely offered this service every time is currently being finalised.

Local D&I Interventions

- D&I Lead delivered a well-received session on D&I as part of a Band 7 development day in SNTC. The purpose was to introduce D&I as an important people management concern and to create greater awareness for individuals of its relevance to their roles.

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Priorities for next month

- Development of the WDES Annual Report and Action Plan
- Publish the WRES Action Plan
- Development of the D&I intranet page, that will integrate and house all available D&I resources and share plans and updates
- D&I Lead continuing to meet with DDOs to start developing local D&I action plans
- BAME Recruitment rep training delivery – in addition to the existing 30 reps, we will be recruiting 30 more for a total of 60
- Development of training modules on Unconscious Bias at work
- Collaborating with Speech and Language Therapists in Community Paediatrics to capture and share good practice in local D&I initiatives
- Commencing development of an organisational framework for coaching and mentoring, and building an internal bank of coaches
- Our D&I Lead is meeting with other D&I leads from across SW London to share best practice and initiate a benchmarking process
- Reviewing all application and selection processes for all CPD, to ensure equality of access and fairness of decision making

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Delivery Tracker Update

(Deliverables and Actions with RED or AMBER status only

Deliverable	Action	Target Date	RAG	Issues causing delay / Risks to escalate	Plan to resolve
All BAME staff who are not successful at interview are offered feedback and a career coaching conversation	Develop and implement a process and proforma in line with positive action that managers will complete to record a career conversation if a BAME staff member is not successful at interview for a role at Band 6 or above (and encouraged for all other bands)	31/8/20		• Process has been developed, but the work to define and update recruitment processes is more involved and complicated than first understood.	• Meeting planned between HR and D&I Lead to agree a clear process and adjust supporting systems
The expectation of all staff to be involved in tackling exclusion and discrimination is role modelled	Executive Team 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 reverse-mentored by a BAME colleague) and cascade to all employees	31/8/20		• There was some slippage on this due to August annual leave. However, all Executive Directors pledges have now been submitted.	• Non-Executive Directors on track to submit personal pledge by 30th September.
D&I networks are actively and visibly supported by an Executive Sponsor	Review and clarify the role of the Executive Sponsor in providing focused support for each D&I Network, including specifically, supporting the implementation of each network's action plan	31/8/20		• Meetings have taken place with respective sponsors but there is one outstanding due to holiday season.	• D&I Lead and HA will be meeting with SM asap
All staff build an awareness of unconscious bias at work as a basis to continue building more inclusive team and organisational cultures	Procure and implement online unconscious bias (UB) training accessible for all staff	31/8/20		• 4 different off-the-shelf products were considered and trialled, but all were considered not fit for purpose for a range of reasons. • We have also reached out to other Trusts and organisations to find out established approaches to organisation wide online UB training.	• The best solution will be to produce our own flexible training module on UB that will work both as an online e-learning module (30-45 mins) or a team face to face workshop (60-90 minutes). • We propose that the date is extended to 31 October to accommodate this extra work.

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Meeting Title:	**Trust Board**		
Date:	24 September 2020	**Agenda No.**	**2.4**
Report Title:	**Freedom to Speak Up Vision and Strategy**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer Karyn Richards-Wright, Freedom to Speak Up Guardian		
Presented for:	Approval		
Executive Summary:	This report sets out the Trust's proposed Freedom to Speak Up vision and strategy. It responds to the need for the Trust to make impactful progress in this area, with the Trust currently ranked 204th out of 230 Trusts nationally for the healthiness of its speaking up culture and with successive staff surveys having identified barriers staff encounter in raising concerns. Following a review by NHS England and NHS Improvement earlier this year, the Trust is taking a number of steps to strengthen its approach to raising concerns. As part of this, the Board agreed at its meeting in June 2020 that a new Freedom to Speak Up vision and strategy should be developed to provide greater focus and clarity to the Trust's efforts to improve in this area. The vision and strategy has been developed by drawing extensively on the results of the Trust's recent staff surveys and pulse surveys, and has been shared across the clinical divisions and corporate teams. It has been developed in line with indicative early feedback from the diagnostic phase of the culture change programme given the independency between building an effective organisational culture and staff feeling safe and supported in speaking up. It also draws on a wide range of national guidance and strategy, as well as on the Trust's clinical and supporting strategies, as well as feedback from Freedom to Speak Up leads at other Trusts. The strategy sets out an analysis of where we are currently – the challenges and barriers staff face in speaking up – and the national drivers in framing what constitutes effective speaking up practice. It proposes five strategic priorities for strengthening our approach to raising concerns as well as a set of steps to be taken in 2020/21 to ensure we make an immediate impact. The strategy also proposes how we will monitor implementation and impact, which will need to align with the nest phase of the culture change programme as well as a set of indicative metrics for measuring progress. The draft strategy has been considered and endorsed by the Workforce and Education Committee and by the Executive Management Team, having been reviewed by the People Management Group and Risk and Assurance Group.		

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	A communications plan for the launch of the strategy is in development and will be launched in early October to coincide with Freedom to Speak Up month. The strategy itself will be available to all staff, but we are also developing a range of supporting materials to communicate the key aspects and commitments to staff.		
Recommendation:	The Board is asked to: • Approve the Freedom to Speak Up Vision and Strategy • Note that the strategy will be launched in early October to coincide with Freedom to Speak Up month • Note the ongoing work to further refine the metrics for measuring impact and the need to align this with any metrics developed to measure the impact of the culture change programme		
Supports			
Trust Strategic Objective:	Build a better St George's; Champion Team St George's		
CQC Theme:	Safe, Well-Led		
NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	Failure to comply with the requirements around Freedom to Speak Up, a regulatory requirement, risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.		
Legal/Regulatory:	NHSI, Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy for the NHS, April 2016. Sir Robert Francis QC, Freedom to Speak Up: An independent report into creating an open and honest reporting culture in the NHS, 2015.		
Equality and diversity:	The strategy is designed to apply to all staff regardless of position, grade or protected characteristic, and is intended to support all staff in feeling safe and supported in speaking up where they have concerns. The strategy seeks to address the barriers staff have encountered in raising concerns.		
Resources:	As set out in the report.		
Previously Considered by:	Partnership Forum Executive Management Team People Management Group Risk and Assurance Group Workforce and Education Committee People Management Group Risk and Assurance Group	**Date:**	15 September 2020 14 September 2020 15 September 2020 2 September 2020 13 August 2020 5 August 2020 5 August 2020

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Freedom to Speak Up Vision and Strategy

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Freedom to Speak Up

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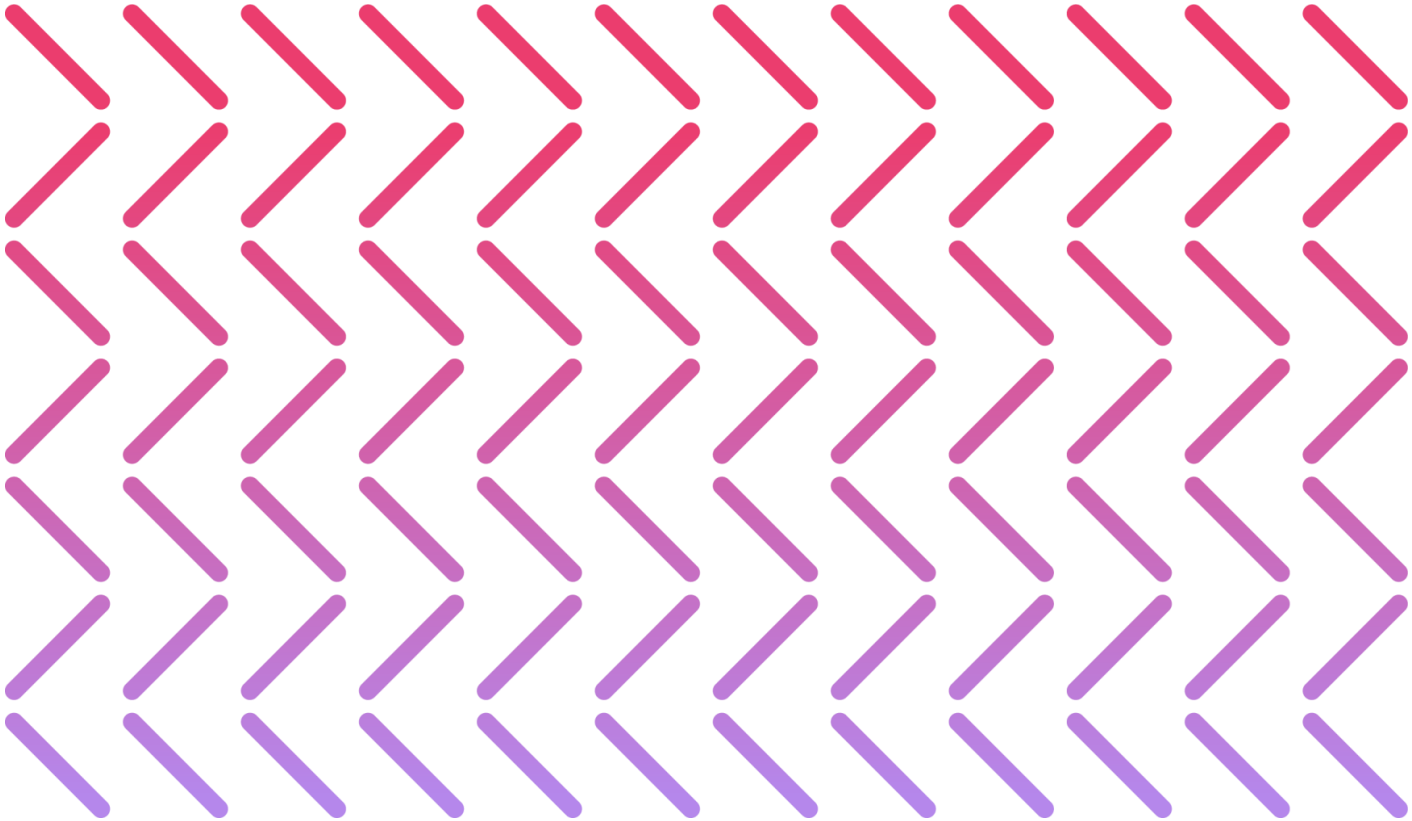
1. Introduction

Why speaking up matters



1. Introduction

What is speaking up and why does it matter?

The Trust's clinical strategy, published in April 2019, sets out our collective ambition to provide outstanding care, every time for our patients, staff and the communities we serve. Key to providing outstanding care is establishing an open and transparent culture in which staff feel safe and supported to speak up when things go wrong.

Our staff are committed to doing their very best for our patients and each other. They want to be able to raise concerns about things they are worried may be going wrong, free from fear that they may be treated badly when they speak up, and confident that effective and appropriate action will be taken when concerns are raised.

But we know from our own staff survey results, from the experience of those who have spoken up, and from national reviews of speaking up across the NHS, that staff do not always feel safe in raising concerns; in some cases staff can feel deeply fearful about the consequences of speaking up – fearful of being victimised, for the future of their jobs, career progression, and their wider welfare. We know, too, that staff across the NHS, and here at St George's, lack confidence that if they raise a concern they will be listened to; this lack of trust and confidence in the process of speaking up deterring those who might otherwise raise concerns. Where staff feel afraid of speaking up or lack the confidence that their concerns will be taken seriously, the care we provide suffers. As the Francis Report into raising concerns noted, every time someone is deterred from speaking up, an opportunity to improve care is missed. Failure to speak up can, ultimately, cost lives.

Ensuring that our staff feel safe, supported and confident in raising concerns is, therefore, fundamental to achieving our collective vision of delivering outstanding care every time for our patients, staff and the communities we serve. That is why building an open and inclusive culture which encourages and supports staff to raise concerns without fear or detriment is so critical – and that is what we are committed to building at St George's.

This Freedom to Speak Up Vision and Strategy aims to support staff to know how to raise concerns, who to raise them with, how concerns will be investigated, and what we will do to feed back on the actions we have taken in response. It sets out five priorities for building an effective and healthy speaking up culture at St George's, which makes clear the support we will provide to those who speak up, the steps we will take to make sure those who speak up do not suffer as a result, and how we will make sure that when someone speaks up, we listen and that it makes a difference.

1. Introduction

Engaging with our staff and stakeholders

In developing this Freedom to Speak Up Vision and Strategy, we have sought to draw on the views of our staff and key stakeholders. In doing so, we have drawn extensively on the results of our staff survey results over recent years, both in terms of the headline results and the free text comments that relate to speaking up, and to our pulse survey results and free text comments. We have drafted the draft strategy for comment and input across our clinical divisions and with our Partnership Forum. In addition, we have sought to develop this Strategy in line with the emerging feedback to and findings of the diagnostic phase of the Trust's ongoing culture change programme – given the inherent interdependency of building an effective organisational culture and staff feeling safe and supported in speaking up when are concerns things are going wrong.

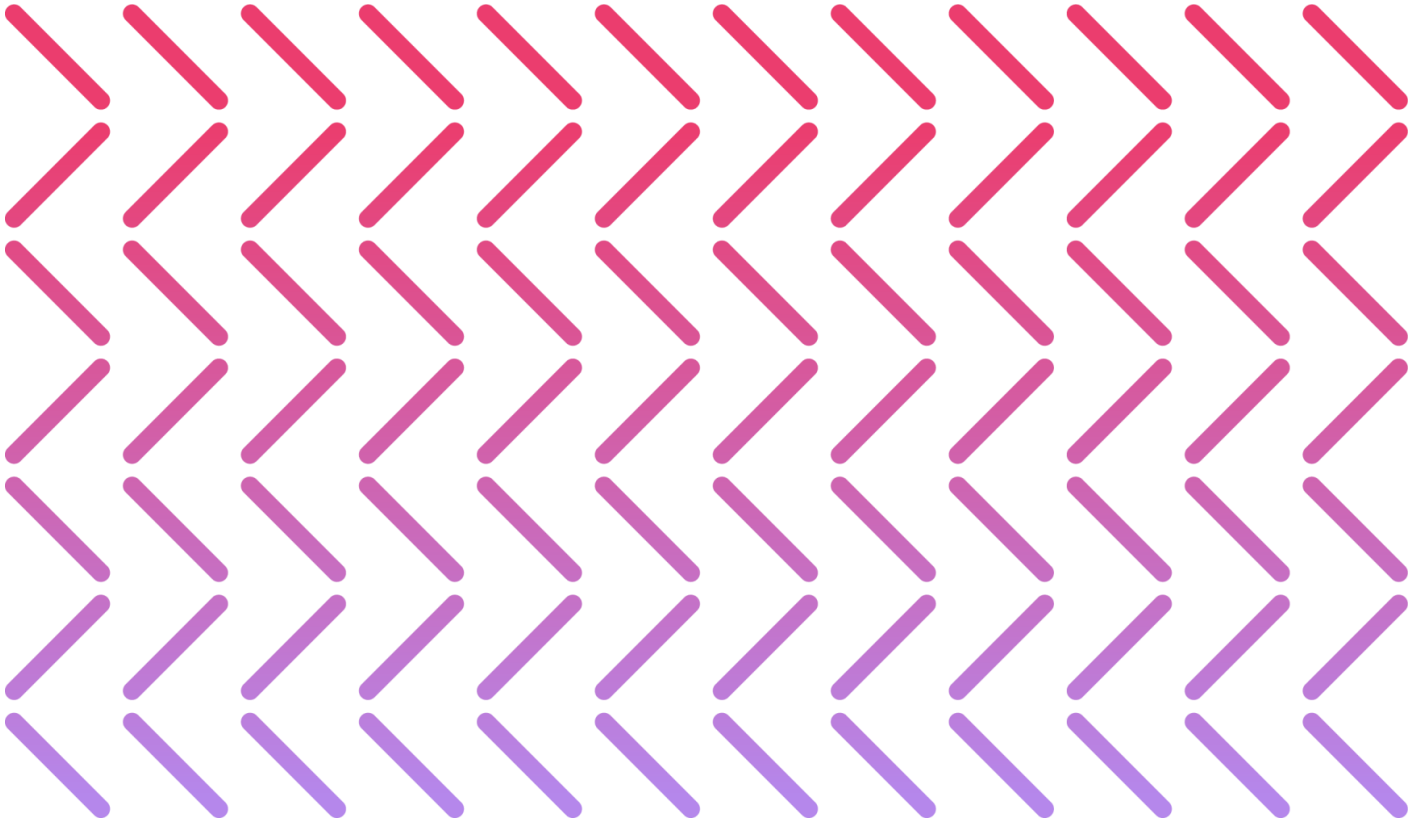
We have also reviewed the following:

- National Guardian's Office's Freedom to Speak Up Index
- Case reviews from the National Guardian's Office
- The Trust's Care Quality Commission inspection report, December 2019
- The Trust's Clinical Strategy, 2019-24
- The Trust's Workforce Strategy 2019-24
- The Trust's Quality and Safety Strategy 2020-24
- "Freedom to Speak Up: An Independent Review", by Sir Robert Francis QC
- Guidance on Freedom to Speak Up, published by NHS England and NHS Improvement in July 2019
- NHS Patient Safety Strategy, published in July 2019
- NHS People Plan, published in August 2020

In addition, we have engaged with Freedom to Speak Up Guardians and FTSU Executive Leads at Trust's which are further along the journey to establishing effective Freedom to Speak Up cultures, as well as with NHS England and NHS Improvement who supported the Trust earlier this year in reviewing our Freedom to Speak Up arrangements.

2. Where did we come from and where are we now?

Being clear about the challenges we face in establishing a healthy speaking up culture at St George's



Freedom to Speak Up

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2. Where did we come from and where are we now?
National drivers

The emphasis we place on establishing the right culture at St George's, and the importance of Freedom to Speak Up within it, is not only a core part of what we need to do to deliver our clinical strategy; it is the right thing to do. It also reflects a series of broader developments nationally which in recent years have recognised the importance and value of staff feeling safe and supported in speaking up when they have concerns.

In February 2015, the independent report into Freedom to Speak Up, by Sir Robert Francis QC, cast new light on the experiences of staff across the NHS who raised concerns and laid bare the fear that too often inhibited staff from speaking up when they had concerns that things were going wrong. The report, which set out 20 principles to guide the development of a healthy speaking up culture throughout the NHS, and which was endorsed by the Government, led to major changes in NHS policy, including the introduction of Freedom to Speak Up Guardians at every NHS trust. The importance of speaking up has more recently been acknowledged both in the new NHS Patient Safety Strategy, published in July 2019, which sees speaking up as a fundamental part of establishing effective patient safety cultures in NHS trusts, and in the new NHS People Plan, published in August 2020, which describes speaking up as essential to building a culture of belonging in the NHS, one in which patients and staff feel safe.

Freedom to Speak Up: An independent review, February 2015

"The NHS is blessed with staff who want to do the best for their patients. They want to be able to raise their concerns about things they are worried may be going wrong, free of fear that they may be badly treated when they do so, and confident that effective action will be taken. This can be a difficult and a brave thing to do, even in a well run organisation or department, but will be extremely challenging when raising concerns is not welcomed…. A service as important and as safety critical as the NHS can only succeed if it welcomes the contribution staff can make to protecting patients and to the integrity of the service. Valued staff are effective staff. A listening system is a safer system. Organisations which ignore staff concerns, or worse, victimise those who express them are likely to be dangerous places for their patients…There is a need for a culture in which concerns raised by staff are taken seriously, investigated and addressed by appropriate corrective measures. Above all, behaviour by anyone which is designed to bully staff into silence, or to subject them to retribution for speaking up must not be tolerated.

"Every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern…We need to get away from the culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement. That is the way to ensure that staff can make the valuable contribution they want to offer towards protecting patients and the integrity of the NHS. Most importantly the risks to patients' lives and well-being will be reduced, and confidence in the NHS protected."

Freedom to Speak Up

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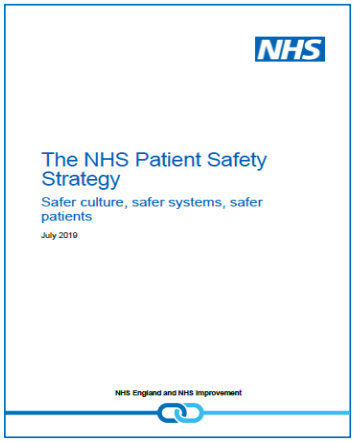
2. Where did we come from and where are we now?
National drivers



NHS Patient Safety Strategy, July 2019

"Our vision is for the NHS to continuously improve patient safety…To realise this vision the NHS will build on two foundations: a patient safety culture and a patient safety system across all levels of care."

A patient safety culture

"Culture change cannot be mandated by strategy, but its role in determining safety cannot be ignored…A consistent message in the consultation responses was that fear is too prevalent across NHS staff, particularly in relation to involvement in patient safety incidents…The key ingredients for healthcare organisations that want to be safe are: staff who feel psychologically safe; valuing and respecting diversity; a compelling vision; good leadership at all levels; a sense of teamwork; openness and support for learning…To work at our best, adapting as the environment requires, we need to feel supported within a compassionate and inclusive environment. Psychological safety operates at the level of the group not the individual, with each individual knowing they will be treated fairly and compassionately by the group if things go wrong or they speak up to stop problems occurring. It means staff do not feel the need to behave defensively to protect themselves and instead opens the space in which they can learn."

NHS People Plan, August 2020

"Given recent national and international events, it has never been more urgent for our leaders to take action and create an organisational culture where everyone feels they belong…The NHS must welcome all, with a culture of belonging and trust."

Ensuring staff have a voice

"We all need to feel safe and confident when expressing our views. If something concerns us, we should feel able to speak up. If we find a better way of doing something, we should feel free to share it. We must use our voices to shape our roles, workplace, the NHS, and our communities, to improve the health and care of the nation…We also need to take the time to really listen, helping one another through challenges and during times of change, and making the most of new opportunities. Many staff have felt unable to speak up, or that they have been ignored."

"Making sure staff are empowered to speak up – and that when they do, their concerns will be heard – is essential if we are to create a culture where patients and staff feel safe. We must all make sure our people feel valued, and confident that their insights are being used to shape learning and improvement."

2. Where did we come from and where are we now?
Our clinical strategy

Our clinical strategy, published in April 2019, sets out our collective vision of providing outstanding care every time to our patients, staff and the communities we serve. A key element of this was the objective of "Championing Team St George's" – building an empowered, inclusive and diverse workforce for the future, addressing concerns about bullying and harassment, listening and responding to the needs and views of our staff, and delivering a wider cultural shift within the organisation.

Our workforce strategy, published in November 2019, set out in more detail how we would build the workforce and culture we need for the future. As part of this, it highlighted the importance of Freedom to Speak Up as a key part of the organisational development journey the Trust needed to embark on to establish the culture we need. In this way, we have embedded changes in national policy which emphasise the importance of speaking up within our local Trust strategy.

At the same time, we know we face significant challenges at the present time with the experience our own staff with speaking up – and we are determined to make improvements so that all our staff feel safe and supported in speaking up when they have concerns.

2. Where did we come from and where are we now?
Our challenges and current position

- An effective strategy for speaking up needs to be based not only on what constitutes good speaking up practice as set out in national guidance; it also needs to capture our collective experience across the Trust of speaking up to date – where we are as a Trust at present, the specific challenges we face at St George's, and where we feel we are based on local feedback, indicators and other measures. This diagnostic has been used to help frame our Freedom to Speak Up Vision and Strategy.

- The numbers of concerns raised with our Freedom to Speak Up Guardian has increased significantly over recent years – from just 10 concerns in 2017/18 to 36 in 2018/19, and to 60 in 2019/20. In the first quarter of 2020/21, 51 concerns have been raised with the Guardian by our staff, 11 of which related directly to concerns about Covid-19. The trend of more concerns being raised is positive and welcome, and suggests that staff are increasingly willing to speak up where they are concerned things are going wrong.

- At the same time, however, much more needs to be done to gain the confidence of staff to ensure that all staff feel confident that when speaking up they will be thanked for doing so, supported, treated fairly and not come to any detriment. Current data and feedback indicates that staff do not feel safe to speak up within the organisation. While we have seen the number of concerns being raised increasing among some staff groups, such as nursing, medical, and administrative and clerical staff, we continue to see very few – if any – concerns raised by our portering and maintenance staff, or our cleaning staff. Over the past year, we have also seen more collective concerns being raised, another indicator of a lack of confidence our staff have in speaking up.

- Working with NHS England, the National Guardian's Office has brought together four questions from the NHS Staff Survey to produce the 'Freedom to Speak Up (FTSU) Index'. These questions relate to whether staff feel knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident. The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared. Currently St George's ranks 204th of 230 trusts with a score of 75.6%. By contrast, the highest ranking trust scores 86.6% on the Index. The Index demonstrates that compared with a large number of Trusts across the country our staff are not confident to raise concerns, and this needs to be addressed.

2. Where did we come from and where are we now?
Our challenges and current position

- Feedback from staff in the latest staff survey and pulse survey results highlight the fear staff have of raising concerns within the organisation. St George's has consistently scored below the best benchmark group between 2015 to current time in all categories within the staff survey, which again indicates the need for strategic action required to improve the experience of our staff and support the trusts vision of outstanding care very time.

- Thematic analysis of the types of concerns being raised is also informative. Concerns about bullying and harassment are, by far, the most common types of concerns raised through Freedom to Speak Up. In 2019/20, out of a total of 60 concerns raised with the Guardian during the year, 25 related to bullying and harassment – more than 40% of the total number of concerns that year. A further 14 concerns related to behavioural issues with a further eight concerns linked to culture and leadership. In total, in 2019/20, 47 out of 60 concerns – 78% – related to issues that were linked fundamentally to staff experience and organisational culture. By contrast, the number of concerns raised about quality of patient care and / or patient safety are comparatively low; in 2019/20 6 quality and safety related concerns were raised, 10% of the total.

- This demonstrates the importance of establishing the right culture within the organisation, and a programme of work in this area is already underway. While Freedom to Speak Up is, of course, not solely about culture and behaviours, the vision and strategy is designed to integrate effectively with the work already underway to improve culture and behaviours across the Trust. Whilst there has been an increase of BAME staff raising concerns during the COVID-19 pandemic, this has also identified other staff groups inclusive of BAME staff requiring support and not feeling confident to raise concerns. The strategy also, therefore, integrates with work already underway to address concerns related to diversity and inclusion and improve diversity and inclusion across the Trust.

- The consistent feedback from staff is that they lack confidence in the transparency, fairness and seriousness with which concerns will be investigated and acted on. The strategy supports actions required to improve the confidence of staff in our processes. While the raising concerns processes are separate from HR investigative processes, the Trust faces a broader challenge in ensuring that all investigations are conducted as promptly as possible.

2. Where did we come from and where are we now?
Strengths, Weaknesses, Opportunities and Threats

Strengths:

- We have a skilled workforce committed to patient care
- We have a clear workforce strategy for the future
- We have seen an increase in staff raising concerns in each of the last three years, and a significant rise during 2020/21 to date which suggests staff are increasingly willing to raise concerns
- We have strengthened our Freedom to Speak Up function
- We have a capable Freedom to Speak Up Guardian who is also the London-wide Chair of FTSU Guardians

Opportunities:

- The informal review of our Freedom to Speak Up function by NHSE&I has provided us with clear guidance on where we need to further strengthen our approach to speaking up
- National guidance published in July 2019 provides clear opportunities for the Trust to improve its approach to speaking up at all levels once implemented
- We can develop a culture for learning, quality and safety
- We can develop processes for triangulating FTSU concerns with a wide range of patient safety and staff data to identify emerging areas of concern
- Active Staff Side participation in Partnership Forum
- There is a clear commitment across the organisation to improve our organisational culture

Weaknesses:

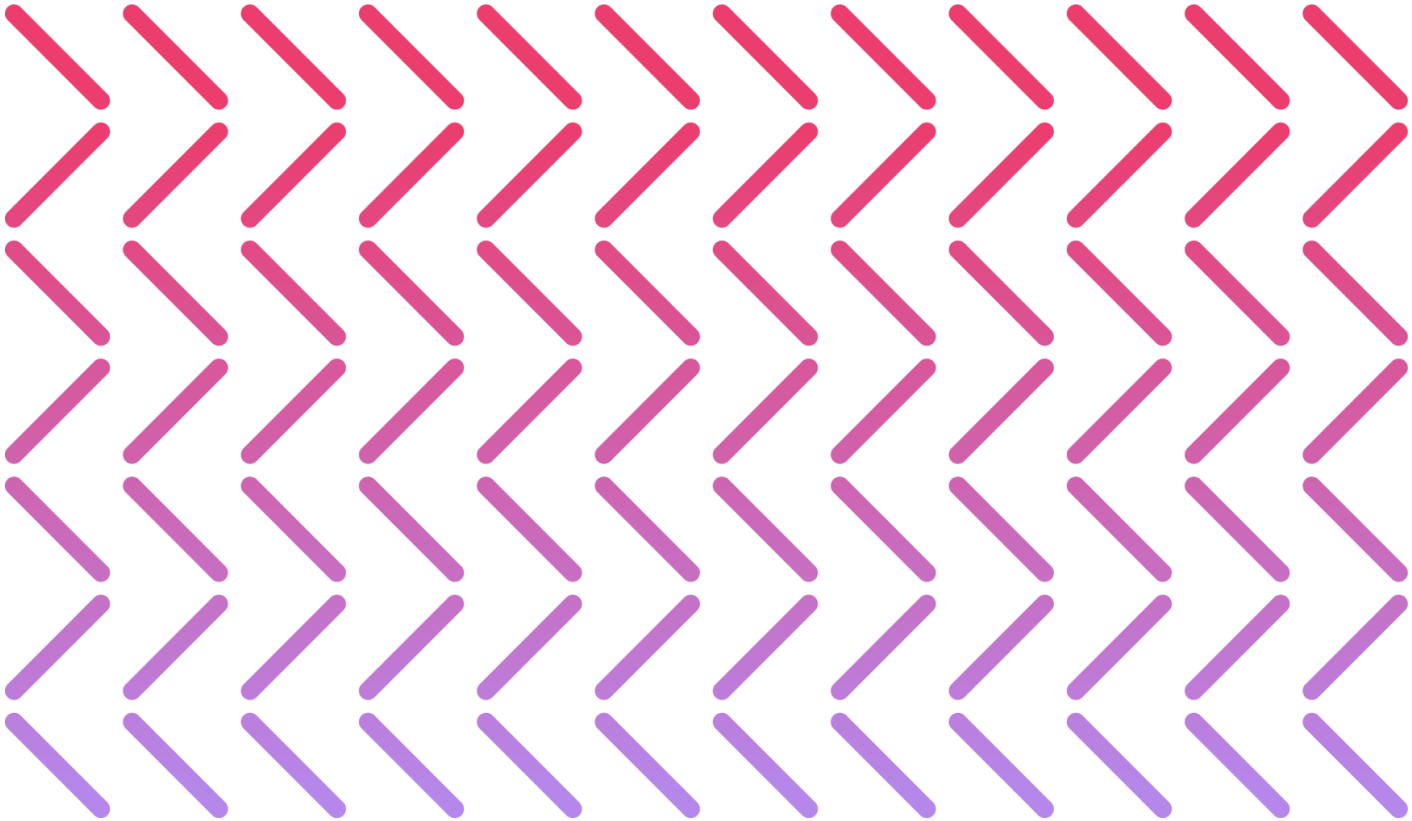
- The NHS Staff survey demonstrates that some staff are fearful of speaking up when they have concerns
- We need to improve our NHS Staff Survey results, in particular reduce bullying and harassment, improve staff engagement and our focus on diversity and inclusion for staff
- We know some staff lack confidence in our processes for speaking up and lack trust that concerns will be investigated and action will be taken
- When concerns are raised, investigations take too long to complete and those who raise concerns do not always hear how their concerns have been resolved
- We need to invest in improving the skills and training for our managers to help them have difficult conversations
- We do not consistently triangulate concerns raised by our staff with other indictors – such as patient safety information and employee relations data – to identify hotspots where a service or team may be encountering difficulties that warrant some form of early intervention
- We need to ensure that we are complying with national guidance and good practice on Freedom to Speak Up
- We do not have a robust means of incorporating the learning from case reviews by the National Guardian's Office and translating this into action at Trust level
- We need to establish an open, transparent and empowering culture where staff feel safe and supported to speak up

Threats:

- The cultural shift we need does not happen, or does not happen quickly enough
- We do not take action that improves our speaking up culture, and this prompts intervention by our regulator and the National Guardian's Office

3. Where we go next

Defining our Vision and strategic priorities



Freedom to Speak Up

Outstanding care every time

3. Where we go next

Our vision for Freedom to Speak Up at St George's

We aim to create a culture of safety and learning in which all staff feel safe, supported and confident to raise concerns without fear or detriment, and where speaking up is visibly championed as a core part of providing outstanding care every time to our patients, staff and the communities we serve.

We aim to become a leader in establishing a positive speaking up culture by encouraging and supporting our staff to speak up, listening to their concerns and acting on them. Staff will not fear speaking up and will be thanked for doing so.

3. Where we go next

Our strategic priorities for Freedom to Speak Up

To achieve our vision for Freedom to Speak Up at St George's, our strategy sets out the strategic themes and priorities that will be relevant not only immediately but also for the full duration of the strategy.

Based on the speaking up model developed by Sir Robert Francis QC, we have developed five draft strategic themes around which we propose to build the full draft strategy.

The strategic themes seek to capture the full range of issues we have identified in our diagnostic so that we cover awareness, safety, support, the investigative process, impact and the role of the strategy in supporting the wider cultural change programme the Trust is developing.

The elements comprising each of the proposed themes are set out in the following slides.

Freedom to Speak Up

Outstanding care every time

3. Where we go next

Strategic Theme 1: Supporting our staff to feel confident about speaking up

Why are we focussing on this?
To establish a healthy speaking up culture, as a first step we need to make sure that our staff feel confident about speaking up – that they understand that they have a right to speak up, that the organisation encourages this, and that our processes are clear and accessible for anyone who wants to raise a concern.

Proposal: We will support our staff to feel confident about how to raise a concern, who to raise it with, and what to expect when they speak up. We will make sure our processes for speaking up are clear, well communicated and accessible to all our staff.

- We will **promote awareness of Freedom to Speak Up** across the Trust. This will include developing and delivering a focused communications campaign to raise awareness of the role of the Freedom to Speak Up Guardian, the Champions, and how to contract them. It will also focus on raising awareness about how to raise a concern and of the FTSU policy.

- We will develop and deliver **training for all staff in Freedom to Speak Up**, and will integrate this into our MAST training programme. This will include an online training module in speaking up and raising concerns.

- We will establish a **wide and diverse network of Freedom to Speak Up Champions** so that all staff have someone independent they can speak to when they have concerns.

- We will promote **visible leadership** on Freedom to Speak Up from the Board to the Ward.

What will success look like?
We will see a **year-on-year-improvement** in the awareness of staff about Freedom to Speak Up and in the number of concerns raised with the Trust's Freedom to Speak Up Guardian.

3. Where we go next

Strategic Theme 2: Making it safe for our staff to speak up

Why are we focussing on this?
We know that staff are sometimes fearful about speaking up, concerned about the impact of raising concerns for their job, their working relationships and their wider welfare. We know, too, that where staff are too frightened to speak up the quality of care we provide can suffer. Only when staff feel safe to speak up will we succeed in building a healthy culture around raising concerns.

Proposal: We will make it safe for our staff to speak up and raise concerns, ensuring the organisation is receptive to concerns raised by our staff.

- We will **deliver training for managers** in receiving and managing concerns, so that managers are approachable and welcoming when staff want to raise concerns, and are trained in how to received concerns.
- We will **provide effective support to our staff** when they raise concerns, and make sure that our staff know how and where to access that support.
- We will **foster a culture free from bullying and harassment**.

What will success look like?
We will see a **year-on-year-improvement** in the number of concerns raised with the Trust's Freedom to Speak Up Guardian and we will see increasing feedback from staff that they feel the organisation welcomes and supports them in speaking up. By the same token, we would expect to see fewer concerns raised directly with the National Guardian's Office or with the CQC in the first instance. Together these would indicate that staff feel safer in speaking up at the Trust.

3. Where we go next

Strategic Theme 3: Investigating concerns promptly, fairly and fully

Why are we focussing on this?
Staff often hold back from speaking up because of concerns about the time it takes to investigate concerns, and because of fears that the investigation may not be sufficiently impartial. Confidence in our investigative processes from start to finish is key if our staff are to feel it is worth speaking up when they are concerned something may be going wrong.

Proposal: We will investigate concerns promptly, fairly and fully, and ensure that all investigations are started and completed within the established national guidelines. We will make sure that there are independent, fair and objective investigations into the facts, that investigations will be undertaken promptly without delay and without the purpose of identifying blame, that investigations will be given the necessary resource and scope and that they will be kept separate from any disciplinary and / or performance management action.

- We will **establish and maintain clear timescales** for undertaking and completing all investigations where concerns are raised.
- We will ensure **those appointed to conduct investigations are independent.**
- We will provide **training for all staff** members who lead investigations into concerns.
- We will ensure **monitoring and evaluation of the number and nature of concerns and the timeliness of investigations** through regular and robust reporting through established Trust governance structures including to the Partnership Forum.

What will success look like?
We will see all investigations completed on time, feedback from staff indicating greater confidence in our investigative processes, and increasing number of concerns being raised.

3. Where we go next

Strategic Theme 4: Ensuring speaking up makes a difference

Why are we focussing on this?
Unless staff feel that they will be listened to fairly and that appropriate action will be taken in response, they are less likely to speak up where they are concerned things may be going wrong. Staff need to feel that speaking up will make a difference, and at the very least that they will be taken seriously.

Proposal: We will investigate concerns promptly, fairly and fully, and ensure that all investigations are started and completed within the established national guidelines. We will make sure that there are independent, fair and objective investigations into the facts, that investigations will be undertaken promptly without delay and without the purpose of identifying blame, that investigations will be given the necessary resource and scope and that they will be kept separate from any disciplinary and / or performance management action.

- We will **thank and value our staff for speaking up.**
- We will provide **feedback to staff who speak up** on what has been done in response to the concerns they have raised.
- We will **triangulate concerns raised by our staff with business intelligence from across the Trust** to identify and address hotspot areas or services or teams facing difficulties.
- We will **ensure we learn lessons from the concerns that are raised** to ensure patients and staff receive outstanding care while respecting confidentiality.
- We will put in place **robust assurance systems and processes** to make sure that there is effective oversight of the rigour of investigation and the consistency of approach.
- We will **seek feedback from staff who raise concerns** so that we continuously improve our approach to speaking up.

What will success look like?
In addition to seeing an increase in the number of concerns raised, we will see greater confidence among staff in speaking up through the staff survey, pulse surveys, and we will also see targeted interventions in services identified as potential hotspot areas.

3. Where we go next

Strategic Theme 5: Supporting the positive development of our organisational culture

Why are we focussing on this?
One of the most important factors in shaping people's willingness to speak up is the culture of the organisation. Establishing a healthy speaking up culture at St George's is an important part of establishing the wider organisational culture we want to see. It also forms part of the wider work on developing a healthy culture for the Trust as a whole.

Proposal: We will support the positive development of our organisational culture, and ensure that we work we take forward to develop a healthy speaking up culture aligns, supports and reinforces our wider work on organisational development and cultural change.

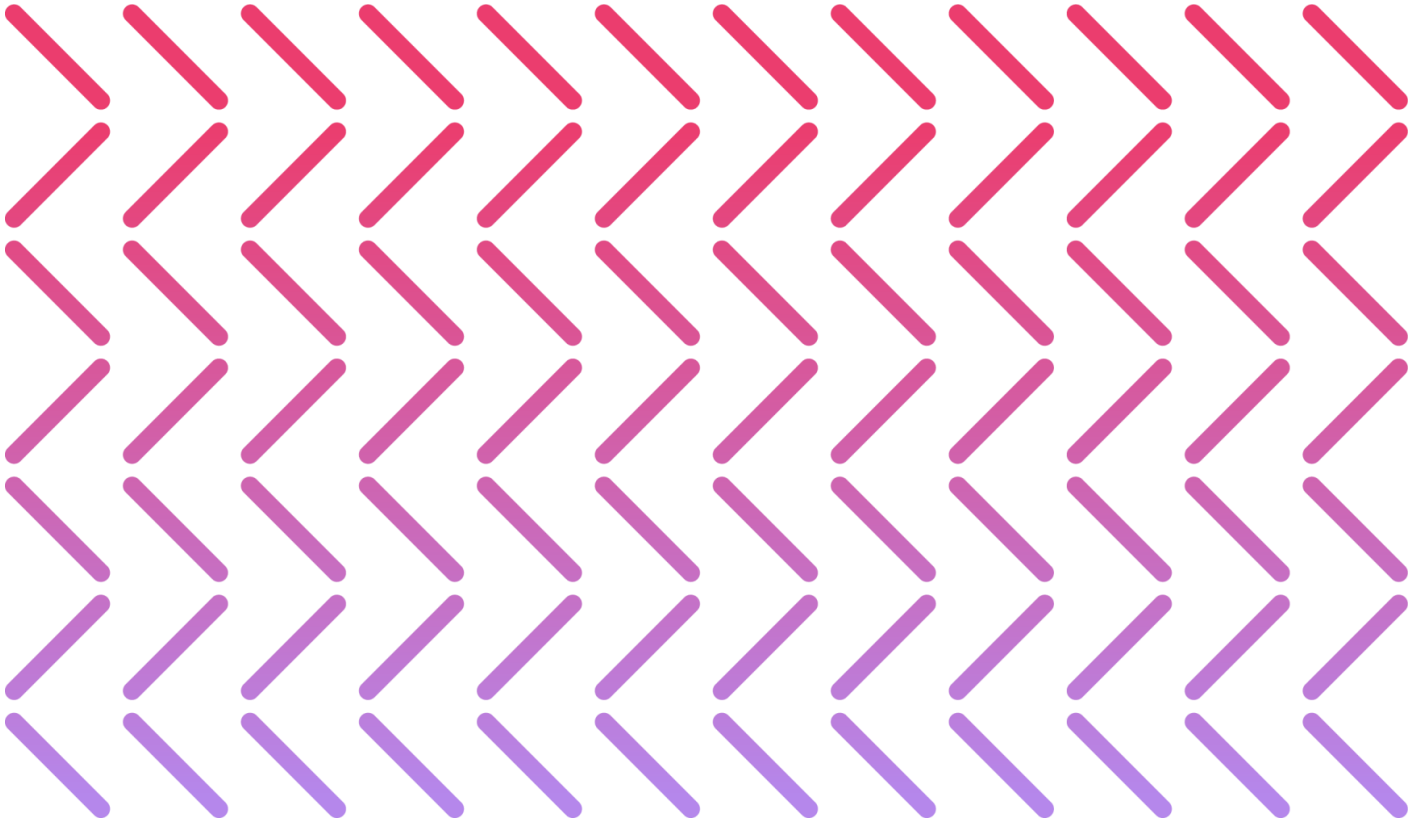
- We will **ensure that establishing a healthy speaking up culture is part of the wider cultural change programme.**
- We will ensure that **issues relating to culture and organisational development identified through our speaking up processes are fed into our cultural change programme** in a timely way so that speaking up has impact**.**

What will success look like?
Success in this objective will be measured through the cultural change programme metrics.

2.4

4. Making an immediate impact

Our 2020/21 Freedom to Speak Up Plan



4. Making an immediate impact

Our 2020/21 Freedom to Speak Up Plan

The strategy is a multi-year strategy intended to realise our vision of creating an open and safe culture in which staff feel safe and supported to speak up about concerns without fear or detriment. But given the importance of speaking up and the scale of the task ahead in realising our vision, we need to make an immediate impact to both establish the Trust's Freedom to Speak Up function and processes, awareness of FTSU among our staff, put in place a robust policy framework, and build more effective triangulation of issues and concerns across the organisation and assurance to the Board. To support the delivery of the strategy and to ensure the strategy has an immediate and visible impact, we propose setting out a plan for how we will start on this journey in 2020/21.

Through our strategy, we are committed to making a fundamental step change in our collective approach to supporting staff to speak up. Our strategy gives clarity about our aims and objectives – what we want to achieve and how we think we can get there. But well meaning words are not enough; the strategy needs to have an impact – we need to make sure that things change in practice, not only in theory. To ensure this is a strategy that has real meaning for our staff, and a positive impact on the working lives of everyone who works here, we have included in this strategy concrete steps we will be taking to deliver the change we need to make:

1. **Strengthen the Freedom to Speak Up function**
2. **Refresh the Freedom to Speak Up Champions Network**
3. **Develop a Freedom to Speak Up Charter**
4. **Refresh the Freedom to Speak Up Policy**
5. **Establish a regular Freedom to Speak Up 'Summit'**
6. **Develop and launch an intensive communications plan and activities to support speaking up**
7. **Develop effective assurance reporting to the Trust Board and Committees**

Freedom to Speak Up Plan 20/21 (2 of 2)

Making an immediate impact

1. Strengthen the FTSU function	• Create dedicated and more senior FTSU role focused solely on FTSU • Create a new role of Deputy FTSU Guardian to build strength in depth of FTSU function • Create dedicated FTSU budget
2. Refresh FTSU Champions	• Clarify role of FTSU Champions & revisit role description and time commitment • Ensure all parts of the Trust have champions, and that the Champions network reflects the diversity of our staff, and identify champions for specific staff groups
3. Develop FTSU Charter	• I have spoken up – what can I expect? • Someone has spoken up about me – what can I expect?
4. Refresh FTSU Policy	• Review of the policy to ensure it is fully up-to-date with national guidance and best practice • Review policy in light of agreed FTSU strategy • Ensure policy is clear about the range of routes for raising concerns
5. Establish FTSU Summit	• Develop proposals for establishing a group to triangulate issues and concerns with a range of other data • Develop ToR for the group • Ensure group is supported by range of data relating to safety, culture, workforce and other sources
6. Develop comms plan	• Develop and promote an annual calendar of FTSU events and activities • Develop communications campaign to raise awareness of how to raise concerns • Use full range of channels inc CEO weekly message, eG, case studies, video clips
7. Develop reporting	• Develop a model for regular reporting to the Trust Board and the sources of assurance and data to include in the report • Develop an FTSU annual report for the Board • Board level training in FTSU

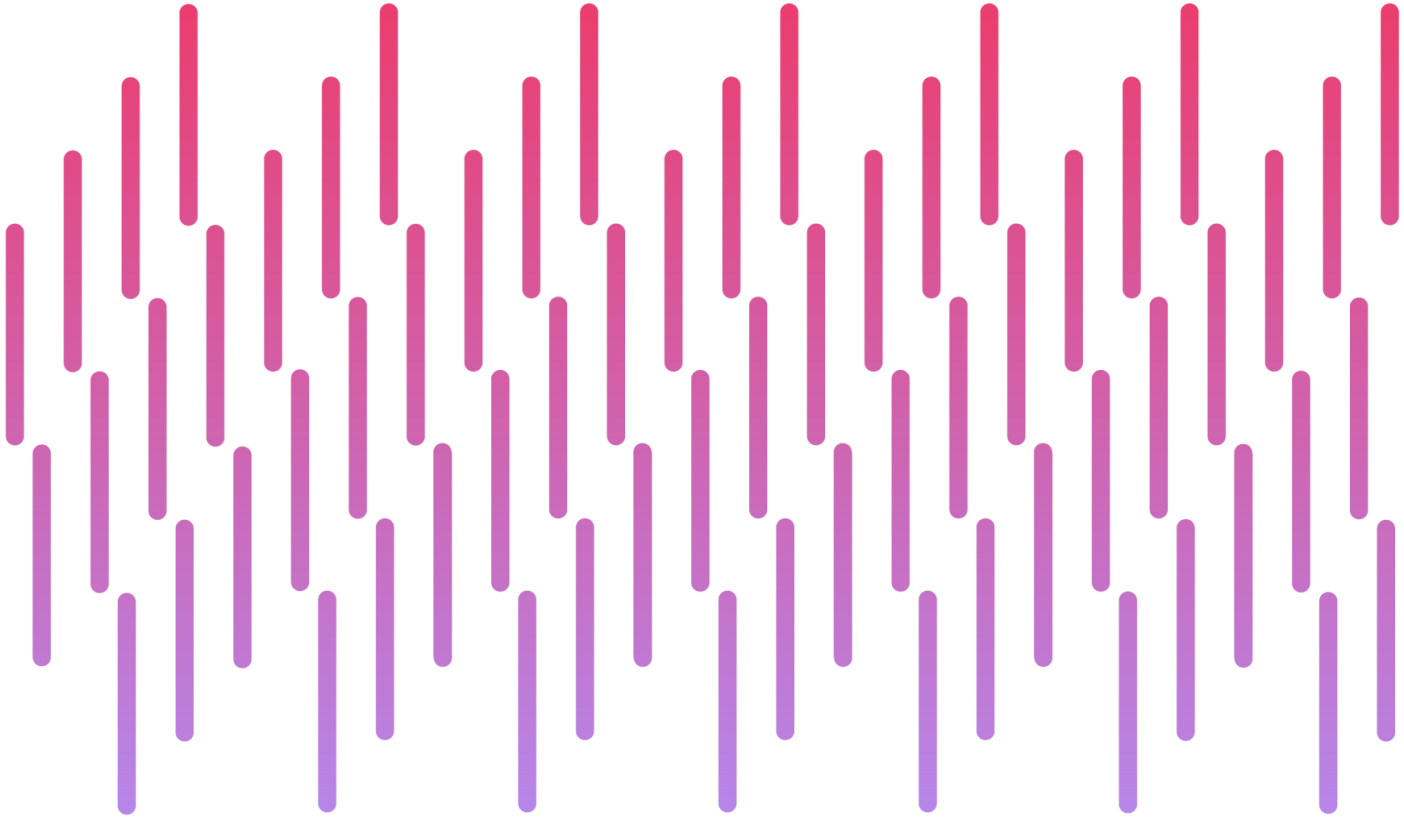
Making sure we deliver the strategy in practice

Monitoring implementation

We will only succeed in fully implementing the strategy when all members of St George's feel safe, supported and confident in raising concerns, knowing these will be taken seriously, investigated in a timely way, and feedback will be provided on what has been done to address them. We know this will take time, but if want to provide outstanding care every time for our patients, staff and the communities we serve, we must succeed – and make prompt and real progress. Measuring impact, however, cannot be disaggregated from the impact of the broader work the Trust is embarking on in terms of establishing the right culture across the organisation, and in practice many of the metrics for measuring changes in the healthiness of our Freedom to Speak Up culture will reflect those metrics for measuring cultural change.

Below are the measures we plan to use to measure and triangulate the impact of this strategy. During 2020/21, we will continue to refine this, and will align it to the metrics for measuring cultural change as these are developed. To ensure effective oversight of our progress, we have established reporting mechanisms for monitoring implementation:

Process for monitoring implementation	• Regular assurance reporting to the Trust Board of Directors from FTSU Guardian and assurance around actions taken by Trust to address concerns raise by the Guardian. • Regular reporting on themes emerging from speaking up to Workforce & Education Committee • Regular assurance reporting on the control framework around FTSU to the Audit Committee • Reporting of themes and issues emerging through FTSU to Partnership Forum • Effective Executive oversight of FTSU themes (via People Management Group) and controls (via Risk and Assurance Group) to the Trust Management Group and Executive Management Team.
Indicative measures	• Annual NHS staff survey results • Pulse survey results • Bullying and harassment reports • Grievances • Suspensions • Disciplinary cases • Exit interviews • Staff retention figures • Litigation • Never Events • Serious Incidents • Issues raised to the CQC • Incident reporting • Numbers of issues raised with FTSUG • National benchmarking data from the National Guardian's Office



Freedom to Speak Up Vision and Strategy
St George's University Hospitals NHS Foundation Trust

Freedom to Speak Up

Outstanding care every time

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	24 September 2020	**Agenda No**	2.6.1
Report Title:	RO update: Annual report to the board		
Lead Director/ Manager:	Richard Jennings, Chief Medical Officer		
Report Authors:	Karen Daly, Responsible Officer Ms Nicola McDonald, Revalidation support officer Ms Karen Daly, Deputy Chief Medical Officer and Responsible Officer		
Presented for:	Approval		
Executive Summary:	This paper supports the annual Responsible Officer (RO) report to the board. In normal times the trust makes a self-assessment return to NHSEI for the Annual Organisational Audit (AOA) in June. This is used to benchmark our processes and performance against other similar designated bodies. In March 2020 at the onset of the COVID-19 surge medical appraisal and all associated activities were paused. However in a recent update we were invited to make a submission to NHSEI at the end of September if we were in a position to do so. That submission is attached. The paper also presents some information about the progress that the trust has made with the processes that support medical appraisal and revalidation and highlights areas that require further improvement. It includes the feedback in the report from a Higher level RO visit that took place in March 2020.		
Recommendations:	That the Board is asked to approve the attached paper for submission to NHSEI and recommends that the CEO signs a statement of compliance.		
Supports			
Trust Strategic Objective:	Right care, right place, right time; Champion team St Georges		
CQC Theme:	Effectiveness and Well Lead		
Single Oversight Framework Theme:	Workforce support and development		
Implications			
Risk:	Failure to ensure high quality appraisal for our Doctors risks disengagement from the Trust.		
Legal/Regulatory:	Failure to respond to feedback and reach an appropriate level of compliance risks scrutiny by NHSEI. Medical appraisal compliance informs the well led domain of the CQC.		
Resources:	No new resources required.		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	The Responsible Officer has ensured that the Trust's medical revalidation and appraisal policies and procedures are in accordance with equality and diversity legislation through the application of an equality impact assessment.		
Appendices:	Appendix 1 – Annual Responsible Officer report to the Board Appendix 2 – Divisional appraisal compliance Feb 2020		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Responsible Officer report to the Trust Board

2020/21

Author: Karen Daly
Responsible Officer

24th September 2020

Purpose

- To present the annual RO report to the board
- To describe the context for the 2020 report
- To highlight progress against our action plan including the outputs of the higher level RO visit in March 2020
- To highlight areas requiring improvement

Background
COVID-19

- It is a regulatory and contractual requirement of Doctors that they participate in annual appraisal of the full scope of their practice.

- In normal years the designated report to the board would contain the results of the annual organisational audit submitted in the previous June. This enables benchmarking against other similar designated bodies. No audit was done in 2020.

March 2020

The CMO of NHSEI paused the requirement for appraisal and all associated activities

The GMC paused revalidation

September 2020

The CMO of NHSEI wrote to all Trusts inviting a submission at the end of September.

Proposed restarting appraisals from October and a less onerous process

Requirements for revalidation unchanged

Luckily we were prepared!

Compliance and reporting
Historical outcomes of AOA

- Connections increased from 699 (2014) to 899 (2019)
- Annual compliance increased from 63% to 85% (same period)
- In 2018/19 we were benchmarked 5% below the average for similar sized designated bodies
- No Annual Organisational audit for 2019/20 so no benchmark
- Monthly reporting to the PMG will restart in January 2021 having restarted appraisals in September
- Further improvements require divisional engagement and leadership

Progress
People

Support

The Revalidation Support Officer post has been appropriately rebanded

Additional resource is being recruited to provide more capacity in the team

Two (of three) appraisal leads have been appointed (Dec 2019)

A program of Quality Assurance has been started

The list of appraisers is being validated and those less engaged removed with consent

An appraiser support program is being planned

ROAG

- Responsible Officer (Chair)
- Chief Medical Officer
- University representative
- Postgraduate education representative
- Lay representation (TBA)

Quarterly meetings

- To improve the sharing of information relevant to revalidation
- To align the appraisal and revalidation processes in the interests of all parties
- To review the report from the AaRG
- To advise on the program of QA and audit
- Report to PMG

AaRG

- Responsible Officer
- Appraisal leads
- Revalidation support Officer
- Head of medical staffing

Monthly meetings

- review, triangulate and log appraisal inputs
  - SI reports
  - Complaints
  - Litigation
  - Audit outcomes
  - other concerns
- Agree requirements are met for pending revalidations
- Planning for QA and support
- Quarterly report to ROAG

- **Progress**
- **Systems and processes**

L2P

Our web-based appraisal and revalidation management system L2P is embedded and has met with universal approval

Alerts and updates are automated.

We can monitor compliance real time.

We can monitor appraiser activity and provide feedback for them

L2P have provided additional functions for us:

- Embedded links to conflict of interests declaration website
- Completion of MAST button to allow reporting

Potential adjustment for use with Physician Associates.

Management

Monthly reports are provided for the Divisions that highlight Doctors overdue appraisal

The ability for the RO to approving missed appraisals is improving

Moving to a system of allocating appraisers

Recovery

The CMO of NHSEI paused the requirement for appraisal and all associated activities – now restarted

- Some Doctors continued to submit appraisals throughout the pandemic response
- The RO is submitting revalidation recommendations for those who indicate they are ready
- We are focussing on those Doctors who were overdue appraisal at the onset of the pandemic

• External assurance
• Higher level Responsible Officer visit – March 2020

• Feedback

The Revalidation Support Officer has created effective and efficient processes to manage a high volume workload

The appraisal leads are engaged, knowledgeable and supportive of the RO

There are robust and effective systems in place to share data around complaints and concerns.

“

• The RO is engaged and forward thinking. The CMO champions appraisal and is supportive of the RO role.

- **Visit team**
- HLRO visit March 2020

- **External assurance**
- **Higher level responsible officer visit – March 2020**

- **Action plan**

- Review RO job description and policy to ensure there is clarity about deputy RO responsibilities

- Identify scope, process, timeline and tool for QA and feedback to appraisers

- Identify training needs from Quality review of appraisals and set up regular appraiser events

- Review appraiser list and establish process for allocation of appraisers

Appendices

Appendix 1

– Designated report to the Board and statement of compliance

Appendices

Appendix 2

– Divisional appraisal compliance February 2020

Designated Body Annual Board Report

Section 1 – General:

The board of St George's University Hospitals NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: N/A. Cancelled by NHS England and Improvement due to Covid-19.

Action from last year: Improve the overall % of completed appraisals, particularly in our non-Consultant groups. The Appraisal Leads will work with their divisions to support appraisal. Appraisal rate review is a part of the regular divisional performance review.

Comments: Two Divisional Appraisal Leads were appointed in January 2020. Appraisal was then put on hold from March due to Covid-19. The Trust is now reinstating appraisal, with those due from September onwards to continue as normal, and a plan for those due between March to August who were suspended, and individual plans for those who were overdue in March.

Action for next year: Carry forward from last year.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: No action from last year.

Comments: Ms Karen Daly completed RO training in November 2015 and commenced as RO in May 2016. The Trust has also appointed two Divisional Appraisal Leads who have undertaken the RO training in 2019 and 2020.

Action for next year: No action required.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year: Appoint Medical Appraisal Leads and provide training.

Comments: We have an electronic appraisal system in use and favorably reviewed by Appraises. The RO is supported by one WTE Revalidation Support Officer and two Divisional Medical Appraisal Leads who can deputise in her absence.

Action for next year: Appoint an additional Divisional Appraisal Lead and review if/what additional administration support is required. There will be a

restructuring of the medical staffing department that can provide additional administrative support for appraisal and revalidation.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: No action from last year.

Comments: The Revalidation Support Officer regularly cross references the GMC Connect database with new starter and leaver reports.

Action for next year: No action required.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: To review and publish the Medical Appraisal Policy.

