Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 28 January 2021, 09:00-10:10**
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 – 24 September 2020**	**Chairman**	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
09:05	**1.5**	**Chief Executive Officer's Report**	**CEO**	Inform	Report
2.0 CARE					
09:10	**2.1**	**Covid-19 Update**	**CN/ CMO / COO**	Update	Report
09:20	**2.2**	**Quality and Safety Committee Report**	**Committee Chair**	Assure	Report
	2.2.1	***Ockenden Maternity Review – Trust Response****	**CN**	Approve	Report
	2.2.2	***Cardiac Surgery Q3 Report****	**CMO**	Note	Report
09:30	**2.3**	**Integrated Quality and Performance Report***	**COO**	Assure	Report
3.0 CULTURE					
09:40	**3.1**	**Workforce and Education Committee Report**	**Committee Chair**	Assure	Report
4.0 COLLABORATION					
09:45	**4.1**	**Finance and Investment Committee Report**	**Committee Chair**	Assure	Report
09:50	**4.2**	**Finance Report (Month 9)**	**CFO**	Update	Report
09:55	**4.3**	**Board Assurance Framework: Q3 2020/21 Report**	**CCAO**	Assure	Report
5.0 CLOSING ADMINISTRATION					
10:05	**5.1**	**Questions from Governors and the Public**	**Chairman**	Note	Oral
	5.2	**Any new risks or issues identified**	**All**	Note	
	5.3	**Any Other Business**		Note	
10:10	**CLOSE**				

Thursday, 25 March 2021, 09:00-12:00 via MS Teams

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

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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
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
Robert Bleasdale	Acting Chief Nurse & Director of Infection, Prevention & Control	ACN
Richard Jennings	Chief Medical Officer	CMO
In Attendance		
Anne Brierley	Interim Chief Operating Officer	ICOO
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	None	
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.*	

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

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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, 26 November 2020
Held virtually via Microsoft 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
Anne Brierley	Interim Chief Operating Officer	ICOO
Robert Bleasdale	Acting Chief Nurse & 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		
Humaira Ashraf	Acting Chief People Officer (Culture)	ACPO(C)
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)
PRESENTERS		
Karyn Richards-Wright	Freedom to Speak Up Guardian *(item 3.3 only)*	FTSUG
Dr Serena Hayward	Guardian of Safe Working Hours *(item 3.4 only)*	GoSWH
Sarah Cook	Speech & Language Therapist (*item 5.1 only)*	SLT
Charlotte Felix-Otoo	Speech & Language Therapist (*item 5.1 only)*	SLT
SECRETARIAT		
Tamara Croud	Head of Corporate Governance/Board Secretary	HCG

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies**	

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		Action
	The Chairman welcomed everyone to the meeting and noted that there were no apologies.	
1.2	**Declarations of Interest** There were no additional or new declarations of interest reported.	
1.3	**Minutes of the meetings held on 24 September 2020** The minutes of the meeting held on 24 September 2020 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed the action log and agreed to close those actions proposed for closure and endorsed the deferral of action TB25.06.20/02 (maternity data).	
1.5	**Chief Executive's Officer (CEO) Report** The Board received the report from the CEO and the following key points were raised and noted: • The number of Covid-19 patients at the Trust was currently stable, but further increases in Covid positive patients was expected in the coming few weeks in light of the current prevalence of the virus. The Trust would be rolling out the lateral flow Covid-19 test to staff shortly. Frontline clinical and vulnerable staff would be prioritised to receive the test, but uptake was voluntary. • The Trust was working to reduce the backlog of elective activity from the first wave of the pandemic and performance was going in the right direction. However, there were some issues with data quality which were being addressed. • The Trust had considered the recently published NHS England and NHS Improvement (NHSE&I) Food Review report and was considering how it could make further changes to improve the quality of food provided to patients. NHSE&I had also asked trusts to identify a Board member to be the named responsible officer for hospital food at the Trust. The ACN has agreed to take on this role. • The Black History and Freedom to Speak Up month initiatives undertaken in October 2020 had been very successful and had been welcomed by the Trust. The Trust had also welcomed Dr Henrietta Hughes, National Guardian for Freedom to Speak Up, to the Trust and this had been a good opportunity to discuss the actions being taken to improve the Trust's approach to raising concerns. • The CFO was representing the Trust at national level to progress the preparations for the end of the transition period (on 31 December 2020) following the UK's exit from the European Union earlier in the year. • The CMO had appointed three Deputy Chief Medical Officers. With the departure of Karen Daly at the end on December 2020 it was proposed that	

		Action
	Dr Lucinda Etheridge take on the role of Responsible Officer for medical staff. The Board noted the report and agreed the following: • **Robert Bleasdale, Acting Chief Nurse, would be the Board member responsible for hospital food at the Trust; and** • **Dr Lucinda Etheridge, Deputy Chief Medical Officer for Workforce and Professional Standards, would be appointed as the Responsible Officer for all of the Trust's medical consultants, speciality and associate specialist doctors and other Trust doctors with the exception of doctors in training**. The Board also noted thanks and appreciation for the contribution of Karen Daly, Acting Deputy Chief Medical Officer.	
2.0	**CARE**	
2.1	**Quality and Safety Committee Report** Professor Dame Parveen Kumar, Chair of the Committee, presented the comprehensive report of the meetings held in October and November 2020, which set out the key matters raised and discussed. Many of the reports discussed by the Committee also featured later on Board agenda. The Committee welcomed the deep dive report on medical care and whilst it was recognised that there was more work to be done the Committee commended the progress made by the Medicine and Cardiovascular Division especially in relation to improving the emergency care pathway. The Committee was also very assured by the progress detailed in the annual reports and noted the milestone development of an annual patient experience report. In response to Ann Beasley's query it was noted that the delay in reporting the adverse incidents to the Human Tissue Authority related to an administrative issue whereby the person with access to the system had been on annual leave. This issue had been addressed and additional members of staff now had access to the system. The Committee noted the report.	
2.1.1	**Infection Prevention & Control Annual Report – 2019/20** The Board received and considered the annual report on infection prevention and control 2019/20 which had previously been discussed at the Quality and Safety Committee. The Board noted that it had been a challenging time for the infection prevention and control team recently with the onset of the Covid-19 pandemic which had called for different ways of working and the introduction of new and additional infection prevention and control measures. The Board commended the team for its work.	
2.1.2	**Seven Day Services** The Board considered the update on the progress the Trust had made in implementing the standards required to achieve seven day services, which had previously been considered by the Quality and Safety Committee. Covid-19	

		Action
	had impacted on the Trust's ability to fully focus on implementing the seven day standards with changes in working patterns having been made to accommodate operational priorities. To be fully compliant with all of the standards the Trust would need to invest sufficient resource and time. Among those organisations which were fully compliant, it was evident that the process for achieving compliance could take up to one year of focused effort. The Board noted the report and agreed that the Quality and Safety Committee would continue to regularly monitor progress in meeting the seven day standards.	
2.1.3	**Cardiac Surgery Services Quarterly Report** The Board received and noted the quarter two 2020/21 report on Cardiac Surgery Services which had previously been considered at the Quality and Safety Committee. The Chairman noted that as part of the planned comprehensive report on cardiac surgery one year on from the publication of the mortality review, the Board would consider how to maintain scrutiny of cardiac surgery services within the bounds of business as usual.	
2.2	**Learning from Deaths Quarterly Report** The Board received and considered the quarter two 2020/21 Learning From Deaths report which had previously been discussed at the Quality and Safety Committee. The Medical Examiner Service had been established at the Trust but there was a need for ongoing work to embed it within the organisation and focus was now being given to building the systems and mechanism around the learning from death lead to strengthen the clinical governance processes for managing mortality. The Trust continued to manage the two mortality alerts in relation to trauma and a further update would be provided in the private meeting. In response to the query from Ann Beasley the CMO advised that there was no single common theme related to the death of six patients and these patients did not have any mental health diagnosis. The Board noted the report.	
2.3	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 7 (October 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 that: • The emergency department continued to perform well at 94.1% against the four hour operating standard given the challenging circumstances. The Emergency Care Intensive Support Team (ECIST) had conducted a follow-up review of the emergency department and reported that the Trust had an exemplary emergency care team and wanted to show case the Trust's work to improve its emergency floor. The Board commented that this was a very positive step forward. • In month, the Trust had focused on increasing elective, day case and outpatient activity. Outpatient activity was 12% under projected activity	

		Action
	levels which related to social distancing measures resulting in the reduction of physical capacity. The Trust was working hard to make the best of the available space and was using virtual clinics. • Day case and elective activity in October had underperformed against the 90% target. The three areas of underperformance related to gynaecology, catheterisation laboratory and endoscopy. • At month 8, activity performance was on trajectory and the Trust was working to reduce the waiting list for diagnostics and cancer with priority being given to 2-week referrals. The Trust was running all screening services for the South West London sector. The bowel cancer screening backlog had been cleared and the cancer and breast screening backlog was projected to be cleared in 2021. • South West London Pathology was working hard to achieve the trajectory for Covid-19 testing, introduced nine testing platforms for use by the Trust, the Royal Nuffield Orthopaedic Centre, Croydon and Kingston Hospitals extended its services to 18 hours per day and was conducting significant numbers of Covid-19 tests each day for on 25 November 1560 tests were processed. The Trust was compliant with all turnaround targets. The service has also launched the 90 minutes rapid testing. It was also noted that this was a good example of collaborative system working. • There had been an improvement in the venous thromboembolism (VTE) performance following resolution of the issue with the data reported in the IQPR. • The Trust had seen an increase in the number of Covid-19 cases in month. There were 7 Hospital Onset Covid-19 infections classified as hospital onset hospital acquired (HOHA) diagnosed greater than14 days after admission, and 1 hospital onset probable hospital associated (HOPA), where COVID-19 was diagnosed 8-14 days after admission. Five of the HOHA cases were associated with an outbreak on a medical ward. The ward was open but remained under surveillance pending absence of new cases for 28 days from the last positive case. • The number of caesarean sections had increased by 30% in month. Whilst this was lower than the 40% national average this was the highest it has been in the Trust and as a result the Trust would conduct a deep dive into maternity services key performance indicators and a separate report would be presented to the Board via the Quality and Safety Committee. • Work was underway across South West London to review Covid-19 nosocomial infection data and share learning to reduce risks and improve systems and measures. • The Trust had incorporated the recommendations from the Dido Harding review into its disciplinary policy. The Trust also continued to conduct Covid-19 risk assessment of staff and was monitoring implementation of any adjustments for staff. The Trust had reduced vacancy rates and staff turnaround was the lowest it had been for some time. The Board noted the report and congratulated the emergency care team for	**ICOO**

		Action
	their exemplary work. **The Board also agreed that the report from ECIST would be circulated for information.**	
2.4	**Sickle Cell Patient Experience in Emergency Department: Patient Story Update** The Board received the update requested following the patient story regarding sickle cell patient experience in the emergency department (ED) in January 2020. The following key points were raised and noted: • The story from the patient in January 2020 had raised important and concerning issues and the Trust had sought to improve the experience for sickle cell patients attending the emergency department. • The Trust had established a patient experience group to co-design improvement actions such as patient information, iClip development, easy access care pathway and education and training. • The Sickle Cell Patient Experience Group had identified improvement actions such as introducing a consultant lead for sickle cell, two nurse champions, and had agreed a standard protocol for sickle cell patients and adopting the 'Always Event' methodology. • Since the Board meeting in January 2020 the ED team had introduced additional staff training, iClip had been amended to include specific blood order sets for acute sickle cell patients, and guidelines had been centralised for easy access for the ED team. • Further projects agreed for co-design with the Sickle Cell Patient Experience Group included development of patient information, including a video and fast pass but this work was paused whilst the organisation focused on managing the Covid-19 operational priorities. • The Trust was assured by the results from the recent audit of Management of Acute Sickle Cell in Acute Painful Crisis which noted: a reduction in the time for initial assessment which was now 9 minutes compared with 23 minutes previously; receipt of analgesia within 18 minutes compared with 75 minutes previously; and 75% of patients pain scores being reviewed within 30 minutes of receiving analgesia. • In line with a suggestion from Tim Wright, it was agreed that the Trust would look at the feasibility of implementing the pre-registration for sickle cell patients who come into the Trust via ambulance. • The Trust was flagging patients with sickle cell on iClip and a survey would be co-designed with patient experience group. **The Board noted the report and agreed that the Quality and Safety Committee would receive another report to assess whether or not the actions taken to date had been fully embedded.**	**ACN**

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		Action
3.0	**CULTURE**	
3.1	**Workforce & Education Committee Report** Stephen Collier, Chair of the Committee, presented the report of the meetings held in October and November 2020, which set out the key matters raised and discussed. The Committee was not proposing any changes to the rating of the Board Assurance Framework risks allocated to the Committee. The Committee had found it encouraging that there was steady operationalisation of the diversity and inclusion workstream. It was important that the Board focused on the culture change programme given the challenges facing the organisation, and the Committee had devoted its November meeting to discussing this work. It was important to note the hard work of the health and wellbeing teams who work to support Trust staff. The Board noted the report.	
3.1.1	**Culture Change Programme: Diagnostics Findings** The Board received the final report of the diagnostics findings from the first phase of the culture change programme. The report had already been discussed, in detail, at the Board seminar in October 2020 and at the November 2020 Workforce and Education Committee. The programme was moving to the next phase of work which was the co-design of the action plan and prioritisation. The Board noted the update.	
3.1.2	**Diversity and Inclusion Report and Action Plan** The Board received and discussed the progress report on implementing the Trust's Diversity and Inclusion Action Plan. The plan was iterative and a new section had been included to ensure the Trust's plans aligned with the London Workforce Race Equality Standards actions. The Trust was tracking progress robustly and there had been some improvements to date. There was a lot of energy around the initiatives but this may be impacted by the second surge of Covid-19. Ann Beasley noted that the graphic for people with disabilities focused on physical disability and expressed concern that this may deter people from declaring other disabilities which were outside physical impairments. **The Board noted the report and it was agreed that the graphic for disabilities would be revised to be more inclusive.**	**ACPO(C)**
3.2	**Workforce Disability Equality Standards Annual Report** The Board received the annual report on Workforce Disability Equality Standards which was also discussed at the Workforce and Education Committee. Focused areas of work included creating an environment where staff felt safe to declare disabilities, educating staff about the different disabilities and developing the disability network. The report also included a robust action plan. Dame Parveen Kumar queried the measures in place to support staff with a	

		Action
	disability and begin to change the culture of the organisation. It was reported that the Trust would focus on celebrating the differences between people and the successes of people with disabilities. Dame Parveen also noted that it was important to think carefully how the Trust supported people with mental health issues; the Trust needed to make reasonable adjustments to the work environment to support people with mental health issues. The Board received the annual report and approved the 2020/21 action plan.	
3.3	**Freedom to Speak Up (FTSU) Vision and Strategy** The Board welcomed the FTSU Guardian, Karyn Richards-Wright, to the meeting. The following points were raised and noted: • The Trust had received 20 FTSU contacts in quarter 2 2020/21 compared with 50 in quarter one. • The key themes among the concerns related to the availability of personal protective requirement, shielding and support staff during the first Covid-19 wave, treatment of staff from Black, Asian, Minority and Ethnic (BAME) backgrounds, bullying and harassment and conflicts within teams. • Forty one percent of complaints have come from administration staff. Maintenance and cleaning staff were still not raising issues and the FTSUG would continue to make contact with relevant leads to engage these groups of staff. • Staff felt that when they raised issues within their teams and with line managers they were not addressed effectively. As a result, these were then raised with the FTSUG. Many of these issues could, however, be addressed locally. • The FTSUG regularly met management teams and HR business partners to progress solutions to issues raised. • It was important that the Trust unpicked the issues raised by administrative and clerical staff who were also key to the Trust's ability to deliver its services. The Trust needed to invest in this staff group who did not always feel valued. • The Trust had made good progress on implementing the recommendations from NHS England and NHS Improvement (NHSE&I) review in March 2020 and work continued to embed the actions. The Board noted the report and the significant progress made to date in addressing the recommendations of the NHSE&I review of the Trust's FTSU arrangements.	
3.4	**Guardian of Safe Working Hours** The Board welcomed the Guardian of Safe Working Hours (GoSWH), Serena Hayward, to the meeting who provided an overview of the quarterly Guardian of Safe Working report which had been discussed at the Workforce and Education Committee. Following the first wave of Covid-19 the junior doctors experienced	

		Action
	a slump in morale and had concerns about their training and education and leave. With the new junior doctors' forum chair and deputy there had been an injection of renewed enthusiasm for its work and the Guardian reported that it had been very helpful to see Board members at the forum. Exception reporting remained down on previous levels but this was not out of the norm given the current situation. A lot of the safety concerns raised related to one trainee and the Trust was supporting that member of staff. The Trust was continuing to look at developing rest areas for junior doctors and was tracking the training provided to trainees during the second wave of Covid-19. Ann Beasley queried whether the Trust monitored exception reports by the ethnicity of junior doctors. It was acknowledged that this was not analysed at present but the information could be identified and included in future reports. The Trust was doing some work around the ethnicity of trainee doctors and their employability after training. The CMO also advised that work was being carried out with the upper GI Care Group to improve the environment for junior doctors. The Board received and noted the report.	
4.0	**COLLABORATION**	
4.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meetings held in October and November 2020. The Committee had noted that the financial strategic risk remained high and there was no proposed change to the risk score. The Committee also noted the significant level of work ongoing to improve the Trust's estates infrastructure and that a strategy was in development. The Committee had also held a discussion about the Trust's readiness to be taken out of financial special measures. The Board noted the report.	
4.2	**Finance Report M07** The Board received and noted the Trust's finance performance at month 7. The Trust, as with other NHS organisations, was being provided with support from NHS England and NHS Improvement to achieve a balanced financial position each month. The circumstances remained the same at month 7. The Trust was £300k favourable against forecast with a deficit of £1.7m. The Trust considered it would achieve breakeven at year end. The Board noted the report.	
4.3	**Audit Committee Report** Elizabeth Bishop, Chair of the Committee, provided an update on the meeting held in October 2020. The Committee discussed plans for completing the year-end financial audit. The key areas of concerns related to the use of resources/value for money. The Committee also noted the risks around Cyber Security and would continue to monitor the Trust's control mechanisms to ensure they were robust.	

		Action
	The Board noted the report.	
4.4	**St George's Charity Report** The Board received and noted the report from the St George's Charity and thanked the Charity for its support during the Covid-19 pandemic. Tim Wright, who also served as a Trustee on the Charity, advised that the Charity was working on applications for the NHS Together Charity funding. The Board noted the report.	
4.5	**Horizon Scanning Report:**	
4.5.1	**Emerging Policy, Legislative, Regulatory and Governance Issues (Q2)** The Board received and noted the quarter two 2020/21 horizon scanning report on emerging policy, legislative, regulatory and governance issues.	
4.5.2	**Local & Regional issues (Q2)** The Board received and noted the quarter two horizon scanning report on local and regional issues.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Staff Story: Diversity & Inclusion** The Board received a staff story from members of the Children's Speech and Language Therapist (SLT) Team, Charlotte Felix-Otoo and Sarah Cook, who outlined how they had used the communication tool developed by the Trust to facilitate conversations about race within their teams and more widely across the speech therapy professional community. The SLT Team had established a working group with the goal of understanding and supporting cultural differences in the workplace and in parenting and how this impacted the experiences of families with the team. The team collected data on the ethnicity of SLT students and the breakdown of ethnicity by pay band in the Trust which highlighted that a majority of people in both groups came from a white background. The SLT had: • Held diversity and inclusion and *'bias and allyship'* in the workplace workshops to explore, raise awareness, share experiences, listen and learn; • Formed the Ethnic Diversity Working Party; • Shared learning across the therapies team; • Developed guidance on recruitment; • Developed and launched the Children's Therapies diversity and inclusion 'Commitments'; • Developed and launched a black lives matters poster; • Redesigned a more inclusive logo for children's therapies; and • Piloted the Exploring your biases and Building inclusion training. Going forward, the SLT planned to: • Hold quarterly diversity and inclusion workshops addressing topics such as cultural awareness and safeguarding our children and families; • Conduct an audit of the Community SLT caseload;	

		Action
	• Share findings across the Children's directorate; and • Recruit Inclusion Specialists to support interviews at band 5 and above locally. The Board thanked the SLT team for sharing their story and commended the notable achievement it such a short space of time. The following key points were raised and noted in discussion: • The findings from the project could be used to encourage people to go into the profession and the SLT had already attended career days at local schools. The team also planned to offer shadowing opportunities. • It was important to share learning across the Trust and it would be useful to record a video message from the team and circulate this in the regular all staff diversity and inclusion message from the Chairman and Chief Executive. • It would also be useful to encourage professional bodies to increase diversity in the profession.	
5.2	**Questions from the public and Governors** There were no questions raised. Richard Mycroft, Lead Governor highlighted the areas where the Council of Governors would find it useful to hear more about in their upcoming meetings, namely, finance, quality and culture. He also reported that a recent patient had commended the excellent service and care they received at Trust.	
5.3	**Any other risks or issues identified** There were no other risks or issues identified.	
5.4	**Any Other Business** There were no matters of any other business raised for discussion.	
	Date of next meeting: Thursday, 28 January 2021, Microsoft Teams meetings	

Trust Board Action Log Part 1 - January 2021						
Action Ref	**Section**	**Action**	**Due**	**Lead**	**Commentary**	**Status**
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~~ ~~28/01/2021~~ 25/03/2021	ACN	The deep dive report was deferred as the organisation focuses on managing the second surge in Covid-19 cases. The report will be considered at the Quality & Safety Committee and presented to the Board in March 2021. *Previous Update: The Acting Chief Nurse as decided to develop a detailed assurance report for presentation to the Quality & Safety Committee in December 2020. This report would include key metrics, soft signals and BAME maternity data.*	**OPEN/DEFERRED**
TB26.11.2020/01	**Integrated Quality and Performance Report (IQPR) (M07)**	The Board also agreed that the report from ECIST would be circulated for information.	28/01/2021	ICOO	ECIST Review has been uploaded to Trust Board Confidential Briefing in Diligent Reading Room.	**PROPOSED FOR CLOSURE**
TB26.11.2020/02	**Sickle Cell Patient Experience in Emergency Department: Patient Story Update**	The Board noted the report and agreed that the Quality and Safety Committee would receive another report to assess whether or not the actions taken to date had been fully embedded.	28/01/2021	ACN	This has been appended to the Quality & Safety Committee's Workplan and updates will be provided to the Board through the Committee's Board report in due course.	**PROPOSED FOR CLOSURE**
TB26.11.2020/03	**Diversity and Inclusion Report and Action Plan**	The Board noted the report and it was agreed that the graphic for disabilities would be revised to be more inclusive.	28/01/2021	ACPO(W)	This action was completed and the Workforce & Education noted the change of the graphic at is meeting in January 2021.	**PROPOSED FOR CLOSURE**

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Meeting Title:	**Trust Board**		
Date:	28 January 2021	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting in November 2020.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
NHS Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

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Chief Executive's report to the Trust Board – January 2021

It is two months since our last Trust Board meeting, and a huge amount has happened in the period since then. The second wave of Covid-19, fuelled by the more infectious new strain, has had a profound impact across the NHS, with services and staff under very significant pressure. We have a dedicated item on the agenda focused on Covid-19 so I will not dwell in detail in this report on the impact of Covid-19 and how the Trust has responded. But I do want to reflect briefly on the pandemic, and the events of the last few weeks; not least because of the significant and ongoing impact it has had on staff, patients, and the communities we serve.

Covid-19

At the time of our last Trust Board meeting in November 2020, we were caring for approximately 15-20 Covid-19 positive patients on our intensive care units – and a further 30-40 Covid-19 positive patients on our wards. We were also making good progress with our elective recovery plan – with a particular focus on reducing the number of patients waiting over 52 weeks for treatment. By early-December, however, it was clear that a second Covid-19 wave was imminent, and by the end of the month, the brutal reality of this was being felt across our services and within our communities. We took the decision to pause the vast majority of non-urgent planned activity until the end of January, and the Christmas/New Year period was profoundly difficult for our teams, with Covid-19 admissions increasing at a rapid rate.

The increase in the number of Covid-19 positive patients we have been caring for has been dramatic, and relentless – on 1 December, we had 56 Covid-positive patients on our wards, and 13 in ITU. By 1 January, this had risen to 181 on our wards, and 57 on ITU – and by 22 January, we had 263 Covid-19 positive patients on our wards, and 91 on ITU.

As I write, we are in a more stable position, but the impact on our communities and on our staff has been profound. As of 21 January, 544 patients have died at the Trust within 28 days of a positive Covid-19 test, and this figure, sadly, is likely to rise further. Our staff are naturally tired, having worked so hard in recent weeks and months – and indeed since the start of the pandemic – in exceptionally difficult circumstances.

We have worked hard to support our staff – with a staff support team (including psychologists) regularly visiting wards and ITU areas to proactively speak to staff and offer support. We have also made a range of self-help resources available – with counselling services for those staff that want more specialist advice and support. However, there is no getting away from the fact that it has been incredibly challenging – and will continue to be. More detail about the actions we are taking to support our staff during these challenging times is included in the Covid-19 update to the Trust Board.

We arranged for the media (including the BBC) to talk to our staff earlier this month about the impact of Covid-19 on our services – and, as important, the strain this was putting on our staff. The BBC's report in particular really struck a chord, and after it aired, we saw staff across the NHS speak out, and I am confident this has helped convey to the public the seriousness of Covid-19, and why we need everyone to follow the rules.

On a positive note, I am very proud of the role our teams have played in the Covid-19 vaccination programme. We were one of the very first hospitals in the world to administer the vaccine on 8 December last year – since when we have vaccinated over 12,500 people, including over 6,400 staff (as of 21 January). The service goes from strength to strength, and it offers a ray of hope for both patients and staff.

Together with St George's University of London, our teams are also helping to further knowledge of Covid-19 through ground-breaking research and clinical trials. We have helped with four separate Covid-19 vaccine trials, and St George's is the lead site for phase 3 of the Novavax trial, which will assess the efficacy and safety of this vaccine in 15,000 participants. Indeed, only last week a study led by Dr Aodhan Breathnach, Consultant Medical Microbiologist, was published in the Journal of Infection. His study found that people infected with Covid-19 in the first wave of the pandemic were 94% protected against reinfection in the second wave, although those with immunity may be vulnerable to catching the virus again.

Exiting Financial Special Measures

Given the organisational focus on Covid-19 at present, we have made little mention of the fact that, just before Christmas, NHS England and NHS Improvement confirmed the news that Trust had exited the Financial Special Measures regime. The news follows the decision by the regulator to take the Trust out of Quality Special Measures in March 2020. The decision to also remove the Trust from the Financial Special Measures regime is a very positive step, and another indicator of the progress we have made in recent years.

The Trust was originally placed into Financial Special Measures by the regulator in March 2017, so the news before Christmas that we had exited special measures was very welcome, despite our focus being elsewhere. This is very positive news but, at the same time, we must not be complacent, and we still have more to do to put the Trust on a truly secure and sustainable financial footing for the future, working with our partners across the South West London Integrated Care System.

NHS England consultation on Integrated Care Systems

In November 2020, NHS England and NHS Improvement launched a consultation on its plans for the development of Integrated Care Systems (ICSs) across England, including steps to put them on a statutory footing. Over the past two years, ICSs have been formed across the country, which has meant NHS organisations – including acute providers like St George's – working in much closer partnership with commissioners, local councils, plus others. The move towards greater integration, and organisations in local areas working together for the benefit of patients is a core element of the NHS Long Term Plan.

We submitted a response to the consultation at the start of this month. We have long believed in the value of close cooperation with our partners across South West London, and collaboration is a fundamental part of our Trust strategy. The experience of and response to the Covid-19 pandemic has brought the need for partnership working into a new light – the benefits of partnership working and the removal of traditional barriers that exist between organisations – has been among the most striking lessons from responding to the pandemic.

In our response, and as a result of our experiences in recent years, we expressed our support for the current direction of travel – in particular the focus on place-based integration and decision making. In addition, we have confirmed our support for giving ICSs a statutory footing from 2022, although we also believe that membership should be sufficiently permissive to allow ICSs to shape their own governance arrangements, simply because that will enable us to serve our local communities in the best way possible.

Our culture programme

Although our focus in recent weeks has been on caring for our patients and supporting staff through the second wave of the Covid-19 pandemic, we have continued to make progress with our work on improving the culture of the organisation. Since the last Board meeting in November 2020, we have moved from the diagnosis phase to the second phase of designing the programme of culture change and the action plan to support this.

I am pleased that all Non-Executive Directors were able to join the Workforce and Education Committee in early January where we discussed the initial programme design, including our plans for staff engagement and key activities, the results of a survey of staff on solutions and priorities, and six areas of potential focus for our culture change programme. Since that Committee meeting, work has started on developing a draft action plan which includes:

- Overall objectives for each of the six proposed workstreams;
- A refined set of solutions reflecting feedback from the Workforce and Education Committee and wider input from Non-Executive Directors;
- A detailed set of actions that will be included under each workstream;
- Indications of priority for delivery, our 'starting point', and whether the solution is already planned/resourced outside of the culture programme.

I am also pleased to report that we have held our first meeting of our new Culture, Diversity and Inclusion (CDI) Programme Board, which I chair. At our meeting on 18 January, we discussed the range of staff who needed to be involved in the programme board to ensure that the right people were able to shape the agenda going forwards. I am, for example, keen that we include the chairs of our staff networks. We also reflected on the need to root our culture change programme in strong organisational framework, drawing on the 'patient first' model pioneered by Western Sussex NHS Trust. As we move forward with the action plan, we need to build a compelling and accessible narrative which will encourage and inspire staff to join the change in culture we want to see. We continue to draw on the support of our fantastic culture champions, who will be involved in helping us develop our action plan, how we deliver this, and how we use our values to drive forward our culture work.

While our immediate focus will continue to be on managing the operational pressures of Covid-19, we will continue to ensure the culture programme is progressed, as this is so central to achieving our vision of providing outstanding care, every time to our patients, staff and the communities we serve.

Leadership appointments

Anna Clough, Divisional Director of Operations (DDO) for our Surgery, Neurosciences, Cancer and Theatres Division, has been appointed Deputy Chief Operating Officer (COO). Anna will continue as DOO alongside her new role as Deputy COO.

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Paul da Gama will join the Trust early next month as our Chief People Officer. Paul joins us from West Hertfordshire Hospitals NHS Trust, where he has been Chief People Officer since 2014.

Ahead of Paul's arrival next month, I would like to say a huge thank you to Elizabeth Nyawade and Humaira Ashraf, joint Acting Chief People Officers, for covering the vacant Chief People Officer role with such commitment over recent months.

2.1

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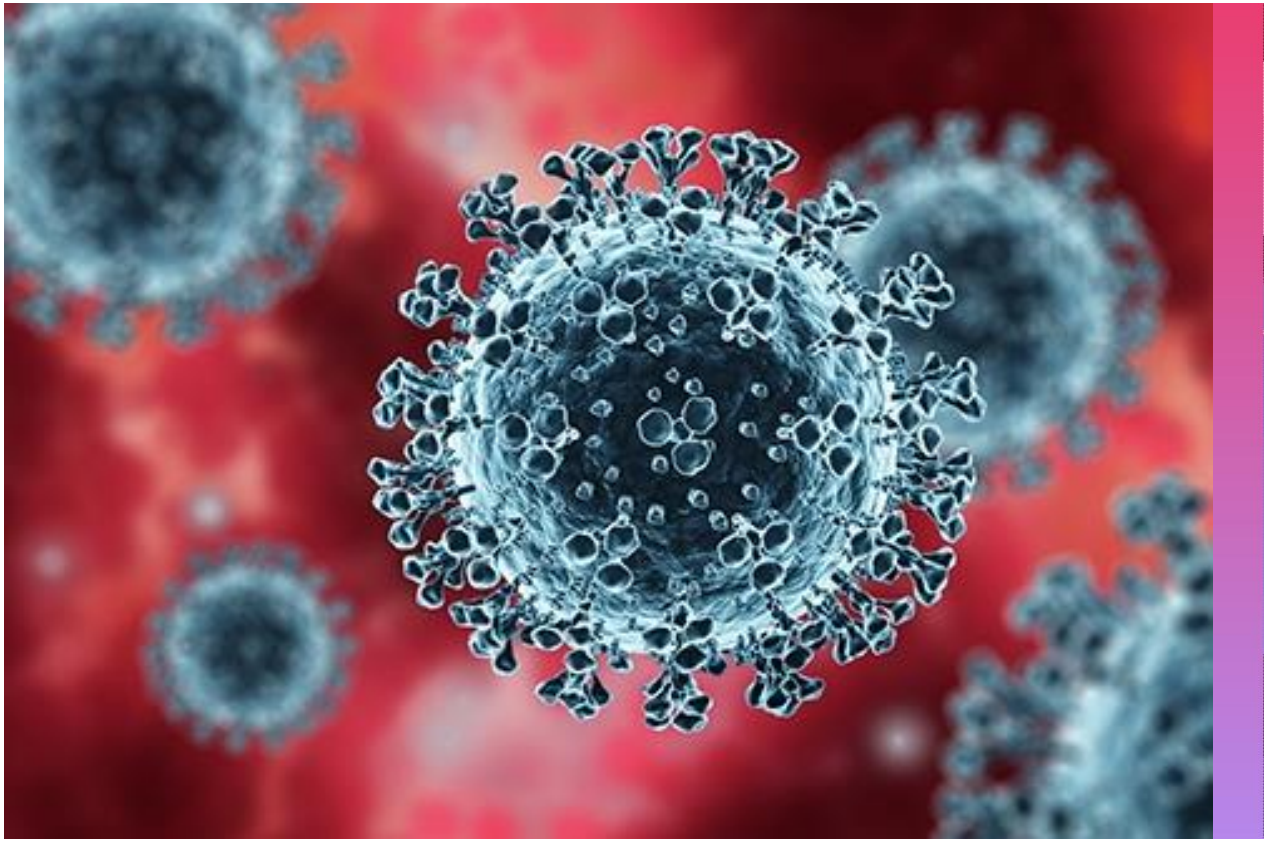
Covid-19 Summary Report



TRUST BOARD

Robert Bleasdale, Chief Nurse and Director of Infection Prevention and Control

Anne Brierley, Chief Operating Officer

Dr Richard Jennings, Chief Medical Officer

Humaira Ashraf, Deputy Chief People Officer

28 January 2021

Executive Summary 12 - 27 January 2021

Covid Strategic Intelligence

- We have activated Plan C (high case scenario) utilising the 'likely' demand forecast at c. 400 beds and in a range of 360 to 440 Covid beds, (ICU and G&A mix at 1:4)
- Over 14,000 people have been vaccinated since we started w/c 7 December
- This includes over 2,800 in the 80+ age group and nearly 7,000 of our staff, with plans being developed to increase capacity further

Covid Operational Response

- Running at 88 - 98% occupancy (excluding closed beds due to infection control measures or to release staff to Covid wards)
- ICU capacity is 126
- Covid admissions 33 and Covid discharges 29 on 12 January compared with Covid admissions 9 and Covid discharges 14 on 17 January
- Daily vaccination rates in the region of 500 with no waste

Workforce and Welfare

- On ICU we have a nurse to patient ratio average of 1:2.5 supported by staff deployed from other areas
- At least twice daily staffing review to maintain safety based on the relative risks of Covid and non-Covid demand versus availability of staff
- ICU and MedCard mega-rota's for medical staff in place and being supplemented to assure sustainable cover in both areas
- Sickness absence remains elevated, with 300+ staff sick due to Covid – the highest incidence being in the nursing professional group

Quality and Safety

- Cumulative total of 608 deaths as at 09:00 on 27 January, daily Covid-19 deaths between 7-17
- Unvalidated 4 hour operating standard for 17 January 2021 83.67% with admitted performance at 68.52% and non-admitted performance at 87.96%
- Ambulance handover performance – ranked 12 out of 27 on 24 January 2021
- We have assured ourselves that we have sufficient piped oxygen supply and pipe capacity to support current and forecast demand in the next 7 days. Our oxygen consumption is monitored daily as part of the daily executive safety huddle.

Executive Summary

- Since the last update, the Trust has experienced significant demand for both non-Covid and COVID-19 patients needing our care and support in ITU and general medical beds. We have continued to run a range of retained services, such as: trauma, maternity, neonatal, cancer, stroke, heart attack, medical and surgical take, paediatrics, imaging and pathology. However, priority 3 and 4 activity is currently suspended. We have maintained our diagnostic services including endoscopy, breast and bowel screening

- The Executive Team hold a twice daily executive safety huddle to oversee the significant associated operational issues

- The Trust has embedded the operating guidance for the management of urgent elective surgical patients. This process has dedicated 'green' Covid protected areas with patients being screened prior to admission. The expanded ITU bed base has also been compliant with these principles

- The London Infection Prevention guidelines and national operating framework have been fully implemented, including the implementation of social distancing measures within the workplace. The hospital has also implemented the national guidance regarding the need for patients and visitors to wear face coverings, and staff to wear face masks as part of it's Stay Safe campaign as highlighted in the last update. Patients are also screened for Covid-19 on admission, day 3 and day 7 of admission

- The individual risks associated with Covid-19 are reflected on the corporate risk register. These are reviewed on a regular basis at the Operational Management Group and as part of the Risk and Assurance Group

- We have needed to take an agile approach to the implementation of our detailed plans for ITU configuration and G&A Adult Bed capacity (as detailed in the Trust Winter Plan 2020/21) which were based on the knowledge from wave 1. However, wave 2 is different. The number of emergency admissions has not reduced as experienced previously (reduced from circa 50 to 30 admissions per day). The demand for general and acute adult beds has increased in excess of expectations for Winter. We have also maintained our elective and diagnostic activity for priority 1 and 2 patients and the patients we are caring for are sicker and younger when compared with those in wave 1

- We have established a senior rota on site to provide visible additional support to staff 7 days a week:

    - Matrons on late shifts to support staff moves for night shifts
    - Saturday and Sunday Executive visits to wards and departments together with onsite senior leader (on a rota basis: Chief Nurse, Deputy Chief Nurse; Chief Operating Officer; Deputy Chief Operating Officer; Divisional Director of Operations; or Divisional Directors of Nursing and Governance)
    - Saturday and Sunday onsite: Head of Nursing with Matron cover for Med card and Surgery; and Tactical on-call (General manager) and Matrons also attend evening handover to ensure all safety issues are mitigated.

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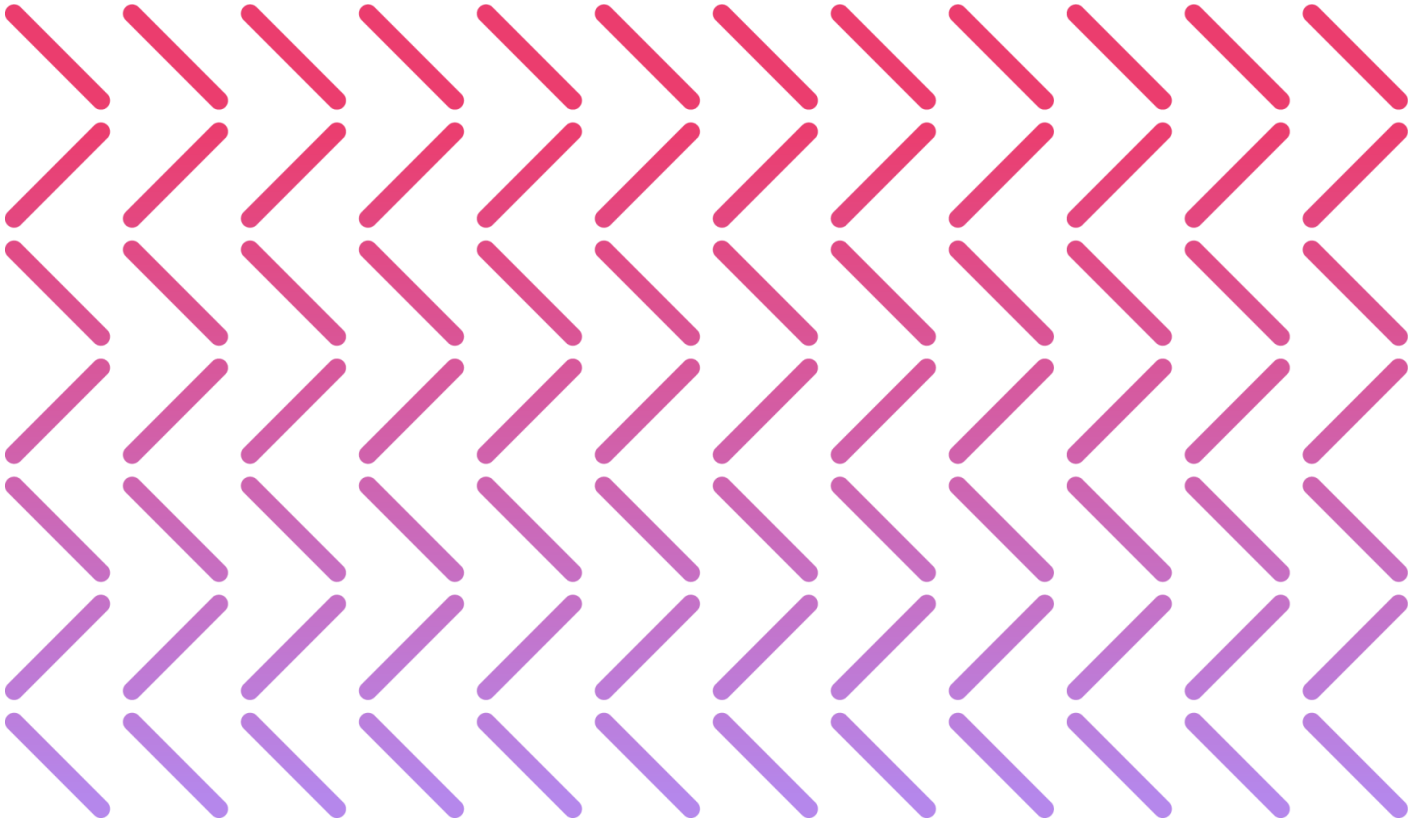
Covid-19 Trust Position

- Covid19 – Trust position 25.01.2021
- ICU – High Case Scenario capacity phasing (plan C)
- Oxygen Consumption



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COVID-19 Position 25 January 2021

- Currently 281 COVID+ inpatients, down from a peak of 354
  - 80 of whom are on ITU
  - 201 of whom are on acute wards

- Daily medical take has reduced to closer to usual numbers for January, down from peak of c.150% maximum expected take
  - Proportion of COVID+ patients in the medical take has reduced to c. 60% (down from 95%)
  - High number of patients with Level 2 Critical Care needs (non-invasive oxygen) being managed outside ITU, on Caesar Hawkins (respiratory ward) and in the Acute Medical Unit (AMU) – capacity for up to 19 patients

- South West London Critical Care Network continues to manage clinical pressures across the 4 SWL acute Trusts and the Royal Marsden, with a dedicated transfer team in place to support
  - SWL Critical Care Network also supporting other sectors in London with providing ITU capacity where possible

- Continued with diagnostics and c. 75% of endoscopy (urgent cases) throughout this COVID surge
- Undertaking Priority 1 (treat within 72 hours) and Priority 2 (treat within 28 days) for cancer and non-cancer
- Continued with all chemotherapy
- Not undertaking Priority 3 (within 3 months) or Priority 4 (3-6 months) currently, as staff redeployed to support COVID ITU capacity

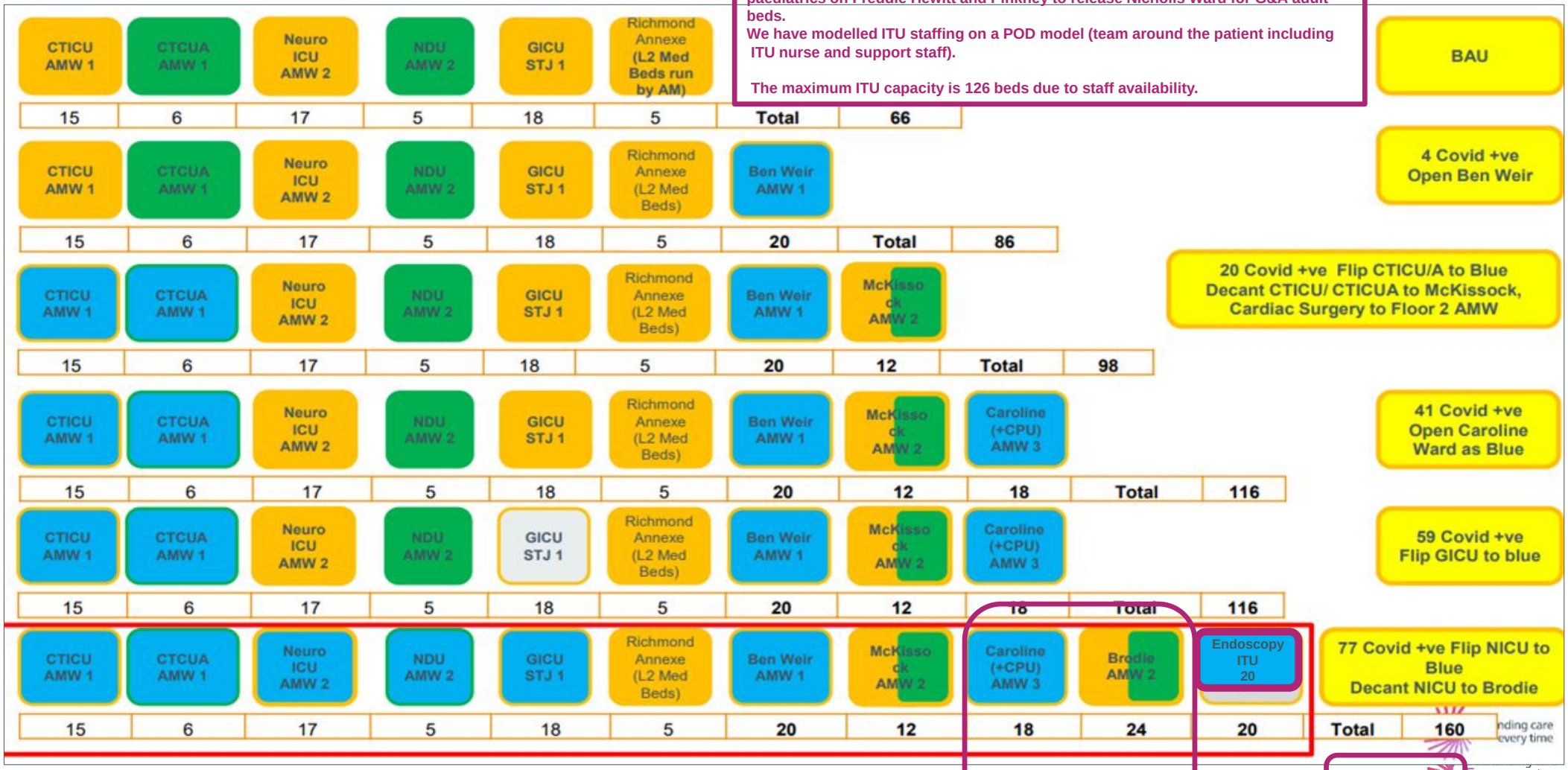
2.1

ITU configuration – Plan vs Actual

5

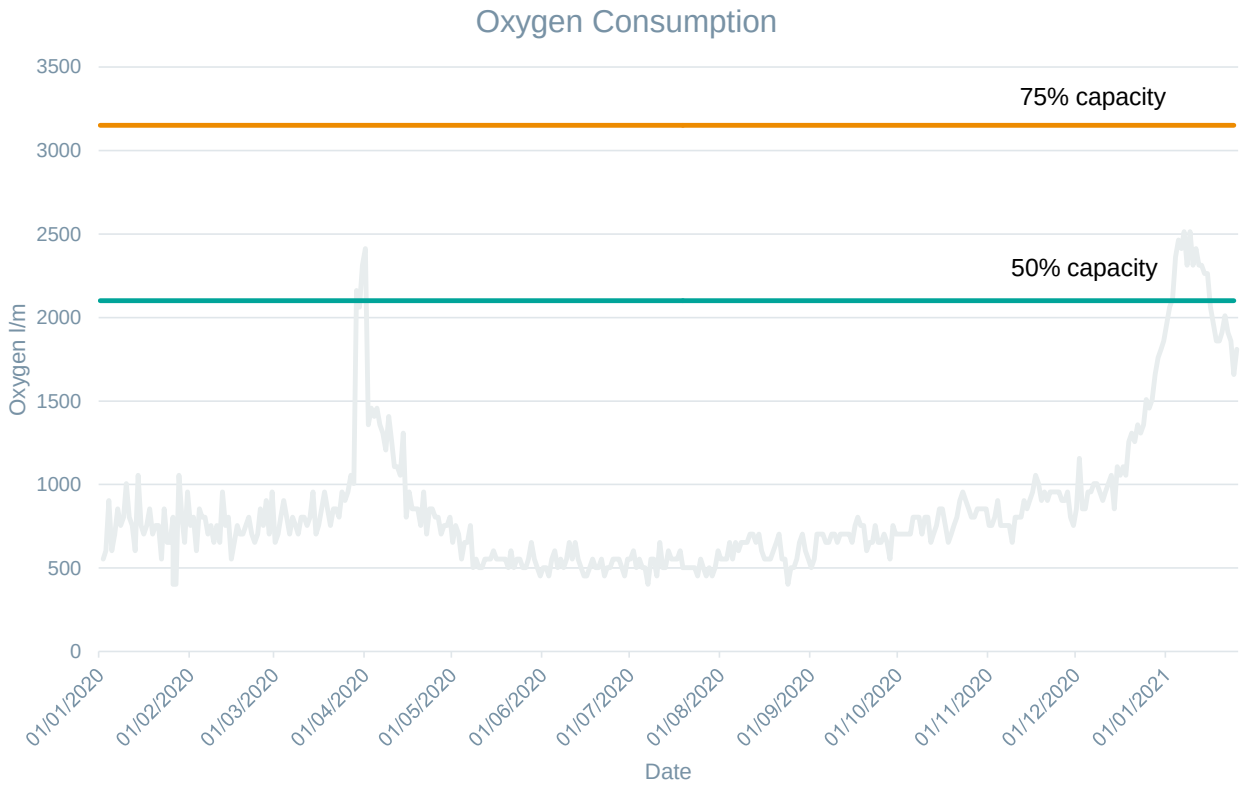
We have needed to be agile in our implementation of our high case scenario plan in order to maintain our G&A capacity. We have also created additional level 2 bed capacity on Caesar Hawkins ward and AMU to support ITU. We also consolidated paediatrics on Freddie Hewitt and Pinkney to release Nicholls Ward for G&A adult beds.
We have modelled ITU staffing on a POD model (team around the patient including ITU nurse and support staff).

The maximum ITU capacity is 126 beds due to staff availability.



Oxygen supply/demand
Oxygen consumption

Graph 1: Daily oxygen consumption in litres per minute at SGH 1 January 2020 – 25 January 2021



As the cases of patients admitted to SGH with Covid-19 rose, so did the demand for oxygen to treat these patients. Under normal circumstances, SGH is resilient to fluctuations in oxygen demand; with a main tank and reserve tank for liquid oxygen, good monitoring processes and an automatic process in place to ensure the tanks are refilled. However, there were concerns that the Trust could reach the maximum 'flow rate' for converting liquid oxygen to gas, which is measured in litres per minute (l/m).

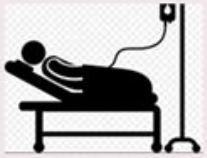
As can be seen by Graph 1, demand for oxygen started to rise from mid-December, which correlated with the increase in Covid-19 in the community, The steep rise in oxygen demand in early January correlates to the period St George's was taking high oxygen patients from St Helier's. However, with the new vaporiser now in place at St Helier's there is no longer a system problem that would put additional pressure on SGH.

Over the last week there has been a continued downward trend in oxygen demand, which is due to a combination of falling demand and mitigations put in place in clinical settings to use less 'oxygen hungry' measures.

Oxygen demand and supply continue to be measured daily, with twice weekly meetings chaired by the Deputy Chief Executive and Chief Medical Officer. Meetings will continue to provide appropriate oversight.

Oxygen supply/demand
Oxygen monitoring summary dashboard

Table 1: Oxygen supply / demand risk summary dashboard

					
Deliveries	**Storage capacity**	**Vaporisers**	**Pipework to wards**	**Patient demand**	**Clinical oversight**
Deliveries from the supplier to the Trust	**On site storage capacity**	**The rate the Trust can convert liquid oxygen to a gas**	**How robust is the distribution system within the Trust**	**The current and forecast demand for oxygen from covid patients**	**Oversight of the use of oxygen at a patient level**
• Automatic, monitored by supplier. • Assurance from supplier and NHSI no threat to delivery	• The Trust has three tank / evaporator sets operating on a ring main • Overall capacity of 33 million litres when full • 6.5 days capacity at yesterdays rate of use.	• Base capacity 4,200 litres per minute. • This can be extended to 5,400 l/pm with manual de-icing. This is a simple low risk activity. • The risk in this area is from demand exceeding the ability to evaporate.	• Authorising engineers report in 2019 rated our systems and processes at 81% compliance • Ongoing monitoring of infrastructure in St James is underway • Site wide new air compressors assist oxygen supply for medical air	• Being developed in conjunction with NHSE/I	• Daily consultant led clinical ward round during which oxygen saturations are monitored and inspired oxygen is reduced as able. • Remote oxygen monitoring being set up to compare oxygen saturations with inspired oxygen concentration.

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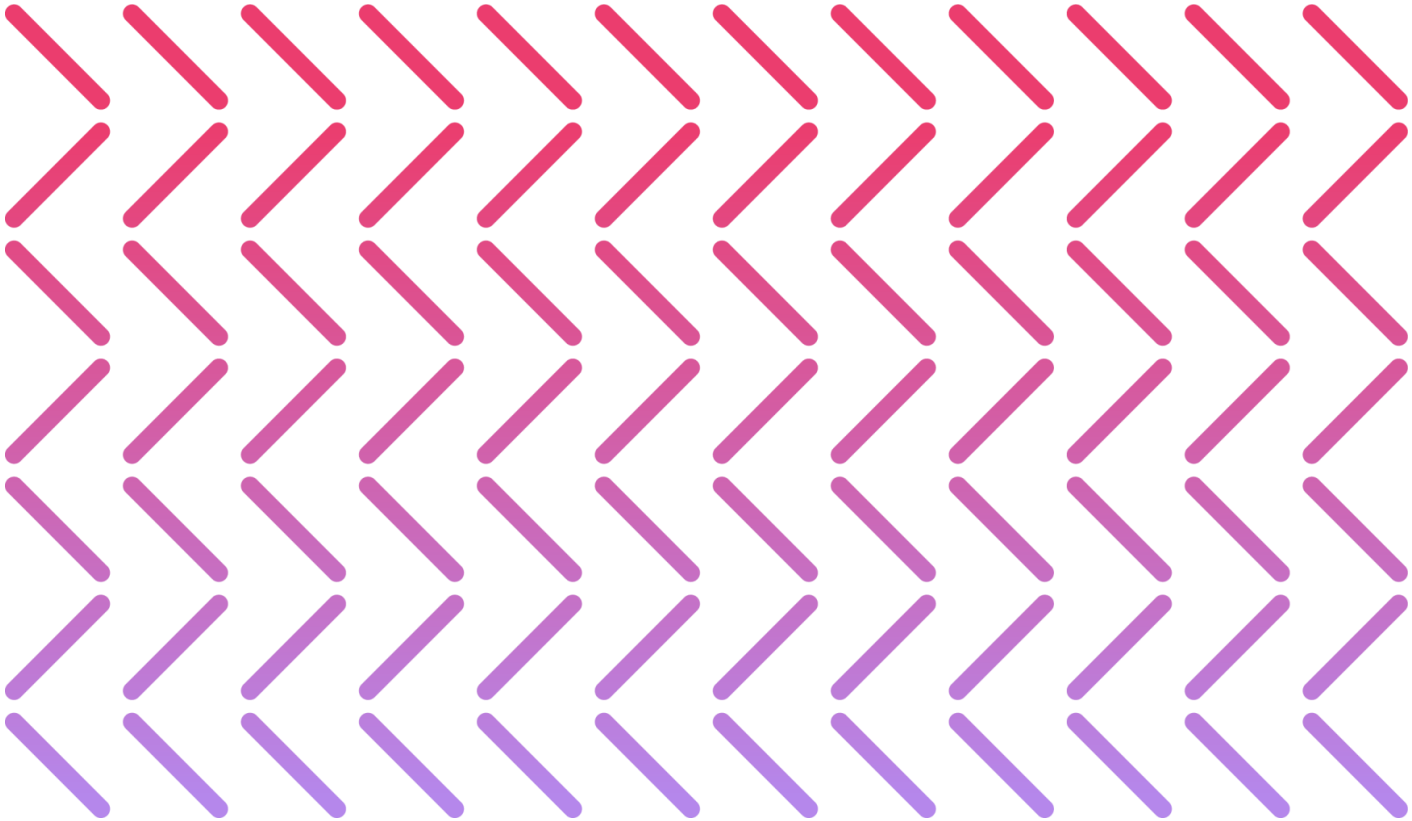
Vaccination, testing, staff absence and staff risk assessments

- Covid Vaccination
- Staff Testing
- Staff Absence
- Staff Risk Assessments
- Staff Health and Well-being



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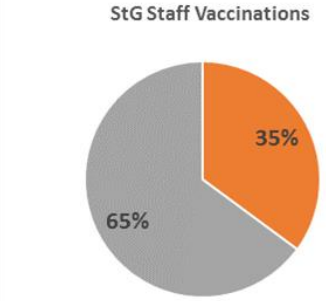
2.1

Vaccination Hub – Daily update
25th Jan 2021

Vaccinations – Weeks history (delivered)

Booking and Attendance	Running total	wc 11.1.21 Weekly (Total)	wc 18.1.21 Weekly (Total)	wc 25.1.21 Weekly (Total)	25/01/21 Monday	26/01/21 Tuesday	27/01/21 Wednesd
1) How many people were booked in to receive the Covid vaccine?	8572	1313	0	0			
2) How many people received the Covid vaccine?*	14718	3133	3901	508	508		
3) How many people DNA'd?	1133	197	312	46	46		
4) How many people attended but declined the Vaccine?	15	2	0	0			
5) How many people were unable to recieve the vaccine for other reasons?	111	22	0	0			
6) Any incidents related to Covid 19 vaccination in the last 24 hours?	10	4	1	0			
7) Waste	12		11	1	1		

1



65% of StG Staff received 1st dose , over 6,100 staff

Vaccinations – Running totals

How many received the Vaccine?	Running total	wc 11.1.21 Weekly (Total)	wc 18.1.21 Weekly (Total)	wc 25.1.21 Weekly (Total)	25/01/21 Monday	26/01/21 Tuesday	27/01/21 Wednesday
2a) Number of People over 80 who are patients of this organisation?	2876	485	232	23	23		
2b) Number of People over 70 who are patients of this organisation?	1098		913	185	185		
2c) Number of Healthcare workers employed by the this organisation?	7077	1931	1750	155	155		
2d) Number of Healthcare workers employed by other organisations?	1441	183	590	104	104		
2e) Number of Social Care workers employed by the this organisation?	47	0	0	0			
2f) Number of Social Care workers employed by other organisations?	244	0	0	0			
2g) Number of care home workers not included above?	579	27	30	2	2		
2h) Number of people not in the above categories	1368	507	387	39	39		
Total	**14731**	**3133**	**3902**	**508**	**508**	**0**	**0**

2

1. Total vaccinated on Monday 25 January 2021 was **508.**
2. **Over, 7,000 vaccinations given to employees (mix of 1st and FUP) – All Staff.**
3. **High Risk list (Swift Q) – 67% (up 1% from Friday) confirmed as 'Booked'.**

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2.1

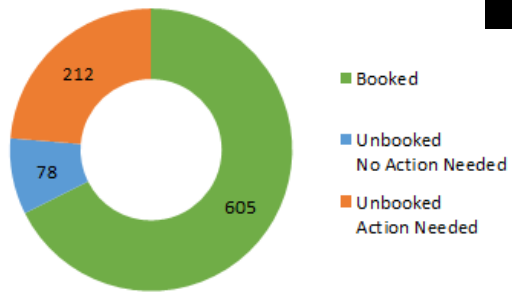
Vaccination Hub – Daily update

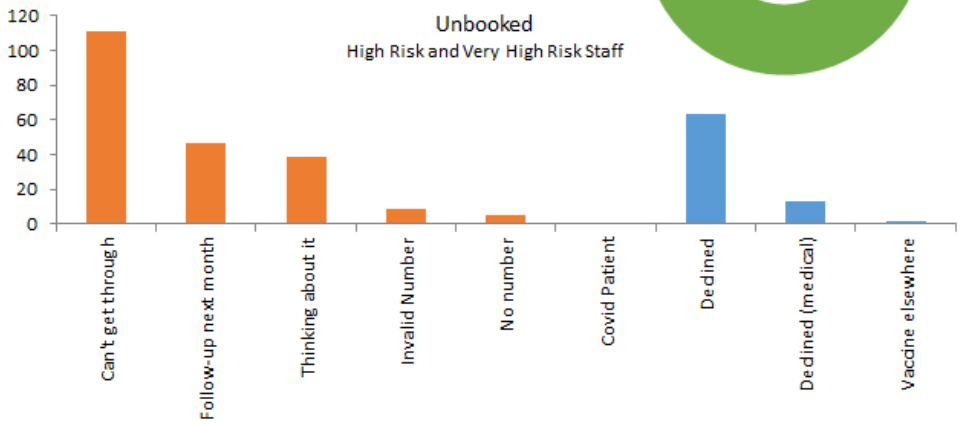
High-Risk Staff Lists

1. 68% confirmed as 'Booked' or Vaccine received.
2. 9% Un-booked – no action needed.
3. 24% 'Un-booked' or unconfirmed as 'Booked' – potentially requiring action.
4. Swift Q bookings helping numbers increase.

