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St George's University Hospitals NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday 26 November 2020, 09:00-11:30**
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**	**Chief Executive**	Inform	Report
2.0 CARE					
09:15	**2.1**	**Quality and Safety Committee Report**	**Committee Chairman**	Assure	Report
	2.1.1	***Infection Prevention & Control Annual Report*** *(Reviewed by Quality & Safety Committee)*	**Chief Nurse & DPIC**	Assure	Report
	2.1.2	***Seven Day Services*** *(Reviewed by Quality & Safety Committee)*	**Chief Medical Officer**	Approve	Report
	2.1.3	***Cardiac Surgery Q2 Report*** *(Reviewed by Quality & Safety Committee)*	**Chief Medical Officer**	Assure	Report
09:30	**2.2**	**Learning from Deaths Q2 Report & TARN Review Briefing Note** *(Reviewed by Quality & Safety Committee)*	**Chief Medical Officer / LfD Lead**	Assure	Report
09:35	**2.3**	**Integrated Quality and Performance Report** *(Reviewed by Finance & Investment Committee and Quality & Safety Committee)*	**Chief Operating Officer**	Assure	Report
09:50	**2.4**	**Sickle Cell Patient Experience in Emergency Department: Patient Story Update**	**Chief Nurse & DPIC**	Assure	Report
3.0 CULTURE					
10:00	**3.1**	**Workforce and Education Committee Report**	**Committee Chair**	Assure	Report
	3.1.1	***Culture Programme: Diagnostics Findings***	**Acting Chief People Officer (Culture)**	Assure	Report
	3.1.2	***Diversity and Inclusion Report and Action Plan*** *(Reviewed by Workforce & Education Committee)*	**Acting Chief People Officer (Culture)**	Assure	Report
10:10	**3.2**	**Workforce Disability Equality Standards Annual Report** *(Reviewed by Workforce & Education Committee)*	**Acting Chief People Officer (Culture)**	Approve	Report
10:15	**3.3**	**Freedom to Speak Up Guardian Q2 Report** *(Reviewed by Workforce & Education Committee)*	**FTSU Guardian / Chief Corporate Affairs Officer**	Assure	Report
10:25	**3.4**	**Guardian of Safe Working Hours Q2 Report** *(Reviewed by Workforce & Education Committee)*	**Guardian Of Safe Working Hours/ Chief Medical Officer**	Assure	Report
4.0 COLLABORATION					
10:35	**4.1**	**Finance and Investment Committee Report**	**Committee Chair**	Assure	Report

Time	Item	Subject	Lead	Action	Format
10:45	**4.2**	**Finance Report (Month 7)** *(Reviewed by Finance & Investment Committee)*	**Chief Finance Officer**	Update	Report
10:50	**4.3**	**Audit Committee Report**	**Committee Chair**	Assure	Report
11:00	**4.4**	**St George's Charity (6 Month) Report**	**Chief Strategy Officer**	Assure	Report
11:05	**4.5**	*Horizon Scanning Report:*			
	4.5.1	**Emerging Policy, Regulatory, Statutory and Governance Issues**	**Chief Corporate Affairs Officer**	Assure	Report
	4.5.2	**Strategic-Local & Regional**	**Chief Strategy Officer**	Assure	Report
5.0 CLOSING ADMINISTRATION					
11:10	**5.1**	**Staff Story: Diversity and Inclusion**	**Acting Chief People Officer (Culture)**	Inform	Oral
11:25	**5.2**	**Questions from Governors and the Public**	**Chairman**	Note	Oral
	5.3	**Any new risks or issues identified**	**All**	Note	
	5.4	**Any Other Business**		Note	
11:30	**CLOSE**				

Thursday, 28 January 2021, 09:00-12:00
MS Teams

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Trust Board
Purpose, Meetings and Membership

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

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

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Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 24 September 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 (*part*)	NED
Dr Pui-Ling Li	Associate Non-Executive Director	ANED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Operating Officer	COO
Robert Bleasdale	Acting Chief Nurse and Director of Infection Prevention & Control	ACN/DIPC
Dr Richard Jennings	Chief Medical Officer (*part*)	CMO
Andrew Grimshaw	Chief Finance Officer and Deputy Chief Executive Officer	CFO/DCEO
IN ATTENDANCE		
Humaria 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
Karyn Richards-Wright	Freedom to Speak Up Guardian *(item 2.4 only)*	FTSUG
Dr Serena Hayward	Guardian of Safe Working Hours *(item 2.5 only)*	GoSWH
Dr Karen Daly	Acting Deputy Chief Medical Officer	ADCMO
SECRETARIAT		
Tamara Croud	Head of Corporate Governance/Board Secretary	HCG

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting and noted that there were no apologies.	

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		Action
1.2	**Declarations of Interest** There were no additional or new declarations of interest reported.	
1.3	**Minutes of the meetings held on 30 July 2020** The minutes of the meeting held on 30 July 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 as there were items on the agenda addressing these. The following updates were also noted: • **TB28.05.20/01 (Integrated Performance and Quality Report)**: The Trust had explored the best way to capture and reflect the quality impact and clinical harm of people waiting to access services that had been paused during the first wave of the Covid-19 pandemic. Capturing this data and incorporating it into the Integrated Quality and Performance Report (IQPR) was complex and therefore the Trust had explored what information it was already producing that could demonstrate effectively any harm caused to patients as a result of delays in treatment caused by Covid-19. The Trust routinely analysed the root cause analysis data for patients waiting for over 100 days on the cancer pathway and any resulting clinical harm was reported and discussed with commissioners. In addition, the Trust had retrospectively coded serious incidents where Covid-19 had been a significant factor in the clinical harm caused to a patient and this information could be reflected in the IQPR. The Board agreed that the Trust should not create data that was not already available and agreed that any available information would be provided in the IQPR in January 2021. • **TB30.01.20/05 (Patient Story: Sickle Cell):** The Chairman reported that she had recently learned that some of the same types of issues that had been reported by the sickle cell patient in her story to the Board in January 2020 were still in evidence at the Trust and this was a concern. The CEO stated that she would be picking these issues up and the Board would receive an update at its November 2020 meeting.	
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: • Despite increased admissions in other parts of London, the number of admissions of Covid-19 patients at the Trust and to across South West London had been relatively low. The Trust currently had one Covid-19 inpatient. • The CTO had been appointed as the Trust's UK EU Exit End of Transition Senior Responsible Officer (SRO). He would work with the national team to support work to ensure the Trust was ready for the end of the transition	

		Action
	period following the UK's departure from the European Union. • The Trust was working in partnership with the South London Genomics hub for testing, based at Guys and St Thomas Hospital, and was working on the translation of genomics findings to clinical treatments for patients. • The Trust continued to be committed to playing a lead role in paediatric cancer services in South London. • The Board meeting was Avey Bhatia's last such meeting at the Trust and she would be greatly missed. The Trust had seconded Anne Brierley into the role of Interim Chief Operating Officer for the next six months while the Trust completed the recruitment for the substantive COO. • In response to the requirement set out in the NHS Patient Safety Strategy that all Trusts have a patient safety specialist to oversee patient safety activities in the organisation, the Trust had appointed a new Head of Patient Safety and Clinical Effectiveness who would start later in the year and work closely with the relevant Deputy Medical Director, once appointed. The Board noted the report.	
2.0	**DIVERSITY, INCLUSION & CULTURE**	
2.1	**Workforce & Education Committee Report** Stephen Collier, Chair of the Committee, presented the report of the meetings held in August and September 2020, which set out the key matters raised and discussed. The Committee maintained focus on compliance and key workforce and education risks and how the Trust was managing in the wake of the Covid-19. The work around the cultural change programme had resumed after a short hiatus during the Covid-19 peak and the Committee considered the early findings at its meeting in September. The Committee recognised the progress being made on diversity and inclusion following the Board's approval of the new Diversity and Inclusion Action Plan at its previous meeting. The Committee had also undertaken a deep dive into the Trust's Workforce Race Equality Standard. The Committee had been assured with the progress of the culture programme, which had demonstrated traction. The Committee had considered the risk that individual elements of the wider culture programme could potentially move forward at different rates and without sufficient coordination, but was assured that the programme management approach being adopted would mitigate this risk and ensure that the critical elements of the programme would be joined up effectively. The Committee had reviewed the two strategic risks on the Board Assurance allocated to it and had recommended no changes to the overall risk scores. The Board noted the report.	
2.2	**Culture Change Programme Update** The Board considered the update on the progress of the culture change programme, which was now at the end of its 'discovery phase'. The work had been led by a network of culture champions drawn from a diverse cross-section of staff at all levels within the organisation. Extensive engagement	

		Action
	work had been undertaken, including a leadership survey which had elicited over 500 responses, 30 focus groups, and interviews with Board members and the divisional leadership. A report setting out the findings of the 'diagnostics phase' was being finalised and would be shared with the Board in the coming weeks, and would be considered by the Workforce and Education Committee and discussed at a Board workshop in October 2020. The next stage would be the 'design phase' which was expected to run to the end of December, with the Board receiving proposals for action in January 2021. The Board received and noted the update.	
2.3	**Diversity and Inclusion Report and Action Plan** The Board received and discussed the report on progress in implementing the Trust's Diversity and Inclusion Action Plan. The following key points were raised and noted in discussion: • The action plan was a dynamic document which would be updated to respond to the needs of the organisation and progress delivered. • The Trust had trained 70 Black, Asian and Minority Ethnic (BAME) staff to be diversity representatives on interview panels for new staff members at Band 8a and above. The Trust was now developing plans to roll out this programme at Band 7 level. • The Trust had developed a conversation facilitation toolkit for managers to use with their teams when having conversations about race. Some divisions had already used the toolkit to have such conversations and feedback had been positive. • Elizabeth Bishop reiterated the importance of encouraging staff to speak up and providing a safe place for staff to raise concerns and issues. • A key factor for many clinical teams was having sufficient access to continuing professional development (CPD). BAME staff have particular anxieties about access to CPD with a number citing inequality and inequities. It was important that the Trust addresses these issues and ensures that there is fair access to CPD activities. The Board noted the plan, the encouraging progress made to date and the next steps planned, and the Chairman commented that it was important to sustain this progress given the experiences reported earlier in the year by BAME members of staff.	
2.4	**Freedom to Speak Up (FTSU) Vision and Strategy** The Board welcomed FTSUG, Karen Richards-Wright, to the meeting. The CCAO noted that the Freedom to Speak Up Vision and Strategy had been developed collaboratively with internal stakeholders over the summer and outlined key elements of the strategy. The following points were raised and noted: • The Trust was lucky to have a well-respected FTSUG who also chaired the London regional FTSU network.	

		Action
	• There were real issues with staff not feeling safe to raise concerns and not being confident that when they did raise concerns the Trust would take appropriate action to address these. • The FTSU strategy set out five strategic priorities for strengthening the Trust's approach to raising concerns and actions for the remainder of 2020-21 in order to ensure the work had an immediate impact. The strategy draws on intelligence from the work on culture and diversity and inclusion. • Measures to gauge the impact of the strategy were set out but these would be refined in the wider context of the culture change programme. In discussion the Board raised and noted the following points: • Ann Beasley noted that the strategy was good and highlighted the importance of tangibly demonstrating to staff that the Trust was taking action. It was reported that a robust communications plan was in place to support the launch of the strategy, and that this would coincide with Freedom to Speak Up month in October 2020. • The Chairman noted that it was important that the Trust implemented the actions set out in the strategy at pace and ensured the right priority was given in the right areas to effect the necessary changes. • The strategy was an excellent opportunity to make a significant difference for staff. It was important to address the issues about effective response when issues are raised through the FTSUG, both in terms of feeding back to those who had raised concerns the actions that had been taken and in relation to ensuring the timeliness of any investigations. • It was noted that creating a separation of the FTSU function and the HR department was already supporting independent scrutiny, greater focus and effective process. The Board noted the quarterly update and approved the proposed FTSU Vision and Strategy and the action plan for 2020/21.	
2.5	**Guardian of Safe Working Hours** The Board welcomed the Guardian of Safe Working House (GoSWH), Serena Hayward, to the meeting who provided an overview of the quarterly Guardian of Safe Working report. Many of the Trust's trainees had been deployed to support the work around the first wave of Covid-19 which had presented challenges in relation to annual leave, training and payment for overtime. It remained a very unsure period for trainees with long waiting times for mandatory training. Despite the pressures of responding to the Covid-19 pandemic there had been a reduction in the number of exception reports being raised by doctors in training. Attendance at Junior Doctors' Forum had reduced but work was underway to address this. The Trust was developing a dashboard to capture the key data in the exceptions reports to help measure and track issues for trainees which could be used in the divisions. The Trust had 1,231 trainees, 517 on site and 714 GP trainees, and the Trust was gaining one trainee from central London healthcare.	

		Action
	The Board raised and noted the following key points in discussion: • In response to a question from Professor Parveen Kumar it was reported that there had been no issues raised about access to education and training. The Trust had identified two areas to utilise as doctors' mess areas. • Professor Jenny Higham reported that staff and students initially felt engaged and supportive of the new ways of working to manage the impact of the Covid-19 pandemic. However, the impact of having their education and training disrupted, and the inability to rotate to their desired speciality and complete mandatory training had left some disillusioned. The Trust could not afford to risk having a disenfranchised workforce and it was, therefore, important to keep junior doctors engaged and address the issues they had highlighted. • Tim Wright reported that the St George's Hospital Charity may be able to support the Trust in its efforts around health and wellbeing for staff. • The CEO noted that that it was important the Trust improve how it engaged with junior doctors and gain a better understanding of the real issues they faced. The Board received and noted the report.	
2.6	**Medical and Nursing Revalidation Reports** The Board received the reports on the revalidation of nurses and medical doctors. It was noted that the national nurse and medical revalidation programmes had been impacted by the Covid-19 pandemic. Nationally, all medical appraisals and associated activities had been paused during the peak of the Covid-19. The Trust had, however, progressed work around medical appraisals and was able to complete the NHS England Responsible Officer self-assessment which would be submitted at the end of September 2020. Nurses, nursing associates and midwives were required to complete revalidations every three years. In light of the pandemic, the NMC had extended the registration of 28 of the Trust's nursing and midwifery staff whose registration had fallen due in the period April to July 2020. The Trust regularly monitored revalidation and NMC registration and there were no nursing and midwifery staff working in the Trust without a valid registration. The Board noted the report and commented that it was assuring that the Trust was able to progress this work in spite of the significant operational challenges.	
3.0	**QUALITY AND PERFORMANCE**	
3.1	**Quality and Safety Committee Report** Professor Parveen Kumar, Chair of the Committee, presented the report of the meetings held in August and September 2020, which set out the key matters raised and discussed. The Committee had considered a deep dive on surgical safety and had heard about the work underway to improve audit data, introduce enhanced quality measures, and improve compliance with the	

		Action
	WHO checklist. The Trust had responded to a Prevention of Future Deaths (Regulation 28) Order in June 2020 related to a neonatal death in November 2018 and all key actions had been implemented. The Committee had considered its regular report on Serious Incidents (SI), but the thematic analysis of Sis had been deferred to its meeting in October 2020. In relation to learning from deaths, the Committee had heard that the Trust had received an outlier alert from the Trauma Audit and Research Network (TARN) for the period July 2017 to June 2019. The Committee also noted that the Trust's mortality rate was categorised as 'lower than expected' under the Summary Hospital-level Mortality Indicator (SHMI). The Committee had received annual reports in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards and Learning Disabilities, with both reports providing significant assurance. Ann Beasley queried if the Trust's internal governance system had identified the issues related to the notification from TARN that the Trust was an outlier for major trauma outcomes. She noted that it was important that the Trust's processes were sufficiently robust to pick up such issues as opposed to an over reliance on receipt of external alerts. In response it was noted that the initial investigation highlighted some issues with the calculation of the injury severity score as opposed to an underlying issue. The investigation would include the specifics of the alert and the underlying governance systems. **The Board noted the report and agreed that a written update on the TARN investigation would be provided to the November 2020 meeting via the Quality and Safety Committee.**	**CMO**
3.1.1	**Learning from Deaths Quarter 1 Report** The Board received and considered the quarter one learning from deaths report which had previously been discussed at the Quality and Safety Committee. The Medical Examiner Servicer was only one of three in London that was fully established prior to the pandemic and had increased its capacity to support clinical teams during the first wave. Although this had since reverted to normal resourcing levels, there were contingency plans in the event of a second wave. **The Board noted the report and agreed that the Learning from Deaths Lead would be asked to present future reports to the Board.**	**CMO**
3.1.2	**Mental Capacity Act and Deprivation of Liberty Safeguards Annual Report** The Board considered the annual report on Mental Capacity Act and Deprivation of Liberty Safeguards 2019-20 which had previously been discussed at the Quality and Safety Committee. The Board noted the report and commended the team for their work.	
3.1.3	**Learning Disabilities Service Annual Report** The Board considered the annual report from the learning disabilities service 2019-20 which had previously been discussed at the Quality and Safety Committee. The service had experienced a 12% increase in activity during the period. The service was also involved in pan-London work to improve	

		Action
	services provided to patients with learning disabilities and use information from the learning disability patient experience group to drive improvements in the service. The Board noted the report and commended the good work conducted by the service.	
3.1.4	**Clinical Negligence Scheme for Trusts (CNST) – Maternity Services** The Board considered the update on the Trust's compliance with the ten safety actions for maternity CNST. While the Trust was achieving seven of the ten safety actions, Covid had significantly impacted on the Trust's ability to achieve standard two (data), standard six (saving babies lives care bundles) and standard seven (training). The issues facing the Trust were recognised nationally. The Trust would continue to put relevant systems in place to ensure that the safety of patients was maintained. The achievement of the safety actions equated to around £900,000 per annum. Ann Beasley reiterated an earlier request that a breakdown of maternity outcomes and information by ethnicity be provided to the Board. The ACN/DIPC noted that the Trust monitored the ethnicity of maternity patients on iClip and the Executive would bring a report to the Quality and Safety Committee setting this out. The Board approved the current position and noted the national compliance framework had been paused.	
3.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 5 (August 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: • In month, the Trust had focused on increasing elective, day case and outpatient activity. There was a steady improvement with a good step up in September 2020. • Referral-to-treatment performance had improved from 52.7% (July 2020) against the national target of 92% to 58% in August. The 52 week breaches had been reduced and stabilised. • Some good work had been undertaken to reduce the backlog of patients waiting on the cancer pathway. The backlog had decreased from 200 patients in August waiting over 104 days to only 20 patients at present, and the aim was to have no patients waiting over 104 days by October 2020.The Trust would conduct focused work on the 63 day waiting list. • The Trust's Emergency Department continued to perform strongly albeit with some slight fluctuations, but the Trust was getting better at recovering following difficult days. The Board received and noted the report.	

		Action
3.3	**COVID-19, Flu and Winter Plan 2020-21** The Board received the comprehensive Covid-19, Flu and Winter Plan 2020-21 which had been discussed in detail and approved by both the Finance and Investment Committee and the Quality and Safety Committee. In developing the plan the Trust used the learning from the first Covid-19 surge and had focused on two main priorities. The first related to how best keep patients, visitors and staff safe during winter and any future surges in Covid cases. The plan set out how the Trust would achieve this priority including actions such as flu vaccination, testing of staff, effective quarantining and risk assessments, providing effective patient pathways which responded to the infection prevention and control mechanisms, and having in place a robust workforce framework. The second priority was focused on keeping the full spectrum of clinical activity going for as long and safely as possible. The Trust needed to ensure it had the right infrastructure in place. The plan set out the sequencing of intensive treatment unit (ITU) additional capacity and ensured there was a good workforce infrastructure. Tim Wright queried whether the Trust had completed all the estates work required to deliver the maximum number of ITU beds during future Covid-19 surges. It was reported that the Trust could already deliver the maximum number of ITU beds, however it was not ideal. The Trust was focusing on using capital funds to improve current infrastructure in wards. The Trust had a plan for navigating through the improvement works. The Trust had improved access to equipment to meet demand. The Board noted and ratified the Trust's Covid-19 Surge, Flu and Winter Plan 2020-21.	
4.0	**FINANCE**	
4.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meetings held in August and September 2020. The Committee considered its strategic risks and noted the good performance in the emergency department. The Committee also considered the Winter Plan and the key assumptions and noted the robustness of this. The financial risks remained very high and would likely remain the same for the rest of the year. The Committee was, however, concerned about the lack of focus on efficiency in a post-Covid environment. The Committee was also concerned about what would happen with demand and activity and how this would be managed going forward. The Trust had made significant process on ICT but recognised that challenges remained. The Trust had also made good progress on developing the Premises Assurance Model and the Trust had the right building blocks to make the required changes. The Committee continued to take business cases at an early stage in preparation for any new funding streams. The Board noted the report.	
4.2	**Finance Report M05** The Board received and noted the finance performance at month 5. The Trust, as with other NHS organisations, was being provided with support from	

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	NHS England and NHS Improvement (NHSE&I) to attain a balanced financial position each month. The circumstances remained the same at month 5 but the Trust would face challenges from month seven onwards as there was no indication that there would be continued support from the centre. The capital position remained robust with an approved budget of £79.7m. The Board noted the report.	
5.0	**STRATEGY, RISK, GOVERNANCE & COMPLIANCE**	
5.1	**Corporate Objectives 2020-21** The Board received and discussed the proposed corporate objectives for the remainder of 2020-21. It was reported that a different approach had been taken to developing the objectives this year which included engagement with senior leaders across the Trust. In addition, the number of objectives had been reduced compared with previous years and honed to three themes: care, culture and collaboration. The objectives had been aligned and triangulated with the clinical and divisional strategies and the Board Assurance Framework. Ann Beasley noted that it was disappointing that there had not been more involvement of the Board, and of the Non-Executives in particular, in the development of objectives. Ann Beasley also voiced concern that finance was not a standalone objective given the Trust remained in financial special measures and the risk that its exclusion may send a message to staff that finance was not a priority. The Chairman also expressed her disappointment about the lack of early engagement with the Board but recognised the challenges in the current environment. She also noted that in her view finance should have been more explicitly stated in the corporate objectives. In response, it was reported that in developing the corporate objectives the executive had sought to focus on striking the right balance; while finance was undoubtedly important the issues around financial management were part of the culture of the organisation and finance would be at the heart of work to improve processes and activity. The corporate objectives had not yet been launched and by engaging with staff and taking a different approach it was hoped that this would improve the extent to which the divisions, and teams across the Trust, bought into and owned the objectives. The Chairman summarised that the Board needed to be pragmatic about the proposed corporate objectives and accept the rational for not involving the Board at an earlier stage. If the Board tried to unpick these now it would undermine the engagement and buy-in across the Trust. As a matter of good practice, development of the corporate objectives was a matter of Board business and, going forward, the Board expected to be involved in the development and shaping of the corporate objectives as it had been in previous years. The Board noted and endorsed the corporate objectives and asked the executive to be mindful of the comments made by Non-Executives during the discussion.	
5.2	**Board Assurance Framework Quarter 2 2020/21**	

		Action
	The Board received and noted the quarter one 2020/21 Board Assurance Framework (BAF). The new BAF had been populated setting out the controls, gaps in controls and assurances and actions to close these gaps, mitigations and assurance mechanisms linked through indicators in the IQPR and through horizon scanning of emerging risks and future opportunities. The relevant BAF risks had been considered by the Quality and Safety Committee (Strategic Risks 1, 2 and 10), the Finance and Investment Committee (Strategic Risks 3, 5, 6 and 7) and the Workforce and Education Committee (Strategic Risks 8 and 9)which had reviewed and endorsed the risks scores and assurances for those risks allocated to them. As discussed at the July 2020 Board meeting, each of the BAF strategic risks now included proposed target risks which had been considered by the relevant Board committees with the exception of strategic risks 7 (estates), 8 and 9 (workforce). A thorough review of the supporting risks was underway which would be supported by the work of a short-term Risk Management and Coordination Group which would foster a standard approach to rating and managing risks on divisional and corporate risk registers, reporting into the Risk and Assurance Group. There had been some slippage in some of actions to mitigate certain risks which in large part could be attributed to Covid. This included, for example, completing the appointments to new posts established following phases 1 and 2 of the clinical governance review (SR2) and seven day services (SR3). Having developed a new approach to reporting, the CCAO noted that the BAF would be refined further ahead of the Q3 report to the Board in January to streamline and embed its utility as an assurance tool for the Board. Elizabeth Bishop queried the deadline for achieving the target risk scores and it was reported that the aim was to achieve these by the end of the financial year. In some cases, it was recognised that these target risks were stretching. The Chairman queried the target score of 12 for SR5 (financial sustainability) and SR6 (capital) and it was reported that the Trust had obtained significant capital funding with the key challenge being the ability to spend that before the year end and therefore the target score for SR6 was achievable. The Trust, like other NHS trusts, had been funded to breakeven for the first six months of the year and had been led to believe that there would be additional funding provisions for the second half of the year. As a result, it was important that the Trust aimed to achieve the target score of 12 for SR6. In relation to financial sustainability, the Trust would face more challenges, but was working on a breakeven position at year-end and was developing a robust plan to mitigate these risks and achieve financial balance. The Board endorsed the risk score, assurance rating and statements for strategic risk four which was reserved for the Board. The Board also noted and agreed risk scores, assurance ratings for the other nine strategic risks assigned to its Committees.	
6.0	**CLOSING ADMINISTRATION**	
6.1	**Questions from the public and Governors**	

		Action
	There were no questions raised. Hilary Harland, Public Governor for Merton, endorse the Board's best wishes to Avey Bhatia on behalf of the Council of Governors.	
6.2	**Any other risks or issues identified** There were no other risks or issues identified.	
6.3	**Any Other Business** The Board noted that this was Avey Bhatia's last meeting and that she would be missed greatly. She had been a pivotal part of driving the Trust forward with her relentless focus on quality and standards. She should also be thanked for stepping in to the interim COO role to which she had brought her customary energy and commitment. The Board wished Avey the very best in her new role. Avey Bhatia noted that she was had enjoyed being part of the Board. She commented that she had been able to raise any issues and had learnt a lot from her Board colleagues. She noted that Robert Bleasdale had been of immense support to her and she had valued and enjoyed her time at St George's.	
Date of next meeting: Thursday, 26 November 2020, Microsoft Teams meetings		

Trust Board Action Log Part 1 - November 2020						
Action Ref	**Section**	**Action**	**Due**	**Lead**	**Commentary**	**Status**
TB30.01.20/05	**Patient Story: Sickle Cell Patients in the Emergency Department**	The Board thanked Ms Vitalis for sharing her story and agreed that a follow-up report would be presented to the Board setting out the actions that had been taken to ensure that her poor experiences would not be repeated either for herself or for others.	~~25/06/2020~~ 26/11/2020	ACN	**See agenda item 2.4** *- Previous Update: The Trust had devised a programme of work which would be informed by a group including sickle cell patients and staff members. The programme was also part of the NHS Improvement/England Always Events initiative. The programme of work was put on hold as a result of the Covid-19 pandemic with patients shielding and staff remobilised to support other parts of the hospital during the peak of the health crisis. The Trust anticipates this would restart in September 2020. Accordingly the Board is asked to agree that the update be deferred until the November 2020 meeting.*	**PROPOSED FOR CLOSURE**
TB24.09.20/01	**Quality & Safety Committee Report (September 2020)**	The Board noted the report and agreed that a written update on the TARN investigation would be provided to the November 2020 meeting via the Quality and Safety Committee.	26/11/2020	CMO	A report is provided in Part 2 of the Board meeting item 2.4	**PROPOSED FOR CLOSURE**
TB24.09.20/02	**Learning from Death Report**	The Board noted the report and agreed that the Learning from Deaths Lead would be asked to present future reports to the Board.	26/11/2020	CMO	See agenda item 2.2	**PROPOSED FOR CLOSURE**
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	COO	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**

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Meeting Title:	Trust Board		
Date:	26 November 2020	**Agenda No.**	1.5
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is asked to note contents of this report and approve the appointment of Lucinda Etheridge as the Responsible Officer for the Trust.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	20 November

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

I am pleased to present this report to the Trust Board, the content of which is structured around our new corporate objectives of **Care**, **Culture** and **Collaboration**.

Our new corporate objectives were shared with staff earlier this month, and – as set out in more detail below - I am confident these will give everyone a much clearer sense of where we need to focus our efforts and energies at the present time.

Since our last Trust Board in September, there has been a huge amount of change, particularly at a national level. This includes a second national lockdown in England, which is currently scheduled to end in early December.

As an organisation, I am pleased at the way we have continued to provide emergency, urgent and planned care over recent weeks and months and it is vital that patients – whether Covid or non-Covid – are able to receive the care treatment they need. As set out in various reports to the Trust Board this month, we continue to make good progress in relation to elective care; with current activity similar to the same period last year.

Our emergency care performance is also strong, despite the building works in our Emergency Department at St George's currently. The works will enhance our ability to provide safe and effective care, and improve infection prevention and control measures within the department.

Our teams continue to work exceptionally hard, and on behalf of the Trust Board, I would like to thank everyone for their efforts, particularly given the demands placed on everybody since March this year. The support from the public - and partner organisations we work with – is also greatly appreciated.

Care

National restrictions on daily life were re-introduced at the start of this month, and remain in place until 2 December. It was also confirmed that the NHS would return to its highest level of preparedness, incident level 4, from 5 November. This means that the response to Covid has moved from a regionally managed and nationally supported approach to one that is coordinated at a national level.

The number of Covid-19 positive patients under our care remains relatively stable at present – with typically between 15-20 on ITU, and 30-40 on our wards – though clearly this could change quickly. This does have an impact on the care we provide – but, for context, it represents a small proportion of our overall activity, given we have over 1,100 beds across both St George's and Queen Mary's Hospitals. Our Covid, Winter and Flu plan, agreed by the Board in September, also means we have clear contingency plans to expand our ITU capacity should we need to.

As stated above, our teams are working hard to deliver elective activity, with a particular focus on reducing the number of patients waiting over 52 weeks for treatment. We are working closely with other hospitals in south west London to ensure a co-ordinated response

to the elective care challenge – and over 500 patients previously under our care have had their operations carried out at Croydon and Kingston Hospitals in recent weeks.

We have also introduced some changes to the way we provide emergency care at both St George's and Queen Mary's. For example, our Emergency Department is now a pilot site for 111 First, which is designed to help manage capacity in our ED, and further prevent the spread of Covid-19 and flu.

In the coming weeks, we will also open a new Enhanced Primary Care Hub at Queen Mary's, which will provide an important service for local people, particularly given the decision we took jointly with commissioners earlier this year to close the Urgent Care Centre at QMH.

Some of our neighbouring hospitals in south west London are now offering Covid-19 testing for asymptomatic patient-facing NHS staff. This is part of a national pilot, and we expect this will be extended to more and more Trusts over the coming weeks. At present, we continue to offer testing to all staff with Covid-19 symptoms; plus friends and family they live with.

As I write this report, there are now two Covid-19 vaccines that have shown positive results following initial trials. There is a huge amount of work still to do – but this is incredibly exciting for all of us, and we are developing robust plans to vaccinate large numbers of staff when the time comes.

We must, however, stay focussed at all times on getting the basics right, in particular maintaining high infection prevention and control standards across our services. We know that the potential for nosocomial infections is higher in hospitals, and the clear message from NHS England is rightly that, as providers, we must be doing everything we possibly can to reduce the spread of infection. I am confident we have steps in place to reduce the risk – but we mustn't be complacent.

Separately, NHS England has also recently announced the creation of 40 'long Covid' clinics to help the thousands of patients who are suffering the debilitating effects of the virus. This is a vital service, and I am pleased to say that St George's – in partnership with other providers in south west London – will play a key part in delivering one of these clinics. Known 'long Covid' symptoms include fatigue, brain fog, breathlessness and pain, so bringing additional support online for these patients quickly is crucial to their recovery.

Moving away from Covid, the Government published its Food Review Report in October, which has implications for all NHS trusts. Among the eight recommendations put forward, each Trust must have a named Board member responsible for food service, which for us is Robert Bleasdale. There have been a number of food reviews in the past, but I view this as a fantastic opportunity to look again at the nutrition and hydration we provide our patients, not least because it is a fundamental aspect of the overall care we provide.

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Culture

Last month, we shared the results of our culture discovery with the Trust Board, and in November, the detailed findings were shared with our 9,000 staff.

I am extremely grateful to our team of culture champions, who took time out of their busy day jobs to meet, interview and survey staff across all parts of the organisation, to discover what our culture really is. As a Trust Board, we will all have our own personal views on what our staff have told us during this discovery phase – and many of the experiences staff have shared really struck a chord with me. The next phase is to define clearly the culture we want to create and take steps to establish it.

On a personal level, I am very proud to be Chief Executive of this fantastic organisation. And I have also always believed in the huge potential we have – and this is main reason I took the role when I was offered it in 2017.

I believe we have made progress, but I also know that, culturally, we have some way to go; from how we treat each other to how we try and deliver improvements and initiate change. The drive and energy within this organisation knows no bounds, however, and it is this that makes me so optimistic for the future.

On the topic of organisational culture, I was delighted to see the time and energy that went into supporting two specific events last month; specifically, Black History Month and Freedom to Speak Up Month. Covid-19 could easily have hampered attempts by staff to mark both events.

However, a large number of virtual events and awareness raising did take place, with cultural dress days and staff profiles for Black History Month, and a #SpeakUp campaign for Freedom to Speak Up Month. We were also fortunate to receive a visit from Dr Henrietta Hughes, who has been the National Guardian for Freedom to Speak Up since July 2016, and to discuss with her the work we are doing to strengthen our own arrangements for supporting staff to raise concerns without fear or detriment.

Collaboration

I am pleased to say that I have been appointed Senior Responsible Officer for outpatients across London. In this role, I will be working closely with the Responsible Officer and five integrated care systems across the Capital to improve this key aspect of patient care; with benefits for our outpatient service at St George's as well.

The way we deliver outpatients in healthcare hasn't changed significantly for over a hundred years, so I am excited to be leading this important piece of work, and building on the changes brought about at pace as a result of the Covid-19 pandemic.

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Back at St George's, we have shared our corporate objectives with staff this month. We have shared the detailed slides presented to the Trust Board in September, but also shared the graphic below, which gives a high level overview of activity:

Of course, we will need to ensure our corporate objectives are agile, and ready to adapt to changing circumstances, particularly as a result of Covid-19. However, we have already agreed and published our plan for Covid-19, flu and winter – one of the key milestones under Care – and, as described above, we have also shared the results of our culture discovery with staff (see Culture above).

On the theme of collaboration, we continue to work closely with our colleagues at Epsom and St Helier, and Arlene Wellman, Chief Nurse, Chief Nurse and Director of Infection Prevention and Control, has agreed to work with us to begin to explore and develop the nursing, midwifery and allied health professional contribution to the collaboration. Arlene will do this by regularly spending one day a week here at St George's, starting this month. This does not affect Arlene's substantive role at Epsom and St Helier, and Robert Bleasdale continues as our Chief Nursing Officer and Director of Infection Prevention and Control here at St George's.

Also in November, the Independent Reconfiguration Panel ruled in favour of plans by Surrey Downs, Sutton and Merton NHS Clinical Commissioning Groups to invest £500 million in a new hospital at Sutton, and in Epsom and St Helier Hospitals. This was subsequently confirmed by the Secretary of State for Health, with work on developing the Sutton site due to start in 2022, with a Specialist Emergency Care Hospital opening in 2025. This is positive and significant development for the whole of south west London, and beyond.

Finally, I would also like to assure the Trust Board that we have contingency plans in place for when the Brexit transition phase ends on 31 December 2020. We are working closely with the local and national stakeholders to ensure that the services we provide – and key issues such as staffing and supplies – are not adversely affected as a result of this important change and significant work has been undertaken to put in place the necessary contingency

measures to ensure continuity of supply, recognising that the majority of critical supply lines are managed centrally by NHS England and the Department of Health and Social Care. We are closely monitoring any developments in our workforce while at the same time assuring our EU staff, who make up around 9% of our workforce, how much they are valued by us. The deadline for EU employees to apply for settled status is 30 June 2021.

New Deputy Chief Medical Officers and appointment of a new Responsible Officer

We have recently appointed three new Deputy Chief Medical Officers who will take up their new roles in early December. James Uprichard will take on the role of Deputy CMO for Safety and Clinical Effectiveness, Carolyn Johnson will become Deputy CMO for Innovation and Improvement, and Lucinda Etheridge will take on the role of Deputy CMO for Workforce and Professional Standards. These appointments are an important step in strengthening our corporate medical directorate and wider clinical governance.

Alongside this, we need to appoint a new Responsible Officer (RO) to succeed Karen Daly who will retire next month having served as RO and Assistant Medical Director for over four years. As a 'designated body' under the Responsible Officer Regulations (2010), the Trust needs to appoint a new Responsible Officer to succeed Karen and this decision needs to be approved by the Board.

It is proposed that Lucinda Etheridge is appointed as Responsible Officer, subject to the approval of NHS England and NHS Improvement. Luci's role as Deputy CMO for Workforce and Professional Standards fits well with the responsibilities of RO. Luci is a consultant paediatrician who joined St George's in 2013. She has worked with the General Medical Council since 2007, initially as an academic fellow and now as a performance assessor and associate trainer and received her doctorate in education from the Institute of Education in 2013, with qualitative research into organisational culture and practitioner learning. Luci would become RO for all of the Trust's medical consultants, speciality and associate specialist doctors and other Trust doctors with the exception of doctors in training.

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St George's University Hospitals NHS Foundation Trust

2.1

Meeting Title:	**Trust Board**		
Date:	**Thursday, 26 November 2020**	**Agenda No**	**3.1**
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 October and November 2020.		
Recommendation:	**The Board is asked to note the updates from the October and November 2020 meetings receive the following reports and raise any queries by exception:** • **2.1.1 Infection Prevention & Control Annual Report 2019-20** • **2.1.2 Quarter 2 Cardiac Surgery Report** • **2.1.3 Seven Day Service Update Report**		
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		

Quality and Safety Committee Report

Matters for the Board's attention

The Quality and Safety Committee met on 22 October and 19 November 2020. The report covers the material matters that the Committee would like to bring to the attention of the Board.

1. Deep Dive – Core Services: Medical Care

The Committee received its first core services deep dive which focused on the quality and safety issues in the medical care service. The service received an overall Care Quality Commission rating of '*requires improvement'* and '*good'* in the caring domain following the 2019 inspection. Since the inspection report was published in December 2019 the service had focused on delivering the improvement actions in response to the two '*must do*' and '*should do*' recommendations. The services implementation of its action plan was impacted with the onset of the national Covid-19 pandemic, however there has been significant progress for example in quarter one and quarter two:

- *Safe domain* - the number and severity of falls have reduced, hand hygiene targets have been met, mandatory and statutory training (MAST) now at 100% (in the MedCard division), and backlog GP quality alerts were being investigated and cleared.
- *Caring domain* – the Trust was rated the second best performer in London in relation to care received in the recent national Cancer patient experience survey, 100% of duty of candour declarations were met within the required timescales.
- *Responsive domain* – length of stay has reduced from 8.1 to 5.15 days (5.9 is the national average), patient flow and discharge have improved with the introduction of the new discharge hub and the emergency department 4-hour standard had improved significantly.
- *Well-led domain* – staff vacancies had improved, sickness rates down to 3.1% and the service launched the governance newsletter which is being used to share learning from incidents and cascade changes implemented to address issues identified from complaints and or incidents.
- *Effective domain* – the rate of admission following discharge had not deteriorated and good progress had been made on completing NICE assessments.

The service recognised that there was much more work to do. However, the recent self-assessment moved the 'requires improvement' rating in the safe and well-led domain to a '*good'* rating. From the above good progress, the Committee was assured by the direction of travel whilst recognising there was more work to do for example around improving elective care performance. This work would be impacted by any future surges in Covid-19 cases. The Committee noted that the service had taken a prudent approach to its self-assessment and reflected that it should celebrate some of the key achievements given the significant focus on Covid-19.

2. 2019-20 Annual Reports

The Committee received four annual reports for 2019-20 - Duty of Candour, Infection Prevention & Control, Human Tissue Authority Designated Individual and the newly developed Patient Experience and Engagement.

- The ***infection prevention and control report*** is presented under agenda item 2.1.1 for the Board's attention and the Committee noted that this was a thorough report and reflected the Trust's compliance with the national hygiene code.

- The Trust was required to submit an annual compliance report to ***the Human Tissue Authority*****.** The Committee noted that the Trust had eight reportable incidents of

which two were adverse events and six related to the post-mortem licence. None of the reportable incidents resulted in any harm to the patient, but there was a delay in the Trust reporting two of these incidents. Covid-19 had impacted on services resulting in a reduction in human application and donation and transplantation licences activity and not surprisingly an increase under the post-mortem licences. Covid-19 had also impacted on the Trust's ability to complete audits with only essential audit activity being undertaken. The Trust would monitor audit activity and performance during winter as this may impact on its annual compliance assessment.

- The Committee received an early draft of the very comprehensive ***Patient Experience and Partnership repor*t**. The report encapsulated the key patient and partnership initiatives undertaken by the Trust including work to reflect the younger voice. The report needed further work. This would be enhanced by the inclusion of feedback from the various partnership groups that the Trust engages with such as Maternity Voices, MacMillan, and the Patient Partnership and Engagement Group etc.

- The Committee also received the ***annual duty of candour report*** which reflected that the Trust had made 93% of all qualifying duty of candour declarations in 2019-20 which was an improvement on performance in 2018-19 which was 79%. To improve performance, each area would be asked to complete a deep dive into the processes around duty of candour to gain a better understanding of practice in each service area.

3. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality and safety performance in months 06 and 07 (2020/21). The Committee is aware that the Board would also consider the month 07 report later under agenda item 2.3 and would like to highlight the following:

- Covid-19 has impacted on the Trust's ability to complete training and reach the required compliance targets especially in relation to basic life support training and resuscitation, the Mental Capacity Act (MCA), and Deprivation of Liberties (DoLs) Level 2. The Committee had previously outlined the challenges created by Covid-19 which impacted on the ability to deliver key face to face modules. The Trust had implemented online training resources, the MCA assessment document was now available on iClip and targeted communication was being sent out to those who had not completed the MCA Level 2 training. This remained a key area of focus for the Trust but it should be noted that new trainees joining the Trust had impacted on performance. However, the Trust was seeking to obtain their certification received as part of their training to validate their basic life training compliance.

- In October the Committee heard about a technical error limited to the reported figures in the IQPR for venous thrombosis embolism which meant that that there was a discrepancy in the figure reported. However, following amendment, the performance was 99%.

- There had been two serious incidents related to medication which were currently under investigation. The Committee would consider the outcome and implementation of key learning.

- The Trust would begin to report to NHS England and Improvement the number cases of nosocomial infections for Covid-19 between day 8-14 for hospital onset probable association and over 14 days for hospital onset healthcare associated.

- Some key maternity performance indicators were not moving in the right direction, in particular, there was an increase in the number of caesarean sections to 30% (23.4% in September). Whilst this was below the regional average of 40% it was unusual for the Trust and therefore a deep dive review would be conducted into the service and the report would be presented to the Committee in December 2020. The report would also include the BAME maternity statistics requested by the Board.

Overall the Committee recognised the challenges facing the organisation as the nation moved to a further surge of Covid-19 cases and began the implementation of phase one of its Covid Surge Plan. The Committee also endorsed the plans to issue more targeted communications to patients to encourage them to continue to access services.

4. Cardiac Surgery Report

The Committee also considered the Cardiac Surgery report which is below under agenda item 2.1.3 for the Board's information. The Committee noted that work continued, in spite of the Covid-19 pandemic, to implement the actions from the independent mortality reviews and to meet with patients' families virtually.

5. Seven Day Services

The Board will recall considering an update on implementing the clinical standards for seven day services in quarter three (2019-20) and was due to receive a further an update in March 2020 ahead of the self-assessment submission to NHS England/Improvement (NHSE/I) in April 2020. In light of the national crisis NHSE/I paused the compliance process and as yet there was no clarity on the timeframe for trusts to comply with the standards. The Trust had continued to assess and investigate its compliance with the ten clinical standards to deliver effective seven day services, in particular the following the four priority standards:

- Standard 2: Consultants reviewing emergency patients within 14 hours of being admitted to the Trust at the weekends;
- Standard 5: Consultants have access to diagnostics reports;
- Standard 6: Patients have 24/7 access to consultant directed interventions; and
- Standard 8: Patients have daily consultant reviews include at weekends.

The Committee noted the good work carried out by the local team and the next steps to close and mitigate the gaps. The report is available under agenda item 2.1.2 for information.

6. Serious Incident Reporting

The monthly serious incidents reports provide the Committee with a greater insight into the serious incidents that have been declared and whether the investigations had been closed and the learning derived from the investigation process.

Since the last report to the Board in September five new incidents had been declared and four closed between September and October 2020.

7. Learning from Deaths (Quarter 2)

The Board would consider the quarter two learning from deaths report under agenda item 2.2 and as agreed at the last Board an update on Trauma Audit & Research Network (TARN) review is presented in part two of the Board meeting. The Committee also noted that the learning from deaths policy was currently under review.

8. Nurse Staffing Report (Planned vs. Actual)

The Committee considered the nurse safe staffing report for September and October 2020. The overall fill rate was in 93.5% for both months, compared with 94.9% in August 2020. Whilst the number of red flags increased significantly in both months these were all managed effectively and mitigated with no harm to patients.

9. Quality & Safety 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 Quality & Safety Strategy Implementation plan in October, that good progress had continued. The Committee did reflect and agree that a further piece of work would be carried out to ensure that the actions and priorities adequately aligned with the new corporate objectives, priorities - care culture and collaboration.

10. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register. As agreed by the Board in May 2020 the Committee was responsible for the following strategic risks (SR):

- **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 noted the risk scores, assurance rating and the mitigations to manage any gaps.

11. Patient Safety & Quality Group (PSQG) Reports

The Committee received and noted the reports from the September and October 2020 meeting of the Patient Safety and Quality Group.

Recommendation

The Board is asked to note the updates from the October and November 2020 meetings receive the following reports and raise any queries by exception:

- **2.1.1 Infection Prevention & Control Annual Report 2019-20**
- **2.1.2 Quarter 2 Cardiac Surgery Report**
- **2.1.3 Seven Day Service Update Report**

Dame Parveen Kumar
Committee Chair
November 2020

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2.1

Meeting Title:	Trust Board		
Date	26 November 2020	No:	2.1.1
Report Title:	Infection Prevention & Control Annual Report		
Lead Director/ Manager:	Robert Bleasdale, Chief Nurse and Director Infection Prevention & Control		
Report Author:	David Shakespeare, Head of Infection Control		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval		
Executive Summary:	The purpose of the Infection Prevention and Control (IPC) Annual Report is to provide the committee with information on Trust performance and provide assurance that suitable processes are being employed to prevent and control infections at St George's University Hospitals NHS Foundation Trust. The report covers the infection prevention and control activities within the Trust for April 2019 to March 2020. The following organisms are subject to mandatory reporting. These are MRSA, MSSA, *Clostridium difficile*, and Gram negative bloodstream infections (*Escherichia coli, Klebsiella species, Pseudomonas aeruginosa)* For the financial year 2019/20 there have been three cases of Trust apportioned MRSA bacteraemia compared to one during the previous year 2018-19. Two cases were found to be line related whilst the third case was related to the patient's existing health condition. A Trust wide audit was undertaken on line management of peripheral lines. This resulted in modification of the line management documentation on the patient electronic record (iClip) for easy completion and monitoring of intravenous line phlebitis score and due date for replacement. There were 36 episodes of MSSA bacteraemia during 2019-20 apportioned to the Trust. This compares to 27 during 2018-19 and 28 during 2017-18. Of the 36 cases, 17 were thought to be associated with intravenous lines. There were 51 cases of Trust apportioned Clostridium difficile infection (CDI) against an NHS Improvement set target of no more than 48 cases. This represents an increase on the 31 cases reported during 2018-19. There were 8 lapses in care recorded. Key themes included antibiotics where not absolutely required and not sending specimens for microbiological testing. Wards where the CDI was acquired were commenced on a Period of Increased Audit and Surveillance (PISA) to ensure that there were high standards of patient care, hand hygiene and environmental and equipment cleanliness. These standards are expected to be maintained for a minimum of 3 weeks before the ward can come off PISA. Influenza cases were lower than other recorded years during the 2019-20		

	winter season in comparison to the previous year, reflecting the national position. The use of point of care testing in the Emergency Department has continued to help the Trust identify cases of flu at the earliest possible on the patient's journey and has facilitated the use of infection prevention measures and isolation at an early stage to avoid spread to other patients. An excellent achievement has been the uptake of staff influenza vaccination, which at 89.3%, once again is the highest uptake of hospitals in London. Norovirus activity was similar to previous years and resulted in temporary closures of some wards to prevent further transmission. A failure of a ventilation system during 2018 has led to improvements in the ventilation infrastructure and governance at the Trust. The global pandemic of SARS-Cov-2, the virus that causes Covid-19 had considerable impact on the Trust operational activities. The Trust responded by reducing normal business and increasing capacity in critical care and other wards areas to care for patients affected. Circa 960 patients tested positive for the virus and were subsequently discharged. However, 295 patients who tested positive for the virus in our care sadly died. The Trust is adapting to a new way of working that minimises future risk from SARS-Cov-2 to our patients and staff and in particular to prevent nosocomial (within the hospital) transmission.		
Recommendation:	The Board is asked to note the annual Infection Prevention and Control Report.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures required to minimise risk from Healthcare Associated Infection.		
CQC Theme:	Safe, Effective, Responsive, Well Led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	Healthcare Associated Infections leading to increased morbidity and mortality at the Trust.		
Legal/Regulatory:	The Health and Social Care Act (2008): The Hygiene Code		
Resources:	N/A		
Previously Considered by:	Executive Management Team Quality & Safety Committee Infection Control Committee members	**Date**	16/11/20 19/11/20 July 2020
Equality Impact Assessment:	N/A		
Appendices:	N/A		

St George's University Hospitals NHS Foundation Trust

Annual Report
Infection Prevention and Control
2019 – 2020

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Executive summary

The purpose of this report is to provide the Board with information on Trust performance and provide assurance that suitable processes are being employed to prevent and control infections at St George's University Hospitals NHS Foundation Trust.

We have been considerably impacted by the global pandemic of SARS-Cov-2, the virus that causes Covid-19. The Trust responded by reducing normal business and increasing capacity in critical care and other wards areas to care for patients affected. Circa 960 patients tested positive for the virus and were subsequently discharged. However, 295 patients who tested positive for the virus sadly died in our care. The Trust is adapting to a new way of working that minimises future risk from SARS-Cov-2 to our patients and staff and in particular to prevent nosocomial (within the hospital) transmission.

During 2019-20 the Trust recorded three cases of Trust apportioned Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia (blood stream infection) compared to 1 during the previous year 2018-19.

There were 51 cases of Trust apportioned *Clostridium difficile* infection against an NHS Improvement set target of no more than 48 cases. This represents an increase on the 31 cases reported during 2018-19. There were 8 lapses in care recorded.

There were 37 Trust apportioned cases of Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia during 2018-19 compared to 27 during 2018-19.

Influenza cases were lower than other recorded years during the 2019-20 winter season in comparison to the previous year, reflecting the national position. The use of point of care testing in the Emergency Department has continued to help the Trust identify cases of flu at the earliest possible point on the patient's journey and has facilitated the use of infection prevention measures and isolation at an early stage to avoid spread to other patients.

An excellent achievement has been in the uptake of staff influenza vaccination, which at 89.3%, once again is the highest uptake of hospitals in London.

Norovirus activity was similar to previous years and resulted in temporary closures of some wards to prevent further transmission.

There continues to be low levels of colonisation and infections with multi-drug resistant bacteria.

A failure of a ventilation system during 2018 has led to improvements in the ventilation infrastructure and governance at the Trust.

A note of thanks to all our staff who continue to take seriously that prevention of infection at the Trust is everyone's business. We continue look forward to further strengthening infection prevention and control at the Trust during 2020-21.

1. Infection Control Team and reporting arrangements

Head of Infection Prevention & Control	1.0 wte
Infection Control Doctor/ Consultant Microbiologist	4 PA's
Lead Nurse-Infection Prevention & Control	0.5 wte
Clinical Nurse Specialists- Infection Prevention & Control	3.0 wte
Infection Prevention & Control Nurse	4.0 wte
Infection Prevention & Control Support Worker	1.0 wte
PA to infection Prevention & Control	1.0 wte

The *Trust Board* recognises and agrees their collective responsibility for minimising the risks of healthcare associated infection and agrees and supports the means by which these risks are controlled. The responsibility for Infection Prevention and Control (IPC) lies with the Director of Infection Prevention & Control (DIPC) who is the *Chief Nurse*. The Chief Nurse is supported by a Deputy Chief Nurse, Assistant Chief Nurse, a Consultant Microbiologist as the Infection Control Doctor and a Head of Infection Control. The Chief Nurse & DIPC reports directly to the Chief Executive and the Board and chairs the Trust Infection Prevention & Control Committee (IPCC).

The *Infection Control Doctor* is a Consultant Microbiologist and provides expert microbiological and infection prevention advice and provides support for the wider Infection Prevention and Control Team (IPCT).

The *Head of Infection Control* is a senior nurse who provides leadership for the IPC Nurse Team. The Head of Infection Control reports professionally to the Assistant Chief Nurse and works closely with the Infection Control Doctor and other Consultant Microbiologists to ensure the agreed annual infection prevention plan is implemented and that an appropriate response is maintained to any infection prevention incident arising.

The *IPCC* is the main forum for governance and monitoring of action around IPC practice at the Trust. The membership of the IPCC includes representation from all Divisions at the Trust, plus a representative from Public Health England. The IPCC is chaired by Chief Nurse / DIPC. The committee meets bi-monthly. Quarterly reports from the IPCC are received in the Patient Safety & Quality Group and the Quality & Safety Committee, which is a subcommittee of the Board.

The *Infection Prevention & Control Team* (IPCT) provides expert knowledge and day to day management of IPC related issues. The IPCT liaise regularly with clinicians and managers across the Trust. They are supported by *IPC Link practitioners* based in clinical areas for whom study events are held quarterly.

Members of the IPCT also attend and participate in (but are not limited to) the following groups / committees:

Infection Prevention & Control Committee	Antimicrobial Stewardship Group
Strategic Water Safety Group	Ventilation Safety Group
Operational Water Safety Group	Decontamination Group
Waste Project Group	Winter preparedness Groups
Occupational Health Groups	Building planning meetings

Matrons Environmental Action Team	Cleaning review meetings

2. Compliance with the Hygiene Code

The Trust is required to demonstrate compliance with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (The Hygiene Code). The Trust declares compliance with all ten criteria of the Hygiene Code (listed below) during 2018-19.

Criterion one: Systems to manage and monitor the prevention & control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
Criterion two: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion three: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
Criterion four: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion
Criterion five: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
Criterion six: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
Criterion seven: Provide or secure adequate isolation facilities
Criterion eight: Secure adequate access to laboratory support as appropriate
Criterion nine: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections
Criterion ten: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

3. Summary of Infection Prevention and Control performance

Trusts are required to participate in six mandatory reporting schemes;

I. Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia
II. Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia
III. *Clostridium difficile* infection
IV. Glycopeptide-resistant enterococcal bacteraemia
V. *Escherichia coli*, *Klebsiella* and *Pseudomonas aeruginosa* bacteraemia
VI. Surgical Site Infection Surveillance

MRSA, MSSA and *E. coli* Bloodstream Infections (BSI) and laboratory detected *Clostridium difficile* toxins are reported monthly via the Public Health England Health Care Associated Infection (HCAIs) data capture system.

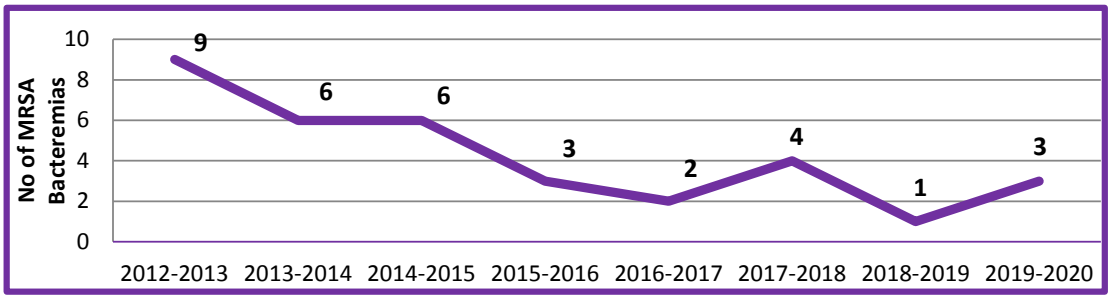
3.1 MRSA Bacteraemia

All MRSA bacteraemia are initially apportioned to the organisation based on the timing of the positive blood culture The MRSA bacteraemia then undergoes a post infection review (PIR) process.

There have been three episodes of Trust-apportioned MRSA bacteraemia during the financial year 2019-20. Two cases were found to be line related; peripheral line in one case and PICC line in the second case. The third case was related to the patient's existing health condition.

A trust wide audit was undertaken on line management of intravenous lines. This resulted to modification of the line management documentation on patient electronic record (iClip) for easy completion and monitoring of intravenous lines phlebitis score and due date for review and replacement.

Figure 1: MRSA bacteraemia St George's University Hospitals NHS Foundation Trust (SGH) 2012-2020

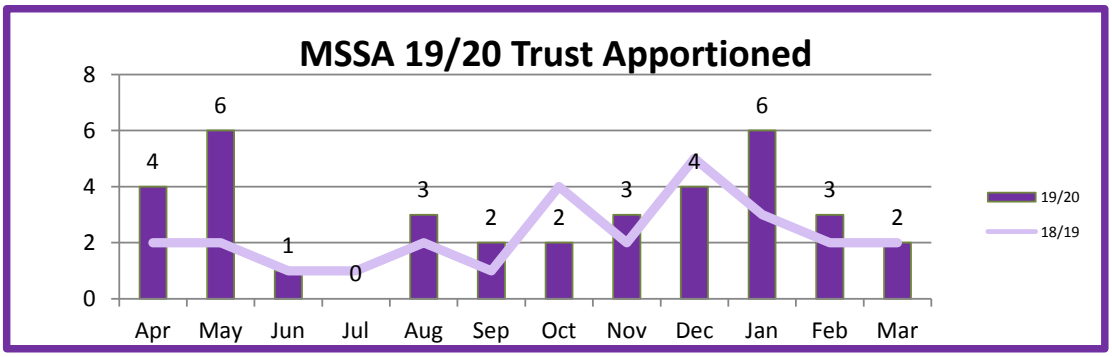


3.2 MSSA Bacteraemia

There were 36 episodes of MSSA bacteraemia during 2019-20 apportioned to the Trust. (See Figure 2). This compares to 27 during 2018-19, 28 during 2017-18, 31 during 2016-17 and 36 during 2015-16. Of the 36 cases, 17 were thought to be associated with intravenous lines. Other key cause groups are respiratory and gastrointestinal infection.

There are no national thresholds for MSSA bacteraemia at present.

Figure 2: MSSA bacteraemia SGUH 2018-20



3.3 *Clostridium difficile*

Clostridium difficile infection (CDI) is a major cause of antibiotic-associated diarrhoea Figure 3 below shows CDI Trust apportioned 2012-20 against NHS Improvement set targets.

During 2019-20 St George's had 51 episodes of Trust apportioned *Clostridium difficile* infection against an NHS Improvement set target of no more than 48 cases. This represents an increase on the 31 cases reported during 2018-19.

However, the method of counting has changed from previous years and now consists of:

- ***Hospital onset healthcare associated***: cases that are detected in the hospital two or more days after admission

- ***Community onset healthcare associated***: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust in the previous four weeks.

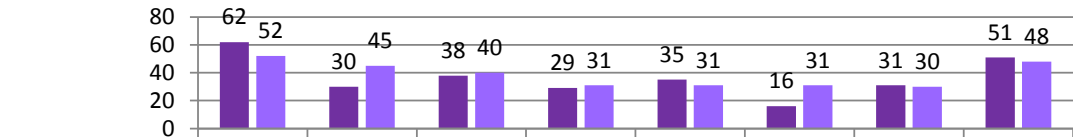
Previously reported cases included those detected in the hospital after day of admission plus two days.

As per the CDI standard operating procedure (SOP), episodes that were Trust-apportioned underwent root cause analysis (RCA) and all isolates of *C difficile* were sent for ribotyping to look for any evidence of cross-infection.

Wards where the CDI was acquired were also commenced on a Period of Increased Audit and Surveillance (PISA) to ensure that there were high standards of patient care, hand hygiene and environmental and equipment cleanliness. These standards must be maintained for a minimum of 3 weeks before the ward can come off PISA.

Most of the cases were attributed to the administration of appropriate antibiotics to patients with infections which were not preventable and life threatening if not treated with antibiotics.

Figure 3: *Clostridium difficile* at St George's University Hospitals Foundation Trust 2012-13 to 2019-20



	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
Number of episodes	62	30	38	29	35	16	31	51
Target	52	45	40	31	31	31	30	48

Number of episodes Target

4.3.1 Analysis of CDI Cases 2019-20

Of the 51 cases, the Trust recorded 8 lapses in care. This means that cases could have been managed better to have potentially prevented the case. Key themes include antibiotics that were not absolutely required and not sending specimens for microbiological testing.

4.3.2 Period of Increased Incidence (PII)

A PII is defined as two or more cases of *Clostridium difficile* infection within a 28-day period that are linked by place and time. There were five PIIs during 2019-20. In one case the ribotyping was the same which indicated possible cross infection and infection prevention measures were strengthened in that area.

4.4 Gram-negative bacteraemia

All Trusts have been required to report cases of *E. coli* bacteraemia using similar mechanisms as for MRSA and MSSA bacteraemia.

4.4.1 *E. coli*

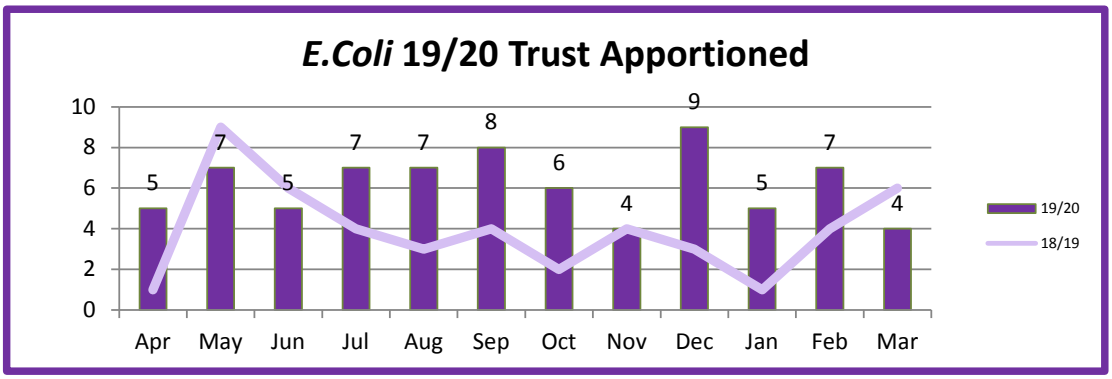
E. coli bacteria are frequently found in the intestines of humans and animals and can survive in that environment. There are many different types of *E. coli*, which can cause a range of infections including urinary tract infection, cystitis and intestinal infection. When primary *E. coli* infection spreads to the blood it is known as *E. coli* blood stream infection (BSI) or bacteraemia.

Typically, community acquired *E. coli* bacteraemia results from abdominal, biliary or urinary tract sepsis. Hospital acquired cases of *E. coli* bacteraemia can also be associated with urinary catheter infections.

The Trust is leading on development of a digital catheter passport and standardisation of catheter products across the health economy of South West London (SWL) through the SWL Catheter Workstream. It is envisaged that the digital catheter passport will be in placed by the first quarter of 2021/22.

For 2019-20 a total of 74 Trust apportioned *E. coli* bacteraemia were reported. This compares to 2018-19 when 47 were reported and 2017-18 when 68 Trust apportioned cases were reported. Predominant cause groups were upper urinary tract and gastrointestinal tract.

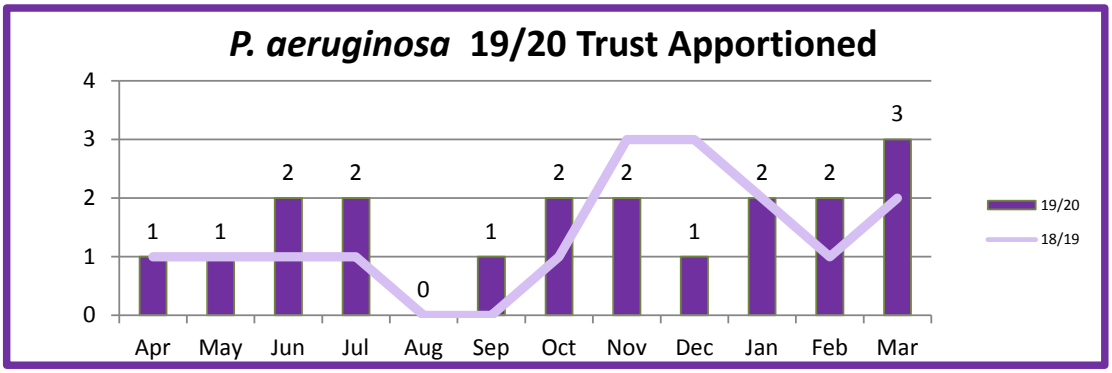
Figure 4: Trust apportioned *E coli* bacteraemia 2019-20 showing 2018-19 figures



4.4.2 *Pseudomonas aeruginosa*

There were 19 cases of Trust apportioned *Pseudomonas aeruginosa* bacteraemia during 2019-20, compared to 16 during 2019-20 and 27 during 2017-18 (Figure 5).

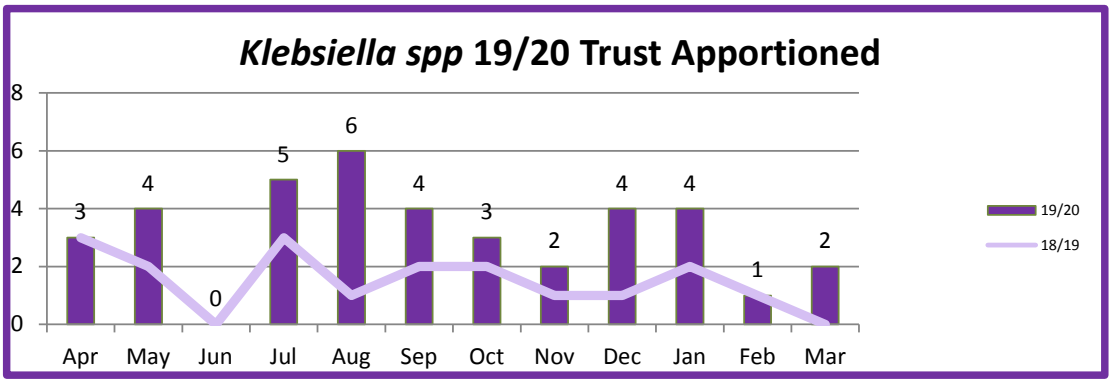
Figure 5: Trust apportioned *P. aeruginosa* bacteraemia 2019-20 showing 2018-19 figures



4.4.3 *Klebsiella*

There were 38 cases of *Klebsiella* bacteraemia were reported during 2019-20, compared to 21 cases reported during 2018-19 and 29 cases during 2017-18 (Figure 6).

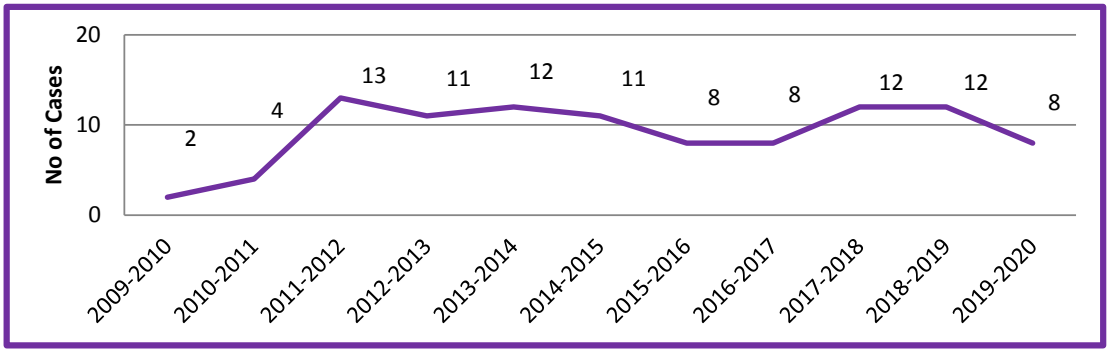
Figure 6: Trust apportioned *Klebsiella* bacteraemia 2019-20 showing 2018-19 figures



4.4.4 Glycopeptide resistant enterococcal bacteraemia (GRE)

St George's figures are illustrated below (Figure 7). There are no national thresholds. St George's has maintained low levels of GRE and 8 cases were reported during 2019-20.

Figure 7: GRE bacteraemia 2009-10 to 2019-2020



4.4.5 Carbapenamase producing *Enterobacteriaceae and* Carbapenem-resistant organisms (CPE/CRE)

These are multiply antibiotic resistant Gram-negative bacteria. The Trust continues with low numbers of patients treated with CPE.

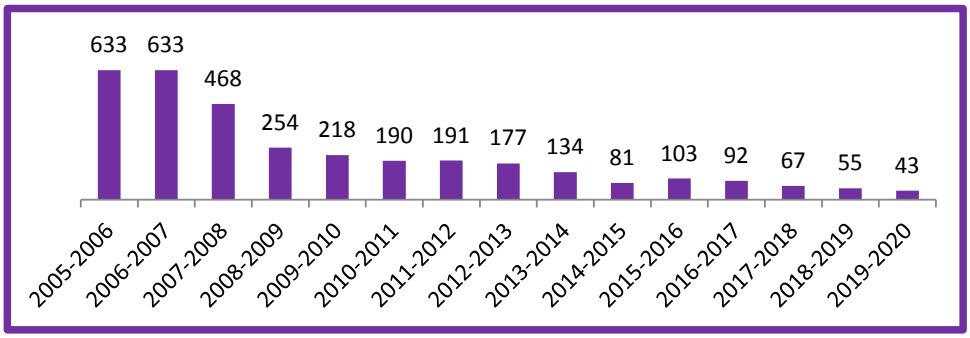
The Trust reports episodes to the voluntary PHE operated CPE database as well as submitting antibiotic resistance data to the PHE.

4.5 MRSA acquisitions

The Infection Prevention and Control (IPC) team record all new MRSA acquisitions in the Trust as part of alert organism surveillance i.e. MRSA grown from clinical samples other than blood cultures, including screening swabs.

The acquisitions are shown 2005-19 in Figure 8.

Figure 8: MRSA acquisitions 2005-06 to 2019-20



Currently all emergency admissions to St George's Hospital are screened for MRSA in accordance with previous NHS requirements mandated in 2010.

In 2014 new advice was published indicating that MRSA screening could be reduced to "high-risk" patients only. The Trust Infection Control Committee therefore agreed to support targeted screening which has commenced for elective surgical patients via pre-assessment. This targeted screening will be expanded during 2020-21 to low risk emergency admissions. Patients who require critical care continue to be screened and high-risk surgical cases e.g. in orthopaedics or cardiac surgery will also continue to be screened.

5 Surgical Site Infection (SSI) Surveillance

The aim of the national surveillance programme is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice.

Data collected will generate two rates of SSI: The cumulative incidence of SSIs and the all hospitals SSI rate. Both results will be presented in this report.

The **Cumulative Incidence of SSI** is calculated from SSIs detected during the inpatient stay and readmission with SSI. This rate is used for comparison against the national benchmark. Only SSIs identified by active surveillance in hospital are included in the main outcome measure for national surveillance because SSIs reported by patients cannot be verified.

The **All hospitals SSI** rate includes all SSIs detected during inpatient stay and readmission with SSI in addition to those infections detected in post-discharge surveillance and reported by patients at 30 day's post-operation.

The SSI Surveillance (SSIS) programme provides an infrastructure for hospitals to collect data on 17 surgical categories. Any infections that are reported using the SSIS data base should be investigated by the relevant MDT team, surveillance nurses, ward manager and IPCT to identify any issues / practices for improvement.

Results are then submitted to Public Health England (PHE). During 2019-20 the Trust participated in SSIS in reduction of long bone fracture, coronary artery bypass graft surgery and spinal surgery.

5.4 Reduction of Long Bone Fracture

Data for 2019 (Table 1 as published by PHE are shown below). These are the figures for St George's Hospital all SSIS:

Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		No patient reported		All SSI*	
		No.	%	No.	%	No	%	No.	%
2019 Q1	128	0	0.0%	2	1.6%	3	2.3%	5	3.9%
2019 Q2	110	2	2.5%	0	0.0%	0	0.0%	2	1.8%
2019 Q3	134	2	1.5%	2	1.5%	1	0.7%	5	3.7%
2019 Q4	92	1	1.0%	2	2.1%	0	0.0%	3	3.3%
*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q1 Jan-Mar 2019, Q2 Apr-Jun 2019, Q3 Jul-Sep 2019, Q4 Oct-Dec 2019).									

Table1: 2019 Reduction of Long Bone SSI data at St. George's (Source: Public Health England SSIS Service, Summary Reports Jan – Dec- 2019)

In the period of Jan – March 2019 we had an additional organ space SSI taking the actual figure to 6. Surveillance is undertaken for up to a year after an implant is placed. This means that patients may present later in the year with a SSI; this was reported to PHE in August 2019 but not included in the PHE report.

We also had a further SSI for the period July – September 2019; organ space reported in April 2020 taking the actual figure to 6 but this was not included in the PHE report. This means that the true infection rate for Q1 and Q3 was 4.7% and 4.5% respectively.

Table 2: 'All Hospitals' SSI for Reduction of Long Bone 2019

SSI period 2019	St George's	All hospitals
January – March	3.9%	1.6%
April – June	1.8%	1.6%
July - September	3.7%	1.6%
October - December	3.3%	1.6%

Table 3: Cumulative Incidence of SSI Reduction of Long bone 2019

SSI period 2019	St George's	All hospitals
January – March	0.0%	1.0%
April – June	1.8%	1.0%
July - September	1.5%	1.0%
October - December	1.0%	0.9%

The cumulative incidence of SSI (Table 3 above) are benchmark figures for the cumulative percentages for patient and readmission figures for 2019. St. George's results are higher than the benchmark in 3 quarters. April to June was 1.8 compared to all hospitals at 1%. In July to September, this was reduced to 1.5% but still 0.5% higher compared to 1.0% for all hospitals, October to December again reduced to 1% which is 0.1% higher in comparison to 0.9% for all hospitals.

When the reported SSI's are above the national average, the Surgeons are asked to review their cases to see if they were truly an infection and recorded correctly.

Actions taken include the following:

- Revising and adapting the SSI root cause analysis tool in collaboration with clinical teams to ascertain any lessons for future clinical practice with feedback to clinicians and Divisional Governance Teams
- Feedback of reports to a wider audience and relevant stake holders (patient infections are currently fed back to individual surgeons for information and confirmation but does not include overall rate
- Review of the type of sutures used, following concerns that this may have been related to some infections.
- Implementation of a post discharge questionnaire for some categories of surgery.
- Walkabouts in Theatres by the IPC team.

5.5 Coronary Artery Bypass Grafts (CABG)

The cardio-thoracic Specialist Nurse in conjunction with the Infection Prevention and Control Team undertook SSI surveillance of all CABG surgery. Post the introduction of multiple measures following the high rates reported in the 2013-14 annual report the infection rate subsequently reduced significantly.

The surgical site infection rate at St George's for CABG was 2.8% for the calendar year 2018 for inpatients and patients readmitted. This consists of 540 procedures of which 15 infections were identified in inpatients or patients readmitted. This is below the participant mean of 3.1%.

The table below shows figures for St. George's Hospital CABG SSIs 2019.

Table 4: 2019 CABG SSI Data at St. George's

Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		No patient reported		All SSI*	
		No.	%	No.	%	No	%	No.	%
2019 Q1	109	2	1.8%	0	0.0%	2	1.8%	4	3.7%
2019 Q2	122	3	2.5%	1	0.8%	0	0.0%	4	3.3%
2019 Q3	128	6	4.7%	3	2.3%	0	0.0%	9	7.0%
2019 Q4	113	5	4.4%	2	1.8%	0	0.0%	7	6.2%
*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q1 Jan-Mar 2019, Q2 Apr-Jun 2019, Q3 Jul-Sep 2019, Q4 Oct-Dec 2019).									

(Source: Public Health England SSIS Service, Summary Reports Jan – Dec- 2019)

Table 5: SSI 'All Hospitals' SSI for CABG 2019 (as published by PHE)

SSI period 2019	St George's	All hospitals
January – March	3.7%	5.9%
April – June	3.3%	5.8%
July - September	7.0%	5.8%
October - December	6.2%	5.8%

Table 6: Cumulative Incidence of SSI for CABG 2019

SSI period 2019	St George's	All hospitals
January – March	1.8%	2.8%
April – June	2.5%	2.8%
July - September	4.7%	2.8%
October - December	4.4%	2.8%

The cumulative benchmark data shown above (table 6) differ from the all hospital data (table 5). However, the trend is the same in that rates of infection increased in the latter half of the year.

There is a plan to expand the Endoscopic Vein Harvest (EVH) Service in order to minimise risk of infection which is higher for open harvesting. Business plan has been put forward by the lead surgeon; however, there is no specific date yet for roll out due to Covid-19 pandemic.

Between July and December there were 6 wound infections identified from non EVH procedures.

There is a plan also to update information for patients for post-surgical advice and the commencement of SSI ward rounds.

5.6 Spinal surgery

Spinal infection surveillance at SGH was introduced from April 2019. Data was collected, submitted and reconciled for 2 periods, Q2 Apr-Jun 2019 and Q3 Jul-Sep 2019. Data for Q4 Oct-Dec 2019 was collected locally but not submitted to PHE in March 2020 due to COVID19 pandemic. It is mandatory to submit at least one quarter of orthopaedics per year and additional submission is voluntary.

At St George's Hospital the overall SSI rate, for all SSIs, from April to December 2019 was 3.0%, this is above the participant rate of 1.7%

The national benchmark for Spinal surgery is 1.1%; at St George's hospital the inpatient and re-admission SSIs overall rate is 2.7%. Although still above the national benchmark, the SSI risk of infection at St George's hospital had a reduction of 2.8%, from 4.6% detected during Q2 to 1.8% during Q4.

Table 7: Spinal surgery SSI data 2019 as published by PHE

2019 Trends in rates of SSI by surveillance period at St George's University Hospital							
Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2019 Q2	259	12	4.6%	0	0.0%	13	5.0%
2019 Q3	230	4	1.7%	0	0.0%	5	2.2%
***All SSI = Inpatient & readmission, post-discharge confirmed and patient reported This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q2 Apr-Jun 2019, Q3 Jul-Sep 2019).**							

Table 8: Spinal surgery SSI data 2019 (collected locally but not submitted to PHE)

2019-2020 Trends in rates of SSI by surveillance period at St George's University Hospital							
Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2019 Q4	220	4	1.8%	0	0.0%	4	1.8%
***All SSI = Inpatient & readmission, post-discharge confirmed and patient reported This table refers to data collected over the selected period for which data has been collected but not submitted and reconciled (Q4 Oct-Dec 2019).**							

5.7 Future actions

The Trust plans a number of actions to reduce SSI.

- Revising and adapting the SSI root cause analysis tool in collaboration with clinical teams to ascertain any lessons for future clinical practice with feedback to clinicians and Divisional Governance Teams.
- To review type of sutures used, following concerns that this may have been related to some infections.
- Reinforce implementation of a post discharge questionnaire for some categories of surgery.

6 Water Safety

The monitoring and preventative measures of *Legionella* and *Pseudomonas* in taps and showers continue. A system of filtering outlets remains in both St James wing and Lanesborough wing and water outlet testing is in place. Capital estates works to improve the quality of water has been completed for St James Wing and a programme aimed to remove point of use filters will occur during 2020-21.

The Operational Water Management Group (OWSG) has led on mitigation and management of this issue with support from IPCT. The OWSG meets on a fortnightly basis and is led by the Head of Estates with representatives from Microbiology, Infection Control and contractor services in attendance. There is also a Strategic Water Safety Group chaired by the Chief Nurse / DIPC.

7 Outbreaks and Incidents

7.4 Ventilation system failure

A patient with extensively drug resistant tuberculosis (XDR-TB) was admitted to the Trust during 2018. Due to the infection risk, the patient was placed in a negative pressure room. As the affected ward was originally commissioned to have both infectious patients and immunosuppressed patients, it has remained possible to switch some side rooms to positive or negative pressure. It was highlighted that the affected room had probably been at positive pressure where negative was indicated.

The incident was reported to Public Health England (PHE) and (as per RIDDOR) to the Health and Safety Executive (HSE) and the HSE issued an Improvement Notice. During 2019-20 improvements were made whereby older ventilation plant was replaced with positive pressure ventilated lobby (PPVL) technology in the affected area and other locations at the Trust. This means that either patients who have an infection or are who are immunosuppressed can be housed in one of these rooms and there is no requirement to alter the ventilation manually. On completion of the work, the HSE confirmed that the requirements of the Improvement Notice had been met.

7.5 Influenza infections and outbreaks

Cases of influenza have been reported but at relatively low levels when compared to other years. The Trust has a standard response once influenza is suspected involving the isolation of patients were possible and staff utilising personal protective equipment and face shield masks to prevent the spread of infection to others. Point of Care Testing continues to be available in A&E as in the previous winter which helps identify patients with influenza virus at the earliest possible point in their patient journey at the Trust so that precautions can be taken to protect other patients. Cases of influenza are managed by isolating in a side room where possible or cohorting within a bay with assessment of other patients where prophylaxis can be offered to at risk patients.

An outbreak of influenza was reported on Mary Seacole Ward following confirmation of a case on 31/12/19. On 03/01/20 there were a total of 7 acquired cases, the ward was closed, contact patients were given prophylaxis and outbreak meetings were commenced. The ward was fully re-opened on 16/01/20 when there had been a total of 8 cases and 1 staff member affected. On 27/01/20 two bays were closed with one confirmed and one other query (negative) case leaving one bay closed. Further sporadic cases were reported with a total of 10 confirmed cases (since onset on 31/12/19) and the ward was fully re-opened on 13/03/20.

Between October 2019 and March 2020 there were 360 reported cases of flu in the Trust. (This does not include staff members)

Influenza A/ H1N1 was the predominant strain throughout the season. There were 64 cases of Influenza B and 3 patients with both Influenza A and B.

7.6 Staff Influenza vaccination

The Trust's staff influenza vaccination campaign successfully led to an uptake of 89.3% by patient facing staff, ranking once again as the highest uptake hospital in London.

Table 9 shows update among a range of patient facing staff groups

Staff Group	Total flu jab
All Doctors	91%
Qualified Nurses	96%
Midwives	41%
Clinical Staff	77%
Support to Clinical + Admin	88%
Patient Facing Students	100%
Total Patient facing staff	89.3%

7.7 Norovirus infections and outbreaks

Four wards were closed due to outbreaks of Norovirus (Table 6).

Table 10 shows outbreaks of Norovirus occurring at the Trust

Ward	Outbreak reported	Ward fully reopened	Total patients tested positive	Number of staff affected
Gunning	26/11/19	08/12/19	6	6
Rodney Smith	17/12/19	02/01/20	9	5
Amyand	17/12/19	23/12/19	5	3
Cavell	07/02/20	05/03/20	16	10

During the time that Amyand and Rodney Smith were affected, due to their proximity, routine cleaning with Chlor Clean was undertaken on the other two 3rd floor adjacent wards Allingham and Marnham as a precaution. There was no evidence of spread to those areas.

Trust response to Norovirus

The Trust has a standard response to Norovirus. This includes daily review of affected patients by the Infection Prevention & Control Team (which also takes place prior to Norovirus being confirmed or full ward closure) and an increase in the frequency of environmental cleaning using a chlorine releasing product including touch point cleaning; and restrictions to visitors and movement of staff. Ward closure signage is stationed outside affected ward areas and outbreak meetings are also held.

Closure of a ward indicates no admissions, transfers in or out, or discharges other than to a patient's own home and restriction on visitors with essential visiting only at the discretion of the nurse in charge. However, discharges to other health care facilities are permitted for asymptomatic patients with the agreement of the receiving organisation so that they can take necessary precautions e.g. identify single rooms for quarantine.

There is no bar on visitors during a Norovirus outbreak but is at the discretion of the nurse in charge. Visitors are asked to perform hand hygiene on entry to and exit from the ward.

Routine cleaning with chlorine was put into place from November 2019 as a precaution for admitting areas in the Trust in order to help prevent spread of Norovirus in the Trust and was put in place in the Emergency Department and Richmond Acute Medical Unit.

Daily outbreak meetings are held for any ward closure attended by Consultant Microbiologist, Infection Prevention & Control Team, clinical team members from the affected area (usually Ward Manger, Matron or Head of Nursing and Deputy DIPC.

7.8 Measles

On 11th December 2019 the trust was notified by South London Health Protection Team of measles circulating in Wandsworth, South London, also affecting one secondary and two primary schools in the borough. Cases have continued to present at the trust.

Symptoms of measles include runny or blocked nose, watery and sore eyes, fever, small greyish white spots inside the mouth with the measles rash developing 2-4 days later.

A throat swab is used to detect Measles IgM (antibodies). The majority of measles cases are IgM positive in the first two days after the onset of rash, with 90% of cases positive three to five days after the rash appears.

The incubation period from exposure to onset of measles symptoms ranges from 7 to 14 days (average, 10-12 days). Patients are contagious from 1-2 days before the onset of symptoms. Healthy children are also contagious during the period from 3-5 days before the appearance of the rash to 5 days after the onset

The main theme is a lack of vaccination history, or before the MMR vaccine is indicated.

The standard response to suspected or confirmed measles is to isolate the patient and establish patient and staff contacts in order to check for immunity. Staff can be checked for their immunity status and offered MMR if non – immune. Patients who remain inpatients are checked for any history of measles or current immune status (IgG positive or negative). At risk or immunosuppressed patients may be given immunoglobulin.

Any patient that has been discharged, but who is subsequently found to have been exposed to Measles are informed that they have potentially been exposed, via a warn and inform letter.

7.9 COVID-19

The novel respiratory coronavirus SARS-CoV-2 which causes Coronavirus Disease 2019 (COVID-19) emerged in Wuhan, China in December 2019. The first cases in the UK were confirmed in late January 2020. COVID-19 surveillance in the UK has been on-going since January 2020. The first inpatients with Covid-19 at St George's Hospital were seen in March 2020.

The work of the IPC team was significantly impacted by the COVID-19 pandemic from mid-January 2020, initially with the management of potential cases of SARS-CoV-2 as a high consequence infectious disease (HCID); and then as significant numbers of cases were managed in the Trust between March and June 2020 when a Covid-19 surge plan was developed and enacted.

As the pandemic progressed, St George's University Hospitals NHS Foundation Trust followed national guidelines and recommendations in ceasing elective work,

reconfiguring acute services with increased intensive care (ICU) capacity, and redeployment of the workforce. Meeting the challenge of the Covid-19 pandemic was a whole trust effort.

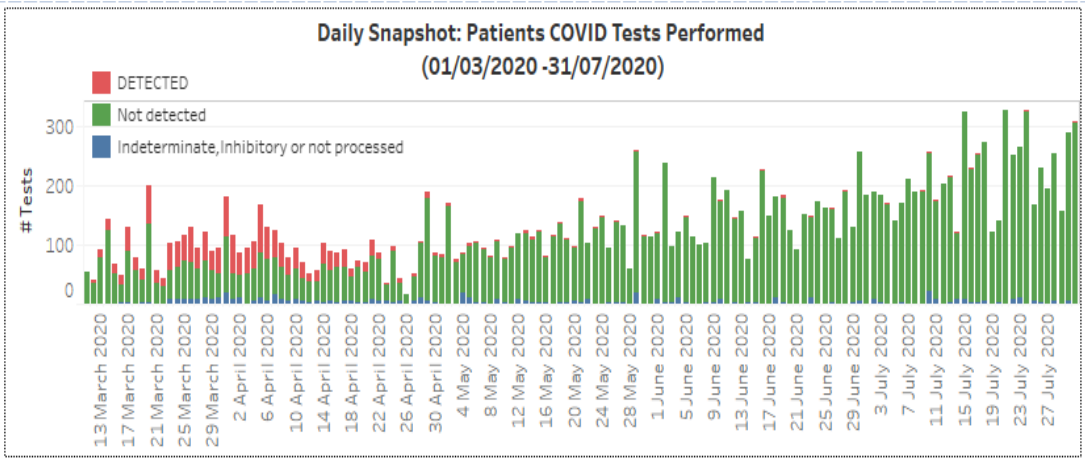
Some of the actions and support offered by the IPCT during this time included but was not limited to:

- Training and education for staff, including redeployed staff and medical students
- PPE donning and doffing in accordance with PHE guidance
- Hand hygiene training and audits
- The Trust held boot camps for the re-training of staff to enhance their competencies for redeployment in both established and newly created critical care areas
- Extension of IPC nursing service to 7-day cover
- Support for setting up the Trust POD for patient and staff testing
- Covid-19 clinical guidance and protocols
- Support for dedicated Trust intranet Covid-19 home page
- Liaison between laboratories and the clinical site management team with regard to Covid-19 testing results
- Support on the trust PPE work stream

<u>Patient and staff testing</u>

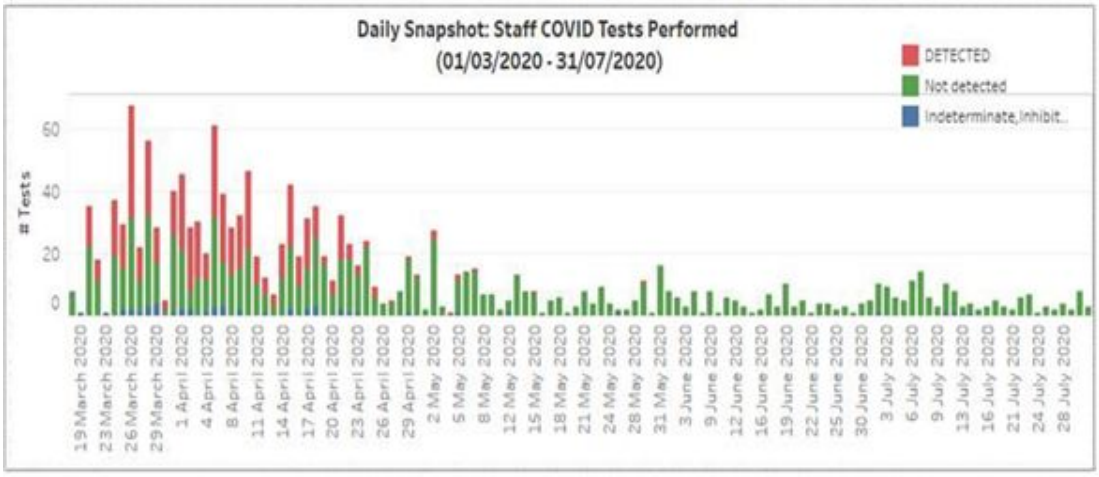
Patient testing first commenced using a 'drive through' system established at St Georges' Hospital, for patients in the community who were referred through the NHS 111 system. Hospital inpatients were first tested for Covid in early March, initially testing patients with severe community acquired lower respiratory tract infection, later expanded to all patients with a decision to admit. (Figure 9).

Figure 9: SARS CoV-2 patient tests



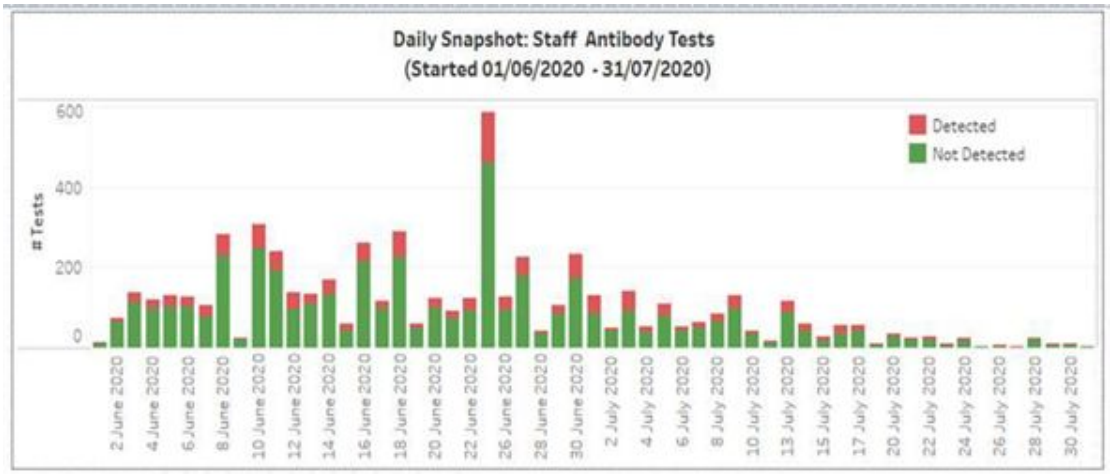
Testing for front line staff was offered during March 2020 (Figure 10) and a staff testing pathway was introduced for referral to the POD testing centre. Symptomatic household members of Trust staff were also offered testing since April 2020 and the testing site operates 7-day service.