Comments: The draft policy was reviewed as part of a routine Higher Level Responsible Officer Quality Review Visit (NHSEI) in March 2020, and amendments were suggested (see appendix B for the full report). This was put on hold due to Covid-19.

In the meantime, new starters are provided with guidance on medical appraisal and revalidation and Clinical Leads are updated via Medical Board and Care Group Lead Forums etc.

Action for next year: Finalise the policy and put forward for authorisation (end of September 2020) so the policy can be published/circulated asap after that. This is an item in the HLRO quality review visit action plan. (appendix C).

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Commission a peer review.

Comments: A peer review did not take place; however, the Trust took part in the Higher Level Responsible Officer Quality Review Visit (NHSEI) in March 2020.

Action for next year: No action required.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: No action from last year

Comments: All doctors with a prescribed connection are supported with appraisal and revalidation and have access to the same governance systems. On request, the Revalidation Support Officer will complete a medical practice information transfer form for those who work at St George's but are connected to another organisation i.e. for their annual appraisal.

Action for next year: No action required.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: The Appraisal and Revalidation Group will triangulate information about doctors from difference sources. Our appraisal leads will support appraisers to challenge supporting information (or lack of).

Comments: All doctors are required to declare their full scope of work in their appraisal and should include supporting information that is proportionate to that, including information from all organisations in which they work, of any complaints and significant events they have been named in (or that they have not been named).

Action for next year: Carry forward from last year.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Improve quality of appraisal inputs.

Comments: The Divisional Appraisal Leads will soon implement an enhanced quality assurance process which will lead to improvements to appraisal inputs in general. (Delayed by COVID-19)

Action for next year: Carry forward from last year.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Publish/circulate updated medical appraisal policy.

Comments: The draft policy was reviewed as part of a routine Higher Level Responsible Officer Quality Review Visit (NHSEI) in March 2020, and

amendments were suggested (see appendix X for the full report). This was put on hold due to Covid-19.

In the meantime, new starters are provided with guidance on medical appraisal and revalidation and Clinical Leads are updated via Medical Board and Care Group Lead Forums etc.

Action for next year: Finalise the policy and put forward for authorisation (end of September 2020) so the policy can be published/circulated asap after that. This is an item in the HLRO quality review visit action plan. (Appendix C).

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Rationalisation of appraiser group, removing those without sufficient activity.

Comments: The Trust has an adequate number of appraisers overall. However, there is no clear process for allocation of appraiser to doctor, as well as a lack of knowledge of the minimum number of appraisals an appraiser should carry out each year (5). There is limited resource in the administrative team to support this. Restructuring of the medical staffing team is anticipated to provide more resource.

Action for next year: Carry forward from last year. This is an item in the HLR quality review visit action plan (Appendix C).

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: Implement an enhanced quality assurance process and introduce appraiser forums.

Comments: The Divisional Appraisal Leads will support the quality assurance process and calibration events. The electronic appraisal system requests feedback from each doctor after their appraisal has been submitted. We need to include this in the quality assurance process and ensure any concerns are highlighted. We also need to provide this feedback annually to appraisers to be included within their own appraisal.

Action for next year: Carry forward from last year. This is an item in the HLRO quality review visit action plan (appendix C).

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The Appraisal and revalidation group provides a quarterly report to the People management group and through them to the workforce and education committee.

Comments: See above.

Action for next year: Carry forward from last year. This is an item in the HLRO quality review visit action plan.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Ensure recommendations are submitted on time and investigate reasons behind the high deferral rate.

Comments: The number of revalidation recommendations between April 2019 and March 2020 totaled 281.

The majority of these were submitted on time. 1 was submitted late as the doctor connected after their submission date. 4 were submitted late due to admin error i.e. submission date was on a weekend. This has not been an issue since the introduction of the Divisional Appraisal Leads, who are available to deputise in making recommendations. The RO has also introduced a process for reviewing portfolios in the month ahead of the submission date.

The number of recommendations to revalidate totaled 204 and the number of recommendations to defer totaled 77. There were no recommendations of non-engagement.

The appraisal and revalidation group is reviewing portfolios two months ahead of the due date moving to three months.

The GMC have automatically deferred all doctors 'revalidation dates by 12 months, if they were due between March 2020 and March 2021. These doctors are currently under notice, so a recommendation can be made any time now until their submission date, if they are revalidation ready.

Action for next year: Revalidation portfolios to be reviewed in good time ahead of the doctor's submission date.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: No action from last year.

Comments: The Revalidation Support Officer will inform each doctor of what recommendation has been submitted. In most cases where a deferral is necessary, the Revalidation Support Officer will communicate this to the doctor beforehand. Either way, the doctors will be given a clear action plan and timeframe to achieve by the next due date. The RO contacts the doctor directly in cases where they are deferred because they are subject to an ongoing process.

Action for next year: No action required.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: An external report in April 2019 highlighted some inconsistencies in process and conduct of our systems for Clinical Governance. There is a clear action plan arising which is to be implemented in the coming year.

Comments: There is continuing work, delayed slightly by the COVID-19 pandemic to improve the quality and the outputs of our governance processes at every level of the organisation. This entails increase in resource to support clinical governance and work to improve consistency of our mortality monitoring and response to adverse events.

Action for next year: to outline the actions and the impacts of the improvements in clinical governance in the Board paper.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: The Appraisal and Revalidation group will develop processes to improve the quantity and quality of information available to Doctors as inputs for their appraisals.

Comments: The electronic appraisal system enables incidents and significant events known to be logged on the appraisal page for inclusion in the next appraisal. Significant events are now being logged directly to appraisals and we will implement a similar process for complaints. In the

meantime, Doctors can contact the Revalidation Support Officer if they would like confirmation that they have/have not been named in any complaints.

Action for next year: Implement process to log complaints, early litigation cases and other information directly to appraisal portfolios.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Share the purpose of the RtC more widely and encourage escalation for benchmarking purposes.

Comments: The Responding to Concerns meeting takes place weekly and considers all concerns raised internally and externally. The Divisions are encouraged to submit concerns to the group for discussion and for the purpose of assuring a consistent approach across the Trust. The group agrees proportionate approach which may range from an informal local process to an MHPS investigation. We ensure that appropriate support including Occupational Health and staff support is available for all Doctors in difficulty.

Action for next year: a review of the cases considered at responding to concerns for the purpose of learning and improvement.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: Our MHPS policy is undergoing external review and there will be a formal review of all historic cases for the purpose of improving our processes.

Comments: Significant concerns about Medical Staff at St George's are managed under the Maintaining High Professional Standards policy the disciplinary policy for Medical and Dental Staff. In addition to this policy, there is a weekly Responding to concerns meeting attended by the Chief Medical Officer, the Director of HR, Responsible Officer, Medical HR Manager and Divisional HR Manager (where appropriate) whereby all cases

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

are reviewed and those in a formal process are monitored to ensure sufficient progress. The RO meets regularly with Liaison Officers from the GMC and PPAS. The progress of MHPS cases is reported to Trust Board.

Action for next year: A further review of our MHPS cases for the purpose of learning and improvement.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: No action from last year.

Comments: Where doctor works for multi-organisations, information of note is transferred from RO to RO using a MPIT form.

Action for next year: No action required.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Our MHPS policy is undergoing external review and there will be a formal review of all historic cases for the purpose of improving our processes.

Comments: All MHPS investigation are included in an anonymized report through the people management group to the Workforce and education committee and the board. The demographics of the cases are scrutinized for the purpose of monitoring diversity.

Action for next year: A further review of our MHPS cases for the purpose of learning and improvement.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: No action from last year.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: The Medical Staffing Team carry out the 6 NHS Employment Check Standards that outline the type and level of checks employers must carry out before recruiting staff into NHS positions.

Action for next year: No action required.

Section 6 – Summary of comments, and overall conclusion

General review of last year's actions

- Several actions have been delayed, largely due to Covid-19. They will be carried forward for the next year.
- Two Divisional Appraisal Leads have commenced in role and have begun to support the RO in developing processes
- The Trust had a Quality Review Visit from the Higher Level Responsible Officer team, which replaced the requirement for a peer review.

Actions still outstanding

- Improve the overall % of completed appraisals, particularly in our non-Consultant groups. The Appraisal Leads will work with their divisions to support appraisal. Appraisal rate review is a part of the regular divisional performance review.
- To review and publish the Medical Appraisal Policy.
- Divisional Appraisal Leads to support appraisers to challenge supporting information (or lack of).
- Improve quality of appraisal inputs.
- Rationalisation of appraiser group, removing those without sufficient activity.
- Implement an enhanced quality assurance process and introduce appraiser forums.

New Actions:

- Need to recruit an additional Divisional Appraisal Lead.
- Review if/what additional administration support is required.
- Improve quality of appraisal outputs.
- Revalidation portfolios to be reviewed in good time ahead of the doctor's submission date.
- Implement process to log complaints directly to appraisal.
- Summary review of improvements in clinical governance
- New review of RtC cases and MHPS

Overall conclusion:

The RO has appointed 2/3 Divisional Appraisal Leads. We would like to appoint an additional Divisional Appraisal Lead. We look forward to finalising the Medical Appraisal Policy and working with the Divisions to achieve higher appraisal rates, as well as improving the quality of appraisal.

Section 7 – Statement of Compliance: Not applicable in 2020

The Board of St George's University Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Official name of designated body: St George's University Hospitals NHS Foundation Trust.

Name: _ _ _ _ _ _ _ _ _ _ _ *Signed: _ _ _ _ _ _ _ _ _ _ _*

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Appendix D: Cumulative compliance with annual medical appraisal shown by Division and grade

These figures are impacted by the timing of the appraisal submission as well as completion of the appraisal documentation. For instance, if the appraisal is due in February and the meeting is held in February but the documentation is not submitted until March (the appraiser has 28 days to submit) that person will show as non compliant in the monthly report. The annual report is produced in June for the year ending in March so is a more accurate representation of the appraisals held on time. A similar report to this is produced for the Divisions each month.

	Number of Doctors	Number with in date appraisal	% compliance
Children and Women's Diagnostic and Therapy Services Division	237	185	78.06%
Consultant (incl Locum Consultant and SGUL)	164	130	79.27%
SAS	2	2	100.00%
Clinical Fellow	60	44	73.33%
Clinical Research Fellow (SGUL)	2	2	100.00%
Bank/Honorary	9	7	77.78%
Corporate Division	4	3	75.00%
Consultant (incl Locum Consultant and SGUL)	3	2	66.67%
Bank/Honorary	1	1	100.00%
Medicine and Cardiovascular Division	305	248	81.31%
Consultant (incl Locum Consultant and SGUL)	204	169	82.84%
SAS	7	6	85.71%
Clinical Fellow	60	47	78.33%
Clinical Research Fellow (SGUL)	1	1	100.00%
Bank/Honorary	32	25	78.13%
Surgery & Neurosciences Division	314	267	85.03%
Consultant (incl Locum Consultant and SGUL)	236	207	87.71%
SAS	2	2	100.00%
Clinical Fellow	67	50	74.63%
Bank/Honorary	9	8	88.89%
SWL Pathology	24	19	79.17%
Consultant (incl Locum Consultant and SGUL)	24	19	79.17%
TOTALS	**884**	**722**	81.67%

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NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	24 September 2020	**Agenda No**	2.6.2
Report Title:	Nursing and Midwifery Professional Registration		
Lead Director/ Manager:	Robert Bleasdale - Chief Nurse & Director of Infection Prevention and Control		
Report Author:	Sharon Suggett, Head of Nursing – Workforce and Professional Standards		
Presented for:	Assurance		
Executive Summary:	The purpose of this report is to provide assurance to the Board that St George's Hospitals has governance mechanism and process in place for monitoring the professional registrations of nurses; nursing associates and midwives on the Nursing and Midwifery Council (NMC). The NMC introduced a new process of revalidation in April 2016. Every registrant must complete the revalidation process every three years and pay an annual retention fee in order to remain on the NMC register. The purpose of revalidation is to improve public protection by making sure that all registrants (nursing associates; midwives and registered nurses) remain fit to practice throughout their career. Nurses, nursing associates and midwives must fulfil the requirements of revalidation to maintain their NMC registration Individuals are responsible for ensuring that they maintain their registration for each statement of entry relating to each part of the NMC register, including recordable entries, in line with the requirements for the role for which they are employed. The Workforce Information team on a monthly basis, access the on-line registration checking system of the professional body (NMC) to verify that the employee has renewed their registration, and a new expiry date is inputted on ESR. The team run a set of reports each month that checks all employees who have an expiring registration that have not yet been renewed. All of the reports are sent to the relevant HR advisor advising on the employees who have not renewed their professional registration. The HR Advisors or HR Managers liaise with the line manager of the employees whose registration is expiring, advising them of the employees who have not renewed their registration The Trust is alerted by the NMC in the event of a practitioner's registration having lapsed. Staffs with expired professional registration are required to cease working until confirmation of valid registration has been received. Failure to maintain registration or revalidate correctly could result in disciplinary or capability action being taken. This could include suspension without pay and/or dismissal for gross misconduct depending on the circumstances. In accordance with the appropriate		

procedure, a senior manager will decide on the appropriate course of action.

A report is produced of all non-contracted bank staff registrations that will expire at the end of each month. If bank staff have not completed registration by the expiry date, the individual will be made 'inactive' on the Bank Staff system and barred from working until this has been updated on the NMC on line system.

As a result of the COVID-19 response, the NMC has automatically extended revalidation application dates by 12 weeks for anyone who was due to revalidate in March, April, May and June 2020. Registrants can also request a further extended deadline if required (confirmed as acceptable in writing by the NMC). For staff who failed to complete registration within the first initial 12 weeks extension, the NMC has also automatically extended another 12 weeks (see table below for staff registration extension)

Number of Registrants with extended registration date during COVID-19 (remain live on the register);

Original Registration Date	New COVID-19 Extended Registration Date	No of registrants
30/04/2020	30/10/2020	6
31/05/2020	31/08/2020	0
30/06/2020	30/09/2020	10
31/07/2020	31/10/2020	12

There are no nursing, registered NA and midwifery staff that have an expired professional registration at the time of writing this report.

The Corporate Nursing team holds bi-weekly 'Professional Standards Meeting' with Divisional Directors of Nursing; the Director of Midwifery and Human Resources to monitor cases involving professional registration/ revalidation; capability; disciplinary and all NMC referral cases.

The HR Workforce Information Team have now been instructed to maintain monthly information on revalidation and NMC pin expiry as this information currently gets overridden as the system is updated. This will allow the provisions of monthly reporting for the Corporate Nursing team.

Recommendation:	The Board is asked to receive and note the report.
Supports	
Trust Strategic Objective:	Treat the patient, Treat the person Build a better St George's

CQC Theme:	Safe, Well-led, Responsive, Caring, Effective		
Single Oversight Framework Theme:			
Previously Considered by:	Workforce and Education Committee	**Date**	13/08/20
Appendices:			

Nursing and Midwifery Professional Registration

1. Introduction

The Nursing and Midwifery Council (NMC) introduced a new process of revalidation in April 2016. Every registrant must complete the revalidation process every three years and pay for the annual retention fee every year in order to remain on the NMC register. The purpose of revalidation is to improve public protection by making sure that all registrants (nursing associates; midwives and registered nurses) remain fit to practice throughout their career. Revalidation builds on existing renewal requirements by introducing new elements which encourage nurses, nursing associates and midwives to reflect on the role of the Code in their practice and demonstrate that they are 'living' the standards set out within it.

Nurses, nursing associates and midwives must fulfil the requirements of revalidation to maintain their NMC registration. Revalidation:

- reinforces the registrant's duty to maintain fitness to practice within their own scope of practice
- encourages registrants to incorporate 'the Code' in day-to-day practice and personal development
- encourages engagement in professional networks and discussions and can help to reduce professional isolation
- enhances employer engagement in NMC regulatory standards and increases access and participation in appraisals and continuing professional development.

2. Revalidation Requirements

All registrants are notified directly by the NMC (with three months-notice) of when the revalidation is due. During the revalidation process, all registrants must;

- obtain five pieces of practice related feedback
- provide five written reflections
- complete 35 hours of continuous professional development (CPD) – including 20 hours of participatory CPD
- undertake a reflective discussion with another NMC registrant
- obtain confirmation that revalidation requirements have been met from an appropriate person
- complete 900 hours of practice (nurse and midwife)
- pay the annual NMC registration fee
- provide a declaration of health and character
- provide proof of professional indemnity

3. Trust Monitoring of Revalidation Compliance

Individuals are responsible for ensuring that they maintain their registration for each statement of entry relating to each part of the NMC register, including recordable entries, in line with the requirements for the role for which they are employed.

The Workforce Information team access the on-line registration checking system of the professional body (NMC) each month to verify that the employee has renewed their registration, and a new expiry date is inputted on ESR.

All of the reports are sent to the relevant HR Advisor and reports 3 and 4 (as per below) are also be sent to the HR Managers advising on the employees who have not renewed their professional registration. The HR Advisors or HR Managers liaise with the line manager of the employees whose registration is expiring, advising them of the employees who have not renewed their registration.

The Trust Workforce Information team run a set of reports each month that check all employees who have an expiring registration that have not yet been renewed. A total of five reports are automatically run during the month at the following times:

Report 1: 20th of each month or previous working day
Report 2: 3 working days before month end
Report 3: Last working day of month
Report 4: 1 working day after month end
Report 5: 2 working days after month end.

An electronic copy of this report will be saved going forward in the Workforce Information folder: J:\Files\Workforce Information\ESR\ESR Reports\Monthly Monitoring\Evidence. This will allow the Workforce Information team and Corporate Nursing teams to report on the numbers of staff whose registration lapses in year.

4. Failure to maintain NMC registration

The Trust is alerted by the NMC in the event of a practitioner's registration having lapsed.

The Workforce Information team inform the relevant HR Advisor and the practitioner is required to cease working until confirmation of valid registration has been received.

If there is a legitimate reason for an employee's professional registration not being renewed, this will be conveyed back to the Workforce Information team where a central record of the reasons will be kept for each month.

The member of staff will remain on annual or unpaid leave until registration has been updated. Failure to maintain registration or revalidate correctly could result in disciplinary or capability action being taken. This could include suspension without pay and/or dismissal for gross misconduct depending on the circumstances. In accordance with the appropriate procedure, a senior manager will decide on the appropriate course of action.

If an individual fails to meet the requirements of their professional body to re-register or revalidate at the required time for all relevant parts of the register required, they will not be eligible for continued employment as a registered practitioner. In addition, they will not be protected by either their professional indemnity insurance or the Trust's Public Liability insurance. They will not be allowed to work as a registered nurse, nursing associate or midwife until this is

rectified. They will be placed upon unpaid suspension until their registration is renewed. Their salary will be affected as they will not receive pay during this time. Staff knowingly working without registration are in breach of their contract of employment of the trust and this will lead to disciplinary action.

Where a nurse, nursing associate or midwife is unable to fulfil the requirements of revalidation because of capability issues then the Trust's Capability Procedure should be used to manage the situation. It is recommended that because of the seriousness of failure to revalidate, that the Capability Procedure should be activated at Stage 2 or 3. Under no circumstances can a nurse, nursing associate or midwife work if they are not registered and failure to revalidate could cause a nurse, nursing associate or midwife to lose their registration. The Trust would view the individual as being in breach of their contract of employment. All patient contact must stop immediately and any appointments reallocated.

Ultimate responsibility for this lies with the Divisional Directors of Nursing & Governance (DDNGs) and Director of Midwifery. In the event that no action has been taken by the relevant line manager or Head of Nursing, the DDNG must be notified by the HR Manager and a decision made about suspension and next steps. Any breach must be brought to the attention of the Chief/Deputy Chief Nurse as soon as possible, as it is illegal to allow a nurse, nursing associate or midwife to work without all relevant registration and line managers will be held to account for any actions and omissions in this regard.

Bank Registered Staff

A report is produced of all non-contracted bank staff registrations that will expire at the end of the month. The Bank Administrative Assistant accesses the NMC online system to check on re-registration, a copy of the verification is then placed in the individuals file. A further check is made prior to the expiry date of registration. If the individual has not re-registered by the expiry date, the individual will be made 'inactive' on the Bank Staff system and barred from working until this has been updated on the NMC on line system. This is reported to the Staff Bank Manager who will liaise with individuals who have not re-registered.

Health Roster

All staff employed at St Georges, including those who work through the bank have a position created within the Healthroster. Within each staff profile the individual NMC registration date is displayed. When a roster is created a warning appears against the individual shift and staff member if their registration has expired. For permanent staff this allows a further opportunity for the staff member and line manager to be notified in advance to ensure the individuals registration is renewed on time. Should this not be the case the warning remains on the shift to alert the ward and department manager. For bank staff, the staff member cannot be booked into shifts if their NMC registration is displayed as expired or future shifts after the revalidation date unless revalidation has been completed and been updated on the central ESR.

5. Current Revalidation position

NMC COVID-19 Temporary Register
The emergency legislation introduced by the Government allows for the temporary registration of fit, and suitably experienced professionals to practice and support the COVID-19 emergency situation.

These professionals include;
- Nurses and midwives who left the NMC register within the last 3-5 years
- Overseas applicants (nurses and midwives) who have completed all parts of the NMC registration process except for the OSCE (24 staff in the trust currently)

The NMC considers each application and has confirmed with each individual if they have met this criteria. These staff have then been entered on the NMC temporary register to allow them to work within the health service. For staff returning to practice this has been coordinated through a national campaign and regional office, for deployment to St Georges. In respect of overseas nurses, this has been overseen through the corporate nursing team. The temporary register will remain live until the Secretary of State confirms that the emergency situation has ended. In this time the Corporate Nursing team will continue to support the overseas nurses complete their OSCE to allow full entry into the NMC permanent register.

COVID-19 extension by NMC
As a result of the COVID-19 response, the NMC has automatically extended revalidation application dates by 12 weeks for anyone who was due to revalidate in March, April, May and June 2020. Registrants can also request a further extended deadline if required (confirmed as acceptable in writing by the NMC). For staff who failed to complete registration within the first initial 12 weeks extension, the NMC has also automatically extended another 12 weeks (see table for staff registration extension)

Number of Registrants with extended registration date during COVID-19 (remain live on the register);

Original Registration Date	New COVID-19 Extended Registration Date	No of registrants
30/04/2020	30/10/2020	6
31/05/2020	31/08/2020	0
30/06/2020	30/09/2020	10
31/07/2020	31/10/2020	12

Professional Standards Meeting
The Chief Nurse and corporate nursing team now holds a bi-weekly 'Professional Standards Meeting' with Divisional Directors of Nursing; the Director of Midwifery; Chief AHP and Human Resources to monitor cases involving professional registration/ revalidation; capability; disciplinary and all NMC referral cases.

Bimonthly meetings are held with the NMC to ensure that the relevant action has been taken on a case by case basis; to determine how the case is progressing and if there is further information that the NMC require to progress the cases.

Relevant Trust Policy
The Trust policy for the 'Registration of Nursing, Nursing Associates and Midwifery Staff and Referral process' available on the intranet, clearly states the information and directives set out in this report.

6. Future Actions

The HR Workforce Information Team has now been instructed to maintain monthly information on revalidation and NMC pin expiry as this information currently gets overridden as the system is updated. This will allow the provisions of monthly reporting for the Corporate Nursing team of staff who have failed to revalidate on time. This will allow future reports to provide details of the numbers of staff failing to revalidate on time, and by division, although on discussion with workforce information and DDNG this number is small.

The professional standards meeting also includes the Chief Therapist and future reports will also include allied health professionals registered with the Health and Care Professions Council (HCPC).

Meeting Title:	Trust Board		
Date:	24 September 2020	**Agenda No**	3.1.2
Report Title:	Mental Capacity Act and Deprivation of Liberty – Annual Report (2019-20)		
Lead Director/ Manager:	Robert Bleasdale – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	James Godber, MCA and DoLS Lead Practitioner		
Presented for:	Assurance		
Executive Summary:	The report highlights some of the key achievements of, and areas of challenge relating to effective application of the Mental Capacity Act (MCA) across The Trust. Good practice in this area protects human rights and champions patient centred care. The CQC findings relating to the MCA in their 2019 inspection report represented a considerable improvement on their feedback from 2016, but there remains a substantial amount of work to do. There were 361 MCA / DoLS related referrals in 2019/20, a 7% increase on the previous year (with last 2018-19 seeing a 45% increase in referrals on the 2017-18) resulting in 173 applications to the local authority. Supporting teams, patients and family members with often complex issues relating to the MCA and DoLS remains the main body of work covered by the team and the complexity of the caseload is increasing as staff awareness and baseline knowledge grows. Patient facing staff working with adults remain auto – enrolled on high quality, scenario based training and rates of compliance are high, with face-to-face training also provided on demand to a variety of areas. Last year's annual report highlighted need for increased audit and assurance tools around staff knowledge and practice in relation the MCA and DoLS. In response a South West London MCA Healthcare Group was set up to pool expertise and develop resources. Within The Trust itself, the MCA team completed a scoping audit in a 'high risk 'area looking at application of the MCA and recognition and response to possible deprivations of liberty that may be occurring. Findings from this are discussed within the report but themes of under- referral and reduced recognition of patients that meet the criteria for a deprivation of liberty point at more work to do. Resource development during 2019-20 focused on: leading group work on the design and development of standardised electronic documentation templates covering capacity assessment and best interest's decisions; supporting policy development in other areas by providing consistent and accurate information about the MCA when and where it impacts other areas of practice; and working with local teams to develop guidance on the use of the MCA that is tailored to their specific needs. An additional post holder (fixed term) was recruited for part of the period covered by this report to try and meet the increased demand for clinical support relating to the MCA. 2019-20 also led to a successful case being made to		

	change and augment the team structure on a substantive basis, towards the end of the reporting year. Looking ahead, the delay in changes to the DoLS scheme (that will bring substantial training, resource and logistics challenges to NHS Trusts) provides a much needed breathing space to a small team in growing demand. It also provides a window of opportunity to further develop knowledge, practice and assurance in relation to the MCA in a thought through, and sustainable way, with the aim of augmenting the impact small central MCA team resource by developing local expertise, systems and resources. Key elements in building this wider resource include completing development, launch and maintenance of a Champions / advanced practice training programme, launching regular programmes of MCA and related audit of staff knowledge, improving 24/7 resources and guidance on the MCA and re-establishing the Trust wide MCA steering group and strategy to ensure divisional guidance, needs analysis, support and buy in to this area of The Trusts work. The challenge will be to protect the resource to deliver these projects, in a timely way, in the face of on-going increase to the number and complexity of operational demands for clinical support.		
Recommendation:	The Trust Board is asked to receive and discuss this report and raise any concerns in terms of further assurance required.		
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:			
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.		
Equality and Diversity:	There are no equality and diversity impact related to the matters outlined in the report.		
Previously Considered by:	Quality and Safety Committee	**Date:**	20 August 2020
Appendices:	Nil		

MCA and DoLS Annual Report 2019-20

1.0 Introduction:

The Mental Capacity Act 2005 (MCA) derives from Human Rights legislation and provides a statutory framework to empower and protect people of 16 years and above who may not be able to make their own decisions and details when and how decisions can be legally and proportionately made on behalf of others. It also enables people to plan ahead and protect their approach to decision making in case they lose capacity in the future.

Deprivation of Liberty Safeguards (DoLS) is an amendment to the MCA that provides a system of legal safeguards covering the patient and the relevant organisation if someone who lacks capacity is being 'kept' in a particular setting in their best interests for the purposes of delivering care or treatment.

Organisations that embed the MCA into all aspects of routine practice are far more likely to keep the people they care for at the very centre of decisions that affect them. Given that The Act sets out powers, duties and responsibilities at a legislative level, there are also serious personal and organisation risks of not applying the MCA correctly when delivering care.

St George's University Hospitals began to resource an MCA practitioner role in mid-2016. At this time, the CQC inspection report rated St George's as Inadequate and a section 29A Warning Notice was issued by the regulator partly on the basis of poor practice in relation to the MCA. Over the four years that have followed, work towards key aims and objectives relating to training, audit and resource development have been on-going.

During this reporting year, a follow up CQC Inspection provided no negative feedback on the MCA itself on this occasion, and highlighted improvements (see fig 1.1 overleaf) in staff knowledge of the MCA. The regulator also provided feedback on problems with the related

area of consent illustrating the broad scope of person centred practice. Whilst the CQC feedback was a welcome step forward, there are no illusions about the on-going work required. Developing good practice around the MCA continues to be recognised as a long term, broad scope programme of behavioural change, involving multiple stakeholders. This report details progress and challenges in this area of work during 2019-20.

Fig 1.1 Side by side comparison of 2016 and 2019 CQC reports on Capacity (including feedback on related area of consent).

2016 CQC Inspection Report		2019 CQC Inspection Report	
Positive Feedback	Negative feedback	Positive Feedback	Negative feedback
No Positive Feedback	There was a lack of formal mental capacity assessments and best interest decision making as required under the Mental Capacity Act, 2005 and some patients had decisions made for them that they were capable making themselves.[1]	Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limited patients' liberty.	Staff did not always record consent in patients' records. We saw some examples … of forms not completed in full and inconsistent recording which meant staff were not sure correct consent for treatment had been obtained.[2]
	On some medical wards, bed rails to prevent falling out of bed and mittens to prevent pulling out of nasogastric tubes, were used on patients, who had not given their consent, nor had mental capacity assessments.	Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.	

[1] Section 29A Warning Notice issued following this (and an unrelated estates issue).
[2] Leading to recommendation – make sure consent is correctly recorded in patients notes in line with best practice.

2.0 Governance and Structure:

The reporting year was a time of change for the MCA team. The year started with a sole Band 7 MCA Practitioner. Following 45% increased referrals in 2018/19 compared with 2017/18 , NHS Improvement money was used to recruit a fixed term full time (secondment based) MCA Support Practitioner (Band 6), in June 2020 with workload split 80% Safeguarding and 20% MCA. Recruitment for a full time additional MCA Practitioner (Band 7 secondment) resulted in one applicant who was offered the post but was only able to work part time basis (21 hours per week). These augmentations to the team (which were extended until the end of the reporting year) were most welcome. The aim of releasing 50% of the substantive MCA Practitioners time to focus on strategic / Development work was not substantially realised though as:

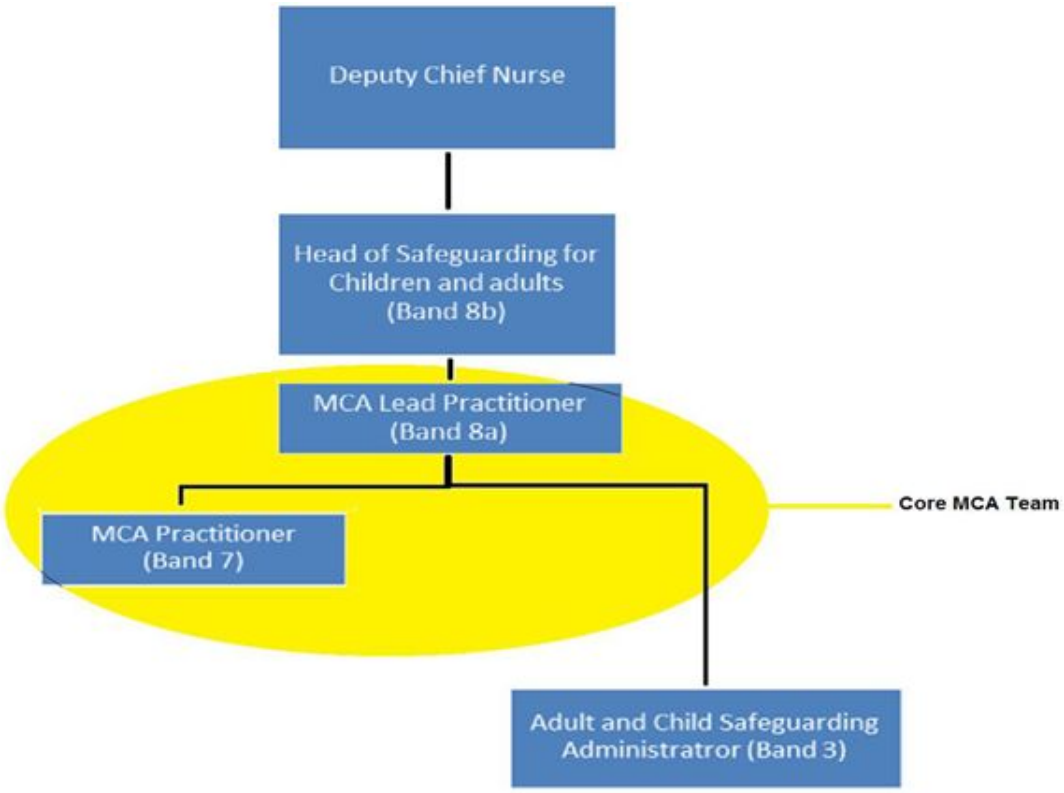
- Both (short-term) roles required development time and resources due to the complex nature of the caseload and the fact that neither of the successful candidates had a background in Safeguarding.

- The ability to release 50% of the substantive MCA Practitioners time was based on the B7 secondment being full time, rather than the 0.55 WTE achieved.

Given these factors, whilst these temporary changes allowed the MCA team to meet increased operational demands, it became clear that a more secure, and longer term full time resource was required to build on the steps already taken in developing trust wide practice, support and assurance around the MCA. A business case supported by the Deputy Chief Nurse the team structure was therefore developed resulting in the full time B7 MCA Practitioner being recruited to a B8 MCA Lead Practitioner role in February 2020 (and reporting to Head of Safeguarding rather than lead nurse for adult Safeguarding as a result of this change). This left the B7 MCA Practitioner role vacant (though it was later filled, in May 2020, by the B6 MCA support practitioner, leaving that post vacant).

As a result of this period of change, from the May (2020) following the reporting year the structure of the MCA team was as depicted overleaf in fig 1.2:

Fig 1.2 MCA Core team and reporting structures from February 2020



The MCA made up one of the Trust Quality Priorities for 2019/20 and was underpinned by an MCA strategy plan and steering group which aims to meet every two months to drive and support locally relevant aspects of the MCA agenda across divisions and clinical groups. The performance and activity of the MCA team is also monitored through the Trust Safeguarding Committee which is scheduled to meet every 2 months and includes representation from the Adult Safeguarding Lead from the CCG.

Organisational resources supporting good governance around the MCA include direct support from MCA team members, The Mental Capacity Act and DoLS Policy and The Restrictions and Restraints Policy, alongside a number of intranet, IClip and bespoke tools for staff to use operationally to work through complex cases. Other members of the Child and Adult Safeguarding team, the Trust's legal, liaison psychiatry and discharge teams also provide invaluable support in responding to complex cases effectively.

Nationally, key guidance and governance sources relating to the MCA include: The Mental Capacity Act and Deprivation of Liberty Safeguards codes of Practice (both currently being revised); NICE guidance on Supported Decision Making and Mental Capacity; The Care Act and, for practice relating to 16 and 17 year olds, The Children's Act. CQC guidance on Best Practice in relation to the MCA and DOLS also provides a framework against which some aspects of practice can be reviewed.

Challenge and Areas for Development:

Whilst the reporting structures around the MCA have developed, the consistency and frequency and review of strategic level processes and structures to enable Trust wide buy in to, and support for, embedding the MCA and providing effective governance still require improvement. The MCA steering group, for example, has not convened since July 2019. Factors that influenced this pause included the demands placed on all stakeholders in the run up to the repeat CQC inspection in November 2019 and the impact of Winter pressures. Unfortunately, the COVID 19 pandemic extended the hiatus into the current year but the steering group is scheduled to restart in November 2020.

Key Next steps:

The creation of the MCA lead role and retention of full time substantive MCA Practitioner role provides a larger resource to drive strategic and governance aspects of this area of practice. The aim in the current financial year is to review and relaunch the MCA strategy and re-convene a regular and divisionally supported MCA steering group from November 2020. To respond to the competing challenge posed by increasing operational demand for clinical support from a small central MCA Team, it is hoped that divisional engagement with the MCA agenda, including support for the development of local MCA Champions (that will have education, audit and reporting functions) will support improved knowledge, practice and reporting in relation to the MCA Trust-wide.

3.0 MCA Training

3.1 Mandatory and statutory training programmes specifically covering the MCA and DoLS

Following the launch of two e-learning packages in 2018 covering essential and intermediate Practice around the MCA and DOLS , patient facing staff working with adults and children over 16 years of age continue to be auto- enrolled onto high quality training that they should complete as part of their mandatory and statutory training requirements.

3.2 Face to Face Training:

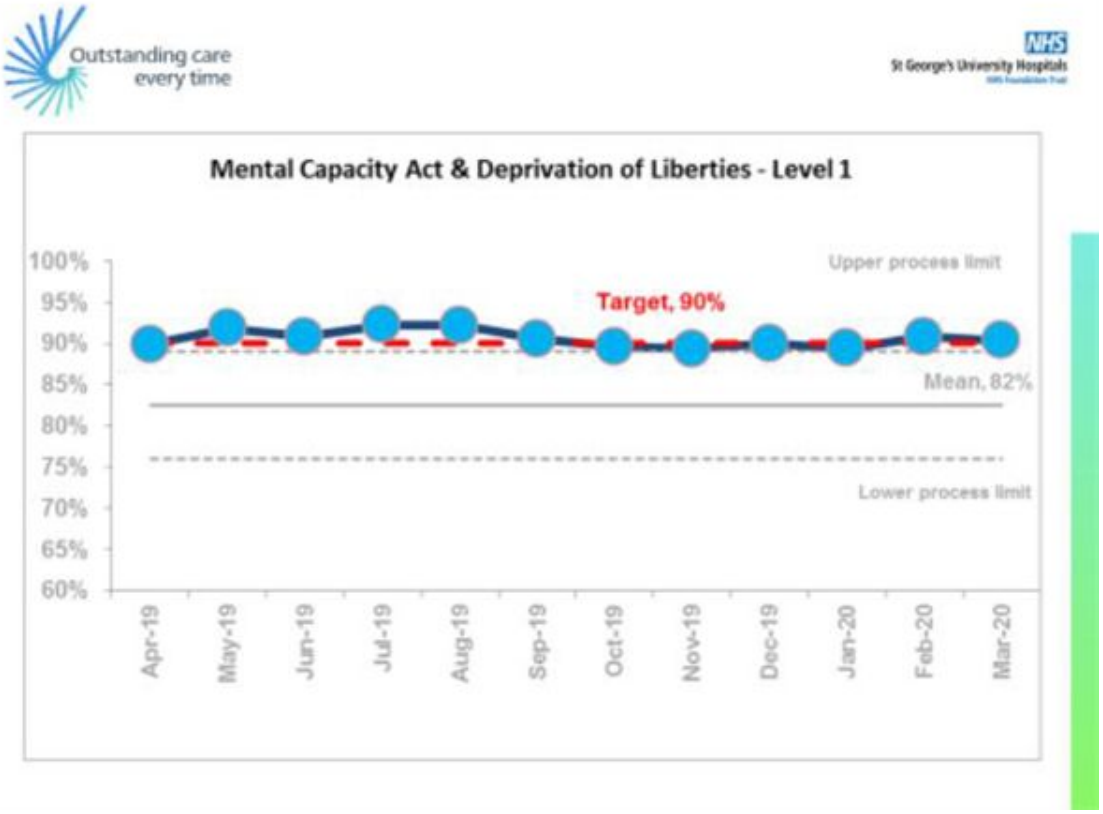
Face to face training also continued with approximately 75 face to sessions delivered over the 2019/20 financial year, to an estimated 600 staff. These sessions were typically delivered to Key areas where additional needs are identified; on request of Practice Educators or other Clinical educational co-ordinators; or to 'difficult to reach' groups. Examples include training delivered to Porter's at George's staff due to the difficulty that staff group had accessing e-learning; training provided to Postgraduate medical trainees working at St George's; sessions for medical and nursing staff rotating through the emergency department; HCAs on the Foundations of Psychological Care Course; therapists working in areas where patients with dementia and neurological disturbance is prevalent; and bespoke training for the non – executive Directors at The Trust.

3.3 Headline Training Figures:

The level of compliance for Level 1 and Level 2 training has plateaued since the introduction of the modules in 2018.

For Level 1 training, training compliance has typically met or exceeded the target of 90%, across the year as a whole (see fig 1.3, overleaf for reference).

Fig 1.3 MCA E –learning Level 1 (Essentials) training compliance 2019-20

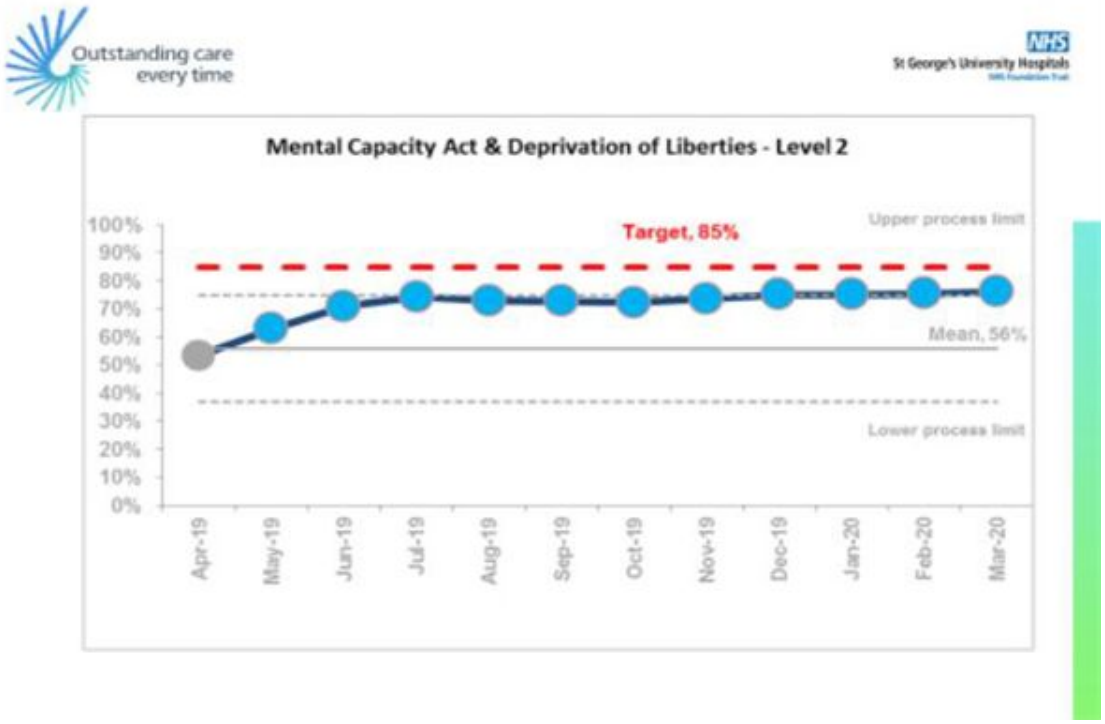


Compliance for Level 2 MCA /DoLS training (intermediate rose from April to July 2020 and has plateaued at approximately 75%, against a target of 90% (see fig 1.4, overleaf, for reference).

For context, at the time of writing current level of compliance for the 3 largest staff groups trained at Level 2 stands as follows:

- Allied Health Professionals 91% (325/329 staff)
- Nursing and Midwifery: 89% (1079 / 1216 staff)
- Medical and Dental: 61% ((568 /988 staff)

Fig 1.4 MCA E –learning Level 2 (Intermediate) training compliance 2019-20



MCA Team Training:

In order to continue to provide up to date and accurate information guidance and clinical support in relation to the MCA and DoLS, the MCA team members maintain an overview of relevant case law and expert commentary in relation to the MCA and DOLS. They also attend externally provided training (often provided by legal firms) covering topics such as the relationship between capacity and consent and the interface between the Mental Health Act and the Mental Capacity Act. Finally, the MCA team members undertake CPD relating to maintenance of their professional registration (current members are an SLT and a nurse by background) to ensure their clinical skills that support their own practice are maintained. This also enables the MCA team to maintain an understanding of the challenges faced by clinicians 'on the ground' and conditioning advice and guidance to be relevant, realistic and applicable as possible to staff working in a busy environment with competing priorities and drivers.

Challenges and Areas for Development

An advanced level of training was due to be developed for the reporting year, but resources have not been sufficient to achieve this in the context of growing and competing operational pressures.

Staff enrolled on e-learning will need to refresh their competencies from 2021. The comprehensive and immersive e-learning modules were created to fill a significant gap in knowledge and practice and could not be circumvented by completing a quiz or similar. This may need reviewing when staff refresh their knowledge, and a balance achieved between demands on staff time / some signs of improving knowledge in relation to the MCA, and a need to guard against simply ticking the box that suggests an ongoing level of competency in what remains a complex and often misunderstood area of practice.

Feedback on e-learning and face to face training is not routinely collected, so whilst there is regular positive unsolicited feedback on face to face sessions, this aspect of feedback and training development could be improved.

Key Next Steps:

The MCA team aim to build on scoping work done during the reporting year to begin a Champions Programme targeting good practice around supportive decision-making, the MCA and DoLS. As part of their role, and with the support of Face to Face training and access to online resources part of their remit would include providing top up training in response to identified needs, or for hard to reach groups. It is also hoped that their very presence as a locally available resource will augment the knowledge and practice of the teams they work with.

4.0 MCA Audit

4.1 Background Context and Summary of Work

Effective and clinically meaningful audit of the Mental Capacity Act is a challenging and resource intensive task. The MCA and DOLS codes of Practice and NICE Guidelines provide a huge pool of information relating to best practice but the narrative and broad nature of legislative based guidance, and its constant evolution via case law, does not blend itself well to neat, binary or quantitate measurement by delegated local assessors[3].

Previous attempts to work with teams to qualitatively review the process of episodes of care, in a way that covers screening for use of the MCA, and attempts to measure the quality and accuracy of work done, have been previously trialled but were not sustainable. Ultimately, this approach was labour intensive, lacked buy-in from busy teams and required bespoke training to support correct administration of questions that can easily be misjudged or misinterpreted, depending on the knowledge & experience of the auditor. The MCA team have therefore taken a pragmatic approach to audit during this year via:

- Maintaining an ability to 'take the temperature' in relation to the MCA around discrete areas of staff knowledge and practice via ward accreditation questions
- Continued work with other healthcare providers within the South West London STP to agree, develop and refine an augmented approach to auditing the MCA that is meaningful and achievable
- Centrally delivering a standalone audit exploring screening and response to patients who may lack capacity and who are potentially being deprived of their liberty[4].

[3] Some organisations try to overcome this by focusing on organisational markers such as the presence or absence of policies and subject matter experts, but this does not, in itself, provide assurance on wider knowledge or practice. Some review capacity assessments completed to see if they contain words or phrases that suggest evidence of key stages of good practice guidance are present. This can provide limited assurance in relation to cases where a need to use the MCA has been identified. Unfortunately, it provides no information about cases where a need to apply the MCA has been overlooked, or perhaps even circumvented.

[4] During this reporting year, a change from Deprivation of Liberty Safeguards was expected to come into force by October 2020, bringing with it greatly increased accountability on the part of NHS trusts to identify and effectively manage cases where Deprivations of liberty were occurring. However, it was announced in July 2020 that the implementation of the scheme replacing DoLS – The Liberty Protection Safeguards (LPS) would be delayed until April 2022 (see further details later in this report).

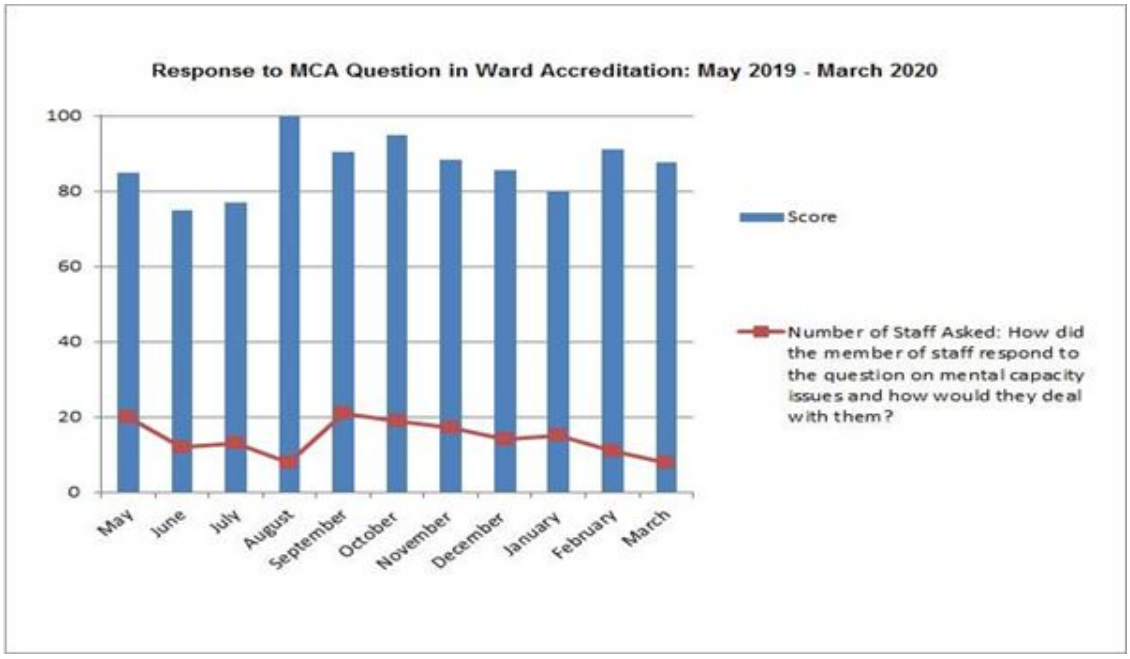
- Developing trust wide templates and guidance for 'formal' capacity assessments and best interests processes (see resource development section of the report) with an anticipated audit side effect being the reduction in subjectivity and time required.

4.2 Ward Accreditation: Findings in relation to the MCA

Two main areas of focus were selected with assurance in mind: Staff knowledge (theoretical, applied hypothetically, and evidenced via discussion) and Staff practice (evidence of supportive discussion with patients if considering use of restrictions and appropriate care plans completed if using restrictions in Best Interests).

Staff Knowledge: The question requires the staff to discuss how they would apply the MCA in response to a clinical situation[5]. Results covering May 2019 – March 2020 in the reporting period are shown in Fig 1.5., below.

Fig 1.5 MCA Ward Accreditation Question: Staff knowledge



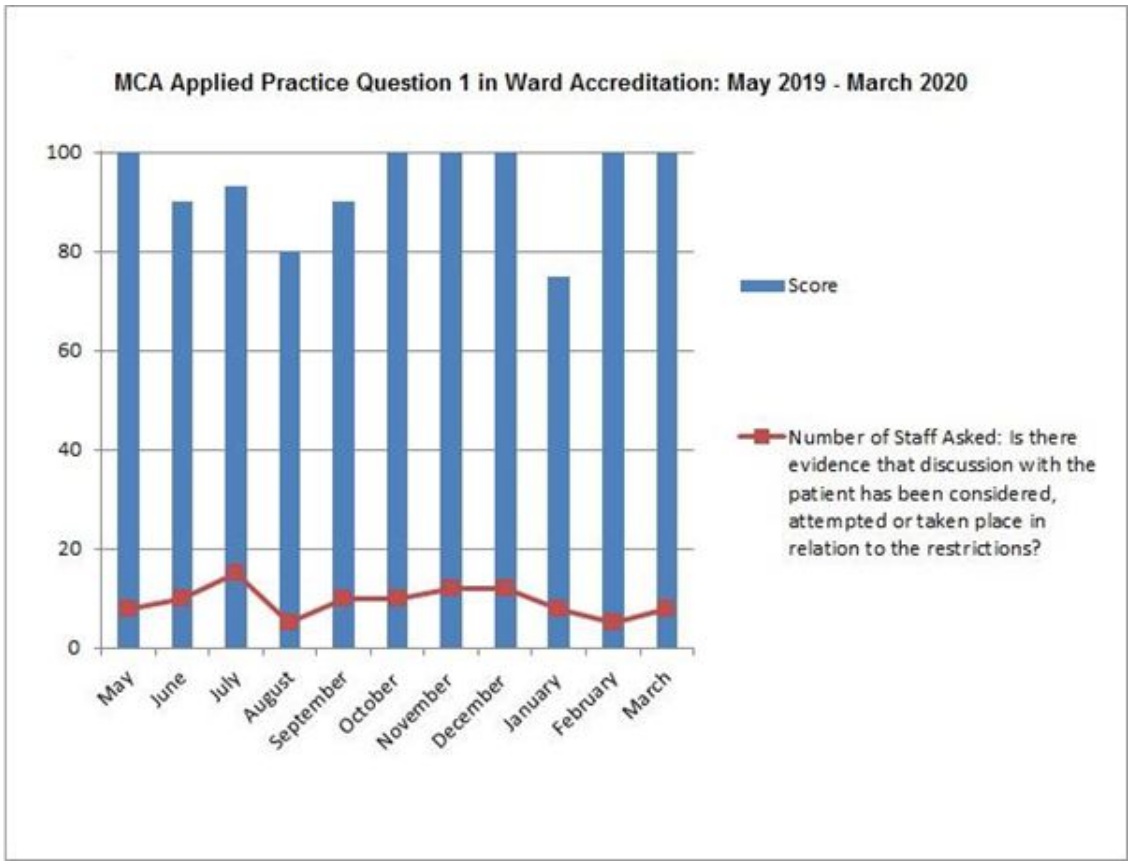
Responses show good to excellent performance on the question throughout the reporting period. This is positive, and reflects CQC feedback. The small sample size and typical focus

[5] An example question included is: if you were responsible for turning a patient in bed but they refused, are there any clear reasons that might make you wonder if they lack capacity? Assessors are provided with suggested answers / issues that should be covered in response.

on nurses during accreditation should be acknowledged though, to prevent over interpretation of these results.

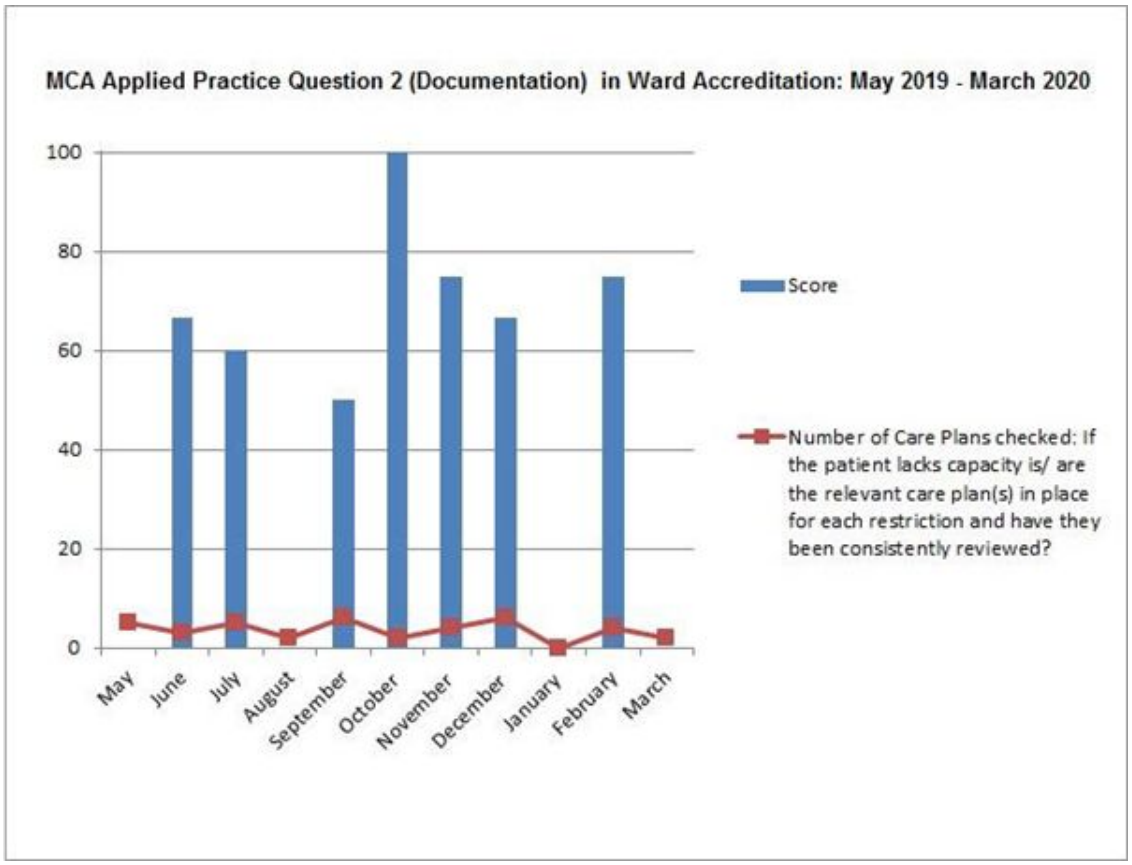
Staff Practice: Two questions relating to applied practice were also included in the ward accreditation scheme, with a focus on the supportive discussion and review to see if appropriate care plan documentation had been completed in relation to use of restraints (see figs 1.6 below and 1.7 overleaf).

Fig 1.6 Ward Accreditation MCA Applied practice question 1 (discussion)



Results relating to staff practice suggest good evidence of discussion with patients about the use of restrictions but, building on evidence from last years report that there is a problem with completion of the appropriate care plan documentation relating to Best Interests documentation, when patients lack capacity to consent. The MCA team plans to address this gap in conjunction with other relevant stakeholders (see next steps).

Fig 1.7. Ward Accreditation MCA Applied practice question 2: Evidence of care plan documentation. *NB this question is not selected every time there is an accreditation, hence gaps in August, January and March.*



These results suggest good evidence of discussion with patients about the use of restrictions but, building on evidence from last years report that there is a problem with completion of the appropriate care plan documentation relating to Best Interests Documentation when patients lack capacity to consent. The MCA team plans to address in conjunction with other relevant stakeholders (see next steps).

4.3: Collaborative work on MCA Audit with partners in South West London STP

Collaboration with partners in South West London resulted in the production of MCA staff knowledge questionnaire to get a better overview of staff knowledge of the legislation in

relation to clinical scenarios. Plans to role this out on a quarterly basis at St George's, (with the support of training, audit and communciations teams) during the reporting year were delayed due to concerns that staff had been asked to complete multiple questionnaires in the preceeding months and that uptake and engagement would be reduced due to staff fatigue. The plan to use this tool as part of audit activity remains, potentially with frequency being annual rather than quarterly in recognition of staff time pressures.

The South West London Working Group continues to work together and future aims include working together to develop practice and documentation audits relating to the MCA.

4.4 Standalone Liberty Protection Safeguards Audit

During the reporting year, government guidance was that the Deprivation of Liberty Safeguards legislation would be substantially revised into the Liberty Protection Safeguards (LPS) with an implementation date of October 2020. Explaining the full implications of this change is beyond the scope of this report but it was clear that the proposed changes contained a significant shift in resource demands and accountability from local authority to healthcare for patients, in hospital, meeting the criteria for Deprivation of Liberty.

The MCA team had concerns (following discussions with others Trusts of similar size, and Wandsworth Local authority) that recognition of and response to care arrangements that might meet the legal criteria for Deprivation of liberty was lower than expected. In order to understand the picture more clearly the MCA team, in conjunction with CCG partners, undertook a scoping audit. In October 2019, the two MCA Practitioners undertook purposive sampling of 22 historic senior health admissions (remotely reviewing I Clip records) to provide a snapshot of the current application of the MCA and DOLS legislation, in particular evidence of key steps that should be present in clinical notes to screen for, identify and respond to potential deprivations of liberty.