Last update: 27/01/2021 14:05

Booked	Unbooked No Action Needed	Unbooked Action Needed
68%	9%	24%
605	78	212





Unbooked or Booked	Action	Reason	Staff
Unbooked	Action needed	Unable get through to	111
		Follow-up call in a month	47
		Patient thinking about it	39
		Invalid number	9
		No phone number	5
		Covid Patient	1
	No Action needed	Patient declined vaccine	63
		Patient declined medical condition	13
		Patient has/had vaccine somewhere else	2
Booked		Booked	365
		Patient had vaccine at SGH already	240
Grand Total			895

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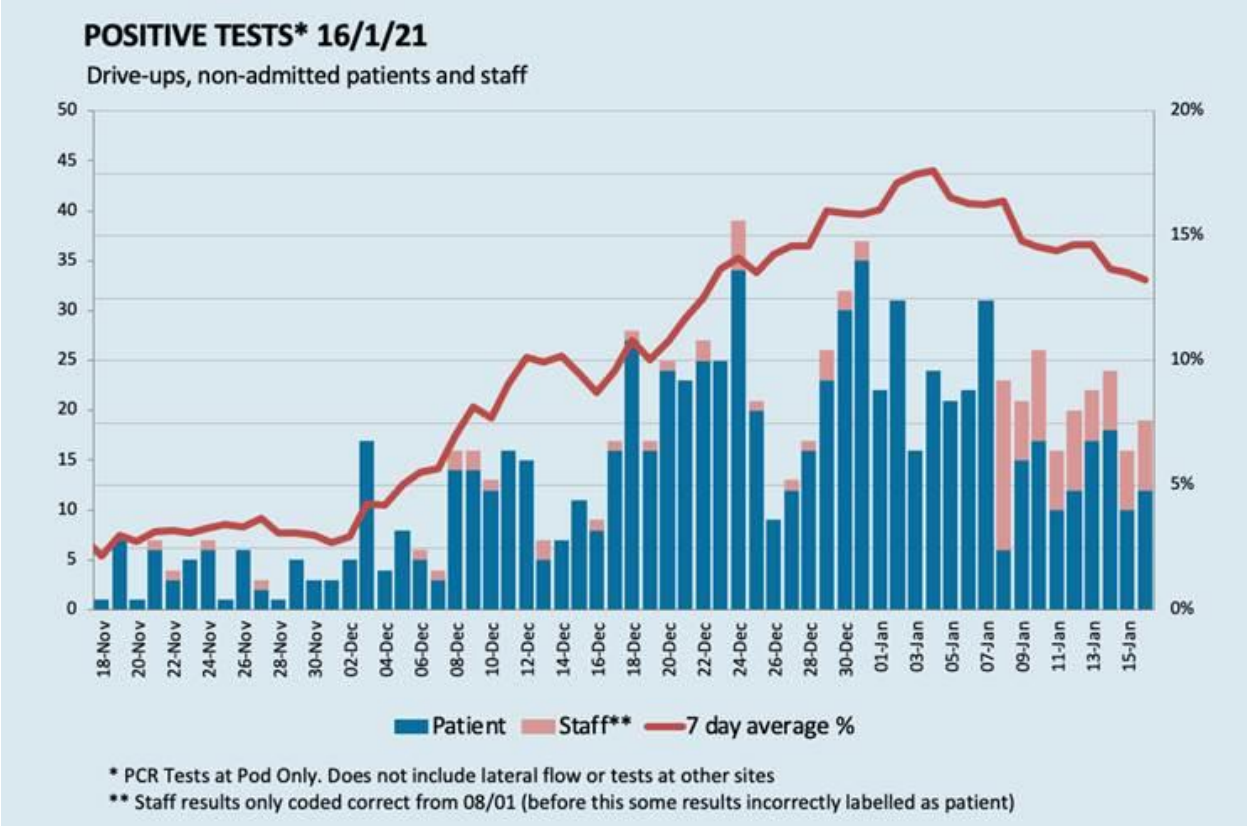
Staff bookings by Care Group

25th Jan 2021

Division	Care Group	% of staff vaccinated
Children and Women's Diagnostic and Therapy Services Division	Breast Screening	44.33%
	C&W Directorate Overheads	68.00%
	Central Community OHDS & MGMT	50.00%
	Children & Family Service	33.33%
	Clinical Genetics	54.24%
	CWDT Division General Mgt	60.00%
	Gynaecology	50.79%
	Imaging	64.06%
	Intensive Therapy Unit	67.75%
	Neonatal	61.24%
	Obstetrics	43.37%
	Other Diagnostic Services	66.67%
	Outpatients	40.21%
	Paediatric Medicine	55.66%
	Paediatric Surgery	46.97%
	Pharmacy	53.28%
	Rehab & Adult Therapy Services	54.61%
	Therapies	69.81%
	Therapies Directorate Overheads	85.71%
Children and Women's Diagnostic and Therapy Ser		**56.06%**
Estates and Facilities Division	Catering Services SGH	46.15%
	Energy and Engineering	32.14%
	Estates	53.57%
	Estates Community Premises	42.86%
	Facilities Services	42.15%
	Hotel Services	50.00%
	Medical Physics	50.63%
	Project Management	66.67%
Estates and Facilities Division Total		**44.55%**
Corporate Division	Chief Executive	56.25%
	Communications	66.67%
	Computing Directorate	54.76%
	Education & Development	43.75%
	Executive Director of Nursing	55.13%
	Finance Directorate	43.17%
	Governance	0.00%
	Human Resources Directorate	47.13%
	Information Directorate	55.88%
	Ops & Service Improvement	50.00%
	Pathology - STG	50.00%
	Procurement & Materials Mgmt	21.31%
	Strategy	33.33%
Corporate Division Total		**44.33%**
Medicine and Cardiovascular Division	Acute Medicine	40.60%
	Cardiac Directorate Overheads	64.71%
	Cardiac Surgery Thoracics	60.00%
	Cardiology CAG.	63.60%
	Chest Medicine	70.73%
	Clinical Haematology	49.62%
	Clinical Infection	48.84%
	Dermatology & Lymphoedema	51.67%
	Diabetes & Endocrinology	58.97%
	Emergency Department	53.97%
	Gastro & Endoscopy	60.53%
	Medical Oncology & Palliative Care	62.62%
	Medicine Directorate Overheads	75.00%
	Renal	55.64%
	Rheumatology	55.56%
	Senior Health	39.35%
	Social Work	0.00%
	Vascular Surgery	38.57%
Medicine and Cardiovascular Division Total		**52.09%**
Research & Development Division	R&D Cardiology	66.67%
	R&D Central Research Management	56.52%
	R&D Clinical Genetics	60.00%
	R&D Gastro and Endoscopy	0.00%
	R&D General Paediatrics	20.00%
	R&D Obs & Gynae Medicine	100.00%
	R&D Oncological Medicine	75.00%
Research & Development Division Total		**59.46%**
Surgery & Neurosciences Division	Anaesthetics	63.60%
	Cancer	32.50%
	Dentistry	53.45%
	ENT & Audiology	54.37%
	General Surgery	52.25%
	Max Fax	59.09%
	Neuro Directorate Overheads	53.85%
	Neurology	54.87%
	Neuroradiology	70.18%
	Neurosurgery	51.64%
	Plastic Surgery	44.34%
	Stroke, Neurorehab, Neurophysiology	47.87%
	Surgery Directorate Overheads	54.35%
	Theatre Services	57.87%
	Trauma & Orthopaedics	56.10%
	Urology	61.04%
Surgery & Neurosciences Division Total		**55.11%**
SWL Pathology Division	SWLP Biochemistry	32.26%
	SWLP Blood Sciences	10.00%
	SWLP Cell Path	46.81%
	SWLP Central Reception	29.25%
	SWLP Haematology	41.18%
	SWLP Immunology	61.54%
	SWLP Management & Overheads	43.48%
	SWLP Microbiology	44.86%
SWL Pathology Division Total		**39.33%**

Covid testing – Bence Jones POD



Lateral Flow Testing

- 8, 319 lateral flow kits for asymptomatic monitoring have been distributed to our staff to date, which represents 98.7% of the total supply
- We are currently working with the Department of Health towards receiving additional lateral flow kits in this month and we are soon to commence distribution to our student bodies
- All staff are to continue with twice weekly asymptomatic monitoring as advised by Public Health England irrespective whether they have received Covid-19 vaccination.

Daily Covid-Related Absences

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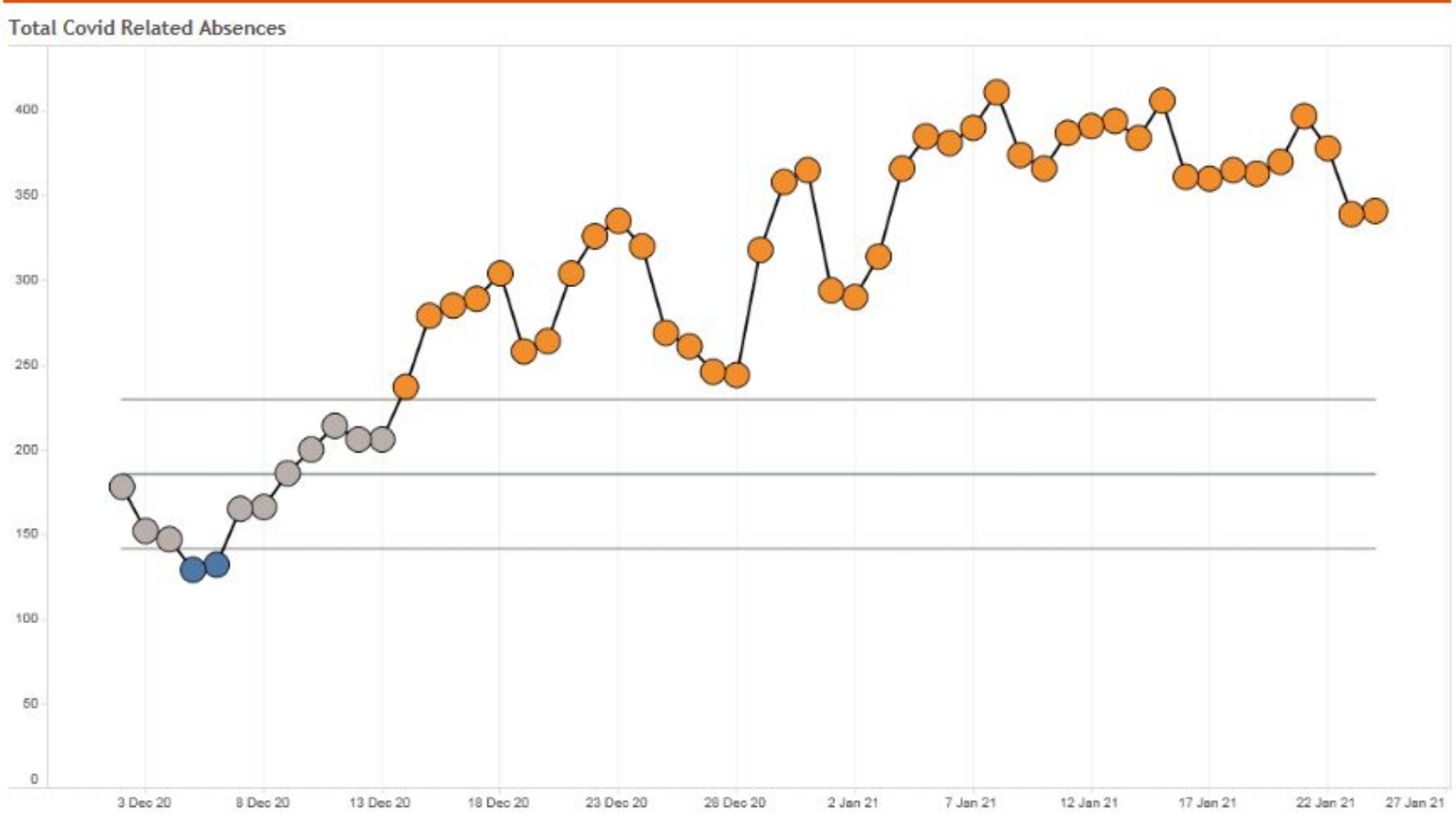
St George's University Hospitals
NHS Foundation Trust



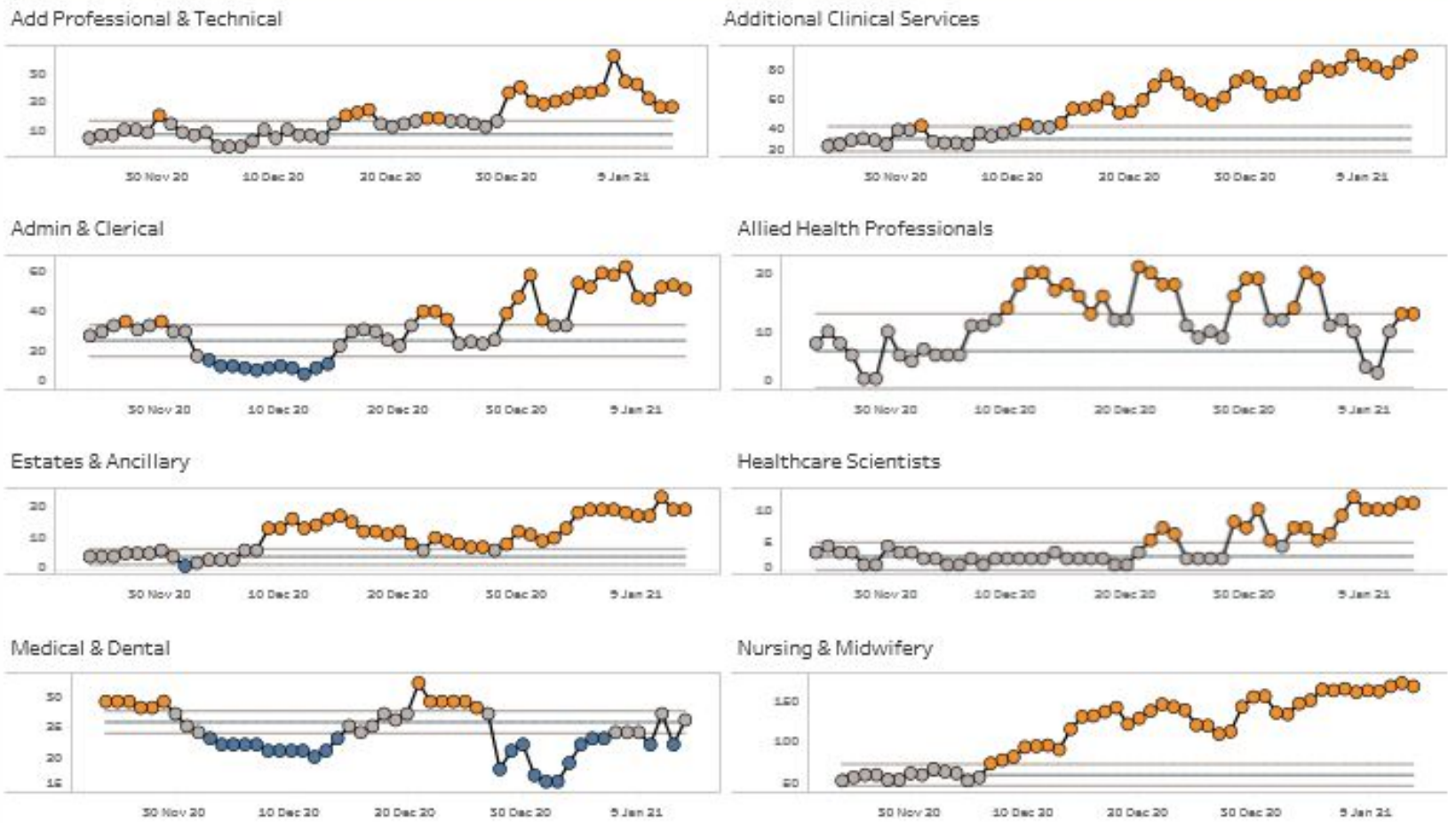
Human Resources - Workforce Intelligence

Outstanding care every time

2.1

Daily Covid-Related Absences - by Staff Group

St George's University Hospitals NHS Foundation Trust



Human Resources - Workforce Intelligence

Staff Risk Assessments

Division	No of forms completed	Total number of staff	% completed
Children and Women's Diagnostic and Therapy Services Division	2673	3159	84.6%
Corporate Division	566	679	83.4%
Estates and Facilities Division	325	344	94.5%
Medicine and Cardiovascular Division	1808	2176	83.1%
Research & Development Division	63	71	88.7%
Surgery & Neurosciences Division	1661	1957	84.9%
SWL Pathology Division	469	506	92.7%
Trust Total	**7565**	**8892**	**85.1%**

Ethnicity	No of forms completed	Total number of staff	% completed
BAME	3607	4153	86.9%
White	3741	4389	85.2%
Unknown	217	350	62.0%
Trust Total	**7565**	**8892**	**85.1%**

Staff Group	No of forms completed	Total number of staff	% completed
Add Prof Scientific and Technic	591	646	91.5%
Additional Clinical Services	931	1039	89.6%
Administrative and Clerical	1582	1810	87.4%
Allied Health Professionals	591	649	91.1%
Estates and Ancillary	268	282	95.0%
Healthcare Scientists	337	346	97.4%
Medical and Dental	876	1448	60.5%
Nursing and Midwifery Registered	2389	2672	89.4%
Grand Total	**7565**	**8892**	**85.1%**

Staff Health and Well-Being

Internal Offer

- **Health and Well-Being Hubs:** two safe rest spaces to manage and process the physical and psychological demands of the work in the Hyde Park Room and on 2nd Floor Grosvenor Wing remain open for all staff to use as rest and break areas.
- **Increased rest space:** Lecture Theatres A, B, and C between Grosvenor and Hunter Wing on the Ground Floor
- **Care packages:** In conjunction with St George's Hospital Charity, care packages are once again being sent out to all areas across the Trust
- **Food provision:** Free food for staff continues to be provided to all Covid-19 wards across the Trust
- **Simple targeted messaging:** Clear and simple evidence-based health promotion messaging is contained within the care packs being delivered to staff. Short videos provided on a variety of topics such as managing sleep and managing worry and shared on common Whatsapp Groups. Posters re-advertising the Staff Support Service distributed across the Trust. Reinforcement of key messaging includes taking regular breaks, winding down at end of shift, the importance of kindness, taking time away from work and spending time communicating with loved ones. The Staff Support Service is advertised within the daily all staff Comms bulletins
- **Health and Well-being bulletin:** A Christmas edition and an early January edition of the Health and Well-being Bulletin was sent to all staff. The bulletin aims to provide focused messaging and detailed information about where staff can access further support and information, both within and external to the Trust
- **Vaccine:** Staff questions around getting the Covid-19 vaccination - all D&I Networks invited to a Vaccine Q&A session with the Chief Nurse, and an all staff Q&A is being planned
- **Ensuring that all staff have access to psychological support:** The number of staff working within the Staff Support Service has risen from 1.8 WTE to 4.9 WTE, with an additional 3.0 WTE to support a pilot project funded for 3 months to provide support to at risk staff groups. The Trust's Staff Support Service continues to provide counselling and emotional support to staff on site Monday – Friday through **Clinical Drop-ins, Support Groups, 1:1 Counselling, Debriefs**

Recovery Plan

- The Trust's Staff Support and Well-being Forum, in conjunction with the Trust's Organisational Development Team are currently building a Trust-wide recovery plan to ensure that staff are supported. This will include providing 1:1 counselling for all staff, providing tailored and specific support to line managers on supporting their teams through recovery and introducing initiatives to reward and thank staff for their contribution throughout this pandemic.

Additional Health and Wellbeing Tools and Support	
Intervention	Detailed information
The Going Home Checklist	A useful tool to help staff wind down before the end of shift https://people.nhs.uk/clinical/going-home-checklist/
The NHS Practitioner Health Programme	A mental health service for all doctors, including psychologists. https://www.practitionerhealth.nhs.uk/
Free psychological support to clinical staff	Association of Psychologists offering free psychological support to senior NHS Medical Staff, Clinical Team Leaders and Senior Management https://acpuk.org.uk/covid_response_senior_colleagues_support/
Intensive Care Society	Free psychological support to all Intensive Care staff https://www.ics.ac.uk/ICS/Wellbeing_hub/wellbeing_support.aspx
Royal College Nursing	Free counselling support to all RCN members https://www.rcn.org.uk/get-help/member-support-services/counselling-service

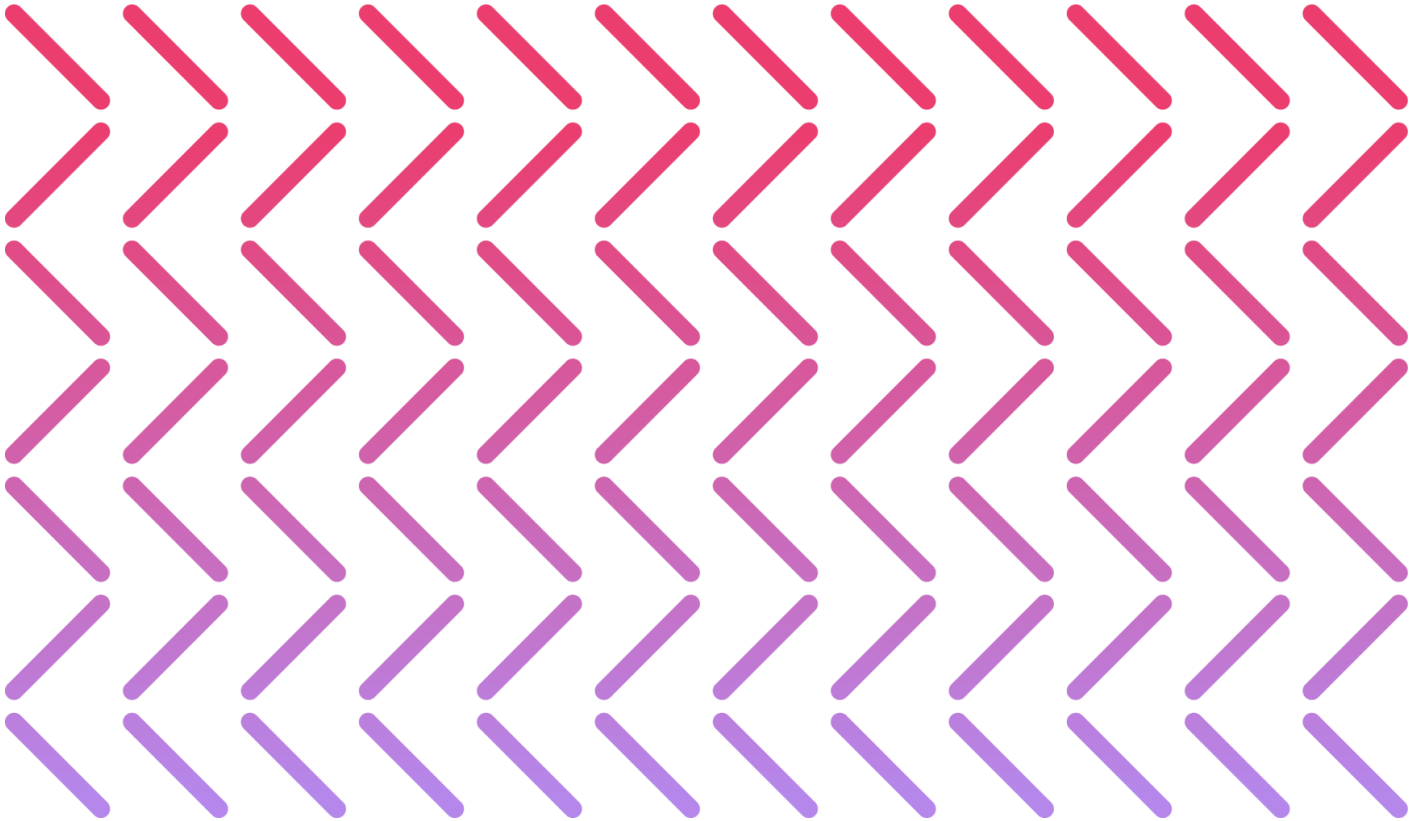
Staff Health and Well-Being – External Offer

National NHS Health & Wellbeing Support Offer	
Intervention	Detailed information
National NHS Staff Support Line	Confidential phone line (open 7am – 11pm) 0800 06 96 222 or text FRONTLINE to 85258 (open 24/7)
National NHS Bereavement Line	Confidential phone line for bereavement 8am – 8pm 0300 303 4434
Bereavement and trauma support for Filipino Colleagues	Confidential phone line for Filipino staff (Tagalog speakers) 0600 303 1115
Counselling support	Association of Christian Counsellors are offering all NHS staff who have been directly impacted from Covid-19; or anyone who has been bereaved during this time up to 10 telephone or online sessions by visiting https://www.acc-uk.org/news/hidden-holding-pages/covid-19-crisis-counselling-support-service.html
Free apps	A wide range of wellbeing apps offered free to NHS staff: Bright Sky; City Parents; Daylight; Headspace; Liberate Meditation; Movement for Modern Life; Stay Alive; Sleepio; and Unmind https://people.nhs.uk/help/support-apps/
Wellbeing support	Project 5 offer up to 3 wellbeing support sessions to all NHS Staff, as well as a host of free information and advice leaflets and short videos. https://www.project5.org/
Virtual staff common rooms	Culturally diverse and all staff common rooms have been set up by the National People Team and NHS Practitioner Health Programme which provides an opportunity for staff to come together and support each other during this time. They are hosted by an approved practitioner. To register visit https://www.events.england.nhs.uk/events/common-rooms
REACT Mental Health Training	Training to provide staff with the tools to hold supportive and compassionate mental health and wellbeing conversations. A Train the Trainer programme has been set up, and the Trust has nominated 5 names to take part in this. https://people.nhs.uk/react-mh-conversation-training/
Financial wellbeing support	Run by the Money Advice Service to offer free and impartial advice on money. 0800 448 0826 open 8am – 6pm Monday – Friday; or via Whatsapp (add +44 7701 342 744) or via webchat. There is also plenty of free advice available here https://people.nhs.uk/guides/financial-wellbeing/steps/financial-wellbeing-resources/
Free arts and craft for parents, carers and families	Place2Be offer free resources and support to help NHS working parents, carers and families during Covid-19. Please visit https://www.place2be.org.uk/keyworkers
Substance misuse and gambling	Sbstance misuse and gambling support information https://people.nhs.uk/substance-misuse-and-gambling-support/
Short wellbeing video collection	Finding calm among the chaos is a short wellbeing video collection to provide staff with simple tools to reduce stress in a short time. https://people.nhs.uk/finding-calm-amongst-chaos/
Manager support	The Start Well>End Well programme developed by Bristol NHS Trust provides managers with some tools on supporting colleagues and promoting effective teaming through busy periods https://people.nhs.uk/startwellendwell/

2.1

Infection Prevention and Control and Covid-19 risks

- SW London position
- Cluster/ outbreak Management Algorithm
- Nosocomial Infection



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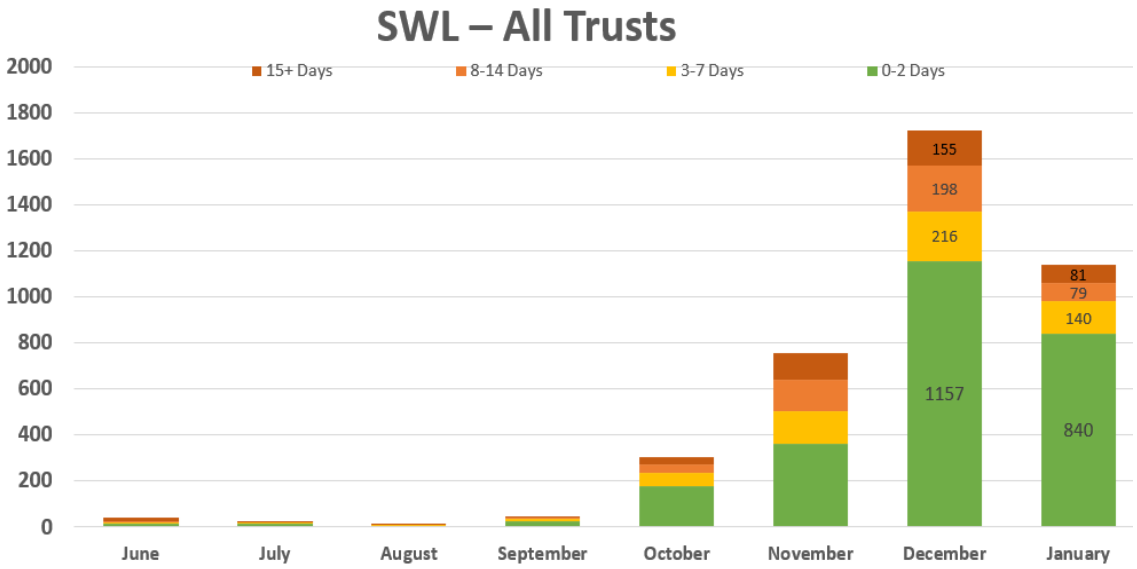
2.1

Nosocomial infections

SWL

- Nosocomial infection across South West London is monitored through the weekly SWL Health and Care Partnership Joint Meeting of Acute and Clinical Cells.
- All Trusts continue to report significant numbers of nosocomial infection.
- Cases of community acquired Covid increased markedly in January as we approached the peak of the second wave. All Trusts have been challenged operationally to balance the needs of patient flow and infection prevention and control.

Graph 3: No. of days following admission that inpatients tested positive for Covid-19 across SWL (June 2020 – January 2021)

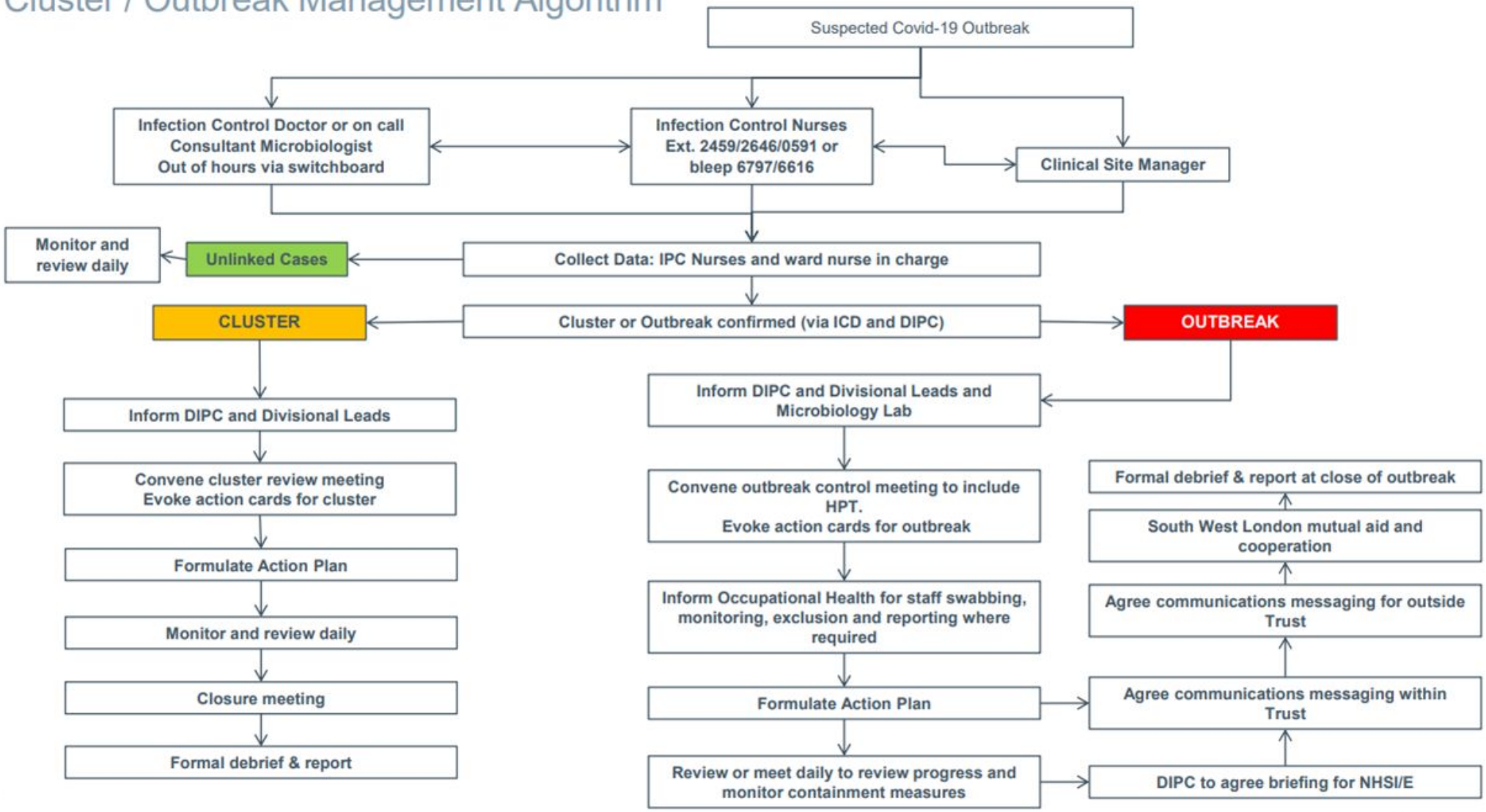


Definitions:

- Green=definitely community acquired
- Yellow = probably community acquired
- Orange = probably hospital acquired
- Red = definitely hospital acquired

19

Cluster / Outbreak Management Algorithm



Nosocomial Infection

December 2020 Outbreak Locations	HOHA	HOPA	Staff outbreak numbers
Allingham DIS	2		
Belgrave DIS	4	8	11
Ben Weir	2	1	
Brodie			3
Caesar Hawkins	2	4	2
Caroline		4	
Cavell	1	9	
Champneys		1	3
Cheselden	2	3	
Dalby	2		
Delivery Suite		1	2
Estates			10
Frederick Hewitt	1		
General Intensive Care Unit		1	
Gwillam			1
Gwynne Holford	3		1
Gordon Smith		2	
Gray	8	12	10
Gunning		4	
Heberden	4		
Heart Failure Unit		1	
Holdsworth	1	1	
Keate	1	5	8
Lymphoedema			2
Marnham	10	10	
Mary Seacole Ward	9	3	
McEntee	1		
NICU	1	1	
Richmond			14
Rodney Smith			7
Security			7
Thomas Young	2		
Trevor Howell	6	5	7
Total	**62**	**76**	**88**

Indicator Description	Jul-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20	YTD total
Nosocomial infections Hospital onset healthcare associated (>14 days) HOHA	0	0	0	7	28	62	97
Nosocomial infections Hospital onset probable associated (8-14 days) HOPA	0	1	0	0	28	76	105
							204

All nosocomial infections were associated with a single outbreak (NHSIE requires an outbreak to remain open until there are no more cases 28 days after the last positive. This means any new cases within that time were added to previous total). In addition, there has been very high community prevalence of late. It is not always possible to confirm if new cases are linked to outbreak or part of high prevalence, however if the cases meet the outbreak criteria (2 or more linked to an area) then the Trust is required to report.

Key Learning from STAFF outbreak root cause analyses:

- Poor mask etiquette
- Lack of social distancing, including at meal times
- General increased community prevalence of Covid

Actions taken include:

- Deep cleaning of affected areas
- Staggering of staff breaks
- Mask etiquette and PPE reminds via safety huddles and staff communications
- Additional provision of staff breakout areas

Key learning from nosocomial PATIENT outbreak root cause analyses:

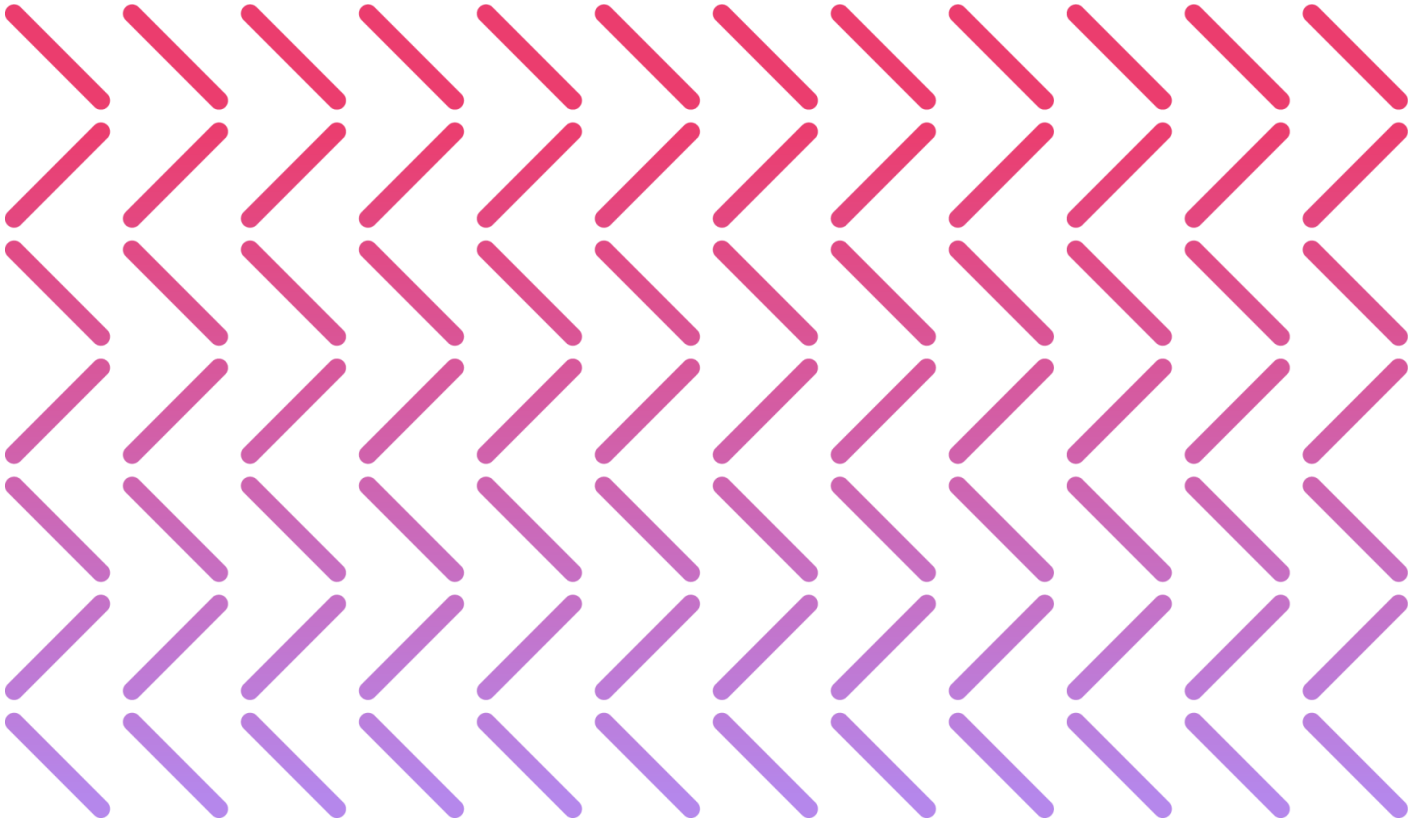
- Suboptimal mask compliance in staff
- Lack of guidance on step down of resolved Covid cases and transfer of patients
- Suboptimal cleaning of medical devices

Actions taken include:

- Staff communications regarding mask etiquette and reinforcement via safety huddles
- Patients encouraged to wear masks if they can be tolerated
- Updated step down guidance and management of associated risk
- Development of Staff Guidance on Management of COVID19 exposures and outbreaks in hospital
- Reinforcement of cleaning for medical devices for example workstations on wheels

2.1

Appendix A: Winter / COVID Plan vs Actual



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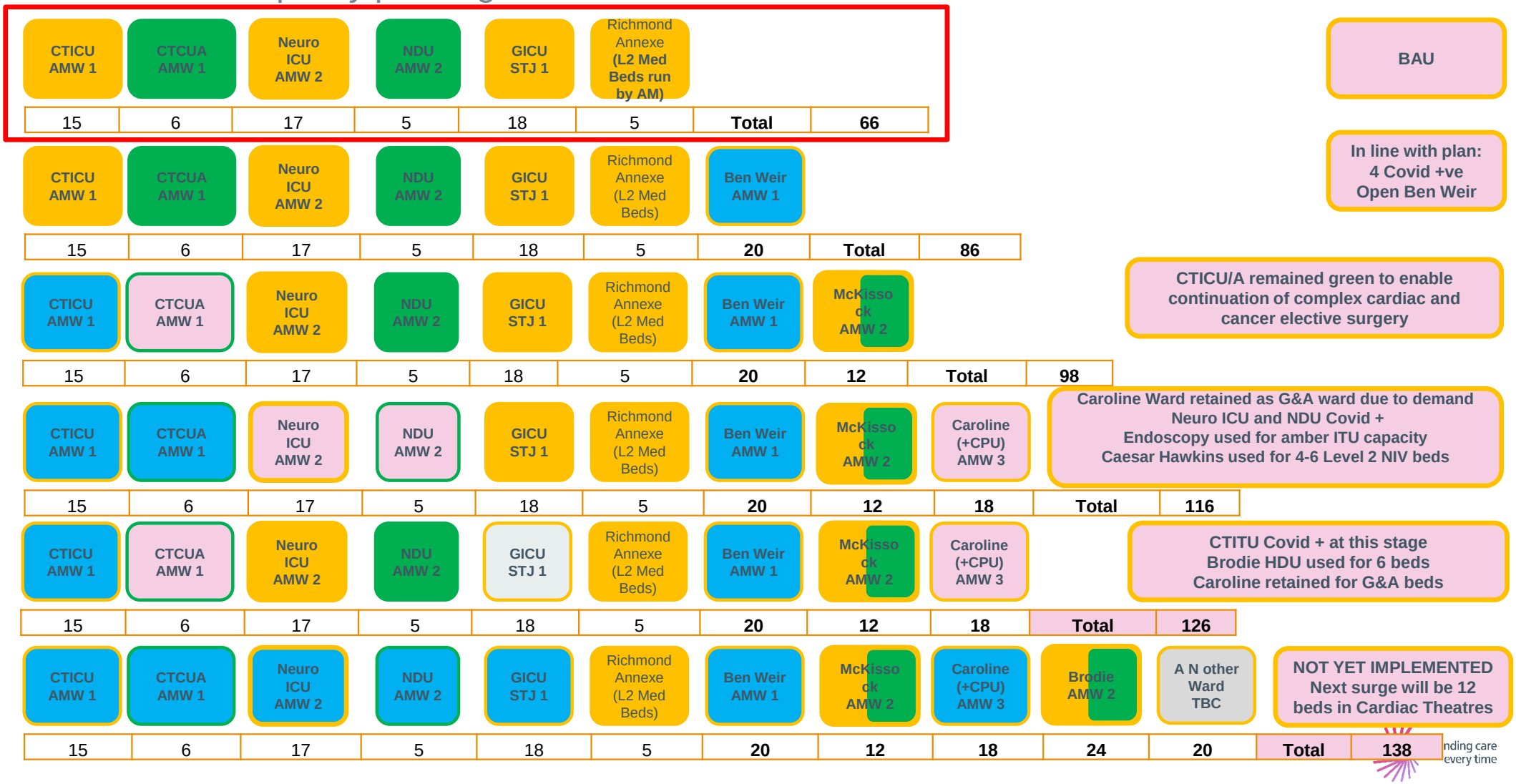
2.1

Plan A - ICU Capacity phasing: *Original Plan*

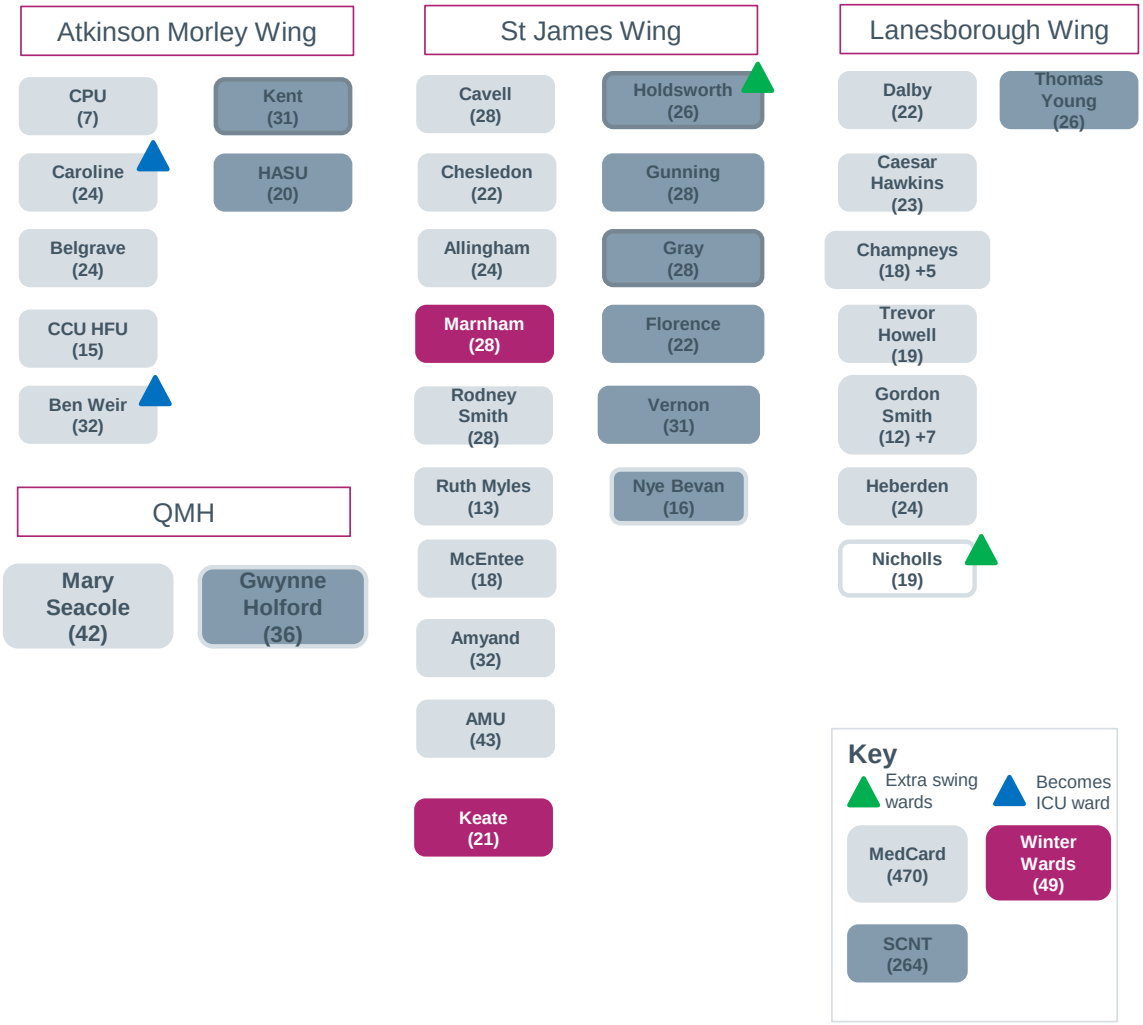
2.1

Plan A - ICU Capacity phasing: *Plan Enacted*



2.1

Plan B - G&A Adult Bed Capacity: *Original Plan*



- **During Plan B - wards move from speciality based to Infection Prevention & Control streamed care - Blue/ Amber/ Green – triggered as soon as we admit patients into the second designated Covid-19 G&A adult medical ward.**
- MedCard has 519 beds (Tooting and QMH sites), including Keate and Marnham as winter wards, 13 short of the 530 forecast winter bed capacity needed for medical patients. This 11 bed gap will be mitigated by either improved flow and discharge or a further SCNT or CWDT ward swinging across to MedCard during the 4-8 week peak demand period in January and February. All ambulatory beds are protected under this plan to maintain flow and access for these unplanned and planned care medical patients. Keate will be the last ward to open for medical G&A patients to support our elective surgical activity for as long as possible.
- This plan also requires Ben Weir and Caroline wards to become ICU wards during the forecast 4-8 week peak period in January and February. These wards will be the last to become ICU wards and this ward capacity will be re-provided by further SCNT or CWDT wards swinging across to MedCard, if needed.
- SCNT and CWDT will continue to run all 'Retained' services (230 beds) and as much of their other unplanned and planned care services within the 'All Other' (207 beds) – which will flex up and down as ICU and G&A medical demand increases/ decreases.
- All staff that need it will be supported with Covid-19 training before the forecast surge in demand. Rotas' for the 6 month period from October to March will be agreed with all staff groups, including planned annual leave to reduce the risk of fatigue.
- G&A adult medical wards re-purposed for Covid-19 will be staffed by their existing teams.

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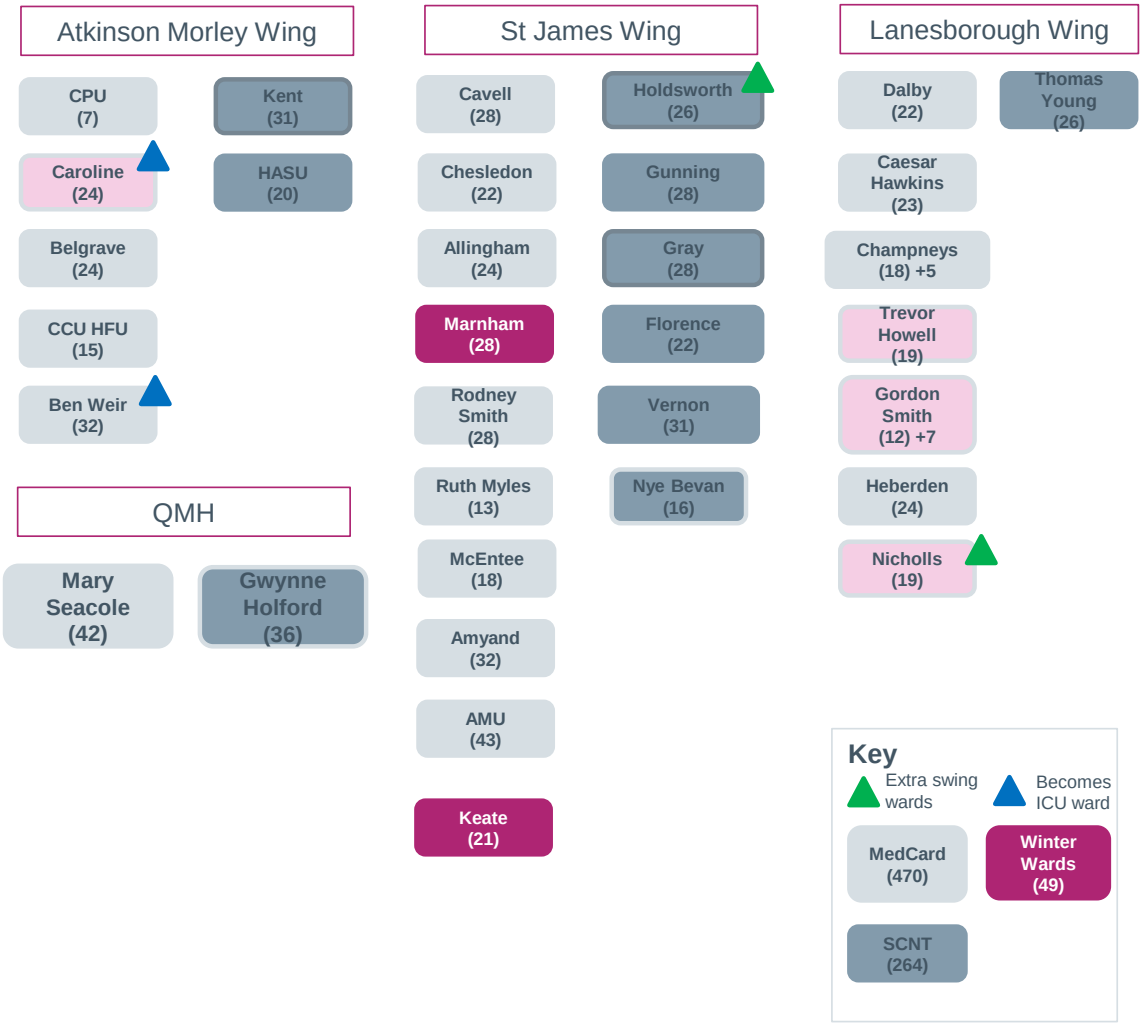
2.1

Plan B - G&A Adult Bed Capacity: *Plan Enacted*



January 2021:

- Due to the increased demand on G&A beds Caroline Ward has been retained as a G&A ward.
- Ben Weir is in use as ICU in line with original plan.
- To provide additional G&A capacity to meet demand, Nicholls Ward (paediatric surgery) has been turned into a green elective surgical ward to maintain urgent and complex surgery. Children's services are being provided across the two remaining children's wards. This was in the original plan.
- Day services provided on Trevor Howell and Gordon Smith (e.g. chemotherapy and apheresis) have bene moved to provide an additional 12 G&A beds. These services have been moved to Day Surgery so that they can continue.
- Endoscopy on the Tooting site has been reprovided in either Day Surgery Unit or Theatres at 80% of the usual available capacity
- Safe Staffing: Nurse rotas are currently running at 1:7 or 1:8 (usual levels 1:6 or 1:7)

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St George's University Hospitals NHS Foundation Trust

2.2

Meeting Title:	**Trust Board**		
Date:	**Thursday, 28 January 2021**	**Agenda No**	**2.2**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	**Prof. Dame Parveen Kumar, Chairman of the Quality and Safety Committee**		
Report Author:	**Prof. Dame Parveen Kumar, Chairman of the Quality and Safety Committee**		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meetings in December 2020 and January 2021.		
Recommendation:	**The Board is asked to:** • **Note the updates from the December 2020 and January 2021 meetings.** • **Consider and approve the Trust Response (Self-Assessment) to the Ockenden Maternity Services Review (2.2.1).** • **Receive and note the Quarter 3 Cardiac Surgery Report (2.2.2).**		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

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St George's University Hospitals NHS Foundation Trust

2.2

Quality and Safety Committee Report

Matters for the Board's attention

The Quality and Safety Committee met on 17 December 2020 and 21 January 2021. The Committee considered and discussed the following matters of business at these meeting:

December 2020	January 2021
• Deep Dive: Minimising harm from treatment delays caused by the COVID pandemic • Ockenden Review of Maternity Services (Initial Essential Actions) • Integrated Quality & Performance Report (M08) • Serious Incident Month Report and Annual Thematic Analysis Review • Medicine Management and Controlled Drugs Report • Research & Development Strategy Quarterly Update • Board Assurance Framework Monthly Report • Patient Safety & Quality Group Monthly Report • Committee Effectiveness Review	• Covid-19 Update • Integrated Quality & Performance Report (M09) • Nurse Safe Staffing Report (M07&08) • Cardiac Surgery Service Report (Q3) • Trust Response to Ockenden Review of Maternity Services • Board Assurance Framework Monthly Report (Q3) • Patient Safety & Quality Group Monthly Report

The Committee held a shorter meeting in January focusing on the key matters of priority so that executive colleagues would have more time to continue to focus on operational priorities. The Committee also formally recorded its assurance level (one of four options: no, limited, reasonable or substantial assurance) having considered the contents of the report, the evidence therein and the discussions at the January meeting.

The report covers the material matters that the Committee would like to bring to the attention of the Board.

1. Deep Dive – Minimising harm from treatment delays caused by the COVID pandemic

The Committee heard about the steps and actions taken by the Trust to minimise harm to patients due to delays in treatment as the Trust focused on managing the second wave of the coronavirus pandemic. The Committee noted that:

- During the first wave the Trust retained a number of its services for example all emergency services, major trauma, maternity, diagnostics radiology, cancer and urgent stroke and neurology services etc. The Trust conducted robust risk assessments of the impact of stepping down any services. The Trust adhered to government guidelines related to ceasing elective activity in wave one.

- The Trust developed a clinical safety strategy which was shared and discussed previously by the Committee and the Board. A key aspect of the strategy required consultants to review and categorise patients on the waiting lists for the relevant care pathway.

- The Trust ensured that staff across the Trust were redeployed to the relevant areas to support with the care and treatment of patients.

- The Trust introduced virtual outpatient appointments and when services were resumed robust measures were taken to ensure that patients coming into the hospital were safe.

- The Trust worked with South West London partners to ensure that all patients waiting for elective care were offered care across the shared clinical pathways and where possible using private and other NHS partners to reduce the waiting times for these patients.

- During the first wave of Covid-19 the Trust had confirmed two serious incidents which were probably as a direct cause of the delay in treatment as a result of the Trust prioritising the care of Covid-19 patients.

- In December 2020 the Trust had continued to make good progress and had met elective/day case activity levels, partially met diagnostics activity, was close to achieving outpatient activity targets, and the 62 day cancer waits were declining. This was all achieved whilst the Trust focused on managing the second wave of Covid-19 cases and retaining elective activity.

The Committee commended the work of the Trust and its staff during this sustained and challenging time and noted the current pressures facing the Trust as it balances increased demand for Covid-19 beds and manages elective activity.