Figure 10: SARS Cov-2 staff tests



In June 2020, the Trust commenced COVID-19 antibody testing for all staff (Figure 10). Antibody tests are used to detect antibodies to the COVID-19 virus to determine if staff have had prior viral infection with SARS Cov-2. The significance of antibody detection is unknown to date, but mass testing of staff was performed and no change to IPC or Occupational Health recommendations for staff have been made based on the results.

Figure 10: Staff Antibody tests



The COVID-19 pandemic and management will be discussed in more detail in the 2020-/2021 Annual Report.

8 Infection Control compliance and audit

8.4 Hand Hygiene

Effective hand hygiene remains the single most important action staff can take to prevent the spread of infection. St George's has placed hand hygiene and monitoring of compliance with hand hygiene technique as a key ongoing priority for infection prevention.

In order to ascertain compliance, each clinical area undertakes a monthly audit via the 'Saving Lives' programme. The audit includes a check on hand hygiene

compliance for a range of members of the multi-disciplinary team including Nurses, Doctors, Physiotherapists and Occupational Therapists. The audit scores reflect the units' compliance and allow them to demonstrate any areas of concern.

Issues of compliance are dealt with by the wards and Divisions themselves. However, for continued non-compliance an escalation process is in place ultimately leading to the Chie Medical Officer or Chief Nurse / Director of Infection Prevention & Control.

In 2019-2020 a total of 46,790 observations were recorded, up slightly from last year. The total compliance Trust wide was 98% (Figure 11).

Hand hygiene audit results are displayed within Saving Lives scorecard and discussed at Care Group and Divisional meetings and in Divisional reports to the IPCC. Compliance by Division is shown in Figure 12.

Figure 11: Hand hygiene compliance Trust wide 2019-20

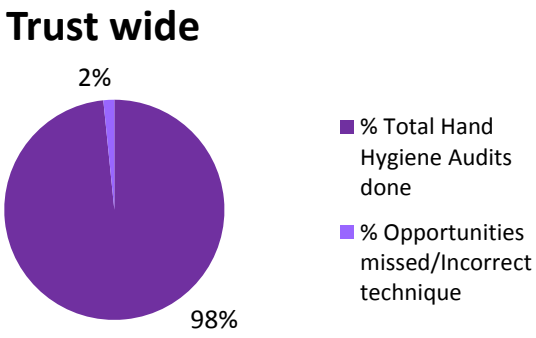
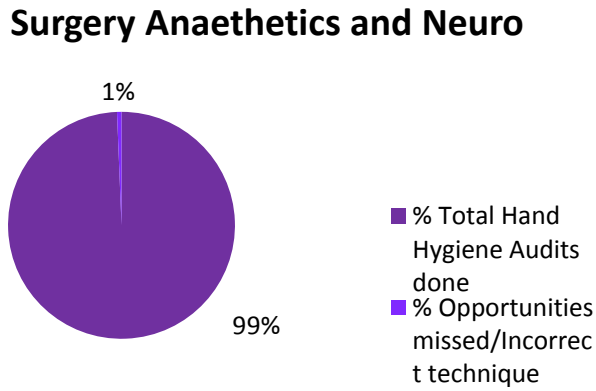
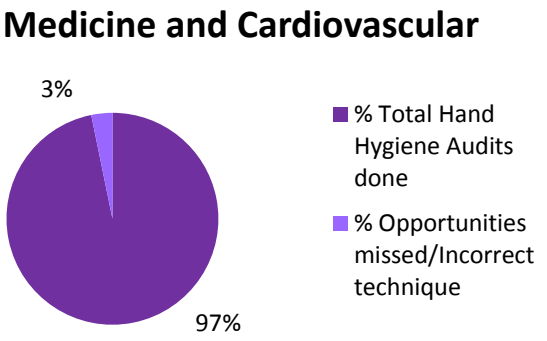
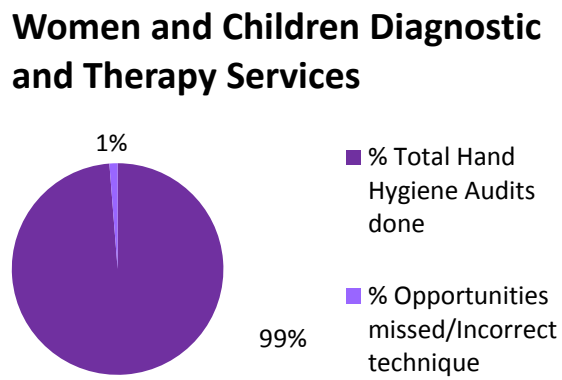


Figure 12: Hand hygiene compliance by Division 2019-20







8.5 Bare below the elbow (BBE)

The Trust continues to monitor compliance with the Department of Health (DH) initiative 'Bare below the elbow' with all staff working in clinical areas. Compliance is monitored during hand hygiene audits, with results discussed at the IPCC. Staff are advised to locally resolve any non-compliance with colleagues and additional escalation to the DIPC, Clinical Director and/ or the Chief Medical Officer where BBE continues to be a challenge.

8.6 **Period of Increased Surveillance and Audit (PISA)**

Since May 2017 the IPC team have been undertaking a process of focussed surveillance and audits for wards with episodes of healthcare-associated infections (HCAI). All wards where patients acquire *Clostridium difficile*, MRSA blood stream infection (BSI) or have a suspected MRSA outbreak, undergo a period of increased surveillance and audit (PISA). These tools allow observation of the management of patients with the infection and others with suspected infections including documentation of medical reviews, hand hygiene, Personal Protective Equipment (PPE), screening and isolation. General ward cleaning, hand hygiene, decontamination of patient equipment, management of clean linen and venous access devices (for MRSA) are also all audited during the PISA process.

The ward must achieve 95% or above to pass and must pass 3 consecutive weeks to be successful and to come off PISA. For *C. difficile* cases the Antimicrobial Stewardship (AMS) team review antimicrobial prescriptions for all patients on the ward. The ward must achieve 95% on one occasion to come off the AMS component of the PISA. On occasion, e.g. relapse of *C. difficile*, it may be decided that a PISA is not indicated and only an RCA will be required for the episode. At times, a PISA may be carried out for more than one patient on the same ward i.e. where a period of increased incidence has been established or there is a

subsequent case identified after the start of the initial PISA. In these instances, the PISA will continue until the criteria outlined above has been met.

There were three MRSA blood stream infections allocated to the trust for 2019-20 and the PISA process was carried out for all three.

28 wards were put on PISA for 36 Healthcare Associated cases of *Clostridium difficile.*

8.7 **Saving Lives Audits**

The Saving Lives Programme is a set of 'Care Bundles' or High Impact Interventions (HII) that are an evidence-based approach relating to key clinical procedures or care processes. They include: insertion and care of venous access devices and urinary catheters; prevention of surgical site infection, ventilator associated pneumonia and the spread of *Clostridium difficile*; isolation practices and the use of PPE. These tools were updated in 2017 and are routinely audited 6-monthly (where applicable) by Infection Control Link Practitioners.

Hand hygiene and Cleaning and Decontamination of Patient Equipment audits are carried out more frequently - on a monthly basis.

Saving Lives audits are completed on the Trust's quality management reporting system (RaTE). This data is broken down by Division and ward/department level to enable monitoring of compliance and is accessible to all staff via the Trust intranet.

Performance is reported to the IPCC and clinical areas that perform poorly are required to produce an action plan to address any failings within a stipulated timeframe.

During the fourth quarter of 2019-20, the hospital responded to the COVID-19 surge and select wards were re-configured as ICUs; other wards and departments were closed and staff re-allocated. Saving Lives audits were unable to be carried out in some of the affected areas from March 2020 as a temporary suspension.

8.8 Estates and Facilities

The Estates and Facilities (E&F) team in conjunction with the nursing and Infection Prevention & Control Team (IPCT) undertook audits to assure the Trust of its obligation to provide a safe care environment.

In 2019-20 the E&F team continued to be part of the audit teams for the ward accreditation programme. These included audits across the community sites, and Queen Mary's Hospital and actions were then taken to rectify any concerns when noted.

8.9 Cleanliness in Hospitals

Cleaning in hospitals is governed by the National Specifications for Cleanliness in Hospitals (2007) and the NHS Cleaning Manual (2009). Each site has a target score which takes into account different risk categorisation and cleaning frequencies.

The Trust actual average score for 2019-20 was 97%

8.10 Ward and Department Accreditation Audits

The ward accreditation was designed to engage staff and empower leaders to improve and maintain standards and quality of patient care and staff experience. The accreditation framework is based around 13 standards that were developed in line with the CQC key lines of enquiry (KLOEs). The wards progress through four levels (Requires improvement, Bronze, Silver and Gold) following formal accreditation visits based on standards of performance against agreed metrics.

The IPC nurses continue to participate in the ward accreditation audits, led by Corporate Nursing and review the infection control practices and adherence to policy.

9 Venous Access Service

9.4 The Venous Access Service is committed to high standards of infection prevention and control in relation to the insertion and on-going care and management of vascular access devices.

The team undertake weekly surveillance on the management of long-term vascular access devices and monitors any variation in weekly dressing compliance. If there is evidence of non-compliance, then this is addressed at the time with the bedside nurse and the nurse in charge. In addition, this measurement of compliance has now been added to the question set for ward accreditation along with observation of any peripheral cannulas.

9.5 The Venous Access Team has been working with the iClip (Patient management system) Team to develop a way of capturing positive blood culture results and cross referencing those with records of central venous access device insertion. There is a framework now in place and it is hoped that this will give a baseline of numbers of catheter related blood stream infections (CRBSIs) and a platform for implementing measures to reduce these rates. The Venous Access team is also working with the IPC team and the iCLIP team to further adapt the recording of venous access devices to ensure that it is more user friendly and accurate.

10 IPC Mandatory and Statutory Training (MAST), Training and Education

10.4 IPC MAST Compliance

All wards and departments were encouraged to ensure that their compliance with MAST on-line training was greater than 85%. At present, the compliance rate for IPC *clinical* on-line MAST is 85% (n=4956) and for *non-clinical* on-line MAST is 93% (n=2581) compared to 18/19 when compliance was 88% and 93% respectively.

Medical and Dental clinical staff were the least compliant group at 70%, down from 76% in 18/19

10.5 Education

The IPC nurses delivered a range of training across the organisation throughout the year. These included the following, for example

- Trust Induction
- Nurse Induction
- HCA Induction
- ED Induction

- Medicine and Senior Health
- Renal
- Trauma and Orthopaedics
- CTICU
- NICU
- GICU
- PICU and Paediatrics and NNU
- Project Search (learning disabilities)
- Physician Associates

Hand hygiene training was delivered to all staff attending induction utilising the Glow and Tell machine which identifies poor hand hygiene using a fluorescent cream. Hand Hygiene technique was also assessed using the Surewash® machines; these were taken to PISA wards, as a priority and on a rotational basis to all wards and departments.

10.6 Covid19 Personal Protective Equipment (PPE) – Donning and Doffing Training

In response to the Covid19 pandemic, the IPC team carried out PPE donning and doffing training across the organisation to key staff groups and individuals, using a train the trainer model, to ensure safe practices.

10.7 IPC Study Day

An annual IPC study was held in July 2019. This was attended by approximately 70 nursing staff and was well evaluated. A number of speakers presented on a range of topics (ventilation, water issues, antibiotic stewardship, respiratory viruses, cleaning).

10.8 Additional Training Events

The annual World Health Organisation Hand Hygiene Day (May 2019) and Infection Prevention and Control Week (October 2019) were observed at both St George's and Queen Mary's Hospitals. These involved the IPC nurses providing mobile hand hygiene training and stands for staff and visitors as well as carrying out lectures. IPC company representatives were invited to attend and participated on the stands.

IPC link meetings were convened on a regular basis during the year, when possible, to update staff with key IPC messages, education and training.

11 Antimicrobial Stewardship

The Trust continued to implement recommendations of NICE guideline [NG15]: Antimicrobial stewardship: systems and processes for effective antimicrobial medicines use. (National Institute of Health and Care Excellence, 2015)

The Antimicrobial Stewardship Group focussed work on antimicrobial stewardship, guideline review, use of alternative antibiotic agents and doses and reduction in duration of therapy. This group also measured compliance with CQUIN related activity.

10.1 Summary of CQUIN achievements

There were 2 CQUINs related to antibiotic prescribing CCG1a and CCG1b.

These are described here:

CCG1a: Aim for 90% of antibiotic prescriptions for older people (65+) meeting NICE guidance for lower UTI and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.

CCG1b: Aim for 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.

Data for the 4th quarter was suspended due to Covid-19. Achievement is presented in table 11 below. Significant amounts of work was undertaken with quality improvement projects in both Accident and Emergency and Lower Gastrointestinal surgery.

Table 11: CQIN Q1-3 2019-20

	CQUIN description	Cost incentive	Q1	Q2	Q3
CCG1a	CCG1a: Antimicrobial Resistance – Lower Urinary Tract Infections in Older People	450k	60% - <90% 47%	60% - <90% 65%	60% - <90% 62%
CCG1b	Antimicrobial Resistance – Antibiotic Prophylaxis in Colorectal Surgery	450k	60% - <90% 72%	60% - <90% 83%	60% - <90% 91%

10.2 Stewardship ward rounds:

Targeted stewardship ward rounds- 1x consultant lead per week.

Wards where cases of *C. difficile* occurred continued to have a targeted weekly antimicrobial ward round where all prescriptions on all patients are reviewed. Wards were reviewed weekly until they passed the pre-designated criteria (achieve 95% of prescriptions being appropriate). Wards where ward pharmacists report poor quality prescribing also are referred for targeted stewardship rounds.

Restricted stewardship rounds- 2x consultant lead per week.

All patients on restricted antibiotics or prescriptions not in line with the microguide are reviewed twice weekly.

10.3 Antimicrobial Audits

We undertake 3 consultant / pharmacy stewardship rounds a week reviewing all antimicrobial prescribing. All data is collected weekly on the impact of these interventions and data from 2019/20 is still being analysed. Pharmacy undertakes two point prevalence audits per year. We present data in Table 12 from the September audit. Data from the March audit is still being analysed.

We undertake one intravenous to oral switch audit per year and present the data in table 13.

Table 12: point prevalence audit September 2019:

	Results	Target	Divisions Meeting Targets			
	Sept-19		QMH	Medicine & Cardiovascular	Surgery & Neurosciences	Women, Children, critical care & Therapies
Indication in medical notes	**82%**	**95%**	**89%**	**98%**	**89%**	**98%**
Indication on drug chart	**92%**	**95%**	**100%**	**93%**	**94%**	**88%**
Stop/review date on drug chart	**98%**	**95%**	**100%**	**100%**	**100%**	**88%**
Compliance with guidelines, micro advice or according to cultures	**95%**	**95%**	**100%**	**97%**	**100%**	**91%**
Protected antimicrobials used as per policy	**95%**	**95%**	**100%**	**98%**	**100%**	**100%**
Review within 72h	**93%**	**95%**	**60%**	**95%**	**92%**	**100%**

Table 13: Intravenous to oral switch audit June 2019:

	2010	2011	2012	2013	2014	2015	2016	2017	2019
Percentage of in-patients on IV antibiotics	18%	16%	19%	14%	17%	26%	19%	20%	25%
Percentage of patients on IV antibiotics for >48 hours	49%	-	46%	53%	42%	51%	77%	66%	68%
Patients on IV antibiotics who met the criteria for an IV to PO switch	16%	7.5%	9%	10%	12%	12%	23%	7.5%	12.5%
% of patients who met the switch criteria and were not on any other IV medicines/fluids	61%	90%	100%	92%	60%	70%	86%	83%	67%

10.4 Covid 19 antibiotic guideline and Microguide updates

The stewardship team played a significant role in the review of antibiotics during the Covid-19 surge. In early March guidelines were added to the microguide on the use of PPE and safe handling of specimens. Antimicrobial prescribing in Covid-19 guidelines were published on the 1st April. A full report of stewardship during Covid-19 falls in next year's report.

12 Support from Public Health

The IPC team continues to work closely and receive support from the consultants and scientists based at the South London Health Protection Unit. A member of

that team will usually be part of any outbreak/incident investigation team and the help and advice received at those times is invaluable.

13 Priorities for 2020-21

A number of actions are to be incorporated into the annual plan for 2020-2021. These include:

- Implement national guidance issued to manage any increase in SARS-CoV-2 cases and minimise nosocomial spread
- Meet targets set by Department of Health for *Clostridium difficile*
- Continue to aim for zero cases of MRSA bacteraemia
- Introduce a programme of targeted screening for MRSA colonisation for emergency admissions
- Further strengthen the process of root cause analysis for SSI identified
- Continue to ensure that optimal infection control practices are in place, and to manage infection incidents and outbreaks efficiently in order to keep our patients as safe as possible while maximising capacity at the Trust
- Work collaboratively within the Trust and with other local organisations to reduce the rate of *E. coli* bacteraemia
- Sustain high rates of compliance with hand hygiene and 'Bare Below Elbow'.
- Introduce enhanced screening for patients transferred into the Trust for critical care
- Introduce and sustain improvements in intravenous line care

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14 Glossary of terms

Bacteraemia / BSI	The presence of bacteria in the blood / blood stream infection
C *difficile*	A bacterium that is one of the most common causes of infection of the colon. It can sometimes produce a toxin leading to colitis
Colonisation	Germs in or on the body but which not make the person unwell
CPE	Carbapenemase producing Enterobacteriaceae are Gram-negative bacteria that are resistant to the carbapenem class of antibiotics, considered the drugs of last resort for such infections
E. coli	*Escherichia coli* form part of the normal intestinal microflora in humans with some strains having the ability to cause disease. These can include food poisoning e.g. E. coli 0157 or infections of the urinary tract and bacteraemia
GRE	Glycopeptide resistant enterococci are bacteria resistant to the Glycopeptide antibiotics (vancomycin and teicoplanin) and are sometimes known as Vancomycin Resistant Enterococci (VRE)
Gram staining	A common technique used to differentiate two large groups of bacteria based on their different cell wall constituents. The Gram stain procedure distinguishes between Gram positive and Gram negative groups by colouring these cells differently, thus affecting treatment options
HCAI	Healthcare Associated Infection: Any infection that develops as a result of receiving healthcare treatment
Influenza	A respiratory illness associated with infection with the influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints

MDT	Multi-disciplinary Team: A meeting of a range of specialists who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions
MSSA	Meticillin sensitive *Staphylococcus aureus*: a bacteria that commonly lives on the skin or inside the nose without causing problems, but which is capable of causing infections e.g. in a wound or blood stream
MRSA	Meticillin resistant *Staphylococcus aureus*: strains of *Staphylococcus aureus* which is resistant to a number of antibiotics
RCA	Root cause analysis: A process for identifying "root causes" of problems or events leading to an approach for responding to them
SGH	St George's Hospital (St George's University Hospitals NHS Foundation Trust)
NHSI	NHS Improvement – an NHS body that oversees Trust driving quality improvement

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

2.1

Meeting Title:	Trust Board		
Date:	26 November 2020	**Agenda No**	**2.1.3**
Report Title:	Seven Day Services		
Lead Director/ Manager:	Richard Jennings, Chief Medical Officer		
Report Author:	Karen Daly, Deputy Chief Medical Officer		
Presented for:	Assurance		
Executive Summary:	The NHSE 7 Day Services (7DS) Clinical Standards were developed to reduce mortality rates and length of stay, improve patient experience and reduce readmission rates. This paper describes the background, the care group level self-assessment that has been done, and the risk assessment process in place to a level of assurance that patient care is safe, even where services are not compliant with the standards. We have inferred our compliance rate by combining the outputs of the self-assessments with data about inpatient episodes. The paper also describes the work that needs to be done to ensure that the self-assessments are translated into a meaningful plan for the organisation to reach compliance and to provide a higher level of assurance. The governance process by which decisions will be taken when improvements involve investment or service reconfiguration is outlined. The Quality & Safety Committee consider this report in October 2020, noted progress and the work underway to ensure that the Trust was fully complaint all the standards whilst focussing on providing high quality and safe care to all patients.		
Recommendation:	The Board is asked note the update on the Trust's assessment of its services with respect to compliance with the four priority NHSE seven day standards.		
Supports			
Trust Strategic Objective:	Right Care, right place		
CQC Theme:	Safe, Responsive		
Single Oversight Framework Theme:	Quality and safety strategy		
Implications			
Risk:	There is a risk that where the services are non-compliant patient care is adversely affected.		
Legal/Regulatory:	There was an expectation that trusts would be compliant with four priority standards by April 2020 but central reporting has been paused.		
Resources:	To be determined.		
Previously Considered by:	Executive Management Team Quality and Safety Committee Patient Safety and Quality Group	**Date**	16/11/20 22/10/20 21/10/20
Appendices:			

Outstanding care every time

NHS
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NHS Seven day services clinical standards

Seeking assurance of compliance with the four priority standards

Richard Jennings, Chief Medical Officer
Karen Daly, Deputy Chief Medical Officer

Purpose

- To describe the current level of assurance, provided through care group self assessment, about the degree of compliance with the four priority NHSE seven day services standards
- To describe the care group self assessment of the degree of risk associated with any shortfall
- To describe the governance approach to addressing areas of non compliance including, if necessary, investing in key areas

The four priority standards were selected to ensure that patients have access to consultant-directed assessment, diagnostics, interventions and ongoing review every day of the week, NHSE Briefing November 2018

Governance and timescales

Overview

- This paper describes the first in depth self assessment of our services at Care Group level and contains a level of detail and visibility that we have not seen before.
- This was a necessary exercise because of the complexity of our organisation, with multiple independent specialities to whom these standards are independently applicable.
- This paper presents an overview of a very detailed piece of work that has been presented to Patient Safety and Quality Group (PSQG) on 21 October 2020
- Each Division will test the Care Group's risk assessments for validity and consistency
- Each Division will prioritise areas according to patient safety, productivity, patient flow and compliance
- The divisions will report progress to PSQG as part of their usual governance processes
- In due course Trust Management Group (TMG) and People Management Group (PMG) will receive from PSQG an overview of the priority areas, the degree of risk involved in not meeting the standards plus a set of options to address those shortfalls. This may involve investment
- QSC and Trust Board will receive regular updates for discussion

Background

Seven day services clinical standards – the four priorities

The 7 Day Services (7DS) Clinical Standards were developed to reduce mortality rates and length of stay, improve patient experience and reduce readmission rate. There are ten standards overall, but there is a greater emphasis on the four priority standards, and an expectation that these four standards will have been achieved for >90% of emergency admissions by April 2020.

There is extensive guidance around standard 8 which relates to going care, including the definition of a Consultant and the circumstances where review can be delegated to another member of the workforce.

Standard 2

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

Standard 5

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week.

Standard 6

Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols

Standard 8

All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway

Background
Board assurance framework

In November 2018 NHSE changed their process for assessment of compliance with Seven day standards (7DS) from self assessment returns to an NHSE recommended board assurance framework approach. This approach was tested nationally in February 2019 with formal submissions being made in June and November 2019. The submission due in May 2020 was paused because of the COVID-19 pandemic but it is anticipated that a submission will be required in November 2020. Guidance is awaited.

NHSE recommended board assurance framework approach

The 7DS board assurance framework for trust self-assessment of 7DS performance follows a set of principles that ensure it is:

- consistent, both in terms of the product (a single template for all providers of acute services) and its contents (assessments of delivery based on evidence aligned with the organisation's planned improvement trajectory)
- robust and accurate, with assessments based on information directly related to 7DS, allowing for board-level scrutiny and external assurance if necessary
- less of an administrative burden than the 7DS survey
- completed bi-annually, with sign-off by the trust board before submission
- compatible with national-level measurement and reporting against the mandate and planning guidance 7DS ambitions.

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Methodology
Previous reporting and new work

In December 2019 the Trust Board was not offered assurance that the trust would be fully compliant with the 7 Days Services four priority standards by April 2020, an NHSE requirement. A further report was brought to the Quality and Safety Committee in January 2020 but the work was delayed from March to June 2020 by CoVID-19, and national reporting was paused. We have now performed a trust wide clinically led self assessment at care group level, of our compliance with the four priority standards, and a self assessment of the risk attached to any areas of non compliance. This paper is an update on those self assessments. Future reports will describe the way in which we build on this detailed self assessment to formulate a plan to address any areas of shortfall, thereby strengthening patient safety, productivity, patient flow as well as compliance.

Methods

A systematic clinically led self assessment was done at Care group level. Evidence (Job plans, standard operating procedures, policies, audits , etc.) supporting the assessment was identified. The criteria were applied stringently.

An additional risk assessment for any areas of non compliance was completed with a list of mitigations put in place to reduce risk.

Progress

Care groups have submitted self assessment returns and the outcome is presented below. Not all standards are relevant to all care groups, eg. Clinical Genetics have no in patients. Compliance is expressed as a percentage of compliant services divided by the number to whom the standards applies

Governance

The Care group reports have been compiled by the Divisional Governance teams and will be presented to Divisional Governance meetings for review and challenge. Mitigations for any perceived risk associated with non-compliance will be challenged and agreed. Options to address any shortfall in meeting the stndards will be developed. Cross Divisional themes will be escalated to PSQG

Further assurance

An audit tool for Trust wide use is being designed and will be rolled out immediately and on a recurring basis to provide a higher level of assurance than care group level self assessment.

A digital ward round template is in development that will assist and simplify the audit of compliance with standards

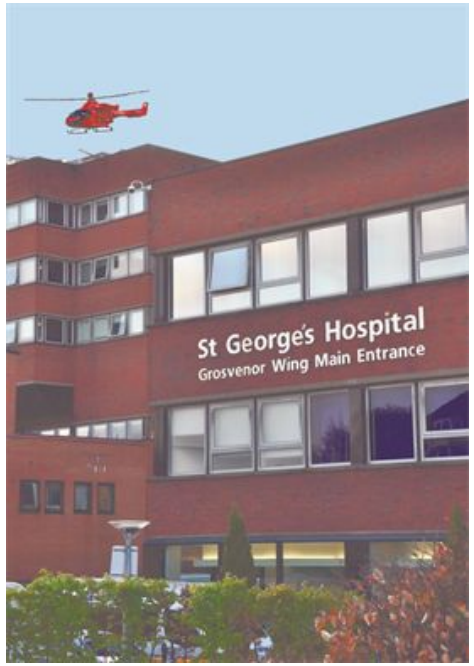
Assurance

Percentage of in patient episodes that are compliant with the standard, as inferred by the care group self assessments, grouped by division*

- The proportions of in patients under different care groups were used to infer these percentages based on the data from the weekend of 3rd/4th October - 900 beds were occupied
- This shortfall is in large part explained by limited access to ultrasound and MRI at weekends

* includes Queen Marys site

Standard	MedCard	CWDT	SNCT	Trust
2 Cons. review of Emergency admissions <14hrs	98%	91%	80%	**90%**
5 7/7 access to Cons. reported diagnostics	63%	61%	72%	**65%**
6 24/7 access to Cons. directed interventions	70%	91%	75%	**79%**
8 daily Cons. Review inc. Weekends	58%	91%	68%	**74%**

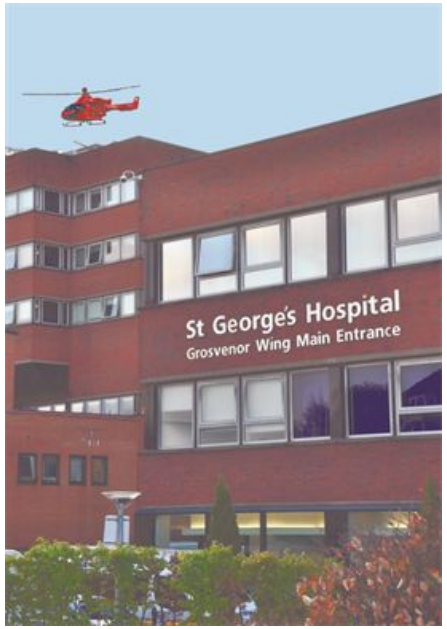


Assurance

Compliance of Services

- In this table the percentage of inpatient episodes that are compliant with the standards have been arrived at by accepting each Care Group's self-assessment of compliance, and then factoring in the proportion of inpatient episodes within that Division that sit with the different Care Groups. The proportion of inpatient episodes that sit with the different Care Groups have been based on the data from the weekend of 3-4 October 2020, when 900 inpatient beds were occupied
- Only full compliance is included – some services declare partial compliance
- Some of the services have small numbers of in patients

Standard	MedCard	CWDT	SNCT	Trust
2 Cons. review of Emergency admissions <14hrs	11/14	10/16	4/11	25/41
5 7/7 access to Cons. reported diagnostics	12/14	7/17	8/13	27/44
6 24/7 access to Cons. directed interventions	11/14	11/17	8/13	30/44
8 daily Cons. Review inc. Weekends	11/14	11/16	5/12	27/42



Risk Assessment
Standard Trust methodology

Clinical leads were asked to describe the risks to patient safety and flow that might arise if they identified partial compliance with any of the four priority standards in their service, and the measures they have put in place to mitigate those risks. They were asked to identify what additional mitigations they could put in place and what resources they would need to do so.

Risk Assessment Considerations and Thresholds

In completing the risk assessment the following key questions should be considered and included in the documentation

- *what is the risk / what can go wrong?*
- *what is the reason for the risk materialising?*
- *what is the impact in terms of patient safety, staff welfare, financial, infrastructure/service, reputation and legal risk?*
- *what controls do you currently have in place which mitigate the risk?*
- *What are the metrics or soft intelligence that assure you that the risk is mitigated in practice?*
- *What are the gaps in the controls and therefore what are the plans /actions to put in place to address the gaps?*

When describing the risk set out the nature of the uncertainty / hazard, what it is caused by and what would then be affected or impacted if the risk materialised.

Key points

Recurring themes

- In patient episode relating to the sickest patients are more likely to be compliant with the standards
- Consultants are available to review patients but job plans do not support twice daily ward rounds therefore patients are selected for twice daily review based on clinical need
- There is evidence of regular board rounds, which is good practice but has not been accepted as evidence of compliance
- There is a shortfall in the availability of MRI and ultrasound scanning at weekends that has a significant effect on compliance with standard 5

Example - Oncolgy

An example of a service declaring they are not compliant with standard 2 and describing the mitigations they have put in place.

"Oncology admissions between 1pm and 830pm will not formally meet the 14-hour standard for consultant review. In practise if an unwell patient is admitted from an outpatient clinic or ambulatory setting this would fall within working hours and there is a designated consultant who will review the patient. If there is an unwell patient admitted via the emergency department during this time they would be clerked by oncology or medical junior staff and escalated to either the tumour site specific consultant or on call consultant to ensure a clear pathway of care. Oncology consultants run a 1:9, Category B 24 hour on call service"

Trust wide rolling Audit
Purpose and methodology

Our clinical leads did a self assessment of their compliance with the standards and in some cases had audited their own performance at care group level. There will be an internal and independent trust wide audit of our compliance to give a higher level of assurance.

Audit principles

- There will be an agreed trust wide methodology
- The audit will measure performance across all seven days, with a split of cases from the week and the weekend
- Proportionality is a key consideration, as certain specialities will be seeing a larger number of patients than others and case sample sizes will be agreed.
- Input has been requested from the National Quality Improvement and Clinical Audit Network, for support and advice on implementing this process

Summary

Where are we now and what do we do next?

- The care group level self assessment of compliance with the four priority standards leads us to infer that 90% of patients have care that is fully compliant with standard 2 (Cons review <14hrs)
- The self assessment leads us to infer that compliance is lower for standards 5,6 and 8
- The trust wide rolling audit will give a further, independent, assessment of compliance
- The care group level self assessment of risk has not identified any services where the Care groups perceive high risk as a result of non compliance, but this will be tested and challenged at Divisional and then executive level
- Where the care groups have perceived moderate risk, they are able to describe mitigations are already in place to reduce that risk.
- The self assessment will be reviewed and challenged by the Divisions before being considered at PSQG as described in slide 3 above
- Work is being done to develop a Trust wide set of metrics and tools that can be used to seek a higher level assurance
- The proposed next steps for governance are described in slide 3 above

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2.1

Meeting Title:	**Trust Board**		
Date:	26 November 2020	**Agenda No**	**2.1.3**
Report Title:	**Cardiac Surgery Report – Quarter 2 2020/21**		
Lead Director	Richard Jennings, Chief Medical Officer		
Report Author(s):	Steve Livesey, Associate Medical Director for Cardiac Surgery Mark O'Donnell, Lead Cardiac Nurse – Governance & Mortality Kelly Davies, Head of Nursing – Cardiovascular Services		
Presented for:	Review and Assurance		
Executive Summary	Following the publication of the Independent Mortality Panel's Review and Independent Scrutiny Panel's Review on 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 Q2 2020/21 This paper provides the Trust Board with an update on the following: 1 The quality and safety of the service in Q2 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 legal claims and 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			
Appendices:			

Cardiac Surgery Report – Quarter 2 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 26 March 2020, the Trust Board reviewed the comprehensive sources of assurance that the cardiac surgery service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these two reports had been, or were being, acted upon. This section provides Trust Board with an update on the sources of assurance that the cardiac surgery service has remained safe through Quarter 2 (Q2) 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 or Adverse Incidents

There was one Serious Incident (DW140551; 2020/15633) declared in Quarter 2 of 2020/21; the investigation is on-going. During Quarter 2 there were no adverse incidents declared.

1.1 Patient safety outcomes – Mortality

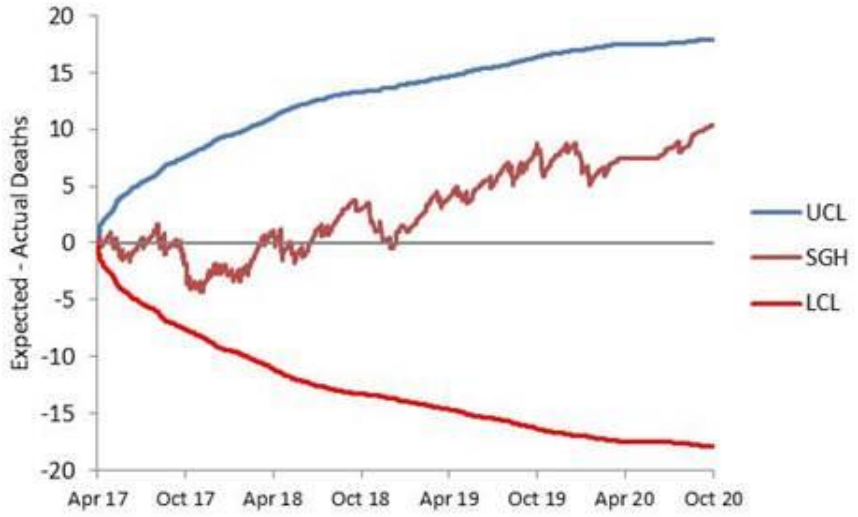
The Trust restarted cardiac surgery on the St George's site on 2 June 2020 with a slow but steady increase in cardiac surgical workload (127 cases in Q2). Cardiac Surgery has now been allocated seven lists per week, and in most weeks has also asked for additional operating time.

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.

The two Variable Life Adjusted Display (VLAD) plots below show the expected versus actual deaths for cardiac surgery at St George's. 'Expected deaths' are calculated using the EuroSCORE II risk of post-operative death tool. EuroSCORE II was widely adopted nationally in April 2017 and the first plot (April 2017 to October 2020) shows continued positive progress in terms of surgical outcomes since January 2018.

The upward trend of the plot below reflects the trend that actual deaths following cardiac surgery are fewer in number than would be predicted using the EuroSCORE II scoring system.

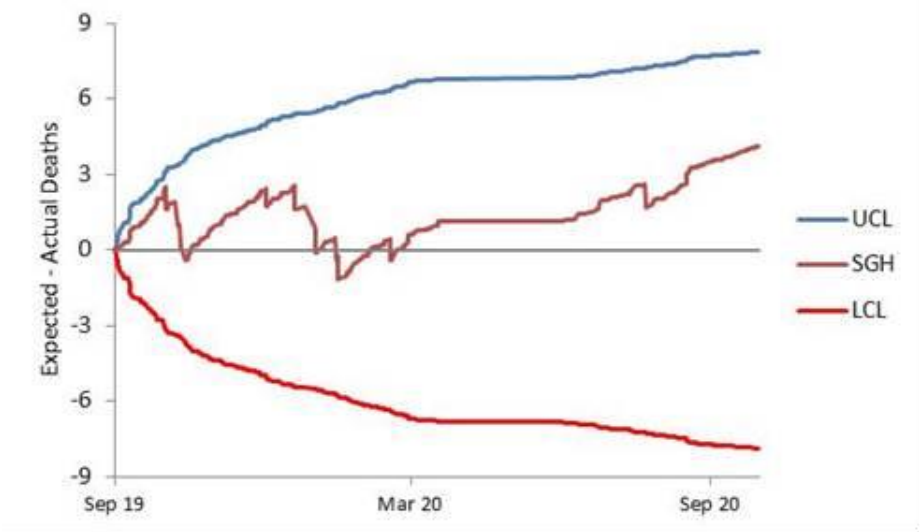
Graph 1: VLAD plot April 2017 – October 2020



Key
UCL = upper confidence limit
LCL = lower confidence limit
SGH = St George's Hospital

The second plot shows outcomes in the last 12 months (September 2019 to September 2020). 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 wave.

Graph 2: VLAD plot April 2019 – April 2020



Key
UCL = upper confidence limit
LCL = lower confidence limit
SGH = St George's Hospital

As has been previously reported to 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 that showed that the Trust Cardiac Surgery Service as 'within limits' for this period.

1.2 Post-operative complications in Q2 2020/21

The trust routinely tracks patient safety outcomes in terms of the significant commonly recognised complications of cardiac surgery (return to 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, and there were very few post-operative complications in this quarter.

In Q2 there was one re-sternotomy. The patient recovered well and was discharged home. This case was discussed at the Cardiac Surgery Morbidity, Mortality & Governance Meeting in July 2020.

There was one post-operative stroke in Q2 2020/21. This incident was discussed at the Cardiac Surgery Morbidity, Mortality & Governance Meeting in October 2020, and is currently being investigated as an Adverse Incident. The findings of this investigation will be discussed at the Serious Incident Declaration Meeting (SIDM) and shared with the Quality & Safety Committee

In terms of surgical site wound infections (SSI), there was one case July and one case in August but none for September (0.5%).

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. 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; none of the patients reported any symptoms of Covid-19 post-operatively. There have been no cases of patients acquiring Covid-19 as a consequence of their admission for cardiac surgery.

1.3 Serious Incidents (SIs) and Adverse Incidents (AIs) that occurred, were declared or closed in Q2 2020/21

1.3.1 Serious Incidents (SIs)

A Serious Incident was declared in Quarter 2 (DW140551) (StEIS 2020/15633) following discussion at the Trust's Serious Incident Declaration Meeting (SIDM). The investigation is on-going at the present time and will be reported to Quality and Safety Committee.

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

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.

The individualised feedback meetings have now been undertaken and this recommendation has 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.

The Trust previously engaged an external HR consultant to work with the cardiac surgery team in response to this recommendation, and it has been agreed that this external consultant will return to complete their work now that the provisions of Recommendation 2 above have been met.

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

Just before the publication of the External Mortality Review Report, 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; 42 families asked for meetings with the Trust to discuss this further. Six of these meetings took place before the report publication date (26 March 2020). Nine more meetings have now been completed (eight in Q1 and one in Q2) which completed all those which had initially opted for a video/telephone meeting or face-to-face before COVID restrictions prevented such meetings. The Trust has

contacted the remaining 27 families again, re-offering video/telephone meetings if they did not wish to wait for face-to-face meetings at a future date.

4.0 Risk register

There have been no changes made to the cardiac surgery risk register since the last report to Trust Board covering Quarter 1 in July 2020.

5.0 Update on Coroner's inquests

As noted in the previous report to the Trust Board in July, 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 CtD score of 1-3.

Since the last report to Trust Board, the Coroner has held four inquests. The outcome for one was "natural causes" and the outcomes for the other three were "recognised complications of essential surgical treatment".

It is anticipated that the Coroner may 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.

As noted in the Board report in July 2020, 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 Developments towards networking cardiac surgery in South London

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

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

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

7.0 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 chaired by Dr Vin Diwakar, Regional Medical Director for the London Region for NHS England, review the progress of St George's cardiac surgery. The group last met on 20 November 2020 and the Group noted the positive progress that is described in this report.

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2.2

Meeting Title:	**Trust Board**		
Date:	26th November 2020	**Agenda No**	2.2
Report Title:	Learning from Deaths and Mortality Monitoring Committee (MMC) Report		
Lead Director:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Kate Hutt, Head of Mortality Services Mr Ashar Wadoodi, Lead for Learning from Deaths		
FOIA Status:	Unrestricted		
Presented for:	Discussion Update		
Executive Summary:	The paper provides an overview of the work of the MMC and Learning from Deaths in Q2 2020/21. A brief outline of work in progress to strengthen governance processes is outlined. This includes extending the deaths that are subject to review under the Learning from Deaths process to include deaths following elective admission. Work is progressing with revising the Learning from Deaths policy and strengthening local Mortality & Morbidity (M&M) meetings, including recruitment to the Team Leader for M&M coordinators. A summary of progress against the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Safety Action 1 is provided. This demonstrates full compliance with the scheme's requirements. In order to demonstrate processes in relation to monitoring and investigating mortality outlier alerts, current work related major trauma and cardiology are presented. National mortality measures are also reported. Our SHMI remains lower than expected and our HSMR is as expected. The investigations underway to examine mortality at a more granular level are detailed.		
Recommendation:	The Board is asked to: • Note the assurances and discuss any priority areas for further action • Note that the Trust is fully compliant with all CNST requirements in this quarter • Consider the assurance provided that current outlier alerts are being investigated robustly and that there is a granular understanding of our mortality data.		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	Work to clearly define and implement Care group and Trust (Learning from Deaths and governance) processes, and their interconnectivity, is underway but has not been completed. Finalising and operationalising this will ensure governance is effectively managed and opportunities for learning are not missed.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by CQC and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:			
Previously Considered by:	Patient Safety & Quality Group Quality and Safety Committee	**Date**	18/11/20 19/11/20
Equality Impact	N/A		

Assessment:	This is in line with the principles of the Accessible Information Standard

MORTALITY MONITORING COMMITTEE UPDATE

1.0 PURPOSE

1.1 The purpose of this paper is to provide Trust Board with an update on the work of the Mortality Monitoring Committee (MMC) and progress against the Learning from Deaths agenda. The report describes the sources of assurance that the Trust is scrutinising mortality and identifying areas where further examination is required. In line with the Learning from Deaths framework we are working to ensure that opportunities for learning are identified and where appropriate, action is taken to achieve improvements.

In order to demonstrate processes in relation to monitoring and investigating mortality outlier alerts, current work related to major trauma and cardiology are presented.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK AND NATIONAL STRATEGY

2.1 Learning from Deaths

This quarter the Learning from Deaths lead has taken forward a number of pieces of work intended to strengthen learning from deaths and mortality governance more widely. The range of deaths subject to structured judgement review has been extended to include deaths following elective admission. It will be necessary in the next quarter to agree at MMC how other deaths that require investigation should be identified. This will form part of the revised Learning from Deaths policy which the lead is currently developing. Ratification of the policy is scheduled for December 2020. Dr James Uprichard will be taking up the role of Deputy Chief Medical Officer for Safety, Quality and Effectiveness on 7th December 2020 and his role will play a significant part in safety governance and learning from Deaths.

Progress has been made in relation to strengthening mortality governance, as required in the external Governance Review (April 2019). The Trust is investing in a new team of six coordinators providing dedicated administrative lead and support for Mortality and Morbidity meetings (M&M). Recruitment is underway for the Team Leader post and following that the coordinator posts will be recruited to. It is anticipated that this process will be completed by year end. Whilst this recruitment is ongoing priority will be given to developing a framework for local M&M meetings. Senior Health has shown a willingness to be involved in shaping and piloting this and other care groups will be recruited in order that the approach is effectively co-designed.

2.2 Medical Examiner Service

This quarter the ME service has scrutinised all deaths and an ME has been available Monday to Friday to discuss cases with the clinical teams. Family conversations have continued to take place and anecdotal feedback has been very positive, with families finding this helpful and supportive. Where MEs identify potential governance issues that need to be further explored they have continued to refer these either to the Lead for Learning from Deaths, to the Risk Team or to the clinical team involved with the patient's care. Comprehensive data reflecting the breadth of ME activity has been reported to the National ME as required.

The service has continued to engage in development of the regional functions, meeting with the Regional ME and Regional MEO and participating in regional networks to both share ideas and learn from others. The service has also supported national developments through testing the new national digital platform which is expected to be available at the beginning of 2021.

During the final quarters of the year the intention is to recruit to the new role of Medical Examiner Officer. These posts, which are intended to support the MEs, are reimbursed centrally and will be essential for extending the service to cover community deaths. This will be required in 2021/22.

The situation in relation to Covid-19 and other winter pressures is being closely monitored. During the first peak of the pandemic additional MEs were trained and it is hoped that in the case of a second

wave of Covid-19 mortality we may able to call on their support. Of note, the ME team recently had the paper 'Deaths in people from Black, Asian and minority ethnic communities from both COVID-19 and non-COVID causes in the first weeks of the pandemic in London: a hospital case not review' published in BMJ Open[1].

2.3 **Perinatal Mortality Review Tool (PMRT)**

To continue to support the delivery of safer maternity care NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. In order to receive a rebate on the yearly CNST premium, Trusts must demonstrate compliance with ten key safety actions.

CNST Safety Action One measures compliance with the appropriate use of the National Perinatal Mortality Review Tool (PMRT). This tool supports systematic, multidisciplinary high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. The reviews are used to understand, wherever possible, why the baby died and whether different actions would have led to a different outcome. Active communication with parents is central to this process. Parents are invited to contribute to the review and receive a plain English copy of the investigation once completed.

To provide assurance that quality and safety are being reviewed in order to identify learning and drive change, whilst also satisfying CNST requirements, the service produce a quarterly report summarising progress against safety standards and any lessons learnt. The comprehensive report is considered at divisional governance meetings and is subsequently presented to MMC. A summary is included in this quarterly report in order to provide assurance to Patient Safety and Quality Group, Trust Management Group, Quality and Safety Committee and ultimately the Trust Board. Trust Boards are asked to sign a declaration to confirm the level of compliance against each standard.

This summary relates to all eligible perinatal deaths in the period 21/12/2019 - 20/03/2020 and the actions and learning arising from them. This quarter, two stillbirths and late fetal losses, and six neonatal and post-neonatal deaths were reported. Eight reviews have been completed and six PMRT panels were held, which were attended by all required participants.

In four of the five completed reviews of stillbirths and late fetal losses, it was agreed that there were no issues of care of the mother or baby prior to the baby having been confirmed to have died. In one case an issue was identified that the panel considered may have made a difference to the outcome for the baby. This case was declared a serious incident (SI). There are eight specific actions related to this SI including an individual reflective learning plan, unit communication of the incident and inclusion in mandatory training days. These actions will be monitored and their impact measured via existing governance processes within the service. There was one case where following confirmation of the death of her baby there was an issue related to care of the mother; however, this was not considered to have made a difference to her outcome.

1 Perkin MR, Heap S, Crerar-Gilbert A, *et al* Deaths in people from Black, Asian and minority ethnic communities from both COVID-19 and non-COVID causes in the first weeks of the pandemic in London: a hospital case note review. *BMJ Open* 2020;10:e040638. Doi:10.1136/bmjopen-2020-040638

In the three completed reviews of neonatal and post-neonatal death cases, the review group concluded that there were no care issues up to the birth of the baby, nor from the point of birth to the death of the baby.

The table below details full compliance with all CNST requirements in this period.

CNST Safety Action One: 4 Standards	Compliance
1. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, will have been started within four months of each death. This includes deaths after home births where care was provided by the trust staff and the baby died.	We are **compliant** with this standard. 100% of babies that were suitable for a review using the PMRT were started within four months of each death.
2. At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your trust, including home births, from Friday 20 December 2019 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool, within four months of each death	We are **compliant** with this standard. 89% of babies suitable for a review using the PMRT that were born and died at St George's trust had a at least a draft report within four months of the death of the baby
3. For 95% of all deaths of babies who were born and died in your trust from Friday 20 December 2019, the parents were told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your trust staff and the baby died	We are **compliant** with this standard. 100% of parents of babies suitable for a review using the PMRT that were born and died at St George's trust were contacted informing them of the review taking place
4. Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the trust maternity safety champion	We are **compliant** with this standard. This paper constitutes the quarterly report to the Board.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 During this quarter independent reviews, using the structured judgement review (SJR), have been completed for all deaths that have been referred to the Learning from Deaths Lead by the Medical Examiner Office. These comprise of deaths of patients with confirmed learning disabilities (n=4), severe mental health diagnosis (n=6) and those where the ME has detected a potential issue with care (n=6). The findings from these structured judgement reviews are shown below. We have also extended the criteria for the deaths that are subject to review under the Learning from Deaths process to include all deaths that have followed elective admission.

3.2 **Overview of July to September 2020**

Between July and September 2020 there were 287 deaths. Members of the Mortality Review Team (MRT) reviewed 22 deaths, representing 7.7% of deaths. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel.

The structured judgement review methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. Of the 22 deaths reviewed this quarter problems were identified in relation to 2 (9.1%) patients. In total there were 4 problems identified. In three instances it was thought that the problem led to harm. Each of these 3 problems that led to harm related to the care of 1 patient.

Problem in healthcare	No harm	Possible harm	Harm
Assessment	0	0	1
Medication	0	0	0
Treatment	0	0	1
Infection control	0	0	0
Procedure	0	0	0

Problem in healthcare	No harm	Possible harm	Harm
Monitoring	1	0	1
Resuscitation	0	0	0
Communication	0	0	0
Other	0	0	0

A judgement regarding avoidability of death is made for all reviews. 17 of 22 (77.3%) deaths reviewed were assessed as definitely not avoidable and 1 death (4.5%) was judged to be probably avoidable. This death was declared as a Serious Incident (SI) – reference DW141358 2020/16567. This incident was initially presented in the Serious Incident paper to Quality and Safety Committee in October 2020. The learning from this SI investigation is scheduled to be presented in January 2021.

Avoidability of death judgement	Number
Definitely not avoidable	17
Slight evidence of avoidability	3
Possibly avoidable but not very likely (less than 50:50)	1
Probably avoidable (more than 50:50)	1
Strong evidence of avoidability	0
Definitely avoidable	0
Total	**22**

An assessment of overall care is also provided for each death reviewed. For 17 patients (77.3%) care was felt to have been good and adequate for 4 patients (18.2%). Poor care was observed in 1 case (4.5%).

Overall care judgement	Number
Excellent care	0
Good care	17
Adequate care	4
Poor care	1
Very poor care	0
Total	**22**

It should be noted that the death where care was judged to be more than likely avoidable was the same case where problems in healthcare were felt to have led to harm and overall care was judged to be poor. The SJR for this death was shared with the Risk Team in order to inform discussion at the Serious Incident Declaration Meeting (SIDM).

3.3 **Learning disabilities**

All deaths that occur in patients with learning disabilities continue to be submitted to the national Learning Disabilities Mortality Review Programme (LeDeR). The LeDeR reviews are co-ordinated by the CCG and we have established effective liaison with these colleagues. We work together closely to share our local independent mortality reviews and in turn receive redacted copies of the LeDeR review.

In November the LD team will present a report to MMC. This will summarise key information from the LeDeR Annual Report. The report will also identify aspects of best practice and highlight any areas for local learning and improvement derived from reviews of patients that have died whilst in our care.

The mortality review team continue to carry out local review using our standard methodology. The table below summarises the deaths of patients with learning disabilities (LD) from the beginning of 2018/19 to the end of Q2 2020/21. In total there have been 33 deaths, with reviews completed for each. No avoidability has been identified to date.

This quarter there have been 4 LD deaths. No problems in healthcare were identified and the death was judged to be definitely not avoidable. Overall care was judged to be good for each of the patients.

LD DEATHS **Avoidability of death judgement score**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**	**Q4 18/19**	**Q1 19/20**	**Q2 19/20**	**Q3 19/20**	**Q4 19/20**	**Q1 20/21**	**Q2 20/21**
TOTAL DEATHS	1	3	3	2	3	7	4	2	4	4
LOCAL REVIEWS COMPLETED	1	3	3	2	3	7	4	2	4	4
Definitely not avoidable	1	3	3	2	3	7	4	2	4	4
Slight evidence of avoidability	0	0	0	0	0	0	0	0	0	0
Poss avoidable but not very likely (< 50:50)	0	0	0	0	0	0	0	0	0	0
Probably avoidable (> 50:50)	0	0	0	0	0	0	0	0	0	0
Strong evidence of avoidability	0	0	0	0	0	0	0	0	0	0
Definitely avoidable	0	0	0	0	0	0	0	0	0	0

4.0 LEARNING FROM MORTALITY

The following summaries give an overview of two mortality outlier alert investigations that are currently underway, demonstrating the processes of monitoring, identification and examination. These investigations are expected to be completed within Q3. Also summarised is a previously completed investigation and the steps currently being taken to drive forward agreed actions.

4.1 Trauma Audit & Research Network (TARN)

The intent to investigate this mortality outlier alert was detailed in the previous report, with a brief outline. The description below provides greater information about the nature of the alert, the investigation and an interim update on progress. It is anticipated that the outcome of the investigation will be included in the Q3 report.

4.1.1 Background

In June 2020 the Chief Executive's Office received a letter from the Trauma Audit & Research Network (TARN) that the Trust was considered an outlier for case-mix adjusted mortality outcomes for the period July 2017 to June 2019. In line with TARN's outlier policy, TARN requested engagement from the Trust in investigating the alert. Immediately following receipt, both the Trauma Lead and the Chief Executive Officer, informed the Mortality Monitoring Committee of the alert.

A previous alert was received in November 2019, relating to the period July 2016 to June 2018. The alert was communicated to the Chief Executive Officer who forwarded the letter to the Trauma service, but due to an oversight it was not correctly escalated to the MMC.

While the correct escalation process was not followed in response to the first alert, it was followed for the second alert and the learning has been embedded to ensure that any future alerts will continue to be escalated correctly.

4.1.2 Investigation

Although there was no escalation of the 2019 alert, the Trauma Lead began to review deaths internally and to examine the quality of data submitted in order to understand the impact this may have on our reported outcomes. This internal review by the Trauma service found that the majority of patients that died following major trauma had either sustained a traumatic brain injury or were elderly patients with chest injuries. Data quality appeared to be robust.

On receipt of the most recent alert, the correct escalation process was followed and this triggered the involvement of the Lead for Learning from Deaths (Mr. Ashar Wadoodi). The MMC was immediately made aware and subsequently the alert has been monitored by the committee. Mr. Wadoodi performed a comparison of our TARN data with similar London trauma centres and found that we remain an outlier and that this needed further analysis.

The Trauma service has engaged with TARN to utilise their expertise in understanding how the quality of data can impact mortality statistics and for their guidance on the appropriate methodology for investigation. Working in partnership with TARN it was agreed that the initial investigation of the alert should focus on the reporting of the CT scan following major trauma, rather than clinical practices. TARN believe that greater detail should be documented in the scan report in order to improve the accuracy of the Injury Severity Score (ISS) for each patient. This score is used in the calculation of each patient's individual probability of survival and therefore impacts upon case-risk adjusted outcomes for the Trust.

It is not believed that the CTs scans have been incorrectly reported thereby compromising care, rather that there are missing injury details which has resulted in assigning the lowest possible severity score for that group of injuries. An initial review of seven CT scans was conducted by a radiologist. In two of these cases further detail was added, and the patient's injuries were re-scored. This would have led to an increase in the ISS and a reduction in the probability of survival. Assigning a 'Not further specified' (NFS) code to an injury most frequently results from missing details related to:

- size of contusions in the brain;
- size or depth of bleeds in the brain;
- the number and location of rib fractures and whether they are flail;
- the number of lobes affected by lung contusions;
- grades of abdominal organ injuries

A decision was made to further investigate the reports of 200 CT scans. This was is now complete and the data was resubmitted to TARN to allow for recalculation of our case mix adjusted outcomes. This recalculation did not result in any major shift that would take the service out of alert. Because of this, the Trust is now undertaking further work, making use of on-going advice and input from TARN to determine if there have been or are any issues with the quality of treatment or care present that may have had or have a negative impact on outcomes. Progress with this work will be reported back to the Mortality Monitoring Committee and Quality and Safety Committee in December 2020.

4.1.3 **Actions arising out of this alert so far**

CT scan reporting
It was recognised that immediate action was required to ensure the depth of CT scan reports is appropriate going forward. This will ensure full information is documented and accurate data on the severity of injury and consequent probability of survival is submitted to TARN. Radiology has amended the CT scan reporting template to ensure the required information is captured prospectively. In addition to discussing the actions needed to prevent recurrence internally, it will also be necessary to work with network trauma units. A considerable number of patients are referred to us from our network partners and we will work with them to ensure the CT reports are in a format that allows accurate ISS calculation. Education and training will be amended accordingly.

Internal management of external mortality outlier alerts
Quality and Safety Committee received a deep-dive paper on 23rd July 2020 that provides assurance about systems in place to manage mortality alerts. It is acknowledged that the internal management of external mortality outlier alerts needs to be further formalised and communicated effectively to clinical teams. This is being addressed within the current programme of work to strengthen mortality governance which includes agreeing and defining processes; clarifying the expectations of local

mortality governance and providing corporate support; and improving the partnership between organisation level and service level mortality monitoring. It is also recommended that as part of our response to TARN we communicate our outlier management process and request that all communication regarding alerts should include the Chief Medical Officer.

4.2 **Cardiology**

In response to a number of frequently occurring signals derived from Dr Foster related to cardiology the Care Group Governance Lead attended the MMC with a proposal from the care group to carry out an internal investigation of mortality and this plan was accepted. This investigation will consider all deaths in the 'Acute myocardial infarction' diagnosis group and those in the procedure groups 'Coronary angioplasty (PTCA)' and 'Contrast radiology or catheterisation of heart'.

Early in 2020 the service completed a detailed review of mortality on a case-by-case basis following signals for 'Acute myocardial infarction' and 'PTCA'. The individual case reviews seemed to provide assurance that in the large majority of cases reviewed there was no avoidability, but this review process led to a number of improvement initiatives including the introduction of a cardiology interventionalist of the week, review of all cardiology patients on CTICU and daily MDT for complex cases. This review process found good evidence of consensus decision making and suggested that futile cases were not undergoing intervention. The Care Group lead continues to review VLAD (variable life-adjusted display) charts by operator regularly and no concerns are observed.

However, as the data analysis, which adjusts for case-mix, continues to show our outcomes to be different to expected, the Governance lead and Care Group lead agree that a deeper, thematic, review is required. The MMC agreed that it would be appropriate to conduct an internal multidisciplinary review in the first instance, but that the threshold for inviting an external review should be low. The investigation will be formulated with the help of insights shared with colleagues in cardiology units in other trusts in South London.

Terms of reference for the investigation have been outlined and confirm that a thematic approach will be taken, considering issues such as decision making with very sick patients, management of critical care patients, technical issues including equipment, team working and timeliness. It is anticipated the investigation will be carried out in Q3 and will be reported to the MMC in January. The MMC will then consider whether the review has provided sufficient assurance or whether further actions are necessary. The MMC will update Quality and Safety Committee in January 2021.

4.3 **Intracranial injury**

In February 2020 the Trust received a mortality outlier alert from the Dr Foster Unit at Imperial College London (DFU) notifying us of a higher than expected mortality rate in the intracranial injury diagnosis group. The signal related to the period December 2018 to November 2019, with 79 deaths observed against 54.3 expected.

A clinical coding review was completed, demonstrating compliance with coding standards. A clinical review was also undertaken, which showed that 75 (94.9%) deaths were definitely not avoidable. For the four remaining deaths there was some evidence of avoidability. In three of these cases potential improvements were not related to care provided at St George's hospital and have been highlighted to the organisations involved.

One case provided learning around the potential to improve documentation at St George's. Actions are being identified in relation to improving documentation of neurosurgical consultation and multidisciplinary consideration of imaging. These actions are being taken forward by the Lead for Learning from Deaths and the Clinical Director for Neurosciences.

5.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

5.1 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]

The latest SHMI data, covering discharges from June 2019 to May 2020, was published on 8th October 2020. The Trust's overall mortality is categorised as 'lower than expected' at 0.88.

During the 12-month period there were 77,970 inpatient spells at the Trust, with 1,820 deaths observed, compared to 2,070 expected deaths. It should be noted that NHS Digital are excluding Covid-19 activity from the SHMI publication in order to make the indicator values as consistent as possible with those from previous reporting periods. The SHMI is not currently designed for pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included. Excluding Covid-19 activity means that, as far as possible, consistency is maintained and each SHMI publication can be interpreted in the same way.

NHS Digital provides a SHMI value for ten diagnosis groups, detailed below. For these groups VLAD (variable life adjusted display) charts, which show the difference between the expected number of deaths and observed deaths over time, are also available. The latest information is summarised in the table below and shows that our mortality is either lower than, or in line with what would be expected for all the diagnosis groups analysed.

Diagnosis Group	SHMI value	SHMI banding
Acute bronchitis	0.79	As expected
Acute myocardial infarction	1.13	As expected
Cancer of bronchus; lung	0.45	Lower than expected
Fluid and electrolyte disorders	0.65	As expected
Fracture of neck of femur (hip)	1.17	As expected
Gastrointestinal haemorrhage	1.30	As expected
Pneumonia (excluding TB/STD)	0.85	As expected
Secondary malignancies	0.59	Lower than expected
Septicaemia (except in labour), shock	1.15	As expected
Urinary tract infections	0.89	As expected

An investigation of Septicaemia is currently underway. It is expected that the outcome will be reported to MMC in December 2020 and an update will be provided in the next Learning from Deaths report.

5.2 **Hospital Standardised Mortality Ratio (HSMR)** [source: Dr Foster]
For the most recent 12 months of data available via Dr Foster (July 2019 – June 2020) our mortality is in line with expected. In contrast to NHS Digital, Dr Foster Intelligence have not excluded Covid-19 activity from their analysis.

HSMR analysis: July 2019 – June 2020	Value	Banding
HSMR (all admission methods)	96.2	As expected
HSMR: Weekday emergency admissions	95.7	As expected
HSMR: Weekend emergency admissions	100.5	As expected

In addition to considering the high-level data above, which is also reported in the Integrated Quality Performance Report, risk-adjusted mortality at both diagnosis and procedure group level is evaluated. The table below summarises the diagnosis and procedure groups that were alerting in the most recent data considered by the MMC in October. As detailed in section 4.2 cardiology signals are currently being investigated. In addition, the current investigation of sepsis will be reported to MMC in December.

Diagnosis/Procedure Group	Current status of investigation
Contrast radiology or	This signal has been present since March 2020, at which point

Diagnosis/Procedure Group	Current status of investigation
catheterisation of heart	reviews completed by the then Mortality Review Team did not identify any concerns that required further investigation. The latest data shows 12 deaths against 7.3 expected. This grouping is included in the current Cardiology mortality review.
Coronary angioplasty (PTCA)	This signal was investigated and reported to MMC in March 2020 and has been presented to PSQG and QSC in the 2019/20 Q4 reports. This grouping is included in the current Cardiology mortality review.
Diagnostic imaging (except heart)	Newly observed in September 2020 (June 2019 – May 2020). A review of the data in October showed deaths in this procedure group are predominantly from the following diagnosis groups: Acute cerebrovascular disease (83), Pneumonia (34), Septicaemia (32), Intracranial injury (21), Viral infection (17), Aspiration pneumonitis, food/vomitus (12)
Gastrointestinal haemorrhage	This signal was first observed in September 2020 (June 2019 – May 2020). There are currently 24 deaths observed against 14 expected. Because this signal has not been observed before and may simply be due to random variation, the current action is simply to monitor outcomes in this diagnosis group – if signals persist the MMC will determine if an investigation is required.
Intracranial injury	Investigated mortality outlier alert received from Dr Foster Unit at Imperial (20 Feb 20). Report presented to MMC June 2020 and summarised in Q1 report. Investigation considered complete and actions are currently being followed up with the Neurosurgical team and will be reported through MMC.
Invalid, method and site codes	Newly observed in October, relating to 5 deaths over a 3 month period. This has not been prioritised for investigation but will be monitored.
Leukaemias	This was first observed in September 2020 (June 2019 – May 2020). The October data (July 2019 – June 2020) shows 14 deaths, with 6.8 expected. Because this signal has not been observed before and may simply be due to random variation, the current action is simply to monitor outcomes in this diagnosis group – if signals persist the MMC will determine if an investigation is required
Other perinatal conditions	This signal is long-standing and relates to the tertiary services we provide and poor risk-adjustment models for babies. Increased understanding of outcomes and assurance is provided by the quarterly PMRT report as summarised in section 2.3
Reduction of fracture of bone (upper/lower limb)	This procedure group was investigated and reported to MMC in April 2020. Members were satisfied that this signal had been appropriately investigated and found no concerns or areas for action. Over the most recent 12 month period 11 deaths are observed, with 5 expected.
Residual codes unclassified	This signal re-emerged in April 2020. An investigation in July 2020 found there to be 279 deaths in this grouping, including 87 in February and 123 in March. The number of spells in this grouping is 5,586 in February and 5,849 in March. This grouping impacted significantly on other groupings and on HSMR for these months. This issue arose as a result of a delay in the coding of deceased patients, which occurred during these months but has since been rectified. The Head of Information Services subsequently arranged for resubmission of the corrected data to ensure the accuracy of our data and to ensure that our mortality can be effectively monitored.

Diagnosis/Procedure Group	Current status of investigation
	This intervention has improved our data retrospectively; however, the greatest improvement appears to have come from improvements to coding practices and since April 2020 there are significantly less episodes and mortality in this grouping. This grouping will continue to be monitored in order to provide assurance that there has been no deterioration and that the signal is due to historic data.
Rest of respiratory	This new signal was reviewed in September 2020. 67 of the 169 deaths were in the diagnosis group 'Viral Infection', 65 of which were patients coded as U07.1 COVID-19, virus identified. The remaining deaths were split amongst a large number of diagnoses. This grouping will continue to be monitored but it was not felt that more detailed investigation was required.
Septicemia (except in labour)	New signal observed in June 2020, related to 155 deaths over 12 months, against 123.9 expected. A clinical review of these cases was reported to MMC in June and subsequently a quality improvement project has been agreed as detailed in the Q1 report. The outcome of this project will be reported to MMC in December 2020.
Short gestation, low birth weight, fetal growth retardation	Prior to September 2020 this signal had not been observed for over a year. In October 2020 there were seen to be 19 deaths over the period July 2019 – June 2020, with 8.8 expected. Previous investigations have found that similarly to 'Other perinatal conditions' this signal relates to the tertiary services we provide and poor risk-adjustment models for babies. Increased understanding of outcomes and assurance is provided by the quarterly PMRT report as summarised in section 2.3
Superficial injury, contusion	Newly observed in September 2020. This relates to 13 deaths against 5.9 expected. The signal will be monitored to determine whether investigation is required.
Therapeutic endoscopic operations on urethra	This alert, observed in September, relates to 1 death in the last 3 months. The coding of this death has been reviewed and was found to have been miscoded and has subsequently been corrected.
Viral infection	This signal was first identified in September 2020 and the data was immediately reviewed and found to be related to covid infection. The signal remains in October and reflects deaths only in March, April and May. There are a total of 189 deaths – 180 are coded as U07.1 COVID-19, virus identified and 9 are coded as U07.2 COVID-19, virus not identified.

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Appendix 1: National Quality Board Dashboard – data to 30th September 2020

NHS

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - September 2020-21

Department of Health & Social Care

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

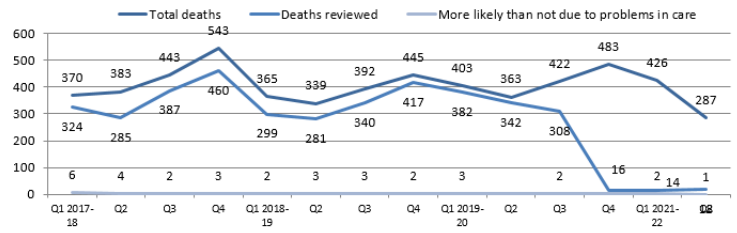
Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
102	98	4	7	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
287	426	18	14	1	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
713	1671	32	1048	3	5

Time Series: Start date 2017-18 Q1 End date 2020-21 Q2

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care
(Note: Changes in recording or review practice may make comparison over time invalid)



Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	50.0%	This Month	2	50.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	5.6%	This Quarter (QTD)	1	5.6%	This Quarter (QTD)	3	16.7%	This Quarter (QTE	13	72.2%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	3	9.4%	This Year (YTD)	1	3.1%	This Year (YTD)	7	21.9%	This Year (YTD)	21	65.6%

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NHS

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - September 2020-21

Department of Health & Social Care

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping below.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	4	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	16	1	2	0	0

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	1	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	4	4	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	16	8	16	0	0

Time Series:	Start date	2017-18	Q1	End date	2020-21	Q2

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St George's University Hospitals NHS Foundation Trust

2.3

Meeting Title:	**Trust Board**		
Date:	26 November 2020	**Agenda No**	**2.3**
Report Title:	**Integrated Quality and 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 September 2020. **Our Finance & Productivity** Outpatient activity continues to increase with Phase 3 October activity expected to rise to 88%; excluding COVID-19 outpatient attendances, October activity is at 76% of previous year and rises to 82% when including all activity. Similarly, with Daycase and Elective activity, October activity was 77% of the same time last year with the expectation that this will rise to 82% October 2020 Emergency Department attendances fell with the daily average attendances decreasing by 26 patients per day compared to the previous month. Compared to October 2019 attendances are 31% lower; similarly, non-elective admissions are 18% below the same period. There are no targets for these PODS for Phase 3 recovery. **Our Patient Perspective** The rate of 2222 calls increased significantly however the number of avoidable cardiac admissions continued to show common cause variation. Treatment Escalation Plan completion rates have fallen from their high of 56% to 29% in October 2020. A number of initiatives have commenced to improve compliance; however a Trust wide approach is required to improve this position. Training rates for Basic, Intermediate and Advanced Life Support continues to be challenged with high DNA rates and reduced capacity due to social distancing. With respect to Patient Safety indicators, the percentage of patients with new harm free care although above 95% shows special cause deterioration. The percentage of patients who have had a VTE risk assessment was 99.1% against a target of 95% which showed special cause improvement. All other indicators showed common cause variation. In October 2020, there were seven Hospital Onset COVID-19 infections (HOCI) classified as hospital onset hospital acquired (HOHA) diagnosed more than 14 days after admission, and one hospital onset probable hospital associated (HOPA), where COVID-19 was diagnosed 8-14 days after admission. There were no MRSA bacteraemia cases reported. The Trust remains below the internal thresholds for C.difficile, E-Coli and MSSA infections. Our Hospital Standardised Mortality Ratios and Summary Hospital Mortality Indicators all remain within the expected range for the latest data released. Our emergency readmission rate has returned to within the upper and lower		

process control limits for the first time since April 2020 and, for September, is within pre-COVID levels.

The maternity team continue with their recruitment strategy with a focus on developing their continuity of carer teams. With new midwives starting in October, the Carmen suite has been able to remain open more than 80% of the time and 100% of supernumerary shifts on the Delivery Suite have been filled. October saw the highest rate of overall caesarean sections for 18 months demonstrating special cause deterioration. The clinical and governance teams are working together to identify the drivers behind this and ensure all the support structures and training processes to optimise safety and reduce harm are appropriate and are robust.

Complaints continue to be compliant with their performance targets.

Our Inpatient, Community and Maternity (Postnatal) Friends and Family survey results continue to exceed our threshold. Emergency Department and Outpatient Services narrowly missed the 90% target with 89.7% and 89.1% performance respectively. Maternity (delivery) services had no completed surveys returned in October 2020 however the service is working toward re-engaging patients.

Our Process Perspective

The Trust's performance against the Four Hour Operating Standard remained above the mean reporting that 94.3% against the Four Hour Standard. Performance in October has been adversely impacted by the challenges in sustaining flow through to inpatient beds caused by the current length of time for COVID testing, and the resulting requirement for a high proportion of amber beds. SWL Pathology have worked hard to secure a joint COVID / Flu rapid testing platform ahead of the planned national deployment, and we are expecting to have local resources in place during November. This will have a significant difference to effectively managing patient infection prevention requirements and improving flow from ED and AMU / Nye Bevan right the way through the hospital.

In September, the Trust met the Cancer 31 Day Second or subsequent Treatment (Drug) at 100% however the Trust was not compliant against the other six Cancer standards. Performance against the Two Week Standard was at 86.5% below the target of 93%. Two Week Referral numbers continue to increase; and have for most tumour types, returned to the baseline; Breast and Upper Gastroenterology have seen significant increases above their pre-COVID mean.

The Trust's six week diagnostic performance improved to 21.2% in October from 24.2% in September though the National Target is 1%. The total number of patients on the waiting list increased by 0.6% compared to September however is significantly higher than the same period last year by 16%.

September 2020's RTT performance was 63.7% against a National target of 92% with 1,097 patients waiting longer than 52 weeks which is a favourable position against trajectory. The total waiting list size although seeing an increase of 2% compared to August is 0.5% lower than the same month last year.

Our Workforce Perspective

Sickness absence rates although continuing to report above target fell to 3.3% in October, indicating that our staff have not been adversely affected during COVID-19

Agency cost was £1.38m against a target of £1.25m, however Trust total pay was £50.26m which is an £1.29m adverse position against a plan of £48.97m.

	Stability index and Employee relations, including disciplinary and employment tribunal cases and COVID staff risk assessments data are all now being reported on a monthly basis.		
Recommendation	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:			
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Equality and Diversity:			
Previously Considered by:	Trust Executive Committee Finance & Investment Committee Quality & Safety Committee	**Date**	16 Nov 2020 19 Nov 2020 19 Nov 2020
Appendices:			

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

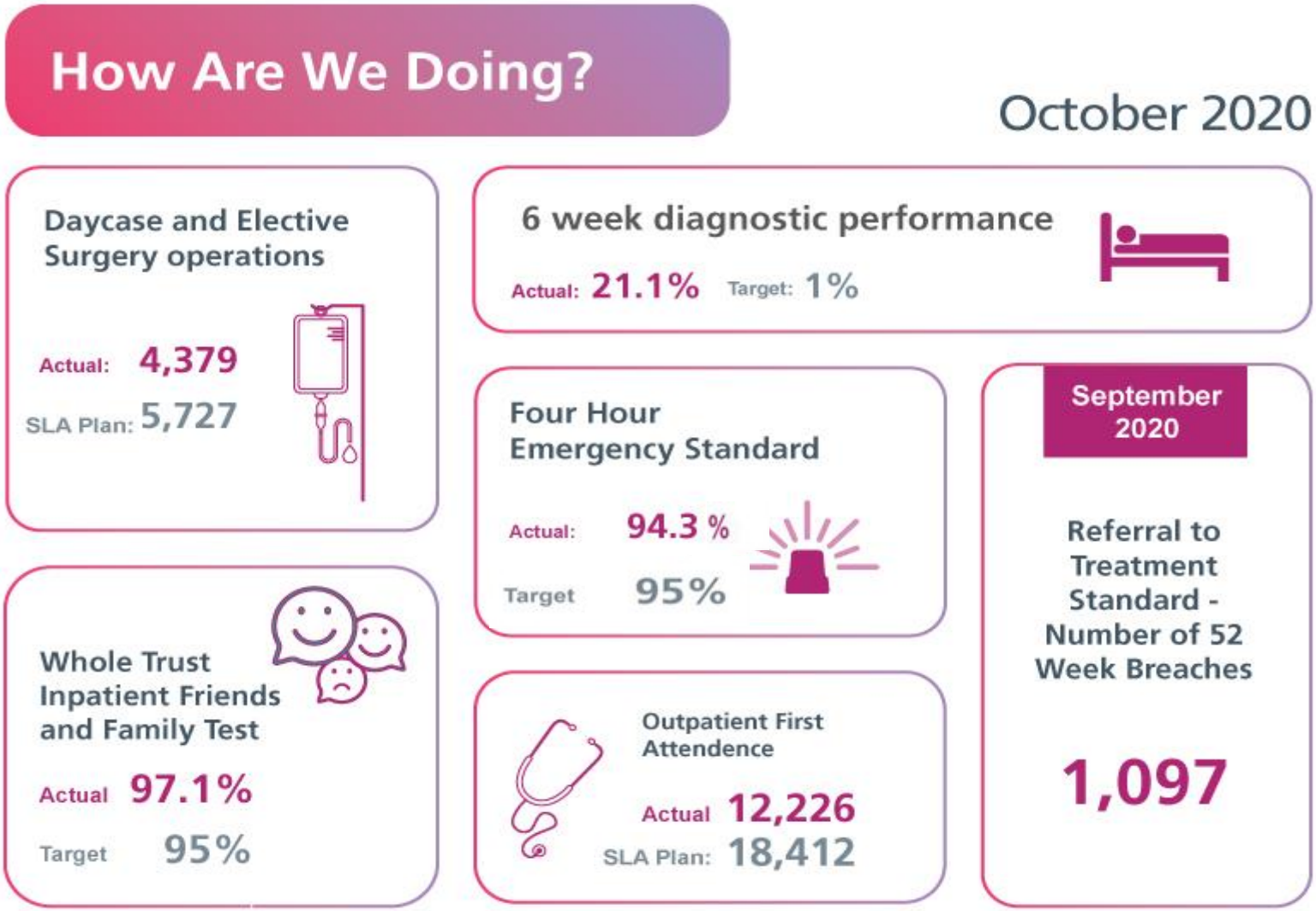
Integrated Quality and Performance Report

For Trust Board
Meeting Date – 26 November 2020

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

16 November 2020

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

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Executive Summary – October 2020

Our Finance and Productivity Perspective

- All outpatient activity continues to increase with October activity expected to rise to 88% from its current 82% however it should be noted that the current activity falls to 76% when COVID-19 activity is excluded
- Similarly, with Daycase and Elective activity, October activity was 77% of the same time last year with the expectation that this will rise to 82%
- As the Trust increases face to face appointments the proportion of virtual appointment reduced in October to 44%.

Our Patient Perspective

- The Trust conducted VTE risk assessments on 99.1% of the appropriate cohort of patients, as defined by NICE against a target of 95%.
- The overall caesarean section rate increased to 30% which is the highest that it has been in over a year, this includes an increase in the emergency caesarean rate.
- The number of babies admitted to the Neonatal Unit was high in the month and this is being investigated by the Neonatal Care Group Lead and maternity colleagues however it is below the Upper Control limit indicating common cause.
- The percentage of women receiving continuity of carer is reported here for the first time. Performance is expected to increase over the next few months, with particular focus on increasing continuity of carer for our Black and Asian women and those from our most deprived communities.
- The Trust has reported no MRSA bacteraemia during October.
- The number of Ecoli and MSSA cases reported remains within control limits; there were seven nosocomial hospital onset hospital acquired COVID-19 infections during October 2020 and zero Hospital onset (probable) 8-14 day infections.
- A significant improvement seen in October with 8.8% of patients discharged in August being readmitted as an emergency in September. The indicator has returned to its pre-COVID levels.
- Inpatients, Maternity Postnatal Ward and Community services have exceeded their target for positive FFT responses. Though Outpatients narrowly missed achieving the 90% target, the service's positive response rates continues to show a special cause variation with a deteriorating position.

Our Process Perspective

- The Trust narrowly missed achieving the Four Hour Operating Standard with a performance of 94.3% against a target of 95% in October. Performance has been adversely impacted by the challenges in sustaining flow through to inpatient beds caused by the current length of time for COVID testing and the resulting requirement for a high proportion of amber beds.
- In September, the Trust met the Cancer 31 Day Second or subsequent Treatment (Drug) at 100% however the Trust was not compliant against the other six Cancer standards.
- In October, the Trust did not achieve the six week diagnostic standard with an adverse performance of 21.1%. The Trust is slowly improving its position compared with last month's with the number of patients waiting for more than six weeks reducing by 12%. The waiting list size has increased by 0.6% compared to August however is 16% higher than the same month last year.
- In the month of September, 1,097 patients have waited longer than 52 weeks to begin treatment, this is a favourable position against trajectory. The total waiting list size although seeing an increase of 2% compared to August is 0.5% lower than the same month last year.

Our People Perspective

- Trust level sickness absence rate is within common cause variation at 3.3%, indicating that our staff have not been adversely affected during COVID-19.
- Stability index and Employee relations, including disciplinary and employment tribunal cases and COVID staff risk assessments data are all now being reported on a monthly basis.
- Agency cost was £1.38m against a target of £1.25m, however Trust total pay was £50.26m which is an £1.29m adverse position against a plan of £48.97m.

Balanced Scorecard Approach

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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	
		Oct-19	Oct-20	Variance	SLA Plan Oct-20	Variance	YTD 19/20	YTD 20/21	Variance	Plan YTD	Variance
ED	ED Attendances	14,308	9,926	-30.63%	14,775	-32.82%	99,701	62,487	-37.33%	101,995	-38.74%
Inpatient	Non Elective	4,178	3,447	-17.50%	4,022	-14.30%	27,864	20,874	-25.09%	27,727	-24.72%
	Elective & Daycase	5,703	4,379	-23.22%	5,727	-23.54%	36,279	20,382	-43.82%	37,759	-46.02%
Outpatient	OP Attendances	60,473	45,922	-24.06%	60,385	-23.95%	391,766	291,016	-25.72%	404,143	-27.99%

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

Note: Figures quoted are as at 09/11/2020 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.

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

'In September at least 80% of their last year's activity for both overnight electives and for outpatient and daycase procedures, rising to 90% in October (while aiming for 70% in August);

100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August)'

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

Phase 3 Implementation- Elective Incentive Scheme

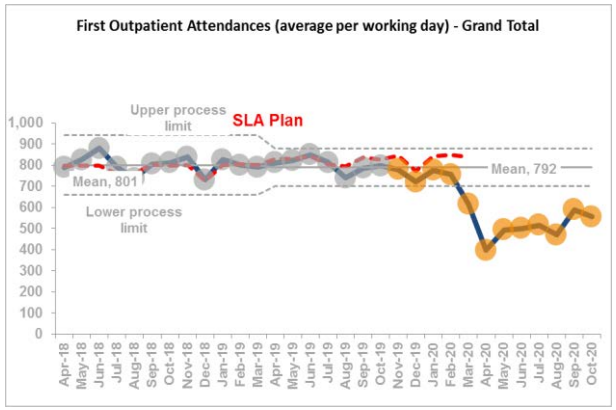
Note: These figures are taken from SLAM, with national figures being taken from SUS. Whilst these 2 data sources are reconcilable, there are explainable differences. Therefore, the below should be taken as valid directionally, rather than exactly correct as per national counting. The Trust is currently 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.

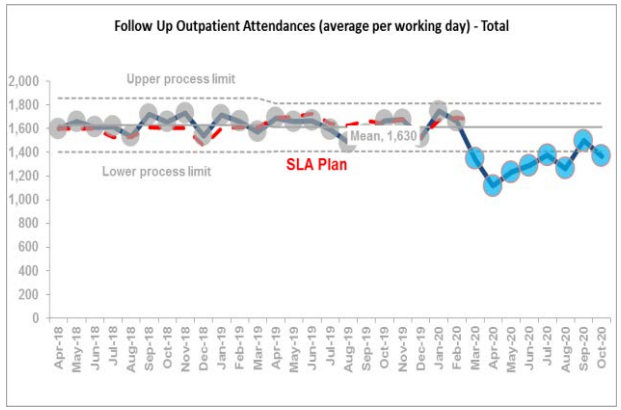
- The letter 'Third Phase of NHS Response to COVID-19' dated 31 July 2020 from NHSE/I sets out expectations for activity performance for Trusts in the latter part of the financial year 2020/21.
- From September 2020 onwards, systems are expected to deliver at least 80% of last year's activity for both 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.
- October's expected performance is adjusted for catch-up based on September's catch up levels for each specialty. **87% for Elective and Daycase is under target by 3% and 88% for Outpatients is under target by 12%.** The Trust has been advised not to factor in any financial penalty for this adverse performance, with more detail expected in future guidance.
- Endoscopy Performance in Daycase & Elective is skewed by Bowel Scope Screening activity (410 in October 2019) that has not been given the go ahead to restart in 2020/21.

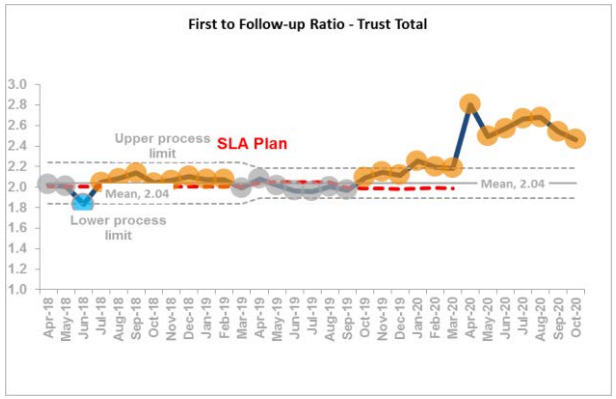
DAYCASE & ELECTIVES					
Specialty	Last Year October	This Year October	% of Previous Year Activity	This Year October updated for catch-up based on Sept	% of Previous Year Activity Updated
Endoscopy	1,431	857	60%	998	70%
Neurology	741	726	98%	840	113%
Plastic Surgery	415	386	93%	430	104%
Urology	312	250	80%	272	87%
Cardiology	293	168	57%	172	59%
Paediatric Medicine	271	207	76%	214	79%
Gynaecology	229	168	73%	182	79%
General Surgery	208	131	63%	138	66%
Neuro Surgery	206	157	76%	170	83%
Paediatric Surgery	203	196	97%	196	97%
Other	1,394	1,133	81%	1,328	95%
Subtotal	**5,703**	**4,379**	**77%**	**4,939**	**87%**
TARGET OCTOBER					**90%**
VARIANCE					**-3%**

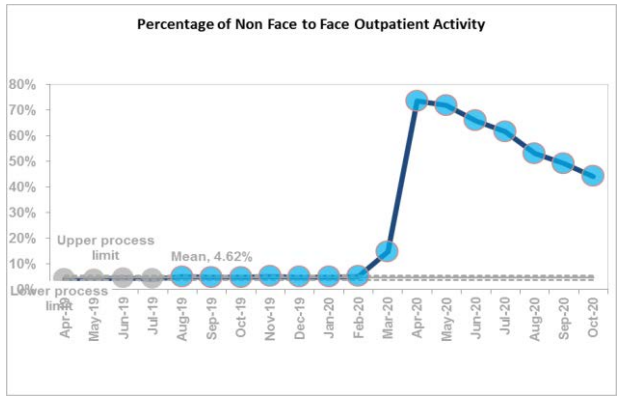
OUTPATIENTS					
Specialty	Last Year October	This Year October	% of Previous Year Activity	This Year October updated for catch-up based on Sept	% of Previous Year Activity Updated
Dermatology	3,604	3,119	87%	3,126	87%
Gynaecology	3,522	2,105	60%	2,470	70%
Chest Medicine	3,219	2,107	65%	2,242	70%
Diabetes/Endocrinology	3,121	2,561	82%	2,654	85%
Neurology	3,033	2,297	76%	2,439	80%
Cardiology	3,012	2,443	81%	2,643	88%
Trauma & Orthopaedics	2,929	2,418	83%	2,539	87%
Rheumatology	2,556	1,971	77%	1,997	78%
Paediatric Medicine	2,411	1,924	80%	2,091	87%
Gastroenterology	2,080	1,854	89%	2,544	122%
Other	31,213	27,189	87%	28,438	91%
Total	**60,700**	**49,988**	**82%**	**53,184**	**88%**
TARGET OCTOBER					**100%**
VARIANCE					**-12%**

Outpatient Productivity









Actions and Quality Improvement Projects

The Outpatient Task and Finish Group continues weekly and has benefited from the support of the Chief Operating Officer, ensuring focus is maintained on the resumption of activity. The procurement of technology to support a diversity of appointment deliverables continues. Outpatient Operational Management continues to support Services in the review of their templates to reflect the changes in media and to assist them in reinstating their activity.

Offsite locations are being investigated for potential virtual clinics or to support freeing up space at the main site to enable clinics to take place there whilst supporting clinicians with their other clinical responsibilities.

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

What the information tells us

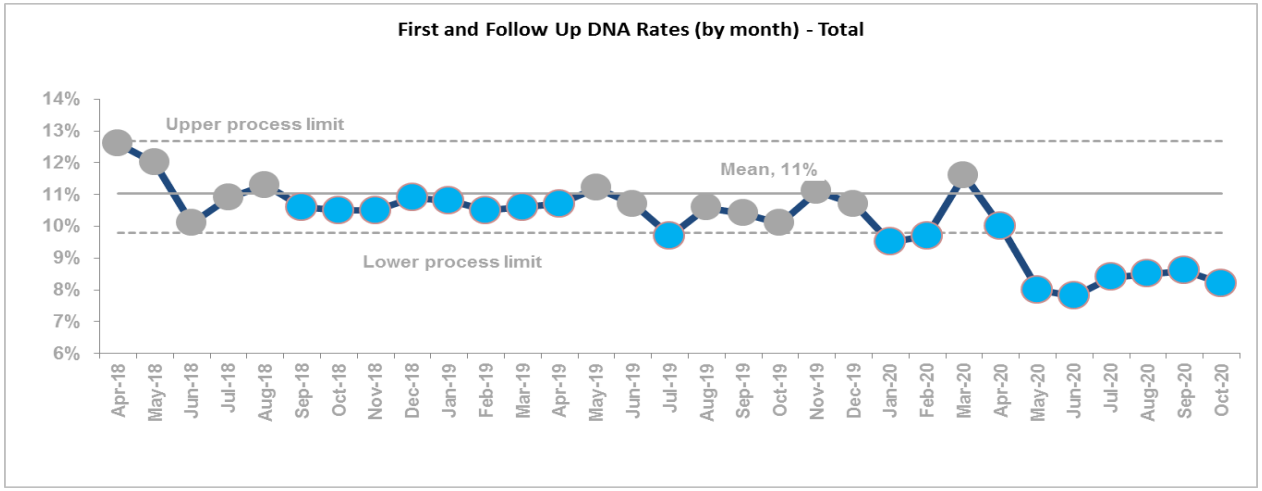
Outpatient (OP) first activity remains below the lower control limit in the month of October reporting on average 556 outpatient first attendances per day compared to 590 in September. The number of attendances per day was 30% lower than the same period last year. Cardiology, Cardiovascular & Vascular Services, Renal & Oncology, Women's as well as Specialty Medicine shows activity below the lower control limit. Surgery although below the lower control limit has seen a steady increase over the past two months with Children's activity within the upper and lower limits although below the mean.

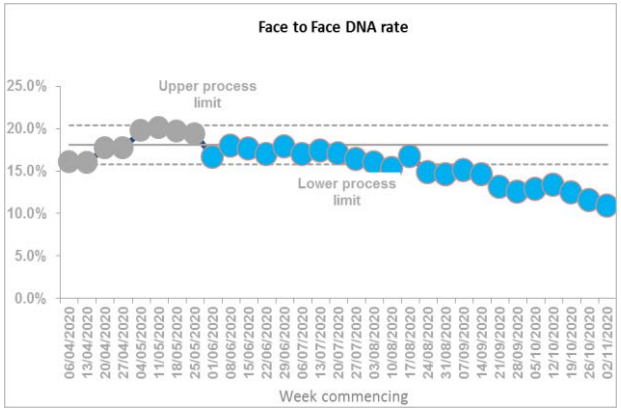
At Trust level, follow-up activity decreased by 131 appointments per day compared to September whist overall activity levels remain below the mean. Compared to the same month last year, activity per day is 18% lower.

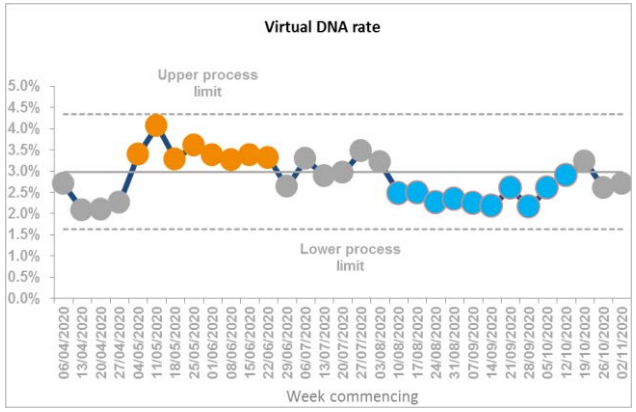
Please note that COVID-19 related OP activity in this financial year has been excluded from the charts.

In October 44% of our outpatient appointments were undertaken in a virtual setting.

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 October remains below the lower control limit reporting that 8.2% of patients did not attend 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 where the DNA rate is 2.7%.

