

## Trust Board Meeting (Part 1) Agenda

**Date and Time:** Thursday, 25 March 2021, 09:00-11:20

**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 – 28 January 2021	Chairman	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
09:05	1.5	Chief Executive Officer’s Report	CEO	Inform	Report
2.0 CARE					
09:10	2.1	Quality and Safety Committee Report	Committee Chair	Assure	Report
	2.1.1	Learning from Deaths Q3 Report*	CMO	Assure	Report
09:30	2.2	Integrated Quality and Performance Report*	COO	Assure	Report
3.0 CULTURE					
09:45	3.1	Workforce and Education Committee Report	Committee Chair	Assure	Report
09:55	3.2	National Staff Survey 2020 Report*	CPO	Assure	Report
4.0 COLLABORATION					
10:10	4.1	Audit Committee Report	Committee Chair	Assure	Report
10:20	4.2	Finance and Investment Committee Report	Committee Chair	Assure	Report
10:30	4.3	Finance Report (Month 11)*	CFO	Update	Report
10:45	4.4	Corporate Objectives Quarterly Update	CFO	Assure	Report
11:00	4.5	Horizon Scanning Report:	CCAO	Assure	Report
	4.5.1	Emerging Policy, Regulatory, Statutory and Governance Issues			
	4.5.2	Strategic-Local & Regional	CSO	Assure	Report
5.0 CLOSING ADMINISTRATION					
11:10	5.1	Questions from Governors and the Public	Chairman	Note	Oral
	5.2	Any new risks or issues identified	All	Note	
	5.3	Any Other Business		Note	
11:20	CLOSE				

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

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

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## Trust Board Purpose, Meetings and Membership

<b>Trust Board Purpose:</b>	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.
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Membership and In Attendance Attendees		
Members	Designation	Abbreviation
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Vice Chairman	NED
Elizabeth Bishop	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li	Associate Non-Executive Director	ANED
Tim Wright	Non-Executive Director	NED
Andrew Grimshaw	Chief Finance Officer and Deputy Chief Executive Officer	CFO/DCEO
Robert Bleasdale	Acting Chief Nurse & Director of Infection, Prevention & Control	ACN
Richard Jennings	Chief Medical Officer	CMO
In Attendance		
Anne Brierley	Chief Operating Officer	COO
James Friend	Chief Transformation Officer	CTO
Paul da Gama	Chief People Officer	CPO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Secretariat		
Tamara Croud	Head of Corporate Governance/Board Secretary	HOCG-BS
Apologies	None	
<b>Quorum:</b>	The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.	

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



**Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting  
In Public (Part One)  
Thursday, 28 January 2021  
Held virtually via Microsoft Teams**

Name	Title	Initials
<b>PRESENT</b>		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director	NED
Elizabeth Bishop	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Prof Jenny Higham	Non-Executive Director	NED
Prof Parveen Kumar	Non-Executive Director	NED
Dr Pui-Ling Li	Associate Non-Executive Director	ANED
Tim Wright	Non-Executive Director	NED
Robert Bleasdale	Acting Chief Nurse & Director of Infection Prevention & Control	ACN/DIPC
Andrew Grimshaw	Chief Finance Officer and Deputy Chief Executive Officer	CFO/DCEO
Dr Richard Jennings	Chief Medical Officer	CMO
<b>IN ATTENDANCE</b>		
Humaira Ashraf	Acting Chief People Officer (Culture)	ACPO(C)
Anne Brierley	Interim Chief Operating Officer	ICOO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Elizabeth Nyawade	Acting Chief People Officer (Workforce)	ACPO(W)
<b>SECRETARIAT</b>		
Tamara Croud	Head of Corporate Governance/Board Secretary	HCG

		Action
<b>1.0 OPENING ADMINISTRATION</b>		
<b>1.1</b>	<b>Welcome, Introductions and apologies</b>  The Chairman welcomed everyone to the meeting and noted that there were no apologies.	
<b>1.2</b>	<b>Declarations of Interest</b>  Tim Wright reported that he had been appointed to the Organisation and Employers Board at the British Computer Society (BCS), the Chartered Institute for IT. The role had started on 27 January 2021.	