2. Ockenden Maternity Services Review

In December 2020, NHS England & Improvement (NHS&I) published the initial findings (from the first 250 of 1862 cases to be reviewed) for the Ockenden Maternity Services Review. The review was initiated to look at maternal and neonatal harm between 2000 and 2019 at Shrewsbury and Telford Hospital. NHSE&I requested that all trusts conduct a self-assessment against the 12 standards of the immediate essential actions identified in the initial report and submit this report on 21 December 2020 and then submit a full response in January 2021. In lieu of the Board the Committee reviewed and approved the immediate essential actions self-assessment before it was submitted on 21 December 2020 and endorsed the full response at its meeting in January 2021 which was presented under agenda item 2.2.1 for the Board's consideration and approval.

The Committee noted that the Trust assessed itself as fully compliant with nine of the standards and:

- Non-compliant against enhanced safety to implement the Perinatal Clinical Quality Surveillance (PCSQ) model. The reason for this was outside the Trust's control as NHSE&I had not defined the model. As soon as this was published the Trust would work to implement the model.

- Partially complaint against the following two standards:
  - *Staff training and working together* – documented evidence to demonstrate there were Consultant-led labour ward rounds twice daily 24/7. There were twice daily ward rounds with the morning ward round conducted by a Consultant and a majority of the evening rounds conducted by the Consultant. However at least two times per week the ward rounds were led by the Senior Registrar with a coordinating midwife because the Consultant was not the resident-on-call. The maternity team were now recording the consultant led ward rounds so that the Trust can evidence and demonstrate compliance with the standard.

  - *Managing complex pregnancy* – understanding of what further steps are required by the Trust to support the development of maternal medicine specialist centres. The Trust was confident that it had a well-established maternal medicine service which would fulfil the requirements of a maternal medicine hub (specialist centre). The Trust was also awaiting the second release of funding from NHSE&I to provide training for

an Obstetric Physician Consultant but this has been delayed by the Covid-19 pandemic. The Trust would also bid to become a South West London Maternal Medicine Hub in collaboration with Epsom and St Helier's Hospital.

The Committee commended the work of the team for completing a robust self-assessment whilst managing the demand on clinical services. The Committee was substantially assured that there were robust quality and safety control systems used to gather the evidence for the self-assessment and to continue to monitor and manage areas on non/partial compliance. The Committee recommends that the Board considers and approve the NHSE&I self-assessment template.

3. Covid-19 Update

The Committee had considered management of Covid-19 cases as part of the Integrated Quality and Performance Report since August 2020 however given the increase in cases the Committee received a stand-alone report in January 2021. A similar update was provided to the Board above under agenda item 2.1.

The magnitude of the challenge facing the Trust and the wider NHS was not lost on the Committee especially given that the Trust was required to retain a level of elective activity unlike in the first wave where the government agreed elective activity could be stepped down. The Committee noted that as a result of retaining a greater level of elective activity the Trust had to deviate from its Covid-19 Surge Plan. During the second wave the Trust had a higher level of bed occupancy and greater medical intake and as such adjusted the areas it surged into to manage Covid-19 patients.

The Trust continued to operate as the hub for the Covid-19 vaccine with the capacity to deliver 800 vaccines per day. Over 5622 staff members including contractors from Bellrock and Mitie have received the vaccine and the Trust continued to target high risk staff for the vaccine and all staff in the Trust and across South West London can register to get the vaccine.

The Trust took steps to continue its training programme for staff redeployed to support the intensive treatment unit (ITU) and as such benefited from their experience during the second wave. The Committee noted that across the NHS there was a dearth of critical care staff to meet the need for an expanded ITU bed base and, in the case of nursing, to maintain quality of care and the safety of patients. The Trust had utilised specialist critical care nurses, and deployed Trust clinical staff, healthcare assistants, registered nurses, and also medical technicians from the army to support the delivery of care to patients in ITU.

4. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality and safety performance in months 08 and 09 (2020/21). The Committee is aware that the Board would also consider the month 09 report later under agenda item 2.3 and would like to highlight the following:

- The number of Covid-19 patients in the hospital had increased with the onset of the second Covid-19 wave. This was reflected in the increase in 'hospital onset healthcare associated' cases (over 14 days) and 'probable' (8-14 days) nosocomial cases. There had also been seven Covid-19 outbreaks in patient areas and six in staff areas during month 08. The appropriate infection control and prevention, deep cleaning, auditing and isolation steps were put in place to prevent further outbreaks.

- The level of resuscitation training remained an area of concern for the Trust. The Trust had invested in two additional trainers and organised more training sessions. The challenge remained having sufficient take up with staff focused on the operational priorities during the second wave in Covid-19 cases.

- The number of cardiac arrests had increased whilst treatment escalation plans numbers remained static. The resuscitation team had been tasked with reviewing cardiac arrest and 2222 calls to establish if there were any areas which require additional support.

- There had been an increase in the number of category three pressure ulcers and unstageable pressure damage which could be associated with the increased acuity of patients. It was also recognised that staff have been deployed to new areas where familiarisation with documentation requirements may not be known. The Trust would conduct retrospective review of each case.

- There had also been three patient falls in month, one of which led to the death of a patient and was currently under review. There were no lapses in care identified in these cases.

- In month 09 key positive movements relate to the increase in number of treatment escalation plans in place to 40%, the Trust had managed all serious incidents investigations within the required timescales and the number of times the Carmen Birthing Suite had been closed had significantly reduced (from 30-40% to 6%) with new staff now in post.

- The Committee also heard the summary details of the two never events which occurred in month 09 and the details of which were circulated separately to the Board members. The Committee would consider the details of the incidents when the investigations have been completed.

Overall the Committee recognised the challenges facing the organisation and noted it was reasonably assured that the systems of internal controls were generally adequate and operating effectively but recognised that some improvements were required to ensure that quality and safety risks were managed effectively to deliver high quality services and safely care for patients.

5. Cardiac Surgery Report

The Committee also considered the Cardiac Surgery report which is below under agenda item 2.2.2 for the Board's information. The Committee noted that work continued, despite the Covid-19 pandemic, to implement the actions from the independent mortality reviews. The Trust was making use of the London Bridge Hospital for non-Covid patients requiring cardiac surgery. There were no changes proposed to the risk rating for the services and the restrictions on non-emergency surgery with a EUROSCORE rating of five or above remain in place for all surgeons, with the exception of Steve Livesey. The Committee noted that the Coroner had begun reviewing the cases identified in the independent mortality review. Of the four cases reviewed to date, the Coroner had concluded that the patients had either died of natural causes in combination with essential surgical treatment or a recognised complication from urgent surgery.

The Committee noted the progress made on implementing the actions from the independent mortality review and maintaining the service. The Committee was substantially assured that there are robust systems of internal controls operating effectively to ensure that cardiac surgery quality and safety risks were being managed to deliver high quality services and care to patients.

6. Serious Incident Reporting

In December 2020, the Committee received two reports related to serious incidents. The monthly serious incidents reports provide the Committee with a greater insight into the serious incidents that have been declared, a summary of findings from closed investigations,

actions taken, and the learning derived. Since the last report to the Board in November 2020, three new incidents had been declared in November 2020 and three were closed in October 2020. The Committee did not receive a monthly report in January 2021 for the reasons outlined above.

The thematic analysis focused on the serious incidents raised between 01 April 2019 and 31 March 2020. The report also contained updates on the actions from the communications, cardiology and radiology serious incident reviews considered by the Committee during 2019/20. The Committee heard that:

- There had been 47 serious incidents, which included never events, during the period, and 44 were included in the thematic analysis. Overall, there had been a slight reduction from the previous year.

- 41% of the serious incidents related to treatment/procedures and 27% related to assessment/diagnostics.

- There were three clinical issues emerging as common themes from the incidents reviewed and included management of anticoagulation medication, required improvement in the clinical information technology infrastructure and non-follow up/delays in treatment of cancer.

- Whilst the Trust had put actions in place following these incidents a key area of ongoing work would relate to ensuring that these actions have been embedded and effecting the desired change to ensure that these issues would not recur.

- Staff also recognised that the Trust was a safer place in their response to the five national staff survey questions related to how the Trust addressed and managed incidents, near misses and concerns.

In February 2021, the Committee would consider the number of declared serious incidents, outcomes of closed investigation and the never events which occurred in December 2020 and January 2021.

7. Medicine Management and Controlled Drugs Report

The Committee considered the medicines management and controlled drug report in December 2020. The Committee were concerned by the reduction in medical wristband scanning which was 54% compared with 74% in the same period in the previous year. The Committee accepted that this reduction may be related to the fact that more areas of the hospital were using Electronic Prescribing and Medicines Administration. However, it asked for further assurance that there were no underlying issues and that the actions taken to improve the IT infrastructure. The issues with the scanners that had negatively impacted on performance required addressing. The Committee noted that this was a key patient safety measure and asked the CMO/ACN to provide an update at a future meeting of the Committee. There were no further areas of concern raised for the attention of the Board.

8. Nurse Staffing Report (Planned vs. Actual)

The Committee considered the nurse safe staffing report for November and December 2020. The overall fill rate was 88.8% and 84% respectively, compared with 93.5% in October 2020. Due to the COVID-19 surge, registered nurses were deployed from the wards and departments to support the increased critical care beds. Supernumerary staff, such as practice educators, matrons, and clinical nurse specialists, had been working clinically to support the wards during the second wave. There was a substantial increase in red flags December (83) compared with November (27). However in both these months they were all

managed effectively and mitigated with no harm to patients. The Committee was substantially assured by the contents of the report.

9. Research & Development Strategy Implementation Plan

The Board received an update on the progress of the supporting strategies in September 2020 and the Committee can confirm, having reviewed the Research & Development Strategy Implementation plan in December that good progress had continued.

10. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register and consider the assurance, mitigations, and risk ratings for the following strategic risks (SR) assigned to it by the Board.

- **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.

- **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.

The Committee endorsed the current risk position for the above strategic risks at quarter three. The Committee noted the challenge with achieving the target risks given the focus on managing Covid-19 wave two and other operational pressures.

11. Patient Safety & Quality Group (PSQG) Reports

The Committee received and noted the reports from the November and December 2020 meetings of the Patient Safety and Quality Group. The Committee commended the report which provided insights and assurance in several areas including, the good progress on developing the shielded patients list, the implementation of the actions from the Care Quality Commission Action plan despite the current demands facing the Trust, and effective complaints investigation and response performance. The Committee noted that the contents on the key areas provided substantial assurance.

Recommendation

The Board is asked to:

- **Note the updates from the December 2020 and January 2021 meetings.**

- **Consider and approve the Trust Response (Self-Assessment) to the Ockenden Maternity Services Review (2.2.1).**

- **Receive and note the Quarter 3 Cardiac Surgery Report (2.2.2).**

Dame Parveen Kumar
Committee Chair
January 2021

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2.2

Meeting Title:	**Trust Board**	
Date:	**28 January 2021**	**Agenda No: 2.2.1**
Report Title:	**Ockenden Review of Maternity Services – Assurance and Assessment review - Immediate Essential Actions (IEA)**	
Lead Director/ Manager:	**Robert Bleasdale, Chief Nurse and Director of Infection Prevention and Control**	
Report Author:	**Janet Bradley, Director of Midwifery and Gynaecology Nursing**	
Presented for:	Approval/Assurance	
Executive Summary:	**OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION** In the summer of 2017, following a letter from bereaved families raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. The first terms of reference in 2017 were written for a review comprising 23 families. These were then amended in November 2019 to encompass a much larger number of families who had come forward to raise concerns. The review is looking at maternal and neonatal harm between the years 2000 and 2019 and includes cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and new-born babies. The total number of families to be included in the final review and report will be 1,862. This initial and first Ockenden report is arising from the 250 cases reviewed to date. The number of cases considered so far includes the original cohort of 23 cases. The review panel has identified important themes which must be shared across all maternity services as a matter of urgency and have formed Local Actions for Learning and make seven early recommendations for the wider NHS, labelled Immediate and Essential Actions (IEA). The immediate requirement on the 21st December 2020 was a letter of confirmation from the CEO also signed by Local Maternity System (LMS) Chair was submitted to NHSE describing the Trusts absolute commitment to fulfil and comply with the requirements of the IEA. An initial paper describing the requirement was presented and reviewed, commitment was supported at each	

	board and the letter from St Georges CEO was submitted accordingly. This subsequent paper describes the Trust's position using the Assessment and Assurance template, benchmarking our service in relation to each of the IEA. This is done by describing our position in respect of the following aspects:- • What process do we have in place currently? • Where and how often do we report this? • What assurance do we have that all of our guidelines are clinically appropriate? • What further action do we need to take? • Who and by when? • What resources or support do we need? • How will we mitigate risk in the short term? This report was discussed at the Quality and Safety Committee on 21 January 2020. The committee endorsed the assessment process and were substantially assured by this.		
Recommendation:	The Trust Board are asked to • Note the Immediate Essential Actions (IEA) for the Trust • Approve the current assessment against the IEA • Approve the process for future assessment		
Supports			
Trust Strategic Objective:	Build a better St George's Treat the patient, treat the person		
CQC Theme:	Safe, Caring, Effective, Responsive, Well Led		
Single Oversight Framework Theme:	Safety and Quality of Care		
Implications			
Risk:			
Legal/Regulatory:			
Resources:	N/A		
Previously Considered by:	Quality and Safety Committee	**Date**	21/01/21
Equality Impact Assessment:	N/A		
Appendices:	List of abbreviations contained within the Assessment and assurance template St Georges SWL - NHSE Assessment and assurance template		

Ockenden Review of Maternity Services
St Georges IEA - Assurance and Assessment Template 2021

1.0 PURPOSE

This paper sets out the Trust's position using the Assurance and assessment framework tool in relation to the Immediate and Essential Actions (IEA) from the Ockenden Review of Maternity Services at Shrewsbury and Telford Trust (SATH).

2.0 BACKGROUND

The key findings of the first Ockenden report; Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust, are

- Poor governance across a range of areas, especially board oversight and learning from incidents
- Lack of compassion and kindness by staff
- Poor assessment of risk and management of complex women
- Failure to escalate
- Poor fetal monitoring practice and management of labour
- Suggestion of reluctance to perform Lower Section Caesarean Section (LSCS) - women's choices not respected
- Poor bereavement care
- Obstetric anaesthetic provision
- Neonatal care documentation and care in the right place

In response to these initial findings the Secretary of State for Health has commanded that NHS Assurance actions are immediately required. Accordingly, a letter to all Chief Executives dated 14 December 2020 was sent out with the requirement of a submission of compliance. This describes twelve enhanced safety statements embedded within seven overarching immediate and urgent actions which were confirmed by out Trust on 21st December 2020.

In addition we are required to complete and take to their next public board, the assurance assessment tool which reflects the position of the Trust in relation to elements including:

1) All seven IEAs of the Ockenden report,
2) NICE guidance relating to maternity,
3) Compliance against the CNST (Clinical Negligence Scheme for Trusts) safety actions, and
4) A current workforce gap analysis

The assurances are reported through each LMS and submitted to the Regional teams by 15 February 2021. This gap and thematic analysis will be reported to the regional and national Maternity Transformation Boards. We are also required to confirm that we have a plan in place to meet the Birthrate Plus (BR+) standard including confirming timescales for implementation to achieve the recommendations to the Regional Chief Midwife by 31 January 2021. This Maternity workforce review is currently underway and confirmed to be completed by March 2021.

3.0 OUTCOME OF ASSURANCE AND ASSESMENT

Following the initial assessment process of each section, the Trust assessed itself as partially compliance against 2 and non-compliant against one (as awaiting PCSQ model).

The standard not meeting current compliance is 1.1 Enhanced Safety to implement the Perinatal Clinical Quality Surveillance Model. This model has not yet been defined by NHSE but we are committed to support its implementation when confirmed.

The standards of current partial compliance are:

> **3.1 Staff Training and working together** – *Documented evidence to demonstrate Consultant led labour ward round twice daily 24/7.*

The current position for the Trust is that there are dedicated and confirmed MDT Labour Ward rounds twice daily. The formal morning ward rounds are exclusively Consultant led and on the majority of occasions the evening ward round is also Consultant led but on the occasions when the Consultant is not resident-on-call the Consultant may not be present. This is only two evenings a week and very occasional weekend evenings. At such times the Senior Registrar would lead the ward round with the Coordinating Midwife and wider MDT and liaise with the on call consultant accordingly. The Maternity team have devised a recording tool to evidence every time consultant ward rounds occur. This evidence will be collected and audited to demonstrate compliance following implementation and the cycle of embedding change from February ‘21.

> **4.2 Managing complex pregnancy -** *Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.*

We have a well-established Maternal Medicine service and fulfil the requirements of a Maternal Medicine hub. We are bidding to become the SWL Maternal Medicine hub in collaboration with Epsom and St Helier Hospital. The Trust requirement to support its development is that we are awaiting the second release of funding from Central NHSE to be released to support further training of an Obstetric Physician Consultant. The release of these funds has been delayed due to the impact of COVID-19.

Table one: Assessment of compliance Dec 2020

Standard	Number of components	Full Compliance	Partial Compliance	Non Compliance
PCQS model- N/A Maternity SI	2	1		1 PCSQ Model
Listening to Women and their Families	2	2		
Staff Training and working together/ Finance	3	2	1 Cons ward round log	
Managing complex pregnancy	2	1	1 NHSE Funding	
Risk Assessment throughout pregnancy	1	1		
Monitoring Fetal Wellbeing	1	1		
Informed Consent	1	1		
Total	12	9	2	1
***Workforce	1	1		

4.0 Next Steps

The Director of Midwifery and Clinical Director will continue to collect and capture supporting evidence to be uploaded to the central e-portal NHSE are devising.

The Director of Midwifery has been asked by the Chief Nurse to work with the LMS to facilitate a peer review of the Trust position, to ensure compliance and share best practice across South West London.

The Ockenden Team are continuing to review the cases highlighted through the review of SATH. There are likely to be supplementary recommendations made following the outcome of these reviews.

The teams will also visit each Maternity Service to seek further assurance in relation to the assurance and assessment and associated evidence collected. There are no dates set for these visits as yet.

Resources – it is likely that additional resource may be required to support partial of overlapping elements of the recommendations. Every attempt will be made to fulfil these within the existing and planned financial footprint of Maternity Services but there may be a requirement to seek additional support where this is not possible. This will be considered through the divisional governance structure and as part of the Trust business planning for next year.

St George's University Hospitals NHS
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Ockenden Review of Maternity Services
NHS England Assessment and Assurance Template
Trust Self-Assessment

St George's University Hospitals NHS
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List of Abbreviations
Ockenden Maternity Services Review: Trust Self-Assessment & Assurance Template

Abbreviation	Meaning
ACSA	Anaesthesia Clinical Services Accreditation
BAME	Black, Asian and Minority Ethnic
BAPM	British Association of Perinatal Medicine
BR+	Birthrate Plus
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Qualty Commission
CS	Caesarean Section
CTG	Cardiotocograph
DDO	Divisional Director of Operations
DDoM	Deputy Director of Midwifery
DMB	Divisional Management Board
DoM	Director of Midwifery
EN	Early Notification
ESHT	Epsom and St Helier Trust
F&F	Friends and Family Test
FFT	
FGR	Fetal Growth Restriction
FM	Fetal movements
GDM	Gestational Diabetes mellitus
GSTT	Guy's and St Thomas' Trust
GTT	Glucose tolerance test
HSIB	Health Services Investigataion Branch
IEA	Immediate and Essential Actions
IQPR	Integrated Quality and Performance Report
LMS	Local Maternity System
MDT	Multi Disciplinary Team
MGM	Maternity Governance Meeting
MIS	Maternity Incentive Scheme
MM	Maternal Medicine
MSDS	Maternity Services Data Set
MVP	Maternity Voices Partnership
MW	Midwife
NICE	National Institute for Health and Care Excellence
NNU	Neonatal Unit
NPID	National Pregnancy in Diabetes
NSHE	NHSE National Health Service England
PALS	Patient Advice and Liaison Service
PCQSM	Perinatal Clinical Quality Surveillance Model
PDM	Practice development midwife
PDSA	Plan Do Study Act

PMA	Professional Midwifery Advocate
PMRT	Perinatal mortality Review Tool
PROMPT	Practical Obstetric Multidisciplinary Professional training
PSCP	Personalised Care and Support Plan
PSQG	Patient Safety and Quality Group
QI	Quality Improvement
QR	Quick Response
QSC	Quality and Safety Committee
RCM	Royal College of Midwives
RCOG	Royal College of Obstericians
SBL	Saving Babies Lives
SBLCBV2	Saving Babies Lives Care Bundle version 2
SIDM	Serious Incident and Declaration Meeting
SW	South West
ToR	Terms of Reference
UCLH	University College of London Hospital
WTE	Whole Time Equivalent

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We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

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Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions (CNST):

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1? **<u>Partial compliance</u> –** **Awaiting final Perinatal Clinical Quality Surveillance Model from NHSe**	- The Trust Board receives a quarterly perinatal mortality report via the Mortality Committee, which has oversight and responsibility for perinatal clinical quality - Formalised perinatal governance processes up to trust Board, including review of SIs at Divisional Level via the Divisional Management Board and upwards through the Patient Safety and Quality Group and then the Quality and Safety Committee. - Maternity Board safety champion actively in place, who links with Local Learning System and Maternity and Neonatal Safety Champions attend Board and actively link with LMS and the regional team - Maternity service shares safety and clinical dashboard data – outcomes and insights with both the LMS and London perinatal board via the monthly - External / peer support is obtained as needed for investigations meeting this criteria - Maternity service has robust relationship with Board Safety Champion, including bi-monthly meetings with Maternity and Neonatal Safety Champions and monthly walkabouts to meet staff - Engages with quality improvement mechanisms across system - Work closely with MVP - PMRT - External clinical specialist opinion from outside the Trust is sought in any case of Intrapartum Fetal Death (HSIB), maternal death (either from HSIB via an NHSE recommended specialist). Cases of neonatal brain injury and neonatal death that meet the criteria for HSIB investigation have external clinical specialist opinion from outside the Trust. As a tertiary referral centre, level 3 NNU, investigations often relate to maternity care provided at other hospitals and so MDT teams work together to review care and make recommendations accordingly. We are fully committed to implementing the Perinatal Clinical Quality Surveillance Model as and when it is fully developed and this will be led by the Women's Directorate team.

Describe how we are using this measurement and reporting to drive improvement?	- Actions and recommendations from SI and risk reports are shared and cascaded out amongst all staff through the 'Risky Business' bulletin and also presented during quarterly unit wide Governance Meetings - Monthly 'case review' Maternity Governance Meetings - Attendance at LMS Safety Meeting and Annual Safety Day to share work and learn from others (clinical staff and management team) - Maternity Dashboard shared with staff on a monthly basis highlighting areas of improvement and areas of concern - Monthly IQPR report to Trust Quality and Safety Committee, responding to queries from Exec Team - PQSG, MGM, DMB, SDIM minutes
How do we know that our improvement actions are effective and that we are learning at system and trust level?	- As part of the CNST safety action 2 MSDS, the maternity service has been improving the documentation of ethnicity at the point of referral into maternity services. This is supporting a review of data in relation to women from BAME backgrounds. - Monitoring improvements over time on Maternity Dashboard and across LMS on Safety Dashboard - Sharing improvement work (e.g. PDSA projects presented as Post Implementation Review posters) - Audit cycles
What further action do we need to take?	- Sharing SI numbers, themes, outcomes and recommendations on a monthly basis with LMS (process and pathways to be determined by LMS) - CNST Safety action 10 – to provide evidence of trust board oversight of qualifying cases from 1.10.2020 to 13.03.2021 and that they are assured that: The family have received information on the role of HSIB and the EN scheme There has been compliance in respect of Duty of Candour - Implement Perinatal Clinical Quality Surveillance Model (PCQSM) once final model has been signed off by the national teams. - Implementation of ward level based Staff Councils to lead QI, safety and governance with direct leadership from ward staff MDT.

Who and by when?	- Governance lead midwife to confirm CNST safety action 10 compliance at associated time. - Monthly reporting to LMS: Starting January 2021 - PCQSM – as and when released - Staff Councils to be implemented as part of Accreditation process. Matron and Lead for Governance to lead and actioned by July 2021.
What resource or support do we need?	- Once detail of PCQSM is released, an assessment of requirements to complete this will be undertaken and resource need will be assessed - Consideration of protected time for ward level staff to be released to lead and drive the councils.
How will mitigate risk in the short term?	- Continue PMRT and HSIB submissions as required, implementing the learning that come from reports - Continued use of incident / risk / governance reporting processes and escalation of concerns and issues as and where required.

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions: **Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?** **Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?**
Link to urgent clinical priorities: (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2? **<u>Fully compliant</u>** 10	- CNST safety action 1 PMRT - Please refer to IEA 1 to demonstrate compliance. - CNST safety action 7 MVP - We have an active and engaged MVP who are seeking to prioritise hearing the voices of women from BAME backgrounds and those living in high areas of deprivation. St George's maternity unit has launched a BAME Maternity Staff Committee. The elected committee were nominated and selected in December 2020 and hold a key priority within their portfolio to involve and engage with the historically hard to reach, pregnant population from BAME backgrounds. - CNST safety action 9 - The trust is meeting compliance with this action in line with the updated guidance at re-launch of the scheme on 1st October 2020. - A Non-Executive Director has been identified to represent women and family voices at Board Level and to work with the Board Level Maternity Safety Champion. - Service continues to work collaboratively with the Maternity Voices Partnership to gather user feedback and co-design resources for sharing important information with the wider community - Women and families are routinely contact as part of risk, serious incident and PMRT / HSIB investigations and offered support through the process as necessary. - Board Safety Champion meets with Maternity and Neonatal Safety Champions bi-monthly and carries out monthly walkabouts to meet staff - Antenatal 'Birth Choice' clinics - Debrief Postnatal Clinics with Consultant Obstetrician, Midwives and Professional Midwifery Advocate - Professional Midwifery Advocate Debrief sessions and support for staff - Improved the rate of user feedback – Maternity QI/governance team piloted a study into using text for patient feedback and there is now a QR code that can be used. This has led to an increase in response rate. - Complaint rate monitored monthly to ensure a timely turn around and feedback to families is provided formally. Themes assessed and actions taken and shared amongst with the women and workforce - Concerns and questions from families are sought for PMRT reviews and are addressed as part of the review process. - Live online Teams Q&A sessions with the Consultant Midwives, MVP, Transformation Lead, women and their partners - QCQ Maternity Patient Survey result from 2019 very positive The independent senior advocate role which reports to both the Trust and the LMS Boards will be a completely new role for the LMS and organisation. Currently there is no specific role in place and no job or role description to benchmark against. The Trust if fully committed to support and facilitate this role and its function once the requirements are fully defined.

How will we evidence that we are meeting the requirements?	- Notes of Maternity Safety Champion meetings, walkabouts and conversations with staff and records of actions arising - Notes from investigations detailing involvement of women and families (or offer for involvement made and declined) - MVP Terms of Reference - Minutes of MVP meetings along with emails regarding co-production / review of communications and information for women - Minutes and agenda from Maternity BAME committee forums - Friends and Family Feedback tool – and ward level feedback via team meetings - Email invitations for live Teams Q&A sessions - Audit of service demand and outcomes - Social media live feeds
How do we know that these roles are effective?	- Feedback from MVP Chairs / annual reports - Feedback from those involved in investigations - Number of compliments/ complaints / PALS contacts
What further action do we need to take?	- Implementation of a dedicated, single point of access Maternity Telephone Helpline. - Once guidance is published regarding the Independent Advocate Role, this will be established and women and families will be offered this option for support as necessary. This is likely to be a role held within the CCG level and cover approximately 2,500 births per advocate. JD and job outline currently in development at NHSE/I - ToR being drawn up by the Maternity BAME committee
Who and by when?	- Telephone Helpline implementation – DoM and GM by April 2021 - Independent senior advocate role appointment within the timeframe set by NSHE Implementations supported by LMS and Trust ASAP after guidance published - Maternity BAME Committee to draw up ToR by February 2021.

What resource or support do we need?	- Telephone Helpline – IT infrastructure/recoding database and supportive equipment needed. 1.0WTE Digital Midwife to support implementation and programme of embedding Identified space within maternity services footprint to house helpline - Collaboration and working dynamic with Independent Advocate will be welcomed once more detail of role is available
	- Review of method for involving families in risk review / PMRT etc. to ensure sufficient support is given - The lack of independent senior advocate role is partially mitigated by- - Our strong and active MVP group - HSIB - Consultant Midwifery/PMA support for women - Birth options clinics - Duty of Candour compliance - PMA's and birth reflections process - Complaints response/ PALS - Review of FFT data - Maternity Instagram/Twitter accounts which provides up to date information and responds to queries - Review and action NHS Choices feedback - St Georges twitter account information sharing and responses to queries - Communications and QI maternity senior team ensure timely dissemination of information via social media and intranet and website

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?** **Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**	
Link to urgent clinical priorities: (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	
What do we have in place currently to meet all requirements of IEA 3? **<u>Partial compliance</u> –** **Documented log of Cons lead Ward rounds; developed reporting tool and implementation underway**	- CNST Safety Action 4 – we are currently undertaking a workforce review internally and have also commissioned a full Birthrate Plus review of the maternity workforce. This report is due to be completed and presented in March 2021. - CNST safety action 8 – Multi-professional classroom and in situ training is live and remains active at St George's. Practical Obstetric Multidisciplinary Professional training - PROMPT has been facilitated throughout the pandemic and still remains in place following comprehensive risk assessments and social distancing measures put in place. - Multidisciplinary Training take place in line with requirements and logs are kept of this through Practice Development Team records, personal training records and the Trust training database. We can give assurance that multidisciplinary training and working occurs and can provide evidence of this. However currently the evidence is not externally validated through the LMS, 3 times a year. - Consultant presence on Labour Ward is over 130hrs per week. - Ward rounds occur formally at least once daily on Labour Ward, seven days a week but we currently do not capture this in any way to evidence. An audit of patient notes would not reflect the process so we are developing an associated reporting tool to capture and reflect the rounds. - Revised funding streams to demonstrate external funding flowing directly to Maternity training budget

What are our monitoring mechanisms?	- London Clinical Quality Standards - Training logs for all midwifery, medical and theatre staff - Annual training needs analysis
Where will compliance with these requirements be reported?	- Reported as part of CNST assessment - PSQG Quarterly Maternity report - London Quality Standards (reported bi-annually to London Clinical Network)
What further action do we need to take?	- Requirement to document and evidence the twice daily Consultant led ward rounds and to audit compliance. Documented log being devised to evidence formal ward rounds – audit of notes wont reflect true level of activity effectively - Requirement to report training statistics to LMS minimum of once per quarter - Continuous monitoring of MDT training stats in light of impact on staffing and training facilities during Covid-19 pandemic - Clinical Governance Training to mandatory for all staff
Who and by when?	- DoM and Clinical Director leading review of practice to document and evidence second daily ward round at Consultant Level - Governance Team to establish method for log to evidence compliance with this - Governance Team and PDN Team to initiate a training package for staff
What resource or support do we need?	- Sufficient space to carry out in-person training at social distance and availability of trainers who may be shielding due to clinical vulnerability. - Increase in IT provision for staff to facilitate on line learning - Support to maintain training through pandemic where possible

How will we mitigate risk in the short term?	- New starters will be prioritised for PROMPT training. - Consultant presence to continue and ward rounds documented wherever possible and recorded in the escalation book - Governance presence at daily escalation huddle to ensure risks are escalated and managed effectively. - Datix review and escalation of risk concerns via trust governance pathway.

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4? **<u>Partial compliance</u> –** **awaiting funding cascade down from central NHSe (already confirmed)**	- Specialist Maternal Medicine Team in place at the Trust comprising midwives, obstetricians, anaesthetists and support workers with strong established collaboration with physicians - St Georges have put in an expression of interest for the region to be a National Maternal Medicine Network with ESHT as the Maternal Medicine Centre working in collaboration with all other units in SW London and further afield. - Maternal Medicine regularly feedback to the rest of the Unit through our Clinical Governance Days. Session (held remotely) example of presentations on GTT screening during Covid and results of the Aspre trial. - All referrals for antenatal care are triaged by Senior Midwife and women with maternal medical conditions are referred to the specialist maternal medicine team. - Women with pre-existing conditions are categorised based on their complexity and all receive an MDT approach to care. - Lead Consultants are assigned to women based on their condition and named as their Lead Doctor - Trust is working with other local Maternity Medicine centre to align clinical pathways, share knowledge and education and smooth pathways for women transferring care - We are awaiting funding from NHSE to complete further training of an Obstetric Physician Consultant as required to provide the MM service. - Maternal Medicine regularly feedback to the rest of the Unit through our Clinical Governance Days. In the last session (held remotely) they gave presentations on GTT screening during Covid and there was a presentation into the results of the Aspre trial. - Mat Med have weekly MDT meetings. - The Diabetes Team participate in the NPID (National Pregnancy in Diabetes) audit and Carolyn (Consultant Midwife) is part of the working group setting up a National GDM Audit. - Mat Med present at the annual SWL Maternal Medicine Meeting. - They participate in the national audit into epilepsy in pregnancy. - The audit they did into GTT screening during Covid has now been published and is referenced in the latest RCOG guidance. - Weekly update on all high risk cases sent out to staff for information via Maternity MDT Notable cases - CNST Safety Action 6 - We are on track to have fulfilled all 5 elements of the SBLV2 by July 2021.

What are our monitoring mechanisms?	- Notes audit - Clinical Outcomes - Outcomes from risk reviews / SI recommendations
Where is this reported?	- MGM - Report to London Maternal Medicine network
What further action do we need to take?	- Confirmation of funding from NHSE/I for Obstetric Physician post (candidate identified and appointed) - Exploration of specialist tariff funding for Maternal Medicine care given complexity of this work CNST safety action 6 SBL: - Ensure submission of MSDS data from specification standards when required by NHS Digital. - Element 1 - Restart Carbon Monoxide screening when identified safe within all areas of the maternity service environment. - Element 3 – Ensure women are being provided with the reduced fetal movement leaflet in different languages.
Who and by when?	- NHSE to confirm when funding is to be released centrally for Obstetric Physician post - Midwifery and Obstetric Audit leads to map out audit and compliance schedule by July 2021.
What resources or support do we need?	- Obstetric Physician - Payment for specialist work undertaken by Maternal Medicine Team

How will we mitigate risk in the short term?	- Continue clinical care and pathway modelling with Epsom and St Helier regarding Maternal Medicine Hub - Maternal Medicine team now linking with midwives on Delivery Suite to provide continuity of care throughout labour and birth
Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include on-going review of the intended place of birth, based on the developing clinical picture.	
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**	
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include on-going review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	

What do we have in place currently to meet all requirements of IEA 5? **<u>Fully compliant</u>** 19	- Every antenatal appointment is a risk assessment be that with midwife or doctor (some women have shared care with GPs and the Trust cannot audit the assessments undertaken during these appointments). Additional and enhanced risk assessments are formally undertaken at booking, 28weeks and 36 weeks appointments. Risk assessments are outlined, described and documented in the woman's hand held records and at booking also recorded on the Maternity Information System (E3). - Antenatal guideline includes: Screening questions, 'what matters to you' at 16 & 28 weeks birth planning at 32 & 36 weeks referral process to birth options clinic referral process to home birth team - Information regarding birth place options available in 'My Maternity Journey' booklet and on Trust website - Birth Options clinics with Consultant Midwife - Savings Babies Lives Bundle: - Monitoring of smoking in pregnancy at booking and 36 weeks (carbon monoxide monitoring currently suspended due to COVID, women asked about smoking status) - All women offered growth appointments at 36 weeks alongside risk assessments and surveillance of pregnancies at risk of Fetal Growth Restriction (FGR) - Women are advised of importance of monitoring their baby's movements and actions to take in case of reduced movements. - Quality Improvement facilitated a revision of risk assessment format in maternity notes for a more standardised approach to risk assessment for all women - Consultations are either midwifery-led and/or midwifery/consultant-led. Professional interpretation services are offered for non-English speaking women. The one-hour consultation offers an opportunity for women and their partners to explore their options whilst ensuring that a discussion takes place based on best available evidence and the recommendations for a safe birth are discussed. Women are offered additional appointments if necessary. If women choose to birth outside of clinical guidance – a robust care plan is created and disseminated to the teams. The consultant midwife provides on-going support during the pregnancy pathway to the midwifery team. On call support for out of guidance birth is provided by the consultant midwife and the midwifery managers on call. - MVP and service users have been involved in the development of all information pertaining to choice of place of birth and birth options available to women.

What are our monitoring mechanisms and where are they reported?	- Audits of Saving Babies' Lives Care Bundle vs 2 carried out and reported through CNST - Personalised care plans – now reported through MSDS data (from December 2020) - Audit of antenatal notes (reported at bi-annual Clinical Audit day and MGM)
Where is this reported?	- Audits reported to Maternity Governance Meeting
What further action do we need to take?	- Update of Trust website to ensure full details of place of birth options are available
Who and by when?	- Consultant Midwife / Programme Manager Maternity Transformation by 31.01.21
What resources or support do we need?	- 1.0 WTE Digital midwife to support reporting compliance, consistency and developing unified IT platform
How will we mitigate risk in the short term?	- All midwives reminded of importance of on-going risk assessments in pregnancy, including discussion - Escalation of concerns with scan capacity to directorate as required. - Review of datix and risk. - Dissemination of care plan to senior midwifery managers for women choosing to birth outside of guidance. - Senior midwifery out of hours on-call support. - Consultant midwife support and attendance for women choosing to birth outside of guidance. - Support from the safeguarding team which includes specialist midwifery support for place of birth

Immediate and essential action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?** **Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**
Link to urgent clinical priorities: a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6? **<u>Fully compliant</u>**	- We have robust and embedded Consultant and Midwifery leads in place for FM at St Georges - Mandatory comprehensive CTG training for all staff involved in monitoring fetal wellbeing - Minimum once weekly CTG meetings attended by multi-disciplinary teams in situ - Case reviews carried out with input from Fetal Monitoring MW and Obstetric leads equally – flattened hierarchy is long established and respected by all at St Georges. - Intermittent auscultation is covered in the fetal monitoring training and in the assessment. - There is a "fresh ears" sticker for IA to be completed every 2 hours and can be audited. - Currently we have a CTG Midwifery Team who have dedicated 0.2WTE for Fetal Monitoring
How will we evidence that our leads are undertaking the role in full?	- Job plans / job descriptions for leads clearly states roles and responsibilities in relation to fetal monitoring - Attendance at weekly CTG meetings - Notes of risk / SI investigations detailing involvement of leads - Evidence of training and development in relation to fetal monitoring e.g. attendance at national and local learning and training events
What outcomes will we use to demonstrate that our processes are effective?	- Reduction of incidents with poor outcomes involving fetal monitoring - Continued high attendance at fetal monitoring training - Clinical outcomes – low HIE rates in neonates
What further action do we need to take?	- Continual review of training syllabus in light of changing requirements
Who and by when?	- Incoming Deputy Director of Midwifery (arrives on the 15th Feb '21) , Lead for Governance MW and Transformation Lead to monitor transformation work streams which incorporate SBLCBV2 - Robust FM Team presence in unit - Continue collaboration with the Neonatal MDT to review care and training provision

What resources or support do we need?	- Support for in-person training including provision of sufficient rooms to safely carry out training with appropriate social distancing
How will we mitigate risk in the short term?	- Continue with sessions with smaller groups as frequently as we can

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7? **<u>Fully compliant</u>**	- Information regarding place of birth available on website via online classes, you tube videos regarding caesarean section and information leaflets - Birth options clinic with Consultant Midwife available as required - Policy regarding Maternal Choice Caesarean Section - Dedicated home birth team - Place of birth discussed with women at antenatal contacts and via risk assessment at booking / 28 weeks and 36 week appointments
Where and how often do we report this?	- Maternity Dashboard includes % of women having maternal request Caesarean section / home birth / birth centre - Website for information and guidance for referral - F&F feedback process
How do we know that our processes are effective?	- CQC Maternity Patient Survey - MVP feedback and meetings - Complaints and compliments - QR code feedback - Social media platforms -
What further action do we need to take?	- Review of website to ensure that pathways of care are clearly stated (reviewed with MVP) – in line with IEA5
Who and by when?	- Consultant Midwife Public Health / Programme Manager Maternity Transformation

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What resources or support do we need?	-
How will we mitigate risk in the short term?	- Reminder to all midwives to discuss birth options with women throughout pregnancy - Review of Maternal Request caesarean pathway

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Section 2
MATERNITY WORKFORCE PLANNING
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+)(or equivalent) standard by the 31st January 2020and to confirm timescales for implementation.

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What process have we undertaken?	- CNST Safety action 4 – clinical medical workforce - Gap analysis being undertaken and all areas requiring obstetric, anaesthetic and neonatal support being reviewed to ensure compliance with: - Requirement of London Maternity Quality Standards minimum step1 consultant obstetric presence on LW - compliant consultant anaesthetist allocated to each CS list - compliant - CNST standards Addressing junior obstetric doctor rota gaps - in progress - Anaesthesia Clinical Services Accreditation (ACSA) - British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing of neonatal unit - meet the BAPM standards for optimal staffing levels - Neonatal nursing standards in neonatal unit – non-compliant. Active recruitment is underway and any deviation is reported via Safer staffing Red flags, Datix and investigated. Other Ockenden standards - Twice daily consultant obstetrician led multidisciplinary ward rounds- compliant but need to evidence - CNST Safety Action 5 - Birthrate Plus review currently being undertaken and report is due to be completed at beginning of March 2021. - Business Planning Cycle for 2021/22 review underway
How have we assured that our plans are robust and realistic?	- Birthrate plus review will provide clear national recommendations and requirements for midwifery and support staff - Matrons have been involved in establishment review conversations with Director of Midwifery and finance / general management teams

How will ensure oversight of progress against our plans going forwards?	- Progress and impact to be reported at Divisional Management Board - Progress and impact to be reported at QSC
What further action do we need to take?	- Once Birthrate Plus review is complete, a workforce action plan will be completed to implement the recommendations with appropriate governance and monitoring arrangements in place to measure progress and impact.
Who and by when?	- Director of Midwifery – March 2021
What resources or support do we need?	- Additional resource requirements will be identified through the Birthrate Plus process and support for same described and sought. - Support for Medical workforce review
How will we mitigate risk in the short term?	- Staffing levels monitored via Safe Staffing tools and escalation/mitigation taken accordingly

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The Director of Midwifery is accountable to the Chief Nurse (executive director)

The Trust meets the following leadership requirements set out by the Royal College of Midwives:

- **Director of Midwifery in every Trust**
  The Trust has a Director of Midwifery and has recently appointed a Deputy Director of Midwifery (starting February 17th 2021) to work alongside and take responsibility for the professional and operational management of the midwifery service
- **More Consultant Midwives**
  The Trust has three Consultant Midwives specialising in Public Health, Complex Pregnancy and Normality
- **Specialist Midwives**
  The Trust has invested in a number of specialist midwifery roles at Band 7 level, including maternal medicine (diabetes, hypertension etc.), mental health and bereavement
- **Sustaining leadership in education and research**
  The Trust works closely with Kingston University to provide excellent midwifery education and there is also a strong research ethos at the Trust with many midwives working part time or full time on a variety of research projects.
- **Commitment to fund on-going midwifery leadership development**
  The Trust has committed to support the Matrons on-going development and has recently commissioned external development teams to facilitate this. There is also internal leadership development available to the Band 7 midwives via the Kings Fund Leadership module and other internal opportunities.

  At St Georges Trust Maternity Services sits within the Children Women's Diagnostic and Therapies Division. The Divisional Director of Operations is responsible and accountable to the Chief Operating Officer. The Director of Midwifery is professionally accountable to the DDO and the Chief Nurse (Exec Director). She has regular contact in formal forums with the DDO and the Chief Nurse as well as one to one meetings. This will be further strengthened as part of the review of the current Midwifery Leadership Structure as per our action for step 1 below.

  St Georges Benchmarking against - Seven steps to strengthen midwifery leadership as set out in the RCM Manifesto:

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Status	St Georges Position	RAG Status	Actions	Date
1. A Director of Midwifery (the most senior practising midwife) in every trust and more Deputy or Heads of Midwifery across the service.	The most senior practicing midwife in the organisation is the Director of Midwifery (DoM). The service has recently appointed into the operational lead role of the Deputy Director of Midwifery (DDoM). This colleague starts on the 17th February 2021. She will report directly into the DoM.		Once DDoM in post we will review of current midwifery leadership structure to improve clarity of titles, roles and reporting lines.	June 2021
2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally	Not Applicable to St Georges	Not Applicable to St Georges		
3. More consultant midwives	St Georges currently have 2.6WTE Consultant Midwives Benchmarking with similar services to ourselves (GSTT, Kings, UCLH) they have around 3 WTE. Currently there is no specific recommended numbers of Consultant midwives. The previous London Maternity Quality Standards would confirm that St Georges would require 3.		Identification of Funding for 0.4 additional Consultant Midwife Plan for developmental posts and succession into the role	April 2021 April 2021
4 Specialist midwives in every trust	St Georges have a wide range of Specialist Midwives to meet the needs of women and families. They include- • Governance and Risk Midwives • Bereavement Midwives • Midwifery Practice Education Team • Perinatal Mental Health/Domestic violence/safeguarding • Infectious Diseases and Antenatal Screening • Infant feeding • Female Genital Mutilation/Perineal trauma • Maternal Medicine • Diabetes • CTG		On-going monitoring of any changing needs via Q&S processes and establishment reviews.	

5 Strengthening and supporting sustainable midwifery leadership in education and research	Though this is not directly in the remit of St Georges as maternity provider, we are fully supportive and collaborative with our research partners in Imperial College and our HEIs.				
6 A commitment to fund on-going midwifery leadership development	Mentoring and coaching available through the Trust for midwifery leaders. Whilst training and development has been reduced during the COVID 19 pandemic there is a strong commitment from St Georges to invest in leadership training for midwives. We have clear examples of Leaders and Aspiring Leaders accessing and being support through leadership training and support.				
7 Professional input into the appointment of midwife leaders	In place. Appointment panels for midwifery leaders always have a string and significant midwifery presence complemented by MDT colleagues.				

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Current NICE guidance The Quality improvement and Governance team assigns each guideline to the clinical specialist every three years. The specialist will review the guideline and this guideline will then be peer reviewed before it is sent to the senior Maternity team and is ratified at the Maternity Governance meeting. New NICE guidance: The Trust Clinical Effectiveness department disseminates new NICE guidance to the relevant division and clinical leads. The clinical lead is required to undertake a review the Trust's compliance against the NICE guidance and identify programme of development to meet the guidance as required. Once a report is drafted by the audit lead and the risk is rated, the document will then go to Directorate meeting for sign off and reported via the Divisional Board to the Trust Clinical Effectiveness and Audit Committee.
Where and how often do we report this?	- Current guidelines are discussed as a standard agenda item at the Maternity Governance meeting. - The compliance risk rating matrix will be discussed at Directorate and Divisional quality and safety meetings.
What assurance do we have that all of our guidelines are clinically appropriate?	- Guidelines are reviewed every three years and more often if there has been an indication to do so. If new or revised NICE Guidance is published, this must be checked against our existing guidelines and updated (if necessary) by our clinical lead specialists in each area, the guideline is then peer reviewed. - There are audits assigned to each clinical guideline to provide assurance that they are clinically appropriate.
What further action do we need to take?	- We currently have a process in place and any amber/red rated guidance is flagged at the Maternity Governance meeting. However, we need to ensure that if there are guidelines which are out of date; this risk is added to the Risk register and escalated to the Divisional Governance meeting.
Who and by when?	- This process will be reviewed and the strategy will be ratified by 01/03/2021. Quality Improvement and Governance Midwife will own this action.

What resources or support do we need?	- The owner of this action will require MDT buy in and support from the Divisional and Directorate Governance managers.
How will we mitigate risk in the short term?	- This is discussed on an individual basis at Directorate and Divisional governance and Q&S meetings, including the action plans. Actions are tracked on the Maternity Governance group action log - Risks can be added to the risk register with immediate effect.

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2.2

Meeting Title:	**Trust Board**		
Date:	28 January 2021	**Agenda No**	**2.2.2**
Report Title:	**Cardiac Surgery Report – Quarter 3 2020/21**		
Lead Director	Richard Jennings, Chief Medical Officer		
Report Author(s):	Steve Livesey, Associate Medical Director for Cardiac Surgery Mark O'Donnell, Senior Nurse for Quality & Governance – CVT & CCAG Kelly Davies, Head of Nursing – Cardiovascular Services		
Presented for:	Review and Assurance		
Executive Summary	Following the publication of the Independent Mortality Panel's Review and Independent Scrutiny Panel's Review on 26 March 2020 Trust Board reviewed the comprehensive sources of assurance that the cardiac surgery service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these reports had been or were being acted upon. Based on this assurance around safety and learning it was agreed at the Trust Board on 30 April 2020 that cardiac surgery reports would from now on be made quarterly to the Quality and Safety Committee (QSC) and then to Trust Board. This report is the report for Q3 2020/21. The information contained within this report has been considered by the Quality and Safety Committee held on 21st January 2021. The Quality and Safety Committee considered the assurance provided the assurance provided to be 'substantial'. This paper provides the Trust Board with an update on the following: 1 The quality and safety of the service in Q3 2020/21 2 The actions that have been taken since the last Trust Board paper to address the recommendations of the Independent Mortality Review and the Independent Scrutiny Panel 3 The communication and support being offered to the bereaved families of deceased patients 4 An update on inquests 5 An update on the current and previous arrangements at St George's for cardiac surgery in the light of the Covid-19 pandemic. 6 An update on the cardiac surgery networking discussions in South London 7 The arrangements in place for continuing internal and external assurance and oversight of the St George's cardiac surgery service.		
Recommendation:	The Board is asked to note and discuss the updated information on safety assurance and other on-going actions.		
Supports			
CQC Theme:	Safe, Well Led		
Single Oversight Framework:	Quality of Care; Leadership and Improvement Capability		
Implications			
Risk:	As detailed in the report (page 4).		
Legal/Regulatory:	As detailed in the report (page 3).		
Resources:	None in relation to this report and not already agreed.		
Appendices:	N/A		

Cardiac Surgery Report – Quarter 3 2020/21

1.0 Quality and Safety

Following the publication of the reports of the Independent Mortality Review Panel and the Independent Scrutiny Panel on 26th March 2020, the Trust Board reviewed the comprehensive sources of assurance that the Cardiac Surgery Service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these two reports had been, or were being, acted upon. This section provides the Trust Board with an update on the sources of assurance that the Cardiac Surgery Service has remained safe through Quarter 3 (Q3) of 2020/21. This assurance is based on:

1) The patient safety outcomes in terms of mortality
2) The patient safety outcomes in terms of post-operative complications
3) The investigation and learning of any Serious Incidents.

There were no Serious Incidents declared in Q3.

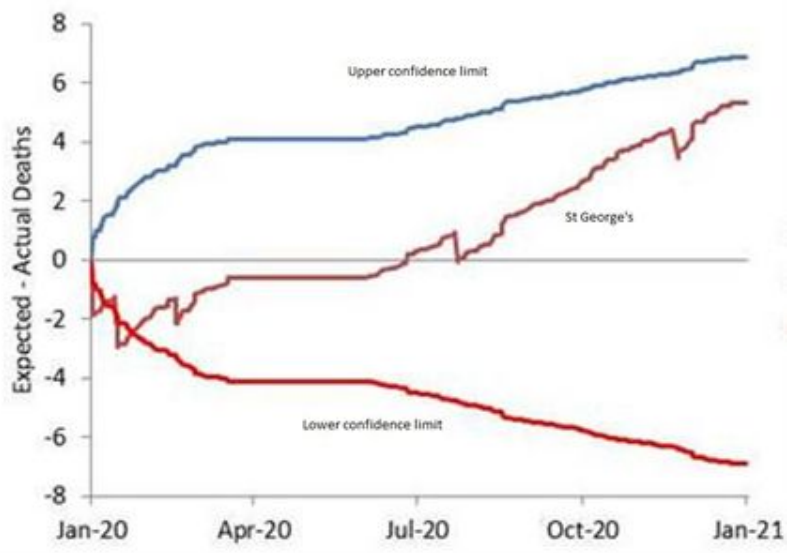
1.1 Patient safety outcomes – Mortality

Cardiac Surgery continued to offer its normal elective and non-elective service thorough much of Q3 until the Covid-19 pandemic precluded this; elective cardiac surgery stopped on 15th December 2020.

The Cardiac Surgery Service monitors mortality and the updated data, which is presented below, is an important part of the assurance that the service remains safe. 128 patients were operated on in Q3 with 1 death (0.73%). 403 patents were operated in the calendar year 2020 with a mortality rate of 1.74%, which is within national norms.

A Variable Life Adjusted Display (VLAD) plot for the Trust's Cardiac Surgery Unit for 2020 is shown below. A VLAD plot shows the cumulative difference in observed mortality from expected mortality. The Trust's VLAD plot shows satisfactory performance throughout the year (the flat period in the middle of the plot corresponds to the time period during which there was no cardiac surgery performed at St George's during the first Covid-19 wave).

VLAD plot for 2020



As has been previously reported to the Trust Board, it should be noted that the Trust remains out of alert in terms of its mortality as analysed by the National Institute for Cardiovascular Outcomes Research (NICOR), and this has been the case since the publication in October 2019 of the survival rate data for the period April 2015 – March 2018. The report for April 2017 – March 2020 has been sent to the unit for validation, but not yet released publically. This shows that the Unit is performing within the nationally expected limits and continues to remain out of alert.

1.2 Post-operative complications in Q3 2020/21

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

The updated data is another important source of assurance that the cardiac surgery service remains safe. In Q3 there were nine resternotomies (in six patients). In one case, the patient underwent four resternotomies during their admission, but died 20 days after admission for infective endocarditis. This patient's case was discussed at the Trust's Serious Incident Declaration Meeting (SIDM) and was not declared an Serious Incident; however, as this case relates to the death of a patient the case has been referred to the Coroner and in accordance with the Trust's Standard Operating Procedure the decision of SIDM will be independently reviewed by a cardiac surgery expert at another Trust in South London. In the other five incidences of resternotomies the patients recovered well and were discharged home. All cases of resternotomies are discussed at the Cardiac Surgery Morbidity, Mortality & Governance Meetings.

There were two post-operative strokes in Q3 2020/21. One patient continues to be treated as an inpatient, and in the other case the patient was transferred for on-going stroke rehabilitation.

There were two cases of new post-operative haemodialysis in Q3 2020/21. One patient continues to be treated as an inpatient, and in the other case the patient was transferred for on-going rehabilitation.

In terms of surgical site wound infections (SSI), there were three cases in October 2020, none in November and none in December 2020; with 76 Coronary Artery Bypass Graft (CABG) operations performed in Q3 this equates to an SSI rate of 5.2%. This is above the National Benchmark SSI rate of 3.0%, but this may be a reflection of the current extraordinary circumstances of the Covid-19 pandemic, which are affecting all Cardiac Surgery Units. The Trust's Case Management Team of nurse specialists are also now routinely contacting patients following discharge, which means we may now be detecting more SSIs that were previously detected and treated in the community, but not necessarily reported back to us by GPs.

With regard to Covid-19 infection prevention and control measures, in accordance with the measures agreed at the Pan-London Emergency Cardiac Surgery (PLECS) group, all elective patients shield for fourteen days prior to their surgery, and are tested for Covid-19 infection two days before surgery. This is termed a "green pathway". Non-elective patients all have Covid-19 swabs before surgery. All patients are telephoned at least one week post-surgery to check on their continued recovery. There have been two cases of patients acquiring Covid-19 whilst in hospital following cardiac surgery. Both these patients were on a "yellow pathway"; that is patients who were admitted from their local hospital requiring urgent surgery and who had negative Covid-19 swabs prior to transfer.

1.3 Serious Incidents (SIs) that occurred, were declared or closed in Q3 2020/21

1.3.1 Open Serious Incidents (SIs)

There were no new SIs declared in Q3.

There was one SI closed in Q3 ((DW140551) (StEIS 2020/15633)) and the findings of the completed investigation will be considered by the Quality and Safety Committee on 18th February 2021.

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

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

There are three specific actions for the Trust from the Independent Mortality Review's report that remain on-going and for which an update can be provided in this report;

Recommendation 2
Each of the cardiac surgeons, the lead for cardiology, the lead for anaesthesia/ICU and the lead for perfusion should have an individualised feedback interview with clinical representatives from the Independent Advisory and Mortality review Panels.

This has now been completed.

Recommendation 3
A change of working relationships between cardiac surgery, cardiology and anaesthesia/intensive care teams should be fostered. This should include a mutually established heads of agreement document, outlining standards of inter-professional behaviour and mechanisms to ensure these values are maintained with oversight from the board.

Dr Richard Jennings and Mr Steve Livesey have met with the HR and this phase is expected to be completed in February 2021.

Recommendation 10
The Trust should continue to ensure robust consultant appraisal and job planning is in place for every consultant working in the Cardiac Surgical Unit.

Job planning is being arranged and actions to fully meet this recommendation are on-going.

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

3.1 Meeting with bereaved families

After the Trust wrote to all bereaved families to communicate the findings of the Independent Mortality Review Panel with regard to the care given to their deceased relatives (just before the publication of the report), a total of 42 families asked for meetings with the trust to discuss this further. Six of these meetings took place before the report publication date (26th March 2020). Fourteen more meetings have now been completed (eight in Q1, one in Q2 and five in Q3 – one of the Q3 meetings has requested a second meeting once we have obtained the Post Mortem report.

In terms of outstanding meetings, nine families wish to wait for a face-to-face meeting once Covid-19 restrictions are lifted, five are still deciding how they wish to proceed, seven made no reply to our enquiry in August on how they wished to proceed and two decided they no longer wished to proceed with any meeting. In January 2021 we will re-contact the families who had not decided on how to proceed or had not replied at all to see if they still wish to have a meeting and in what format.

4.0 Risk register

The table below shows the cardiac surgery risk register. Since the Q2 report to the Trust Board only the Reputational risk has been changed (CVT-1642).

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

Ref	Opened	Title	Risk level (current)	Rating (current)	Reasoning for change
CVT-1660	12/09/2018	Risk to patient safety within cardiac surgery	Moderate	8	This risk was reduced from 'high' to 'moderate' in June 2020. This change was made because of the collective assurance provided by the outcome data, including mortality, regarding safety within the Cardiac Surgery Service.
CVT-1642	29/08/2018	Reputational Impact of service challenges within Cardiac Surgery unit at St Georges	Moderate	9	This was reduced from 'high' in October 2020 by the Divisional Triumvirate as there was no evidence of a deteriorating perception of the unit.
CVT-1661	12/09/2018	Strategic risk of loss of cardiac surgery service	Moderate	8	This risk was previously closed by the Directorate in April 2020 following the publication of the Independent Mortality Review's report in March 2020, as the Report did not recommend any discontinuation of the service. However, there is a clear pan-London plan for cardiac surgery, and networking discussions continue in South-London, and so this risk is now rated as 'moderate'.
CVT-1608	23/07/2018	Loss of income within the Cardiac Surgery service	Low	4	This risk has been reduced from 'moderate' to 'low' in June 2020. Following review from the divisional triumvirate the risk was reduced to 'low' as cardiac surgery income has been appropriately factored into the trust's projected financial performance for 2020/21.

5.0 Update on Coroner's inquests

The Trust has liaised closely with HM Coroner, Professor Fiona Wilcox, throughout the time that the Independent Morality Review Panel has been carrying out their work. The Coroner has indicated to the Trust and to NHSI (and we have accordingly shared this with bereaved families) that she may have to open or reopen a number of investigations and inquests, particularly in those cases where the Panel allocated a Contribution to Death (CtD) score of 1-3. When the Coroner commences an investigation she requests the Trust to provide reports. Once she has reviewed the clinicians' reports, and other information supplied by the Trust, and other information such as the Post-mortem report, and the General Practitioner report, she will either discontinue the case, or proceed to an inquest.