The headline from these results was that of the 7 patients identified as meeting the criteria for DoLS, only one had a DOLS in place. Interpretation acknowledged that senior health is a 'high risk area' in terms of the MCA and that the audit was a small sample size and had methodological limitations. However, there were indications of a potentially significant

unmet need in terms of the recognising and responding to Deprivations of Liberty. This possibility carries risks of patients being denied their human rights and may make the trust vulnerable to litigation and reputational damage, particularly in the context of changing legislation that increases the responsibilities for and scrutiny of healthcare Trusts in this area of practice. For context, though, there has always been debate about the use of DoLS in the hospital setting, and any response needs to avoid unnecessarily taking staff away from patient facing activities to complete documentation, but there is clearly work to do. The increasing referral rate for DOLS in reassuring in this context, and recently announced delays to the change to LPS provide an opportunity to mount a proportionate response.

4.5 Next Steps:

- As part of broadening audit activity in relation to the MCA, The MCA Practitioner is working with the Clinical records group to directly contribute to the Trust working Group on clinical record and consent, and seek inclusion of relevant aspects of the MCA in audit tools developed[6]. Baseline audit is scheduled for August 2020.
- Development of further MCA audit tools, partly in conjunction with South West London STP partners, for in depth audit of the application of the MCA. This is likely to focus on areas treating patient's in high risk groups from an MCA perspective (e.g. those with dementia, delirium, neurological illness) and will occur after the new trust-wide documentation (see section 5 of this report) and associated guidance has been released and in use for a period of at least three months. It is hoped that the MCA Champions programme will allow for more effective delegation and therefore scope of audit activity in due course.
- Work with Head of Safeguarding, Deputy Chief Nurse, Comms, training and audit teams to revisit the launch of Trust-wide audit of staff knowledge during 2020-21 reporting year and agree monitoring of results via MCA steering group, to ensure The Board and Divisions are appropriately linked in.

[6] Given the crossover between consent and capacity, relationship between records relating to patient presentation at and during admission, and the prospect of medical buy in / bodies on the ground to support this process.

- Participate in working groups to review the Iclip care plan documentation relating to the use of mechanical restraint (as part of nursing care plans) with aims to include reducing administrative burden and increasing completion rates.

5.0 MCA Awareness Raising and Resource Development

Awareness raising is predominantly provided through face to face training, e-learning programmes and via MCA direct and indirect clinical support provided through MCA team direct support in complex cases, accessible via bleep, email and phone. Policies relating to the Mental Capacity Act and the use of Restrictions and Restraints under the MCA provide further in depth guidance. An Intranet homepage for MCA and DoLS also provides information and advice on key aspects of practice and signposts further help. All wards have also been provided with posters providing details of key aspects of the MCA Practitioner's remit and how to contact them for support. In addition, during the reporting year, a team email address is in place making it easier to find support around the MCA via a random outlook search (type in MCA to outlook search and our team appears).

Resource development in the reporting year has focused on the design, development and review of standardised, trust-wide electronic templates for documentation of formally supported decision-making, capacity assessments and best interests decisions. The content and layout of documentation has been developed with input from patient facing staff including medics, surgeons, AHPs and nurses. The clinical change team have supported the build of these templates to include conditional logic and embedded guidance and advice around correct completion and example content. A working version of these templates is being finalised for testing, at the time of writing, by the Clinical Documentation Change Team.

<u>Challenges and Next steps (planned within the current financial year):</u>

- As previously stated, an MCA Champions programme is due to be developed this year. To optimise the chances of the Champions programme succeeding it is hoped that clinicians from across professions will be involved. Senior influencers, aswell as staff

directly connected to the challenges of the front line will be needed to overcome existing hierarchies and established approaches to practice. Champions will ideally provide quality augmentation of awareness raising and feedback across The Trust in relation to the MCA.

- The MCA policy and the Restriction and Restraints policy are both currently out of date. They have been extended by 6 months and will be updated by April 2021.

  As part of the update process to the MCA policy, it will be more closely aligned to the Consent policy and guidance on the use of new MCA electronic documentation will also be included

  For the Restrictions and Restraint Policy update, The Corporate Nursing Team have established a working group who will meet initially in September 2020 to facilitate review and potential rationalisation or re-framing of the restrictions and restraint policy (and associated guidance and documentation). This is due to concerns that this policy does not meet the needs of some staff who want practical guidance on safe use of restraint, and blends purely clinical reasoning for the use of certain 'treatments' with the legal implications / considerations under the MCA if those treatments may be construed as restraints. Given that the MCA only covers those of 16 and above, it provides no guidance on how to approach restraint itself, and is not the only piece of law that needs to be considered when restraint may be used, we will be working with the newly appointed lead nurse for mental health and other key stakeholders to develop an improved resource.

6.0 Clinical Support: MCA and DoLS referrals 2019-20

There are clear duties under the Mental Capacity Act (2005) that staff have to all patients. Patients who may have difficulty making decisions should be adequately supported to make their own decisions whenever possible. When a patient lacks capacity, decisions made for them, must have regard for the principles laid out in The MCA. Not doing so carries the risk of litigation, loss of reputation and infringement of human rights. In addition, the hospital, as a 'managing authority' has a responsibility to ensure that all those patients who could

potentially meet the criteria of deprivation have the appropriate safeguards triggered (Deprivation of Liberty Safeguards) are referred to the 'supervisory authority' (the appropriate local authority) for independent assessments and that any such assessment or authorisation is reported to the Care Quality Commission. To meet these requirements and to obtain support with working within the MCA in clinical cases, teams can currently refer for information, advice, and direct support. The range of issues the MCA team deal with is large, and can include the following:

- Phone advice on a particular aspect of applying the MCA,

- Helping someone complete a DoLS form correctly / completing it for them.

- Reviewing cases from admission to the point of referral to unpick advice relating to the MCA from other issues such as disagreements over clinical reasoning and approach, or a breakdown in communication between the treating team and other stakeholders.

- Escalating to and co-ordinating with others when their input is needed (e.g. psychiatry, psychology, the discharge team, social services, speech and language therapy)

- Supporting / Reviewing capacity assessments and best interests processes led by others.

- Leading capacity assessments and chairing best interests discussions.

- Providing longitudinal support, stakeholder co-ordination, documentation and legal escalation (of required) around complex and at times contentious cases relating to multiple treatment episodes or complex discharge decisions.

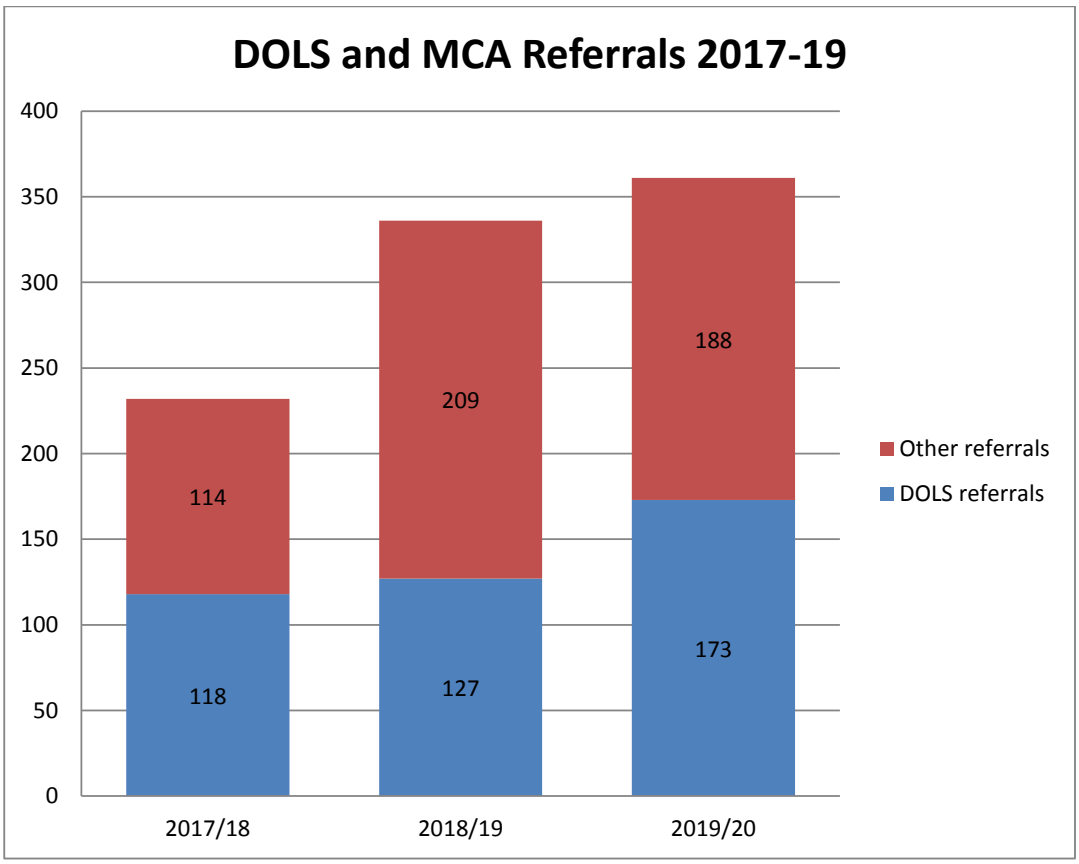
Dealing with an individual referral can take as little as 30 minutes to hear, respond to and record simple enquiries. Complex cases can require several days of work over periods of weeks to many months.

During 2019/20 there has been 361 referrals relating to the Mental Capacity act and DoLS, a 7% increase on the 2018-19 figure of 336 (which was itself a 45% increase on the 2017-18 figure of 232) (see fig 1.8 overleaf) . Of the 361 referrals received by team at St George's, 173 of these resulted in an urgent DoLS being put in pace and a request being sent to the local authority to grant a Standard Authorisation.

Subjectively, the complexity of cases has again increased compared to the previous year (which may reflect increased staff knowledge because of increased training, awareness raising, and clinical support). Cases can include decisions considering the withdrawal of medical treatment; navigating the risks of discharge for someone with reduced insight into their care needs refusing support recommended keeping them safe on discharge from hospital and decisions relating to high risk surgical procedures that might extend life but increase disability.

As staff and service user knowledge and understanding of this legislation continues to grow, and as more cases relating to hospital care and treatment are overseen by The Court of Protection, there's a high chance that referrals to the MCA team will continue to grow.

Fig 1.8 DoLS and MCA Referrals Covering period 2017-2020



Case Studies / Vignettes

To provide examples of the referrals the MCA team receives, three anonymised examples similar to cases referred during the reporting year are outlined below and overleaf.

Case Study 1:

Referral to review a case involving Katie, a frequent attender at the emergency department (ED) . She regularly uses alcohol and becomes unwell requiring admission to the ED. She arrives confused and often unwell. She allows treatment in her best interests when acutely confused and lacking capacity to consent. As soon as she is physically able to leave (though at times barely strong enough to do so) and her capacity recovers, she elects to self-discharge against medical advice, sometimes requiring re-admission the same day having returned to using alcohol immediately after discharge. Staff in ED are very worried that Katie is progressively getting worse and that her behaviour is ultimately going to kill her. They make a referral to the MCA team and want to know if they can admit her in Best Interests for a full detox and to keep her in a place of safety to allow effective review of her community support package.

Case Study 2:

Referral for review of a case involving Rakesh, a wheelchair user with complex physical needs and fiercely independent approach to life wishing to return home without care to a property where the only available space was a narrow route from front door to small area of kitchen, sofa and sink in bathroom. Social services report that all other areas were inaccessible and that there are serious environmental health concerns relating to continence and waste disposal issues. Due to the state of his accommodation, he is at risk of eviction. He has a very high risk of deterioration and re-admission if care needs in the community are not met and has a history of non-engagement with social care. Described as eccentric and single minded by friends, he appears to have short-term memory difficulties and can confabulate at times, but has no diagnosed impairment of mind or brain and refuses cognitive assessment. At times, in conversation, he comes across as intelligent and articulate. Two assessments of capacity to self-discharge have been undertaken, with contradictory findings. Referral is made to the MCA team to support discharge planning.

Case Study 3:

Referral made to support treatment decision making for Grace, a 73 year old with treatable bowel cancer. Grace has a background background of recurrent and difficult to treat mental health difficulties and has had multiple admissions to in-patient mental health services. Grace sometimes agrees to cancer staging assessments and sometimes to the idea of treatment when discussing options with surgeons, but at other times it is clear that she does not believe that she has cancer and is paranoid about the motives of health professionals from the cancer team trying to support her. The surgical team want to operate, but not against her wishes, and request support for future consultations. There are varying views about her capacity to consent to surgery. Family are resistant to surgical treatment but have limited understanding of the risks of conservative management. The surgical team refer to the MCA team to support future discussions around consent and available treatment options.

8.0 Collaborative Working

During 2019-20, the MCA team were involved in multiple partnership working projects both within and outside The Trust including:

- Pan-London training for senior Emergency Department nurses.

- Working with Child Safeguarding to develop MCA training for 16/17 year olds.

- Continuing to work as a committee member for a National Clinical Excellence Network on Mental Capacity for Speech and Language Therapists.

- On-going membership of the London-wide MCA and DoLS network.

- Attendance at the Weekly Dementia and Delirium Team MDM

- Continuing to work with and co-chair a group of South West London healthcare professionals to collectively develop shared learning and practice development approach to the Mental Capacity Act.

- Working with stakeholders from health and social care in South West London to prepare for change from DoLS to LPS

Additional collaborative working being undertaken this year includes continued involvement with the Trust Patient Record Group and joint working with the newly appointed medical lead for consent to improve recognition of and response to patient's who may lack capacity to consent to key aspects of their care and treatment.

9.0 Risks to delivery and service

- **Managing change from the Deprivation of Liberty Safeguards to the Liberty Protection Safeguards (LPS):**

Health and social care providers alike hoped for the recently announced delay to implementation of the Deprivation of Liberty Safeguards to 2022. Deciding how to plan for and invest in service and systems development for a scheme without a finalised code of practice was always a difficult ask but not achieving sufficient readiness for LPS remains a key risk for this area of work. The time extension provides a window of opportunity to:

- Improve staff knowledge and practice in relation to Deprivation of liberty through a cycle of training and audit.

- Source, develop and resource training relating to the new LPS scheme including training for doctors, nurses and allied health professionals that might be undertaking completion of legal documents as part of the LPS assessment process.

- Understand the central resource, systems, processes and networks to meet the demands and implications of LPS.

- Develop a business plan to ensure the demands of LPS are adequately resourced.

- **Launching and Maintaining and MCA Champions Programme**

Devolving expertise on the MCA and developing local support structures for teams to apply the MCA effectively in practice , and support assurance, is likely to be a key element of embedding the MCA into everyday practice. A meaningful MCA Champions programme is likely to require Champions who have influence across the MDT, who are being released from clinical duties for study time, and who receive high quality resources, education and advice from the MCA team. Divisional support and buy in is likely to be crucial in supporting recruitment, and balancing the time required to develop Champions, with increasing operational demands being placed on MCA team, will be a challenge that can only be met effectively if resources are adequate.

- **Senior and Divisional Guidance and Stewardship**

The Mental Capacity Act has been described as 'everyone's business. From the point of admission, and through each care and treatment decision taken, including those relating to discharge, there will be multiple decisions encountered each day that should fall under the MCA. For this to happen as a matter of course, the conversations around consent, admission, and the processes around MDT review of patients, and approach to screening on admission are just some areas that might be addressed. Staff need to feel able to challenge entrenched ways of practising and approaching patient care as part of the process of behavioural change needed to move towards a truly consultative patient centred model of care. To tackle and address all this is beyond the reach of a small central team. Restarting the Steering Group will allow wider issues like this to be signposted and prioritised, but it is ownership of applying, reviewing and maintaining solutions to these issues at a local level that is likely to make the biggest difference

- **Project Management Support**

There remains a lack of project management support to drive key aspects of the development plan in respect of MCA and DoLs. The core members of the team do their

utmost to maintain the necessary expertise to support clinicians and patients, and provide advice to The Trust on what is needed to provide a high quality approach in relation to the MCA. Without additional support, delivery on to some of the trust wide projects relating to the MCA is likely to be slower or in some cases, not achieved.

10. Conclusion

This year has seen a further growth in the demand for support in applying the Mental Capacity Act to Clinical Practice. The increase in referrals and complexity of cases seen suggests that there is some credence to the CQC's findings in 2019 that staff knowledge in relation the MCA had improved at The Trust. This also reflects well on the impact of a sustained period of online and face-to-face training as a key part of the Team's activity.

Groundwork done around Trust wide documentation and audit during the reporting year should pay dividends this year, and the delay of the looming spectre of the Liberty Protection Safeguards provides a window of opportunity for all NHS Trusts to mount an effective response.

As this report shows, there is still work to do around assurance and higher level training in particular, but with an augmented and expanded team structure, a welcome support for the challenges ahead, the job of driving long-term behavioural change in relation to the MCA continues.

With the continued input of patient facing staff, and the continued support of senior stakeholders to help drive key elements of the agenda forward, St George's will continue to improve its ability to provide care and treatment that respects autonomy, individuality and truly support patients to be at the centre of decisions about their care.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

3.1

Meeting Title:	Trust Board		
Date:	24 September 2020	**Agenda No**	**3.1.3**
Report Title:	Learning Disability Services Annual Report		
Lead Director/ Manager:	Robert Bleasdale – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Padraic Costello Learning Disability Clinical Nurse Specialist		
Presented for:	Assurance		
Executive Summary:	The purpose of this report is to provide an overview of the work of the Learning Disability Liaison Nursing Team (LDLNT) in association with patient experiences for adults with a learning disability accessing St George's Hospital site during April 2019- March 2020. A total of 1,327 referrals were received by the LDLNT for the period of April 2019 to March 2020. This represents a growth increase of 11.9% on the previous year. The reasons for admission to hospital were varied but comprised predominately of care and treatment for aspiration pneumonia, generalised infection, epilepsy related events, falls and strokes. A 5% increase was seen in the number of general referrals related to pathway planning. At SGUHFT, there is strong evidence to suggest that people with learning disabilities and their carers continue to benefit greatly from the intervention of the LDLNT. This is supported by the number of expressions of gratitude received via email and general correspondence. An electronic questionnaire disseminated to 80 carers of patients with learning disability last year, had a response rate of 55%, with 86% of respondents describing the patient experience at St George's as 'excellent'. The LDLNT is represented at number local fora aimed at developing pathways of health promotion for people who have a learning disability. The Learning Disability Patient Partnership Engagement Group (LDPPEG) also meets every 3 months. The LDPPEG is member-led and membership is cross sectional. It includes people with a learning disability, family members, paid carers from community support groups, nurses from the LDLNT and other health professionals. The pandemic brought additional distress for people with a learning disability. A total of 17 adults with a learning disability diagnosed with COVID 19, were treated at St George's. Sadly 3 of those patients did not survive the hospital admission and COVID 19 was recorded as the cause of death. The LDLNT was already using video technology to communicate with patient's families before the Trust adapted this means of communication for all patients at St George's and carers reported how this form of contact offered some consolation in the absence of being able to visit. Strict visiting restrictions during the pandemic resulted in the LDLNT receiving a higher volume of telephone calls from families and community professionals, anxious to know more about the condition of a patient. Even though referral		

	rates to the LDLNT were significantly lower during this period, the intensity of the work increased with nurses from the LDLNT spending significantly more time on the wards with patients. Many patients with a learning disability continue to feel challenged by Covid-19 restrictions when accessing St George's. Visiting restrictions limit the number of people a patient with a learning disability will see. The Trust however supports a reasonable adjustment for a patient with a learning disability to have one visitor, if the absence of that visitor negatively impacts the patient's experience. All NHS Trusts are required to meet the new Learning Disability Improvement Standards. The standards are intended to help organisations measure quality of service and ensure consistency across the NHS in how they approach and treat people with learning disabilities, autism or both. The standards are prominent in the learning disability ambitions of the NHS Long Term Plan and are included in the NHS standard contract for 2019/20. The standards are expected to apply to all NHS-funded care by 2023/24. The LDLNT worked in partnership with the Chief Nurse to ensure that the Trust participated in the NHSi learning disability benchmarking standards project. This involved completion of 90 audit questions, the dissemination of a questionnaire to 50 members of Trust staff and sending 100 easy read questionnaires to people with a learning disability and/or their carers to comment on patient experiences at St George's. All information had to be returned directly to NHSi and the Trust has yet to be informed of the results. Support received from the ICT Department with the implementation of flagging, has also resulted in the LDLNT being able to access an updated report every 10 minutes, which identifies bed spaces being occupied by patients with a learning disability. Access to this information alerts the LDLNT to patients with a learning disability who might not yet have been referred by ward staff.
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 / Well Led
Single Oversight Framework Theme:	
Implications	
Risk:	
Legal/Regulatory:	The Annual Report references the Trust's legal and regulatory duties in relation to the safe care and treatment of patients with a learning disability.
Resources:	The Annual Report references the currently available resources.
Equality and Diversity:	This report focuses on the treatment of patients with learning disabilities.
Previously Considered by:	Patient Safety and Quality Board Quality & Safety Committee **Date** 16/09/2020 17/09/2020
Appendices:	N/A

St George's University Hospitals NHS
NHS Foundation Trust

Learning Disability Liaison Nursing Team (LDLNT)

Annual Report 2019/2020

Aisling Cotter, Learning Disability Liaison Nurse

Shevon Dalena, Learning Disability Liaison Nurse

Padraic Costello, Clinical Nurse Specialist, Learning Disabilities

Supporting adults with a learning disability, their families and carers to access St George's Hospital.

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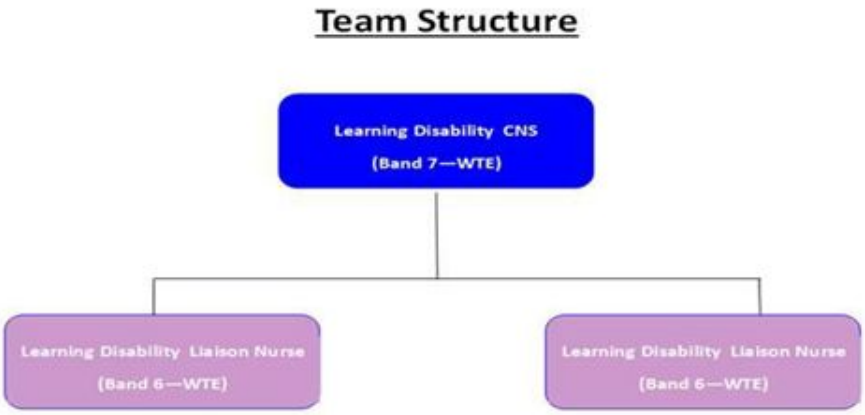
Introduction:

The purpose of this summary is to provide an overview of the work of the Learning Disability Liaison Nursing Team (LDLNT) in association with patient experiences for adults with a learning disability accessing St George's Hospital site during April 2019- March 2020.

SGUHFT continues to operate an enhanced learning disability nursing service which provides support to people with learning disabilities and their carers to access St George's Hospital. Wandsworth Clinical Commissioning Group (WCCG) are the main commissioners of this service which sits under the umbrella of Adult Safeguarding and is provided by 3 registered learning disability nurses, a Band 7 Clinical Nurse Specialist and 2 Liaison Nurses employed at Band 6. WCCG commissions one Band 6 post and one Band 7 whilst the remaining Band 6 post is commissioned by the Trust.



The core aim of the service is to ensure that adults with a learning disability have access to supplementary support, if required.

The objectives of this service are:

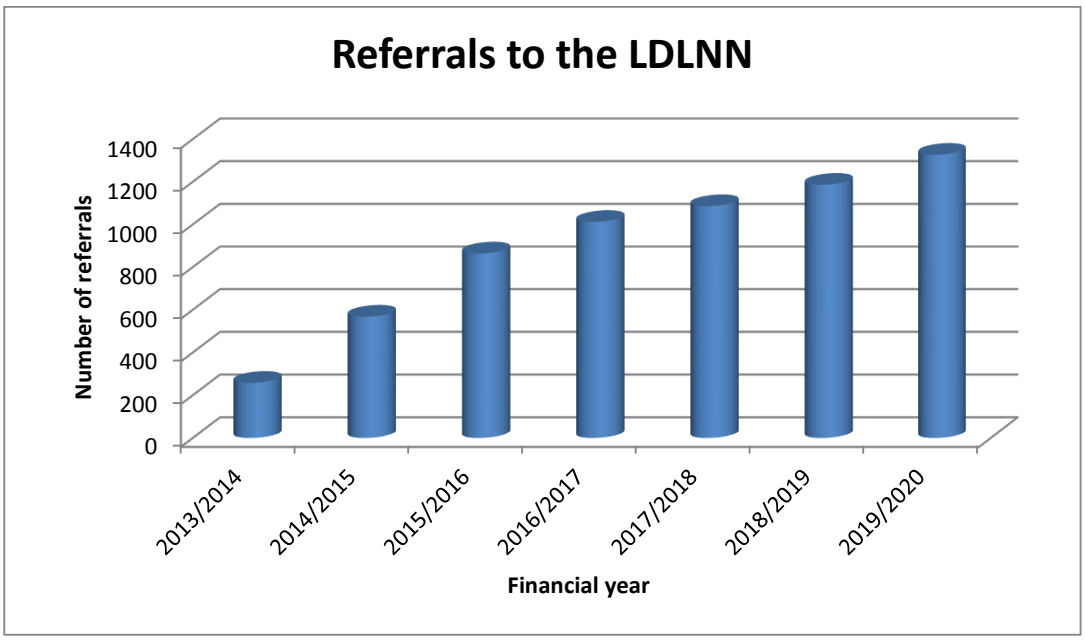
- To enable patients with a learning disability to access high quality care and treatment through navigation of services provided by SGUHFT
- To work in partnership with the other professionals and agencies to ensure that the patient remains safe along the pathway of care from the point of admission to discharge
- To facilitate discussion and guidance around best interest decision making in accordance with the Mental Capacity Act (2005)
- To coordinate and implement reasonable adjustments where appropriate as required in accordance with the Equality Act (2010).

The service operates between 8.30am and 5.50 pm Monday – Friday. Referrals can be made by any source to the team via email, telephone, and bleep or in general correspondence.

Referrals:

A total of 1,327 referrals were received by the LDLNT for the period of April 2019 to March 2020. This represents a growth increase of 11.9% on the previous year. The majority of referrals were received from nursing and medical staff working at SGUHFT. Referrals were also received from health and social care colleagues in community settings and parent/carers, in advance of elective interventions and treatments. A small number of referrals (7.4%) were self-referrals from people who have a learning disability, highlighting that some users feel confident in contacting the LDLNT directly without need for support from carers. Hospital admissions accounted for 19% of all referrals received.

General referrals remained unchanged (51%) compared to last year (18/19). These referrals related to pathway planning, addressing informal concerns, responding to queries related to the patient's experience and the implementation of reasonable adjustments in addition to facilitating best interest discussions. Outpatient appointment related matters accounted for 21% of referrals received. 9% of referrals were terminated following fact finding, the majority of which resulted in onward referral to another service, down from 12% last year.



The majority of referrals received were from the boroughs of Wandsworth (38.7%) and Merton (19.1%). Small increases in referrals were seen for those ordinarily resident in Sutton (1.8%) and Croydon (2%) whilst a reduction of 4.5% was noted in the number of referrals received from outside of the London Boroughs compared to 2018/19.

There was no percentage increase in the total of inpatients seen by the LDLNT compared to the previous year.

The reasons for admission to hospital were varied but comprised predominately of care and treatment for aspiration pneumonia, generalised infection, epilepsy related events, falls and strokes. A 5% increase was seen in the number of general referrals related to pathway planning whilst the number of referrals received by the LDLNT but deemed appropriate for another service fell by 2%.

Percentage of referrals based on patient's borough or area of residence

Borough	2018/19 (1186 referrals)	2019/20 (1327 referrals)
Wandsworth	39.9%	38.70%
Merton	19.1%	19.06%
Croydon	6.1%	8.13%
Surrey	6.0%	6.93%
Kingston	6.0%	6.56%
Lambeth	5.9%	6.33%
Sutton	3.9%	5.72%
Other	13.1%	8.57%

Patient journeys supported by the LDLNT:

The LD nurses at SGUHFT are contactable via telephone and bleep. Their contact numbers are widely published within hospital and community settings. Each adult ward and department has been provided with a learning disability information pack and team poster. Once notified, the LD nurses will endeavour to retrieve any available collateral history before meeting the patient and will review past and recent history whilst also exploring any requirements for reasonable adjustments.

There is a legal requirement for the Trust to consider and where appropriate, make changes in their approach or provision to ensure that services are accessible to people with a disability pursuant to the Disability Discrimination Act 1995 and the Equality Act 2010. This involves making adjustments to services so that people with a disability are not disadvantaged.

Examples of reasonable adjustments put in to practice over the past year have included arrangement for a family member or carer known to the patient to stay overnight with a patient sometimes for up to 2 weeks; working in partnership with multiple teams to ensure that patients with anxiety, received reasonably adjusted care and treatment to achieve the best clinical outcome, liaising with various departments and multi-disciplinary teams to ensure that multiple investigations/interventions were undertaken under one episode of general anaesthetic reducing the need for additional admissions to hospital; rearranging appointment times to make access to the hospital easier and facilitating pre-planned visits to departments and wards particularly for patients with known anxieties related to hospital admissions.

The LDLNT has further developed its relationships with Out Patient Departments and Patient Pathway Coordinators to enable patients with a learning disability to have a fast track experience when it is known that a delay in the waiting room area may cause distress to the patient or others.

This year, patients with learning disabilities have availed of fast tracking experiences in the following Out Patient Departments; The Emergency Department, Ambulatory Assessment Area, Urology Clinic, Colo Rectal Clinic, X Ray Department, MRI Scanning and CT Scanning Departments, Phlebotomy, Fracture Clinic, Epilepsy Clinic, Gastro Clinic, Cardio Clinic, Audiology Department, Chest Clinic and Gynae Clinic.

The safety of patient journeys through St George's Hospital has been further complimented over the last year when the LDLNT has linked with the Pre Op Care Centre, discharge planning coordinators, IMCAs, carers, and Social Services departments. Best interest decision making/MDT meetings facilitated by the LDLNT have also ensured that the patient's episode of care is planned, delivered and concluded as safely as possible at a pace manageable for the patient.

The experience of those using the service

At SGUHFT, there is strong evidence to suggest that people with learning disabilities and their carers continue to benefit greatly from the intervention of the LDLNT. This is supported by the number of expressions of gratitude received via email and general correspondence. An electronic questionnaire disseminated to 80 carers of patients with learning disability last year, yielded information to indicate continued positive patient experiences for patients with a learning disability. A response rate of 55% was received with 86% of respondents describing the patient experience at St George's as 'excellent'.
Of those who responded, 95% opined that hospital admissions for patients with a learning disability resulted in better outcomes when the LDLNT was involved whilst 92% of respondents stated how they would feel less confident if the service provided by the LDLNT was withdrawn. This patient experience survey will be repeated annually as the team work to produce a LD accessible discharge survey.

Complaints, Concerns, Compliments and Incidents
This information has been broken down into the subheadings below for ease of reference.

Concerns Raised by carers to the LDLNT:
The LDLNT has received an increase in the number of concerns expressed by carers around the care of patients with a learning disability over the past year. Many relate to the apparent absence of reasonable adjustments for people with a learning disability.

Examples include a man with a learning disability who had to sit in his wheelchair for 3 hours beyond the appointed time to see a consultant with no hoisting equipment in the department for the consultant to examine the patient thoroughly, even though the request for a hoist was conveyed by the LDLNT to the department 3 days earlier. This resulted in the

LDLNT facilitating a learning disability awareness training session for the relevant department.

A further example was a gentleman with a learning disability who has a known fear of coming to hospital was attending his first outpatient appointment following receipt of his new communication aid. He is unable to verbalise and this appointment offered the patient the first opportunity to express himself electronically without his mother having to articulate on his behalf. The doctor facilitating the appointment gave the patient a thumbs sign when he switched on the aide but then ignored the patient for the remainder of the appointment, communicating with his mother only. This concern was conveyed by the LDLNT to the Divisional Director of Nursing who asked a general manager to investigate further.

Formal complaints:
In the year 19/20, one formal complaint was received about the care of a patient with a learning disability by the Complaints and Compliments Department. This related to the apparent absence of a reasonable adjustment. On further investigation, it was noted that the patient did not have a learning disability but a cognitive deficit of other aetiology. The LDLNT however, was able to assist in finding a resolution by providing the patient and the complainant with some accessible information to enhance improved access to the hospital for future attendances.

PALS contacts:
One informal complaint was received by the LDLNT from PALS following a very unsatisfactory patient experience for a man with a learning disability. Whilst a learning disability liaison nurse communicated with many departments in the days and weeks prior to the patient's arrival to hospital, his care and treatment fell very short of the outstanding experience that patients with a learning disability have come to expect. The patient's carer had received multiple calls to attend for a COVID -19 swab at an appointed time in advance of attending St George's for a CT Scan under general anaesthetic, only to be told on arrival, that the patient was not listed for the swab. The ensuing delay caused unnecessary distress for the patient. A few days later, the patient and his carer having shielded for 2 weeks as requested, were due to come to St George's for the CT Scan under general anaesthetic to investigate the patient's on-going pain. On the afternoon prior to the appointment, the patient's carer received a telephone call and was informed that the CT Scan would not be proceeding as there was no anaesthetist available. Her distress is apparent in the following extract from her correspondence.

*'As much as it will distress ***** to sit for hours or overnight in accident and emergency I will be doing it. I will bring a blanket and pillow for him to lie on the floor, pad him up (as distress often leads to incontinence) and will bring his food and medication.*
*He will be extremely distressed by this action and it breaks my heart to have to bring someone like ***** down to this level in order to get treatment.*
*I will ask my GP if he can give him something on the day to try and keep him calm but generally Valium or things similar to that don't work. If we have to stay all night I will.*I need you to inform the relevant people in Accident and emergency and any other relevant parties that we will be coming*. I am at the end of my tether with all this and cannot do this anymore. In 2020 it is so desperately sad that the only way to get help is to bring a 49 year*

old man with severe learning difficulties, Down's syndrome, mobility issues, autism and severe communication issues in pain and distressed with high anxiety levels to sit in A@E to get his voice heard. I thought having the LD team on board was going to make things run smoothly. If all of the departments and professionals on board can't make this work what hope is there for my poor precious boy. I'm at a loss for any more words'.

Compliments:

Most of the complimentary feedback was received through correspondence, which highlighted positive patient experiences for people with a learning disability and their carers. Extracts include;

*'I particularly want to mention **** *****, the LD nurse and ******* ***** the anaesthetist. I felt very reassured by them and appreciated them asking and taking my advice about how best to manage ***** stress to ensure the best possible outcome. He required a large amount of sedation before he was able to allow an IV to be sited which is distressing for him to experience and for me to witness. It was managed and monitored by ********* and ********** expertly and sensitively. They both kept me informed of the plan of action and made me feel at ease.'*

A residential area services manager for people with a learning disability when reflecting on another patient's experience, following critical illness said, *'I cannot thank the staff at St Georges enough for RB's treatment resulting in her recovery after many tears and sleepless nights for us that know her well'.*

The sister of a man with a learning disability, who spent a considerable period of time in a critical care setting, enlisted the support of LDLNT. Following the patient's discharge, she wrote to the team and said '*You will long remain in our memories as your care and commitment to your role in the hospital is beyond anything we could have expected and we are very grateful'*

The LDLNT sent the following message to the manager of one of the neurosurgical wards following a patient's experience of care and treatment at St George's;

'The patient's mother told me that the hospital admission was the family's first experience of using adult services at St George's Hospital. They were keen to tell me how thorough and welcoming their experience was and that also of the patient. The patient's mother described ward staff as 'absolutely superb'. She was especially grateful to be allowed to remain overnight in a side room with the patient for the duration of the admission This has left the family with a very positive image of how St George's views the needs of patients with a learning disability. I thought that you should be aware of this in case the patient's mother did not have an opportunity to inform you in person'.

Serious Incidents:

There has been no Serious Untoward Incident involving the care and treatment of a patient with a learning disability at St George's over the past 6 years. The national report 'Treat Me Well' (Mencap 2018) highlights how an estimated 1,200 adults per year with a learning disability die avoidably due to poorly met health needs but there have been no such deaths attributed to St George's over the past 7 years.

A total of 16 adults with a learning disability died in St George's Hospital in period April 2019 to March 2020, compared to 9 in the same period of the previous year. The Coroner's Office was notified of 6 deaths but recommended no further action. All deaths of people with a learning disability in England continue to be reported to the national Learning Disability Mortality Review (LeDeR) programme and any death of a person with a learning disability occurring at St George's is notified to LeDeR by the LDLNT.

Raising Awareness

Over 500 staff at St George's availed of a learning disability awareness training session provided by the LDLNT in the past year. Attendees have included Preceptorship Nurses, HCAs on the Foundations of Psychological Care course, junior doctors, therapists, ICT staff and ward and clinic staff. Evidence from evaluation of the sessions indicates new learning which participants were intending to introduce to their future practice. The key themes of new learning were reported to be a greater understanding of the distinction between a learning disability and learning difficulty, the usefulness of the Hospital Passport, a greater awareness of the legal requirement for reasonable adjustments to be incorporated in to the patients care and using alternative communication strategies with patients who have a learning disability. This new learning can only add to the quality and safety of the patient experience in hospital.

Patient Representation and Partnerships

The LDLNT is represented at number local fora aimed at developing pathways of health promotion for people who have a learning disability, in partnership with other agencies. Examples include the Wandsworth Clinical Reference Group for people with a learning disability facilitated by Wandsworth Clinical Commissioning Group.

The Learning Disability Patient Partnership Engagement Group (LDPPEG) also meets every 3 months. The LDPPEG is member-led and membership is cross sectional. It includes people with a learning disability, family members, paid carers from community support groups, nurses from the LDLNT and other health professionals. It seeks to represent the whole community and to be accessible, inclusive and openly run. Aside from the aforementioned stakeholders, the LDPPEG includes in its membership; Beverley Dawkins OBE, the author of Death By Indifference (2007), the first national study to examine premature deaths of people with a learning disability in the UK. Within the past year, an accessible terms of reference was designed for the group using pictorials and simple language to ensure that people with a learning disability attending the LDPPEG had increased access to understanding the function of the group. Members of the group have talked about their experiences of inpatient care and outpatient access, in addition to reviewing easy read information related to treatment interventions and receiving updates from the LDLNT.

COVID-19 and patients with a Learning Disability:

The pandemic brought additional distress for people with a learning disability. Many found increased difficulty coping with a break in routine. A total of 17 adults with a learning

disability diagnosed with COVID-19, were treated at St George's. Sadly 3 of those patients did not survive the hospital admission and COVID-19 was recorded as the cause of death. The LDLNT was already using video technology to communicate with patient's families before the Trust adapted this means of communication for all patients at St George's and carers reported how this form of contact offered some consolation in the absence of being able to visit.

In March 2020, NICE advised doctors to use the Clinical Frailty Scale (CFS) when making difficult and quick decisions about the patients who would benefit most from a referral to a critical care environment to ensure best use of NHS resources during the pandemic.

The CFS rating scale ranges from 1-9, with a score of 1 indicative of a very physically fit patient and a maximum score of 9 attributed to a patient deemed to be terminally ill. Mencap, a national organisation providing support to people with a learning disability and their carers, raised serious concern and opposition to the suitability of the CFS being used for people with a learning disability to determine suitability for treatment escalation.

It highlighted how the CFS discriminated against people with Cerebral Palsy and other physical conditions even though many of this cohort of patients were ordinarily living very active and fulfilling lives prior to the hospital admission. Use of the CSF as a guide for determining Treatment Escalation Plans (TEP) initially caused confusion, disadvantage and risk for people with a learning disability until pressure from Mencap resulted in NICE advising that the CFS should not be used for this patient group when making clinical decisions around treatment escalation.

Strict visiting restrictions during the pandemic resulted in the LDLNT receiving a higher volume of telephone calls from families and community professionals, anxious to know more about the condition of a patient. Even though referral rates to the LDLNT were significantly lower during this period, the intensity of the work increased with nurses from the LDLNT spending significantly more time on the wards with patients.

Ever changing national guidance for residential care providers resulted in some patients with a learning disability being deemed medically optimised for discharge but remaining in hospital longer than expected. Some residential care providers for people with a learning disability were not prepared to accept a patient back until 7 days post a negative COVID-19 swab. This resulted in nurses from the LDLNT becoming more actively involved in the discharge process for some patients. One nurse from the LDLNT was shielding during the pandemic and this limited the number of nurses having direct patient contact. Whilst many patients with a learning disability may not be able to recount their story about COVID-19, most patients and their families will never forget the experience.

Patient Story:

A 32 year old man with a learning disability was admitted to a ward at St George's with symptoms of COVID-19. His mother accompanied him to hospital. A consultant assessed the patient and based on clinical

observations, informed the patient's mother that the prognosis was guarded. The patient was deemed to lack capacity and his mother was informed that he would not be considered for TEP or CPR. It is believed that this decision was informed by the Clinical Frailty Scale as the patient was not usually physically active, although he attended a day centre many days per week. The patient's mother was also informed that she would not be able to stay overnight in a side room with the patient, owing to infection prevention and control associated with COVID-19. She was not satisfied with the plan and contacted the LDLNT for further advice. A second clinical opinion was sought from another consultant and the decision was reversed. The patient was then deemed suitable for consideration to TEP and CPR, if required. A few days later the patient's condition deteriorated and he was admitted to ICU.

Each day the patient's parents were provided with a medical update by a doctor. His family also received a daily video call from a nurse in the LDLNT when family members could see the patient in a critical condition but also being made comfortable by ward staff.

The patient required intubation, ventilation, re intubation and acquired Klebsiella Pneumonia. He remained critically ill and his family was notified on more than one occasion, that he was highly likely not to survive the hospital admission.

After a number of weeks, the patient's condition began to stabilise. He started to give eye contact to those providing his care and treatment. He was weaned slowly and the therapists began to support the patient with gentle bedside exercising before he was well enough to be supported to a bed side chair. Ward staff downloaded numerous episodes of Thomas The Tank Engine, the patient's favourite TV programme, on to an iPad which was placed on the bedside table. The patient then began to show more awareness of his environment and before long, the therapists were able to support patient in being able to move from a seated to standing position. The LDLNT videoed the patient's therapy sessions so that his parents who could not visit him, were able to give him verbal praise and positive reinforcement to make progress during the sessions. The patient managed to walk 3 metres on the final day of his stay on ICU.

After continued clinical improvement, the patient was discharged to a ward. A side room was secured on step down to the ward so that the patient's mother could stay with him. On the first day of step down to the ward, with his mother present, the patient walked a distance of 40 metres. The patient made continued progress, which became accelerated by his mother's presence. A short time later the patient's clinical condition improved significantly and he was deemed medically optimised for discharge. There may have been a very different outcome for the patient if a second opinion had not been sought but this example also highlights the thin line associated with decision clinical making and the consequences of those decisions.

When this patient's situation was reflected upon, it became the catalyst for two experienced consultants to contact the LDLNT with a request to meet. The meeting was used to explore how patients with a learning disability experiencing symptoms of COVID-19, could not be disadvantaged when decisions were being made regarding clinical escalation.

The following pathway was agreed;

- Communication with NOK/nominated contact/care facility manager/family member/community health professional is essential to appreciate all facets of care for PWLD
- A medically explicit reason for TEP/DNAR decision must be documented on the patient's notes
- If a PLWD has an LPA who's decision to forego resuscitation conflicts with that of medical team, this needs to be escalated to the MCA Lead in The Trust for further consideration

It was further agreed that when a patient with a learning disability is being assessed, a proforma should be available to document discussion and decision reached for all stages as follows:

- What decision is being made- TEP/DNAR
- Check if a medical LPA has been appointed and document discussion regarding TEP/DNAR
- Capacity assessment for TEP/DNAR
    - Patient has capacity- record outcome
    - Patient lacks capacity- best interest decision making (tool here: https://www.gmc-uk.org/Mental_Capacity_flowchart/). Explain and discuss with NOK/nominated contact/care facility manager/family member/community health professional
- Contact LD team on bleep 8386, highlight patient is for "urgent" review if necessary to assist TEP/DNAR process
- Consultant caring for patient to review TEP/DNAR decision making process and ensure all steps complete

Many patients with a learning disability continue to feel challenged by COVID-19 restrictions when accessing St George's. Visiting restrictions limit the number of people a patient with a learning disability will see. The Trust however supports a reasonable adjustment for a patient with a learning disability to have one visitor, if the absence of that visitor negatively impacts the patient's experience.

Some patients with a learning disability experience difficulty in adhering to infection prevention and control guidance around shielding prior to surgery, although each case gets discussed with Patient Pathway Coordinators.

Developments over the past year;

The LDLNT has increased its workforce with an additional nurse working at Band 6, taking the full complement of nurses to 3 whole time equivalents.

A retrospective review of all 2,513 referrals to the LDLNT since March 2018 has resulted in the flagging of all patients with a formal diagnosis of a learning disability referred since this time. Flagging is a recommendation from the NHS Learning Disability Improvement Standards which is applicable to all NHS Trusts. The placing of the flag on iClip will notify the user that the patient has a formal diagnosis of a learning disability and this information should become the prompt for reasonable adjustments to be considered. The information can be accessed by professionals in in-patient or out-patients settings and should strengthen the safety of the patient's pathway. Examples of this in practice would include Patient Pathway Coordinators knowing that a double appointment is likely to be required for the patient's attendance at Out Patient Clinic or staff in the Emergency Department

knowing that fast tracking might be required as a reasonable adjustment to minimise the patient's anxiety.

Support received from the ICT Department with the implementation of flagging, has also resulted in the LDLNT being able to access an updated report every 10 minutes, which identifies bed spaces being occupied by patients with a learning disability. Access to this information alerts the LDLNT to patients with a learning disability who might not yet have been referred by ward staff. The implementation of a flagging system will help facilitate adjustments and timely care.

The LDLNT has continued to work collaboratively with Share Community a local charity which provides social and community support to adults with a learning disability. Staff from The LDLNT and Share Community having jointly devised a health access programme, designed to educate people with learning disabilities around appropriate use of the Emergency Department at St George's.

The Learning Disability Patient Partnership Engagement Group (LDPPEG) has developed an easy read Terms of Reference for its members to enhance participation

All deaths of patients with a learning disability occurring at St George's have been notified by the LDLNT to LeDeR in accordance with national guidance.

The LDLNT worked in partnership with the Chief Nurse to ensure that the Trust participated in the NHSi learning disability benchmarking standards project. This involved completion of 90 audit questions, the dissemination of a questionnaire to 50 members of Trust staff and sending 100 easy read questionnaires to people with a learning disability and/or their carers to comment on patient experiences at St George's. All information had to be returned directly to NHSi and the Trust has yet to be informed of the results. The LD standards have informed the development works in year, such as the implementation of the electronic flagging system on the patient record. These standards and results will inform the LD development action plan for this year, and will build on the work completed.

Future Plans

Whilst there has been a small increase in the number of informal complaints received on behalf of patients with a learning disability, the LDLNT is mindful that the overall total is low. This may be a testament to the high level of quality care patients receive but the LDLNT also hopes to devise an accessible format of the Complaints Procedure to ensure that patients with a learning disability have easier access to report any concerns or shortcomings related to their care and treatment. The LDLNT will need to discuss this initiative further with the Compliments and Complaints Department and this should lead to the LDLNT becoming aware of all complaints related to the care and treatment provided to patients with a learning disability accessing St George's.

Many patients with a learning disability have difficulty in completing the Trust's standard patient satisfaction survey. For this reason, the LDLNT will produce an easy read survey for patients to complete at the point of discharge.

Some adults with a learning disability find great difficulty in accessing scans without a General Anaesthetic. In the past, when a patient required a General Anaesthetic for such intervention, considerable time was spent engaging multiple services to enable a safe pathway. The amount of time spent planning such interventions could be greatly reduced by the availability of an adapted GA pathway. The LDLNT has had initial exploratory discussions with CT Scanning and Anaesthetics Department with a view to involving representation from Bed Management, Theatres and Recovery in a collaborative approach to overcoming the current challenges.

All NHS Trusts are required to meet the new Learning Disability Improvement Standards. This is a large piece of work which will involve the LDLNT liaising with numerous departments at St George's.

The four standards concern:

- respecting and protecting rights
- inclusion and engagement
- workforce
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

The standards are intended to help organisations measure quality of service and ensure consistency across the NHS in how they approach and treat people with learning disabilities, autism or both. The standards are prominent in the learning disability ambitions of the NHS Long Term Plan and are included in the NHS standard contract for 2019/20.

The standards are expected to apply to all NHS-funded care by 2023/24. The third standard will require the attention of Human Resources department whilst the final standard is not applicable to the Trust. The remainder will require significant interdepartmental and strategic involvement to ensure compliance. The team have already started to progress these standards and participated in the national audit completed by NHS Benchmarking. The plan for the year will build on these results to improve compliance and experience for our patients and those important to them. Following the implementation of a flagging system, it is anticipated further works can be completed to improve the pathway for patients, removing the dependency of the LD nurses to coordinate this. It is also hoped that the Trust will be able to monitor patients with a known LD on waiting lists, to prevent cancelations and the facilitation of timely investigations and appointments.

Some elective surgery patients with a learning disability are likely to find aspects of shielding requirements to be challenging. The LDLNT will need to work closely with Patient Pathway Coordinators and others coordinating admissions to ensure that reasonable adjustments are made but that patient safety is not compromised.

The Oliver McGowan Mandatory Learning Disability Training will require all NHS employees to receive learning disability awareness training. Whilst this is not in place yet, its requirement is imminent and an e-learning module will need to be devised by the LDLNT in consultation with Training and Development Department.

Padraic Costello
Clinical Nurse Specialist
Learning Disability Liaison Nursing Team

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3.1

Meeting Title:	**Trust Board**		
Date:	24 September 2020	**Agenda No.**	**3.1.4**
Report Title:	**Progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions**		
Lead Director/ Manager:	Emilie Perry, Divisional Director of Operations		
Report Author:	Julia Crawshaw, Maternity Transformation Programme Manager		
Presented for:	Update & Assurance		
Executive Summary:	In early 2020, NHS Resolution launched the third year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, to continue to support the delivery of safer maternity care. As in previous years, Trusts that demonstrate delivery of all ten maternity safety actions are eligible to recover a share of their CNST premium. St George's Hospital NHS Trust, has been successful in delivering full compliance with these safety standards in the previous two years of the scheme. NHS Resolution announced in March 2020 that due to the Covid-19 pandemic the Maternity Incentive Scheme, including all required actions as part of the scheme, would be suspended. An update is expected at the end of July with details of how and when the scheme will re-launch. This is anticipated to be in September 2020. This report provides an update on the Trust's progress against the 10 safety actions contained in the pre-COVID Maternity Incentive Scheme guidance and identifies areas of concern in meeting these actions, and the steps being considered to address these. At present, there are three safety actions which are not being met and of which achievement is not assured: - Safety Action 2 (Data) - Safety Action 6 (Savings Babies Lives Care Bundle) - Safety Action 8 (Training). Each of these safety actions have been affected by the Covid pandemic, and other Trusts have also highlighted difficulties in achieving these. Achievement is expected of all 7 other safety actions, however until the new timelines and standards are published, this cannot be confirmed. A more detailed review of progress against each of the safety actions is contained in the report.		
Recommendation:	The Board is asked to approve the current position and note that reporting has currently paused as result Covid-19.		
Supports			
Trust Strategic Objective:	1. **High Quality Care**: To ensure consistently high quality care for		

	patients by ensuring it is safe, effective and patient led. 2. **Financial sustainability**: To make the Trust financially sustainable with effective financial monitoring and reporting systems.		
CQC Theme:	Safe (currently rated as Good)		
Single Oversight Framework Theme:			
Implications			
Risk:	**Quality:** The 10 safety standards are designed to measure how safe a maternity service is; failure to meet the required progress towards these standards could demonstrate a safety / quality issue within the service.		
Legal/Regulatory:	Indemnity agreement with NHS Resolution		
Resources:			
Equality and Diversity:	There are no equality and diversity impact related to the matters outlined in the report.		
Previously Considered by:	Quality & Safety Committee Executive Management Group	**Date:**	20/08/2020 14/09/2020
Appendices:			

Update on CNST Maternity Incentive Scheme Year 3

In early 2020, NHS Resolution launched the third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. As in previous years, Trusts that can demonstrate delivery of all ten maternity safety actions are eligible to recover a share of their CNST premium. Trusts that do not meet all ten safety actions will not receive this rebate. St George's Hospital NHS Trust has been successful in delivering full compliance with these safety standards in the previous two years of the scheme.

NHS Resolution announced in March 2020 that due to the Covid-19 pandemic the Maternity Incentive Scheme, including all required actions as part of the scheme, would be suspended. On 3rd July 2020, the Trust was notified that further communication would be sent towards the end of July 2020, with an interim update, in preparation for the re-launch of the scheme safety actions in September 2020. A brief update was issued on 13 August, which gave some indication of changes expected to the Safety Actions, but did not include a timescale for when these would be released.

NHS Resolution confirmed that the reporting period for the scheme would be updated and shared with Trusts in due course. There was no indication given as to whether any standards would be changed or updated as a result of new ways of working required by the COVID response.

This report provides an update on the Trust's progress against the 10 safety actions contained in the pre-COVID Maternity Incentive Scheme guidance up to now, and identifies the challenges faced in meeting these actions going forward and the steps being taken to address these.

At present, there are three safety actions that were areas of concern for delivery prior to the Covid outbreak and which are now further challenged due to issues associated with the Covid response such as room availability, infection control risks and social distancing. Plans were in place to address the challenges (for example, upgrade of the maternity information system, a training schedule and purchase of additional carbon monoxide monitors) however, these plans had to be paused due to Covid and achievement of these safety actions is therefore not assured:

- Safety Action 2 (Data)
- Safety Action 6 (Savings Babies Lives Care Bundle)
- Safety Action 8 (Training).

Of the remaining seven safety actions, progress at present suggests that these should be achieved, however until the new timelines and standards are published, this cannot be confirmed.

The following table shows the safety action standard to be achieved; current progress, anticipated achievement and the actions required.

CNST Safety action	Requirement	RAG Rating	Lead
Safety Action 1 National perinatal mortality review (PMRT}	From 20th December 2019 • 95% of all deaths of babies suitable for review using the PMRT have started • 50% of each death would have been reviewed and completed by MDT with a draft report generated • 95% of all deaths the parents are informed a review is taking place – opportunity to share their perspectives and concerns • Quarterly reports submitted to the trust board	On track to achieve	Quality Improvement Midwife
Progress: PMRT reporting and review has continued throughout the COVID pandemic and the quarterly reports submitted to the Mortality Review group on time and onwards to the Trust Board. Therefore all of the requirements to date have been met.			
Actions required: Continue to report on and review all eligible babies and provide quarterly reports to the Mortality Group as required.			
Risk: No risk to delivery of Safety Action			
Safety Action 2 Maternity services data set (MSDS)	• MSDS 14 submission criteria • Submit data from Nov 2019- May 2020 – looking at April and May data • 80% of booked women has valid ethnic group • 90% of women booked with continuity of carer • 95 % of women booked has an EDD and postcode • 30/04/20 trust board confirms to NHS resolution a plan is in place	Not on track to achieve at present	Information Manager and Maternity Programme Manager
Progress: Reporting of the MSDS was suspended during COVID. Prior to this, tests had been done to check data completeness against relevant criteria and to identify gaps. These showed a number of areas of risk, many of which would be addressed by an upgrade of the Maternity Information System (E3/Euroking), which was due in March, and regular data quality checks. This upgrade was postponed due to Covid and discussions are on-going with the provider to establish a new date for the upgrade.			
Action: The information team are liaising with E3 to get this upgrade installed as soon as possible and the issue has been escalated within the information team. However, no timelines have yet been provided by E3, who are currently testing the system upgrade with another organisation. In the meantime, data quality checks continue and other options for completing the data are being explored.			