		Action
1.3	<p><b>Minutes of the meetings held on 26 November 2020</b></p> <p>The minutes of the meeting held on 26 November 2020 were approved as a true and accurate record.</p>	
1.4	<p><b>Action Log and Matters Arising</b></p> <p>The Board reviewed the action log and agreed to close those actions proposed for closure and noted that the Emergency Care Improvement Support Team (ECIST) report on the Emergency Department had been uploaded to the Diligent Reading Room in relation to action TB26.11.20/01.</p>	
1.5	<p><b>Chief Executive's Officer (CEO) Report</b></p> <p>The Board received the report from the CEO and the following key points were raised and noted:</p> <ul style="list-style-type: none"> <li>• The past few months had been very challenging for the Trust in managing the operational impact of the second surge in Covid-19 cases alongside expected winter pressures. While there were signs that this pressure was easing, the Trust currently had 129 intensive care unit beds open compared with the 66 ICU beds provided for within the business as usual framework. The Trust was supporting partners across South West London to care for Covid-19 patients while managing elective activity.</li> <li>• The Trust recognised the impact of sustained operational pressure and was focused on supporting staff, particularly in relation to their health and wellbeing. The Chairman, supported by the Board, agreed that this was important and commended the exemplary work of staff across the organisation during what had been an unprecedented time for the Trust. The Board expressed its gratitude to staff for their dedication in responding to Covid-19.</li> <li>• The Trust and the University had been heavily involved in research activity around Covid-19 with some significant milestones achieved.</li> <li>• NHS England and NHS Improvement (NHSE&amp;I) had, in December 2020, taken the decision to remove the Trust from Financial Special Measures. This was an important milestone and a testament to the hard work of staff to improve the Trust's financial position. Combined with the Trust's exit from quality special measures in March 2020, this demonstrated the tangible improvements being made.</li> <li>• Strengthening the culture of the organisation remained a key priority. This work had commenced prior to the pandemic, but the Trust had pressed ahead as far as possible without overloading staff as this work was pivotal to delivering outstanding care, every time. While timescales for delivery had been impacted by the current period of intense operational pressure, the Trust had continued to make progress and the first meeting of the Culture, Diversity and Inclusion Programme Board had taken place earlier in the week. Stephen Collier reflected that given the current challenges and their cumulative impact on the staff it was appropriate to adjust the pace of the culture programme to ensure it was set up effectively to deliver for the long-term.</li> </ul>	





		Action
	<ul style="list-style-type: none"> <li>Tim Wright and Stephen Collier noted that a recent BBC media report which recorded staff in the emergency department had been very impactful and demonstrated a culture of strong team working.</li> <li>The Trust was exploring a new model for developing its corporate objectives and priorities, learning from the patient first approach adopted by Western Sussex.</li> </ul> <p>The Board noted the report.</p>	
<b>2.0 CARE</b>		
<b>2.1</b>	<p><b>Covid-19 Update</b></p> <p>The Board received and noted the report on how the Trust was responding to the second surge of Covid-19. The following key points were raised and noted in discussion:</p> <ul style="list-style-type: none"> <li>The Trust had learnt a lot from wave one and had addressed some key issues ahead of the second wave. Despite having a robust Covid-19, Winter and Flu Plan, the Trust had needed to respond in an agile way to differences in demand for ICU and general and acute beds. The executive team were logging key decisions and any deviation from the agreed Covid, Winter and Flu Plan so that decision-making during the pandemic response was clearly recorded.</li> <li>In wave two, the Trust, like much of the NHS, had continued with some of its elective activity and its diagnostics and the operational pressures on the Trust were higher in the second wave than they had been in the first.</li> <li>The workforce had needed to respond to these challenges and had adopted different ways of working. The Trust had adapted its ITU framework and, like much of the NHS, had adjusted its usual patient-to-ITU nurse ratios.</li> <li>Staff had been working in a very difficult environment for almost a year. To support staff, the Trust had implemented a number of staff and health and wellbeing initiatives, including the provision of psychological support. The Trust had listened to staff about the impact of the pandemic in the first wave and had put in place training and development initiatives to ensure staff felt they had sufficient knowledge when they were redeployed in wave two. The Trust was now planning the additional measures to support staff to decompress when the second wave eased.</li> <li>The Trust was one of the first 50 vaccine hubs in the country and had operationalised the hub within a short timeframe. The Trust had focused on vaccinating the over 80s and over 70s across South West London (SWL) and the wider healthcare landscape and high risk Trust staff in line with national guidance. The Trust had vaccinated over 15,000 people and over 60% of its workforce. Within the Trust and across the wider NHS, there was a disparity in the uptake of the vaccine in the lower banded NHS staff and in some BAME groups.</li> <li>All trusts had seen a rise in hospital-acquired Covid infection and this was a</li> </ul>	