The following is a summary of the number of inquests that have occurred so far and the number that are currently anticipated

1. Inquests that have taken place between 2014 – 2018 = 14
2. Inquests that took place in 2019 = 3
3. Investigations opened by the Coroner, and subsequently discontinued (where she was satisfied that the cause of death was natural) = 3

4. Since June 2020, 25 Coroner investigations have been notified to the Trust, the latest being added in November. These are cases where the Coroner has requested clinicians' reports, which are being obtained. Once these are submitted it is likely that the Coroner will schedule an inquest and require the attendance of relevant members of staff to give evidence. Two cases are now scheduled for March 2021.
   Of these 25 cases the following outcomes of concluded Investigations are of note:
   - Case 52 (CtD score of 2) was heard on 22nd September 2020. Conclusion of Coroner: Natural causes
   - Case 2 (CtD score of 3) was heard on 4th December 2020. Conclusion of Coroner: Recognised complications of urgent surgical treatment
   - Case 3 (CtD score of 2) was heard on 16th December 2020. Conclusion of Coroner: Natural causes and complications of essential surgical treatment
   - Case 66 (CtD score of 2) was heard on 16th December 2020. Conclusion of Coroner: Natural causes in combination with essential surgical treatment.

It is anticipated that the Coroner will notify us of more investigations, given that she has indicated that she may have to open investigations and possibly inquests into those cases in particular where the CtD score was 1 – 3.

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

6.0 Developing changes in the Trust's Cardiac Surgery service in response to Covid-19

After the first wave of Covid-19, the Trust restarted cardiac surgery on the St George's site on 2nd June 2020, but with a further surge in Covid-19 cases had to limit operations to urgent Inter-Hospital Transfer cases from 15th December 2020 onwards.

As noted above in section 1.2, elective patients were all shielded for 14 days prior to their surgery, and had tested swab negative for Covid-19 infection two days prior to surgery; this is known as a "green pathway" and they are nursed separately from patients who are not on a "green pathway". Since the 8th July 2020, the Trust has been accepting non-shielded patients for cardiac surgery; these patients are also tested to ensure they are negative for Covid-19 ahead of surgery; this is known as a "yellow pathway".

Due to theatre availability, the Trust had the capacity to operate on up to 14 patients per week in Q3. In common with all London Cardiac Surgery Units, elective referrals have fallen from pre-Covid-19 levels. The cardiac surgery waiting list has fallen from 113 patients on 1st July 2020 to 69 patients on 30th September 2020 and then risen to 75 patients on 31st December 2020. The current and projected capacity and demand for cardiac surgery across South London is regularly reviewed in joint meetings between Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust and St George's, and the projections and plans have been reviewed at regional level at the Programme Board.

The Trust has developed Covid, Flu and Winter Plans, which describe how it will accommodate an increase in the number of patients needing ITU care as a result of Covid-19 infection. This resulted in the conversion of Ben Weir into an ITU in December 2020. Cardiac surgery patients are now nursed on the Heart Failure Unit (which has 16 beds). This will clearly impact on cardiology and cardiac surgery activity levels. It is intended that all London Cardiac Surgery Units will continue to undertake planned surgery while the Covid-19 situation permits. Reverting to the previous PLECS arrangement of maintaining the London service at Barts Health NHS Trust and Royal Brompton and Harefield NHS Foundation Trust is still under discussion.

7.0 Developments towards networking cardiac surgery in South London

Throughout period of the Covid-19 emergency, the three lead surgeons from Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust and St George's have continued to meet regularly via a virtual platform and are committed to the principle of closer working for cardiac surgery across South London. Virtual multi-disciplinary meetings (MDTs) are held on a daily basis, shared by the three Trusts.

The South London ODN is now focusing on the response to Covid-19 and has developed a pathway for urgent priority 2 patients to be treated at the London Bridge Hospital. The Royal Brompton and Harefield NHS Trust have all agreed to accept urgent P2 patients from the South London ODN if needed.

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

The SGUH Programme Board meetings were originally designed to oversee the St George's response to the Independent Mortality Review; the focus of these meetings now concentrates on issues around closer networking arrangements for cardiac surgery in South London.

The Single Item Quality Surveillance meetings review the progress of St George's cardiac surgery. The group last met on 20th November 2020. The meetings are now to be held quarterly instead on monthly. The next meeting will be on 8th March 2021.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

2.3

Meeting Title:	**Trust Board**		
Date:	28 January 2021	**Agenda No**	**2.3**
Report Title:	Integrated Quality & Performance Report		
Lead Director/ Manager:	James Friend, Chief Transformation Officer Anne Brierley, 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 December 2020. Because of current operational pressures due to COVID-19, the report does not include updates on actions and progress. Verbal updates on actions and improvement projects will be provided at the Committee meeting. **Our Finance & Productivity** In December, outpatient activity was 111% of previous year's activity; however, excluding COVID-19 activity, the activity was 94% of the previous year. Daycase and Elective activity was 85% of previous year's activity with the expectation that this will rise to 93% once coding is complete. Length of Stay for elective and non-elective admissions have increased significantly showing special cause variation. **Our Patient Perspective** The rate of 2222 calls and the rate of cardiac arrests per 1,000 adult inpatient admissions were both above the upper control limit reflecting the acuity of patients. The completion of Treatment Escalation Plans (TEP) also increased in December with 41.5% of inpatients having a completed TEP. There were two Never Events and thirteen Category 3 pressure ulcers reported in December. All services except the emergency department (ED) achieved their targets of having "Good" or "Very Good" overall ratings as measured by the Friends and Family Test. **Our Process Perspective** The Trust's Four Hour Operating Standard performance was 84.6% with high acuity level patients presenting to ED and impaired patient flow. For November, the following three of the seven cancer standards were met: • 62-day screening referral to treatment • 31-day subsequent drug treatment, and • 31-day subsequent surgery treatment The six-week diagnostic standard was 22.6% in December compared to 20.0% in November. However, the waiting list size reduced by 4.3%.		

	November 2020's RTT performance was 71% against a National target of 92% with 1,261 patients waiting longer than 52 weeks. **Our Workforce Perspective** Trust level sickness absence rate shows common cause variation at 3.9% compared to 3.3% in November. COVID-19 Risk Assessment form completion rate was 85.1% with Medical and Dental Staff having the lowest completion rate of 60%. Agency cost was on target with £1.25m spend against a target of £1.25m. The largest area of underspend was Nursing at £0.23m		
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:			
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:			
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Equality and Diversity:			
Previously Considered by:	Finance & Investment Committee Quality & Safety Committee	**Date**	21 Jan 21 21 Jan 21
Appendices:			

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

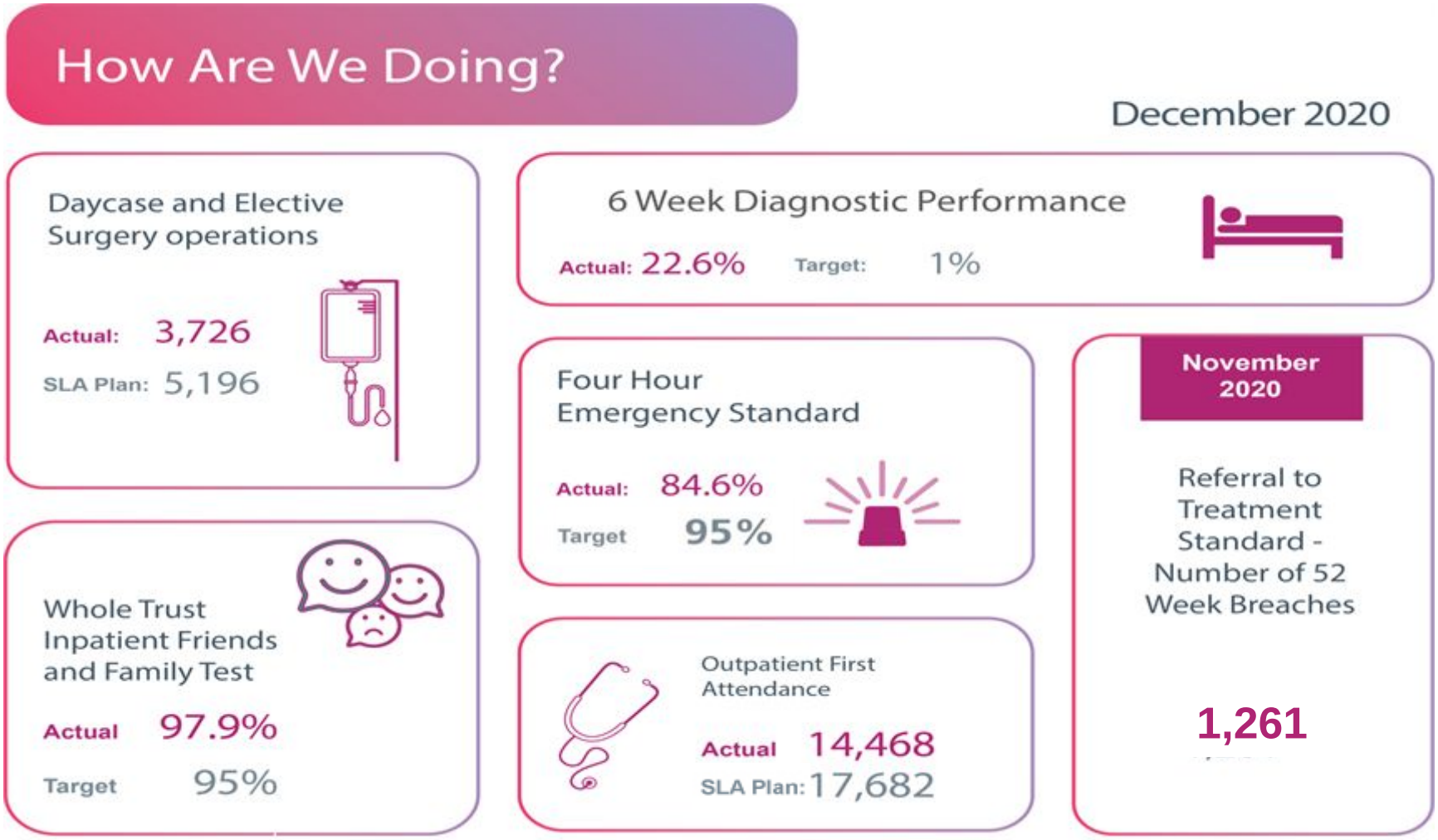
Integrated Quality and Performance Report

For Trust Board
Meeting Date – 28 January 2021

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

28 January 2021

Our Outcomes



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

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Executive Summary – December 2020

Finance & Productivity Perspective	• DC/EL activity was 85% of 19/20 activity
	• OP activity was 94% of 19/20 activity
	• Length of Stay for EL and NEL have increased significantly showing special cause variation
		Process Perspective	• Four Hour Standard was 84.6% with high acuity level patients presenting to ED
			• Patients staying in excess of 7, 14 or 21 days have risen consistently from a low in March 2020
			• For November, three of seven cancer standards met:
			  • 62 day screening referral to treatment
			  • 31 day subsequent drug treatment, and
			  • 31 day subsequent surgery treatment
			• Six week diagnostic standard was 22.6% with waiting list reduced by 4.3%
			• RTT for November
			  • RTT incomplete performance 71%
			  • 1,261 patients waiting over 52 weeks

Patient Perspective	• Two Never Events reported • Thirteen Category 3 Pressure Ulcers showing special cause deterioration • The 2222 call rate and the cardiac arrest rate remained above the upper control limit reflecting patient acuity • COVID-19 nosocomial infections continue to increase in December • Completion of Treatment Escalation Plans (TEP) has maintained its upward trajectory with 41.5% completion rate • Due to a change in systems for Friends and Family Test (FFT) in emergency department (ED), response rates fell from 23% to 9% • All services achieved FFT targets except ED	**People Perspective**	• Trust sickness absence rate was 3.9% • COVID-19 risk assessment form completion rate was 85.1% with Medical and Dental staff lowest at 60% • In month agency spend returned to target at £1.25m

Verbal update to be given on actions on the above issues

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 R	Patient Voice A
OUR **PROCESS** PERSPECTIVE	Emergency Flow A	Cancer A	Diagnostics	On the day cancellations A	18 Week Referral to Treatment	
OUR PEOPLE PERSPECTIVE	Workforce	Agency Use A	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 compared to previous year			Activity against plan YTD	
		Dec-19	Dec-20	Variance	SLA Plan Dec-20	Variance	YTD 19/20	YTD 20/21	Variance	Plan YTD	Variance
ED	ED Attendances	13,799	9,579	-30.58%	14,775	-35.17%	127,679	81,590	-36.10%	131,069	-37.75%
Inpatient	Non Elective	4,383	3,651	-16.70%	4,463	-18.19%	39,876	28,738	-27.93%	39,923	-28.02%
	Elective & Daycase	4,500	3,726	-17.20%	5,196	-28.29%	47,963	30,059	-37.33%	50,397	-40.36%
Outpatient	OP Attendances	43,610	41,056	-5.86%	48,210	-14.84%	447,100	387,266	-13.38%	461,151	-16.02%

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

Note: Figures quoted are as at 11/01/2021 and do not include an estimate for activity not yet recorded e.g. 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**. Activity data presented above is now based on POD1

Phase 3 recovery plans are covered in the following slide which includes breakdowns by key specialties and includes estimates of catch up activity.

Phase 3 Implementation- Elective Incentive Scheme

Note: These figures are taken from SLAM, with national figures being taken from SUS. Whilst these 2 data sources are reconcilable, there are explainable differences. Therefore, the below should be taken as valid directionally, rather than exactly correct as per national counting. The Trust is currently working on updating activity reporting inline with national currency. The Trust is also working with NHSI/E colleagues on a more detailed evaluation of the guidance from the Phase 3 letter. The below analysis is based on current understanding.

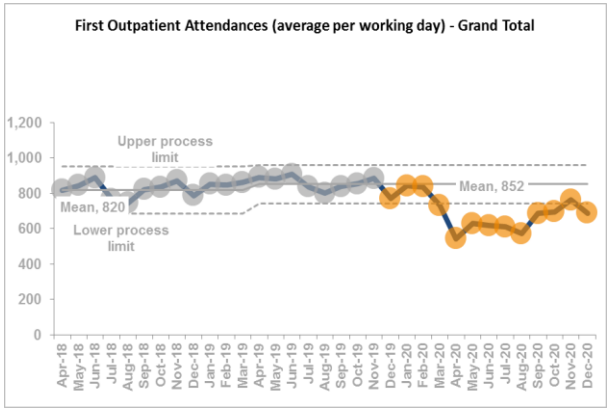
- The letter 'Third Phase of NHS Response to COVID-19' dated 31 July 2020 from NHSE/I sets out expectations for activity performance for Trusts in the latter part of the financial year 2020/21.
- From September 2020 onwards, systems are expected to deliver at least 80% of last year's activity for both overnight electives and for day case procedures, rising to 90% from October through the balance of the year and 100% of last year's activity for outpatient attendances from September through the balance of the year.
- December's expected performance is adjusted for catch-up based on M6-8 catch up levels for each specialty. **93% for Elective and Daycase against target by 90%; 111% for Outpatients against target 100%.** The Trust has been advised on a financial penalty for adverse performance in earlier months, which is being clarified centrally. For information, Non Elective performance is 80% compared to last year.
- Endoscopy Performance in Daycase & Elective is skewed by Bowel Scope Screening activity (331 in December 2019) that has not been given the go ahead to restart in 2020/21.

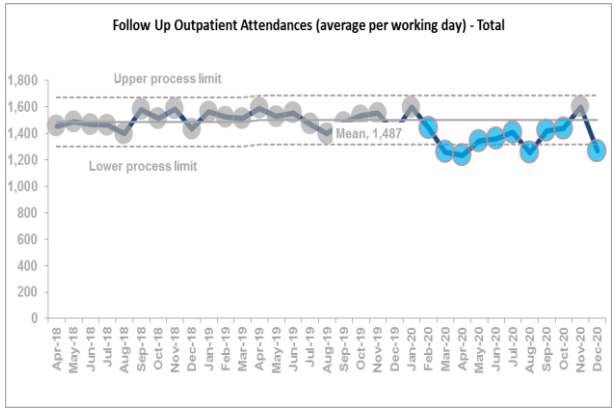
DAYCASE & ELECTIVES					
Specialty	Last Year December	This Year December	% of Previous Year Activity	This Year December updated for catch-up based on Nov /Oct/Sept	% of Previous Year Activity Updated
Endoscopy	1,131	628	56%	687	61%
Neurology	494	550	111%	592	120%
Plastic Surgery	316	267	84%	295	93%
Paediatric Medicine	260	261	100%	280	108%
Urology	221	288	130%	324	147%
Cardiology	201	166	83%	171	85%
Gynaecology	179	133	74%	141	79%
Neuro Surgery	167	114	68%	119	71%
ENT	140	108	77%	117	84%
Paediatric Surgery	139	168	121%	172	124%
Other	1,112	1,025	92%	1,156	104%
TOTAL	**4,360**	**3,708**	**85%**	**4,055**	**93%**
TARGET DECEMBER					**90%**
VARIANCE					**3%**

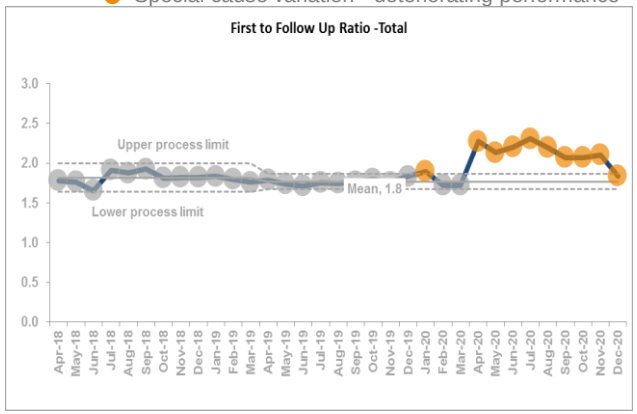
OUTPATIENTS					
Specialty	Last Year December	This Year December	% of Previous Year Activity	This Year December updated for catch-up based on Nov /Oct/Sept	% of Previous Year Activity Updated
Dermatology	3,191	3,089	97%	3,208	101%
Gynaecology	2,750	1,927	70%	2,406	88%
Diabetes/Endocrinology	2,730	2,224	81%	2,232	82%
Chest Medicine	2,477	1,827	74%	2,082	84%
Neurology	2,435	2,067	85%	1,990	82%
Cardiology	2,405	2,328	97%	2,439	101%
Trauma & Orthopaedics	2,330	1,686	72%	1,686	72%
Rheumatology	1,944	1,844	95%	1,773	91%
Paediatric Medicine	1,875	1,610	86%	1,777	95%
Gastroenterology	1,847	1,591	86%	2,247	122%
Other	24,422	28,275	116%	31,741	130%
TOTAL	**48,406**	**48,468**	**100%**	**53,580**	**111%**
TARGET DECEMBER					**100%**
VARIANCE					**11%**

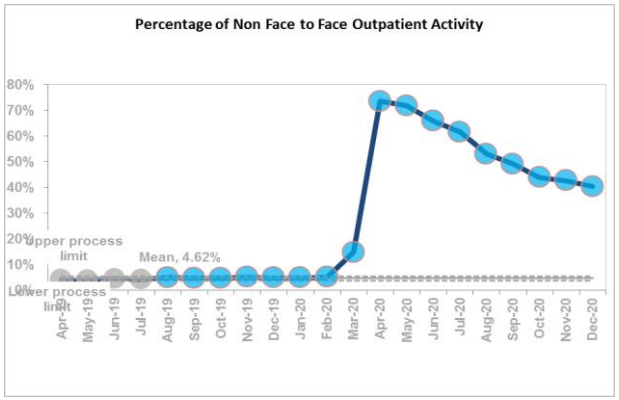
Outpatient Productivity

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









Actions and Quality Improvement Projects

Verbal update to be given

What the information tells us

Outpatient (OP) first activity remains below the mean with 689 outpatient first attendances per day compared to 762 in November; 10.5% lower than the same period last year. All areas have seen a decrease in activity throughout December however, Cardiology, Cardiovascular & Vascular Services, and Trauma & Orthopaedics show activity levels remaining below the lower control limit. Other services although reporting activity lower compared to last year have seen activity this month within the upper and lower control limits.

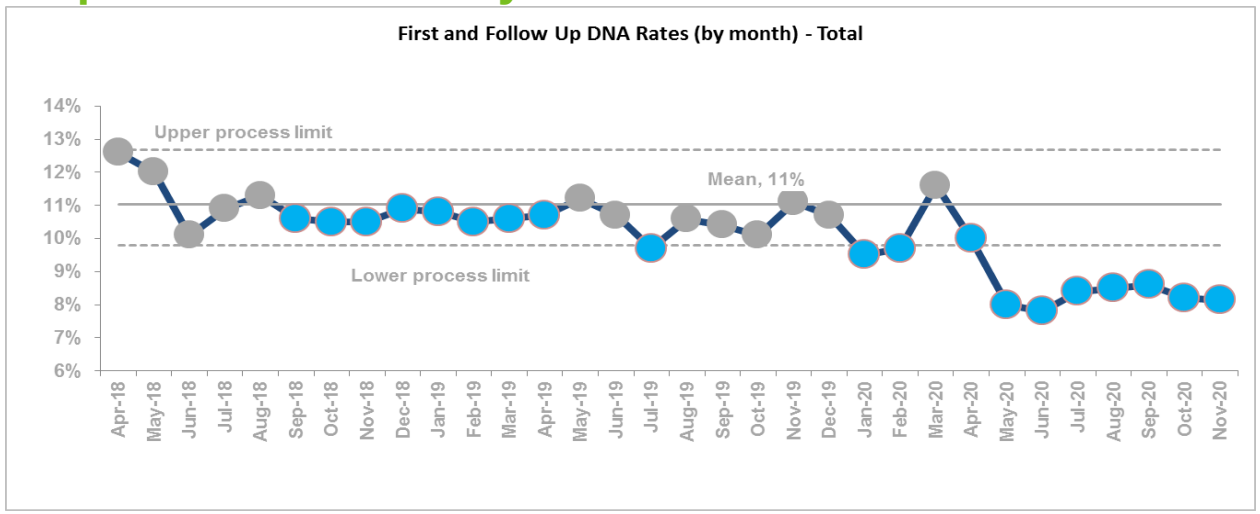
At Trust level, follow-up activity has seen a decrease in activity with on average 1,266 attendances per day compared to 1,600 in November. Neurosciences and Renal & Oncology services report activity below the mean, which is consistent with the previous two months. In December, Cardiology, Cardiothoracic & Vascular Services. Specialised Medicine, Surgery and Women's services saw activity higher than the same period last year.

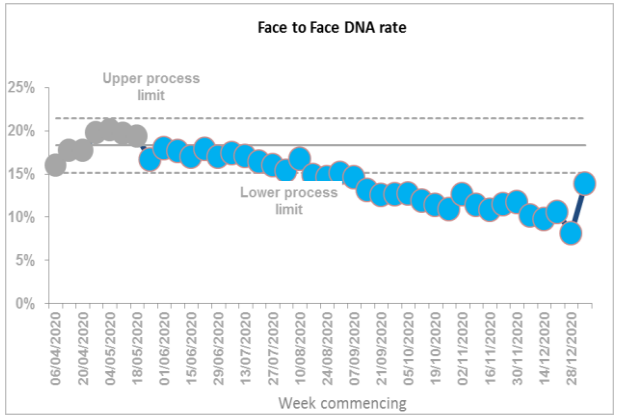
In total, all outpatient activity in December 2020 was 94% of the activity reported in the same month last year. In last month's IQPR, 47,206 Outpatient attendances in November were reported whereas, due to catchup, November's activity increased to 49,592 (an additional 2,386 outpatient appointments).

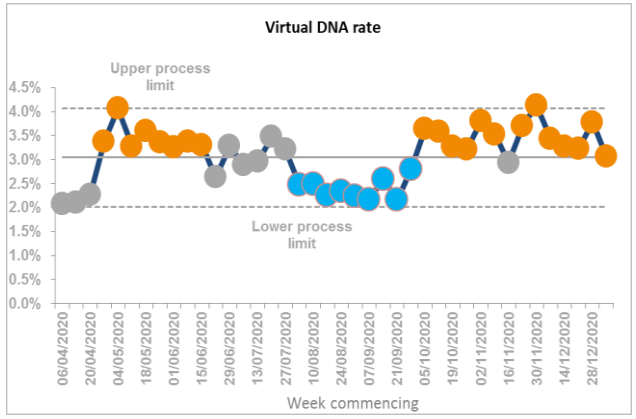
Please note that COVID-19 related OP activity in this financial year has been excluded from the charts.

In December, 40% of our outpatient appointments were undertaken in a virtual setting, seeing a decrease month on month.

Outpatient Productivity – DNA Rates







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

What the information tells us

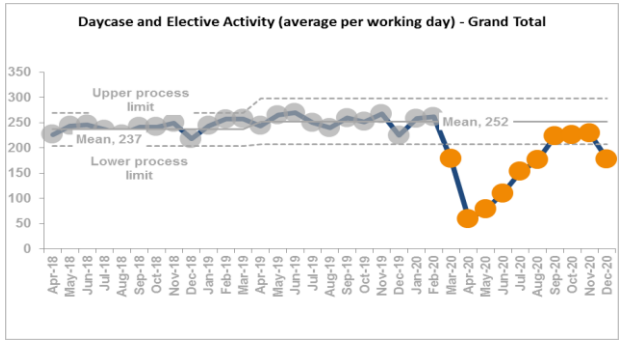
Although overall outpatient activity remains lower than normal, the DNA rate in December remains below the lower control limit with 7.7% of patients not attending their scheduled appointment.

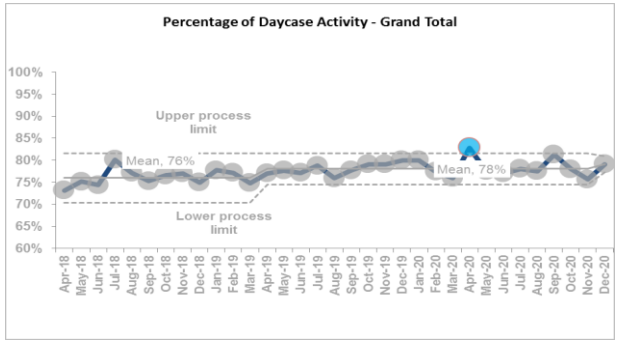
Although the DNA rate for patients attending a face to face (F2F) appointment remains below the lower control limit, there remains a significant difference when compared to patients seen in a virtual setting. Face to face DNA's has seen a recent decline however we have seen this increase in the first week of January.

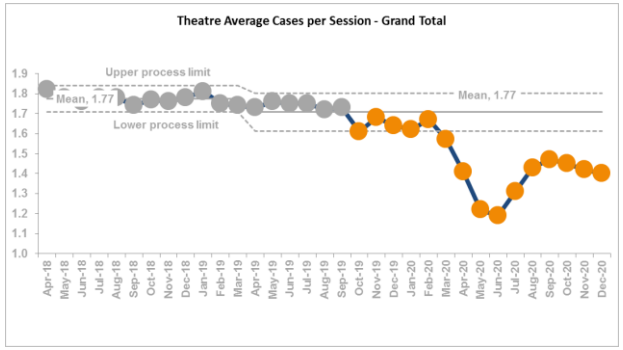
Actions and Quality Improvement Projects

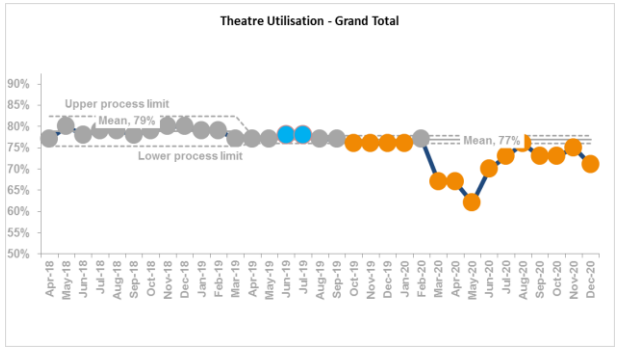
Verbal update to be given

Elective Activity & Theatre Productivity









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

What the information tells us

Elective activity in December fell below the lower control limit after a steady increase through to November. On average there were 177 patients were treated per day compared to 229 in November and 225 per day in the same month last year (not all this activity is theatre based). Overall elective activity was 85% of last years activity (Dec 19).

All areas with the exception of Pediatric Medicine reported a fall in activity within the month although many remain within the upper and lower control limits. An element of data catch up remains through the coding of activity.

In December, Theatres ran 749 theatre sessions, 97% of the number of sessions in the same month last year.

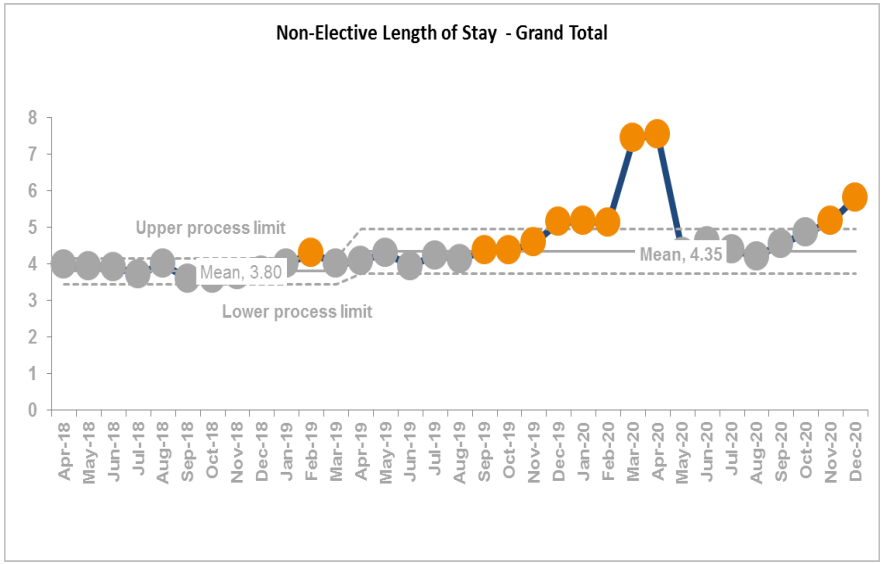
Both Trust level theatre cases per session and utilisation in December was lower compared to the previous month particularly within Neurosurgery. Theatres continue to adhere to process changes implemented as a result of COVID-19.

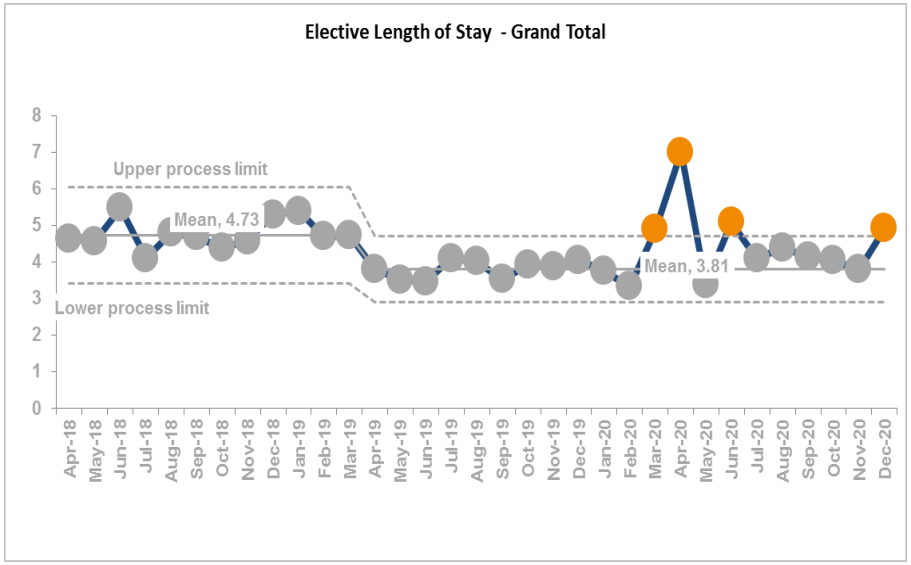
Patients that have been treated though the Independent Sector are included within the activity data, however there is an element of data catch up through coding and we expect this to increase once complete.

Actions and Quality Improvement Projects

Verbal update to be given

Length of Stay





What the information tells us

Non-elective length of stay has seen an increase over the past two months moving above the upper control limit in December. On average patients admitted to a hospital bed stayed for 5.8 days compared to 5.2 days in November. Increases in the month have particularly been seen within General Medicine and Infectious Diseases where we have seen the number of patients being admitted for COVID-19 increase. Throughout December we have seen the number of non-elective admissions increase with the acuity of the patients rising. The increase in length of stay is also reflective of the number of patients we have in our wards with a length of stay greater then 7, 14 and 21 days.

Elective length of stay has also seen an increase moving above the upper control limit in December reporting on average patients staying 4.9 days compared to 3.8 days in November. Neurosciences and Clinical Haematology increases have impacted the overall increase

Actions and Quality Improvement Projects

Verbal update to be given

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

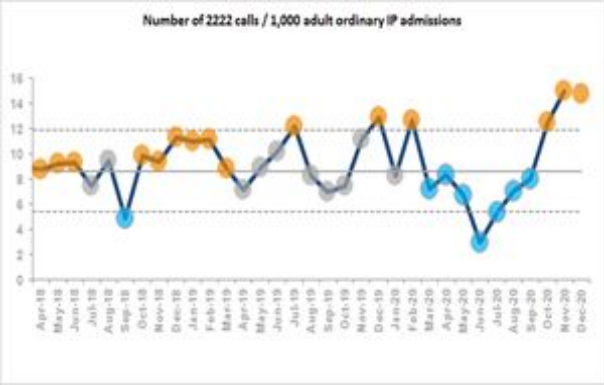
Key

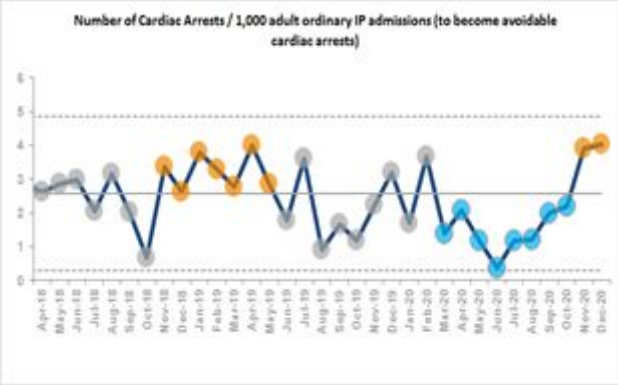
Current Month

A Previous Month

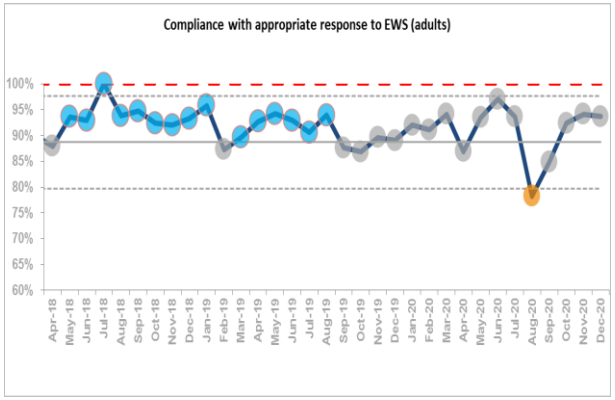
Scorecard RAG rating based on PreCOVID-19 plan

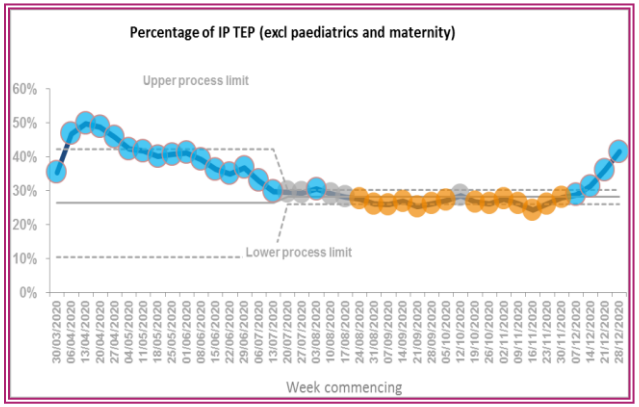
Quality Priorities – Treatment Escalation Plan





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





What the information tells us

- The rate of 2222 calls per 1,000 Inpatient (IP) admissions and the rate of cardiac arrests showed special cause variation.
- Compliance with appropriate response to Early Warning Score (EWS) remained at 94% this month and continues to show common cause variation.
- Treatment Escalation Plans (TEP) form compliance was rebased as at 6 July 2020 when lockdown was lifted. In December, there has been a significant special cause increase in TEP completion rates

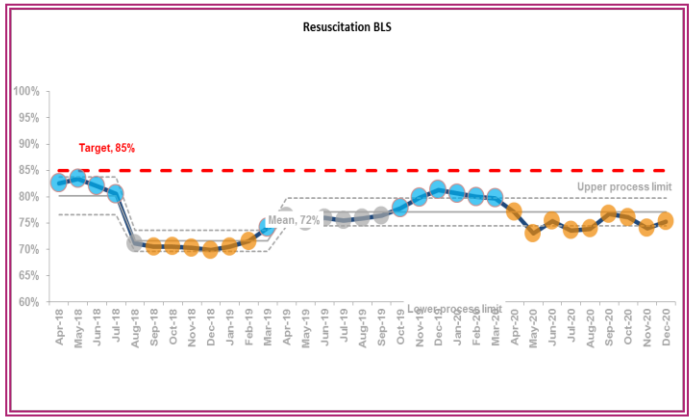
Actions and Quality Improvement Projects

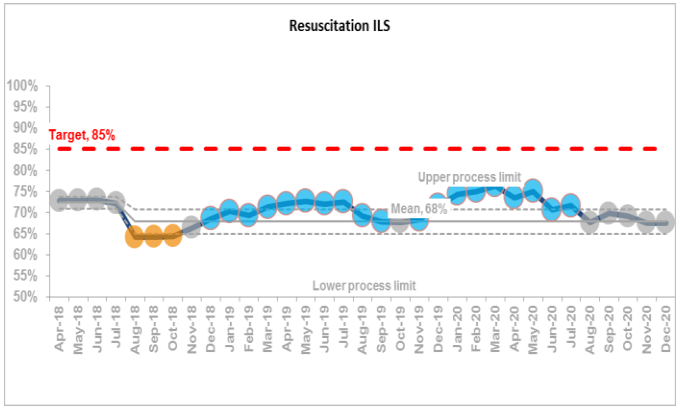
Verbal update to be given

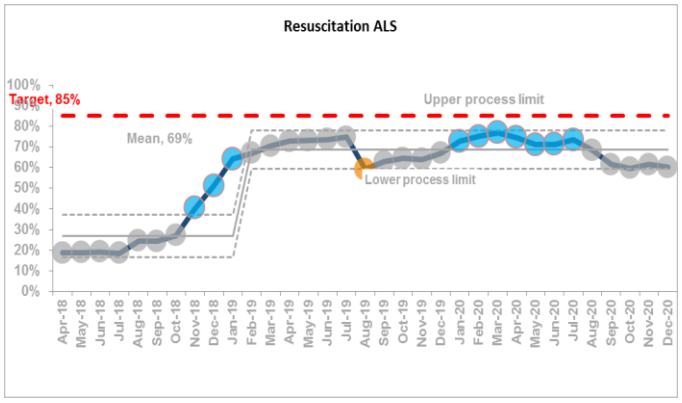
2.3

Our Patient Perspective

Quality Priorities – Deteriorating Patients







- BLS (Basic Life Support) training performance shows special cause variation with performance at 75%.
- ILS (Intermediate Life Support) continues to show common cause variation.
- ALS (Advanced Life Support) training performance remains within common cause variation.
- All training life support training modules have not reached their targets.

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

Actions and Quality Improvement Projects

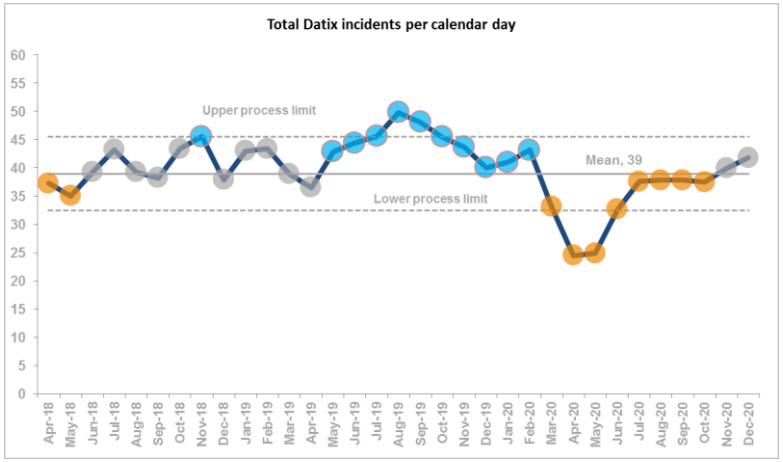
Verbal update to be given

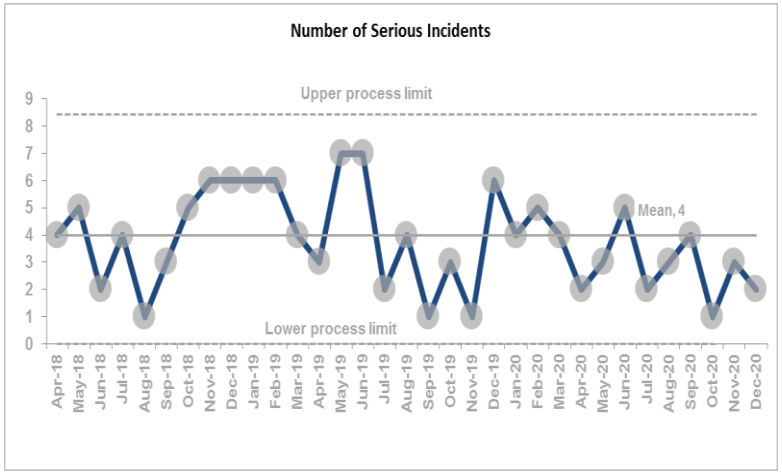
2.3

Our Patient Perspective

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Monthly percentage of Incidents of Low and No Harm		96.0%	96.0%	96.0%	93.0%	93.0%	94.0%	95.0%	97.0%	97.0%	95.0%	97.0%	95.0%	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%	86.0%	94.0%	82.0%	86.0%	84.0%	80.0%	89.0%	87.0%	93.0%	92.0%	93.0%	data two months in arrears	
Total Datix incidents per calendar day		40	41	43	33	24	25	33	38	38	38	37	40	42





What the information tells us

- Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- There were two Never Events in December 2020.

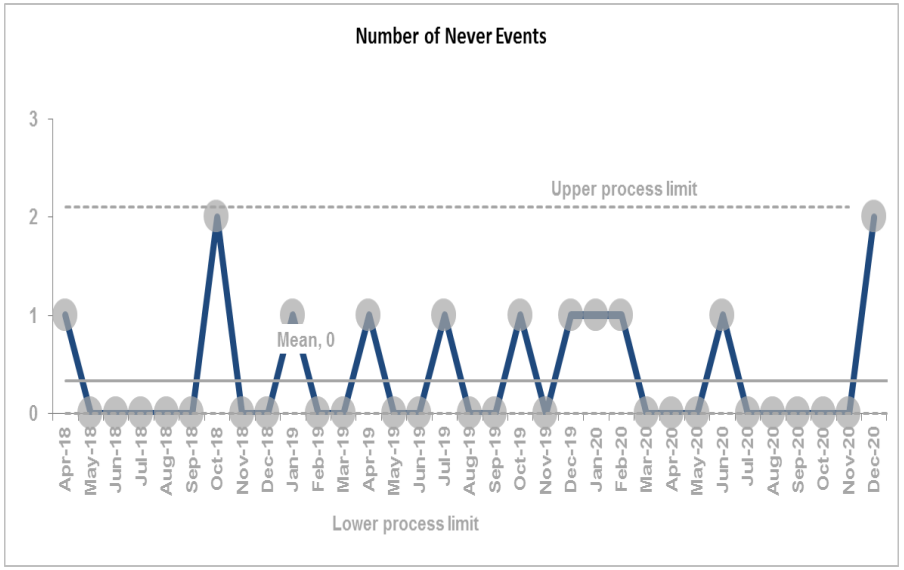
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

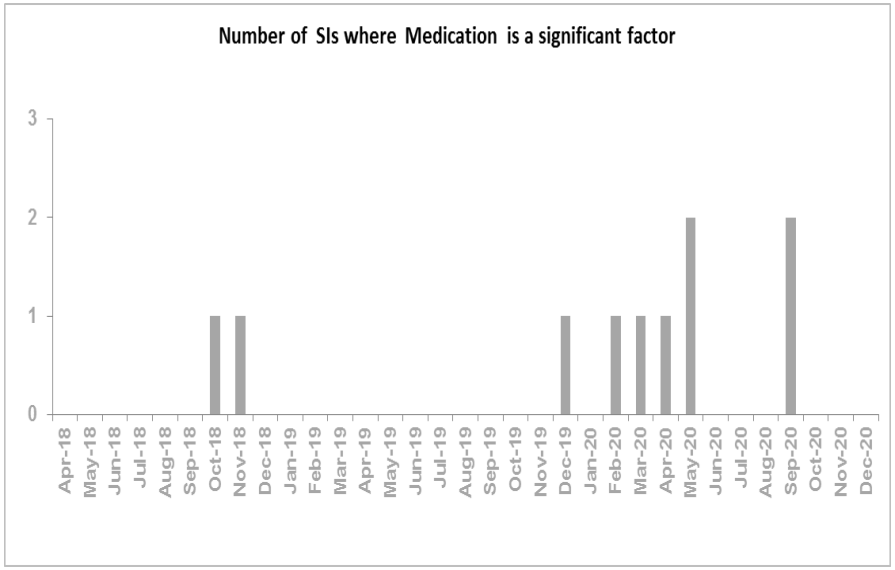
Actions and Quality Improvement Projects

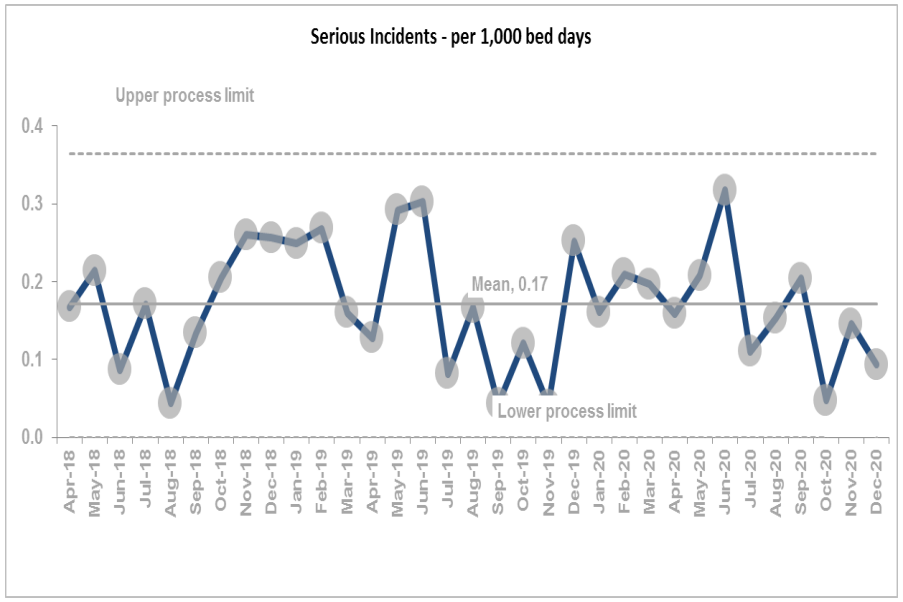
Verbal update to be given

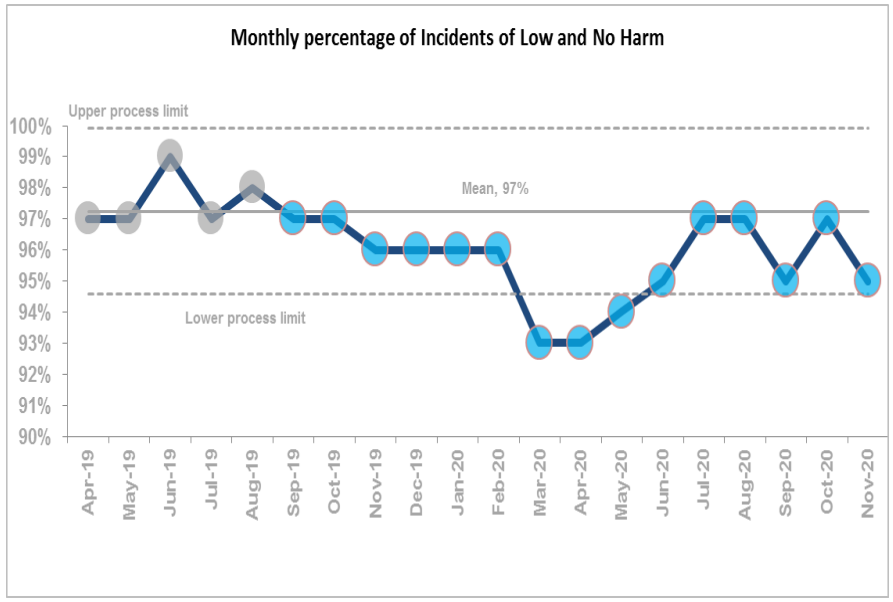
Quality Priorities – Learning from Incidents

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



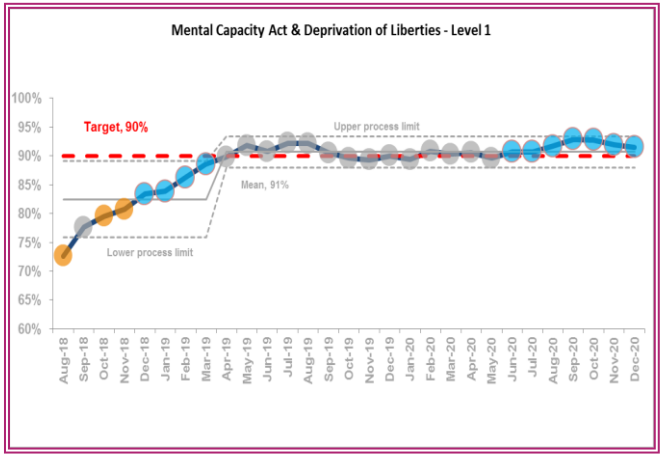


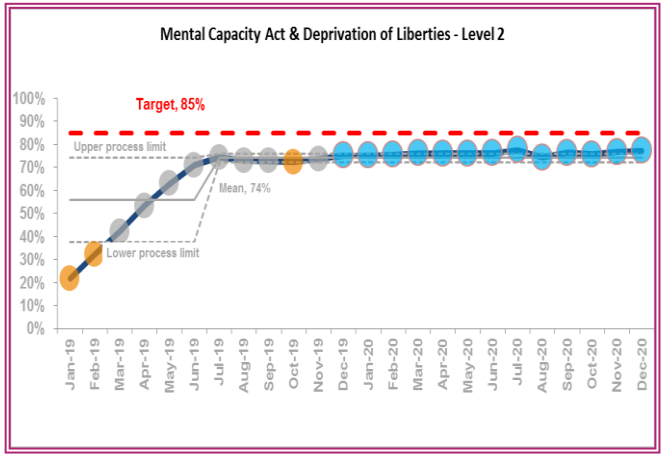


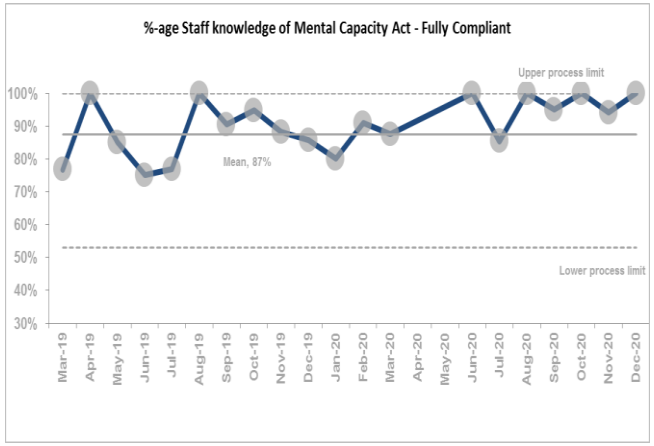


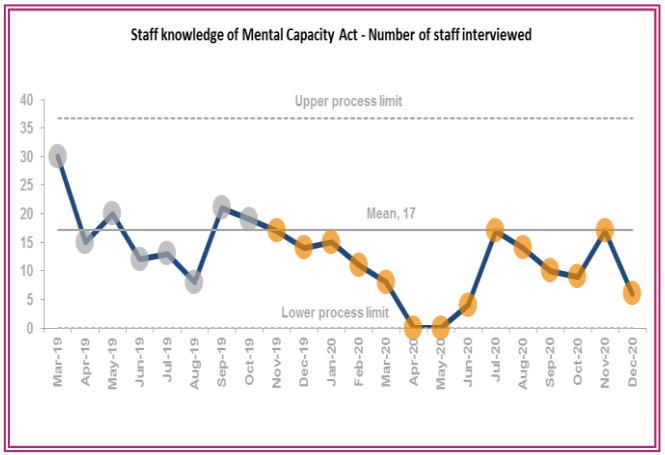
Data is 1 month in retrospect.

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









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

What the information tells us

- Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 is above target.
- Level 2 training performance has plateaued. Overall Level 2 compliance was 77% this month.
- Metrics showing the number of staff interviewed and their level of knowledge was suspended in April and May due to COVID-19 and recommenced in June 2020.

Actions and Quality Improvement Projects

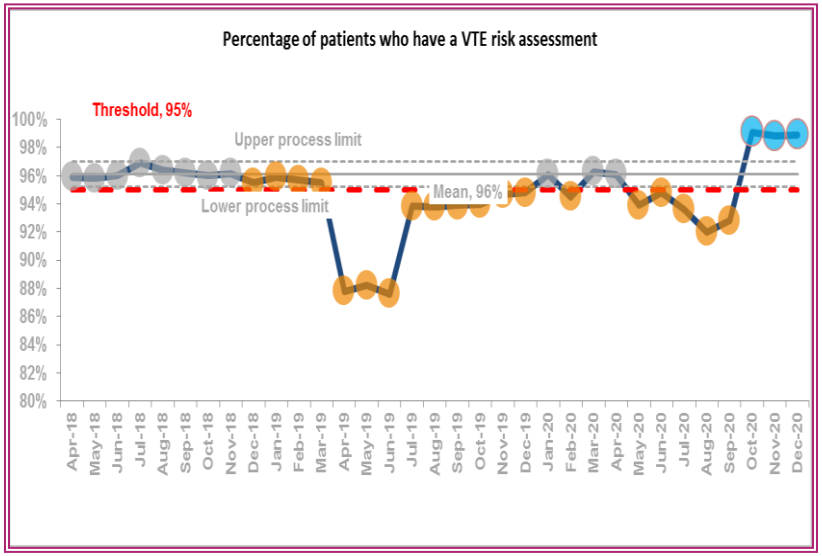
Verbal update to be given

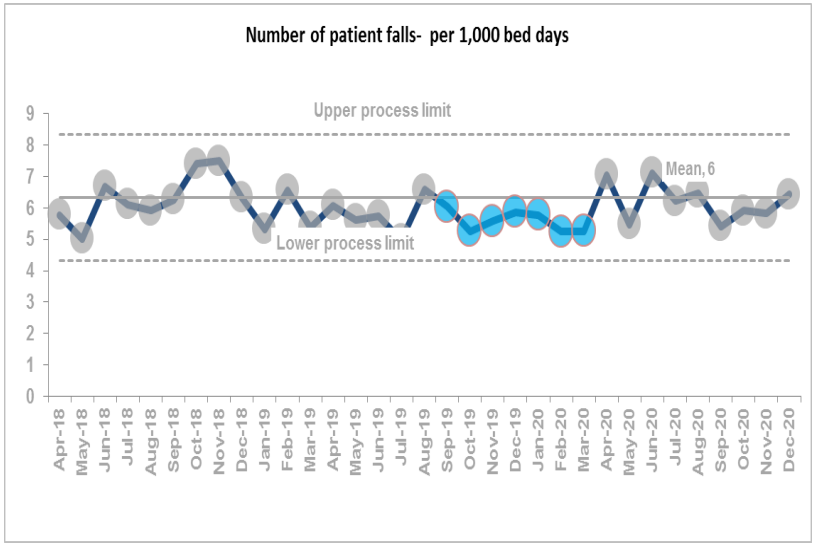
2.3

Our Patient Perspective

Patient Safety

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





What the information tells us

- The percentage of patients who have had a VTE risk assessment was 98.9% against a target of 95%
- The total number of Patient Falls (next slide) show special cause improvement however the Number of Patient Falls per 1,000 bed days show common case variation with the number of bed days over the same period decreasing.
- The number of Category 2 Pressures ulcers shows special cause improvement with seven months consistently below the mean (next slide).
- The number of Category 3 Pressure ulcers shows special cause deterioration in December.

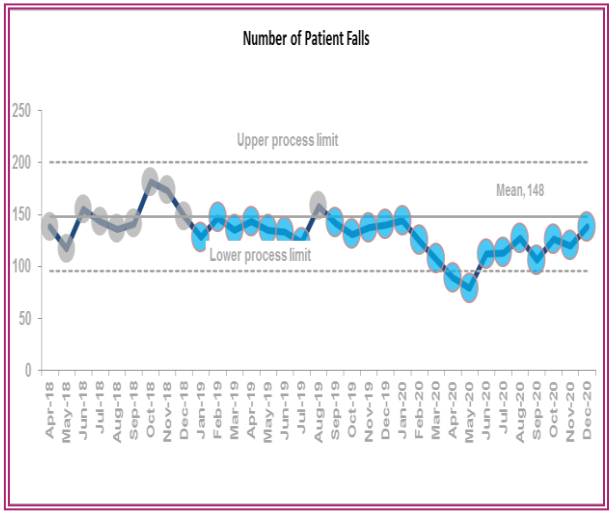
Actions and Quality Improvement Projects

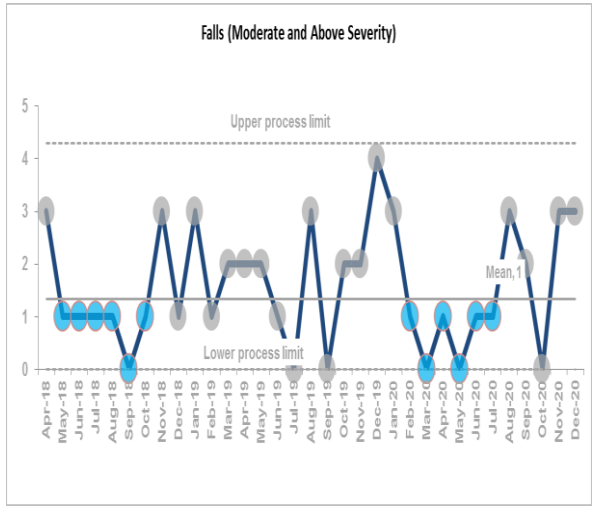
Verbal update to be given.