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

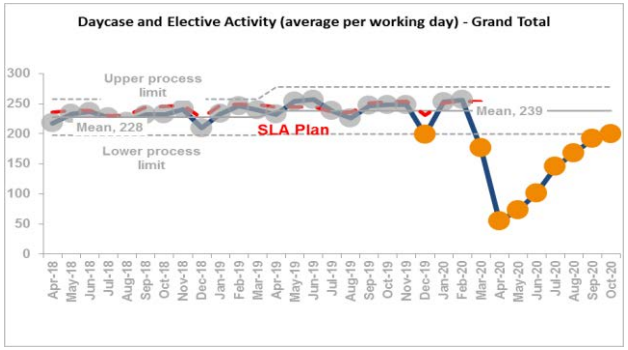
Actions and Quality Improvement Projects

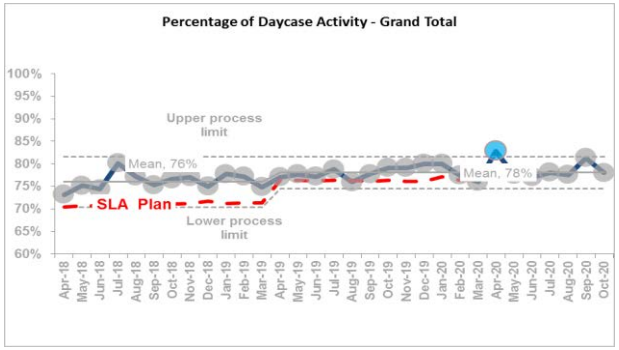
We continue to audit non-attendance. The template review work continues after concerns around mixed communications through letters and text messages to patients were raised at the weekly Task and Finish Group.

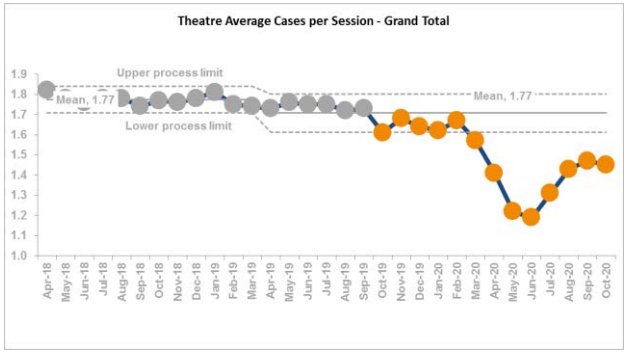
Changing templates is a resource intensive task and continues slowly; there is still a significant amount of work to be done to ensure our templates reflect our activity. Services are regularly reminded to check the messages that are going out to patients and we are actively working with Services to ensure that clinicians call patients at the expected appointment times.

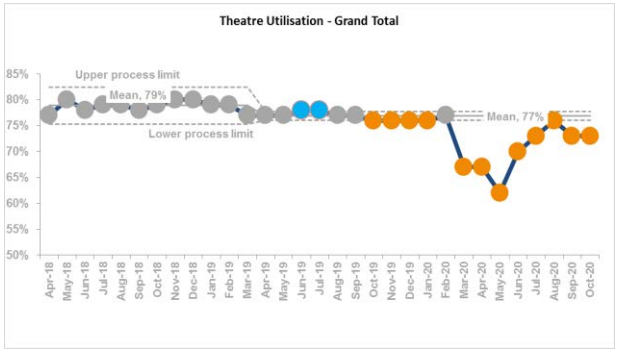
Deep dives for those Services struggling with the completion of electronic Clinic Decision Outcome Forms (eCDOF) continues supported by Transformation including understanding challenges and blockers and finding solutions to support improved completion.

Elective Activity & Theatre Productivity









Actions and Quality Improvement Projects

Currently 28 of 29 operating theatres on site at St George's are open and with the Independent Sector (IS) there are a total of 30 theatres available. There is a plan to bring us back down to 29 operating locations (27 internally and 2 in the IS) to support the significant anaesthetic staffing challenges which continue. This marginal reduction is likely to have a limited impact on activity as we will manage this reduction carefully through existing 6-4-2 processes.

Infection, Prevention and Control (IPC) guidelines limit emergency theatre throughput and therefore one additional theatre is being used for emergency care. By improving productivity in this second emergency theatre, we are expecting to convert half a day back to elective operating to further increase elective capacity.

We have also increased the number of weekend operating lists for a number of specialties. We have held one high volume surgery day, with a total of 12 operating theatres open for elective/day case activity (typically there are an average of 3 elective theatres open on a Saturday).

There is significant work underway in our Preoperative Assessment team, to improve booking processes and improve our ability to maximise capacity at short notice, particularly replacing short notice cancellations.

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

Elective activity continues to see a steady increase as the standing up of activity continues through October, approaching near within normal limits of activity compared to pre-COVID-19. On average 200 patients were treated per day throughout the month compared to 191 in September and 248 per day in the same month last year (this is not all theatre based activity).

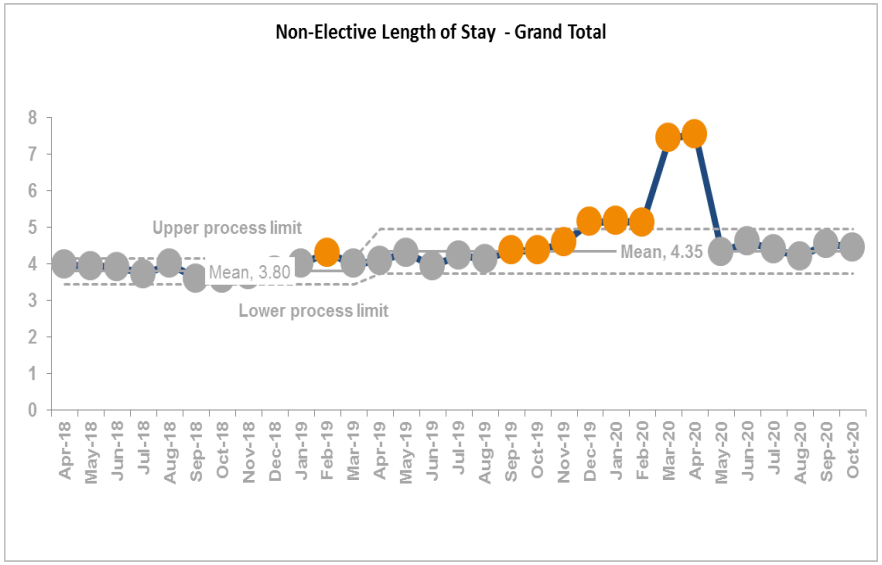
Compared to last year theatres have run more four hour sessions than the same period in 2019 although less activity has been reported. This is a result of Infection Prevention & Control (IPC) guidance in theatres which has reduced throughput. An element of data catch up remains through the coding of activity.

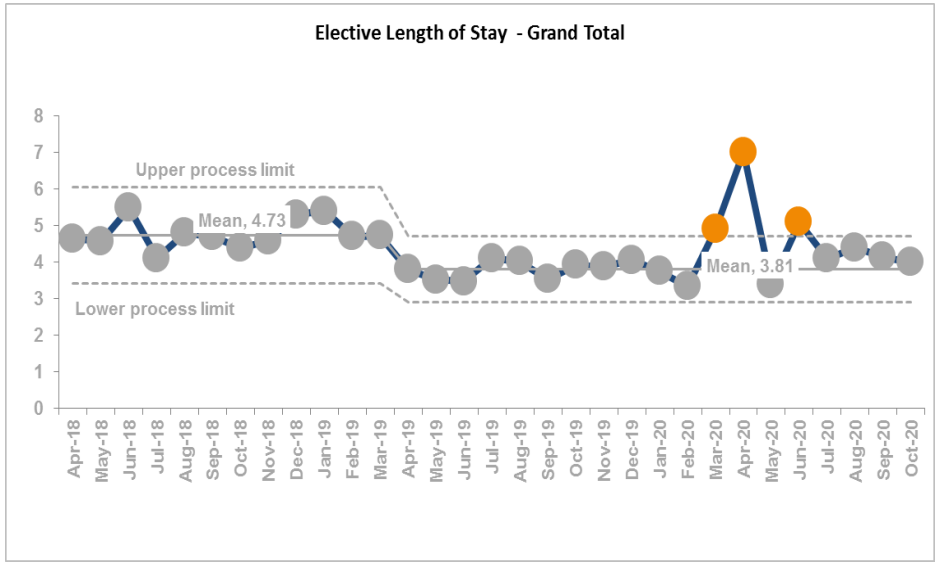
All specialties have seen a positive increase in the number of treatments with the activity coming back online; an increasing and sustained improvement is particularly seen within Endoscopy, and Surgical Specialties.

Both Trust level theatre cases per session and Utilisation in October was similar to the previous month seeing a sustained improvement whilst continuing 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.

Length of Stay





What the information tells us

Non-elective length of stay has consistently been within the upper and lower control limits for the past six months after seeing an increase in March and April where length of stay increased due to both patients staying in hospital longer due to COVID-19 mixed with a lesser demand on our non-elective admissions. In October, on average, patients admitted through the Emergency pathway stayed 4.5 days, a slight decrease compared to September with the number of patients admitted increasing by 3% compared to the previous month. Compared to the same period last year non-elective admissions are 17.5% lower.

Within Acute Medicine non-elective length of stay increased in October by 0.4 days although remaining below the lower control limit. Women's and Children and General Surgery the average length of stay remains below the lower control limits whereas other specialties have seen more variability with Senior Health and Neurosciences remaining above the upper control limits although is in line with previous trends.

Elective length of stay remains within the upper and lower control limits showing only common cause variation, with the number of elective procedures increasing by 9% compared to the previous month.

Actions and Quality Improvement Projects

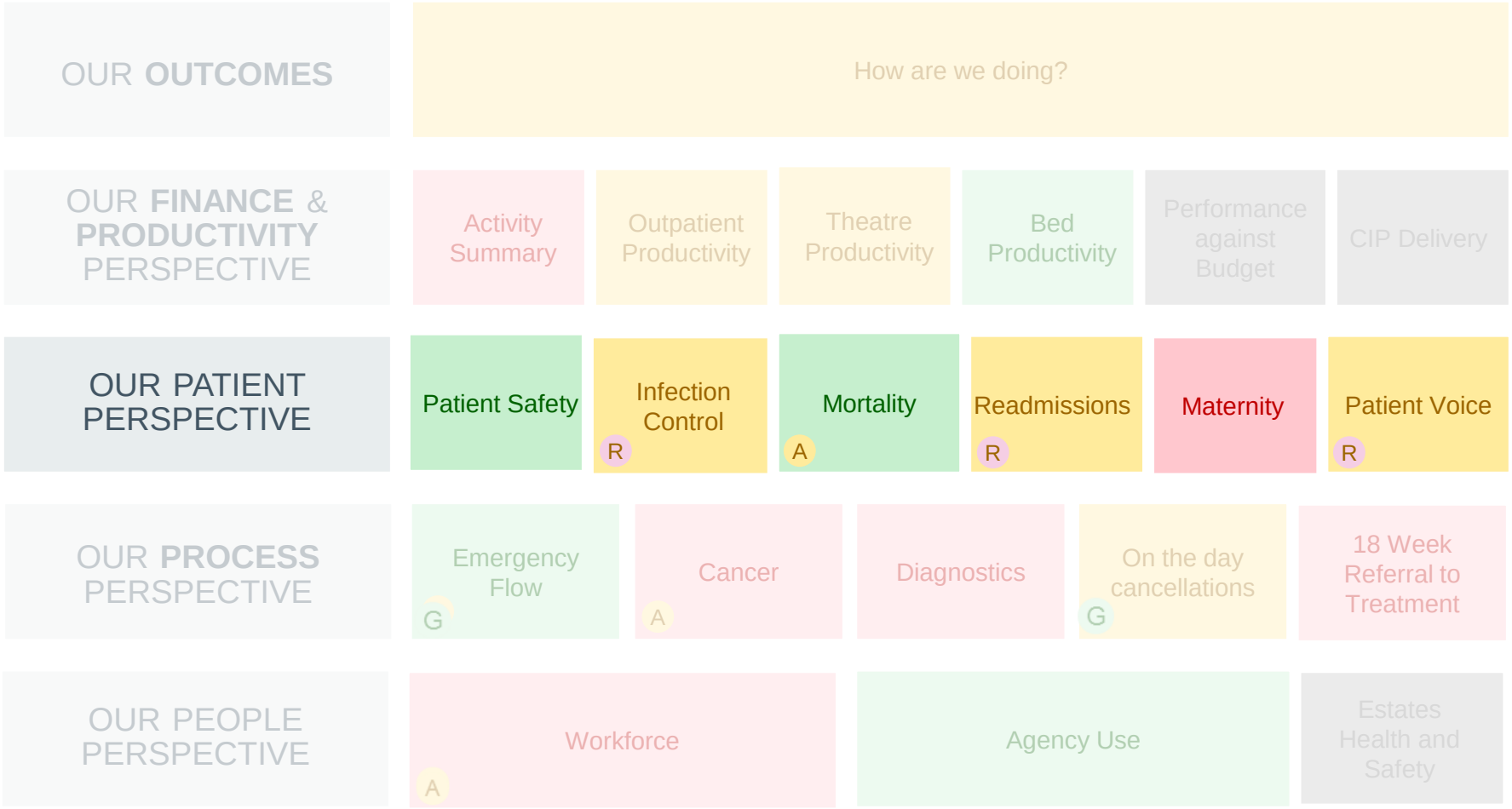
Medcard and Surgery will each have a dedicated Long Length of Stay (LLOS) meeting with the process changing to emulate best practice as per MADE (multi agency disciplinary events).

These meetings will improve performance ahead of winter and a 2nd COVID-19 surge. Bed occupancy reduction will allow flow for emergency and COVID-19 admissions

Divisional oversight following LLOS meetings where delays in patients pathways will be clinically challenged using PDSA cycles to test and rapidly improve the process.

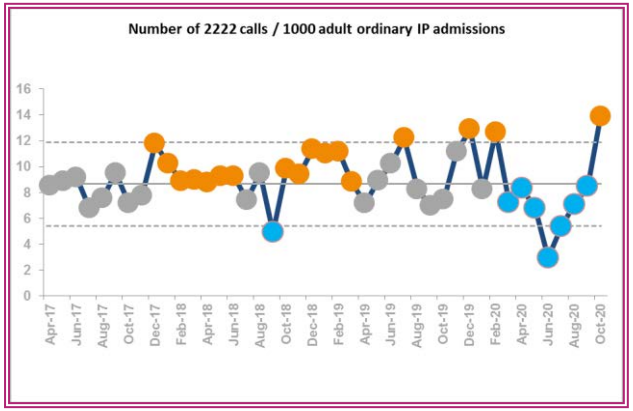
Working towards launching discharge hub 7 days a week moving from Monday to Friday service.

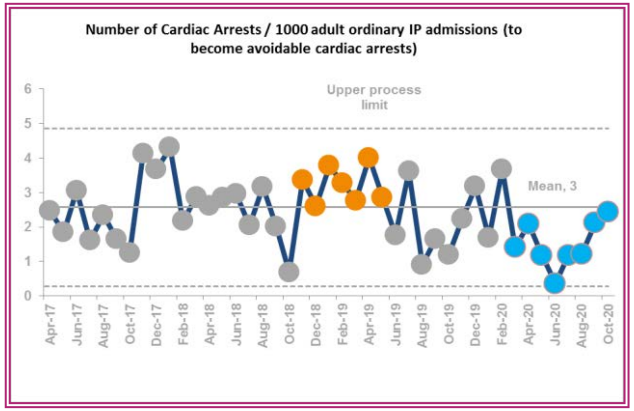
Balanced Scorecard Approach

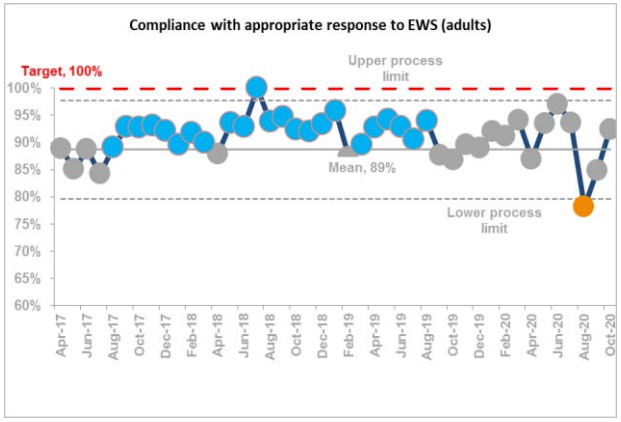


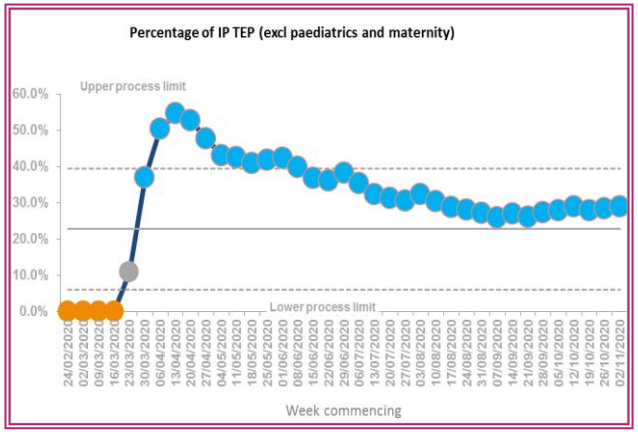
Scorecard RAG rating based on PreCOVID-19 plan

Quality Priorities – Treatment Escalation Plan









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

What the information tells us

- The number of 2222 calls per 1000 IP admission increased markedly in October however the number of cardiac arrests continues to show common cause variation.
- Compliance with appropriate response to Early Warning Score (EWS) increased this month to 92% compared to 85% last month and continues to show common cause variation. The cohort of EWS patients increased slightly and can be seen in the Appendix.
- TEPS undertaken has remained steady since July.

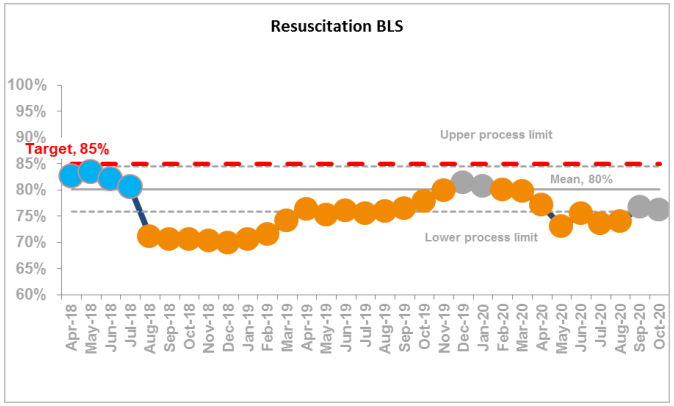
Actions and Quality Improvement Projects

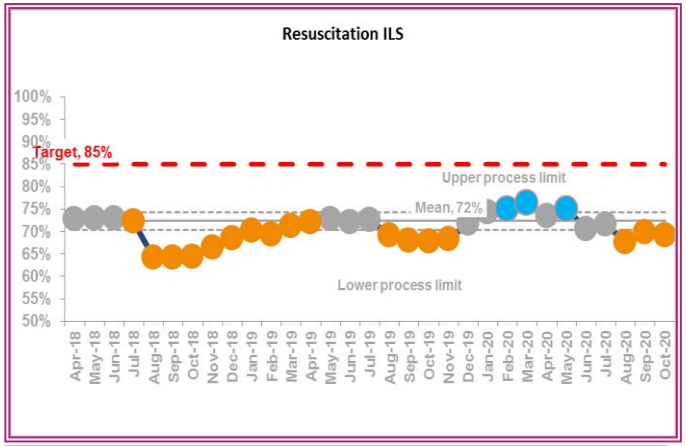
Treatment Escalation Plans (TEPs) are now live in iClip and live data is available online on Tableau. The Trust target is for all in-patient admissions to have a TEP within 24hrs.

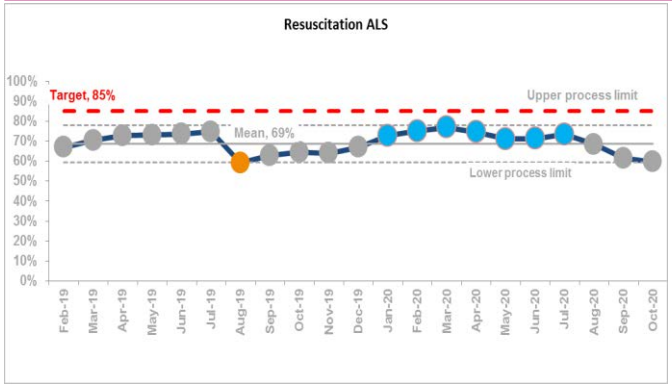
A monthly point prevalence (PP) audit is currently underway to examine the extent to which TEPs are restrictive or reflective of patients for full escalation. Compliance has deteriorated with completion from 56% in April to 29% in October 2020: this is consistent with the data from Tableau presented above. A number of initiatives have commenced to improve compliance, however a Trust wide approach is required to improve this position.

Bi-annually the NEWS audit is completed jointly by the Critical Care Outreach Team and senior ward staff in an attempt to standardise the audit process. The last joint audit took place over August/September 2020 and is likely therefore to have impacted these results. It is hoped that this impact will continue and provide a more accurate picture of compliance than the previous RATE audits.

Quality Priorities – Deteriorating Patients







- BLS (Basic Life Support) training performance shows common cause variation with performance at 76%.
- ILS (Intermediate Life Support) remains below the mean showing special cause variation.
- ALS (Advanced Life Support) training performance remains within common cause variation and below the target of 85%.

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

Actions and Quality Improvement Projects

There has been an increase in the number of face-to-face assessments being booked implying a better uptake of Level 2 training. However, there is a 25-50% DNA rate for booked face-to-face sessions. Monthly DNA reports are sent to General Managers (GMs) and Heads of Nursing (HoNs)for follow up.

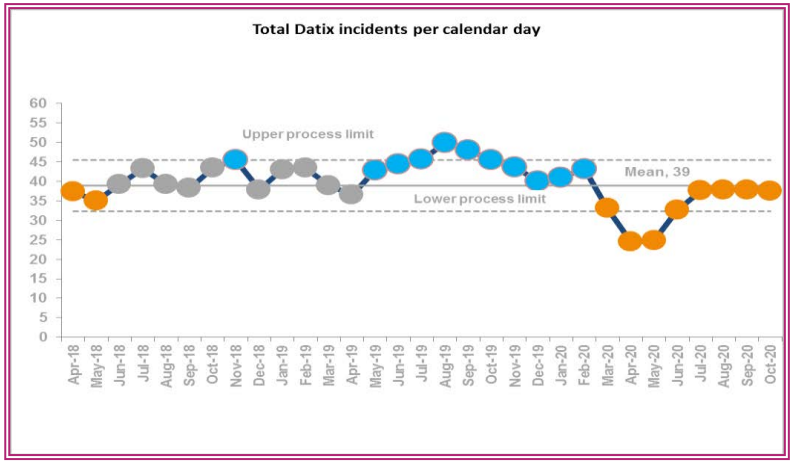
To improve DNA rates, ILS and BLS registers are distributed to HoNs and GMs weekly to ensure staff are rostered to attend and are not on long term sick, maternity leave or on annual leave. Training compliance continues to be monitored through Divisional Board and directorates governance meetings.

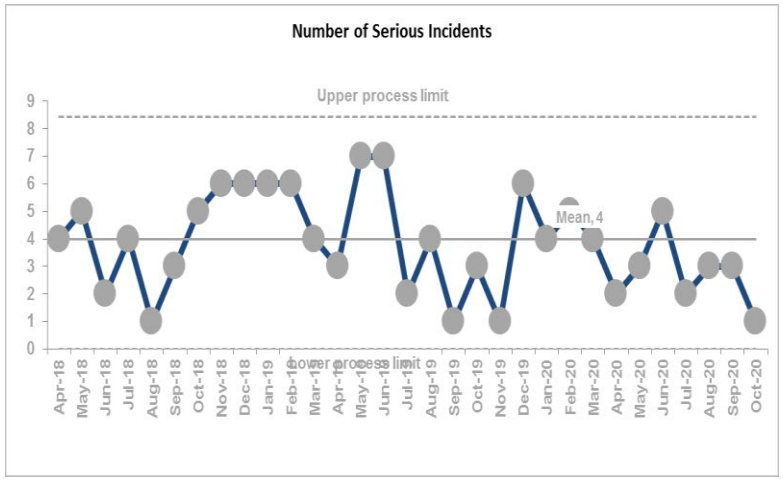
All courses are running at reduced capacity to allow for Social distancing.

BLS Self-Assessment model is currently being explored including cost implications.

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/ Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Monthly percentage of Incidents of Low and No Harm		97.0%	96.0%	96.0%	96.0%	96.0%	93.0%	93.0%	94.0%	95.0%	97.0%	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%	97.0%	98.0%	86.0%	94.0%	82.0%	86.0%	84.0%	80.0%	89.0%	87.0%	90.0%	data two months in arrears	
Total Datix incidents per calendar day		45	44	40	41	43	33	24	25	33	38	38	38	37





What the information tells us

- Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- The number of Datix incidents reported in October 2020 are increasing in line with figures pre-COVID19 pandemic. The daily number has remained below the pre-COVID mean since March 2019.
- There were no Never Events in October 2020.
- 27 out of 30 moderate and above severity patient safety incidents in August 2020 had Duty of Candour completed within 20 working days demonstrating 90% completion rate.

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

Actions and Quality Improvement Projects

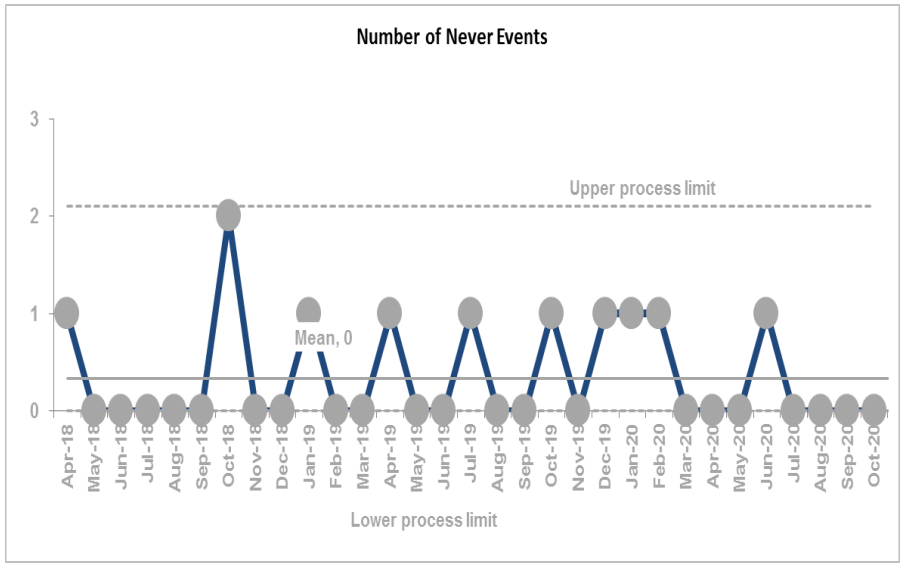
Incidents – The monthly percentage of incidents of low and no harm continues to be monitored and reported.

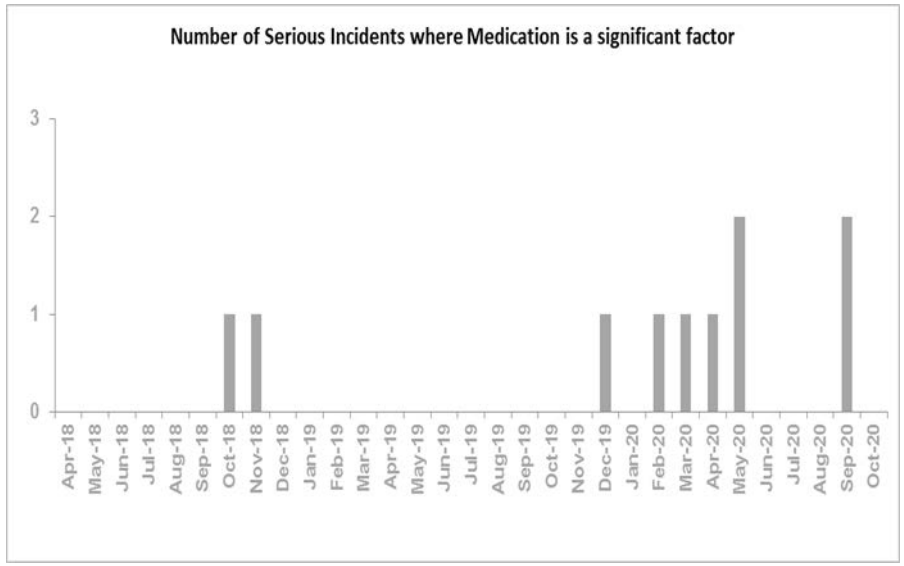
Continue monitoring of Divisional performance on Duty of Care completion and improvement plan by the Patient Safety and Quality Group (PSQG).

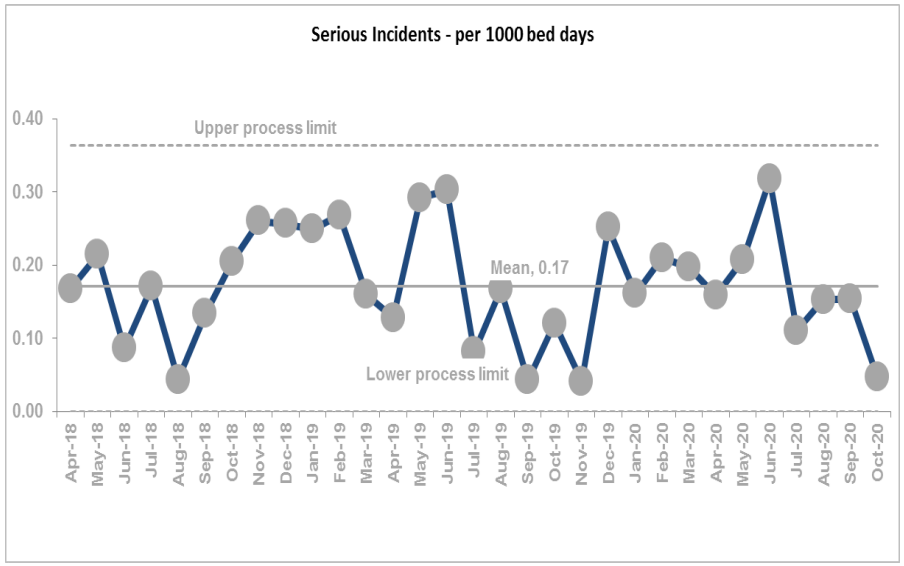
Our Patient Perspective

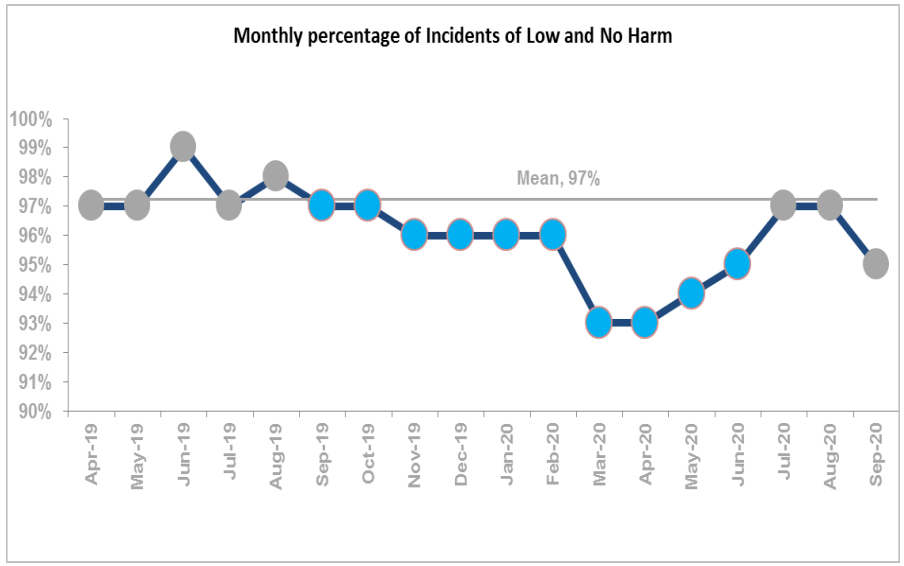
Quality Priorities – Learning from Incidents

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



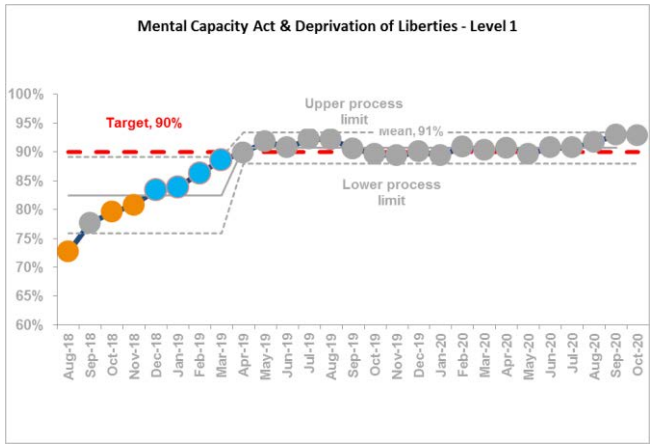


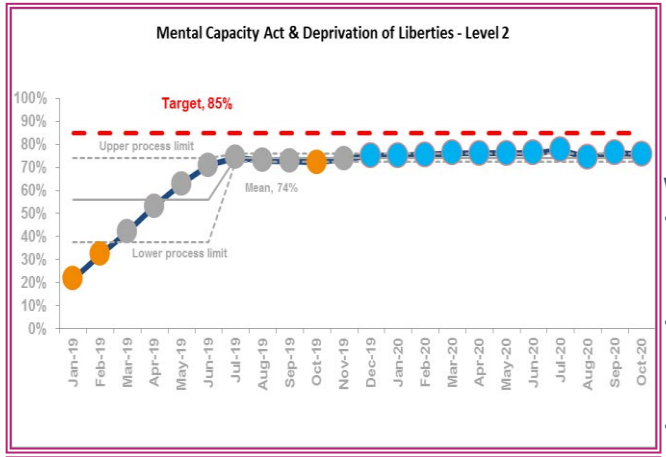


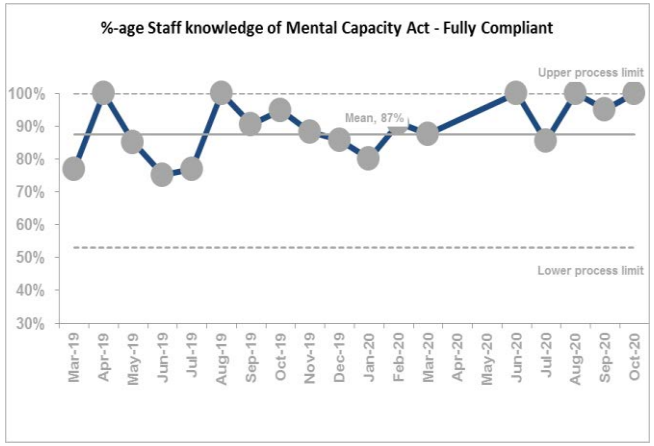


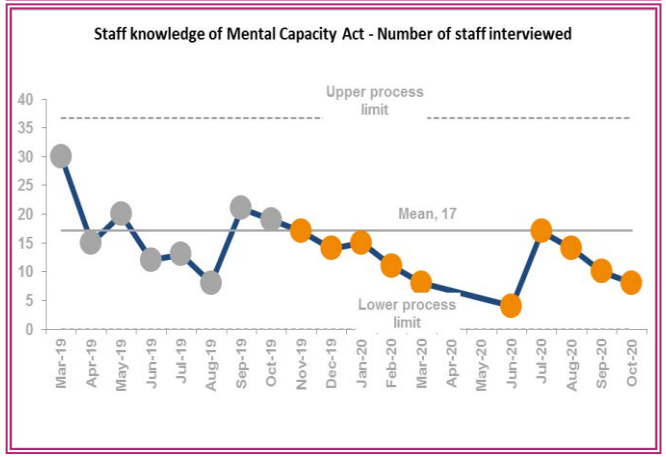
Data is 1 month in retrospect

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









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

What the information tells us

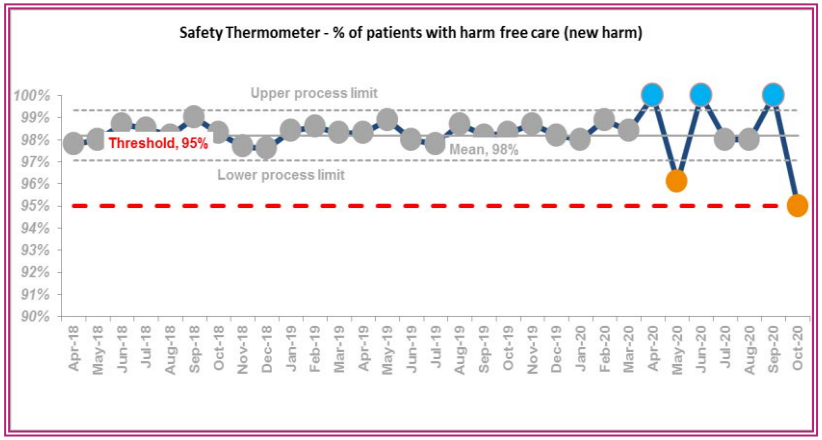
- Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 is above target.
- Level 2 training performance has plateaued. Overall Level 2 compliance was 76% this month.
- Metrics showing the number of staff interviewed and their level of knowledge was suspended in April and May due to COVID-19 and recommenced in June 2020. Although the number of staff interviewed has shown a month on month reduction the level of knowledge assessed in October demonstrates full compliance.

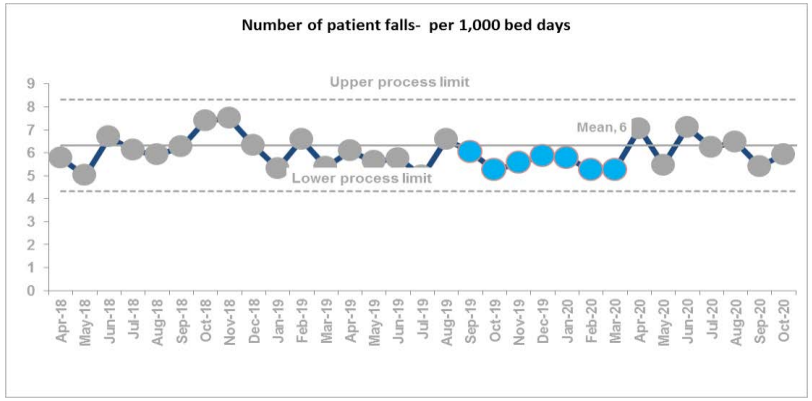
Actions and Quality Improvement Projects

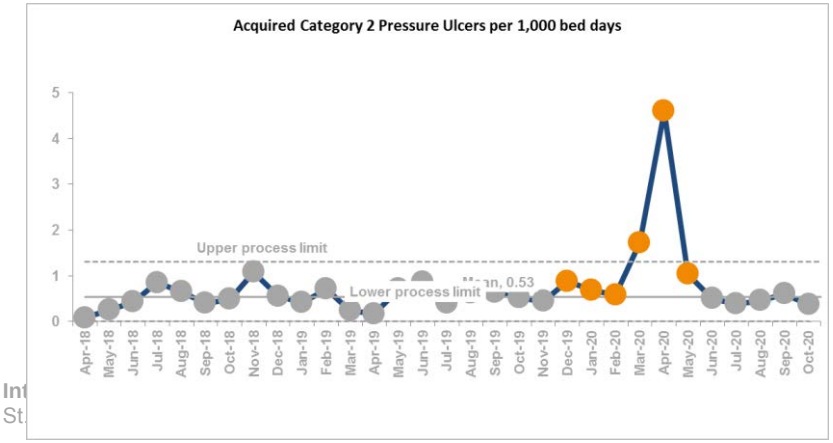
- Iclip Templates for Mental Capacity Assessments and Best Interests Decision Making Launched Trust wide on 2 November 2020.
- Six monthly audit of MCA knowledge amongst relevant trust staff launches this month (November 2020)
- Divisionally led Audit of consent (including Capacity) in relation to serious medical treatments currently in progress. MCA Lead and Consent Lead to audit cross section of results and report on findings in December 2020
- Trust restrictions and Restraint Policy currently under substantive working party review which will be completed by February 2021 which will involve working jointly with the new Head of Nursing for Mental Health.

Patient Safety

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







What the information tells us

- Safety thermometer – percentage of patients with new harm free care although above 95% shows special cause deterioration.
- The number of falls per 1000 bed days remains within common cause variation.
- The percentage of patients who have had a VTE risk assessment was 99.1% against a target of 95% (next slide).
- The number of Category 3 Pressures ulcers shows common cause variation (next slide).

Actions and Quality Improvement Projects

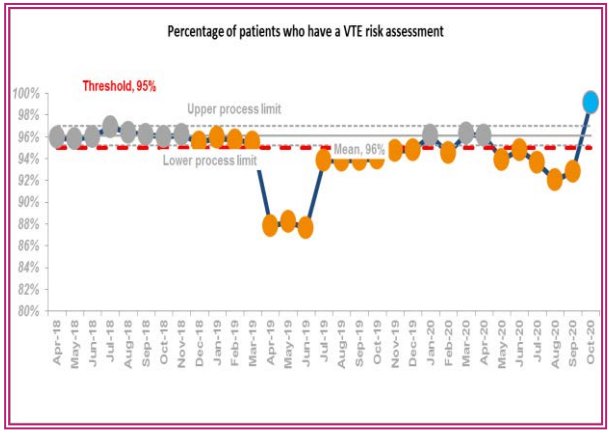
The Hospital Thrombosis Group (HTG) continues to monitor the Trust performance on VTE risk assessments. Work is on-going to further improve the data collection in Maternity services through collaborative work between IT, maternity team and information team. The issue reported in September 2020 with alerts on iCLIP has now been resolved. All clinical teams continue to be encouraged to review their check lists on ward rounds to ensure on-going review of VTE prevention.

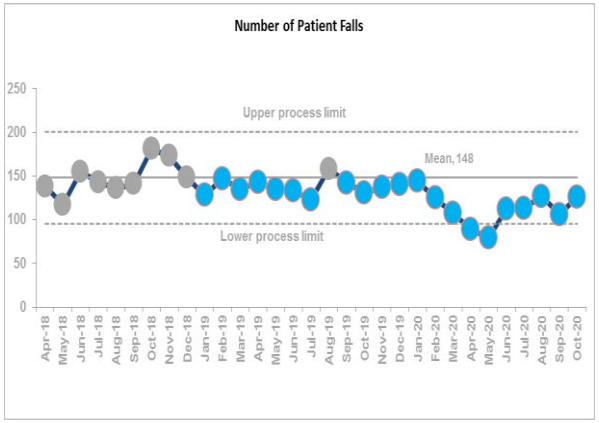
Pressure ulcer categories 3 and above continue to trigger root cause analysis to facilitate learning and identify lapses in care. This is undertaken through review meetings with senior nursing staff. Tissue viability nurses continue ward visits and provide teaching sessions. Stop the Pressure day will be held in November 2020 and COVID-19 secure events are planned to raise awareness.

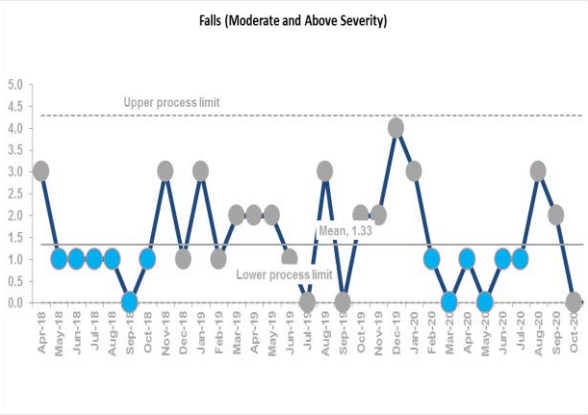
The Trust falls prevention coordinator continues to review all patients with recurrent falls as well as all moderate or above falls and works closely with a network of ward based falls prevention champions to support education for all groups of staff. A virtual falls prevention study day was also held in September 2020 informed by this work. The number of recorded falls is higher than in September 2020 but remains lower than the previous year, there were no moderate falls in October 2020.

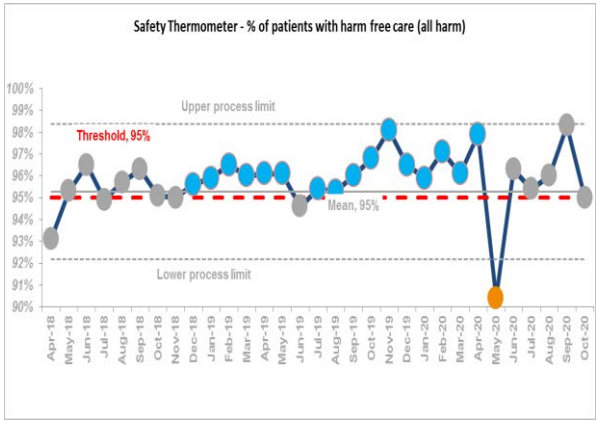
Patient Safety

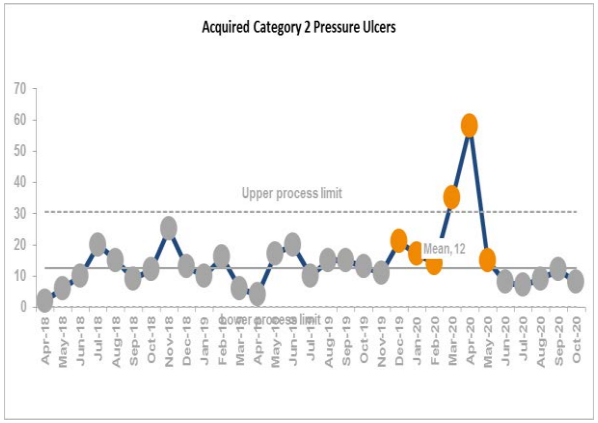
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

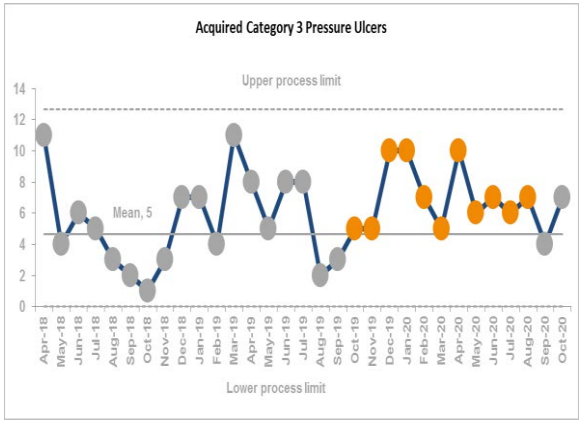








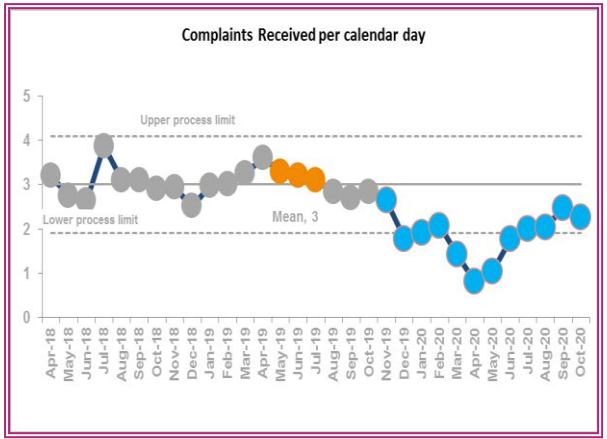


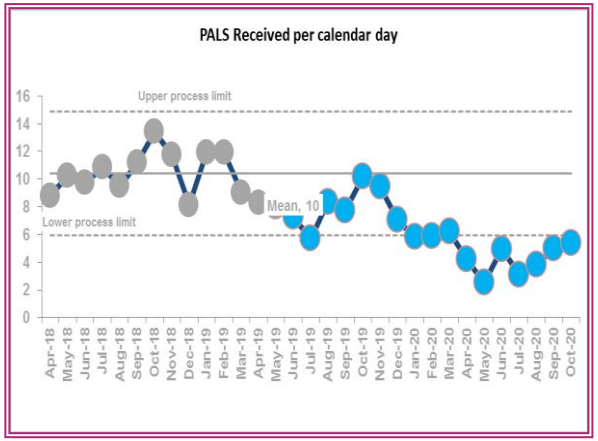


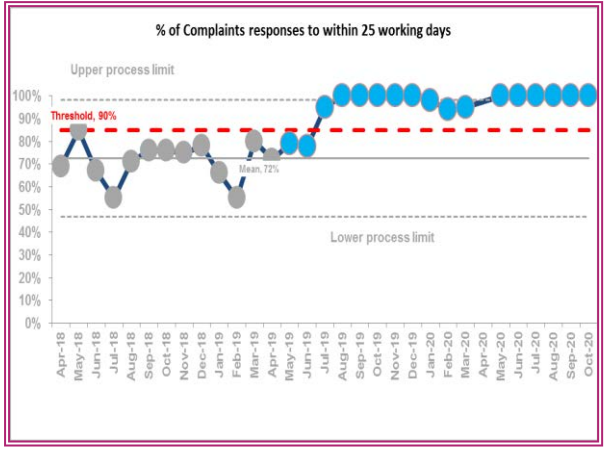
Our Patient Perspective

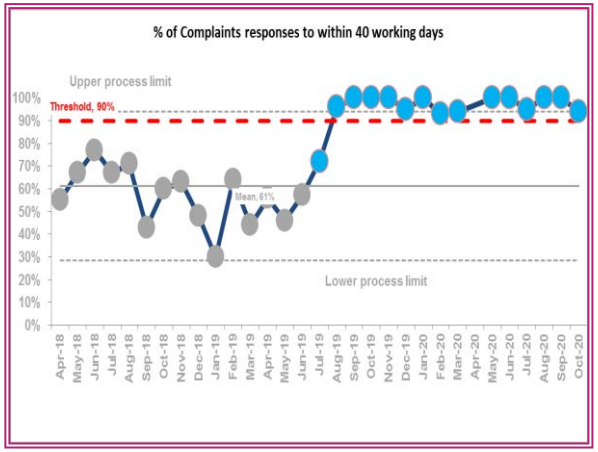
Complaints

Indicator Description	Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Complaints Received per calendar day		3	3	2	2	2	1	1	1	2	2	2	2	2
% of Complaints responses to within 25 working days	85%	100%	100%	100%	98%	94%	95%	57%	100%	100%	100%	100%	100%	100%
% of Complaints responses to within 40 working days	90%	100%	100%	95%	100%	93%	94%	75.0%	100%	100%	95%	100%	100%	94%
% of Complaints responses to within 60 working days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A
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 shows special cause variation with volumes increasing as activity increases.
- Performance across all response categories has remained above target since April 2020.
- Whilst the number of PALS enquiries received has been impacted by the current closure of the service to walk-ins due to COVID-19 there has been a steady increase in the numbers received since July 2020.

Actions and Quality Improvement Projects

Daily complaints comcell continues to focus attention on timely investigation and response from the Trust and has expanded its focus to include timely management of complaints received. This alongside weekly divisional meetings has ensured performance targets continue to be met.

Infection Control

Indicator Description	Threshold 2020-2021	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	YTD Actual
MRSA Incidences (in month)	0	1	0	1	0	0	0	0	0	0	0	1	1	0	2
Cdiff Hospital acquired infections	48	3	2	2	5	3	1	1	3	5	4	3	2	0	20
Cdiff Community Associated infections		1	2	0	0	0	2	0	0	1	0	0	1	0	
MSSA	25	2	3	5	6	3	2	3	0	2	5	4	2	3	19
E-Coli	60	6	4	9	5	7	4	4	8	3	3	0	6	5	29

Hospital Onset COVID-19 Infection Indicator	Jul-20	Aug-20	Sep-20	Oct-20	Total
Hospital onset healthcare associated (>14 days) HOHA	0	0	0	7	7
Hospital onset Probable association (8 - 14 Days) HOPA	0	1	0	0	1

What the information tells us

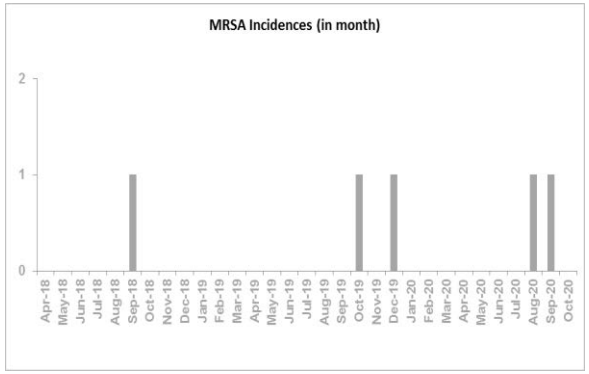
- There were no MRSA bacteraemia reported in October.
- During October there were no cases of hospital onset *C.difficile* infection. There have been a total of 20 cases of *C.difficile* infection (April to October) against a presumed trajectory of no more than 48 cases for the year and no more than 28 for the period April – October; indicating the Trust is below threshold. These consist of 18 hospital onset cases where the specimen was taken more than two days after admission and two 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* remain within control limits.
- In October 2020, there were 7 Hospital Onset COVID-19 infections classified as hospital onset hospital acquired (HOHA) diagnosed > 14 days after admission, and 1 hospital onset probable hospital associated (HOPA), where COVID-19 was diagnosed 8-14 days after admission. 5 of the HOHA cases were associated with an outbreak of COVID-19 on a medical ward. The ward is open but remains under surveillance pending absence of new cases for 28 days from last positive.

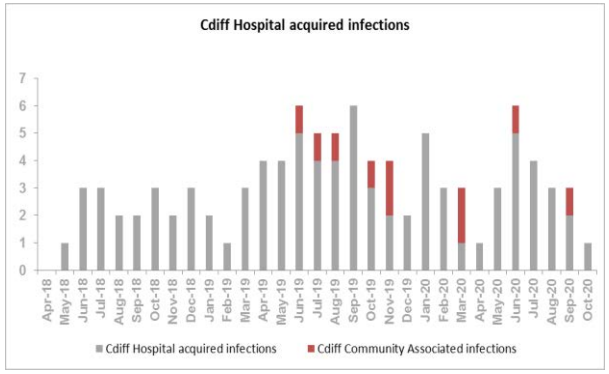
Actions and Quality Improvement Projects

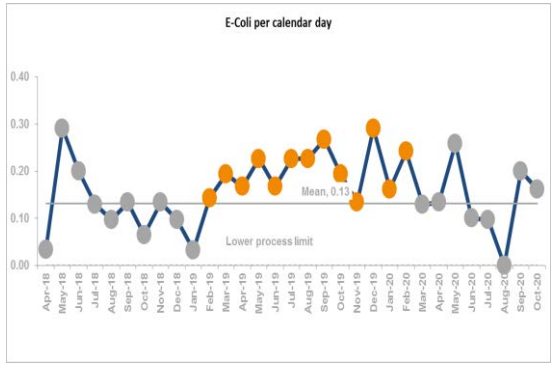
- The Trust continues to conduct hand hygiene audits weekly in ward areas and these are validated monthly by the Infection Prevention & Control (IPC) nurses.
- The IPC nurses are undertaking audits of mask etiquette compliance.
- The ward and departmental accreditation programme remains in place and includes measures on infection control and cleaning standards.
- There is daily monitoring and data validation of COVID-19 hospital onset infections by the PIC team, Assistant Chief Nurse and Information Team. National Data submissions on COVID-19 hospital onset infections submission will be signed off by the Director of Infection Prevention & Control

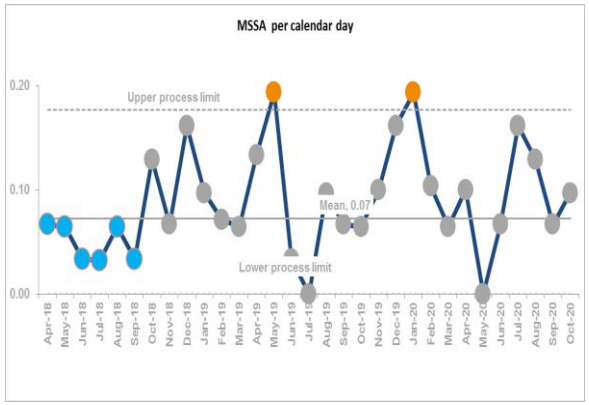
Infection Control

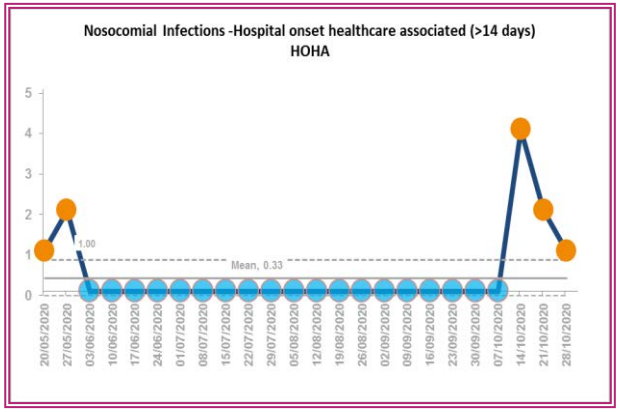
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance











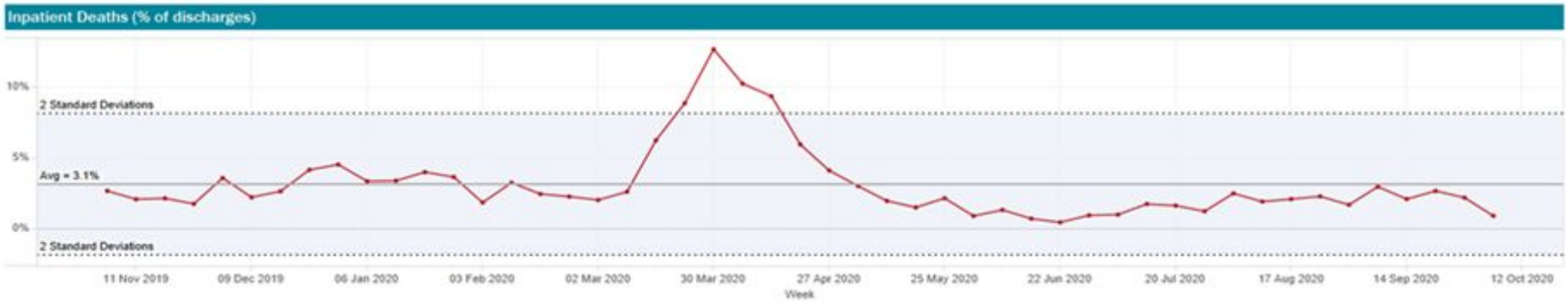
Mortality and Readmissions

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 2019 to July 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	94.3
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	100.6
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	92.7

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
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

Indicator Description	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	9.9%	7.9%	10.9%	10.2%	10.7%	11.3%	11.1%	8.8%

Note: HSMR data reflective of period August 2019 – July 2020 based on a monthly published position. This month we see discharges to July 2020.
SHMI data is based on a rolling 12 month period and reflective of period June 2019 to May 2020 published (Oct 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 June 2019 – May 2020. We are one of 16 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 August 2019 to July 2020 shows our mortality to be as 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. It should be noted that SHMI and HSMR have taken differing approaches to managing the impact of COVID-19,which is just starting to be included in the periods reported. Dr Foster, who produce the HSMR, include COVID-19 activity; whereas NHS Digital who are responsible for SHMI have excluded COVID-19 activity.

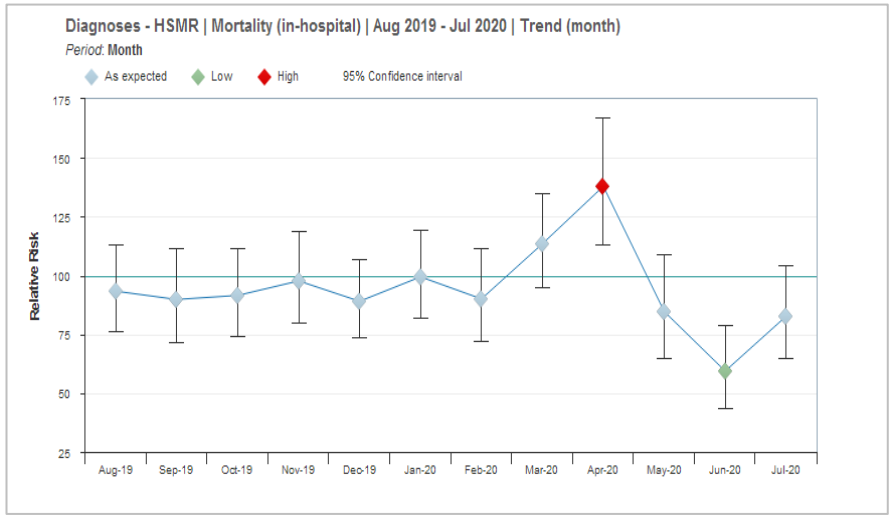
Actions and Quality Improvement Projects

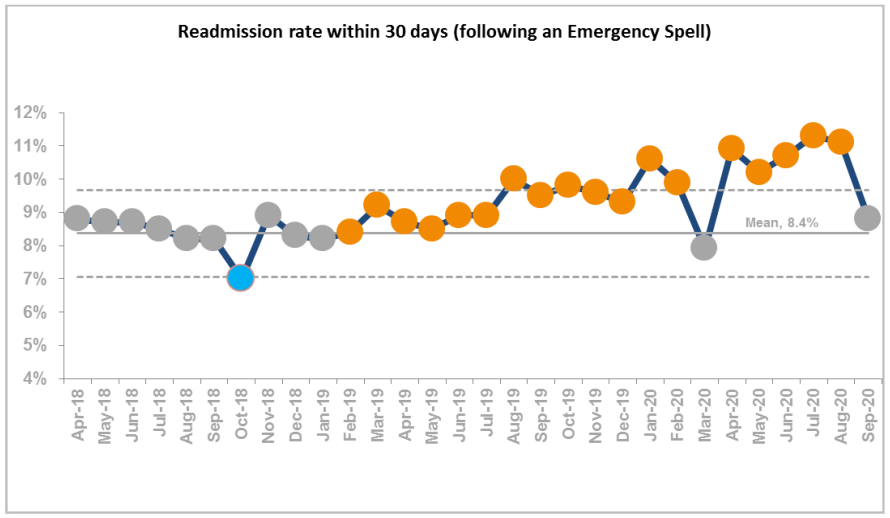
We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Committee (MMC). Current investigations underway are related to sepsis, cardiology and major trauma. The outcome of these investigations are expected to be reported to MMC in December 2020 and January 2021.

Mortality and Readmissions (Hospital Standardized Mortality Rate)

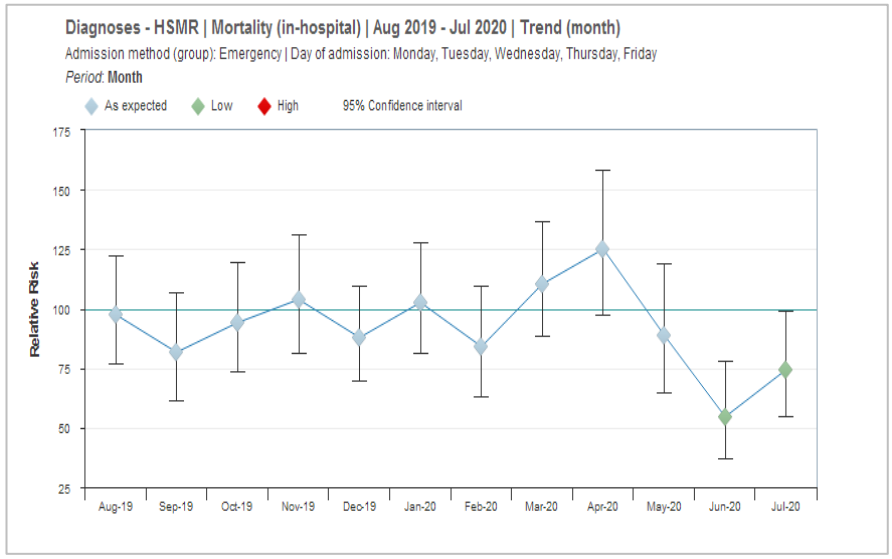
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

HSMR

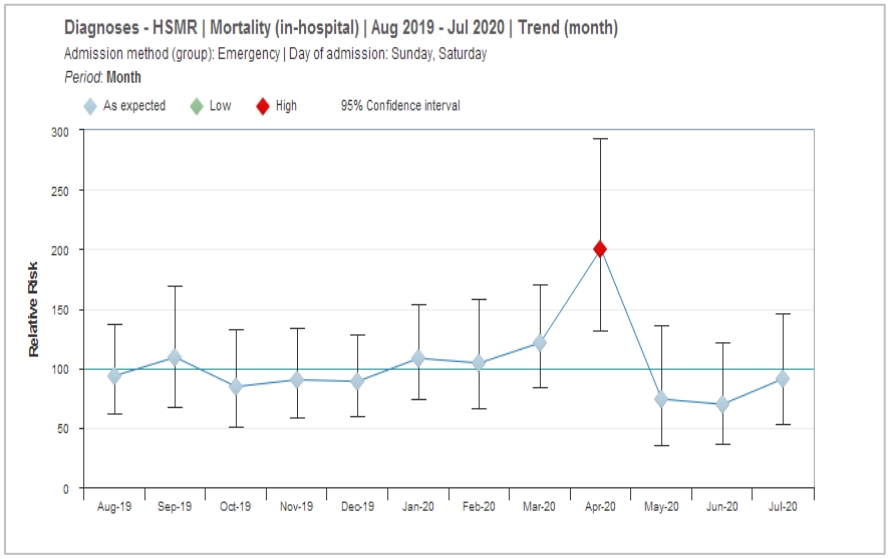




HSMR Weekday

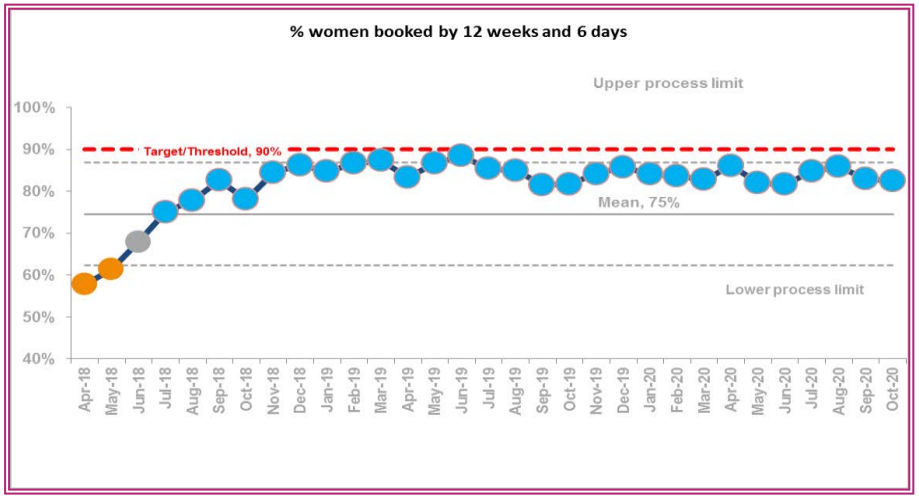


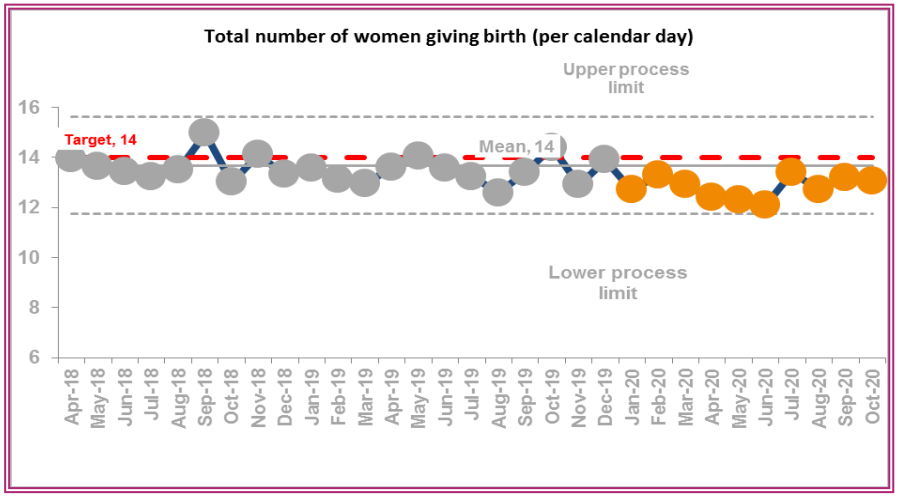
HSMR Weekend



Maternity

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





What the information tells us

New midwives started during October which is reflected in improvements in the staffing related indicators, namely a reduction in the percentage of time that Carmen Suite closed and 100% of shifts on Delivery Suite being covered by a supernumerary coordinator. Women continued to choose to book to have their baby at St. George's, including many from 'out of area', suggesting that our work to support women and their families during the pandemic has been well received.

The overall caesarean section (CS) rate increased to 30% in month which is the highest that it has been in over a year; this includes an increase in the emergency CS rate. However, St George's maternity service has a unique intrapartum monitoring system supported by bespoke and regulated clinical guidance which is responsible for the historically lower CS rates. To illustrate its significance and add further context the regional average CS rate in month is routinely 40% for similar high risk units. To understand the overall increase in CS rates the clinical and governance teams are working together to identify the drivers behind this and ensure all the support structures and training processes to optimise safety and reduce harm are appropriate and are robust. The Consultant leads are continuing monthly reviews of each case from a clinical perspective along with a review of the induction and training processes used to integrate our newly rotated Obstetric Registrars to understand if this on-boarding process needs to be bolstered in any way in consideration of the increased overall CS rate.

The number of babies admitted to the Neonatal Unit saw an increase in the month and this is being reviewed by the Neonatal Care Group Lead and maternity colleagues and may be a natural consequence of the increased emergency CS rate. Despite this increase in admissions, the Hypoxic Ischaemic Encephalopathy rate for October was zero.

The percentage of women of all antenatal bookings in month booked directly onto continuity of carer (CoC) teams at their initial 12 week appointment reduced slightly in month to 23.6%. We have increased the availability of CoC teams and with the subsequent transfer and alignment of women into these teams as appropriate before 28 weeks as recommended, we have a total of over 30% of women in our four continuity teams. This will continue to increase over the next few months, with particular focus on increasing continuity of carer for our Black and Asian women and those from our most deprived communities.

Actions and Quality Improvement Projects

- Review all the emergency CS cases in October to identify/ understand the reasons for the increased CS rate
- Review all term neonatal admissions
- Continue on-going recruitment strategy
- Develop additional continuity of carer teams in line with trajectories, linking our community and hospital midwives.

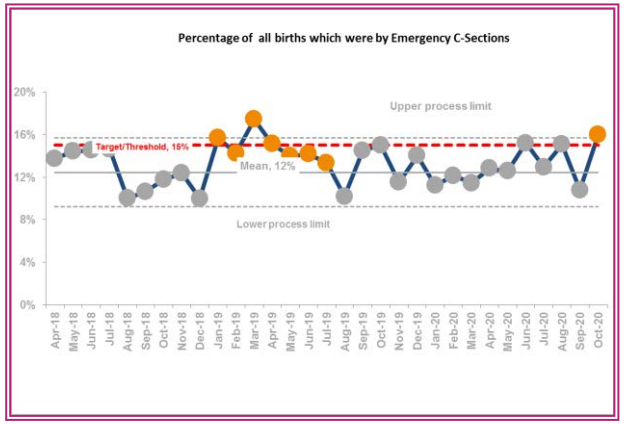
Maternity

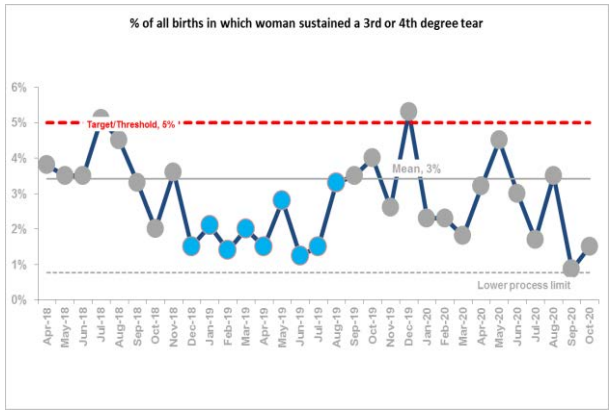
Maternity Dashboard

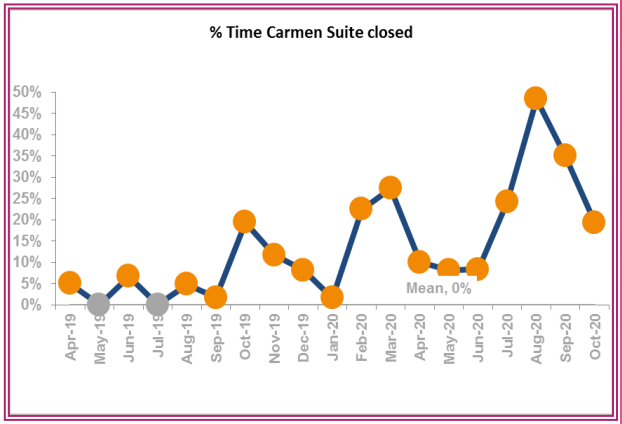
Definitions	Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Total number of women giving birth (per calendar day)	14 per day	14.4	12.9	14	13	13	13	12	12	12	13	13	13	13
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	25.7%	24.2%	26.7%	24.8%	26.0%	23.3%	24.9%	22.3%	29.4%	24.1%	27.1%	23.4%	30.9%
% deliveries with Emergency C Section (including no Labour)	<8%	4.5%	1.5%	4.0%	1.3%	3.6%	3.3%	1.9%	2.6%	2.7%	3.1%	4.6%	3.0%	3.7%
% Time Carmen Suite closed	0%	19.4%	11.7%	8.1%	1.6%	22.5%	27.4%	10.0%	8.1%	8.3%	24.2%	48.4%	35.0%	19.4%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	4.0%	2.6%	5.3%	2.3%	2.3%	1.8%	3.2%	4.5%	3.0%	1.7%	3.5%	0.8%	1.5%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.3%	3.4%	3.0%	1.5%	2.1%	1.8%	2.9%	2.1%	1.4%	1.9%	2.0%	5.3%	2.5%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		7	14	11	12	11	13	9	9	15	20	11	13	20
Supernumerary Midwife in Labour Ward	>95%	96.8%	96.7%	96.8%	96.8%	94.8%	93.5%	100.0%	96.8%	96.7%	96.8%	93.5%	90.0%	100.0%
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	<2	0	0	3	0	0	0	0	0	4	0	0	1	0
Continuity of Care Bookings- % of total bookings made	35%	17.5%	16.8%	21.2%	18.8%	17.0%	18.8%	20.0%	16.8%	21.3%	23.0%	21.4%	27.3%	23.6%
Percentage of all births which were by Emergency C-Sections	15%	15.1%	12.4%	14.9%	12.4%	13.9%	12.7%	13.2%	12.5%	15.2%	12.9%	15.1%	10.8%	16.0%
% women booked by 12 weeks and 6 days	90%	81.7%	84.1%	85.7%	84.0%	83.6%	82.7%	86.1%	82.0%	81.2%	84.6%	85.8%	83.0%	82.4%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	1.6%	3.6%	2.6%	3.0%	2.9%	3.3%	2.4%	0.2%	4.1%	4.8%	2.8%	3.3%	5.1%

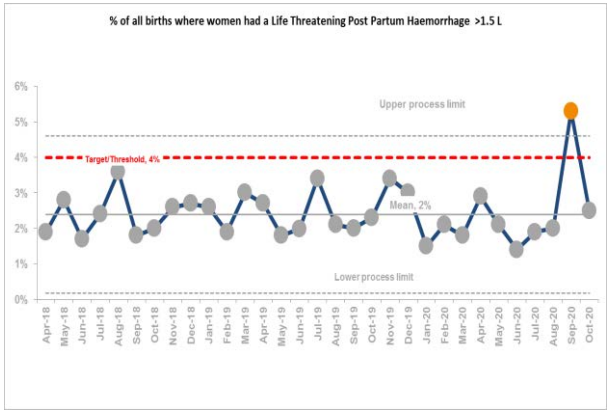
Maternity

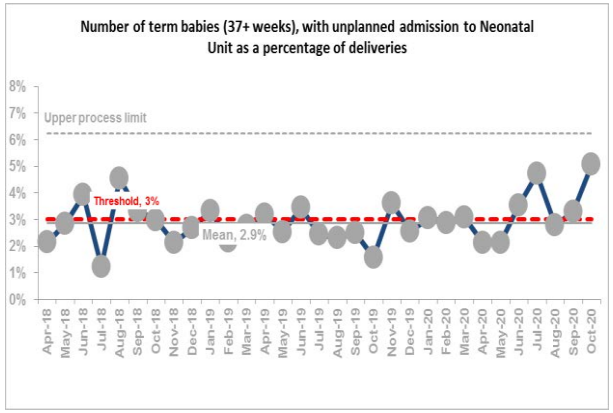
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

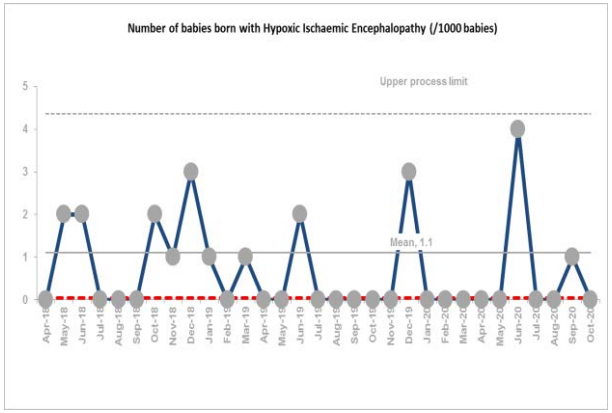


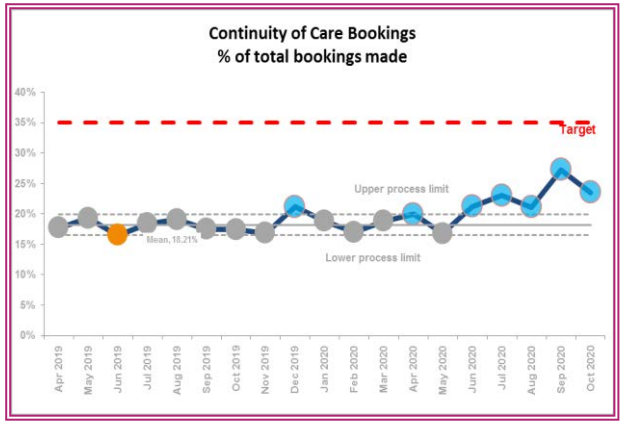












Friends & Family Survey

Indicator Description	Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Emergency Department FFT - % positive responses	90%	81.5%	79.0%	80.3%	84.2%	86.2%	87.8%	93.9%	93.6%	90.0%	89.7%	90.1%	89.5%	89.7%
Inpatient FFT - % positive responses	95%	96.0%	96.5%	96.9%	96.8%	96.6%	97.2%	100.0%	97.2%	93.6%	97.7%	97.2%	96.3%	97.1%
Maternity FFT - Antenatal - % positive responses	90%	N/A	N/A	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	N/A	N/A	N/A	N/A	N/A
Maternity FFT - Delivery - % positive responses	90%	95.2%	100.0%	100.0%	94.1%	100.0%	100.0%	N/A	100.0%	N/A	100.0%	N/A	66.7%	N/A
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	97.3%	88.0%	90.7%	96.9%	100.0%	N/A	0.0%	0.0%	89.9%	100.0%	N/A	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%	100.0%	100.0%	98.0%	90.0%	100.0%	N/A	100.0%	N/A	N/A	N/A	N/A	N/A
Community FFT - % positive responses	90%	99.3%	98.1%	97.7%	100.0%	98.6%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Outpatient FFT - % positive responses	90%	89.6%	90.7%	90.3%	89.9%	89.9%	91.7%	98.2%	89.9%	88.8%	90.3%	89.1%	89.0%	89.1%

What the information tells us

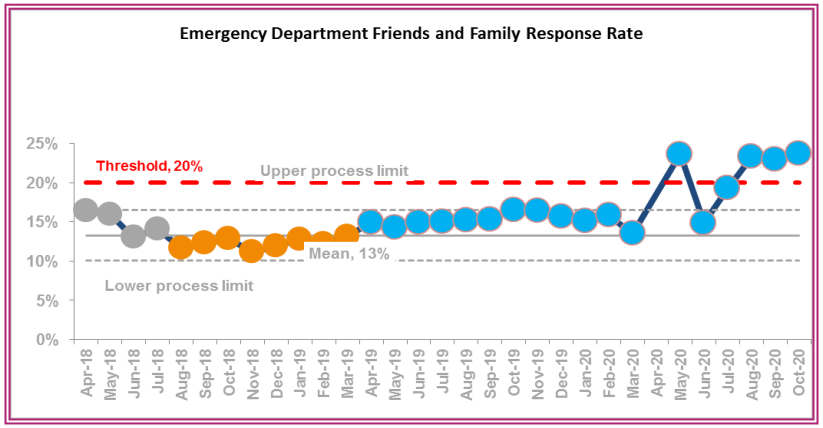
- Inpatients, Maternity Postnatal Ward and Community services have continued to exceed their target for positive FFT responses.
- Though Outpatients narrowly missed achieving the 90% target, the service's positive response rates continues to show a special cause variation with a deterioration with position.
- Maternity delivery had no response through the trust website in October 2020 affecting the overall positive response rate. Maternity FFT survey collection has been paused due to COVID-19 as per NHSE/I directives and this will be reintroduced in Nov 2020, although patients can continue and are encourage to complete this through the trust website.

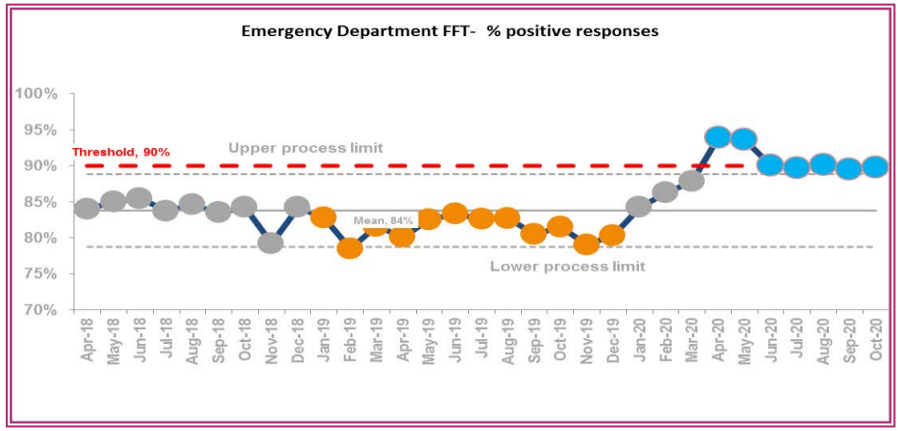
Actions and Quality Improvement Projects

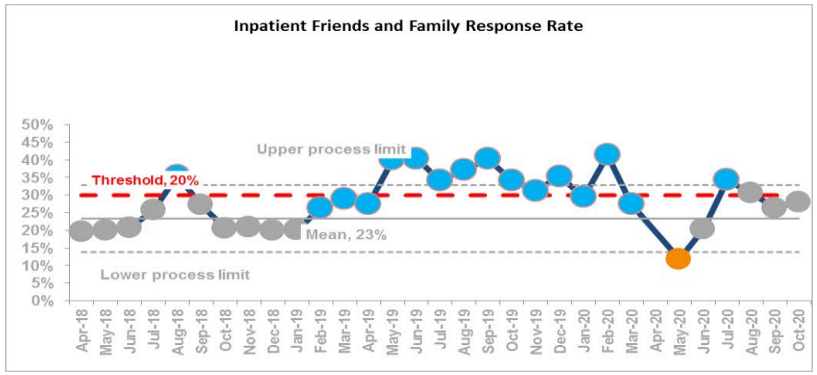
- The FFT surveys completed on tablet computers have been reactivated since July 2020.
- The FFT surveys will resume across all areas by 1 December 2020 and data submission on NHS Digital will recommence.
- QR codes will be explored to link to the FFT survey in order to increase sample of patient experience feedback.

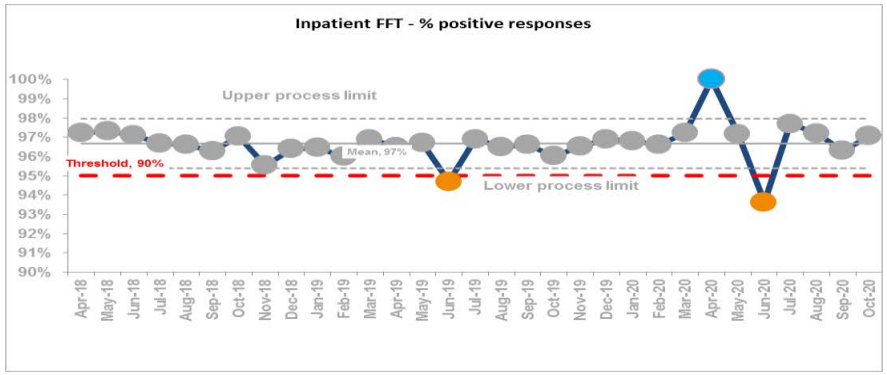
Friends and Family Test

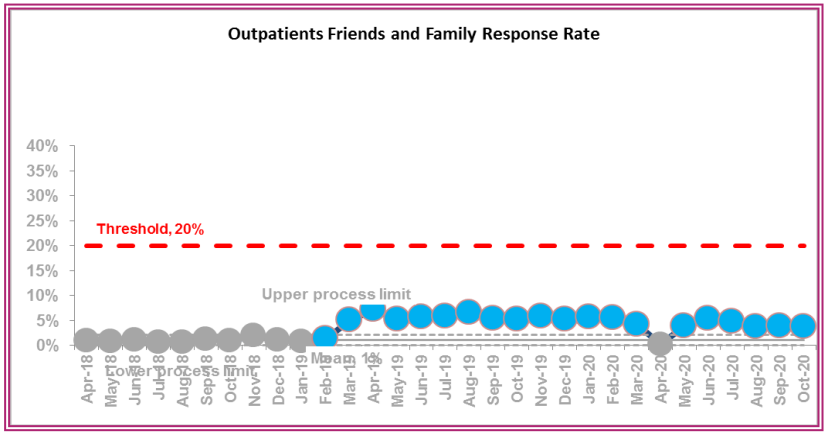
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

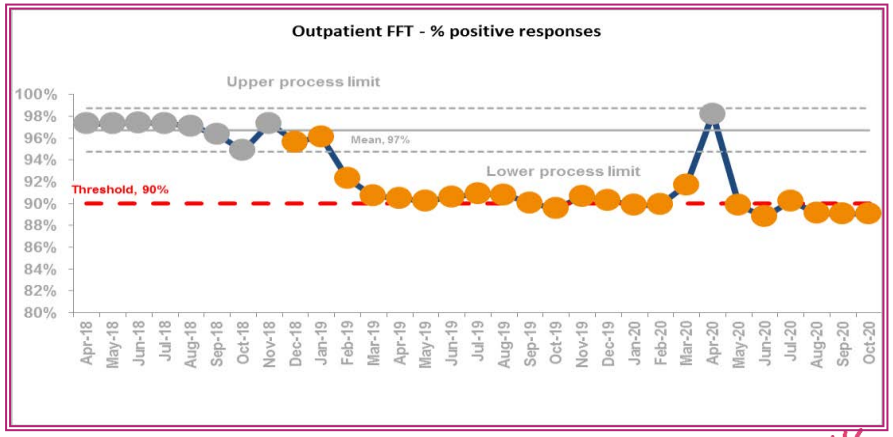






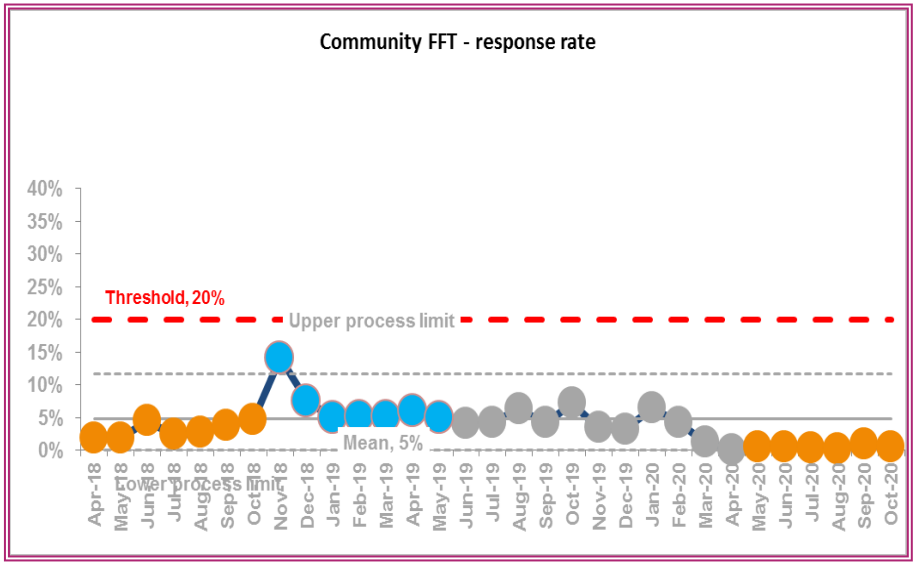


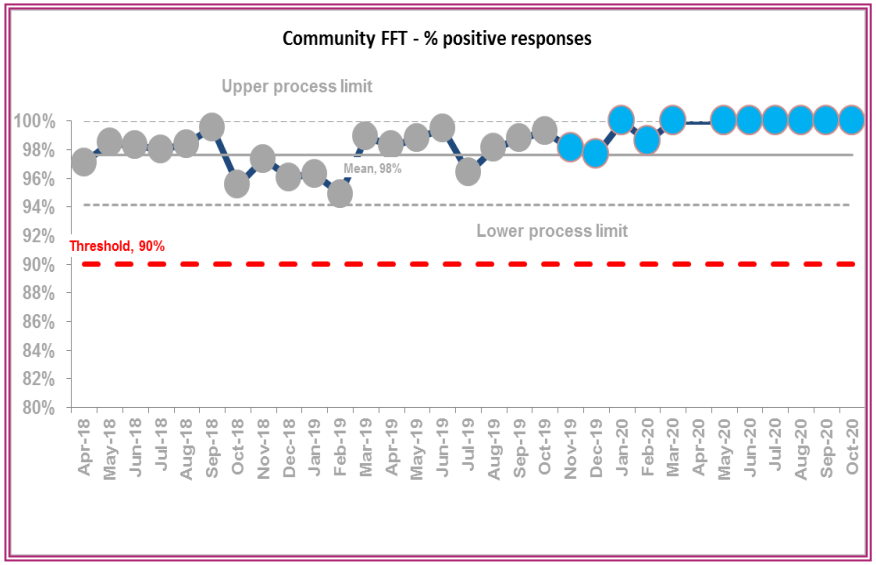


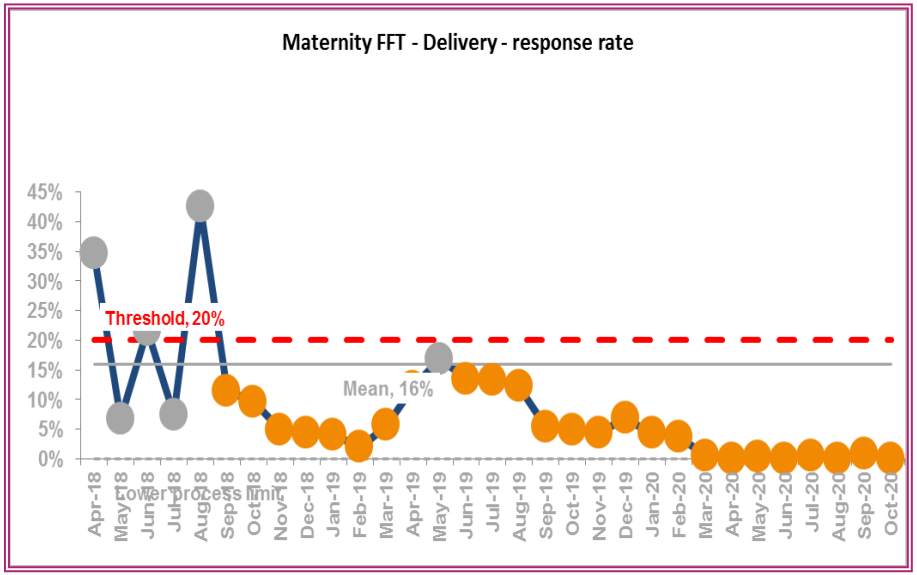


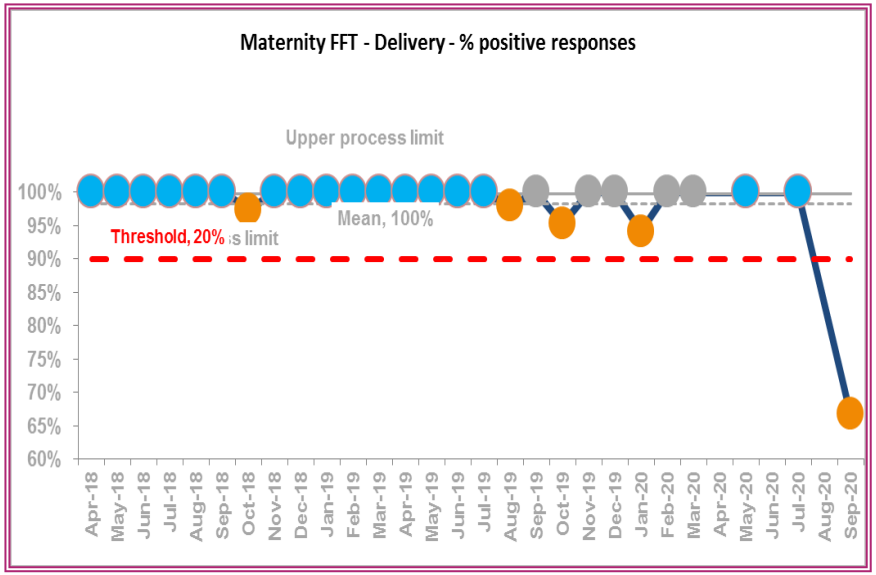
Friends and Family Test

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









Note: no completed maternity delivery surveys in October 2020

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

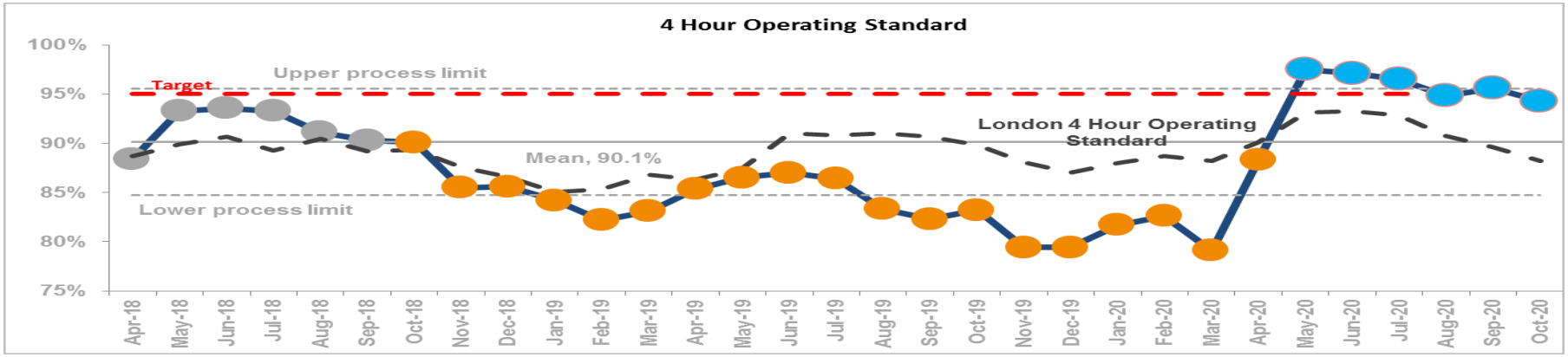
Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Emergency Flow



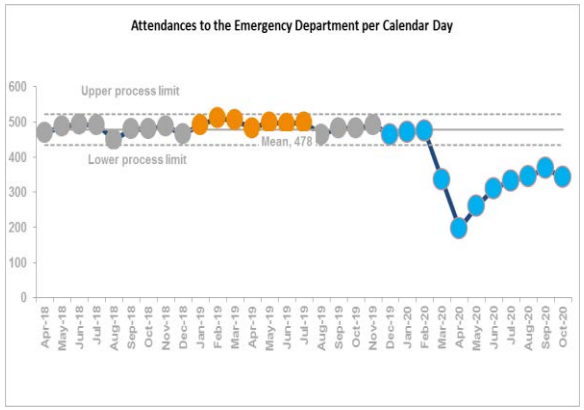
The Trust's performance against the Four Hour Operating Standard remained above the mean reporting that 94.3% of patients being either discharged, admitted or transferred within four hours of their arrival in the month of October continuing to perform above the London average. Both admitted and non-admitted performance remains above the mean however admitted performance has been challenged at times throughout the month. Performance in October has been adversely impacted by the challenges in sustaining flow through to inpatient beds caused by the current length of time for COVID testing, and the resulting requirement for a high proportion of amber beds. The number of patients attending our Emergency Department (ED) reduced by 4% compared to September, on average a decrease of 26 patients per day. Activity levels compared to the same period last year is 29% lower. The proportion of patients arriving by ambulance increased by 2% with the number of ED admissions rising by 4% compared to the previous month. In the month of October seven patients waited more than 12 hours to be admitted, in each case to a Mental Health bed.