		Action
	<p>major area of focus for the Trust, which was working with partners across South West London in responding to nosocomial infection.</p> <ul style="list-style-type: none"> <li>There was a rota in place for senior staff members including the executive team to be on Trust sites over the weekend.</li> <li>Ann Beasley reported the immense pride she felt being part of the Trust and the fantastic response of staff to the pandemic. She also asked about the measures the Trust had put in place to support staff when mistakes were made in what had been a particularly challenging situation. It was reported that the executive team had focused on engaging with staff across the organisation and were clear that staff needed support to help them deal with the pressures of the pandemic response. The Trust's messages were supported by similar communications from professional bodies and the Trust had put in place local initiatives to support staff. In addition, senior leaders regularly visited wards and talked to staff about their experiences and what they needed in terms of support.</li> </ul> <p>The Board noted the report.</p>	
<b>2.2</b>	<p><b>Quality and Safety Committee Report</b></p> <p>Professor Dame Parveen Kumar, Chair of the Committee, presented the report of the meetings held in December 2020 and January 2021, which set out the key matters raised and discussed. Many of the reports discussed by the Committee also featured later on Board agenda. The Committee, having given the reports due consideration, recommended that the Board receive, note and approve the self-assessment against the Ockenden Maternity Services Review and note the cardiac surgery report.</p> <p>The Committee noted the report.</p>	
<b>2.2.1</b>	<p><b>Ockenden Maternity Review – Trust Response</b></p> <p>The Board received and considered the Ockenden Review of Maternity Services: Assurance and Assessment Review Immediate Essential Actions which had previously been discussed and endorsed by the Quality and Safety Committee.</p> <p>The Board noted the immediate essential actions taken by the Trust and approved the current self-assessment and the process for future assessment.</p>	
<b>2.2.2</b>	<p><b>Cardiac Surgery Services Quarterly Report</b></p> <p>The Board received and noted the quarter three 2020/21 report on Cardiac Surgery which had previously been considered at the Quality and Safety Committee. It was assured by the progress being made in improving outcomes and implementing the recommendations of the independent mortality review and independent scrutiny panel. The Board would consider a comprehensive report on the improvements in cardiac surgery since the receipt of the first mortality outlier alert from the National Institute for Cardiovascular Outcomes Research (NICOR) as part of its quarter 4 update.</p>	