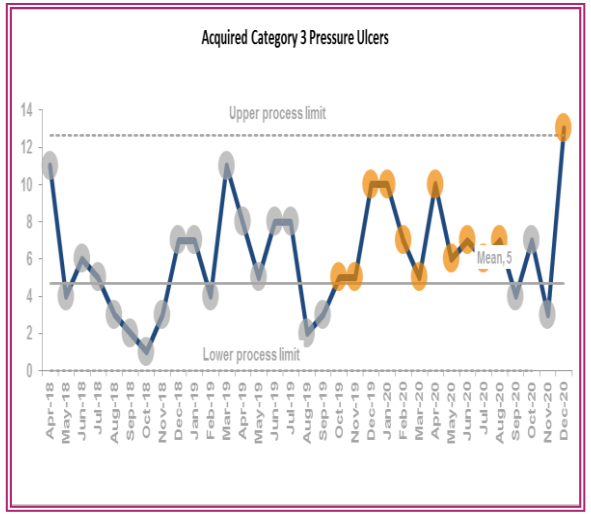
Our Patient Perspective

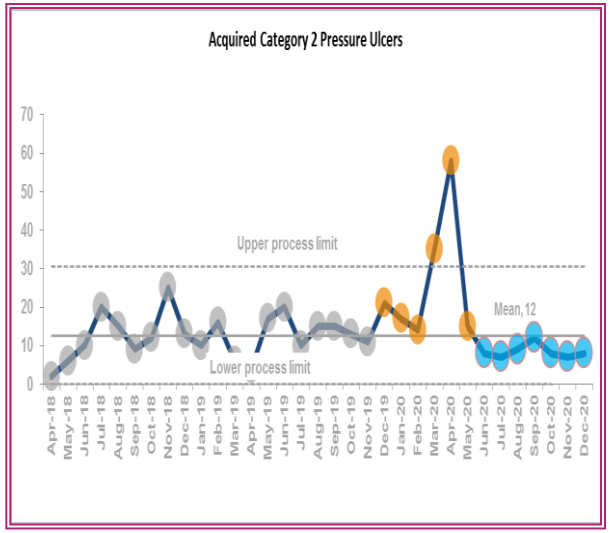
Patient Safety

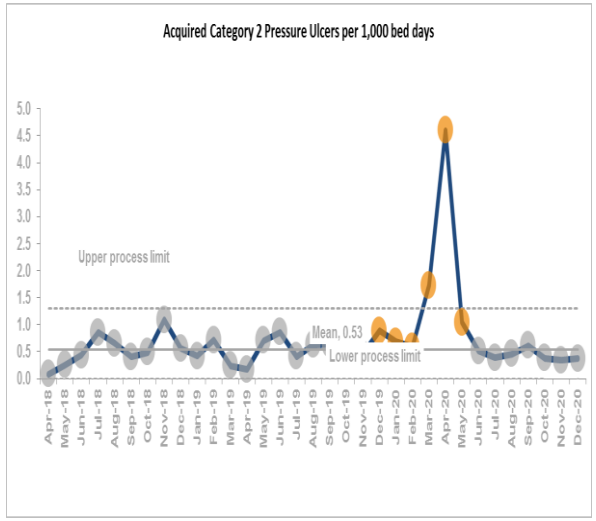
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance







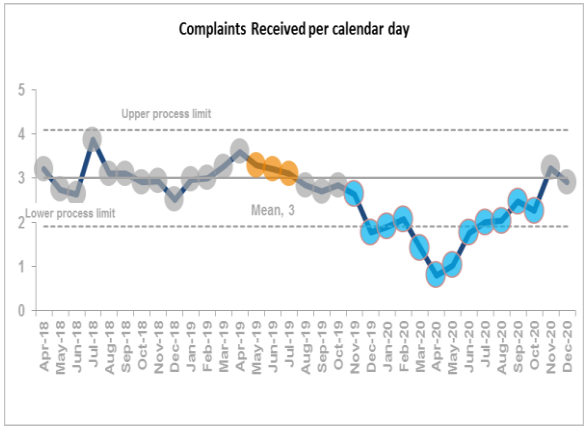


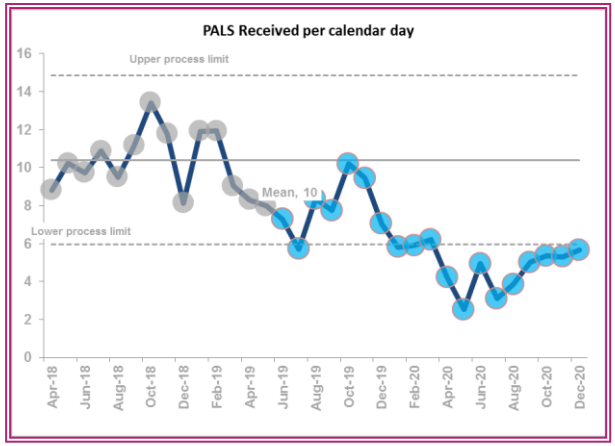


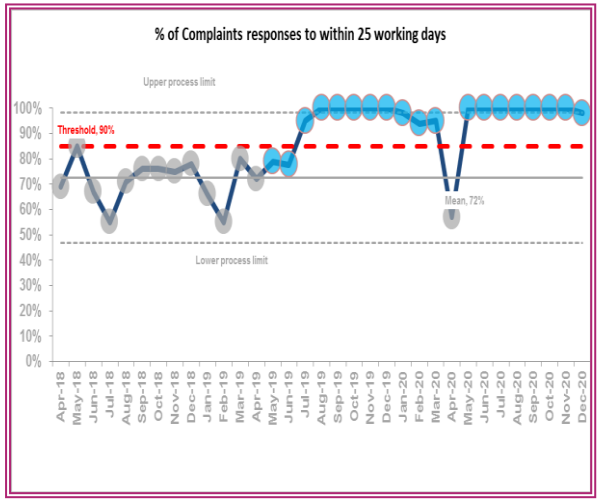
Our Patient Perspective

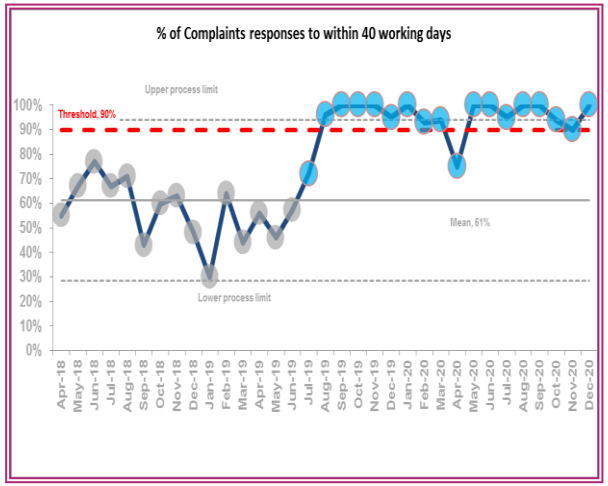
Complaints

Indicator Description	Target	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Complaints Received per calendar day		2	2	2	1	1	1	2	2	2	2	2	3	3
% of Complaints responses to within 25 working days	85%	100%	98%	94%	95%	57%	100%	100%	100%	100%	100%	100%	100%	98%
% of Complaints responses to within 40 working days	90%	95%	100%	93%	94%	75.0%	100%	100%	95%	100%	100%	94%	90%	100.0%
% of Complaints responses to within 60 working days	100%	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	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 has returned to common cause variation with volumes increasing as activity increases.
- All response categories show special cause variation.
- Patient Advice Liaison Service (PALS) contacts at time of reporting are provisional and are currently being validated

Actions and Quality Improvement Projects

Verbal update to be given

Infection Control

Indicator Description	Threshold 2020-2021	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Actual
MRSA Incidences (in month)	0	1	0	0	0	0	0	0	0	1	1	0	0	0	2
Cdiff Hospital acquired infections	48	2	5	3	1	1	3	5	4	3	2	0	5	5	33
Cdiff Community Associated infections		0	0	0	2	0	0	1	0	0	1	0	0	3	
MSSA	25	5	6	3	2	3	0	2	5	4	2	3	5	4	28
E-Coli	60	9	5	7	4	4	8	3	3	0	6	5	3	9	41
Nosocomial Infections Hospital Onset healthcare associated (>14 days) HOHA	N/A								0	0	0	7	28	62	97
Nosocomial Infections Hospital Onset Probable associated (8-14 days) HOPA	N/A								0	1	0	0	28	76	105

What the information tells us

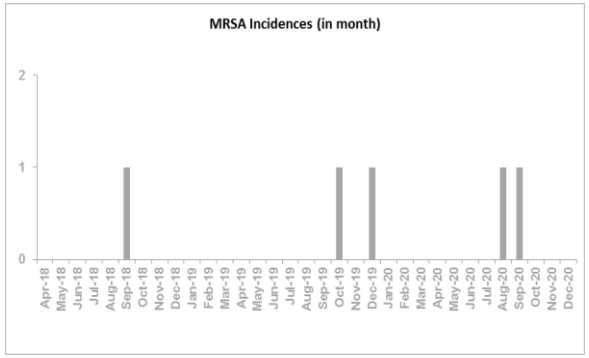
- There were no MRSA bacteraemia reported in December.
- During December there were five cases of hospital onset *C.difficile* infections. There have been a total of 33 cases of *C.difficile* infection (April to December) against a presumed trajectory of no more than 48 cases for the year and no more than 36 for the period April – December; indicating the Trust is below threshold. These consist of 28 hospital onset cases where the specimen was taken more than two days after admission and five Community onset where the specimen was taken on admission day or the next day. Targets for *C.difficile* infections for 2020-21 have not been set on a National basis. Cases are currently being measured on the trajectory for 2019/20 with the aim of having no more than 48 cases.
- MSSA and *E.coli* remains within control limits.
- COVID-19 Hospital onset hospital acquired (HOHA) diagnosed > 14 days after admission, and Hospital onset probable hospital associated (HOPA) where COVID-19 was diagnosed 8-14 days after admission continues to increase.

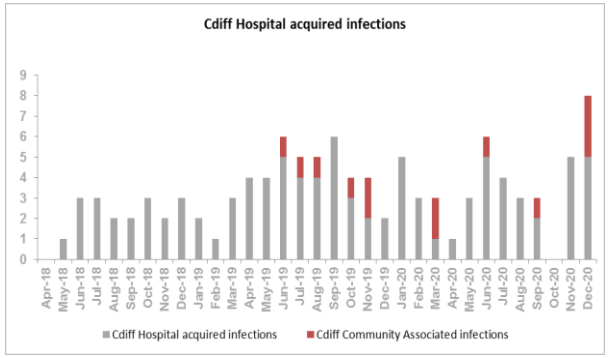
Actions and Quality Improvement Projects

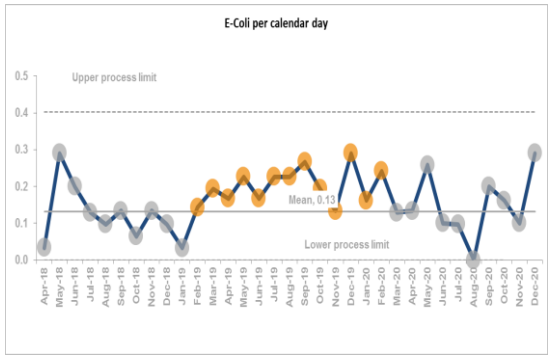
Verbal update to be given

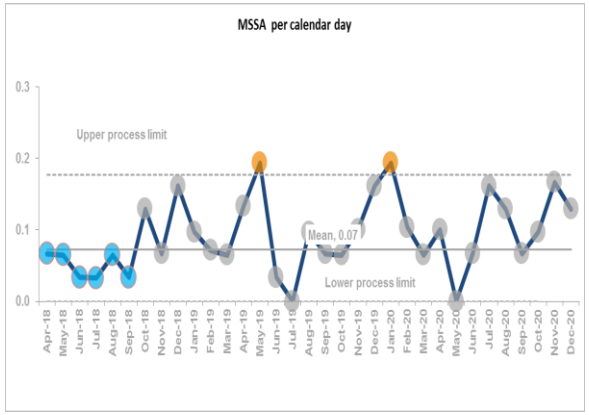
Infection Control

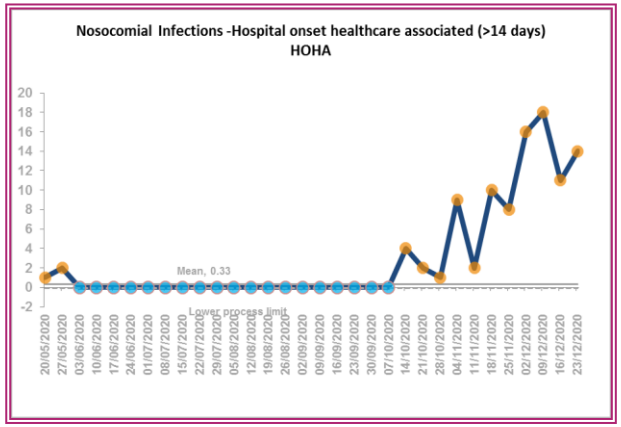
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

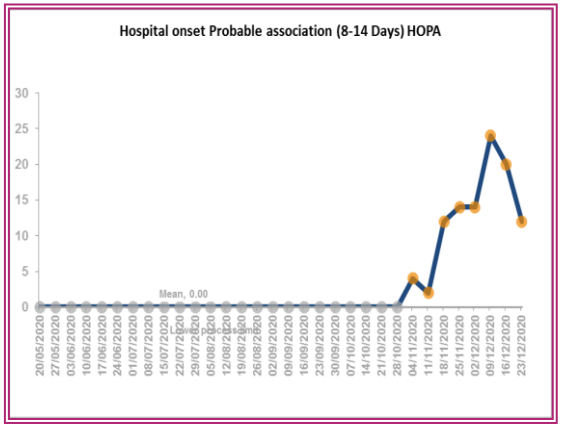












2.3

Our Patient Perspective

Mortality and Readmissions

Indicator Description	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct 2019 to Sep 2020
Hospital Standardised Mortality Ratio (HSMR)	105.5	87.9	92.1	88.5	95	101.6	91.4	90.2	64.1	105.8	81.8	59.3	82.7	81.9	75.0	93.7
Hospital Standardised Mortality Ratio Weekend Emergency	113	77.2	93.8	107.3	80.6	100.1	87.6	112.3	68.4	102.7	62.7	66.8	91.1	96.3	150.6	102.0
Hospital Standardised Mortality Ratio Weekday Emergency	100.4	90.8	96.2	80.4	102.9	102.9	90.8	90.1	57.4	96.7	87.5	54.7	74.3	77.8	69.2	91.5

Indicator Description	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	May-19-Apr-20	June-19-May-20	July-19-June-20	Aug-19-Jul 20
Summary Hospital Mortality Indicator (SHMI)	0.83	0.83	0.83	0.85	0.85	0.85	0.86	0.88	0.89	0.89	0.88	0.88	0.87	0.87

Indicator Description	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	9.9%	7.9%	10.7%	10.1%	10.4%	11.3%	11.1%	9.7%	9.5%	9.4%

Note: HSMR data reflective of period October 2019 – September 2020 based on a monthly published position. This month we see discharges to September 2020.
SHMI data is based on a rolling 12 month period and reflective of period August 2019 to July 2020 published (Dec 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 August 2019 – July 2020. We are one of 14 trusts in this category, and one of 11 trusts that also had a lower than expected number of deaths for the same period in the previous year. Our latest HSMR, for the 12 months from October 2019 to September 2020 also shows our mortality to be lower than expected.

Looking specifically at emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend. SHMI and HSMR have taken differing approaches to managing the impact of COVID-19, which is now 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 all COVID-19 activity.

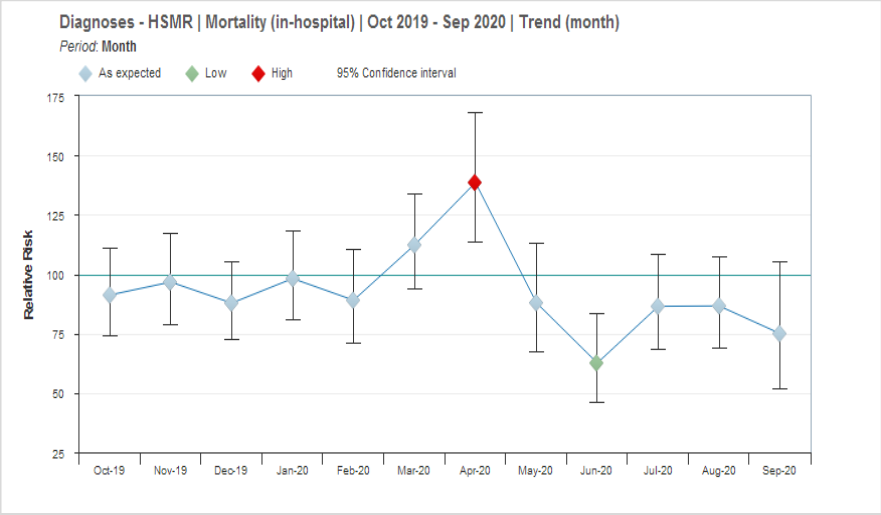
Actions and Quality Improvement Projects

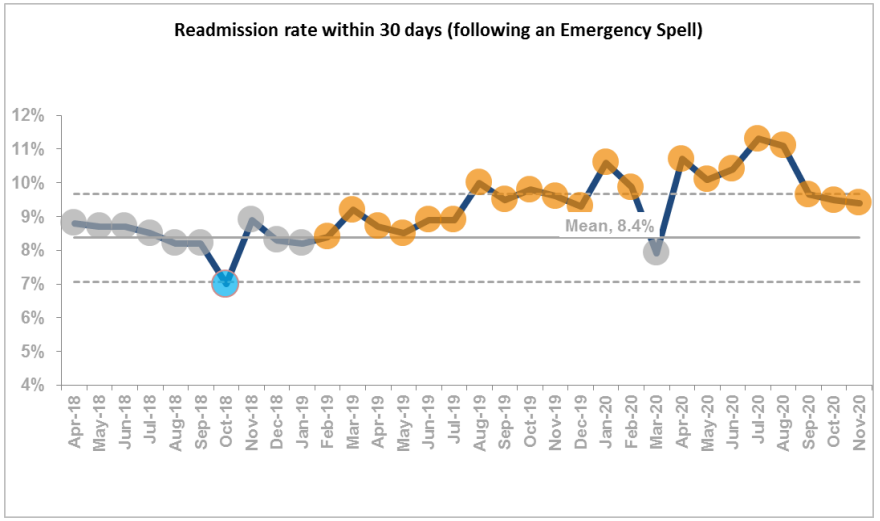
We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Committee (MMC). There are currently investigations underway related to cardiology, intracranial injury and major trauma; the progress of each is being overseen by the committee and the committee will be receiving updates on these in January.

Mortality and Readmissions (Hospital Standardized Mortality Rate)

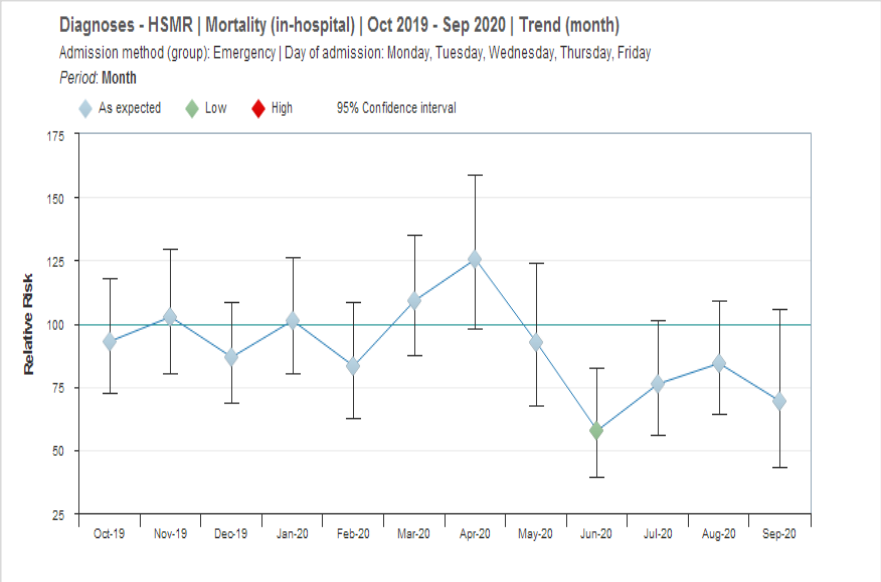
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

HSMR

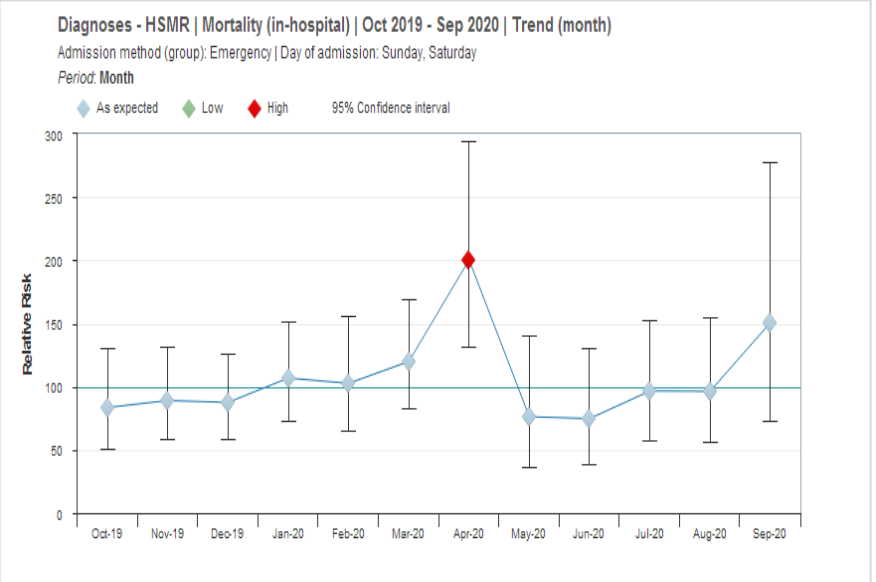




HSMR Weekday

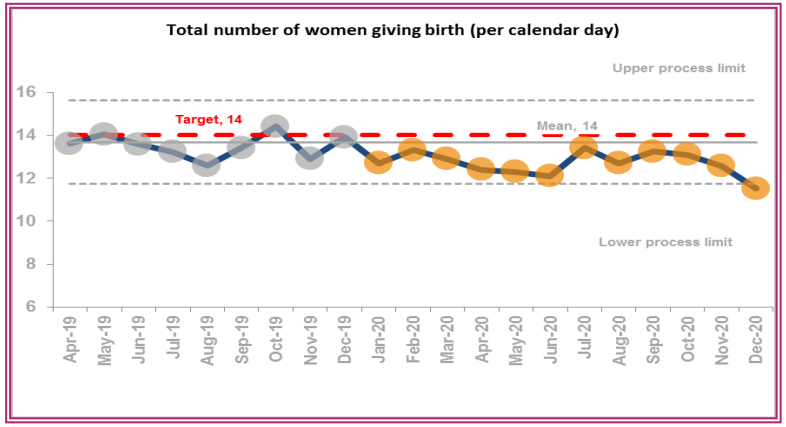


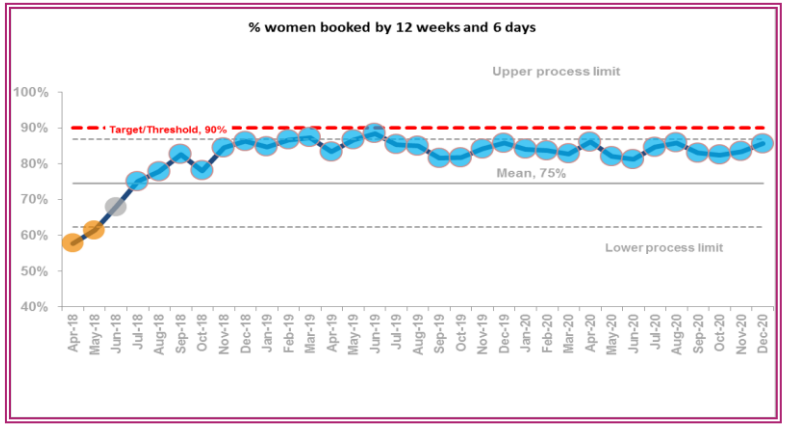
HSMR Weekend



Maternity

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





What the information tells us

The birth rate dropped this month, as expected from the drop in bookings earlier in the year during the first months of the COVID-19 pandemic. The overall caesarean section rate also reduced further in month compared to the peak in October.

Midwifery staffing has been a challenge during the month, as demonstrated by the fall in the percentage of time Carmen Suite was open and the reduction in number of shifts where the coordinator was supernumerary. Although further midwives started in the month, many more were off work due to COVID-19 issues of self-isolation or positive tests. Staffing was re-organised to prioritise safety for all women.

There were two stillbirths during the month which were both pre-term. During the full year of 2020, there was sadly one intrapartum stillbirth (during labour or birth), down from two in 2019.

The number of women booked to receive Continuity of Carer increased to 1 in 3, with 30% of Black, Asian and Mixed Race women being booked onto these pathways. Analysis of outcomes for women receiving continuity showed a higher percentage having vaginal birth compared to the rate overall

Actions and Quality Improvement Projects

Birthrate Plus review is underway.

Trust response to Ockenden Report - Recommendations to be submitted to Local Maternity System (LMS) in January.

Communication with Women regarding Maternity response to COVID-19 pandemic continues to be a priority.

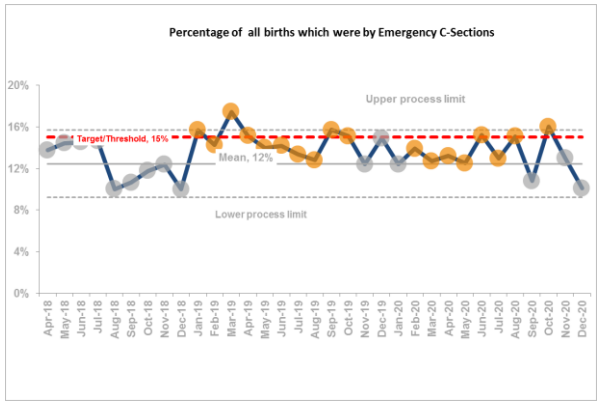
Maternity

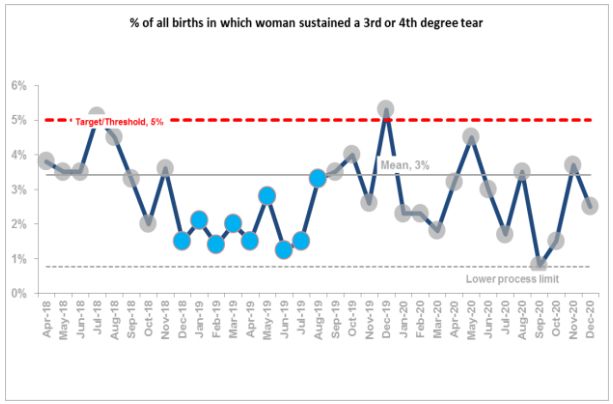
Maternity Dashboard

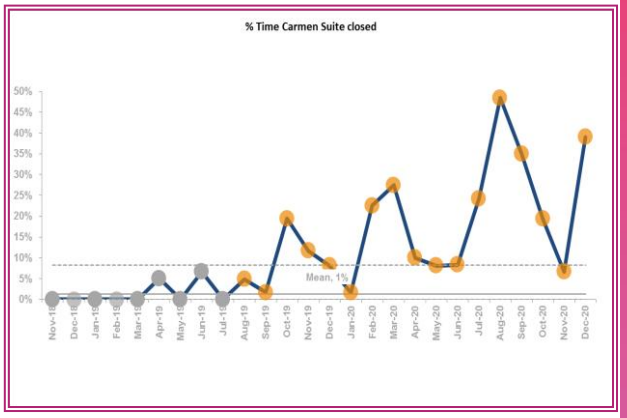
Definitions	Target	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Total number of women giving birth (per calendar day)	14 per day	13.9	12.7	13.3	12.9	12.4	12.3	12.1	13.4	12.7	13.2	13.1	12.6	11.5
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	26.7%	24.8%	26.0%	23.3%	24.9%	22.3%	29.4%	24.1%	27.1%	23.4%	30.9%	27.3%	23.8%
% deliveries with Emergency C Section (including no Labour)	<8%	4.0%	1.3%	3.6%	3.3%	1.9%	2.6%	2.7%	3.1%	4.6%	3.0%	3.7%	2.9%	3.4%
% Time Carmen Suite closed	0%	8.1%	1.6%	22.5%	27.4%	10.0%	8.1%	8.3%	24.2%	48.4%	35.0%	19.4%	6.7%	39.0%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	5.3%	2.3%	2.3%	1.8%	3.2%	4.5%	3.0%	1.7%	3.5%	0.8%	1.5%	3.7%	2.5%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	3.0%	1.5%	2.1%	1.8%	2.9%	2.1%	1.4%	1.9%	2.0%	5.3%	2.5%	2.9%	2.5%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		11	12	11	13	9	9	15	20	11	13	20	16	11
Supernumerary Midwife in Labour Ward	>95%	96.8%	96.8%	94.8%	93.5%	100.0%	96.8%	96.7%	96.8%	93.5%	90.0%	100.0%	98.3%	91.9%
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	<2	3	0	0	0	0	0	4	0	0	1	0	0	3
Still Births per 1000 Births	<3	4.6	2.5	7.8	10.0	8.0	7.9	8.2	16.9	12.6	2.5	7.4	5.3	5.6
Neonatal Deaths	<3	1	2	1	1	1	1	3	1	0	1	5	1	2
Continuity of Care Bookings- % of total bookings made	35%	21.2%	18.8%	17.0%	18.8%	20.0%	16.8%	21.3%	23.0%	21.4%	27.3%	23.6%	28.3%	29.7%
Percentage of all births which were by Emergency C-Sections	15%	14.9%	12.4%	13.9%	12.7%	13.2%	12.5%	15.2%	12.9%	15.1%	10.8%	16.0%	13.0%	10.1%
% women booked by 12 weeks and 6 days	90%	85.7%	84.0%	83.6%	82.7%	86.1%	82.0%	81.2%	84.6%	85.8%	83.0%	82.4%	83.4%	85.6%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	2.6%	3.0%	2.9%	3.3%	2.4%	0.2%	4.1%	4.8%	2.8%	3.3%	5.1%	4.1%	2.8%

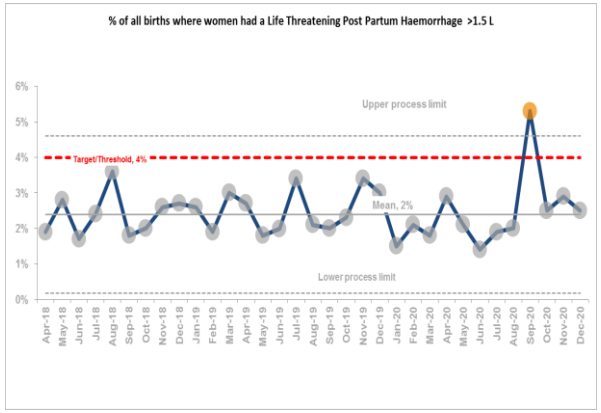
Maternity

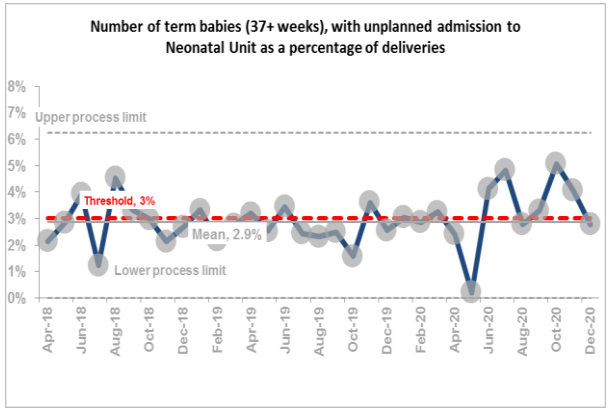
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

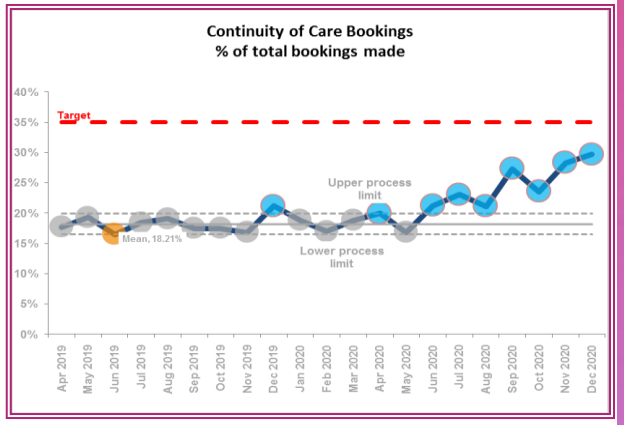












Friends & Family Survey

Indicator Description	Target	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Emergency Department FFT - % positive responses	90%	80.3%	84.2%	86.2%	87.8%	93.9%	93.6%	90.0%	89.7%	90.1%	89.5%	89.7%	89.2%	80.6%
Inpatient FFT - % positive responses	95%	96.9%	96.8%	96.6%	97.2%	100.0%	97.2%	93.6%	97.7%	97.2%	96.3%	97.1%	98.6%	97.9%
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	N/A	N/A	N/A	N/A	N/A	N/A	100.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	94.1%	100.0%	100.0%	N/A	100.0%	N/A	100.0%	N/A	66.7%	N/A	89.2%	100.0%
Maternity FFT - Postnatal Ward - % positive responses	90%	88.0%	90.7%	96.9%	100.0%	N/A	0.0%	0.0%	89.9%	100.0%	N/A	100.0%	100.0%	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%	98.0%	90.0%	100.0%	N/A	100.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community FFT - % positive responses	90%	97.7%	100.0%	98.6%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Outpatient FFT - % positive responses	90%	90.3%	89.9%	89.9%	91.7%	98.2%	89.9%	88.8%	90.3%	89.1%	89.0%	89.1%	89.5%	90.4%

What the information tells us

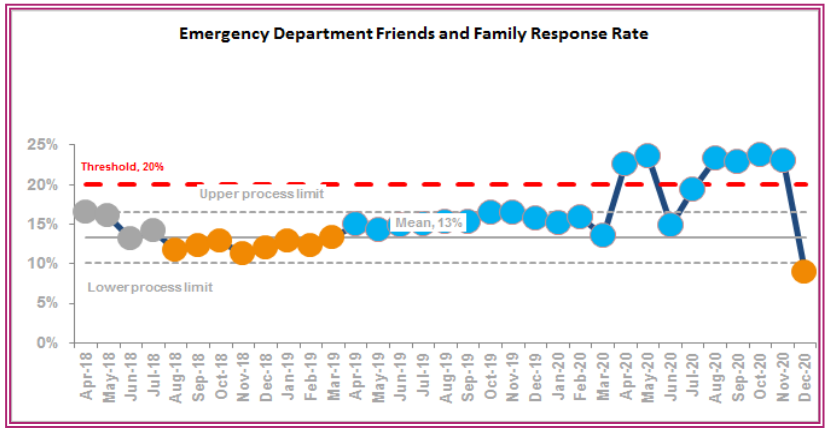
- Inpatients, Maternity Postnatal Ward and Community services have continued to exceed their target for positive FFT responses.
- Maternity delivery had just two responses in December 2020. Maternity FFT survey collection had been paused due to COVID-19 as per NHS England and Improvement directives.

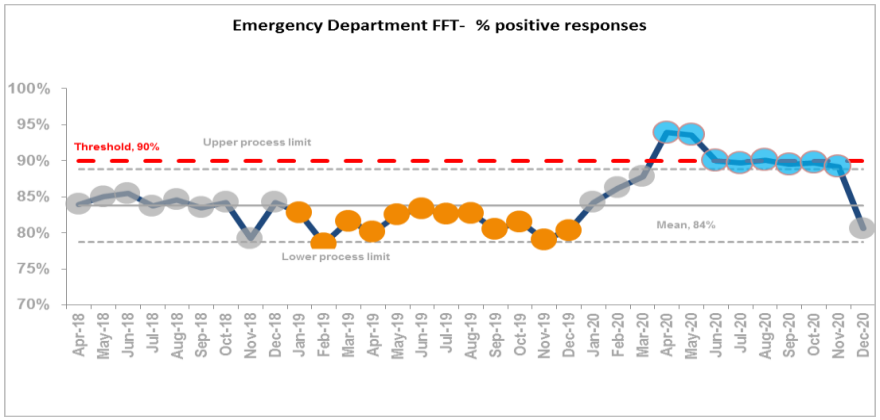
Actions and Quality Improvement Projects

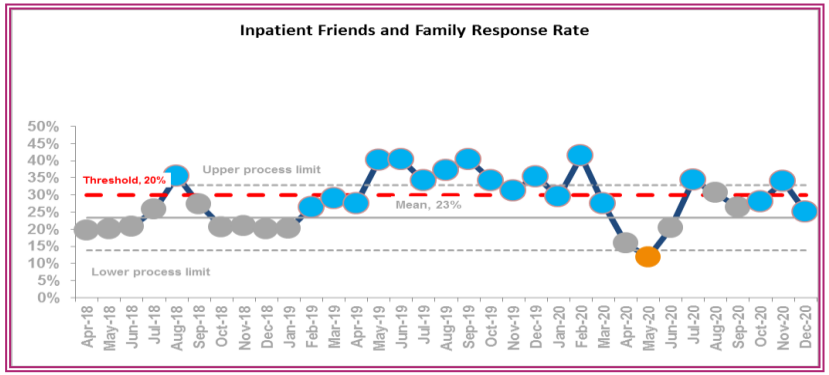
- Verbal update to be provided

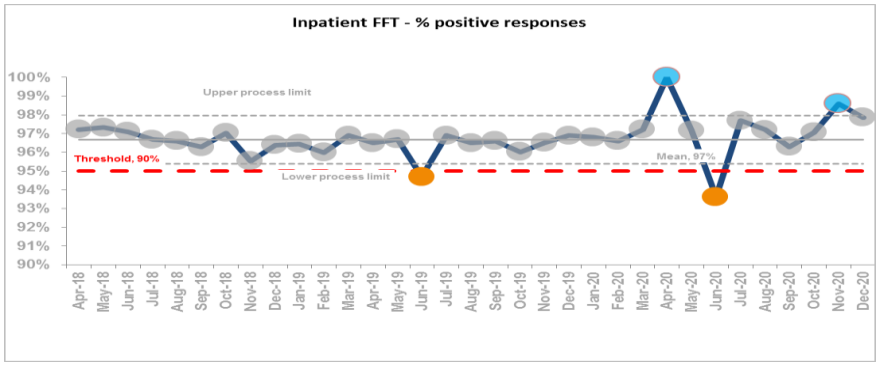
Friends and Family Test

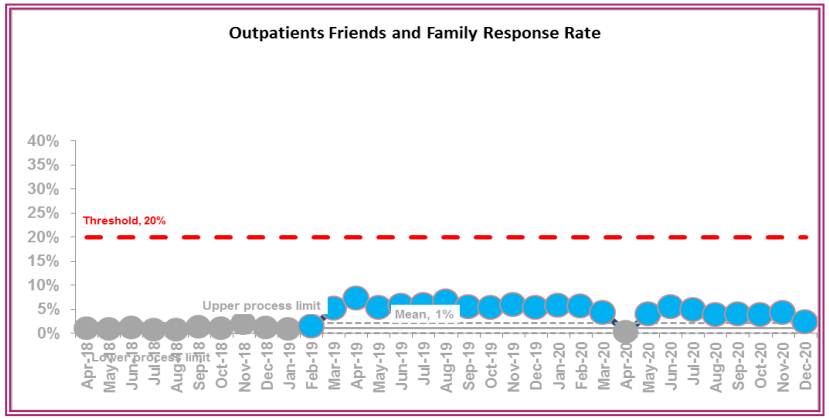
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

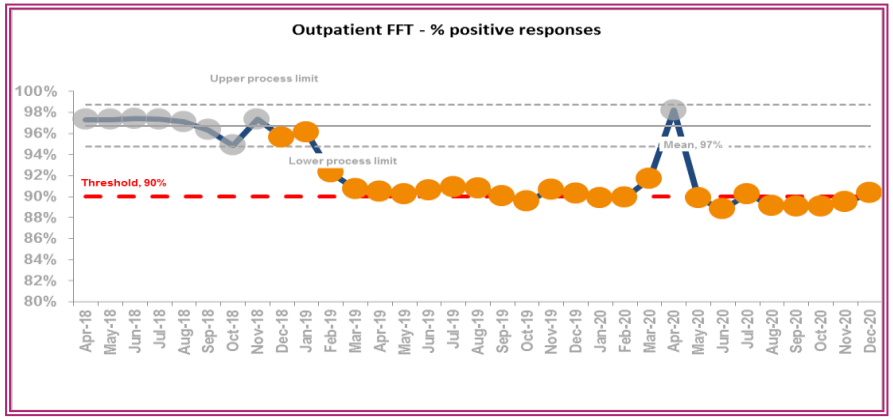






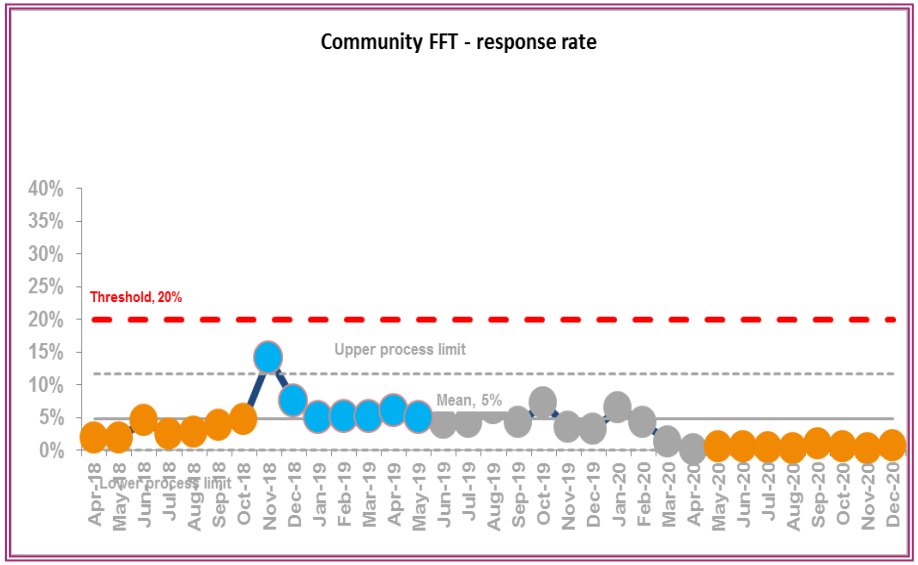


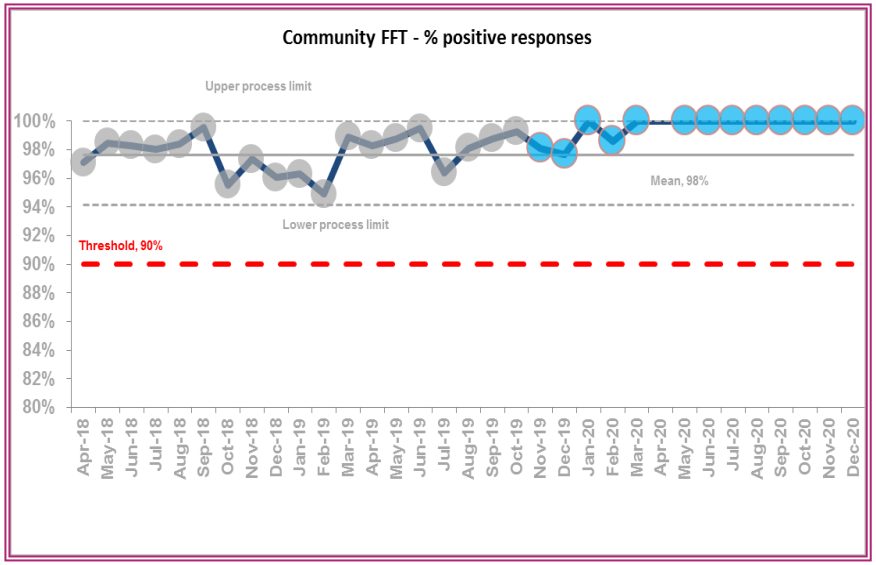


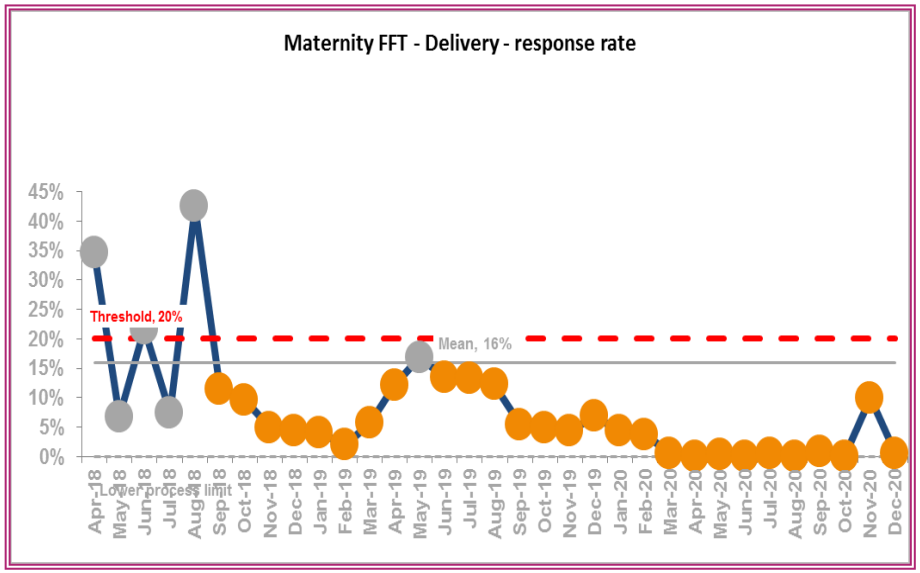


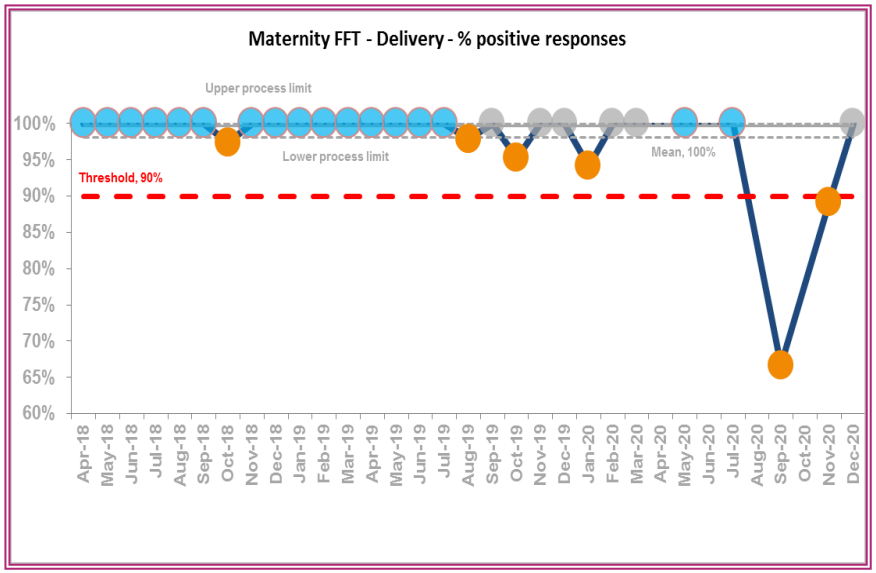
Friends and Family Test

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









Note: no completed maternity delivery surveys in October 2020

2.3

Our Patient Perspective

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

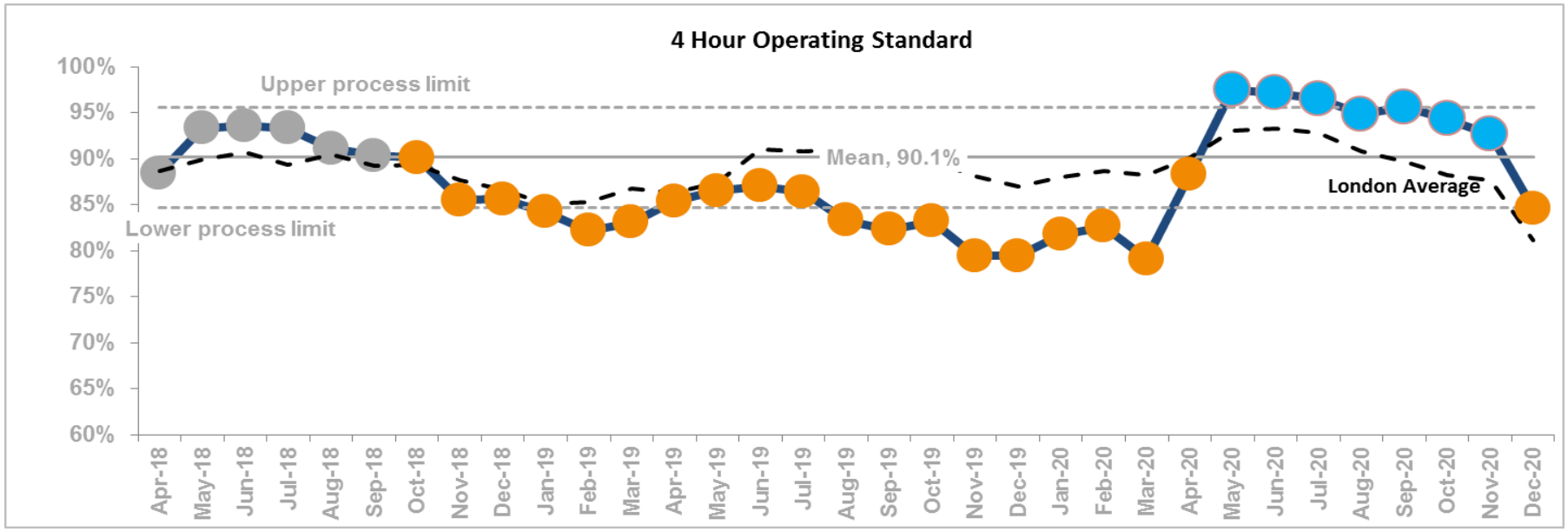
Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Emergency Flow



In December, the Four Hour Operating Standard performance decreased with 84.6% of patients attending were either discharged, admitted or transferred within 4 hours of their arrival to the emergency department (ED); the admitted pathway performance fell below the lower control limits. The acuity levels of the patients attending continue to be much higher than the same period last year with 63% of patients attending in December being scored between 1-3 against the Manchester Triage system.

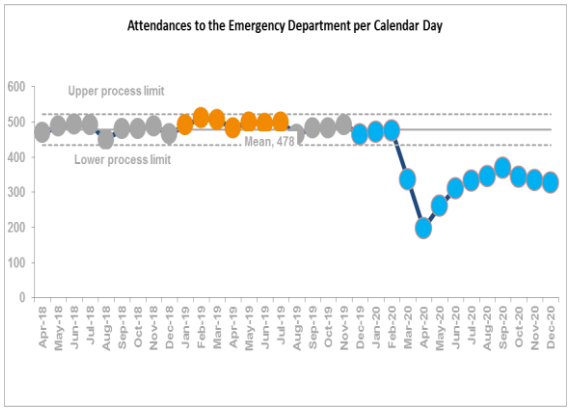
The proportion of ambulance conveyances was 5% higher compared to the same month last year. Despite the challenges, the Four Hour Operating Standard performance was 7% higher than the same period last year.

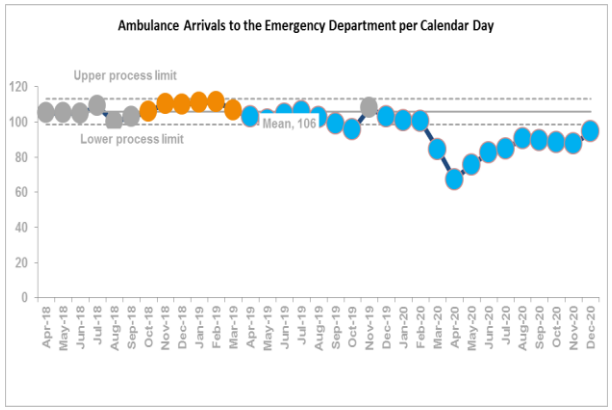
Patient flow throughout the month has been challenged with the number of emergency admissions outweighing the number of discharges on the majority of days throughout the month. AMU had a total of 22 days where bed occupancy was above 80% at midday, this was impacted by COVID-19 testing turnaround times and the increasing bed demand for suspected COVID-19 patients. Also impacting flow, there was a further increase in the number of patients who have been in a hospital bed longer than 7,14 and 21 days. In December there was a 6% increase in the number of patients with a length of stay greater than 21 days moving back within range of the upper and lower control limits for the first time since March 2020.