Risk: Likely to not deliver Safety Action unless upgrade to Maternity Information System is implemented within year			
Safety Action 3 Transitional care services to support the recommendations -avoiding term admissions into NNU (ATTAIN) Year 3 is embedding and sustaining TC pathway	• TC pathway which has been jointly approved by NNU and maternity • Monthly audit of TC pathway finding shared with neonatal safety champion – starting Feb.2020 • A data process for capturing TC activity – ward and NNU • Action plan to address local findings – shared with NNU safety champion and board level champion • Progress monitored from March 2020	Expected to achieve	Maternity Governance Team Neonatal Care Group Lead
Progress: Most elements of this standard are in place with all relevant timescales met prior to Covid. The outstanding elements relate to audits and monitoring of the pathway which were due to take place from March onwards. At present, there are issue with implementing the pathway overnight due to staffing, however within the standard this would be addressed by having an action plan in place to achieve improvements. Data regarding transitional care activity continues to be collected by NNU. It is expected that this standard will be achieved once the new timelines are established.			
Actions: To ensure all preparatory work is complete to enable monitoring and audits to restart once new timescales are known			
Risk: No anticipated risk to delivery of Safety Action, but this is subject to successful outcomes of timed audits and on-going monitoring of the pathway within the review period			
Safety Action 4 Demonstrate an effective system of clinical workforce planning	• Obstetric • Anaesthetic • Neonatal medical workforce • Neonatal nursing workforce	Expected to achieve	Maternity Programme Manager
Progress: The monitoring period for this standard was not complete when the scheme was suspended. However, the expectation prior to this was that the standard would be achieved as all of the specialties meet the relevant criteria for staffing standards or have plans in place to mitigate these.			
Actions: To continue audits when new timescales are known.			
Risk: No anticipated risk to delivery of Safety Action, but this is subject to successful outcomes of timed audits during the			

monitoring period			
Safety Action 5 Demonstrate an effective system of midwifery workforce planning	• Systemic evidence process to calculate midwifery staffing establishment • Supernumerary midwifery shift coordinator • Women in active labour receive one to one care • Submit a bi-annual midwifery staffing report that cover staffing/safety issues to the board	Expected to achieve	Director of Midwifery
Progress: A draft establishment review was led by the Director of Midwifery (April 2020) with a view to be discussed with Chief Nurse and National Maternity Lead. This is yet to be concluded. Monitoring of other standards is on-going (on the maternity dashboard and through safe staffing reports) and an audit will be completed once the new timelines are known. It is anticipated that this standard will be achieved.			
Actions: To finalise the midwifery establishment report and to audit red flags as soon as new timescales are known.			
Risk: No anticipated risk to delivery of Safety Action, but this is subject to successful outcome of timed audit of red flags within monitoring period and submission of establishment review			
Safety Action 6 Saving babies lives care bundle 2 – five elements	**Element 1** Recording CO (carbon monoxide) at booking and 36weeks – April MSDS (80% compliance) **Element** 2 Identifying fetal growth restriction Quarterly audit of the % of babies born <3rd centile >37+6 gestation **Element 3** % of women received leaflet or information about reduce fetal movement by 28+0 weeks **Element 4** 90 % of staff who have received fetal monitoring training **Element 5** % of singleton live births receiving a full course of steroids within 7 days of birth (< 34+0 gestation) -receiving Mgso4 within 24 hours prior to birth	Not on track to achieve at present	Consultant Midwife, PDM and Maternity QI Team

Progress: There are five elements of this standard, and all were due to be audited within specific timescales. Compliance was expected for three of the five standards, however both Element 1 (carbon monoxide monitoring in pregnancy) and Element 4 (fetal monitoring training) were and remain areas of concern as described below. Element 1 – The requirement to record CO1 levels at two points in pregnancy was not met as the 36 week assessment was not done routinely prior to the COVID restrictions and was specifically suspended after this due to infection control risks associated with the monitors. A plan was made to purchase additional monitors and was in progress prior to lockdown. Depending on how this issue is addressed in the new guidance, this element may not be achieved and therefore leaves the safety action at risk. The update issued on 13 August suggests that this requirement will be replaced and instead will audit whether women are asked about their smoking status at 36 weeks. Element 4 – St George's offers gold standard fetal monitoring training delivered in person by experts. This standard required a different type of training to be offered which the clinical team feel would be of a lesser standard for staff, however a plan to work around this was in place. This will be reviewed alongside the other training requirements in Safety Action 8			
Actions: To complete audits when new timescales are known. Element 1: To provide additional CO1 monitors to antenatal midwives once infection control have signed these off and to ensure the 36 week check is complete. In the meantime midwives continue to check smoking status and refer women to smoking cessation services as required.			
Risk: Likely to not deliver Safety Action unless infection control standards approve the use of CO monitoring, and, fetal monitoring training standard adjusted or investment in training provision.			
Safety action 7 Users feedback	Demonstrate mechanism for gathering users feedback	On track to achieve	Maternity Programme Manager
Progress: This safety action has been enhanced during the COVID response, with an on-going proof of co-design and acting on feedback provided by the maternity user group, the Maternity Voices Partnership. All of the requirements had been met prior to Covid.			
Actions: To continue to act on user feedback and record instances of co-design.			
Risk: No risk to delivery of Safety Action			
Safety Action 8 Multi professional training	• Demonstrate 90% of each maternity staff group has attended multi-professional emergencies training within the last year • 90% have attended NLS or neonatal resuscitation in the last	Not on track to achieve at present	Practice Development Midwives

	training year		
Progress: This standard was on track prior to the pandemic, albeit with some concerns about getting the number of staff through to meet the requirements. However, training was suspended for a number of weeks and although this is now running again, requirements of social distancing and the availability of rooms at the University mean that this is at a significant slower pace than before. Take up of on-line training is very limited amongst staff and staff have concerns about the quality of this compared to 'hands on' options. All local Trusts reported concern in achieving this standard to the Local Maternity System			
Actions: To review timescales and requirements when new standards are produced. Senior Clinical Team and Triumvirate to identify any issues of concern in relation to quality of training advised by NHS Resolution compared to local standards. The new guidance suggests there will be a move to more on-line / remote training. The implications of this will need to be considered once the full changes are known.			
Risk: Probably likely to not achieve Safety Action unless training standard adjusted or investment in training provision.			
Safety action 9 Trust safety champions	Safety champions are meeting bimonthly with board level champions Monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety Agreed action plan that describes how the service is working towards a minimum of 51% of booked women are on a Continuity of Carer pathway by 03/21	Expected to achieve	Director of Midwifery, Clinical Director Maternity Programme Manager
Progress: All elements of this standard had been on track prior to the pandemic with the timescales met as required. Work has continued since to listen to staff safety concerns and make progress with developing Continuity of Carer (CoC) model. Therefore, depending on the new timescales released this standard should be achieved.			
Action: To ensure that safety pathways remain visible to staff			
Risk: No anticipated risk to delivery of Safety Action, but this is subject to completion of activities within defined monitoring period			
Safety Action 10 NHS resolution's early notification scheme	100% reporting of babies who meet early notification scheme	On track to achieve	Maternity Governance team
Progress: Details of all eligible babies have been submitted to the Early Notification Scheme as required and therefore it is expected that this standard will be achieved. This is monitored through the Maternity Governance Meeting and is regularly reported to the Local Maternity System Safety Committee			

Action: To continue to report cases as required.
Risk: No risk to delivery of Safety Action

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3.2

Meeting Title:	**Trust Board**		
Date:	24 September 2020	**Agenda No**	**3.2**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	James Friend, Chief Transformation Officer Avey Bhatia, Chief Operating Officer Rob Bleasdale, Chief Nursing Officer and Director of Infection Prevention & Control		
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 for the month of August 2020. **Our Finance & Productivity** Daycase and elective activity in August was 63% of August 2019's activity. The August Phase 3 recovery target is to achieve 70% of 2019 in-month activity, however there has been a positive increase in month as activity continues to increase as July 2020 had 53% of July 2019 activity. Similarly for Outpatients, the Trust booked 69% of August 2019's activity; the National aim is to deliver 90% of August 2019 outpatient activity across all consultation mediums. August 2020 Emergency Department attendances were 26% below August 2019 activity; similarly, non-elective admissions are also 14% below the same period. There are no targets for these PODS for Phase 3 recovery. **Our Patient Perspective** The rate of 2222 calls and avoidable cardiac admissions has fallen below the mean for the past six months likely as a result of the introduction of Treatment Escalation Plans, the Critical Care Outreach Team and the Emergency Department's sepsis work. Training for Intermediate and Basic Life Support has not reached target however training was relaunched in August. Most Patient Safety metrics demonstrate common cause variation though Category 3 Pressure Ulcers remain above the long term mean for the past 10 months. An appropriate response triggered by an Early Warning Score for inpatients occurred only 78% which below the lower process limit. There was one MRSA infection reported in August; the Post Infection Review (PIR) process is on-going and the review outcome will be reported to Infection Control Committee. There were no nosocomial COVID-19 Hospital Onset Hospital Acquired infections reported in August. There are no published thresholds for this new indicator. All other infection control metrics show common cause variation. In August the percentage of all Emergency C Section metrics have risen above target and shows special cause variation deterioration above the upper control limit. Due to staffing Carmen Birth Suite was closed for 48% of available time however there is a staffing plan in place which will be implemented in the Autumn. This also affected the number of Supernumerary Midwives available within the Labour Ward. Complaints continue to be compliant with their performance targets. All of our services met or exceeded the Friends and Family Tests targets except Outpatient services who narrowly missed the 90% target with a performance of 89.1%.		

	Our Process Perspective The Trust's Four Hour Operating Standard performance in August was 94.8% against a target of 95%. Performance was impacted due to higher attendance and ambulance conveyances during the heatwave in early August. The Trust met two of the seven cancer standards for July 2020 and was non-compliant against the 14, 31 and 62 day standard. The Trust continued to access 15 weekly cancer sessions in the Independent Sector in the month of July and plans are in place to extend this to October 2020. The backlog has started to reduce and it is anticipated that it will be cleared by October whilst maintaining service for new referrals. The Trust's six week diagnostic performance improved slightly to 28.8% in August from 34.2% in July though the National Target is 1%. July 2020's RTT performance was 52.7% against a National target of 92% with 825 patients waiting longer than 52 weeks. The Trust has identified 295 patents that are suitable to be operated on at other South West London Trusts from Urology, ENT, and General Surgery. 93 patients have been transferred, with 202 returning to St George's due to either patient choice or receiving surgeon opinion. **Our Workforce Perspective** Agency cost continues to be below its monthly £1.25m threshold with August spend at £1.11m. However the Trust total pay was £49.32m which is an £0.68 adverse position against a plan of £48.64m Appraisal and Revalidation for medical staff is to be re-started across the Trust as the processes were paused due to COVID-19.
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:	N/A
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance
Equality and Diversity:	There is no equality and diversity impact arising from the matters discussed in this report. The report does provide insights into the workforce performance data which may address equality and diversity matter but the Board is not being asked to make a decision which impacts on any individual or group disproportionately.
Previously Considered by:	Trust Executive Committee Finance & Investment Subcommittee Quality & Safety Subcommittee **Date** 14 Sep 2020 17 Sep 2020 17 Sep 2020
Appendices:	

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3.2

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 24 September 2020

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

10th September 2020

Our Outcomes

How Are We Doing?

August 2020

Daycase and Elective Surgery operations

Actual: 2,976

SLA plan: 4,875

6 Week Diagnostic Performance

Actual: 28.8% Target: 1%

Four Hour Emergency Standard

Actual: 94.8%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual 97.2%

Target 95%

Outpatient First Attendence

Actual 9,689

SLA plan: 16,279

July 2020

Referral to Treatment Standard - Number of 52 Week Breaches

825

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	Maternity (A)	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow (G)	Cancer (A)	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR PEOPLE PERSPECTIVE	Workforce (A)	Agency Use	Estates Health and Safety			

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Executive Summary – August 2020

Our Finance and Productivity Perspective

- Elective and Daycase activity for August 2020 was 63% of August 2019 activity. The Phase 3 recovery target for August was 70% of previous year's activity. Activity continues to increase as July 2020 had 53% of July 2019 activity.
- Outpatient activity in August was 69% of the same period last year with the Phase 3 recovery target for August at 90%.
- The Trust saw 53% of all outpatient appointments in a virtual environment.
- In August, non-elective lengths of stay showed special cause variation improvement with patients staying 4.3 days as compared to the mean of 5.3 days.

Our Patient Perspective

- The rate of 2222 calls and avoidable cardiac admissions show special cause variation improvement with six months' data below their respective means. This may be the impact of Sepsis work in Emergency Department (ED), the introduction and uptake of Treatment Escalation Plans and the Critical Care Outreach Team.
- In August, when an Early Warning Score was triggered for inpatients, an appropriate response was recorded 78% of the time; this performance shows special cause variation deterioration.
- Training for Intermediate and Basic Life Saving is below the lower process limit however CPR training was relaunched in August.
- Due to staffing Carmen Birth Suite was closed for 48% of available time however there is a staffing plan in place which will be implemented in the Autumn.
- The Trust has reported one MRSA bacteraemia during August 2020. Post Infection Review (PIR) process is on-going and the review outcome will be reported to Infection Control Committee.
- The number of Ecoli and MSSA cases reported remains within control limits; there were no nosocomial hospital onset hospital acquired COVID-19 infections during August 2020.
- In August, all services across St. George's across exceeded the Friends and Family positive feedback target except Outpatients Services which narrowly missed the 90% target with a performance of 89.1%.

Our Process Perspective

- The Trust narrowly missed achieving the Four Hour Operating Standard with a performance of 94.8% against a target of 95% in August. Services did exceed the 95% target for 18 of 31 days in the month.
- In July, the Trust met two of the seven cancer standards however it didn't meet the 14, 31 or 62 day standard. Focus remains on addressing the backlog of waiters.
- In August, the Trust did not achieve the six week diagnostic standard with an adverse performance of 28.8%. The Trust is slowly improving its position compared with last month's performance of 34.2%.
- 18 week RTT Performance continued to deteriorate with July 2020 performance down to 52.7% and 825 have waited longer than 52 weeks to begin treatment; the RTT incomplete pathway list size has returned to within its upper and lower control limits increasing for the first time in over four months as referrals have started to increase.

Our People Perspective

- Mandatory and Statutory Training (MAST) compliance was at 89.9% remains above the target of 85%.
- Medical appraisals was paused during COVID-19. In September 2020, the General Medical Council wrote to the Trust requesting that this process be re-started.
- Agency cost was £1.11m against a target of £1.25m however Trust total pay was £49.32m which is an £0.68 adverse position against a plan of £48.64m.

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	Maternity A	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow G	Cancer A	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR PEOPLE PERSPECTIVE	Workforce A	Agency Use	Estates Health and Safety			

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Activity against our Plan

		Activity compared to previous year			Activity against SLA plan for month		Activity against Phase 3 plan for month		Activity compared to previous year			Activity against plan YTD	
		Aug-19	Aug-20	Variance	SLA Plan Aug-20	Variance	Phase 3 Activity Target	Variance	YTD 19/20	YTD 20/21	Variance	Plan YTD	Variance
ED	ED Attendances	13,798	10,230	-25.86%	14,775	-30.76%	N/A	N/A	71,451	42,115	-41.06%	72,922	-42.25%
Inpatient	Non Elective	3,805	3,276	-13.90%	4,005	-18.20%	N/A	N/A	19,920	14,346	-27.98%	19,813	-27.59%
	Elective & Daycase	4,751	2,976	-37.36%	4,875	-38.95%	3,326	-10.52%	25,373	10,892	-57.07%	26,044	-58.18%
Outpatient	OP Attendances	51,443	35,462	-31.07%	53,118	-33.24%	46,299	-23.41%	278,092	189,710	-31.78%	283,942	-33.19%

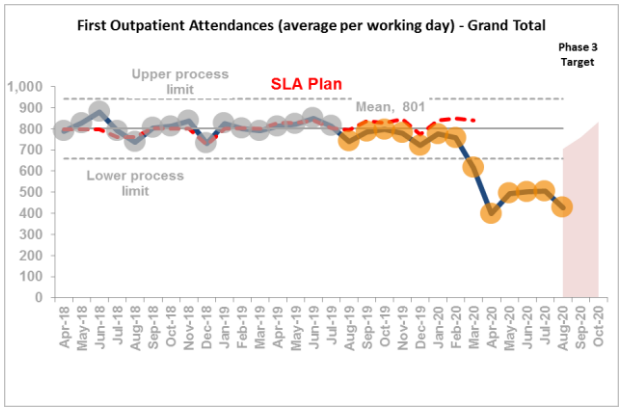
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

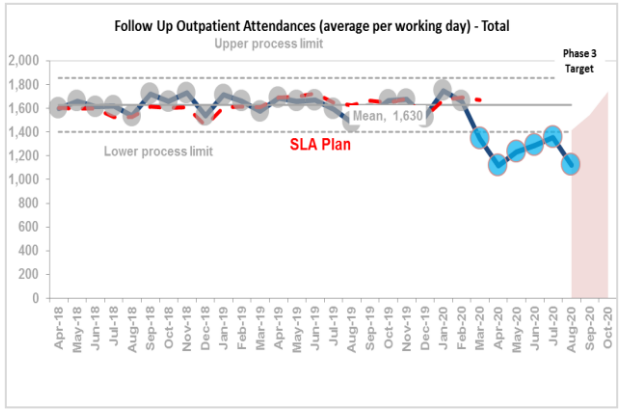
Note: Figures quoted are as at 10/08/2020, and do not include an estimate for activity not yet recorded eg. un-cashed clinics, To Come In's (TCI's). Plan for 2020/21 is based on pre COVID-19 SLA plan. Outpatient data above excludes COVID-19 Attendances / Bence Jones.

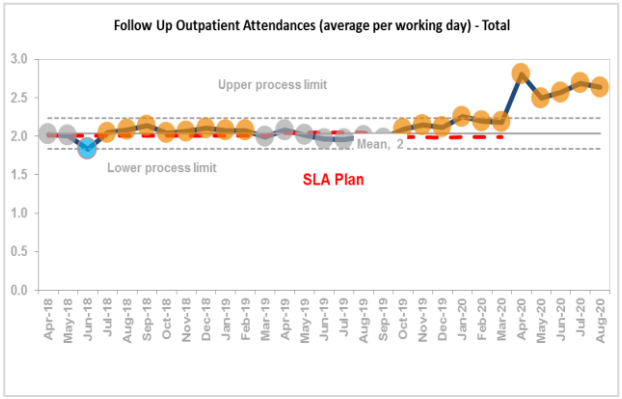
'In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (while aiming for 70% in August);
100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August)'

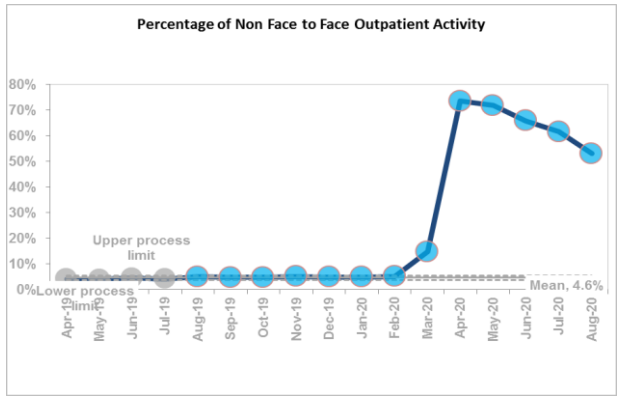
- Simon Stevens, Phase 3 NHS response to COVID, 31 July 2020

Outpatient Productivity









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

What the information tells us

Outpatient (OP) first activity is below the lower control limit in the month of August reporting on average 426 outpatient first attendances per day compared to 504 in July. The number of attendances per day was 42% lower than the same period last year. All specialties are reporting activity in August below the mean.

At Trust level, follow-up activity reduced in August and continues to perform below the lower control limits. Compared to the same month last year, activity per day is 24% lower.

Within both new and follow up activity all services in August are performing with activity levels below the mean, with many specialties dipping slightly compared to July as is usually the case in August.
An element of data catch up will also impact this. Activity overall is below the activity target as set out by NHS England's Phase 3 letter which was to see 100% of our last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).
Please note that COVID-19 related OP activity in this financial year has been excluded from the charts.

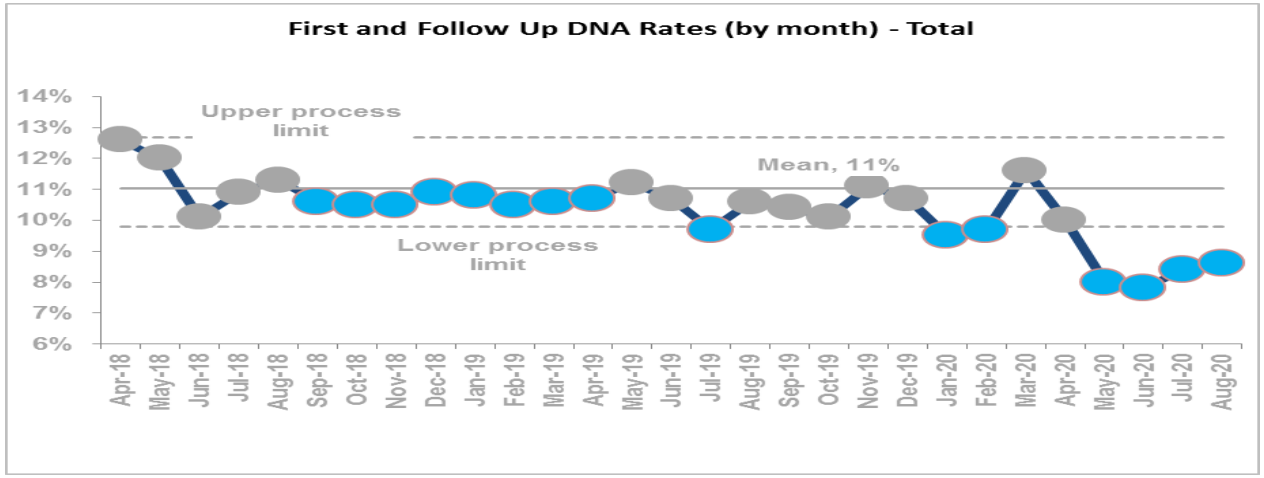
We continue to see over half of our Outpatient appointments virtually, with 53% of patients seen in a virtual setting within August.

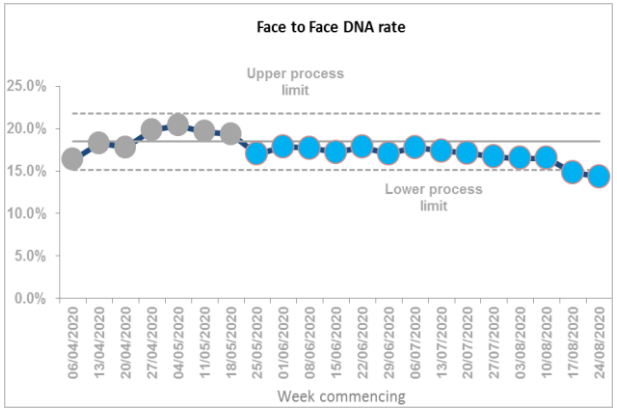
Actions and Quality Improvement Projects

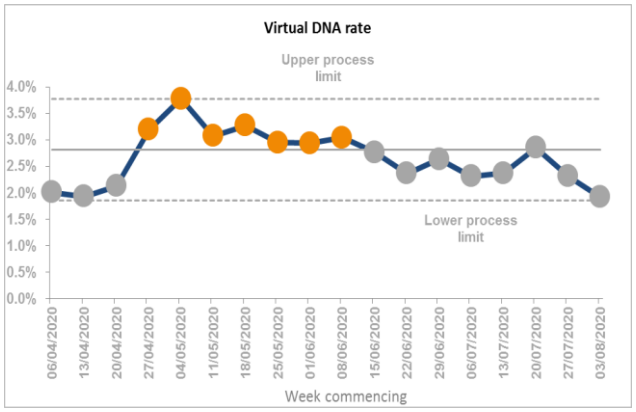
A clinic activity work stream continues to support the re-start and/or increase of clinically appropriate Face-to-Face (F2F) appointments, in line with service led clinical prioritisation. This work stream is led by the Corporate Outpatient team, working closely with Infection Prevention & Control, Estates 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. An assessment of all outpatient clinics has been carried out to identify what additional technology is required to support services deliver their activity safely.

Outpatient Productivity – DNA Rates







Actions and Quality Improvement Projects

An on-going audit has commenced to review non-attendance of F2F appointments. Patient communication requires further improvement as patients are receiving mixed messages regarding their appointment types (F2F or virtual, often with last minute changes). We are engaging with Services regarding template changes so appointments on iCLIP and text messages match. We are also engaging with Services to improve the completion rate of electronic Clinic Decision Outcome Forms (eCDOF) to enable a better picture as figures are currently skewed due to high backlog of non-completion.
There is still a reluctance from some patients to attend the hospital and work continues to ensure patient and GP communication can help to allay fears and encourage patient attendance.

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

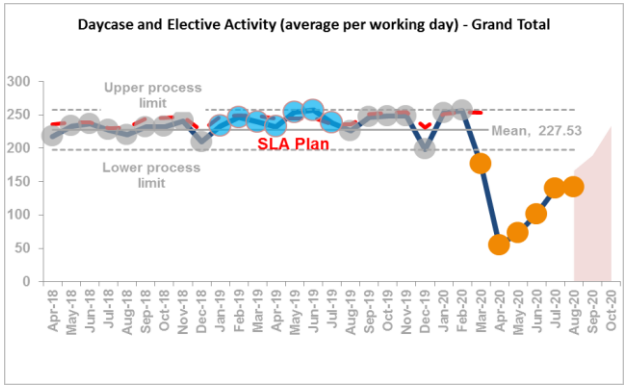
What the information tells us

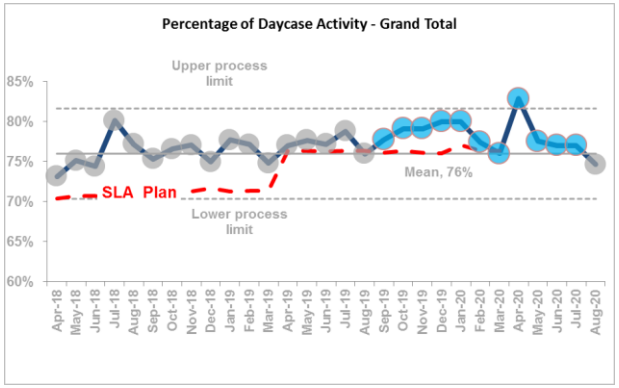
Although overall outpatient activity remains lower than normal, the DNA rate in August remains below the lower control limit reporting that 8.6% of patients did not attend their scheduled appointment.

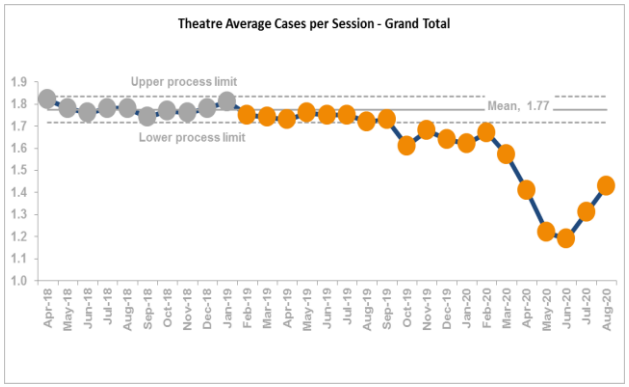
There remains a significant difference seen between the face to face (F2F) and non face to face DNA rate. In the last week of August the face to face DNA rate was 14% compared to a 1.8% DNA rate for those patients seen in a virtual setting.

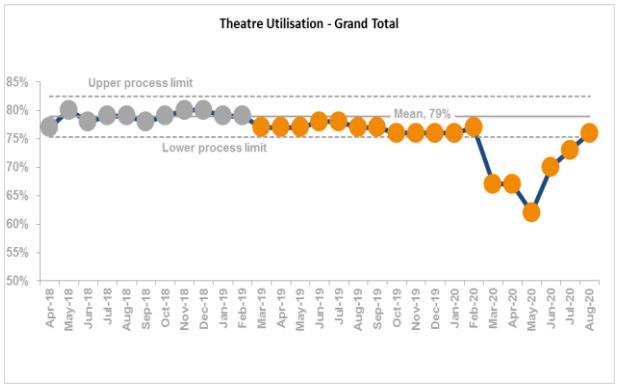
The five specialty areas with the highest number of patients not attending a face to face appointments are within Physiotherapy, Diabetic Medicine, Dermatology, Urology and Gynaecology.

Elective Activity & Theatre Productivity









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

Elective activity continues to see a steady increase as the standing up of activity continues in August, however activity levels remain below the lower control limits and below NHS England target which outlined the aim of at least 70% of last year's activity for both overnight electives and for outpatient / daycase procedures. This rises to 80% in September. On average 142 patients were treated per day throughout the month compared to 226 per day in the same month last year (this is not all theatre based activity). There remains to be an element of data catch up through the coding of activity.

All specialties have seen a positive increase in the number of treatments with the activity coming back online; some services are nearing activity within normal limits. Haematology and Oncology have maintained activity above the upper control limits.

Trust level theatre cases per session continues to see a month on month improvement whilst continuing to adhere to process changes implemented as a result of COVID-19. Theatre utilisation rates have seen a further positive increase in August.

Patients that have been treated though the Independent Sector are included within the activity data, however there is an element of data catch up through coding and we expect this to increase once complete.

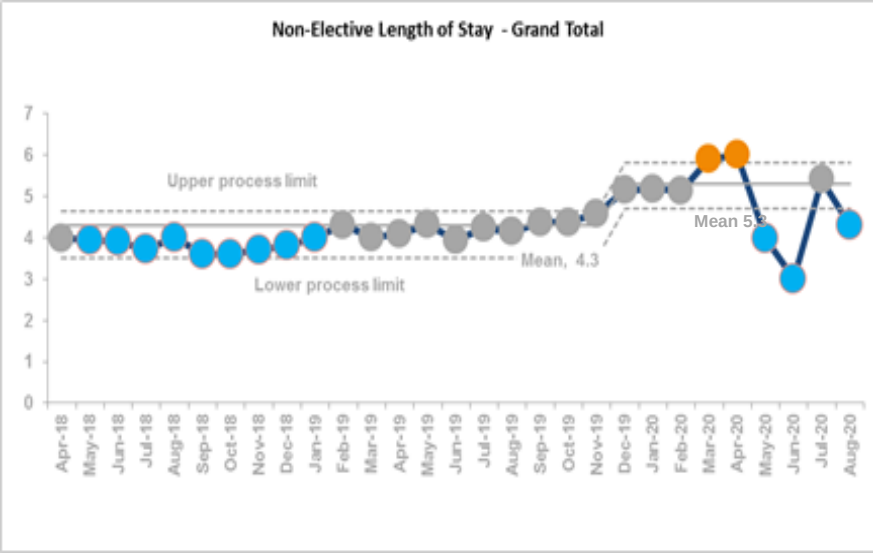
Actions and Quality Improvement Projects

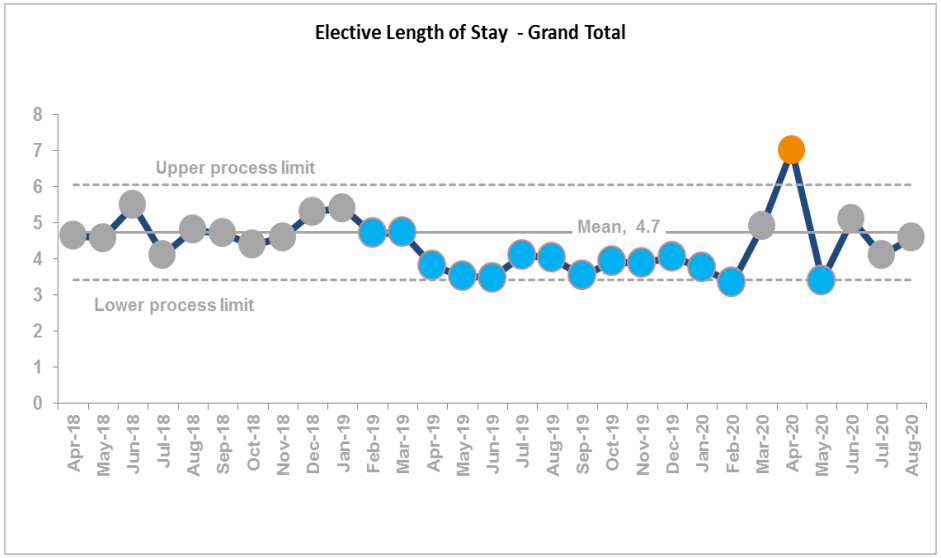
Currently 26 of 29 operating theatres on site at St George's are open, but with the Independent Sector (IS) there are currently 31 theatres available. It is expected that 28 theatres on site will be fully operational from 14th September, as well as the five IS theatres. With the additional capacity, forecast theatre activity levels are expected to be 90% of last year's activity.

Following changes to Infection, Prevention and Control (IPC) guidelines, booking processes are less restrictive, enabling lists to be booked more effectively. We therefore expect to see the average cases per list to increase, as well as overall theatre numbers. This is expected to correlate with reduced opportunity across theatre lists. All lists are reviewed by clinical and management teams as part of list planning processes to ensure maximum utilisation.

Although activity in August was initially restricted by anaesthetic workforce issues, this has been effectively managed through ongoing recruitment processes. This has not proved to be a limiting factor for the establishment of new templates, and we have already seen an improved position following the reopening of schools.

Length of Stay





What the information tells us

Non-elective length of stay has seen variability over the past four months, in August length of stay moved below the lower control limit showing special cause variation. On average, patients admitted through the Emergency pathway stayed in a hospital bed for 4.3 days compared to 5.4 days in July with the number of admissions increasing by 1% compared to the previous month. Compared to the same period last year non-elective admissions are 14% lower.
Within Acute Medicine, Women's and Children and General Surgery the average length of stay remains below the lower control limit. Senior Health and Therapeutics length of stay, although remaining above the mean shows a consistent trend with previous months.

Elective length of stay remains shows common cause variation, with the number of elective procedures and ordinary elective admissions reducing by 37% compared to the same period last year.

Actions and Quality Improvement Projects

Weekly Long Length of Stay meetings continue with all specialties and there continues to be a focus on Red2Green Training.

Discharge to Assess (D2A) is being built in iClip to increase efficiency and enable clinicians to expedite patient discharge.

Homeless pathway and Hospital Avoidance pathway is currently being costed as requested by system partners to assist in planning.

System wide workshop is being led by St. George's where partners such as Local Authorities and community providers will share and explain their service offerings. The objective is to ensure clinicians are able to discharge patients to the most appropriate environment and care and strengthen relationships within networks.

The Trust continues to meet with system partners daily, excluding Sundays, 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?					
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OUR PATIENT PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions	Maternity A	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow G	Cancer A	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR PEOPLE PERSPECTIVE	Workforce A	Agency Use	Estates Health and Safety			

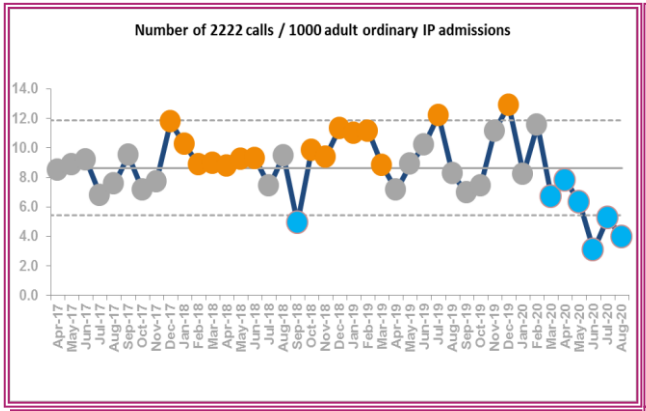
Key

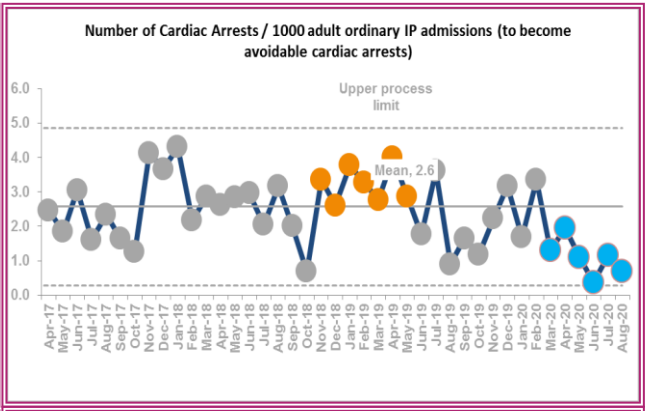
Current Month

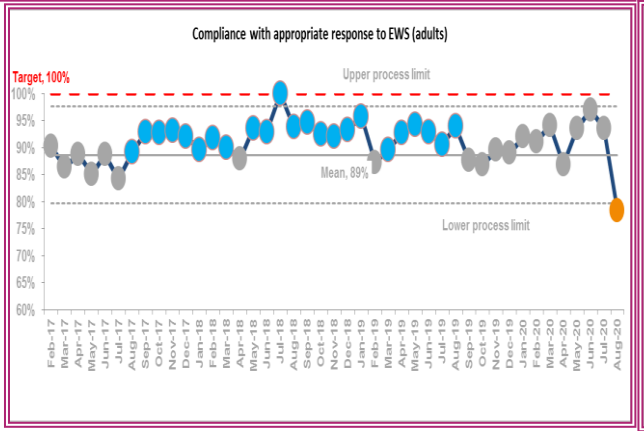
A Previous Month

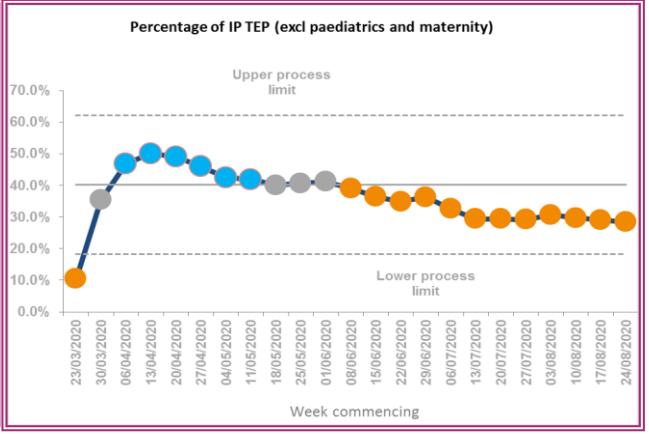
Scorecard RAG rating based on PreCOVID-19 plan

Quality Priorities – Treatment Escalation Plan









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

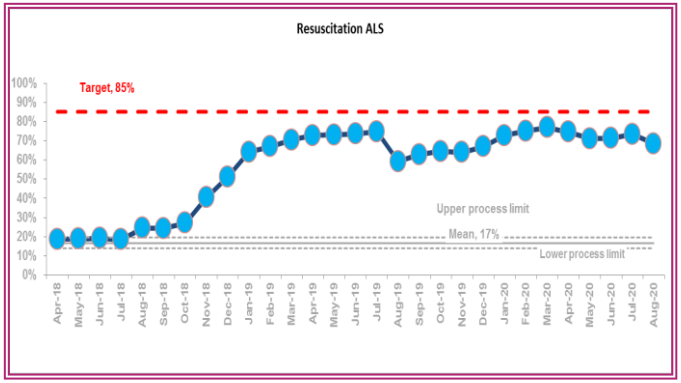
What the information tells us

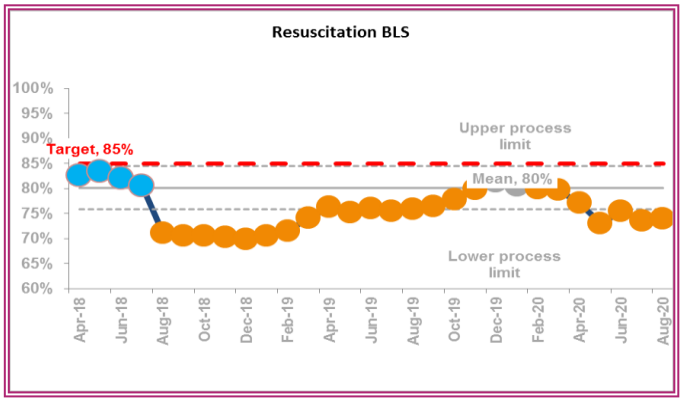
- The number of 2222 calls performance continues to show special cause variation which may be indicative of the impact of the Critical care Outreach Team (CCOT)
- Compliance with appropriate response to Early Warning Score (EWS) fell significantly from 98% last month to 78% this month, The cohort of patients also increased considerably now showing special cause variation. The cohort of EWS patients can be seen in the Appendix.
- On average 30% of all adult inpatients have had a TEP since March. Since June, there has been a steady decline in the number of TEPS undertaken, showing special cause variation.

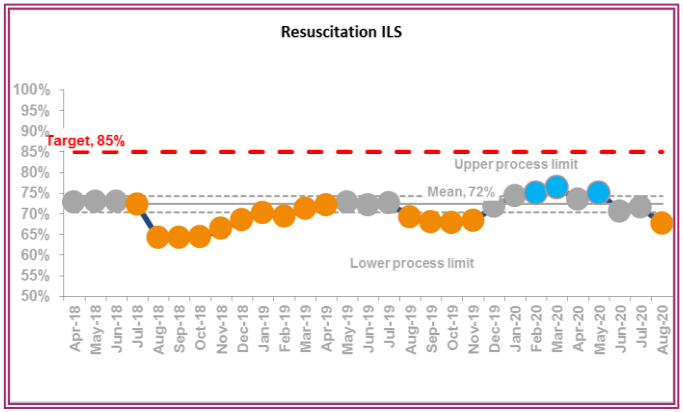
Actions and Quality Improvement Projects

- 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 continues with ward staff regarding low rates of completion
- Between April – July 2020 a monthly point prevalence (PP) audit has been undertaken to examine the extent to which TEPs are restrictive or reflective of patients for full escalation. The PP audit showed that 44.2% of TEPS were completed for adult inpatients
- NEWS appropriate response audit now undertaken jointly by CCOT and ward sister to standardise the audit approach

Quality Priorities – Deteriorating Patients







- ALS (Advanced Life Support) training performance remains within special cause variation but has not met the 85% performance target.
- BLS (Basic Life Support) training performance remains on average around 75%.
- ILS (Intermediate Life Support) fell below the mean showing special cause variation.

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

Actions and Quality Improvement Projects

To increase access to training an on-line BLS level 2 module with face to face assessment of CPR skills is in development was launched in August 2020. This on-line module is now 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.

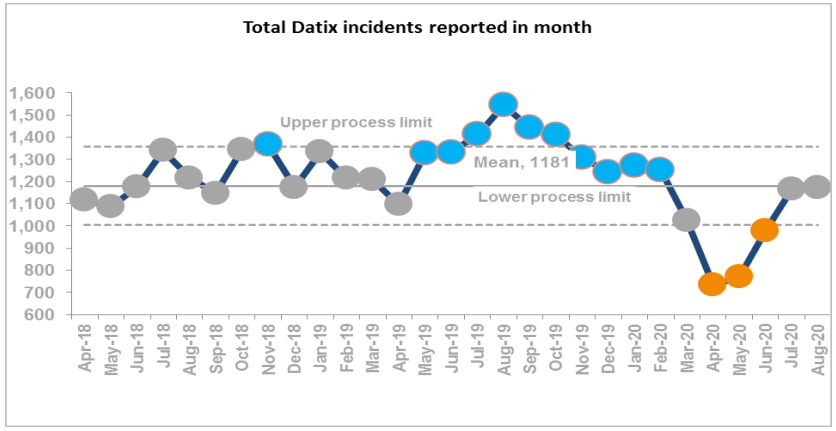
The Resuscitation Council UK has extended provider and instructor certificates for a further six months.

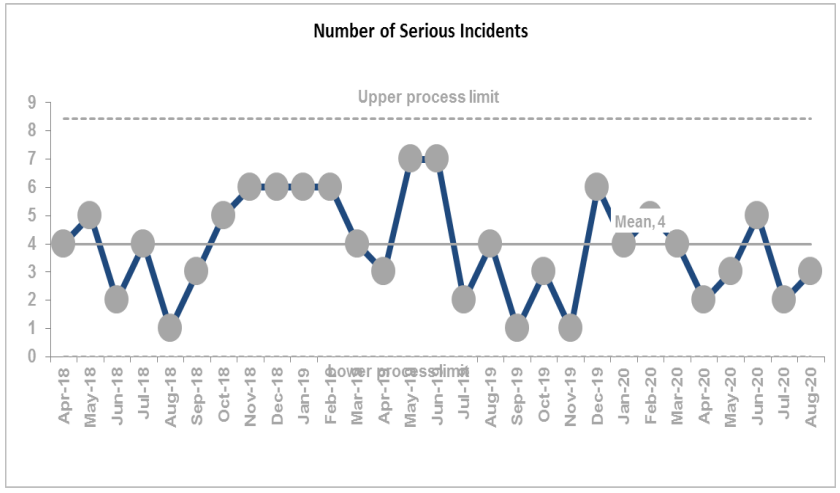
Additional 2-day Advanced Life support courses are to commence including paediatrics, as courses continue to be oversubscribed.

All courses are running at reduced capacity to allow for Social distancing.

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/ Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Total Datix incidents reported in month		1,544	1,442	1,410	1,309	1,241	1,271	1,252	1,026	734	770	979	1,166	1,173
Monthly percentage of Incidents of Low and No Harm		98.0%	97.0%	97.0%	96.0%	96.0%	96.0%	96.0%	93.0%	93.0%	94.0%	95.0%	97.0%	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%	93.0%	97.0%	97.0%	98.0%	86.0%	94.0%	82.0%	86.0%	84.0%	80.0%	90.0%	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 August 2020 remains consistent with July (in line with figures before April 2020).
- There were no Never Events in August 2020

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

Actions and Quality Improvement Projects

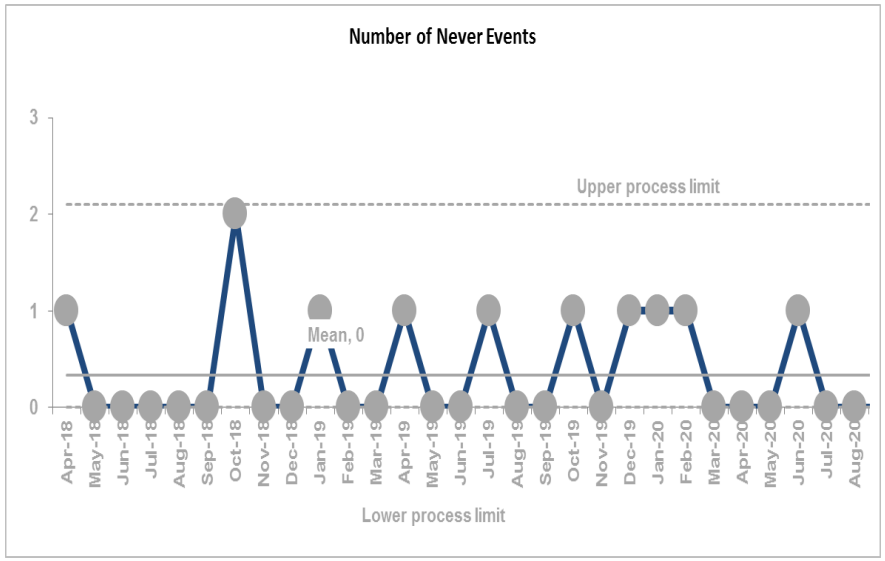
Incidents – The monthly percentage for incidents of low and no harm continues to be monitored and reported. This will allow for benchmarking against other Trusts and tracking of the harm profile.

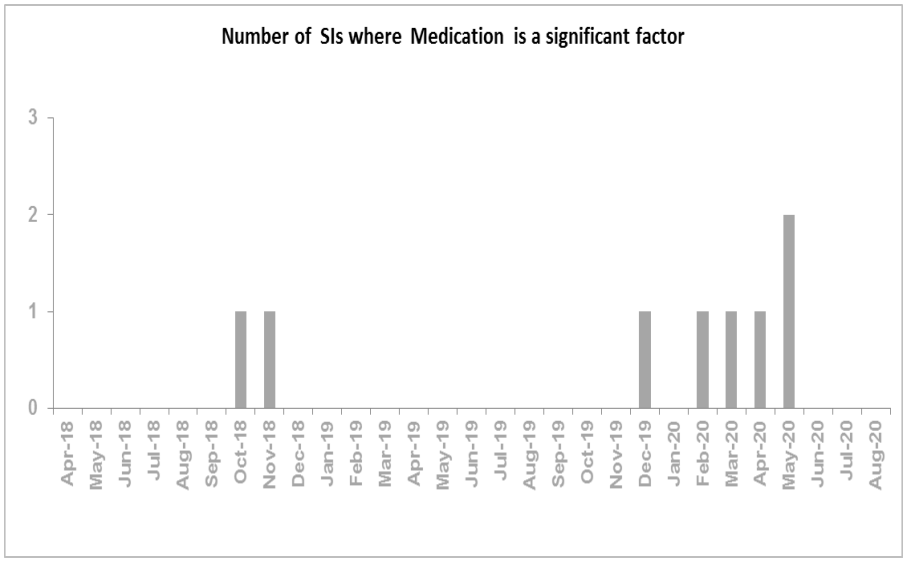
3.2

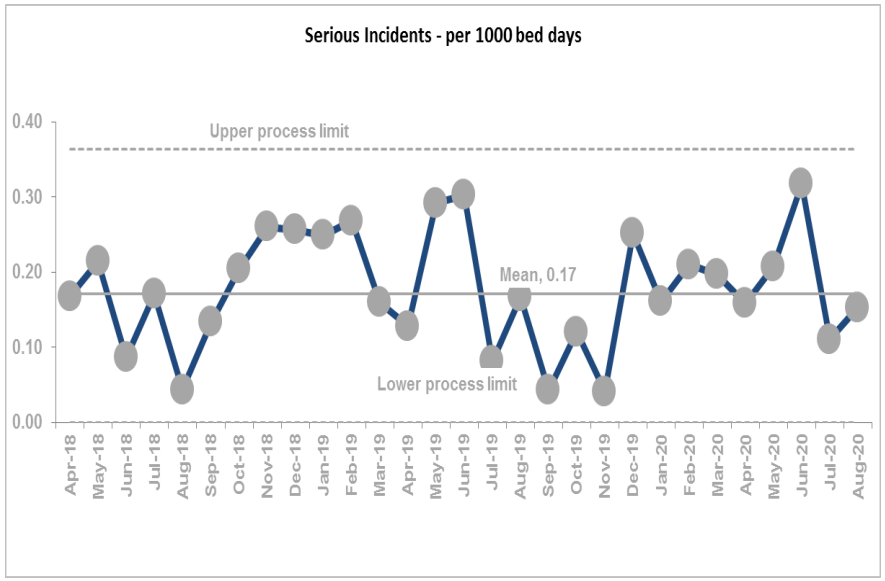
Our Patient Perspective

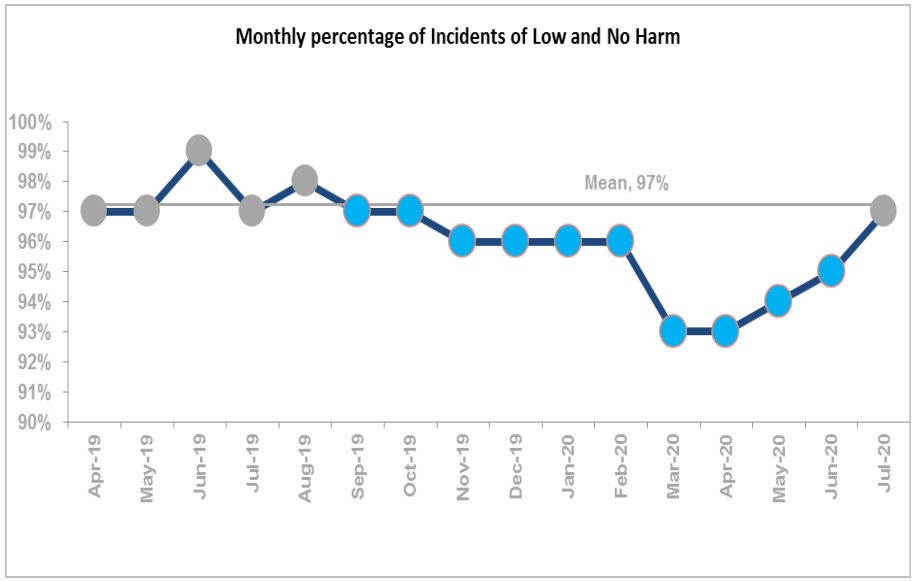
Quality Priorities – Learning from Incidents

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



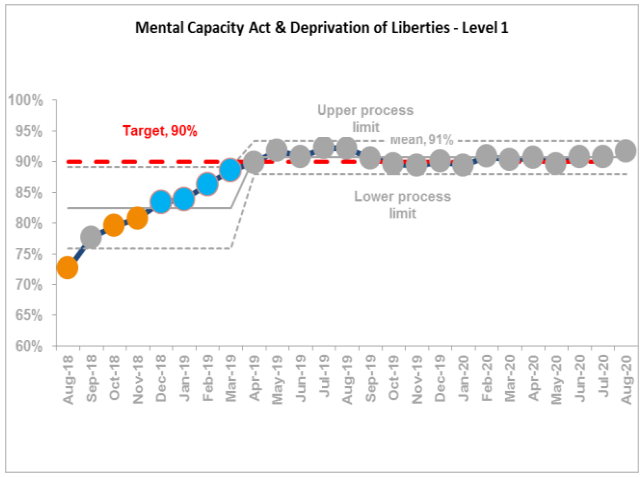


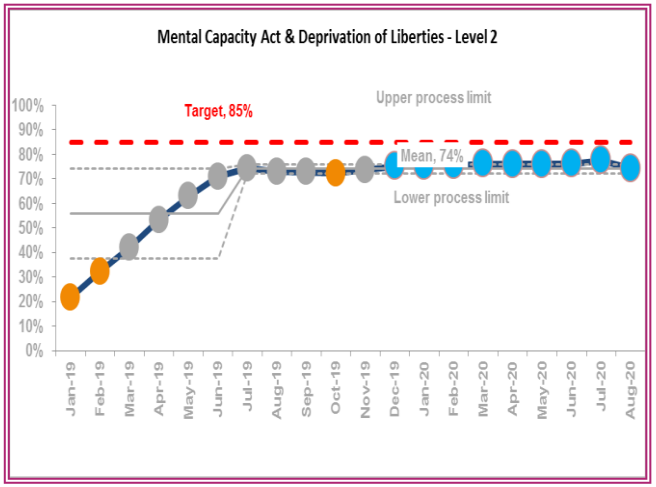




Data is 1 month in retrospect

Quality Priorities – Mental Capacity Act & Deprivation of Liberties





What the information tells us

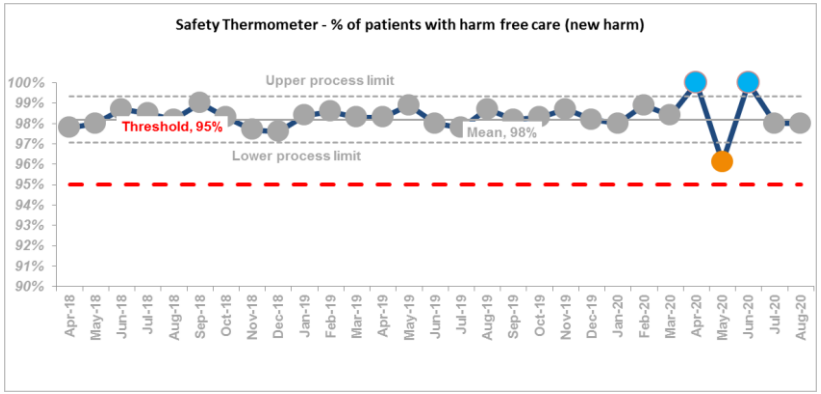
- Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 remains within target.
- Level 2 training performance has plateaued. Overall Level 2 compliance was 74% this month..

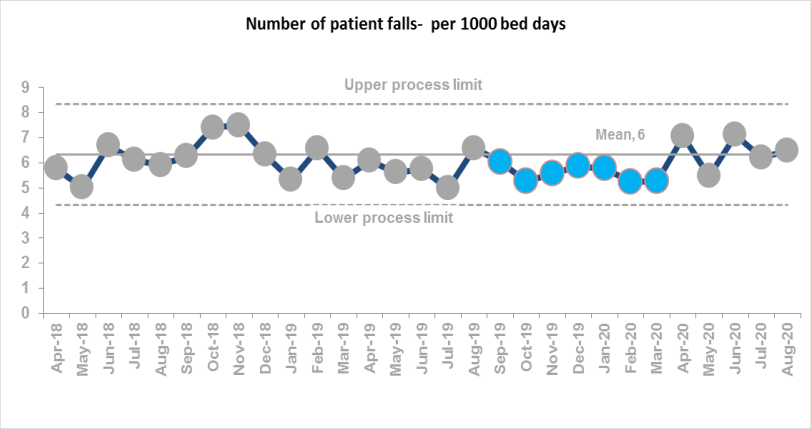
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

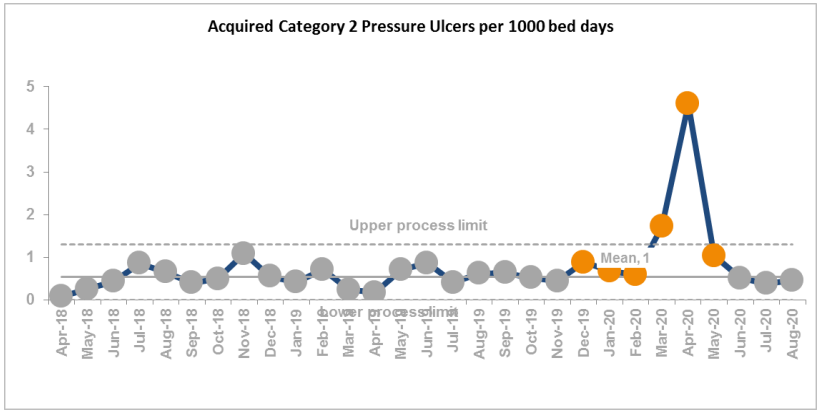
Actions and Quality Improvement Projects

- iCLIP MCA templates now being finalised by IT.
- Further planning is underway to establish an appropriate timeframe for the quarterly staff knowledge audit. The aim of this audit, developed in partnership with South West London partners, is to enable the Trust to benchmark and review level of staff knowledge against an expert agreed pass mark and in relation to other local healthcare organisations
- Audit of consent including capacity, with deep dive component undertaken in August 2020
- MCA Steering Group due to re-start November 2020.
- Level 2 training- MCA lead will send communications to all staff regarding training and to their ensure compliance

Patient Safety







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

What the information tells us

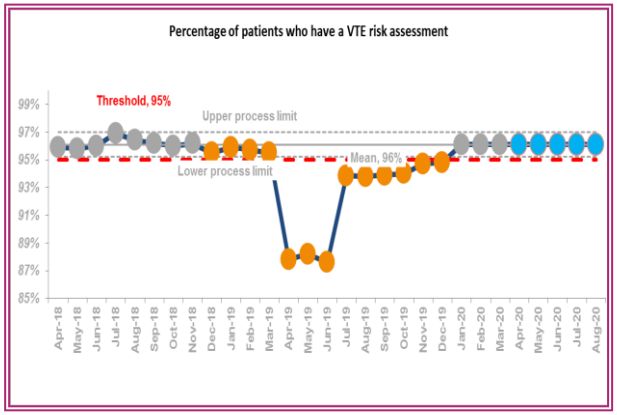
- The Trust VTE standards is above the upper process control limit.
- Safety thermometer– percentage of patients with harm free care is within target
- The number of Category 3 Pressures ulcers show special cause variation.
- The number of falls per 1000 bed days shows common cause variation.

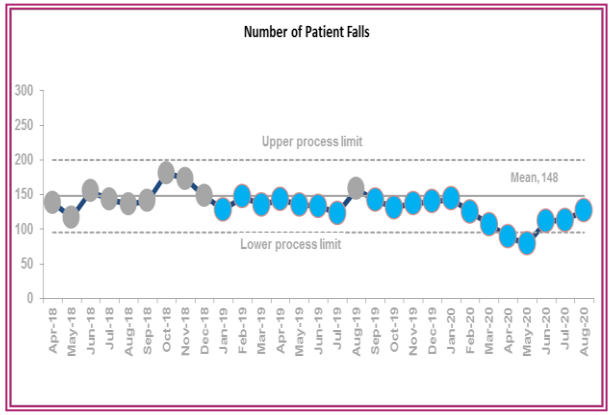
Actions and Quality Improvement Projects

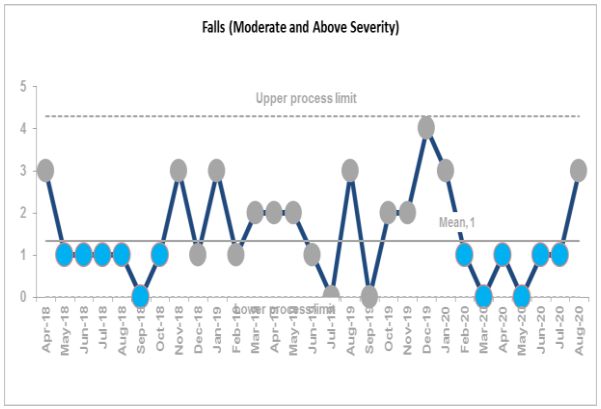
- The Hospital Thrombosis Group (HTG) continues to monitor the Trust performance on VTE risk assessments. Results from Q1 for VTE risk assessments show an overall compliance of 94.9% which is a slight decrease in comparison to Q4 performance of 95.5%. The slight decline in Q1 performance appears to be due to the impact of Covid-19 on ward statuses, frequent ward moves and re-deployment of staff.
- All Category 3 and above pressure ulcers (PU) continue to be reviewed following completed Root Cause Analysis. The review is conducted at ward level with senior nursing input and subsequent action plans agreed with the clinical areas. Tissue viability nurses continue ward visits and facilitate audit and teaching sessions.
- The Trust Falls Prevention Group paused during the pandemic has now been reinstated. The group terms of reference and membership have been reviewed and updated. The Trust Falls prevention co-ordinator has resumed ward visits and has re-established regular education activities. Moderate harm falls continue to be reviewed following completed Root Cause Analysis. This is reviewed at ward level with senior nursing input and an action plan agreed with the clinical areas.