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<b>2.3</b>	<p><b>Integrated Quality and Performance Report (IQPR)</b></p> <p>The Board received and noted the IQPR at Month 9 (December 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:</p> <ul style="list-style-type: none"> <li>• Unlike in the first Covid-19 surge the Trust had continued to treat more priority one and priority two patients.</li> <li>• The Trust retained all diagnostics services and theatre schedule for urgent patients.</li> <li>• To manage demand the Trust had implemented changes to its discharge process to support patient flow.</li> <li>• Patient length of stay had increased in month with 151 patients staying over 21 days.</li> <li>• The emergency department performance had deteriorated in December 2020, but in January 2021 performance had improved. The redesigned emergency floor entrance was supporting with managing the infection prevention and control challenges.</li> </ul> <p>The Board noted the report.</p>	
<b>3.0</b>	<b>CULTURE</b>	
<b>3.1</b>	<p><b>Workforce &amp; Education Committee Report</b></p> <p>Stephen Collier, Chair of the Committee, presented the report of the meetings held in December 2020 and January 2021, which set out the key matters raised and discussed. The Committee reviewed and endorsed the Modern Slavery Statement and recommended that the Board agree to its adoption. It had also considered progress in taking forward work to strengthen the Trust's culture and had, at its January meeting, considered some early thinking around how to frame the culture programme action plan. The Committee had also received a report from the Guardian of Safe Working and had noted the impact of the pandemic on the demands being made of junior doctors which had led to an increase in the number of exception reports, notwithstanding the fact that the number of rota gaps were being reduced.</p> <p>The Board noted the report and approved the Modern Slavery Statement.</p> <p>The Chairman proposed that Tim Wright be appointed as the Non-Executive Lead for Health and Wellbeing, a role set out in the NHS People Plan, and the Board agreed to the appointment.</p>	
<b>4.0</b>	<b>COLLABORATION</b>	
<b>4.1</b>	<p><b>Finance and Investment Committee Report</b></p> <p>Ann Beasley, Chair of the Committee, provided an update on the meetings held in December 2020 and January 2021. The Committee welcomed the news that the Trust had been taken out of financial special measures. The Committee</p>	



		Action
	<p>had agreed to recommend to the Board a reduction in the score of Strategic Risk 5 on the Board Assurance Framework (financial sustainability) and had also reviewed risks in relation to ICT and operations.</p> <p>The Board noted the report.</p>	
4.2	<p><b>Finance Report M09</b></p> <p>The Board received and noted the Trust's financial performance at month 9. The Trust's current position was in line with the forecast submitted to NHSE&amp;I, which was for a £10.8m deficit at year end excluding the £13m of non-NHS income adjustment which would put the trust's year end position at £2.2m surplus. The Trust had incurred greater expenses related to the second Covid-19 surge than had been expected. It was focused on delivery of key capital projects. The cash position was higher than in previous years.</p> <p>The Board noted the report.</p>	
4.3	<p><b>Board Assurance Framework (Quarter 3)</b></p> <p>The Board received and noted the quarter three 2020/21 Board Assurance Framework (BAF). 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). Strategic Risk 4 (system working) was reserved to the Board.</p> <p>Following a verbal update from the CFO, at its December 2020 meeting the Finance and Investment Committee had agreed to recommend to the Board that the risk score for Strategic Risk 5 (financial sustainability) be reduced from 25 to 20 on the basis of the Trust's improved financial position and the system-wide financial arrangements now in place. The Workforce and Education Committee and Quality and Safety Committee had reviewed their respective risks in the weeks ahead of the Board meeting and had held the risk scores and assurance ratings at their existing levels.</p> <p>Across a number of the strategic risks, the impact of the second wave of the Covid-19 pandemic was apparent. A number of actions to address gaps in control planned for completion at this stage of the year had not yet been implemented fully. This was most apparent across SR1 (patient safety), SR2 (clinical governance), SR3 (timeliness of care), and to a lesser extent SR8 (culture). The most significant of these delays had been to the full implementation of the phase 1 and phase 2 clinical governance review recommendations, receipt and agreement of the phase 3 review, and compliance with seven day standards.</p> <p>The Trust Chairman noted that some Governors had challenged why the progress being made by the Trust was not necessarily evident in changes to the risk scores in the Board Assurance Framework. The Chairman also suggested that the BAF should be linked to the Trust's corporate objectives to assist in providing that sense of progress. She also queried whether the risks on the BAF were worded too broadly and whether they needed to be framed more narrowly in terms of specific risks. The CCAO noted that it was certainly the case that the BAF should link to the Trust's corporate objectives but observed that the current BAF had been approved in May 2020, at which point</p>	