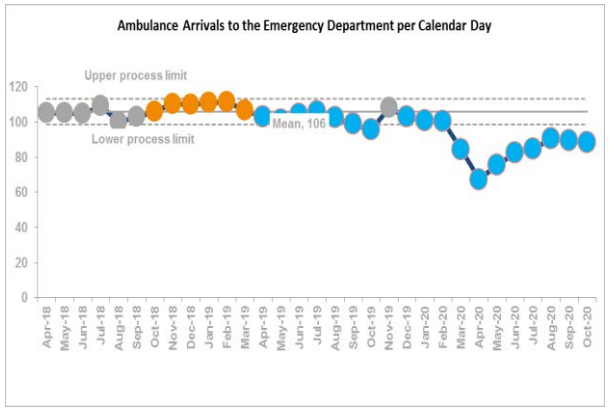
General and acute bed occupancy continues to increase as the Trust admits more non-elective patients with AMU midday occupancy levels averaging 77% daily which, whilst seeing an increase, remains lower than our target threshold of 80%. The Trust has seen increases in the number of patients who have been in a hospital bed longer than 7,14 and 21 days however remaining much lower than the same period last year. The number of patients awaiting external assessment and care has increased in month. The Trusts performance against ambulance handover times year on year is consistently improving and we have worked on developing close working relationships with our ambulance partners in order to maintain a joint focus on improving how we work together to improve patient experience

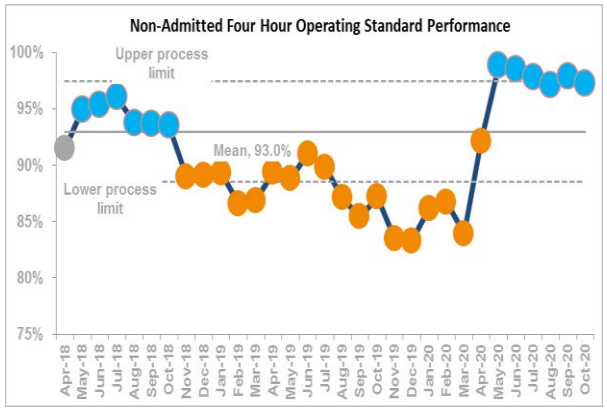
Actions and Quality Improvement Projects
SWL Pathology have secured a joint COVID / Flu rapid testing platform ahead of the planned national deployment which is expected to be in place during November. This will make a huge difference to managing patient infection prevention requirements effectively and flow from ED and AMU / Nye Bevan right the way through the hospital.
Collaborative Working: Cross divisional unscheduled care performance meetings are now business as usual; meetings include patient level breach review. The Divisional Silver chair daily flow & safety huddles to mitigate Medcard flow issues. The COO leads the Trust wide Emergency Flow and Performance Group to drive sustainable improvements through the organisation. There are a number of whole system initiatives currently being worked on to deliver sustainable improvements, which include digital front door and Same Day Emergency Care (SDEC). The Trust has secured £2.5m to deliver improved COVID secure emergency flow through winter (reprovision of MIU, Level 2 beds, CDU improvements); building work has now commenced to ensure delivery of key estates capital projects.
Next steps: Unscheduled care meetings with ICU, Surgery, & Paediatrics continue to focus on mitigating specialty breaches. In addition, new regular meetings have been instigated with Radiology and Transport. .
Emergency Care Processes: ED environment remains reconfigured to deliver social distancing to meet Infection Prevention & Control (IPC) standards. All pathways are risk assessed and standard operating procedures are agreed to ensure IPC standards are met. The new COVID capital works will further ensure our patients will receive care in a distanced and safe environment.
Mental Health: Alternative mental health pathways have been put in place to support this patient cohort. There is a South West London (SWL) Task & Finish group to focus on sustaining this improvement for the future led by South West London & St. George's Mental Health. Surrey & Hampshire continue to be challenged for beds having an impact on the Trusts performance (12hr) mental health breaches.

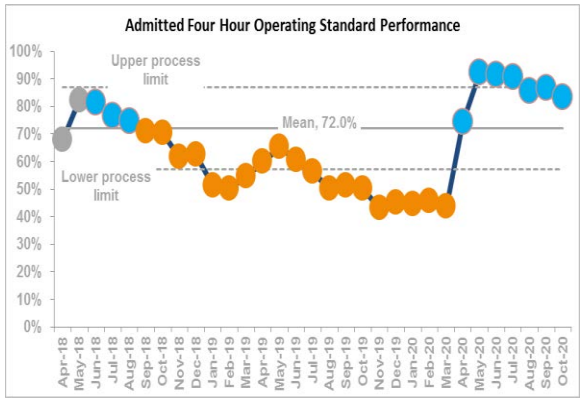
Emergency Flow

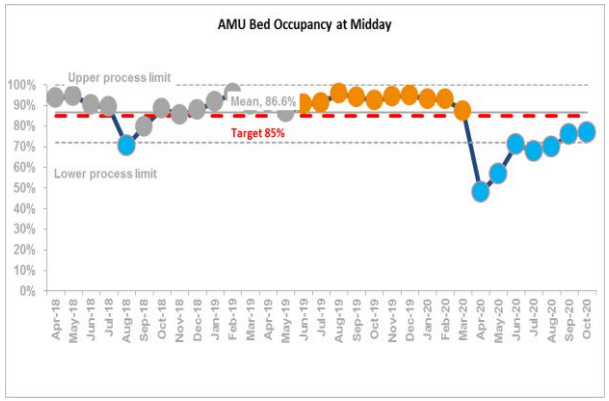
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

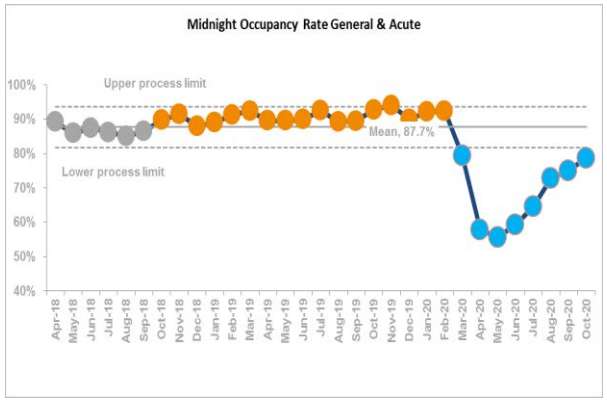


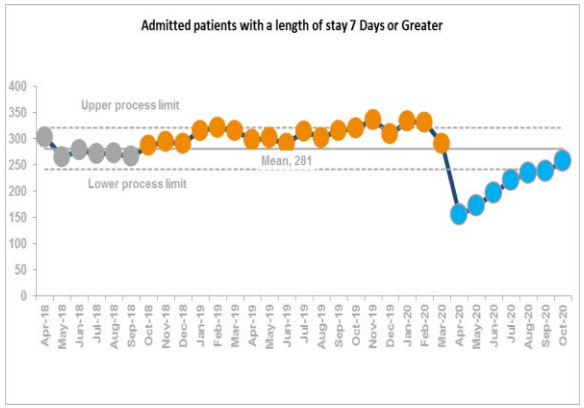


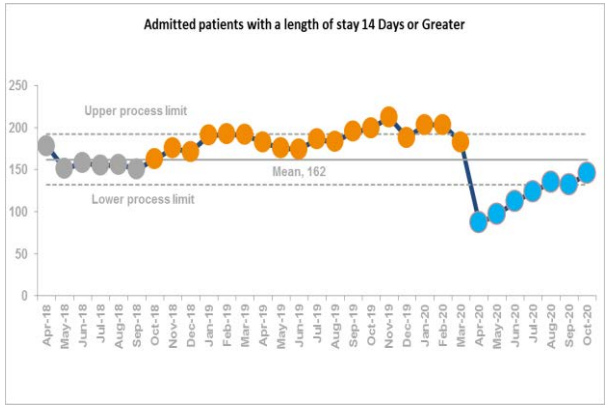


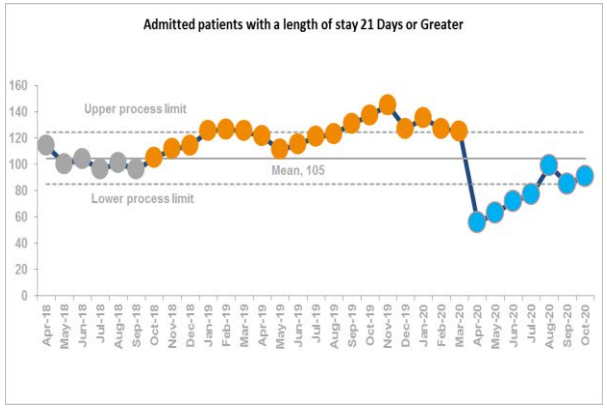






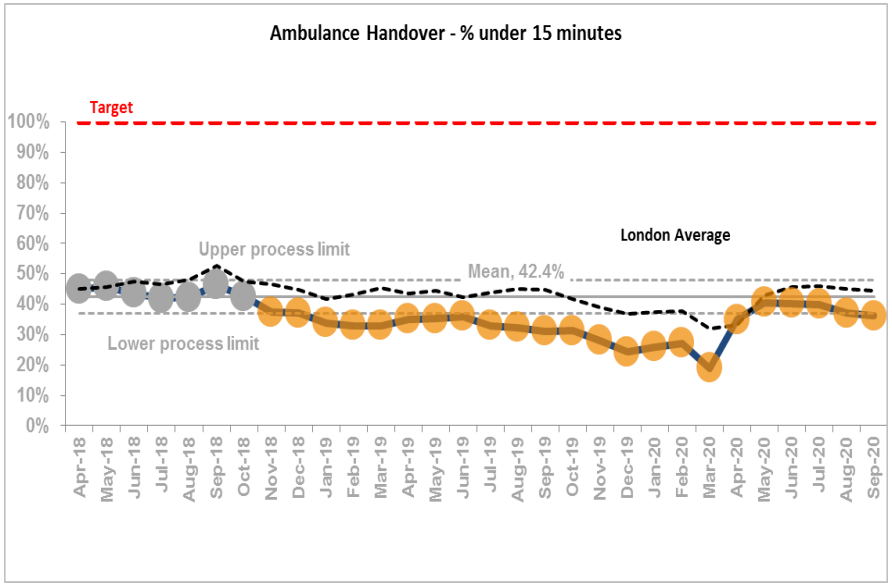


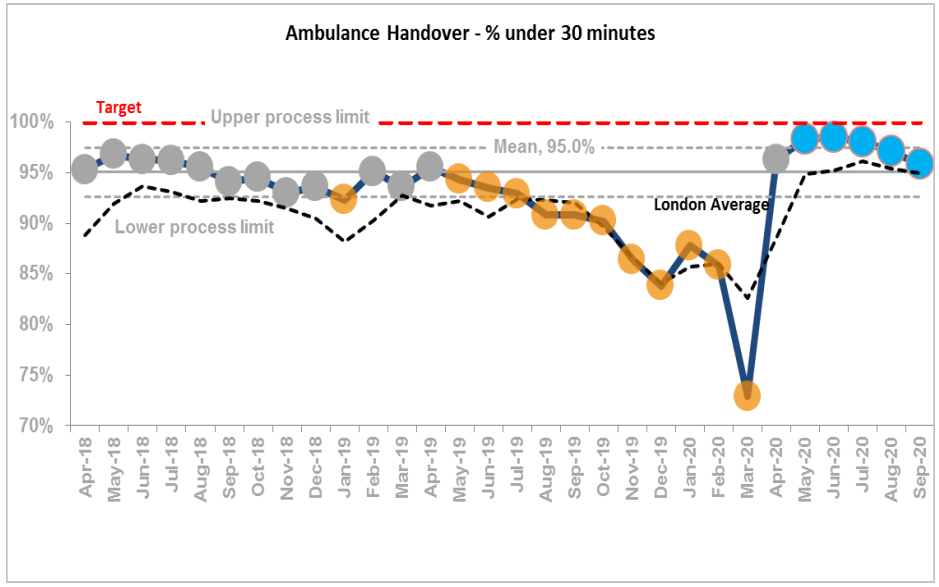


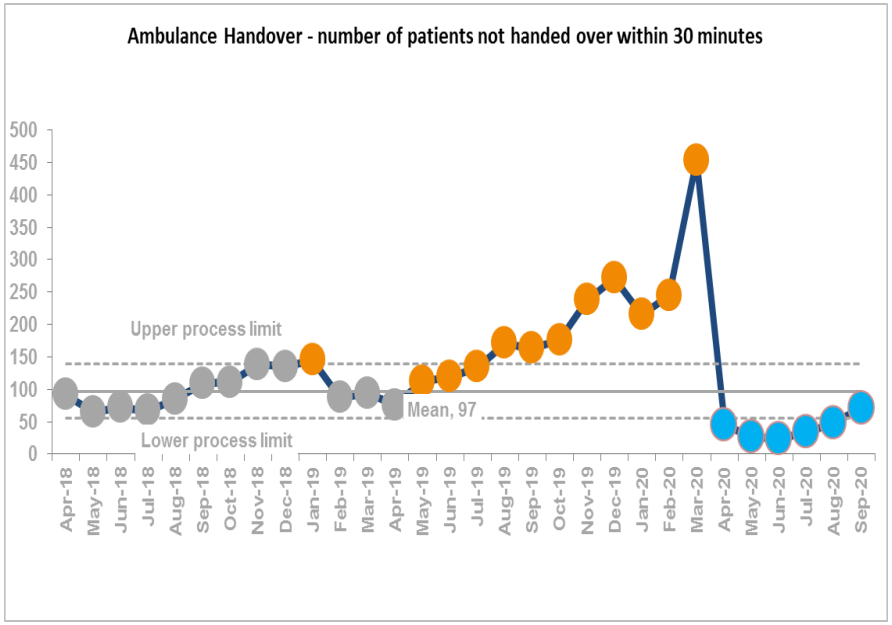


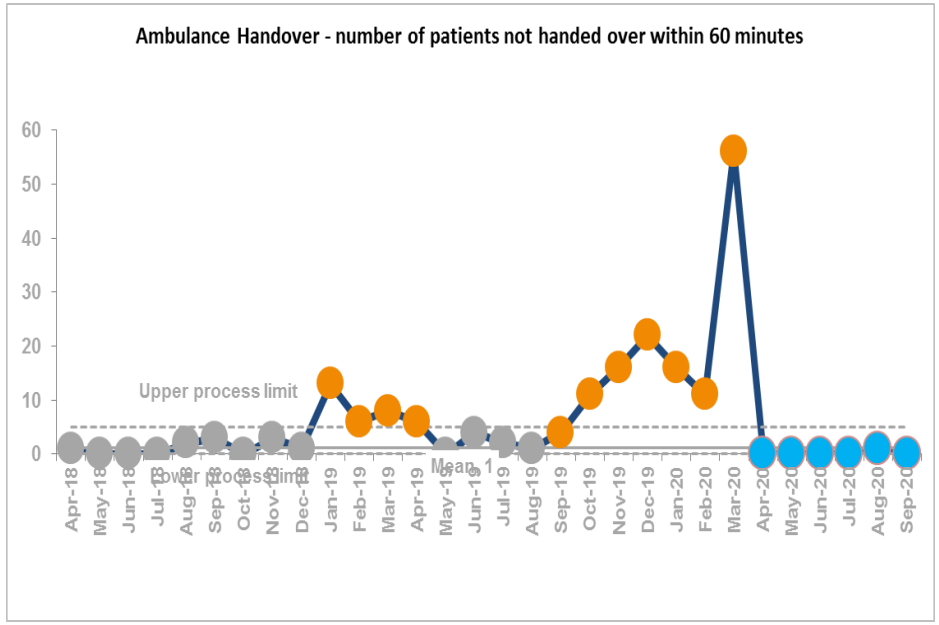
Emergency Flow

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





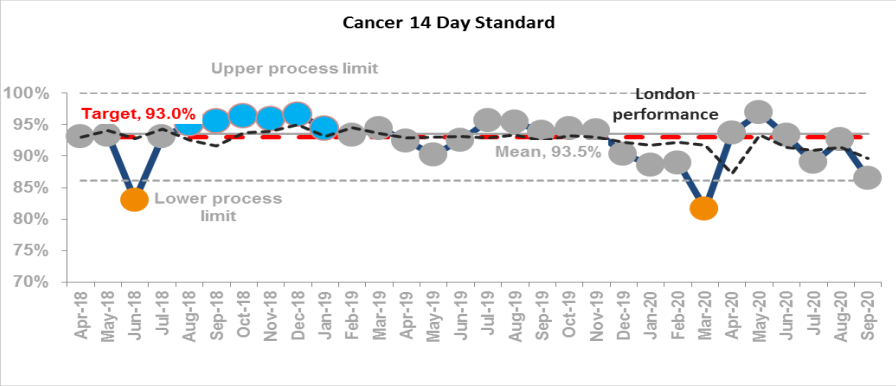


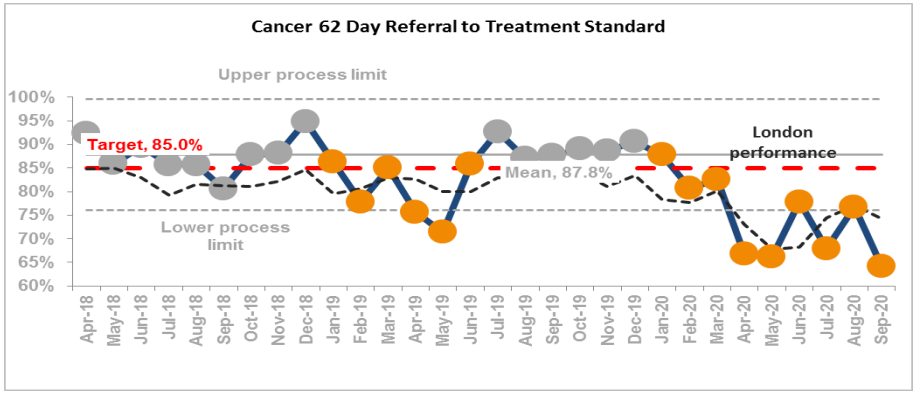


2.3

Our Process Perspective

Cancer





What the information tells us

In September, the Trust was non-compliant against the 14-, 31- and 62-day cancer standards. The 31-day subsequent treatment standard for drugs continued to be met at 100%.

Two Week Referral 14 day standard performance was 86.5%. A total 1,310 patients were seen in month with referrals returning to pre COVID-19 levels. Performance has been particularly challenged within Breast where there was an increase of 29% in activity. Overall compliance against the 93% standard was met within Children's Services, Haematology, Skin and Upper Gastroenterology.

There were 61.5 (0.5 being a shared treatment) total treatments on the 62-day GP pathway. Monthly performance remained below the lower control limits at 64.2%. There were 22 breaches of the 62 Day standard, attributed to clinical complexity, patient choice and COVID-19 related delays.

Cancer 31-day decision to treatment performance remains below the lower control limit at 94.4%; however performance has increased over the past three months as the backlog has reduced . All these breaches are attributed to treatment plans being agreed and then delayed by COVID-19 related constraints.

62 day referral to treatment screening performance fell to 50% in September with a total of six patients being treated; very few screen modalities are referring patients for treatment. Although remaining below target, performance is in line with the London average

Actions and Quality Improvement Projects:

TWR – Two Week Referral numbers continue to increase; and have for most tumour types, returned to the baseline; Breast and Upper Gastroenterology have seen significant increases above their pre-COVID mean

Breast - Additional Royal Marsden Partners (RMP) funding has been provided to support an additional three clinics per week -

Lower Gastroenterology process mapping and pathway re-design has resumed, which will increase direct to test slots, now that endoscopy is available

Head & Neck - Challenges are sector wide. Recovery plans focus on additional WLI clinics to bring patients forward for review and diagnostics – many of the delays are speciality specific relating to Infection, prevention and control processes in place

Skin – RMP funding for additional Waiting List Initiatives (WLI) for clinics and minor operating sessions in place to support capacity challenges, relating to backlog and increasing referrals

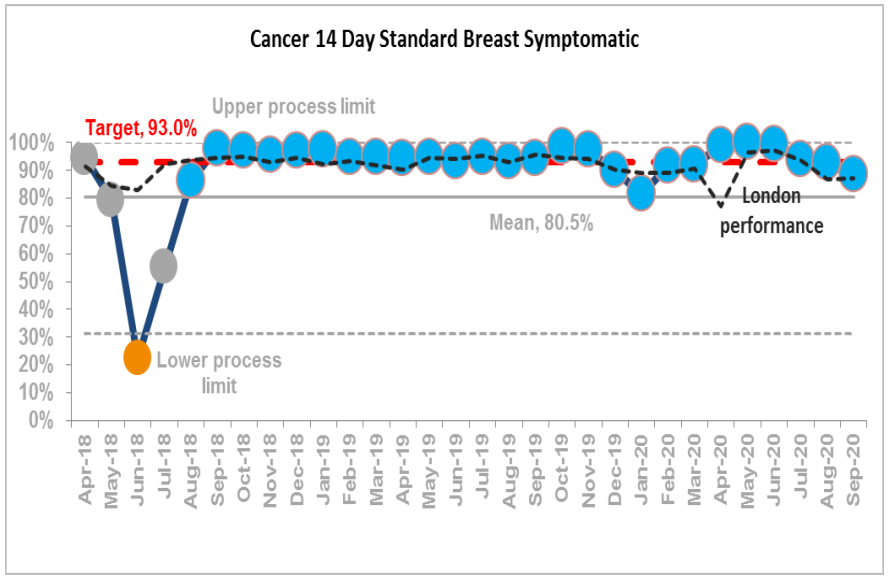
Theatres – Close collaborative work taking place with theatres and services via weekly Patient Pathway Coordinators (PPC) huddle to increase booking volumes.

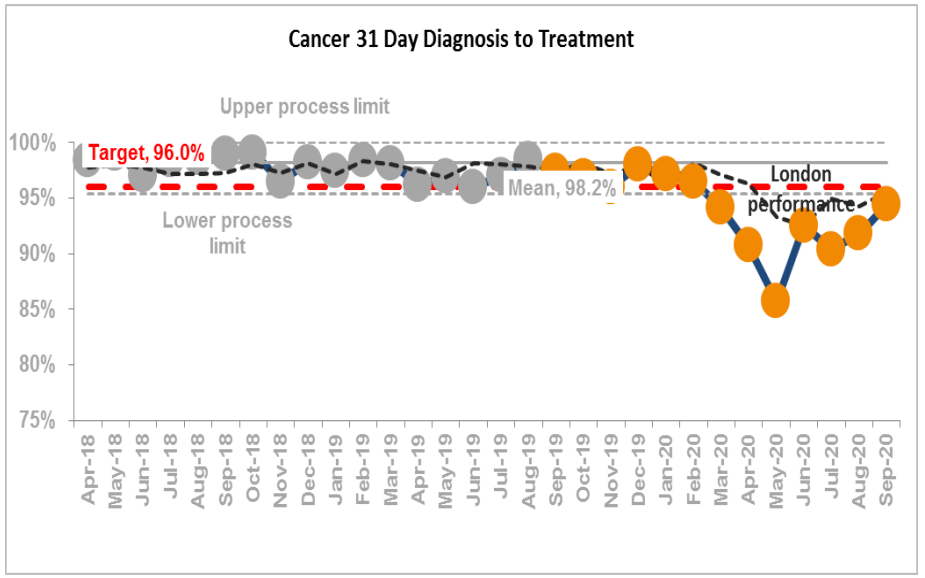
The **Rapid Diagnostic Clinic** will support the earlier diagnosis of cancer in patients who have a range of vague symptoms that are at risk of cancer. This is due to see first patients in December and launch formally in January

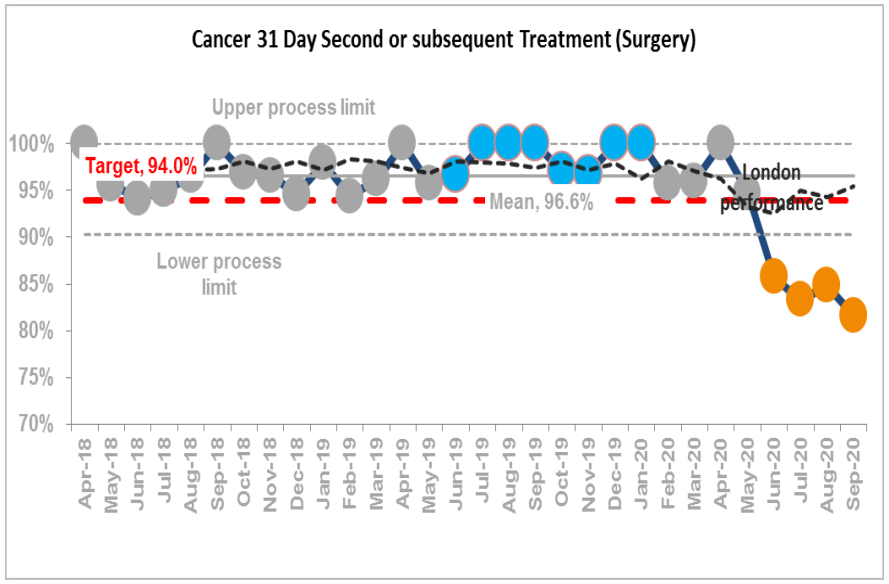
104 + days Recovery remains focused on treating patients above 104 days on the 62 day PTL, there are currently 42 patients, 12 of which have taken the decision to delay their own treatment. All services have full visibility of these patients, all have on-going clinical reviews, all investigations and surgical dates are being expedited.

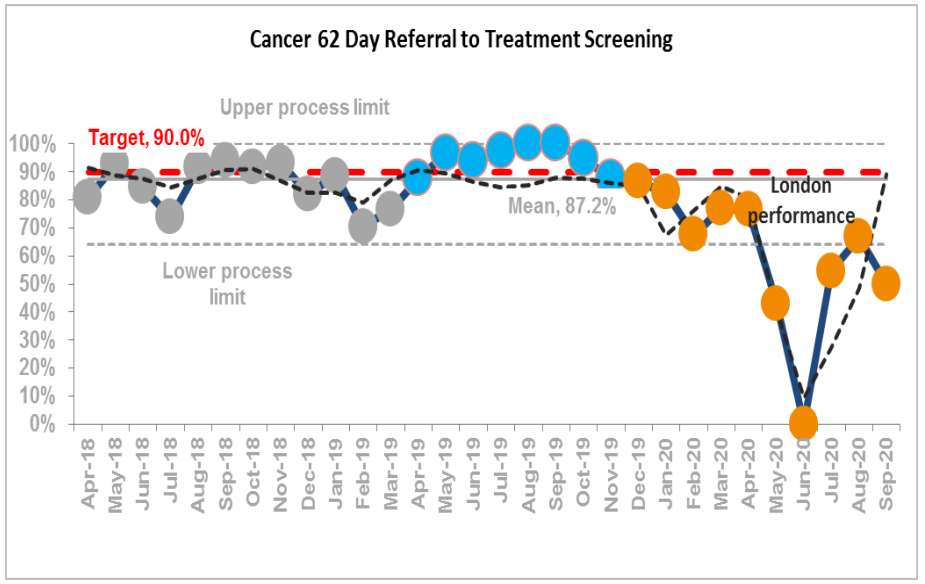
Cancer

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









Our Process Perspective

Cancer

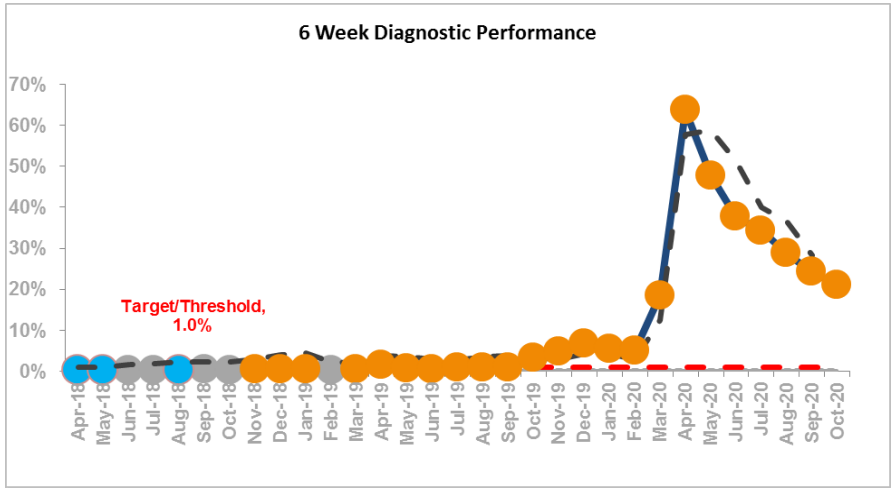
14 Day Standard Performance by Tumour Site - Target 93%

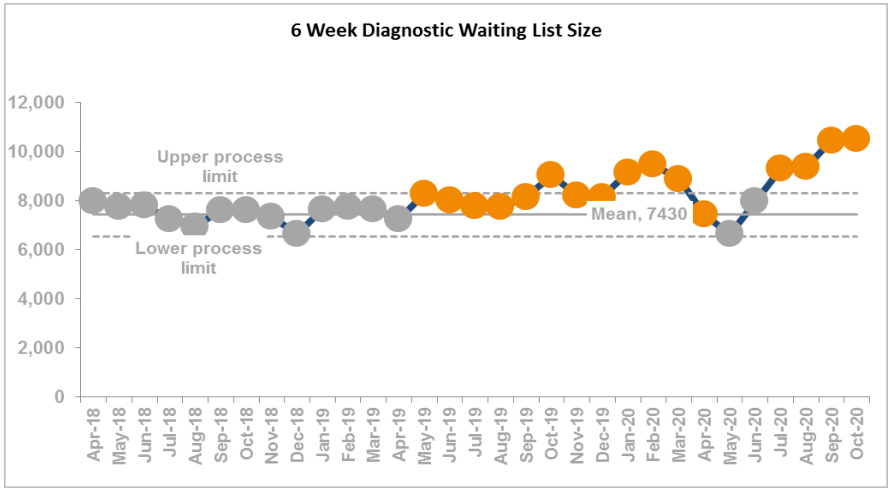
Indicator Description	Target	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	No of Patients
Cancer 14 Day Standard	93%	93.8%	94.3%	94.0%	90.3%	88.6%	88.9%	81.6%	93.7%	96.9%	93.3%	89.0%	92.6%	86.5%	1,310
Cancer 14 Day Standard Breast Symptomatic	93%	94.3%	98.4%	97.4%	90.0%	81.4%	91.7%	92.1%	98.9%	100.0%	99.3%	93.8%	92.6%	88.5%	278
Cancer 31 Day Diagnosis to Treatment	96%	97.4%	96.9%	96.0%	98.0%	97.1%	96.5%	94.1%	90.7%	85.7%	92.5%	90.4%	91.8%	94.4%	197
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	100.0%	97.1%	96.8%	100.0%	100.0%	95.8%	96.0%	100.0%	94.7%	85.7%	83.3%	84.8%	81.6%	49
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100.0%	100%	100%	100%	100%	100%	100%	100%	100%	75
Cancer 62 Day Referral to Treatment Standard	85%	87.6%	89.0%	88.6%	90.6%	87.8%	80.7%	82.6%	66.7%	66.2%	77.8%	67.9%	76.7%	64.2%	61.5
Cancer 62 Day Referral to Treatment Screening	90%	100.0%	94.9%	87.7%	86.4%	82.7%	67.5%	77.0%	76.5%	42.9%	0.0%	54.5%	66.7%	50.0%	6

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	No of Patients
Brain	93%	100.0%	-	-	-	100.0%	-	-	-	-	-	-	-	-	0
Breast	93%	95.9%	100.0%	97.0%	95.6%	84.7%	95.6%	93.3%	97.5%	100.0%	98.6%	95.5%	94.3%	88.6%	254
Children's	93%	100.0%	100.0%	100.0%	75.0%	85.7%	100.0%	100.0%	-	83.3%	100.0%	75.0%	75.0%	100.0%	3
Gynaecology	93%	95.4%	97.6%	99.2%	99.0%	94.4%	95.9%	86.9%	93.0%	96.3%	93.8%	92.5%	97.2%	91.6%	95
Haematology	93%	86.7%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	91.3%	96.0%	25
Head & Neck	93%	96.6%	99.0%	96.6%	89.4%	95.2%	95.5%	90.8%	97.1%	100.0%	97.7%	96.1%	96.2%	84.1%	132
Lower Gastrointestinal	93%	92.8%	89.7%	91.5%	80.3%	81.8%	69.9%	63.8%	86.8%	95.6%	93.6%	86.9%	78.7%	61.8%	204
Lung	93%	97.1%	97.7%	100.0%	84.1%	80.6%	90.9%	85.7%	83.3%	90.9%	72.7%	62.5%	80.0%	90.5%	21
Skin	93%	91.8%	95.9%	91.0%	94.8%	94.7%	93.3%	84.1%	93.2%	96.7%	91.4%	87.4%	97.0%	95.4%	393
Upper Gastrointestinal	93%	87.2%	82.5%	88.1%	82.7%	75.3%	84.4%	75.5%	93.5%	98.4%	93.1%	84.4%	95.8%	93.0%	86
Urology (Suspected testicular cancer)	93%	97.0%	88.4%	95.6%	92.9%	93.6%	93.6%	93.9%	94.0%	85.5%	82.4%	80.4%	78.3%	85.6%	97

Diagnostics





What the information tells us

In October, the Trust did not achieve the six week diagnostic standard with an adverse performance of 21.2% with a total of 2,215 patients waiting for more than six weeks and a waiting list size of 10,508 patients.

There has been a consistent performance improvement with the number of six week waiters reducing by a further 12% compared to September with significant reductions within Echocardiography and Endoscopy modalities where booking has improved significantly. All modalities, with the exception of Audiology, Cystoscopy and Urodynamics, have seen a month on month reduction in the number of patients waiting for more than six weeks. Whilst the total number of patients on the waiting list remains above the upper control limit, we have not seen a significant growth in October with the waiting list size increasing by only 0.6% compared to September.

In October, the average waiting time was 5.6 weeks compared to just over 6 weeks in September; Echocardiography and Endoscopy performance improvement was the main contributing factor for this reduction. A weekly assurance review is being undertaken of any urgent referrals waiting > 6 weeks. All services are reporting that these are either patient choice, due to COVID-19, or triage and downgrading to routine by the Consultant. Of the patients waiting greater than six weeks, 4% of those are currently categorised as either Cancer or Urgent.

Actions and Quality Improvement Projects

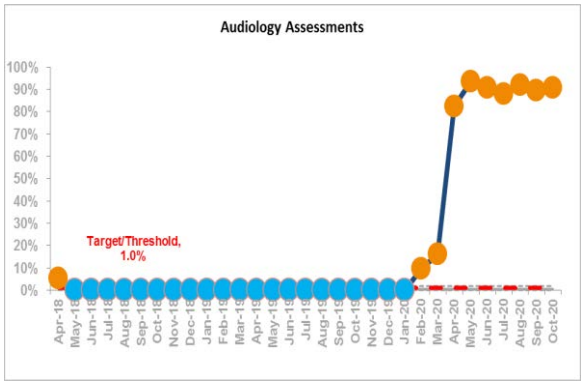
Echocardiography - Insourcing work by external company, 'Elective Services', re-commenced in June 2020. As a result, capacity has been increased with outpatient lists running on both Saturdays and Sundays. An additional room has also been acquired at Queen Mary Roehampton Hospital site (QMH) with an increase in lists at that site. Echocardiographer with specialist Paediatric Echo experience was recruited with a start date in Feb/Mar 2021.

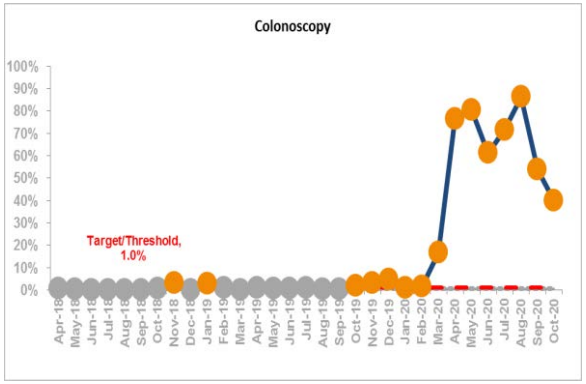
Endoscopy recovery plan continues with daily NHSI reporting including plans to move backlog and future demand of activity to CT Colonography. Working parties within the South West London Acute Provider Collaborative are considering options. The recovery plan submitted to NHSE (and reflected in Phase 3 Plan) is on course to be achieved. Second room at the Nelson has reopened providing additional capacity and Appointment text reminder including swab & isolation rules to be rolled out.

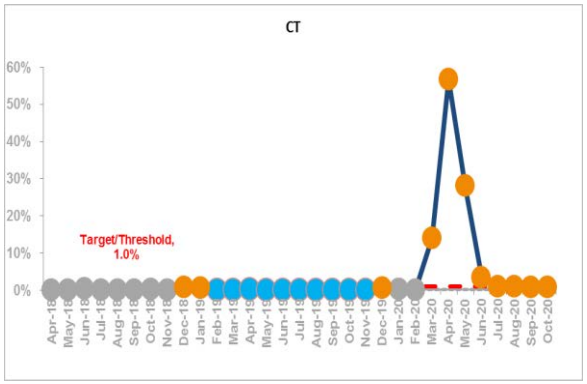
Audiology – Capacity has increased compared to pre-COVID with additional evening and weekend slots being available.

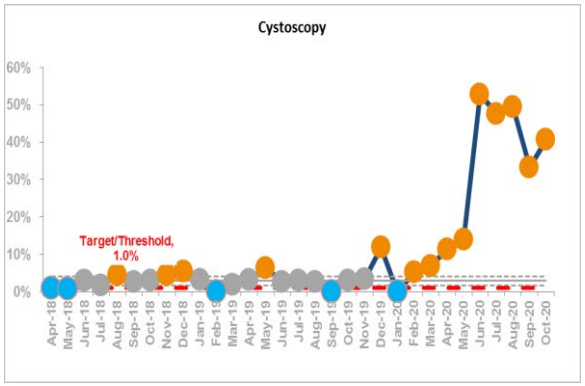
Diagnostics

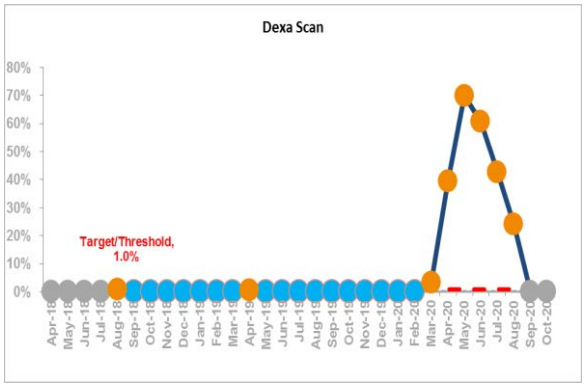
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

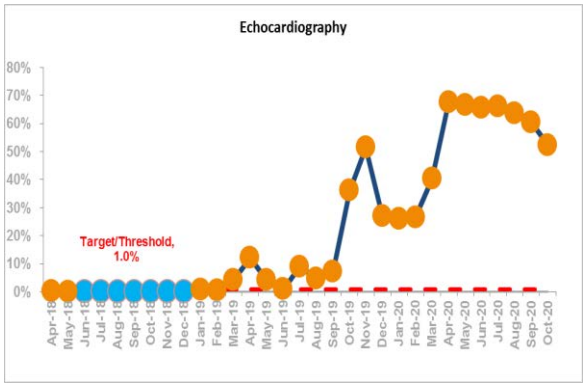


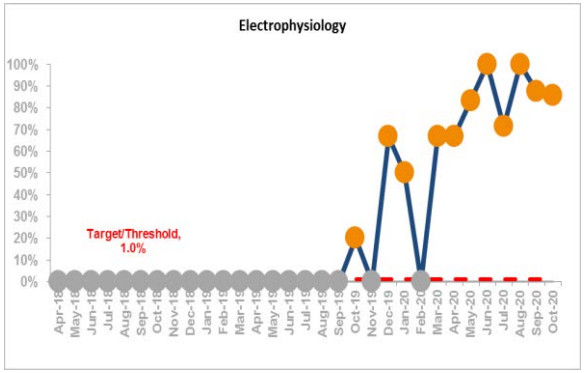


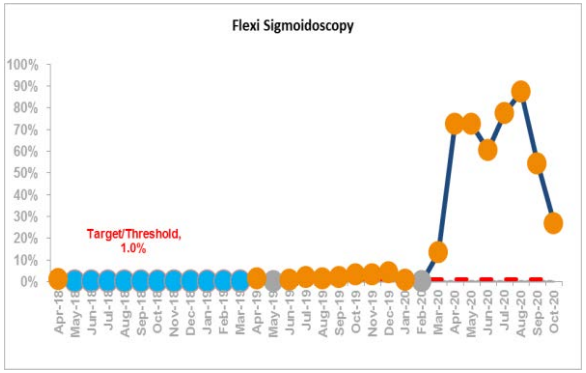


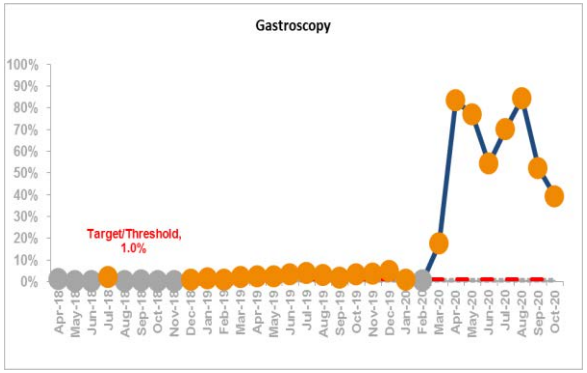






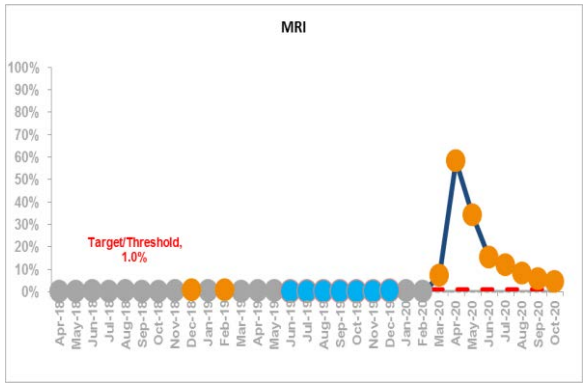


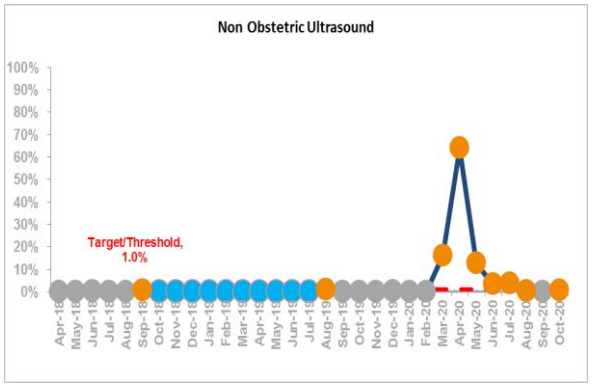


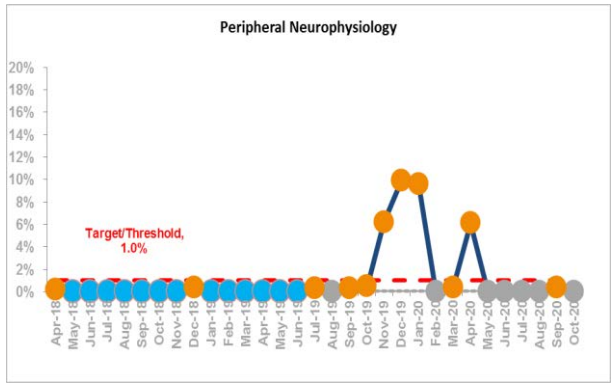


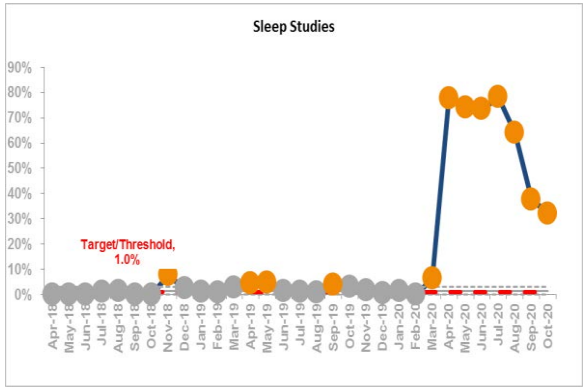
Diagnostics

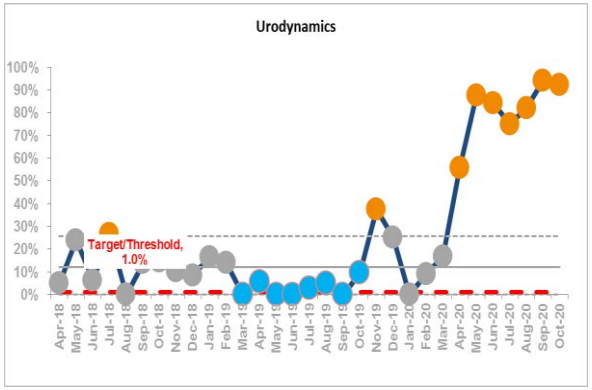
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



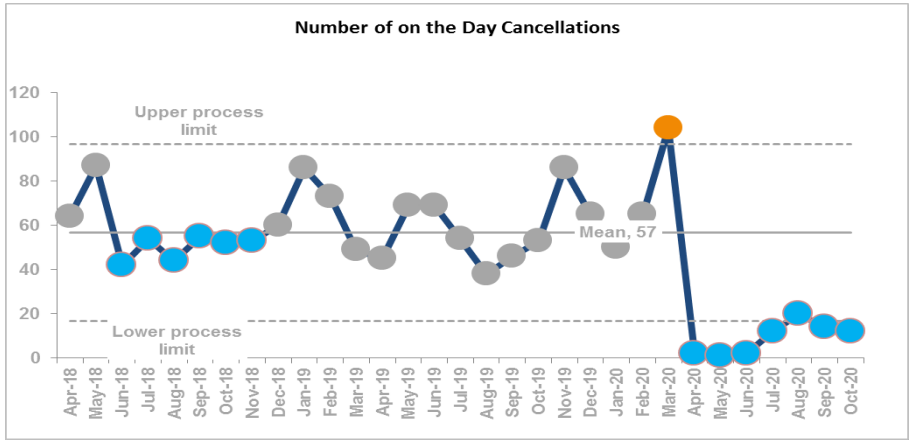


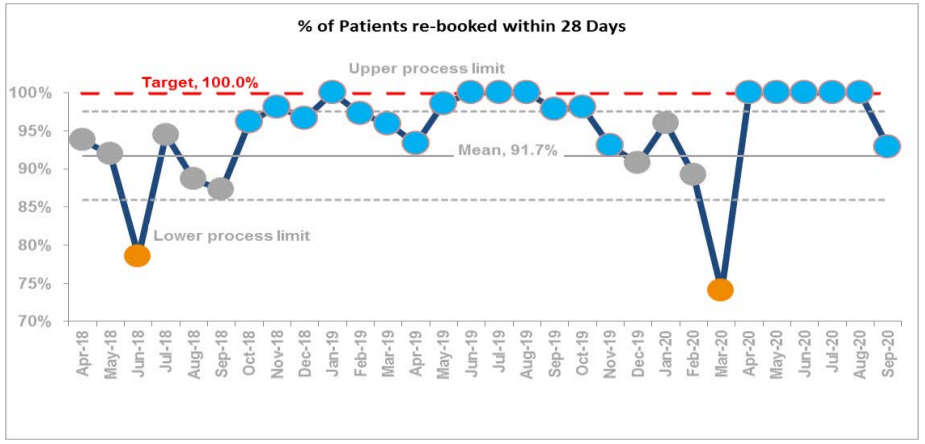






On the Day Cancellations for Non Clinical Reasons



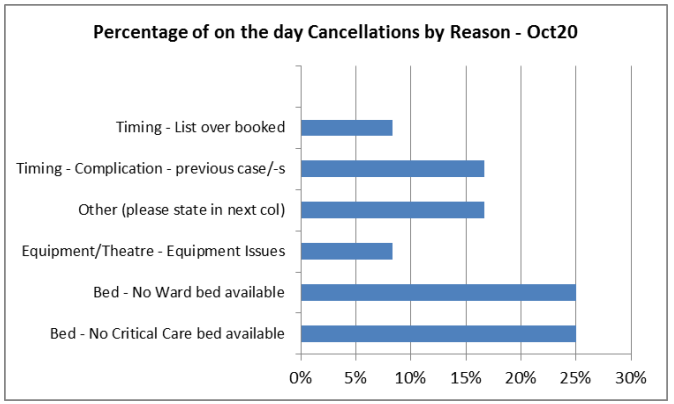


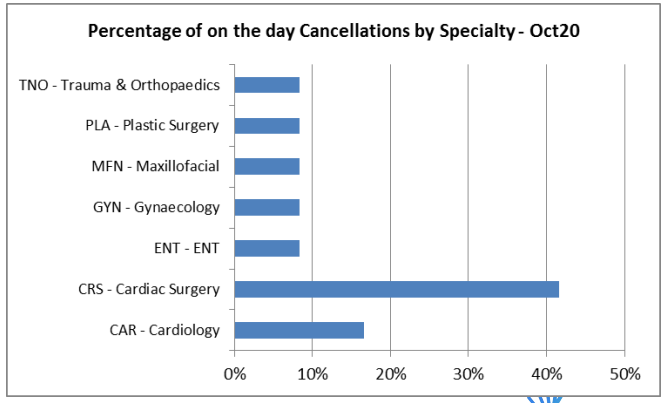
What the information tells us

In October, one patient was unable to be re-booked within 28 days, however performance against the expected 100% standard remains above the mean with 91.7% of on the day cancellations re-booked within 28 days.

Twelve patients had their elective treatment cancelled on the day for non-medical reasons. Performance remains below the mean against a rising number of elective treatments being booked across services. The number of cancellations were reasonably spread across a number of services with Cardiac Surgery impacted by bed availability.

Of the twelve patients, two experienced a substantially elongated pre-operative stay (4 and 5 days respectively). One of these patients was cancelled on the day for a second time during this period. Four patients remained in hospital for an additional night pre-operatively. Six patients were discharged on the same day of admission but experienced long waiting times in SAL/ ward areas due to list delays.





Actions and Quality Improvement Projects

Team leaders complete a regular review of theatre lists alongside services at list planning to flag specific actions regarding kit availability and scheduling.

On-going work with services as part of Theatres Improvement Programme to implement staggered admissions across DSU and Inpatient theatre lists in order to reduce waiting times in SAL.

Additional CEPOD theatre included as part of new templates to increase emergency operating capacity.

The opening of a 4-6 bedded PACU unit based in St James' recovery has supported an increase in green level 1.5 capacity- preventing cancellations due to lack of ITU beds and improving elective flow. On-going review and categorisation of patients on all waiting lists.

Referral to Treatment — September 2020

Indicator Description	Target	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
RTT Trust Incomplete Performance	92%	86.1%	85.1%	84.2%	82.6%	82.2%	82.3%	79.3%	71.5%	63.8%	55.7%	52.7%	58.4%	63.7%
RTT Total Incomplete Waiting Lize Size (inc UCS)		47,714	49,495	48,640	46,918	47,089	48,061	47,048	43,643	42,196	42,672	44,814	46,569	47,471
Total waits greater than 18 weeks (inc 52Wk waiters)		6,651	7,353	7,701	8,183	8,382	8,498	9,755	12,440	15,268	18,924	20,863	19,177	16,974
Total waits greater than 52 weeks	0	6	1	7	9	10	11	32	129	274	554	825	972	1097
RTT Incomplete Performance - Admitted		65.9%	65.3%	63.7%	61.4%	60.5%	61.9%	57.2%	49.0%	42.4%	34.1%	31.8%	35.6%	38.3%
Total waits greater than 18 weeks - Admitted		1,643	1,686	1,719	1,876	1,950	1,891	2,186	2,720	3,308	3,955	4,207	3,816	3,373
Total waits greater than 52 weeks - Admitted	0	4	0	2	5	2	3	20	88	190	393	529	588	626
RTT Incomplete Performance -Non Admitted		88.3%	87.3%	86.4%	85.0%	84.7%	84.7%	82.0%	74.6%	67.2%	59.2%	56.1%	61.8%	67.1%
Total waits greater than 18 weeks - Non Admitted		5,008	5,667	5,982	6,107	6,432	6,607	7,569	9,720	11,960	14,969	16,656	15,361	13,601
Total waits greater than 52 weeks - Non Admitted	0	2	1	5	4	8	8	12	41	84	161	296	384	471

What the information tells us

Over the last four months the total number of patients waiting for treatment has steadily increased. In September, although the total number of patients on the Patient Tracking List (PTL) increased, the number of patients waiting greater than 18 weeks reduced by 2,203 with performance against the incomplete waiting time standard showing an improvement compared to August with 63.7% of patients waiting 18 weeks or less.

In September, the Trust reported 1,097 patients waiting for more than 52 weeks to receive treatment which accounts for 2.3% of the total waiting list; this is below the 3.7% projected in September. The largest proportion of patients waiting greater than 52 weeks are within the admitted PTL with General Surgery, Ear Nose & Throat and Plastic Surgery showing particular challenges.

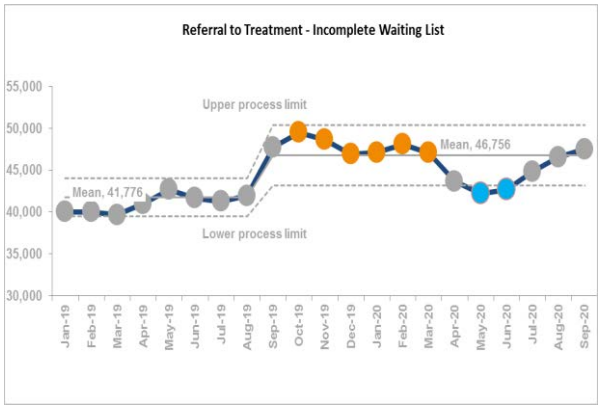
Actions and Quality Improvement Projects

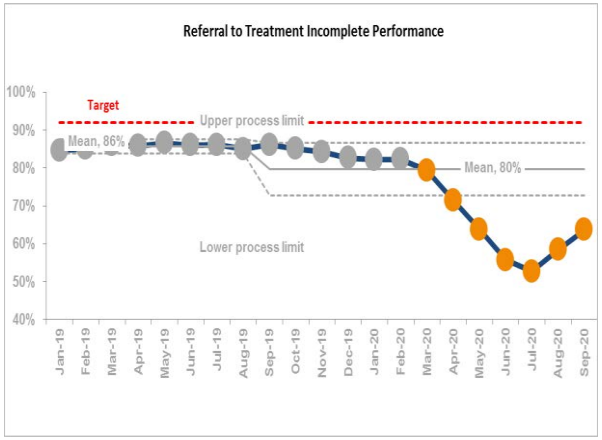
A trajectory has been submitted for 52 week forecast through to March 2021, which includes specialty level forecasting assuming activity levels return to at least pre-COVID levels. The current plans shows 1,477 patients waiting more than 52 weeks for treatment by March 2021. This plan also relies upon the use of the Joint Referral Unit, the SWL Hub model and continued Independent Sector use.

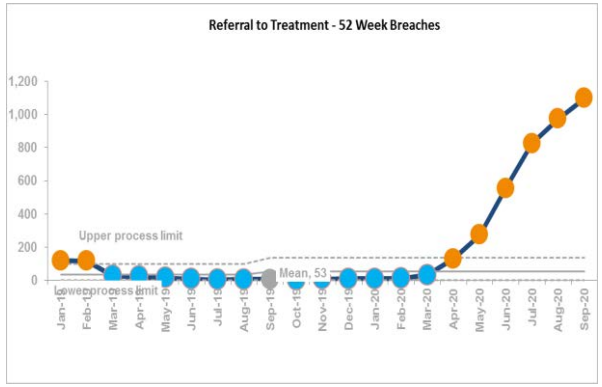
Services continue to focus on booking the longest waiting patients, alongside the most clinically urgent patients. The percentage of 52 week waiters booked continues to increase and is closely managed through local PTL meetings and the Access Committee.

Services with the largest number of 52 week breaches are actively engaged with the South West London (SWL) lead providers networks. There is now dedicated resource to manage this process, with an expected increase in the number of patients referred to the JRU and elective hubs.

All patients on an admitted PTL are being contacted to confirm their details and to understand their treatment wishes in line with the Trust Access Policy. This process will be managed centrally and where patients are not available for treatment, they will be clinically reviewed and discharged back to their GP where safe and appropriate. This will ensure that the our waiting list is as accurate as possible and that we can prioritise patients appropriately.







Referral to Treatment — September 2020

Specialty	Admitted		Non Admitted	
	Total	% within 18 weeks	Total	% within 18 weeks
GENERAL SURGERY	469	27.5%	1,103	62.7%
UROLOGY	327	35.8%	1,795	70.8%
TRAUMA & ORTHOPAEDICS	216	22.7%	1,880	78.1%
ENT	599	13.4%	2,768	66.5%
OPHTHALMOLOGY			896	49.6%
ORAL SURGERY	4	0.0%	225	61.8%
NEUROSURGERY	227	36.6%	2,475	59.3%
PLASTIC SURGERY	530	46.6%	931	78.6%
CARDIOTHORACIC SURGERY			2	1
GENERAL MEDICINE			29	86.2%
GASTROENTEROLOGY	835	77.4%	1,999	75.5%
CARDIOLOGY	943	28.2%	2,586	64.8%
DERMATOLOGY	5	40.0%	3,358	58.5%
RESPIRATORY MEDICINE			1,053	86.0%
NEUROLOGY	21	81.0%	2,458	71.7%
RHEUMATOLOGY	3	1	1,029	64.1%
GERIATRIC MEDICINE			69	91.3%
GYNAECOLOGY	73	28.8%	2,647	65.9%
Other	1,218	35.9%	13,982	66.6%
Grand Total	**5,470**	**38.3%**	**41,285**	**67.1%**

Incomplete Pathway					
Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
821	751	1,572	52.2%	123	145
1,388	734	2,122	65.4%	82	38
1,518	578	2,096	72.4%	84	24
1,921	1,446	3,367	57.1%	210	217
444	452	896	49.6%	39	1
139	90	229	60.7%	32	12
1,550	1,152	2,702	57.4%	192	36
979	482	1,461	67.0%	89	110
2	0	2	100.0%	0	0
25	4	29	86.2%	1	0
2,156	678	2,834	76.1%	96	0
1,942	1,587	3,529	55.0%	246	88
1,966	1,397	3,363	58.5%	187	15
906	147	1,053	86.0%	9	1
1,780	699	2,479	71.8%	16	1
663	369	1,032	64.2%	50	5
63	6	69	91.3%	0	0
1,765	955	2,720	64.9%	139	28
9,753	5,447	15,200	64.2%	810	376
29,781	**16,974**	**46,755**	63.7%	**2,405**	**1,097**

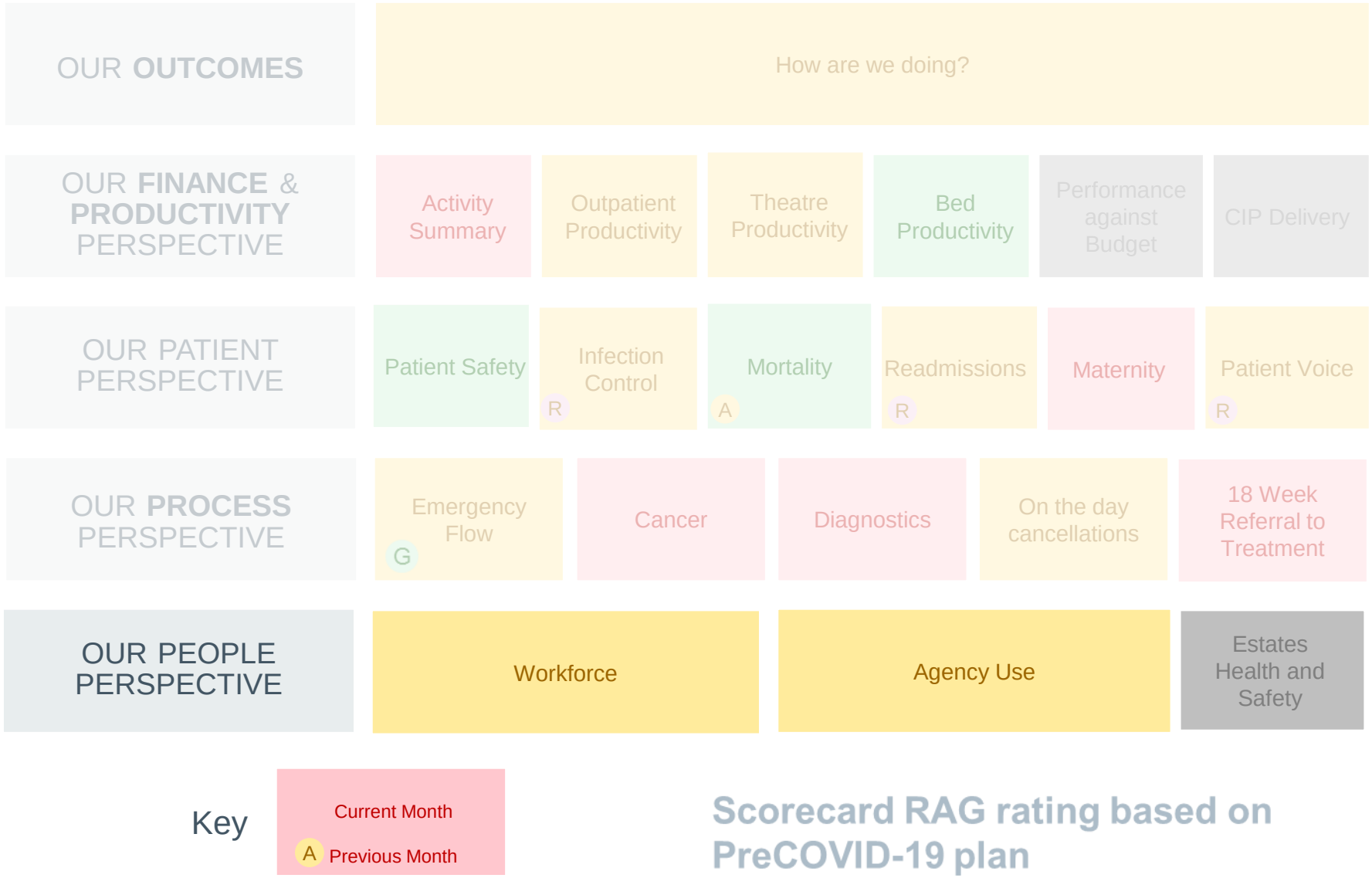
The numbers reported above and on the following slide exclude Unknown Clock Starts(UCS)

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.

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

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

Balanced Scorecard Approach



Workforce

Indicator Description	Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Trust Level Sickness Rate	3.2%	3.7%	3.8%	4.0%	3.9%	4.0%	5.1%	5.6%	4.1%	3.5%	3.2%	3.4%	3.6%	3.3%
Trust Vacancy Rate	10%	9.3%	9.9%	11.2%	10.8%	10.7%	10.6%	10.5%	6.8%	8.3%	8.4%	8.2%	9.1%	9.4%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.8%	17.6%	17.6%	17.4%	17.3%	16.9%	16.7%	16.1%	15.3%	15.1%	15.2%	15.4%	15.3%
Trust Stability Index	85%	82.8%	83.0%	82.8%	81.5%	83.0%	83.0%	83.7%	84.2%	84.9%	85.4%	86.3%	86.1%	85.8%
Total Funded Establishment		9,280	9,294	9,403	9,383	9,369	9,369	9,373	9,098	9,289	9,256	9,263	9,265	9,320
IPR Appraisal Rate - Medical Staff	90%	83.9%	81.5%	83.6%	84.9%	81.7%	80.0%							
IPR Appraisal Rate - Non Medical Staff	90%	70.9%	72.3%	72.3%	72.0%	72.4%	69.6%	67.9%	67.6%	69.9%	73.6%	74.6%	72.4%	71.7%
Overall MAST Compliance %	85%	89.7%	89.7%	90.0%	89.7%	90.6%	90.7%	90.2%	89.7%	89.9%	89.8%	89.9%	89.9%	90.5%
Ward Staffing Unfilled Duty Hours	10%	6.1%	3.8%	5.3%	5.4%	6.2%	15.2%	17.4%	3.0%	1.6%	2.8%	3.7%	5.4%	

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 is slightly above target and within common cause variation at 3.3%.

Appraisal rates for Non Medical staff fell to 71.7% in October against a target of 90% and continues to be encouraged.

Appraisal rates for Medical staff has restarted and recording will commence by the end of the year.

Vacancy Rate at 9.4% in October continues to be below the set target of 10%, showing special cause variation.

Stability Index at 85.8% is slightly above target. This measure will be used to inform retention strategies.

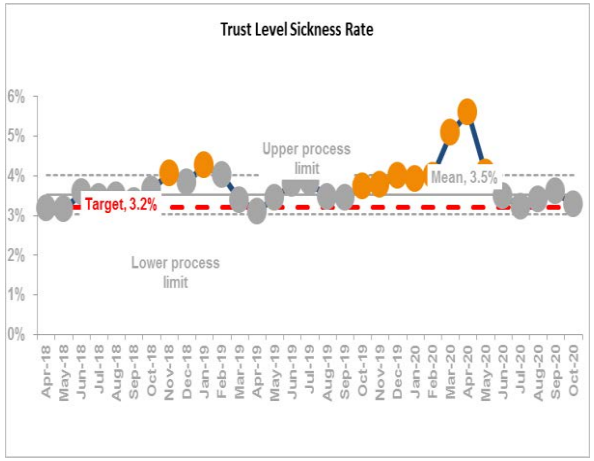
The Turnover Rate has plateaued averaging 15% since June 2020.

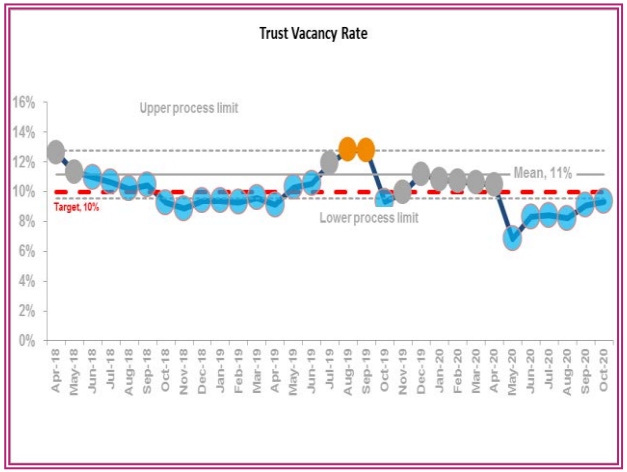
Actions and Quality Improvement Project

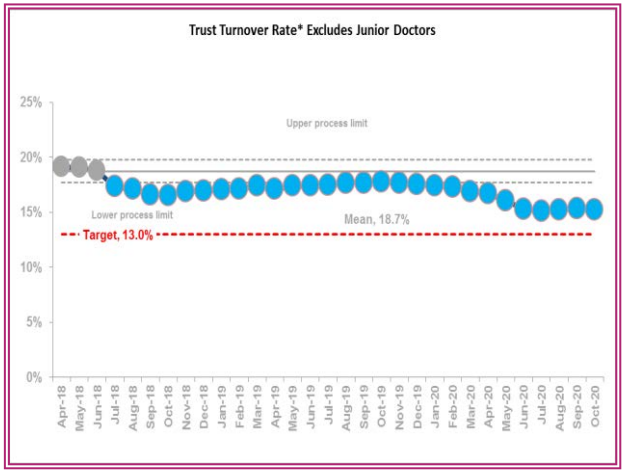
- The Employee Relations team is working closely with managers to ensure timely referral to Occupational Health and management.
- A new approach to completing exit questionnaire was implemented on 2 November and will provide useful and timely information to help with putting in place required interventions
- With a reduction in COVID-19 pandemic related activities, the Trust is now focussing on completion of Appraisals and MAST training. Medical staff appraisal have also restarted.

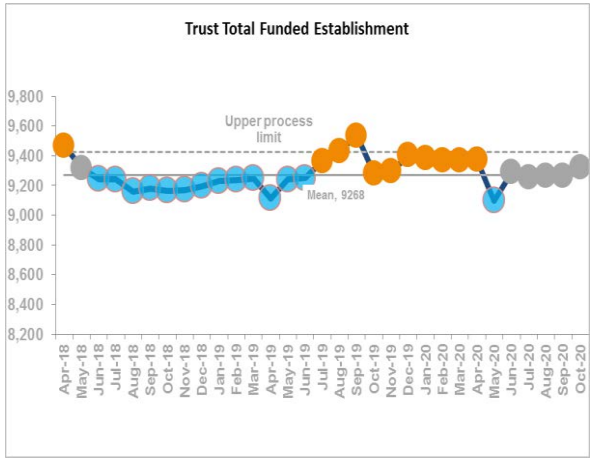
Workforce

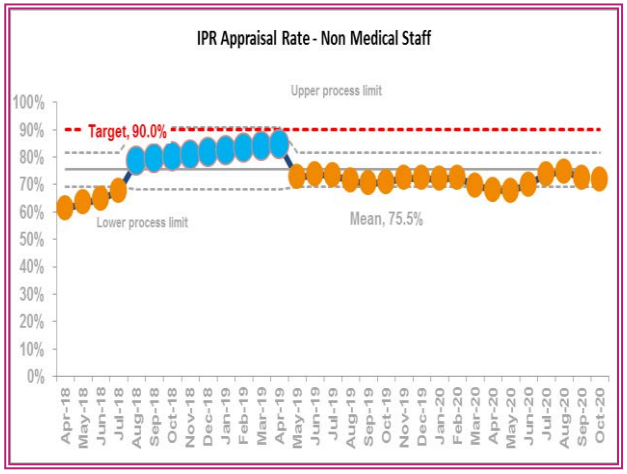
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

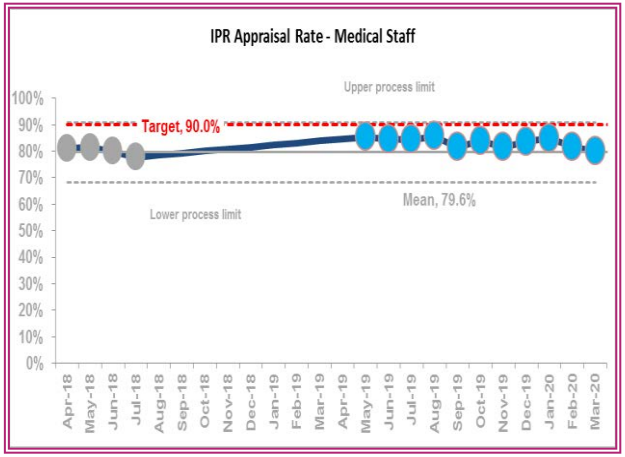












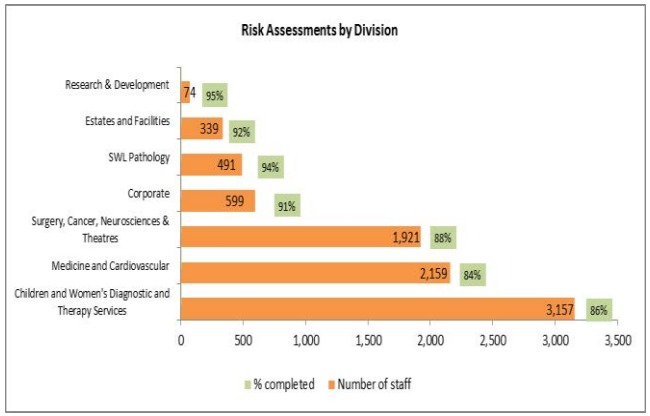
Our People Perspective

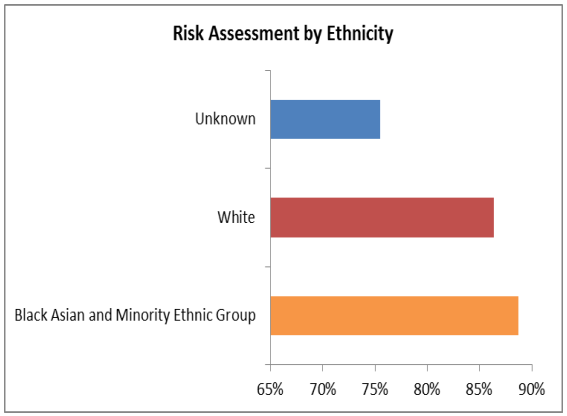
Workforce – October COVID-19 Risk Assessment

Division	Number of forms completed	Number of staff	% completed
Children and Women's Diagnostic and Therapy Services	2,709	3,157	86%
Medicine and Cardiovascular	1,820	2,159	84%
Surgery, Cancer, Neurosciences & Theatres	1,681	1,921	88%
Corporate	546	599	91%
SWL Pathology	463	491	94%
Estates and Facilities	313	339	92%
Research & Development	70	74	95%
Trust Total	7,614	8,740	87%

Staff Group	Number of forms completed	Number of staff	% completed
Medical and Dental	885	1,449	61%
Allied Health Professionals	598	655	91%
Nursing and Midwifery Registered	2,380	2,598	92%
Administrative and Clerical	1,586	1,725	92%
Add Prof Scientific and Technical	597	648	92%
Additional Clinical Services	967	1,048	92%
Estates and Ancillary	269	280	96%
Healthcare Scientists	332	337	99%
Trust Total	7,614	8,740	87%

Ethnicity	No of forms completed	Number of staff	% completed
Black, Asian and Minority Ethnic Group	3,617	4,076	89%
White	3,775	4,370	86%
Unknown	222	294	76%
Trust Total	7,614	8,740	87%



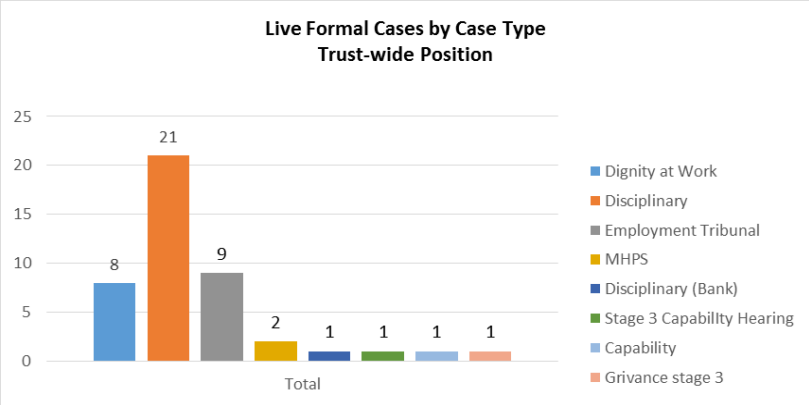


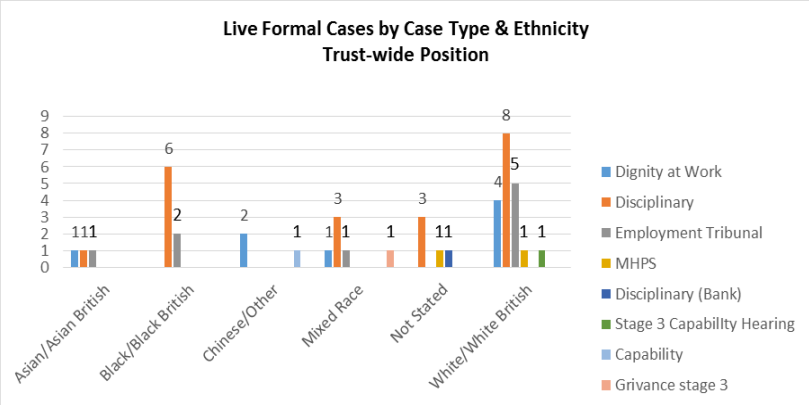
What the information tells us

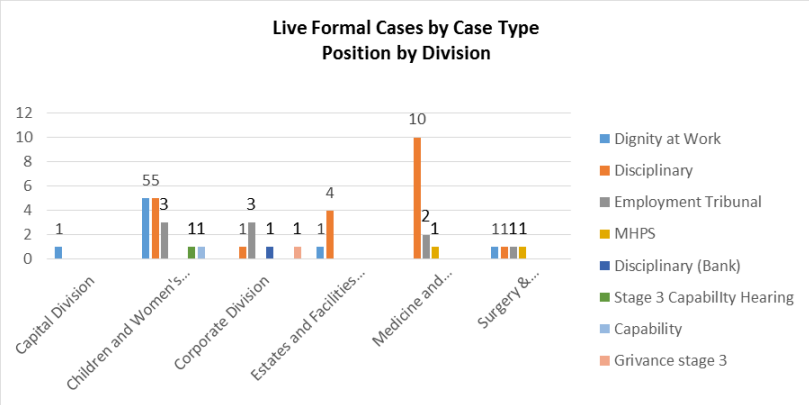
- The table shows completion of COVID-19 Risk Assessment as at 31 October 2020.
- The Trust completion rate is at 87.1%. Completion rate for BAME (Black, Asian and Minority Ethnic group) staff stands at 88.7% and White staff at 86.4%.
- Medical and Dental staff group have the lowest completion rate at 61%.

Actions and Quality Improvement Project
The Director of Medical Education and Chief Medical Officer supported by the HR team have sent reminders to junior doctors who recently joined the Trust to ensure completion.

Workforce - Employee Relations Cases as at 31 October 2020







What the information tells us

There are a total of 44 live cases Trust-wide.

Disciplinary cases are the highest at 21, followed by 9 Employment Tribunal cases and 8 Dignity at Work cases.

The Children and Women's and Medicine Division have the highest number of cases at 15 and 14 respectively.

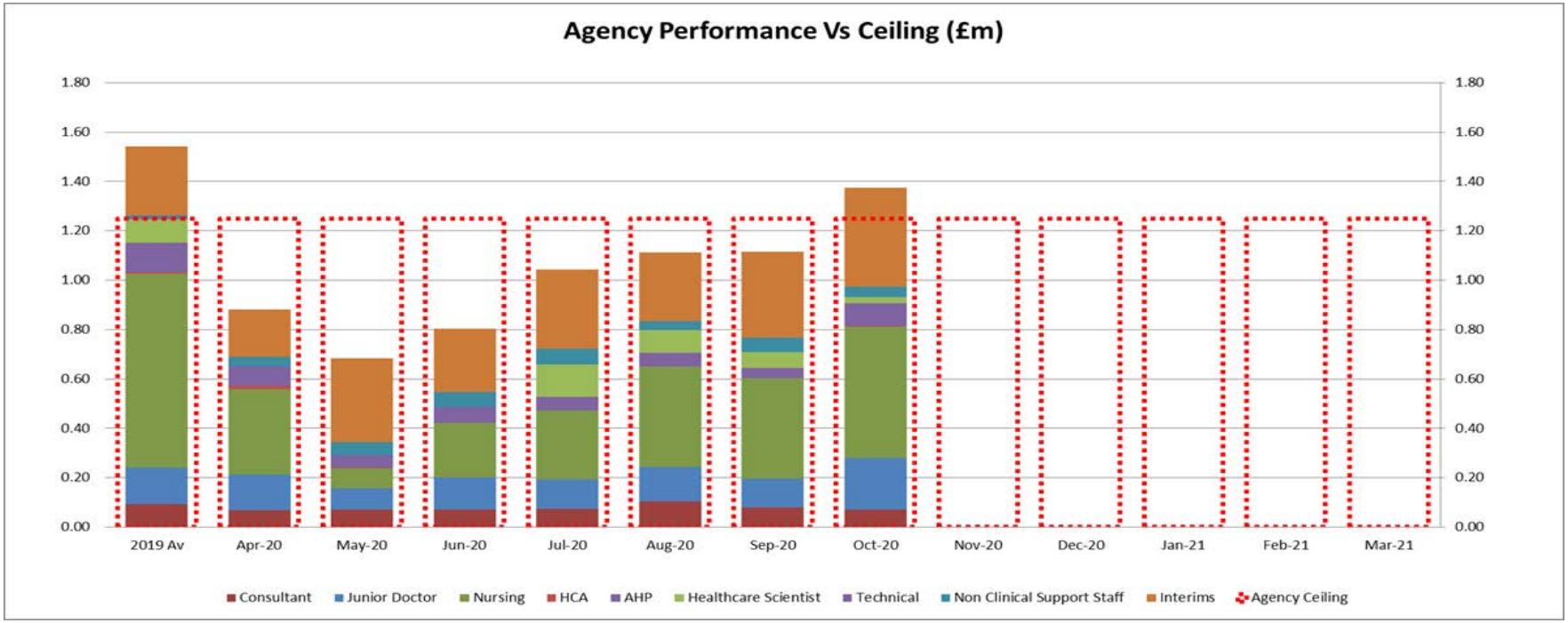
White and White British and Black and Black British have the highest number of disciplinary cases at 8 and 6 respectively. White and White British account for the highest number of Employment Tribunal cases at a total of 5 and the highest number of Dignity at Work cases.

Actions and Quality Improvement Project

Trend information is not yet available due to the new way of recording Employee Relation cases.

A disciplinary pre investigation panel and checklist has been introduced to scrutinise allegations made to determine if an informal process would be the best cause of action. This should result in a reduction in the number of formal disciplinary cases.

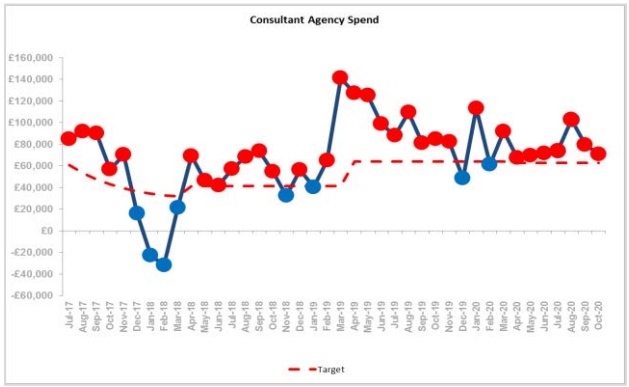
Agency use

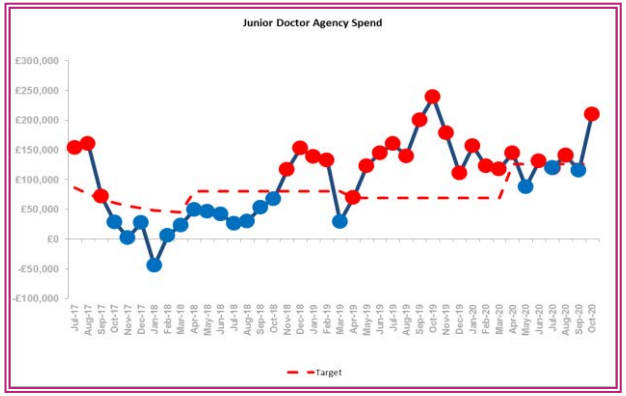


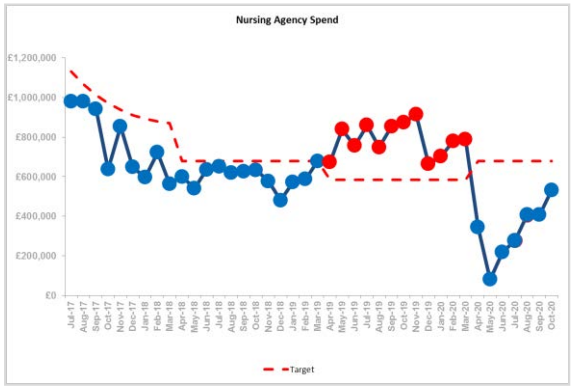
- The Trust's total pay for October was £50.26m.This is £1.29m adverse to a plan of £48.97m.
- The Trust's 2020/21 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.
- Agency cost was £1.38m or 2.7% of the total pay costs. For 2019/20, the average agency cost was 3.3% of total pay costs.
- For October, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.13m.
- The biggest areas of overspend were Interims (£0.23m) and Junior Doctors (£0.08m). The biggest area of underspend was Nursing (£0.15m).