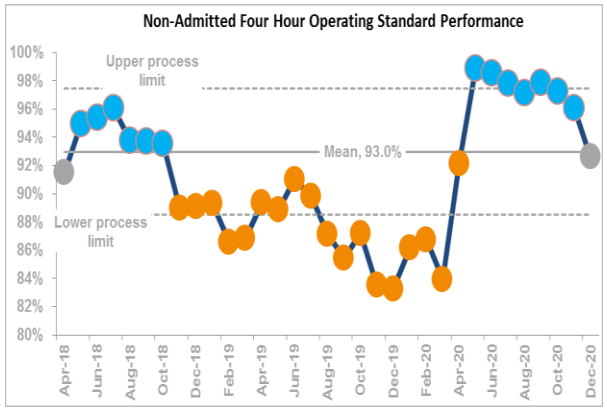
Actions and Quality Improvement Projects
Verbal update to be given

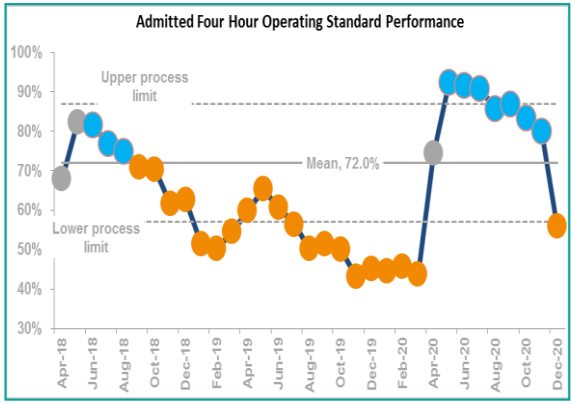
Emergency Flow

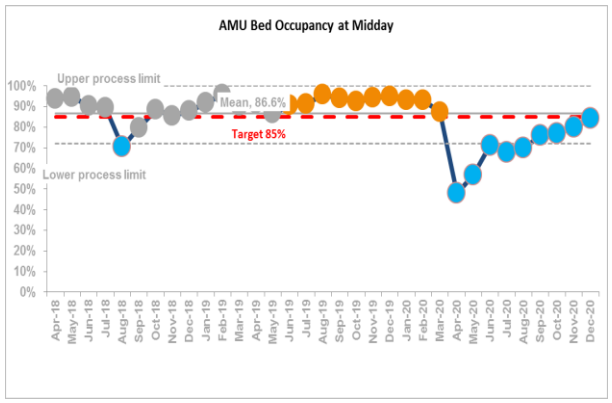
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

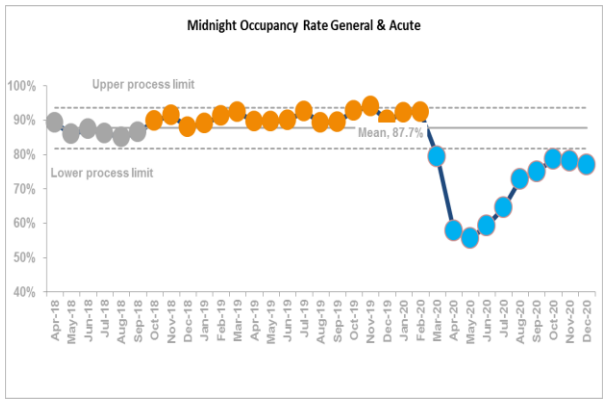


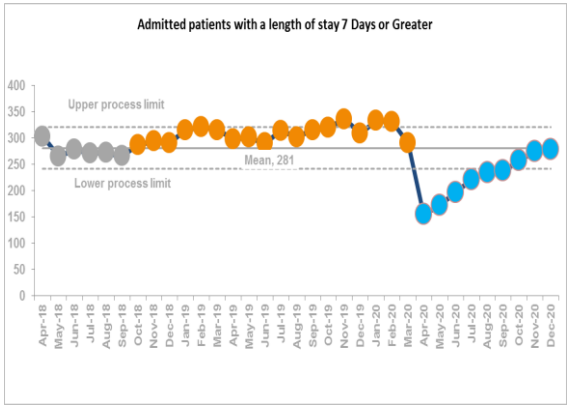


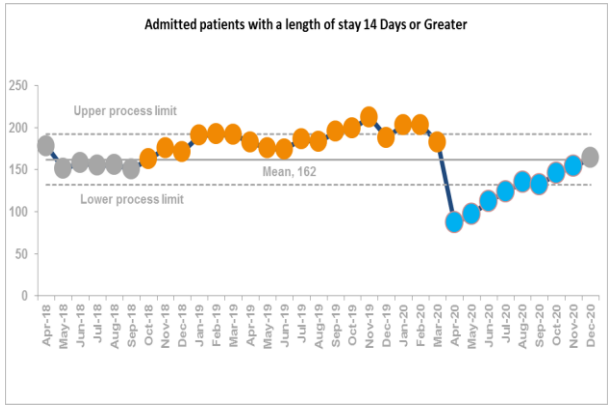


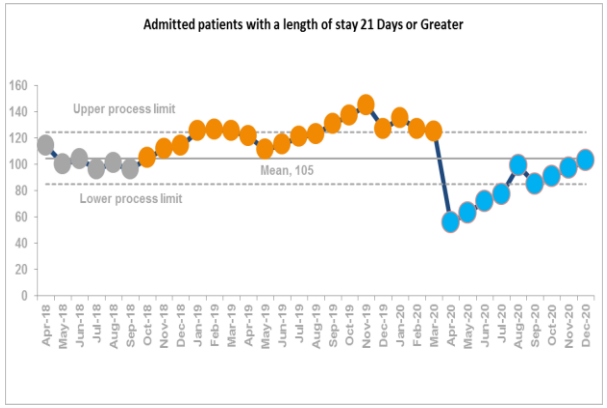






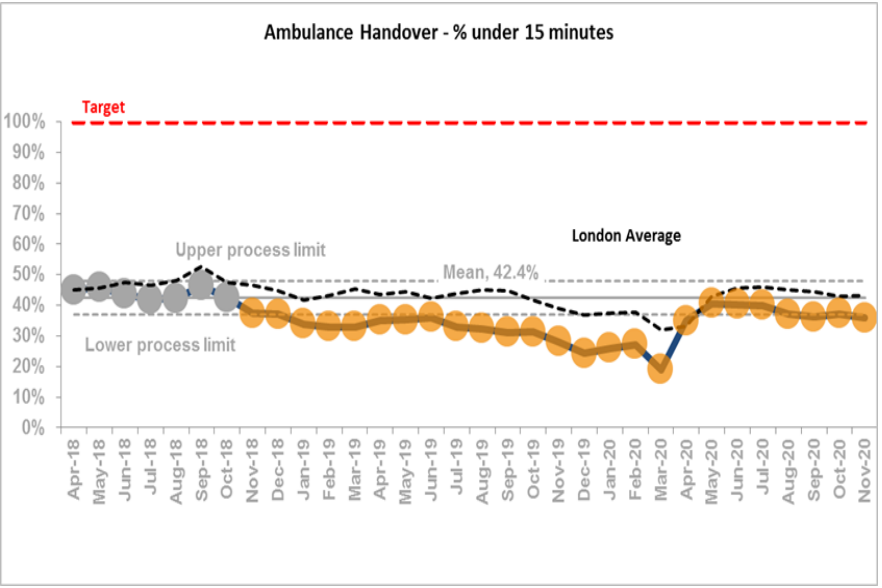


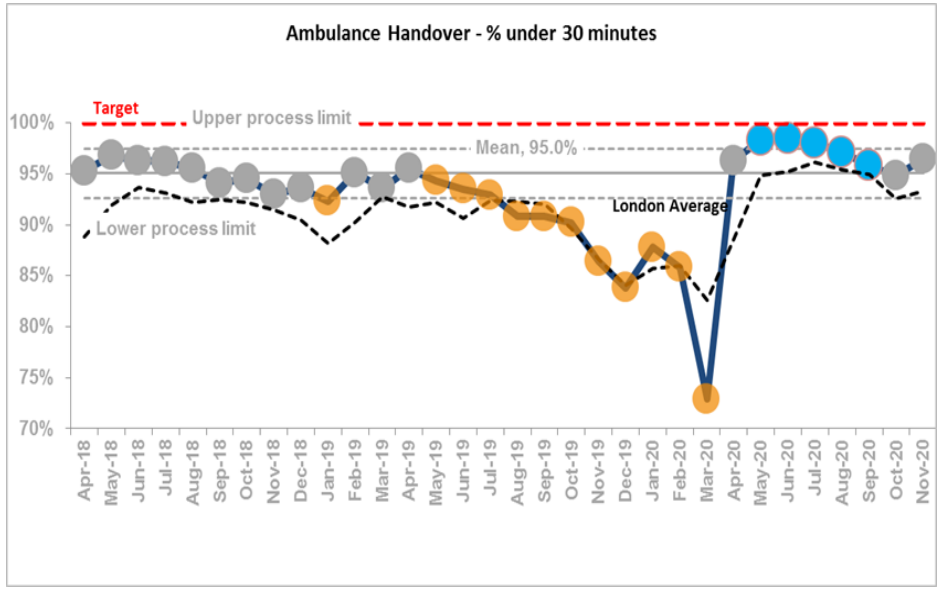


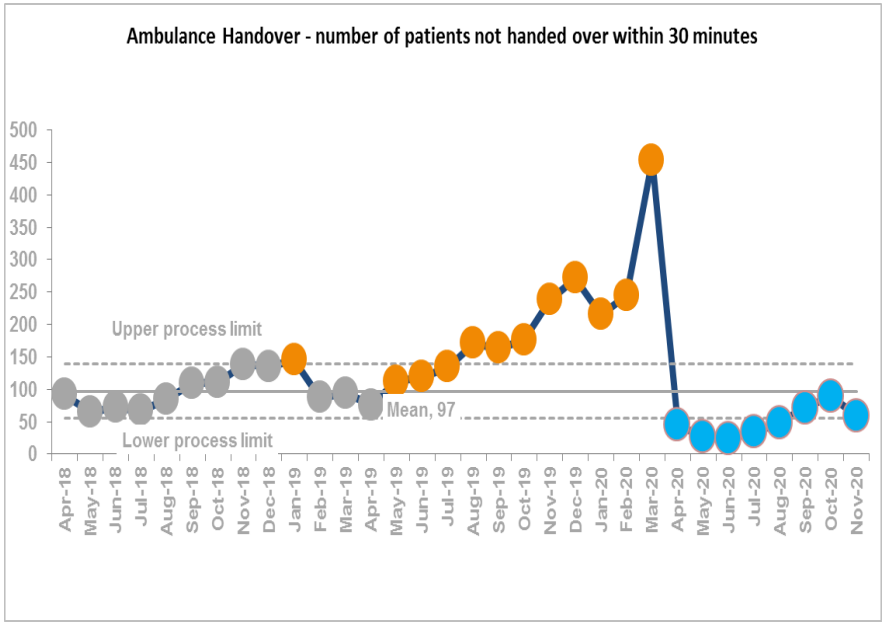


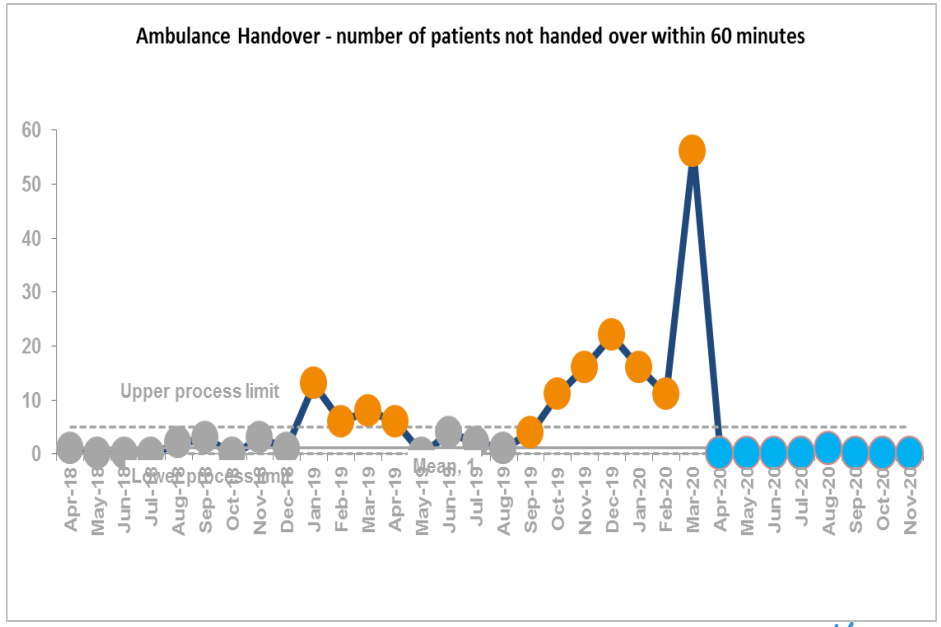
Emergency Flow

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

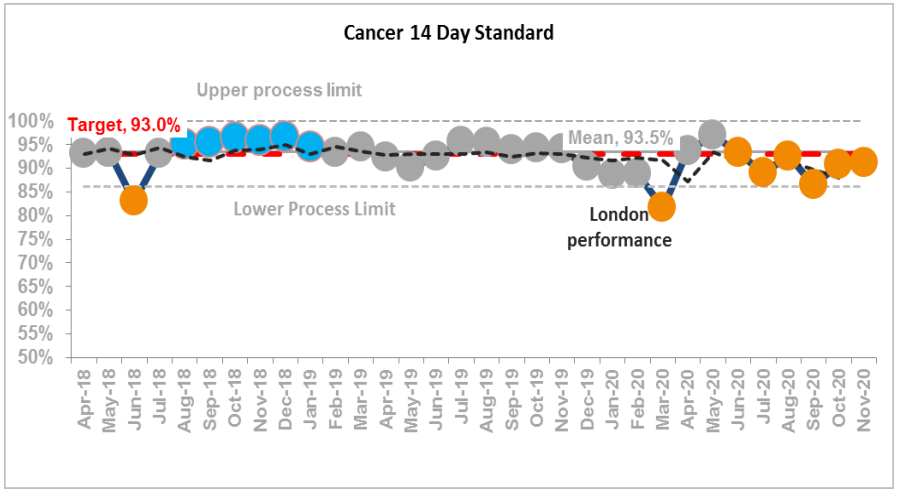


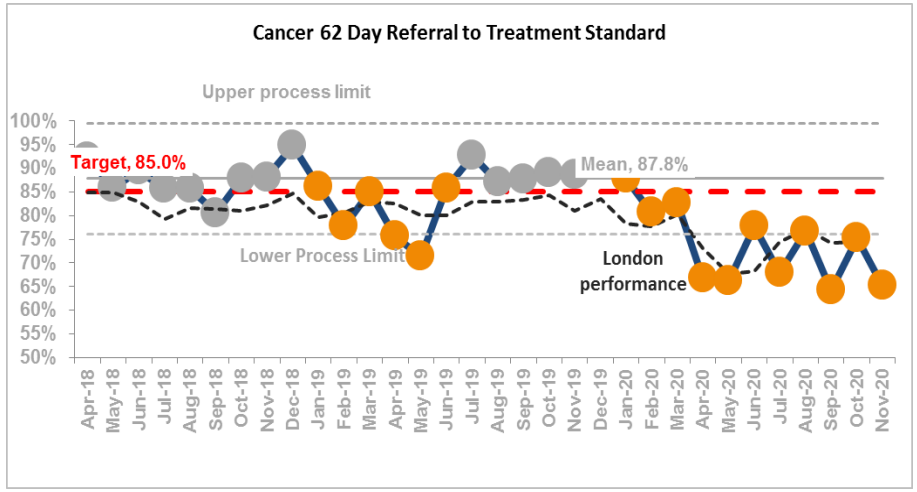






Cancer





What the information tells us

In November, the Trust met three of the seven cancer standards – 62 day screening referral to treatment, 31 day subsequent drug treatment, and 31 day subsequent surgery treatment.

Two Week Referral 14 day standard performance improved from 90.8% in October to 91.2% in November. A total of 1,422 patients were seen in month increasing by a further 8.5% compared to the previous month. Breast referrals continue to increase with an 11% increase in month; Head & Neck and Urology also had significant increases compared to October. Throughout November the proportion of patients being seen within 0-7 days of referral substantial improved.

There were 57.5 (0.5 being a shared treatment) total treatments on the 62-day GP pathway. Monthly performance although remaining in a sustained trend continues below the lower control limits with a 10% decrease in November and a performance of 65.2% compared to 75.2% in October. There were twenty breaches of the 62 Day standard, attributed to clinical complexity, patient choice and late InterTrust transfers.

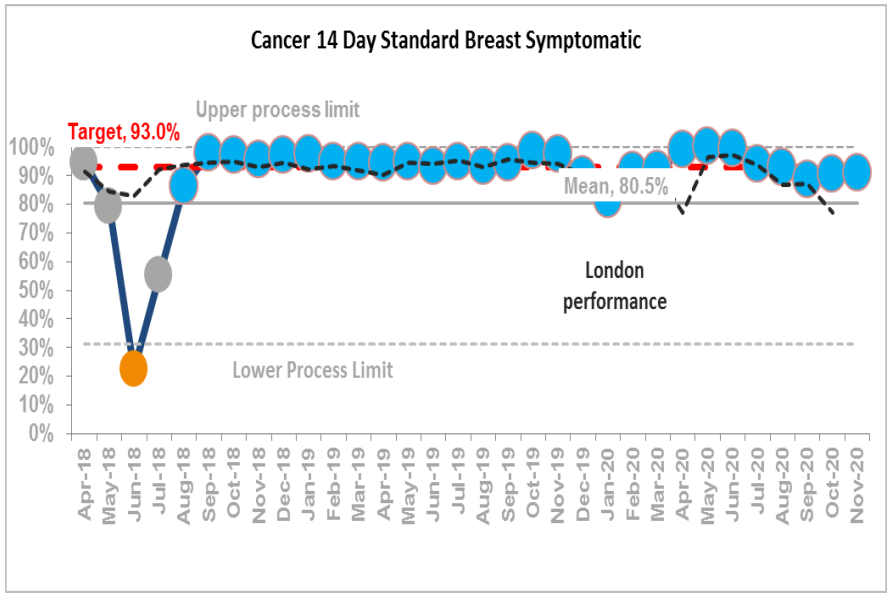
Cancer 31-day decision to treatment performance was 94.4% with five tumour groups below the 96% standard.

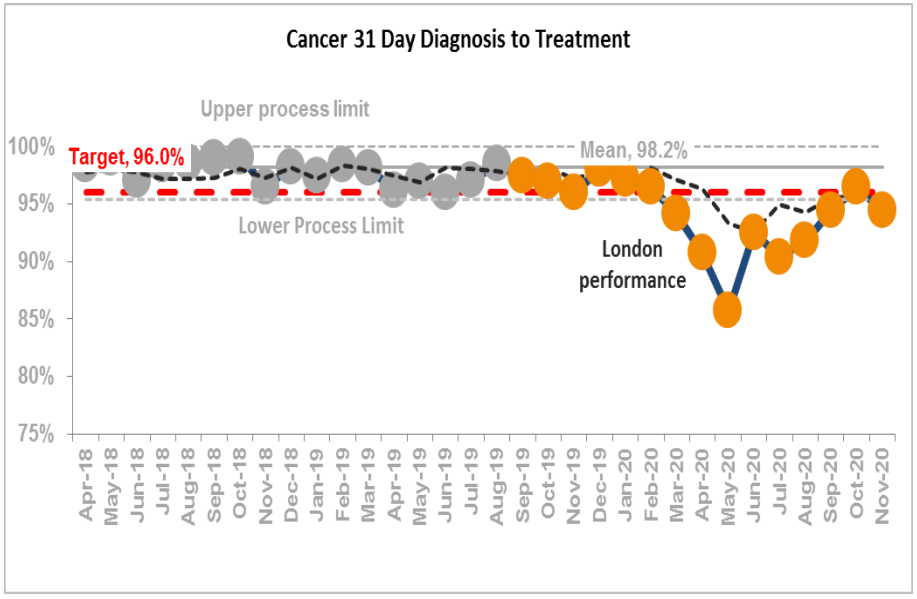
Actions and Quality Improvement Projects

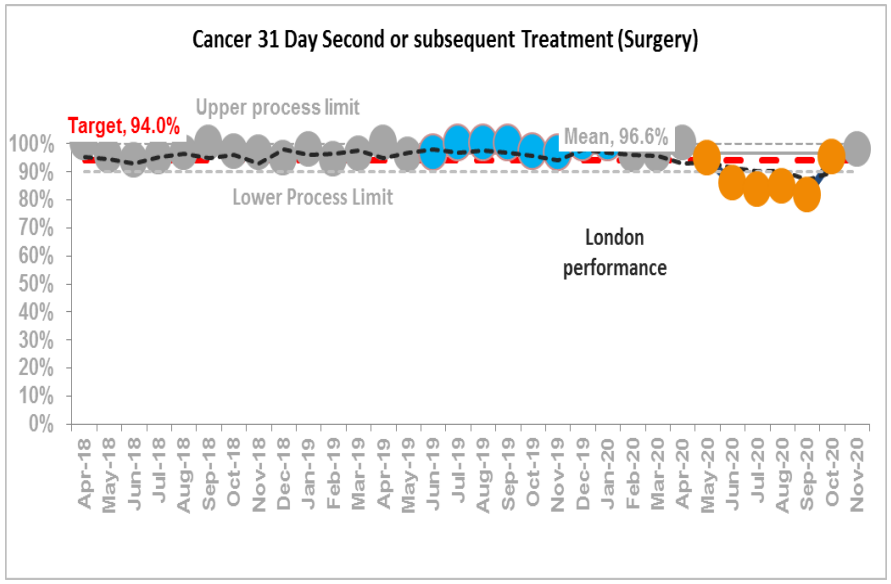
Verbal update to be given

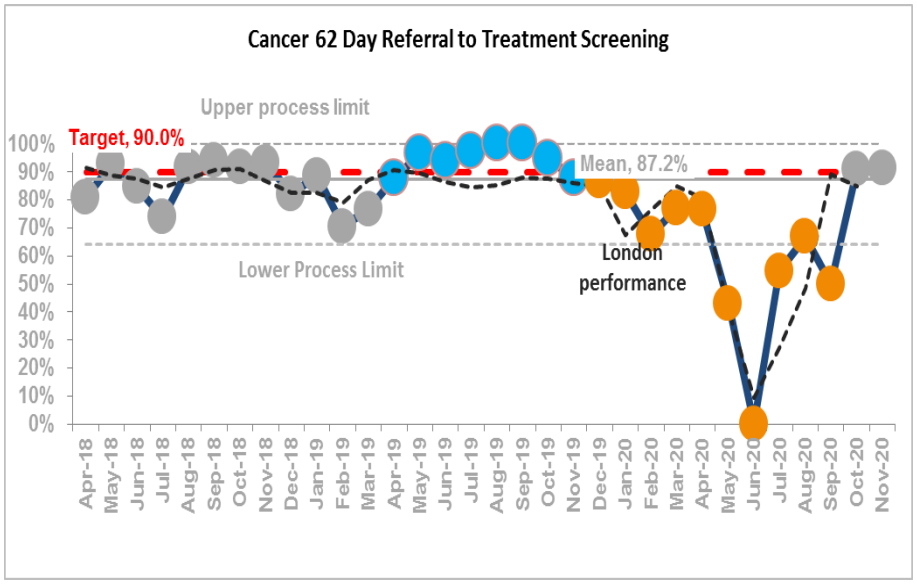
Cancer

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









Cancer

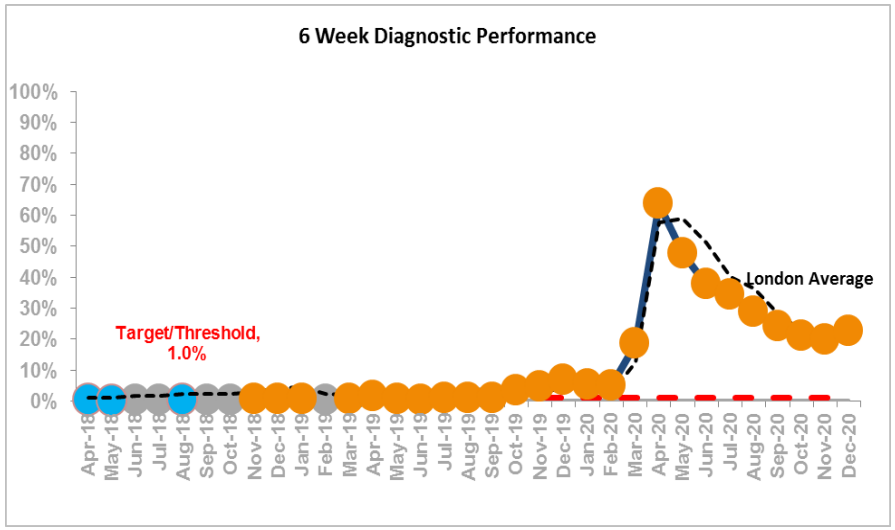
14 Day Standard Performance by Tumour Site - Target 93%

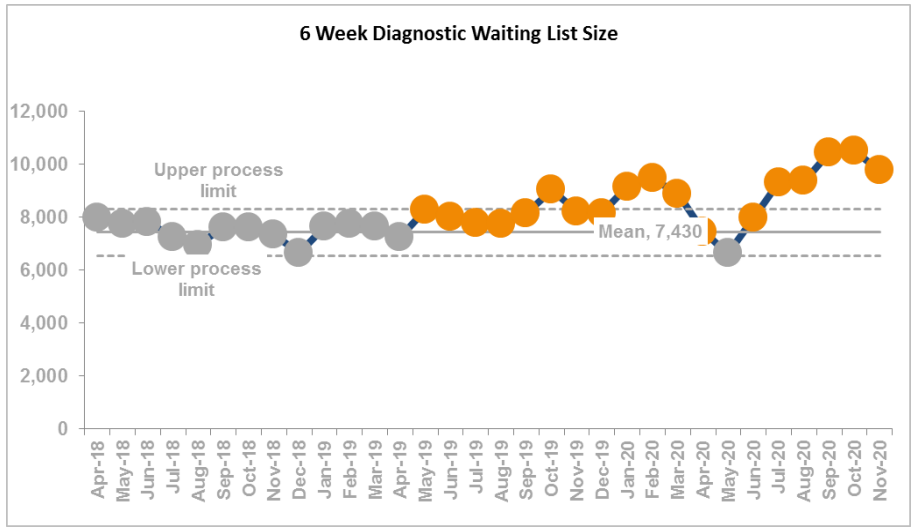
Tumour Site	Target	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	No of Patients
Brain	93%	-	-	100.0%	-	-	-	-	-	-	-	-	-	-	0
Breast	93%	97.0%	95.6%	84.7%	95.6%	93.3%	97.5%	100.0%	98.6%	95.5%	94.3%	88.6%	92.0%	91.6%	262
Children's	93%	100.0%	75.0%	85.7%	100.0%	100.0%	-	83.3%	100.0%	75.0%	75.0%	100.0%	75.0%	100.0%	4
Gynaecology	93%	99.2%	99.0%	94.4%	95.9%	86.9%	93.0%	96.3%	93.8%	92.5%	97.2%	91.6%	91.9%	94.3%	106
Haematology	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	91.3%	96.0%	96.2%	96.2%	26
Head & Neck	93%	96.6%	89.4%	95.2%	95.5%	90.8%	97.1%	100.0%	97.7%	96.1%	96.2%	84.1%	93.7%	96.0%	173
Lower Gastrointestinal	93%	91.5%	80.3%	81.8%	69.9%	63.8%	86.8%	95.6%	93.6%	86.9%	78.7%	61.8%	83.1%	76.4%	216
Lung	93%	100.0%	84.1%	80.6%	90.9%	85.7%	83.3%	90.9%	72.7%	62.5%	80.0%	90.5%	100.0%	94.4%	18
Skin	93%	91.0%	94.8%	94.7%	93.3%	84.1%	93.2%	96.7%	91.4%	87.4%	97.0%	95.4%	93.7%	95.1%	364
Upper Gastrointestinal	93%	88.1%	82.7%	75.3%	84.4%	75.5%	93.5%	98.4%	93.1%	84.4%	95.8%	93.0%	94.8%	90.6%	106
Urology (Suspected testicular cancer)	93%	95.6%	92.9%	93.6%	93.6%	93.9%	94.0%	85.5%	82.4%	80.4%	78.3%	85.6%	83.3%	93.3%	147

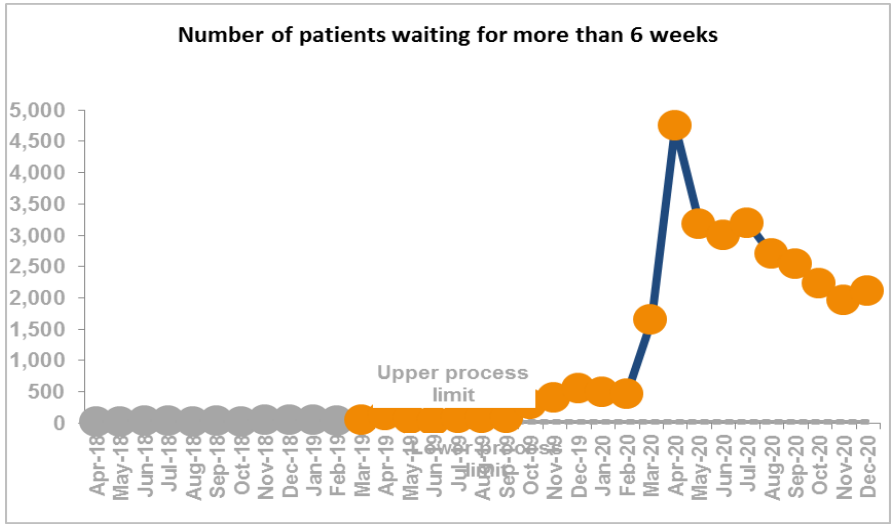
62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	No of Treatments
Brain	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Breast	85%	100.0%	100.0%	100.0%	66.7%	58.8%	100.0%	100.0%	100.0%	100.0%	50.0%	92.3%	83.3%	84.6%	13
Children's	85%	-	-	100.0%	100.0%	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	80.0%	66.7%	100.0%	100.0%	0.0%	50.0%	50.0%	100.0%	100.0%	71.4%	33.3%	100.0%	1
Haematology	85%	100.0%	80.0%	85.7%	66.7%	33.3%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%	4.5
Head & Neck	85%	76.9%	68.2%	89.5%	73.7%	81.0%	50.0%	66.7%	83.3%	52.4%	100.0%	25.0%	60.0%	61.5%	6.5
Lower Gastrointestinal	85%	87.5%	83.3%	60.0%	71.4%	75.0%	42.9%	50.0%	-	100.0%	60.0%	22.2%	25.0%	42.9%	10.5
Lung	85%	66.7%	100.0%	100.0%	100.0%	100.0%	62.5%	0.0%	85.2%	50.0%	60.0%	77.8%	55.6%	33.3%	1.5
Skin	85%	89.5%	100.0%	91.7%	100.0%	100.0%	52.9%	81.8%	85.2%	82.4%	100.0%	100.0%	100.0%	50.0%	6
Upper Gastrointestinal	85%	50.0%	100.0%	0.0%	40.0%	-	0.0%	33.3%	71.4%	80.0%	100.0%	28.6%	100.0%	100.0%	1
Urology	85%	87.8%	100.0%	85.0%	84.0%	81.5%	100.0%	64.3%	25.0%	27.3%	78.8%	55.6%	71.4%	57.1%	10.5
Other	85%	-	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	28.6%	-	0.0%	100.0%	100.0%	3

Diagnostics







What the information tells us

In December, the Trust reported a decline in performance against the six week diagnostic standard with a performance of 22.6% compared to 20% in November. In total there are 9,339 patient on the diagnostic waiting list of which 2,107 patients are waiting beyond 6 weeks compared to 1,950 patients in the previous month. There has been a continued improvement in the number of patients waiting for more than 13 weeks, where compared to November there has been a further reduction of 12.6%. The two areas with the largest proportion of patients in this category are Echocardiology and Gastroscopy.

The waiting list size reduced by 4.3% compared to the previous month, however remains above the upper control limit. Many modality groups have seen reductions in their waiting list size however areas where there has been growth includes Flexi Signmoidoscopy, MRI and Neurophysiology.

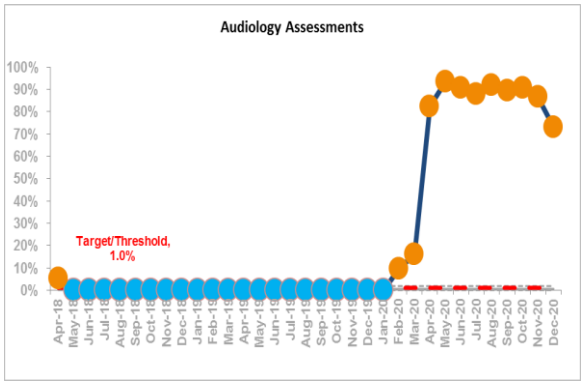
In December, the average waiting time for all patients to receive a diagnostic test was 5.2 weeks compared to 4.9 weeks in November showing a slight increase overall.

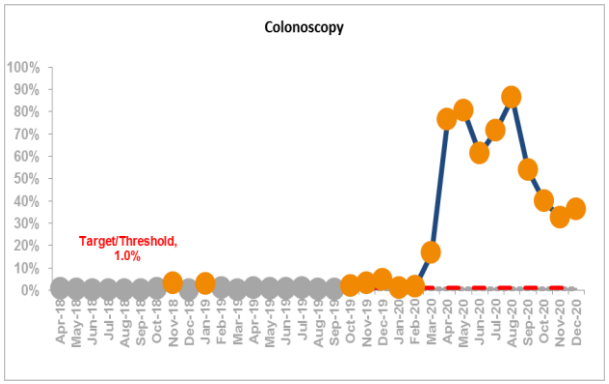
Actions and Quality Improvement Projects

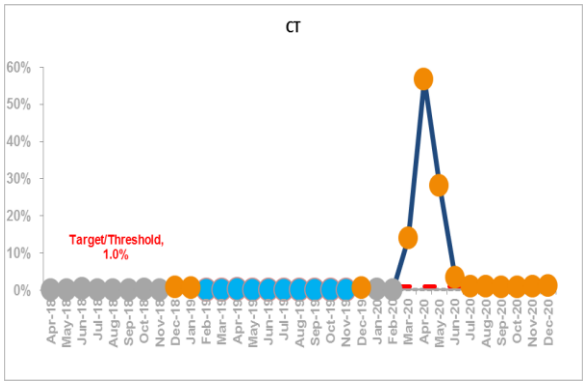
Verbal update to be given

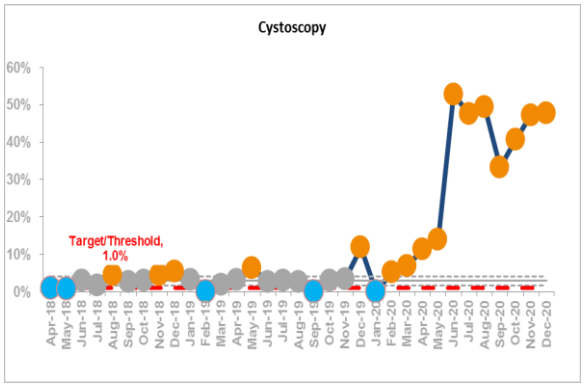
Diagnostics

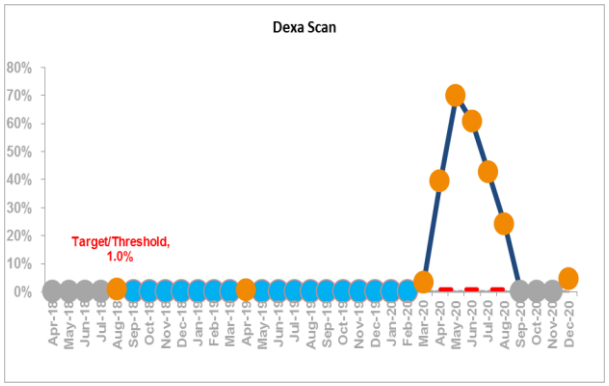
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

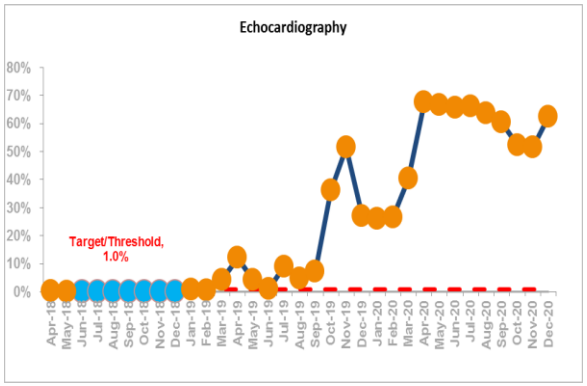


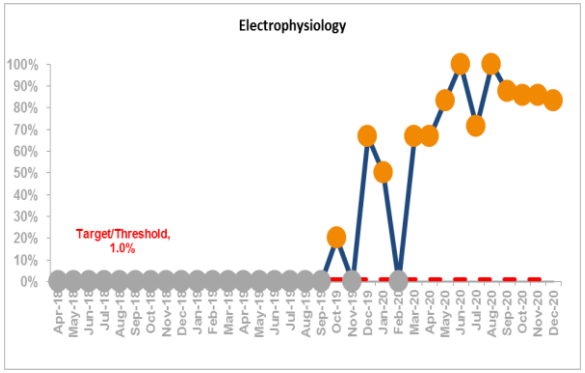


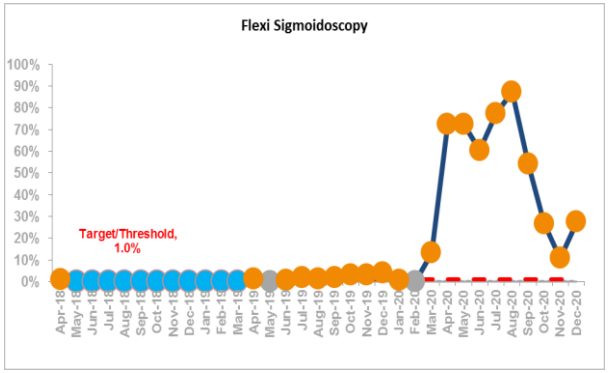


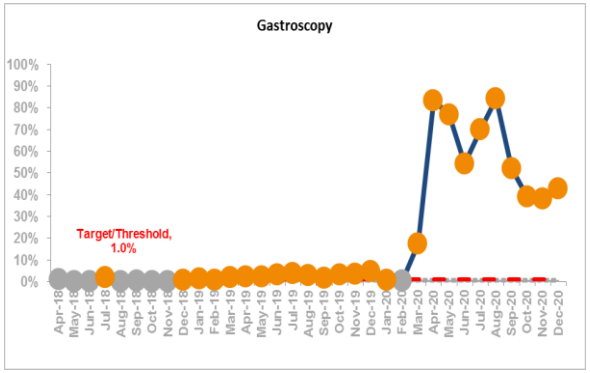






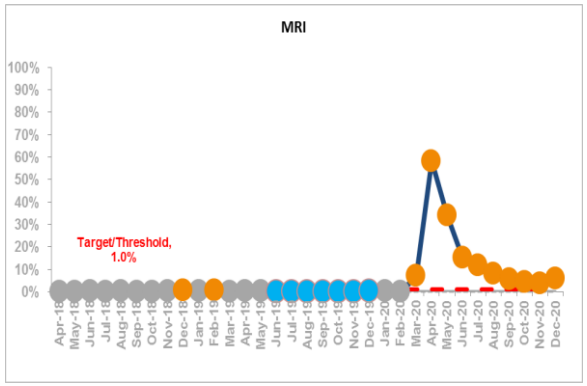


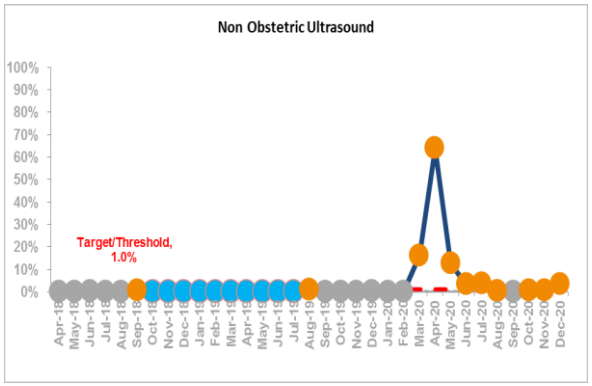


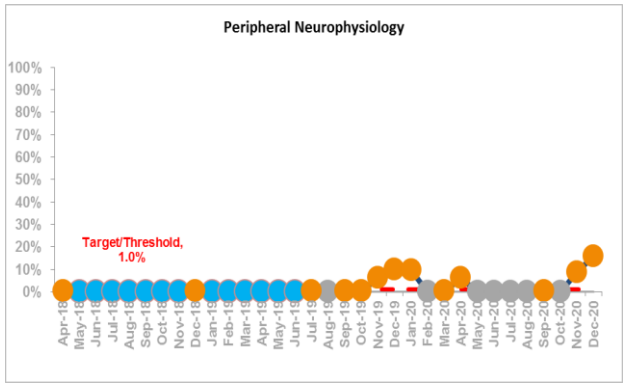


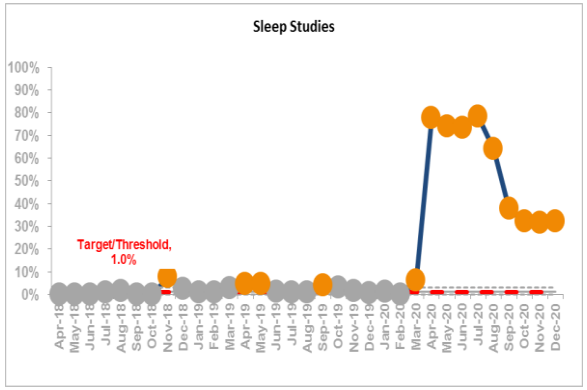
Diagnostics

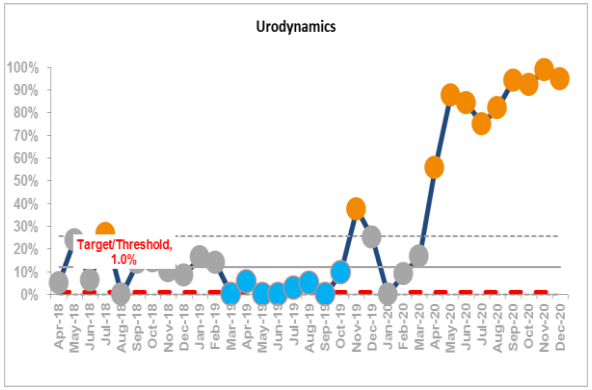
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance









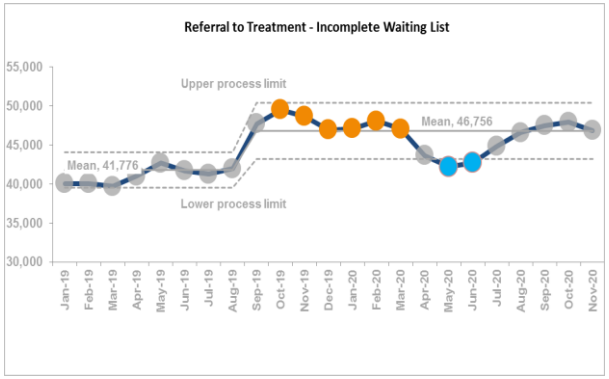


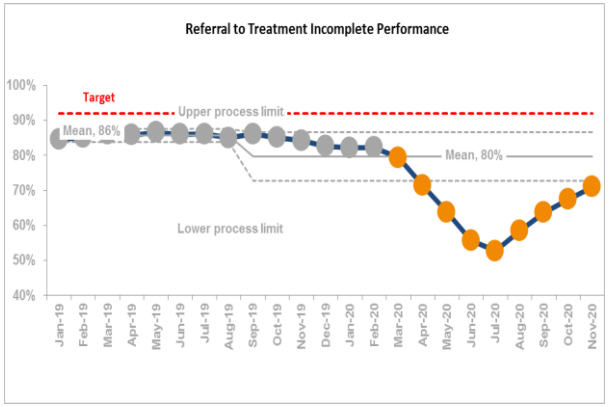
2.3

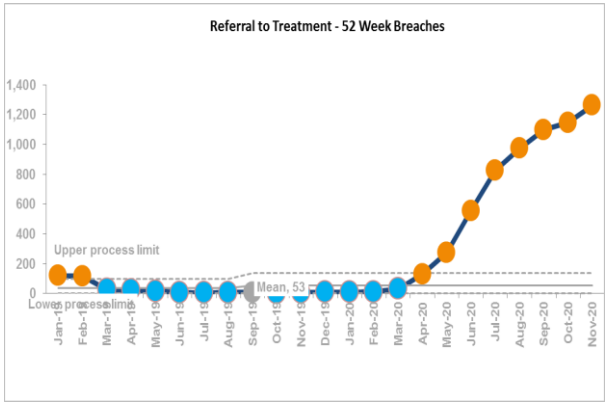
Our Process Perspective

Referral to Treatment — November 2020

Indicator Description	Target	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
RTT Trust Incomplete Performance	92%	84.2%	82.6%	82.2%	82.3%	79.3%	71.5%	63.8%	55.7%	52.7%	58.4%	63.7%	67.4%	71.0%
RTT Total Incomplete Waiting Lize Size (inc UCS)		48,640	46,918	47,089	48,061	47,048	43,643	42,196	42,672	44,814	46,569	47,471	47,905	46,835
Total waits greater than 18 weeks (inc 52Wk waiters)		7,701	8,183	8,382	8,498	9,755	12,440	15,268	18,924	20,863	19,177	16,974	15,443	13,365
Total waits greater than 52 weeks	0	7	9	10	11	32	129	274	554	825	972	1,097	1,146	1,261
RTT Incomplete Performance - Admitted		63.7%	61.4%	60.5%	61.9%	57.2%	49.0%	42.4%	34.1%	31.8%	35.6%	38.3%	44.2%	50.6%
Total waits greater than 18 weeks - Admitted		1,719	1,876	1,950	1,891	2,186	2,720	3,308	3,955	4,207	3,816	3,373	2,891	2,541
Total waits greater than 52 weeks - Admitted	0	2	5	2	3	20	88	190	393	529	588	626	579	559
RTT Incomplete Performance -Non Admitted		86.4%	85.0%	84.7%	84.7%	82.0%	74.6%	67.2%	59.2%	56.1%	61.8%	67.1%	70.3%	73.6%
Total waits greater than 18 weeks - Non Admitted		5,982	6,107	6,432	6,607	7,569	9,720	11,960	14,969	16,656	15,361	13,601	12,552	10,824
Total waits greater than 52 weeks - Non Admitted	0	5	4	8	8	12	41	84	161	296	384	471	567	702







What the information tells us

In the month of November there were 46,835 patients waiting for treatment on the Patient Tracking List (PTL), this is a decrease of 2% compared to October and compared to the same period last year, a decrease of 3.7%.

In November, there was a further reduction in the number of patients waiting greater than 18 weeks, reducing by 2,078 patients compared to October with performance against the incomplete waiting time standard showing a continued improvement reporting 71% in month. Audiology, Ear Nose & Throat, Cardiology and Dermatology remain to be the most challenged services with a larger proportion of patients waiting for more than 18 weeks although seeing improvements overall compared to the previous month.

In November, the Trust reported 1,261 patients waiting for more than 52 weeks to receive treatment which accounts for 2.7% of the total waiting list; this is below the 5% projected. There has been a slight decrease in the number of patients waiting on an admitted pathway beyond 52 weeks however, there has been a significant shift within the non-admitted pathway with 702 patients waiting above 52 weeks seeing an increase of nearly 24% compared to the previous month with larger increases within General Surgery and Max Fax.

Actions and Quality Improvement Projects

Verbal update to be given

Referral to Treatment — November 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	478	36.0%	1,144	67.4%	943	679	1,622	52.3%	159	109
UROLOGY	341	59.5%	1,729	81.7%	1,616	454	2,070	69.8%	81	26
TRAUMA & ORTHOPAEDICS	187	52.9%	2,163	84.1%	1,919	431	2,350	81.7%	68	17
ENT	426	26.3%	3,304	68.4%	2,371	1,359	3,730	60.6%	220	176
OPHTHALMOLOGY			926	46.5%	431	495	926	50.2%	122	19
ORAL SURGERY	2	50.0%	196	67.9%	134	64	198	64.7%	10	22
NEUROSURGERY	181	54.7%	2,263	70.2%	1,687	757	2,444	62.9%	151	45
PLASTIC SURGERY	520	62.3%	680	76.5%	844	356	1,200	67.0%	77	76
CARDIOTHORACIC SURGERY			2	1	2	0	2	66.7%	0	0
GENERAL MEDICINE			23	65.2%	15	8	23	85.7%	1	0
GASTROENTEROLOGY	730	82.7%	2,424	75.5%	2,434	720	3,154	77.2%	90	27
CARDIOLOGY	944	27.8%	2,493	72.4%	2,067	1,370	3,437	57.0%	302	136
DERMATOLOGY	3	66.7%	3,064	68.5%	2,102	965	3,067	63.8%	287	38
RESPIRATORY MEDICINE	3	66.7%	1,036	93.8%	974	65	1,039	91.2%	4	1
NEUROLOGY	24	79.2%	1,918	82.5%	1,602	340	1,942	76.1%	46	0
RHEUMATOLOGY	8	1	1,075	68.7%	743	340	1,083	66.9%	49	11
GERIATRIC MEDICINE			71	88.7%	63	8	71	92.6%	1	0
GYNAECOLOGY	185	53.5%	2,424	78.3%	1,997	612	2,609	70.9%	127	30
Other	1,109	53.9%	14,066	72.8%	10,833	4,342	15,175	67.7%	925	528
Grand Total	**5,141**	**50.6%**	**41,001**	**73.6%**	**32,777**	**13,365**	**46,142**	67.4%	**2,720**	**1,261**

The numbers reported above exclude Unknown Clock Starts(UCS)

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.

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

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Workforce

Indicator Description	Target	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Trust Level Sickness Rate	3.2%	4.0%	3.9%	4.0%	5.1%	5.6%	4.1%	3.5%	3.2%	3.4%	3.6%	3.3%	3.3%	3.9%
Trust Vacancy Rate	10%	11.2%	10.8%	10.7%	10.6%	10.5%	6.8%	8.3%	8.4%	8.2%	9.1%	9.4%	9.1%	8.5%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.6%	17.4%	17.3%	16.9%	16.7%	16.1%	15.3%	15.1%	15.2%	15.4%	15.3%	15.3%	15.0%
Total Funded Establishment		9,403	9,383	9,369	9,369	9,373	9,098	9,289	9,256	9,263	9,265	9,320	9,331	9,336
IPR Appraisal Rate - Medical Staff	90%	83.6%	84.9%	81.7%	80.0%									
IPR Appraisal Rate - Non Medical Staff	90%	72.3%	72.0%	72.4%	69.6%	67.9%	67.6%	69.9%	73.6%	74.6%	72.4%	71.7%	70.6%	69.6%
Overall MAST Compliance %	85%	90.0%	89.7%	90.6%	90.7%	90.2%	89.7%	89.9%	89.8%	89.9%	89.9%	90.5%	90.0%	89.4%
Ward Staffing Unfilled Duty Hours	10%	5.3%	5.4%	6.2%	15.2%	17.4%	3.0%	1.6%	2.8%	3.7%	5.4%	6.3%	10.4%	15.8%
Trust Stability Index	85%	82.8%	81.5%	83.0%	83.0%	83.7%	84.2%	84.9%	85.4%	86.3%	86.1%	85.8%	87.0%	88.5%

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 remains above target and within common cause variation at 3.9%.

Appraisal rates for Non Medical staff declined for the fourth consecutive month to 69.6% in December against a target of 90%.

Vacancy Rate at 8.5% in December is below the set target of 10%, showing sustained special cause variation.

Stability Index at 88.5% is above target, and is used to inform retention strategies.

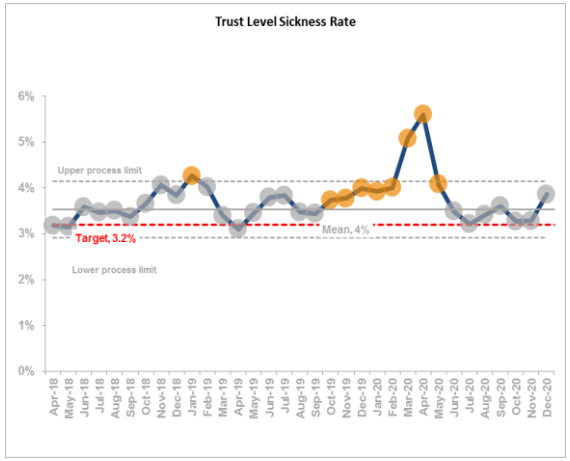
The Turnover Rate has plateaued averaging 15% since June 2020.

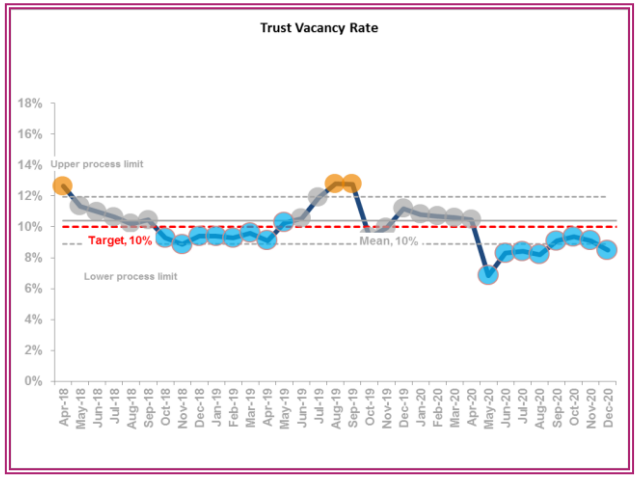
Actions and Quality Improvement Project

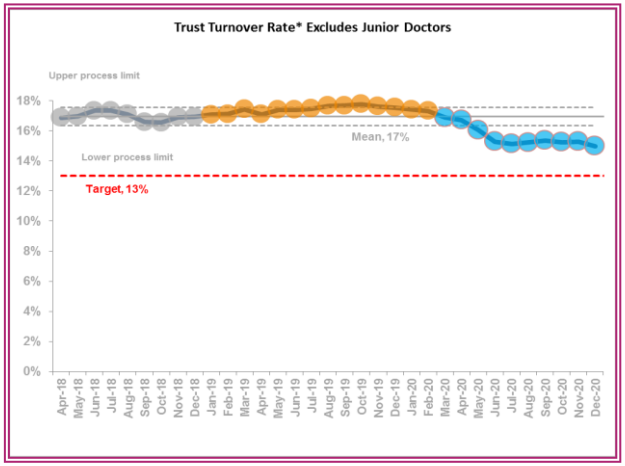
- The Employee Relations team is working closely with managers to ensure timely referral to Occupational Health and management.
- Trust turnover– a new approach to completing exit questionnaires was implemented on 2 November and will provide useful and timely information to help with putting in place required strategies.
- Appraisal rates for Medical staff will commence in this year.
- Completion of appraisals for non-medical staff continues to be encouraged.

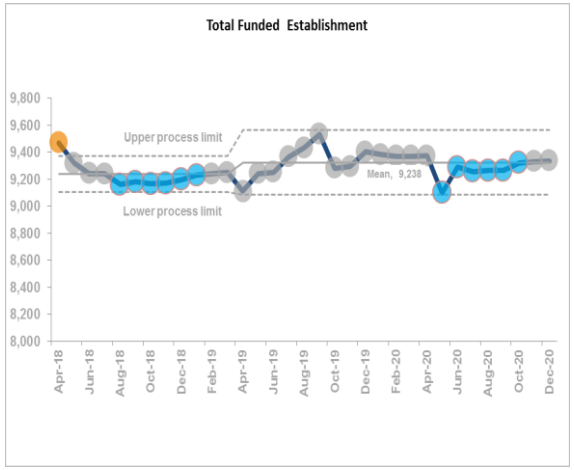
Workforce

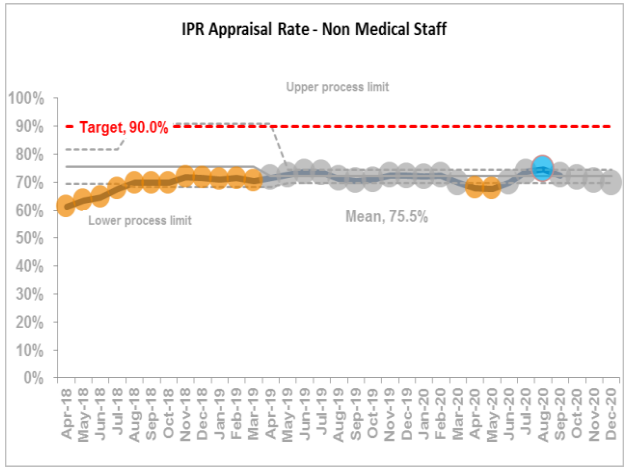
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

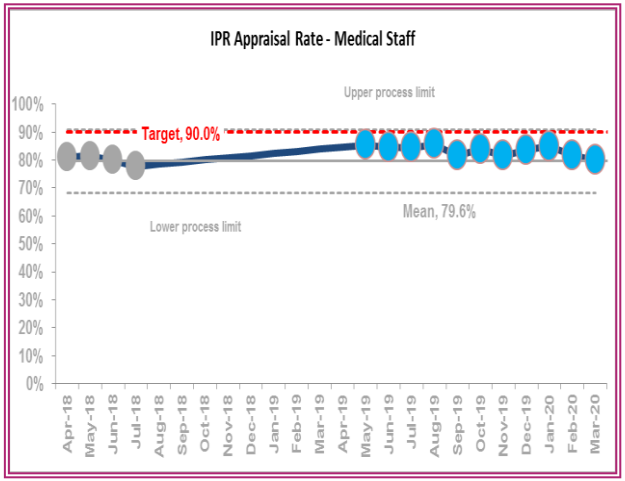












2.3

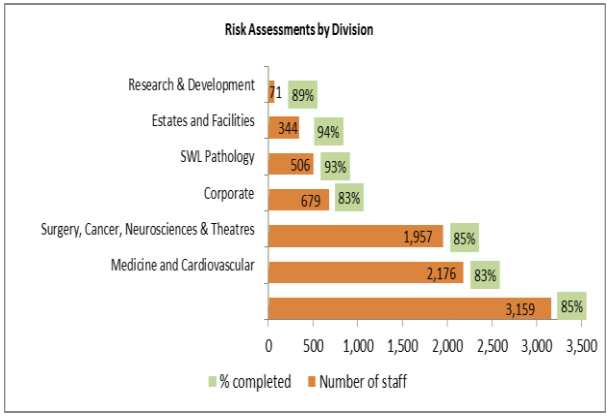
Our People Perspective

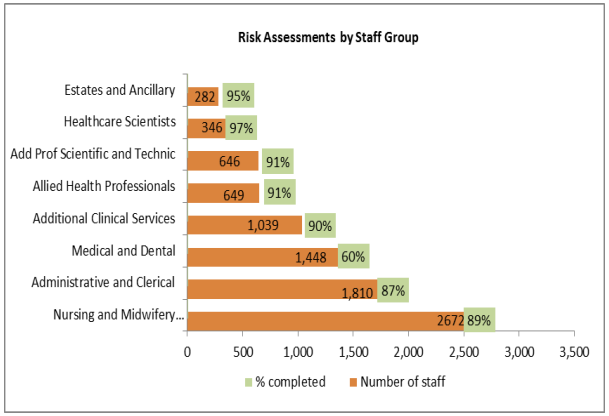
Workforce – November COVID-19 Risk Assessment

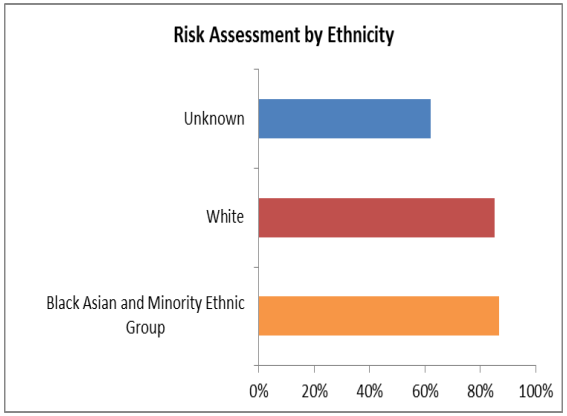
Division	Number of forms completed	Number of staff	% completed
Children and Women's Diagnostic and Therapy Services	2,673	3,159	85%
Medicine and Cardiovascular	1,808	2,176	83%
Surgery, Cancer, Neurosciences & Theatres	1,661	1,957	85%
Corporate	566	679	83%
SWL Pathology	469	506	93%
Estates and Facilities	325	344	94%
Research & Development	63	71	89%
Trust Total	7,565	8,892	85.1%

Staff Group	Number of forms completed	Number of staff	% completed
Medical and Dental	876	1,448	60%
Administrative and Clerical	1,582	1,810	87%
Nursing and Midwifery Registered	2389	2672	89%
Additional Clinical Services	931	1,039	90%
Allied Health Professionals	591	649	91%
Add Prof Scientific and Technic	591	646	91%
Estates and Ancillary	268	282	95%
Healthcare Scientists	337	346	97%
Trust Total	7,565	8,892	85.1%

Ethnicity	No of forms completed	Total number of staff	% completed
Black Asian and Minority Ethnic Group	3,607	4,153	87%
White	3,741	4,389	85%
Unknown	217	350	62%
Trust Total	7,565	8,892	85%







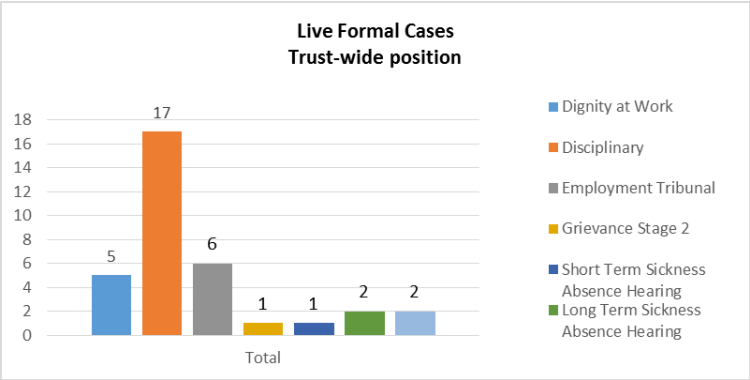
What the information tells us

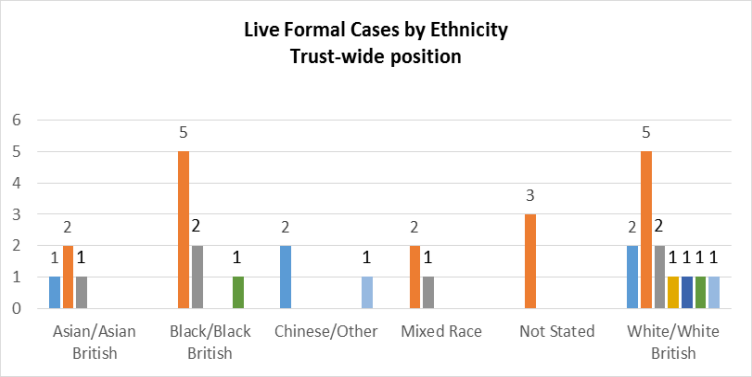
- The table shows completion of COVID-19 Risk Assessment as at 11 January 2021.
- The Trust completion rate is at 85.1%. Completion rate for BAME staff stands at 86.9% and White staff 85.2%.
- Medical and Dental staff group have the lowest completion rate at 60.5%.

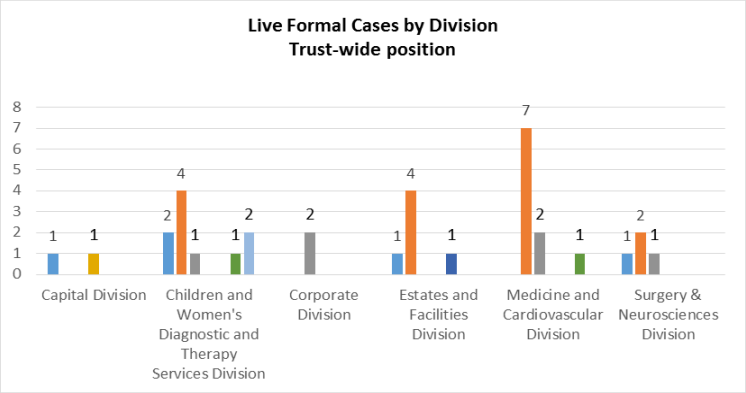
Actions and Quality Improvement Project

The Director of Medical Education and Chief Medical Office supported by the HR team, have sent reminders to junior doctors to ensure completion of COVID-19 Risk Assessments for those who recently joined the Trust.

Workforce - Employee Relations Cases as at 31 December 2020







What the information tells us

There are a total of 34 live cases Trust-wide.

Disciplinary cases are the highest at 17, followed by 6 Employment Tribunal cases and 5 Dignity at Work cases.

The Children and Women's and Medicine Divisions have the highest number of cases at 10 and 10 respectively.

White/White British and Black/Black British have the highest number of disciplinary cases at 13 and 10 respectively. White and White British and Black/Black British account for the highest number of Disciplinary cases at a total of 5.