		Action
	<p>the Trust did not have in place agreed corporate objectives; these were agreed by the Board in September 2020. The BAF, however, did link to the strategic objectives set by the Board and the updated BAF for 2021/22 would link to the corporate objectives as these had now been defined. Progress was evident from many of the risks that fed into and supported the BAF and the CCAO suggested that the Board may benefit from periodic sight of the corporate risk register, alongside the BAF. The Trust's approach to framing its strategic risks was in line with that of most Trusts and the BAF, by definition, tended to contain broad risks to the delivery of the strategy. However, there was scope for highlighting in-year progress more overtly. The Board would hold a seminar to inform the development of the 2021/22 BAF and there was an opportunity here to discuss key priorities for the year and how these were captured in the BAF.</p> <p>In relation to Strategic Risk 4, the Chairman queried whether the current risk score of 12 remained appropriate in light of the fact that there had been a good deal of progress in system-wide collaboration during the pandemic. Ann Beasley commented that while it was undoubtedly the case that progress had been made, the pandemic had also increased the stakes in relation to cross-system working and, in light of this, the current risk score of 12 felt appropriate. The CSO agreed that a score of 12 remained appropriate. The CCAO added that while the Government's legislative reforms would help address some of the tensions between the push for system working and the current legislative framework, that tension would remain for some time and the proposals around Integrated Care Systems presented both opportunities and risks. The BAF needed to reflect both the Trust's actions in working with its partners in South West London and the inherent risks around system working which were not fully within its ability to control.</p> <p>The Board agreed to:</p> <ul style="list-style-type: none"> <li>• <b>Reduce the risk rating for SR5 to 20 from 25 to reflect the good progress made which resulted in the Trust being taken out of financial special measures.</b></li> <li>• <b>Maintain the risk score for SR4 at 12, recognising the progress made in cross-system working allied to the inherent risks that remained.</b></li> <li>• <b>Review the BAF strategic risks for 2021/22 at a Board development session and align these with the new corporate objectives.</b></li> </ul>	Board
<b>5.0</b>	<b>CLOSING ADMINISTRATION</b>	
<b>5.1</b>	<p><b>Questions from the public and Governors</b></p> <p>There were no questions raised.</p>	
<b>5.2</b>	<p><b>Any other risks or issues identified</b></p> <p>There were no other risks or issues identified.</p>	
<b>5.3</b>	<p><b>Any Other Business</b></p> <p>On behalf of the Board, the Trust Chairman thanked Elizabeth Nyawade and Humaira Ashraf for jointly acting up to cover the role of Chief People Officer</p>	



		Action
	<p>since late May 2020, commenting they had both helped the Trust develop in some key areas. This was their last Board meeting ahead of Paul da Gama joining the Trust as the new substantive Chief People Officer in early February 2021.</p> <p>The Trust Chairman also thanked outgoing Governors for their support and service to the Trust.</p>	
<b>Date of next meeting: Thursday, 25 March 2021, Microsoft Teams meetings</b>		

DRAFT

Trust Board Action Log Part 1 - March 2021						
Action Ref	Section	Action	Due	Lead	Commentary	Status
TB25.06.20/02	Quality & Safety Committee Board Report (June 2020)	The Board agreed that data on maternal deaths and outcomes for Black, Asian, Minority and Ethnic mothers would be presented to a forthcoming Quality and Safety Committee.	<div> <div>31/08/2020</div> <div>26/11/2020</div> <div>28/01/2021</div> <div>25/03/2021</div> </div>	ACN	This report would be considered by the Quality & Safety Committee in April 2021. Once it is considered at by the Committee it would be represented to Board in May 2021 - The deep dive report was deferred as the organisation focuses on managing the second surge in Covid-19 cases. The report will be considered at the Quality & Safety Committee and presented to the Board in March 2021. Previous Update: The Acting Chief Nurse as decided to develop a detailed assurance report for presentation to the Quality & Safety Committee in December 2020. This report would include key metrics, soft signals and BAME maternity data.	OPEN/DEFERRED
TB28.01.21/01	Board Assurance Framework (Quarter 3)	Review the BAF strategic risks for 2021/22 at a Board development session and align these with the new corporate objectives.	29/04/2021	CCAO		NOT YET DUE



Meeting Title:	Trust Board		
Date:	25 March 2021	Agenda No.	1.5
Report Title:	Chief Executive Officer’s Update		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
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





## Chief Executive's report to the Trust Board – March 2021

I present this report to the Trust Board during the same week that the UK holds a day of reflection to mark the anniversary of the UK's first Covid-19 lockdown.