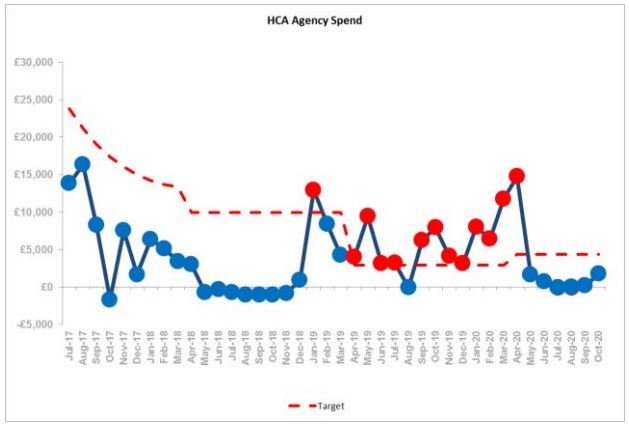
Agency use

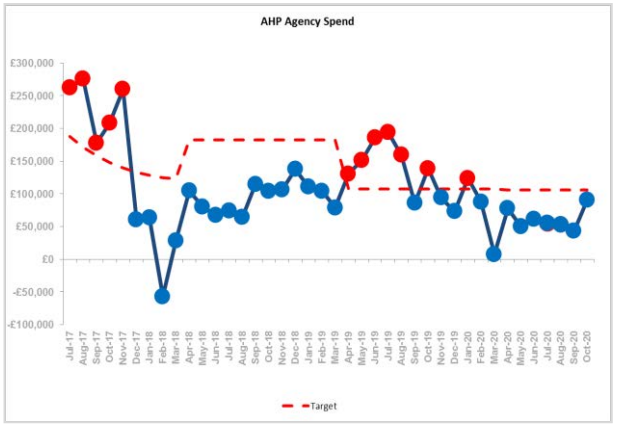
Below cap
Above cap

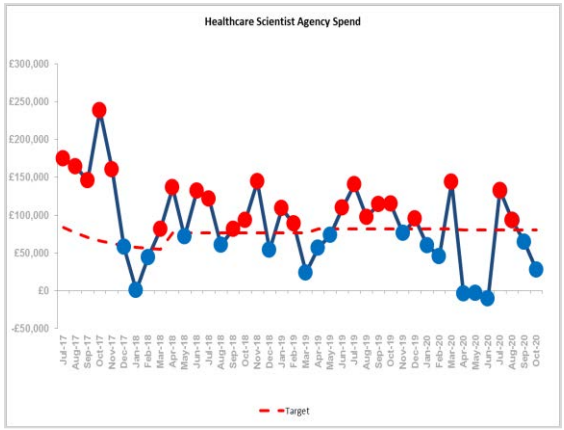


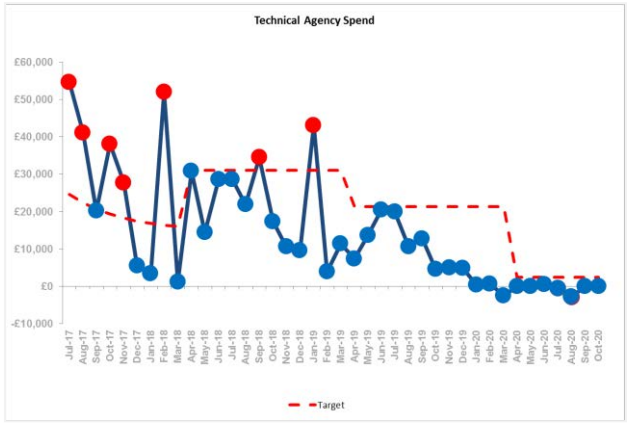


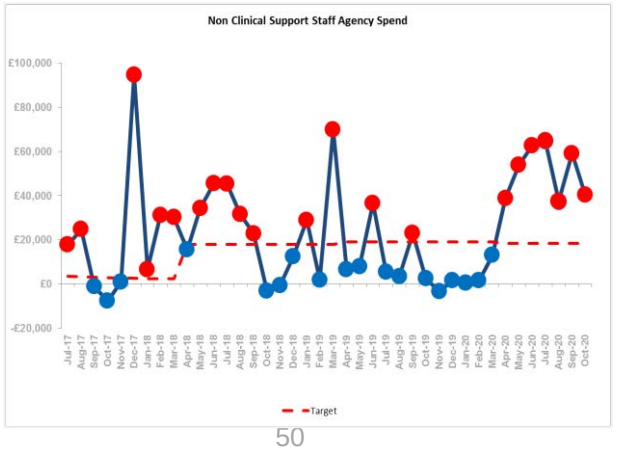


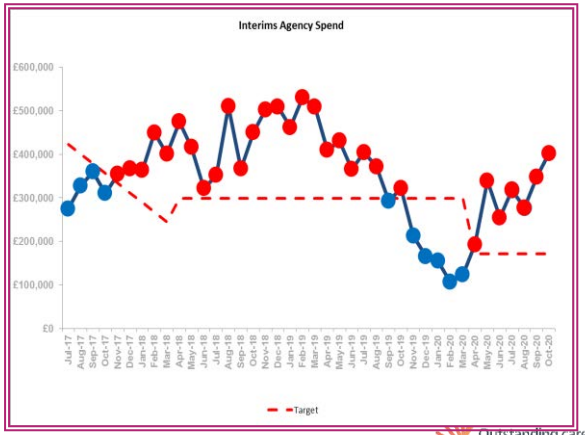




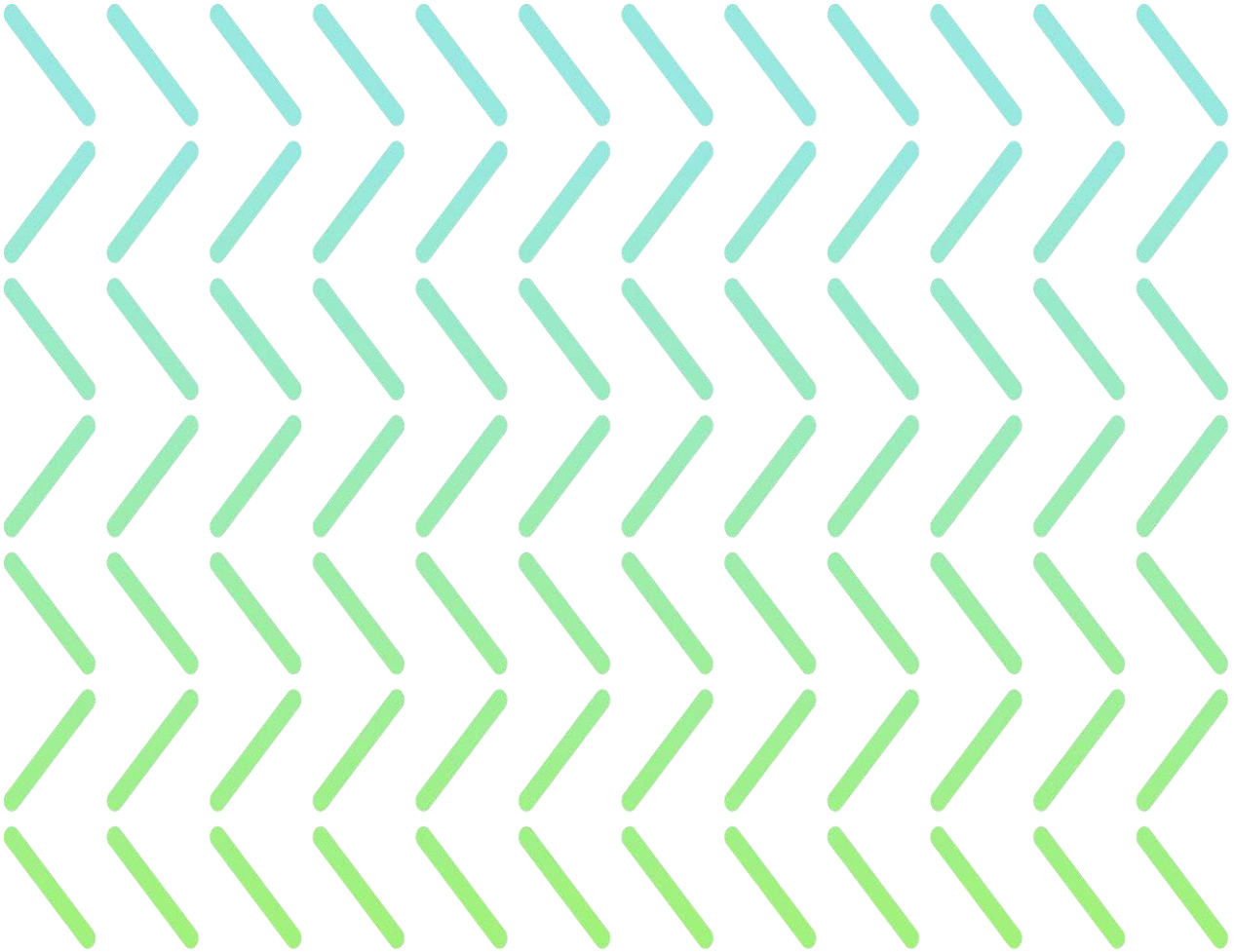




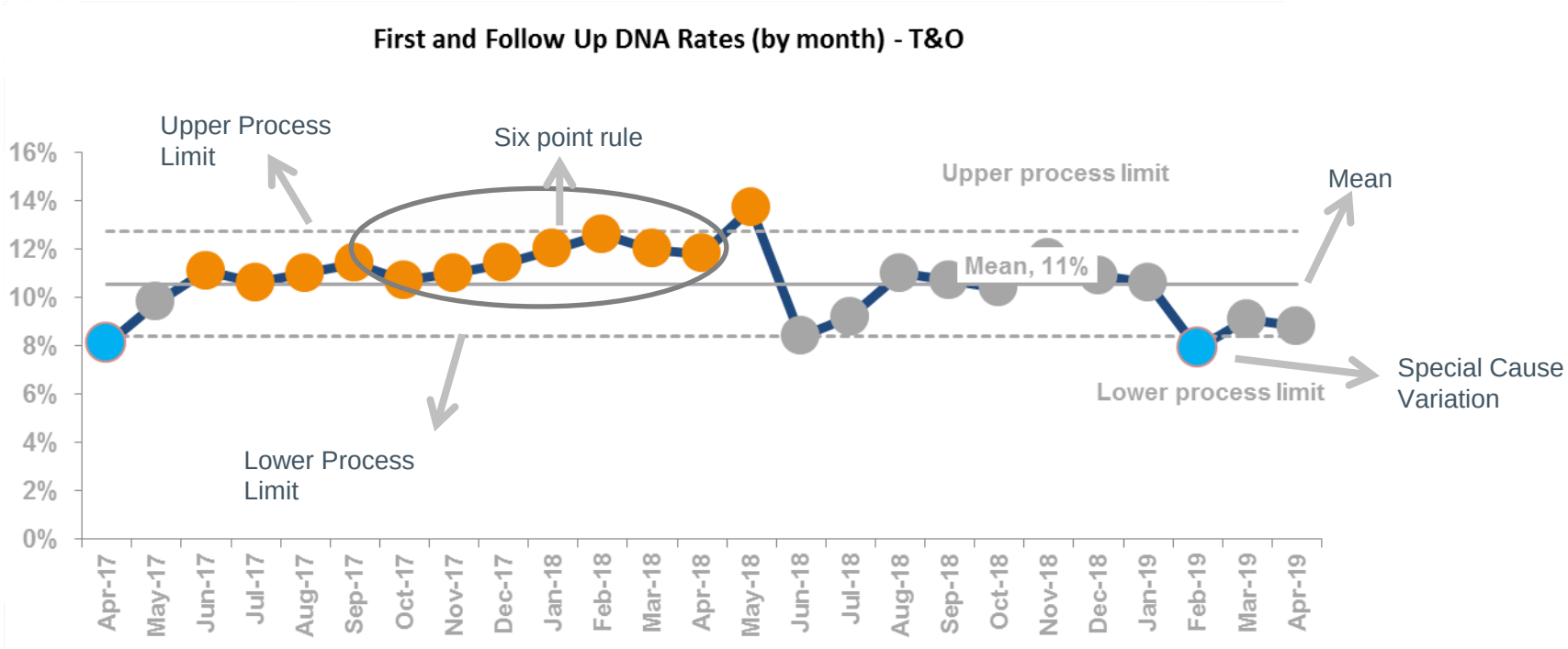




Appendix
Additional Information



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	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Compliance with appropriate response to EWS (Adults)	100%	86.8%	89.6%	89.0%	92.0%	91.1%	94.1%	86.9%	93.5%	97.0%	93.6%	78.3%	84.9%	92.4%
Number of EWS Patients (Adults)		356	534	420	400	460	289	290	403	474	512	634	465	474

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2.4

Meeting Title:	**Trust Board**		
Date:	**26 November 2020**	**Agenda No**	**2.4**
Report Title:	**Update on Patient Story to Board: Patient with Sickle Cell - Experience in Emergency Department (ED)**		
Lead Director/ Manager:	**Robert Bleasdale, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	**Alison Benincasa, Director of Quality Governance and Compliance** **Terence Joe, Head of Patient Experience and Partnership** **Tori Cooper, Head of Nursing for ED** **Tim Hardiman, ED Matron**		
Presented for:	**Update**		
Executive Summary:	This paper provides a synopsis of the patient story to the Board in January 2020 and an update on the improvement actions undertaken in collaboration with the newly established Sickle Cell User group with a specific focus on: • Easy access to care pathways • Education and Training • iClip developments • Patient information Assurance has been provided on the impact of the improvement actions in the form of a monthly audit to review the application of the ED pathway: Management of Sickle Cell in Acute Painful Crisis which demonstrated the following: • 9 minute average time for completion of the initial nursing assessment (reduced from 23 minutes) • 18 minute average time to analgesia from arrival (reduced from 75 minutes) • 75% of patients had their pain score reviewed after 30 minutes of analgesia (Baseline audit data October 2020) The next steps have been drawn out in response to the audit findings.		
Recommendation:	The Board is asked to note the update as provided within this report.		
Supports			
Trust Strategic Objective:	Ensuring quality of care and positive patient experience		
CQC Theme:	Safe, Effective, Responsive, Caring, Well-led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	There is a risk that poor patient experience can impact on the reputation of the service.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	Appendix 1 ED Pathway: Management of Sickle Cell in Acute Painful Crisis		

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2.4

Update on Patient Story to Board:
Patient with Sickle Cell - Experience in Emergency Department (ED)

26 November 2020

1.0 Purpose

This paper provides an update on the improvement work undertaken prior to and following the January 2020 patient story to the Trust Board which outlined the experience of a patient presenting to the Emergency Department (ED) with a sickle cell crisis.

2.0 Synopsis of Patient Story to Trust Board in January 2020

The patient attended the ED on two occasions in September 2019. She described the intense level of pain she was experiencing at the time and the way she had been treated by the staff in ED. She also described her daily management of pain at home with a high concentration of pain medication and the agreed treatment protocol on her medical records for staff to use when she attended ED. She highlighted that she brought a copy of the protocol with her to all ED attendances because of past experiences. Often ignored, left alone and scared she described the discriminatory attitude of staff. Despite the agreed treatment protocol being in place she had often been treated either with disdain, or with suspicion: as someone looking to obtain drugs. It was noted that only when clinical specialists were contacted was she treated with dignity and respect. The Board reflected that the treatment received was unacceptable and distressing and apologised to her for the shortfall in service.

3.0 Immediate actions undertaken prior to and following the Board Patient Story

Prior to the presentation of her experience to the Board the patient discussed their ED experience in September 2019 with the Haemoglobanopathies Team Specialist Nurse for Sickle Cell and was encouraged to speak to the Head of Patient Experience and Partnership. The patient wanted to offer their feedback with a view to improving service provision for patients living with Sickle Cell disease. The feedback was then shared with ED staff at a department meeting.

In December 2019 a focus group was held with patients living with Sickle Cell attended by 18 patients (including the patient who presented to Board) and was facilitated by the Head of Patient Experience and Partnership with support from Patient Experience staff and the Sickle Cell Specialist Nurse. The focus group discussed the ED attendance experiences of patients living with Sickle Cell and attendees were solution focused in their approach and identified the following resources/ initiatives that would drive service improvement in the ED:

- A Consultant lead for Sickle Cell
- Two sickle cell nurse champions in ED
- Standard protocol: Management of Sickle Cell in Acute Painful Crisis
- Always Event: The Always Event Programme is a national improvement programme led by NHS England/ Improvement using quality improvement framework and tools.

The focus group attendees agreed that adoption of the Always Event methodology was key to improving the patient pathway and an Always Event was subsequently developed as part of the national programme with a focus on what should always happen when patients living with sickle cell attend ED in Acute Painful Crisis.

A Trust-wide study day was held for staff in December 2019 by the Specialist Nurse for Sickle Cell to improve knowledge and confidence in responding to patients living with Sickle Cell

Alongside the focus group work, further work was facilitated in January 2020 by the Sickle Cell Specialist Nurse and patients living with Sickle Cell and a Sickle Cell patient user group was established with an agreed terms of reference to support the development of solutions for improving pain management in ED.

4.0 Improvement actions January 2020 to date

The work to date has been patient led and this is a key strength. The service development will continue in collaboration with Sickle Cell patients through the Sickle Cell User group.

Consistent and timely application of care plans/ pathway

- The ED team created a dedicated online folder for easy access to Sickle Cell care plans, the Management Pathway for patients with Sickle cell in Acute Painful Crisis and NICE guidelines
- The Trust implemented the Covid-19 guidance for patients attending ED with Sickle Cell crisis

Education and Training

- The Specialist Nurse for Sickle Cell worked with the ED Practice Educators to provide Early Morning Teaching Sessions and assessment against a competency document for staff. All ED staff will be assessed against the competency document by end-March 2021
- The ED team completed a Super 7 education week which provided daily teaching and was focused on Sickle Cell education and awareness with input from the lead consultant and nurse link Sickle Cell champions
- A second Trust-wide study day was held for staff in February 2020 by the Specialist Nurse for Sickle Cell to improve knowledge and confidence in responding to patients living with Sickle Cell. This programme was suspended from March 2020 and will be re-launched alongside the development of the online module outlined below

IClip/ IT development

- In January 2020 a specific bloods order set for patients presenting with an Acute Sickle Cell Crisis was introduced on iCLiP and disseminated to the ED Team. This was implemented to ensure the ED team consistently request the correct blood tests at the assessment stage for all patients living with Sickle Cell presenting in the ED to support timely consideration of additional treatment options e.g. Intravenous fluids, and/or antibiotic therapy

Patient Information – under development

- Patient Video: The Sickle Cell User group identified the need for a patient information video specifically targeted at people living with Sickle Cell when attending the ED. Members of the Sickle Cell User Group together with members of the ED team will develop the script and form part of the video with the support of our communications department by end-March 2021
- Always Event: Patient Information Card ‘fast pass’. The Sickle Cell User group and ED team initially considered the creation of a flag on iClip to alert the ED team to the patient’s specific needs. However, the group opted for the development of a ‘fast pass’ as a more proactive process for the patient to alert staff to the need to initiate the Sickle Cell Acute Painful Crisis pathway. This will be co-designed by end-March 2021.

5.0 Monitoring and Assurance

From May 2020 a monthly audit was undertaken to review the application of the ED pathway: Management of Sickle Cell in Acute Painful Crisis and a randomised selection of twelve sets of patient notes were reviewed together with an iClip report on time to nurse assessment and time to first analgesia. The results were monitored and discussed at the ED Governance Meeting. Between September 2019 and October 2020 127 patients living with Sickle cell attended the ED with distribution by month identified in Table 1 below.

Table 1: Number of attendances per month patients living with Sickle Cell (127)

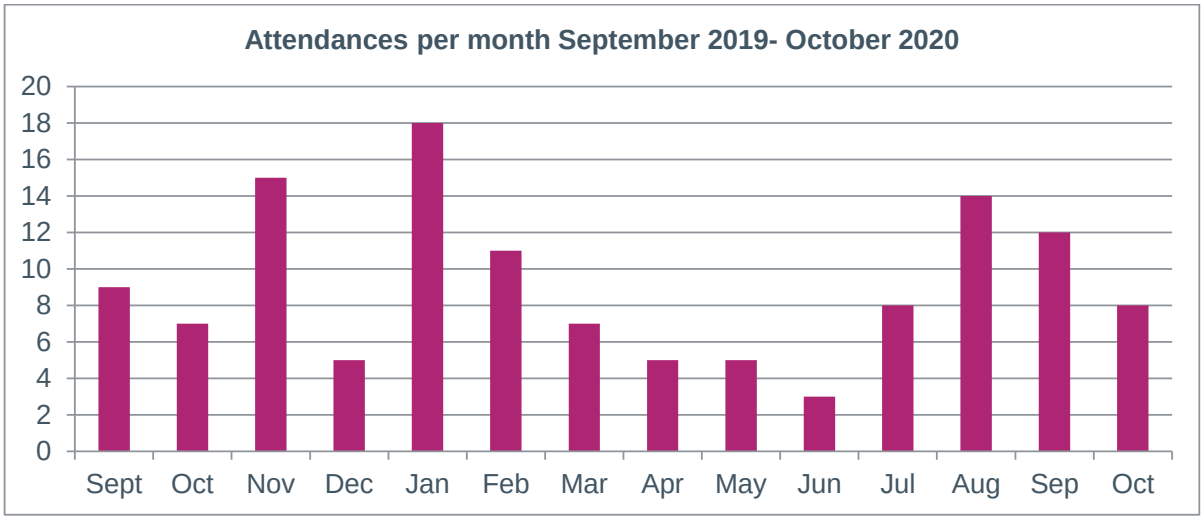


Table 2 and 3 below demonstrate an improvement from an average of 23 minutes to an average time of 9 minutes for completion of the initial nursing assessment and an improvement from an average of 75 minutes to analgesia from arrival to 18 minutes.

Table 2: Average time for initial nursing assessment

Table 3: Average time to analgesia from arrival

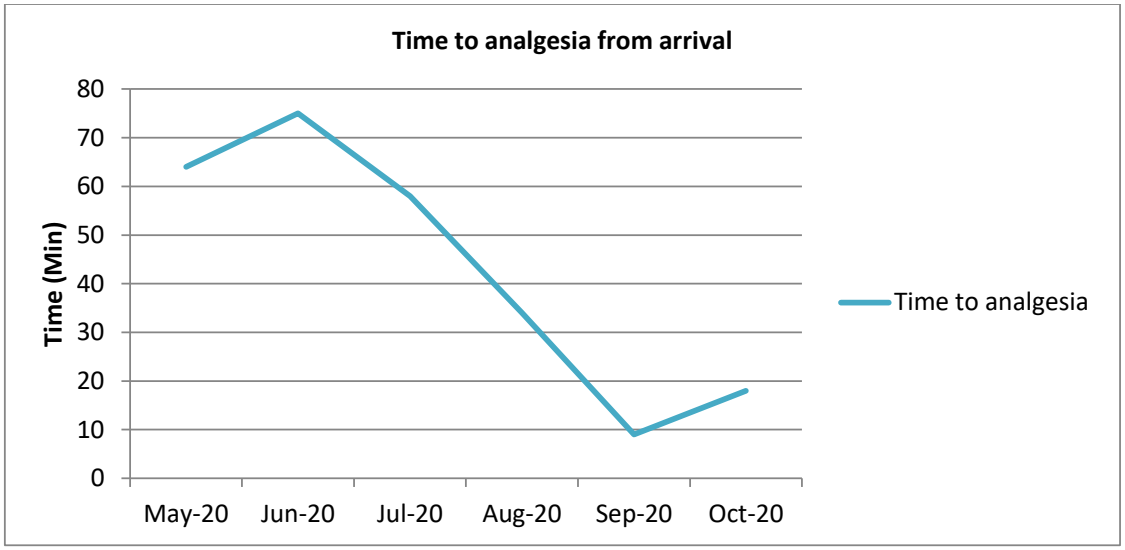
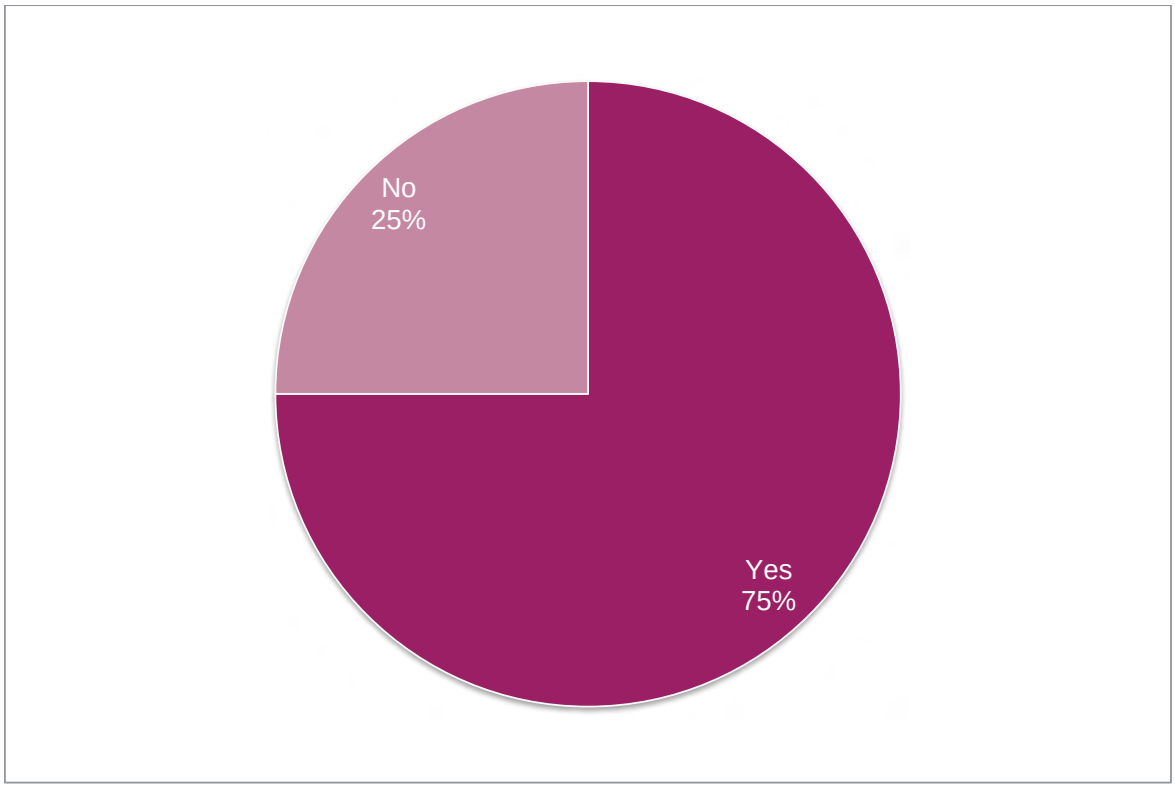


Figure 1 identifies that 75% of patients had their pain score reviewed after 30 minutes of analgesia. (Baseline audit data October 2020: to be incorporated into the monthly audit schedule)

Figure 1: Repeat pain assessment 30 minutes post analgesia



6.0 Summary and Next Steps

The improvement actions undertaken to date have resulted in an improvement in the average time for completion of the initial nursing assessment and time to analgesia from arrival as summarised below:

- 9 minute average time for completion of the initial nursing assessment (reduced from 23 minutes)
- 18 minute average time to analgesia from arrival (reduced from 75 minutes)

However, further work is required to improve ED performance from 75% to 100% in the assessment of a patients pain score after analgesia.

The following improvement actions will be continued and/ or initiated:

1. Continuation of early morning teaching sessions where the importance of documentation and timely re-assessment will be emphasised together with on-going assessment of staff against the competency document
2. Continuation of monthly audit monitored through the ED Governance meeting, reported to the Divisional Governance Meeting and to Patient Safety and Quality Group through the divisional quarterly report
3. On-going engagement with patients living with Sickle Cell will continue via the Sickle Cell User group and its membership integrated with the Patient Experience and Partnership Group
4. Working with the Sickle Cell user group to develop an online Sickle Cell awareness module by end-March 2021
5. Bi-annual patient survey of patients living with Sickle Cell attending ED to triangulate audit findings with patient experience.

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Appendix 1

Emergency Department

Management of Sickle Cell Acute Painful Crisis

June 2019

Analgesia must be given within 30 minutes

Triage

- Observations (give oxygen if saturations ≤ 95%)
- Document pain score
- Check if patient has individualised sickle cell plan (red folder in Majors)

Pain Score (0-10)

Mild: 1-3

Moderate: 4-7

Severe: ≥7

Analgesia < 30 minutes

- Consultant in Charge to prescribe analgesia/allocate named doctor
- If own protocol available, follow instructions. If not:
  - All patients: **paracetamol 1g PO and ibuprofen 400mg PO** (unless contraindicated)
  - Severe pain: **morphine 10mg S/C** (consider 5mg if opiate naïve or low body weight)
  - Moderate pain despite analgesia: **morphine 10mg S/C**
  - Moderate pain no analgesia: **codeine or dihydrocodeine 30-60mg PO**

Reassess pain at 30 minutes

- If ongoing pain, prescribe second bolus **morphine 5-10mg S/C**
- Continue to reassess pain every 30 minutes until controlled

Other Medical Care

- Fluids: consider IV fluids if dehydrated
- Oxygen: consider O2 if sats ≤ 95%
- Antibiotics: if febrile. Co-amoxiclav + clarithromycin OR levofloxacin alone if penicillin allergic
- Laxatives: consider if constipated OR with strong opioid use

Haematology Referral

- Refer if uncontrolled pain, chest crisis or complications
- In hours: red cell reg bleep 7080
- Out of hours: via switchboard/haem SpR bleep 6068
- Discuss with obstetric SpR if pregnant

Consider Chest Crisis if:

- Respiratory symptoms
- Fever
- Chest pain
- Saturations ≤ 95%

Complications:

- Acute stroke
- Aplastic crisis
- Infection
- Osteomyelitis
- Splenic sequestration

Authors: H Emms (ED SHO); M Haden (ED Con); E Rhodes (Haem Con)	Approval date: Aug 2019 Review Date: Aug 2022	Reference: NICE Guideline CG143 June 2012

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3.1

Meeting Title:	Trust Board Meeting		
Date:	26 November 2020	**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 meetings on 15 October and 12 November 2020 including commenting on assurance to the Board on key risks allocated to the Committee. No changes are proposed to the current risk ratings for Trust Risks SR8 and SR9. The Committee received updates on a number of programmes and initiatives which are currently in flight. 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. As previously notified, the Committee has scheduled a number of additional meetings to allow for greater focus on Deep Dive areas, and an Appendix to this Report summarises the assurance received at the Deep Dive session of the Committee held on 15 October. This focussed on a report from the Culture Champions (in effect, the engine room of the Culture Change Programme) on the key focus areas within the five culture domains being reviewed.		
Recommendation:	The Board is asked to note this report and the updates on the culture programme and diversity and inclusion action plan under agenda items 3.1.1 and 3.1.2.		
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 meeting on 12 November the Committee received updates on a number of programmes and initiatives which are currently in flight. 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 progress being made on diversity and inclusion, Freedom to Speak Up, and staff with a disability.

At a compliance level, there are no adverse matters to be drawn to the attention of the Board in relation to Safe Working for our junior doctors, or Freedom to Speak Up.

The Board's attention is drawn specifically to the work of the Staff Health and Wellbeing Group which is doing an important job in difficult circumstances, and with only limited recognition of the contribution they make to the wellbeing of our staff. We all owe this Group, and those who work with it, a vote of thanks for their commitment and hard work.

2. Key points:-

Board Assurance

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

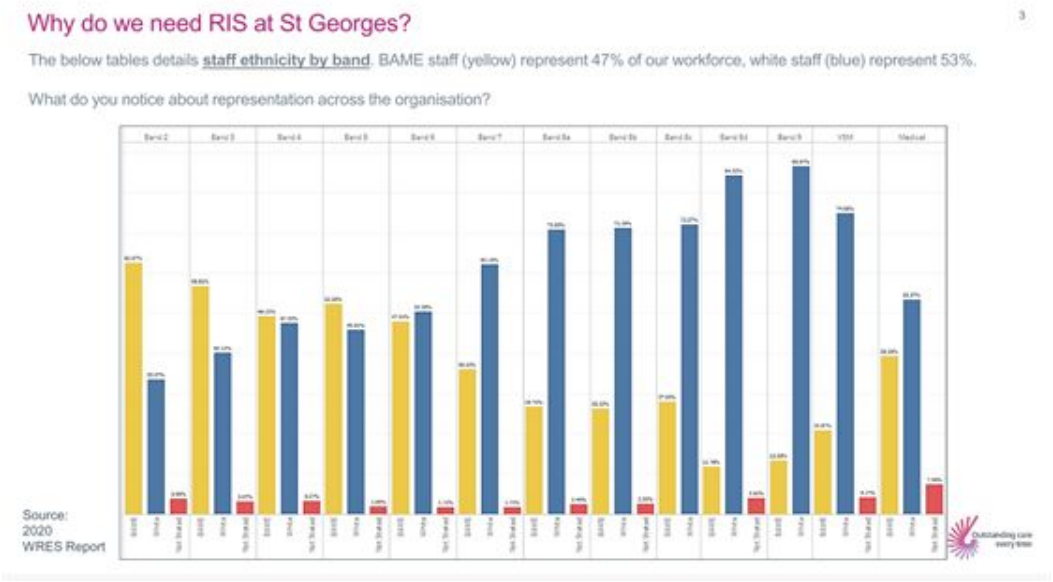
At its meeting in October, the Committee concluded that there were no circumstances or matters of which it was aware that mandated a change to the existing risk ratings (currently: SR8, 20; SR9, 16). That said, the Committee noted continuing progress in a number of areas, but that these had not yet delivered a material change. The Committee also noted that a very 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. The Trust's planning for a second surge was a mitigant to this, and in present circumstances looked to be appropriate and effective.

Theme 1 - Engagement

Diversity and Inclusion (D&I) – Humaira Ashraf and Joseph Pavett-Downer presented an update on progress with the D&I Action Plan. This included a briefing on how the Action Plan had been updated to track nationally-set KPIs and measures of progress. The significance of this is that the Trust is now using a similar measurement set to assess progress to that used by NHSE/I.

We also received an encouraging update on the progress within the Trust of ethnically balanced recruitment panels. A number of Recruitment Inclusion Specialists had been trained and had been actively engaged in appointment panels for roles at Band 8A and above. The roll-out to panels for all roles was being progressed. It was noted that where a BAME panel member was appointed, they were an equal member of the relevant panel. Guidance to panel chairs is being updated to make this clear. I have attached below a slide extracted from that guidance which sets out the staff ethnicity by agenda for change (AfC) band. The disparity at Bands 7 and above is clear, particularly given we are a Trust where some 47% of our staff are of BAME ethnicity.

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



The Trust-developed 'Challenging our Biases' training programme was to be piloted across November and early-December and launched in December 2020. We will receive a report back at a subsequent meeting of the Committee.

Culture Programme Update – Humaira Ashraf and Tom Kenward provided an update on the current (Design) phase of the Culture Programme, and the emerging leadership strategies to be delivered from the start of 2021. These had been built on the results of the initial Discovery phase, which had identified a number of key findings and themes (summarised in the Appendix to this Report).

What was particularly noteworthy (and concerning) was that for each of five measures across the five cultural elements adopted by the Programme, so 25 measures in total, only three were rated green. These were patient experience (x2) and staff teamwork. Ten were 'red' rated (=negative) and twelve were neutral. In broad terms, key themes within the red ratings were: failure to translate vision and values into action; lack of transparency in decision making, particularly around staff progression; behaviour; and the presence of a bullying and non-inclusive approach to staff. We took this as an indication of both the scale of the challenge and the clarity of the analysis undertaken within the Discovery phase. It is clear that these issues will be central in the planning of the next (Delivery) phase of the Programme.

Theme 2 – Leadership and Progression

We noted the impact of the Recruitment Inclusion Specialists, one of whom was routinely appointed as a panel member for all roles at Bands 8a and above (reported in more detail above).

Theme 3 - Workforce Planning and Strategy

Workforce Report - Elizabeth Nyawade summarised a detailed report on workforce metrics for September. These were generally stable, although we noted modest upticks in staff sickness rate to 3.6% (against a target of 3.2%) which is consistent with what we saw in the pre-Covid period. The Vacancy Rate had risen to 9.1% but was still below the 10% target.

Staff turnover had risen marginally to 15.4%, but was still well below the 17.6% seen 12 months ago. We were encouraged by the Stability Index (measure of proportion of staff in post for 12

months or more) being above target for the third month in a row, at 86.1%. The overall picture is of a modestly more stable staff group, but under continuing pressure.

We reviewed a new report summarising Live Employee Relations cases. This is useful in providing us with a snapshot of the types of case, their distribution, and their analysis by ethnicity. Over time, the trend data that this will generate will be helpful in assessing the impact of the various actions being taken to improve diversity and inclusion.

Health and Wellbeing Update - Humaira Ashraf presented the Update on behalf of Dr Rhia Gohel. The pandemic had exacerbated pressure that staff were having to deal with, and had also necessitated the shift of the Health and Wellbeing Week from place-based events to an entirely virtual basis. This had identified shortcomings in some areas, and the lessons learned – particularly around the use of Microsoft Teams, and early promotion of events – would be applied. The Committee was updated on a number of initiatives designed to support staff wellbeing and help address their very real concerns. The work of the Staff Support and Wellbeing Group does not get the profile it deserves, and we owe this Group, and all who work with it, a vote of thanks for their commitment and hard work. Their work enables Trust management to get rapid and informed feedback on the impact on individual staff members of Trust-wide initiatives, and adapt them accordingly. I attach below a slide illustrating some of the issues of concern to staff being so reported:

Education Strategy Implementation Progress Update – Humaira Ashraf provided a short update on progress of implementation of the Education Strategy, noting that in spite of the pandemic good progress was being achieved.

Theme 4 – Compliance.

Guardian of Safe Working Report – In Dr Serena Haywood's absence, the report was delivered by Richard Jennings, our CMO. There was a very helpful update on the Trust's management of concerns relating to gastrointestinal surgery, and the impact on trainees. We took good assurance that the wellbeing of trainees had been a factor in decision-making here. The meeting noted the declining attendance at the Junior Doctors Forum although it was hoped that the new Chair, Dr Emma Amoafo, would help re-invigorate it.

Overall, exception reports in the July-September 2020 quarter were down against the preceding quarter and the same quarter in prior years, but as Richard rightly reminded us the impact of the

pandemic was probably the proximate cause and this reduction should not be viewed as a trend. Of the 41 exception reports received, 34 related to hours of working. Richard provided a helpful overview on how the Trust was addressing these. We will continue to monitor the Trust's position here.

Freedom to Speak Up Guardian Report – Karyn Richards-Wright (the Trust's FTSU Guardian) and Stephen Jones (Executive Lead) jointly gave a report on analysing current trends in staff raising concerns and progress on Speaking Up within the Trust. What was clear was that mechanism was being increasingly used by staff, which suggested increased confidence in the system. Many of the concerns raised in the first two quarters of 2020/21 related to Covid, although bullying and harassment remained a recurrent theme. The speed and timeliness of investigation completion remained a concern to the Guardian and Executive Lead, and actions were being taken to address this as part of the seven action streams agreed by the Board in September. The Committee reviewed progress on these, and on the recommendations that had been made by NHSI/E in March.

Karyn also updated the Committee on the visit to the Trust from the National Guardian, Dr Henrietta Hughes, and the areas discussed. The current Trust policy on Speaking Up was being reviewed, and a charter was being developed setting out what staff should expect when they raise a concern. A number of Speak-Up champions in the Trust had withdrawn from their roles and Karyn and Stephen were working jointly to identify and appoint more. The potential for Karyn to have additional support or a nominated Deputy was being considered.

Workforce Disability Equality Standard: Action Plan – The Committee reviewed and endorsed the proposed Action Plan, which Humaira Ashraf presented. This was a key part of the Trust's commitment to diversity and inclusion. However, there is still a reluctance amongst staff to declare a disability, and the Trust's strategy is to change this so that it an better respond to staff with a disability and ensure that their experience of work is as good as it can be. One factor that had been identified was a lack of clarity as to what constituted a disability, so work was being done to provide a clearer understanding of this. The Committee reviewed the detailed plan underpinning this.

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.

Stephen J Collier

Committee Chair

November 2020

APPENDIX

REPORT BACK FROM COMMITTEE CULTURE PROGRAMME DEEP DIVE, 15 OCTOBER 2020

The Committee held a Deep Dive meeting on 15 October, with a detailed focus on progress on the Culture Change Programme and its next steps. As the Board was to receive a summary briefing on the Culture Change Programme later in October, I circulated a summary to non-executive Board members at that point. That summary is reproduced below for information.

"I thought it would be useful to provide you with some headline comments on the presentation we received at WEC earlier this month from a number of the Culture Champions. These are not external consultants brought in, but rather our own people stepping up and investing their time and credibility in this process. This note is not intended to repeat what is in the Diligent pack, but rather to capture the depth and intensity of support for what was presented at WEC, and some of the broad themes that ran across the five culture domains that were individually presented. It therefore focuses on the feel and themes rather than the detailed content, as much of that content is set out in the Report in our Board material.

Overall:-

- The Culture Champions are a real team. Draw strength from each other and committed to telling it as it is. They were impressive and had put a lot of themselves into the presentation.
- The presentation we received from the Champions was well-thought through, insightful, and showed a depth of research and engagement with a wide group of staff. As far as it is possible, it appeared that what we were being presented with was genuinely representative of the views of staff.
- The presentation reached clear conclusions about where the focus of the culture work should be, and the supporting actions and areas for attention.
- Although slightly 'academic' in parts, this was largely to support the reasons why intervention in certain areas would have impact, and could shift culture.
- Key themes that the Champions referenced:-
    - The Trust has a compassionate leader
    - There is a consistent message from the top of caring for patients (and supporting staff). Staff endorse this and think patient care is generally good.
    - The Trust's response to Covid has brought out the best in many people and areas, and cut right through what is normally a silo'd mentality and approach
    - Silos within the organisation are deep and embedded
- Poor behaviour is seen particularly in:
    - Bullying and harassment;
    - Unclear responsibilities and accountability
    - Poor behaviour going unchallenged.
    - A belief that there are potential consequences for those who speak out
- Strong belief in staff that it is difficult to call out poor behaviour and make real change. Possible feelings of helplessness as a result.
- This links to a bigger issue, of some targets (particularly those seen as unrealistic or over-stretching) being ignored.
- Overall, staff want to do better and improve things – but feel held back by resource / operational constraints / lack of local leadership support. Also slightly over-awed at the scale of what might be required.

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NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 November 2020	**Agenda No**	**3.1.1**
Report Title:	**Strengthening Our Culture – Programme Update**		
Lead Director/ Manager:	Humaira Ashraf, Acting Chief People Officer, Culture and OD Tom Kenward, Programme Director for Culture, Leadership and OD		
Report Author:	Humaira Ashraf, Acting Chief People Officer, Culture and OD Tom Kenward, Programme Director for Culture, Leadership and OD		
Presented for:	Update		
Executive Summary:	The slide deck, Appendix (A) provides an outline of the programme background and methodology, summary of the findings for the 'Discovery' phase, next steps as we move to the design and delivery phases and an appendix outlining each diagnostic tool.		
Recommendation	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Board Assurance, Risk management		
Implications			
Risk:			
Legal/Regulatory:			
Resources:			
Equality and Diversity:			
Previously Considered by:		**Date**	
Appendices:	Appendix A – slide pack: Strengthening Our Culture – Programme Update		

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NHS Foundation Trust

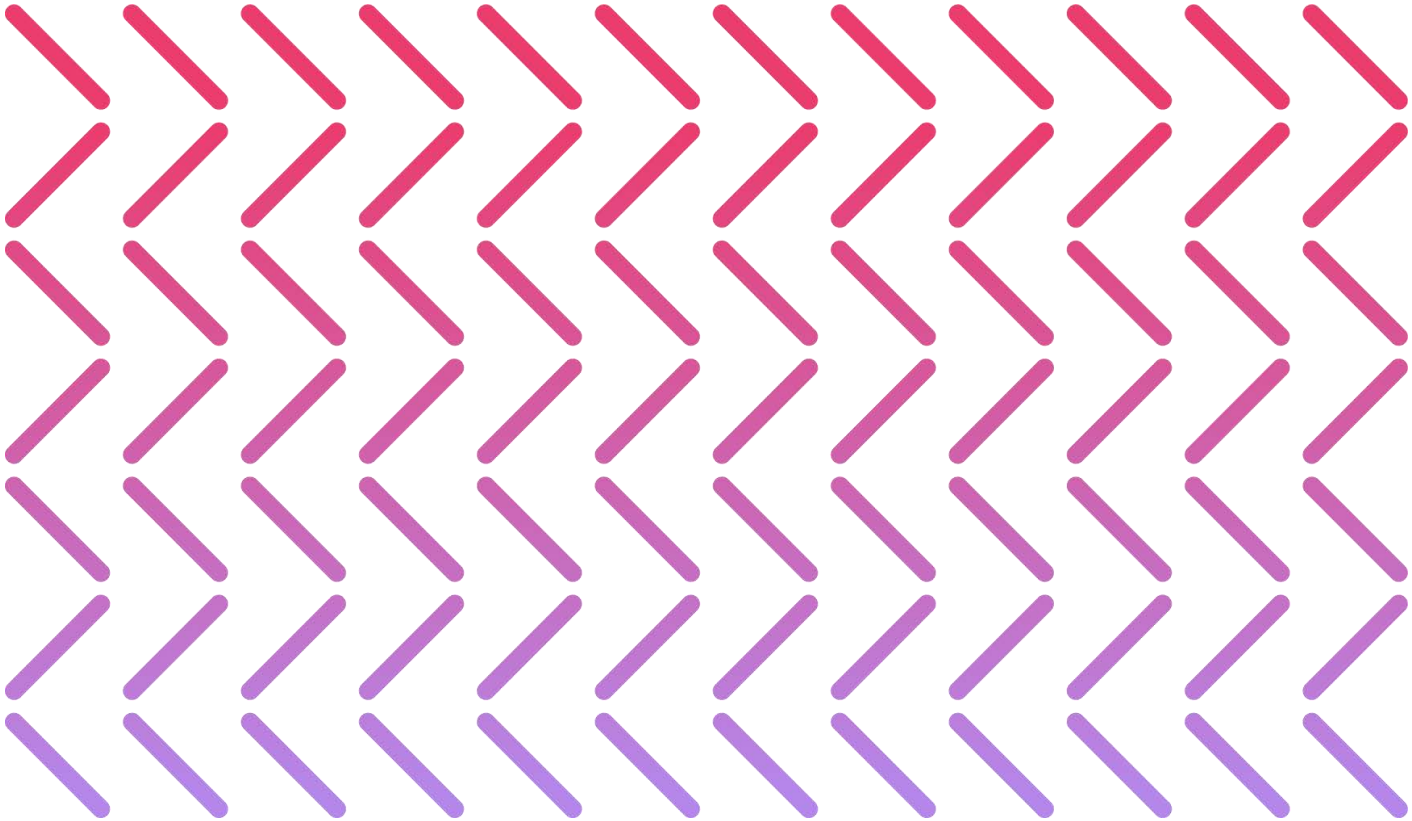
Strengthening Our Culture – Programme Update

Update

Humaira Ashraf, Acting CPO (Culture)
Tom Kenward, Programme Director, Culture, Leadership & OD

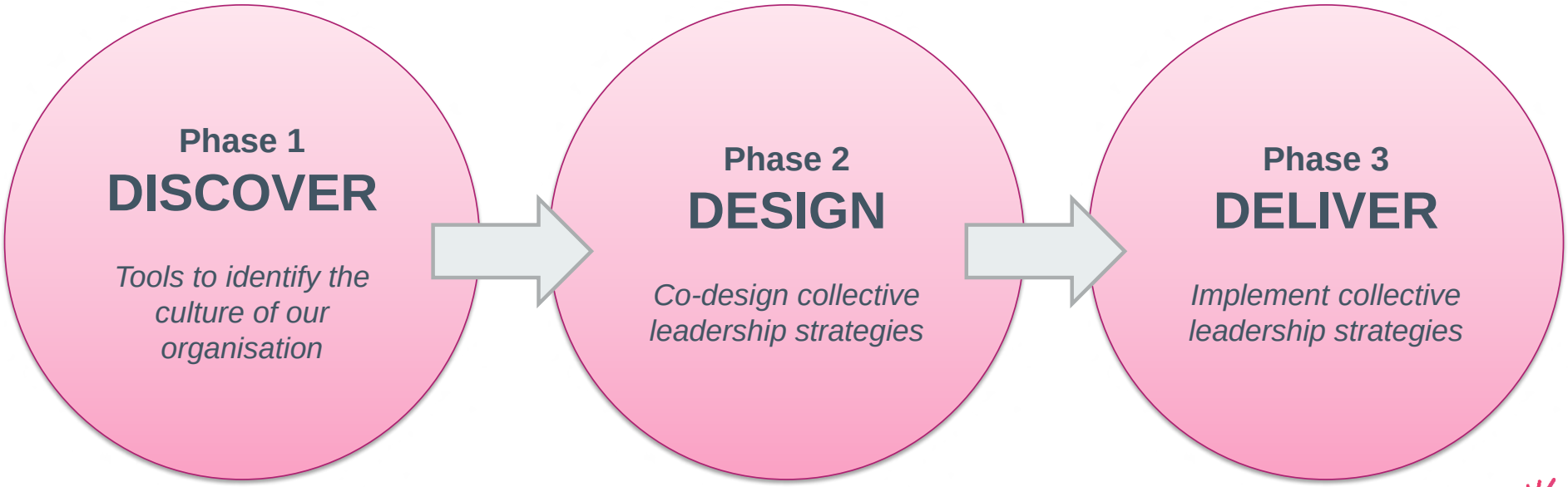
November 2020

Programme Background and Methodology



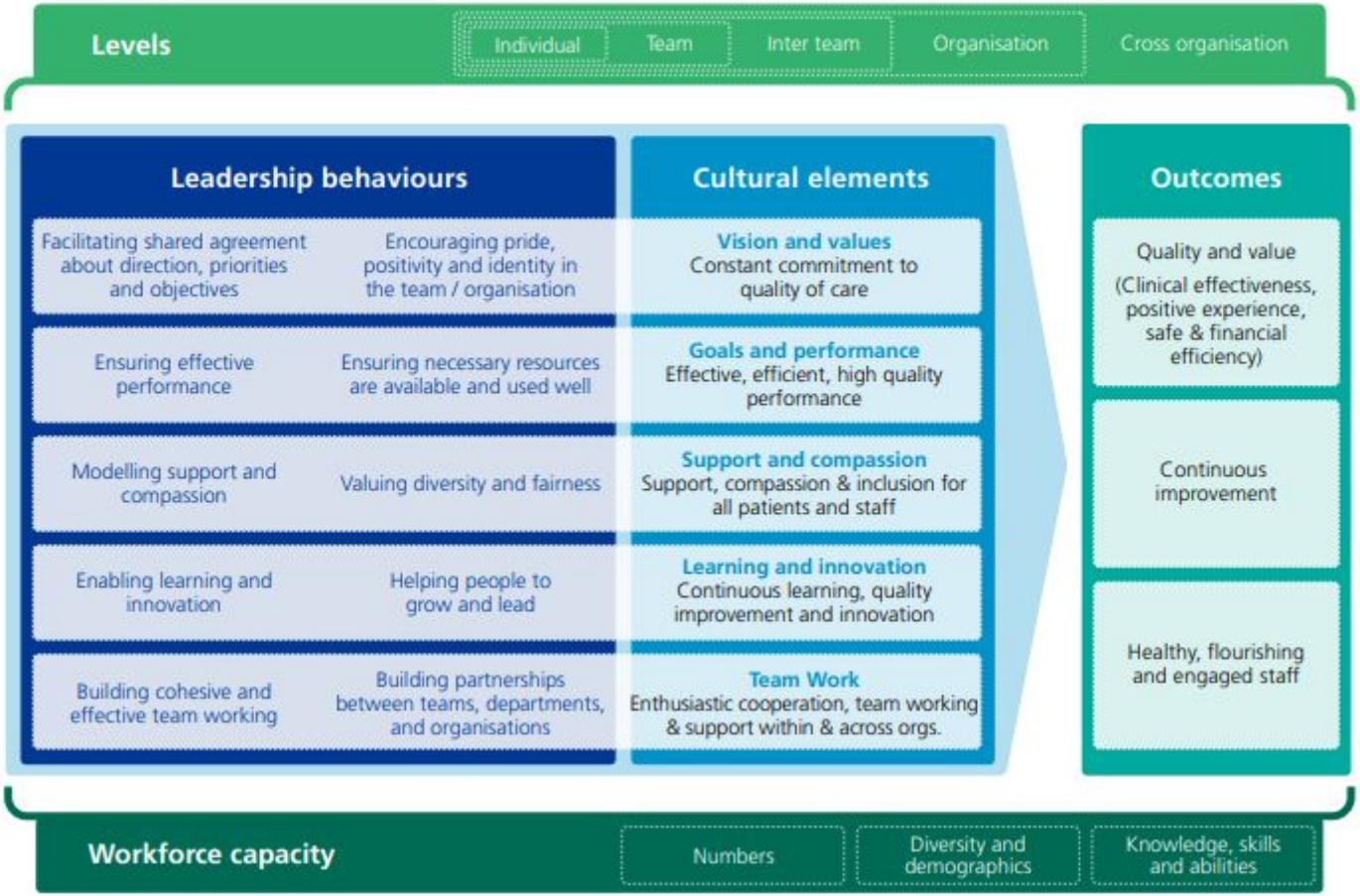
Background

- In the Autumn of 2019, the Board decided to strengthen culture through an approach that would enable bolder, more ambitious and more sustainable action.
- It was decided that we would utilise NHSI framework known as the ‘Culture and Leadership Programme’
- This approach has now been used in nearly 100 trusts, including many acute trusts of a similar size to SGH



NHS Improvement's Culture and Leadership Programme

A framework for improving organisational culture



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Culture Champions

- Central to the NHSI Culture and Leadership Programme framework is a group of ‘culture champions’ to advocate for and deliver the work
- Internally recruited by an application process , ensuring maximum diversity.
- Champions will continue to play a key role in the process for phases 2 (‘Design’) and 3 (‘Deliver’).

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Diagnostic Tools and Data Collection

Diagnostic Tools	Data collection / analysis activities undertaken	# of participants
 **Culture and outcomes dashboard** High level understanding	• Primarily Staff survey data • MES, Friends & family test, Pulse survey tools	1000+
 **Board interviews** The Board's approach to supporting effective organisational cultures	• 25 senior leaders interviewed including non-executive directors, executive directors and divisional leaders	25
 **Leadership behaviours survey** Staff and stakeholder views on behaviours of organisation's staff and leaders as a whole	• Online questionnaire targeting staff at Band 7 or above • Includes questions about the individual and group leadership	500+
 **Culture focus groups** Individuals' experience of current organisational culture	• Over 30 focus groups - junior staff from across sites and services • Also includes COVID debriefs and BAME listening events	180
 **Leadership workforce analysis** The organisation's needs on leadership workforce capacity	• Current and future leadership capacity - numbers, diversity • A combination of quantitative and qualitative data	10
 **Patient experience**	• Used pre-existing patient experience data	1000+ patient comments

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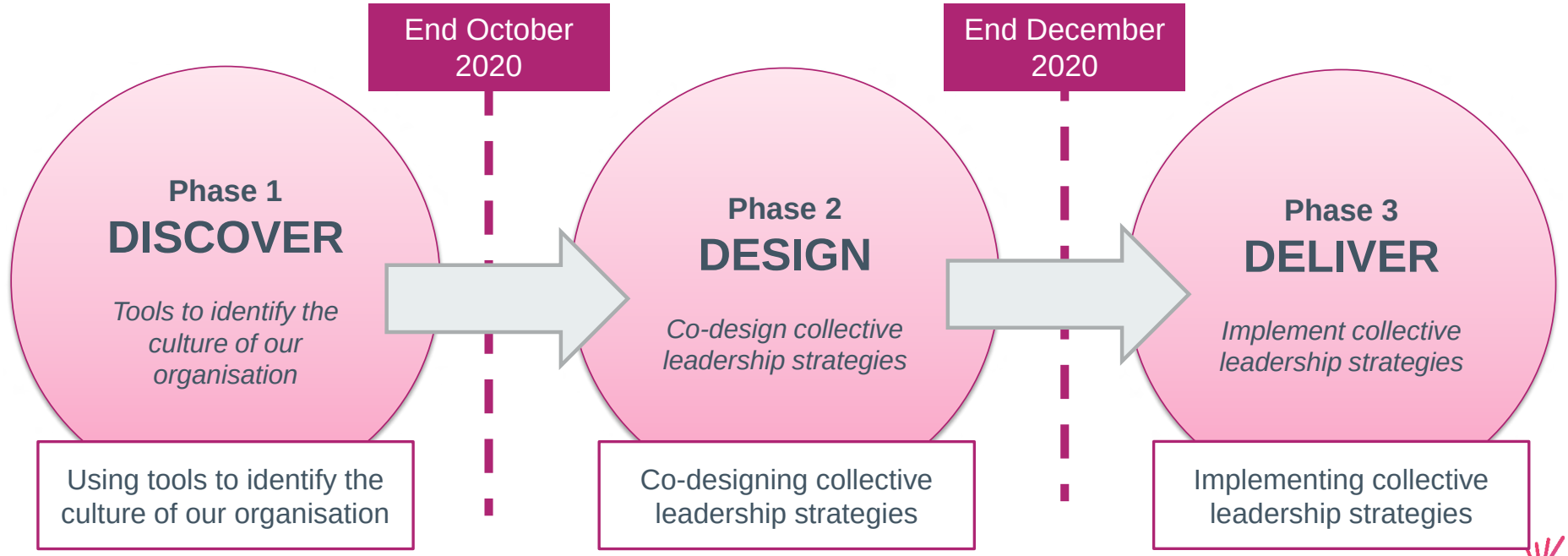
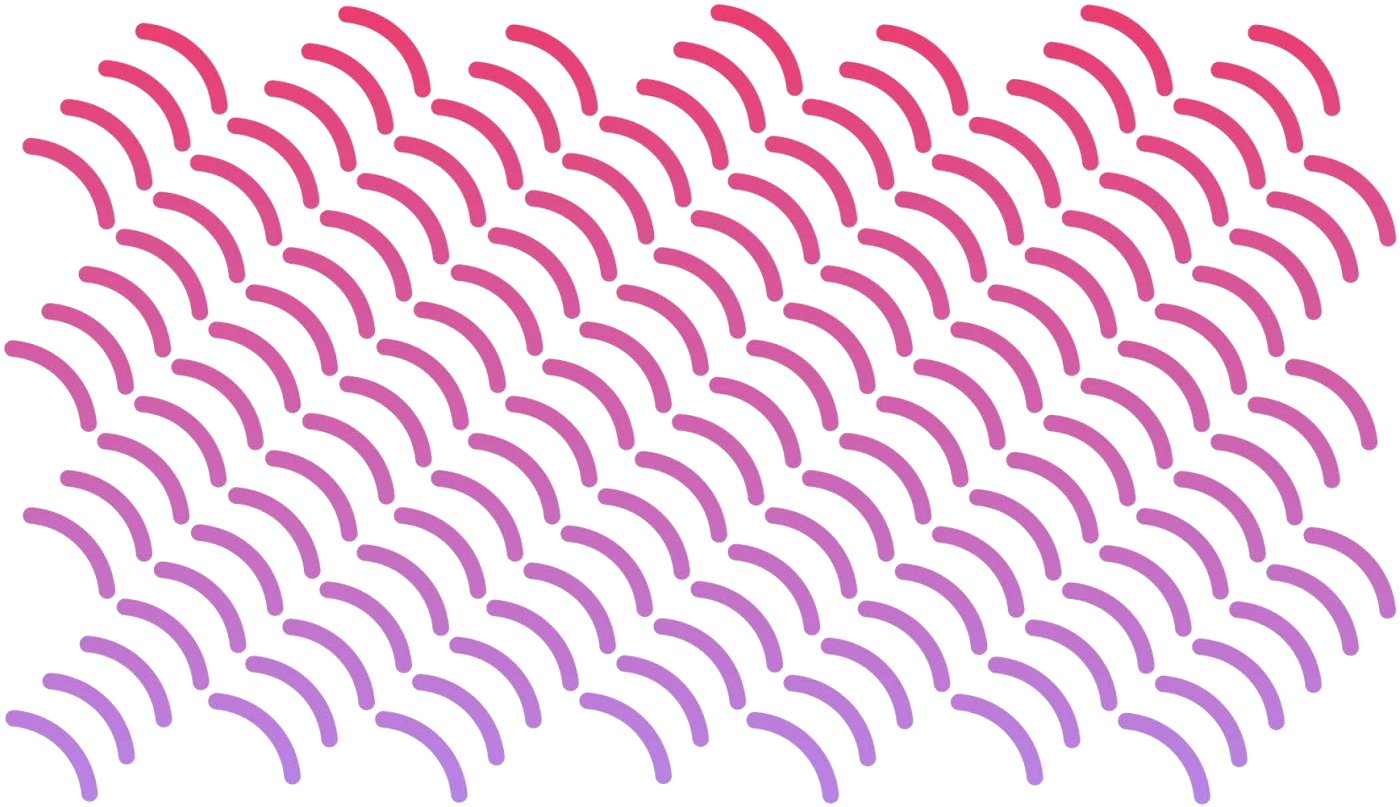
Where we are now in the process

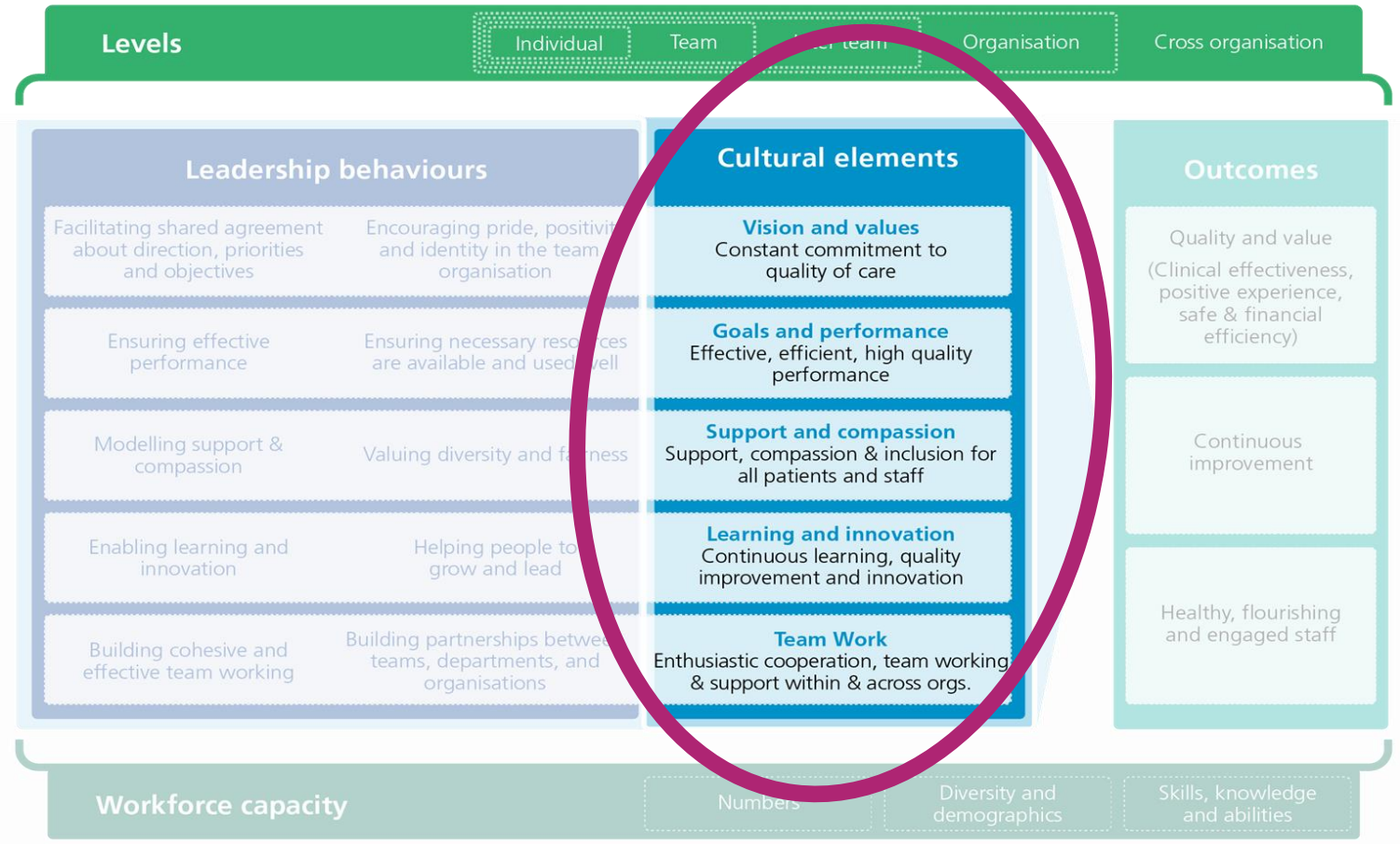
- COVID affected progress, but we are now still on schedule to the original deadlines
- Entering phase 2, we will share findings with the Board, staff and patients and collect responses to shape actions
- Phase 2 will involve more cycles of engagement - a core part of the participatory process, to bring our people *with* us
- Building awareness, ownership and energy for change at all levels will enhance success and sustainability of change



Summary of Findings
Results of the ‘Discover’ Phase



5 Cultural Elements



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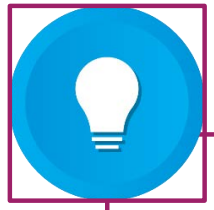
Cultural Element 1: Vision and Values
Overall Findings

Strengths

- All staff committed to wider values of NHS
- Values awards
- Staff want to provide best possible care - *We do it for the patients*
- Staff in managerial/leadership or senior clinical roles familiar with the vision
- Band 6 staff and below (especially clinical staff) generally familiar with values
- Senior leaders acknowledge poor staff experience

Areas for Improvement

- Clear disconnect between top and bottom of the organisation with squeezed middle
- Vision lacks clarity for most staff: The direction of the Trust is not always clear which is hard to then pass on
- Lack of accountability for not living the values, for example not embedded through practices such as consistent appraisals



Key Learnings

- The Vision is not recognised / understood by many staff
- Values have more meaning to most staff but they need to be lived and reinforced
- Behaviours need to be consistent and challenged when not

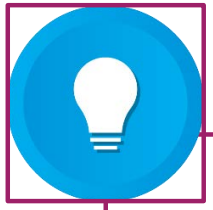
Cultural Element 2: Goals and Performance
Overall Findings

Strengths

- Spots of good performance, for example with appraisals in some areas
- Other points, as noted by CQC
- Some good performance during Covid (ITU capacity increase, training and redeployment of staff)

Areas for Improvement

- Accountability & responsibility - perceived lack of ownership for results / too many priorities
- Work-arounds undermine processes and policies. Focus on *short term* care sacrifices long term care improvement
- Lack of collaboration, listening and fairness leads to inefficiency and staff disengagement
- Lack of challenge (except for BAME staff?) and support to perform / but also on what is *realistic* through hierarchy



Key Learnings

- Tensions between targets / performance / compassion need more careful navigating
- Care often good, but in spite of systems and processes - short term focus undermines long term improvement
- More collaboration, more listening and consistent behaviour could yield higher staff engagement, productivity and efficiency
- Management and leadership needs a little more time, skill and perhaps will to tackle the above issues

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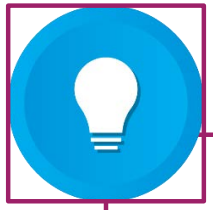
Cultural Element 3: Support and Compassion
Overall Findings

Strengths

- Care provided is good
- Listening events success
- CEO seen as compassionate
- COVID crisis support perceived as strong
- Values awards are popular

Areas for Improvement

- Staff experiences vs espoused values
- COVID crisis support also perceived as weak
- Lack of confidence in leaders – staff feel unsafe to admit mistakes or speak up
- Un-acknowledged for achievement and not heard
- BAME inconsistencies



Key Learnings

- Psychological safe place created by clearer governance, ‘rules’, listening and behaviour
- Leaders and managers to lead by example - interact in a values based way
- Consider demands / resources vs autonomy to empower staff to deliver and receive quality care

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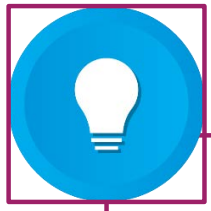
Cultural Element 4: Learning and Innovation
Overall Findings

Strengths

- Staff desire to learn and improve
- Covid19 has shown potential to change
- Many local examples of clinical improvements

Areas for Improvement

- Supportive management and leadership to enable innovation - management can 'block'
- Clearer career progression, support & development for leaders
- Open and transparent recruitment based on skills & talents
- Time and resources to engage in training or innovation - 'Survival' mentality
- QI not mainstream /joined up



Key Learnings

- Core data needed to enable learning, organisational memory and more systematic approach to developing talent and innovation
- Relationships and collaborative working in & outside hospital provide huge potential for greater innovation
- Learning journey for all STG staff
- Joint pathways with STG University & strengthening of QI embedded in all work

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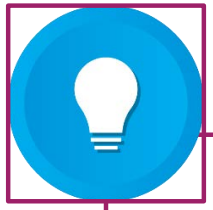
Cultural Element 5: Teamwork
Overall Findings

Strengths

- Positive team-working at Board level and with SW London partners
- Patients commend teams and departments
- Local teams often working well and with pride
- ‘Good teams are the ones where you feel comfortable approaching different people’
- COVID showed we can achieve more

Areas for Improvement

- Siloes prevent cross-team success
- Lack of medical consultant engagement
- Too much hierarchy
- BAME issues – still lack of ‘whole team’ engagement
- One key person can block progress of whole team
- Bullying still an issue



Key Learnings

- Some good local team working
- Desire for more collaborative working
- Key driver at organisational level

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Board Interviews Diagnostic Tool
Summary of Findings

OVERALL SENTIMENT
●=Positive ●=Neutral ●=Negative

25 senior leaders were interviewed, including non-executive directors, executive directors and divisional leaders.

Cultural Element 1:
Vision & Values

- Commitment to see a stronger level of connection and collaboration across divisions and teams
- Tendency of 'silo working' in the Trust
- Vision and values are not cascaded down
- Values are recognised more than the vision
- Values do not influence strategic decisions
- A gap between values and action – 'behaviours do not reflect what we describe'
- Many staff do not feel empowered to speak up

Cultural Element 2:
Goals & Performance

- Lack of role clarity
- Sense of 'managing numbers' and not people and performance
- Unclear objectives
- Inconsistent appraisals; Appraisals are a 'tick box' exercise; No team appraisals
- Poor recognition of good performance
- Very hierarchical

Cultural Element 3:
Support & Compassion

- Low psychological safety – staff do not feel confident to challenge others
- Value awards are brilliant
- Lack of incentive for staff who perform well
- Well-being area and access to quiet area in dept
- Good mediation service
- Raising awareness of bullying and harassment
- Listening events

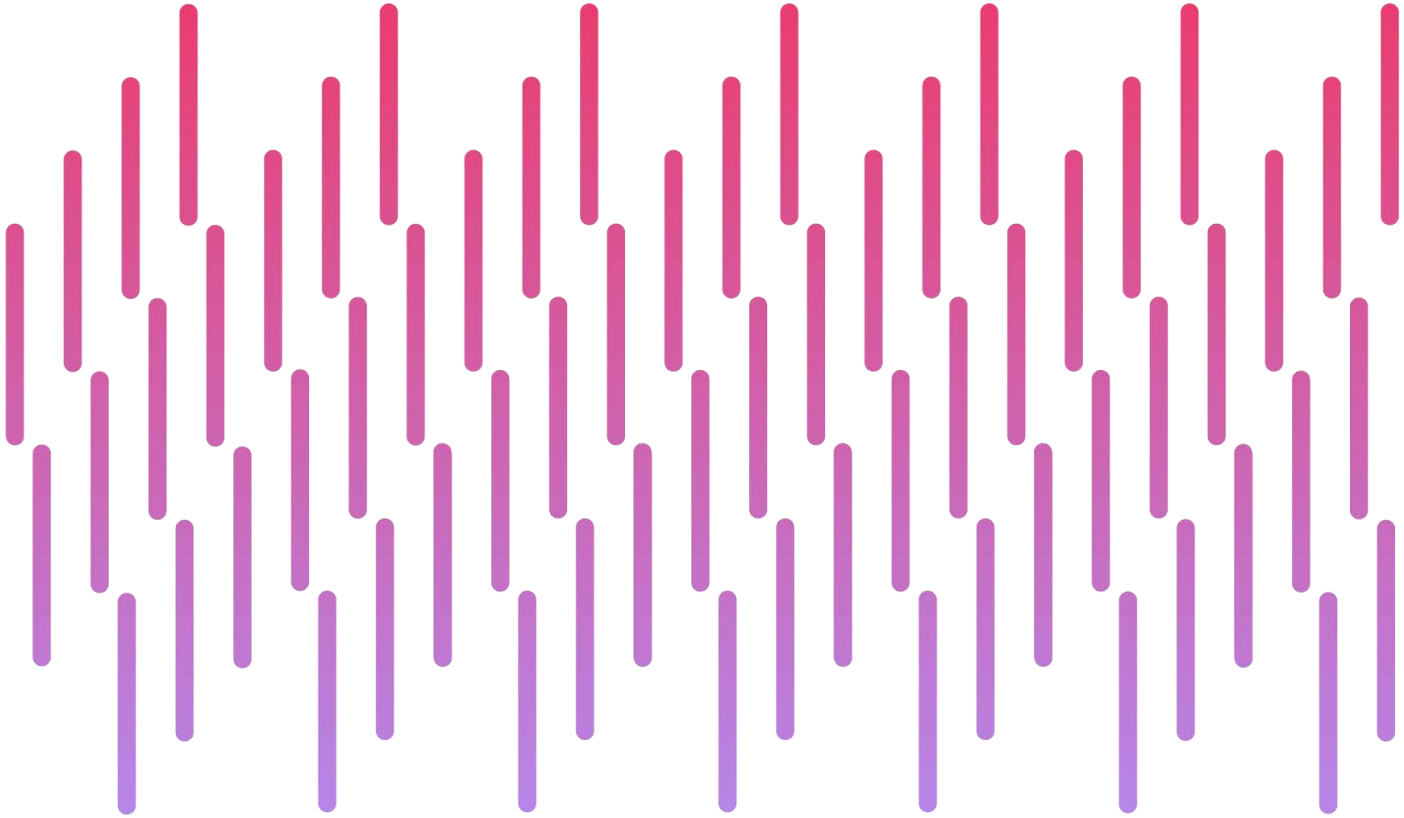
Cultural Element 4:
Learning & Innovation

- Mixed feelings - innovative organisation but some describe it as 'old-fashioned' with 'no money to do anything'
- Lack of succession planning
- Link to medical school provides lots of learning opportunities
- Leaders not always appropriately skilled
- Ambition to become a learning organisation
- Strengthen governance to support safety around innovation

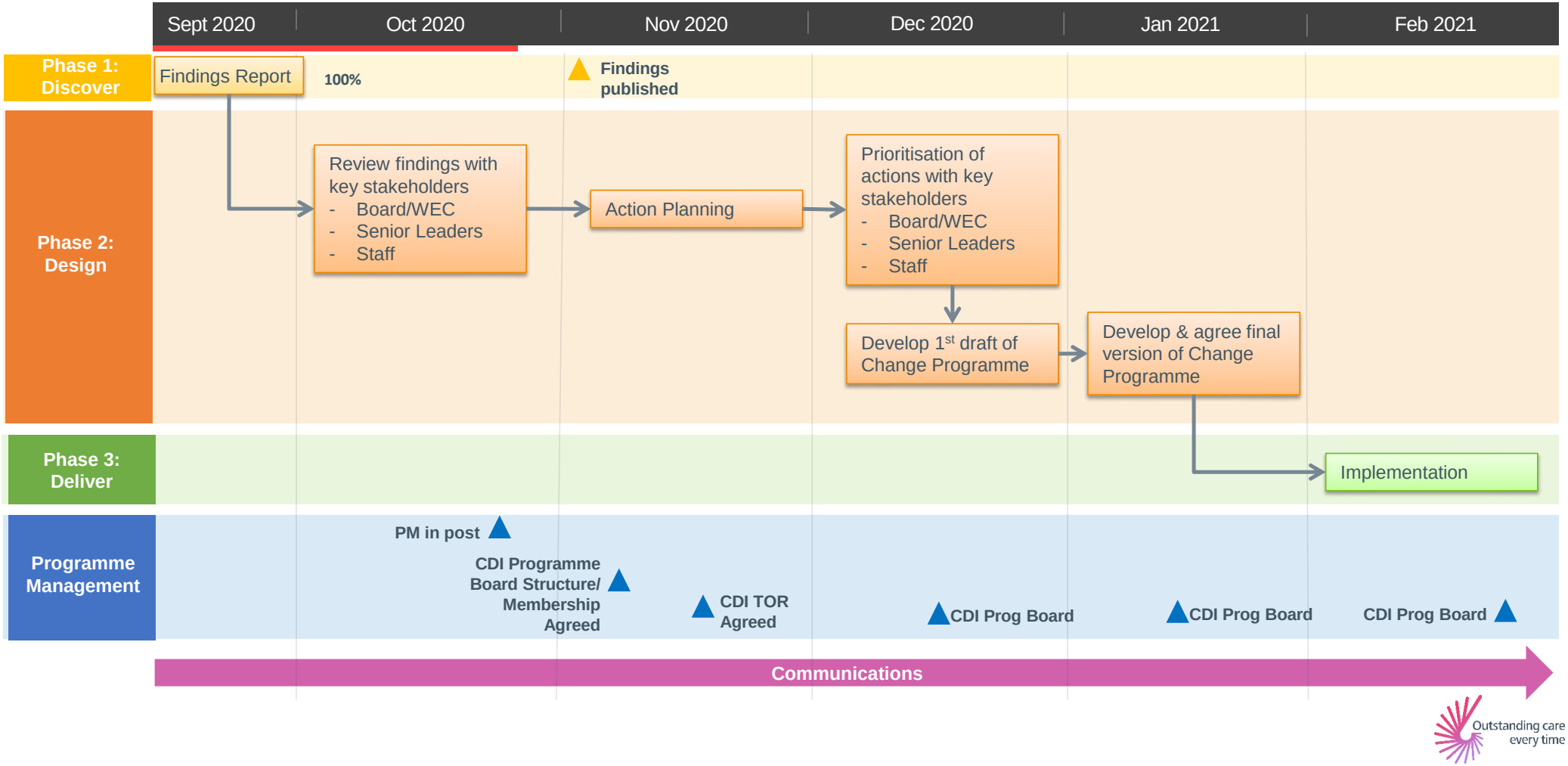
Cultural Element 5:
Teamwork

- Silo working across divisions and services with teams often working against each other
- Covid-19 has 'brushed aside silos'
- Teamwork within departments and local teams is positive
- Good team spirit

Next Steps
Moving to the Design and Delivery Phases



Programme Plan
Phases 2 & 3



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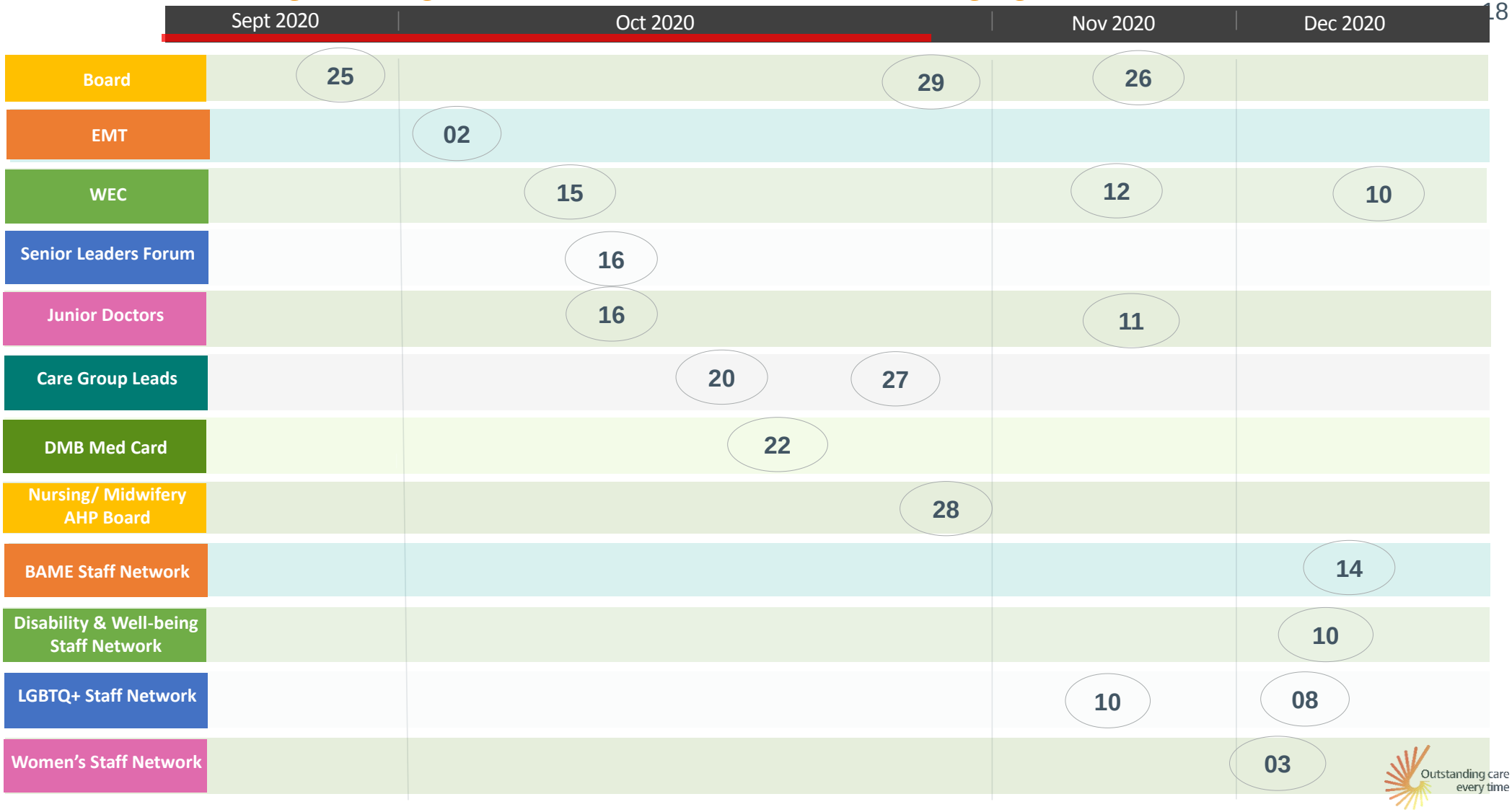
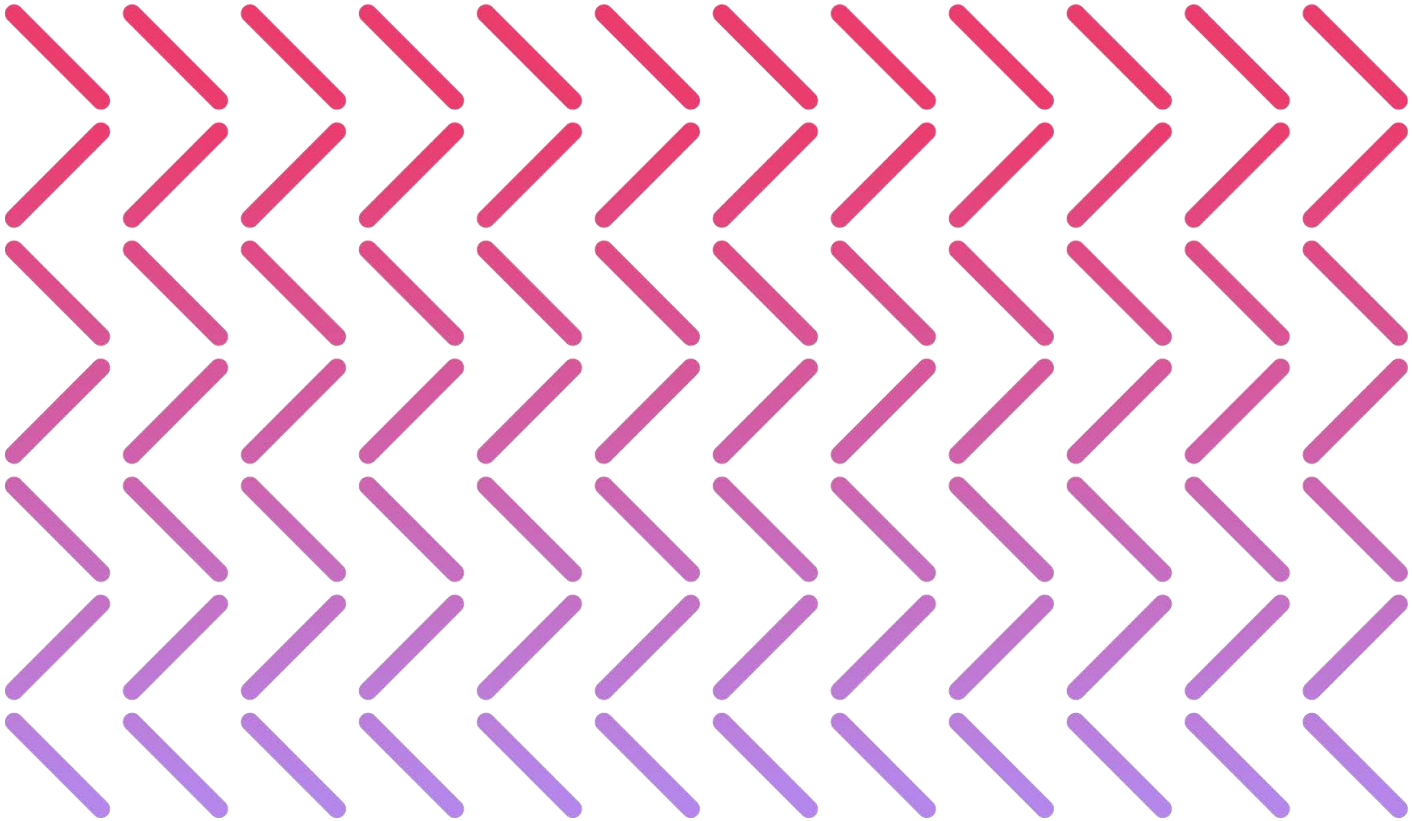
Strengthening our Culture - Stakeholder Engagement Schedule



Appendix
Findings from each diagnostic tool



Cultural Element 1: Vision and Values
Findings from each diagnostic tool

●=Positive ●=Neutral ●=Negative

This cultural element describes a strong culture as everyone taking responsibility in their work for living a shared vision and embodying shared values

Diagnostic Tool	*Summary of Findings*	*Overall Sentiment*
Board interviews Non-executive directors, executive directors and divisional leaders	• Commitment to see a stronger level of connection and collaboration across divisions and teams • Tendency of 'silo working' in the Trust • Vision and values are not cascaded down • Values are recognised more than the vision • Values do not influence strategic decisions • A gap between values and action – 'behaviours do not reflect what we describe' • Many staff do not feel empowered to speak up	●
Leadership Behaviours survey Band 7 members of staff and above	• Lacks direction (i.e. vision) and clear leadership (i.e. displaying the values) • Values are clear but 'way of living those values is not that clear'	●
Focus Groups Junior staff across different sites, services, and professions	• Vision is not clear (i.e. 5 year Trust strategy) • Lack of voice in shaping direction • Lack of clarity about priorities and values are not embodied consistently by senior staff • CEO is seen as visionary and connects across the organisation • Better understanding of values than vision • Siloes, divisions and barriers prevent collaborative working and create competition between departments	●
Dashboard Primarily staff survey data	• Lack of consistent appraisals prevent discussions about vision and values • Senior leadership team do not display the values • Bullying culture - bullying behaviour managed poorly with no consequences • Staff feel penalised for speaking out	●
Patient Experience Patients	• Excellent service and outstanding service	●

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Cultural Element 2: Goals and Performance
Findings from each diagnostic tool

●=Positive ●=Neutral ●=Negative

This cultural element defines a strong culture as everyone ensuring that there are clear priorities and objectives at every level and intelligent data constantly informing all our performance

Diagnostic Tool	*Summary of Findings*	*Overall Sentiment*
Board interviews Non-executive directors, executive directors and divisional leaders	• Lack of role clarity • Sense of 'managing numbers' and not people and performance • Unclear objectives • Inconsistent appraisals; Appraisals are a 'tick box' exercise; No team appraisals • Poor recognition of good performance • Very hierarchical	●
Leadership Behaviours survey Band 7 members of staff and above	• Leadership display poor behaviour • Senior management's siloed thinking and lack of strategic direction lead to repeated failures and 'destroys engagement' • Strong and clear local leadership • Need to simplify and improve systems and processes • More flexible working • Trust have indicated a strong anti-racism stance	●
Focus Groups Junior staff across different sites, services, and professions	• Racism evident in some areas, blocking opportunities • Staff not feeling valued or listened to especially when concerns raised • Policies are not adhered to • Hierarchical – gaps between clinical and managerial levels • Poor communication – communication is not filtered down through all layers of management; Lack of feedback • Clear goals but no clarity on how to get there • The need for better IT infrastructure	●
Dashboard Primarily staff survey data	• Unclear roles, accountabilities and responsibilities • Lack of appraisals and feedback	●
Patient Experience Patients	• Lack of communication between departments • Inefficient processes • Poor systems (i.e. self-check-in machine) • Good Wi-Fi • Useful physio app	●

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Cultural Element 3: Support and Compassion
Findings from each diagnostic tool

●=Positive ●=Neutral ●=Negative

This cultural element describes a strong culture as everyone making sure all interactions involve careful attention, empathy and intent to take intelligent helping action

Diagnostic Tool	*Summary of Findings*	*Overall Sentiment*
Board interviews Non-executive directors, executive directors and divisional leaders	• Low psychological safety – staff do not feel confident to challenge others • Value awards are brilliant • Lack of incentive for staff who perform well • Well-being area and access to quiet area in dept • Good mediation service • Raising awareness of bullying and harassment • Listening events	●
Leadership Behaviours survey Band 7 members of staff and above	• Racism; Lack of BAME career progression • Recognition for effort and achievement not consistent • Lack of compassion and support for senior staff • Culture of caring for patients and concern for outcomes • Low psychological safety – 'need to create a channel to raise concerns' as staff feel they do not have a voice • During Covid crisis 'The wellbeing programme was excellent'; Others felt taken 'advantage of' during the crisis • Staff happy with the 'wellbeing hubs' • The need to modernise working environment; Improving surroundings e.g. office spaces / kitchen / changing facilities / children's wards so that patients and staff work in a pleasant environment.	●
Focus Groups Junior staff across different sites, services, and professions	• Leaders are approachable • CEO has an 'open democratic style' • Communication does not filter down • Not listened to when raising issues to management	●
Dashboard Primarily staff survey data	• Bullying, harassment, diversity and inclusion are an issue • Inadequate staffing levels	●
Patient Experience Patients	• Caring and empathetic staff (i.e. nurses, receptionists, doctors and consultants) • Patients felt at ease and comfortable	●

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Cultural Element 4: Learning and Innovation
Findings from each diagnostic tool

●=Positive ●=Neutral ●=Negative

This cultural element describes a strong culture as everyone taking responsibility for improving quality, learning and developing better ways of doing things

Diagnostic Tool	*Summary of Findings*	*Overall Sentiment*
Board interviews Non-executive directors, executive directors and divisional leaders	• Mixed feelings - innovative organisation but some describe it as 'old-fashioned' with 'no money to do anything' • Lack of succession planning • Link to medical school provides lots of learning opportunities • Leaders not always appropriately skilled • Ambition to become a learning organisation • Strengthen governance to support safety around innovation	●
Leadership Behaviours survey Band 7 members of staff and above	• There are lots of policies and words but lack of clarity about how to implement them • New ideas and innovation often blocked by management • Career progression not managed transparently or proactively; Recruitment not open and transparent • Discrepancies between departmental policies • Better investment in training (few management courses, external training opportunities, diversity awareness) • Limited access to training for BAME staff	●
Focus Groups Junior staff across different sites, services, and professions	• Local departments open to innovation • Recruitment needs to be more open and transparent • Better communication (i.e. welcome space for staff from a different site, more computers) • Lack of training budgets	●
Dashboard Primarily staff survey data	• Lack of dedicated time for staff to engage in anti-racism training • Better training for medical records staff and HR (i.e. to reduce error in recruitments and visa applications)	●
Patient Experience Patients	• Hospital needs modernisation • Need more experienced staff with practical experience (versus learners and students with 'book knowledge') • Better training (taking blood tests, diversity awareness and showing compassion)	●

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Cultural Element 5: Teamwork
Findings from each diagnostic tool

●=Positive ●=Neutral ●=Negative

This cultural element describes a strong culture as everyone taking responsibility for effective team-based working, interconnectedness within and across organisations, systems thinking and acting

Diagnostic Tool	*Summary of Findings*	*Overall Sentiment*
Board interviews Non-executive directors, executive directors and divisional leaders	• Silo working across divisions and services with teams often working against each other • Covid-19 has 'brushed aside silos' • Teamwork within departments and local teams is positive • Good team spirit	●
Leadership Behaviours survey Band 7 members of staff and above	• Difficult to get teams to work together on a shared objective as they feel they don't have time • Silo working between departments, teams and divisions • Inter team working and collaboration isn't good • Clinicians and non-clinicians working together to find solutions and innovate during Covid-19	●
Focus Groups Junior staff across different sites, services, and professions	• Silo working with teams working against each other. • Family spirit at St Georges	●
Dashboard Primarily staff survey data	• Good teamwork (excellent colleagues and clinical staff)	●
Patient Experience Patients	• Professional team • Friendly, polite and helpful staff • Rude and unwelcoming reception staff	●

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St George's University Hospitals NHS Foundation Trust

3.1

Meeting Title:	Trust Board		
Date:	26 November 2020	**Agenda No**	**3.1.2**
Report Title:	Diversity and Inclusion Action Plan Update		
Lead Director/ Manager:	Humaira Ashraf, Acting Chief People Officer (Culture & OD)		
Report Author:	Humaira Ashraf, Acting Chief People Officer; Daniel Scott, Senior Interim OD Lead; Joseph Pavett-Downer, Workforce D&I Lead		
Presented for:	Update		
Executive Summary:	The updated D&I Action Plan is attached as appendix (A). This updated plan includes a new section three: 'Aligning with the NHS National WRES strategy'. The D&I Action Plan Progress Report is attached as Appendix B. This document provides an update on the main achievements and progress for last month and an update on the delivery tracker for deliverables and actions with RED or AMBER status only. Appendix (C) is the FAQ for the Recruitment Inclusion Specialists; Appendix (D) is the Guide for Interview Chairs and Panel Members.		
Recommendation:	For the Trust Board to note the progress that has been to date on the implementation of the D&I Action Plan		
Supports			
Trust Strategic Objective:	Culture		
CQC Theme:	Well Led		
Single Oversight Framework Theme:			
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	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.		
Equality and Diversity:	The D&I Action Plan is designed to close the gap in workplace inequalities.		
Previously Considered by:		**Date**	
Appendices:			

APPENDIX (A)

St George's University Hospitals NHS Foundation Trust

Diversity & Inclusion Action Plan

Our Organisational Commitment to Tackling Discrimination and Building an Inclusive Culture

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Last modified: 6 October 2020

Introduction

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

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

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

Development of the D&I Action Plan

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

This action plan is a 'living document'. It will be further developed and refined over the next 18 months to reflect and integrate what

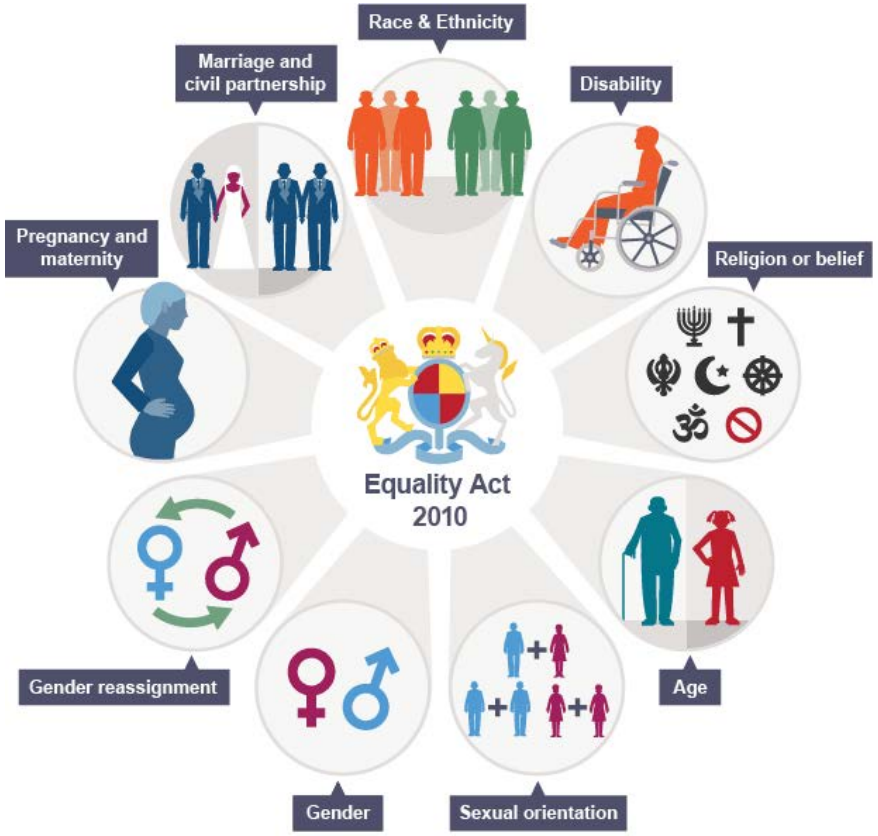


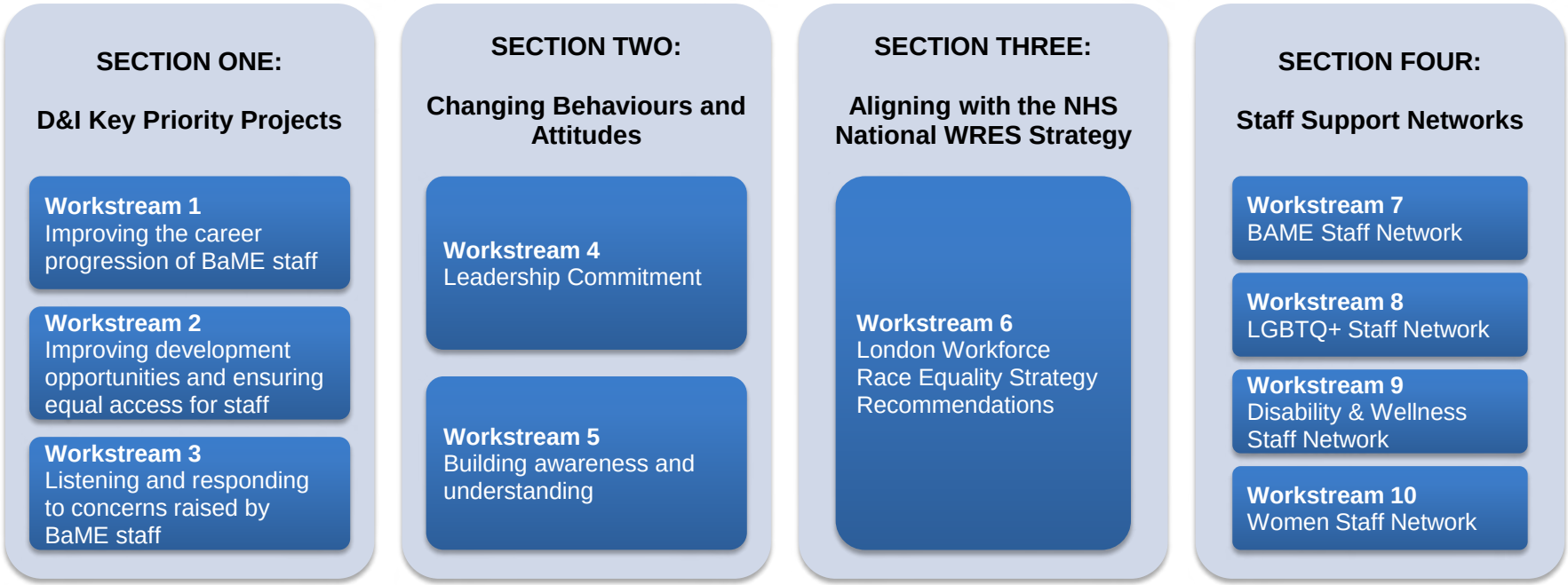
Figure 1The 9 Protected characteristics enshrined in the Equality Act 2010

we learn about the impact of our interventions, and through additional input from stakeholders around the Trust. It will also incorporate the D&I Networks' own individual action plans.