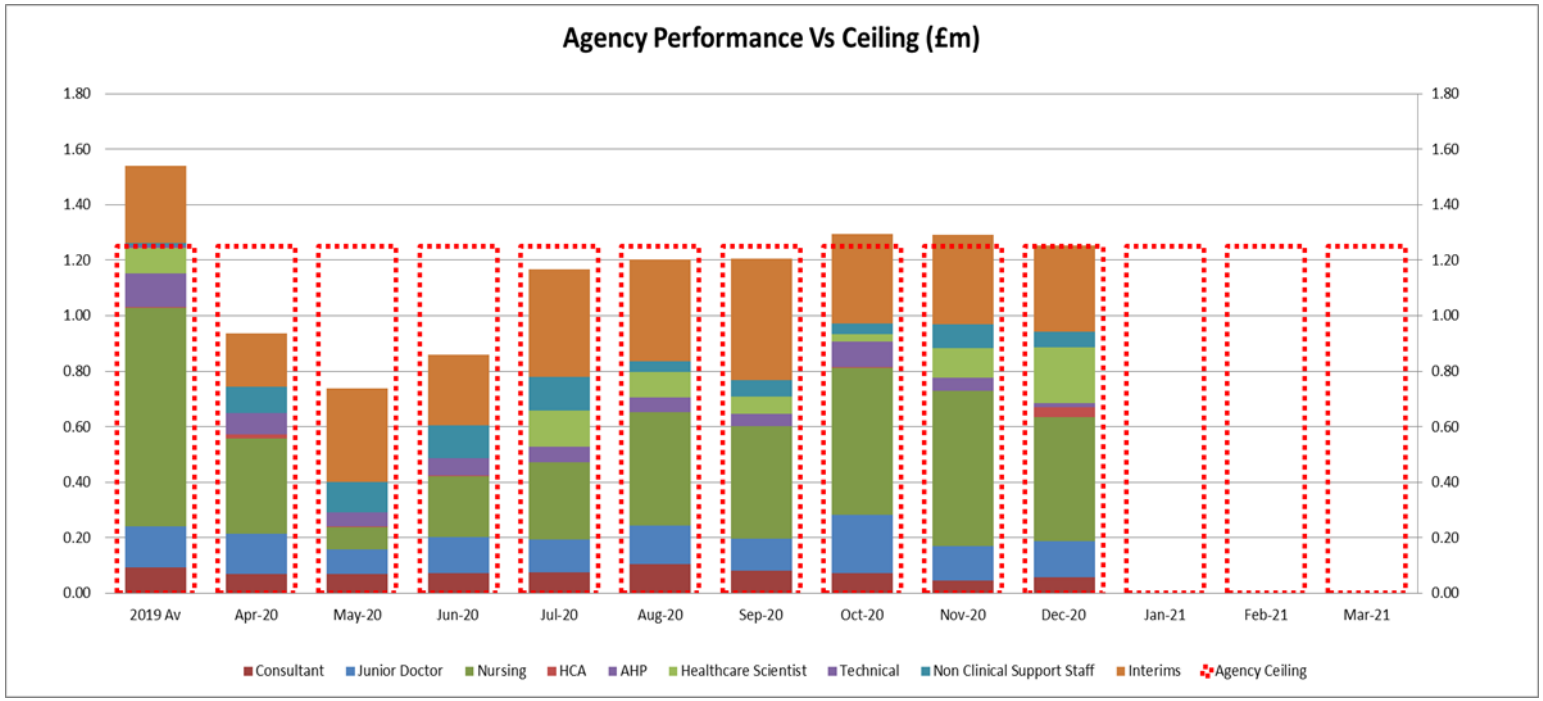
Actions and Quality Improvement Project

Verbal update to be provided.

Dignity at Work
Disciplinary
Employment Tribunal
MHPS
Disciplinary (Bank)
Stage 3 Capability Hearing
Capability
Grievance stage 3

Our People Perspective

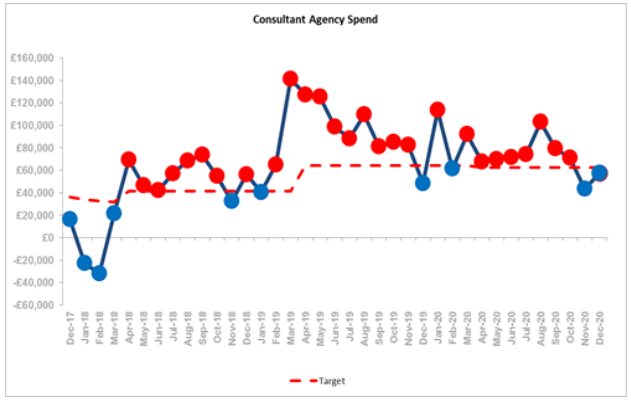
Agency use

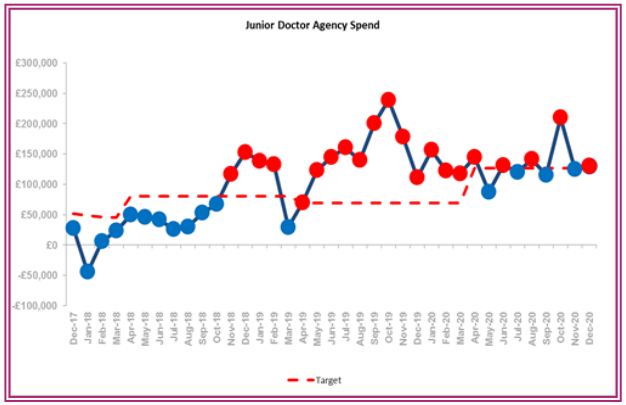


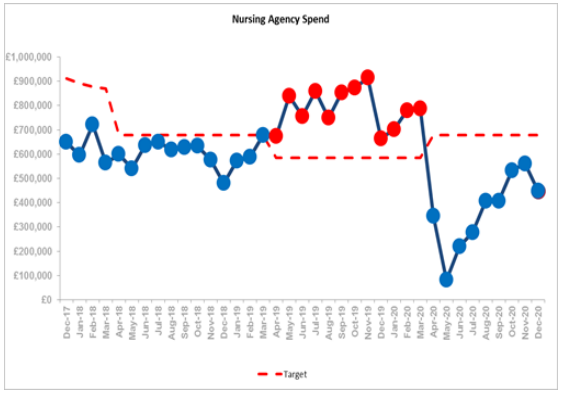
- The Trust's total pay for December was £50.77m. This is £2.00m adverse to a plan of £48.77m
- The Trust's 2020/21 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m
- Agency cost was £1.25m or 2.5% of the total pay costs. For 2019/20, the average agency cost was 3.3% of total pay costs
- For December, the monthly target set is £1.25m. The total agency cost is on plan
- The biggest areas of overspend were Interims (£0.14m) and Healthcare Scientists (£0.12m). The biggest areas of underspend were Nursing (£0.23m)

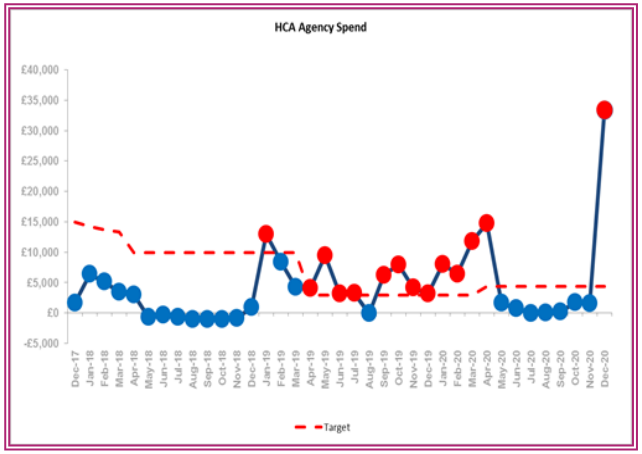
Agency use

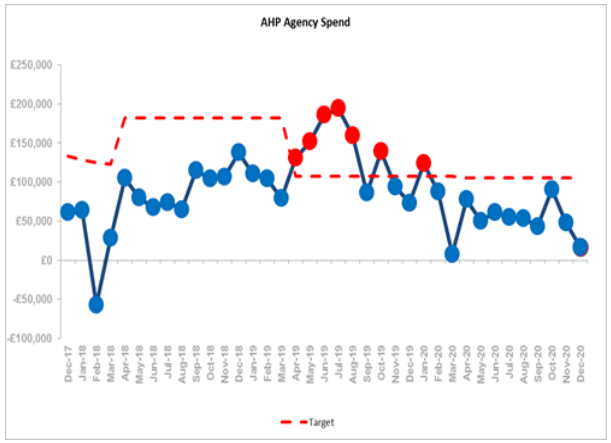
Below cap
Above cap

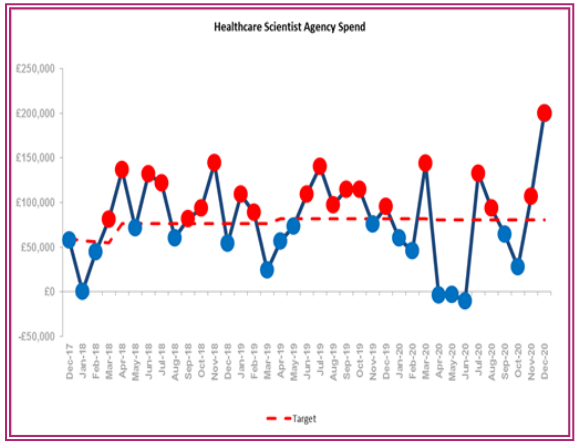


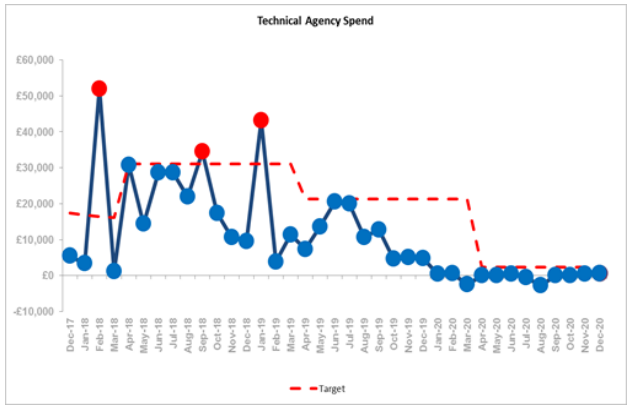


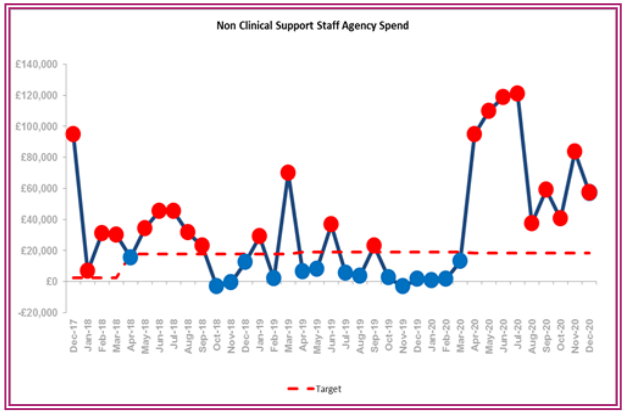


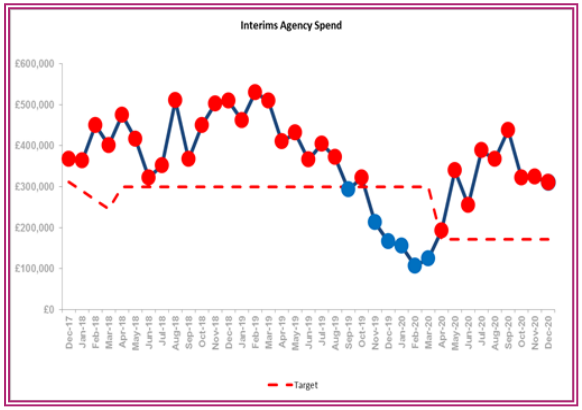






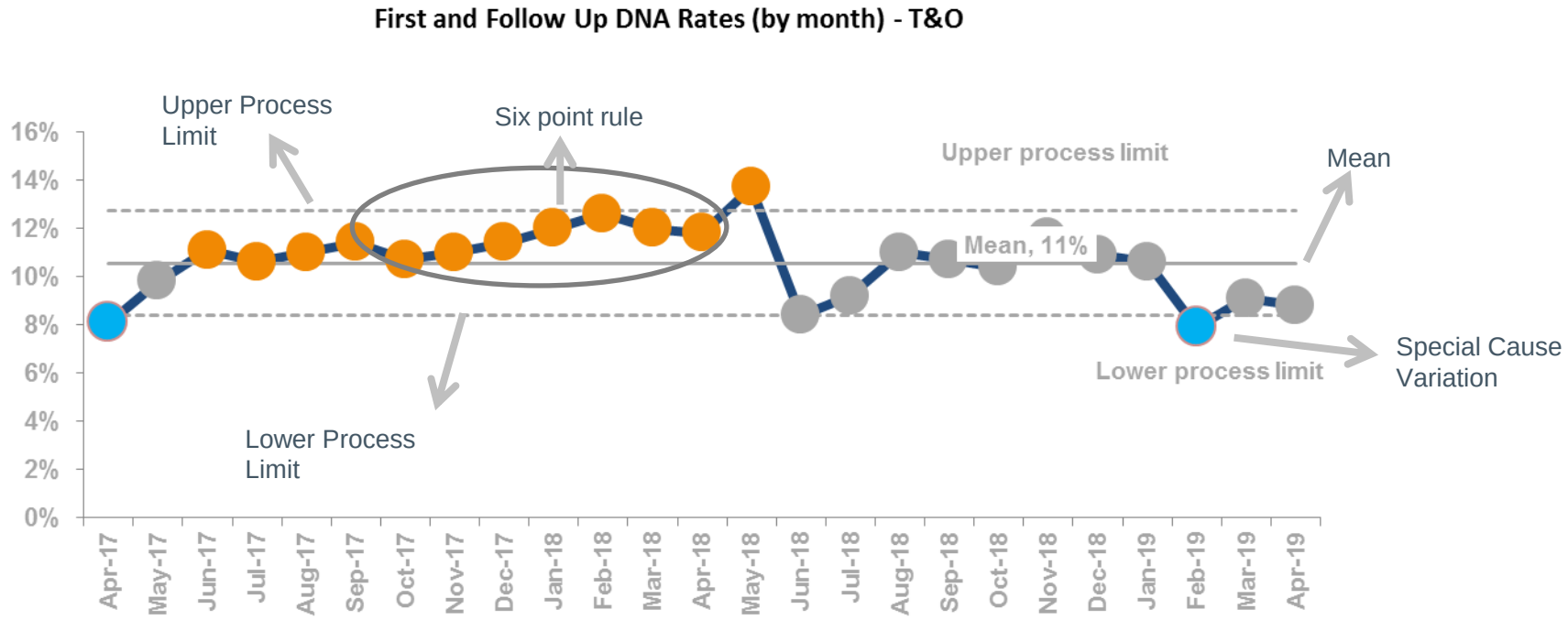






Appendix
Additional Information

Interpreting SPC (Statistical Process Control) Charts



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

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

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

Early Warning Score

Indicator Description	Threshold	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Compliance with appropriate response to EWS (Adults)	100%	89.0%	92.0%	91.1%	94.1%	86.9%	93.5%	97.0%	93.6%	78.3%	84.9%	92.4%	94.1%	93.7%
Number of EWS Patients (Adults)		420	400	460	289	290	403	474	512	634	465	474	426	478

Meeting Title:	Trust Board Meeting		
Date:	28 January 2021	**Agenda No.**	**3.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Stephen Collier, Chair of Workforce and Education Committee		
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 10 December including commenting on assurance to the Board on **key risks** allocated to the Committee. After detailed consideration at the December meeting, no changes are proposed to the current risk ratings for Trust Risks SR8 and SR9. However the Committee noted encouraging progress in a number of areas and will return to this issue with a further detailed assessment at its February meeting. The Committee also met on 7 January for one of its Deep Dive Sessions, to review a small number of areas in more detail. Across both meetings, the. **Culture Change** programme remains the critical priority and it is good to report that this is being moved forward with vigour, and its momentum maintained as it approaches the delivery phase. It is important that the Board has a clear sense of the scale at which this is being planned to operate, and the time that the change programme will require for its results to become clear. The move to the third phase (implementation) will not yield an immediate step change in culture, but it will set the critical foundations and changes to our ways of working from which that change will be delivered. One point that the Committee asked me to make to the Board relates to the time that will be needed for culture change to become embedded. The changes sought are largely behavioural and process in nature, and will require real and sustained commitment. None is of the quick-fix variety. So it is critically important that the Trust, and the Board, remain active in support of the programme and give time for the deeper changes that the programme targets to have effect. December was the last meeting for the Trust's retiring **Responsible Officer** Karen Daly, and it was good that both Karen and her successor, Lucinda Etheridge, were able to join us for the meeting. Karen was thanked for her contribution, and in particular the way she has moved forward the RO role, and the Trust's wider engagement with the GMC. We look forward to working with Lucinda.		
Recommendation:	The Board is asked to note this report, approve the Modern Slavery Statement (attached at Appendix 1) and note that, subject to the Board's approval, the Statement will be published on the Trust's website.		
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

At its meetings on 10 December and 7 January the Committee received updates on a number of programmes and initiatives which are currently under way. Progress is being made across all fronts, although it is clear that the pandemic has slowed down some areas.

The Culture Change programme remains the critical priority and it is good to report that this is being moved forward with vigour, and maintaining its momentum. The Board had a full briefing on this in October, and this Report therefore concentrates on the position since then. What also stands out is that the Trust executive is maintaining focus on other (linked) areas as well, so we were encouraged about the overall progress being made on diversity and inclusion, Freedom to Speak Up, education and training, and staff with a disability.

The availability of real-time data on the impact of Covid on the Trust's workforce continues to improve, and we took assurance from the range and detail of the data made available to the Committee.

The Committee initiated planning for its Effectiveness Review, which would be undertaken during February – and any actions required fed into the Committee's forward planning for 21-22.

At a compliance level, there are no adverse matters to be drawn to the attention of the Board.

2. Key points:-

Board Assurance

The Committee has two Trust-level risks[1] allocated to it as part of the Board Assurance Framework. After detailed consideration at the December meeting, no changes are proposed to the current risk ratings for Trust Risks SR8 and SR9. However the Committee noted encouraging progress in a number of areas and will return to this issue with a further detailed assessment at its February meeting.

I mentioned in the November report to the Board that a significant upturn in hospitalised Covid-19 cases and the consequent re-allocation of staff could pose a risk to delivery of a number of culture-related initiatives. At the time of the 10 December meeting there had been no such impact, however consideration is being given by the executive to ensuring the delivery part of the Culture programme is set across realistic timescales given that the continued significant increase in Covid-19 cases into January has the potential to affect delivery timescales.

The Committee received an update from the Trust's People Management Group, summarising current and planned activities being progressed by the executive. This was extremely helpful, both in terms of understanding the extensive initiatives being progressed and helping the Committee with its planning of future focus areas.

Theme 1 - Engagement

Culture Programme Update – From 'Discover' to 'Design'. Humaira Ashraf, Tom Kenward and Daniel Scott updated the Committee at both the December and the January meeting on the move into the Design phase of the programme, and specifically the 5+1 areas identified as the core of the Delivery part of the programme (from January 2021), and the associated Action Plan to support effective delivery and maximise its impact. The discussion at the January meeting was broader, allowing for a useful review of the emerging shape of the delivery phase. This was particularly helpful to the Board, given the number of NEDs who were able to attend. The Committee considered: coverage; content; outcomes and measures; phasing; and how values translated into behaviour.

A clear message which the Committee received was the need to temper expectations about the speed of change that the Delivery phase could and would generate. The 5+1 focus areas are

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

largely behavioural and process in nature, and will require real and sustained commitment to deliver the cultural change sought. None is of the quick-fix variety. So it is critically important that the Trust, and the Board, remain active in support of the programme and give time for the deeper changes that the programme targets to have effect.

In addition, as previously highlighted, there are factors that could have an adverse effect on the programme. The distraction of Covid and the potential for it (unintentionally) to encourage a highly directed command-and-control approach could de-prioritise the culture change programme, and potentially cut across the values and autonomy embodied within it.

Medical Engagement – The Committee received a report from Chief Medical Officer, Richard Jennings, summarising how it was proposed that the work on medical engagement, following on from the survey undertaken in the second half of 2019, would be incorporated within the wider culture programme. The Committee's view was that this made sense for a number of reasons, provided the current momentum could be maintained.

Diversity and Inclusion Action Plan – Progress Update. The Committee received and noted the content of an update at each meeting, showing continuing progress against planned activities. The new Culture Diversity and Inclusion Board will be up and running later this month.

Theme 2 – Leadership and Progression

The Committee was pleased to hear that all interviews for roles in Band 8A and above now routinely include a Recruitment Inclusion Specialist, and that from January 2021 this will be extended to roles at band 7. The anticipation is that later in 2021 this will be further extended to Band 6 roles.

The King's Fund Advanced Leadership Development Programme has begun across three cohorts of managers (20-22 per cohort).

Theme 3 - Workforce Planning and Strategy

Workforce Report - Elizabeth Nyawade summarised a detailed report on workforce metrics for November. Key points were: The new HR Workforce teams restructure that took place in May 2020 introduced a new role - Human Resource Business Partner (HRBP) for each of the four operating divisions; the HRBPs have now been appointed and one of their roles is to review workforce metrics and put in place required actions to support delivery of set targets. Staff completion of the Covid-19 Risk Assessments stood at just over 87%. The Committee noted that for all staff groups other than medical and dental the rate exceeded 90%, but the impact of a new cohort of rotating junior doctors yet to complete their risk assessments had had the effect of slewing the uptake in the medical and dental category to 61%, and of the Trust overall to 87%. Steps were being taken to help secure completion by the new junior doctors.

The Committee reviewed a comprehensive dashboard summarising Covid-related staff absences which in early December were running at c 165 per day. Trust-wide sickness rate (excluding Covid-related) was c4%. Flu vaccine uptake at the end of November was 77.45% (slightly below prior year, but impacted by staff pressures on other fronts). The Committee also noted good progress on internal analysis and categorisation of the Trust's workforce an agreed to review the data in more detail at a future meeting. The Committee reviewed an analysis of Live Employee Relations cases.

Management of Disciplinary Cases – Elizabeth Nyawade briefed the Committee on a new approach to disciplinary cases, which had been introduced from November.

The key change was to formalise the use of a pre-investigation panel, which would bring its joint experience to bear on the management of potential disciplinary cases. The expectation was that this pre-investigation stage and the use of a pre-investigation checklist would facilitate a

greater proportion of cases being dealt with informally, rather than requiring use of the formal processes under the Disciplinary Policy.

In addition, the additional focus on staff health and wellbeing was consistent with the approach recommended in Baroness Harding's advice to Trusts on the use of disciplinary processes. The Trust's Disciplinary Policy had been amended to effect this change. The Committee was briefed on the underlying processes and operational arrangements that had been made in support of this change.

Education and Development Update – Humaira Ashraf and Nicholas Gosling briefed the Committee on progress in a number of related areas within the purview of the Education Strategy Implementation Group, which continued to meet monthly. The stand-out here was the innovation and creativity being shown in many areas, to enable education and training to continue in ways that minimise the risk of Covid transmission. This was most notable in the development of a Covid-secure training area; the creation of a pop-up simulation training facility; and the changed approach allowing the continuation of 'hands-on' surgical training. The Trust can rightly be proud of the commitment to maintaining professional education and training demonstrated here.

Theme 4 – Compliance.

Modern Slavery Annual Statement – the Committee reviewed and endorsed a proposed policy, and then a Statement, by the Trust of its position on modern slavery. The Modern Slavery Statement is attached at Appendix 1. The Board is asked to approve the Statement and, subject to this, note that the Statement will be published on the Trust's website.

Policy Update Programme – we took great assurance from a report prepared by Stephen Jones and Tamara Croud on an organisation-wide programme of checking and where appropriate updating policy documents. The specific focus of the report was in relation to the Trust's workforce and organisational development policies, where activity is being led by the People Management Group.

Safe Working – Dr Serena Haywood joined the January meeting to update on safe working. The key message was that Covid was having a material impact on the demands being made on our junior doctors, leading to a material increase in the number of exception reports this quarter-notwithstanding that rota gaps through to November were generally being reduced. Rota gaps were last assessed prior to the recent redeployments of junior doctors and the gaps will therefore be reappraised once the trainees move back down off the current 'mega rota' and into individual positions. Critically, Serena was also able to set out also what the Trust was doing to provide active support and situation management to reduce some of the impact of the Covid-driven pressure. Whilst this was clearly providing real benefit, the picture we were left with was nonetheless one of severe pressure on our junior doctors, and across the Trust more widely. We took assurance that the junior doctors were not being overlooked in the Trust's approach to providing what support it could to front-line staff.

Bank Staff Holiday Pay – The Committee in private session received a briefing on the impact of the Working Time Regulations and endorsed the approach being adopted by the executive team.

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-compliance by the Trust.

Appendix 1

Modern Slavery Act Trust Statement

The Trust is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Currently, all awarded suppliers sign up to our terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with the Trust's stance on anti-slavery. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

We operate a number of internal policies to ensure that we are conducting business in an ethical and transparent manner. These include:

- Recruitment policy. We operate a robust recruitment policy, including conducting eligibility to work in the UK checks for all directly employed staff, and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will
- Equal Opportunities. We have a range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These fair terms and conditions of employment, and access to training and development opportunities.
- Safeguarding policies. We adhere to the principles inherent within both our safeguarding children and adults' policies. Our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain
- Raising Concerns Policy.We operate a Freedom to Speak Up, Raising Concerns at Work so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals.
- Standards of business conduct. This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes.
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials.
- Random requests that the main contractor provides details of its supply chain.
- Ensuring invitation to tender documents contain a clause on human rights issues.
- Ensuring invitation to tender documents also contain clauses giving the Trust the right to terminate a contract for failure to comply with labour laws.
- Using the standard Supplier Selection Questionnaire (SQ) that has been introduced (which includes a section on Modern Day Slavery).

Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Supplier adherence to our values: we are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.

Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

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4.1

Meeting Title:	**Trust Board**		
Date:	28 January 2021	**Agenda No**	**4.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meetings on the 17th December 2020 and 21st January 2021.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee – December 2020 & January 2021

The Committee met on 17 December and 21 January. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on Annual Planning for 2021/22, Big Projects, Financial Systems, Exiting Financial Special Measures, EU Exit Preparedness, a Procurement Report and Technical Releases.

Committee members discussed the Board Assurance Framework (BAF) risks on Finance, ICT, and Operational Risk, and agreed changes in overall risk scoring in Finance (lower risk) and Operations (higher risk) in view of the impact of the COVID-19 pandemic. The Committee praised the day to day operation of the Trust and commitment of staff in view of unprecedented challenges posed by the virus on ITU and General & Acute beds, which has had a detrimental impact on Trust performance metrics; Emergency Flow 4 hour target, Diagnostics, Cancer and RTT. The Committee discussed current financial performance, cash management and capital expenditure. **The Committee wishes to bring the following items to the Board's attention:**

1.1 Finance, ICT and Operational Risks – the Deputy Chief Financial Officer (DCFO), the Chief Information Officer (CIO) and the Chief Operations Officer (COO) gave updates on their respective BAF risks. In December the committee agreed to increase the Operational Risk score from a 20 to a 25 in view of the pressures of the COVID-19 pandemic on elective activity, Cancer performance and diagnostic recovery, as well as staff sickness. At the same meeting the committee agreed to reduce the Finance Risk score from 25 to 20, following the expected delivery of a financial surplus in 2020/21.

1.2 Estates Report – in December the Director of Estates & Facilities (DE&F) noted the current situation with oxygen supply and the latest on Violence & Aggression on staff at the Trust.

1.3 Activity Performance – the Chief Operations Officer (COO) noted the challenges of delivering daycase and elective targets during December due to COVID-19 pressures, as increasing numbers of COVID+ admissions in acute and ITU beds meant other services needed to redeploy staffing to support. This started during December although it was encouraging to see that performance was still achieved 93% (pending final validation) because of the strong performance at the beginning of the month.

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 84.6% in December. The COO noted that ED performance slowly deteriorated over the month due to the pandemic response and the changes in the clinical pathway this prompted (waiting for COVID test results before admitting into the appropriate COVID+ / COVID- ward, or the challenges in sustaining patient flow across the hospital whilst wards were repurposed to meet increasing COVID need). The COO also noted that the hospital had done extremely well to sustain its usual performance on ambulance handover times and minimal 12 hour breaches, both of which are important in minimising clinical risk and notable achievements given the pandemic pressures during December.

1.5 Diagnostics Performance – the COO noted that the six-week diagnostic standard performance was 22.6% in December compared to 20.0% in November. However, the waiting list size reduced by 4.3%. The COO also noted that the Trust had made significant efforts to sustain diagnostic activity during this current COVID surge, and that this was reflected in the reduced numbers on the waiting lists.

1.6 Cancer Performance – the COO noted further improvements in Cancer performance in November where 3 of the 7 targets were met, and 31, 62 and 104 day metrics are all being improved upon. 2 week wait referrals have increased significantly during October and November although they have reduced during December.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in November of 71.0% had improved against the previous month's value of 67.4%, although the number of 52 week waits of 1,261 was more than the previous month's 1,146. The size of the waiting list (including QMH patients) was 46,835 patients.

1.8 Financial Performance– the DCFO noted performance in month 9 of an £1.8m deficit, which is £1.8m adverse to budget, including £3.8m of COVID costs. The YTD deficit is £5.5m which is £5.5m adverse to budget. The Trust is on forecast which is a £1.9m deficit in month. This aligns to the forecast submitted to NHSI/E in November.

He also noted that the trust cash balance is £79.9m which is £76.9m favourable to plan. The Trust has spent £38.7m of capital at month 9, against a plan of £42.1m (values including COVID).

1.9 Capital Update– the DCFO introduced the Committee to the paper providing an update on capital which showed that since December's committee, the Trust has received confirmation from NHSI/E that it may spend £5m against the London Capital Underspend. This means that the Trust is now pursuing capital spend of £81.4m.

1.10 Financial Forecast– the DCFO introduced a paper describing the work undertaken to develop the Trust's bottom line financial forecast for 2020/21 in January. The paper noted the movements to this month's annual surplus of £2.2m, following increased COVID and reduced non-COVID cost.

1.11 Planning 21-22 – the DCFO noted the progress being made on planning for 2021/22 following the expectation that formal business planning would be delayed for quarter 1 (April-June).

1.12 Projects Update – the Director of Financial Planning introduced papers updating on some of the larger projects that the trust is working on at the moment.

1.13 Exiting Financial Special Measures – the Deputy Chief Executive Officer (DCEO) introduced a paper on progress for the Trust to be removed from Financial Special Measures.

1.14 EU Exit Preparedness – the Chief Transformation Officer (CTO) introduced the paper updating the committee on the Trust's EU Exit Preparedness.

1.15 Procurement Report – the quarterly Procurement Report was circulated for information.

1.16 Financial Systems– the DCEO introduced a paper updating on the Trust's progress with upgrading its financial systems.

1.17 Technical Releases– the latest Technical Releases information was circulated for information.

2.0 Recommendation

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

Ann Beasley
Finance & Investment Committee Chair,
January 2021

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4.2

Meeting Title:	**TRUST BOARD**		
Date:	**28 January 2021**	**Agenda No**	**4.2**
Report Title:	**M9 Finance Report**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer		
Report Author:	Tom Shearer, Deputy Chief Financial Officer		
Presented for:	Update		
Executive Summary:	From M07 onwards, the Trust has received a revised level of block commissioning income. In addition, the Trust is funded on a cost and volume basis for high cost drugs income and COVID testing costs. Previously, the Trust had been requested to report a breakeven financial position by NHSE&I, achieved through an income "top up" accrual to offset the deficit position, as per central guidance. The in-month reported position at M09 is a £1.8m deficit, which is £1.8m adverse to budget, made up of: £3.8m of COVID costs; £3.4m shortfall in block income vs Trust budgeted costs, as set out in the Trust's interim plan for 20/21; £0.7m lower Non NHS income due to significantly reduced BAU activity due to COVID; £0.3m reduced expenditure as a result of not undertaking BAU activity because of COVID; and £5.8m of revised block income and additional funding (net of high cost drugs expenditure funded). The YTD deficit is £5.5m which is £5.5m adverse to budget. The Trust is on forecast which is a £1.9m deficit in month. This aligns to the forecast submitted to NHSI/E in November, which is expected to show a £10.8m deficit at year end (which excludes the £13.0m of Non NHS income adjustment expected to give the Trust a £2.2msurplus). Performance by division is shown in section 4. The Trust has spent £38.7m of capital at month 9, against a plan of £42.1m (values including COVID). The YTD COVID plan is £7.8m, with COVID cost £6.0m. The non- COVID capital spend is therefore £1.5m favourable to plan, with £32.7m spend against the plan of £34.3m. The Trusts cash balance at M9 was £79.9m.		
Recommendation:	The Trust Board notes the update on the financial position at M9		
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		
Equality and Diversity:	There are no equality and diversity impact related to the matters outlined in the report.		
Previously Considered by:	Finance & Investment Committee	**Date**	21/1/21
Appendices:	N/A		

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4.2

Financial Report Month 09 (December 2020)

TB Jan 21

Chief Finance Officer

28th January 2021

Executive Summary

Month 09 Financial Position

- From M07 onwards, the Trust has received a revised level of block commissioning income. In addition, the Trust is funded on a cost and volume basis for high cost drugs income and COVID testing costs. Previously, the Trust had been requested to report a breakeven financial position by NHSE&I, achieved through an income "top up" accrual to offset the deficit position, as per central guidance.

- The in month reported position at M09 is a **£1.8m deficit, which is £1.8m adverse to budget**, made up of: £3.8m of COVID costs; £3.4m shortfall in block income vs Trust budgeted costs, as set out in the Trust's interim plan for 20/21; £0.7m lower Non NHS income due to significantly reduced BAU activity due to COVID; £0.3m reduced expenditure as a result of not undertaking BAU activity because of COVID; and £5.8m of revised block income and additional funding (net of high cost drugs expenditure funded). This is shown graphically in the slide in section 2. The **YTD deficit is £5.5m which is £5.5m adverse to budget**.

- The Trust is **on forecast** which is a £1.9m deficit in month. This aligns to the forecast submitted to NHSI/E in November, which is expected to show a £10.8m deficit at year end (which excludes the £13.0m of Non NHS income adjustment expected to give the Trust a £2.2m surplus). Performance by division is shown in section 4.

- The Trust has received retrospective top up income covering the underlying deficit in full for M1-6, following payment being confirmed for the value of bad debt provision included YTD.

- The Trust has spent **£38.7m of capital at month 9, against a plan of £42.1m** (values including COVID). The YTD COVID plan is £7.8m, with COVID cost £6.0m. The non-COVID capital spend is therefore £1.5m favourable to plan, with £32.7m spend against the plan of £34.3m.

- The Trusts cash balance at M9 was £79.9m. 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 09 Financial Performance

			Full Year Budget (£m)	M9 Budget (£m)	M9 Actual (£m)	M9 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding COVID and Income Top Up	**Income**	SLA Income	787.6	66.4	67.2	0.7	590.2	574.7	(15.5)
		Other Income	164.2	13.6	13.2	(0.4)	123.2	113.7	(9.5)
	Income Total		**951.8**	**80.1**	**80.4**	**0.3**	**713.4**	**688.4**	**(25.0)**
	Expenditure	Pay	(583.6)	(48.8)	(48.8)	(0.1)	(437.2)	(429.6)	7.5
		Non Pay	(329.1)	(28.1)	(26.4)	1.6	(246.9)	(237.2)	9.7
	Expenditure Total		**(912.7)**	**(76.8)**	**(75.3)**	**1.5**	**(684.1)**	**(666.8)**	**17.3**
	Post Ebitda		(39.1)	(3.3)	(3.2)	0.1	(29.3)	(29.1)	0.3
	Grand Total		**0.0**	**(0.0)**	**2.0**	**2.0**	**0.0**	**(7.5)**	**(7.5)**
COVID and Income Top Up	**COVID**	Pay	0.0	0.0	(1.9)	(1.9)	0.0	(14.8)	(14.8)
		Non Pay	0.0	0.0	(1.9)	(1.9)	0.0	(13.0)	(13.0)
	Total COVID		**0.0**	**0.0**	**(3.8)**	**(3.8)**	**0.0**	**(27.9)**	**(27.9)**
	Income Top Up	SLA Income	0.0	0.0	0.0	0.0	0.0	29.9	29.9
	Reported Position		**0.0**	**(0.0)**	**(1.8)**	**(1.8)**	**0.0**	**(5.5)**	**(5.5)**

Month 09 Financial Position

- The in month reported position at **M09 is a £1.8m deficit, which is £1.8m adverse to budget. The YTD position is a £5.5m deficit, which is £5.5m adverse to budget.** Between April and September, guidance from NHSE&I stated that the Trust should report a breakeven position, which was achieved by an income top up accrual to balance the position.
- For October to December, the Trust's revised forecast Block Commissioning income is £198.9m, which consists of: National Block Income; Sector Funding; and COVID Funding. In addition to this, the Trust receives additional income for: NHSE High Cost Drugs, Hep C and CDF Funding (£2.5m YTD); and COVID Testing Funding (£2.1m YTD).
- The YTD financial impact of COVID on the Trust from additional expenditure is £27.9m and the YTD income top up value, received between April and September, is £29.9m (with no top-up between October and December).
- Excluding COVID costs, and excluding the income top-up accrual, the Trust's YTD position would be £7.5m adverse to plan. This is due to the shortfall in block income of £30.8m, £6.2m of lower non-NHS income as a result of not undertaking BAU activity because of COVID. This is offset by £15.8m of underspends as a result of not undertaking BAU activity because of COVID, and £13.6m of Commissioning income from revised block and additional funding (net of drugs overspend).

2. Balance Sheet as at December 2020

Statement of Financial Position	FY 19-20 Audited Mar-20 (£m)	M09 December-20 FY20-21 YTD Actual (£m)	Variance
Fixed assets	**426.9**	**445.1**	**18.2**
Current assets			
Stock	**11.9**	12.7	0.8
Debtors	**93.7**	83.7	(10.0)
Cash	**3.5**	79.9	76.4
Total Current Assets	**109.1**	**176.3**	**67.2**
Current liabilities			
Creditors	**(94.0)**	(192.3)	(98.3)
Capital creditors	**(22.5)**	(15.2)	7.3
PDC div creditor	**0.0**	(3.5)	(3.5)
Int payable creditor	**(0.1)**	(0.1)	0.0
Provisions< 1 year	**(0.3)**	(0.2)	0.1
Borrowings< 1 year	**(322.5)**	(5.1)	317.4
Total current liabilities	**(439.4)**	**(216.4)**	**223.0**
Net current assets/-liabilities	**(330.3)**	**(40.1)**	**290.2**
Provisions> 1 year	**(2.5)**	(2.8)	(0.3)
Borrowings> 1 year	**(69.9)**	(57.9)	12.0
Total Long-term liabilities	**(72.4)**	(60.7)	11.7
Net assets	**24.2**	**344.3**	**320.1**
Taxpayer's equity			
Public Dividend Capital	**135.7**	461.9	326.2
Retained Earnings	**(226.5)**	(232.6)	(6.1)
Revaluation Reserve	**113.8**	113.8	0.0
Other reserves	**1.2**	1.2	0.0
Total taxpayer's equity	**24.2**	**344.3**	**320.1**

M09 FY20-21 YTD Statement of Financial Position

Fixed assets increased by £18.2m since March-20. This includes the impact of depreciation and capital expenditure YTD.

Stock level is £0.8m higher compared to Mar-20.

Debtors has decreased by £10.0m since March 2020.

The cash position is £76.4m higher than reported at year-end in March-20. This is due to the block contract payment for January-21 received in advance in December-20.

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

Creditors are £98.3m 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 January-21 funding received in advance.

Capital creditors are £7.3m better than March-20. This is due to the payment of year-end capital invoices.

Department of Health (DoH) has converted £325m of both capital and revenue loan to PDC on 1st September-20. So in M06 PDC increased to £462m. After conversion, the Trust is left with outstanding loans to DoH of £11.4m for capital as shown on slide 12g.

3. YTD Analysis of Cash Movement

Statement of Cash Flow	M09 YTD FY 20-21 Actual £m
Opening Cash balance	**3.4**
Income and expenditure deficit	(6.1)
Depreciation	20.6
Interest payable	1.6
PDC dividend	7.5
Other non-cash items	(0.1)
Operating surplus/(deficit)	**23.5**
Change in stock	(0.8)
Change in debtors	10.0
Change in creditors	98.3
Change in provisions	0.2
Net change in working capital	**107.7**
Capital spend	(38.5)
Capital Creditors	(7.3)
Capital additions Finance leases	2.1
Interest paid	(1.6)
PDC dividend paid/refund	(4.0)
Interest Received	0.0
Net change in investing activities	**(49.3)**
PDC Capital Received	326.2
DH Loan converted to PDC	(325.0)
DH Loan YE Accrued Interest Reversal	(1.4)
DH Capital £14.747m Loan repaid	(0.6)
LEEF Loan (Other Loan)	(1.5)
PFI	(0.9)
Finance lease repayments	(2.2)
Net change in financing activities	**(5.4)**
Cash balance as at 31.12.2020	**79.9**

M09 FY20-21 YTD cash movement

The cumulative M09 20-21 I&E deficit is £6.1m. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).

Within the I&E deficit of £6.1m, depreciation (£20.6m) does not impact cash. The charges for interest payable (£1.6m) and PDC dividend (£7.5m) 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 £23.5m.

The net change in working capital has increased to £107.7m in December-20 compared to £13.8 in March-20. This is due to major movement in creditors of £98.3m, which is due to the deferred income as a result of Covid-19. Stock level is increased in M09 as compared to March-20.

DH capital loan repayment of £0.6m has been repaid until Dec-20 and LEEF loan payment of £1.4m until December-20.

The Trust received PDC of £1.1m in July-20 for Capital. The Trust has requested and received £13.3m from the total PDC award for capital of £50.4m in Month 10. The Trust intends to submit another request for £10m in January and the remaining by March. Drawdown cannot be requested in advance of spend

DH loan amount of £325m was converted to PDC in September 2020.

<u>December-20 cash position</u>

The Trust achieved a cash balance of £79.9m on 31st December 2020, £76.9m higher than the £3m minimum cash balance required by NHSI. This is due to January-21 block contract income received in advance in December-20.

4. M09 Capital

The Trust has spent £38.7m of capital at month 9, against a plan of £42.1m (values including COVID). The YTD COVID plan is £7.8m, with COVID cost £6.0m.

TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	Budget £000	M01	M02	M03	M04	M05	M06	M07	M08	M09	M09 YTD budget £000	M09 YTD exp £000	*M09 YTD var £000*
Infrastructure renewal	**21,724**	680	706	1,204	449	464	617	378	1,253	351	**6,576**	6,102	*474*
P22	**10,000**	47	72	560	793	1,322	1,629	165	1,686	974	**7,636**	7,248	*388*
Major projects	**21,937**	864	172	51	578	370	853	912	3,482	2,368	**9,674**	9,650	*24*
IT	**7,670**	1,736	1,335	(933)	753	425	729	300	810	257	**5,590**	5,412	*178*
Medical equipment	**1,500**	215	223	(12)	82	58	22	(173)	576	(46)	**985**	945	*40*
Leases	**5,000**	913	(894)	477	241	157	1,173	229	68	744	**3,500**	3,108	*392*
SWLP	**820**	-	108	(108)	-	-	-	79	218	(17)	**320**	280	*40*
Total	**68,651**	4,455	1,722	1,239	2,896	2,796	5,023	1,890	8,093	4,631	**34,281**	32,745	*1,536*
COVID	**7,799**	1,595	1,441	766	1,976	329	8	51	77	(276)	**7,799**	5,967	*1,832*
Total inc COVID	**76,450**	6,050	3,163	2,005	4,872	3,125	5,031	1,941	8,170	4,355	**42,080**	38,712	3,368

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4.3

Meeting Title:	**Trust Board**		
Date:	28 January 2021	**Agenda No**	**4.3**
Report Title:	**Board Assurance Framework (BAF) – Quarter 3 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 3 2020/21. The BAF has been updated with the Q3 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 3 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. At Q3 2021/21, there is one change to the Strategic Risk scores. At the December Finance and Investment Committee, the Committee agreed to a proposal from the Chief Finance Officer that the score for Strategic Risk 5 (financial sustainability) be lowered from a maximum score of 25 to a score of 20 (5 consequence x 4 likelihood), on the basis of the improved Trust financial position and the system-wide financial arrangements now in place. There are no other changes to the headline Strategic Risk scores at Q3. Across a number of the strategic risks, the impact of the second wave of the Covid-19 pandemic is apparent. A number of actions to address gaps in control planned for completion at this stage of the year have not yet been implemented fully. This is most apparent across SR1 (patient safety), SR2 (clinical governance), SR3 (timeliness of care), and to a lesser extent SR8 (culture). The most significant of these delays has been to the full implementation of the phase 1 and phase 2 clinical governance review recommendations, receipt and agreement of the phase 3 review, and compliance with seven day standards. **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.		
	The Board is asked: 1. For the strategic risk reserved to itself (SR4) to: • Agree the proposed score of 12 (4c x 3L) (no change)		

	• Agree the proposed assurance rating as 'partial' and the assurance statement 2. For the 9 risks assigned to its assuring committees to: • Approve the risk score for SR5 (financial sustainability) which was agreed by the Finance and Investment Committee in December 2020 • Note the risk scores, assurance ratings and associated statements following review by the relevant Committee		
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:	Quality and Safety Committee Finance and Investment Committee	**Date**	21.01.2021 21.01.2021
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 Q3 2020/21		

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4.3

Board Assurance Framework 2020/21

Trust Board
Quarter 3 BAF Report

Stephen Jones
Chief Corporate Affairs Officer

28 January 2021

Executive Summary

The Board approved the new Strategic Risks on the Board Assurance Framework (BAF) at its meeting in May 2020. 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)

Quarter 3 2020/21 Update:
This report presents the Quarter 3 2020/21 position for the BAF. The BAF has been updated with the Quarter 3 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 is regularly undertaken.

At Q3 2021/21, there is one change to the Strategic Risk scores which the Board is asked to endorse. At the December Finance and Investment Committee, the Committee agreed to a proposal from the Chief Finance Officer that the score for Strategic Risk 5 (financial sustainability) be lowered from a maximum score of 25 to a score of 20 (5 consequence x 4 likelihood), on the basis of the improved Trust financial position and the system-wide financial arrangements now in place. There are no other changes to the headline Strategic Risk scores at Q3.

Across a number of the strategic risks, the impact of the second wave of the Covid-19 pandemic is apparent. A number of actions to address gaps in control planned for completion at this stage of the year have not yet been implemented fully. This is most apparent across SR1 (patient safety), SR2 (clinical governance), SR3 (timeliness of care), and to a lesser extent SR8 (culture). The most significant of these delays has been to the full implementation of the phase 1 and phase 2 clinical governance review recommendations, receipt and agreement of the phase 3 review, and compliance with seven day standards.

Executive Summary

Strategic Risks 4 (system working) is reserved to the Board. 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.

The Q4 BAF report will set out how the Trust's performance in delivering against the target risk scores at year-end.

The Board is asked:

1. For the Strategic Risk reserved to itself (SR4) to:
    - Agree the proposed score of 12 (4c x 3l) (no change)
    - Agree the proposed assurance rating as 'partial' and the assurance statement

2. For the 9 risks assigned to its assuring Committees to:
    - Approve the risk score for SR5 (financial sustainability) which was agreed by the Finance and Investment Committee in December 2020
    - Note the risk scores, assurance ratings and associated statements following review by the relevant Committee

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 - 20	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

Outstanding care every time

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 • Demand for services in wave 2 is significant and bed occupancy remains high despite temporary suspension of priority 3 and 4 activity
	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. This work has now recommenced with revised dates, however progress has been impeded again due to the second wave • Clinical Safety Strategy developed • Delay in implementing recommendations from phase 1 and 2 governance review • Delay in receipt of the outcome of the phase 3 governance review and Trust response to the findings
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	• Vaccine hubs have been established and vaccines offered initially to high risk patient groups and staff (working in SW London Hospitals) and now open to all staff working with/ alongside patient facing staff and partner organisations • The Winter Plan 2020/21 includes comprehensive plan to respond to a second wave of Covid-19 including temporary suspension of priority 3 and 4 activity
	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	• The Trust is continuing to work with system partners to integrate Covid-19 recovery activity/ governance arrangements with pre-existing plans/ governance structures • The SWL Integrated Care System (ICS) has established a Covid-19 Recovery Board which has overseen the development, and will oversee delivery, of the SWL ICS Covid-19 recovery plan. The Trust CEO is a member of the SWL ICS Covid-19 Recover Board • 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
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	• New financial framework in place for 2020/21 aimed at addressing Covid-19 activity, as well a standing back up elective activity • Monthly reporting will review spend to ensure costs are stepped down where expected, and cost increases due to COVID-19 are reasonable and justified • Top up funding has been received to cover costs in M1-5, with M6 funding confirmation pending. • An interim block arrangement for NHS income is to continue through M7-12 of 2020/21
	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 has committed to material capital spend in response to the COVID-19 pandemic (£7.8m), for which it awaits confirmation of £1.8m of funding • Further spend has been included in the Trusts capital plan for 2020/21 relating to standing back up elective activity, and addressing urgent IT issues associated with virtual working

Outstanding care every time

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

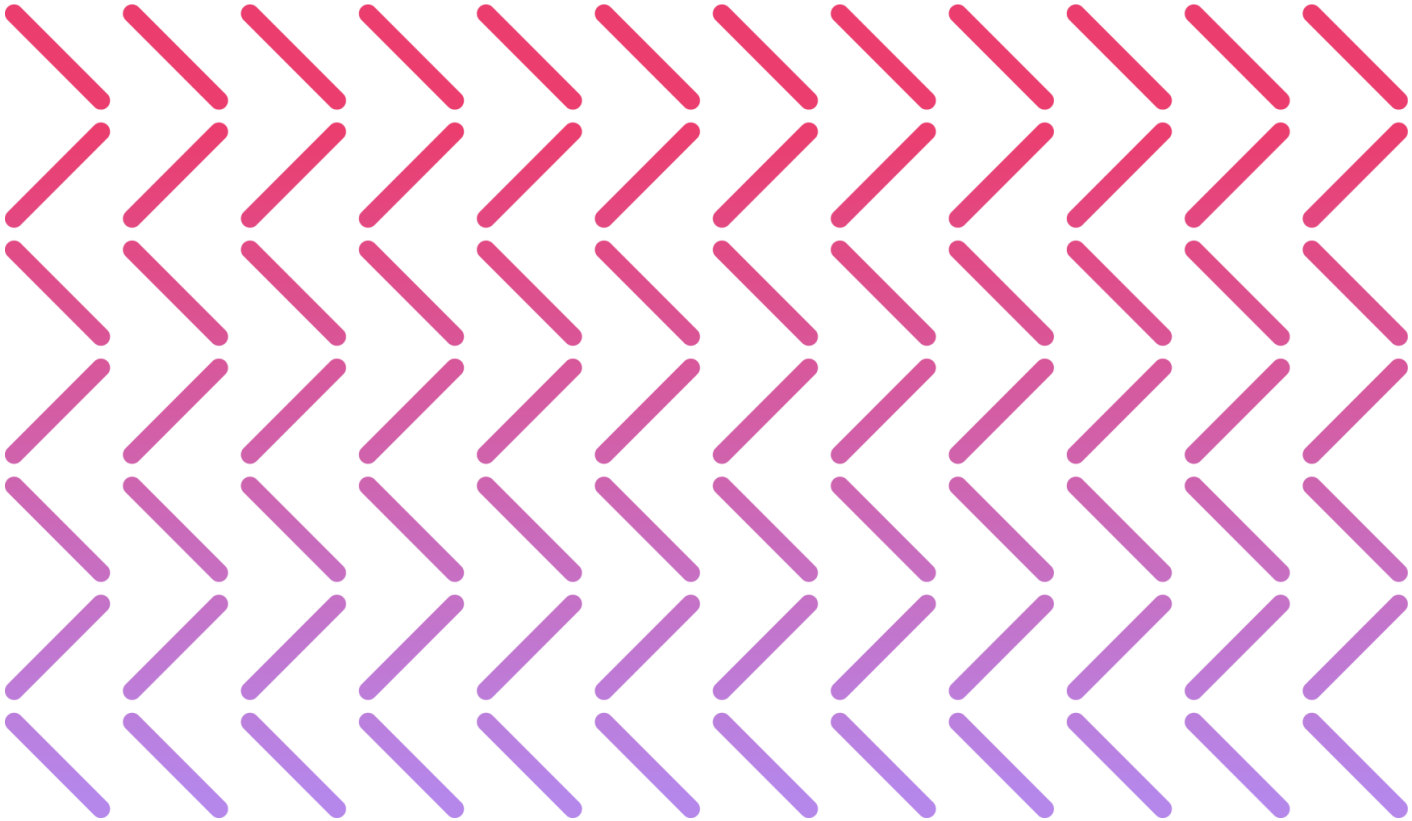
Strategic Objective	Risk Reference	2020/21 Strategic Risks	Covid-19: Implications for the Board Assurance Framework
4. Build a better St George's	SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates 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 had an impact on the completion of the diagnostic phase of the culture programme and the secon wave has impacted on the timings of the development of the action plan. • Covid highlighted certain underlying issues in relation to diversity and inclusion that the Trust is now seeking to address. • There has been an increase in the number of staff raising concerns during the pandemic. • Additional staff support systems have been implemented together with regular Trust wide communications
	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. • Staff remain under significant pressure in the second wave. Redeployment has again been successful but agency spend has increased over the Christmas period and due to the current levels of staff sickness and Covid related absence
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 recommenced • 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.

Outstanding care every time

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	21 January 2021

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) was approved at Board in September 2020 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-19, 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	Extreme 16 = 4(C) x 4(L)	Partial	N/A		
Q4					

Summary COVID-19 Impact

Infection Prevention and Control guidance continues to be implemented and revised as and when required directed by Public Health England.

The Trust has revised its hospital visiting policy. The Trust has developed a COVID-19, Flu and Winter Plan which was approved at Board in September 2020. Demand for services in wave 2 is significant and bed occupancy remains high despite temporary suspension of priority 3 and 4 activity.

The Executive Team hold a daily Covid-19 Gold meeting to oversee the significant associated operational issues and priorities and to review a Covid daily dashboard.

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	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	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	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 • Learning from complaints included in divisional governance reports		x x xx x	x x
Infection Control Policy including Root Cause Analysis (RCA) for all C. Diff cases to ensure learning in place	S	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	G		• nEWS assurance audit completed over August/September 2020: Complete set 83%; Correctly scored 88%; Appropriate response 60%; Frequency 82% • 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	x x	x x	
Sepsis tool live on iClip	G	G	G			x		

Strategic Objective	Treat the patient, treat the person
SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Gaps in resourcing of governance functions within the corporate and divisional teams impacting on learning across the organisation	**Recruit to new positions as approved within the business plan** • *Head of Patient Safety and Clinical Effectiveness commenced in post 11 January 2021* • *Head of Risk and Compliance: second candidate withdrew. Recruitment process to recommence* • *Deputy CMO posts appointed to, commenced in post 7 December 2020* • *Recruitment to legal services team commenced, two Band 7 roles appointed to* • *Team leader M&M and MDT Co-ordinator: appointed, start date TBC* • *M&M and MDT Co-ordinators: Advert closed*	Sep 2020	
Seven day clinical services standards (also see SR3)	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** *All Care Groups have updated their risk assessment. Directorates have defined plans to address all non- compliance.* *Provision of MRI has an action plan which depends on re-tendering for the expansion, which has been paused. In the meantime, the Trust is planning to mitigate the impact by expanding the staffing of the current MRI capacity.*	Sep 2020	
Critical Care Outreach team not recruited to full establishment	**Deliver recruitment plan to Critical Care** *Critical Care recruitment plan reviewed and revised as partial recruitment only achieved due to Covid-19. The multidisciplinary make-up of the team is being reassessed which may involve recruiting more senior nurses B7. Re-costing models expected to be finalised by April 2021*	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	
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*** *SMS feedback method in place for virtual and face to face outpatient appointments. SMS surveys for inpatient surveys set up and scoping commenced to extend SMS surveys to inpatient areas. This will provide contactless surveys in all areas and free up staff time but reduce response rates, testing phase completed in December 2020 as planned.*	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					In December 2020 there has been and increase in completed TEPS for adult inpatients compared with the monthly number completed between July and November 2020
Compliance with appropriate response to Early Warning Score (adult)					December 2020 - Compliance with appropriate response to EWS (adults) was 94%
Severity of reported incidents					Severity of adverse incidents – 97% No harm/ Low harm in October 2020
Number of declared serious incidents					2 serious incidents were declared in December 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)					2 Never Events were declared in December 2020
Infection Control (MRSA, C. Diff, MSSA, E-Coli)					MRSA 0, Hospital Acquired CDiff 5; MSSA 4; and E-Coli 9 reported in December 2020
Number of hospital acquired pressure ulcer category 3 and above					13 category 3 pressures ulcers in December 2020
Safety Thermometer percentage of patients with Harm Free Care (new harm)					Safety thermometer– percentage of patients with harm free care was 95% in October and remains within target
Friends and Family Test					In December 2020 all services have continued to exceed their target for positive FFT response. The Emergency Department only reaching 80.6%

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	21 January 2021					
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. Following the publication of the Independent Mortality Panel's Review and Independent Scrutiny Panel's Review on 26 March 2020 Trust Board reviewed the comprehensive sources of assurance that the cardiac surgery service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these reports had been or were being acted upon. The CMO and the Associate Medical Directors continue to progress improvement actions and drive engagement. The Board has requested a comprehensive report on cardiac surgery one year on from the publication of the review. The Trust has key controls and sources of assurance in place, for example the 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 of 8(4x2) was approved at Board in September 2020 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	High 12 = 4(C) x 3(L)	Partial	N/A		
				Q4					
			Summary COVID-19 Impact	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 with the agreement of the CQC. There have been delays in implementing recommendations from phase 1 and 2 governance review and a delay in delay in receipt of the outcome of the phase 3 governance review and the Trust engagement with the review. Other plans have also been delayed due to resources being diverted to other Covid-19 priorities.				