Covid-19 has affected every single one of us, in so many different ways, and it is incredible to think that it is already more than 12 months since the pandemic started. Civilian life has changed a huge amount in that time – and so has life here at St George's. Our patients, staff and the many organisations we work with have changed the way we work – and the response from everyone has been extraordinary.

I am pleased at how staff have responded to the challenge of getting services back up and running, and returning to some sort of normality. Staff have had an incredibly difficult year, and whilst the way they have responded has saved lives, we are working hard to ensure they look after their own health and wellbeing as well.

### Covid-19 and our response

It is worth me touching briefly in this report on Covid-19, and the impact it continues to have on the services we provide.

As I write, we have 22 Covid positive patients in intensive care – this compares to nearly 90 at the start of the year. We have also been able to slightly reduce the number of ITU beds we have open (from a high of 129 during the New Year peak). ITU surge areas are gradually being converted back into ward areas, but we expect to maintain a potentially higher number of ITU beds as part of business as usual, and going forward.

As the immediate operational pressures of the second Covid-19 surge begin to ease, we are increasingly focused on elective recovery to ensure our patients get the care and treatment they need. We are doing more and more elective work – more detail below, and in the papers for this meeting – and our focus continues to be on treating priority 1 and priority 2 patients. Some specialities are starting to treat priority 3 patients – but this is very much on a case by case basis at present, and only where capacity allows.

Our Covid-19 vaccine clinic administered its 30,000<sup>th</sup> vaccine last week, and to date, 68% of Trust staff have attended the clinic for their first dose. We have launched a new campaign to encourage staff to get their vaccine, with targeted communications to engage our BAME staff, where take up is lower – and key for me is that we encourage managers to engage with their teams, and have 'confident conversations' with staff who are hesitant, or unsure.

As mentioned above, a lot has happened in the last 12 months, and we have this month initiated a piece of work to look at how we can learn from the way we have responded to Covid-19. This will include what has worked well, and where we can improve – and we will bring a report on this to the Trust Board at a future meeting.



## Performance and elective recovery

I won't provide a detailed performance update at this juncture as this is set out in the Integrated Quality and Performance Report, but I want to draw the Trust Board's attention to a couple of specific areas.

Firstly, I am pleased to say that our emergency care performance continues to be amongst the best in London *and in the top ten nationally*, and for a concerted period now. The ED team have worked incredibly hard to maintain this performance – and the engagement from other specialities has also been a key factor in our improvements.

The Emergency Department at St George's now looks very different, and we opened our new front of house last month, which is better for patients from an infection control point of view, but it also makes it easier for staff to manage patient flow within the department. Our diagnostic performance is also strong, and this has been the case throughout the pandemic.

In terms of elective recovery, it is worth mentioning briefly developments at Queen Mary's Hospital, and the creation of our new modular operating theatres on the hospital's existing car park. The new facility will be shared with other Trusts across south west London, and enable us to carry out high volume, low complexity operations, for which many patients have been waiting a long time as a direct result of the Covid-19 pandemic.

Our operational teams are rapidly agreeing which procedures will be carried out in the new facility, and the staffing model we will use. However, I am pleased with the progress that has been made in a very short space of time – and I am confident we will have the facility up and running later in the spring.

## Improving our culture

Earlier this month, we shared the latest results of the NHS Staff survey with staff. Last year, nearly 60% of staff completed the survey, and I am pleased to say that – overall – the results were positive, and show we are heading in the right direction (in most areas).

Key headlines include 79% of staff saying they thought patient care was our top priority (69% in 2016) and a four year high (67%) in the number of staff who would recommend the Trust as a place to work.

There is more work to do as always – but this is a positive step in the right direction. We are doing a lot around staff health and wellbeing at present – and helping our staff through this particularly challenging period is one of our key priorities at present.