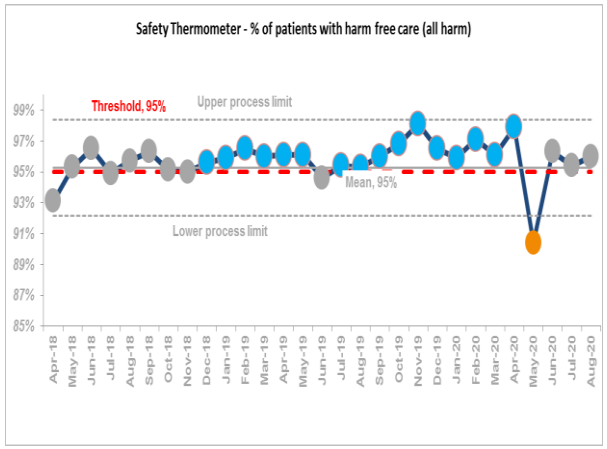
Patient Safety

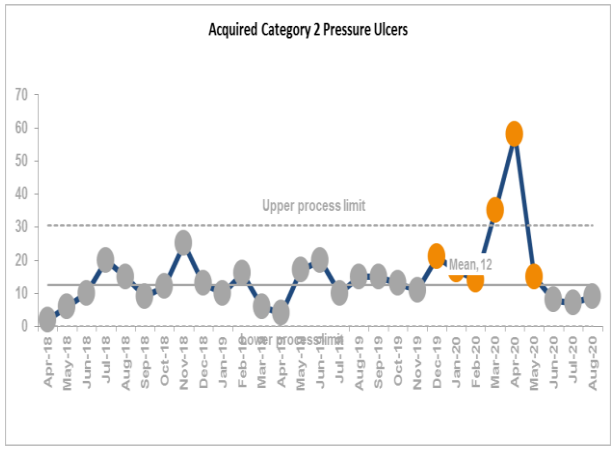
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

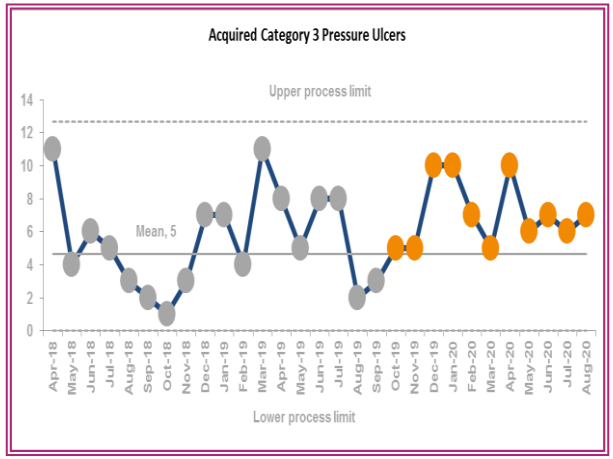






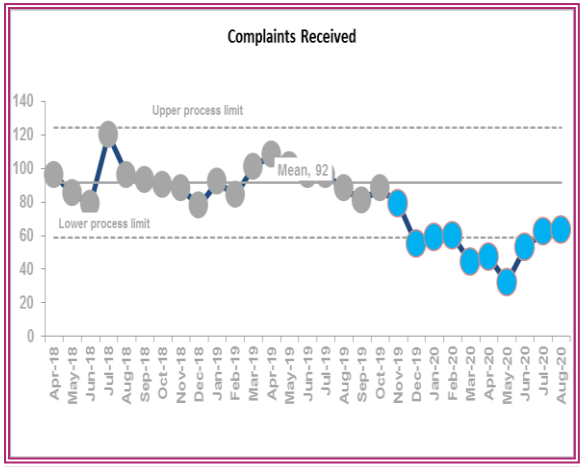


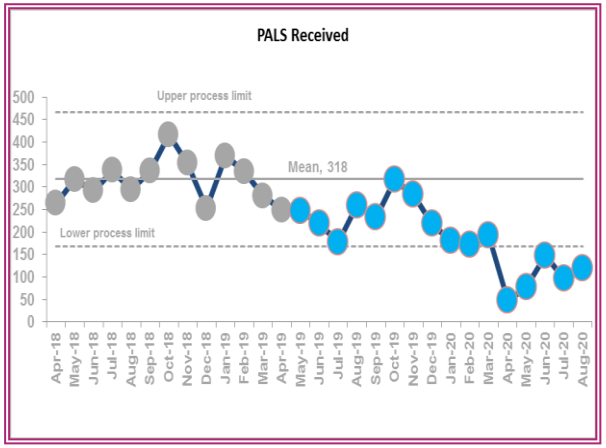


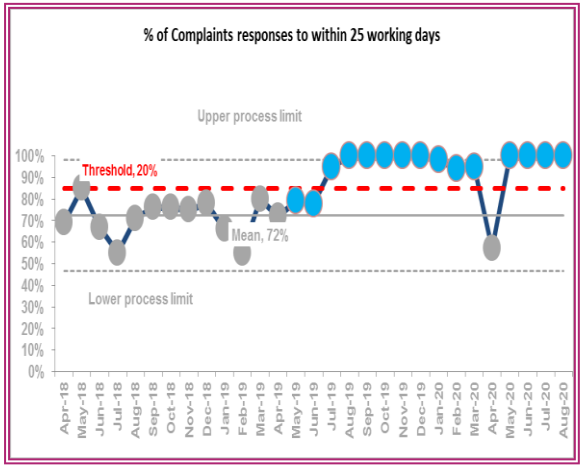


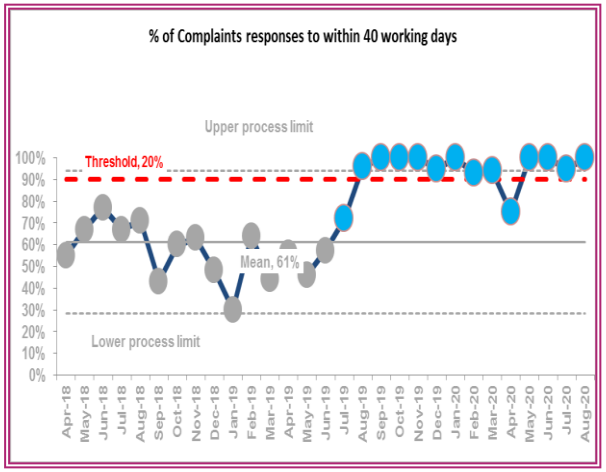
Complaints

Indicator Description	Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Complaints Received		88	81	88	79	55	59	60	44	24	32	53	62	63
% of Complaints responses to within 25 working days	85%	100%	100%	100%	100%	100%	98%	94%	95%	57%	100%	100%	100%	100%
% of Complaints responses to within 40 working days	90%	96%	100%	100%	100%	95%	100%	93%	94%	75.0%	100%	100%	95%	100%
% of Complaints responses to within 60 working days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	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 remains lower than expected.
- Performance across all response categories is above target.
- The number of PALS enquiries received has increased this month but is still impacted by the current closure of the service to walk-ins due to Covid-19

Actions and Quality Improvement Projects

- Daily complaints comcell continues to focus attention on timely investigation and response from the Trust

3.2

Our Patient Perspective

Infection Control

Indicator Description	Threshold 2020-2021	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	YTD Actual
MRSA Incidences (in month)	0	0	0	1	0	1	0	0	0	0	0	0	0	1	1
Cdiff Hospital acquired infections	TBC	4	6	3	2	2	5	3	1	1	3	5	4	3	17
Cdiff Community Associated infections		1	0	1	2	0	0	0	2	0	0	1	0	0	
MSSA	25	3	2	2	3	5	6	3	2	3	0	2	5	4	14
E-Coli	60	7	8	6	4	9	5	7	4	4	8	3	3	0	18

Nosocomial Infections

Indicator Description	Target	20/05/2020	27/05/2020	03/06/2020	10/06/2020	17/06/2020	24/06/2020	01/07/2020	08/07/2020	15/07/2020	22/07/2020	29/07/2020	05/08/2020	12/08/2020	19/08/2020	26/08/2020
Nosocomial Infections -Hospital onset healthcare associat	N/A	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0

What the information tells us

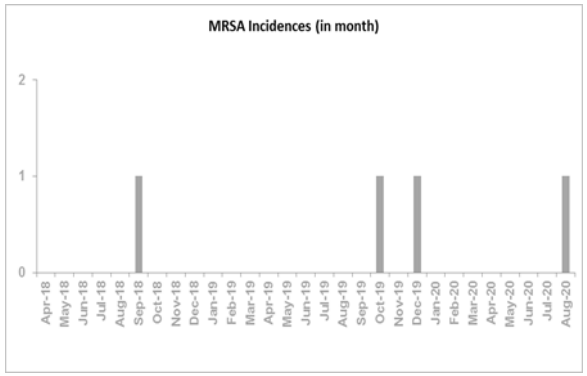
- The Trust has reported 1 MRSA bacteraemia during August 2020: Specimen date 23/08/20 from General Intensive Care Unit. At point of admission to the Trust the patient had positive nose and groin swabs. Post Infection Review (PIR) process is on-going and the review outcome will be reported to Infection Control Committee
- There were three cases of *C.difficile* infection, all hospital onset healthcare associated cases; no community onset healthcare associated. RCA's currently underway to identify any contributing causes
- The number of Ecoli and MSSA cases reported remains within control limits
- There were no nosocomial COVID-19 infections during August 2020. A possible cluster of 3 COVID cases investigated in May 2020 were found to be unrelated and not hospital acquired

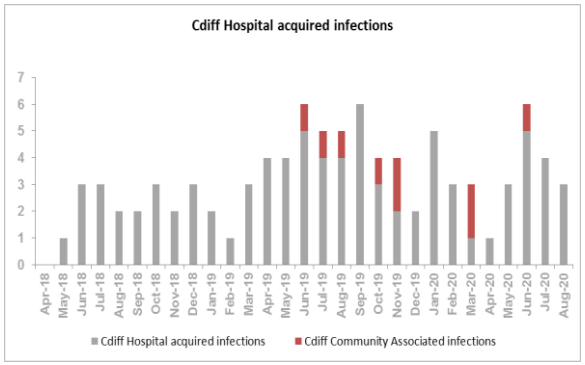
Actions and Quality Improvement Projects

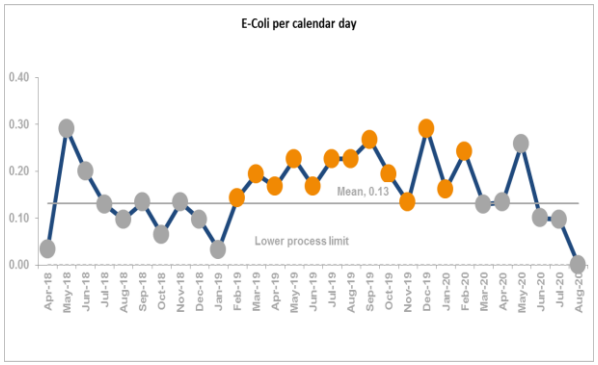
- The Trust is conducting hand hygiene audits weekly in ward areas and these are validated monthly by the Infection Prevention and Control nurses
- The ward and departmental accreditation programme remains in place and includes measures on infection control and cleaning standards
- Enhanced cleaning and point of contact cleaning currently in place on ward and communal areas in the trust.

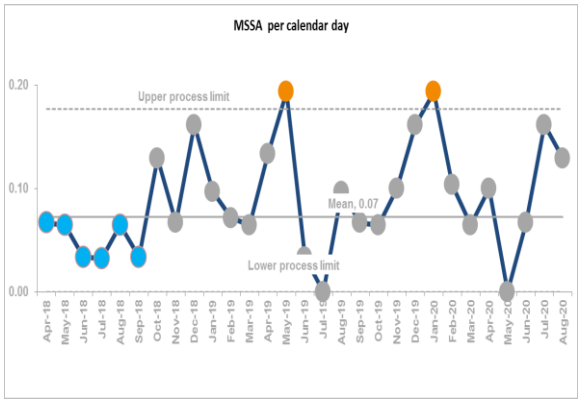
Infection Control

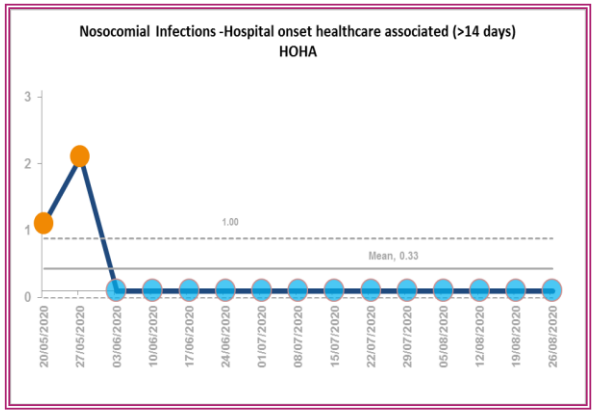
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance











3.2

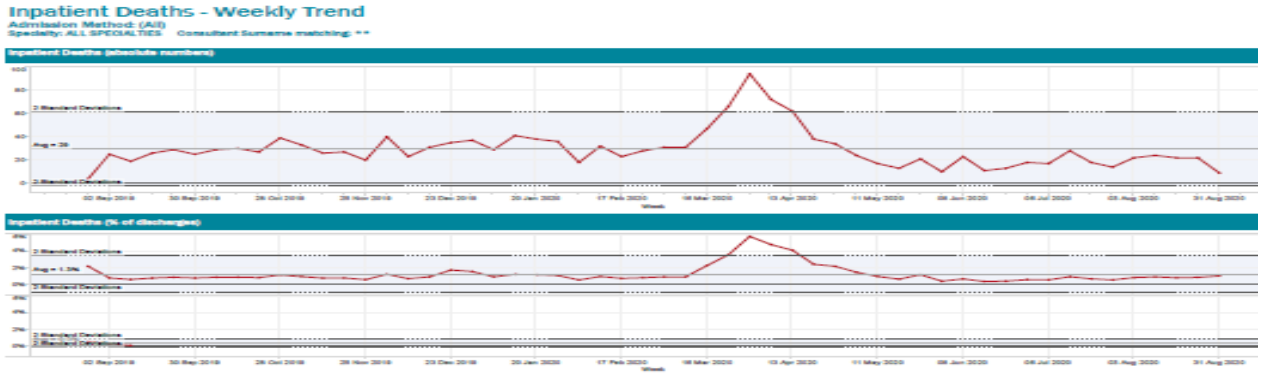
Our Patient Perspective

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	May-20	Jun 2019 to May 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	105.8	81.8	99.6
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	102.7	62.7	103.7
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	96.7	87.5	99.0

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	Mar-19-Feb-20	Apr-19-Mar-20
Summary Hospital Mortality Indicator (SHMI)	0.81	0.83	0.83	0.83	0.85	0.85	0.85	0.86	0.88	0.89	0.89

Indicator Description	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	10.6%	9.9%	7.9%	10.3%	9.8%	10.0%	10.6%



Note: HSMR data reflective of period Jun 2019 – May 2020 based on a monthly published position. This month we see discharges to May 2020. As is the norm this time of year, the data reported for March is the second submission of data for this period for Dr Foster i.e. HSMR.
SHMI data is based on a rolling 12 month period and reflective of period April 2019 to Mar 2020 published (Aug 2020). Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways

What the information tells us

Mortality as measured by the summary hospital-level mortality indicator (SHMI) is lower than expected for the year April 2019 – March 2020. Our latest HSMR shows our mortality to be as expected. It should be noted that these indicators have taken differing approaches to managing the impact of Covid-19, which is just starting to be included in the periods reported. Dr Foster, who produce the HSMR, include Covid-19 activity; whereas NHS Digital who are responsible for SHMI have excluded Covid-19 activity.

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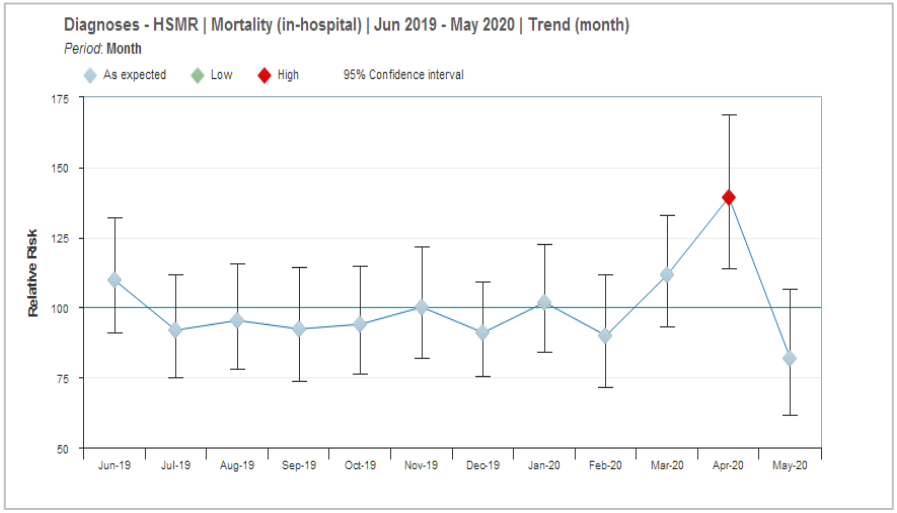
Actions and Quality Improvement Projects

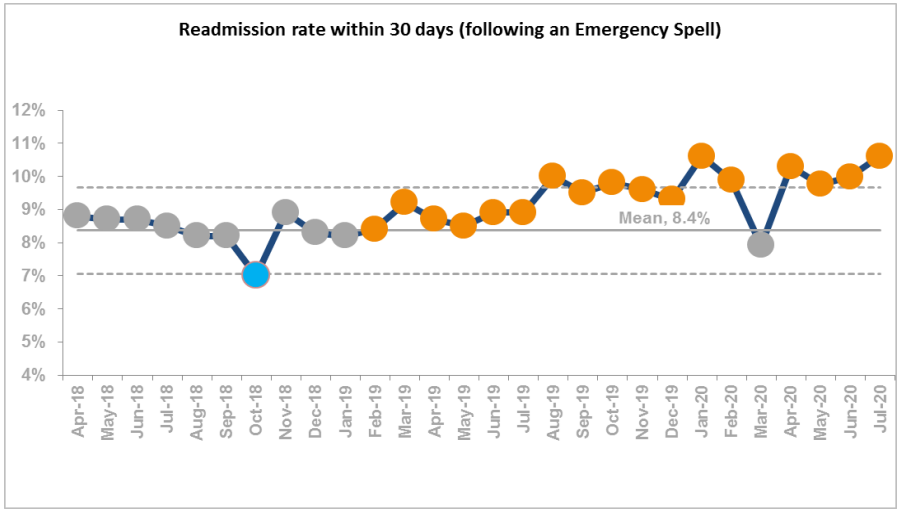
We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Committee (MMC). The committee has currently prioritised the investigations of sepsis, following signals identified through Dr Foster and SHMI and trauma, following an external alert from TARN(Trauma Audit & Research Network).

Mortality and Readmissions (Hospital Standardized Mortality Rate)

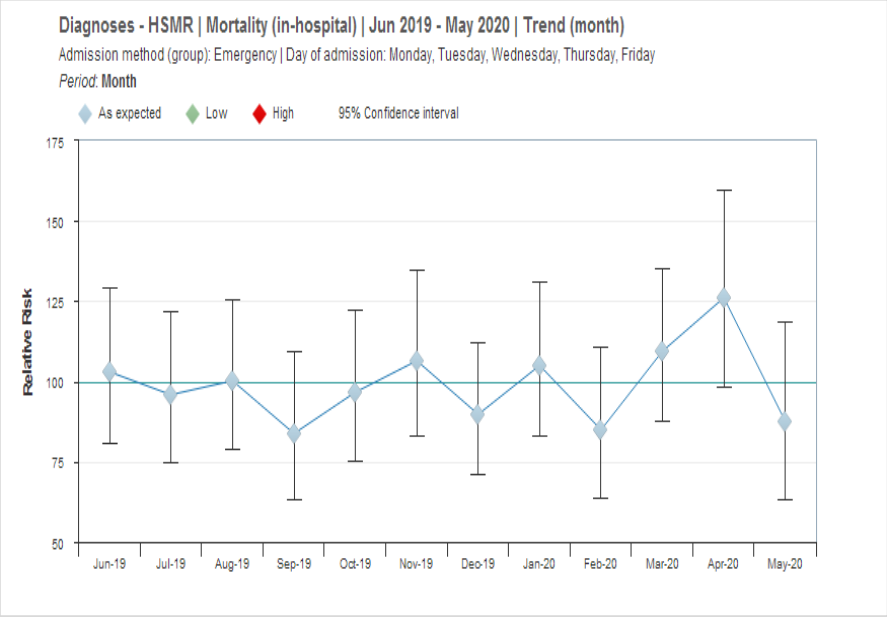
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

HSMR

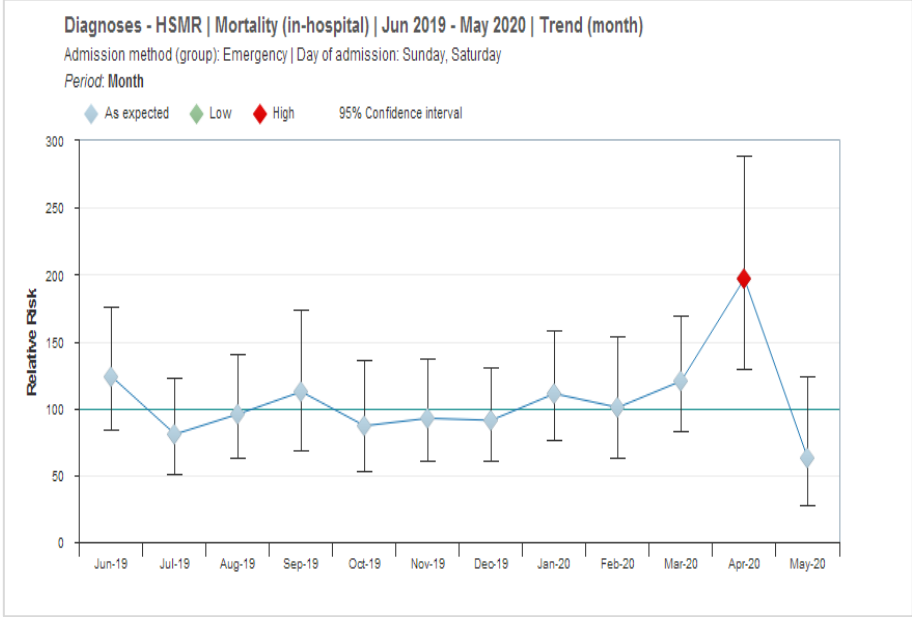




HSMR Weekday



HSMR Weekend

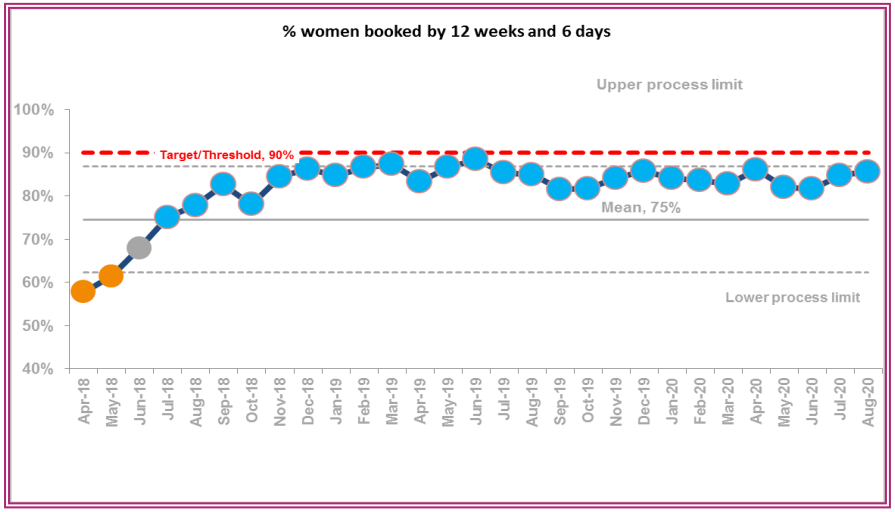


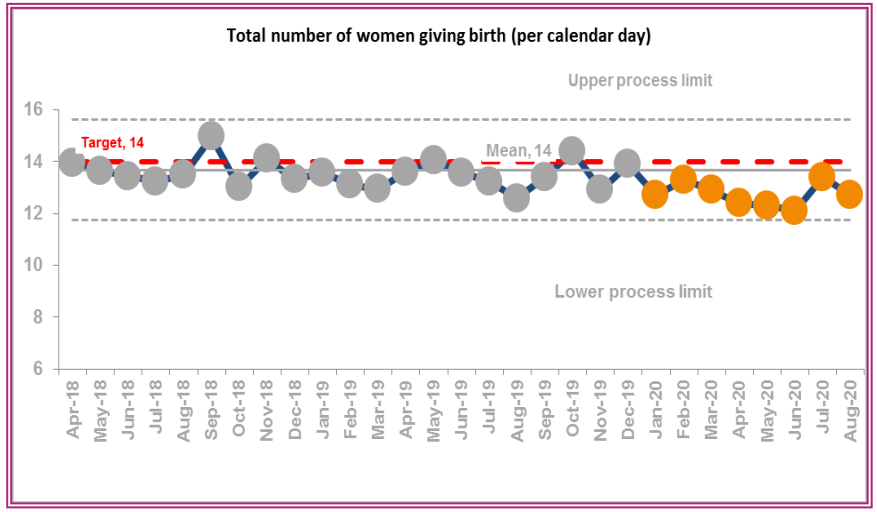
3.2

Our Patient Perspective

Maternity

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





What the information tells us

The number of births fell slightly in August, however complexity remained high.

Carmen Suite was closed for almost half of shifts in the month. This was due to staffing issues across the unit and the need to deploy midwives to ensure the safest staffing across maternity services as a whole. The number of substantive staff on Carmen ward is due to increase in the Autumn as 16 new midwives are due to start between September and November 2020. In addition, the Director of Midwifery, along with the Finance Team, have produced a trajectory to increase staffing further by the end of December 2020. This will include a further 15 posts.

The number of stillbirths in August fell compared to July 2020, but remained higher than normal. All of the cases have been reviewed and will be reported appropriately externally in line with current requirements. The stillbirth number includes all cases reported to 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRACE), which includes two feticides and three still births (from 24 weeks). Initial review suggests no clear patterns over the last few months, although a number relate to the death of one baby in a multiple pregnancy.

The percentage of women booked by 12 plus 6 weeks of pregnancy rose to over 85% which is one of the highest numbers in the last year. However, the overall number of bookings in month was down.

Actions and Quality Improvement Projects

Continued in depth analysis of still births and implementation of urgent actions arising from the review.

Senior midwives reviewing staffing each day to keep Carmen Suite open as much as possible and recruitment process underway for additional staffing.

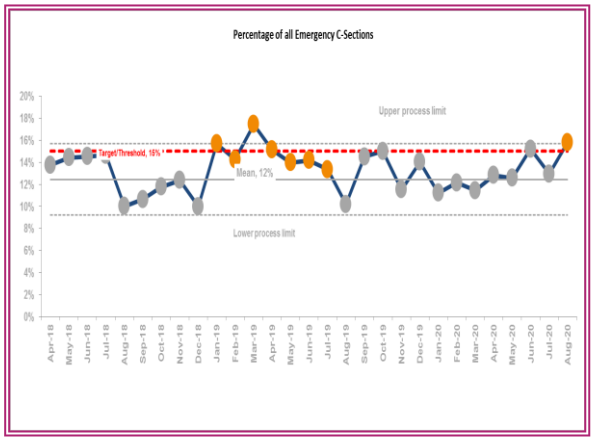
Maternity

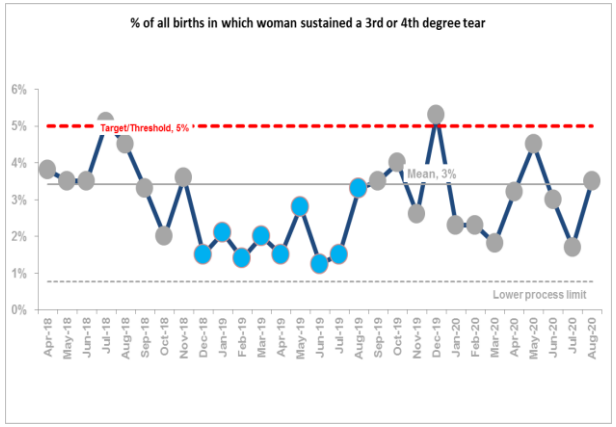
Maternity Dashboard

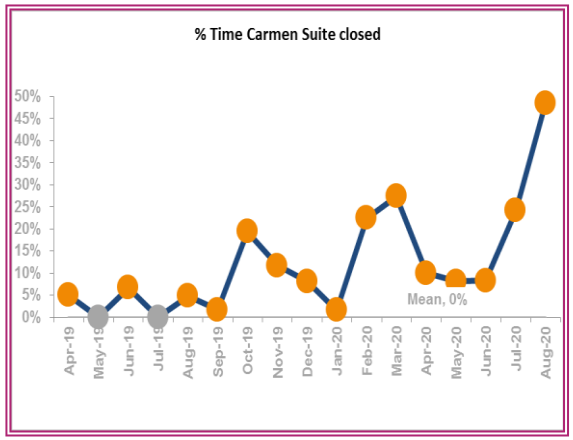
Definitions	Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Total number of women giving birth (per calendar day)	14 per day	12.6	13.4	14.4	12.9	14	13	13	13	12	12	12	13	13
% Time Carmen Suite closed	0%	4.8%	1.7%	19.4%	11.7%	8.1%	1.6%	22.5%	27.4%	10.0%	8.1%	8.3%	24.2%	48.4%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	3.3%	3.5%	4.0%	2.6%	5.3%	2.3%	2.3%	1.8%	3.2%	4.5%	3.0%	1.7%	3.5%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.1%	2.0%	2.3%	3.4%	3.0%	1.5%	2.1%	1.8%	2.9%	2.1%	1.4%	1.9%	2.0%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		9	10	7	14	11	12	11	13	9	9	15	20	11
Supernumerary Midwife in Labour Ward	>95%	96.8%	96.7%	96.8%	96.7%	96.8%	96.8%	94.8%	93.5%	100.0%	96.8%	96.7%	96.8%	93.5%
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	<2	0	0	0	0	3	0	0	0	0	0	4	0	0
Percentage of all Emergency C-Sections	15%	12.8%	15.7%	15.1%	12.4%	14.9%	12.4%	13.9%	12.7%	13.2%	12.5%	15.2%	12.9%	15.8%
% women booked by 12 weeks and 6 days	90%	84.9%	81.5%	81.7%	84.1%	85.7%	84.0%	83.6%	82.7%	86.1%	82.0%	81.6%	84.8%	85.6%

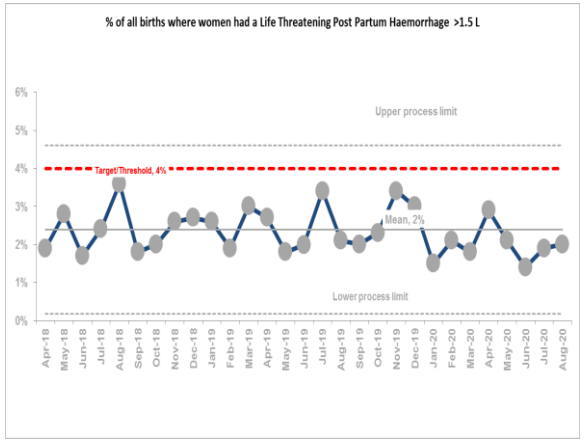
Maternity

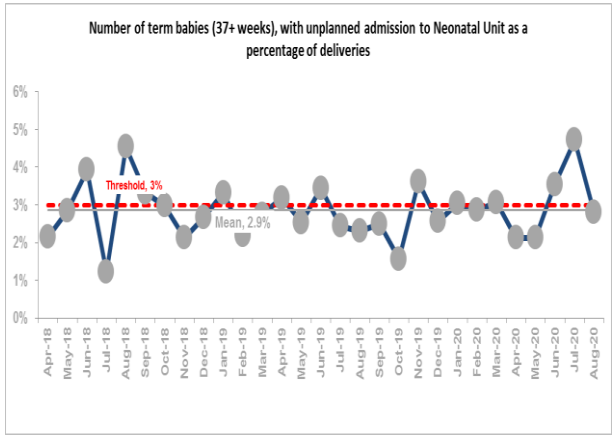
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

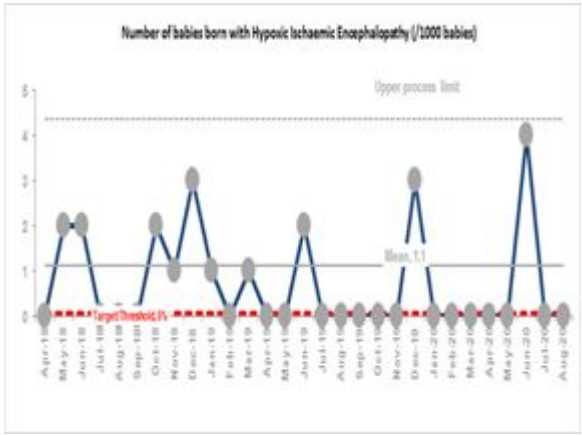












3.2

Outstanding care every time

Friends & Family Survey

Indicator Description	Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Emergency Department FFT - % positive responses	90%	82.7%	80.5%	81.5%	79.0%	80.3%	84.2%	86.2%	87.8%	93.9%	93.6%	90.0%	89.7%	90.1%
Inpatient FFT - % positive responses	95%	96.5%	96.6%	96.0%	96.5%	96.9%	96.8%	96.6%	97.2%	100.0%	97.2%	93.6%	97.7%	97.2%
Maternity FFT - Antenatal - % positive responses	90%	N/A	100.0%	N/A	N/A	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	N/A	N/A	N/A
Maternity FFT - Delivery - % positive responses	90%	97.9%	100.0%	95.2%	100.0%	100.0%	94.1%	100.0%	100.0%	N/A	100.0%	N/A	100.0%	N/A
Maternity FFT - Postnatal Ward - % positive responses	90%	98.3%	95.2%	100.0%	97.3%	88.0%	90.7%	96.9%	100.0%	N/A	0.0%	0.0%	89.9%	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	90.0%	100.0%	N/A	100.0%	N/A	N/A	N/A
Community FFT - % positive responses	90%	98.1%	98.8%	99.3%	98.1%	97.7%	100.0%	98.6%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%
Outpatient FFT - % positive responses	90%	90.8%	90.1%	89.6%	90.7%	90.3%	89.9%	89.9%	91.7%	98.2%	89.9%	88.8%	90.3%	89.1%

What the information tells us

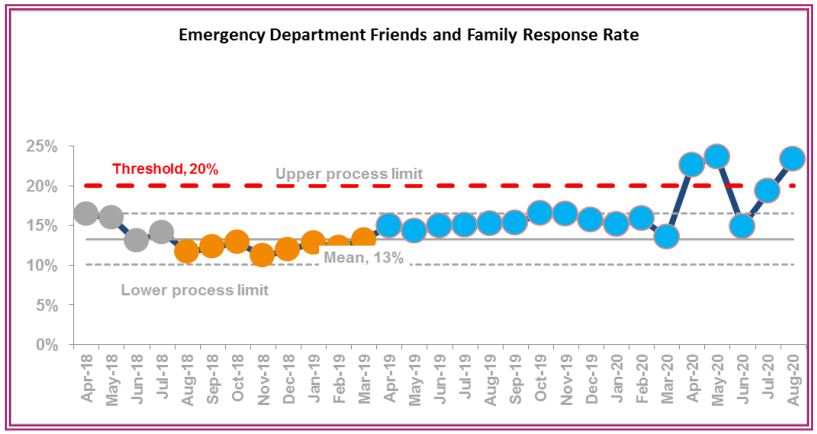
- The cohort of patients surveyed is gradually increasing.
- The percentage of positive responses are within target for the Emergency Department, Inpatients, Community and Maternity Postnatal Ward.
- Though Outpatients narrowly missed achieving the 90% target, the service's positive response rates continues to show a special cause variation with a deterioration with position.

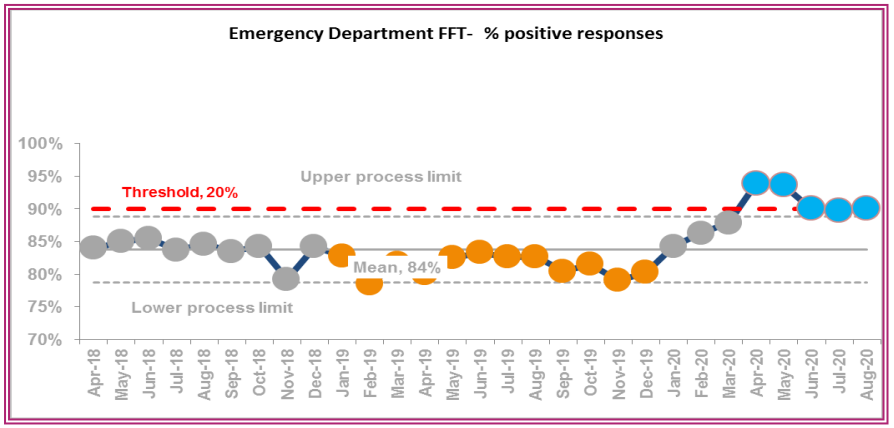
Actions and Quality Improvement Projects

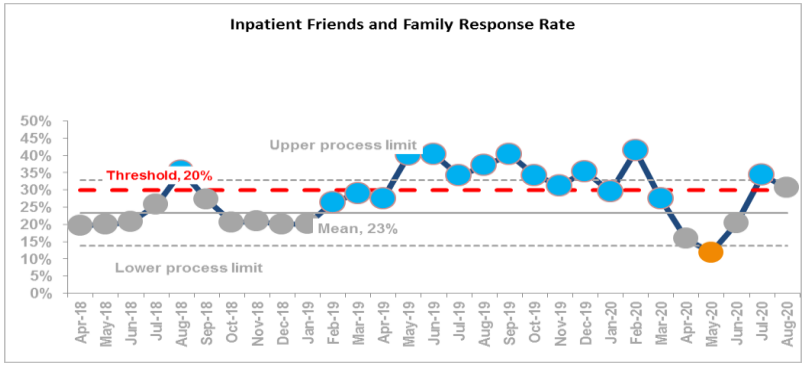
- The FFT surveys completed on tablet computers have been reactivated since July 2020
- The FFT surveys will resume across all areas by 1 December 2020 as data submission NHS Digital will recommence by then.

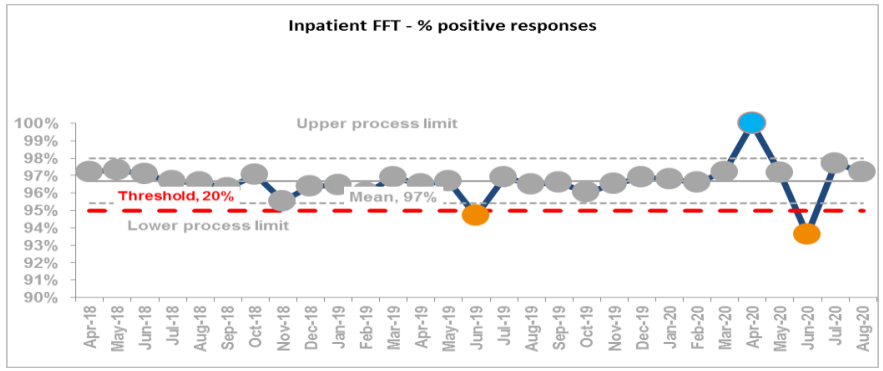
Friends and Family Test

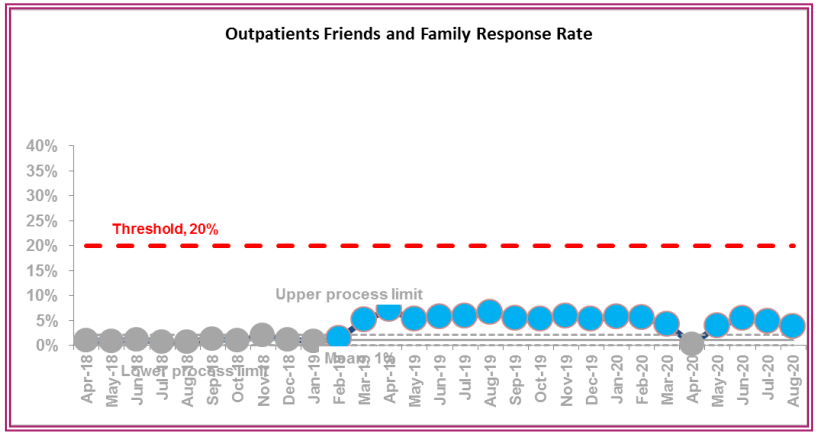
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

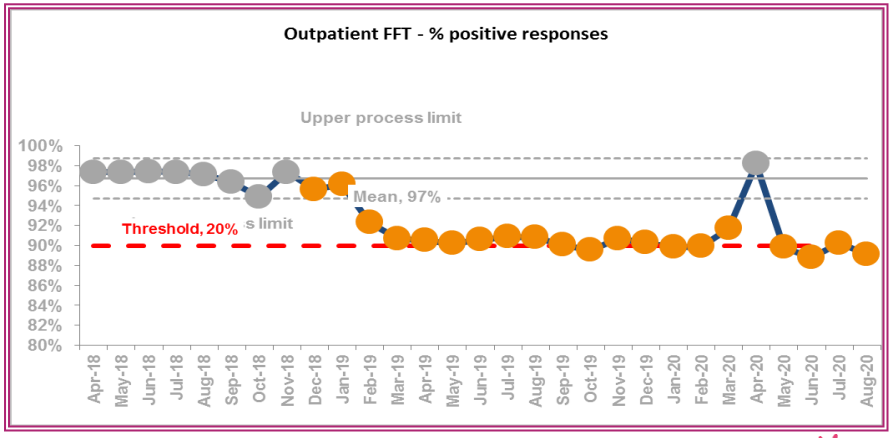










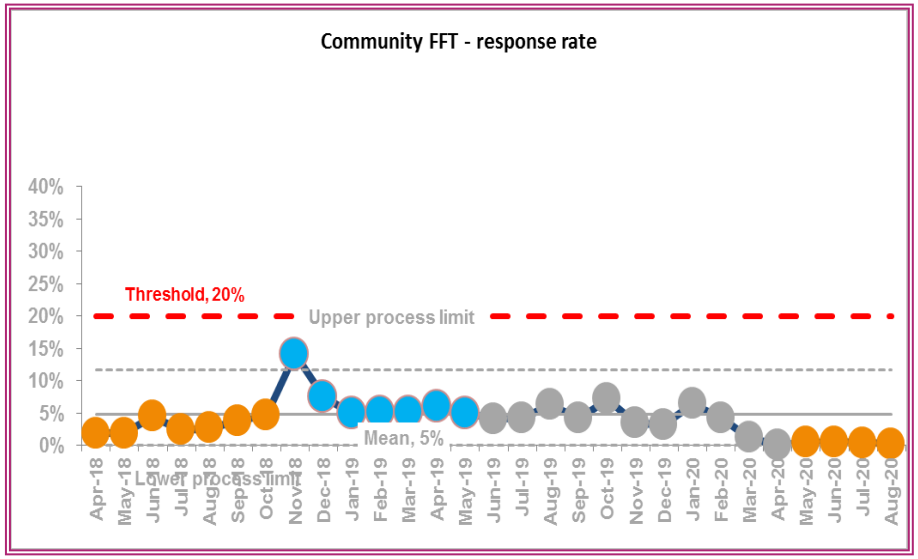


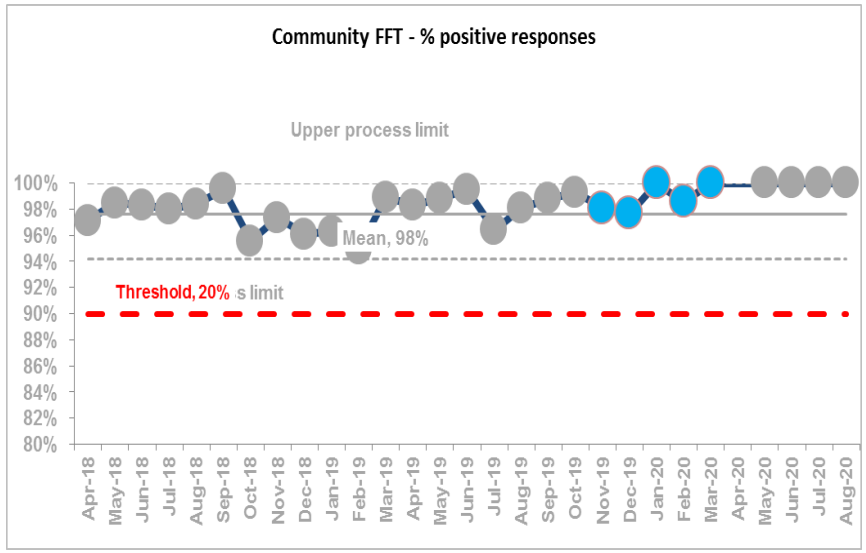
3.2

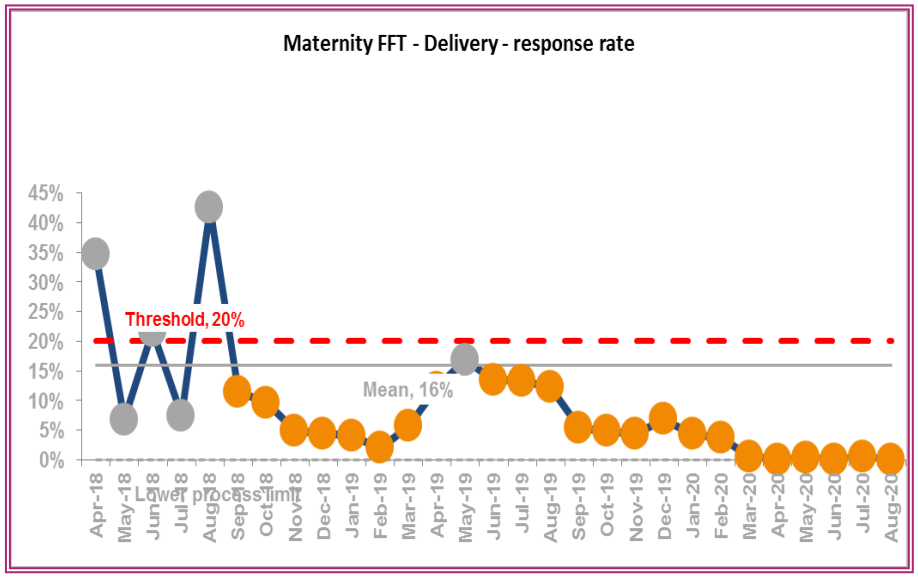
Our Patient Perspective

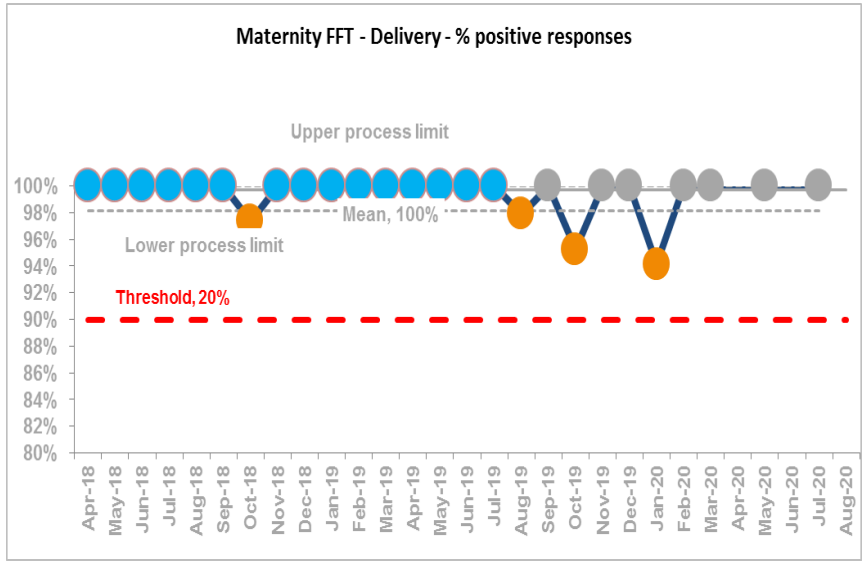
Friends and Family Test

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	Maternity (A)	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow (G)	Cancer (A)	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR PEOPLE PERSPECTIVE	Workforce (A)	Agency Use	Estates Health and Safety			

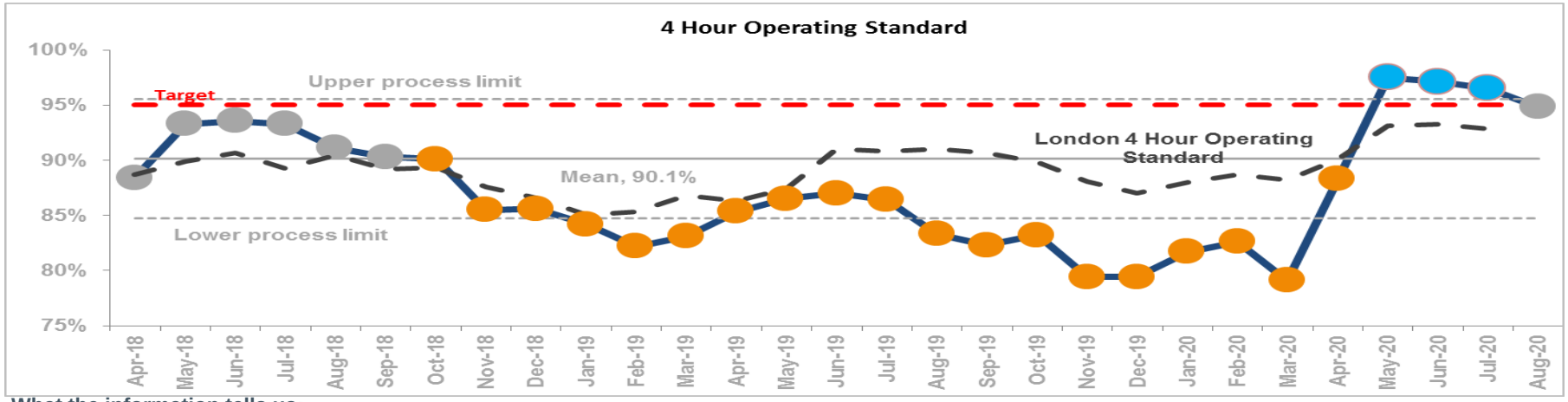
Key

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) has continued to increase throughout August, as well as an increase in the number of walk in patients, ambulance attendances also continue to rise, seeing nearly a 7% increase compared to July. Overall attendance numbers compared to the same period last year were 26% lower.

Performance against the Four Hour Operating Standard has been maintained above the mean for the fourth consecutive and has performed above the London average, however the Trust was slightly below the Four Hour Standard in August reporting 94.8% of patients either being discharged, admitted or transferred within four hours of their arrival. Performance was impacted by a heatwave in early August combined with Infection Prevention and Control measures that impacted our Performance during the week of 8 August 2020. In the month of August three patients waited more than 12 hours to be admitted, in each case to a Mental Health bed.

General and acute bed occupancy shows a steady increase with AMU occupancy steady for the last four months averaging 70% occupancy at midday which remains better than our target of 80%. 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 continues to see an upward trend however remaining much lower than the same period last year. Focus remains on internal and external teams supporting our inpatients to return home and daily escalation calls to review medically optimised patients.

Positive performance against the Ambulance Handover Times continues with the percentage of patients handed over within 30 minutes of arrival above the London average.

Actions and Quality Improvement Projects

Collaborative Working: Unscheduled care performance meetings now embedded as business as usual, reviewing breaches and identify solutions. This has now been extended to Surgery & Intensive Care Unit. There are solution focused flow & safety huddles to provide understanding of capacity & flow issues. The Emergency Flow and Performance Group is Divisional Director of Operations led and is a Trust wide group that has representation from all Divisions working together to deliver and sustain 95% Emergency Care performance. There are a number of whole system initiatives currently being worked on to deliver sustainable improvements, which include digital front door and Same Day Emergency Care (SDEC). The Trust has secured 2.5M to deliver improved performance through winter, estates led project meetings have now commenced.

Next steps: Unscheduled care meetings with ICU requires improved clinical representation to mitigate breaches. Deliver Urgent & Emergency Care funded ED improvements.

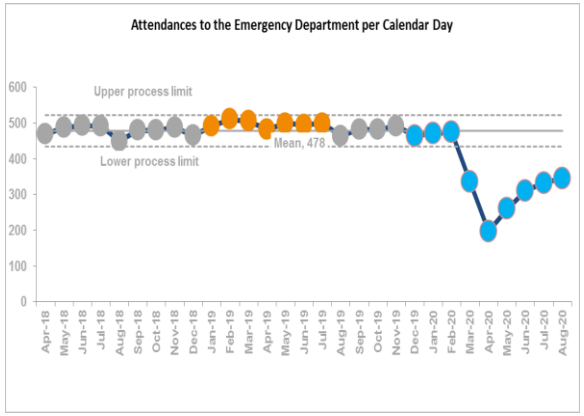
Emergency Care Processes: The number of ED attendances for walk-in and ambulance arrivals has been steadily increasing post COVID-19. The acuity of patients remains high. ED environment remains reconfigured to deliver social distancing to meet Infection Prevention & Control (IPC) standards. The ED Team continues to explore and review the capacity within the current footprint to ensure that efficient safe pathways are delivered.

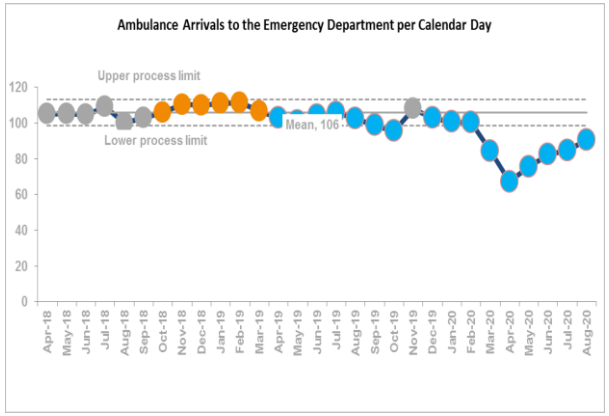
Urgent Care Centre (UCC) Waits and Direct Access: UCC direct pathways continue to ensure timely turnaround for patients. All pathways are risk assessed and standard operating procedures are agreed.

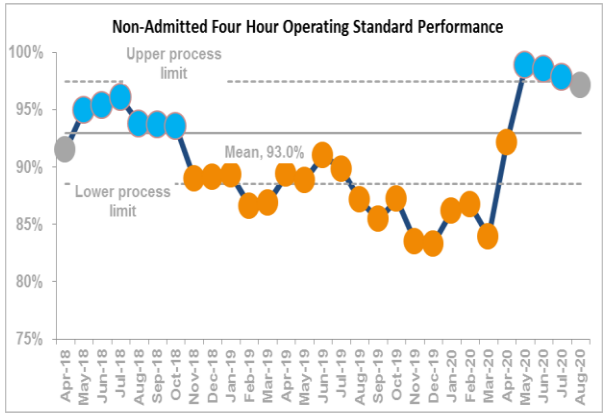
Mental Health: Alternative mental health pathways have been put in place to support this patient cohort. There is a South West London (SWL) Task & Finish group to focus on sustaining this improvement for the future led by South West London & St. George's Mental Health Trust.