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	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 • CQC reviewed progress against the CQC action plan at the Trust engagement meeting on 13 October 2020	X	X	X X X
Board agreement to invest in identified improvements to clinical governance	S	S	S		• Phase 1 and phase 2 external governance reviews			X X
Improvement plan for Cardiac Surgery services	S	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	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	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	R		• MCA level 1 and 2 training levels across all staff groups reported	X X	X X	
Electronic templates for the recording of Capacity Assessment and best interest decisions			G		• Electronic templates for the recording of Capacity Assessment launched on 2 November 2020	X		
Medical Examiner System in place	S	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	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	R		• Trust does not comply with NHS England Standard Contact for Discharge Summary			X

Outstanding care every time

Strategic Objective	Treat the patient, treat the person
SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Gaps in resourcing of governance functions within the corporate and divisional teams impacting on learning across the organisation	**Recruit to new positions as approved within the plan** • *Head of Patient Safety and Clinical Effectiveness commenced in post 11 January 2021* • *Head of Risk and Compliance: second candidate withdrew. Recruitment process to recommence* • *Deputy CMO posts appointed to, commenced in post 7 December 2020* • *Recruitment to legal services team commenced, two Band 7 roles appointed to* • *Team leader M&M and MDT Co-ordinator: appointed, start date TBC* • *M&M and MDT Co-ordinators: Advert closed*	Sep 2020	
MCA level 3 training module not developed	**Develop and implement MCA level 3 training module. Level 3 / Champions programme** *There is limited resource to develop and implement the level 3 MCA training module. However, the module will be developed by the end of Quarter 4 2020/21 and implemented in Quarter 1 2021/22.*	Mar 2021	
OrderComms catalogue not kept up to date therefore not all results are reported via Cerner	**Update Cerner OrderComms catalogue** *Plans being finalised for IT team, Radiology team and SWLP team to engage to update catalogue.* *Plans have been delayed due to resources being diverted to set up COVID vaccine hub*	TBC	
eDischarge Summary Form not available on iClip	**Finalise the eDischarge form to be included onto iClip** *The requirement for this action has changed in that these documents have to be structured with discrete data and headings. This requires GPs to be able to receive this form and the Trust to be able to send it. The GP functionality is now available but Cerner do not have a solution yet and this will require significant investment when it becomes available.* *The Trust is mitigating this risk by sending discharge documentation electronically via DOCMAN albeit in an unstructured form.*	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** *Consent audit methodology developed and Trust wide audit has commenced.*	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

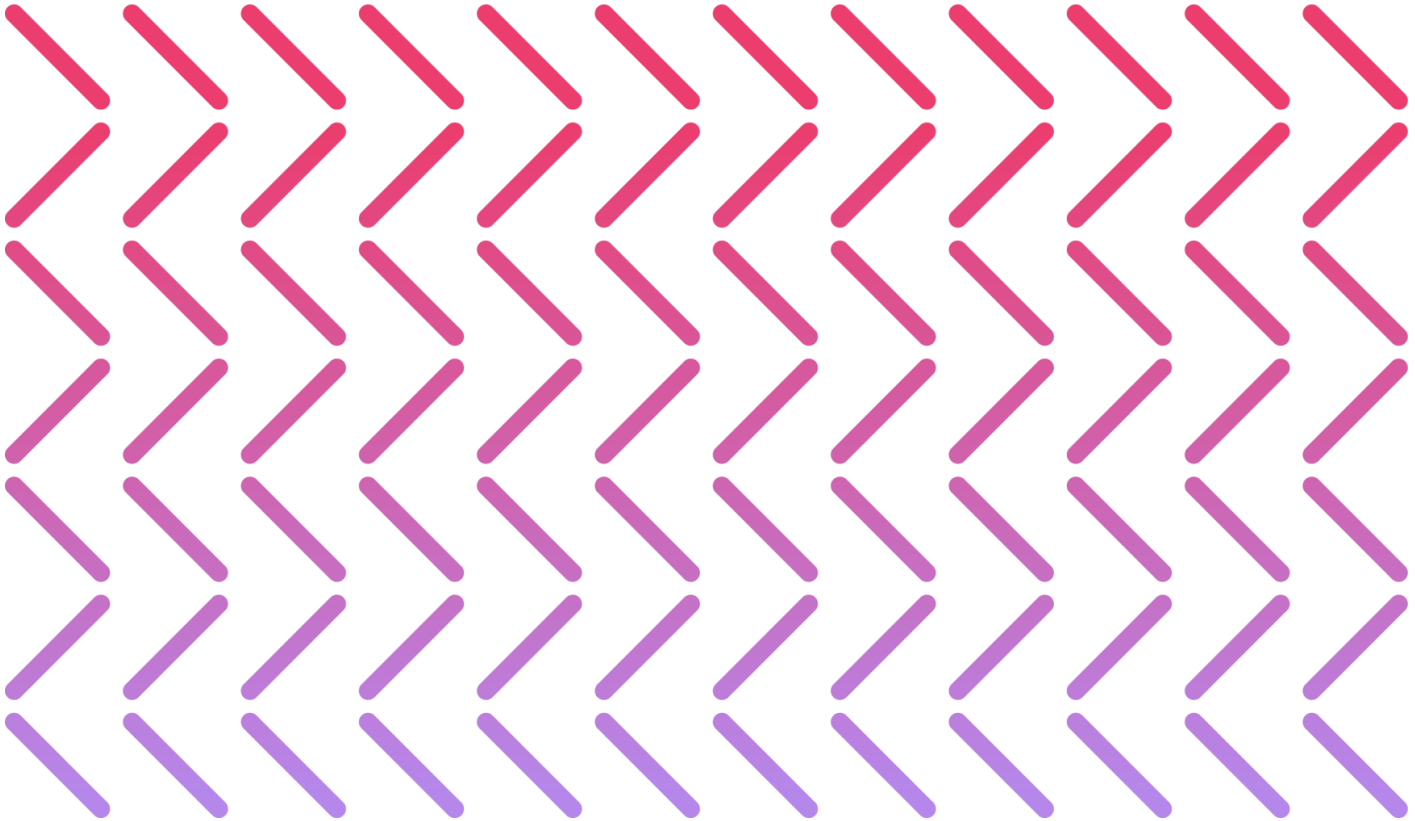
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Progress against phase 1 and phase 2 governance reviews					Learning from Deaths lead in place. Successful recruitment to X3 DCMO posts, Head of Patient Safety and Effectiveness, and x2 Band 7 posts within the Legal Services team
Maintaining the SHIMI within the confidence level (<0.1)					SHMI is 0.87 and is lower than expected for the year August 2019 – July 2020
Open serious incident investigations > 60 days					All serious incident investigations continue to be completed within the 60 day timeframe
Readmission within 30 days (linked to failure in discharge planning)					9.4% readmission rate in November 2020
Number of open actions on CQC Trust wide action plan (2 Must dos: 44 should dos)					December 2020 8 actions completed, 18actions reported as completed and evidence is being gathered. Progress impacted by Covid-19
MCA level 1 and level 2 training performance					December 2020 - Level 1 MCA training compliance is 92% and it is above target, level 2 compliance is 77% against the 85% target
Diagnostic indicators – DM01					In December 2020, the Trust did not achieve the six week diagnostic standard with an adverse performance of 22.6% against the target threshold of 1%.

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

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	21 January 2021					
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 four of the 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	**Extreme – 20 5(c) x 4(L)**	**Limited**	N/A		
				Q4					
			Summary COVID-19 Impact	The Trust has embedded the operating guidance for the management of urgent elective surgical patients. This process has dedicated 'green' Covid protected areas with patients being screened prior to admission. The Trust has continued to run a range of retained services, such as: trauma, maternity, neonatal, cancer, stroke, heart attack, medical and surgical take, paediatrics, imaging and pathology. However, priority 3 and 4 activity is currently suspended. Diagnostic services including endoscopy, breast and bowel screening have been maintained including our elective and diagnostic activity for priority 1 and 2 patients.				

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	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	R		Performance included in Integrated Quality and Performance Report (IQPR)		X	
Digital strategy - ICT Work plan aligned to Digital strategy	G	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	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	R		Information Governance Group		X	
New workflow in iClip for Referral Assessment Service clinics as part of Covid19 changes	S	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	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	S		ICT Covid-19 Service Management Report presented to IGG in April 2020		X	
ED rapid assessment and triage process in place	G	G	G		Clinical pathway and Standard Operating Procedure (SOP)	X		
Direct access pathways	G	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	R		Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	G	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 All Care Groups have updated their risk assessment. Directorates have defined plans to address all non- compliance. Provision of MRI has an action plan which depends on re-tendering for the expansion, which has been paused. In the meantime, the Trust is planning to mitigate the impact by expanding the staffing of the current MRI capacity.	Sep 2020	
Availability of paediatric trained physiologist / ECHO technicians to carry out ECHO	Recruitment of vacant post within the new cardiac physiology structure Appointment of one member of staff. To start in February 2021	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 project re-scoped with COS post-Covid and re-prioritised. Plan date changed due to other demands placed on ICT resourcing	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. Proof of concept completed, business case in draft for purchase and installation by end of financial year	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 DSU has gone live with updated content; Lanes theatre teams and QMH DCU prepping for go live. Completion date change due to other demands placed on ICT resourcing	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 additional testing underway with ICT currently piloting Win10 VDI desktop before roll out to trust	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					Nov 20 – 9,984 ED Attendances 32% less than November 2019 activity (on average -158 attendances per day)
Inpatient – non elective					Nov 20 – 3,156 Non Elective Spells 23% lower than Nov-19 activity. Compared to the previous month there has been an average decrease of 3 admissions per day
Inpatient – elective and day case					Nov 20 – 4,458 Day case / Elective activity. 82% of last years November 2019 activity. With data catch up and guidance against the wave 3 elective guidance performance was 91% of last years activity against a target of 90%.
Outpatient attendances					Nov 20 – 48,536 Att. 83% of the same period in 2019 with the phase 3 recovery target at 90% (this excludes COVID-19 activity). The Trust saw 44% of all outpatient activity in a virtual environment
RTT					Performance improved to 67.4% in October compared to 63.7% in September with the number of patients waiting greater 18 weeks reducing by 1,531 patients. In total 1,146 patients have waited longer than 52 weeks to begin treatment.
6 week Diagnostic Performance					In November 20% against the target of <1% which was an improvement on last month position of 21.1% in October. A reduction of 12% in patients waiting for more than 6 weeks. The waiting list has seen a reduction of 7%
ED 4hr operating standard					December performance was 84.6%%.
Cancer 14 Day Standard					Improvement seen in November with performance at 91.2%, compared to 86.5% in September. The number referrals returning to pre COVID-19 levels.
Cancer 62 Day referral to Treatment Standard					Performance in November was at 65.2%

Emergent / future risks	Future opportunities
Cerner nightly extracts being terminated so need to rebuild reporting in data warehouse to meet SUS/SLAM etc requirements	The restructure of the Genomics services will increase the demand on ECHO

Strategic Objective	Right care, right place, right time			
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**			
Risk Appetite / Tolerance	**MODERATE**	Because we recognise that significant changes are necessary across the South West London system, we have a moderate appetite for risks that impact on system transformation and cross-system working in order to facilitate changes that will improve care for patients across South West London.	**Assurance Committee**	**Trust Board**
			Executive Lead(s)	Chief Strategy Officer
			Date last Reviewed	25 November 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 its 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.

COVID-19 has had an impact on this risk. There is a risk the Trust will not meet the stretching recovery trajectories set on elective care ,cancer and urgent/emergency care, and a risk to delivery of pre –COVID strategic priorities due to the required focus on COVID recovery plans. These risks and mitigations are set out in more detail under 'summary COVID-19 impact'. However COVID-19 has also accelerated some areas of collaborative transformational work across the system.

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	N/A		
Q3	High 12= 4(C)x3(L)	Partial			
Q4					

Summary COVID-19 Impact

There is a risk the Trust will not meet the stretching recovery trajectories set on elective care ,cancer and urgent/emergency care. The Trust will mitigate this risk via robust internal management of recovery trajectories, risks and mitigations, and via collaboration with external partners through the SWL Elective Recovery Programme. There is also a risk to delivery of pre –COVID strategic priorities due to the required focus on COVID recovery plans. The Trust is continuing to work with system partners to integrate COVID recovery activity / governance arrangements with pre-existing plans/governance structures.

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 Trust CEO is a member of the SWL ICS Covid-19 Recover Board. 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

Strategic Objective	Right care, right place, right time
SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Limited clinical and management capacity within the Trust to engage with and deliver the clinical priorities for Wandsworth and Merton as set out in their respective Local Health and Care Plans	Both Wandsworth and Merton Health and Care Partnership Boards have reviewed 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. NHSE/I have delayed business planning due to COVID, so this will be completed later than Mar 2021	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 Agreement with CCG that given SWL-wide financial control total, costs of rental will not be moved around the system	Complete	

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

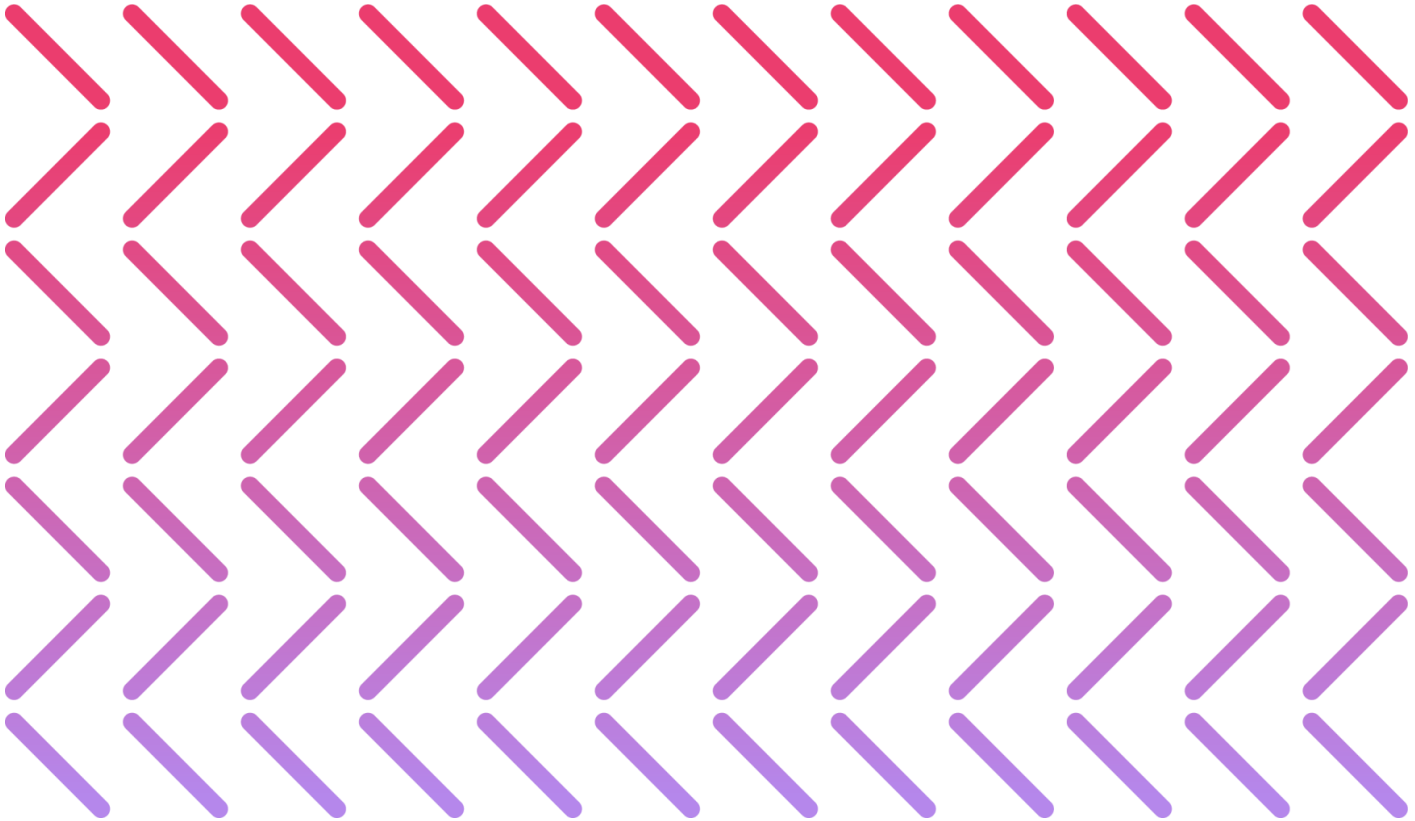
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
A SWL Covid19 recovery plan in place					The Trust is represented on the SWL Recovery Board and associated workstreams leading the development of the Covid-19 recovery plan, which has now been agreed.
Clinical Safety Strategy in place and has identified revised clinical pathways across SWL					14 SWL clinical networks have now been established – though some elements of their work programmes have been paused due to COVID
The number of clinical networks which are fully established for which SGUH is the lead provider					SGUH clinicians have leadership roles in 8 of the 14 networks
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.
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 was 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 was presented to Trust Board September 2020

Emergent / future risks	Future opportunities
The continued focus on the response to Covid-19 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 Building Your Future Hospitals (BYFH, previously Improving Healthcare Together or IHT) programme may present some risks to the Trust's ability to manage the potential increase in demand. The Trust has set out the capital investment it would require from the programme, as well as enabling investment in ED required from other sources, but these have not yet been confirmed.	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 The consultation on the future of Integrated Care Systems may support closed system working and provide a statutory framework on which to build closer collaboration and integration.

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	21 January 2021

4.3

Current risk and assurance assessment

The Finance and Investment Committee reviewed the scoring of the Strategic Risk at its meeting in December 2020 and agreed to propose a reduction in the score from 25 (5c x 5l) to 20 (5c x 4l), representing a reduction in the likelihood.

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. Funding envelopes have been confirmed for M7-12 20/21, and the Trust is currently planning for a £2.2m surplus. It should be noted that this includes the assumption of £13m of additional "top-up" income from NHSI/E to offset losses in non-NHS income, which is yet to be confirmed. This plan also does not include the financial impact of a second COVID wave, as per national guidance. There is yet to be clarity on how any potential additional costs associated with this are funded.

An in-year target risk score of 12(4x3) was agreed by the Board in September 2020 on the recommendation of the CFO to reflect the changes in the system financial position in SWL and the impact of this on the Trust.

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**	N/A		
Q3	**Extreme 20 = 5(C) x 4(L)**	**Partial**	↓ Risk reduced to 20 from 25		
Q4					

Summary COVID-19 Impact

New financial framework in place for 20/21 aimed at addressing COVID 19 activity, as well a standing back up elective activity.

Monthly reporting will review spend to ensure costs are stepped down where expected, and cost increases due to COVID are reasonable and justified.

Top up funding has been received to cover costs in M1-5, with M6 funding confirmation pending.

An interim block arrangement for NHS income is to continue through M7-12 of 20/21.

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	S		Monthly divisional finance reports	XX	XX	
Monthly reporting of financial issues through to OMG, TMG, FIC and Trust Board	S	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	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	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	R		SWL Monthly Finance Report			X
Plan in place for financial balance in 21/22 , or in line with NHSI/E control total			P		Plan agreed as part of SWL for financial balance in 21/22.			X

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
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. - Issues picked up by CFO following monthly review. Escalation in place via HoFs.	Complete	
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 - Trust reporting balanced financial position including some efficiencies. Delivery to be monitored through monthly reporting.	Complete	
Current forecast predicts c£75m shortfall against current levels of funding	- Challenge to be made through divisional financial reviews - Issues to be raised through SWL ICS to NHSEI regarding funding shortfalls - Awaiting confirmation of M7-12 funding to confirm scale of challenge.	Complete	
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 - Framework agreed by CFOs and CEOs - Further work required to ensure full benefit realised from SWL working.	Sept 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 - Whilst complete for theatres and inpatient beds, further work required on outpatients.	Sept 20	
Lack of accountability within services for financial performance and delivery	- Finance to be included within objectives of all leadership posts with financial responsibility within the organisation	Nov 20	
Plan for 21/22 currently year still in infancy, with no clarity in level of income the Trust will be in receipt of	- Continue to progress work as per planning timetable internally and with SWL ICS - Await planning guidance, and funding enveloped so scale of challenge, and action required can be confirmed.	Mar 21	

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 to M6. Funding confirmation required of non-NHS income shortfall to ensure balance through M7-12.
Financial balance forecast through to year end					Balanced forecast submitted, pending confirmation of £13m non-NHS income funding.
CIP/improvement plan to be agreed and delivered					Efficiency plan in place for 20/21. Further work required on stepping back up recurrent efficiency programme ahead of 21/22.
SWL plan to be developed to remain within control total					First draft SWL forecast complete, showing balance pending non-NHS income funding confirmation.

Emergent / future risks	Future opportunities
- COVID second wave not included in forecast, so poses risk to delivery of forecast - Competing priorities within divisions meaning finance isn't prioritised	Financial improvement/mitigation through further collaboration within the SWL ICS

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	21 January 2021

Current risk and assurance assessment

Prioritisation completed at SWL level as part of planning process

Trusts capital plans currently have funding confirmed against them for 20/21.

Monthly reviews taking place with DCFO to ensure significant level of spend forecast through Q4 20/21 takes place in a structured and managed way.

Trusts capital plans for 21/22 and beyond do not have sources of funding confirmed against them.

Alternative sources of funding to continue to be explored where feasible (ie. Leasing) for 21/22 and beyond.

SWL prioritisation to be completed for 21/22 schemes, although capital allowance yet to be confirmed by NHSI/E for 21/22.

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	N/A		
Q3	**Extreme 20 = 4(C) x 5(L)**	Partial	N/A		
Q4					

Summary COVID-19 Impact

The Trust has committed to material capital spend in response to the COVID 19 pandemic (£7.8m), for which it awaits confirmation of £1.8m of funding.

Further spend has been included in the Trusts capital plan for 20/21 relating to standing back up elective activity, and addressing urgent IT issues associated with virtual working.

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	S		Monthly finance reports		x	
Weekly COVID Capital funding update and discussion at OMG, to review clinical urgency of requests.	S	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	S		SWL Capital Plan report		x	

4.3

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 Emergency funding approved	Complete	
No alternative means of financing identified to fund programme	Alternative methods of financing current programme to be developed by DCFO Alternative options identified	Complete	
Confirmation of funding for 21/22 programme in place	Further work required through ICS to ensure funding for 21/22 (and beyond) in place.	Feb 21	

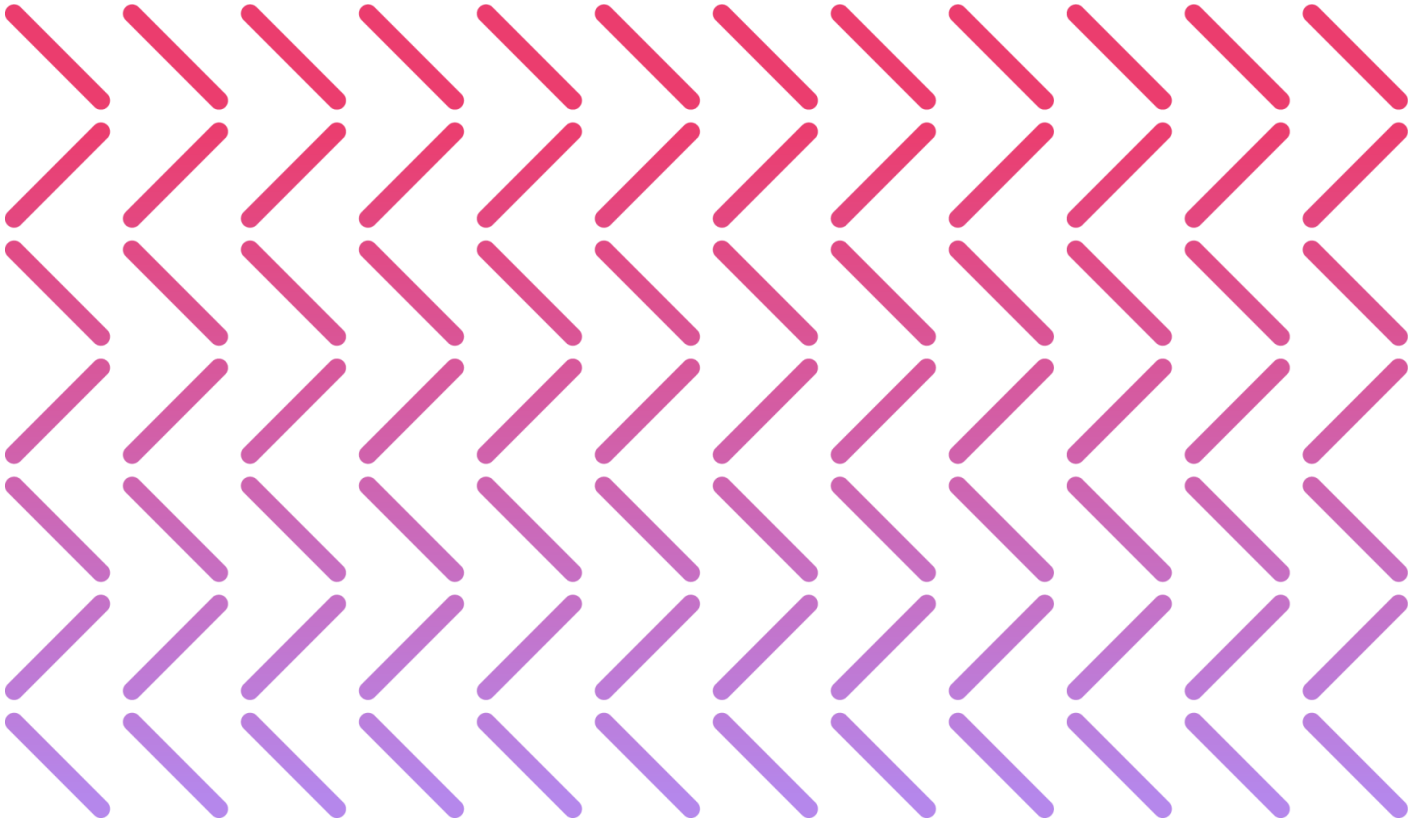
Strategic Objective	Balance the books, invest in our future
SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Funding confirmed for full 20/21 capital programme					Funding confirmed for 20/21 plan.
Funding confirmed for 5 year capital plan					No further clarification on additional sources of finance for 21/22 and beyond.
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					Full spend forecast, although risks and mitigations in place for higher spend forecast in Q4

Emergent / future risks	Future opportunities
- Risks associated with funding commitments made around ITU expansion into 21/22 still to be mitigated through SWL capital allocation process. - Funding for 21/22 BAU and projects still to be identified/confirmed.	- 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 as well as ITU expansion.

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	21 January 2021					
Current risk and assurance assessment	Our current risk assessments indicate that this is a High risk for the Trust. We have progressed better implementation of the Premises Assurance Model. An independent third party consultancy has reviewed our evidence base, suggested and implemented changes and improvements and helped design a dashboard for regular review. Having reviewed our risk registers as a leadership team, we have decided to completely rewrite our risk assessments to move towards complete alignment with the PAM subject areas. This will allow for clearer management of actions aligned with the PAM costed action plans. We plan to have this complete rewrite of our risks completed by February 2021, together with a physical 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. We have commenced work on the development of our estates strategy with the appointment of our professional team, aiming to have a draft strategy in place by the end of March 2021. Our 3D model of the site is also complete. An in-year target risk score of 16 (4x6) was agreed 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	N/A		
				Q3	**Extreme 20 = 4(c) x 5(L)**	Partial	N/A		
				Q4					
			Summary COVID-19 Impact	Significant work is ongoing to develop short and long term ITU expansion solutions, the first physical works should be over the next 4-6 weeks. Improvement works to ED ongoing to improve social distancing. No anticipated impact on project delivery due to COVID at this time.					

Strategic Objective ch	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	S		Independent surveys and AE reports provide assurance on key issues Assurances are provides through safety working groups. PAM now provides enhanced assurance, this has now been assessed externally and improvements being implemented.. 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	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	R		Subject specific safety groups (e.g.. Ventilation, water etc) are now being regularly held, reporting and assurance will be reviewed by the new Estates Assurance Group PAM now provides better assurance, although we need to enhance our data and systems capability to provide the right levels of assurance in an accurate manner.		XX	XX
Compliant Premises Assurance Model (PAM) in place			R		Independent testing and deep dive report to FIC November 2020		X	X

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 independently tested PAM compliance	Audit PAM compliance level – Report to be issued w/c 12th October, FIC deep dive due in November 2020	Complete	
No monitoring group to oversee activities	Estate Assurance Group to oversee activities (group will consist of Director, Deputy Director and AD Health & Safety) from November 2020	Complete	
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, New post being created to manage data and systems across the team, to be advertised in November 2020	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 A range of capital planning scenarios will be developed as part of the development of the estate strategy. It is envisaged that the work will be completed by March 2021	Jan 2021	
Governance groups are not aligned with new wider assurance arrangements	Groups restarting with reviews of ToRs being undertaken. Estates activities to be overseen by new Estates Assurance Group, first meeting to be held in November 20. Suggesting wider governance review to be undertaken over next quarter	Feb 2021	
Current Estate Strategy is not aligned with Clinical Strategy	New estate strategy to be developed in line with other Trust strategies Team appointed in October 20 to commence work on strategy, work is now actively underway	Mar 2021	

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

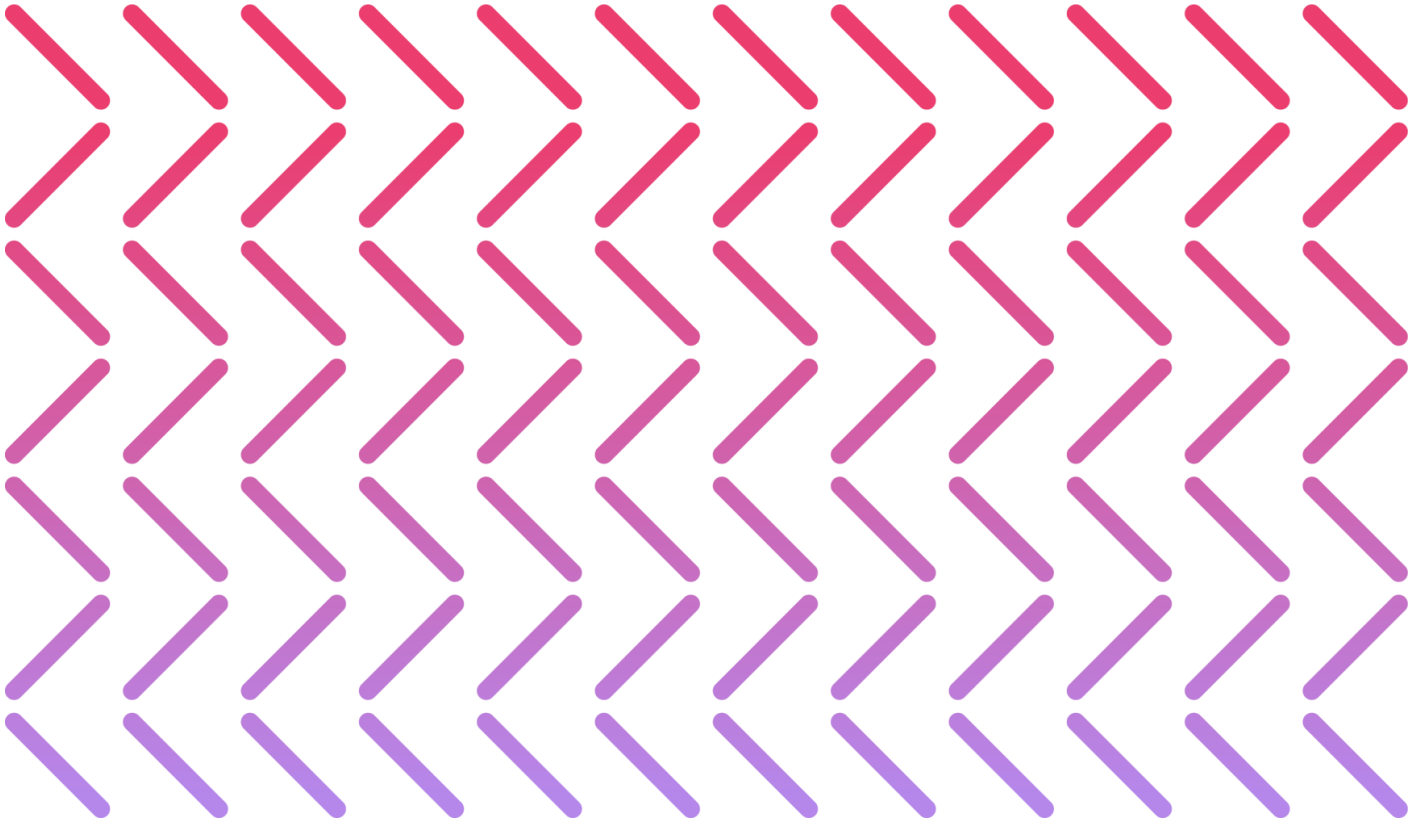
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
% of reports on items of statutory compliance completed to required timescales					Latest figures show no adverse reports on statutory compliance, remedial work is needed on the level of training and resources for Authorised Persons.
% of backlog maintenance tasks (reactive / planned) undertaken in line with plan					Currently 84% of reactive calls are dealt with in accordance to internal performance levels, planned maintenance at 67%
Capital expenditure spend profile against agreed plan					Anticipated spend profile is behind target due to lack of certainty on budget
% of PAM compliance					First PAM dashboards now being produced to show level of compliance and progress against costed action plans

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

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	10 December 2020					
Current risk and assurance assessment	The Trust continues to face significant challenges in relation to diversity and inclusion, with staff feeling unable 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 are being addressed by the new D&I Lead. A new FTSU Strategy and Vision was approved by the Board in September 2020. A new D&I action plan is in place and there is regular reporting on this to the Board and the Workforce and Education Committee. The strengthening culture work is progressing and the diagnostic phase is completed. The FTSU strategy is now being implemented. A year-end target risk score of 16 (4c x 4l) was agreed by the Board 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	**Extreme 20= 4(C) x 5(L)**	**Limited**	N/A		
				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. Staff have been under significant pressure during the current second wave of the pandemic and a range of staff support measures have been in place, with further steps planned in the coming weeks.					

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	S		Approved by Trust Board			X
The Diversity and Inclusion action plan agreed by the Trust Board in July 2020		G	G		Progress of D&I action plan delivery reviewed at PMG fortnightly		X	
Robust Diversity and Inclusion Strategy delivery plan		S	S		D&I action plan, delivery tracker and impact tracker in use to track progress		X	
Culture change programme established with clear timelines for delivery	S	S	S		Initial culture change progress report presented to the Board Feb 2020; diagnostics findings report presented to execs in Sep 2020 and to Board in Nov 2020		X	
Freedom to Speak Up Strategy and Vision in place			S		FTSU vision and strategy approved by Trust Board		X	
Freedom to Speak Up function established with dedicated Guardian in place	G	G	G		Trust is rated 204 out of 230 Trusts in England on FTSU Index			X
Policy framework in place (EDI, Dignity at Work, Raising Concerns)	G	G	S		Approved by Board		X	
Staff networks in place to support particular groups	G	G	S		Networks in place and meeting regularly. Positive early engagement from staff in staff network groups		X	
B&H helpline established supplemented by access to Staff Support	R	R	R		Staff survey			X
Leadership and Management Development Programmes in place (paused during COVID-19 and challenges in organising new meetings	R	R	R		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	S		Effectiveness and board visibility assessed through staff survey and Culture diagnostic review.		X X	
Trust D&I lead recruited and in place	G	G	S		D&I Lead in post.	X		
Inclusion of BAME Recruitment Inclusion Specialists (RIS) on panels at Bands 8a+			S		% of 8a+ panels that include a RIS monitored DI Dashboard (100% in Sept-Nov)	X		
IT software package to record FTSU concerns	W	G	G		Case management solution in place to support FTSU case tracking and reporting	X		
Central repository for capturing and recording B&H		G	G		Excel currently; will be replaced by Selenity (to be implemented by end Feb 2021)	X		
Covid surge plan and Health and Well-being plan available on the Intranet			G		Plan reviewed by PMG, OMG. Surge plan includes initiatives in place to support staff about the physical and emotional well-being of staff		X	
Staff well-being group setup to respond to emerging staff concerns			R		Emerging themes reviewed at PMG as part of the Health and Well-being update	X	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
Survey pulse tool yet to be agreed	Agree which survey pulse tool to be used Go Engage tool has been discontinued. Decision on which pulse tool to use now likely to be made in Feb 2021.	Sep 2020	
Updated EDI (Equality, Diversity and Inclusion) policy	Review of EDI at Work policy to ensure clarity and ease of usage Approved by Partnership Forum 10/12/2020	Complete	
Positive shift 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 Diagnostic phase completed 11/2020, Design phase in progress (output = action plan to address key findings) due to complete 02/2021.Implementation/delivery phase to start 03/2021.	Dec 2020	
Staff do not feel safe to raise concerns and lack confidence that actions will be taken where concerns are raised	Implementation of 2020/21 FTSU action plan, including development of FTSU Charter, revision of raising concerns policy, development of JD for FTSU champions, review of FTSU champions network, development of reporting pack on concerns for sharing / engagement with divisions	Mar 2021	
Need for skilled Org Development capability and capacity to deliver agreed culture programme and D&I interventional activities and training programme	Build Organisational Development capacity and capability for the delivery of the D&I and Culture programmes	Mar 2021	
Programme management approach to deliver the D&I and Culture programme (including governance and oversight)	Develop Programme management approach Programme management approach has been developed, will be completed in 01/2021 with launch of the Culture, Diversity & Inclusion (CDI) programme board.	Jan 2021	
NEW: Staff access to MS Teams (required as on-line meetings replace face-to-face meetings) is inconsistent across the Trust	Work with IT to ensure all staff can access MS Teams	Feb 2021	
NEW: Dynamic feedback loop with ops team and staff support/well-being sub-group.	ACPO(C) + ACPO(W) to attend staff support/well-being sub-group meetings and report findings to exec, PMG + Ops groups as required.	Jan 2021	
Robust system to manage employee relations data (incl bullying & harassment incidents). Spreadsheet limitation in relation to data capture and ESR system does not have the facility to retain info audit trail (moved from SR9)	Central spreadsheet repository introduced for current ER activities (supported by Head of workforce intelligence). Selenity to be implemented in Feb 2021 to manage data going forward.	Mar 2021	

Strategic Objective	Champion Team St George's
SR8	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Number of Freedom to Speak Up concerns raised with Guardian					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, If restarts it won't be before 1st Jan 2021.
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					Nov 2020 turnover rate (excluding junior doctors) was 15.3% against a target of 13%
Number of BAME staff in band 6, 7 and 8a roles					BAME recruitment from Aug to Nov in Band 6 has increased 1.2%, 0.1% in Band 7, .2% in Band 8a+ – workforce data
Staff sickness numbers					Aim to remain stable in spite of Covid surge. Benchmark data/sickness records

Emergent / future risks	Future opportunities
• Risk that the Trust is not seen to have taken decisive action to address serious concerns raised by staff • 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 • Risk that culture programme does not deliver anticipated changes / improvements	• Delivery of the culture change programme • Learning from Trusts with positive FTSU cultures and from NHSE&I's ongoing support on FTSU.

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	10 December 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 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 = 4(C) x 4(L)**
				Q2	**Extreme 16 = 4(C) x 4(L)**	Partial	N/A		
				Q3	**Extreme 16 = 4(C) x 4(L)**	Partial	N/A		
				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. Government social distancing guidelines have severely impacted the delivery of education programmes (due to lack of suitable space large enough for face-to-face training and infrastructure for remote provision). Additionally, there is a risk of further impact to staff well-being as reduced face-to-face staff and network meetings continue and feelings of isolation and exclusion may increase.				

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
Trust-wide workforce plan that sets out recruitment requirements for 2021/22	Develop Trust-wide workforce plan for 2021/22 which includes the review of funding establishment against Staff in Post to identify the gap, review use of contingency workforce, and develop required recruitment strategies to fill the gaps, the review of service demand and capacity to identify gaps; and the development of plans to recruit MTIs to address ongoing medical workforce rota gaps	Mar 2021	
Trust-wide workforce plan that sets out retention policies, practices and requirements	Develop and implement Trust-wide workforce plan that sets our retention policies, practices and requirement. (Implement NHS People Plan; Develop/ launch Health & Well-being/ staff support initiatives; New exit survey has been implemented; flexible working policy/procedure & role mapping toolkit has been developed, and the Flexible Working policy/procedure has been implemented. Plan to improve appraisal completion rates are being addressed by HRBPs	Dec 2021	
Governance process for existing extended roles – ACPs and PA	Deploy new roles on relevant patient pathway – for ACPs and PAs	Mar 2021	
International Recruitment Strategy for hard to recruit to posts	HRBPs to identify hard to recruit to posts ACPW - Develop an International Recruitment Strategy working with SWL APC Recruitment Hub	Mar 2021	
Trust-wide workforce plan that sets out education & development needs to upskill existing and future workforce	Develop Trust-wide workforce plan that sets our Education & Development needs: HRBPs to Conduct Training Needs Analysis for each division by staff group; Deliver advanced leadership programme; Develop programme of blended on-line/face-to-face training	May 2021	
No minimum CPD funding allocated for non-NMAP staff	Include the CPD funding for non-NMAP into the 2021/22 business planning process	Jul 2021	
System to track CPD funding and dedicated administrative support to implement it	Commence implementation of system to track CPD funding and appoint CPD funding administrator System to track CPD funding implemented	Jan 2021	
Structured identification and development of new roles required to deliver patient care	Develop governance process for the identification of new roles and required funding On-going identification of new roles and development governance process for the new roles identified Identified training needs required and funding where relevant	Mar 2021	
Implementation of Apprenticeship Strategy	Implement Strategy. Apprenticeship Roles to be identified and apprenticeship manager to be recruited to facilitate the implementation of the Apprenticeship strategy	Apr 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

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	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	S		Education strategy implementation progress report to WEC		X	
Development of new roles (i.e. ACPs) to help fill the gaps in vacancies	S	S	S		Workforce report to WEC		X	
Monthly review of the funded establishment	S	S	S		Monthly reports to Trust Board		X	
Workforce priority plan in place with an underpinning action plan	G	G	G		Successful nursing recruitment days – national award won in October 2019 Reduction in use of agency staff – spend below cap in April 2020		X	
Advanced Clinical Practitioner Working Group established to work with HEE	G	G	G		Participation in NHSI regional retention scheme – reduction in nursing vacancies			X
Monthly qualified nursing and healthcare assistant open days	S	S	S		Guardian of Safe Working Hours Report		X	X
Appraisal training sessions / ad hoc training in place	R	R	R		Training completion log in Education Centre booking system		X	
Workforce strategy implementation plan		S	S		Quarterly report to Trust Board		X	
Education implementation plan		S	S		Monthly Strategy group meeting to monitor progress with all key stakeholders, including IT team		X	
New compliant contracts of employment templates			G		Monthly report to Medical staffing team	X		
Performance and Development Review (Appraisal) guidance reviewed and in place			G		Appraisal completion monitoring via ESR, appraisal training available for all appraisers. PDR system transformation programme (including Totara upgrade) in progress.	X		
CPD funding system process			G		Funding established for NMAP staff		X	
Apprenticeship Strategy			G		Strategy signed off, to be implemented		X	

4.3

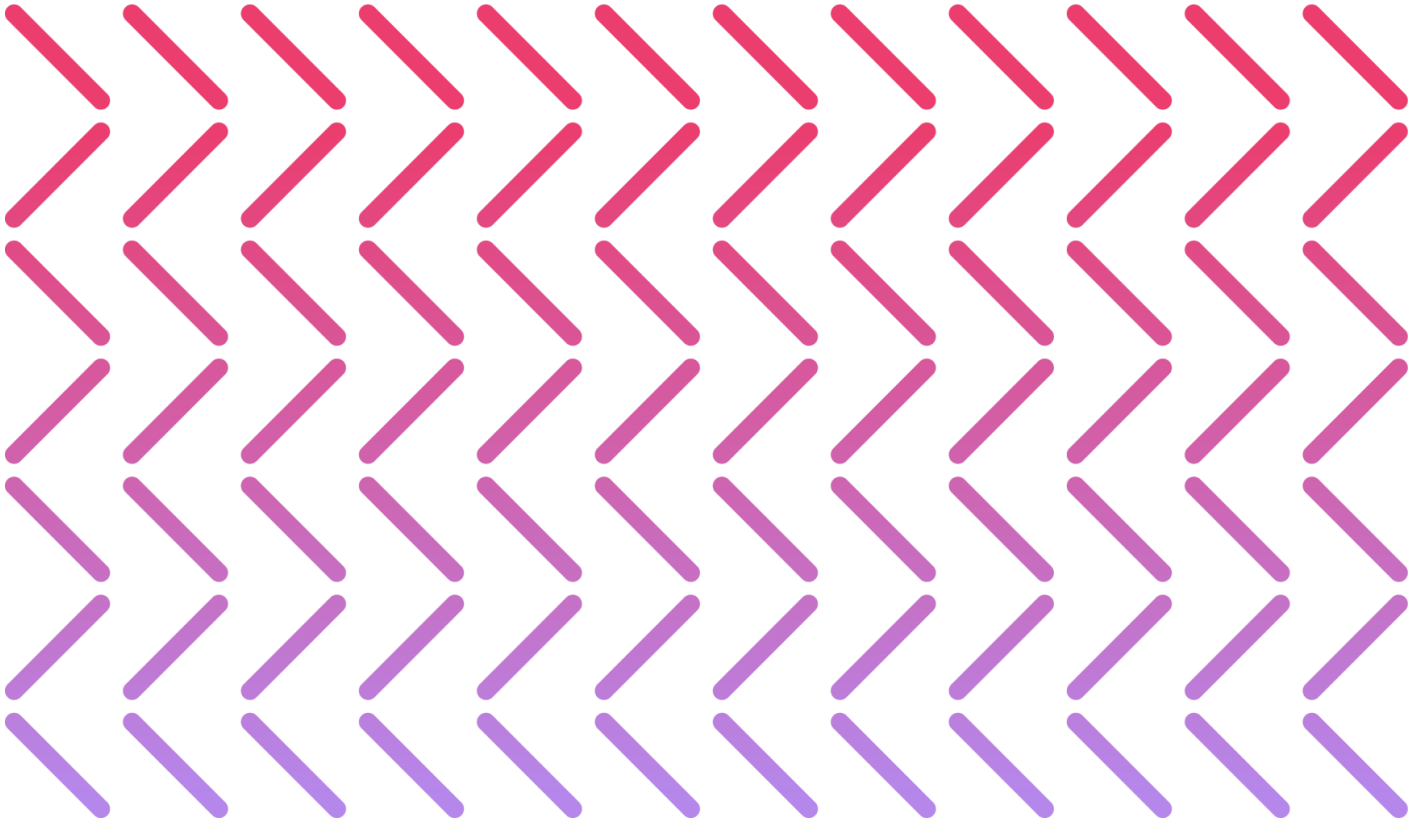
Strategic Objective	Champion Team St George's
SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Trust vacancy rate					Trust vacancy rate in November 2020 was 9.1% against a target of 10%
Turnover Rate					Trust turnover rate (excluding junior doctors) in November 2020 was 15.3% against a target of 13%
Sickness absence rates					Trust sickness absence rate of 3.3% in November 2020 compared with Trust target of 3.2%
Bank and agency rate					In November 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 November 2020 were at 70.6% compared with Trust target of 90%. Target not met throughout 2019/20
MAST compliance percentage					November performance of 90.0% compared with Trust target of 85%
Stability Index					November 87% (target 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

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	21 January 2021					
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. The in-year target risk score of 6 (3x2) was approved at Trust Board in September 20200 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	Moderate 9 = 3(c) x 3(L)	Good	N/A		
				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.				

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	S	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	G		Partnership in place. The Institute of Clinical Research and all four Clinical Academic Groups, which are joint Trust/University structures, have been set up	X	X	
Key role in south London Clinical Research Network (chaired by CEO)	S	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	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	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	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	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	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	S		Bi-monthly meeting		X	
Four Clinical Academic Groups formerly established	S	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

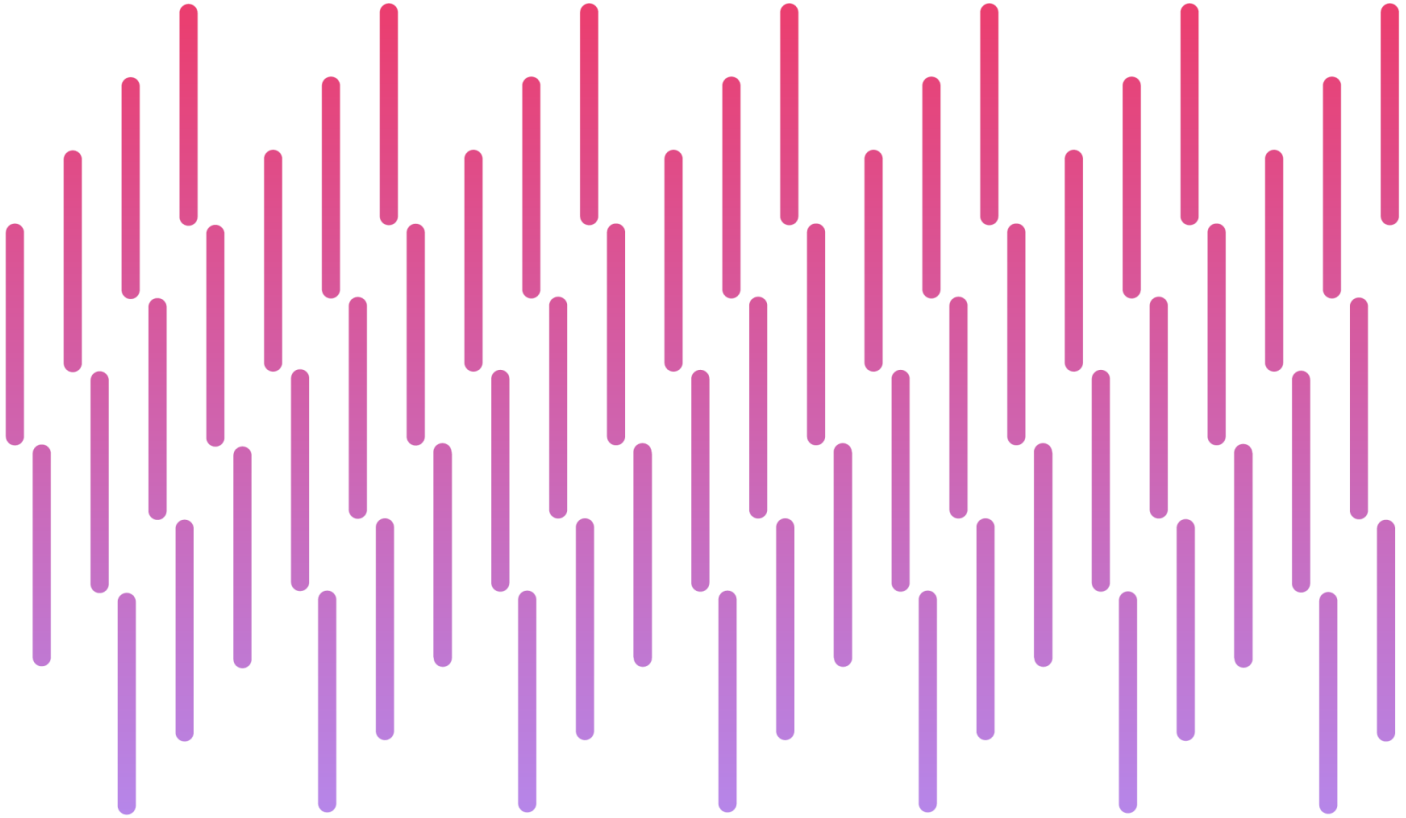
Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Few clinical academics - Many areas of Trust activity are not reflected in St George's University London research	**Seek investment to allow more clinical academic appointments** *The new Institute 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	
Institute for Clinical Research fully functioning	Re-establish fully functional Institute for Clinical Research and recruit to administrator position Administrator has been appointed and will start in January	December 2021	

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

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 Dec 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**	**6**
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	Dec 2016	**20**	**8**
7 Day Service Standards	MD1118	Failure to comply with 4 standards of the Seven day Service due to resource limitation and/or lack of defined operating model	Nov 2016	**12**	**12**
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 Dec 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 SR1)	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 SR1)	Apr 2020	20	20
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	16	12
Diagnostics within 6 weeks	TBC	Risk that under-compliance with 6 week diagnostic standard will allow patient harm	TBC	20	9
Patient flow	TBC	Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission	TBC	20	16
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	20	12
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	12
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	IT- 1717	Sub-optimal Virtual Desktop Infrastructure (VDI) due to insufficient licenses, insufficient compute power, and upgrade to Win10.	Nov 2018	12	12
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 Dec 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	20
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

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 Dec 2020
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	HR-2178	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**

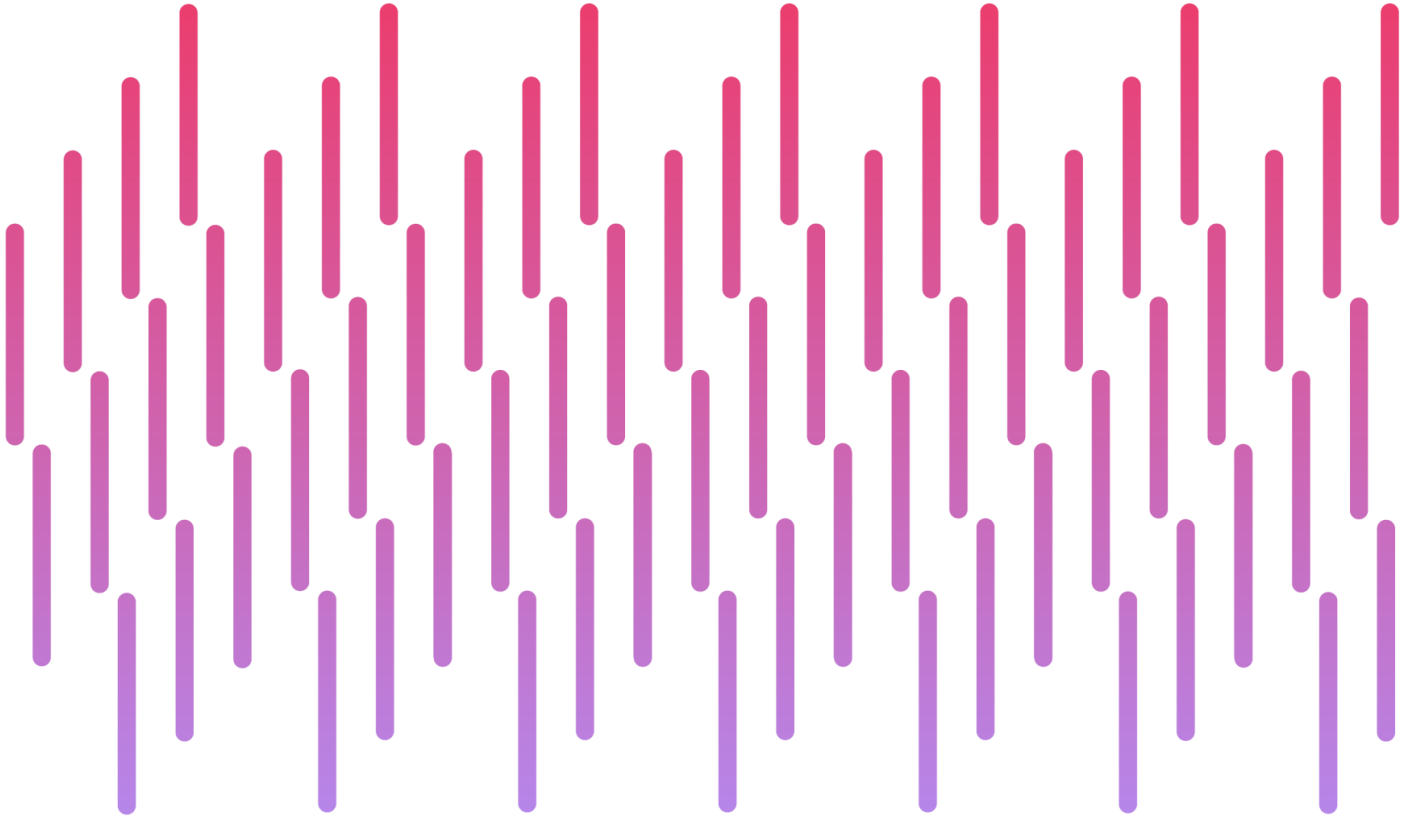
Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Dec 202
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**
Compliance with section 1 of the Employment Rights Act (1996)	HR-2164	Failure to comply with changes to the Section 1 of the Employment Rights Act (1996) statement come into effect on 6 April 2020	Sep 2020	**16**	**12**
Administration of honorary contracts staff	HR-2166	Risk that Trust does not comply with the training/legal requirement for honorary contract staff	Sep 2020	**12**	**8**
Employee relations activities	HR-2163	Inability to provide historical data on Employee relations activity	Sep 2020	**20**	**16**
Disciplinary process	HR-2165	Risk that fair, effective, independent and objective disciplinary actions are not taken	Sep 2020	**20**	**15**
Education Strategy	HR-2179	Failure to deliver the Education Strategy due to potential lack of organisational engagement and financial constraints	Oct 2020	**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 Dec 202
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

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

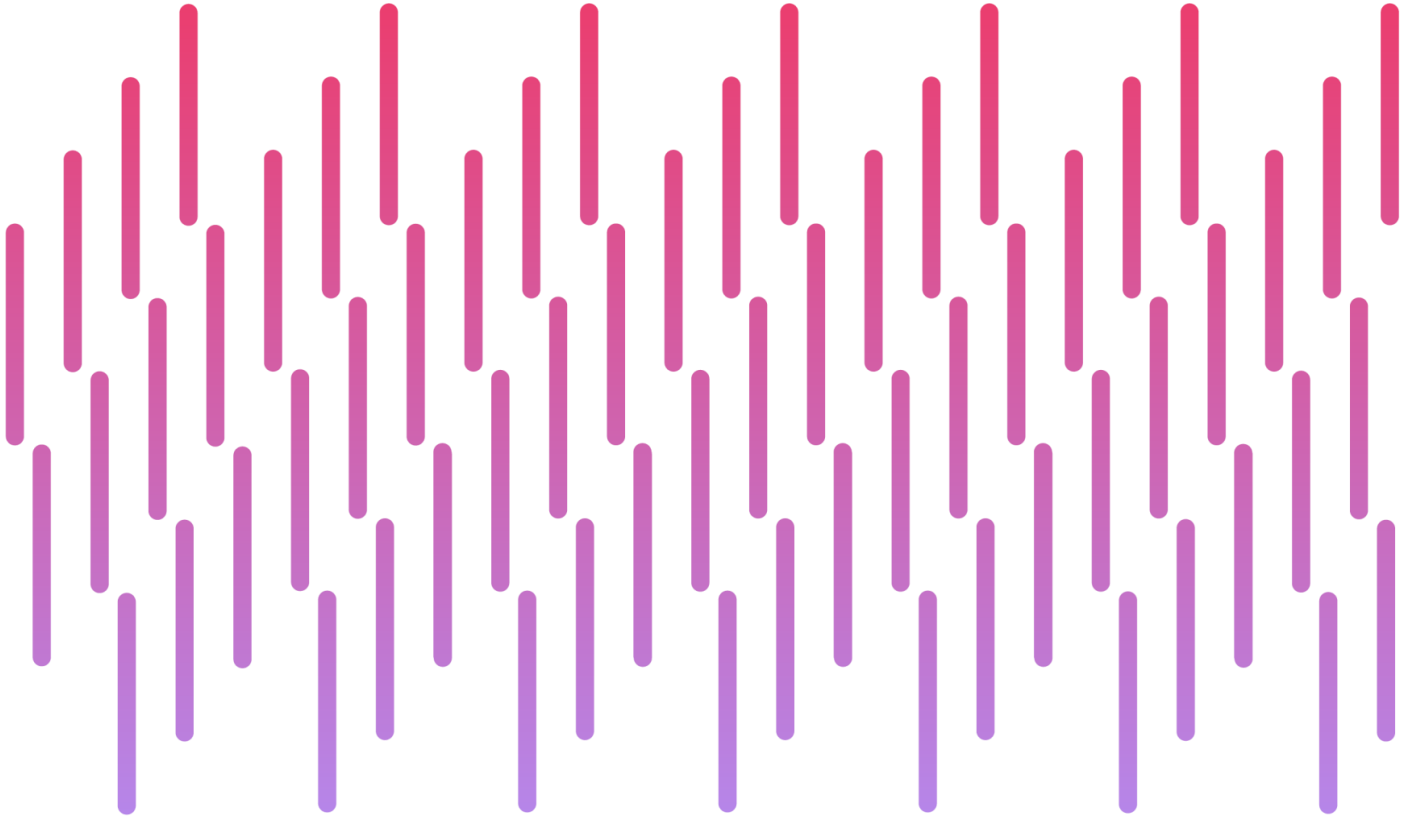
Progress on actions to address gaps in control / assurance

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