The action plan will include the actions that we are currently in the process of implementing and also actions that we are planning to undertake for all other workforce protected characteristics.

Structure of the Action Plan

The action plan will be delivered through a structured programme management approach. The specific actions have been grouped into 4 sections and 10 workstreams, as outlined below:



Key deliverables are formulated for each workstream, along with actions, delivery dates and measures / targets.

Deliverable	This is a statement of what the project will achieve or deliver for the trust
Actions	Each deliverable is broken down into one or more key actions. These describe the main milestones, outputs, products or activities to be completed which will result in the deliverable.
Delivery Date	A projected date for the completion of each action. Potential delays will be escalated and communicated, and dates may need to be adjusted as priorities shift and new ones emerge.
Measure & Target	The measure describes the factor that we will measure (e.g. number of staff trained, or % of BAME staff at Band 8a) and the target sets a goal of how many (e.g. 100 people, or 48%)

Roles and Responsibilities

It is proposed that each workstream will be led by and Executive Sponsor and supported by a professional lead and project manager. Appendix A provides an outline of the respective roles and responsibilities of the Executive Sponsor, Professional Lead and Project Manager at various stages of project delivery.

Targets and Success Measures

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

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

SECTION ONE: Diversity & Inclusion Key Priority Projects

WORKSTREAM 1: Improving the Career Progression of BAME Staff

Executive Sponsor: Chief Strategy Officer

Objective: To develop and implement initiatives that will help to remove barriers to career progression and help increase the likelihood that BAME staff will be successful in securing senior level appointments within the Trust

Key Success Measures:
- Increased % of BAME leaders in bands 6, 7 and 8A and above;
- Increased likelihood of appointment for BAME shortlisted applicants;
- Decreased relative likelihood of white staff being appointed over BAME staff
- Improved BAME staff survey score: 'Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion'

Deliverable	Actions	Prof. Lead	Project Manager	Delivery Date	Measure / Target
1.1 All recruitment panels are ethnically balanced / representative (to be mandated for band 8A and above)	1.1.1 Design and schedule 2-3 half day trainings for approx 30 BAME recruitment reps who have already been recruited and received some basic initial training	ACPO (W)	D&I Lead, Recruitmt	31/08/20	By end of 2021, we will have a pool of **120** trained BAME recruitment reps (Recruitment Inclusion Specialists) By end of 2021, **100%** of recruitment panels will include a BAME inclusion representative (Recruitment Inclusion Specialist)
	1.1.2 Assess the necessary number of BAME recruitment reps to recruit, train and retain, based on average number of recruitment panels per year • For bands 8A and above, initially • For band 7 also	ACPO (W)	D&I Lead	31/08/20	
	1.1.3 Define and implement an organisation-wide process for ensuring that: • trained BAME recruitment reps are invited to sit on recruitment panels in a reasonable timeframe after completing their training • All 8A and above recruitment panels include a trained recruitment rep	ACPO (W)	D&I Lead, Recruitmt	31/07/20	
	1.1.4 Train additional BAME staff to sit on recruitment panels, and establish an ongoing training offer to retain enough representatives	ACPO(W)	D&I Lead, HoCT	31/01/21	
1.2 All recruiting managers and recruitment panel members are trained in recruitment and selection (including countering unconscious bias in recruitment)	1.2.1 Develop and implement a training offer in recruitment and selection (R&S) for all recruiting managers and recruitment panel members, that includes unconscious bias.	ACPO(C)	HoCT, Recruitmt	31/01/21	In Q4 of 2021, **60%** of all panel members have been trained in R&S. By end of 2021, **500** total will be trained.
	1.2.2 Develop and implement a process to make R&S training (which includes bias) mandatory for all staff participating on a recruitment panel	ACPO(C)	HoCT, Recruitmt	31/03/21	

1.3 All BAME staff who are not successful at interview are offered feedback and a career coaching conversation	1.3.1 Develop and implement a process and proforma in line with positive action that managers will complete to record a career conversation if a BAME staff member is not successful at interview for a role at Band 6 or above (and encouraged for all other bands)	ACPO(C)	D&I Lead, Recruitmt	31/08/20	By endof 2021, **90%** of BAME staff not successful after interview are offered a career coaching conversation
	1.3.2 Develop supportive guidance for recruitment panel chairs offering feedback and a coaching conversation for BAME staff who are not successful at interview	ACPO(C)	D&I Lead, Recruitmt	31/08/20	
1.4 BAME staff have greater access to coaching and mentoring	1.4.1 Develop and implement a career coaching and mentoring offer (including policies and processes) that is connected to the performance appraisal process, to be made available for BAME staff (includes creating a communication plan to launch the offer to staff)	ACPO(C)	OD Lead, HoCT L&D Mgr	31/01/21	By end of 2021, **50** BAME staff are in coaching/mentoring relationships
	1.4.2 Create and build up list/bank of internal career coaches/mentors, and train new/existing coaches/mentors as necessary	ACPO(C)	HoCT, L&D Mgr	30/09/20	
1.5 BAME staff have access to interview training to boost their performance when applying for roles	1.5.1 Develop a short course and supporting written guidance on 'preparing for job interviews' and ensure it is routinely offered year round	ACPO(C)	HoCT, L&D Mgr	30/09/20 (complete)	By end of 2021, **80** BAME staff attend interview preparation training
1.6 All interviews at all levels include D&I questions and decision making criteria	1.6.1 Make D&I questions mandatory in all selection interviews, and use the candidate's response as a criteria to make recruitment decisions.	ACPO(W)	D&I Lead	31/01/21	By end of 2021 **100%** of interviews will include a D&I question (measured by the presence of a BAME Recruitment Rep)

Workstream Risks and Dependencies:

- The new process of mandatory BAME recruitment being invited onto panels may be difficult to embed
- Introducing a policy that all panel members must have completed R&S training may be unpopular when it slows a recruitment process, and will require strong and consistent leadership support (and no exceptions) for it to embed successfully
- Building and nurturing a bank of internal coaches and mentors relies on goodwill of coaches and mentors, and permission to spend time to carry out the coaching and mentoring
- Any face to face training (e.g. interview training) may be hampered by Covid-19 restrictions, while a reliance on online training can put excess pressure on any IT system hardware or software deficits (e.g. lack of web cams)

WORKSTREAM 2: Improving Development Opportunities & Ensuring Equal Access for All Staff

Executive Sponsor: Chief People Officer

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

Key Success Measures:
- Increased likelihood of staff (BAME and white) accessing non-mandatory training and CPD;
- Equal (or lower) likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff;
- Improved BAME staff survey score: 'Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion'
- Key success measures for Workstream 1

Deliverable	Actions	Prof. Lead	Project Manager	Delivery Date	Measure / Target
2.1 Equal access to training and development opportunities for all staff	2.1.1 Review and revise all policies, processes and procedures related to application and attendance for training and development to ensure selection is equitable.	ACPO(C)	Education Centre Leads	30/09/20	By end of 2021, **40%** of BAME staff are accessing training and development
2.2 Transparent, fair and equal access panel-based decision making process for selection on high value development programmes	2.2.1 Develop panel process for HEE CPD higher value development programmes (including specification of high value programmes, clear criteria, panel composition requirements, assessment techniques etc.)	Head of Corporate Nursing/ ACPO(C)	Head of Prof Dev	30/09/20	By the end of 2021, **100%** of high value programme selection processes will involve BAME represented panels
2.3 BAME staff have greater access to career coaching and mentoring	*Equivalent to deliverable 1.4 in Workstream 1 above*				By end of 2021, **50** BAME staff are in coaching/mentoring relationships
2.4 Improved personal development and career planning for employees	2.4.1 Clarify line manager expectations and responsibilities (as part of a future 'management charter') in relation to supporting staff to develop meaningful PDPs as a part of the annual appraisal process (including updating appraisal training)	ACPO(C)/ ACPO(W)	HRBPs, HofCT	31/03/21	By the end of 2021, **60%** of PDR records include evidence of career focused conversations (beyond the usual 'development conversation') *[Measurement will require new LMS functionality]*
	2.4.2 Revise Performance Development Review Process to ensure that there is a structured career development section in place	ACPO(C)	HoCT, OD Lead	31/03/21	
	2.4.3 Develop guidance and training module for managers to conduct career planning discussions (which may be part of the performance review discussion, but not exclusively)	ACPO(C)	HoCT, OD Lead	31/12/20	

2.5 An talent management approach that is inclusive in assessing, developing and retaining talent to improve representation of BAME groups	2.5.1 Develop an Inclusive Talent Management Process that is integrated into the succession planning and performance development review process	ACPO(C)	OD Lead	31/12/21	TBC with design of the talent management approach
	2.5.2 Establish Inclusive Talent Management moderation processes and panels	ACPO(C)	HRBPs OD Lead	31/12/21	
	2.5.3 Implement and embed the talent management processes using a phased approach	ACPO(C)	HRBPs OD Lead	31/12/21	
2.6 A succession planning process that is inclusive, to improve representation of BAME groups	2.6.1 Develop a succession planning approach, policies and processes for the Trust and trial the process	ACPO(C)/ ACPO(W)	HRBP/ OD Lead	31/12/21	TBC with design of the succession planning approach
	2.6.2 Implement the succession planning process across the Trust	ACPO(C)/ ACPO(W)	HRBP/ OD Lead	31/12/21	

Workstream Risks and Dependencies:

- Introducing new processes around selection for CPD (deliverables 2.1 and 2.2) may attract resistance as they will require more time and paperwork. Strong role modelling and commitment from senior leaders will be required to fully embed these new selection procedures
- Conducting a career conversation relies on the level of skill and confidence of the manager to initiate the conversation, so the risk is that the benefits will be very patchy from team to team
- Whether a career conversation has been held is fairly subjective. Clarity will need to be provided around a standard development conversation, and a truly forward looking career conversation
- Introducing talent management and succession planning methodologies requires allocating resources in time to participate in the relevant assessment and decision making processes from leaders, so resistance may be experienced and participation levels may be affected
- Assessing latent talent (or potential) can be particularly open to bias due its limitations on objectivity
- Sustainable talent management systems may benefit from some IT infrastructure to manage them which may attract necessary investment

WORKSTREAM 3: Listening, Supporting and Responding to Concerns Raised by our BAME Staff

Executive Sponsor: Chief Corporate Affairs Officer

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

Key Success Measures:
- Decreased likelihood of BAME staff entering the formal disciplinary process;
- Decreased relative likelihood of BAME staff entering the formal disciplinary process compared to white staff;
- Reduction in BAME staff survey score: 'Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months' and
- Reduction in BAME staff survey score: 'Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months'

Deliverable	Actions	Prof. Lead	Project Manager	Delivery Date	Measure / Target
3.1 Staff are offered and encouraged to raise concerns through highly accessible routes	3.1.1 Clarify and/or develop and communicate opportunities for concerns around discrimination and exclusion to be raised through a variety of routes, including Acting CPO structure, D&I Lead, FTSUG, HR, other	CCAO	FTSUG D&I Lead	01/01/21	Continuous feedback from the BAME network that channels to raise issues are adequate and effective
	3.1.2 Communicate and review the grievance/raising concerns processes with BAME network colleagues	ACPO(W)	HR Lead	30/09/20	
3.2 Teams are supported with focused OD interventions to assess and respond to team or departmental issues around diversity and inclusion	3.2.1 Work with BAME Network Chair to identify BAME staff raising issues 'hot spots' (an area where there are a number of issues being raised by BAME staff around inappropriate behaviour, discrimination and bullying and harassment)	ACPO(C) ACPO(W) CCAO	D&I Lead	31/12/21	Measures and targets will be determined for each local issue addressed.
	3.2.2 In conjunction with key stakeholders (managers responsible for 'hot spot' areas devise an OD plan to identify, address and resolve issues as raised	ACPO(C)	OD Lead	07/08/20	
3.3 Recommendations from the culture change diagnostic project around inclusion are implemented	3.3.1 Review culture change diagnostic data and incorporate improvement actions	ACPO(C)	OD Lead	31/12/21	TBC (when culture diagnostic report is complete)
3.4 Real experiences of exclusion are sensitively recorded and communicated so they are clearly and effectively heard across the Trust	3.4.1 Follow up Gillian's and Jacqueline's communication piece with a lived experience story from BME staff members that bring out real examples of what has been said to them at SGH and how it feels	BAME Network Chair, D&I Lead	Comms Lead	31/12/21	By end of 2021, we will have captured **8** personal stories of lived experience at SGH
3.5 Team leaders are supported to initiate meaningful dialogues	3.5.1 Provide structured support in the form of techniques, guidelines and where possible facilitation for Team leaders to have meaningful	ACPO(C)	OD Lead	31/08/20	Number of team level discussions

around inclusion with their teams	conversations about diversity and inclusion				conducted around Race and Inclusion

Workstream Risks and Dependencies:

- Encouraging our BAME staff to share their concerns and experiences can inadvertently force colleagues to re-live painful and traumatic events that we need to be quick to support, through means such as Staff Support
- Similarly, participating in team discussions around race and inequality will likely trigger emotional responses that leaders will need to respond to appropriately and sensitively and signpost colleagues to sources of support when necessary
- There may be a high level of requests for support around preparing for and/or facilitating team conversations around inclusion and we currently have very limited OD capacity and capability to offer in response

SECTION TWO: Changing Attitudes and Behaviour

WORKSTREAM 4: Leadership Commitment

Executive Sponsor: Chief Executive Officer

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

Key Success Measures: - Improved staff survey scores for BAME and ALL staff groups: 'Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion'
- Reduction in staff survey scores for BAME and ALL staff groups: 'Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months'

Deliverable	Actions	Prof. Lead	Project Manager	Delivery Date	Measure / Target
4.1 The expectation of all staff to be involved in tackling exclusion and discrimination is role modelled	4.1.1 Executive Team and Board members to come up with one personal action which they will take to improve the working lives of the BAME workforce (e.g., I am being reverse-mentored by a BAME colleague) and cascade to all employees	Chair, CEO, CCAO	ACPO(C), D&I Lead	31/08/20	**100%** of Exec team comply
4.2 D&I networks are actively and visibly supported by an Executive Sponsor	4.2.1 Review and clarify the role of the Executive Sponsor in providing focused support for each D&I Network, including specifically, supporting the implementation of each network's action plan	ACPO(C)	D&I Lead	31/08/20	Each network has an action plan with active endorsement from Exec sponsor
4.3 Leadership competencies specific to inclusion are defined and integrated in all leadership development initiatives	4.3.1 Develop competency framework for leaders/senior managers, specifying building the capability to promote D&I as a core management and leadership competency	ACPO(C)	OD Lead	31/12/21	By the end of 2021, all existing and new management and leadership programmes explicitly focus on D&I competencies as a core requirement of good leadership and management
	4.3.2 The Advanced Leadership Programme aimed at Deputy General Managers and Service Managers to include the development of inclusive leadership capabilities.	ACPO(C)	HoCT	01/11/21	
	4.3.3 Ensure that all existing general programmes, and future Leadership Development programmes commissioned for functional directorates contain inclusive leadership capabilities as a core part of the programme	ACPO(C)	HoCT	31/01/21	
4.4 Leadership position successors are required to demonstrate a strong commitment to inclusion	4.4.1 Succession planning to include D&I as a gateway; The Trust can only promote (or nominate to promote) an individual if they have an excellent track record of promoting D&I **NB Connection to Deliverable 2.6 on succession planning*	ACPO(C)	OD Lead	31/12/21	TBC with design of the succession planning approach

4.5 Each Division and Directorate has a D&I action plan in place that translates organisational D&I initiatives locally and focuses on local D&I priorities	4.5.1 Divisions and Directorates are supported to produce local D&I action plans which consider: What are we going to do as a division/directorate to improve diversity and inclusion within our function? To include a toolkit/template for identifying priorities and formulating an action plan.	COO	HRBPs D&I Lead	31/01/21	Evidence of local D&I action plans
4.6 St George's D&I strategy and action plan (and its measurable outcomes) are comparable to and continually learning from the D&I successes (and challenges) of other Trusts, organisations and sectors	4.6.1 Introduce an annual benchmarking exercise with other Trusts (link to WRES data)	ACPO(C)	D&I Lead	31/01/21	Participation in relevant networks, annual benchmarking, and adoption of best practice from other organisations
	4.6.2 Build and/or connect with a network of D&I Leads in other comparable Trusts with similar challenges, to offer a forum for continuous learning, and improvement (including visits to other Trusts)	ACPO(C)	D&I Lead	ongoing	
	4.6.3 Learning from other organisations and sectors country wide through networking and other relationship building efforts	ACPO(C)	D&I Lead	ongoing	
4.7 D&I is systematically considered in all leadership and governance discussions and decision making forums/processes at Board and Exec levels	4.7.1 To ensure that D&I features in our discussions and decision making processes we will: • Wherever possible include D&I issues as a discussion agenda item; • Review our meetings in relation to how effective we were in considering D&I • Include a section on our paper submission template that explicitly outlines the impact of decisions/plans on D&I	CCAO	D&I Lead, ACPO(C)	31/08/20	Continuous explicit focus on D&I in all Board and Exec level meetings
4.8 Board level meetings regularly include reviewing patient and staff stories and monitoring WRES data	4.8.1 Agree as part of our Patient and staff story at Trust Board we will also consider a D&I staff or patient story	CCAO, D&I Lead	Comms Lead	31/01/21	TBC
	4.8.2 Use the WRES and survey data to make a simple dashboard to track progress at each Board meeting	ACPO(C)	D&I Lead	31/01/21	
4.9 All staff communications will regularly feature updates, successes and stories that promote the agenda for building a culture of inclusion	4.9.1 Regular communications on D&I are developed and disseminated to all staff from the CEO/Chair/Exec team	D&I Lead	Comms Lead	ongoing	Monthly communications reflecting D&I specific content
4.10 The D&I action plan is fully aligned with the organisational culture change programme	4.10.1 Align all D&I leadership work with the culture change programme and ensure all recommendations are integrated	ACPO(C)	OD Lead	31/01/21	TBC (when culture diagnostic report is complete)

Workstream Risks and Dependencies:

- Some D&I networks may require additional budgets depending on their plans and expectations may have to be managed sensitively
- Newly identified leadership competencies and expectations around inclusion may trigger a surge in required funding or in-house capacity and skills to design and deliver leadership and inclusion training

WORKSTREAM 5: Building Awareness and Understanding

Executive Sponsor: Chief People Officer

Objective: To develop an understanding of the barriers to inclusion and diversity and build an awareness of the role that inclusion and diversity play in organisational learning, innovation and performance.

Key Success Measures: - Reduction in BAME staff survey score: 'Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months' and
- Reduction in BAME staff survey score: 'Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months'

Deliverable	Actions	Prof. Lead	Project Manager	Delivery Date	Measure / Target
5.1 The workforce has renewed and strengthened connection and meaning with our organisational values, specifically 'Respect'	5.1.1 Plan, launch and implement the 'Respect' culture and values programme (previously a St Helier initiative), likely to involve a range of facilitated team discussions, learning experiences, special events and provision of tools and resources. Activities will include: • Setting up a working group • Scoping logistics and resources • Output, outcomes and project planning • Communication planning with key stakeholders • Programme delivery • Monitoring and tracking progress	ACPO (C)	HoCT/ OD Lead/ HRBP	31/01/21	TBC
5.2. Different minority groups are recognised and celebrated across St George's	5.2.1 Plan and deliver a sustainable range of diversity and faith awareness and celebration events throughout the year.	D&I Lead	D&I Network Leads	ongoing	TBC
5.3 The D&I action plan is fully aligned with the organisational culture change programme	5.3.1 Align the D&I Action Plan with the culture change programme	ACPO(C)	OD Lead	31/01/21	TBC
5.4 All staff build an awareness of unconscious bias at work as a basis to continue building more inclusive team and organisational cultures	5.4.1 Specify and develop a bespoke training workshop '	ACPO(C)	OD Lead, L&D Mgr	30/09/20	By the end of 2021, **2000** individuals in the Trust will have completed the F2F or online module.
	5.4.2 Pilot and launch a short online workshop	ACPO(C)	OD Lead, L&D Mgr	31/10/20	
	5.4.3 Make the workshop widely available as both an online or in-person experience, sourcing the help of external providers as needed	ACPO(C)	OD Lead, L&D Mgr	31/12/20	
	5.4.4 Develop a self-directed online e-learning module reflecting the same content	ACPO(C)	L&D Mgr	31/12/20	

5.5. All staff have highly accessible access to the full range of D&I resources, trainings, contacts, policies and other information via the intranet	5.5.1 Develop a D&I intranet page that integrates all existing and future resources, trainings, contacts, policies, and networks information etc.	ACPO(C)	D&I Lead	31/12/20	TBC (target hits on intranet site to be set when launched)

Workstream Risks and Dependencies:

- Budget required for online unconscious bias training
- Unconscious bias training needs to align with recruitment and selection training (also including UB elements) and wider D&I training initiatives
- 'Respect' programme is dependent on some input and support from St Helier to try and replicate some of their successful outcomes

SECTION THREE: Aligning With the NHS National WRES Strategy

WORKSTREAM 6: London Workforce Race Equality Strategy Recommendations

Executive Sponsor: Chief People Officer

Objective: To ensure that all 15 of the recommendations set out in the London WRES strategy are reflected and implemented in our organisational approach to strengthening diversity and inclusion

Measures of Success: **-** Decreased likelihood of BAME staff entering the formal disciplinary process;
- Decreased relative likelihood of BAME staff entering the formal disciplinary process compared to white staff;

Deliverable	Actions	Prof. Lead	Project Manager	Delivery Date	Measure / Target
6.1 Authoritarian managerial processes are replaced with person centred learning processes	6.1.1 Develop a new approach and process to respond to serious or chronic performance issues, thus reducing our dependency on formal disciplinaries (to be used only for extreme cases, e.g. theft, violence and patient safety breaches)	ACPO (W)	ACPO(W)	30/11/20	**25%** reduction in number of formal disciplinaries by end of 2021.
	6.1.2 Implement new approach and processes as designed	ACPO (W)	ACPO(W)	30/11/20	
6.2 An executive on each board has completed the WRES Advisor programme	6.2.1 Executive level advisor to be nominated	ACPO (C)	ACPO (C)	30/09/20	Evidence of completion
	6.2.2 Nominated executive level advisor to attend the WRES Advisor Programme	ACPO (C)	ACPO (C)	31/03/21	
6.3 An organisational culture transformation programme is in place to strengthen racial inclusion	6.3.1 Align the D&I Action Plan with the culture change programme	ACPO(C)	OD Lead	31/01/21	TBC (when culture diagnostic report is complete)
6.4 Increased BAME representation among Freedom to Speak Up Guardians and champions	6.4.1 Align the D&I Action Plan with the organisational FSUG strategy	D&I Lead	D&I Lead	31/12/20	By end of 2021, % of FSUGs is **equivalent** to the BAME staff %
6.5 Independent STP/ICS WRE oversight panels are in place	FOR INFORMATION ONLY (implemented outside of the Trust)				
6.6 Commissioners are working with providers in enhancing their performance against indicators of race inequality	FOR INFORMATION ONLY (implemented outside of the Trust)				
6.7 CQC Assessments include specific race	FOR INFORMATION ONLY (implemented outside of the Trust)				

related key lines of enquiry					
6.8 Competency Frameworks and Development Programmes for supervisors and line managers	*Covered by deliverable 4.3 in Workstream 4 above*				
6.9 White Allies Programme is in place and supported to more effectively distribute responsibility for equality and inclusion	6.9.1 Research best practice among white ally programmes in NHS and other organisations	ACPO (C)	Engmt Ld	31/12/20	TBC on development of the programme
	6.9.2 Develop and agree a proposal to establish and support a white allies programme/network, in collaboration with the BAME network Chair and Workforce D&I Lead	ACPO (C)	Engmt Ld	31/01/21	
	6.9.3 Implement the proposal	ACPO (C)	Engmt Ld	31/03/21	
6.10 A Frontline Staff Forum is established to enable more feedback on the success of this action plan, and other aspects of working life in the NHS	6.9.1 Research best practice among Frontline Staff Forums in NHS and other organisations	ACPO (C)	Engmt Ld	30/04/21	TBC on development of the programme
	6.9.2 Develop and agree a proposal to establish and support a Frontline Staff Forum	ACPO (C)	Engmt Ld	31/05/21	
	6.9.3 Implement the proposal	ACPO (C)	Engmt Ld	31/07/21	
6.11 A London-specific WRES experts cohort is established	FOR INFORMATION ONLY (implemented outside of the Trust)				
6.12 Recruitment and secondment processes are debiased	*Recruitment aspect is covered by Workstream 1 above*				
	6.12.1 Develop a process for applying for and awarding secondments that is transparent, unbiased and equally accessible	ACPO (W)	ACPO(W)	31/10/20	TBC
	6.12.2 Implement new processes, including effective staff engagement and communications	ACPO (W)	ACPO(W)	31/12/20	
6.13 Identification and closure of the gap in experience for agency, bank and temporary staff	FOR INFORMATION ONLY (to be implemented initially by London-wide intervention, and may require future organisational level actions)				
6.14 Improved understanding of the experience of staff in primary care	FOR INFORMATION ONLY (implemented outside of the Trust)				
6.15 Implemented key recommendations from the London Nursing and LAS priority plan	FOR INFORMATION ONLY (implemented outside of the Trust)				

SECTION FOUR: Staff Support Networks

WORKSTREAM 7: BAME Staff Network

Executive Sponsor: Chief People Officer

Objective: To maintain and actively nurture the BAME staff network as a source of support for BAME staff and an important point of reference and consultation for BAME issues across the organisation

Measures of Success: TBC

WORKSTREAM 8: LGBTQ+ Staff Network

Executive Sponsor: Chief People Officer

Objective: To maintain and actively nurture the LGBTQ+ staff network as a source of support for LGBTQ+ staff and an important point of reference and consultation for LGBTQ+ issues across the organisation

Measures of Success: TBC

WORKSTREAM 9: Disability and Wellness Staff Network

Executive Sponsor: Chief People Officer

Objective: To maintain and actively nurture the Disability and Wellness staff network as a source of support for staff with disabilities and health conditions and an important point of reference and consultation for disability and wellness issues across the organisation

Measures of Success: TBC

WORKSTREAM 10: Women Staff Network

Executive Sponsor: Chief People Officer

Objective: To maintain and actively nurture the Women staff network as a source of support for female staff and an important point of reference and consultation for women and gender issues across the organisation

Measures of Success: TBC

Appendix A: Overview of Roles and Responsibilities

- The **Project Manager** is responsible for the overall completion of the agreed project deliverables, using agreed the project methodology. They will oversee and coordinate day to day activities and involvement of team members and external suppliers to ensure the project is delivered on time, within budget and to the required quality;
- The **Professional Lead** is a subject matter expert who ensures that the project deliverables will strategically achieve the desired outcomes, and in alignment with other projects. They advise and oversee the Project Manager in developing sound project documentation, provide coaching and support to complete all deliverables to the required level of quality, and act as an escalation and sign-off route for risks, issues and project changes;
- The **Executive Lead** is a senior/chief level sponsor and champion who supports adequate resourcing and alignment and recognition of projects across the Trust. They offer high-level oversight of the project and act as a final escalation point for risks, issues and changes.

Project Phase	Project Manager	Professional Lead	Executive Lead
Inception	• Prepare a project brief to clearly communicate the project's desired outcomes and deliverables • Identify measures for monitoring and evaluating project outcomes	• Ensure the that the stated project deliverables will achieve the desired measurable outcomes • Sign off the brief and communicate new projects to Executive Lead and other departments as required • Ensure strategic alignment with other projects in and outside of the department	• Support the inception of projects that will meet the needs of the Trust • Ensure strategic alignment with other projects and programmes across the Trust • Sign off briefs that are of particular risk or expense to the Trust
Planning	• Develop a project plan (within a PID) to outline how the deliverables will be completed over time, including key stages, milestones and resources • Identify main risks and corresponding mitigation strategies, and build these into the project plan	• Advise on, contribute to and sign off the project plans and budgets (PIDs)	• Sign off project plans (PIDs) that are of particular risk or expense to the Trust
Implement-ation	• Complete all deliverables in the plan within agreed timescales, engaging and overseeing the work of any project team members • Resolve emerging issues and escalate significant issues and risks to the Professional Lead • Manage and monitor the project budget • Coordinate and chair project meetings as required • Report on progress as required to the Professional and Executive Leads	• Maintain an overview of the project ensuring the quality of the deliverables and process • Support and coach the project manager to prioritise, problem solve and make decisions • Sign off on necessary changes to the project that may affect quality of outcomes, timescales and budgets • Escalate significant issues/risks when necessary	• Champion the project across the Trust and ensure continued alignment and integration with other projects • Advise Professional Lead of external or internal changes that may impact the project
Integration and Evaluation	• Capture lessons learned to benefit future projects • Ensure an appropriate evaluation of the outcomes of the project • Integrate the project into BAU so that its benefits are sustainable	• Oversee evaluation of the outcomes and ensure that the benefits of the project can be demonstrated • Ensure sustainability of the project deliverables and outcomes	• Communicate outcomes and successes of the project to the wider organisation • Ensure that resulting changes of the project are integrated across the Trust

Appendix B: Workforce Race Equality Standard (WRES) 2019

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

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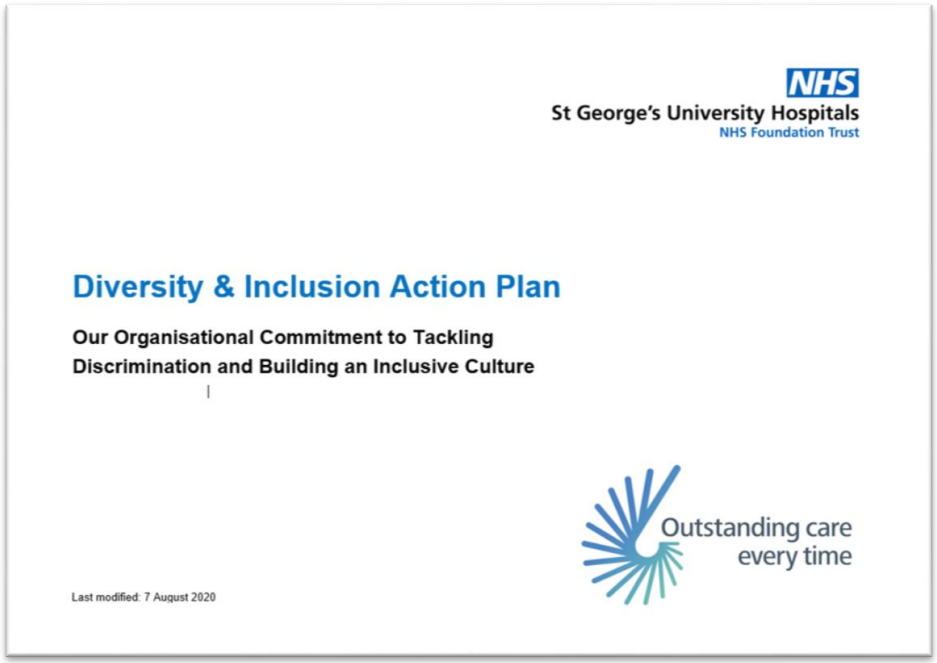
APPENDIX (B)

D&I Action Plan Progress Report

October 2020



November 2020

Main achievements and progress this month

Tracking D&I Outcomes

- As set out in the D&I Action Plan Impact Tracker, the end of Sept ember involved taking our first measures of impact of the D&I Action Plan.
- Overall, we are starting to see small shift in the right direction, in line with what we would deem an appropriate and positive change. In future quarterly measurements, we hope the shift will gradually become more pronounced.
- The four measures below indicate the proportion of leaders who identify as BAME at bands 6, 7 and 8a+. The baseline figure is from August – taken from the 2019 WRES report.

MEASURE	BASELINE (Aug 20)	Q3 30/9/20
Proportion of leaders who identify as BAME at **Band 6** (clinical and nonclinical combined, excluding medical)	48.1% (714 of 1482)	49.1% (735 of 1498)
Proportion of leaders who identify as BAME at **Band 7** (clinical and nonclinical combined, excluding medical)	34.3% (406 of 1183)	34.7% (419 of 1208)
Proportion of leaders who identify as BAME at **Band 8A and above** (clinical and nonclinical combined, excluding medical)	25.1% (167 of 665)	25.2% (167 of 662)

BAME Recruitment Panel Representatives

- The half day training workshop has now been delivered 4 times, training a total of 67 BAME recruitment representatives. Due to popular demand for this training, another two workshops have been organised for 23 October and 19 November.
- In the last month, 11 recruitment panels have recruited posts at levels 8a or above, and all 11 (100%) included a BAME Recruitment Representative.
- Responding to feedback from BAME Recruitment Reps, we are producing written guidance that will include:
  - the roles and responsibilities of the panel chair, BAME recruitment reps, and other panel members, and how they should work together
  - The process for finding BAME recruitment reps
  - A Q&A covering the main questions and concerns arising

Recruitment and Selection Training

- BAME recruitment representatives have called for for more *general training on Recruitment and Selection (R&S)*, which is already planned within the D&I Action Plan. As well as supporting them to participate effectively on panels, this training would also more explicitly and appropriately share the responsibility of tackling bias with their white colleagues.
- General R&S training will focus on following our organisational processes, good recruitment practices and making the decision as objectively as possible, which will help to eliminate bias. It will also feature a section on bias specifically.
- This training will target all staff participating in recruitment panels, with future plans to mandate the course for all panel members. BAME Recruitment Representatives will also be invited to participate in addition to the half day course designed specifically for them.

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Main achievements and successes this month

'Challenging Our Biases' Training

- This will be St George's tailored and modernised take on Unconscious Bias training. It has been repeatedly called for by many staff and leaders, in recognition that we need to be directly supporting people to recognise and tackle their own biases, and those of others.
- This widely accessible learning experience will continue to embed the language of bias and inclusion at St George's, and the expectation for leaders and all staff to support building an inclusive culture. This key product of the D&I action plan will inform many other learning initiatives including recruitment and selection, people management and leadership training.
- We are partnering with an external specialist in to co-create a high quality product, which we can be confident will be well received and achieve results. Content will be closely tailored to the context and realities of St George's including real examples, statistics and stories (and possibly video content).
- Training materials produced will be owned by St George's, and be available for us to adapt and deliver to a range of staff groups. Our partnership will enable us to flexibly draw upon expert facilitators when demand calls for it, to train up our own internal facilitators (or to use a combination of both), enabling more sustainable training provision.
- The workshop is initially being designed as a 2.5 hour live online experience (via MS Teams), which can also be facilitated in-person where venue and Covid-safe measures allow for it. We will then look to develop the content into a self-directed e-learning module, accessible via our Learning Management System.
- See the Appendix for a list of learner objectives and a draft workshop outline.

2020 Workforce Disability Equality Standard (WDES) Report

- The WDES report first draft is complete and has been reviewed by PMG.
- An extension for submission has been granted until 30 November while the report is finalised.

Launch of the new London Race Equality Strategy

- Last week this new London-wide strategy was officially launched by the D&I team at NHSEI. It includes 15 new recommendations including a white allies programme and a frontline staff forum.
- All of the recommendations have been built into the existing D&I Action plan, and aligned to existing plans where they exist.

Intranet Site

- The D&I Intranet pages are now under development which will offer valuable and much needed housing for all existing and future D&I tools

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Main achievements and successes this month

Black History Month

- This month our Black, Asian and ME (BAME) Staff Network are shining a light on Black History and encouraging staff to honour the past and inspire the future.
- We have asked staff across the organisation to look inwards at commitments they can make that go beyond October 2020 - commitments to be a better leader, a better colleague, a better friend
- The network have a number of initiatives running across the month, including:
  - Weekly staff profiles featured in comms and twitter
  - Cultural dress day – staff encourage to wear national dress and submit photos across their division and to the network leads. At the end of the month a panel will vote on the best dressed/most effort for BHM.
  - African and Caribbean menu days hosted in Ingredients Café
  - Goody bags

Local (Team / Departmental) Updates

QI / Transformation

- The QI / Transformation team organised an online event to explore their interest, responsibilities and priorities in supporting to build an inclusive culture.
- Facilitated by the Organisational Development (OD) Team, the group were introduced to some D&I concepts, discussed their own experiences of exclusion, and shared ideas for what needs to happen next.
- A smaller subgroup of inclusion champions has been formed to start developing and taking forward a local D&I plan.

Paediatrics

- The Paediatric Department are in the process of organising an introductory event to invite the formation of an Inclusion Committee to develop a local D&I action plan.
- Within Paediatrics, the Children's Therapies team's own D&I Working Group have made designed a poster to capture and formalise their commitments to D&I work (see below).

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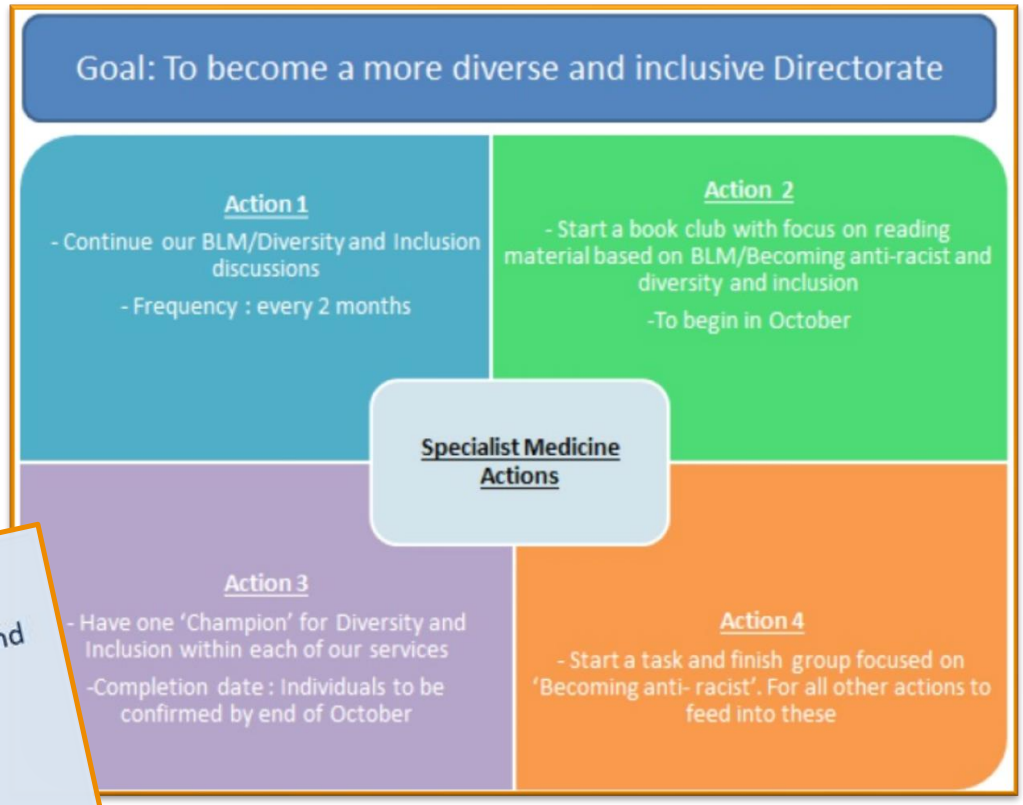
Local (Team / Departmental) Updates

Specialist Medicine

- Specialist Medicine have organised and facilitated a Black Lives Matter / D&I team conversation which was well attended.
- They have also developed their own set of behavioural commitments and set our 4 focused actions toward building a stronger culture of inclusion across the team (see opposite).

Cardiac Physiology

- Leaders in the Cardiac Physiology team have sought some advice on starting to build a more inclusive culture and are currently making plans to proceed.



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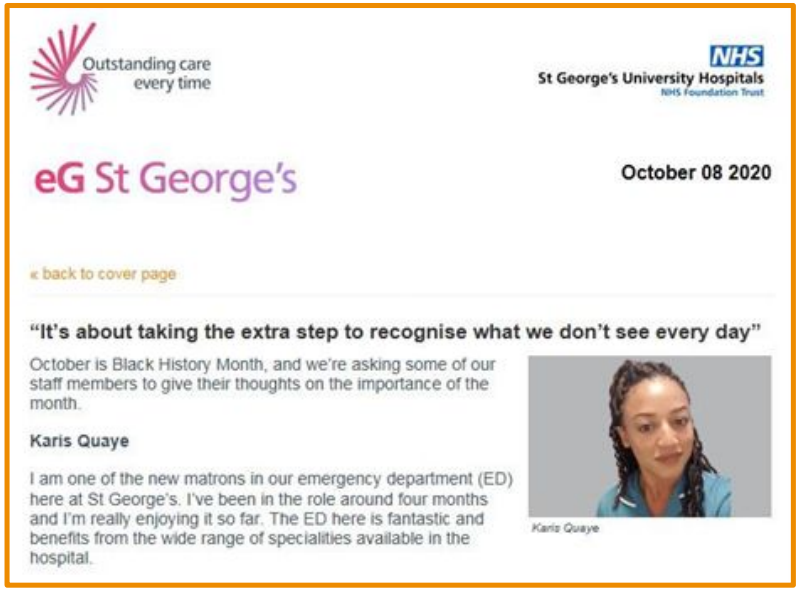
Local (Team / Departmental) Updates

Pharmacy

- The Pharmacy Team have continued to organise and self-facilitate regular Listening Events (usually monthly), welcoming both BAME and white colleagues to share experiences and to learn.
- They organised and held a Black History Month event on 15th October. In November they will meet with the OD team to start focusing their objectives and to form a local D&I action plan.

Emergency Department / A&E

- The ED team have organised several activities to celebrate Black History Month and are busy advertising these to staff and building up interest (see opposite)
- They have also published ED matron Karis Quaye's recent interview on what Black History Month means to her.



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eG St George's

October 08 2020

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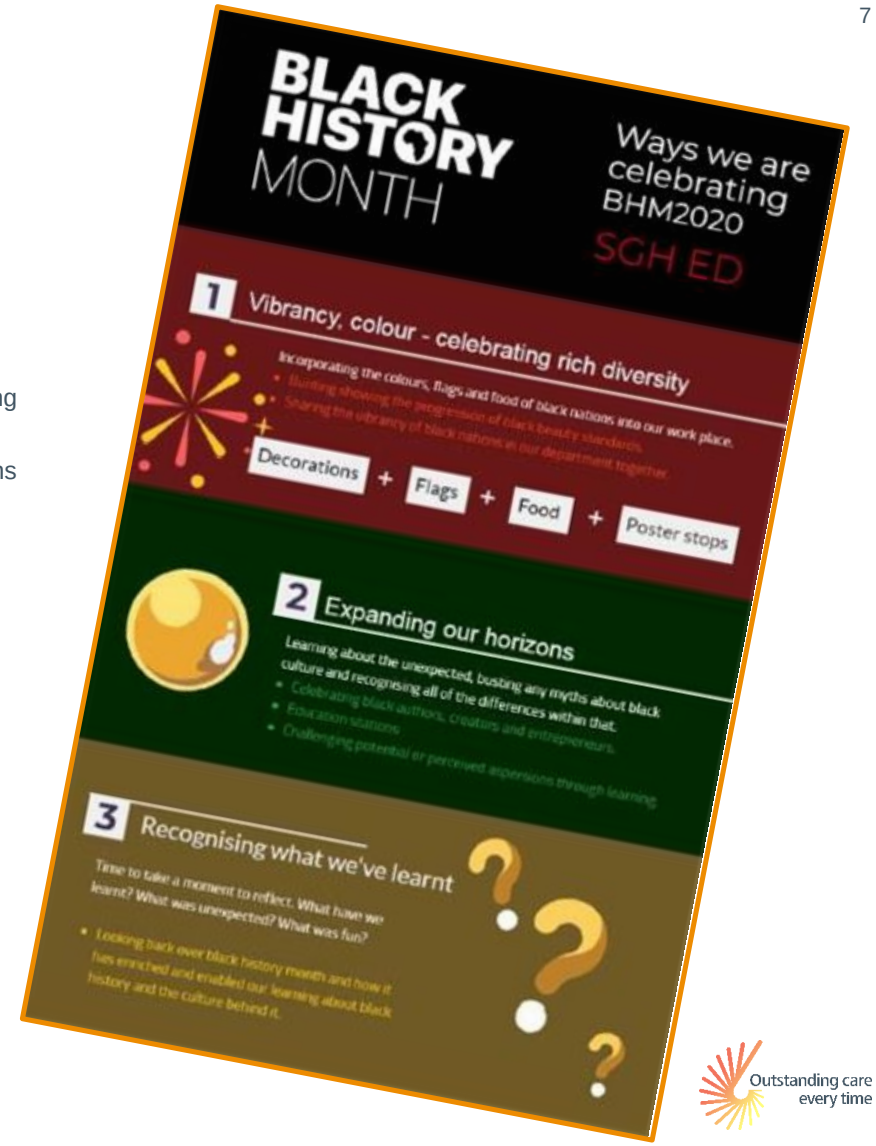
"It's about taking the extra step to recognise what we don't see every day"

October is Black History Month, and we're asking some of our staff members to give their thoughts on the importance of the month.

Karis Quaye

I am one of the new matrons in our emergency department (ED) here at St George's. I've been in the role around four months and I'm really enjoying it so far. The ED here is fantastic and benefits from the wide range of specialities available in the hospital.

Karis Quaye



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Appendix: Challenging Our Biases Training
Learner objectives and workshop outline

Format

- 2 ½ hour workshop
- To be facilitated on MS Teams

Proposed Workshop Objectives

- Understand and appreciate the urgency and importance of tackling bias and supporting inclusion
- Recognise the many faces of bias, how it leads to exclusion and the effects this has on our organisation
- Identify when and how we can challenge **ourselves** on our biases
- Identify when and how we can best challenge **others** on their biases
- Propose how we can continue to personally develop and take action to tackle the negative effects of bias at work in future

The importance and urgency of challenging bias	• Some facts about bias and discrimination at St Georges • What is D&I? How do they work together? • Benefits of belonging and inclusion for the org and patients • The negative impact of exclusion • Why we all need to be involved
Exploring bias	• What is bias? It's origin as a human function • System 1 vs System 2 thinking (Kahneman) • Consious vs. unconscious bias • Research showing how unconscious bias impacts healthcare • Types of bias and its many faces • What are we biased against? Why are people excluded? • Where do our biases come from? How do we identify them?
Challenging bias in ourselves	• Knowing yourself and your biases • How biases impact our behaviour (eg micro-agressions) • Thinking critically when it counts • Spotting and challenging your assumptions in the moment
Challenging bias in others	• Overt discrimination – our duty to protect our colleagues • Challenging bias with peers, managers, and patients • Some real scenarios of bias and discrimination at St Georges – how would you respond? What would you say? • Likely reactions to your challenge and responding to them
What can we do now?	• An overview of what St George's is doing to tackle bias and discrimination and build a culture of inclusion • Personal commitments of actions to challenge bias • Continuing your learning

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Delivery Tracker Update

(Deliverables and Actions with RED or AMBER status only)

Deliverable	Action	Target Date	RAG	Issues causing delay / Risks to escalate	Plan to resolve
All BAME staff who are not successful at interview are offered feedback and a career coaching conversation	Develop and implement a process and proforma in line with positive action that managers will complete to record a career conversation if a BAME staff member is not successful at interview for a role at Band 6 or above (and encouraged for all other bands)	30/08/2020 Proposed new completion date 30/01/2021	■	• Original vision was that the process could be automated in the Trac recruitment system (via a flag for unsuccessful internal BAME candidates and an automatically-generated notification to recruitment panel chairs). However, this isn't possible due to IT system limitations.	• A process (instead of system change) has been developed; will be finalised and incorporated into RIS and panel chair guidance. Proposed to complete now in Jan 2021.
The expectation of all staff to be involved in tackling exclusion and discrimination is role modelled	Executive Team and Board members to come up with one personal action which they will take to improve the working lives of the BAME workforce (e.g., I am being reverse-mentored by a BAME colleague) and cascade to all employees	15/12/2020	■	• All pledges have now been received. Need to decide if okay to cascade as they are and if so, how.	• D&I Lead to confirm if any adjustments required to wording and agree mechanism to communicate to staff. Now aim to complete Dec 2020.
D&I networks are actively and visibly supported by an Executive Sponsor	Review and clarify the role of the Executive Sponsor in providing focused support for each D&I Network, including specifically, supporting the implementation of each network's action plan	15/12/2020	■	• Meetings with all sponsors now completed and role of sponsor is included in Network TORs . Need to agree if further formal guidance is required. Disability and Women's Network Exec Sponsor temporarily carried out by DCEO, need to agree permanent sponsor.	• D&I Lead to confirm if guidance already exists and if so, agree if update is required. Likely to complete now in Dec 2020.
D&I is systematically considered in all leadership and governance discussions and decision-making forums/ processes at Board and Exec levels	1) Include D&I issues as a discussion agenda item wherever possible 2) Review our meetings in relation to how effective we were in considering D&I 3) Include a section on our paper submission template that explicitly outlines the impact of decisions/ plans on D&I	31/08/2020	■	• The progress on the delivery of the D&I Action Plan is being considered at all key leadership and governance meetings. To ensure that these discussion continue on an ongoing basis the process needs to be more systematic.	• Seek feedback from stakeholders on how to make these discussions more systematic.
All staff build an awareness of unconscious bias at work as a basis to continue building more inclusive team and organisational cultures	Procure and implement online unconscious bias (UB) training accessible for all staff	30/10/2020	■	• Off-the-shelf training was unsuitable, so a 3rd party has been brought in to support the development of bespoke training.	• Training development nearly completed. • Workshops will be piloted with Children's Therapies on 18/11 and QI on 01/12. • On track to make workshop available in Dec 2020.

Priorities for November

- Development of the D&I intranet page, that will integrate and house all available D&I resources and share plans and updates
- Recruitment Inclusion Specialist training delivery – 85 currently trained, 2 more sessions planned
- Complete design and start pilot for Challenging our Biases training
- Commencing development of an organisational framework for coaching and mentoring, and building an internal bank of coaches
- Start development of training programme for managers and recruitment panel members in general recruitment and selection (including unconscious bias)
- Launch King's Fund Advanced Leadership Development Programme (1st module focusing on inclusion)
- Continue to support local D&I committees to identify priorities and produce local D&I action plans

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APPENDIX (C)

Recruitment Inclusion Specialist FAQs

Common questions from Recruitment Inclusion Specialists:

Q What is my role in shortlisting?

You are not required to be involved in shortlisting, at present, the role of the RIS is to support at interview. There is a large varied workforce across the organisation and it is highly unlikely you'll be experienced / in a role relevant to all of the interviews you support as a RIS.

Q I haven't heard from anyone since I agreed to be on a panel and the interview date is getting close?

Follow up with recruitment officer or the chair. Please outline your expectations in terms of what you need and by when.

Q I haven't been sent the interview paperwork in advance / the interview chair said I'll get copies of the paperwork on the day?

Follow up with the chair and advise you need the paperwork in advance to allow you sufficient time to prepare. You can advise that if you do not receive the paperwork in advance you may not be able to support the interview. If you have any difficulties here please contact the recruitment officer that set the interview up. They'll support or escalate as required.

Q The chair doesn't have a set process for scoring the interviews?

It is expected that the chair and panel members will agree on a measureable process for scoring the interviews, much like how we score the application forms on trac. If the chair does not have a process, you should recommend this to them as best practice.

Agree a total number of points per question and have each panel members score candidates responses independently, without any discussion/consultation with the rest of the panel. This will give each panel member a total score per candidate; you can now review/discuss each candidate. Add the totals for each candidate and this should give you a clear indication of the candidate/s that performed best at interview. An example of scoring is below:

Points:	Measure:
0	Did not answer the question
1	Very Poor (response showed no understanding / knowledge)
2	Poor (response showed little understanding / knowledge)
3	Adequate (response showed basic understanding / knowledge)
4	Good (response showed good understanding / knowledge)
5	Excellent (demonstrated complete understanding / best possible response to the question)

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Q The chair has advised this is an internal job / informal arrangement and only one person has applied?

Ask the chair for details of how the opportunity was advertised, how long it was out for and who it was shared with? Advise the chair that due process is still required and continue as you would with any other interview. If you have concerns about how the job was advertised please raise this with recruitment and the chair. Alternatively, you can contact our D&I Workforce Lead Joseph.Pavett-Downer@stgeorges.nhs.uk

Q Where can I find ideas for good D&I interview questions?

Example questions can be found on the trust intranet under *Diversity and Inclusion > Recruitment Inclusion Specialists*

Q I don't agree with the outcome of the interview

If you felt the interview process was fair and unbiased but preferred another candidate, we have to accept that the chair has ultimate responsibility for the appointment and no concerns were present in terms of treatment of the candidates.

If you felt the interview process was unfair, the candidate suggested for appointment wasn't the best suited or there was bias at play, you should raise this during the post interview discussions. If you are still uncomfortable with the decision, following this discussion, please email our D&I Workforce Lead Joseph.Pavett-Downer@stgeorges.nhs.uk to discuss your concerns.

Q I didn't feel able to challenge the decision made by the panel / I felt my views weren't taken into consideration, what can I do?

Please contact our D&I Workforce Lead Joseph.Pavett-Downer@stgeorges.nhs.uk to discuss your concerns

Q I can't make an interview date I have agree to, what do I do?

Please email the chair and the recruitment officer to advise as soon as possible so the reserve RIS can be informed.

Q How do I feedback regarding my experience with on a panel?

Please email our D&I Workforce Lead Joseph.Pavett-Downer@stgeorges.nhs.uk

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Appendix (D)

Recruitment Inclusion Specialists (RiS)

A guide for Interview Chairs and panel members

CONTENTS

Joseph Pavett- Downer
Diversity and Inclusion Workforce Lead

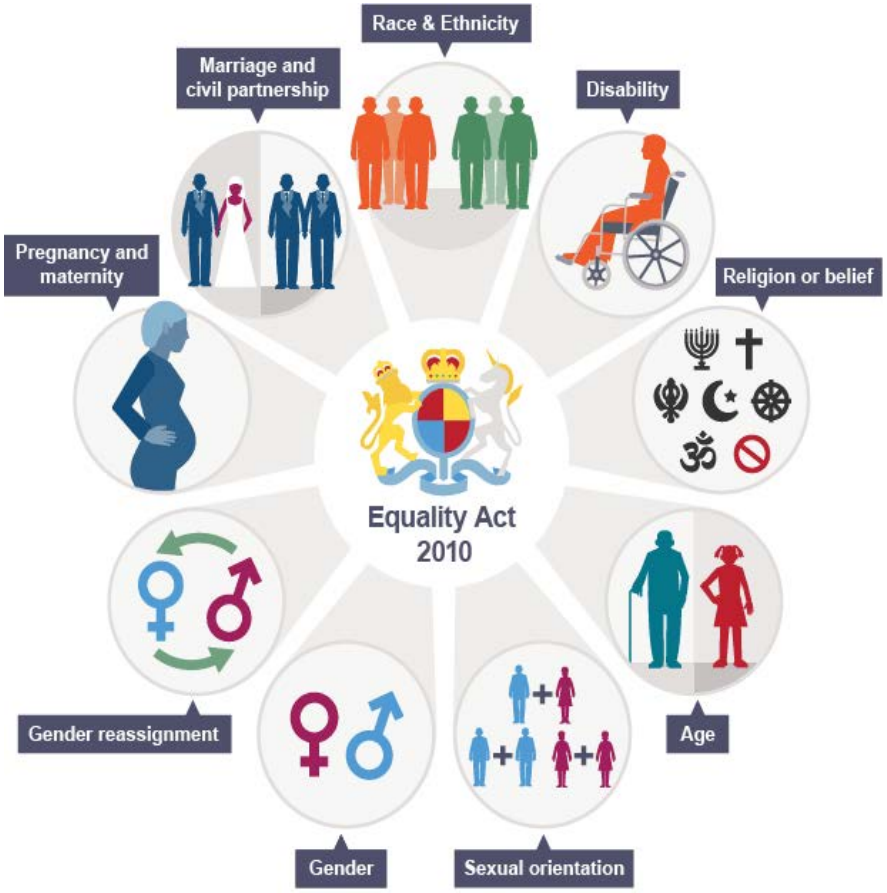
October 2020

A commitment from St George's

St George's Hospital is a is committed to building a workforce which is valued and whose diversity reflects the communities it serves, enabling it to deliver the best possible healthcare service to those communities.

Everyone who works in the Trust, or applies to work in the Trust, should expect to be treated fairly and valued equally irrespective of age, disability, race, nationality, ethnic or national origin, gender, religion or belief; sexual orientation, marital status, pregnancy and maternity status, domestic circumstances, gender reassignment. These are known as protected characteristics (see opposite).

The Trust is committed to enabling everyone in the Trust to achieve their full potential in an environment characterised by dignity and mutual respect. There are a number of resources (appendix 1-3) at the end of this guide, we hope they help to set the context of recruitment and inclusion across St George's and why this piece of work is vital.



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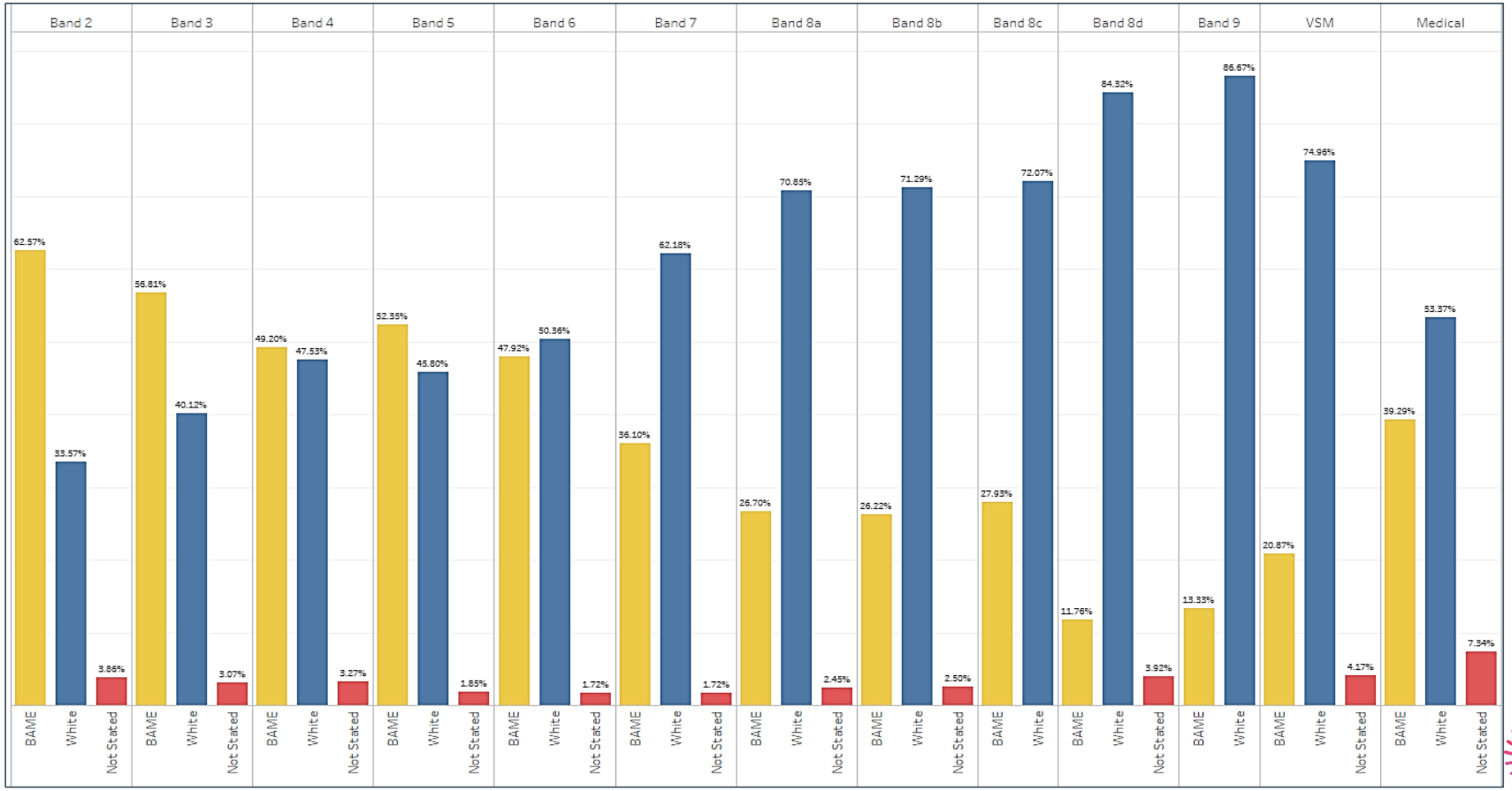
Why do we need RIS at St Georges?

The below tables details **staff ethnicity by band**. BAME staff (yellow) represent 47% of our workforce, white staff (blue) represent 53%.

What do you notice about representation across the organisation?



Source:
2020
WRES Report

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A Guide for Interview chairs and panel members

What is a RiS?

A Black, Asian and Minority Ethnic (BAME) staff member who has been trained to provide a neutral and unbiased perspective of the recruitment process, and support panels in reaching an unbiased recruitment decision. The RIS's key objective is to ensure a fair process and that the best person for the role gets the job. A decision they'll make based on each individuals ability to demonstrate, from application and during the interview, their suitability for the role.

Why do we need a RIS?

- To promote and ensure a fair and unbiased process.
- To provide better representation at interview, enabling BAME candidates to better identify with their assessors, feel more comfortable, and give the best interview they can.
- To raise the diversity of backgrounds, thinking, values, perceptions of behaviour etc.
- Encourage better BAME representation in senior/leadership roles
- Improve the decision making process and influence better decisions

What are my responsibilities as chair?

- Whilst recruitment will source a RIS for your interview you will be responsible for making contact with the nominated RIS and providing all relevant paperwork – applications, JD, PS. Please ensure this is done well in advance of the interview date to allow sufficient time for your RIS to prepare.
- Introduce the RIS to the rest of the panel and explain how they will be supporting you.
- Advise that the RIS will be providing feedback at the end of the interviews: this could be a direct challenge to the scoring (i.e. if there are significant differences) or could be feedback about the process, questions etc.
- Explain how you expect any questions or challenges to be received and responded to. It is vital that the RIS is able to provide honest feedback and that all panel members recognise this is a necessary part of our work to drive equal opportunities across the organisation.
- Recognise you may have your own biases and be prepared to discuss them as part of this process.
- Ensure your RIS is part of any decision making process following interviews
- Ensure all unsuccessful (internal) BAME candidates are offered a career coaching session with you as part on the organisations efforts to support the career development of our BAME workforce.

Before, During and After the Interview

Stage	How can I support my nominated RIS?	How they'll support a fair recruitment process…
Before the Interviews	• Introduce yourself, tell them a bit about the role you are recruiting to, what you are looking for in a candidate and how the interviews will be structured on the day. • Agree which questions will be asked by each panel member, including which questions your RIS will ask • Allow them to prepare for the interview by providing the job description, person specification and applications of those being interviewed with plenty of notice.	• Ensure that a JD and personal specification are being used • That the most important criteria has been identified and discussed with the panel beforehand – what are we looking for, and what does good 'look' like? • That the assessments proposed are for a clear purpose, and non-discriminatory
During the Interviews	• Ensure they are part of any pre-interview briefings. • Ensure all panel members recognise them as an equal member of the panel. • Ensure questions that help you get a better understanding of a candidates values, particularly regarding D&I are given adequate attention. • Be inclusive and make them feel welcome.	• Recognise any short cuts and changes to the agreed process • Recognise any biases, strong inconsistencies in questions or candidate treatment
After the Interviews	• Ensure the interview notes/scores from your RIS are included in the review along with other panel members. • Ensure they are included in the debrief and allow time for them to provide reflections on the process and candidates interviewed. • You may not agree on who to appoint, but ensure you allow time to discuss any objections or different opinions.	• Query conclusions that aren't grounded in objective data • Query unexplainable interpretations ('I just feel') • Query quick or unjustifiable decision making • Promote genuine panel consultation and joint decision making

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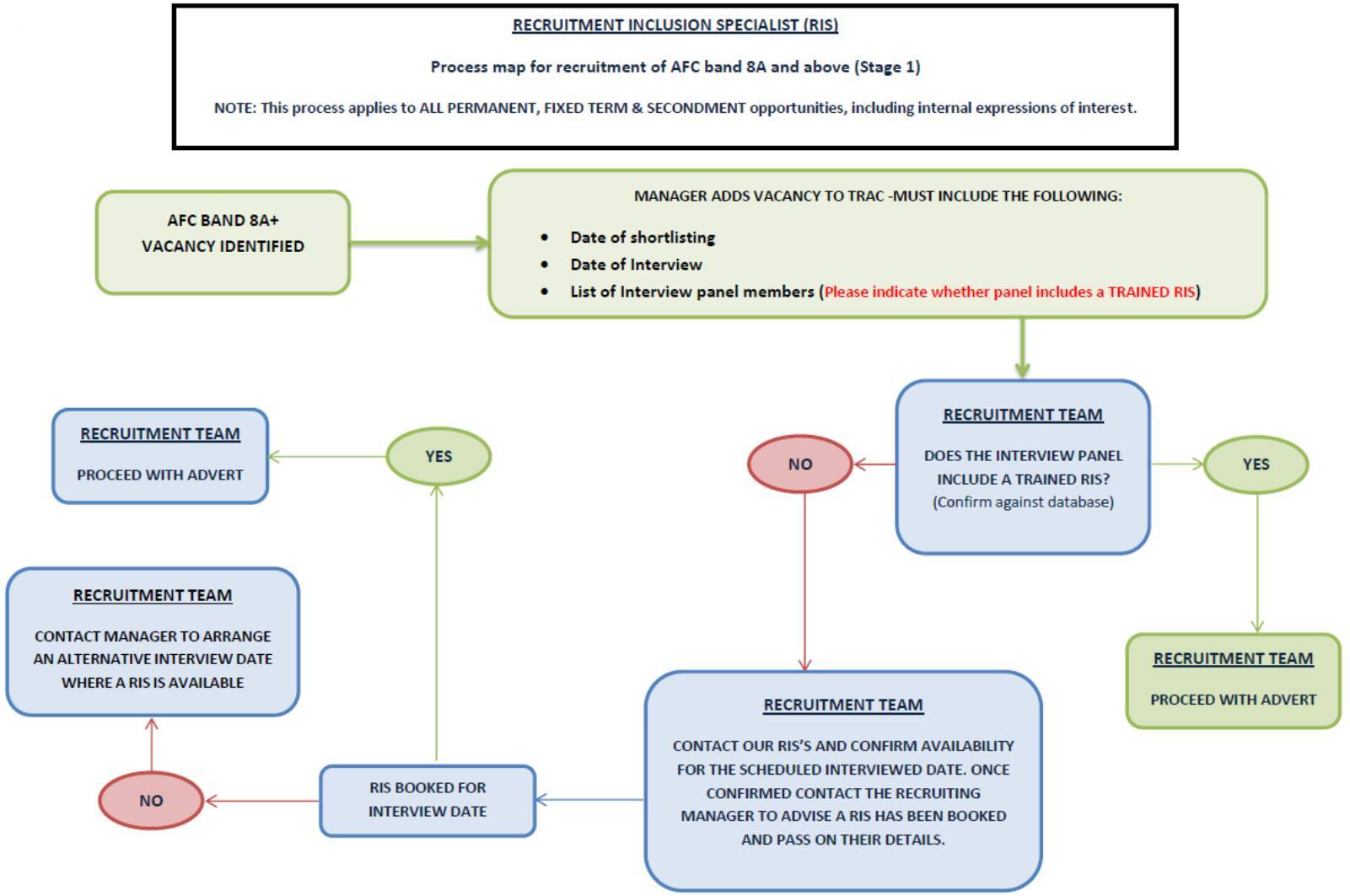
every time

RIS Process Map



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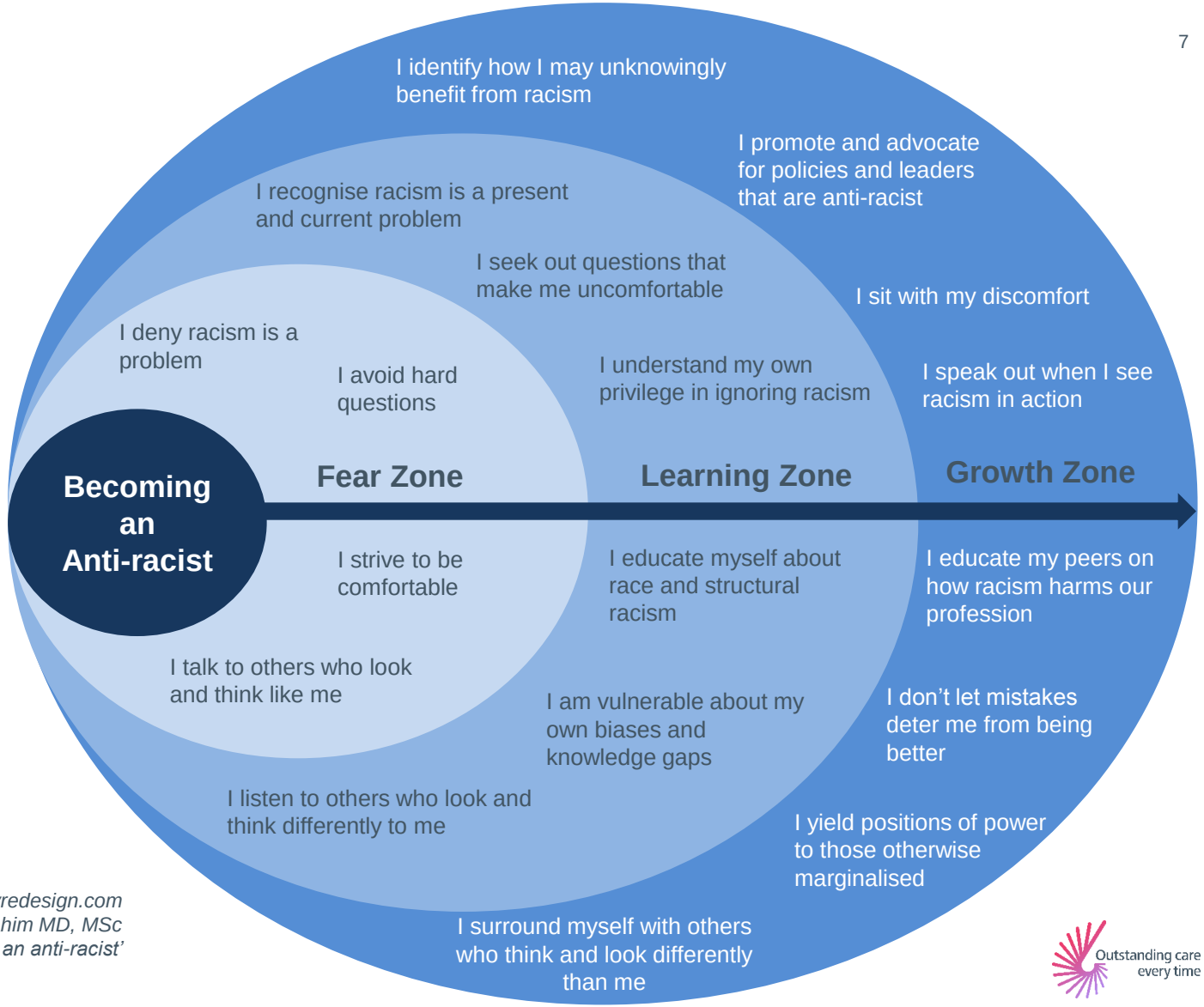
APPENDIX 1:

A model of anti-racism

This model of anti-racism has been distributed widely on social media, and was shared by our CEO and Chair in a recent message to all staff about racism.

Its popularity lies in its ability to make us question where we truly sit in relation to being anti-racist. It is based on the premise that 'not being racist' isn't enough. To build a truly inclusive culture, we all need to be more actively *anti-racist*.

Consider this model and where you might sit as a starting point. Share with your panel members and encourage them to do the same.



Graphic by www.surgeryredesign.com
Andrew M. Ibrahim MD, MSc
Inspired by Dr Ibram X. Kendi 'Becoming an anti-racist'

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APPENDIX 2:

Perception of Equal Opportunity

NHS Staff Survey 2019

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

	Average (Acute NHS Trusts)	St George's
White staff	86.7%	82.6%
BAME staff	74.4%	63.0%

Recruitment Statistics

2020 WRES Report

	White	BAME	Unknown
Number of shortlisted applicants	4057	6598	970
Number appointed from shortlisting	1266	1402	654
Likelihood of appointment from shortlisting	31.21%	21.25%	67.42%
Relative likelihood of White staff being appointed from shortlisting compared to BAME staff	1.47		

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APPENDIX 3:

Continuing your learning

At the heart of tackling systemic and organisational patterns of racism is learning and education. We each have a responsibility for advancing our understanding of racism, and the roles we all play within it. Here you'll find several resources in a range to medium to support further learning.

Articles and blogs

- After the speeches: what now for NHS staff race discrimination? Blog post by Roger Kline, June 2020
- Time to speak up: Some necessary words about racism Blog post by Tracie Jolliff, Head of Inclusive Leadership Development at NHS England and Improvement
- 'A long way to go': ethnic minority NHS staff share their stories – King's Fund report (includes audio clips)
- How the best bosses interrupt bias on their teams – Harvard Business Review
- The diversity and inclusion revolution: eight powerful truths – Deloitte Review 2018
- Inclusivity and Growth Mindset: Why You Need to Cultivate Both – Matter, July 2020
- The 7 A's of Authentic Allyship – Yvonne Coghill, Twitter post

Podcasts

- About Race (9 Episodes) – Reni Eddo-Lodge
- Brown Ambition, episode 219: Black Lives Matter, Periodt.

Videos

- Why "I'm not racist" is only half the story – Robin DiAngelo
- Race, Equality, Equity (The Race of Life)
- Fighting the power: Britain after George Floyd - BBC3 documentary
- The school that tried to end racism - Channel 4 two-part documentary
- Colour Blind or Colour Brave – TED talk by Mellody Hobson
- Cracking the Codes: 'A Trip to the Supermarket' - Joyce deGruy
- Little things you can do to combat racism – Buzzfeed

Books

- *Why I'm No Longer Talking to White People About Race* by Reni Eddo-Lodge
- *So You Want to Talk About Race* by Ijeoma Oluo
- *White Fragility by Robin DiAngelo*
- *How to be an Antiracist* by Ibram X. Kendi
- *Sway: Unravelling Unconscious Bias* by Dr Pragya Agarwal

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St George's University Hospitals NHS Foundation Trust

3.2

Meeting Title:	Trust Board		
Date:	26 November 2020	**Agenda No**	**3.2**
Report Title:	Workforce Disability Equality Standard (WDES) Report		
Lead Director/ Manager:	Humaira Ashraf, Acting Chief People Officer (Culture & OD)		
Report Author:	Humaira Ashraf, Acting Chief People Officer; Daniel Scott, Senior Interim OD Lead; Joseph Pavett-Downer, Workforce D&I Lead		
Presented for:	Assurance		
Executive Summary:	Appendix (A) is the NHS Workforce Disability Equality Standard (WDES) Annual Report 2020 and Action Plan. This report sets out our organisational commitment to advancing the equality and experience of Disabled people within the Trust. This document has been developed to serve two main purposes:- 1. To set out the organisation's ambition and action plan for supporting the diversity and inclusion of Disabled people in our organisation; 2. To provide the data, updates and planned actions required for our 2020 annual report to the Workforce Disability Equality Standard (WDES) To fulfil these aims, the document has been arranged into three parts: • Part 1: Context, this section sets out our ambition and the background that informs it; • Part 2: Review, this section is a summary of actions to date and analysis of the current data • Part 3: Action, this section outlines what we will do to effect positive change		
Recommendation:	The Trust Board is asked to note and approve the progress to date on actions and the analysis of the WDES data and the 20/21 action plan.		
Supports			
Trust Strategic Objective:	Culture		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:			
Legal/Regulatory:	N/A		
Resources:	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.		
Equality and Diversity:	The WDES is designed to close the gap in workplace inequalities.		
Previously Considered by:	Workforce & Education Committee People Management Group	**Date**	12/11/20 10/2020
Appendices:	Appendix (A): Workforce Disability Equality Standard (WDES) Report		

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St George's University Hospitals NHS Foundation Trust

NHS Workforce Disability Equality Standard (WDES)

Annual Report 2020 and Action Plan

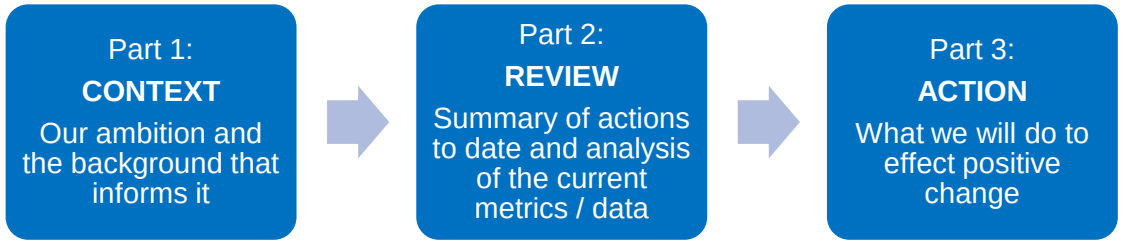
Our organisational commitment to advancing the equality and experience of Disabled people at work

Aims and Structure of This Document

This document has been developed to serve two main purposes:

- To set out the organisation's ambition and action plan for supporting the diversity and inclusion of Disabled people in our organisation; and
- To provide the data, updates and planned actions required for our 2020 annual report to the Workforce Disability Equality Standard (WDES)

To fulfil these aims, the document has been arranged into three parts:

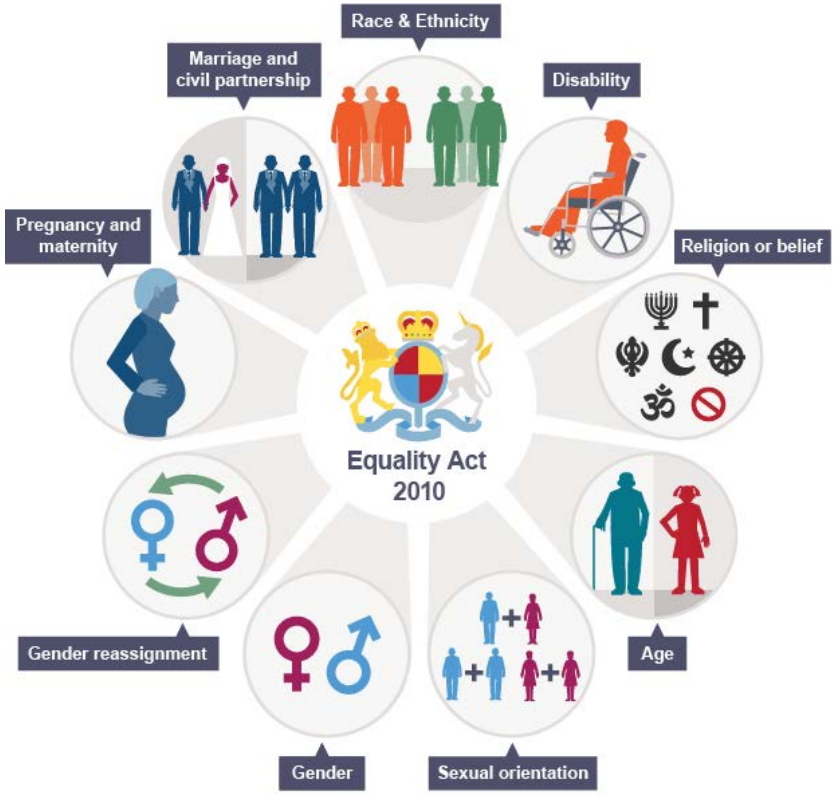


CONTEXT: Disability is a Core Strand of Our D&I Agenda

Everyone who works at St George's, or applies to work in the Trust, should expect to be treated fairly and valued equally irrespective of age, disability, race, ethnicity, gender, gender identity, religion or belief, sexual orientation, marital status, or pregnancy and maternity status. These are known as protected characteristics. The Trust is committed to enabling everyone in the Trust to achieve their full potential in an environment characterised by dignity and mutual respect.

In August 2020, St George's developed a wider organisational Diversity and Inclusion Action Plan that aims to support and strengthen the equality and experience of our staff who represent any and all of the protected characteristics. While many of the outcomes and deliverables set out in this plan will also benefit Disabled staff, it is deemed important to have a connected but separate action plan that specifically focuses on disability.

We hope that the action plan we set out below, nested within our wider organisational D&I action plan, reflects the extent and authenticity of this ambition.



WDES Annual Report 2020 and Action Plan

CONTEXT: Our Ambition

Serving a diverse population of 1.3 million and with nearly 9000 employees, St George's University Hospitals Trust is the largest healthcare provider in South West London. It is crucial that the diversity of our workforce reflects the diversity of the communities we serve, and we are proud that in 2020 Disabled people are statistically well represented at all levels in our organisation. However, equally important to strong diversity and representation is authentic inclusion.

St George's is committed to building a workforce in which each employee can enjoy a strong sense of belonging and where diversity, difference and uniqueness are truly valued. As well as being well-represented across all levels, we must ensure that people from marginalised groups, including Disabled people, are actively and always included, and that this inclusion is felt *authentically* at a personal level. Lip-service will not suffice.

Achieving strong diversity and inclusion of Disabled people at St George's will offer significant benefits for our organisation:

- Delivery of better patient care, because…
    - Staff who feel included, engaged and supported have greater personal resources and resilience to offer thorough and compassionate care
    - Staff who are differently-abled may offer enhanced empathy and support to patients due to their lived-experience of disability
    - Patients with disabilities may be more able to identify with and relate to our Disabled staff
- Stronger team performance by maximising our blend of skills, talents, knowledge and professional experience
- Stronger individual performance by enabling Disabled staff to use their disability at work as advantage instead of a disadvantage
- Improved retention of our staff, especially our Disabled staff (including staff who may become Disabled)
- A reduction in bullying, harassment, discrimination and other forms of exclusion by building greater understanding, appreciation and respect for people with disabilities
- Supporting our organisational journey towards adopting a more compassionate and inclusive culture

Our ambition is to create an organisation - and a reinforcing culture - that not only offers equality and a positive experience for all of our Disabled colleagues, but one that actively nurtures and celebrates our physical and mental differences in ability. We strive for this in the certainty that our rich diversity and a universal sense of belonging will be integral to our success as a healthcare organisation.

CONTEXT: Background to Disability and WDES

The Workforce Disability Equality Standard (WDES)

The WDES was introduced in 2019 and is designed to improve the experiences of Disabled people working in, or seeking employment within the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its staff. The 10 metrics on which we report against each year are included in the table opposite.

The WDES report compares data between Disabled and non-Disabled staff in order to identify disparities and barriers in the workplace. These findings inform the organisation's WDES Action Plan, which aims to directly address inequalities faced by Disabled members of staff.

We are pleased that the NHS, our parent organisation, is currently the only UK employer that mandates its member organisations to report annually on its representation and inclusion of Disabled people. However, our ambition is to go far beyond what is mandated, and to become a truly great employer of Disabled people, and an exemplar for other NHS Trusts.

Metric 1	% Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)
Metric 2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure
Metric 4	Staff Survey Q13: % Disabled staff compared to non-disabled staff: a) experiencing harassment, bullying or abuse from different groups b) saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
Metric 5	Staff Survey Q14: % Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
Metric 6	Staff Survey Q11: % Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
Metric 7	Staff Survey Q5: % Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
Metric 8	Staff Survey Q28b: % Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
Metric 9	a) The staff engagement score for Disabled staff, compared to non-disabled staff b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?
Metric 10	% difference between the organisation's Board voting membership and its organisation's overall workforce

WDES Annual Report 2020 and Action Plan

What is 'Disability'?

Defining 'disability' is not always straightforward. The Equality Act 2010 defines a Disabled person as:

> *"someone who has a mental or physical impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities."*

Some of the terms in this definition are open to interpretation, and further guidance is found in Appendix C. However, instead of trying to judge whether a person falls within the statutory definition of disability, we should focus on meeting the needs of the worker (or job applicant). In supporting a Disabled member of staff, it is almost always more important to understand and support the *effects* of a disability rather than the cause.

It is important to note that the definition of disability regards the person as they are *without* aids, support or medication (the exception being visual impairment where it can be addressed by use of wearing prescription spectacles). This is particularly relevant for those with mental health conditions who are able to control their condition with medication, and also for those with conditions such as epilepsy and diabetes that are otherwise controlled by medication.

Additional information on the definition of disability is attached in Appendix C, taken directly from guidance produced and published by NHS Employers. This guidance was published in 2014. We will continue to closely monitor best practice and guidance and communicates updates as necessary.

Legal Obligations of Employers and Reasonable Adjustments

Protection against disability-based discrimination is enshrined in the Equality Act 2010. Due to the additional barriers faced by Disabled people, it is permitted to treat Disabled *more* favourably than their non-Disabled colleagues. Understanding this, and the reasons for it, is crucial to removing the barriers that continue to deny Disabled people equality of *outcome* in work and more broadly.

The Equality Act 2010 protects employees, and covers areas including recruitment, assessment and selection, terms of employment, promotion and training opportunities, dismissal or redundancy, and discipline and grievances.

The Equality Act 2010 also requires that *reasonable adjustments* are made to working conditions, policies and practices that put a Disabled member of staff at a disadvantage. A reasonable adjustment could include any of the following:

- making adjustments to premises or acquiring/modifying equipment
- providing a reader or interpreter, or employing a support worker
- reallocating a Disabled employee's duties to another person
- providing supervision, training, mentoring or other support
- transferring a person to fill an existing suitable vacancy without competitive interview
- altering working hours or the place of work
- allowing someone to be absent during working hours for rehabilitation, assessment or treatment
- modifying procedures for testing or assessment

Useful checklists and further detail on the legal obligations can be found in the Guidance relating to disability for the NHS document, published by NHS Employers. This guidance document also sets out examples of good practice (when not legally obligated), particularly around the supporting carers and disability related absence from work.

While St George's is mandated and committed to meet its legal obligations in protecting Disabled people, our ambitions to support the equality and experience of Disabled people go far beyond this.

REVIEW: Progress Updates in 2019/20

Over the last year, the Trust has taken the following steps to help improve the experiences of Disabled workers and increase their access to employment opportunities at the Trust.

Project Search

Project Search is a supported internship for local young adults with a learning disability and/or autism. The aim is to provide work experience leading to employment, either in the host business or elsewhere. These internships include a mix of classroom based teaching and work experience placements. At St George's we employ 8 of our previous graduates across a range of services, including Portering, Sterile Services, Catering, Health Records and Outpatients. Refer to Appendix B for further details.

Guaranteed Interview Scheme

All candidates with a disability, who are applying for jobs at St George's, will be invited for interview if they meet the minimum criteria for the post.

Disability and Wellbeing Staff Network

Introduced in late 2019, this has been an opportunity for Disabled staff to feel supported in the workplace, and for their views to feed into a wider system for change. The Wellbeing Team also attends these meetings to ensure the needs of staff with disabilities form a part of project plans for supporting staff health and wellbeing.

Reasonable Adjustments e-Learning module

This module provides an overview in the context of 'working environments' and is currently being finalised for release. The aim of the resource is to raise managers' awareness of reasonable adjustments pertaining to a spectrum of disabilities and to help managers see what steps can be taken to make a real difference to the lives of Disabled staff.

Culture Diagnostics

The Trust is committed to the creation of a culture that is inclusive and one where staff from all backgrounds and protected characteristics can thrive. A detailed diagnostic process has been implemented with the aim of both understanding and improving the organisation's culture so that we can properly understand the experiences and needs of all our staff and in particular staff who have disabilities.

Appointed Network Executive Sponsor

A member of our Executive Team has been appointed as Executive Sponsor to support the Disability And Well-Being Staff Network in driving meaningful change across the organisation. This role will hold a particular focus on improving awareness and engagement across the organisation.

REVIEW: Current WDES Metrics

At the time of writing, St George's Hospital employs 8,927 staff, 181 of these staff members (2%) have formally declared themselves as living with a disability, while 744 (8%) did not disclose. In contrast, our 2019 Staff Survey results indicate that 11% of respondents consider themselves to have a disability.

Data collected via the staff survey, Electronic Staff Records (ESR) and recruitment records have been compiled and used to report against the 10 WDES metrics.

Findings Per Metric

The full set of data responses are set out in Appendix A. The list below summarises the analysis of each metric, and conclusions of the data as a whole can be found below

Metric One: % Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)

Non-clinical roles

- The number of non-Disabled staff has increased in bands 5 and upwards, with an average lift of 1.58% across these bands
- Despite this increase, we see specific decreases in disabled representation of 0.2% in Bands 8a and 8b and of 0.27% in bands 8c and above
- The Trust has seen an increased number of Disabled staff in bands 4 and under, from 44 in 2019 to 55 in 2020 (+25% on last year)
- The number of staff that did not declare a disability has decreased by 1.4% in bands 5 and above, suggesting a small increase in confidence in the Trust's ability to understand and support them to carry out their jobs; For staff in bands 1-4, we see a smaller decrease at 0.3% on last year

Disabled staff in clinical roles

- The number of Disabled people working in clinical roles has decreased in all band clusters, except for bands 8c and above. Here the clinical workforce shows an increase by 2%.
- Non-consultant career-grade representation by Disabled staff remains at 0% of for the second year running, while the number of non-disabled staff has increased across most bands.
- The data strongly demonstrates that addressing employment inequalities in clinical work at the Trust must form part of the wider plan for equal access to opportunities for Disabled staff.
- There is a reduction in the number of staff choosing not to declare a disability from 2019 to 2020 across all banding clusters

Metric 2: Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts

- Non-disabled staff are slightly more likely than Disabled staff to be appointed from shortlisting

Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

- Disabled staff have not entered the formal capability process at the Trust since 2018. There are a number of possible reasons for this, including:

- Disabled staff being more than capable of performing their role and delivering to a high standard
- Disabled staff being appropriately supported by their managers that they are effectively able to carry out their job roles
- A very low proportion (2%) of self-declared Disabled staff compared to non-Disabled (90%) and 'unknown' staff (8%)

Metric 4: Staff Survey Q13: % Disabled staff compared to non-disabled staff: a) experiencing harassment, bullying or abuse from different groups; and b) saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

- Disabled staff experiencing harassment, bullying and abuse increased across all categories compared to last year
- In 2019 there was a much higher rate of harassment, bullying or abuse reported by Disabled staff, compared to last year and non-disabled staff.
- Reported abuse from patients and service users has increase as much as 7% on last year
- The number of Disabled staff who felt able to report harassment, bulling or abuse in 2019 was slightly higher compared to non-disabled staff, an improvement from the previous year.
- The percentage of Disabled staff who felt able to report harassment, bullying and abuse also increased from 2018, from 41.3% to 46.9%.