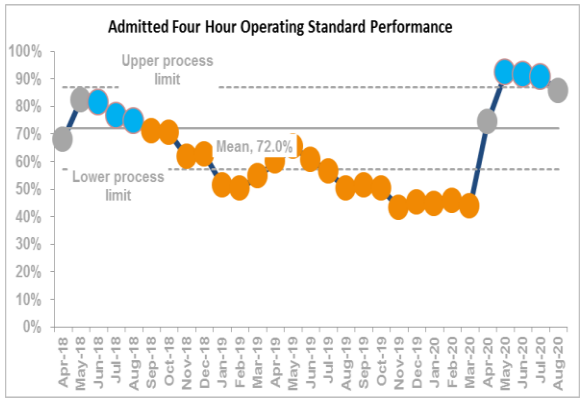
Emergency Flow

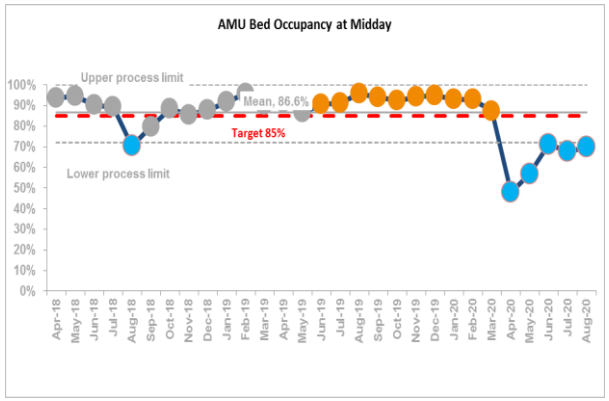
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

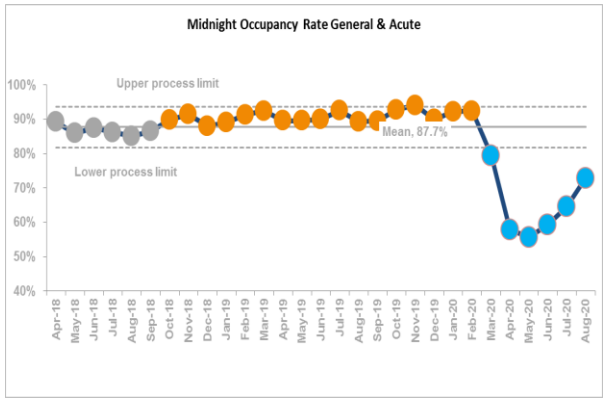


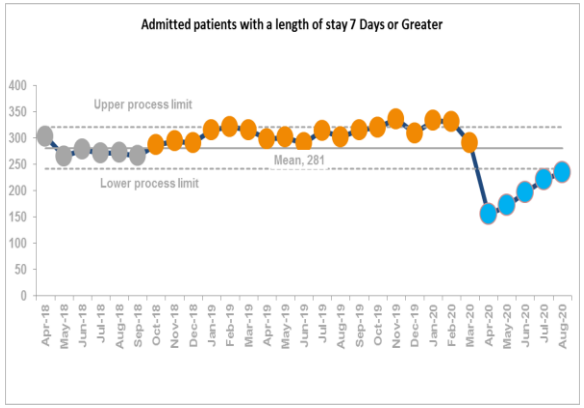


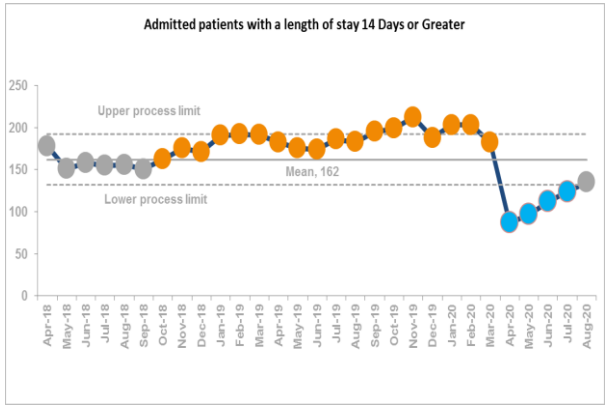


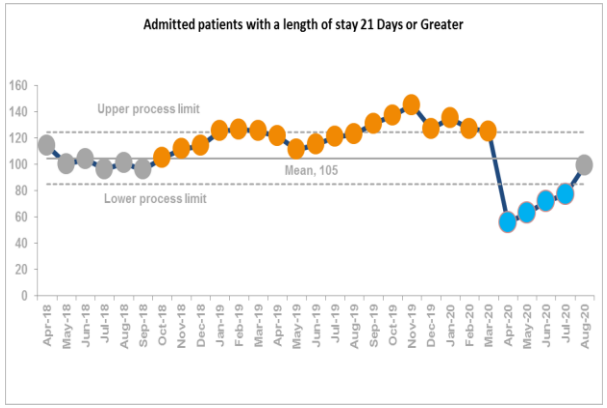






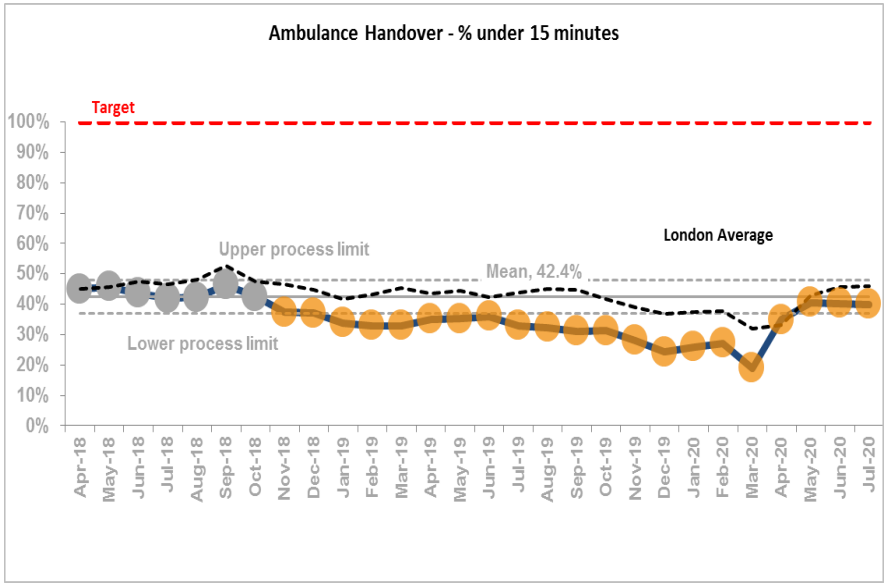


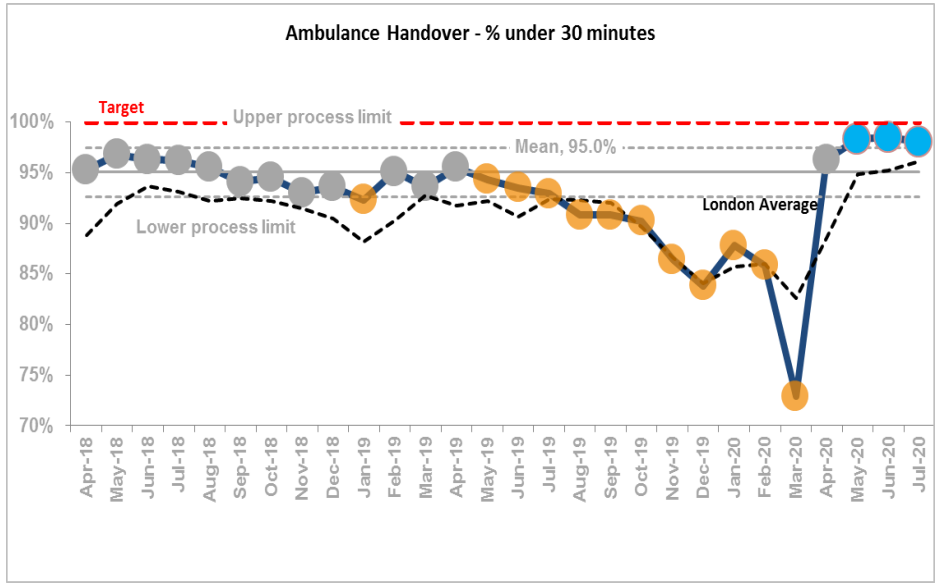


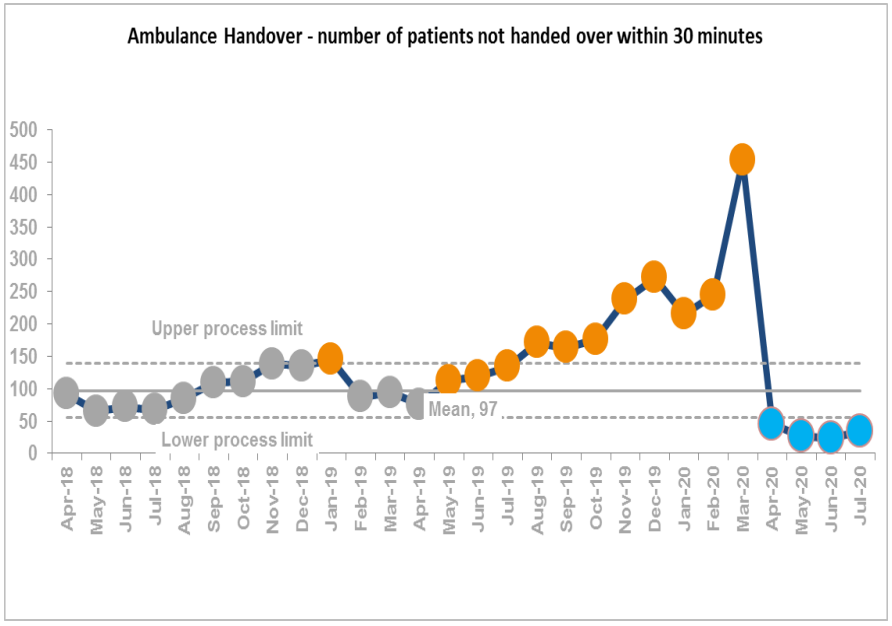


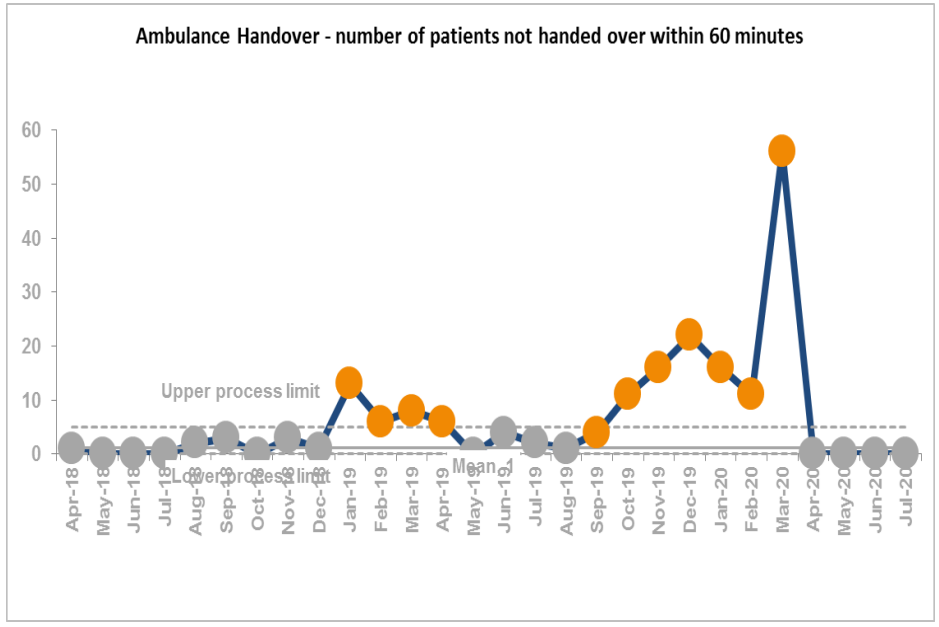
Emergency Flow

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





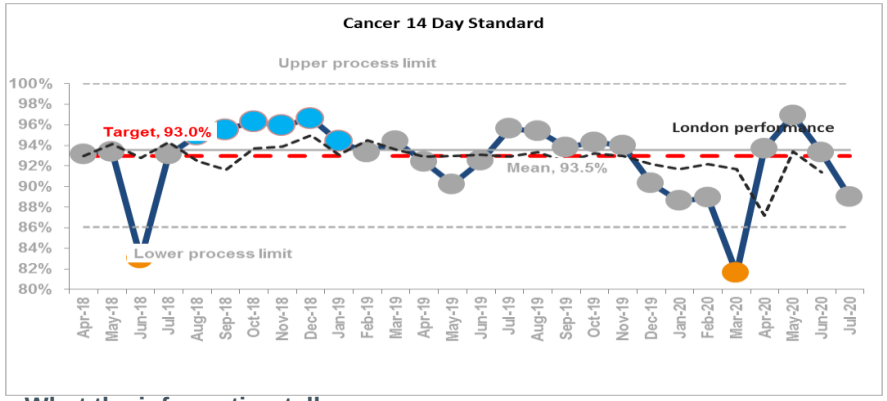


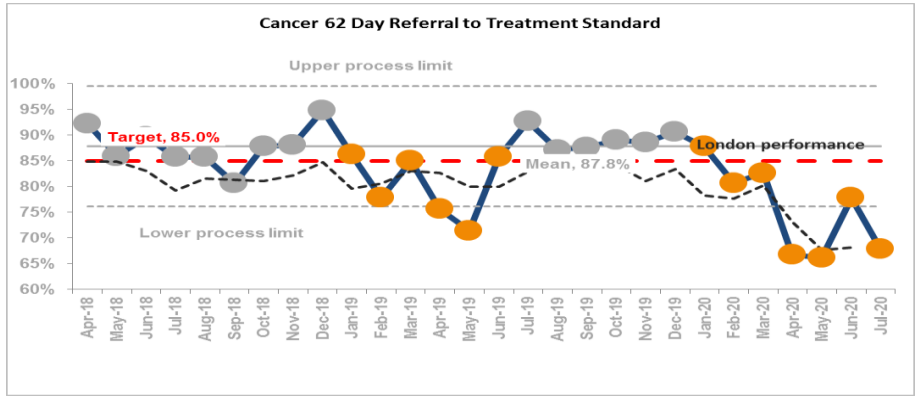


3.2

Our Process Perspective

Cancer





What the information tells us

The Trust met two of the seven cancer standards for the month of July and was non-compliant against 14 day, 31 day and 62 Day standards.

Performance for the TWR 14 day standard for the month of July fell to 89% compared to 93.3% in June. A total 1,260 patients were seen in month, and numbers have recovered 75/80% of the baseline with performance remaining within the upper and lower control limits. Non performance was related to a number of factors, specifically: increasing numbers of patients in urology, UGI and LGI going straight to test and the associated IPC restrictions and increasing volumes of F2F in dermatology.

In July more patients were treated on a 62 day pathway compared to June, an increase of 32%. The monthly performance fell below the lower control limits. There were 65.5 treatments in July which was an increase of 20% compared to last July. There were 21 breaches of the 62 Day standard. Two were clinically complicated, 13 are attributed to COVID-19 related delays and a further 3 were patient initiated.

Cancer 31 Day Diagnosis to Treatment performance remains below the lower control limit with a performance of 90.4%. Five tumour groups were non-compliant, all these breaches are attributed to treatment plans being agreed and then delayed by COVID-19 related constraints.

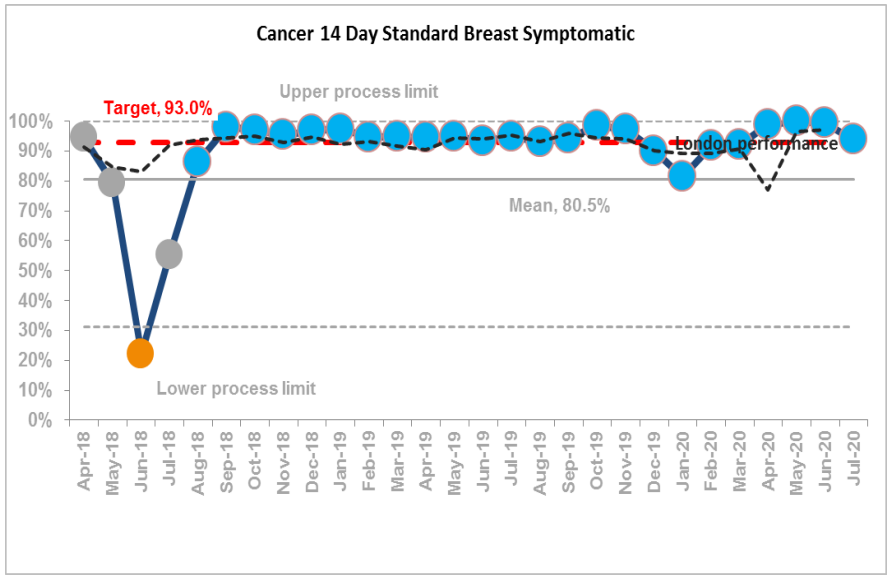
62 day referral to treatment screening performance has seen improvement in the month of July with a total of 5.5 patients being treated (0.5 being a shared treatment) although remaining below target. Delays in treatments were due to screening services (all) being paused in the month of April and June 2020.

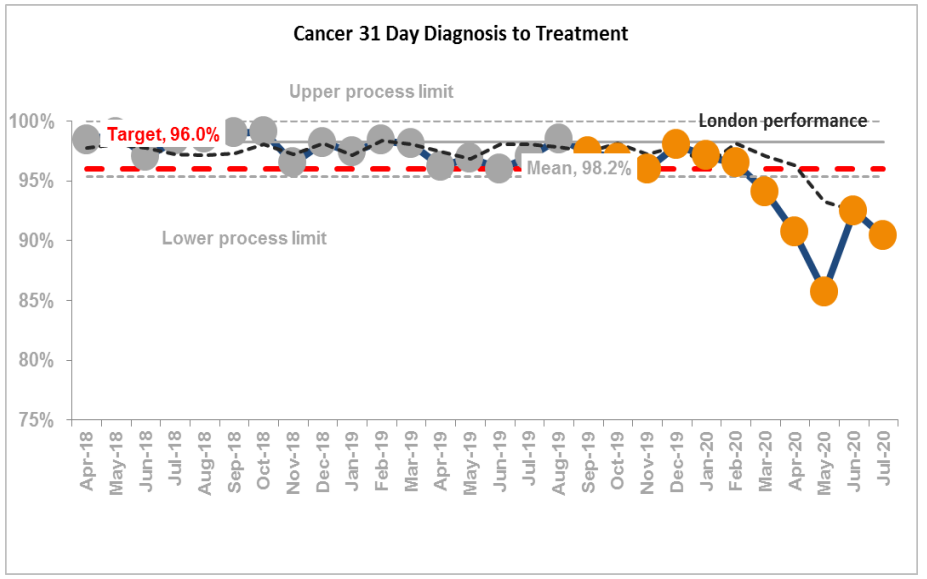
Actions and Quality Improvement Projects

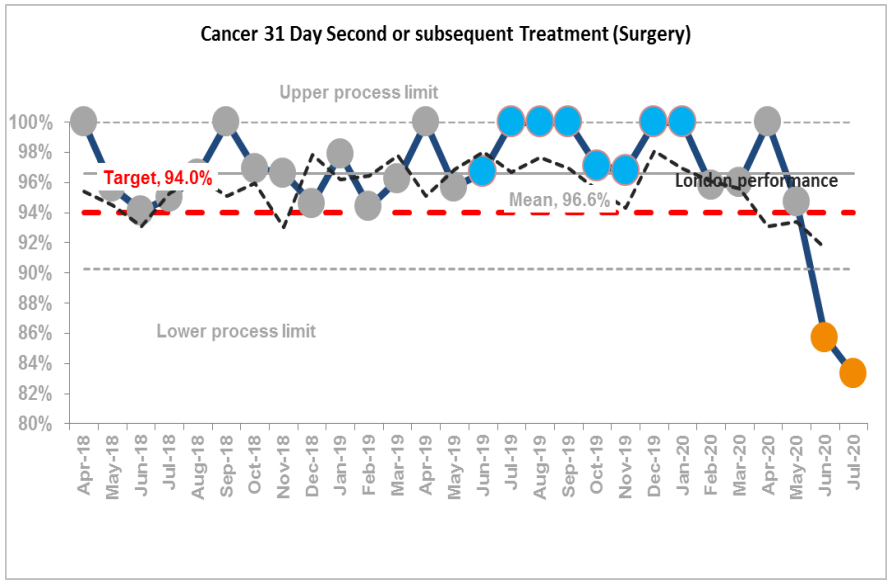
TWR - Drive to increase face to face appointments to facilitate increasing referrals and service plans in place full use of capacity available.
104 + days Trajectory –Recovery planning is focused on reducing the back log of patients above 104 days on the 62 day PTL, (based on the rate of backlog reduction) the cancer trajectory predicts the backlog of 104 day patients can be reduced to pre-COVID levels by October 2020.
Theatres – STG continued to access to 15 weekly cancer session at St Anthony's in the month of July 2020 and plans are in place to extend this to October 2020. Targets in place to operate on an additional 70 cases above baseline in the month of August and September to treat patient on the 62 + day and 104+ day backlog. Focus is through optimisation of theatre capacity, through weekly cancer Patient Pathway Coordinator huddle, weekly PTL assurance and clinical meetings and collaborative work with theatres.
Endoscopy - Endoscopy continued to run IS sector and here at STG in July 20. Recovery planning in place is focused on additional onsite capacity, additional nurses to support with cover at STG, additional resource in the form of bank staff to increase bookings. RMP funding requested for X 1 band 4 scheduler.
Diagnostics - Focus is on increasing CT Colonoscopy capacity to manage increasing referrals, Royal Marsden Partners (RMP)have offered to finance additional sessions, with plans to run the perfect week. Extension of IS sector capacity to March 2020 in place.
Other initiatives - 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. This is under development with an updated forecast start date of October 2020. Screening (Bowel and Breast) we restarted which saw an increase in screening treatments.

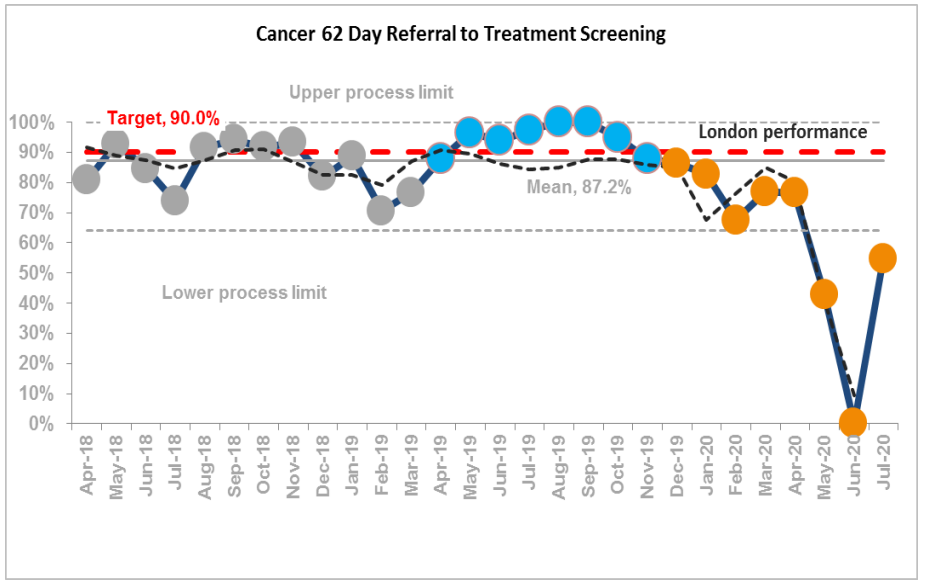
Cancer

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









3.2

Our Process Perspective

Cancer

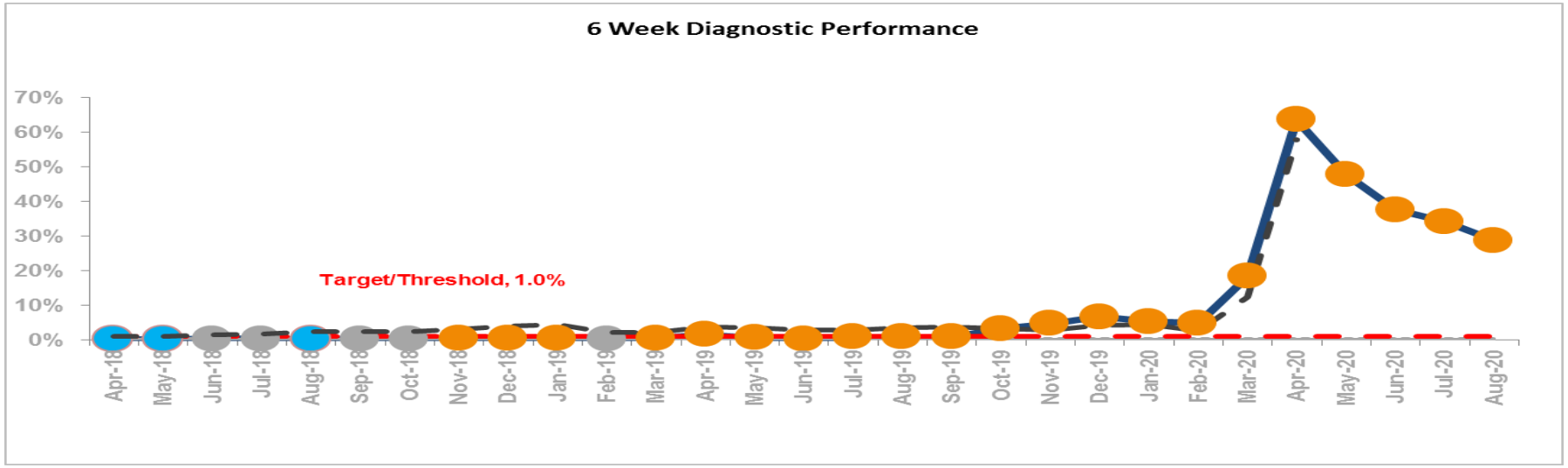
14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	No of Patients
Brain	93%	-	100.0%	100.0%	-	-	-	100.0%	-	-	-	-	-	-	0
Breast	93%	95.4%	94.9%	95.9%	100.0%	97.0%	95.6%	84.7%	95.6%	93.3%	97.5%	100.0%	98.6%	95.5%	221
Children's	93%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	85.7%	100.0%	100.0%	-	83.3%	100.0%	75.0%	4
Gynaecology	93%	95.5%	97.2%	95.4%	97.6%	99.2%	99.0%	94.4%	95.9%	86.9%	93.0%	96.3%	93.8%	92.5%	93
Haematology	93%	100.0%	100.0%	86.7%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	12
Head & Neck	93%	98.9%	96.4%	96.6%	99.0%	96.6%	89.4%	95.2%	95.5%	90.8%	97.1%	100.0%	97.7%	96.1%	154
Lower Gastrointestinal	93%	93.7%	93.1%	92.8%	89.7%	91.5%	80.3%	81.8%	69.9%	63.8%	86.8%	95.6%	93.6%	86.9%	176
Lung	93%	95.7%	100.0%	97.1%	97.7%	100.0%	84.1%	80.6%	90.9%	85.7%	83.3%	90.9%	72.7%	62.5%	16
Skin	93%	96.0%	98.0%	91.8%	95.9%	91.0%	94.8%	94.7%	93.3%	84.1%	93.2%	96.7%	91.4%	87.4%	388
Upper Gastrointestinal	93%	95.1%	88.9%	87.2%	82.5%	88.1%	82.7%	75.3%	84.4%	75.5%	93.5%	98.4%	93.1%	84.4%	109
Urology	93%	93.8%	93.0%	97.0%	88.4%	95.6%	92.9%	93.6%	93.6%	93.9%	94.0%	85.5%	82.4%	80.5%	87

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	No of Treatments
Brain	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Breast	85%	73.3%	88.6%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	58.8%	100.0%	100.0%	100.0%	100.0%	14
Children's	85%	-	100.0%	-	-	-	-	100.0%	100.0%	-	-	-	-	-	0
Gynaecology	85%	100.0%	100.0%	100.0%	60.0%	100.0%	80.0%	66.7%	100.0%	100.0%	0.0%	50.0%	50.0%	100.0%	2
Haematology	85%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	85.7%	66.7%	33.3%	100.0%	0.0%	100.0%	100.0%	2
Head & Neck	85%	80.0%	80.0%	75.0%	76.5%	76.9%	68.2%	89.5%	73.7%	81.0%	50.0%	66.7%	83.3%	52.4%	10.5
Lower Gastrointestinal	85%	83.3%	63.6%	90.0%	100.0%	87.5%	83.3%	60.0%	71.4%	75.0%	42.9%	50.0%	-	100.0%	4
Lung	85%	91.7%	89.5%	60.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	62.5%	0.0%	85.2%	50.0%	2.0
Skin	85%	100.0%	100.0%	78.9%	100.0%	89.5%	100.0%	91.7%	100.0%	100.0%	52.9%	81.8%	85.2%	82.4%	8.5
Upper Gastrointestinal	85%	100.0%	53.8%	66.7%	80.0%	50.0%	100.0%	0.0%	40.0%	-	0.0%	33.3%	71.4%	80.0%	2.5
Urology	85%	100.0%	94.4%	100.0%	83.8%	87.8%	100.0%	85.0%	84.0%	81.5%	100.0%	64.3%	25.0%	27.3%	16.5
Other	85%	-	-	-	100.0%	-	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	100.0%	2

Diagnostics



What the information tells us

In August, the Trust did not achieve the six week diagnostic standard with an adverse performance of 28.8%. The total number of patients waiting greater than six weeks was 2,695 of a total wait list of 9,368. There has been a month on month performance improvement with the total number of patients waiting over six weeks decreasing by 16% compared to July. Reductions in long waiters have been seen within Non-Obstetric Ultrasound, DEXA and Sleep Studies in the month of August.

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.

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, 5.3% of those are currently categorised as Urgent.

Actions and Quality Improvement Projects

Risk assessments underway for modalities to restart routine work with a number of areas with some modalities already commenced and others due to commence in September.

In August, Echocardiogram Services restarted outsourcing Echo diagnostic tests to the Independent Sector providing weekend capacity with plans to commence routine tests on the St George's site in September.

Weekly assurance review of all Urgent and Cancer diagnostic referrals

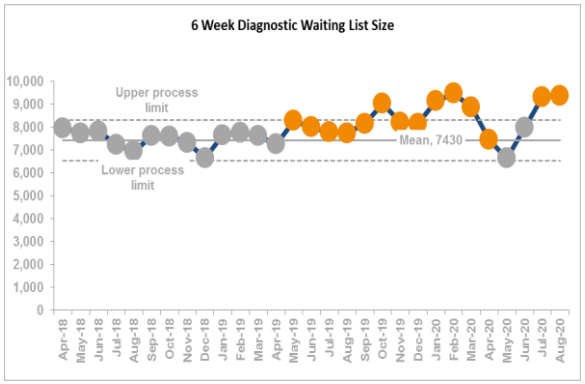
Endoscopy recovery plan with daily NHSI reporting, with plans to move backlog and future demand of activity to CT Colonography, working parties within the South West London Acute Provider Collaborative considering options

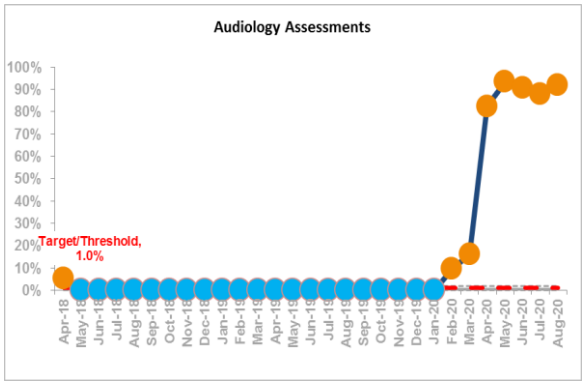
Continue to send both MRI & CT to the Independent Sector. Capacity options currently being reviewed by NHSE. Additional sessions (extended days, weekend imaging, additional mobile days) are all options subject to approval.

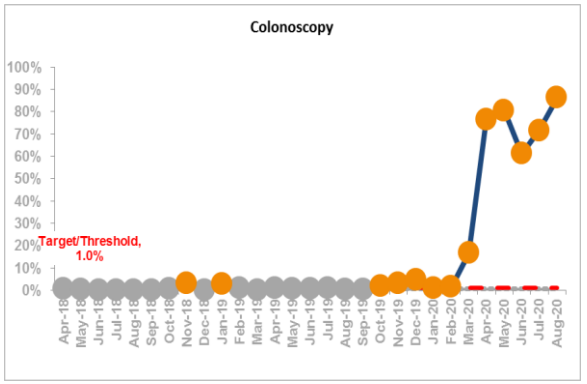
Gynae Non-Obstetric Ultrasound re-commenced routine activity with extra clinics, overbooking and re-scheduling patients to cope with the influx and minimise breaches.

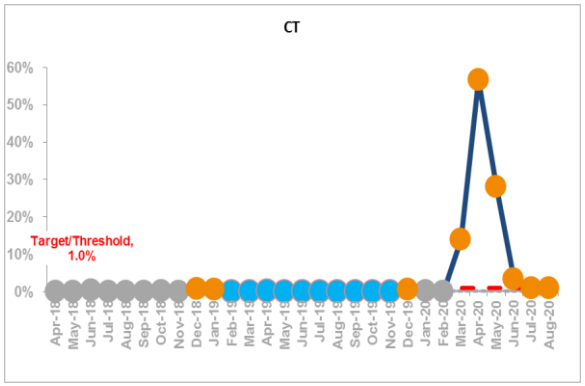
Diagnostics

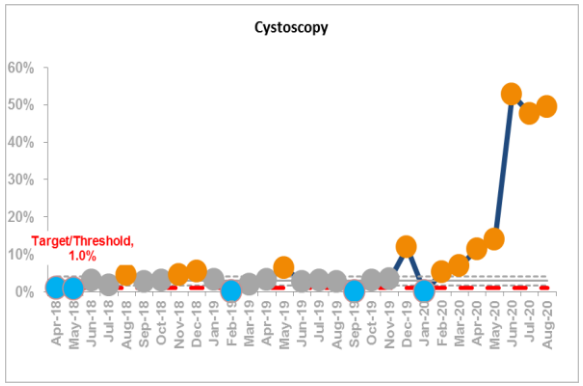
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

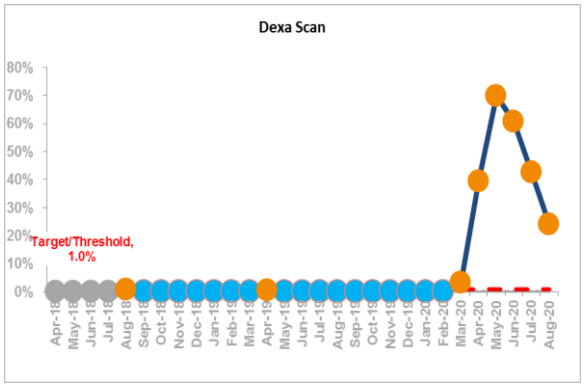


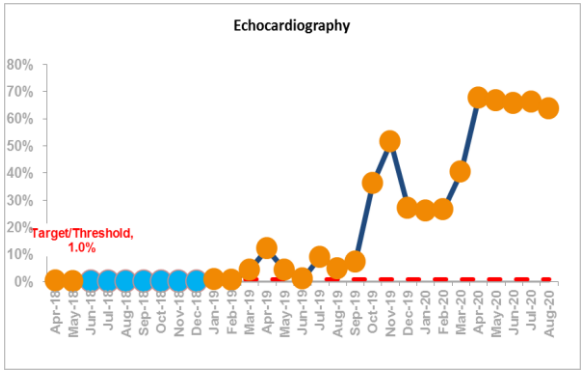


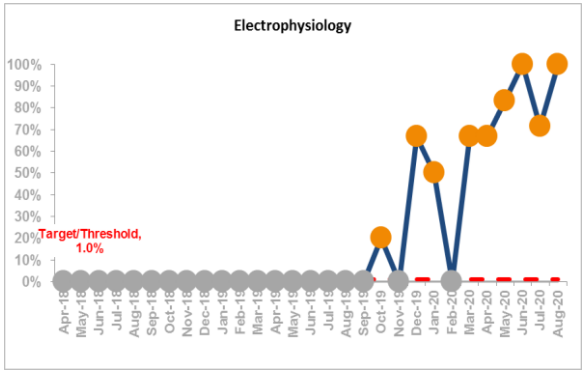


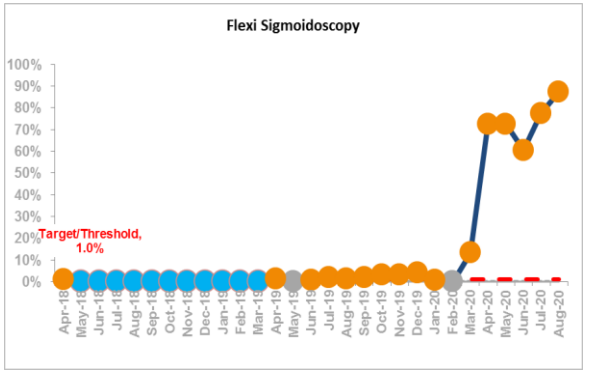










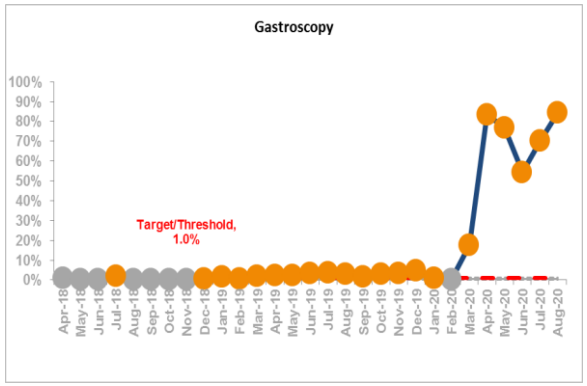


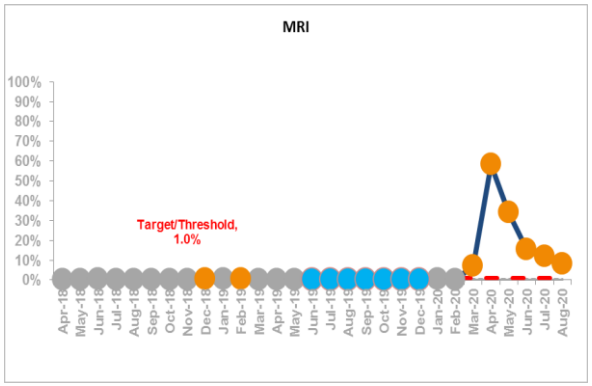
3.2

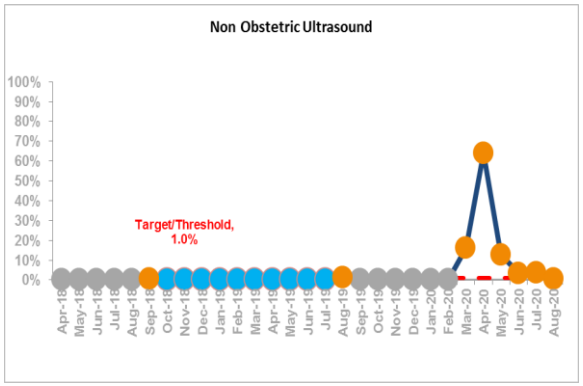
Our Process Perspective

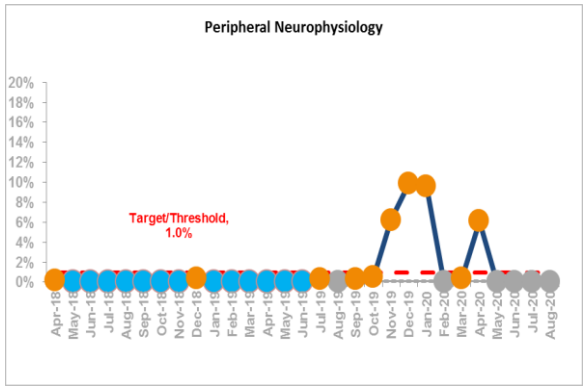
Diagnostics

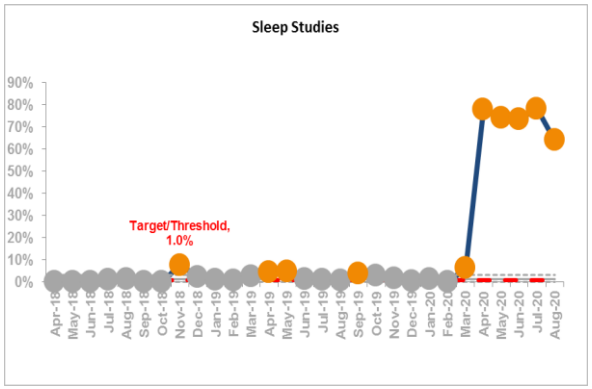
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

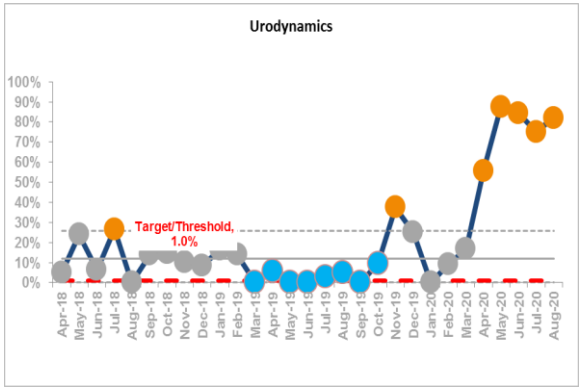




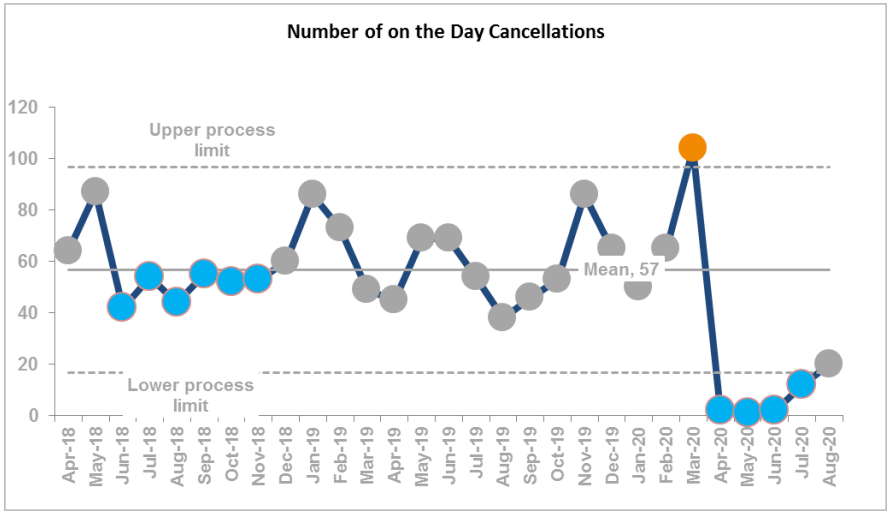


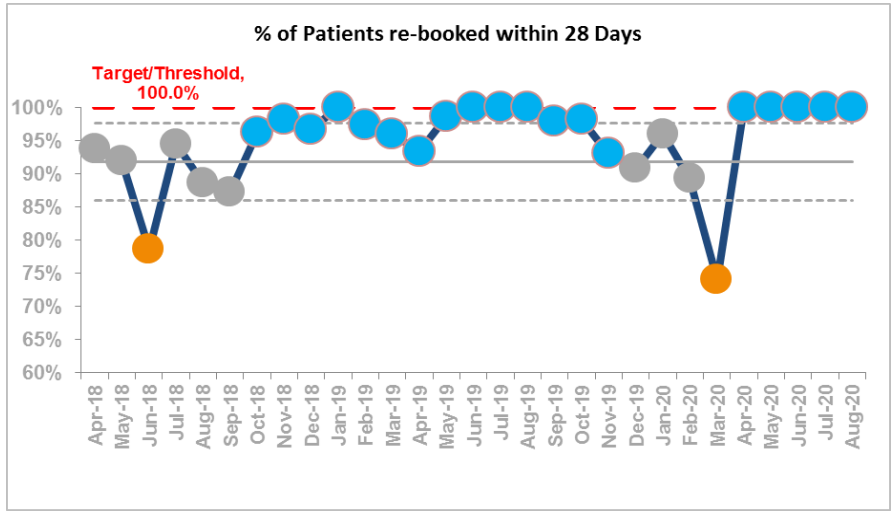






On the Day Cancellations for Non Clinical Reasons





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. The number of Elective procedures are now starting to increase and in August we have seen an increase in the number of on the day cancellations however remaining significantly below the mean and below the lower control limit.

In August, 15 patients were cancelled on the day with the majority of cancellations due to an emergency case taking priority. All 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.

Specialties have been allocated fixed sessions as part of new theatre templates to support the forward booking of patients in line with shielding requirements across St George's and the Independent Sector.

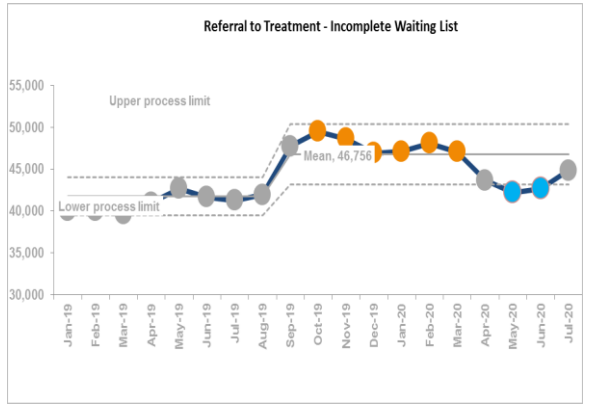
Re-instigation of 642 processes to support effective allocation of lists and resources across all specialties.

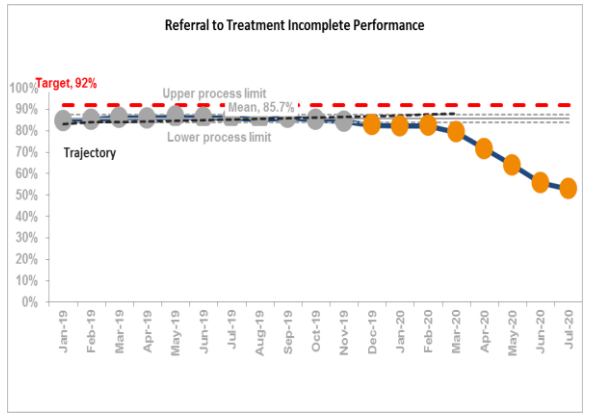
Clinical prioritisation occurs twice daily for urgent and emergency patients.

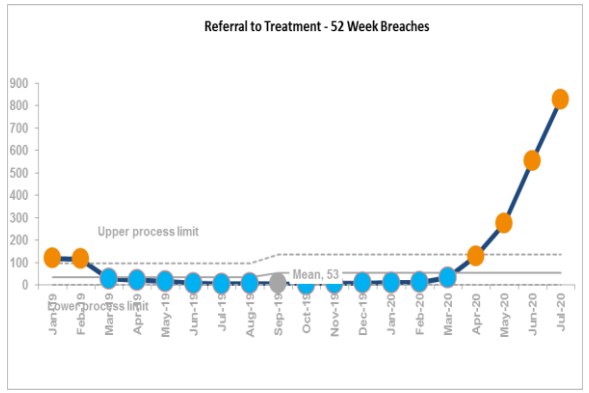
On-going review and categorisation of patients on all waiting lists.

Referral to Treatment — July 2020

Indicator Description	Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
RTT Trust Incomplete Performance	92%	86.1%	85.0%	86.1%	85.1%	84.2%	82.6%	82.2%	82.3%	79.3%	71.5%	63.8%	55.7%	52.7%
RTT Trust Incomplete Performance Trajectory for 19/20		85.3%	85.5%	85.8%	86.1%	86.5%	86.8%	87.2%	87.7%	88.1%				
RTT Total Incomplete Waiting Lize Size		41,259	41,945	47,714	49,495	48,640	46,918	47,089	48,061	47,048	43,643	42,196	42,672	44,814
RTT Total Incomplete Waiting Lize Size Trajectory		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)		5,739	6,305	6,651	7,353	7,701	8,183	8,382	8,498	9,755	12,440	15,268	18,924	20,863
Total waits greater than 18 weeks Trajectory		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	5	6	6	1	7	9	10	11	32	129	274	554	825
Total waits greater than 52 weeks Trajectory		5	5	5	0	0	0	0	0	0				
RTT Incomplete Performance - Admitted		66.3%	63.7%	65.9%	65.3%	63.7%	61.4%	60.5%	61.9%	57.2%	49.0%	42.4%	34.1%	31.8%
Total waits greater than 18 weeks - Admitted		1,523	1,655	1,643	1,686	1,719	1,876	1,950	1,891	2,186	2,720	3,308	3,955	4,207
Total waits greater than 52 weeks - Admitted	0	1	2	4	0	2	5	2	3	20	88	190	393	529
RTT Incomplete Performance -Non Admitted		88.5%	87.6%	88.3%	87.3%	86.4%	85.0%	84.7%	84.7%	82.0%	74.6%	67.2%	59.2%	56.1%
Total waits greater than 18 weeks - Non Admitted		4,216	4,650	5,008	5,667	5,982	6,107	6,432	6,607	7,569	9,720	11,960	14,969	16,656
Total waits greater than 52 weeks - Non Admitted	0	4	4	2	1	5	4	8	8	12	41	84	161	296







What the information tells us

Performance continued to deteriorate throughout July 2020 down to 52.7% reporting in total 20,863 patients waiting greater than 18 weeks, this is an increase of 1,939 patients compared to June. The largest proportion of patients waiting greater than 18 weeks are within the non-admitted PTL (Patient Tracking List) increasing by 11% compared to June. A more rapid increase is seen within the admitted PTL where patients waiting greater than 18 weeks is 35% higher in July compared to the previous month.

Ear Nose & Throat, Neurosurgery, Cardiology, Dermatology and Gynaecology (as well as specialties making up the 'other ') have the highest number of 18+ patients on an incomplete pathway.

The number of 52 week breaches had seen a sharp rise in recent months following the standing down of activity in both elective and outpatient services. In July, the number of patients waiting was 825, this is a 49% increase compared to June, with General Surgery, and Ear Nose & Throat reporting most patients.

Actions and Quality Improvement Projects

All patients on an admitted pathway can be easily identified based on clinical urgency – previously patients were categorised as two week wait, urgent or routine only.

An initial trajectory has been submitted for 52 week forecast through to March 21. More detailed trajectories will now be developed at specialty level ensuring that all options for outsourcing activity are considered and included.

Services with the largest number of 52 week breaches are actively engaged with the South West London (SWL) lead providers networks. The Trust have identified 295 patents who are suitable to be operated on at other SWL Trusts (mainly Kingston and Croydon) from Urology, ENT, and General Surgery. 93 patients have been transferred, with 202 returning to St George's due to either patient choice or receiving surgeon opinion.

An amendment to the access policy has been agreed across SWL that allows for patients to be referred to the GP if they wish to postpone treatment due to COVID-19. The decision will be clinical and patients who are high risk will remain on St George's waiting list.

Referral to Treatment — July 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	438	23.8%	891	55.9%	602	726	1,328	45.3%	80	104
UROLOGY	407	30.2%	1,646	63.5%	1,167	880	2,047	57.0%	49	36
TRAUMA & ORTHOPAEDICS	308	20.7%	1,589	57.8%	982	911	1,893	51.9%	51	16
ENT	726	14.9%	2,287	59.4%	1,467	1,544	3,011	48.7%	150	179
OPHTHALMOLOGY			703	38.8%	273	430	703	38.8%	4	2
ORAL SURGERY	7	14.3%	231	39.4%	92	146	238	38.7%	34	5
NEUROSURGERY	305	32.1%	2,527	43.2%	1,190	1,642	2,832	42.0%	115	24
PLASTIC SURGERY	530	14.4%	739	67.8%	577	688	1,265	45.6%	108	106
CARDIOTHORACIC SURGERY			1	1	1	0	1	100.0%	0	0
GENERAL MEDICINE			17	76.5%	13	4	17	76.5%	0	0
GASTROENTEROLOGY	944	66.8%	1,652	64.6%	1,692	896	2,588	65.4%	53	0
CARDIOLOGY	995	30.1%	2,529	58.1%	1,768	1,754	3,522	50.2%	148	58
DERMATOLOGY	5	40.0%	3,382	42.0%	1,421	1,966	3,387	42.0%	127	25
RESPIRATORY MEDICINE	3	100.0%	1,453	75.2%	1,095	361	1,456	75.2%	5	1
NEUROLOGY	18	62.5%	2,362	62.3%	1,476	894	2,370	62.3%	11	1
RHEUMATOLOGY	2	1	1,113	46.2%	516	599	1,115	46.3%	25	5
GERIATRIC MEDICINE			57	77.2%	44	13	57	77.2%	0	0
GYNAECOLOGY	124	12.1%	2,459	57.6%	1,431	1,152	2,583	55.4%	74	21
Other	1,437	31.4%	12,314	56.9%	7,447	6,257	13,704	54.3%	510	242
Grand Total	**6,249**	**31.8%**	**37,952**	**56.1%**	**23,254**	**20,863**	**44,117**	52.7%	**1,544**	**825**

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

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	Maternity (A)	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow (G)	Cancer (A)	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR PEOPLE PERSPECTIVE	Workforce (A)	Agency Use	Estates Health and Safety			

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Workforce

Indicator Description	Target	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Trust Level Sickness Rate	3.2%	3.5%	3.4%	3.7%	3.8%	4.0%	3.9%	4.0%	5.1%	5.6%	4.1%	3.5%	3.2%	3.4%
Trust Vacancy Rate	10%	12.8%	12.8%	9.3%	9.9%	11.2%	10.8%	10.7%	10.6%	10.5%	6.8%	8.3%	8.4%	8.2%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.7%	17.7%	17.8%	17.6%	17.6%	17.4%	17.3%	16.9%	16.7%	16.1%	15.3%	15.1%	15.2%
Total Funded Establishment		9,432	9,534	9,280	9,294	9,403	9,383	9,369	9,369	9,373	9,098	9,289	9,256	9,263
IPR Appraisal Rate - Medical Staff	90%	85.7%	81.5%	83.9%	81.5%	83.6%	84.9%	81.7%	80.0%					
IPR Appraisal Rate - Non Medical Staff	90%	71.3%	70.4%	70.9%	72.3%	72.3%	72.0%	72.4%	69.6%	67.9%	67.6%	69.9%	73.6%	74.6%
Overall MAST Compliance %	85%	91.3%	90.6%	89.7%	89.7%	90.0%	89.7%	90.6%	90.7%	90.2%	89.7%	89.9%	89.8%	89.9%
Ward Staffing Unfilled Duty Hours	10%	5.4%	6.5%	6.1%	3.8%	5.3%	5.4%	6.2%	15.2%	17.4%	3.0%	1.6%	2.8%	

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 has seen a significant (over 40%) reduction from a high of 5.6% at the height of COVID-19 pandemic to now 3.4% in August, slightly above target of 3.2%.

Appraisal rates for Non Medical staff increased to 74.6% in August against a target of 90%.

Mandatory and Statutory Training (MAST) compliance at 89.9% remains above the target of 85%.

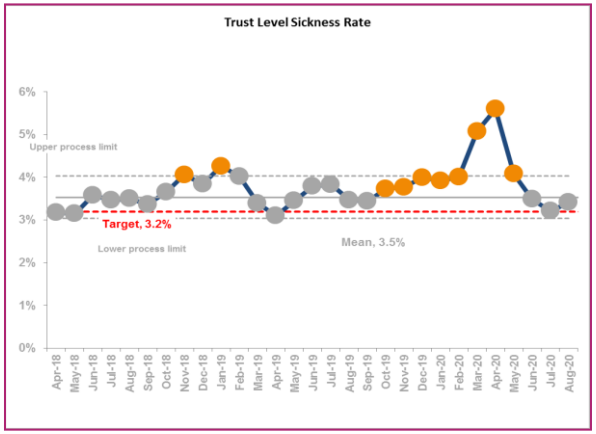
Appraisal rates for Medical staff was paused during COVID-19. In September 2020 the General Medical Council wrote to the Trust asking that this process be re-started.

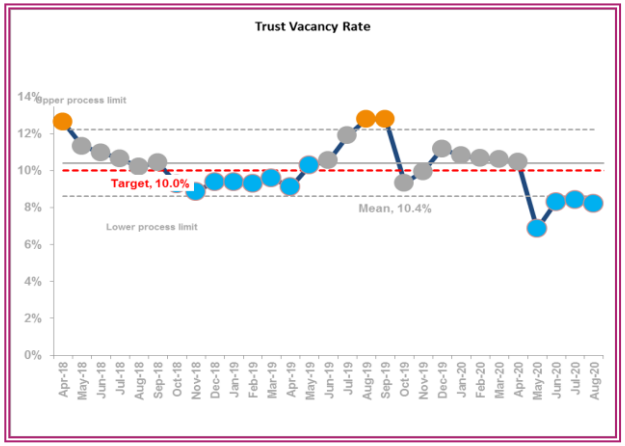
Vacancy Rate at 8.2% in August continues to be below the set target of 10%.

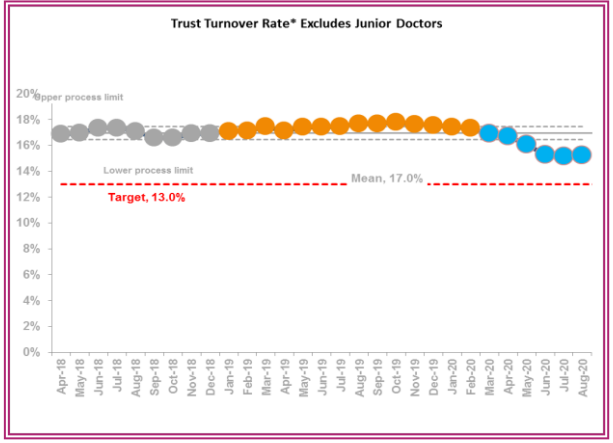
Actions and Quality Improvement Project
Appraisal and Revalidation for medical staff is to be re-started across the Trust.