Metric 5: Staff Survey Q14: % Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

- Disabled staff felt notably less confident about the Trust providing equal opportunities with regards to carer progression and promotion.
- There was no improvement from 2018 to 2019 on the % of Disabled staff who believed that the Trust provided them with equal opportunities for progress in the workplace.

Metric 6: Staff Survey Q11: % Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

- A higher number of Disabled staff compared to non-Disabled staff reported feeling pressure to come into work despite not feeling able to carry out their duties. This was reported in years 2018 and 2019.
- There was a 6.9% difference between the likelihood of Disabled and non-Disabled staff to have felt pressure to work compared to non-Disabled people in 2018. In 2019, the gap between the two groups had widened further, with a 7.45% difference.

Metric 7: Staff Survey Q5: % Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

- Disabled staff at the Trust are much less likely to feel that their work is undervalued. In 2018, 32.1% of Disabled staff who responded to the Staff Survey said that they felt this way. This can be compared to 43.7% of non-Disabled staff who feel that their work is undervalued. This equates to a difference of 11.6% between the two groups.
- The difference between Disabled and non-Disabled staff and whether they feel that their work is valued is greater in 2019. There is an increase in the number of non-Disabled staff feeling that they are satisfied to the extent that their work is valued

Metric 8: Staff Survey Q28b: % Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

- Only 65.9% of Disabled employees felt that adequate adjustments had been made in their work place

Metric 9: a) The staff engagement score for Disabled staff, compared to non-disabled staff; b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

- Staff engagement is higher for non-disabled staff compared to Disabled staff. This has decreased slightly in 2019 (compared to 2018)
- The Trust has an active Disability Network consisting of Disabled staff members, executive sponsors and representatives from Human Resources, Health and Wellbeing and Diversity and Inclusion
- Our Disability awareness day took place on October 25th and aimed to drive engagement and raise understanding and awareness across the organisation

Metric 10: % difference between the organisation's Board voting membership and its organisation's overall workforce

- 2% of the Trust's workforce have declared themselves as having a disability
- At board level is this 0%, highlighting an underrepresentation at board level

Conclusions of the Current Data

By comparing the experiences of (declared) Disabled staff with non-disabled staff across bandings and professions, we see that staff with disabilities face a number of challenges and inequalities in the workplace.

The key findings from the data against these metrics suggest:

1. Some staff are reluctant to declare their own disability. While declaring a disability helps organisations provide appropriate support and adjustments, it can leave these staff members feeling vulnerable.
2. Staff in lower bands are less likely to declare and access support, compared to staff in higher bands.
3. Disabled staff are more likely to experience bulling, harassment and abusive behaviour, and less likely to report it.
4. Disabled staff feel there is a lack of equal opportunity in terms of career progression and development. However, Disabled staff are more likely than non-disabled staff to feel that the work they produce is valued.
5. At the Trust, engagement levels are generally higher amongst non-disabled staff compared to Disabled staff.
6. Disabled staff are more likely (compared to non-disabled staff) to feel that they need to work when they are unwell.
7. Not all Disabled staff at the Trust feel that adequate adjustments have been made to support them in carrying out their work.

ACTION: Disability Equality and Experience Action Plan 2020/21

Identifying Priority Themes

Based on our experiences of delivering our WDES actions during 2019/2020 as outlined above, and the analysis of our WDES metrics (refer to appendix A below), we recognise that for Disabled staff to thrive in the workplace, an improved understanding of their needs is required. In addition we appreciate that improved resource, dedicated time and increased visibility of this community will be critical to success in working towards workplace equality and a better experience of working at St George's.

Though our Disabled staff are recognised as a community that empowers and enriches our workforce, they often feel overlooked and misunderstood. Maintaining a dialogue with our Disabled staff, responding appropriately and taking action, will ensure that progress is meaningful and these staff members feel valued.

In order to better understand and tackle the workplace inequalities experience by our Disabled staff, we must work with key stakeholders to examine policies, training and provisions that affect them.

Enhanced by an Organisational Diversity & Inclusion Action Plan

We must also recognise the wider context of Equality, Diversity and Inclusion across the organisation and how improvements can be made for all staff with protected characteristics. To enable this, a Diversity and Inclusion Action Plan has been developed following discussions at Executive Management and Trust Management Group meetings, and in response to issues raised by staff, Diversity & Inclusion steering group meetings and on an individual basis to the CEO. This action plan is a 'living document' that will be further developed and refined to reflect and integrate what we learn about the impact of our interventions, and through additional input from stakeholders around the Trust. It is intended that this Diversity & Inclusion Action Plan will incorporate the Staff Networks' own individual action plans as well as the actions identified in this paper and outlined below, and in Appendix B.

4 Key Areas of Focus

The four areas of focus for the WDES action plan are as follows, and the full plan follows on the next page.

1. A rigorous approach to exploring and providing guidance to managers through training and additional resources
2. Review core line management processes and documents that affect Disabled Staff
3. Increase forms of engagement and declaration rates amongst Disabled Staff
4. Raise awareness amongst staff and build on the understanding of disability and how this impacts staff affected by or living with a disability

Disability Equality and Experience Action Plan 2020/21

Metric	Deliverable	Action/s	Timescale	Lead/s	Measure of Success
N/A	Improved understanding and awareness of the types of disabilities and how these impact members of staff across the organisation	1. Work with OH & H&W to develop a series of posters and hand-outs to raise awareness of common disabilities and what staff and managers can do to support their colleagues in the workplace 2. Work with the staff network to identity and promote a series of staff stories to further the learning of non-Disabled staff and help raise awareness of disabilities in the workplace.	Jan 2021	D&I Lead	
1: % of staff in AfC pay bands, medical subgroups and VSM (incl. executive board members) compared with the % of staff in the overall workforce	Increase staff declaration rates	3. Encourage staff to validate their ESR 4. Work with LiA Lead to promote importance of declaration as part of the staff survey 5. Work with Recruitment to review on-boarding information/process regarding disability and declaration	March 2021	Network Chair & D&I Lead	
4: % of Disabled staff compared to non-Disabled staff experiencing harassment, bullying or abuse.	Reduced number of Disabled staff experiencing harassment, bullying or abuse from managers and colleagues.	6. Mandatory online disability awareness training including neuro-diversity and ableism to be rolled out for all staff. 7. Disability Awareness Section on the Intranet – signposting for staff as well as guidance and support for managers	May 2021	HoCT & D&I Lead	
4: % of Disabled staff compared to non-Disabled staff experiencing harassment, bullying or abuse.	Increase the numbers of Disabled staff reporting incidents of harassment, bullying or abuse at work	8. Work with F2SU Guardian to develop a targeted approach and support mechanism for Disabled Staff 9. Mandatory line manager training sessions on reporting abuse relating to protected characteristics 10. Disability Awareness Section on the Intranet – signposting for staff as well as guidance and support for managers	May 2021	HoCT & D&I Lead	
8: % of Disabled staff saying that their employer has made adequate adjustment(s).	Improve staff satisfaction with the level of reasonable adjustment(s) implemented to support them to carry out their work	11. Finalise and roll out Reasonable Adjustments guidance and mandatory e-learning resource	Jan 2021	HoCT	

APPENDIX A: WDES Metrics Report

Detailed below is the organisation's WDES data which was submitted on 31st August 2020, covering data available in March 2020. (Please note, Staff banding and role is categorised into 4 'clusters' as outlined in the table below)

Metric 1: % of staff in AfC pay bands, medical subgroups and VSM (incl. executive board members) compared with the % of staff in the overall workforce

Non-clinical workforce

	Disabled staff in 2019	Disabled staff in 2020	Disabled staff in 2019/2020	Non-disabled staff in 2019	Non-disabled staff in 2020	Non-disabled staff in 2019/20	Unknown/null staff in 2019	Unknown/null staff in 2020	Unknown/null staff in 2019/20	Total staff in 2019	Total staff in 2020
	(%)	(%)	% points difference	(%)	(%)	% points difference	(%)	(%)	% points difference	Headcount	Headcount
Cluster 1 (B1 - 4)	3.52%	4.1%	+0.58%	85.9%	85.6%	-0.3%	10.6%	10.3%	-0.3%	1251	1349
Cluster 2 (B5 - 7)	2.2%	2.6%	+0.4%	89.4%	90.4%	+1%	8.4%	7%	-1.4%	452	470
Cluster 3 (B8a - 8b)	1.6%	1.4%	-0.2%	83.9%	85.5%	+1.6%	14.5%	13.1%	-1.4%	124	145
Cluster 4 (B 8c – VSM)	2.7%	0%	-0.27%	90.7%	94.7%	+4%	6.7%	5.3%	-1.4%	75	94

(Data source: ESR)

Disabled staff in non-clinical roles

- The numbers of non-Disabled staff has increased in clusters 2-4, with an average lift of 1.58% across these bands.
- The Trust has seen an increased number of Disabled staff in cluster 1, from 44 in 2019 to 55 in 2020 (+25% on LY).
- For non-Disabled staff we see a small lift of 1.6% in Cluster 3 and 4% in Cluster 4 from 2019 to 2020. However, for Disabled we see decreases of 0.2% in Cluster 3 and 0.27% in Cluster 4.

Declaring disability

- The number of staff that did not declare a disability ('unknown') has decreased by 1.4% in clusters 2-4. This indicates increased confidence amongst staff from these bands in the Trust's ability to understand and support them to carry out their jobs.
- For cluster 1 we see a smaller decrease at 0.3% on LY.

Clinical workforce

	Disabled staff in 2019	Disabled staff in 2020	Disabled staff in 2019/2020	Non-disabled staff in 2019	Non-disabled staff in 2020	Non-disabled staff in 2019/2020	Unknown/null staff in 2019	Unknown/null staff in 2020	Unknown/null staff in 2019/2020	Total staff in 2019	Total staff in 2020
	(%)	(%)	% points difference	(%)	(%)	% points difference	(%)	(%)	% points difference	Headcount	Headcount
Cluster 1 (1 - 4)	2.3%	2.05%	-0.25%	89.2%	91.63%	+2.43%	8.5%	6.32%	-2.18%	1376	1266
Cluster 2 (B5 - 7)	2.1%	1.96%	-0.14%	91.5%	92.06%	+0.56%	6.4%	5.97%	-0.43%	3810	3767
Cluster 3 (B8a - 8b)	0.8%	0.5%	-0.3%	90.5%	91.18%	+0.68%	8.7%	8.31%	-0.39%	379	397
Cluster 4 (B8c – VSM)	2.3%	4.26%	+1.96%	93.2%	91.49%	-1.71%	4.5%	4.26%	-0.24%	44	47
Cluster 5 (Consultants)	0.5%	0.31%	-0.19%	72.4%	73.83%	+1.43%	27.2%	25.86%	-1.34%	615	642
Cluster 6 (Non-consultant career grade)	0.0%	0%	0%	65.5%	67.86%	+2.36%	34.5%	32.14%	-2.36%	29	28
Cluster 7 (Medical and Dental staff & trainee grades)	1.0%	0.83%	-0.17%	94.6%	94.6%	0%	4.5%	4.5%	+0.07%	718	722

(Data source: ESR)

Disabled staff in clinical roles

- The number of Disabled people working in clinical roles has decreased in all clusters, except Cluster 4. Here the clinical workforce shows an increase by 2%.
- Cluster 6 remains at 0% for the second year running.
- In comparison, the number of non- Disabled staff has increased across most bands.
- The data strongly demonstrates that addressing employment inequalities in clinical work at the Trust must form part of the wider plan for equal access to opportunities for Disabled staff.

Declaring disability

- There is a reduction in the number of ‘unknown’ from 2019 to 2020 across all clusters.

Metric 2: Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts

	Relative likelihood in 2019	Relative likelihood in 2020	Relative likelihood difference (+-)
Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	1.09	1.09	0

(Data source: Trust's recruitment data)

- Non-Disabled staff are slightly more likely than Disabled staff to be appointed from shortlisting.

Metric 3: Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

	Relative likelihood in 2018/19	Relative likelihood in 2019/20	Relative likelihood difference (+-)
Relative likelihood of Disabled staff entering formal capability process compared to non-disabled staff	0	0	0

(Data source: Trust's HR data)

- Disabled staff have not entered the formal capability process at the Trust since 2018. There are a number of possible reasons for this, including:
  - Disabled staff being more than capable of performing their role and delivering to a high standard
  - Disabled staff being appropriately supported by their managers so that they are effectively able to carry out their job roles
  - A very low proportion (2%) of self-declared Disabled staff compared to non-Disabled (90%) and 'unknown' staff (8%)

Metric 4: Percentage of Disabled staff compared to non-Disabled staff experiencing harassment, bullying or abuse.

	Disabled staff responses to 2018 NHS Staff Survey	Non-disabled staff responses to 2018 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2018	Disabled staff responses to 2019 NHS Staff Survey	Non-disabled staff responses to 2019 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2019
	(%)	(%)		(%)	(%)	
Staff experiencing harassment, bullying or abuse from patients/ service users,	31.5%	31.1%	-0.4%	38.4%	29.6%	-8.8%
Staff experiencing harassment, bullying or abuse from managers	24.3%	15.3%	-9%	28.3%	15.4%	-12.9%
Staff experiencing harassment, bullying or abuse from other colleagues	30.2%	22.2%	-8%	33.5%	21.6%	-11.9%
Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	41.3%	43.9%	+2.6%	46.9%	45.2%	-1.7%

(Data source: Question 13, NHS Staff Survey

- Disabled staff experiencing harassment, bullying and abuse increased across all categories compared to LY.
- In 2019 there was a much higher rate of harassment, bullying or abuse reported by Disabled staff, compared to LY and non-Disabled staff.
- Reported abuse from patients and service users has increase as much as 7% on LY.

Reporting bullying, harassment or abuse

The number of Disabled staff who felt able to report harassment, bulling or abuse in 2019 was slightly higher compared to non-Disabled staff, an improvement from the previous year. The percentage of Disabled staff who felt able to report harassment, bullying and abuse also increased from 2018, from 41.3% to 46.9%.

Metrics 5 to 8

	Disabled staff responses to 2018 NHS Staff Survey	Non-disabled staff responses to 2018 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2018	Disabled staff responses to 2019 NHS Staff Survey	Non-Disabled staff responses to 2019 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2019
	(%)	(%)		(%)	(%)	
Metric 5 - Percentage of Disabled staff compared to non-Disabled staff believing that the trust provides equal opportunities for career progression or promotion.	64.7%	74.4%	+9.7%	64.6%	75.3%	+10.7%
Metric 6 - Percentage of Disabled staff compared to non-Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	33.3%	26.4%	-6.9%	32.7%	25.3%	-7.4%
Metric 7 - Percentage of Disabled staff compared to non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work.	32.1%	43.7%	+11.6%	32%	46.9%	+14.9%
Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	66.4%	N/A	N/A	65.9%	N/A	N/A

(Data source: Questions 14, 11, 5, 28b, NHS Staff Survey)

Beliefs about equal opportunities, career progression and promotion

- Disabled staff felt notably less confident about the Trust providing equal opportunities with regards to carer progression and promotion.
- There was no improvement from 2018 to 2019 on the % of Disabled staff who believed that the Trust provided them with equal opportunities for progress in the workplace.

Feeling pressure to go to work when unwell

- A higher number of Disabled staff compared to non-Disabled staff reported feeling pressure to come into work despite not feeling able to carry out their duties. This was reported in years 2018 and 2019.
- There was a 6.9% difference between the likelihood of Disabled and non-Disabled staff to have felt pressure to work compared to non-Disabled people in 2018. In 2019, the gap between the two groups had widened further, with a 7.45% difference.

Feeling that work is undervalued

- Disabled staff at the Trust are much less likely to feel that their work is undervalued. In 2018, 32.1% of Disabled staff who responded to the Staff Survey said that they felt this way. This can be compared to 43.7% of non-Disabled staff who feel that their work is undervalued. This equates to a difference of 11.6% between the two groups.
- The difference between Disabled and non-Disabled staff and whether they feel that their work is valued is greater in 2019. There is an increase in the number of non-Disabled staff feeling that they are satisfied to the extent that their work is valued.

Adjustments in the workplace

- Only 65.9% of Disabled employees felt that adequate adjustments had been made in their work place.

Metric 9: Disabled staff engagement

	Disabled staff engagement score for 2018 NHS Staff Survey	Non-Disabled staff engagement score for 2018 NHS Staff Survey	Difference (+/-) between Disabled staff and non-Disabled staff engagement scores 2018	Disabled staff engagement score for 2019 NHS Staff Survey	Non-Disabled staff engagement score for 2019 NHS Staff Survey	Difference (+/-) between Disabled staff and non-Disabled staff engagement scores 2019
a) The staff engagement score for Disabled staff, compared to non-Disabled staff.	6.4	6.9	+0.5	6.3	7	+0.7

(Data source: NHS Staff Survey)

- Staff engagement is higher for non-Disabled staff compared to Disabled staff. This has decreased slightly in 2019 (vs. 2018)
- The Trust has an active Disability Network consisting of Disabled staff members, executive sponsors and representatives from Human Resources, Health and Wellbeing and Diversity and Inclusion.
- Our Disability awareness day took place on October 25th and aimed to drive engagement and raise understanding and awareness across the organisation.

Metric 10: Percentage difference between the organisation's board voting membership and its organisation's overall workforce

	Disabled Board members in 2019	Non-Disabled Board members in 2019	Board members with disability status unknown in 2019	% points difference (+/-) between Disabled Board members and Disabled staff in overall workforce	Disabled Board members in 2020	Non-Disabled Board members in 2020	Board members with disability status unknown in 2020	% points difference (+/-) Between Disabled and non-Disabled Board members in 2020
% difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting.	(%)	(%)	(%)		(%)	(%)		
	Exec = 0 Non-exec = 0 Voting = 0 Non-voting = 0	Exec = 100 Non-exec = 100 Voting = 100 Non-voting = 100	Exec = 0 Non-exec = 0 Voting = 0 Non-voting = 0	Total Board = 0 Overall workforce = 187 Difference = -2%	Exec = 0 Non-exec = 0 Voting = 0 Non-voting = 0	Exec = 100 Non-exec = 100 Voting = 100 Non-voting = 100	Exec = 0 Non-exec = 0 Voting = 0 Non-voting = 0	Total Board = 0 Overall workforce = 181 Difference = -2%

(Data source: NHS ESR and/or trust's local data

- 2% of the Trust's workforce have declared themselves as having a disability. In contrast, at board level is this 0%.Highlighting an underrepresentation at board level

APPENDIX B: Project Search

Project SEARCH is an international trademarked and copyrighted programme model, which requires a licensing agreement with their national office based at Cincinnati Children's Hospital Medical Centre. DFN Project Search holds the licence for Europe and the UK.

The model is a supported internship for local young adults with a learning disability and / or autism. It is a collaboration between a host business (St Georges University Hospitals NHS Foundation Trust), an education provider (Cricket Green School in Mitcham) , a supported employment provider (Kaleidoscope) and the intern's family. On-site support is provided by the tutors and job coaches and funding for these posts is provided by the intern's home Local Authority and Access to Work funding. Interns must have an existing Education Health and Care Plan in order for funding to be agreed. Project Search at St Georges has been running for 8 years, in which we have achieved some fantastic employment outcomes both within the hospital and externally.

Our aim is to develop the young people's employability skills through total immersion in the workplace: the internships run from September to August with interns attending the Trust every day, Monday to Friday, for a mix of classroom based teaching and work experience placements across the trust. As the year progresses the interns spend less time in the classroom and more in the departments hosting the work experience placement (hours in the final term are from 9.30am to 3.30pm).

The interns undertake real work, rather than shadowing and they learn these work skills from staff and managers hosting a placement. These staff are called Project SEARCH mentors and they take on this role on a voluntary basis. Mentors and managers receive practical advice and support from the job coach and tutors. Any 'reasonable adjustments' needed to enable the interns to do the work are developed with the placement mentor/s manager and Project SEARCH job coach and tutors. Systematic instruction is one of the methods used to teach work skills. Placement staff have access to group training sessions and the team deliver training in departments too.

We aim to place interns in 3 different departments over the year, 1 placement per academic term. However, some interns may stay in one department for the whole year if it is obvious they have found their career niche. Increasingly interns may have 2 concurrent placements where a department is unable to accommodate an intern 'full time'.

Together with St Georges, we have developed an employability skills rubric with a grant from the South West London Academic Health and Social Care System. We routinely use this to assess the employability skills of each intern at the start of their year and at the end of each placement. Progress reports are shared with placement mentors and managers and managers are invited to discuss these at the mentor's performance appraisal. The interns and their next of kind also receive the reports and end of year employability skills profiles are given to each intern to assist with the job applications.

Success is achieved when the interns secure paid employment of at least 16 hours a week. This international measure of success is not always relevant or achievable for each of our interns, however we deem it to be as much of a success when an intern secures the hours of employment they are looking for, or voluntary work where they prefer, or another form of personal and professional development programme.

Since 2012 our interns have achieved 75% employment compared to the national average of 7%. We have had a total 12 interns secure

employment across many different departments within St Georges Hospital.

Three interns have secured full time employment with Theatre Porters, two interns in Catering and one intern in each of the following: General Porters, Sterile Services, Outpatients, Medical Records, Student Union Shop, Marks and Spencer's. One intern secured an apprenticeship with the St Georges Advanced Patient Simulation Centre (GAPS).

We have also had interns secure paid employment, by gaining valuable work experience through completing Project Search at St Georges, with external companies such as Next, Pret, Starbucks, and local nurseries, leisure centres and theatres.

Project SEARCH @ St Georges has been assessed by an external inspector twice and at our last assessment in 2017 our 'quality of provision' was rated as *'outstanding'*.

Over the years the interns at Project Search have received so much support from various departments in St Georges providing placements within; Pharmacy Pre Pack, Medical Staffing, HR-Recruitment, the Education Centre: Haematology Services, Atkinson Morley Reception, the Playroom, the University Library, Macmillan Cancer Support Services and Gardening. The Project Search Team are incredibly grateful for so many departments being involved in our programme and mentoring our interns through their rotations.

APPENDIX C: Additional Information on the Definition of Disability

The meaning of disability

In order to avoid discrimination, it is recommended that instead of trying to make a judgement as to whether a person falls within the statutory definition of disability, we focus on meeting the needs of each worker and job applicant.

When is a person Disabled?

A person has a disability if he/she/they have a physical or mental impairment, which has a substantial and long-term adverse effect on his/her ability to carry out normal day-to-day activities.

What about people who have recovered from a disability?

In most circumstances, people who have had a disability within the definition in the past are protected from discrimination even if they have since recovered.

What does 'impairment' cover?

It covers physical or mental impairments; this includes sensory impairments, such as those affecting sight or hearing.

Are all mental impairments covered?

The term 'mental impairment' is intended to cover a wide range of impairments relating to mental functioning, including what are often known as learning disabilities. Hidden impairments such as mental illness, mental health conditions, diabetes and epilepsy may count as disabilities where they meet the definition in the Act.

What is a 'substantial' adverse effect?

A substantial adverse effect is something which is more than a minor or trivial effect. The requirement that an effect must be substantial reflects the general understanding of disability as a limitation going beyond the normal differences in ability which might exist among people.

Account should also be taken of where a person avoids doing things which, for example, cause pain, fatigue or substantial social embarrassment; or because of a loss of energy and motivation. An impairment may not directly prevent someone from carrying out one or more normal day-today activities, but it may still have a substantial adverse long-term effect on how they carry out

those activities. For example, where an impairment causes pain or fatigue in performing normal day-to-day activities, the person may have the capacity to do something but suffer pain in doing so; or the impairment might make the activity more than usually fatiguing so that the person might not be able to repeat the task over a sustained period of time.

What is a 'long-term' effect?

A long-term effect of an impairment is one: (i) which has lasted at least 12 months, or (ii) where the total period for which it lasts is likely to be at least 12 months, or (iii) which is likely to last for the rest of the life of the person affected.

Effects which are not long-term would therefore include loss of mobility due to a broken limb which is likely to heal within 12 months, and the effects of temporary infections, from which a person would be likely to recover within 12 months.

What if a person has no medical diagnosis?

There is no need for a person to establish a medically diagnosed cause for their impairment. What it is important to consider is the effect of the impairment, not the cause.

What if the effects come and go over a period of time?

If an impairment has had a substantial adverse effect on normal day-to-day activities but that effect ceases, the substantial effect is treated as continuing if it is likely to recur; that is if it is more probable than not that the effect will recur.

What are 'normal day-to-day activities'?

They are activities which are carried out by most people on a fairly regular and frequent basis. The term is not intended to include activities which are normal only for a particular person or group of people, such as playing a musical instrument or a sport to a professional standard or performing a skilled or specialised task at work. However, someone who is affected in such a specialised way but is also affected in normal day-to-day activities would be covered by this part of the definition. Day-to-day activities thus include – but are not limited to – activities such as walking, driving, using public transport, cooking, eating, lifting and carrying everyday objects, typing, writing (and taking exams), going to the toilet, talking, listening to conversations or music, reading, taking part in normal social interaction or forming social relationships, nourishing and caring for one's self. Normal day-to-day activities also encompass the activities which are relevant to working life.

What about treatment?

Someone with an impairment may be receiving medical or other treatment which alleviates or removes the effects (though not the impairment). In such cases, the treatment is ignored and the impairment is taken to have the effect it would have had without such treatment. This does not apply if substantial adverse effects are not likely to recur even if the treatment stops (i.e. the impairment has been cured).

Members of staff requiring treatment for an impairment must be allowed time off work to attend. This must be recorded as disability related absence and not counted as sickness absence. For more information, see absence management policy.

Does this include people who wear spectacles?

No. The sole exception to the rule about ignoring the effects of treatment is the wearing of spectacles or contact lenses. In this case, the effect while the person is wearing spectacles or contact lenses should be considered.

Are people who have disfigurements covered?

People with severe disfigurements are covered by the Act and are automatically treated as this having a substantial adverse effect on their ability to carry out normal day-to-day activities. However, they do need to meet the long-term requirement.

Are there any other people who are automatically treated as Disabled under the Act?

Anyone who has HIV infection, cancer or Multiple Sclerosis is automatically treated as Disabled under the Act. In addition, people who are registered as blind or partially sighted, or who are certified as being blind or partially sighted by a consultant ophthalmologist, are automatically treated under the Act as being Disabled. People who are not registered or certified as blind or partially sighted will be covered by the Act if they can establish that they meet the Act's definition of disability.

What about people who know their condition is going to get worse over time?

Progressive conditions are conditions which are likely to change and develop over time. Where a person has a progressive condition he/she/they will be covered by the Act from the moment the condition leads to an impairment which has some effect on ability to carry out normal day-to-day activities, even though not a substantial effect, if that

impairment is likely eventually to have a substantial adverse effect on such ability in the future. This applies provided that the effect meets the long-term requirement of the definition.

Are people with genetic conditions covered?

If a genetic condition has no effect on ability to carry out normal day-to-day activities, the person is not covered. Diagnosis does not in itself bring someone within the definition. If the condition is progressive, then the rule about progressive conditions applies.

Are any conditions specifically excluded from the coverage of the Act?

Yes. Certain conditions are to be regarded as not amounting to impairments for the purposes of the Act. These are:

- addiction to or dependency on alcohol, nicotine, or any other substance (other than as a result of the substance being medically prescribed)
- seasonal allergic rhinitis (e.g. hay fever), except where it aggravates the effect of another condition
- tendency to set fires
- tendency to steal
- tendency to physical or sexual abuse of other persons
- exhibitionism
- voyeurism.

Also, disfigurements which consist of a tattoo (which has not been removed), non-medical body piercing, or something attached through such piercing, are to be treated as not having a substantial adverse effect on the person's ability to carry out normal day-to-day activities (from The Equality Act 2010, Employment statutory code of practice).

This information is not definitive. Further guidance on matters to be taken into account in determining questions relating to the definition of disability is also available from the Office for Disability Issues.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Freedom to Speak Up

Quarter 2 2020/21 Report to the Trust Board of Directors

Report author:
Karyn Richards-Wright
Freedom to Speak Up Guardian

Executive Lead:
Stephen Jones
Chief Corporate Affairs Officer

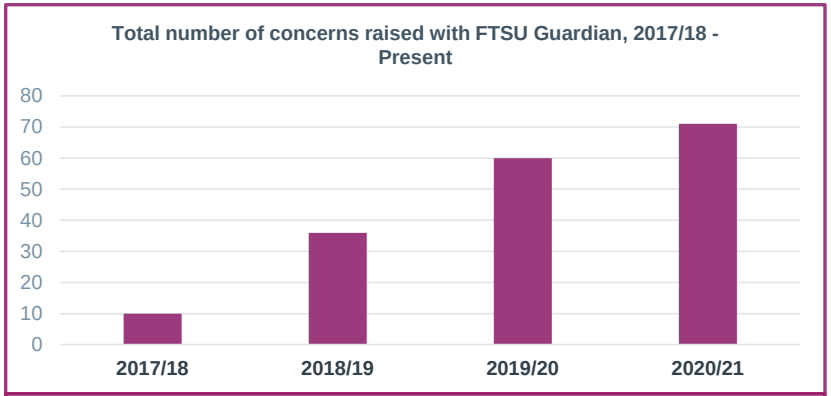
20 November 2020

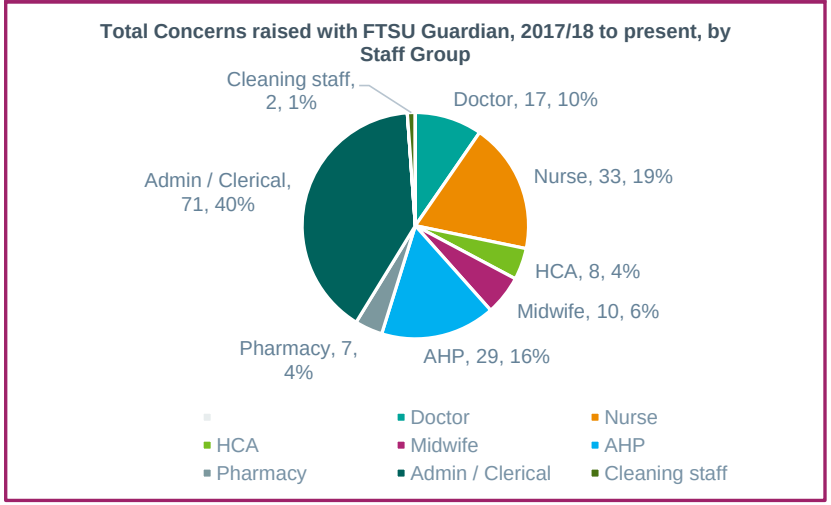
1. Executive Summary

- The number of concerns raised with the Trust's Freedom to Speak Up Guardian has increased significantly this year, with a total of 51 concerns raised in Q1 and a further 20 concerns raised in Q2 2020/21.
- The increase in concerns this year, and in Q1 2020/21 in particular, is attributable in significant part to concerns related to Covid-19 – including concerns around the availability of Personal Protective Equipment, shielding and staff support during the first wave of the pandemic, and the treatment of staff from BAME backgrounds. Themes around bullying and harassment and conflicts within teams and with line managers have continued during 2020/21, having been themes identified in previous years.
- Administrative and clerical staff are the staff group which raise the highest number of concerns – 41% of all concerns in Q1 and Q2 2020/21 were raised by administrative and clerical staff. 2020/21 has also seen an increase in the number of medical staff raising concerns – up significantly on previous years. Maintenance staff, porters and catering staff remain the staff groups least likely to raise concerns with the FTSU Guardian.
- The vast majority of concerns raised with the FTSU Guardian are dealt with informally, typically through signposting to the appropriate route for handling the issue (e.g. a relevant HR process). A small number of concerns are formally investigated. As at the end of Q2 2020/21, there are six live Freedom to Speak Up investigations. The timeliness of investigations remains a concern, with one of the six investigations having started in Q4 2019/20. The Guardian has escalated this to the Executive Lead who is following up on the delays and will detail the factors contributing to this and the actions to address these in the next report.
- October 2020 was national Freedom to Speak Up month and the Trust, along with other NHS organisations, participated fully in this and used the month to begin a significant push on staff communications on speaking up. During the month, the Trust received a visit from Henrietta Hughes, the National Guardian for Freedom to Speak Up and Dr Hughes met members of the Board, members of the staff networks, and staff who have previously raised concerns. Feedback was positive.
- The priorities for FTSU over the coming months include: holding our first FTSU / Raising Concerns Summit to triangulate a range of data and identify emerging and potential hotspots to enable sand support timely intervention by divisional and corporate teams; publishing a FTSU Charter for staff setting out clearly what they can expect when they raise a concern; and beginning a recruitment drive to strengthen and diversify our network of FTSU Champions. We are also reviewing our FTSU and Raising Concerns policy and developing a divisional reporting pack on FTSU for each clinical and corporate division.
- We have also undertaken a review of the recommendations set out by NHSE&I following its review of the Trust's structures and processes for FTSU earlier this year and the report sets out the actions taken in response.

2. Current activity and themes

Total number of concerns raised with FTSU Guardian, 2017/18 – Present





- There has been a steady increase in the number of concerns raised with the Trust's Freedom to Speak Up Guardian since 2017/18, from 10 concerns in 2017/18 to 60 concerns in 2019/20, the last full year for which total numbers are available.
- The number of concerns raised in the first two quarters of 2020/21 (71) already exceeds the total number of concerns raised in 2019/20 (60), which was previously the year with the highest number of concerns.
- A key driver of the increase in the number of concerns raised in 2020/21 to date has been concerns related to Covid-19 (see slide 5 for more details)
- Since the start of 2017/18, the staff group which has raised the highest number of concerns has been administrative and clerical staff. A total of 71 concerns have been raised by this staff group during this period. This is more than double the number of concerns raised by nursing staff, which accounts for 33 concerns over the same period and is the staff group with the second highest number of concerns in this period.
- Concerns among medical staff have increased over the past 18 months. Prior to 2019/20, only one concern had been raised by medical staff, whereas since the start of 2019/20 a total of 16 concerns have been raised, including 11 concerns among medical staff in the first two quarters of 2020/21.

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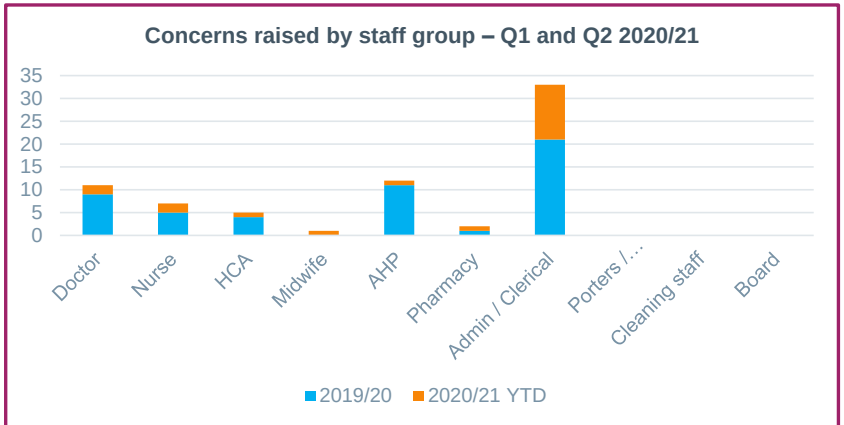
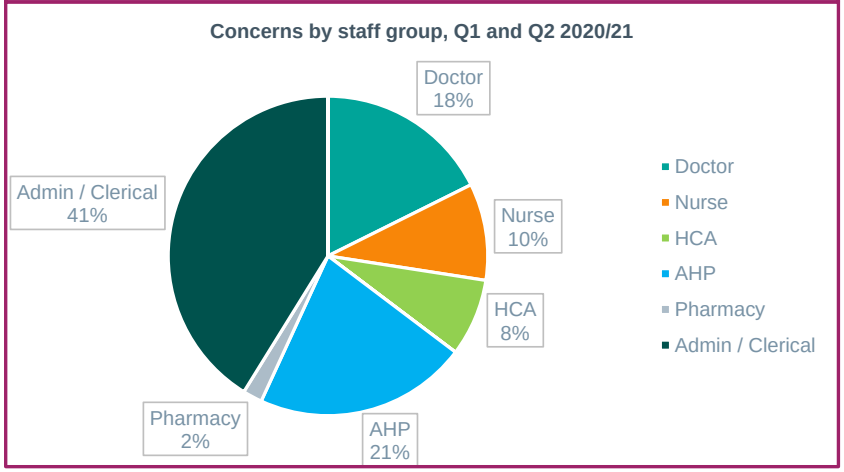
2. Current activity and themes

Number of concerns raised with FTSU Guardian during Q1 and Q2 2020/21





- At total of 71 concerns were raised over the first two quarters of 2020/21, 51 in Q1 and 20 in Q2. The number of concerns raised over the first two quarters of 2020/21 far exceeds the total number of concerns raised in each of the past three years, and represents two thirds (67%) of the combined total of concerns raised over the past 3 and-a-half years.
- By some margin, the staff group which has raised the greatest number of concerns has been administrative and clerical staff, with a total of 33 concerns being raised over the first two quarters of 2020/21, 21 concerns in Q1 and 12 concerns in Q2 2020/21. This is around three times higher than among HCAs, doctors and nurses which represent the staff groups with the next highest number of concerns in 2020/21. The proportion of concerns raised by administrative and clerical staff in the first two quarters of the year – representing 41% of the total concerns in this period – reflects the overall proportion of concerns from this staff group since 2017 (40%) and an increase from 36% over the period 2017/18 to 2019/20.
- As referenced above, there has been an increase in the number of concerns raised by doctors in 2020/21. These account for almost one fifth of concerns (18%) raised in Q1 and Q2, compared with 6% in the period 2017/18 to 2019/20.
- As a proportion of the total number of concerns, nursing staff accounted for 10% - 7 concerns - of the total concerns raised in the first two quarters of the year. This compared with 24% of the total number of concerns raised (26 of a total of 106) in the period 2017/18 to 2019/20.
- Continuing the trend send in previous years, no concerns have been raised in the first two quarters of 2020/21 among porters and maintenance staff or among cleaning staff. The absence of concerns raised among these groups, particularly in light of the impact of the Covid-19 pandemic on these staff groups, is notable and emphasises the continuing need for engagement with them by the Freedom to Speak Up Guardian.
- We are undertaking engagement with staff groups which raise fewer concerns to understand what stops staff from speaking up, and this will inform and shape our communications and awareness raising plans going forward.

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2. Current activity and themes

Themes arising from concerns raised in Q1 and Q2 2020/21

Division	Q1 2020/21 No of concerns	Q2 2020/21 No of concerns	Themes in concerns
CWDT	24	11	Bullying and harassment Conflict within teams Conflict with line manager Shielding during Covid-19 Lack of support during bereavement during Covid-19 Personal Protective Equipment during Covid-19 BAME concerns
MedCard	11	3	Bullying and harassment Conflict within teams Shielding during Covid-19 Personal Protective Equipment during Covid-19 BAME concerns
SNCT	10	2	Bullying and harassment Personal Protective Equipment during Covid-19 BAME concerns
Corporate	6	4	Bullying and harassment Processes Conflict with line manager Shielding during Covid-19
Total concerns	**51**	**20**	

- The increase in the number of concerns raised in 2020/21 can be attributed to a significant degree to Covid-19. This was particularly the case in Q1 2020/21 where Covid-19 related concerns accounted for a large proportion of the concerns received by the Freedom to Speak Up Guardian. The number of Covid-19 related concerns fall during Q2 2020/21, which coincided with the decline in the number of Covid positive patients at the Trust and the decline in the transmission rate of Covid among the population. As at early November 2020, the Guardian has seen concerns related to Covid-19 all but cease but this will be monitored closely in the coming weeks as the number of Covid positive patients at the Trust is expected to increase.
- The main Covid-19 themes in the concerns raised to the Guardian included: concerns about the availability and appropriateness of Personal Protective Equipment for staff during the first Covid wave; concerns related to staff shielding; and concerns relating to support during bereavement. The Guardian also received a significant number of concerns relating to the treatment of staff from ethnic minority backgrounds, a significant proportion of which were linked to Covid in terms of the reported higher mortality and morbidity rates among people from a BAME background.
- Bullying and harassment has been a recurrent theme in the concerns raised to the Guardian over several years and this has continued as a prominent theme in 2020/21 to date. Other longstanding themes which have also been evident in concerns raised this year have been conflicts with line managers and among teams.
- There have been no concerns directly related to patient safety raised with the Trust's Freedom to Speak Up Guardian to date this year, although one concern which related to patient safety was raised directly with the CQC and is currently being investigated by the Trust.
- The division with the highest number of concerns is the Children's Women's Diagnostics and Therapies Division (CWDT), which, at 35 concerns over the first two quarters, account for half of the total concerns raised by staff in 2020/21. The Guardian is actively working with and supporting managers and teams within CWDT and is delivering sessions on raising and responding to concerns to help identify and address the themes coming through from the concerns raised. The Guardian is actively working with staff from OD, Staff Support and Staff Engagement to triangulate themes and proactively work together to support areas. Within CWDT, the majority of concerns relate to Outpatients.

2. Current activity and themes

Current investigations – at end Q2 2020/21

- The vast majority of concerns raised with the FTSU Guardian are dealt with informally and rapidly, typically through signposting to the appropriate route for handling the issue (e.g. a relevant HR process) or through raising with the relevant team to enable prompt action to be taken to address the concern raised. Only a small number of concerns require formal investigation.
- There are a total of six active Freedom to Speak Up investigations at the Trust, two of which were opened in Q2 2020/21.
- Of the four investigations that pre-date Q2, one investigation remains open from Q4 2019/20. The Freedom to Speak Up Guardian has escalated this to the Executive Lead for Freedom to Speak Up who is addressing this with the investigating officer. A full analysis of the delays is currently being undertaken but a key issue based on current analysis is lack of engagement by a staff member whose behaviour is part of the scope of the review. The Non-Executive lead for Freedom to Speak Up has been briefed and a full review of the issues identified and lessons learnt is being developed and will be shared with the NED lead.
- One of the steps being considered by the Guardian and Executive Lead is the recruitment and development of a pool of staff who are trained in investigating concerns raised to the Freedom to Speak Up Guardian. Proposals, costings and implications of this are being worked through and will be brought through the People Management Group and Risk and Assurance Group in Q3 2020/21.
- A new IT software platform for confidentially logging concerns and producing high level reports has been procured and is at the last stages of refinement before go live which is anticipated within the next two weeks. Issues with access to the trust server and the speed in which these were able to be resolved have delayed the start date and subsequent training sessions planned for the Guardian.

3. Freedom to Speak Up Month – October 2020

Key developments

- October was national Freedom to Speak Up Month and, as such, all Trusts were asked to promote FTSU within their organisations by using the alphabet. There was a strong communications drive and daily updates on twitter from the Guardian.
- The National Guardian, Dr Henrietta Hughes, attended the Trust in person on 23rd October and met with the members of the Board and executive team, staff networks and staff who have raised concerns through the Guardian who can reflect on their experiences in person with the National Guardian. Feedback from the National Guardian was positive.
- The Guardian has collaborated with Epsom and St Helier Trust to commission a joint virtual presentation by Dr Chris Turner on the topic Civility Saves Lives. This took place on 22 October and was also advertised in our Trust communications to staff.
- The Chairman, Chief Executive, Executive Lead and Non-Executive Lead for Freedom to Speak Up have all recorded video messages for staff on what speaking up means to them and these have been publicised through the Trust's social media channels.
- We have developed a new FTSU poster and flyer promoting how to raise concerns to the Trust's FTSU Guardian, and posters and flyers have been placed at key locations across the Trust.

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4. Implementation of the Trust's new Freedom to Speak Up Vision and Strategy

The Board approved the Trust's new FTSU vision and strategy at its meeting in September 2020. Implementing the steps identified as priority areas for 2020/21 has been the focus of the FTSU function since then and the table below sets out the commitments made and a progress update against each area (in blue). There has been very positive feedback on our new FTSU vision and strategy from the national FTSU team at NHSE&I, which plans to use it as a strategy exemplar with other Trusts.

1. Strengthen the FTSU function	• Create dedicated and more senior FTSU role focused solely on FTSU • Create a new role of Deputy FTSU Guardian to build strength in depth of FTSU function • Create dedicated FTSU budget	• New Band 8a FTSU role now established. • Dedicated FTSU budget now created. • Resources to establish Deputy FTSU Guardian currently being explored.
2. Refresh FTSU Champions	• Clarify role of FTSU Champions & revisit role description and time commitment • Ensure all parts of the Trust have champions, and that the Champions network reflects the diversity of our staff, and identify champions for specific staff groups	• New role description and advertisement for FTSU Champions has been developed and will be launched later this month. • Process due to complete phase 1 by January 2021.
3. Develop FTSU Charter	• I have spoken up – what can I expect? • Someone has spoken up about me – what can I expect?	• Draft FTSU Charter has been prepared and taken through People Management Group and Risk and Assurance Group • Staff Side to be engaged later this month • Plans to publish Charter in December 2020
4. Refresh FTSU Policy	• Review of the policy to ensure it is fully up-to-date with national guidance and best practice • Review policy in light of agreed FTSU strategy • Ensure policy is clear about the range of routes for raising concerns	• Policy to be reviewed by January 2021 and updated policy to go through WEC and Audit Committee. • Policy will be reviewed with assistance from National Guardian's Office's FTSU Policy Review Tool
5. Establish FTSU Summit	• Develop proposals for establishing a group to triangulate issues and concerns with a range of other data • Develop ToR for the group • Ensure group is supported by range of data relating to safety, culture, workforce and other sources	• Plans for what the summit would involve have been developed and a date for the first summit meeting is being finalised, with the intention of holding this in December 2020.
6. Develop comms plan	• Develop and promote an annual calendar of FTSU events and activities • Develop communications campaign to raise awareness of how to raise concerns • Use full range of channels inc CEO weekly message, eG, case studies, video clips	• Significant communications push undertaken to coincide with national FTSU month. • Plans for continuing this are in preparation but will include further work to coincide with Charter launch and policy
7. Develop reporting	• Develop a model for regular reporting to the Trust Board and the sources of assurance and data to include in the report • Develop an FTSU annual report for the Board • Board level training in FTSU	• New Board and Committee report developed and will be refined further • Reporting to Divisions currently in preparation

5. Responsibilities of the Board

Integrating Board training and review into the Board development plan

- Recommendations from the National Guardian's Office and NHS England and NHS Improvement state that it is the responsibility of the Board to create a culture of learning within organisations which focuses on improving the quality of patient care and the experience of their workers. They have identified that the behaviour of executives and non-executives, which is often reinforced by managers, has the most impact on organisational behaviours and culture.

- In July 2019, NHS England and NHS Improvement together with the National Guardian's Office produced guidance setting out the roles and responsibilities of the Board and the Guardian will be working with the Board as part of the 2020/21 Board Development Plan to ensure that the expectations within the new guidance are considered and used to form the basis of Board- and Trust-wide training and development together with the self-review tool for NHS Trusts and NHS Foundation Trust also published in July 2019.

- The expectation within the Board self-review tool is that the Executive Lead for Freedom to Speak Up will use the guidance and the tool to help the Board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office. Ideally, the Board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the Board meeting. The Executive Lead should take updates to the board at least every six months. NHS England and NHS Improvement consider that it is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views is considered a useful way of testing the Board's perception of itself.

6. Reviewing recommendations from NHSE&I

Update on steps taken to implement advice (1 of 3)

- In December 2019, the CQC identified some weaknesses in the Trust's Freedom to Speak Up arrangements. Following this, the national FTSU team at NHS England and NHS Improvement undertook a review of the Trust's arrangements and set out advice to the Trust on how its arrangements could be strengthened. The review looked at Board papers, data from the National Guardian's Office, NHS Staff Survey results, the CQC inspection report December 2019, the most recent internal audit report on FTSU, an NGO case review gap analysis, and the existing FTSU job description. The reviewer met with the Trust Chairman, Acting Chief Executive, Chief People Officer, Chief Corporate Affairs Officer, the NHSI Improvement Director. The review identified eight areas in which the Trust's FTSU arrangements could be strengthened. The full report is set out at Appendix 1. The table below summarises the advice given by NHSE&I and the steps taken since to improve and strengthen the Trust's arrangements, which has been led jointly by the FTSU Guardian and the Chief Corporate Affairs Officer as Executive Lead since mid-June 2020.

Action No	Recommendation / Advice from NHSE&I	Steps taken by the Trust to respond to NHSE&I advice
1	Review FTSU Guardian resources to enable more time for the FTSU Guardian to explore emerging themes and developing hot spots	The FTSU Guardian role was revised and re-banded from a part-time Band 6 role (combined with responsibilities around Liaise) to be a full-time Band 8 role focused exclusively on FTSU. The FTSU Guardian had informed NHSE&I that she would find it helpful to have more time to explore emerging themes and the creation of a role focused solely on FTSU is intended to assist with this. The recommended administrative support to the Guardian is available through the CCAO's EA. The broader reach of the Guardian is being strengthened through the recruitment of a refreshed and expanded network of FTSU Champions, with the aspiration in time of ensuring there is at least one Champion within each Care Group and each corporate department. Consideration is being given to the possibility of establishing a Deputy FTSU Guardian. There are informal arrangements to this effect at present. A decision on this will be taken following the recruitment of the new Champions.
2	Develop collective engagement on FTSU	The review recommended FTSU summits to enable multi-disciplinary oversight of cases and discussion of issues. Plans for a new set of quarterly FTSU summit meetings have been developed which would bring together a wide range of staff and data including FTSU, ER, patient safety and complaints (among others) and this is due to start from December 2020. A ToR is in development.

6. Reviewing recommendations from NHSE&I

Update on steps taken to implement advice (2 of 3)

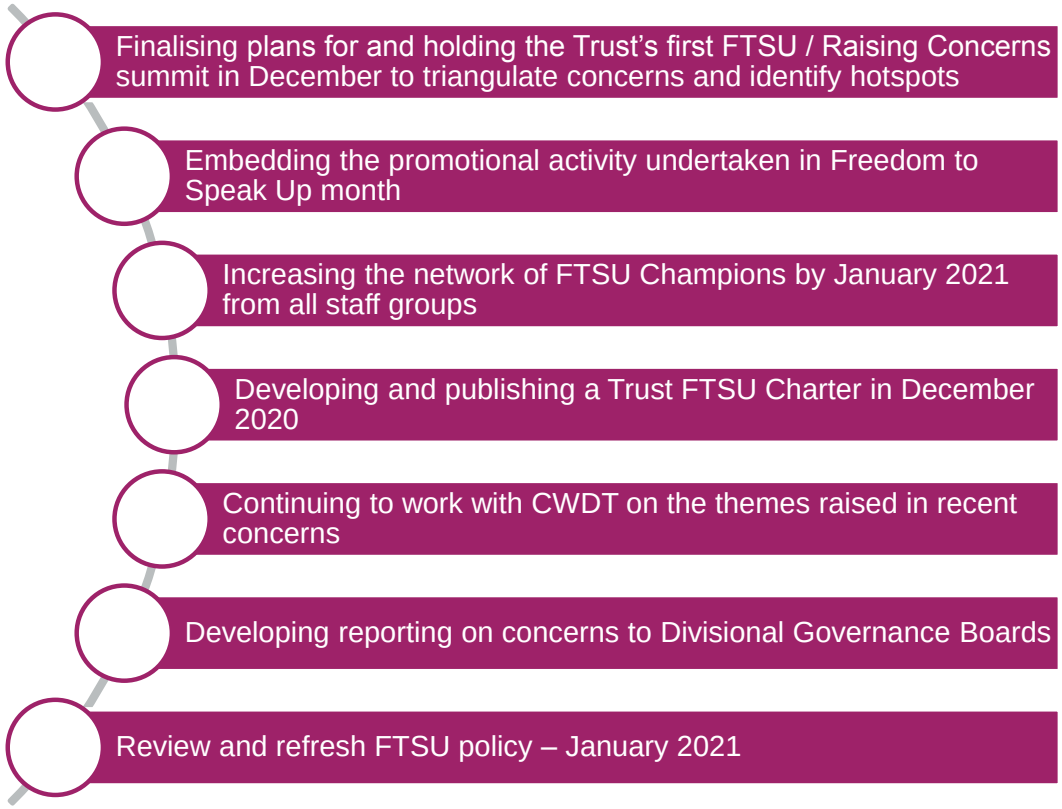
Action No	Recommendation / Advice from NHSE&I	Steps taken by the Trust to respond to NHSE&I advice
3	Clarify the FTSU aspects of the role	The review concluded that the FTSU's Job Description was lacking in some areas and that it was not clear from the Trust's existing JD how the role related to FTSU and lacked a number of areas of responsibility. The job description was fundamentally re-written by the Executive Lead in June 2020 and this drew extensively on the guidance published by the NGO and the universal template. The JD was used as part of the recruitment to the newly established Band 8 FTSU Guardian role in June 2020. The JD addresses the gaps identified in the NHSE&I review.
4	Develop a FTSU strategy / success measures	The review found that the Trust's approach to FTSU was not sufficiently clear and recommended that the Trust develop a clear FTSU strategy either as a stand alone document or integrated into a wider / pre-existing strategy such as the workforce or quality strategy, though it suggested a stand alone strategy would be preferable. The Executive Lead and FTSU Guardian developed a stand alone new FTSU vision and strategy for the Trust and, following engagement with staff groups, this was approved by the Board in September 2020. The strategy is intended to provide clarity as to the Trust's approach and areas of focus in the short, medium and long term. This is intended to assist the Board in overseeing action to improve FTSU and to enable staff to hold the Board to account for delivery of the strategy. The new strategy also sets out a series of success measures, albeit that these will be developed and honed further over time.
5	Executive Lead for FTSU	The CQC noted that the line management of the FTSU Guardian by the CPO was not in line with best practice, however, the NHSE&I review also noted that there was no national guidance on who should be the Executive Lead. Following the departure of the previous CPO in May 2020, the Trust appointed a new Executive Lead (CCAO) in June 2020. Close links are maintained between the Executive Lead and FTSU Guardian with the Acting CPOs.

6. Reviewing recommendations from NHSE&I

Update on steps taken to implement advice (3 of 3)

Action No	Recommendation / Advice from NHSE&I	Steps taken by the Trust to respond to NHSE&I advice
6	Develop the FTSU Guardian report for Board	The CQC noted various weaknesses in the reporting of FTSU to the Board and Board Committees, and this was reinforced by the review by NHSE&I. In particular, the review noted that greater detail was needed and the reporting needed to reflect the national guidance published in July 2019. Board reporting has been strengthened since June 2020 and the November report to WEC and the Board provides the report in a new format. The format and content will be further developed to incorporate additional intelligence and metrics on the Trust's FTSU culture, the identification of potential hotspots, and processes of investigations. This will be assisted by the creation of the new FTSU summits from December 2020, and the intelligence from these meetings will be used to inform the reports to the Board and Board Committees.
7	Improve timeliness of investigations	The review identified that FTSU investigations often took far longer than they should. The Trust has procured a new IT solution to ensure there is a centralised case management tool for tracking the progress of investigations and concerns, which issues alerts at key milestones in investigations enabling discussions to take place where timescales risk being impacted. The software is now operational. The FTSU Guardian and Executive lead are developing plans to roll out the new national FTSU training module to all staff to help reinforce the message about the importance of timeliness in investigations and what to expect. Alongside this, we are exploring the possibility of recruiting a pool of independent and trained staff who could take the lead on FTSU investigations. The Executive lead is currently reviewing the causes of delays in current and previous investigations and will report back to the WEC and Board in the next report.
8	Create a designated FTSU budget	The review recommended the creation of a stand alone FTSU budget, but noted there were no national requirements around this. A separate budget has been created and resource for communications activity and engagement is aligned to this.

7. Priorities of the Freedom to Speak Up function in Q3 and Q4 2020/21



- The FTSU Guardian's priorities over the next quarter focus on the actions necessary to implement the new FTSU vision and strategy agreed by the Board in September 2020, including those steps identified as priority actions for 2020/21 that would have an immediate impact on the profile and impact of FTSU.
- A new role description for FTSU Champions has been developed and this will be launched in the coming weeks with a view to refreshing the Champions' network. A number of FTSU Champions have withdrawn from the roles in recent months citing work pressures connected with Covid-19. Our ultimate aspiration is to recruit several dozen new Champions, including a Champion in every Care Group and across each of the corporate departments. This, however, will take time and we are taking a step-by-step approach to recruitment to ensure we have the time and resource to put in place appropriate training and support to new Champions. We are seeking to recruit Champions that reflect the full diversity of our staff – both in terms of roles and protected characteristics.
- In December, we plane to launch a new FTSU Charter – setting out clearly what staff can expect when they raise a concern and for staff who have a concern raised in relation to them what they too can expect from the process. We are consulting Staff Side on this later this month.
- In December, we also plan to hold our first FTSU summit, a meeting designed to bring together and triangulate a broad range of data – FTSU, Employee Relations, patient safety, complains and other data – to identify emerging hotspot areas that may require / benefit from additional support and / or early intervention to address emerging issues.

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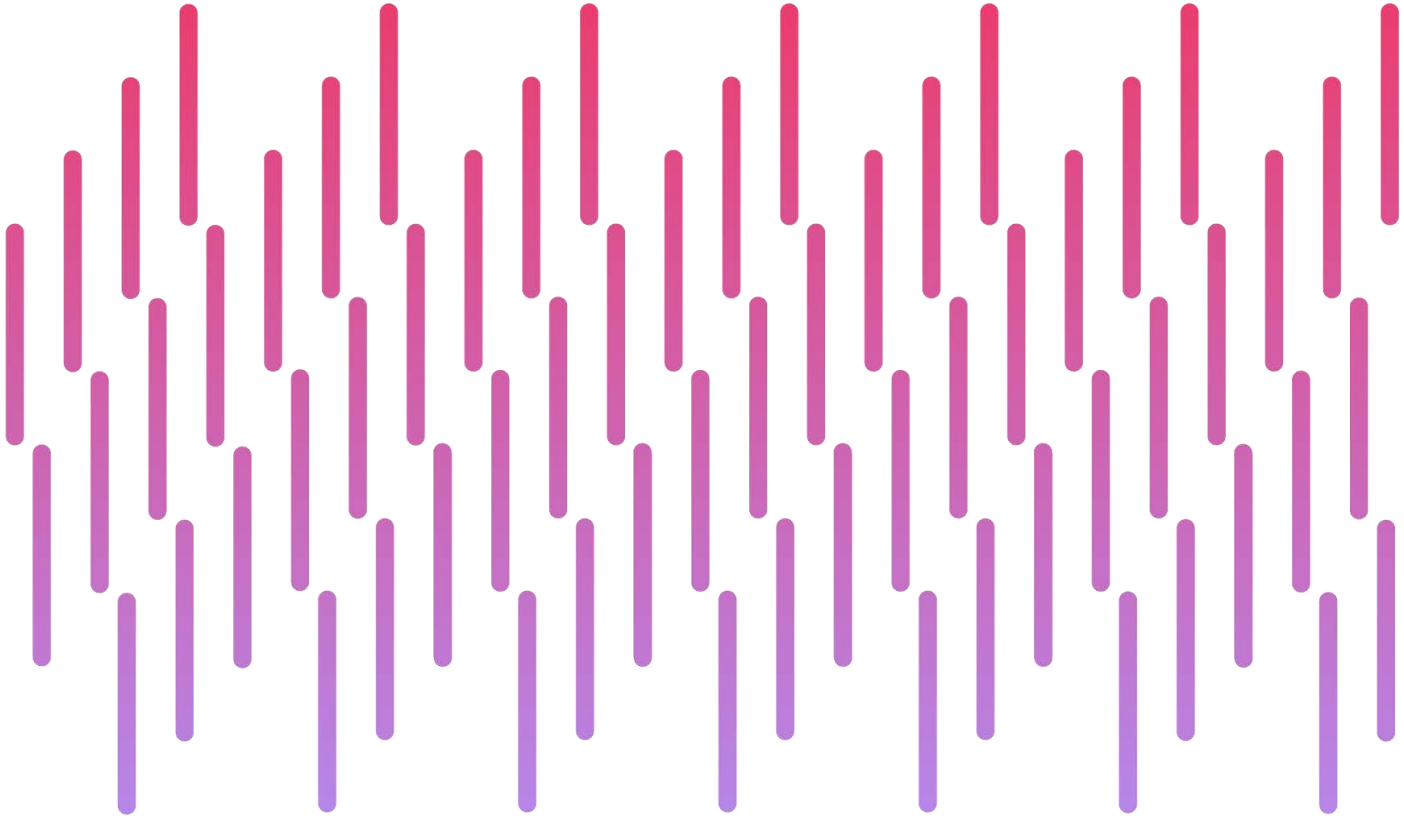

Freedom to Speak Up: Q2 2020/21 Report to the Trust Board of Directors
St George's University Hospitals NHS Foundation Trust

Freedom to Speak Up

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Appendix 1

FTSU advice for St George's University Hospital NHS FT

Author: Rachel Clarke, Advocacy and Learning Senior Manager (FTSU)

Version: Final

Date: 4 March 2020

NHS England and NHS Improvement

The ask

In December 2019 CQC identified some weaknesses in the trust's FTSU arrangements.

The trust's NHSI/E Improvement Director arranged for the national FTSU Team at NHSI/E to meet key people at St George's to identify ways the trust could develop their FTSU arrangements in response to CQC's feedback.

This report contains our advice, based on our knowledge of effective FTSU arrangements in other NHS trusts and on the national requirements for FTSU set out by NHSI/E and the National Guardian's Office (See Annex 1).

What we did

We looked at….	We spoke with…
Board papers FTSU board assessment and action plan NGO data NHS staff survey results CQC inspection report and evidence bundle FTSU audit report FTSU Guardian JD NGO case review gap analysis	FTSU Guardian Executive Lead – HRD Chief Corporate Affairs Officer Acing CEO Chair NHSI Improvement Director Programme Director – OD and Leadership

Our expectations

We will be interested to understand which elements of the advice are accepted by the board and which are not, and understanding why.

Therefore, please let us know which aspects of the advice you accept and which you don’t (and explain why).

Summary of suggested development areas

		Page reference
1	Review FTSU Guardian resources to enable more time for the FTSU Guardian to explore emerging themes and developing hot spots	6
2	Develop collective engagement on FTSU	7
3	Clarify the FTSU aspects of the role	8
4	Develop a FTSU Strategy/success measures	9
5	Exec Lead for FTSU	10
6	Develop the FTSU Guardian report for Board	11
7	Improve the timeliness of investigations	12
8	Create a designated FTSU budget	13

Advice: Review FTSU Guardian resources to enable more time for the FTSU Guardian to explore emerging themes and developing hot spots	
Page 2 – Guidance for boards on FTSU Chapter 2 – Supplementary Information on FTSU	
Rational for advice	CQC identified that the trust's FTSU Guardian had enough resource to support staff to raise concerns but also highlighted a finding from the recent audit that there was not adequate coverage of the FTSU Guardian service across all divisions and sites. The trust's FTSU Guardian has said that she would like more time in order to explore emerging themes and developing hotspots. Karyn would be an ideal person to sit in on the culture and leadership workgroups particularly with the view to making sure that FTSU skills was included in the leadership programme and the value of staff feedback was highlighted. This wider cultural work is an aspect of the NGO's universal FTSU Guardian job description and NHSI has set out that trusts should regularly review whether their FTSU Guardians have enough time to carry out their role fully. Extra resource could involve having a second FTSU Guardian (which would echo the arrangements that Epsom and St Hellier have (one full time and one part time Guardian) or some admin support. The HRD has said that he is happy to receive proposals from the FTSU Guardians around extra resource.
Available support/resources	I am happy to help Karyn shape some options if that would help

Advice: Develop collective engagement on FTSU	
No national requirements around collective engagement on FTSU	
Rational for advice	The trust's FTSU Guardian spoke positively about previous FTSU summits at the trust which enabled multi disciplinary oversight of cases and discussion of issues. Reinstating this would signal the value the Exec Team place in FTSU (as aspect of NHSIs FTSU Guidance for Boards) and would echo Epsom and St Hellier's FTSU quarterly Oversight meetings.
Available support/resources	I have already provided the HRD with two example of ToRs by email. Page 8 and 9 NGO Feb 2020 newsletter describes the impact of multi Exec involvement at London Ambulance Service.

Advice: Clarify the FTSU aspects of the role	
NGO **Universal Job Description**	
Rational for advice	We reviewed the FTSU Guardian's job description and believe that it lacks some of the important aspects of the NGO's universal JD template. It wasn't clear from the trust's JD how the role related to FTSU and seemed to lack some of the responsibilities around: • Working with the senior leadership team • Supporting the development of policy, training around speaking up • Challenging senior leaders to effectively role model speaking up • Identifying barriers to speaking up and tackling them • Board reporting • Measuring the success of the FTSU service • Participating in inductions • Participating in comms and engagement around FTSU • Identifying and sharing learning within the local, regional and national FTSU networks • Leading a band of champions
Available support/resources	I have already provided the HRD with two examples of FTSU Guardian JDs organisations (that scored the highest in the NGO FTSU Index) by email.

Advice: Develop a FTSU Strategy/success measures	
Page 2 – **Guidance for boards on FTSU** Chapter 2 – **Supplementary Information on FTSU**	
Rational for advice	CQC highlighted that some board members felt that the FTSU approach needed to be pulled together into a strategy. We understand that there are mixed views on whether there should be a stand alone FTSU strategy if the principles behind a healthy speaking up culture were in existing OD and patient safety strategies. NHSI are not wedded to trusts having standalone FTSU strategies. But we do think trusts should have clear plans in place showing how they plan to develop their FTSU arrangements and how they intend to measure progress. These could flow from existing overarching OD/leadership strategies or form a separate document. The advantage of a separate document is that it stands alone, which gives it clarity and potentially makes it easier for workers and others to hold the board to account.
Available support/resources	I have already provided the HRD with three examples of FTSU strategies (from organisations that scored the highest in the NGO's FTSU Index) by email.

Advice: Exec Lead for FTSU	
No national requirements around who is or isn't the Executive Lead for FTSU.	
Rational for advice	CQC noted that the trust's FTSU Guardian was lined managed by the HRD and stated that his was not in line with best practice guidance (which identified that there should be separation between these two functions). I am not sure what CQC based their comment on because we are unaware there is no national guidance on who should or should be the Exec Lead for FTSU. We are aware of many organisations that use the HRD as the executive Lead for FTSU and we are not aware that CQC have comment on them in the same way. The trust's HRD appeared impressive and it is clear he and the FTSU Guardian have thought about conflict and attempted to reduce it. However, given the HRD is leaving and (as I understand it) there won't be a permanent HRD in post in the near future, it seems to me to make sense to transfer the responsibility to another long standing exec and then establish regular meetings with the interim HRD to maintain close contact around cultural themes.
Available support/resources	If the trust chose to maintain the existing arrangements then we would happily link the FTSU Guardian and HRD up with other HRDs so that they could discuss if there is anything else the trust could do to mitigate conflict. Equally, if the trust chose to change the Exec Lead arrangements we could connect the trust with non HR Executive FTSU Leads to discuss how best to maintain a link with HR/OD.

Advice: Develop the FTSU Guardian report for Board	
Chapter 7 – **Supplementary Information on FTSU**	
Rational for advice	CQC noted that FTSU reporting processes were not operating effectively and that reporting to the board and workforce and education committee were limited in detail. We reviewed the latest FTSU Guardian reports and believe that the Board would get greater detail about what the trust's speaking up culture is like if the report to board followed the FTSU Guidance set out by NHSI/NGO. In summary, I think the FTSU Guardian report would benefit from the following additional information: • How does FTSU fit into the bigger picture? Ie what other information have you considered FTSU concerns alongside in order to try and identify emerging issues/hot spots? • Who does not know how to speak up or lacks confidence or opportunity to do so? What has been done to resolve that? • How effective are your speaking up arrangements? • What has the trust done to identify what detriment looks like at St Georges and proactively try and prevent it? What has the trust done to evaluate allegations of detriment made?
Available support/resources	I have already provided the HRD with our internal NHSI FTSU Guardian report checklist which might help the FTSU Guardian identify information gaps. It also includes hyperlinks to a number of examples from other trusts.

Advice: Improve the timeliness of investigations	
Page 6 National FTSU: raising concerns (whistleblowing) policy	
Rational for advice	The FTSU Guardian flagged the delays she experiences with managers completing FTSU investigations (which was an issue picked up in the internal audit that took place a year ago). Both the FTSU Guardian and the HRD suggested this problem would be resolved with the development of a new IT system. However, I wonder how much work has been done to 'sell' the FTSU message to managers so that they understand the value of staff feedback (which is what speaking up is) and the need to encourage this by showing to workers that action has been taken to evaluate/respond to concerns. I think it would be useful for the FTSU Guardian to be as closely aligned as she can be with the culture and leadership work that is ongoing with Tom Kenward so that the trust can be confident that the core messages set out in the NGO Guidance on FTSU training are incorporated/reflected. In addition, it may be worth exploring with Tom how FTSU behaviours/values and investigation skills could be tied into JDs/appraisals going forward.
Available support/resources	

Advice: Create a designated FTSU budget	
No national requirement around budgets	
Rational for advice	The trust's internal audit report touched on the lack of budget for FTSU - but the corresponding recommendation only talked about increasing champions and did not address the budge point. There are no national requirements around budget for FTSU, but there are expectations around executive engagement with staff and having a dynamic and effective communication and engagement strategy; both of which could require budget.
Available support/resources	Here are links to two organisations that entered the HSJ's FTSU culture award that have creative engagement initiatives: 'Time for Tea' FTSU communication campaigns

Annex 1 - National requirements around FTSU

NHSI National Whistleblowing policy template 2016

NHSI/NGO FTSU Guidance for boards 2019
NHSI/NGO FTSU Supplementary Information

KLOE 3 of the Well Led Framework 2017

10 recommendations in the NGO Annual Guardian Survey 2017
12 recommendations in the NGO Annual Guardian Survey 2018
20 recommendations in the NGO Annual Guardian Survey 2019

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3.3

Meeting Title:	**Trust Board**		
Date:	26 November 2020	**Agenda No**	**3.3**
Report Title:	**Freedom to Speak Up Report**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Authors:	Karyn Richards, Freedom to Speak Up Guardian		
Presented for:	Assurance		
Executive Summary:	This report provides the Board with an overview of the concerns raised with the Trust's Freedom to Speak Up Guardian as at Q2 2020/21. The report sets out the number of concerns raised and breaks this down by staff group. It also provides an update on the current investigations underway at the end of Q2. October 2020 was national Freedom to Speak Up month and the report sets out some of the key activity undertaken and provides an update on the visit to the Trust of the National Guardian for Freedom to Speak Up on 23 October. In addition, the report sets out the progress in implementing the new FTSU vision and strategy, particularly in relation to the 2020/21 immediate priority areas. Separately, the report sets out the progress made against each of the recommendations of the review of the Trust's FTSU arrangements by NHS England and NHS Improvement in March 2020.		
Recommendation:	The Board is asked to: • Note the current activity levels in relation to raising concerns during Q1 and Q2 2020/21; • Note the current investigations underway at the end of Q2 2020/21; • Note the progress in implementing the new FTSU vision and strategy, particularly in relation to the identified 2020/21 priority areas; • Note the update on progress in addressing the recommendations of the March 2020 NHSE&I review into the Trust's FTSU arrangements.		
Supports			
Trust Strategic Objective:	Build a better St George's; Champion Team St George's		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	Failure to comply with the requirements around Freedom to Speak Up, a regulatory requirement, risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.		
Legal/Regulatory:	NHSI, Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy for the NHS, April 2016. Sir Robert Francis QC, Freedom to Speak Up: An independent report into creating an open and honest reporting culture in the NHS, 2015.		
Resources:	As set out in the report.		
Equality and Diversity:	As set out in the report.		
Previously Considered by:	People Management Group Risk and Assurance Group Trust Management Group Workforce and Education Committee	**Date**	4 November 2020 4 November 2020 11 November 2020 12 November 2020
Appendices:	N/A		

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3.4

Meeting Title:	**Trust Board**		
Date:	**26 November 2020**	**Agenda No**	**3.4**
Report Title:	Guardian of Safe Working Hours (GOSWH) Report – Quarter 2 2020/21 for the periods 01/07/2020-30/09/2020		
Lead Director/ Manager:	Dr Richard Jennings		
Report Author:	Dr Serena Haywood, Guardian of Safe Working Hours ('The Guardian')		
Presented for:	Assurance		
Executive Summary:	From 4th August 2020 new foundation trainees joined the Trust and the other trainees will resume their training rotas following the changes made to their rotas in response to the Covid-19 emergency. An increase in the number of patients admitted to receive treatment for Covid-19 is anticipated in Quarter 3 2020/21, but at this stage, no reallocation of trainees has been made whilst direction is awaited from NHS England. Rota gap data is included in the report. Trainees are concerned that not all pre-Covid training opportunities are on offer both in and outside of the Trust due to waiting times for mandatory courses. The Trust is offering online training and routine monitoring of uptake is on-going. The Director of Medical Education (DME) report will detail the internal trust decision to temporarily reallocate F1 trainees away from lower gastrointestinal surgery because of significant negative feedback received via As is standard trust practice, the current trainees have been moved to other surgical specialities whilst an investigation takes place. This investigation will be completed by the postgraduate department. No completion date is available yet. There were 41 exception reports with all but 7 related to working hours. There were 54 reports in the first quarter. Most are reported in medicine. No fines were issued in Quarter 2 2020/21. Fine monies and Wellbeing money remains available to be spent with a space in the Emergency Department identified as a wellbeing space, which will be available for all Trust staff to use. Plans for development of the Junior Doctor Mess, including a sleeping area, is being costed and will include a contribution from the Wellbeing fund. The GOSWH is concerned about reduced attendance at the Junior Doctors' Forum, but following the recent appointment of a new Junior Doctors' Forum Chair, a recruitment drive for speciality representatives is under way.		
Recommendation:	The Board is asked to note the update from the Guardian of Safe Working.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well led, Safe		

Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	Failure to ensure that doctors are safely rostered, and enabled to work hours that are safe, risks patient safety and the safety of the doctor. Failure to ensure that doctors are safely rostered, and enabled to work hours that are safe, risks overtime payments and fines being levied.		
Legal/Regulatory:	Compliance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016. Update 2019.		
Resources:	Funding for overtime payments, fines and service charges arising from work schedule reviews Additional PA allocation in consultant job plans for time taken to personalise work schedules, resolve exception reports and perform work schedule reviews Administrative support for the role of Guardian		
Previously Considered by:	Workforce & Education Committee Executive Management Team	**Date:**	12/11/20 16/11/20
Appendices:			

Guardian of Safe Working Hours (GOSWH) Report – Quarter 2 2020/21 for the periods 01/07/2020-30/09/2020

1.0 PURPOSE and BACKGROUND

Available in previous reports.

2.0 COVID-19 and DOCTORS IN TRAINING

a) Rota. From August 4th the trainees joined the Trust or returned to their allocated rotas. A few rotas were not sent out within two weeks of starting, which has not been the trend over the last year and may reflect the unusual circumstances of this year. The trainees are aware that they may be redeployed if there is a need for another emergency response to Covid-19.

b) Wellbeing. The trainees appreciated the facilities on offer at the Trust during the emergency response to Covid-19 and the GOSWH will monitor the support and facilities offered to trainees should there be a need for further emergency responses in the light of Covid-19.

c) Pay discrepancies continue to be addressed by the Trust. Trainees have not reported an inability to take annual leave by the autumn.

d) Training. The Director of Medical Education (DME) is sending regular updates to ensure the trainees feel supported and directing them to appropriate information for their specialties. Flexibility is being offered to ensure any necessary training paused during the emergency response to Covid-19 is not missed. However a number of trainees have expressed dissatisfaction that training has not been available as expected particularly mandatory off-site training which now has a considerable backlog in several cases. Trainees are worried that they will not be able to fulfil their training requirements to move onto their next stage. Health Education England (HEE) is aware of this potential problem. Trainees have asked for extra courses to be run but this is not always possible. National and International organisations in healthcare training and management currently have large backlogs due to the pandemic. There has been reassurance from HEE that training will be honoured and any disputes sue to lost training looked at proportionately.

3.0 ANALYSIS of REPORTS and FINES

3.1. Fines None in Quarter 2 2020/21.

3.2 Wellbeing Money Spend

See previous report for details
Total £ 42,027.58

Current projects which will include:

a) Junior DoctorMess; redecoration, provision of a sleep area, showers. Costs awaited
b) ED multi-agency wellbeing room. Costs awaited.
c) Paediatrics rest facilities; costs awaited

3.3. Exception Reports

Exception Reports (ER) over past quarter	
Reference period of report	01/07/20 - 30/09/20
Total number of exception reports received	41
Number relating to immediate patient safety issues	6
Number relating to hours of working	34
Number relating to pattern of work	1
Number relating to educational opportunities	4
Number relating to service support available to the doctor	2

***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

A total of 41 exception reports were submitted, the majority of these related to working hours /conditions in this quarter.

This remains an exceptional time with most reports post-Covid and is notable for the reduced numbers of reports compared to previous years (97 in 2019 and 202 in 2018). This is thought to be due to the aftermath of the Covid-19 peak and returning to previous rotas; it is assumed trainees were tired and many were on leave. There is a hope that with the start of winter pressures and the inevitable extra hours needed to be worked that trainees will begin to report again in the numbers that they have before in order to support any changes that need to be made.

All reports were eligible for review.

St George's is the lead employer of GP trainees across South London and no exception episodes were reported by this cohort of doctors.

3.4 Full Exception Report Breakdown by specialty with resolutions where available

See Appendix A

3.5 Immediate Safety Concerns (ISC) raised by trainees

A response to an ISC is made by the GOSHW, who decides whether a work schedule review is justified. In Quarter 2 2020/21, six ICSs were raised with two being incorrectly notified as immediate concerns; these two are marked with an asterisk below. Of these six reports, one of the trainees wanted to notify their trainers, but did not want any further action, two are now resolved and the remaining three are still open with on-going discussions being held with the trainee. The trainee who made these reports declined two recent invitations to meet with the GOSWH. The GOSWH has met with the department and immediate mitigations were sought for staffing and on-going work on the rota.

Occurrence time	Grade	Variance from work schedule	Steps taken to resolve
23 Aug 2020	CT2	Normal working schedule was ward cover SHO St James weekend. No registrar was present for either days (Saturday and Sunday) and I was asked to step up as a reg for the whole weekend. No cover was found to replace the vacant post for either days hence I did a ward cover SpR weekend across the hospital.	The plan to step the doctor up was made by the medical registrar on-call that day and the consultant on-call was not made aware, but the consultant on-call did make sure that the trainee was adequately supervised. Discussions have been had to prevent this happening again. This ISC is now closed.
*02 Sep 2020	FY2	Stayed late due to number of important jobs and not enough doctors/PAs on outliers week. This was escalated to the department for help, including getting help from a medical student, F1 and Physician Associate (PA) on different days. The Service Manager was informed of a likely late finish.	There were no patient safety concerns as the “clinical concern” box was ticked by mistake and the trainee was unable to amend this after submission. Things might be better managed by having more flexibility earlier in the day where either a PA is allocated to round with the outliers’ doctor or that the on-call PA when not busy in resuscitation can help out. The trainee has been advised to cut through the “hierarchy” and ring the on-call consultant/Consultant of the Week. The trainee will need to be remunerated for the additional hours. Incorrectly notified as an ISC, but reviewed and closed.
*01 Sep 2020	FY2	Had to stay 2.5 hours late due to sheer volume of important jobs on Outliers week.	Incorrectly notified as an ISC, but reviewed and closed (see above ISC for further details).
29 Aug 2020 09:30	ST4	I was on call for the bank holiday weekend. At the end of my first day on call the consultant informed me that we would be an FY1 down and covering 2 teams the next day (standard and post take). When I arrived the nursing staff were concerned/surprised that there was only one team instead of the usual 2. Hence we were very low staffed. There were also multiple acutely unwell patients. The consultant in charge and medical staffing already knew - so there was nothing I could do. I just hoped the rest of the weekend would not be so low staffed (less than one team instead of the usual 2).	On-going work to resolve staffing issues and support individual trainees.
20 Jul 2020 09:00	ST4	I am on call for Geriatrics (OPAL). However the ward has only myself and an SHO for a ward that can hold 32 patient's, with 9 new patient's on a Monday. We have and MDT at 11.30 and the departmental quarterly	A meeting was held with the GOSWH, rota coordinator, the doctor’s educational supervisor and the departmental lead. The rota gaps were

Occurrence time	Grade	Variance from work schedule	Steps taken to resolve
		meeting this afternoon. My consultant has informed me that I am unlikely to be able to do any speciality work or attend the afternoon meeting as I will be required to try and keep the ward as safe as possible. This is exactly the same situation I have repeatedly been in Hence I am concerned that the hospital is consistently over working doctors and running wards understaffed which prevents people from gaining speciality experience, or taking leave. As this is consistently occurring it will affect the health of both patients and staff	acknowledged and a significant difficulty with acquiring an appropriate locum was discussed. More proactive work on changes to the rota was agreed. A meeting with the doctor, DME and GOSWH was planned for October, but the offer was not accepted. On-going work to resolve staffing issues and support individual trainees.
14 Jul 2020 09:00	ST4	When I arrived on the ward I found that there was only myself and an SHO who was on-call for the ward to cover up to 32 patients. A locum consultant arrived; I messaged around and got an additional junior from a different ward I am concerned consistent low staffing could cause danger for patient's and affect staff health.	On-going work to resolve staffing issues and support individual trainees (see above).

3.6 DETAILS OF SPECIFIC EXCEPTIONS BY SPECIALTY

No other discussions with The Guardian this quarter. Correspondence is noted in each exception report.

3.11 Rota gaps

See below

3.12 Junior Doctor Forum

The Junior Doctor Forum (JDF) attendance has dropped significantly. The GOSWH is concerned that reduced attendees in the Junior Doctors' Forum suggests reduced engagement. With a new Chair of the JDF a recruitment drive for speciality representatives is under way. The meeting will return to the mess with social distancing and food to attract more trainees. Lower attendance at the local JDF has been noted in other London Trusts.

3.13 Lower GI surgery

The Director of Medical Education (DME) report will detail the internal trust decision to temporarily reallocate F1 trainees away from lower gastrointestinal surgery because of significant negative feedback from trainees. As is standard trust practice, the current trainees have been moved to other surgical specialities whilst an investigation takes place. This investigation is underway by PGME and there is no completion date available at present. Concerns were also raised by trainees a year ago (see GOSWH report passim). The response from general surgery management was that unless specific consultants were named by the trainees who at the time wanted to remain anonymous that no changes could be made. The GOSWH had suggested examining the cultural concerns referred to as a division. These concerns have now been repeated by a second group of trainees.

3.14 Freedom of Information

Two freedom of information requests were made for immediate safety concerns for 2018 and 2019. This was supplied.

4.0 IMPLICATIONS

4.1 Risks

The long term impact of Covif-19 on working life, personal health and wellbeing is the overarching concern for all trainees. In addition, the concerns about possible loss of training opportunities in specialities remains a concern despite assurance, from statutory bodies that junior doctors will receive appropriate training.

The lack of engagement from the trainees (shown through a drop in the attendance of the Junior Doctor Forum) is a concern. The GOSWH is reengaging them as a body as much as possible.

4.2 Legal Regulatory

The GOSWH follows the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (update 2019)

5.0 NEXT STEPS

5.1 Supporting trainees to exception report

The GOSWH will be continuing helping the consultants to help the trainees' exception report and expects to be invited to present in the next Local Negotiating Committee meeting.

6.0 CONCLUSION

There are various risks to safe working hours and trainee wellbeing in relation to the Covid-19 pandemic and the potential of a need for a second emergency response to Covid-19. In taking steps to mitigate these risks, the Trust is being flexible, responsive and involving the GOSWH in decision making. The GOSWH remains available for strategic advice and reflecting the concerns of the trainees who are on the frontline of acute work. Steps are being taken to ensure that the junior doctors know that the Trust will listen to their concerns. The first step is to bolster engagement through the JDF. Board members have a standing invitation to attend the JDF both to hear the discussions and to assure the junior doctors that the Trust wishes to listen to their experiences and to continuously improve their opportunities for training and their wellbeing.

Appendix A – Full Exception Reports by speciality and grade with resolutions where available

Submitted	Specialty	Grade	Type	Breach type	Normal hours	Premium hours	Summary of Exception Report and resolution where noted
25/09/2020	General medicine	FY1	Hours	Overtime		02:00	Discussed with SpR and Consultant.
25/09/2020	General medicine	FY1	Hours	Overtime		01:45	Was raised with Consultant team due to short staffing on the ward.
17/09/2020	Acute Medicine	CT2	Pattern				No registrar was present for either days (Saturday and Sunday) and I was asked to step up as a reg for the whole weekend. No cover was found to replace the vacant post for either days hence I did a ward cover SpR weekend across the hospital. GOSWH discussed with department lead. Better planning, planned.
13/09/2020	General medicine	FY1	Hours	Overtime		01:30	Post shift - Was raised with Consultant team due to short staffing on the ward.
13/09/2020	General medicine	FY1	Hours	Overtime	03:00		Whole team worked until 8pm to ensure all important jobs completed
12/09/2020	General medicine	FY1	Hours	Overtime	01:15		Stayed late to complete extensive jobs list generated from ward round. Assistance from red team who were waiting to leave to go for a ward social afterwards
12/09/2020	General medicine	FY1	Educational				Missed out on full F1 protected teaching day (8:30-16:30) due to being scheduled for night shift on same day. Rota manager and AMU consultants refused to provide cover

Submitted	Specialty	Grade	Type	Breach type	Normal hours	Premium hours	Summary of Exception Report and resolution where noted
							despite ample notice and being classed as 'mandatory' for all F1s/ classed as a study day. Will I get a study day provided in lieu? Email chain between Rota manager, DME, and F1 programme director from 01/09/20 to resolve.
12/09/2020	General medicine	FY1	Hours	Overtime	03:15		Busy working day. Stayed late to complete jobs from ward round- then was delegated to finish jobs while IMT attended paces training. List updated to high standard as per requirements of consultant following morning. Caught up with IMT before going home who stayed even later than myself.
12/09/2020	General medicine	FY1	Hours	Overtime	03:15		Had to stay late to complete jobs from ward round with consultant, order bloods + update list. Colleague on training day/clinic so high workload.
12/09/2020	General medicine	FY1	Hours	Overtime	00:45		After end of F1 AMU Take shift. Also only had one 30 min break rather than the mandated 3x breaks as per EWTD rules. Consultant made aware. In person handover required
06/09/2020	General surgery	FY1	Hours	Overtime	13:00		12 hour weekend general surgery locum shift at £43/hour. There are usually two registrars to cover the wards and unfortunately there was only 1. We worked well as a team and took 1x 20 min break during the day to remain efficient (whilst answering bleeps during this time). Unfortunately there was a sick patient but as soon as the plan was in place we came together as a team to delegate remaining jobs from the weekend and finished at 9pm.

Submitted	Specialty	Grade	Type	Breach type	Normal hours	Premium hours	Summary of Exception Report and resolution where noted
06/09/2020	Paediatrics	FY1	Hours	Overtime	01:00		Finished late on 12 hour weekend locum shift £43/hour. Worked constantly with team general surgery on call. Usually there would be two registrars however given a gap there was only one. The ward round finished at 6pm given difficulties in continuity and calls from other teams for jobs. We worked efficiently but by 9pm there were still 8 discharge summaries to be completed but we decided as a team to do these on Sunday morning and to go home to rest as these were non urgent.
04/09/2020	Trauma & Orthopaedic Surgery	FY2	Hours	Overtime	01:30		Stayed late due to important jobs that needed doing - I escalated to the team for help, including getting help from a medical student and an F1 on different days.
02/09/2020	General medicine	FY1	Hours	Overtime	02:30	00:30	Sunday antisocial locum rates of £26.80, but finished over 2 hours 10 mins after shift should have ended. Worked continuously throughout the day. We had taken measures to aim to prevent a late finish and ensure an appropriate hand over to the night team however given medical complexity, the shift overran.
01/09/2020	General medicine	FY1	Hours	Overtime	02:00		Outstanding jobs. Had to wait to upload jobs to hospital @ night due to system freezing List needed to be updated following 3 day weekend which had 7 new patients ES meeting - Lots of new pts after bank holiday weekend, sensibly passed on jobs that could be passed on safely - on

Submitted	Specialty	Grade	Type	Breach type	Normal hours	Premium hours	Summary of Exception Report and resolution where noted
							Nov 26th, 3 members on firm so will arrange TOIL on that day.
26/08/2020	General surgery	FY1	Hours	Overtime	01:15		Extremely busy with multiple unwell patients. SpR also extremely busy in resus so unable to do board round/handover.
19/08/2020	Vascular Surgery	FY1	Hours	Overtime	03:30		Jobs for same-day completion, registrar delayed in ED due to emergency case, so delay in handover to night registrar. Attempted to resolve by contacting registrar, handed over when available.
18/08/2020	Vascular Surgery	FY1	Hours	Overtime	02:45		It was necessary to stay late in order to complete patient safety-critical tasks Additionally; it had been a particularly busy day with many unwell referrals and patients on the list.
11/08/2020	General medicine	FY1	Hours	Overtime	00:45		Still completing jobs that if left unfinished would have created a concern for patient safety. At the end of the day reviewed any changes with sick patients and to confirm plans. Prioritized tasks to make sure none urgent jobs were added to the list for follow up tomorrow and remaining tasks were evenly delegated among the team.
30/07/2020	Child & adolescent psychiatry	FY1	Hours	Overtime			Excess in hours

Submitted	Specialty	Grade	Type	Breach type	Normal hours	Premium hours	Summary of Exception Report and resolution where noted
20/07/2020	Psychiatry	FY1	Hours	Overtime			Referral and other prescribing jobs outstanding, seniors unable to stay due to personal commitments and asked if I could pick up random odd bits for them. Still had handover for the weeks annual leave outstanding to write, so was delayed in starting this in order to make patients safe.
13/07/2020	Psychiatry	FY1	Hours	Overtime			Four admissions over the weekend on a 12 bedded ward, work and tasks generated +++ . Informed CS would be exception reported, agreed
09/07/2020	Psychiatry	FY1	Hours	Overtime			Asked to stay by cons and MDT as only NG trained member of MDT - stayed back and making this exception report was agreed on with the Cons. MDT needs to consider when a decision is made on relieving one member how that's communicated and the clear lines of communication (especially when this relies on the availability of other wards' staff)

Appendix B – Rota Gaps September 2020

Full rota data including numbers of trainees and trust doctors in each department available in previous report.

SNTC	
Orthodontics	1
ENT	2
CWTD	
Paeds	2
MedCard	
Rheumatology	1
Respiratory	1
Cardiothoracic Surgery	1
GP	
Bexley & Sidcup	6
Bromley	1
Croydon	3
Greenwich	9
Guy's & St Thomas'	2
King's	5
Kingston	0
Lewisham	4
St George's	4
St Helier	2

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4.1

Meeting Title:	**Trust Board**		
Date:	26 November 2020	**Agenda No**	**4.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meetings on the 22nd October and 19th November 2020.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

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4.1

Finance and Investment Committee – October & November 2020

The Committee met on 22 October and 19 November. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on Costing, Larger Projects, Exiting Financial Special Measures, EU Exit Preparedness, a Procurement Report and an SWLP Report.

Committee members discussed the Board Assurance Framework (BAF) risks on finance and ICT, although noting no change in overall risk scoring at present. The Committee continued to commend the achievement of the Emergency Flow 4 hour target and noted performance in Diagnostics, Cancer and RTT which have been affected to varying degrees by the COVID-19 pandemic. The Committee discussed current financial performance, cash management and capital expenditure. **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. ICT discussions in the October meeting's deep dive referred to audiovisual and cyber security risks.

1.2 Estates Report – in November the Director of Estates & Facilities (DE&F) introduced a paper with a deep dive on Estates' BAF risk and the Premises Assurance Model (PAM). Discussions at committee focussed on the limiting factor of available capital expenditure across multiple financial years, which could be used to address backlog infrastructure issues.

1.3 Activity Performance – the Chief Operations Officer (COO) noted the expectation that the trust would be very close to delivering the elective and daycase targets set for October (90% of last October's activity levels). In November's meeting the COO noted that based on experience of September 'catch-up', the figure was estimated at 87% although it could be higher than this. The Committee noted that October activity increased as the month developed, which would bode well for future month delivery should this trend continue.