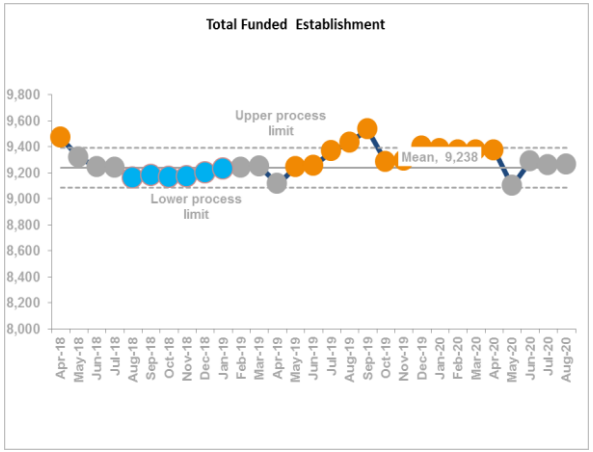
Workforce

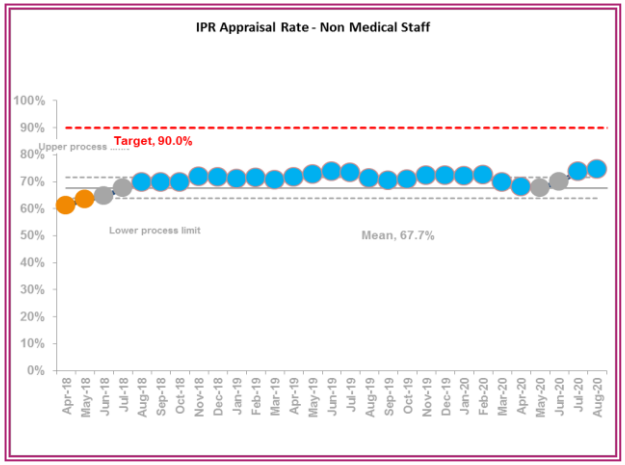
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance







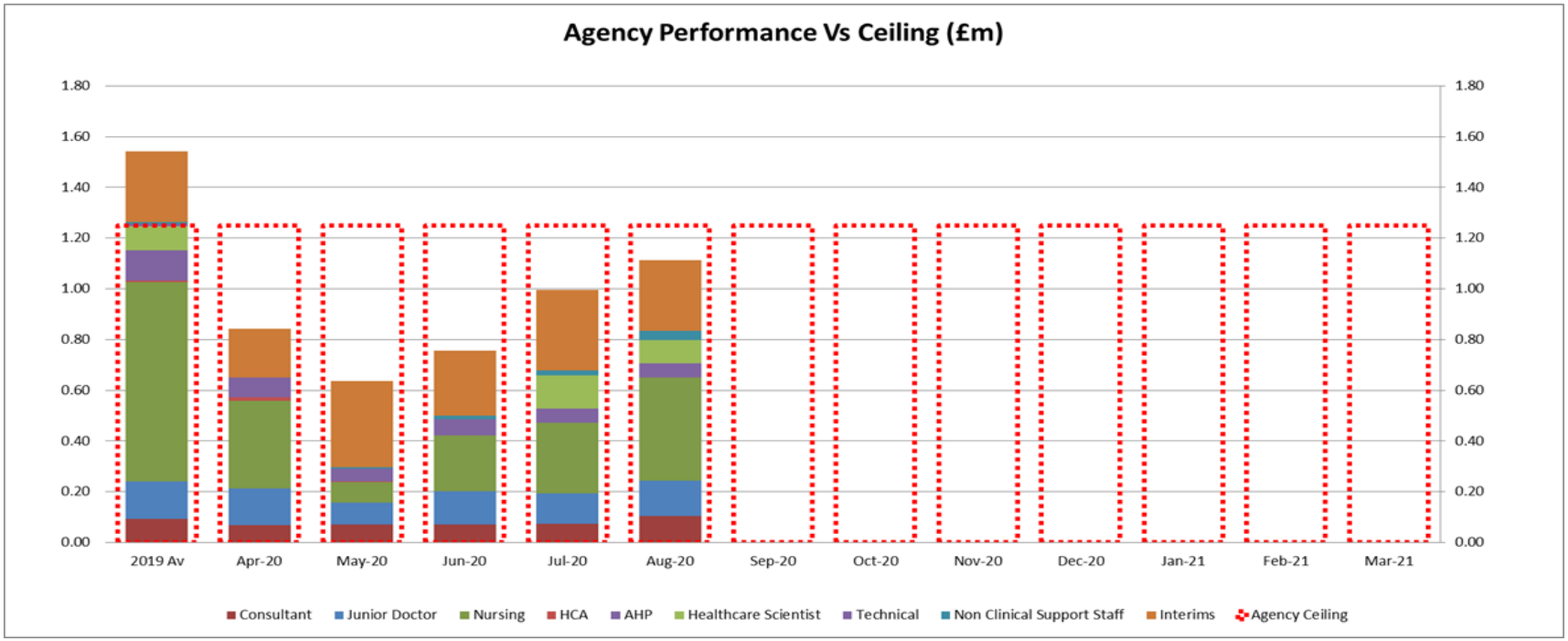




3.2

Our People Perspective

Agency use



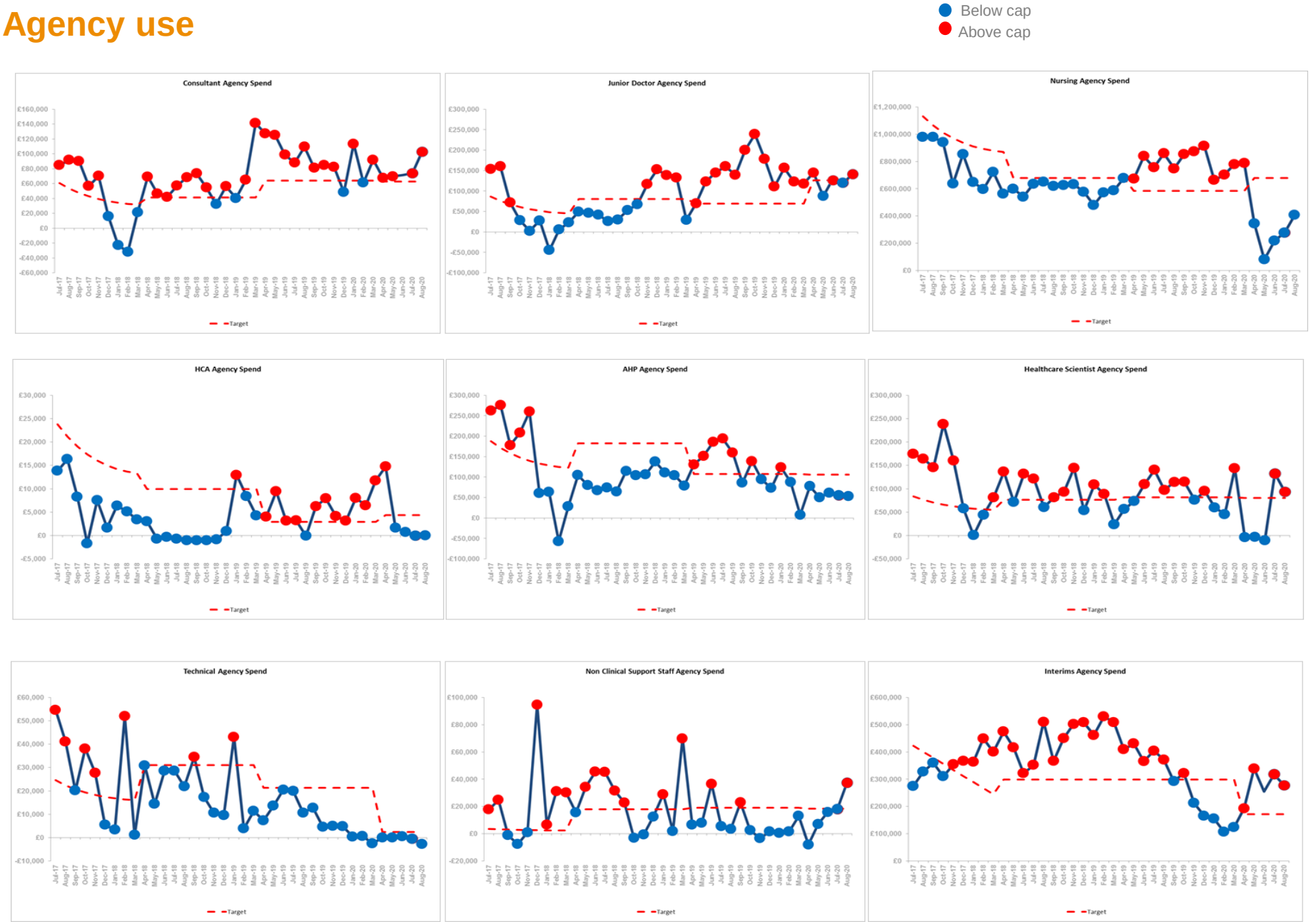
The Trust's total pay for August was £49.32m. This is £0.68m adverse to a plan of £48.64m.

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 £1.11m or 2.2% of the total pay costs. For 2019/20, the average agency cost was 3.3% of total pay costs. For August, the monthly target set is £1.25m. The total agency cost is better than the target by £0.14m.

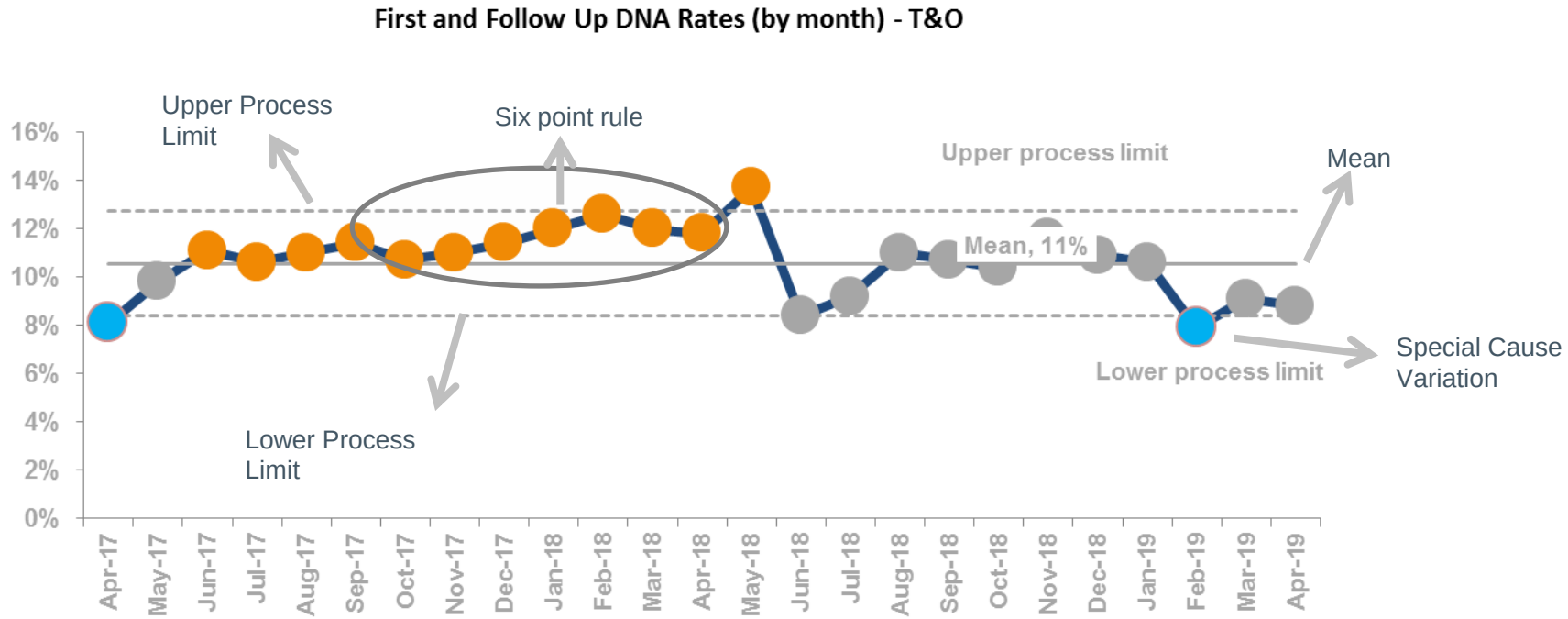
The biggest areas of overspend were Interims (£0.11m) and Consultants (£0.04m). The biggest areas of underspend were Nursing (£0.27m)
Agency spend is low across the Trust due to staff redeployment as a result of COVID -19 but slightly increased from last month

Agency use


Below cap
Above cap
Consultant Agency Spend
Junior Doctor Agency Spend
Nursing Agency Spend
HCA Agency Spend
AHP Agency Spend
Healthcare Scientist Agency Spend
Technical Agency Spend
Non Clinical Support Staff Agency Spend
Interims Agency Spend
Target

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	Aug-19	Sep-19	Oct-19	Discharges/wumabe00@net.stgeorges.nhs.uk/AdultOrdinaryInpatientAdmissionexclMaternity?iframeSizedToWindow=true&:embed=					Apr-20	May-20	Jun-20	Jul-20	Aug-20
Compliance with appropriate response to EWS (Adults)	100%	93.9%	87.6%	86.8%	89.6%	89.0%	92.0%	91.1%	94.1%	86.9%	93.5%	97.0%	93.6%	78.3%
Number of EWS Patients (Adults)		360	380	356	534	420	400	460	289	290	403	474	512	632

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4.2

Meeting Title:	**TRUST BOARD**		
Date:	**24 September 2020**	**Agenda No.**	**4.2**
Report Title:	**M5 Finance Report 2020/21**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer/Deputy Chief Executive		
Report Author:	Tom Shearer, Deputy Chief Financial Officer Michael Armour, Financial Planning		
Presented for:	Update		
Executive Summary:	The Trust has been requested to report a breakeven financial position at M5 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 M5 includes £15.2m of COVID costs (£2.8m in-month) and £21.3m of Income Top Up (£5.4m in-month). The underlying position, therefore, is a £6.0m deficit to date (£2.6m deficit in-month). This is made up of £17.1m 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 £11.1m (£0.8m in-month) underspends and lower income due to significantly reduced BAU activity due to COVID. The Trust Cash balance is £53.1m which is £50.1m favourable to plan. The Trust has spent £19.2m of capital at month 5, against a plan of £24.8m (values including COVID). The YTD COVID plan is £11.8m, with COVID cost £6.1m. The non-COVID capital spend is therefore £0.1m overspent, with £13.1m spend against the plan of £13.0m.		
Recommendation:	The Trust Board is asked to note the Trust's financial performance at M5.		
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	17/09/2020
Appendices:	N/A		

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4.2

Financial Report Month 05 (August 2020)

Trust Board

Chief Finance Officer

24th September 2020

Executive Summary

Month 05 Financial Position

- The Trust has been requested to report a breakeven financial position at M05 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 M05 includes £2.8m of COVID costs and £5.4m of Income Top Up. The underlying position, therefore, is a £2.6m deficit (excluding COVID costs).
- This £2.6m 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 £0.8m 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 & M3 payment was short by the value of bad debt provision included YTD. This is being queried with NHSI/E for resolution (expected in the coming month), and is accrued into the position as per national guidance.
- The Trust has spent £19.2m of capital at month 5, against a plan of £24.8m (values including COVID). The YTD COVID plan is £11.8m, with COVID cost £6.1m. The non-COVID capital spend is therefore £0.1m overspent, with £13.1m spend against the plan of £13.0m.
- The Trusts cash balance at M5 was £53.1m. 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.

1. Month 05 Financial Performance

			Full Year Budget (£m)	M5 Budget (£m)	M5 Actual (£m)	M5 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding COVID and Income Top Up	**Income**	SLA Income	785.5	65.4	62.0	(3.5)	327.3	310.0	(17.3)
		Other Income	162.8	13.8	12.5	(1.3)	67.9	60.8	(7.1)
	Income Total		**948.3**	**79.3**	**74.5**	**(4.8)**	**395.2**	**370.8**	**(24.4)**
	Expenditure	Pay	(581.2)	(48.6)	(47.7)	0.9	(242.5)	(234.5)	8.0
		Non Pay	(327.9)	(27.3)	(26.1)	1.3	(136.4)	(126.0)	10.4
	Expenditure Total		**(909.2)**	**(76.0)**	**(73.8)**	**2.2**	**(378.9)**	**(360.5)**	**18.4**
	Post Ebitda		(39.1)	(3.3)	(3.3)	(0.0)	(16.3)	(16.3)	0.0
	Grand Total		**(0.0)**	**(0.0)**	**(2.6)**	**(2.6)**	**(0.0)**	**(6.0)**	**(6.0)**
COVID and Income Top Up	**COVID**	Pay	0.0	0.0	(1.6)	(1.6)	0.0	(8.3)	(8.3)
		Non Pay	0.0	0.0	(1.2)	(1.2)	0.0	(7.0)	(7.0)
	Total COVID		**0.0**	**0.0**	**(2.8)**	**(2.8)**	**0.0**	**(15.2)**	**(15.2)**
	Income Top Up	SLA Income	0.0	0.0	5.4	5.4	0.0	21.3	21.3
	Reported Position		**(0.0)**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**

Month 05 Financial Position

- Guidance from NHSE&I states that the Trust should report a breakeven position in August, 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 £15.2m.
- The YTD income top up value is £21.3m, which brings the position to breakeven.
- Excluding COVID costs, and excluding the income top-up accrual, the Trust's YTD position would be £6.0m adverse to plan. This is due to the shortfall in block income of £17.1m being offset by £11.1m of underspends and lower income as a result of not undertaking BAU activity because of COVID.

2. Balance Sheet as at August 2020

Statement of Financial Position	FY 19-20 Audited Mar-20 (£m)	M05 August-20 FY20-21 YTD Actual (£m)	Variance
Fixed assets	**426.9**	**434.8**	**7.9**
Stock	**11.9**	10.7	(1.2)
Debtors	**93.7**	87.9	(5.8)
Cash	**3.5**	53.1	49.6
Creditors	**(94.0)**	(161.3)	(67.3)
Capital creditors	**(22.5)**	(6.2)	16.3
PDC div creditor	**0.0**	0.0	0.0
Int payable creditor	**(0.1)**	(0.2)	(0.1)
Provisions< 1 year	**(0.3)**	(0.3)	0.0
Borrowings< 1 year	**(322.5)**	(330.6)	(8.1)
Net current assets/-liabilities	**(330.3)**	**(346.9)**	**(16.6)**
Provisions> 1 year	**(2.5)**	(2.8)	(0.3)
Borrowings> 1 year	**(69.9)**	(59.7)	10.2
Long-term liabilities	**(72.4)**	(62.5)	9.9
Net assets	**24.2**	**25.4**	**1.2**
Taxpayer's equity			
Public Dividend Capital	**135.7**	136.9	1.2
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**	**25.3**	**1.1**

M05 FY20-21 YTD Statement of Financial Position

- Fixed assets have increased by £7.9m since March-20. This includes the impact of depreciation and capital expenditure YTD.
- Stock is £1.2m lower compared to Mar-20.
- Debtors has decreased by £5.8m since March 2020.
- The cash position is £49.6m higher than reported at year end in March-20. This is due to the block contract payment for September-20 received in advance in August-20.
- Cash resources are tightly managed monthly to meet the £3.0m minimum cash target at the end of the year.
- Creditors are £67.3m 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 September-20 fund received in advance.
- Capital creditors are £16.3m better than March-20. This is due to payment of year end capital invoices.
- Department of Health (DoH) has confirmed the conversion of £325m of both capital and revenue loan to PDC from the 1st September-20. PDC will increase to £462m in month 6 after conversion leaving the Trust with outstanding loans of £11.7m for capital as shown on slide 12g.

3. YTD Analysis of Cash Movement

Statement of Cash Flow	M05 YTD FY 20-21 Actual £m
Opening Cash balance	**3.4**
Income and expenditure deficit	(0.1)
Depreciation	11.5
Interest payable	5.2
PDC dividend	0.0
Other non-cash items	(0.1)
Operating surplus/(deficit)	**16.5**
Change in stock	1.2
Change in debtors	5.8
Change in creditors	67.3
Change in provisions	0.3
Net change in working capital	**74.6**
Capital spend (excl leases)	(19.2)
Capital Creditors	(16.3)
Capital donation	0.0
Interest paid	(5.1)
PDC dividend paid/refund	0.0
Interest Received	0.0
Net change in investing activities	**(40.6)**
PDC Capital Received	1.1
PDC Capital Paid	0.0
DH Loan YE Accrued Interest Reversal	(1.3)
Capital Loan repaid	(0.3)
Other Loans/ PFI /finance lease repayme	(0.3)
Net change in financing activities	**(0.8)**
Cash balance as at 31.08.2020	**53.1**

M05 FY20-21 YTD cash movement

- The cumulative M05 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 (£11.5m) does not impact cash. The charges for interest payable (£5.2m) 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 £16.5m.
- Net change in working capital has increased to £74.6m in M05. This is due to major movement in creditors of £67.3m which is due to the deferred income as a result of Covid-19. Stock level is decreased by £1.2m in M05 as compared to March-20.
- DH capital loan repayment of £0.3m repaid in May-20 and LEEF loan payment of 0.739m in June-20.
- PDC amount of £1.1m received in July-20 for Capital.

August-20 cash position

- The Trust achieved a cash balance of £53.1m on 31st August 2020, £50.1m higher than the £3m minimum cash balance required by NHSI. This is due to September-20 block contracts income received in advance in August-20.

4. M05 Capital

- The table below shows capital spend year to date of £19.2m against a plan of £24.8m. This includes £6.1m of costs associated with COVID 19 against a plan of £11.8m.
- The key reason for the underspend is the delay in delivery of some medical equipment associated with COVID 19.

TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	**Internal Budget £000**	M01	M02	M03	M04	M05	**M05 YTD budget £000**	M05 YTD exp £000	*M05 YTD var £000*
Infrastructure renewal	**11,600**	742	692	1,147	452	464	**3,011**	3,497	*-486*
P22	**10,000**	47	72	560	793	1,322	**3,324**	2,794	*530*
Major projects	**14,400**	802	186	108	594	380	**1,523**	2,070	*-547*
IT	**6,500**	1,736	1,335	(933)	753	425	**3,710**	3,316	*394*
Medical equipment	**2,000**	224	233	100	82	58	**422**	697	*-275*
Leases	**5,000**	904	(904)	365	225	147	**1,000**	737	*263*
SWLP	**500**	-	108	(108)	-	-	**-**	0	*0*
Total	**50,000**	4,455	1,722	1,239	2,899	2,796	**12,990**	13,111	*-121*
COVID	**20,623**	1,595	1,441	766	1,976	329	**11,805**	6,107	*5,698*
Total inc COVID	**70,623**	6,050	3,163	2,005	4,875	3,125	**24,795**	19,218	5,577

Meeting Title:	Trust Board		
Date:	24 September 2020	**Agenda No**	**5.1**
Report Title:	**Corporate Objectives 2020/21**		
Lead Director/ Manager:	Suzanne Marsello, Chief Strategy Officer Andrew Grimshaw, Deputy Chief Executive/Chief Finance Officer		
Report Author:	Sarah Brewer, Head of Business Planning		
Presented for:	Assurance		
Executive Summary:	Every year as part of the annual business planning round, the Trust agrees a set of Corporate Objectives for the forthcoming year. Whist work had commenced at the start of the year on developing objectives for 2020/21, this was paused due to Covid-19. The Trust therefore does not yet have an agreed set corporate objectives for 2020/21. The Executive Management Group together with the Divisional Triumvirates have worked together during the summer to propose some objectives for the remainder of the year which reflects where the organisation is at the current time i.e. starting to recover from phase 1 of Covid-19 whilst continuing to plan for a potential second wave, flu and winter. It was therefore agreed to focus on a smaller set of priority areas to provide clear direction to staff on the objectives for the remainder of the year. The areas being proposed are: **Care** (Lead: Chief Nursing Officer with support from the Chief Medical Officer) **Culture** (Lead: Deputy Chief Executive with support from the Acting Chief People Officer) **Collaborate** (Lead: Chief Operating Officer with support from the Chief People Officer) (Full details are set out on pages 5-7 of the attached paper) **Alignment with clinical divisional and corporate strategy implementation plans:** The corporate objectives have also been considered alongside the clinical divisional and corporate strategy implementation plans for the remainder of 2020/21 to ensure there is appropriate triangulation particularly as the strategy implementation plans will be the main delivery vehicle for the corporate objectives with progress reported to Trust Board. (See separate Board paper on Strategy Implementation Plans 2020/21) **Alignment with the Board Assurance Framework:** The proposed corporate objectives have been reviewed against the BAF Strategic Risks to ensure alignment. (The specific strategic risks and links to the proposed corporate objectives are set out in detail in page 9 of the attached paper) **Staff Engagement:** The draft corporate objectives have been tested with a cross section of clinical, non-clinical and corporate staff. Details of the staff engagement carried out and feedback is set out on page 11 of the attached paper. High level messages includes:		

	• Staff agree with having a smaller set of priorities to focus on • Like the 3 Cs - easy to remember and the areas are things that most people can buy into • These need to be communicated to staff in the right way – presentation and language to ensure they mean something to all staff • Need to be presented in a way that is doesn't feel like it is being 'done' to staff • It can be difficult for some corporate teams to see how their role fits into corporate objectives particularly if they appear quite clinically focussed. This needs to be addressed in how these are then cascaded to teams **Next Steps** One of the aims in developing the objectives was to ensure that they provide opportunity for ALL staff, no matter what role in the Trust, to recognise the part they can play in delivering these – therefore, subject to Board approval, **work will commence to develop a clear engagement and communication plan** to cascade these to staff and ensure they are translated in a way that 'speak' to all staff Delivery of the objectives will also **be linked to personal objectives and appraisals** to ensure **ownership** across the organisation and **empower** staff to play their part		
Recommendation:	Trust Board is asked to review and agree the proposed corporate objectives and proposed next steps.		
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:	**Safe**: you are protected from abuse and avoidable harm; **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.; **Well-Led**		
Single Oversight Framework Theme:	Strategic Change		
Implications			
Risk:			
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality & Diversity:	The proposed corporate objectives are expected to have a positive impact on equality & diversity, with an explicit focus on delivering and measuring improvement in this area.		
Previously Considered by:	Executive Management Meeting Trust Management Group	**Date:**	2rd &10th August and 1st and 14th September 12th August and 9th September
Appendices:	Proposed Corporate Objectives for 2020/21		

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Corporate Objective Refresh – Trust Board 24th September

5.1

Suzanne Marsello, Chief Strategy Officer

Andrew Grimshaw, Deputy Chief Executive/Chief Finance Officer

Author: Sarah Brewer, Head of Business Planning

8th September 2020

Corporate Objective Refresh 2020/21

Introduction

Every year the Trust agrees corporate objectives for the forthcoming year as part of the annual business planning process. Work had commenced on developing a set of corporate objectives for 2020/21 for Trust Board to approve but this work was paused due to Covid-19. **The organisation therefore does no yet have an agreed set of corporate objectives for this year.**

The **Executive Management Group together with the Divisional Triumvirates** have worked together over the summer to agree some corporate objectives for the remainder of the year which will **provide direction to the whole organisation particularly at a time of uncertainty** as the Trust is starting to recover from the first phase of Covid-19, whilst at the same time continuing to plan and be prepared for a potential second wave and winter.

With this aim in mind, the objectives being proposed are focussed around three priority areas:

CARE	Patients and staff feel cared for when accessing and providing high quality timely care at St Georges; in how the Trust starts to recovers from Covid-19 and in how we respond to any future wave
CULTURE	Transform our culture to create an inclusive, compassionate and enabling place to work where staff feel respected and understand their role in the delivery of high quality clinical care for our patients and service users.
COLLABORATE	We will engender an ethos of collaborative working across our teams within St George's and with our system partners to achieve the best outcomes for patients, building on the spirit of collaboration developed internally and externally through Covid-19 response

Further details including specific actions for each of the 3 priority areas are set out in slides 5-7

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Corporate Objective Refresh

Alignment with Divisional and Corporate Strategies

The corporate objectives have also been considered alongside the **divisional and corporate strategy implementation plans** agreed for the remainder of 2020/21 to ensure there is appropriate triangulation particularly as the strategy implementation plans will be the main **delivery vehicle** for the corporate objectives with progress reported to Trust Board (see separate Board paper on Strategy Implementation Plans 2020/21)

Alignment with the Board Assurance Framework (BAF)

The proposed corporate objectives have been **reviewed against the BAF Strategic Risks** to ensure alignment . The specific strategic risks and links to the proposed corporate objectives are set out in detail in slide 9

Staff Engagement

The proposed corporate objectives have been developed in a way that makes them **applicable to all staff groups .**The proposed objectives have been **tested with a cross section of clinical, non-clinical and corporate staff** through informal engagement sessions held during August. Further details and specific feedback is set out on slide 11.

High Level Feedback:

- Staff agree with having a smaller set of priorities to focus on
- Like the 3 Cs - easy to remember and the areas are things that most people can buy into
- These need to be communicated to staff in the right way – presentation and language to ensure they mean something to all staff and avoid use of 'trigger' language
- Need to be presented in a way that is doesn't feel like it is being 'done' to staff
- It can be difficult for some corporate teams to see how their role fits into corporate objectives particularly if they appear quite clinically focussed. This need s to be addressed in how these are then cascaded to teams

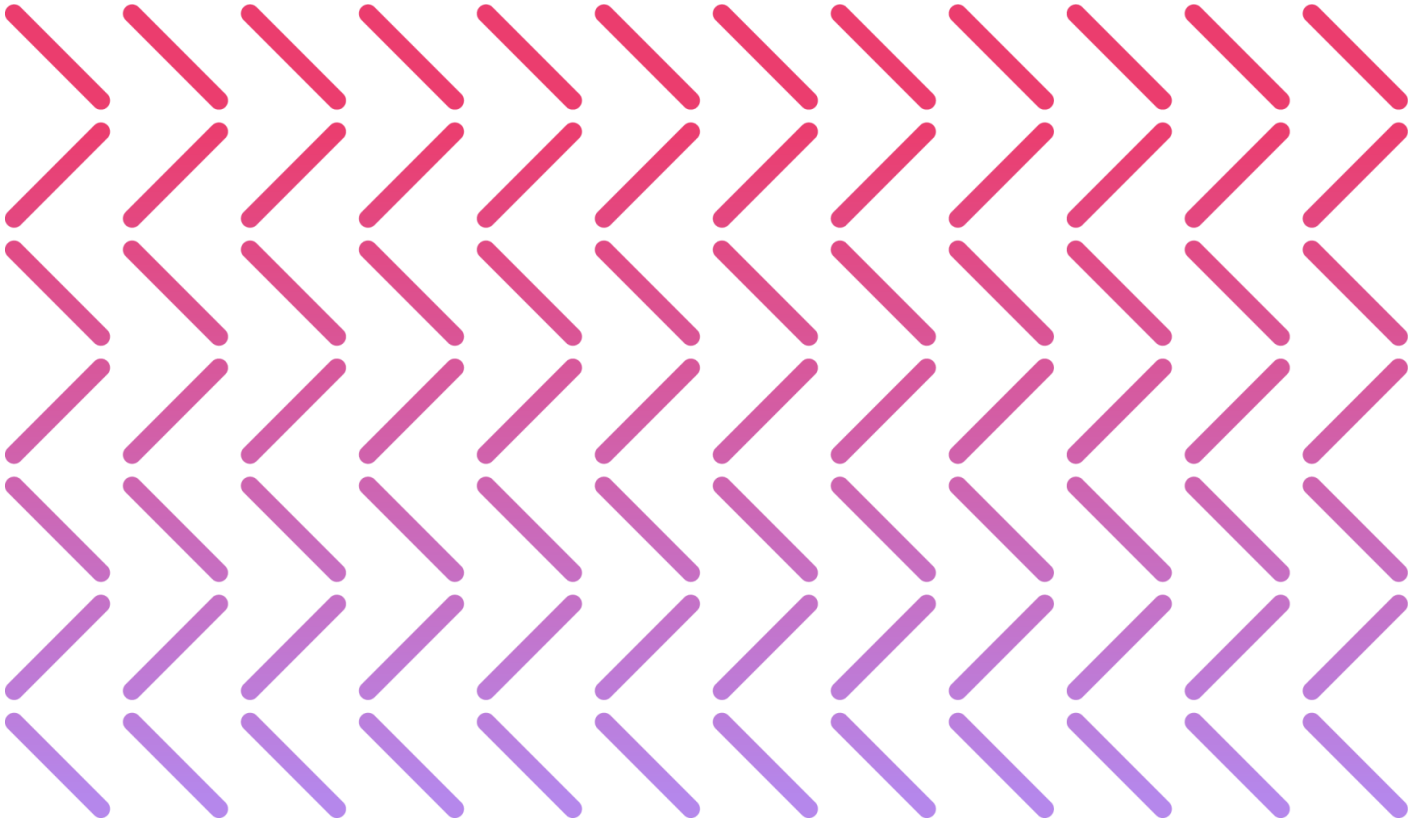
Next Steps

One of the aims in developing the objectives was to ensure that they provide opportunity for ALL staff, no matter what role in the Trust, to recognise the role they can play in delivering these – therefore, subject to Board approval, work will commence to develop a **clear engagement and communication plan** to cascade these to staff and ensure they **are translated in a way that 'speak' to all staff.** This will include setting out some illustrations of what it might mean for staff at different levels and in different roles

Delivery of the objectives will also be **linked to personal objectives and appraisals** to ensure **ownership** across the organisation and **empower** staff to play their part

Corporate Objectives

Detailed Plans



5.1

Corporate Objective Refresh -Care

Trust Strategic Objective	
Care	
This year's Trust objective (what exactly are we wanting to do this year?)	**Lead:** Chief Nursing Officer **Support:** Chief Medical Officer
Patients and staff feel cared for when accessing and providing high quality timely care at St Georges; in how the Trust starts to recover from Covid-19 and in how we respond to any future wave	
What are the actions we need to take? What does this include?	
• **Planning and preparedness** - Drawing on the learning from Covid-19, and working with partners, the Trust will ensure there is a robust winter/surge plan in place that is agile to meet fluctuating demands. This will include ensuring staff have the necessary skills to be able to respond to a further wave of Covid-19. Implement Infection Prevention Control standards through a harmonised approach with partners across SWL. • **Supporting our staff –** a structured package of health and wellbeing support will be available to staff. Staff will have access to appropriate Personal Protective Equipment, risk assessments and flu vaccinations. • **Recovering and maintaining services –** We will deliver national targets in waiting times including, were possible maintaining specialist, regional services such as national screening programme and tertiary referral services. We will ensure same day emergency/ambulatory pathways are maintained. • **Communication - C**ommunicate effectively with our patients and visitors regarding the safe access to Trust services, detailing measures the Trust has implemented and actions patients can take to 'stay safe' and we will work with system partners and South West London to standardise patient information regarding the accessing of health services • **New ways of working** – develop new roles and ways of working, this will include continuing to optimise IT and investment in new equipment.	
What do we want you to do (what are the outcomes, actions we want)	What else can you, your team or your department do to help? (for our staff to complete)
• Think about how your service can support the front line and the delivery of first class care for all our patients • Engage with winter /surge planning sessions. • Work to ensure the safety of our patients through effective governance at care group level. • Support new ways of working; organisational projects by developing ideas within your service. • Promotion the Health & Wellbeing of yourself and your colleagues; e.g. covid risk assessments, flu vaccinations and wellbeing • Speak openly about your concerns and experience at work.	
How will we know we have been successful? What will we measure?	
<u>Patient Outcomes:</u> • Meet waiting time targets • Nosocomial Infections in line with target • Reduction in avoidable harm and death associated with missed opportunities when compared with 2019/20 • Performance against recovery targets for specialties i.e. endoscopy • Number of outpatient appointments accessed virtually • Incident of nosocomial infections	<u>Staff outcomes :</u> • Workforce is able to flex to peaks in demand • Increased use of the Freedom To Speak Up Guardian and Champions • Improved health and wellbeing support for staff; timely access to Occupational Health and staff psychological support • 90% of staff have had the Flu Vaccination • % of staff risk assessments completed against 100% target

Corporate Objective Refresh Culture

Trust Strategic Objective	
Culture	
This year's Trust objective (what exactly are we wanting to do this year?)	**Lead**: Deputy CEO **Support:** Acting Chief People Officer

Transform our culture to create an inclusive, compassionate and enabling place to work where staff feel respected and understand their role in the delivery of high quality clinical care for our patients and service users.

What are the actions we need to take? What does this include?

- Undertake a culture diagnostic led by our staff and share the findings, making connections to related work and to the Collaborate and Care objectives.
- Listen to our staff and jointly agree with them where we need to focus our efforts on changing the culture and what this means in terms of individual and collective behaviour;
- From this work we hope to be able to:
  - Agree actions to change our culture and work with all staff to ensure they understand their role and the behaviour needed to improve patient care;
  - Develop all our leaders at every level within the Trust to ensure that they have the behavioural capability and capacity to be truly inclusive, responsible, compassionate and effective leaders.
  - Agree plans with all departments to improve our systems and processes to make day to day activities simpler, more efficient and effective – making it easier to do the right thing, behaviourally.
- With our staff pick a few things we need to change and complete these. Establish the behavioural pattern of doing a few things well rather than try and change everything and fail.
- Review/redefine the Trust values and consider how these values will manifest themselves as behaviours in how we interact with one another.
- Create high performing, patient centred teams; align support and resources of diversity & inclusion, quality improvement, Leadership Development and wider education initiatives to support behaviour change in team work.

What do we want you to do (what are the outcomes, actions we want)	What else can you, your team or your department do to help? (for our staff to complete)
• Support the culture diagnostic and action plan; to engage positively in this • Work with your team to agree ways to help deliver this plan. Play an active role in our improvement journey • Discuss issues and concerns openly and constructively. Listen to your colleagues • Be an enthusiastic team worker, cooperating with your own team and others you work with; • Be accountable and responsible as well as holding those around you to account.	

How will we know we have been successful? What will we measure?

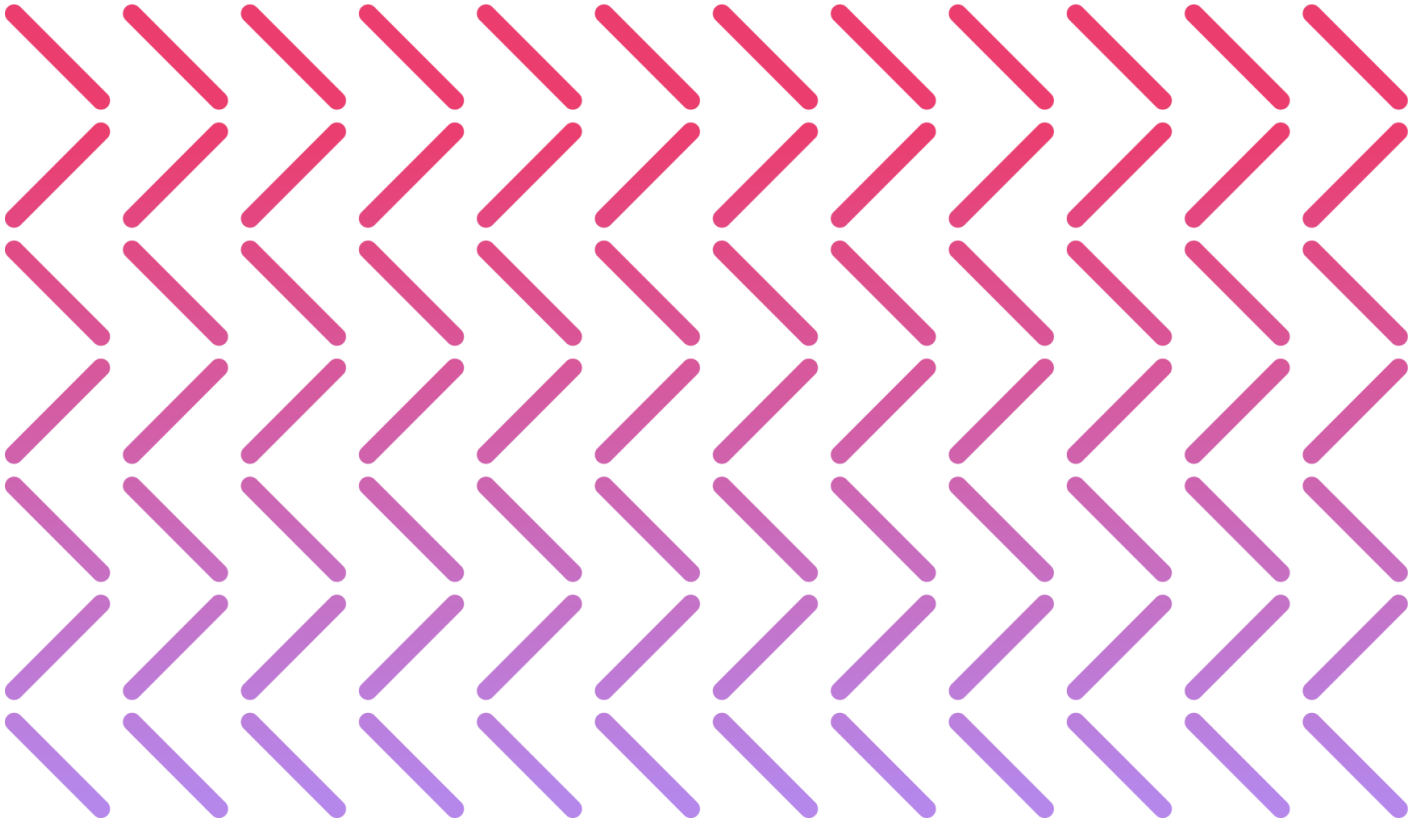
- We deliver excellent services for patients, and all of us understand our role in achieving that. (Success measured in moving CQC from "Requires Improvement to Outstanding")
- All of us enjoy working here and feel enabled to succeed. (Success measured through Friends & Family Test, Staff Survey scores)
- We have established an inclusive and diverse workforce. (Success measured through improved Human Resource data metrics)
- We achieve our targets and objectives; at an organisational level, by service and personally (Success measured in the various targets; organisational, department and personal via appraisal)

Corporate Objective Refresh
Collaborate

Trust Strategic objective:	
Collaborate	
This year's Trust objective (what exactly are we wanting to do this year?)	**Lead:** Chief Operating Officer **Support:** Chief Strategy Officer
We will engender an ethos of collaborative working across our teams within St George's and with our system partners to achieve the best outcomes for patients building on the spirit of collaboration developed internally and externally through Covid-19 response	
What re the actions we need to take? What does this include?	
SWL System Working : We will actively support SWL to plan and deliver as a system rather than individual organisations on performance, money, workforce, quality- working with our system partners to identify opportunities for ways of working across SWL to improve efficiency, reduce costs and identify, replicate and share best practice. **Clinical services.:** To work with colleagues within SGH and the wider SWL health community to serve our population, maximise capacity and prioritise our patients equitably and without unwarranted variation. For example working with other acute Trusts and the independent sector to reduce the current elective backlog and to prepare for any future Covid-19 surge. **Infrastructure :** work with partners across SWL to optimise the use of the infrastructure across SWL to maximise capacity, strengthen, expand and consolidate services (where appropriate) to provide the best care for patients **Research and Education -**working with St George's University of London and other partners we will maximise our potential around education, training, innovation and research	
What do we want you to do (what are the outcomes, actions we want)	What else can you, your team or your department do to help? (for our staff to complete)
• To look for opportunities to work with teams and colleagues outside of your team on initiatives or innovations which could improve the care we provide to patients • Engage in the development and delivery of joint initiatives with SWL partners and help identify where St George's can really add value	
How will we know we have been successful? What will we measure? How often will we report progress and achievement? What's the process for accountability?	
• Team members will see themselves as part of a wider St George's team and SWL system to benefit our patients - measured through various staff engagement opportunities for example staff survey and listening events • Willingness of staff to be re-deployed during periods of high demand- measured through the workforce re-deployment and 'up skilling' logs. • Reduced waiting times - measured through referral to treatment (RTT) performance • Increased utilisation of Independent Sector contributing to reduced waiting times - measured through the number of lists/procedure directed to the Independent Sector • No shortages of the necessary staff or equipment during winter and/or second surge of Covid-19 – measured through usage of SWL staff bank, single procurement hub • Partners see St George's as an organisation they want to collaborate with - measured through the range of joint initiatives the Trust is engaged in • Reduced spend on procurement and agency staff - measured through financial accounts	

Corporate Objectives

Links to the Board Assurance Framework (BAF)



5.1

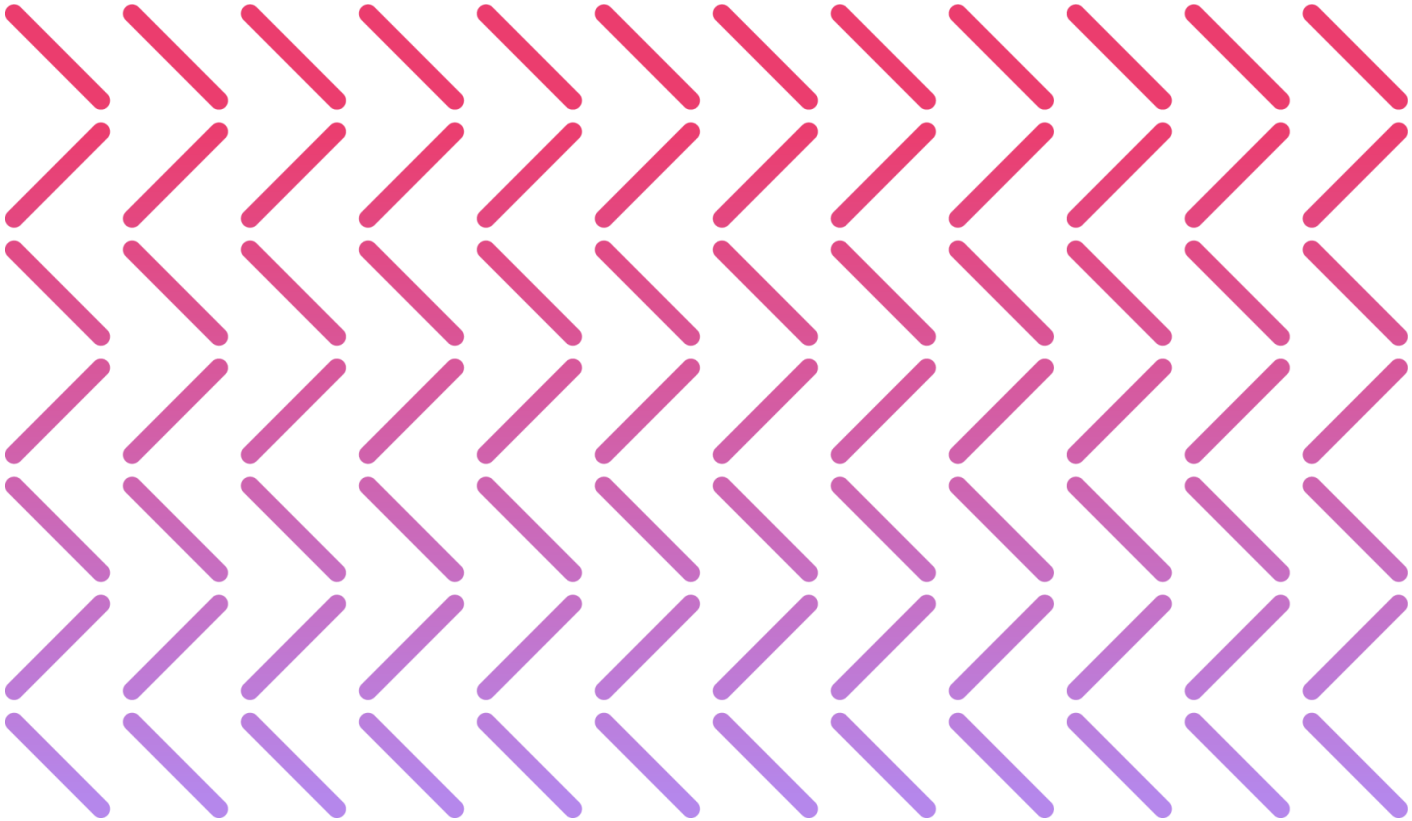
Alignment with Board Assurance Framework

The proposed corporate objectives have been reviewed against the BAF Strategic Risks to ensure alignment - the table below sets out the specific strategic risk and identifies which corporate objective(s) in particular will contribute to addressing these risks

Risk Reference	2020/21 Strategic Risks	Link to Corporate Objective
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	Care Culture
SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	Care Culture Collaborate
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	Care Culture Collaborate
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	Care Culture Collaborate
SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities	Culture Collaborate
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	Culture Collaborate
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	Care Collaborate
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	Care Culture
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	Care Collaborate Culture
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.	Collaborate

Corporate Objectives

Staff engagement



5.1

Staff Engagement

Forum	Date	Summary of feedback
Junior Doctors Forum	20th August	• Agreement that the 3 areas seemed sensible and the right things to be focusing on rather than being over ambitious • Commented that it can sometimes be hard for junior doctors to actively engage with this type of thing due to them being 'immersed' in the job – so need to think about the most appropriate approach and mechanisms to make it easy for them to engage (i.e. not one size fits all)
Matron and Ward Managers Forum	25th August	• Liked the 3 Cs – simple and easy to remember and felt these were the right things • Agreed with the need to focus on smaller number of priorities • Felt that 'identity' needs to factor into the work on culture • Need to think about how these are communicated to staff and teams to help them identify their role - the language and how they are presented when they are formally 'launched'
Care Group Leads	26th August	• Agreement on a smaller set of priories and felt the those being proposed are the right things • Need to ensure meaningful engagement and communication of the objectives to all staff groups is important to help everyone recognise their role in delivering • Welcomed the opportunity to comment
Corporate Staff Focus Groups (Including Finance, HR, Estates & Capital, Strategy, Comms)	25th and 26th August	• Agreement that the focus should be on a smaller number of things and liked the 3 Cs idea • There was recognition that it is sometimes hard for corporate teams to identify their role in some of the corporate objectives especially when they can seem quite clinically focussed such as the 'care' objectives • There need to be opportunity for teams to have the right /quality conversations to be able to really understand their role and contribution - communication and how these are presented to staff is important • There was a suggestion that 'Care' objective should also include something about the hospital environment - both in terms of making patients and staff feel safe but also a 'duty of care' for everyone to look after and respect the environment they work in • On culture – it was felt that the actions will only be delivered in the medium/long term and questioned whether there should be things in there that address the 'here and now' issues • Culture - Senior team need to lead by example and needs to come from top. Recognition that management and leadership are different – managers don't always make good leaders and this need to be part of the leadership development action • Need to be clear about how the objectives will be measured - this could be strengthened in areas
Culture Champions	9th September	• Need to ensure the actions in the culture objective don't pre-empt any findings from the work they are doing • Need to present them in a way that is more of a two way process and demonstrates staff are being listened to • Agree with the focus on 3 areas • They need to be communicated in a way that all staff can relate to. We can't assume many staff know what corporate objectives are
Pharmacists	10th September	• Agree with the focus on the 3 areas • Can identify things their teams can contribute to delivering these • Need to ensure they are communicated effectively • Work needs to be done with teams to help translate and make relevant to them

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	24 September 2020	**Agenda No**	**5.2**
Report Title:	**Board Assurance Framework (BAF) – Quarter 2 2020/21**		
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, Assurance**		
Executive Summary:	This paper presents the Board Assurance Framework at Quarter 2 2020/21. The BAF has been updated with the Q2 assurance rating and statements from the Committees of the Board. The BAF also provides the detail associated with the risk scores for each strategic risk, the controls and assurances and outlines the actions to be taken to address any gaps. Lead indicators and progress against these are also detailed. 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 annex includes the contributing risks from the corporate risk register. **Quarter 2 Assurance rating:** 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:** There are 7 extreme risks, 2 high risks and 1 moderate risk. **Strategic Risks for the Board – SR4:** The Board is asked to agree the assurance level for this risk of partial' 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 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. Following a request from the Board at its meeting in July 2020, target risk scores have been proposed for each Strategic Risk. A review of the risks that sit below and inform the BAF on the corporate and divisional risk registers is underway.		
	The Board is asked: 1. For the strategic risk reserved to itself (SR4) to: • Note the risk rating • Agree the proposed target risk score • Agree the proposed assurance rating • Agree the proposed assurance statement 2. For the 9 risks assigned to its assuring committees to: • Note the risk score, assurance rating and statement from the relevant assuring committee • Approve the risk scores and target risk scores for SR7, SR8, SR9 • Approve the proposed in-year target risk scores for each strategic risk		

5.2

Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	The strategic risk profile		
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:	Executive Management Committee Quality and Safety Committee Finance and Investment Committee	**Date**	14.09.2020 17.09.2020 17.09.2020
Equality and diversity:	The BAF reflects agreed risks in relation to quality and diversity and the actions being taken to address these.		
Appendices:	Board Assurance Framework Q2 2020/21		

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NHS
St George's University Hospitals
NHS Foundation Trust

Board Assurance Framework 2020/21

Trust Board
Quarter 2 BAF Report

5.2

Stephen Jones
Chief Corporate Affairs Officer

24 September 2020

Executive Summary

The Board approved the new Strategic Risks on the Board Assurance Framework (BAF) at its meeting in May 2020 and received the quarter 1 report in July 2020. Under the new BAF, the Board and its Committees are assigned the Strategic Risks as follows, with Strategic Risk 4 (system working) reserved to the Board:

- Quality and Safety Committee: Strategic Risks 1 (patient safety and learning), 2 (clinical governance), and 10 (research)
- Finance and Investment Committee: Strategic Risks 3 (operational performance and access), 5 (financial sustainability), 6 (capital), and 7 (estates)
- Workforce and Education Committee: Strategic Risks 8 (culture) and 9 (workforce)

At its meeting in July 2020, the Board reviewed the BAF at Quarter 1 2020/21 and agreed:

- The proposed risk scores and assurance statements for each of the strategic risks on the BAF.
- In relation to Strategic Risk 4 (system working), the Board agreed that this should be set at a score of 12 (4 consequence by 3 likelihood) to reflect the significant changes in system working following the Covid-19 pandemic and the inherent tensions between individual organisational accountability under the current statutory framework and the move to greater system working in practice, which is not yet underpinned by legislation.
- That stretching but realistic in-year target risk scores should be developed for each Strategic Risk;
- That the risks sitting below and informing the BAF on the corporate and divisional risk registers should be reviewed and updated where appropriate.

Quarter 2 2020/21 Update:

This report presents the Quarter 2 2020/21 position for the BAF. The Q2 position is reported now, slightly ahead of the end of Q2 in light of the alignment of quarterly cycles with the cycle of Board meetings (the Board would otherwise have received the Q2 report in November, two months after the quarter. We do not expect material shifts in position between now and the end of September). The BAF has been updated with the Quarter 2 risk scores, assurance ratings and statements from the Committees of the Board. The BAF also provides the detail associated with the risk scores for each strategic risk, the controls and assurances, the gaps in controls and assurances and actions being taken to address these, and progress against those actions. Lead indicators and progress against these are also updated. As agreed by the Board at its meeting in May 2020, Covid-19 is not listed as a stand-alone strategic risk on the BAF. Instead, the implications of Covid-19 for the Board Assurance Framework have been provided both as a high level overview and in detail against each Strategic Risk.

- **Risk scores:** There are seven extreme risks on the BAF, two high risks and one moderate risk.

- **Assurance Ratings**: 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).

- **Target risks:** Target risks have been proposed and reviewed by the Board Committees, and these are set out in the paper.

- **Supporting risks:** A review of the supporting risks on the corporate and divisional risk registers has started, and will be overseen by the Risk and Assurance Group. This review has been completed for those risks sitting under SR8 (culture) where the Board considered the risk scores to be particularly low.

Executive Summary

- **Strategic Risks for the Board – SR4**: The Board is asked to agree the assurance level for this risk of partial' 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 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.

Further points to note:

- The risk scores and target risk scores for SR7, SR8 and SR9 have not been approved at the assigned Board Commitees, but have been reviewed by the Executive Management Team. The latter two are due to the timing of the Workforce and Education Committee.

- There is slippage against the delivery of mitigating actions for SR1 and SR2 due to the impact of Covid-19 on recruitment to key posts recommended by the external governance review and demonstrable compliance against clinical standards for 7 day services

The Board is asked:

1. For the Strategic Risk reserved to itself (SR4) to:
    - Note the proposed score (no change)
    - Agree the proposed target risk score
    - Agree the proposed assurance rating
    - Agree the proposed assurance statement

2. For the 9 risks assigned to its assuring Committees to:
    - Note the revised target risk scores, risk scores, assurance ratings and statements from the relevant assuring Committee
    - Approve the risk scores and target risk scores for SR7, SR8, SR9
    - Approve the proposed in-year target risk scores for each Strategic Risk

Strategic Risks: High Level Summary – Assurance Rating and Risk Score

Strategic Objective	Risk Reference	2020/21 Strategic Risks	Assurance Rating	Risk Score	Target 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	High -12
	SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	Partial	High - 12	Moderate - 8
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	High-12
	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	High - 12	High -12
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	High - 12
	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	High - 12
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	Extreme - 16
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	Extreme - 16
	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	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	Low - 6

Covid-19: Implications for the Board Assurance Framework (1 of 2)

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 • Delay in implementing recommendations from phase 1 and 2 governance review
	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 • Delay in implementing recommendations from phase 1 and 2 governance review • Delay in receipt of the outcome of the phase 3 governance review
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 • Increase in the number of people waiting 52 weeks or more for treatment • Increase in the total number of patients waiting for treatment on the PTL • The Winter Plan 2020/21 includes comprehensive to respond to a second wave of Covid-19
	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 plan submitted to NHSE/I
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

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Covid-19: Implications for the Board Assurance Framework (2 of 2)

Strategic Objective	Risk Reference	2020/21 Strategic Risks	Covid-19: Implications for the Board Assurance Framework
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	• Fostered elements of a Team St George's spirit and staff network groups have continued to meet (and faith calendar days have been celebrated) • A number of engagement events have been paused (Go Engage pilot; TeamTalk) • Covid-19 has had an impact on the completion of the diagnostic phase of the culture programme and highlighted underlying issues with diversity and inclusion that the Trust is now seeking to address.
	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.	• Non-Covid-19 clinical research studies have started to recommence • The Trust has had the opportunity to participate in numerous Covid-19 clinical research studies and has currently recruited to 21 Covid-19 studies, placing the Trust joint highest in England.

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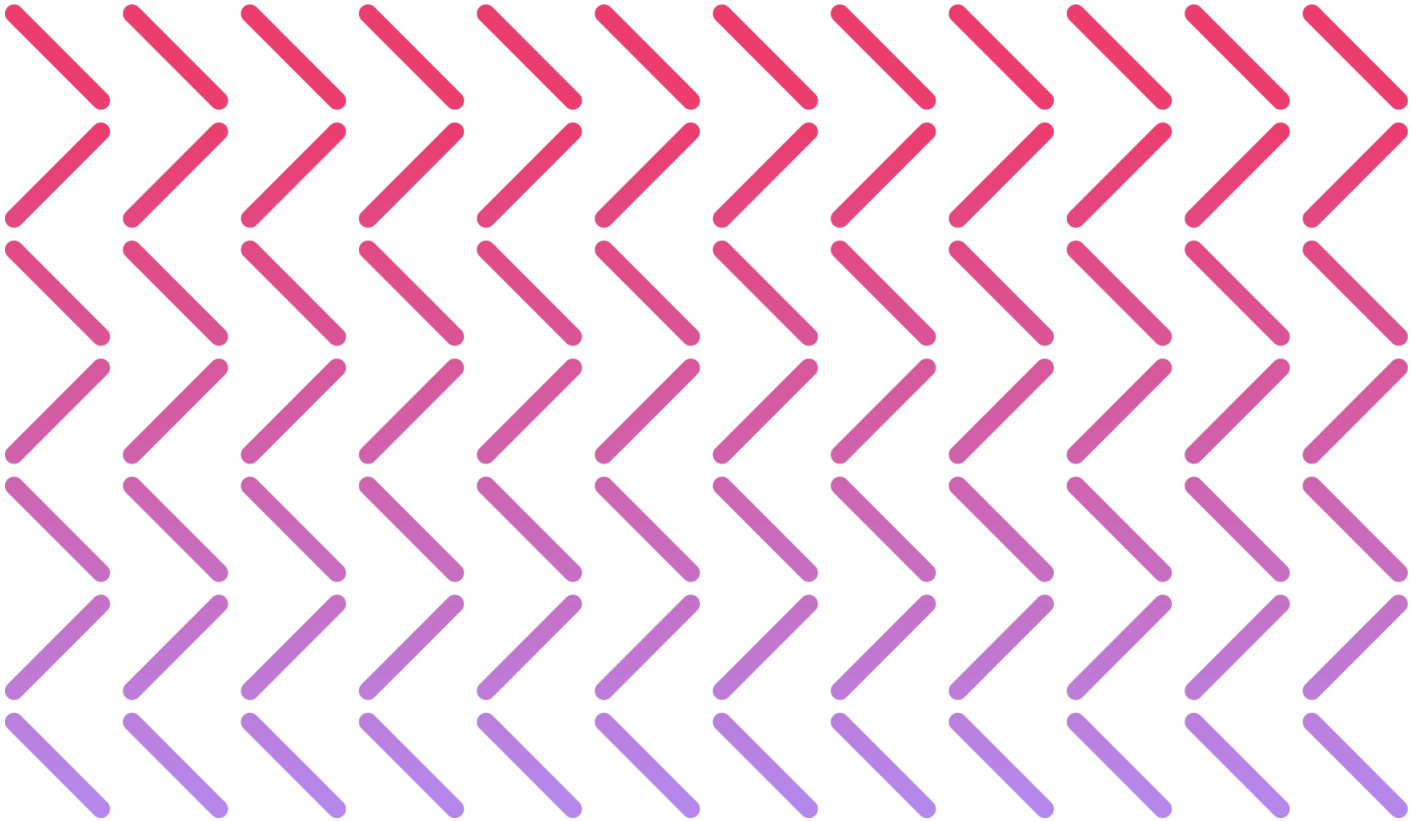
Strategic Objective 1: Treat the Patient, Treat the Person
Strategic Risks SR1 and SR2

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	17 September 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 iClip which facilitates their promotion and auditability.

However, there are number of gaps in controls and sources of assurance, in particular 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.

An in-year target risk score of 12(4x3) is proposed to reflect a realistic year end position for this risk due to the expected delivery of the identified actions to mitigate the risk and therefore reduce the risk score. This includes steps to recruit to new clinical governance positions across corporate and divisional areas, steps to improve the Trusts position on seven day services, and the role of the Trust's new Covid, flu and winter plan in keeping the Trust's patients safe during the next six months to year-end.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
Q1	**Extreme 16 = 4(C) x 4(L)**	**Partial**	N/A	**20 = 4(C) x 5(L)**	**12 = 4(C) x 3(L)**
Q2	**Extreme 16 = 4(C) x 4(L)**	**Partial**	N/A		
Q3					
Q4					

Summary COVID-19 Impact

Selected elective services directed by the Clinical Safety Strategy have continued to re-start. Infection Prevention and Control guidance continues to be implemented and revised as and when required directed by Public Health England. The Trust continues to see 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 Trust continued to investigate and report serious incidents and complaints. The number of declared serious incidents has not materially changed. The number of complaints is now increasing to the expected level pre-COVID. A number of meetings were suspended, including the Patient Partnership and Experience Group (PPEG). PPEG has now re-established virtual meetings. The Trust has revised its hospital visiting policy.

The Trust has developed a COVID-19, Flu and Winter Plan which the Committee – as well as the Finance and Investment Committee – will consider at its meeting in September and the Board will consider on 24 September 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

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) supported by an implementation plan	S	S			• Trust removed from Quality Special Measures in March 2020 following improvements documented in CQC inspection report published in December 2019 • Treatment Escalation Plan (TEP) in place and implementation tracked in IQPR • Quarterly progress delivery reports to committee		x x	x
Serious Incident reporting and Investigation Policy including electronic incident reporting system (Datix) in place	S	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) • Internal Audit report including internal management action plan: rated substantial assurance		x x	x x
Complaints Policy in place	G	G			• Quarterly complaints report to Patient Safety Quality Group identifying emerging themes and learning • Internal Audit report including internal management action plan: rated reasonable assurance • Friends and Family Test: provides a measure of how we learn from our complaints		x x	x x
Infection Control Policy including Root Cause Analysis (RCA) for all C. Diff cases to ensure learning in place	S	S			• Year end position for 2019/20: Hospital Acquired C.Diff - 43; MSSA - 37; and E-Coli – 74 • YTD (Apr 20-Jul 20): Hospital Acquired C.Diff -13; MSSA - 9; and E-Coli – 18 • Infection control audit reports identifying emerging themes and improvement actions • Ward round monitoring to ascertain that infection control requirements are in place and followed and periods of increased Surveillance and Assessment (PISA)	x x x x	x x x x	
Early Warning Score training in place	G	G			• EWS January 2020 audit :complete set of observations 75%; correctly scored 78%; Appropriate response 74%; Frequency 77% • Compliance with mandatory training – ALS BLS and ILS training are below 85% performance target. To increase access to training an on-line BLS level 2 module is being launched • Critical Care Outreach team – funded establishment	x x	x x x	
Sepsis tool live on iClip	G	G				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
Implementation plan for Quality and Safety Strategy	Implementation plan to be developed and approved Implementation plan developed and approved	Complete	
Electronic Sepsis screening tool for inpatients	Develop and roll out electronic screening tool on iClip Sepsis tool went live in iClip	Complete	
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 • Head of Risk and Compliance and Head of Patient Safety and Clinical Effectiveness recruited to start December 2020 • Deputy CMO posts interviews w/c 14 September 2020 • Recruitment to legal services team commenced	Sep 2020	
Seven day clinical services standards (also see SR3)	Implementation of Divisional action plans to achieve seven day clinical service standards compliance There was a delay to the implementation of previous action plan due to the COVID-19 emergency response. The Deputy Chief Medical Officer, supported by the Divisional Clinical Governance and Clinical Audit Team, is leading a project to deliver a thorough, clinically-led self-assessment of compliance, identification of risks, immediate mitigations and a longer-term audit and assurance plan. A paper to update the Quality and Safety Committee and the Trust Board on progress will be taken in November 2020	Sep 2020	
Critical Care Outreach team not recruited to full establishment	Critical Care recruitment plan 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: Wi-Fi will be addressed through the ICT Network improvement Project which is expected to run until the end of 2021	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	

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					On average 30% of all adult patients have had a TEP since March 2020.
Compliance with appropriate response to Early Warning Score (adult)					Compliance with Early Warning Score. Between April – July 2020 a monthly point prevalence (PP) audit has been undertaken to examine the extent to which TEPs are restrictive or reflective of patients for full escalation. The PP audit showed that 44.2% of TEPS were completed for adult inpatients Compliance with appropriate response to EWS (adults) was 78% in August.
Severity of reported incidents					Severity of adverse incidents – 97% No harm/ Low harm in June 2020
Number of declared serious incidents					3 serious incidents were declared in August 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 August 2020
Infection Control (MRSA, C. Diff, MSSA, E-Coli)					MRSA 1, Hospital Acquired CDiff 3; MSSA 4; and E-Coli 0 reported in August 2020
Number of hospital acquired pressure ulcer category 3 and above					7 category 3 pressures ulcers in August 2020
Safety Thermometer percentage of patients with Harm Free Care (new harm)					Safety thermometer– percentage of patients with harm free care was 98% and remains within target
Friends and Family Test					The number of eligible responders are increasing across services. All services saw an increase in the number of positive responses apart from outpatients which narrowly missed achieving the 90% target. The service's positive response rates continues to show a special cause variation with a deterioration with position.

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	17 September 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.

In July 2020 the Committee received the first quarterly report into Cardiac Surgery since the independent mortality report was published in March 2020. The restriction on elective cardiac surgery cases remains in place with only one surgeon able to conduct operations with a EUROSCORE of 5% or above. Health Education England continues to scrutinise the training provided to trainee doctors who receive a comprehensive training programme. The CMO and service lead continue to progress improvement actions and drive engagement.

The Trust has key controls and sources of assurance in place, for example the recently implemented Medical Examiner service 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. The target risk score has been revised from 6(3x2) to 8(4x2) to reflect a realistic year end position for this risk due to the expected delivery of the identified actions related to the phase 1 and phase 2 governance reviews and the completion of the phase 3 external governance review.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
Q1	High 12 = 4(C) x 3(L)	Partial	N/A	20 = 4(C) x 5(L)	8 = 4(C) x 2(L)
Q2	High 12 = 4(C) x 3(L)	Partial	N/A		
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 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.

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

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	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	S			• Phase 1 and phase 2 external governance reviews			X X
Improvement plan for Cardiac Surgery services	S	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	R	R			• 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	S			• MCA Steering Group reports to PSQG demonstrating progress against MCA strategy		X	
MCA level 1 and level 2 training programme in place	R	R			• MCA level 1 and 2 training levels across all staff groups reported	X X	X X	
Medical Examiner System in place	S	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	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	R	R			• Trust does not comply with NHS England Standard Contact for Discharge Summary			X

Outstanding care every time

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
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	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	Complete	
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 • Head of Risk and Compliance and Head of Patient Safety and Clinical Effectiveness recruited to start December 2020 • Deputy CMO posts interviews w/c 14 September 2020 • Recruitment to legal services team commenced	Sep 2020	
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 for patient record documentation including consent and monitor resultant action plans	Mar 2021	
Full implementation of the Cardiac Surgery action plan to address all recommendations from the reviews	Implement the Cardiac Surgery action plan The outstanding recommendations of this and the St George's Cardiac Independent Oversight Panel Report are currently being actioned. The majority of the recommendations have been met. There are three remaining actions which are being progressed	Jan 2021	

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				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Progress against phase 1 and phase 2 governance reviews					Learning from Deaths lead in place.
Maintaining the SHIMI within the confidence level (<0.1)					SHMI 0.89
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)					10.6% readmission rate in July 2020
Number of open actions on CQC Trust wide action plan (2 Must dos: 44 should dos)					46 open actions. Progress impacted by Covid-19 August 2020 – 15 actions have been reported as completed. Evidence is being gathered
MCA level 1 and level 2 training performance					Level 1 MCA training compliance within target (90%), level 2 compliance is 74% in August 2020 against 85% target
Diagnostic indicators – DM01					In August the Trust did not meet the 6 week diagnostic standard with an adverse performance of 28.8% against the target threshold of 1%. However, this was an improvement from 34.2% in the previous month.

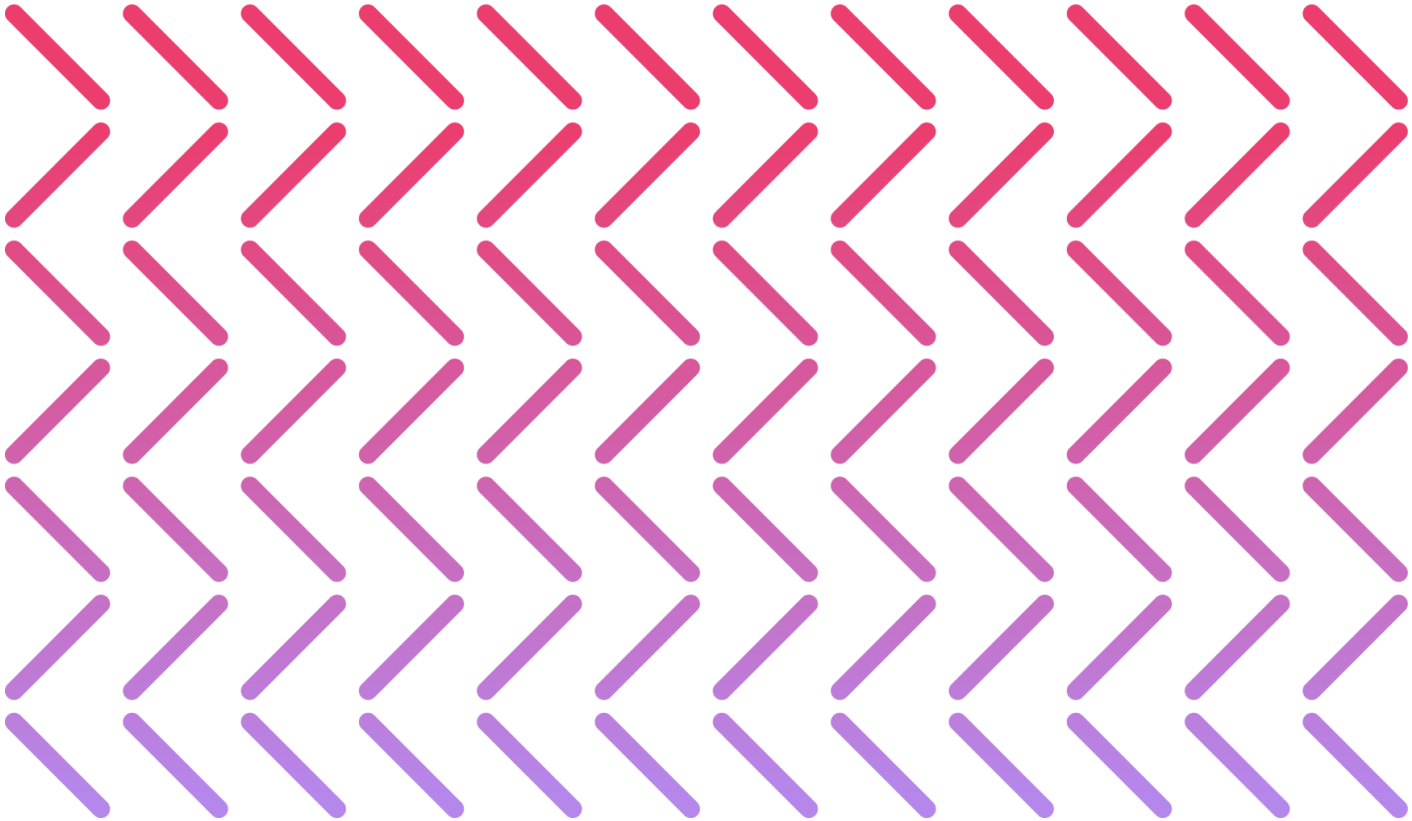
Emergent / future risks	Future opportunities
• A second wave of Covid-19 may impact on the delivery of improvement actions in the Trust CQC action plan and the Integrated Clinical Governance review action plan	• The phase 3 governance review, looking at ward to Board reporting and monitoring of quality 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	17 September 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.

An in-year target risk score of 12(3x4) is proposed to reflect a realistic year end position for this risk due to the current position for 52 week waits and the overall PTL.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
Q1	Extreme 20= 5(C) x 4(L)	Limited	N/A	25 = 5(C) x 5(L)	12 = 3(C) x 4(L)
Q2	Extreme 20= 5(C) x 4(L)	Limited	N/A		
Q3					
Q4					

Summary COVID-19 Impact

The Trust has seen a steady daily increase on patients attending the ED and the 4 hour operating standard for June was 97.1%, 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.

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

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	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	R			Performance included in Integrated Quality and Performance Report (IQPR)		X	
Digital strategy - ICT Work plan aligned to Digital strategy	G	G			Annual penetration test last conducted August 2020 National "Cyber Essentials Plus" or equivalent becomes mandatory by April 2021 Information Governance Group		X	X X
VDI	G	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	R			Information Governance Group		X	
New workflow in iClip for Referral Assessment Service clinics as part of Covid19 changes	S	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	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	S			ICT Covid-19 Service Management Report presented to IGG in April 2020		X	
ED rapid assessment and triage process in place	G	G			Clinical pathway and Standard Operating Procedure (SOP)	X		
Direct access pathways	G	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	R			Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	G	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	
Sufficient availability of VDI upgrade to support remote working	VDI Horizon upgrade to support remote working	Oct 2020	
ICT network infrastructure is old and not sufficiently resilient or able to meet today's demands for Wi-Fi and video-conferencing	Replacement of network core in the data centre and then replacement of the peripheral network, an 18-month project	Mar 2022	

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					25.86% less than August 2019 activity
Inpatient – non elective					13.9% less than August 2019 activity
Inpatient – elective and day case					63% less than August 2019 activity
Outpatient attendances					69% of the same period in 2019 with the phase 3 recovery target at 90%. The Trust saw 53% of all outpatient activity in a virtual environment
RTT					Performance down to 52.7% and 825 patients have waited longer than 52 weeks to begin treatment
6 week Diagnostic Performance					28.8% against the target of <1% which was an improvement on last month position of 34.2%
ED 4hr operating standard					95.87% quarter 2 to date (12 September 2020)
Cancer 14 Day Standard					Fell from 93.3% for June 2020 to 89% in July 2020
Cancer 62 Day referral to Treatment Standard					In July 2020 23% more patients were seen when compared with the previous month

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

5.2

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)	Chief Strategy Officer
			Date last Reviewed	14 September 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. As the Trust works towards 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 programme**s** 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).

An in-year target risk score of 12(4x3) is proposed to reflect a realistic year end position for this risk to reflect the risk that other members of the Acute Provider Collaborative in SWL will pursue clinical/ commercial relationships with other tertiary NHS providers that pose a strategic threat to SGUH. There remains an inherent tension between the statutory framework which places accountability on individual organisations and the move to greater system working, and this tension will continue pending legislative change.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
Q1	High 12= 4(C)x3(L)	Partial	N/A	16 = 4(C) x 4(L)	12 = 4(C) x 3(L)
Q2	High 12= 4(C)x3(L)	Partial	None		
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 has overseen the development of, and will oversee delivery of, the SWL ICS Covid-19 recovery plan. The plan is to not only ensure the system can continue to respond to the on-going threat of Covid-19 but to start to make progress in the delivery of 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 albeit barriers to further integration exist due to existing legal/ statutory frameworks.

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	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	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	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	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	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	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	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	R			• Implementation plans are in place and being delivered against		X	
Annual review of Trust Strategy	R	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	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

5.2

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
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 The developed process will ensure relevant representation at the SWL meetings	Complete	
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	Mar 2021	
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

5.2

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 Covid19 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. SGUH representative at key meetings has been 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 be presented to Trust Board in September 2020
Delivery of Corporate Support Strategy implementations plans	n/a				Implementation plans have been developed and approved during Q2. First progress report to be presented to Trust Board September 2020

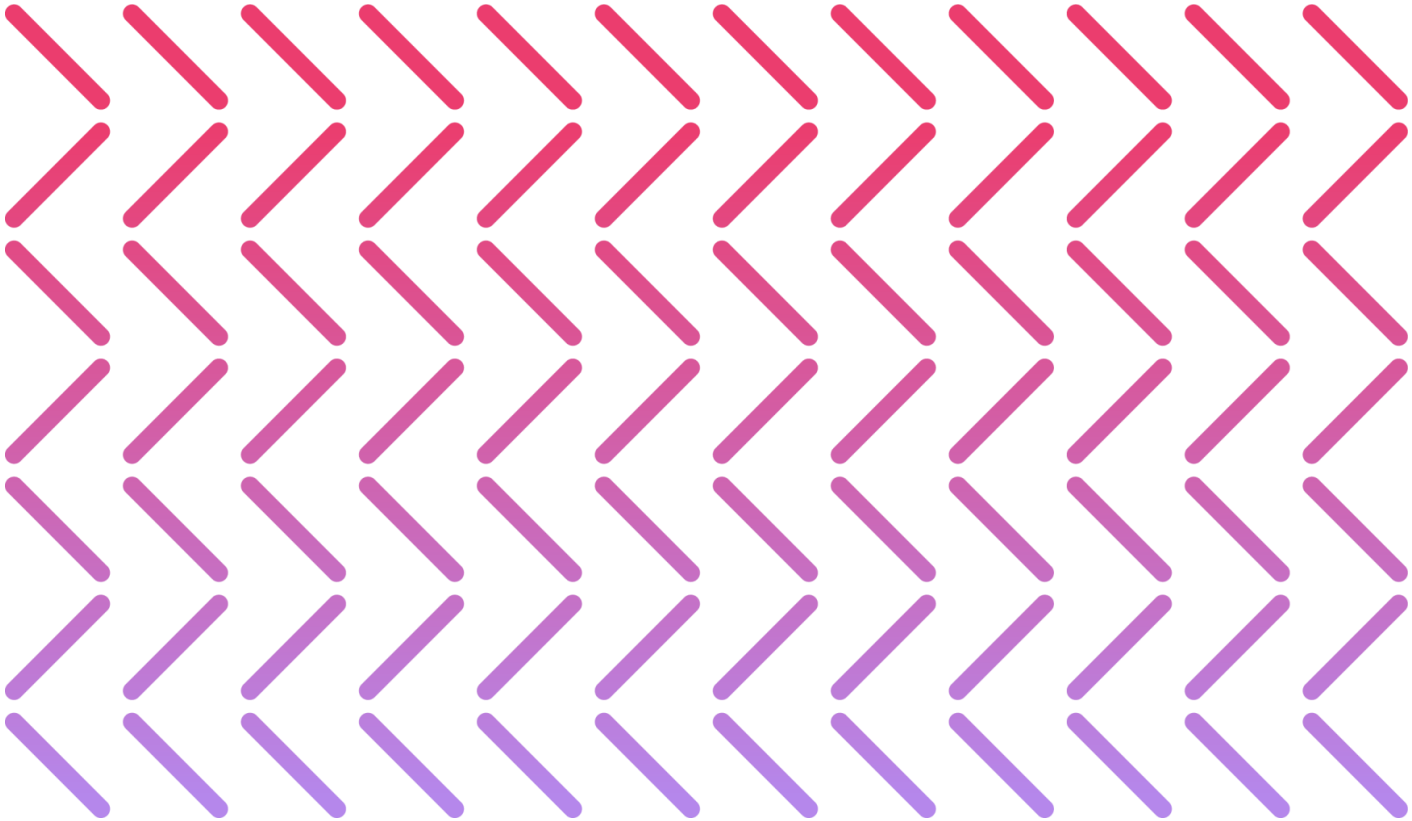
Emergent / future risks	Future opportunities
The continued focus on the response to Covid-19 for the foreseeable future and the threat of a second wave may put additional pressure on the clinical and management capacity within the Trust to focus on SWL five year plan priorities The outcome of the Improving 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	17 September 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 limited delivery of CIPs with procurement, lead by the CFO and Director of Procurement. Engagement has been challenging due to operational and clinical focus on the response to COVID 19.
- 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 bottom up forecast has been completed to provide a view of the financial position to the year end
- A review of financial governance will be completed on the receipt of guidance for M7-12 from NHSI/E.
- A £42.7m planning gap currently remains due to shortfalls in block funding due to the national method for calculating this
- 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.
- An in-year target risk score of 12(4x3) is proposed to reflect long term challenges with moving the organisation to an improved state of financial improvement

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score for 2020/21
Q1	**Extreme 25= 5(C)x5(L)**	Partial	N/A	**25= 5(C) x 5(L)**	**12 = 4(C) x 3(L)**
Q2	**Extreme 25= 5(C) x 5(L)**	**Partial**			
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 are reasonable and justified.

The Trust has received indication that organisations will be funded at a level to break even if it can be evidences that spend levels are reasonable.

The Trust has been instructed by NHSE to report a breakeven position for M1-M4 20/21

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
Monthly divisional finance meetings with in place with DCFO to discuss areas for escalation (underspends/overspends)	S	S			Monthly divisional finance reports	xx	xx	
Monthly reporting of financial issues through to OMG, TMG, FIC and Trust Board	S	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	S			Top up payment made to Trust		x	x
Bottom up forecast in place, with monthly performance being scrutinised vs both budget and forecast.	S	S			Monthly report to Finance and Investment Committee	x	x	
South West London FAC continued to develop system financial management processes in support of delivery of control totals.	W	W			SWL Monthly Finance Report			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 - Some progress, but further progress expected on receipt of M7-12 funding envelopes.	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	Complete	
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. - Operational focus on activity step up so action not fully closed.	Sept 20	
No formal CIP plan of efficiency plan in place	- CIP/efficiency targets to be established alongside financial forecast - Limited is scope due to constraints of COVID - On receipt of M7-12 guidance, process likely to need to be re-invigorated	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 - Capacity plan agreed as part of activity trajectory's. Still a work in progress	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 - Control totals not yet received, so focus remains on activity recovery.	Nov 20	

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**

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. Overall challenge to be confirmed through guidance.
SWL plan to be developed to remain within control total					First draft SWL forecast complete. 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 ICS

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
			Date last Reviewed	17 September 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. (ie. Leasing)
- Monthly reviews taking place with DCFO to ensure urgent items to mitigate significant clinical risk are addressed, whilst considering the material financial risk to proceeding with the full programme.
- Critical Infrastructure Bid made to NHSE/I aimed at securing funding shortfall for 20/21 capital programme
- An in-year risk score of 12(4x3) is proposed due to continued uncertainty expected on years 2 – 5 funding of the capital plan.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
Q1	**Extreme 20 = 4(C) x 5(L)**	Partial	N/A	**20 = 4(C) x 5(L)**	**12 = 4(C) x 3(L)**
Q2	**Extreme 20 = 4(C) x 5(L)**	Partial			
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	S			Monthly finance reports		x	
Weekly COVID Capital funding update and discussion at OMG, to review clinical urgency of requests.	S	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	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 As there is some external delay in confirmation of national funding regime, it is expected that this action will be completed by September 2020	Aug 20	
No alternative means of financing identified to fund programme	Alternative methods of financing current programme to be developed by DCFO Further work is on-going to ensure all options are explored between now and the end of the year. Awaiting confirmation of national funding regime.	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**

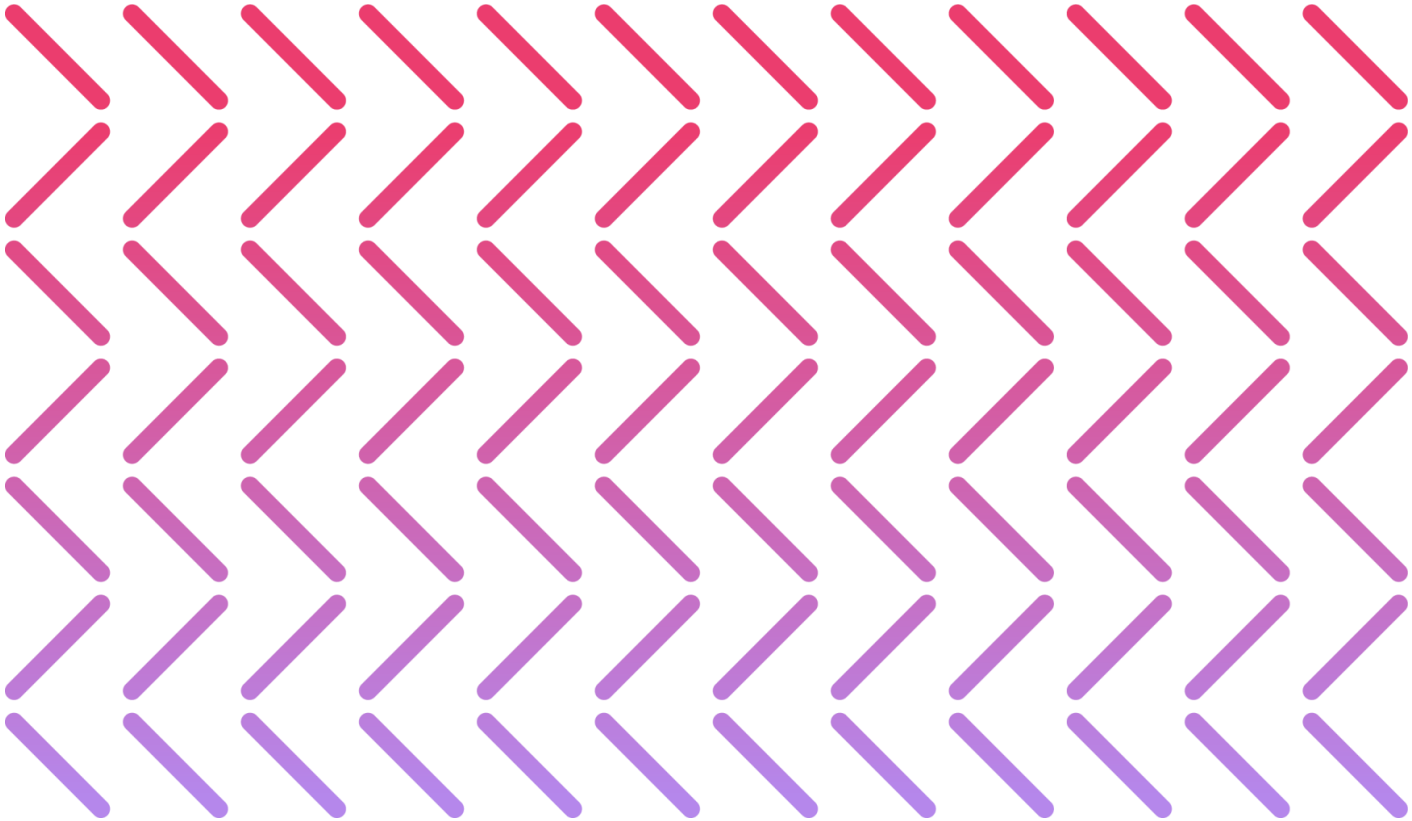
Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Funding confirmed for full 20/21 capital programme					Discussions continue with SWL ICS and NHS London to confirm funding for full plan
Funding confirmed for 5 year capital plan					
Reduction of clinical risk resulting from 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	14 September 2020						
Current risk and assurance assessment	Our current risk assessments indicate that this is a High risk for the Trust. We have agreed full implementation of the NHS Premises Assurance Model as the key assurance mechanism for this risk. We have appointed external support to review our processes and evidence and to provide independent oversight of our assurance. We will appoint a professional team to develop our new estate strategy at the end of September through the NHS SBS framework. In preparation for this, we are developing a full 3D model of the Tooting site to bring together estates data into one place. 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. Our risk reduction strategy will be that no risk should be above a 16, nor have any rating at 5. An in-year target risk score of 16 (4x6) is proposed to reflect a realistic year end position for this risk due to the expected delivery of the identified actions to mitigate this risk, for example the Board approval of the Estates Strategy, a centralised data management system in place and improvement in Estates governance processes. However, the continued uncertainty expected on years 2 – 5 funding of the capital plan is also recognised.		**Overall SR Rating – Quarterly Scores**	**Period 2020/ 2021**	**Risk Score**	**Assurance Strength**	**Change (last reporting period)**	**Inherent Risk Score**	**Target Risk Score For 2020/21**
				Q1	**Extreme 20 = 4(c) x 5(L)**	Partial	N/A	**20 = 4(c) x 5(L)**	**16= 4(c) x 4(L)**
				Q2	**Extreme 20 = 4(c) x 5(L)**	Partial			
				Q3					
				Q4					
			Summary COVID-19 Impact	Significant work is ongoing to develop short and long term ITU expansion solutions, the first physical works should be completed towards the end of November. 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), all projects have now restarted and we are reviewing programme 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	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	W	W			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	R			Subject specific safety groups (e.g.. Ventilation, water etc) are now beginning to meet again to receive assurance reports. PAM will provide assurance, although we need to enhance our data and systems capability to provide the right levels of assurance in an accurate manner.		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 2021	
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 2021	
Governance groups are not aligned with new wider assurance arrangements	Groups restarting with reviews of ToRs being undertaken	Oct 2020	
Current Estate Strategy is not aligned with Clinical Strategy	New estate strategy to be developed in line with other Trust strategies	Mar 2021	
No independently tested PAM compliance	Audit PAM compliance level	Sep 2020	
No monitoring group to oversee activities	Establish Estate Assurance Group to oversee activities	Nov 2020	

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

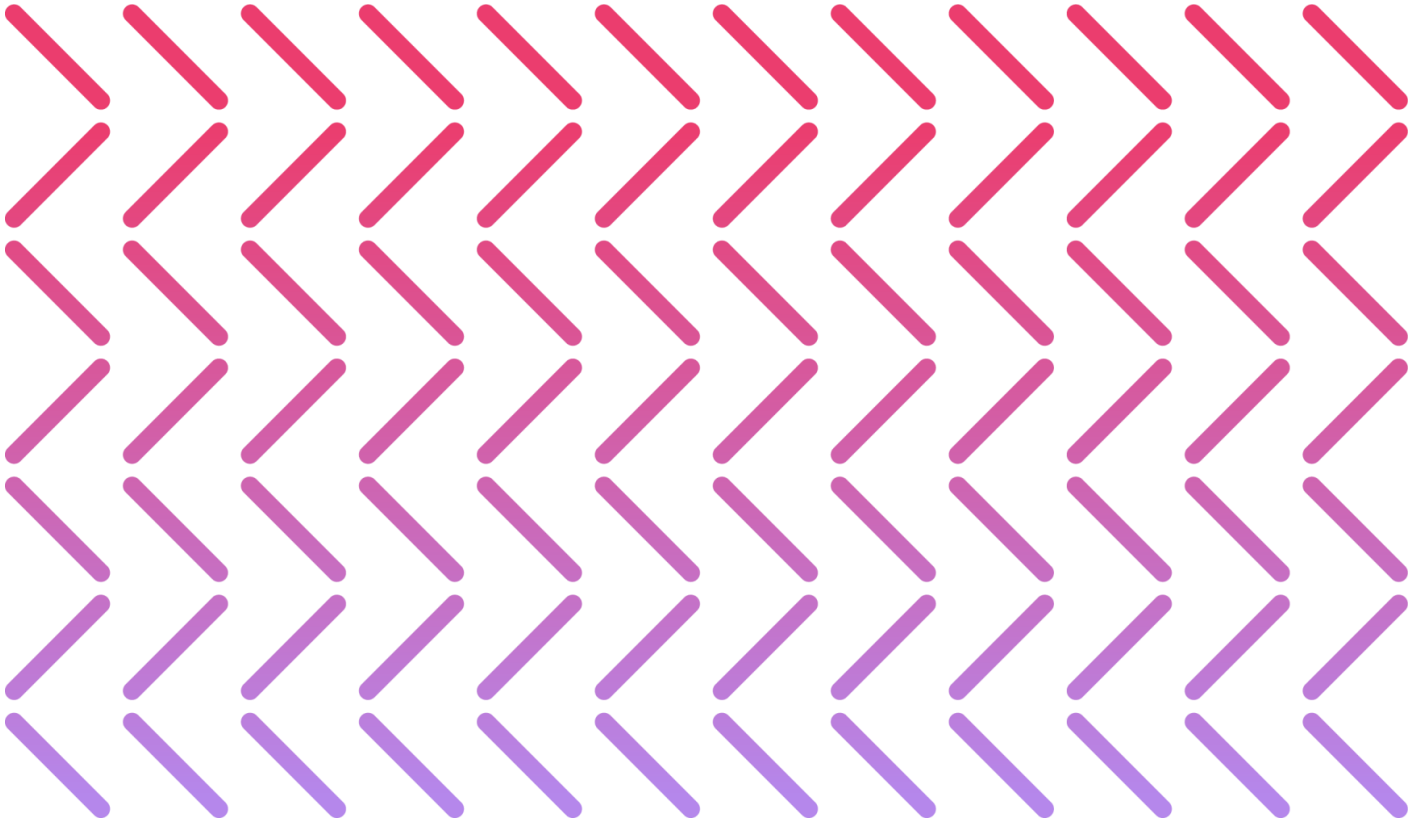
Emergent / future risks	Future opportunities
Impact of COVID on estate planning Lack of investment leads to further deterioration, therefore Trust is unable to deliver its wider strategic objectives Failure to produce / agree new estate strategy South West London health planning impact on estate planning 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	15 September 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
- 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.

A year-end target risk score of 16 (4c x 4l) is proposed as a realistic score for mitigating this risk by end March 2021 on the basis that actions to improve the Trust's position on D&I, raising concerns and culture change should, by then, start to show some impact which would warrant the Board considering a lowering of the risk from its current score of 20.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
Q1	Extreme 20= 4(C) x 5(L)	Limited	N/A	20= 4(C) x 5(L)	16 = 4(C) x 4(L)
Q2	Extreme 20= 4(C) x 5(L)	Limited	N/A		
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). Covid-19 has had an impact on the timings for the completion of the diagnostic phase of the culture programme and highlighted underlying issues with diversity and inclusion that the Trust is now seeking to address.

5.2

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	S			NHS Staff Survey shows that levels of bullying and harassment are not acceptable			X
The Diversity and Inclusion action plan agreed by the Trust Board in July 2020		R			Number of concerns raised with FTSU Guardian has increased year-on-year		X	
Culture change programme established with clear timelines for delivery	S	S			Initial report of progress update of culture change the Board in February 2020, with report on findings from the diagnostics due to Executives in late September and to Board in November 2020		X	
Freedom to Speak Up function established with dedicated Guardian in place	R	R			Trust is rated 204 out of 230 Trusts in England on FTSU Index			X
Policy framework established (including E&D; Dignity at Work; Raising Concerns)	R	R			Ethnicity and gender pay gaps reported to Board		X	
Staff networks in place to support particular groups	R	R			Positive early engagement from staff in staff network groups		X	
Bullying and harassment helpline established supplemented by access to Staff Support	P	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	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	S			Culture Change programme launched and diagnostic phase underway	X		
Trust D&I lead recruited and in place	R	R				X		
IT software package to record FTSU concerns	W	R			Case management solution in place to support FTSU case tracking and reporting	X		
Central repository for capturing and recording B&H		R				X		

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. The D&I Plan was approved by the Board at its meeting in July 2020	Complete	
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	Complete	
No centralised system for recording FTSU concerns raised with Guardian and Champions	Fully implement IT software package to record concerns – Implemented on 1 September 2020	Complete	
No established system to record the reporting of cases for bullying and harassment	Develop key indicators to B&H cases A central repository for capturing and recording B&H cases is in place	Complete	
The Trust does not have a Freedom to Speak Up Strategy and Vision	Develop FTSU Strategy and Vision. Board due to consider the proposed strategy at its meeting on 24 September 2020	Sept 2020	
Bullying and Harassment (B&H) policy does not address latest best practice	Undertake full review of Dignity at Work policy	Sep 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 GO Engage paused due to cultural diagnostic work currently underway. Review the best survey tool to adopt following NHS Staff Survey (5th Oct to 27th Nov);	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	
Positive shifting in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care	Complete culture diagnostics phase and define action plan to address key findings	Dec 2020	

5.2

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				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Number of Freedom to Speak Up concerns raised with Guardian					The number of cases raised with the FTSUG has continued to rise, though at a slower rate compared with Q1 2020/21
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. BAME staff are 2.38 times more likely to enter into a formal disciplinary process compared to White staff.
Trust turnover rate					August 2020 turnover rate (excluding junior doctors) was 15.2% 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	15 September 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.

A year-end target risk score has been defined as a 16, which reflects the current risk score approved by the Board. The fact that the target score remains the same as the current score reflects the level of risk, particularly in relation to the impact of a no deal Brexit and the impact of Covid-19 on education, training and development particularly in the event of a second wave. Maintaining this as a 16 at year end is considered to be a realistic assessment of the extent to which this risk can be mitigated in material way over the next six months.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
Q1	Extreme 16 = 4(c) x 4(L)	Partial	N/A	20 = 4(c) x 4(L)	16 = 4c) x 4L)
Q2	Extreme 16 = 4(c) x 4(L)	Partial			
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	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	S			Reduction in use of agency staff – spend below cap in April 2020		X	
Development of new roles (i.e. ACPs) to help fill the gaps in vacancies	S	S			Workforce report to WEC		X	
Monthly review of the funded establishment	S	S			Monthly reports to Trust Board		X	
Workforce priority plan in place with an underpinning action plan	G	G			Successful nursing recruitment days – national award won in October 2019		X	
Advanced Clinical Practitioner Working Group established to work with HEE	G	G			Participation in NHSI regional retention scheme – reduction in nursing vacancies			X
Monthly qualified nursing and healthcare assistant open days	S	S			Guardian of Safe Working Hours Report		X	X
Appraisal training sessions / ad hoc training in place	R	R			June 2020 - Trust vacancy rate 8.3% against target of 10%		X	
Workforce implementation plan		S			Quarterly report to Trust Board		X	
Education implementation plan		S						

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 approved at PMG and TMG and WEC	Jun 2020	
Board-level approved implementation plan for Education Strategy (via WEC)	Develop implementation plan and secure WEC approval Plan approved at PMG and TMG and WEC	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.	Nov 2020	
Appraisal rates are below target and appraisal quality is variable	Develop plan to address appraisal rates	Oct 2020	
Junior doctor rota gaps as reported by Guardian of Safe Working	Development of plan to address rota gaps Trust is to recruit MTIs	Mar 2021	
Performance and Development Review (Appraisal) guidance not in place	Develop performance and development review Guidance has been developed and is in place.	Complete	
Mentor training not provided to increase the availability of mentors for staff	Develop mentor training	Dec 2020	
Limited assurance internal audit report on the use of medical consultants	Review underway led by Chief Medical Officer	October 2020	
Implementation of NHS People Plan	Work to implement key recommendations	March 2021	

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

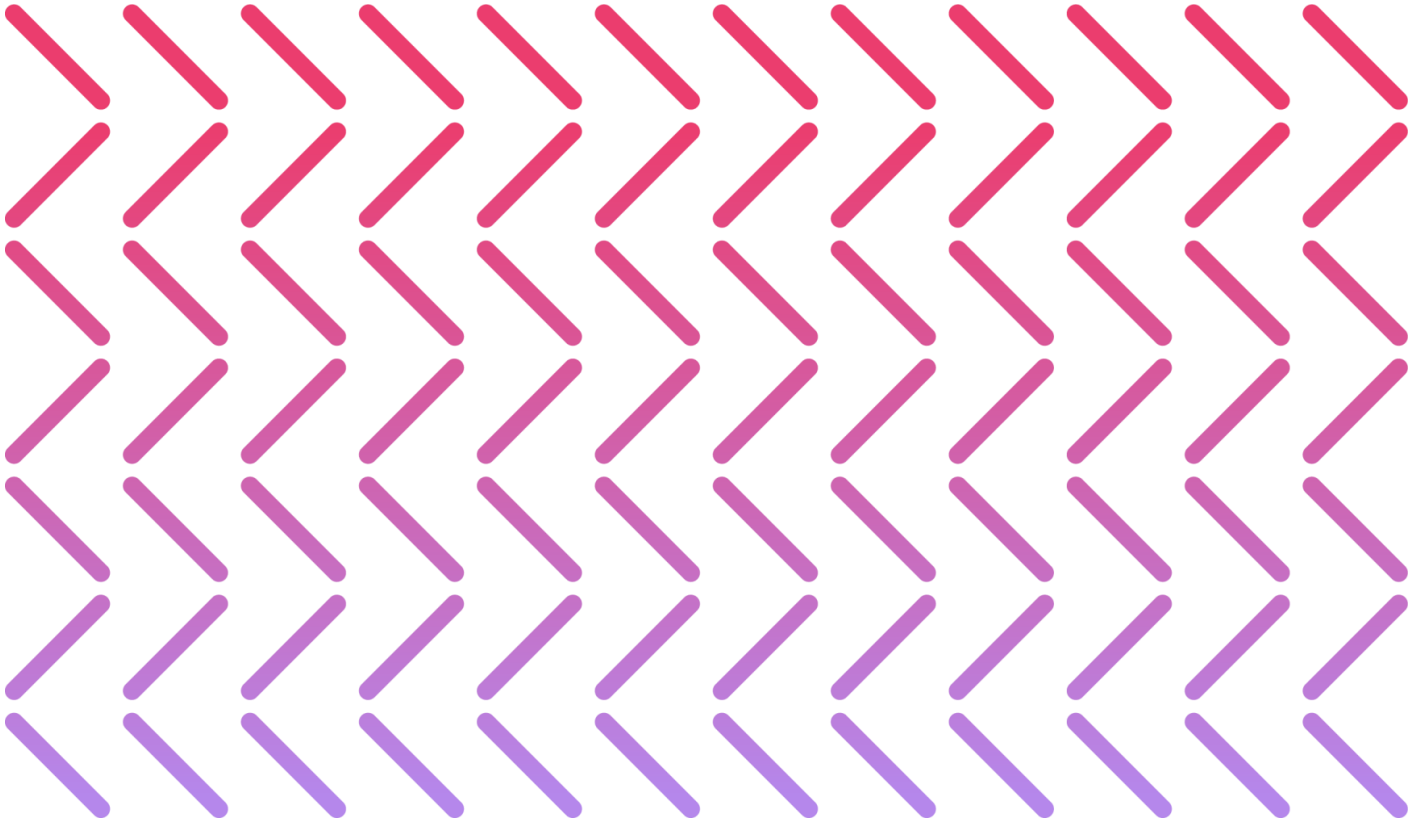
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Trust vacancy rate					Trust vacancy rate in August 2020 was 8.2% against a target of 10%
Turnover Rate					Trust turnover rate (excluding junior doctors) in August 2020 was 15.2% against a target of 13%
Sickness absence rates					Trust sickness absence rate of 3.4% in August 2020 compared with Trust target of 3.2%
Bank and agency rate					In July 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 August 2020 were at 74.6% compared with Trust target of 90%. Target not met throughout 2019/20
MAST compliance percentage					August performance of 89.9% 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 • 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	17 September 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

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.

The current risk score of 9 (Moderate) highlights the strong progress of research in the Trust including in Covid research, whilst recognising that Covid has caused the suspension of most of our clinical research in recent months and delayed part of the strategy implementation, and that there is uncertainty of the future effects of Covid on our research.

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 though with delays in some areas due to Covid.

A proposed in-year target risk score of 6 (3x2) is proposed to reflect a realistic year end position for this risk and the anticipated continuing implementation of the research strategy, notwithstanding the potential impact of a second wave of Covid on our research programme.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
Q1	Moderate 9 = 3(c) x 3(L)	Good	N/A	16 = 4(c) x 4(L)	6= 3(c) x 2(L)
Q2	Moderate 9 = 3(c) x 3(L)	Good	N/A		
Q3					
Q4					

Summary COVID-19 Impact

Most non-Covid-19 clinical research studies have been temporarily suspended since March 2020 but we have now restarted many studies and the number of re-opened studies is increasing all the time.

The Trust has had the opportunity to participate in numerous Covid-19 clinical research studies and has currently recruited to 21 Covid-19 studies, placing the Trust joint highest in England.

The implementation plan to support the delivery of the new Research Strategy has now been developed and after being significantly impacted Covid-19 it is now progressing.

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 and supported by an implementation plan for the research strategy has been devised with several strands.	S	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	G			Partnership in place	X	X	
Key role in south London Clinical Research Network (chaired by CEO)	S	S			Leadership positions in the Clinical Research Network St George's CEO now chairs the CRN Partnership Board and Prof Paul Heath of St George's co-chairs the South London Vaccine Task Force.		X	X
Implementation of process of horizon scanning clinical studies, including 'easy win' studies to balance portfolio against lower recruiting more intensive studies	S	S			We have increased the numbers of patients recruited to clinical trials, which are now double the numbers of 3 years ago.	X	X	
Regular research resource and portfolio review meetings with research teams	S	S			JRES holds regular meetings with research teams to review patient recruitment and troubleshoot any problems.	X		
Joint Research and Enterprise Services review and ratify (with researchers) all study targets and resources required	S	S			There is annual target setting process for patient recruitment which is monitored and supported by JRES	X	X	X
Membership agreed for the Institute for Clinical Research steering committee	S	S			Steering Committee in place and reports to Patient Safety Quality Group and QSC	X	X	
Funding to implement 2019-24 research strategy and allow more staff protected research time	S	S			£200K initial funding to implement the research strategy has been agreed and we are working on a plan to most effectively use this funding.		X	
Institute for Clinical Research committee meetings set up	S	S			Quarterly meeting		X	
Four Clinical Academic Groups formerly established	S	S			Four CAGs have been established, and a CAG Director has been appointed for each.		X	

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
Funding to implement 2019-24 research strategy not yet agreed	Seek funding to implement 2019-24 research strategy £200K initial funding to implement the research strategy has been agreed and we are working on a plan to most effectively use this funding	Completed	
Institute for Clinical Research steering committee not started	Set up meeting schedule for the Institute for Clinical Research committee The Institute Steering Committee has been appointed and held its first meeting in June 2020.	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	
Protected research time for staff	Seek investment to allow more protected research time £200K initial funding to implement the research strategy has been agreed and we are working on a plan to most effectively use this funding.	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 The new Institute of Clinical Research will help to mitigate this. Longer term, investment will be needed from both the Trust and SGUL if new clinical academic posts are to be appointed.	December 2021	
Poor research IT infrastructure	Seek investment /work with IT to set up research data warehouse We have established interest in a data warehousing project from both Trust and SGUL researchers and have held initial discussions with Trust IT and IT companies to look at options to establish a research data warehouse	December 2021	
Implementation plan for Research Strategy	Develop and deliver implementation plan to drive research strategy The plan is being implemented albeit with some delays due to Covid in some areas.	September 2020	
Institute for Clinical Research fully functioning (currently suspended due to Covid-19)	Re-establish fully functional Institute for Clinical Research and recruit to administrator position	December 2929	

5.2

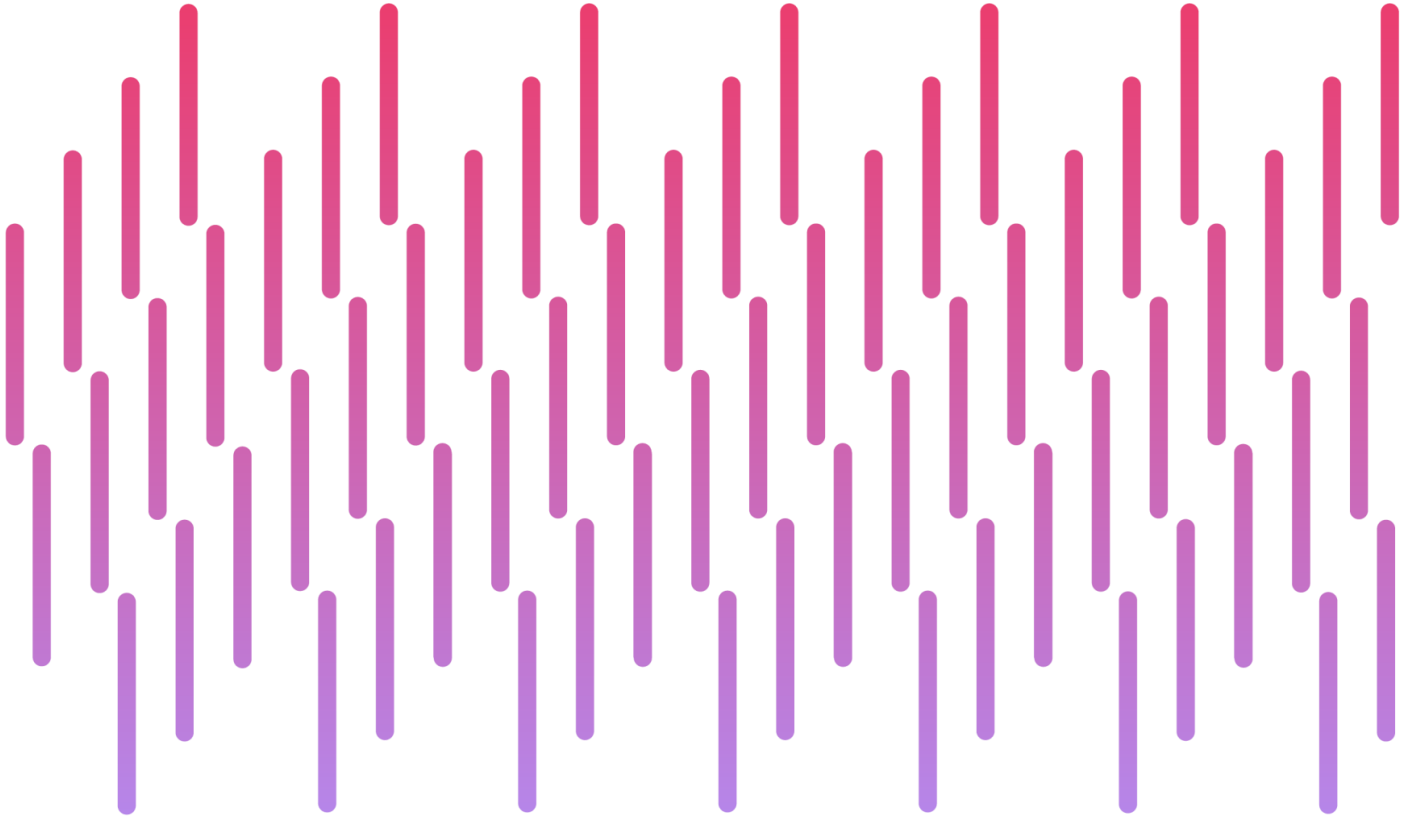
Strategic Objective	Develop tomorrow's treatments today
SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation

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 Sep 2020
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	16
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**	**8**
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**

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 Sep 2020
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		TBC	**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 RTT	TBC	Risk that patient pathways and waiting times (RTT) 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**
VDI Sub-optimal	1717	Sub-optimal Virtual Desktop Infrastructure (VDI) due to insufficient licenses, insufficient compute power, and upgrade to Win10.	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**
ICT Disaster Recovery Plan	CRR-803	In the event of an ICT disaster, there is a RISK this would result in delays or a complete failure in the Trust's ability to recover its ICT systems.	Feb 2011	**20**	**20**

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 Sep 2020
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	12
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
Inability to transform services to support collaborative working	TBC	Risk that the Trust is unable to transform services for the benefit patients and support collaborative working across South West London due to the limitations imposed by the tensions between the current statutory framework and the move to greater system working	TBC	**TBC**	**TBC**
Lack of representation SWL decision making forums	TBC	Risk that the Trust is not represented at relevant SWL decision making forums and will not be able to influence system planning	TBC	**TBC**	**TBC**
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	15	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	15

5.2

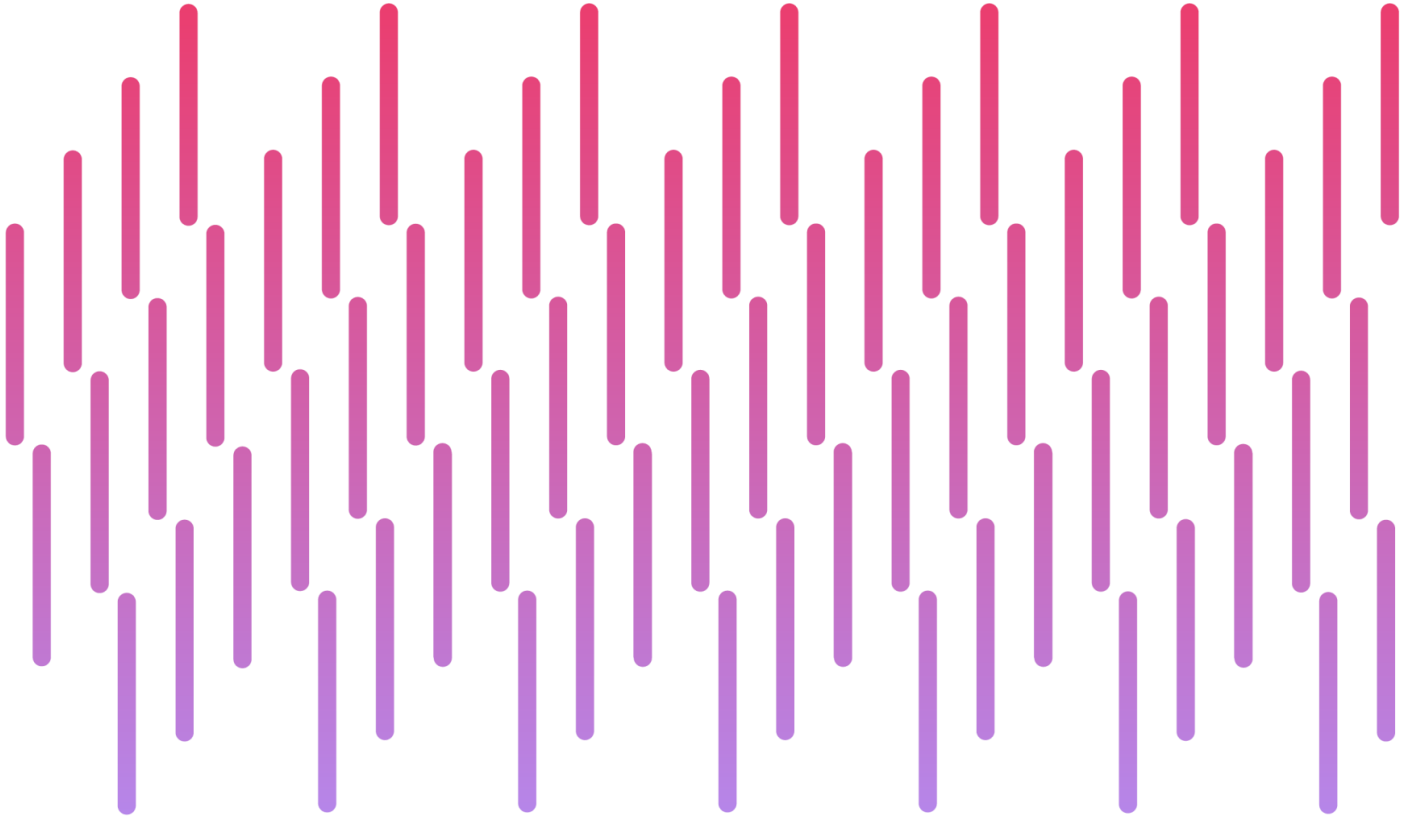
Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep2020
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	**20**	**15**
Cardiac Catheter Labs breakdowns	CCAG-1025	Cardiac Catheter Labs breakdown /failure due to old equipment/ infrastructure	Sep 2016	**20**	**20**
Data Centre	CRR-810	Risk that a fire, flood, power failure in the Data Centre could cause loss of data due to having a single data centre which hosts all on-site critical systems	Mar 2014	**20**	**15**
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**			**20**	**20**
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	**20**	**16**
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	**20**	**16**
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	**20**	**16**
Effective Engagement	HR-1364	There is a risk that we fail to effectively engagement with our staff	Apr 2016	**15**	**12**
Organisational culture	TBC	There is a risk that we fail to achieve a significant shift in culture to support the delivery of the Trust strategic objectives	Sep 2020	**20**	**20**

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 Sep 2020
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**			**20**	**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	**12**	**12**
Recognise good practice	HR-1361	A risk that we do not recognise success or good practice amongst our workforce.	Nov 2017	**12**	**12**
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**
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**
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
Good	The identified control provides a reasonable mechanism for helping to control the risk
Reasonable	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

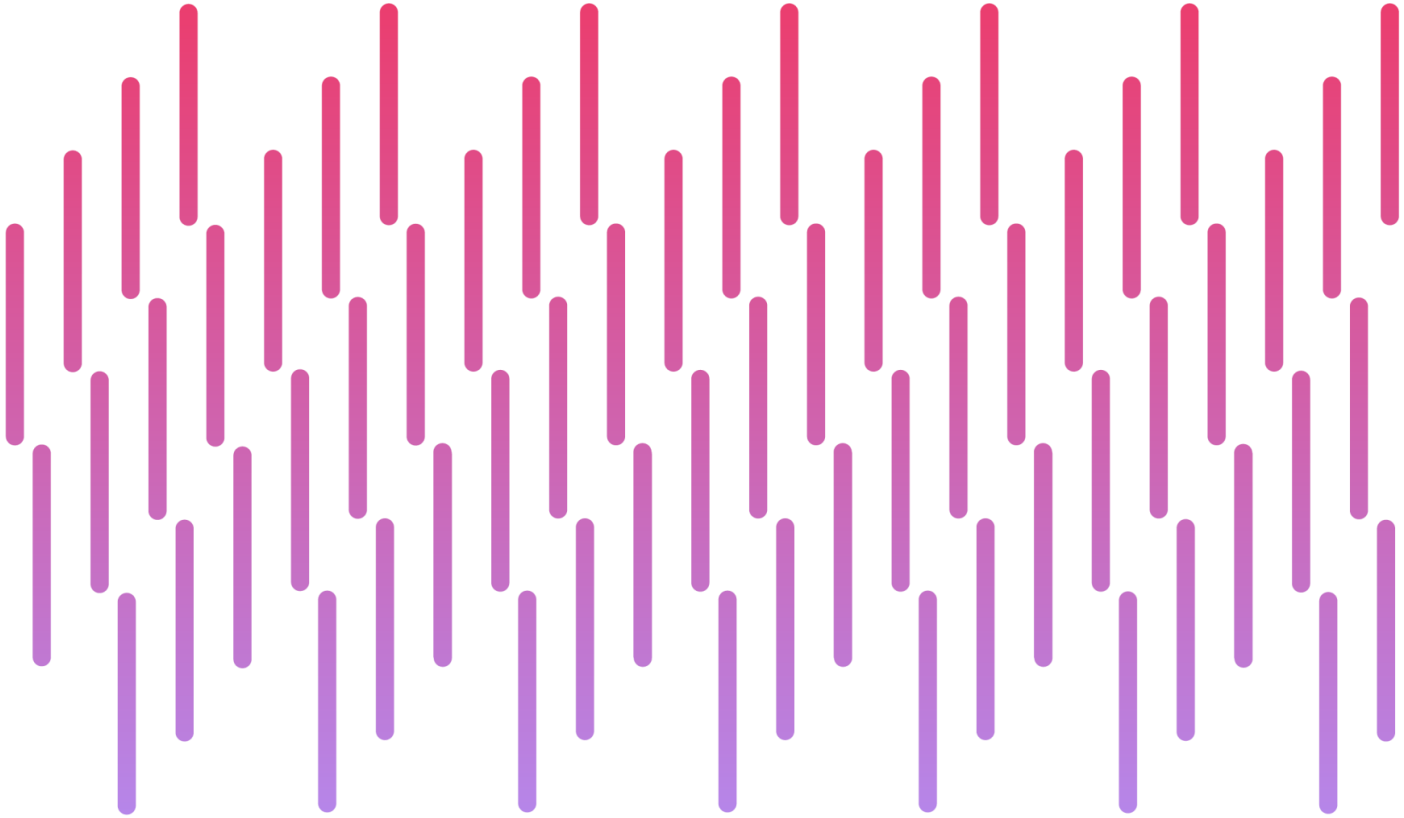
Sources of Assurance

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
Partial	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