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 95.6% in September, with attendances at 76% of the activity recorded in the same period last year. In October, performance remained high, at 94.3%, and the Committee commended the findings of ECIST, which had fed back that the Trust was an exemplar in terms of ED team culture and performance.

1.5 Diagnostics Performance – the COO noted the ongoing recovery of diagnostics following the first surge of COVID. Diagnostics performance continues to move in the right direction with figures in October at 21.2% of patients having a Diagnostic wait of over 6 weeks compared with the previous month's 24.2%. Crucially, the numbers of patients waiting 13+ weeks has dropped significantly (MRI from 638 to 57, non-obstetric ultrasound from 1,456 to 19 and CT from 497 to 6). Echocardiography remained the area of focus with the pace of recovery reflecting the longstanding national challenges in recruitment of technicians.

1.6 Cancer Performance – the COO noted that the Trust met 1 of the 7 cancer targets in August and September, with a concerted effort to get through the backlog of patients caused by the pandemic, across the 31, 62 and 104 day metrics. Two week wait referrals had seen a significant increase which has slowed the recovery of the 104 day trajectory. The COO noted that this presented low clinical risk, with regular and ongoing clinical review and liaison with patients affected.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in September of 63.7% had improved against the previous month's value of 58.4%, and the number of 52 week waits of 1,097 was more than the previous month's 972. The size of the waiting list (including QMH patients) was 47,471 patients. However, it was noted that the

recovery of the 52+ week waiters on the admitted pathway is 200 better than trajectory. This reflects the focus within the Trust as well as continued support from Croydon Health Services and Kingston Hospital NHSFT to reduce the numbers of patients who have waited a long time for treatment.

1.8 Financial Performance– the DCFO noted performance in month 6 of breakeven, following a £8.7m top-up accrual to offset the deficit position as per central guidance. He noted that £2.8m of COVID costs had been incurred, with a £3.4m shortfall in block income and £2.5m of net overspend due to the Medical Pay Award (£1.1m), shortfall in CEA income (£0.6m) and other net overspends / income shortfalls (£0.8m). He confirmed that no retrospective top-up was expected to be at risk at M6, and in particular, that the bad debt provision increase had now been confirmed as funded for M1-5.

In month 7, the financial regime changed, with retrospective top-up to breakeven no longer in place. The position in M07 and YTD is a £1.7m deficit, which is £1.7m adverse to budget, made up of: £2.9m of COVID costs; £3.4m shortfall in block income and £0.7m lower Non-NHS income due to significantly reduced BAU activity due to COVID; and £5.5m of revised block income and additional funding (net of high cost drugs expenditure funded). The Trust is £0.3m favourable to the forecast which is a £2.0m deficit in month. This aligns to the forecast submitted to NHSI/E in October.

He also noted that the trust cash balance is £50.6m which is £47.6m favourable to plan. The Trust has spent £26.2m of capital at month 6, against a plan of £27.8m (values including COVID).

1.9 Capital Update– the DCFO introduced the Committee to the paper providing an update on capital which showed an annual budget expected of £83.4m, with £74.3m confirmed. The Committee noted the more settled nature of capital in 2020/21 than in previous financial years at this time.

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 November. The paper noted the movements to this month's annual surplus of £2.2m, including the distribution of £24.7m of COVID funding and £13.0m of Non-NHS Income recovery expected to be funded by NHSI/E. The Committee then discussed the position of the rest of SWL.

1.11 Costing Update– the Director of Financial Planning (DFP) introduced the Committee to the paper providing an update on costing, including the results of the 2018/19 audit, with a rating of 'requires improvement'. The Committee discussed how these results could be improved, noting that a large proportion of trusts had received this rating.

1.12 Planning & LTFM Update– the DCFO noted the progress being made on planning for 2021/22 and the longer term financial plan for the Trust. The Committee expressed concern about the delay in developing next year's plan whilst noting the unusual nature of the financial regime with respect to the pandemic had caused this.

1.13 Projects Update – the DFP introduced papers updating on some of the larger projects that the trust is working on at the moment.

1.14 Exiting Financial Special Measures – the Deputy Chief Executive Officer (DCEO) introduced a paper on the steps to be undertaken for the Trust to be removed from Financial Special Measures, with the case presented at the Provider Oversight Committee in December. The Committee welcomed this update.

1.15 EU Exit Preparedness – the Chief Transformation Officer (CTO) introduced the paper updating the committee on the Trust's EU Exit Preparedness, including the different workstreams set up. The Committee welcomed this update.

1.16 Procurement Report – the DCFO introduced the Procurement Report, which focussed on the various items being sourced as the Trust prepares for an increase in COVID-19 patients.

1.17 SWLP Report – the DCFO introduced the SWLP Report, which noted that the Division remains on plan, excluding the costs of COVID testing which are to be reclaimed on a monthly basis by the Trust.

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,
November 2020

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4.2

Meeting Title:	**TRUST BOARD**		
Date:	**26 November 2020**	**Agenda No**	**4.2**
Report Title:	**M7 Finance Report 2020/21**		
Lead Director/ Manager:	Andrew Grimshaw, Chief People Officer		
Report Author:	Tom Shearer, Deputy Chief People Officer		
Presented for:	Update		
Executive Summary:	From M07, 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 M07 and YTD is a £1.7m deficit, which is £1.7m adverse to budget, made up of: £2.9m 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; and £5.5m of revised block income and additional funding (net of high cost drugs expenditure funded). The Trust is £0.3m favourable to the forecast which is a £2.0m deficit in month. This aligns to the forecast submitted to NHSI/E in October. 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 review of the M6 top-up value by NHSI/E is expected to be finalised for payment in December. The Trust Cash balance is £50.6m which is £47.6m favourable to plan. The Trust has spent £26.2m of capital at month 6, against a plan of £27.8m (values including COVID). The YTD COVID plan is £7.8m, with COVID cost £6.2m. The non-COVID capital spend is therefore on plan, with £20.0m spend against the plan of £20.0m.		
Recommendation:	The Trust Board is asked to note the Trust's financial performance at M7.		
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**	19/11/20

Appendices:	N/A

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4.2

Financial Report Month 07 (October 2020)

Trust Board

Chief Finance Officer

26th November 2020

Executive Summary

Month 07 Financial Position

- From M07, 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 M07 and YTD is a **£1.7m deficit, which is £1.7m adverse to budget**, made up of: £2.9m 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; and £5.5m 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 Trust is **£0.3m favourable to the forecast** which is a £2.0m deficit in month. This aligns to the forecast submitted to NHSI/E in October, which is expected to show a £15.8m deficit at year end. 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 review of the M6 top-up value by NHSI/E is expected to be finalised for payment in December.

- The Trust has spent **£26.2m of capital at month 6, against a plan of £27.8m** (values including COVID). The YTD COVID plan is £7.8m, with COVID cost £6.2m. The non-COVID capital spend is therefore on plan, with £20.0m spend against the plan of £20.0m.

- The Trusts cash balance at M7 was £50.6m. 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 07 Financial Performance

			Full Year Budget (£m)	M7 Budget (£m)	M7 Actual (£m)	M7 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding COVID and Income Top Up	**Income**	SLA Income	785.6	65.5	68.8	3.3	458.3	440.8	(17.5)
		Other Income	164.0	14.0	13.1	(0.9)	95.9	86.7	(9.1)
	Income Total		**949.6**	**79.5**	**81.9**	**2.4**	**554.1**	**527.5**	**(26.6)**
	Expenditure	Pay	(583.5)	(49.0)	(48.9)	0.1	(339.7)	(331.7)	8.0
		Non Pay	(327.0)	(27.3)	(28.7)	(1.4)	(191.6)	(183.8)	7.8
	Expenditure Total		**(910.5)**	**(76.2)**	**(77.6)**	**(1.3)**	**(531.3)**	**(515.5)**	**15.8**
	Post Ebitda		(39.1)	(3.3)	(3.2)	0.1	(22.8)	(22.7)	0.1
	Grand Total		**0.0**	**(0.0)**	**1.2**	**1.2**	**(0.0)**	**(10.7)**	**(10.7)**
COVID and Income Top Up	**COVID**	Pay	0.0	0.0	(1.4)	(1.4)	0.0	(11.1)	(11.1)
		Non Pay	0.0	0.0	(1.5)	(1.5)	0.0	(9.9)	(9.9)
	Total COVID		**0.0**	**0.0**	**(2.9)**	**(2.9)**	**0.0**	**(21.0)**	**(21.0)**
	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)**	**(1.7)**	**(1.7)**	**(0.0)**	**(1.7)**	**(1.7)**

Month 07 Financial Position

- The in month reported position at **M07 and YTD is a £1.7m deficit, which is £1.7m 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).
- From October, the Trust's revised forecast Block Commissioning income is £66.3m, 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 (£1.5m in M7); and COVID Testing Funding (£0.6m in M7).
- The YTD financial impact of COVID on the Trust from additional expenditure is £21.0m and the YTD income top up value, received between April and September, is £29.9m (with no top-up in October).
- Excluding COVID costs, and excluding the income top-up accrual, the Trust's YTD position would be £10.7m adverse to plan. This is due to the shortfall in block income of £24.0m, £5.0m of lower non-NHS income as a result of not undertaking BAU activity because of COVID. This is offset by £12.8m of underspends as a result of not undertaking BAU activity because of COVID, and £5.5m of Commissioning income from revised block and additional funding (net of drugs overspend, all in M7).

Financial Report Month 07 (October 2020)
St George's University Hospitals NHS Foundation Trust

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2. Balance Sheet as at October 2020

Statement of Financial Position	FY 19-20 Audited Mar-20 (£m)	M07 October-20 FY20-21 YTD Actual (£m)	Variance
Fixed assets	**426.9**	**437.0**	**10.1**
Stock	**11.9**	11.3	(0.6)
Debtors	**93.7**	98.6	4.9
Cash	**3.5**	50.6	47.1
Creditors	**(94.0)**	(169.5)	(75.5)
Capital creditors	**(22.5)**	(7.1)	15.4
PDC div creditor	**0.0**	(4.7)	(4.7)
Int payable creditor	**(0.1)**	(0.2)	(0.1)
Provisions< 1 year	**(0.3)**	(0.3)	0.0
Borrowings< 1 year	**(322.5)**	(5.6)	316.9
Net current assets/-liabilities	**(330.3)**	**(26.9)**	**303.4**
Provisions> 1 year	**(2.5)**	(2.8)	(0.3)
Borrowings> 1 year	**(69.9)**	(59.2)	10.7
Long-term liabilities	**(72.4)**	(62.0)	10.4
Net assets	**24.2**	**348.1**	**323.9**
Taxpayer's equity			
Public Dividend Capital	**135.7**	461.8	326.1
Retained Earnings	**(226.5)**	(228.7)	(2.2)
Revaluation Reserve	**113.8**	113.8	0.0
Other reserves	**1.2**	1.2	0.0
Total taxpayer's equity	**24.2**	**348.1**	**323.9**

M07 FY20-21 YTD Statement of Financial Position

- Fixed assets increased by £10.1m since March-20. This includes the impact of depreciation and capital expenditure YTD.
- Stock is £0.6m lower compared to Mar-20.
- Debtors have increased by £4.9m since March 2020.
- The cash position is £47.1m higher than reported at year-end in March-20. This is due to the block contract payment for November-20 received in advance in October-20.
- Cash resources are tightly managed monthly to meet the £3.0m minimum cash target at the end of the year.
- Creditors are £75.5m 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 November-20 fund received in advance.
- Capital creditors are £15.4m 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 2020. So in M06 PDC increased to £462m. After conversion, the Trust was left with outstanding loans to DoH of £11.7m for capital as shown on slide 12g.

3. YTD Analysis of Cash Movement

Statement of Cash Flow	M07 YTD FY 20-21 Actual £m
Opening Cash balance	**3.4**
Income and expenditure deficit	(2.2)
Depreciation	16.1
Interest payable	2.5
PDC dividend	4.7
Other non-cash items	(0.1)
Operating surplus/(deficit)	**21.0**
Change in stock	0.6
Change in debtors	(4.9)
Change in creditors	75.5
Change in provisions	0.3
Net change in working capital	**71.5**
Capital spend	(26.2)
Capital Creditors	(15.4)
Capital additions Finance leases	2.1
Interest paid	(2.4)
PDC dividend paid/refund	0.0
Interest Received	0.0
Net change in investing activities	**(41.8)**
PDC Capital Received	326.2
DH Loan converted to PDC	(325.0)
DH Loan YE Accrued Interest Reversal	(1.3)
Capital £14.747m Loan repaid	(0.3)
Other Loans/ PFI /finance lease repayme	(3.0)
Net change in financing activities	**(3.5)**
Cash balance as at 31.10.2020	**50.6**

M07 FY20-21 YTD cash movement

- The cumulative M07 20-21 I&E deficit is £2.2m. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £2.2m, depreciation (£16.1m) does not impact cash. The charges for interest payable (£2.5m) 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 £21.0m.
- The net change in working capital is £71.5m in October-20. This is due to major movement in creditors of £75.5m, which is due to the deferred income as a result of Covid-19. Stock levels have decreased by £0.3m in M07 as compared to March-20.
- The Trust made the following loan repayments in 2020/21: DH capital loan repayment of £0.3m repaid in May-20 and LEEF loan payment of 0.7m in June-20.
- PDC of £1.1m was received in July-20 for Capital.
- The DH loan amount of £325m converted to PDC on 1st September 2020.

October-20 cash position

- The Trust achieved a cash balance of £50.6m on 31st October 2020, £47.6m higher than the £3m minimum cash balance required by NHSI. This is due to November-20 block contract income received in advance in October-20.

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4. M07 Capital

- The table below shows capital spend year to date of £27.8m against a plan of £26.2m. This includes £6.2m of costs associated with COVID 19 against a plan of £7.8m.

TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	**Budget £000**	M01	M02	M03	M04	M05	M06	M07	**M07 YTD budget £000**	M07 YTD exp £000	*M07 YTD var £000*
Infrastructure renewal	**31,900**	680	706	1,204	449	464	617	378	**4,650**	4,498	*152*
P22	**10,000**	47	72	560	793	1,322	1,629	165	**4,897**	4,588	*309*
Major projects	**19,373**	864	172	51	578	370	853	912	**3,260**	3,800	*-540*
IT	**7,000**	1,736	1,335	(933)	753	425	729	300	**4,650**	4,345	*305*
Medical equipment	**1,500**	215	223	(12)	82	58	22	(173)	**533**	415	*118*
Leases	**5,000**	913	(894)	477	241	157	1,173	229	**2,000**	2,296	*-296*
SWLP	**820**	-	108	(108)	-	-	-	79	**-**	79	*-79*
Total	**75,593**	4,455	1,722	1,239	2,896	2,796	5,023	1,890	**19,990**	20,021	*-31*
COVID	**7,799**	1,595	1,441	766	1,976	329	8	51	**7,799**	6,166	*1,633*
Total inc COVID	**83,392**	6,050	3,163	2,005	4,872	3,125	5,031	1,941	**27,789**	26,187	1,602

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St George's University Hospitals NHS Foundation Trust

4.3

Meeting Title:	**Trust Board**		
Date:	26 November 2020	**Agenda No**	**4.3**
Report Title:	**Audit Committee Report**		
Lead Director/ Manager:	Elizabeth Bishop, Chair of the Audit Committee		
Report Author:	Elizabeth Bishop, Chair of the Audit Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on 08 October 2020.		
Recommendation:	**The Board is asked to note the report and note that the key areas of risk related to Cyber Security and impact of International Financial Reporting Standards 16 (Leases) and be assured that the Committee keep these areas under review.**		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Audit Committee Report – October 2020

Matters for the Board's attention

The Audit Committee met on 08 October 2020 and agreed to bring the following matters to the attention of the Board.

1. External Auditors Report

The Committee heard about the preparations and early planning for completion of the 2020-21 financial audit. Covid-19 would impact on the completion of the audit. Firstly, most of the work would be conducted virtually, secondly the financial structure of the NHS organisations had changed during the year with NHS England/Improvement (NHSE/I) support trusts to financial balance which would impact going concern considerations and finally changes from the National Office and the Code of Practice require external auditors to conduct more scrutiny of the trusts value for money conclusions. The external auditors would also work with NHSE/I and the wider-system to understand the implications of the having funding centralised in local integrated care systems and practicalities of transferring monies between organisation which was not currently afforded for in the statutory framework. The Committee would receive a full audit plan at its next meeting in January 2021.

The Committee heard the that the nature of the External Auditors' report on Use of Resources (Value for Money) would change for the 2020-21 audit. This report will be more narrative rather than a binary opinion, but the format of the report is still under consideration.

1.1. Implementation of International Financial Standard (IFRS) 16 (Leases)

In addition, as previously reported, all NHS trusts would be required to implement the International Financial Standard 16 related to transfer all operating leases to the balance sheet. This remains a material risk for the Trust in terms of completing the work on time to meet the April 2021 deadline and the potential financial impact. The Trust had made good progress identifying and transferring its operating leases to the balance sheet and when benchmarked with the work of other organisations the Trust was applying the right parameters. The Trust was on track to complete 90-95% of this work by January 2021. The Committee also heard that like other trusts there would be cost pressures from the transfer of the leases to the balance sheet currently estimated at £917k for the Trust.

2. Internal Auditors Reports

The Committee considered the following reports from internal auditors:

- Internal Auditors Progress Reports and Recommendation Tracker
- Payroll (Reasonable Assurance)
- DSP Toolkit (Follow-up Review)
- Theatre and Outpatient Productivity (Reasonable Assurance)

The Committee was assured by the good progress made in completing internal audits in quarter 2 (2020/21) despite the Trust being heavily focused on managing the impact of Covid-19. The Committee were also reassured to learn that the new management governance forum, the Risk Assurance Group, was proactively managing the progress of internal audits and the completion of audit recommendations.

The Committee noted that that the payroll internal audit received a reasonable assurance rating. The theatre and outpatient productivity audit also received reasonable assurance in relation to the internal controls and mechanisms in place. The audit scope was however developed in September 2019 and then delayed at the onset of the Covid-19 pandemic and since then the Trust's outpatient model had changed in response Covid-19. The Committee

agreed that further work was required to understand the operational model and the implications for driving and delivering productivity in theatres. The Committee endorsed the executive management team approach which included a review of the audit findings by the Operational Management Group and consideration of whether or not a review was required to understand the operational model and the work to drive productivity in the Trust.

At its meeting in July 2020 the Committee asked internal auditors to review the robustness of the Trust's evidence in support of the Data Security Protection Toolkit self-assessment. This work had been severely impacted by the Covid-19 pandemic which required the ICT teams to focus on implementing solutions to support more staff working from home and conducting virtual patient appointments. The Committee heard that the auditors found strong assurance against evidence to support five of the National Data Guardian 10 data security standards but noted that the Trust needed to strengthen its evidence for the other five areas. The management team noted that whilst there were evident areas were the Trust could do much better the Trust had passed the toolkit threshold for the period. The Committee recognised and flagged risks around the Trust's cyber security measures and noted that regular penetration testing was carried out as the Trust implement its plans. The Committee also raised concerns about the ensuring the Trust ICT infrastructure was sufficiently robust in light of the new ways of working. The Committee noted that the Finance & Investment Committee would consider all ICT related risks and issues.

3. Internal Compliance and Assurance

The Committee considered the following compliance and internal control reports:

- HR Internal Controls
- Use of Medical Consultants (Internal Review) Report
- Annual Review of Trust's Clinical Audit Programme
- Counter Fraud Report
- Breaches and Waivers
- IFRS16 Update (update provided under section 1.1 above)
- Review of Trust-wide Policies

3.1. HR Internal Controls

The Committee noted the steps taken to identify and address internal controls issues related to the lack of effective standard systems for recording employee relations cases in the Trust. The Committee was pleased that despite the other challenges facing the Trust there were adequate systems in place to identify the issue and action taken immediately. The Committee noted that the Workforce & Education Committee would continue to provide oversight in this area, endorsed the plans to find a digital solution beyond an excel spreadsheet and noted that the integrated quality and performance report would include enhanced reporting on employee relations cases to improve the visibility.

3.2. Use of Medical Consultant (Internal Review) Report

The Committee at its last meeting considered the report from internal auditors on the Use of Consultants which received a limited assurance rating and agreed to have further update from management. The internal review highlighted the good progress made on validating the honorary contract data and that the Trust had put in additional controls to manage the process of appointment, reappointment and recruitment of medical consultants including a business case process. The Committee also noted that the historic issues with medical pay spend related to consultant rota management and not the recruitment or appointment of medical consultant.

3.3. Annual Clinical Audit Programme

The Committee received and noted the clinical audit programme and noted that a majority of the clinical audits in the 2020/21 programme were mandatory and in 2021/22 the Trust would enhance the programme to include those areas which had been flagged as key quality and safety concerns or risks. The Committee also noted that the Quality and Safety Committee reviews the clinical audit programme each year.

3.4. Counter Fraud

The Committee also received the Counter Fraud report and there were no material matters of concern raised. The Trust remained vigilant in relation to key fraud risks especially those related to Covid-19 and continued to complete proactive work to increase awareness.

3.5. Breaches and Waivers

The Committee considered the reports on breaches and waivers and noted the good progress made on improving the internal controls. A majority of the breaches and waivers for the period related to urgent and or Covid-19 purchases.

3.6. Review of Trust-wide Policies

The Committee noted the update on the management of the trust-wide policies and the controls in place to ensure that all policies were reviewed and kept updated in line with the Trust's procedure for the management of policies. Like many other controls systems progress on policies had been impacted by Covid-19 as the organisation focused managing operational priorities but the Committee was assured that management groups and Board Committees were regularly reviewing policies.

Recommendation

The Board is asked to note the report and note that the key areas of risk related to the Cyber Security and impact of International Financial Reporting Standards 16 (Leases) and be assured that the Committee keep these areas under review.

Elizabeth Bishop
Audit Committee Chair, NED
November 2020

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4.4

Meeting Title:	**Trust Board**		
Date:	26 November 2020	**Agenda No**	**4.4**
Report Title:	**St. George's Hospital Charity: Six Monthly Update (Q1-2 2020/21)** **St George's University Hospital Foundation Trust and London United: Foundation Partnership Working**		
Lead Director	Suzanne Marsello, Chief Strategy Officer, Director Sponsor for St George's Charity		
Report Author:	Amerjit Chohan, CEO, St George's Hospital Charity Vivien Gunn, Grants Manager, St George's Hospital Charity Kathryn Brook, Strategy and Planning Manager		
Presented for:	Noting		
Executive Summary:	**St. George's Hospital Charity: Six Monthly Update (Q1-2 2020/21)** The report is provided to give the Trust Board an update regarding the activities of the Charity since May 2020 and to highlight the ways in which our collaboration with the Trust can reach new heights in the coming year. The charity's unaudited income to 30 September 2020 reported to the Charity's Finance Sub Committee on 29 October 2020 was £1.424m. This includes income from the COVID Appeal of £578,000, legacy income of £196,000 (of which £173,000 is for cancer equipment) and a single donation of £100,000 which was received from a donor whose son was treated at St George's Hospital. Donations in kind were £224,000.Going forward the Charity expects to be bidding for a further £1m from NHS Charities Together across a number of distribution bidding stages announced by NHS Charities Together. While the impact of COVID has restricted normal grant giving activity, the Charity is optimistic this will pick up in the second half of the year. The Charity's COVID Appeal raised £578,000.The Charity has either committed or spent £527,000. This leaves £51,000 to allocate to scheme in the second surge phase. The Charity's fundraising team continues to find inventive ways to hold virtual events and is grateful for the support from Trust staff and the public. The Charity's Arts St George's Programme has adapted to the new environment seeking to support patients. In consultation with the Trust, a potential COVID art commemoration is in the planning. The Charity is grateful for the support in the community for the Trust and its services. The Charity is delighted with the outstanding progress and wishes to build on this support in partnership with the Trust over the coming period. We are working with the Trust to maximise the opportunities presented by NHS Charities Together funding having received funding for the various COVID 19 Support Programmes. In the next six months we will aim to secure further funding under Stage 3 Recovery Grants with a bid of circa £200,000 to benefit staff.		

	St George's University Hospitals Foundation Trust and London United: Foundation Partnership Working London United is an umbrella organisation that consists of London Football Clubs and their community foundations. The five club community organisations in SW London – Brentford, Fulham, AFC Wimbledon, Chelsea and Crystal Palace – all share similar goals, to support those in local neighbourhoods who need their help the most. They are uniquely positioned to make a difference, through their facilities, fan bases, the power of their brands and skill-sets in delivering community sport, wellbeing, employability programmes and more. Since August 2020 the Chief Strategy Officer has worked with these Club Community Organisations to identify areas where there could be joint initiatives to support both our staff and patients. The Club Community Organisations are keen to work with the Trust once football grounds are able to reopen in relation to both physical use of facilities, and thanking NHS staff for their effort during Covid-19.
Recommendation:	The Trust Board is asked to: ➢ Note the Charity report, and the investment that has been awarded by the Charity in support of Trust projects ➢ Note the Trusts partnership working with London United
Supports	
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieve good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Well-Led**
Single Oversight Framework Theme:	▪ Strategic Change
Implications	
Risk:	N/A
Legal/Regulatory:	N/A
Resources:	N/A
Previously Considered by:	Trust Executive Team **Date:** 18 November 2020
Appendices:	None

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4.4

St. George's Hospital Charity May 2020 to November 2020 Update

1.0 Purpose

The report is provided to give the Trust Board an update regarding the activities of the Charity since May 2020 and to highlight the ways in which our collaboration with the Trust can reach new heights in the coming year.

2.0 St George's Hospital Charity Activity Update

This report covers the period from May 2020, the time of the Charity's last report to the Trust, to November 2020.

With the outbreak of the COVID 19 virus before the first quarter of the financial year 2020/21, the Charity continues to navigate through unprecedented times. Now moving into the second lockdown, the future still remains uncertain. The charity's unaudited income to 30 September 2020 reported to the Charity's Finance Sub Committee on 29 October 2020 was £1.424m which includes income from the COVID Appeal of £578,000, legacy income of £196,000 (of which £173,000 is for cancer equipment) and a single donation of £100,000 which was received from a donor whose son was treated at St George's Hospital. Donations in kind were £224,000. Going forward the Charity expects to be bidding for a further £1m from NHS Charities Together. Grant Giving to 30 September 2020 is below forecast at £324,000 as a result of activity impacted by the COVID pandemic, with this particularly impacting the normal expected spend from the Charity's Special Purpose Funds portfolio. The Charity is optimistic that charitable spend will pick up in the second half of the financial year as a result of further allocations from the COVID Appeal and NHS Charities Together funding and the normal grant spend from the Charity's annual budget prior to COVID.

Formal Board of Trustee meetings took place on 20 May 2020 and 25 September 2020.

2.1 Charity Capital Projects Update

The Charity is working with the Trust Estates Team with which it meets on a monthly basis. Of note:

- Plans for the **refurbishment of the Forget-Me-Not-Suite** (a separate suite of rooms for parents who have sadly faced the death of their new born baby) have been started again after the easing of lockdown. The Trust Estates Team is hopeful it can be completed by the financial year, notwithstanding further restrictions due to COVID 19. Project budget circa £66,000.
- Similarly the resumption of plans to use a longstanding grant for £60,000 to **renovate the maternity reception** on Level 1 are underway once more and the Trust Estates Team are hopeful it can also be completed by end March 2021.
- The **redevelopment of the Children's Garden** located next to the Dragon's Centre was completed. A small opening ceremony, socially distanced with 6 people attending, was held on October 23rd 2020. The Charity and the donor are very pleased with the final result, with thanks to the Trust Estates Team for their efforts in completing this project despite the difficulties presented in the current climate.

2.2 Christmas Grant

- The Charity is organising the distribution of its **Christmas Grant award for 2020**.
- The grant is chiefly used on presents, food and non-alcoholic drink for staff and patients in hospital over the Christmas festivities. This year Christmas will sadly feel very different due to COVID restrictions but nevertheless the Charity aims to bring some Christmas cheer and wishes to show its appreciation to staff.
- In addition, the **Charity is funding Rainbow Christmas Lights** to be installed outside the Grosvenor Wing main entrance and is undertaking Gifts for George's appeal to cater for both staff and patients.
- Though provisional, the charity expects it **Christmas charitable expenditure** to be in the region of circa £20,000.

2.3 Additional Support

The Charity has also supported Black History Month with items to mark the month and has trialled a staff Running Club for 6 weeks which it is now funding for a further 3 months given its promising beginning.

3.0 The Charity's COVID-19 Appeal

The Charity's COVID-19 Appeal was successful. The COVID-19 Appeal ended formally at the beginning of July 2020. As of August 31st 2020 the Charity's income raised and pledged from the **Appeal was circa £578,000**. This included £98,000 which the Charity has received from NHS Charities Together. Of the £578,000 the Charity has either committed or actually spent £527,000 from the COVID Appeal. This leaves £51,000 to allocate which, as the second lockdown approaches, gives the Charity ability to respond to emerging needs once more.

In September 2020 the Charity received a further £50,000 from NHS Charities Together for a community project to support the health of the BAME community in the boroughs of Merton and Wandsworth.

3.1 COVID-19 Support Programmes

The Charity's May 2020 Trust report detailed the various programmes which the Charity supported in response to the COVID pandemic: Wellbeing Hubs, Staff Care Bags, iPads, Team Thank You Awards, Patient Care Boxes and PPE gowns.

Since then:

- The Cardiac Gym **Wellbeing Hub closed** on September 7th so that the space could be redeployed. A home for the furniture was found in ENT, Lady Youde Unit, Clinical Site Management and Portering Management.
- The Hyde Park and Grosvenor Hubs though **Project Wingman** (whereby airline staff served refreshments) **has ceased**.
- The **Staff Care Bags programme came to a close** due to a reduction in donations and volunteers returning to resume their lives.
- The Charity held a **Thank You event for volunteers** without whom the daily production of compiling and distributing Staff Care Bags would not have been possible. The Charity has

distributed over 5,000 care bags. The Volunteers' commitment was outstanding. The Charity wishes to formally acknowledge its gratitude to them.

- The **iPad Programme to connect patients with family and friends continues** and is expected to be needed once again particularly with the second lockdown. The Charity will be using COVID 19 Appeal funds to make a contribution to the soon to come into effect Wi-Fi as a result of the increased number of iPads in use by patients.
- The **Team Thank You Awards** programme was a great success with staff clearly expressing their enthusiasm for this initiative; providing staff an opportunity to express their appreciation for one another during a very difficult time.
- **Patient Care Boxes** are distributed on the wards to patients. The Charity is currently reviewing box content and developing a Standard Operating Procedure with Trust leads to ensure they continue to align with infection prevention control standards and ward specific requirements
- The **distribution of £10 vouchers** for 4,800 nurses, healthcare assistants and midwives to mark the **International Year of the Nurse** began in October 2020 and is proceeding well.

3.2 New Initiatives:

The Charity recognised staff wanted to enjoy the outdoors if the space available to them could be improved; this being all the more pertinent during COVID. As a result, the Charity supported the **renovation of the Therapies Courtyard in St James Wing** and the **Education Centre garden** with outdoor furniture and new planting. It would like to particularly express thanks to the support of the Trust's Head Gardener, John Greco, and his team for the enthusiasm and hard work in supporting both these projects.

- The Charity has also **funded and actively supported the Trust's Wellbeing Week** and Thank You framed pictures for Medicine and Cardiovascular Division. This Division held an event whereby department staff collected pictures of Thank You shooting stars at allotted intervals in recognition of their dedication throughout COVID.
- The Charity in response to a request by the Trust has invited a funding application for staff **headsets to the value of £26,000 to assist virtual meetings**.
- **9,000 re-usable face coverings for staff**, branded with St George's Hospital Charity colours, were donated by the personalised photo gifting company Photobox to help staff protect themselves and others while outside the hospital, such as when travelling to and from work. These have been distributed to Trust staff and have been well received.
- **The Charity supported scrubs for staff** with £10,000 produced by the Scrubbery, a local sewing initiative in South West London.
- The Charity is working with the Trust on the development of a **Wellbeing Garden outside Atkinson Morley Wing** and is contributing £25,000 received from NHS Charities Together funding towards the project. Garden designers Bowles & Wyer broke ground on 26 October 2020 and are due to complete the transformation by the 16 November 2020. The garden has been designed with the 'five ways to wellbeing' in mind as a concept, enhancing the environment to promote better health and wellbeing of staff and patients. A new walkway through the woodland style planting with quiet seating areas provides spaces for relaxing, whilst a seating area close to the entrance surrounded by pots will create a more social and cosy atmosphere. The planting will complement the existing planting bed previously donated and increase the biodiversity across the garden. The choice of new trees and plants provides

seasonal interest and varied texture and forms. Colours of the plants will change as you travel through the garden with warmer tones at the top near the entrance, then becoming lusher and greener the further you move down the site. A large expanse of lawn remains with an area planted with naturalised spring bulbs. The project will feature on the Lorraine Kelly TV Show as an example of how the public's donations to NHS Charities Together are being used.

- The Charity has awarded a grant for the **purchase and installation of a bespoke research cabinet specifically for COVID research** undertaken by St George's University.

3.3 COVID-19 Call for Applications

In early May 2020 the Charity launched its COVID-19 Call for Applications under which staff could apply to the Charity for funding under various categories to support patients and staff. The grant application window closed on June 19th 2020.
There was a strong uptake with staff applying for funding chiefly to support their work with patients as well as support for their fellow colleagues, particularly to improve staff areas and amenities. The Charity worked with the Trust by sharing information on applications and seeking guidance on how best to respond to funding requests for which the Charity is thankful. To date the Charity has awarded 66 grant grants with a total value of circa £102,000. Of this circa £87,000 was for requests by staff to support their care of patients and circa £15,000 were requests for improving staff environment, team support and amenities. There are a few outstanding applications under consideration for a further possible £18,000, chiefly for medical equipment.

3.4 Fundraising Events

Though COVID has severely affected the normal course of fundraising events, our fundraising team have nevertheless been quick off the mark to find new ways to continue fundraising. Throughout the first COVID lockdown the Charity held virtual events such as a Virtual Balloon Race and a Virtual Raffle as well as assisting an army of Community Fundraisers to find inventive ways to raise funds.

Going forwards there is Bid for George's, a Virtual Fundraising Auction from 1st to 15th December to win some amazing prizes and there is Santa Hat Day where the Charity is asking people to put on a Santa Hat on Wednesday 16 December, all in support of Team George's.

There are many events lined up for 2021, notwithstanding COVID. These are all advertised by the Charity and the Charity is grateful for the continued support of Trust staff and the public alike.

4.0 NHS Charities Together Funding

The membership organisation for NHS Charities, NHS Charities Together (NHSCT), has raised over £130,000,000 (this includes the £30,000,000 raised by Captain Tom) to distribute to its members. It is doing this in 4 distribution stages which are summarised in the table below. The Charity, as one of its members, is bidding for funding under all four Stages.

	Available Bid	Actual	% Received By Charity
Stage 1: to benefit staff and patient during the height of the first COVID lockdown This stage is now closed.3 distributions received *(1&2: £98K 3: £50K)*	£148,000	£148,000	100%
Stage 2: Community Partnerships Grants Round opened late August 2020.	£757,000	0	In progress
Stage 3: Recovery Grants Round – for Trust Staff recovery and wellbeing Stage 3 opened 01.09.2020.	£200,000	0	In progress
Stage 4: working title 'Second Wave' – details still to be announced	£50,000	0	Not yet started
Total Available Bid	£1,155,000	£148,000	13%

NHS Charities Together Funding Summary
Stage 1 : First Wave Pandemic
Distribution 1 & 2: £98,000 received for projects benefitting staff and patients during the height of the COVID pandemic lockdown – funds allocated and reported to NHS Charities Together
Distribution 3 – Focus on communities disproportionately affected by Covid-19
We have been awarded the maximum grant of £50,000, award dated August 21st 2020, by NHS CT for an application submitted by us on behalf of NHS South West London CCG for a Merton and Wandsworth project which builds on a previous pilot programme enabling community partners to increase their capabilities to become more effective and sustainable co-producers of ill health prevention and early intervention work for the BAME community.
Stage 2: Community Partnership Grants – £757,000
This round was launched on August 25th 2020. £30million has been allocated nationally for Stage 2.
Stage 2 community partnership grant allocations are based on population figures, for south west London the grant allocation will be £757,000 (population 1.4m). We are the lead charity for our area which consists of the boroughs of: Merton, Wandsworth, Kingston, Sutton, Croydon and Richmond. The Charity will be responsible for applying, distributing and managing the funding awarded. Applications will be submitted by the Charity on behalf of community partners. These bids are being coordinated by the Borough partnership meetings which contain representation across health, social care and voluntary sector for each Borough. The key meetings linked to St George's are the Merton Health and Care Together Board, and Health and Care Wandsworth.
Some examples of potential projects include managing the transition of the elderly from hospital to home, mental health support, and supporting vulnerable members of the community or end of life care. Projects may also support early intervention, reducing disparity or focus on preventative health and social care with a focus on diversity within the population.
The Charity aims to secure funding by March 31st 2021 when Stage 2 round closes.
Stage 3 :Recovery Grants – bid up to £200,000
This was launched on September 1st 2020. These grants are to support recovery plans within

NHS Charities Together Funding Summary
the NHS Trusts and wider community. £35million has been allocated nationally for Stage 3. Funds have been allocated based on the staff headcount of the NHS Trusts each member charity serves. The Charity can apply for up to £200,000 on behalf of the Trust.
Examples of recovery projects are adjustments and resumption of normal services; longer-term plans to support staff health; projects that improve well-being and mental health; plans to support specific staff cohorts reducing disparity and focussing on diversity; plans that have a role to play in wider economic or social recovery, for example through employment or training; projects that may dovetail with social prescribing plans that will support staff.
Projects should not duplicate existing work, but add value to and enhance existing work or introduce innovation. The plans should aim to make a visible and meaningful difference. Projects or initiatives that should be covered by core NHS or social care funding are not admissible.
The Trust is considering options including a bid for funding the construction of a shower block to enable more staff to cycle to work, to undertake exercise classes on site and be able to shower after finishing their working day. This is being led by Humaira Ashraf, Acting Chief People Office (OD)
Stage 4: "Second Wave" - £50,000 to £100,000
Details regarding this fourth distribution have not yet been given but the Charity understands it may bid for an amount ranging from £50,000 to £100,000.
The Charity is working closely with the Trust in developing proposals under Stage 3 as well as any future funds which become available under which the Trust can benefit from further NHS Charities Together funding.

5.0 The Charity's Arts Programme: Art's St George's

The Charity's Arts Advisory Group meeting took place on 21 October 2020, with representation from across the Trust, Charity and local community. A virtual online music concerts is planned for Christmas, alongside arts and crafts packs for patients. St George's Music Month with a mixture or pre-recorded and live online performances is planned for 2021. The Charity received new donations of artwork from Damien Hirst and Ronnie Wood and a potential Covid-19 commemoration commission is planned.

6.0 Looking Forward

The Charity is grateful for the support in the community for the Trust and its services. The Charity wishes to build on this support in partnership with the Trust over the coming period. We are working with the Trust to maximise the opportunities presented by NHS Charities Together funding having received funding for the various COVID 19 Support Programmes.

In the next six months by working with the Trust we will aim to secure further funding under Stage 3 Recovery Grants with a bid of circa £200,000 to benefit Trust staff.

The Charity welcomes working closely with the Trust on these which will assist the Charity's newly established Development Advisory Group in driving forward the Charity's fundraising.

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St George's University Hospitals Foundation Trust and London United: Foundation Partnership Working

1.0 Purpose

London United is an umbrella organisation that consists of London Football Clubs and their community foundations. The world of football was keen to show its willingness to support the NHS through the pandemic and to keep the momentum going. The five club community organisations (CCOs) in SW London – Brentford, Fulham, AFC Wimbledon, Chelsea and Crystal Palace – all share similar goals, to support those in local neighbourhoods who need their help the most. They are uniquely positioned to make a difference, through their facilities, fan bases, the power of their brands and skill-sets in delivering community sport, wellbeing, employability programmes and more. A number of the clubs already work in partnership with local health and social care services.

Since August 2020 the Chief Strategy Officer has worked with these Club Community Organisations to identify areas where there could be joint initiatives to support both our staff and patients. There have been positive discussions regarding support for staff health and wellbeing as outlined below, as well as a joint meeting with the Deputy Chief Medical Officer (Innovation) regarding support for the Get Set for Surgery programme of work.

2.0 Proposed Programme of Health and Wellbeing Activities

In partnership with Fulham Football Club Foundation the following activities are being considered to support our staffs health and wellbeing:

- Access for staff to take part in activities held within the football club ground
  - Walking football (for men aged 50+)
  - Circuit training sessions (for all genders)
  - Female-only exercise sessions
  - Preferential staff rates to book areas to use for 5-a-side football
- 5-a-side football competition for staff taking place over Summer 2021
  - Opportunity to facilitate an 'inter-Trust' competition and recruit team members to take part from different divisions, or
  - Establish up a tournament with other neighbouring NHS Trusts/organisations

3.0 Implementation and Next Steps

In addition to the initiatives outlined above, the Club Community Organisations are keen to work with the Trust once football grounds are able to reopen in relation to both physical use of facilities, and thanking NHS staff for their effort during Covid-19.

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4.5

Meeting Title:	**Trust Board**		
Date:	26 November 2020	**Agenda No**	4.5.1
Report Title:	**Horizon Scanning Report, August – November 2020: Emerging Policy, Legislative and Regulatory Issues**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Noting		
Executive Summary:	This report provides a quarterly update to the Trust Board on emerging political, legislative, policy and regulatory issues that have relevance to the Trust. This report focuses on key developments between August and November 2020, highlighting particular developments relating to: • The political and legislative environment; • The NHS policy and institutional landscape • System and professional regulation • Reports from key stakeholders The report is intended to support the Board in providing a regular and systematic review of national political, policy and regulatory developments. It is distinct from the local and regional horizon scanning work which is reported in a separate report on the agenda. Previous reports on emerging political, legislative and regulatory issues were provided to the Board in July 2019, October 2019, February 2020 and July 2020.		
Recommendation:	The Board is asked to note the update.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-led		
NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)		
Implications			
Risk:	Horizon scanning is a key element in assisting the Board to understand emerging risks that could impact on the Trust's strategy and its operation.		
Legal/Regulatory:	N/A		
Equality, Diversity and Inclusion	N/A		
Resources:	N/A		
Previously Considered by:	Executive Management Team	**Date**	16 November 2020
Appendices:	N/A		

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4.5

Horizon Scanning report

Emerging policy, political, legislative and regulatory issues, August – November 2020

Stephen Jones
Chief Corporate Affairs Officer

26 November 2020

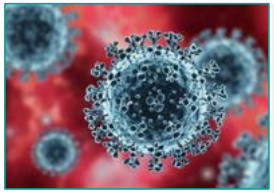
1. Purpose

The NHS Leadership Academy identifies three essential 'building blocks' in helping NHS boards to exercise their roles of formulating strategy, ensuring accountability and shaping a healthy culture effectively. Effective boards are informed by the external context within which they operate. They are informed by and shape the intelligence on understanding local needs, trends and comparative information on organisational performance, and give priority to engagement with stakeholders and opinion formers. This report provides the Board with a regular update on key developments in the Trust's external environment at the national level, particularly in relation to:

- **Political and legislative developments**: Current and emerging political and parliamentary developments at a national level with direct or indirect implications, or potential implications, for the Trust; key changes, or potential future changes, to primary legislation and regulations.
- **NHS policy and institutional landscape**: Changes and developments in relation to significant new national policy as determined by the central NHS organisations, and changes to the national architecture and structures of the NHS and those organisations with which the Trust interacts.
- **System and professional regulation**: Changes and prospective changes to the regulatory landscape, of both system regulators and relevant professional regulators with potential relevance to the Trust.
- **Reports and updates from key stakeholders**: Topical reports from key national bodies and other stakeholders of relevance to the Trust, and highlights of recent Board meetings of key system partners.
- **Current inquiries**: Summary of key inquiries that are underway.
- **Appointments**: Key appointments to national bodies and other key stakeholders.

This is the fifth such report to the Board and the format and issues will be kept under review to ensure the Board receives, through this report, a comprehensive quarterly update on key issues relating to these areas. It is distinct from the strategy horizon scanning report which focuses on regional and local issues.

2. Political and legislative developments



Covid-19

- Due to the rapidly evolving situation relating to Covid-19, this report does not set out details of the responses to manage the pandemic. Separate papers on the Board's agenda set out the Trust's position in relation to Covid-19. On 23 November, the Government announced that the national lockdown in England would end on 2 December, and be replaced with an enhanced system of local and regional tiers to help manage the responses to Covid-based on local patterns of infection. Those regions in the highest tier, with the most severe restrictions are also expected to receive additional support through increased testing. Restrictions relating to the festive period have not yet been published, but are expected following further discussions between the Government in Westminster and the devolved administrations.It is expected that vaccines for Covid-19 could be deployed starting in December 2020, targeted initially at older and vulnerable people and NHS frontline staff, following news regarding successful clinical trials.
- Links to Strategic Risk 1 (patient safety) and Strategic Risk (access to care) on the Board Assurance Framework, scored at 16 and 20 respectively.

HM Treasury

Spending Review 2020

- The Government's Spending Review is expected to be announced on Wednesday 25 November. The Spending Review will likely set out the Government's assessment of the outlook for the economy in the context of the current Covid-19 pandemic, and set out forecasts for growth and the public finances. It has been widely reported that the measures to be announced may include additional funding for the NHS, in the region of £3 billion in 2021/22. It is not clear at this stage whether the Spending Review will include any announcements in relation to the NHS capital settlement, including investment in relation to the Government's previously announced hospital building programme.
- Links to Strategic Risk 5 (financial sustainability) and Strategic Risk (capital) on the Board Assurance Framework, scored at 25 and 20 respectively.

UK withdrawal from the EU

- The end of the transition phase following the UK's withdrawal from the European Union in January is due to end on 31 December 2020. Negotiations between the UK and EU are ongoing at the time of writing. No agreements have yet been announced, though media speculation in recent days suggests a deal may potentially be reached. The Trust is working closely with local and national stakeholders to ensure the services we provide - and key issues such as staffing and supplies – are not adversely affected and significant work has been undertaken to put in place the necessary contingency measures.
- Links in particular with Strategic Risk 9 (workforce) on the Board Assurance Framework, currently scored at 16.

2. Political and legislative developments

Parliamentary and legislative developments:

Health and Social Care Select Committee Inquiries
Parliamentary Select Committees have met virtually during the pandemic, and the Health Select Committee are currently holding a number of inquiries of relevance to the Trust:

- Delivering Core NHS and Care Services during the Pandemic and Beyond: On 1 October 2020, the Committee published its report into the delivery of core NHS services during the Covid-19 pandemic. The report set out the impact of and challenges caused by Covid-19 to the provision of essential services and called for urgent action to assess and tackle the backlog of appointments and patent demand for all health services. Launched in April, the inquiry heard from NHS Providers, the NHS Confederation, the medical Royal Colleges, health think tanks, patient groups, the Chief Executive of NHS England and other senior NHS leaders. The report praised the work of frontline NHS staff but also found that the pandemic had had a profound impact on normal NHS services and that this could have been mitigated with earlier infection control measures in hospitals and clearer communication to patients whose care was disrupted. It highlighted the risk of the disruption in leading to more avoidable deaths, and called for mass testing for all NHS staff in order to avoid further disruption and help manage services during the second wave.

- Coronavirus: lessons learnt: The Committee is currently holding a joint inquiry with the House of Commons Science and Technology Committee into the lessons that can be learned from the response to the Coronavirus pandemic so far. The issues being considered by the inquiry include: the deployment of non-pharmaceutical interventions like lockdown and social distancing rules to manage the pandemic; the impact on the social care sector; the impact on BAME communities and other at-risk groups; testing and contact tracing; modelling and the use of statistics; Government communications and public health messaging; the UK's preparedness for a pandemic; and the development of treatments and vaccines. A report is likely in early 2021, and follows the Committee's inquiry into the management of the coronavirus outbreak earlier this year.

- Safety of Maternity Services in England: Launched in July 2020, the Committee's inquiry is looking at recent failures in maternity services and the actions needed to improve safety for mothers and babies. The inquiry seeks to build on recent investigations following incidents at East Kent Hospitals University Trust and Shrewsbury and Telford Hospitals NHS Trust, as well as the inquiry into the University Hospitals of Morecambe Bay NHS Trust. The inquiry is considering whether clinical negligence and litigation processes need to be changed to improve the safety of maternity services, as well as the extent to which a blame culture affects medical advice and decision-making. The inquiry is currently hearing evidence and is unlikely to publish its report until the new year.

2. Political and legislative developments

Parliamentary and legislative developments (Continued):

Health and Social Care Select Committee Inquiries (Conintued)

- Workforce burnout and resilience in the NHS and social care: Launched in July 2020, the Committee is undertaking an inquiry to examine workforce burnout across the NHS and social care. It is considering the increased pressures brought by Covid-19 and the resilience of services to cope with high levels of staff stress. The inquiry was launched in the context of NHS Providers reporting that 92% of Trusts were concerned about burnout among their staff. The inquiry is expected to focus on the impact of burnout on service delivery as well as on broader themes relating to workforce planning and the measures set out in the NHS People Plan.

Public Accounts Committee:

- NHS Nursing Workforce: On 23 September 2020, the Public Accounts Committee published a report of its inquiry on the NHS nursing workforce. The report found that despite overall increases in the numbers of nurses over the past 10 years, the NHS does not have the nurses it needs, and that it has around 40,000 nursing vacancies, or 12% of posts. The report was critical of the absence of a detailed workforce plan for addressing this shortage in the NHS Long Term Plan. The report also raised concerns that the NHS had “reverted from long-term planning to short-term firefighting”. The report stated that the pace of progress on increasing the number of nurses in the NHS was too slow and concluded that the removal of the NHS bursary in 2017 had failed to achieve its ambition of increasing student numbers. In relation to Covid-19, the report recommended that the Department of Health and Social Care and the NHS arms-length bodies “quickly learn the lessons from the Covid-19 outbreak, which present both challenges and opportunities in how we recruit and retain the nurses we need”. The report also raised concerns about the Department’s approach to addressing shortages in adult social cars nurses.

3. NHS policy and institutional landscape

‘Bureaucracy-busting’ drive

- On 24 November 2020, the Secretary of State for Health and Social Care announced a new strategy to empower frontline staff by reducing excess bureaucracy in the health and care system in England and locking in the positive changes seen during the Covid-19 pandemic. This follows a call for evidence over the summer from frontline health and care staff, through which over 600 respondents identified 1,000 examples of excess bureaucracy that they face in their day-to-day jobs, such as improving the way data is collected and shared to allow our frontline staff to focus more on patient care. A wide range of other stakeholders in the health and care system also contributed. The new strategy identifies 8 priority areas for action :
  - Data and information will be shared, asked for and used intelligently
  - System and professional regulation will be proportionate and intelligent
  - Day-to-day staff processes will be simple, helpful and effective
  - The government will legislate to make procurement rules more flexible
  - GPs will have more time to focus on clinical work and improving patient care
  - Medical appraisals will be streamlined and their impact increased
  - There will be greater digitisation of services
  - A supportive culture is needed at a national and local level
- Specific measures proposed include:
  - rethinking medical staff appraisals by putting an end to lengthy paperwork and ensuring a more meaningful assessment
  - modernising outdated and prescriptive professional regulation. This includes reforming the legislation which sees specialist doctors, including GPs, from outside the UK who want to work in the NHS, submitting up to 1,000 pages of evidence to support an application.
  - reducing duplicative or repetitive data requests which can take up a significant amount of frontline staff’s time. NHSX and Department of Health and Social Care will launch a data strategy in the coming months to harness the power of data for better patient outcomes.
- Links in particular to Strategic Risks 8 (culture) and 9 (workforce) on the Board Assurance Framework, scored at 20 and 16 respectively.

Launch of long Covid clinics in England:

- On 15 November, NHS England announced that a network of more than 40 ‘long Covid’ specialist clinics would be launched starting in late November to help patients suffering the debilitating effects of the virus months after being infected. NHS England has provided £10m to fund the clinics which would see patients who had been hospitalised, officially diagnosed after a test, or who reasonably believe they had Covid. Ten sites have been identified in the Midlands, seven in the North East, six in the East of England, South West and South East respectively, three in the North West, and five in London. Patients will be able to access the service through GP referral or referral through other healthcare professionals. Links to Strategic Risks 1 (patient safety) and 3 (access to care) on the Board Assurance Framework (workforce), scored at 16 and 20 respectively.

3. NHS policy and institutional landscape

A Greener NHS

- As reported in the February 2020 horizon scanning report, on 25 January 2020 the NHS Chief Executive, Sir Simon Stevens, launched the “greener NHS campaign” through which the NHS and its staff will step up action to tackle the climate “health emergency” this year, helping prevent illness, reducing pressure on A&Es, and, it is intended, saving tens of thousands of lives.
- In early October 2020, NHS England adopted a multi-year plan for the NHS to become the first carbon net zero national health system. In January, NHS England convened an NHS Net Zero Expert Panel following the launch of the Climate Assembly UK to take and analyse evidence on how the health service could contribute to nationwide carbon reduction efforts. Its report, which was endorsed by the Board of NHS England, set out how the NHS had already cut its carbon footprint and what more needed to be done.
- Based on the findings of the report, NHS England formally adopted two targets;
    i. for the NHS Carbon Footprint (emissions under NHS direct control), net zero by 2040, with an ambition for an interim 80% reduction by 2028-32; and
    ii. for the NHS Carbon Footprint Plus (which includes the wider supply chain), net zero by 2045, with an ambition for an interim 80% reduction by 2036-39.
- A wide range of interventions are envisaged, including exploring new ways of delivering care at or closer to home meaning fewer journeys to hospitals, greening the NHS fleet, reducing waste from consumable products, making sure hospital buildings are built to net zero emissions, and building energy conservation into staff training and education programmes.
- Links to Strategic Risks 3 (access to care), 7 (estates), 9 (workforce) on the Board Assurance Framework, rated as 20, 20 and 16 respectively, as well as having financial and capital implications (SR5 and SR6).

‘We are the NHS’ recruitment campaign

- NHS England has recently launched a new recruitment drive intended to capitalise on the ‘Nightingale effect’ as the NHS responds to the second wave of Covid. It aims to tap into the unprecedented interest in joining the NHS seen during the pandemic. The ‘We are the NHS’ campaign aims to increase applications for both degree courses and direct entry jobs
- Links to Strategic Risks 1 (patient safety) and 9 (workforce) on the Board Assurance Framework, both of which are currently rated as 16.

4. System and professional regulation

Development of new CQC strategy

- The CQC is expected to launch a formal consultation on the development of its new strategy in January 2021. Ahead of this, it has published the key themes that have emerged from its engagement to date, which will help to frame its future approach to regulation. On 30 September, the CQC published four key areas in which it was developing its new strategy:
    - People: The CQC has stated that it wants to be an agent for change, ensuring that its regulation is driven by what people expect and need form health services, rather than how providers want to deliver them. It has also said it wants to regulate to improve people's experiences so that they can move easily between different service.
    - Smart: The CQC has said it wants to be smarter in how it regulates, with an ambition to provide an up-to-date, consistent and accurate picture of the quality of care in a service and in a local area.
    - Safe: The CQC says it wants all services to promote strong safety cultures, which includes transparency, openness and taking learning seriously, and with a view to achieving zero avoidable harm.
    - Improve: The CQC has also said it wants to play a much more active role in ensuring services improve.

Links to all Strategic Risks on the BAF.

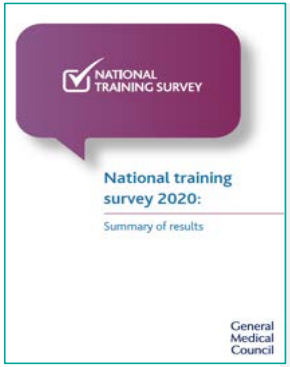
CQC prosecutions

- **East Kent Hospitals University NHS Foundation Trust:** On 9 October 2020, the CQC announced that it was prosecuting East Kent Hospitals University NHS Foundation Tryst following complications which led to the death of a baby in its care. The Trust was charged with exposing a baby on his moth to significant risk of avoidable harm. The baby died in November 2017 seven days after birth. The Trust faces two separate charges in relation to the safety of care and treatment provided to the baby and the mother.
- **University Hospitals Plymouth NHS Trust:** On 23 September 2020, University Hospitals Plymouth was ordered by Plymouth Magistrates Court to pay a total of £12,565 after admitting it failed to disclose details relating to a surgical procedure or apologise following the death of a 91-year old woman. The CQC had brought the prosecution after the Trust failed to share details of what had happened to the patient following an unsuccessful endoscopy procedure, and the CQC judged it to have breached Regulation 20 of the Health and Social Care Act.
- Links to Strategic Risks 1 (patient safety) and 2 (clinical governance) on the Board Assurance Framework, scored at 16 and 12 respectively.

4. System and professional regulation

Changes to General Medical Council revalidation regulatory requirements

- **Changes to revalidation dates:** As reported in the July 2020 horizon scanning report, the General Medical Council (GMC) the GMC decided to reschedule the revalidation dates of more than 50,000 doctors who were due to revalidate between March 2020 and March 2021. On 29 October 2020, the GMC announced that it was rescheduling the revalidation dates for a further group of doctors as a result of the pandemic. The decision means that around 9,000 doctors due to revalidate between March and July 2021 will have their revalidation dates postponed for four months. This group of doctors is able to revalidate at any point between now and their new date (August to November 2021) if they are ready to do so and if their Responsible Officer is able to make a recommendation. But it means that ROs and individual doctors are not under pressure to meet revalidation requirements during the pressures caused by the pandemic.
- **Medical Revalidation and appraisals:** New guidance published by the GMC on 17 November has advised doctors to focus on quality over quantity when gathering supporting information for appraisals and revalidation. The new guidance makes clear that doctors should be allowed enough time to engage properly with the process, as well as having access to data and systems that allow them to prepare properly.
- Links to Strategic Risk 9 on the Board Assurance Framework (workforce), currently scored at 16.



GMC National Training Survey 2020

- On 22 October, the GMC published its annual National Training Survey. The survey was shorter than usual due to the Covid-19 pandemic and focused on the experiences of doctors in training during the pandemic and the impact of Covid-19 on their training experience.
- Out of 38,000 responses, more than 80% of doctors in training reported that disruption caused by Covid-19 had reduced their access to the learning they needed to progress their careers and had adversely affected their ability to gain the experiences they needed to progress through their training. 38% reported that training opportunities had been reduced significantly, and another 43% said that training opportunities were reduced slightly.
- At the same time, most said that their workplaces were supportive, that they felt valued in their roles, were working in an environment in which teamwork was encouraged and in which patient safety was taken seriously.
- Links to Strategic Risk 9 on the Board Assurance Framework (workforce), currently scored at 16.

4. System and professional regulation

Nursing and Midwifery Council processes and protected characteristics

- On 20 October 2020, the NMC published the findings of new equality, diversity and inclusion research relating to NMC processes and people's protected characteristics. The research examined NMC processes - including education, overseas registration, revalidation and fitness to practise - and has identified disparities in people's experience and outcomes, depending on who they are. The differences identified in the NMC's research mirror those experienced by other health and care professionals, including doctors, dentists and social workers.
- The key findings of the report were:
  - Nurses and midwives from a Black and minority ethnic background are more likely to be referred to fitness to practise by employers, while White professionals are more likely to be referred by the public.
  - Black practitioners are more likely to see their case go to the adjudication stage, although they're not more likely to be removed from the register than White nurses and midwives.
  - Male nurses and midwives, and disabled nurses and midwives, are more likely to go to the adjudication stage of fitness to practise and be removed from our register compared to female and non-disabled professionals.
  - Black and Asian students are less likely to be accepted onto NMC-approved nursing and midwifery courses
- Links to Strategic Risk 8 (culture) and 9 (workforce) on the Board Assurance Framework, currently scored at 20 and 16 respectively.

5. Reports and updates from key stakeholders

CQC State of Health and Care report 2019/20

- On 15 October 2020, the CQC published its annual State of Health and Care report for the year 2019/20. Overall, it found that the care that people received in 2019/20 was mostly of good quality. There was some improvement in NHS acute care, where 75% of core services were rated as good or outstanding compared with 72% the previous year. But there are still services where the quality of care needs to improve substantially – more than half of urgent and emergency care services in hospital were rated as requires improvement or inadequate as at 31 March 2020, as were almost a third of medical care and outpatient services. The quality of maternity services has barely changed, with at least one in four rated as requires improvement overall at 31 March 2020. However, while quality was largely maintained compared with the previous year, there was no improvement overall. Before the arrival of the coronavirus pandemic, the CQC stated that it remained concerned about a number of issues:
    - the poorer quality of care that is harder to plan for
    - the need for care to be delivered in a more joined-up way
    - the continued fragility of adult social care provision
    - the struggles of the poorest services to make any improvement
    - significant gaps in access to good quality care, especially mental health care
    - persistent inequalities in some aspects of care
- The report also considered the impact of the Covid-19 pandemic on health and care services. It found that as the pandemic gathered pace health and care staff across all roles and services showed resilience under unprecedented pressures and adapted quickly to work in different ways to keep people safe. In hospitals and care homes, it recognised that staff worked long hours in difficult circumstances to care for people who were very sick with Covid and that some staff also had to deal with the loss of colleagues to Covid. The report recognised the key challenge for providers has been maintaining a safe environment – managing the need to socially distance or isolate people due to Covid. The report noted that the crisis has accelerated innovation that had previously proved difficult to mainstream, such as GP practices moving rapidly to remote consultations. The changes have proved beneficial to, and popular with, many. But the report also found that many of these innovations excluded people who do not have good digital access, and some have been rushed into place during the pandemic.
- The report looked at the impact of the pandemic on elective care and urgent services, recognising the huge pent-up demand for care and treatment that has been postponed. The CQC found that the pandemic is having a disproportionate effect on some groups of people, and is shining a light on existing inequality in the health and social care system. It found that it was vital that it understood how it could use this knowledge to move towards fairer and more equitable care. It also suggested that it was important that the learning and innovation that has been seen during the pandemic was used to develop health and social care for the future. It concluded that new approaches to care, developed in response to the pandemic and shown to have potential, must be fully evaluated before they become established practice
- Links in particular to Strategic Risks 1 (safety), 3 (access), 8 (culture) and 9 (workforce) on the BAF, scored at 16, 20, 20 and 16 respectively.

5. Reports and updates from key stakeholders

Whistleblowing disclosures report 2020 from healthcare professional regulators

- On 24 September 2020, the regulators of healthcare professionals published their annual report on whistleblowing disclosures. The report covers the period from April 2019 to March 2020 and was published jointly by the General Medical Council, Nursing and Midwifery Council, General Dental Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, and the Health and Care Professions Council. All prescribed bodies are required by law to publish an annual report on the whistleblowing disclosures made to them.
    - General Medical Council: The GMC received a total of 36 whistleblowing disclosures in this period, 24 of which were regarding fitness to practise and two regarding registration and revalidation. 21 disclosures were made by doctors, 7 by other health professionals, and 8 were received anonymously. The GMC noted that a number of those raising concerns expressed fear of the repercussions of doing so, showing that more progress was needed in developing a culture that supports raising and acting on concerns. At the same time, fewer concerns were made anonymously compared with previous years. Regulatory action was taken in 28 cases, no action was taken in 5 cases, and 3 cases were referred onwards to an alternative body.
    - Nursing and Midwifery Council: A total of 107 whistleblowing disclosures were received. Regulatory action was taken in all 107 cases, with onwards referral undertaken in 24 cases.
    - General Pharmaceutical Council: A total of 22 disclosures were received. Regulatory action was taken in 13 cases, 5 were referred to another body and 4 remain under review.
    - Health and Care Professionals Council: A total of 8 concerns were received, out of which regulatory action was taken in 7 cases and one was closed with no action. Seven concerns came from registered healthcare professionals and one was received anonymously. The subject of the disclosures was diverse but included concerns regarding an employer's approach to investigating concerns.
- Links to Strategic Risks 1 (safety), 8 (culture) and 9 (workforce) on the Board Assurance Framework, scored at 16, 20 and 16 respectively.

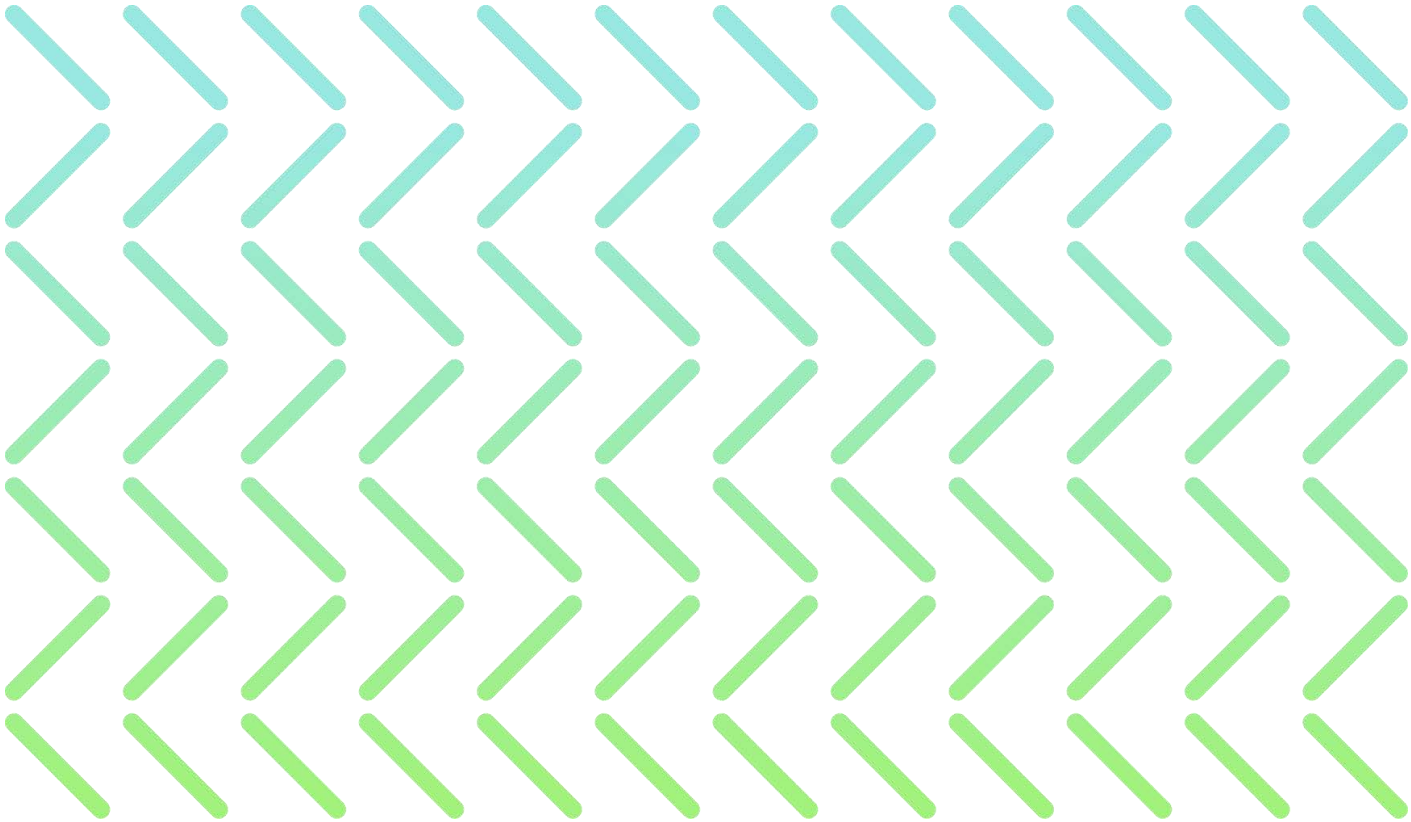
5. Reports and updates from key stakeholders

Freedom to Speak Up Guardians report

- On 1 October 2020, the National Guardian for Freedom to Speak Up published its latest data report revealing that between April 2019 and March 2020 FTSU Guardians received 16,199 speaking up cases. This was a 32 per cent increase compared with the previous year in which 12,244 speaking up cases were raised with Freedom to Speak Up Guardians.

- Freedom to Speak Up Guardians continued to support workers from all professional groups to speak up. Nurses continued to account for the biggest portion (28 per cent) of cases raised with Freedom to Speak Up Guardians. Administrative and clerical workers accounted for the next biggest portion of cases raised with Freedom to Speak Up Guardians (19 per cent), up three percentage points on the previous year. Twenty-three per cent (23%) of cases raised with Freedom to Speak Up Guardians included an element of patient safety/quality. Thirty-six per cent (36%) included an element of bullying and harassment. Thirteen per cent (13%) of cases raised with Freedom to Speak Up Guardians were raised anonymously. Detriment for speaking up was indicated in three per cent of cases raised with Freedom to Speak Up Guardians. This is lower compared to the previous year where detriment was indicated in five per cent of cases. Eighty-five per cent (85%) of workers who gave feedback said they would speak up again. Workers said they would not speak up again in three per cent of cases where feedback was received.

- Links to Strategic Risk 8 (culture) on the Board Assurance Framework, scored at 20.



Outstanding care every time

St George's University Hospitals NHS Foundation Trust

4.5

Meeting Title:	Trust Board		
Date:	26 November 2020	**Agenda No**	**4.5.2**
Report Title:	**Horizon Scanning Q2, 2020-21 Report**		
Lead Director/ Manager:	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Laura Carberry, Strategy and Partnership Manager		
Presented for:	Note		
Executive Summary:	This Horizon Scanning Quarterly Report is intended for Trust Board; apprising the Board of the latest Local and Regional Updates, based on CCG Governing Body and Health and Wellbeing Board papers in south west London, and on current and future Clinical Tenders or Opportunities for St George's. It should be considered alongside the Corporate Office's Horizon Scanning Q2, 2020-21 Report on National Policy. Areas of interest/ particular relevance to the Trust, include: • COVID-19; • Flu Season and Winter, and; • Building Your Future Hospitals (BYFH) Programme, formerly Improving Healthcare Together (IHT) Programme.		
Recommendation:	Trust Board is asked to note the latest Local and Regional Updates.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person; Right care, right place, right time; Balance the books, invest in our future; Build a better St. George's; Champion Team St. George's; Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring**: staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led**: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	Executive Management Team	**Date**	16 November 2020
Appendices:	N/A		

Outstanding care every time

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NHS Foundation Trust

4.5

Horizon Scanning Report Q2, 2020- 21

Local and Regional Updates

This Horizon Scanning Quarterly Report is intended for Trust Board; apprising the Board of the latest Local and Regional Updates, based on CCG Governing Body and Health and Wellbeing Board papers in south west London, and on current and future Clinical Tenders or Opportunities for St George's.

It should be considered alongside the Corporate Office's Horizon Scanning Q2, 2020-21 Report on National Policy.

Suzanne Marsello, Chief Strategy Officer

Laura Carberry, Strategy and Partnership Manager

November 2020

CONTENTS

HIGHLIGHTS

Below are the Common Themes or Headlines/ Highlights that are of particular relevance to the Trust.
NB: Areas covered in the Main Body of this Report are not fully replicated or summarised in this Table.

Item	Notes	Likely to be of particular interest to..
COVID-19	Agendas for the CCG Governing Body and its Sub-Committees and also the Health and Wellbeing Boards all covered COVID-19 with an emphasis and focus on learning and plans in relation to: • Access to Healthcare • Alignment with Health and Care Plans • Capacity in Critical Care/ Intensive Care • Care Homes • Children's and Adolescent Mental Health (CAMHS) • Clinical Models • Communications • Community Health • COVID-19 Antibody and Antigen Testing • Elective Planned Care • Financial Performance • Health Inequalities • Impact and Learning from the 1st Wave • Infection Prevention and Control (IPC) • Information Governance • Mental Health • Operational Performance • Outbreak Management • Partnership • Patient Pathways • Preparation for a 2nd Wave + Winter • Primary Care/ Primary Care Networks • Public Health • Recovery and Restart of Services in SWL • Social Care • Staff Support and Wellbeing (Bereavements, BAME, PPE, Staff Testing, etc.) • Voluntary Sector • Ways of Working e.g. Virtual	• Executive Management Team
Flu Season and Winter	Agendas for the CCG Governing Body and its Sub-Committees and also the Health and Wellbeing Boards all covered the ability to balance COVID-19 with the Flu Season and resilience in Winter. £12m Capital has been confirmed to deliver improvements in SWL Urgent and Emergency Care ahead of Winter 2020.	• Chief Nurse • Chief Operating Officer • Deputy Chief Executive / Chief Finance Officer • Executive Management Team
Building Your Future Hospitals (BYFH) Programme *(formerly Improving Healthcare Together (IHT) Programme)*	The CCG covered the decision for Epsom and St Helier University Hospitals NHS Trust to be reconfigured, establishing a Major Acute Hospital at Sutton with an investment of £500m across the Trust: the Decision-Making Business Case, Implementation and Next Steps including the development of an OBC and the establishment of a Strategic Oversight Group reporting into a Strategic Executive Group. It was also confirmed that the CCG's decision had been formally referred by the London Borough of Merton to the Secretary of State. (The Secretary of State has since referred the case to the Independent Reconfiguration Panel, which concluded that there was no reason to disagree with the choice of Sutton as the preferred option, and recommended the proposals should proceed).	• Executive Management Team

SOUTH WEST LONDON CCG: Q2, 2020- 21

GOVERNING BODY MEETING PAPERS SUMMARY

CCG Governing Body Meeting (July 2020)

Bi-Monthly Meetings

- The Governing Body received a report from the Chair and Accountable Officer which noted:
  - the development a Covid-19 recovery plan with a focus on restarting planned and elective care along with an emerging plan to increase the capacity of intensive treatment units to mange the expected next peak.
  - confirmation the South West London and Care Partnership has been formally designated as an Integrated Care System (ICS) by NHS England.
  - Covid-19 serology testing has been introduced and rolled out with half of SWL staff accessing the test (June 2020).
  - Annual report and accounts were submitted to the SWL Audit committee and approved .
- **The Governing Body received a report on the SWL CCG's community response to COVID 19**. The report noted whilst much of the focus at the initial stages of the outbreak was in acute hospitals and intensive care settings, there was equally dynamic responses across teams, services and organisations to provide radically transformed care in communities. The report details service responses from community nursing and therapies; specialist teams in care homes; end of life care; role of voluntary sector , focusing on areas most impactful.
- **The Governing Board received an update from each of the 6 Borough Committee Chairs**. Each focused on the COVID-19 pandemic response and future planning of the borough and partners over the next 6-12 months. Key areas highlighted covered the need to maintain discharge to assess pathways even if legislation on funding responsibilities revert to post Covid-19 position, Care Home support must be maintained, and reliance on a flexible and cohesive workforce is key.
- **The Governing Body received a quality report**, acknowledging the approach to monitor quality across providers during the pandemic needed to be propitiated to demand and pressures . A CCG corporate risk register is in the process of being constructed for risks identified through the Covid- 19 Major Incident Cell, those reported through Borough Teams and risks identified as new NHS SWL.
- **The Governing Body was asked to approve the revised South West London CCG Memorandum of Understanding with Croydon Health Services NHS Trust**, to reflect the merger of the CCG's. The MOU seeks to describe the governance arrangements, joint posts and wide workforce considerations, and arrangements for collective recourses. Whilst not legally binding it was noted the MOU helps to restate the commitment to an integrated care partnership in Croydon and the arrangements for the joint executive and aligned teams within the borough.

Board Papers can be found at: https://swlondonccg.nhs.uk/previous-governing-body-meetings/july2020-governing-body-meeting/

SOUTH WEST LONDON CCG: Q2, 2020- 21

GOVERNING BODY MEETING PAPERS SUMMARY

CCG Governing Body Meeting (September 2020)

Bi-Monthly Meetings

- The **Chair and Accountable Officers Report** covered the approach to COVID-19 in future and the latest position including: access to Healthcare, Antibody Testing, Care Homes, additional capacity in Critical Care/ ICU/ ITU, Clinical Models, Elective Care, exacerbation of Health Inequalities, Infection Prevention and Control (IPC), Outbreak Management and Patient Pathways as well as the Community and Mental Health, Primary Care, Public Health and Social Care responses and Staff Support (Bereavements, BAME, PPE, Staff Testing, etc.) in SWL.
- It was acknowledged that the Acute Sector had agreed to participate in the Siren Study in SWL; its aim is to assess COVID-19 infection rates and prevalence as well as the degree of immunity and/ or likelihood of reinfection in the Workforce.
- An Infection Prevention and Control (IPC) Summit had facilitated learning and also focused on plans for the recovery and restart of services in SWL.
- A Preventing Mental Health Crisis Summit had facilitated learning and identified improvements in prevention and support in SWL.
- The Governing Body received a report on the **SWL Primary Care Response to COVID-19**; covering the COVID-19 response from Primary Care with an emphasis on GP Practice recovery and restart of services in SWL. It advises on the approach to Infection Prevention Control (IPC) and Outbreak Management and details 5 Core Objectives and 7 Core Workstreams that are being progressed and supported in SWL.
- The Governing Body were advised of **Borough Committee Chair Updates**; the approaches at Borough-level to COVID-19 and future plans in Primary Care were reviewed.
- The Governing Body received a **SWL Performance Report**; it was acknowledged that COVID-19 had had an impact on, and implications for, performance in Q1, 2020/21 with:
  - an improvement to 95.1% against the **95% A&E (4 Hour) standard** in May 2020 with an emphasis on the improvement in performance at St George's in particular;
  - a deterioration to 67.1% against the **92% RTT (18 Week) standard** in May 2020 with challenges in Ophthalmology and Trauma and Orthopaedics in particular and an increase in patients waiting 52+ Weeks;
  - an improvement to 97.98% against the **93% Cancer (2 Week Wait) standard** in May 2020;
  - an increase to 76.4% against the **85% Cancer (62 Day) standard** in June 2020;
  - a deterioration to 44.6% against the **99% Diagnostic (6 Week) standard** in May 2020 with challenges in Echocardiography, MRI and Non-Obstetric Ultrasound and deterioration emphasised at Epsom and St Helier University Hospitals NHS Trust in particular;
  - a decrease to 3.38% against the **25% IAPT (Access Rate) standard** in May 2020 with all Boroughs challenged except for Richmond and the deterioration emphasised in Croydon in particular; and,
  - an improvement to 59.71% against the **50% IAPT (Recovery Rate) standard** in May 2020.

It was confirmed that the Integrated Care System was leading on, and overseeing the plans for the recovery and restart of services in SWL. In addition, £12m Capital has been confirmed to deliver improvements in SWL Urgent and Emergency Care ahead of Winter 2020.

SOUTH WEST LONDON CCG: Q2, 2020- 21

GOVERNING BODY MEETING PAPERS SUMMARY

Bi-Monthly Meetings

- The Governing Body received a **Month 4 Finance Report**; allocation to the CCG is confirmed to July 2020 (Month 4) with arrangements continuing on funding to September 2020 (Month 6) and details expected to be issued for the remainder of the year. At Month 4, the CCG is indicating a £9m requirement (less £4.3m received) and COVID-19 expenditure of £27.7m (less £19.3m received) with an NHSE reimbursement requested for the shortfall.
- The Governing Body received a report on the **South West London CCG Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Policy**; the EPRR and Business Continuity Policy based on COVID-19 experience and learning from the Level 4 Major Incident as well as legislative and regulatory requirements was signed-off by SWL CCG. A Business Continuity Plan is being developed and it is expected that there will be an NHSE/ I Review in the Autumn 2020.
- The Governing Body received a **Quality and Performance Oversight Committee Chairs Report**; the Annual Child Death Overview Panel and Infection Prevention and Controls (IPC) Reports were covered with local plans in place to respond to this. In addition, the CCGs Performance, Quality and Safeguarding Reports were discussed; assurances covered the delivery of Elective Care including the RTT (18 Week) standard and 52 Week Waits as part of the recovery and restart of services in SWL and Health Inequalities. At Borough-level, it was considered that Health Watch's interactions with patients were responsive and supportive of this. In addition, arrangements at Borough-level were confirmed for the Local Safeguarding Partnerships involving the Local Authority, the NHS and the Police.
- The Governing Body received a **Remuneration Committee Chairs Report**; agreement on the impact of implementing 'Moving Forward Together' and the payment of redundancies was reported. In addition, the Clinical Leadership Framework development was discussed.
- The Governing Body received a **Report from the Chair of the Finance Committee**; advising on the arrangements for funding and the M2 and M3 Finance Reports as well as a M3 ICS System Report. In addition, agreement of alternative funding for a GP Practice relocation in Merton, the approach to Primary Care Rebate Schemes, approval for Croydon to develop an Estates and IT OBC in Primary Care and the approval of 9 Single Tender Waivers were reported.
- The Governing Body received a **Chair's Report: Primary Care Commissioning Committee**; arrangements for the Governance and Oversight of Primary Care in SWL, approvals for COVID-19 decisions expedited at Extraordinary Meetings and the continued development of PCNs and progress were reviewed.
- The Governing Body received an **Improving Healthcare Together Update and the Draft Minutes of the Improving Healthcare Together (IHT) Committees in Common Meeting on 3 July 2020**; covering the Decision-Making Business Case, Implementation and Next Steps including the development of an OBC and the establishment of a Strategic Oversight Group reporting into a Strategic Executive Group. It was also confirmed that the CCG's decision had been formally referred by the London Borough of Merton to the Secretary of State.
- The Governing Body received a report on the **SWL Information Governance Response to COVID-19**; advising on the approach to the Control of Patient Information Notice issued in March 2020, changes to Information Governance and the establishment of a COVID-19 IG Strategy Group in SWL.

Board Papers can be found at: https://swlondonccg.nhs.uk/wp-content/uploads/2020/08/SWL-CCG-Governing-Body-Meeting-2-Sept-2020_complete.pdf

SOUTH WEST LONDON CCG: Q2, 2020- 21

GOVERNING BODY MEETING PAPERS SUMMARY

Annual General Meeting

4.5

CCG Annual General Meeting (September 2020)

- First annual general meeting for the new, merged SWL CCG.
- Received annual reports / accounts for the 6 predecessor, borough-level CCGs, for 19/20.
- The AGM was asked to note that all the predecessor CCGs had maintained financial stability, delivered fair and effective use of resources, invested in mental health in line with growth allocations, and staying within running costs of £20 per head of population.
- A number of best practice projects in19/20 were highlighted, including the Trust's gastroenterology virtual clinical assessment service for Merton/Wandsworth.
- The new governance structure for the merged CCG (which Trust Board has seen previously) was presented.
- It was noted that South West London had successfully become an Integrated Care System (ICS) in April 2020.
- AGM was updated on the decision by the CCG that Sutton was its preferred option to be the future location of Epsom St Helier's specialist emergency care services, following public consultation.
- Updates were also given on responding to COVID, and on improving children and young people's mental health services in South West London.

Board Papers can be found at: https://swlondonccg.nhs.uk/previous-governing-body-meetings/september-2020-annual-general-meeting/

HEALTH AND WELLBEING BOARDS: Q2, 2020- 21

BOARD PAPERS SUMMARY

Croydon HWB (October 2020)

- Winter Planning Report - key points to note:
  - Health and social care services have been re-designed/ reconfigured to adapt to COVID-19 secure requirements, but this is likely to have a knock-on effect on non-COVID care during winter, potentially causing delays in access to treatment.
  - The plan leaves the local system in an advanced state of preparedness to control and respond to the Covid-19 second wave. Collaborative working has created enhanced system resilience that will help to mitigate and respond to winter pressures.
  - Notes the enhanced flu vaccination programme as an aid to managing healthcare demand.
  - Overarching winter plan covering all agencies currently in development.
- A report into health inequalities in the borough- for discussion.
- The 2019/20 Annual report with recommendation for submission to full council.
- DONM: 20 January 2021.

Board Papers can be found at:
https://democracy.croydon.gov.uk/ieListMeetings.aspx?CommitteeId=172&utm_source=mod-gov&utm_medium=taxonomy&utm_campaign=%20committee-calendar-healthwellbeing

Kingston HWB (October 2020)

Quarterly Meetings

- Received a Partners Update that detailed various statutory and voluntary organisations status. Key points to note include:
  - Kingston Council noting the financial challenges and uncertainty they faced going forward, exacerbated by Covid-19.
  - The CCG notes the suspension of normal NHS financial arrangements, with a simplified commissioning process put in place, coupled with top up funding to support delivery of breakeven positions against reasonable expenditure. Notes these run until end September and waiting on guidance for remainder of the year.
  - Public Health note the impact of lockdown and the re-purposing and focussing of large numbers of council and other providers towards Covid management.
  - Kingston Hospital is currently delivery 80% of its outpatient appointments virtually, and is working to reassure the public about infection control and prevention on site and, along with other NHS organisations, notes the overall reduction in other referrals and the need to ensure patients are coming forward with other conditions.
  - A new appointment of Corporate Director of Health, Housing and Adult Social Care has been made- Sharon Houdlen starts 19th October.
  - Co-production of Winter Plans by NHS organisations and Councils are noted – first draft of Kingston's winter plan expected mid-October.
- Proposals to develop a taskforce to identify local health and care system priorities and recommended actions in 2021-2023, in light of emerging and new priorities due to Covid-19 and with a focus on prevention, and to refresh the local Health and Care Plan for 2021-2023. The aim is to approve in March 2021.

HEALTH AND WELLBEING BOARDS: Q2, 2020- 21

BOARD PAPERS SUMMARY

- The Better Care Fund was discussed and the following was noted: South West London Clinical Commissioning Group and Kingston Borough were jointly working within the published guidance to affirm the Better Care Fund Plan for 2020/21 in light of the impact of the system wide response to the Covid-19 pandemic during the current financial year; with a renewed commitment between the Council and the CCG to work towards greater integration of services, a more efficient and effective use of the resources available and better outcomes for both patients and those who use the Council's services.
- Report by Martin Ellis, SWLCCG Director of Transformation about post-Covid recovery of NHS services in Kingston.
- DONM: 26 January 2021.

Board Papers can be found at:
https://moderngov.kingston.gov.uk/ieListMeetings.aspx?CommitteeId=488

Merton HWB (June and September 2020) *Quarterly Meetings*

- Both meetings focussed on Covid-19 and its impacts. Key points relating to Covid-19 were:
  - A particular focus on the collection of improved data relating to BAME communities and Covid-19, and improving BAME communities experience of using health and social services linked to Covid-19.
  - Work to understand the impact on, and support for, Care Homes through the Covid-19 pandemic.
  - A need to improve the communication channels with the voluntary sector in relation to Covid-19.
  - The good work of the Community Response Hub, and also local voluntary organisations, in helping managed demand for a range of health and social services through the pandemic.
  - Noted that Covid-19 testing hubs have been set up in all major hospitals in the sub region for primary care staff and their families who are symptomatic. This was a new measure which would assist in identifying who was positive and who would need to isolate.
- DONM: 24 November 2020.

Board Papers can be found at:
https://democracy.merton.gov.uk/ieListMeetings.aspx?CId=184&Year=0

HEALTH AND WELLBEING BOARDS: Q2, 2020- 21

BOARD PAPERS SUMMARY

Richmond HWB (July 2020)

Quarterly Meetings

- It was noted that the impact of COVID-19 had affected all HWB partner work programmes. All partners had set aside business as usual work and, using a partnership approach, prioritised support (including in some instances diverting resources) to local health and care services, residents and creating a volunteer workforce.
- The community hub has worked with 7,561 residents who were “shielding” (with only 4% known to social care). They note that this has led to them working in a more integrated way with a much wider population, working with residents usually supported by the NHS only. The ‘hub’ has created a database on the Council’s case management system of all shielded residents regardless of social care needs. They note that this will enable them to work more preventatively going forwards.
- Transforming the Future programme. A work stream within the programme will focus on health and care integration. The work will also reflect and align with some of the SWL Health and Care Partnership Covid-19 recovery plan and with the NHS Long Term Plan.
- Richmond note that responding to Covid-19 will be a key part of the programme of work over the next 12 – 18 months and that new, COVID 19 related priorities materialised- of which accelerated hospital discharge schemes are the key point to note for St. George’s.
- Four categories of Health & Care Plan priorities: Existing H&CP priorities to place on hold; Existing H&CP priorities to take forward; Newly identified COVID 19 related H&CP priorities; H&CP priorities yet to be defined.
- It was noted that the new priorities would be agreed and formulated into action tasks by the end of August, including contingency planning for a 2nd Covid wave. These are not yet publically available.
- The HWB noted the message that the NHS was open for patients and that people should go back to using it should be disseminated. Communications would continue to reassure patients that those who need medical treatment could visit the relevant services and that it was a safe thing to do.
- DONM: 26 November 2020.

Board Papers can be found at:
https://cabnet.richmond.gov.uk/ieListMeetings.aspx?CommitteeId=643

HEALTH AND WELLBEING BOARDS: Q2, 2020- 21

BOARD PAPERS SUMMARY

Sutton HWB (July 2020)

- The meeting received and approved the Sutton Covid Outbreak Control Plan which primarily focuses on the establishment of a local Test and Trace service.
- Presented the Sutton Heath & Care Plan, which addressed Covid-19 response and management and plans for the future areas of focus. Key areas of development identified include the following:
  - Rapid, co-ordinated 'discharge to assess' arrangements.
  - Maintain the reduction in minor ED attendances.
  - Accelerate innovation and integration, with the resident at the centre.
  - Enhanced weekly communications (to primary care, across ESH services, to care sector).
  - Seven day working.
  - More engagement of voluntary sector as key partners.
  - Develop Sutton system modelling to help plan responses for next phases.
  - Further develop an integrated approach to care homes as key providers in the Place landscape.
  - Support staff/manage wellbeing/retain skilled people.
- The positive collaboration amongst all health, social, statutory and voluntary organisations through the pandemic was commented on, and the need to build on this going forward.
- CANCELLED: 5 October 2020; DONM: 25 January 2021.

Board Papers can be found at:
https://moderngov.sutton.gov.uk/ieListMeetings.aspx?CommitteeId=471

Wandsworth HWB (June and September 2020)

Quarterly Meetings

The agenda for the Health and Wellbeing Board included:

- Both meetings were dominated by Covid-19 and the boroughs planning and response to the pandemic. Key points to note are:
  - The need to focus on identifying and addressing the impact of Covid-19 in 2020/21 and 2021/22, noting the need to work across traditional organisational boundaries.
  - In September it estimated that additional costs of £16m would be incurred in relation to managing Covid-19 in the borough and the level of government support to mitigate these extra costs was unclear
  - It was noted that having a major hospital in the borough "was a benefit" but noted St. George's needed to support the whole of south-west London, not just Wandsworth
  - Noted the really positive way organisations collaborated and implementation of 'cell' structure led to consistent decision making across south-west London
  - Noted that managing Covid-19 and its long term impacts will alter the HWB focus for the next 12- 18 months with the focus on maintaining a 7 day a week rapid discharge from hospital the most important take-away for St. George's
- DONM: 19 November 2020.

Board Papers can be found at:
https://democracy.wandsworth.gov.uk/ieListMeetings.aspx?CId=508&Year=0

CURRENT OPPORTUNITIES FOR ST GEORGE'S

CLINICAL TENDERS

There are no new clinical tender opportunities currently open nor future opportunities that have been notified to the Trust at present. It is likely that any planned procurements may have been paused during Covid-19.

CWDT Division

Abnormally Invasive Placenta (AIP)

An evaluation panel was held on 15 October 2020 at which the team gave a 20 minute presentation followed by a questions and answers. The team is waiting the outcome of the panel , timescale unknown.

Genomic Medicines Alliance Services (GMSA) - Joint Bid St George's and Guys and St Thomas'

The Trust continues to develop a bid in partnership with Guy's and St Thomas' (GSTT) to establish a Genomic Medicine Service Alliance (GMSA) across South London and the South East of England. The bid was originally due to be submitted to NHSE in March 2020, but was delayed by COVID. The Trust has now reached agreement with GSTT on key areas, and expects to be in a position to submit a joint bid by 20 November, with both trusts playing a leadership role in the region.

Non-Invasive Prenatal Testing (NIPT) Laboratory Services

The procurement process for the roll out of NIPT screening remains at the market engagement stage. The Trust responses are still being reviewed and as such the procurement process has not yet progressed to the ITT stage. No time scale available for the ITT stage at present.

Wheelchair Service- North West Surrey CCG (Spelthorne) expected notice for Wheelchairs, Rehab Engineering & Special Seating

The Trust received (24 August) notice from Surrey Heartland CCG Commissioners on their intentions to cease the commissioned Wheelchair and Specialist Seating Service, effective 1 April 2021. The Trust has notified the CCG of significant concerns in regards to the cessation of this services and the expected loss of income is likely to make a material impact on the financial viability of the remaining SWL service. Further discussions with the CCG are required around coverage of standard costs related to the QMH estates for a period of 2 years and wider impact on the sustainability of the service.

MEDCARD Division

Severe Intestinal Failure Services- Integrated Centres

The bid was submitted on 7 November 2019 and the Trust is awaiting the outcome decision end of October/ early November.

NHSE issued a tender for SIF Integrated Centres on 15 September 2019. The service worked on a joint bid for the West London and South East England areas, in collaboration with St Mark's Hospital at London North West Healthcare NHS Trust, who would be the lead provider.