Making the lives of our staff easier is important, and I am pleased to say we have secured £200,000 of NHS Charities Together funding, which will be used to create a new shower block and cycle storage facilities at St George's, new outdoor wellbeing/rest areas, new electrical goods and furniture for staff areas, plus free health and wellbeing classes for staff.



Work continues on our culture programme, and having completed the culture discovery phase last year, we are progressing our action plan to strengthen our organisational culture and will bring this to the Trust Board shortly. Many Trusts have already trodden this path, and we are looking at approaches other organisations have taken to inform what we are doing here at St George's.

There is a huge appetite for change here at St George's. Indeed, only last week, I sent a message to all staff to mark International Women's Day, and I've had such a fantastic response from people who are so positive about the organisation, but also keen to make things better. This is just one example, but it illustrates how much potential we have to tap into – and I find this really encouraging.

### **Engaging with our communities**

We continue to engage with local communities, and earlier this month, we held a successful engagement event, run (for the first) virtually via MS Teams. The event was attended by our Governors, and included brief presentations from Dr Richard Jennings, Chief Medical Officer, and Robert Bleasdale, Chief Nursing Officer and Director of Infection Prevention and Control.

Attendees asked a number of questions – many related to the pandemic – and I hope we can run and host more of these meetings going forward. I also shared two written updates last month with our local communities, and Members – and received a number of kind responses in return, all of them supportive of our staff, and the excellent job they are doing.

### **St George's and the wider NHS**

As always, we remain engaged with key discussions and developments at a regional and national level.

Last month, the Government published a white paper that included detailed proposals for NHS and social care reform, with a strong focus on collaboration between the NHS, local government, and delivery partners.

A key measure in the white paper “working together to integrate care” includes proposing to implement NHSE/I's recommendations in the NHS Long Term Plan & Legislating for Integrated Care Systems document, and legislate for every part of England to be covered by an ICS.

The statutory ICS will be comprised of an ICS NHS Body (subsuming CCG functions and several NHSE commissioning functions for specialised commissioning, primary care and other directly commissioned services) and a separate ICS Health and Care Partnership (together referred to as the ICS).

This has implications for the local NHS, but given the way we have worked so collaboratively in recent times, accelerated by the Covid-19 pandemic, I am confident the changes have the potential to benefit patients, staff and the communities we serve.



## Leadership update

Finally, I am delighted to confirm the appointment of Anne Brierley as our Chief Operating Officer on a permanent basis.

Anne took on the role on an interim basis in the autumn, but was appointed to the position on a permanent basis last week, following a formal recruitment process.

Anne is a fantastic addition to the executive team, and played a key role in managing our response to the second Covid-19 wave in December/January, and since then as we really accelerate our elective recovery.



Meeting Title:	Trust Board		
Date:	Thursday, 25 March 2021	Agenda No	2.1
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 December 2020 and January 2021.		
Recommendation:	<b>The Board is asked to:</b> <ul style="list-style-type: none"><li>• <b>Note the updates from the February and March 2021 meetings; and</b></li><li>• <b>Receive and note the Quarter 3 learning from deaths report (2.1.1).</b></li></ul>		
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 18 February and 25 March 2021. The Committee considered and discussed the following matters of business at these meeting:

February 2021	March 2021
<ul style="list-style-type: none"> <li>• Integrated Quality &amp; Performance Report (M10)</li> <li>• Serious Incident Monthly Report</li> <li>• Update on Care Quality Commission Action Plan</li> <li>• Quality Priorities: 2020-21 Review and 2021/20 Proposal</li> <li>• Trust-wide Policies: Patient Care and Research</li> <li>• Quality &amp; Safety Strategy Quarterly Update</li> <li>• Board Assurance Framework Monthly Report</li> <li>• Patient Safety &amp; Quality Group Monthly Report</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated Quality &amp; Performance Report (M11)</li> <li>• Nurse Safe Staffing Report (M09&amp;10)</li> <li>• Infection Prevention &amp; Control Report</li> <li>• Quality Improvement &amp; Transformation Update</li> <li>• Seven Day Services – Compliance and Update</li> <li>• Learning from Deaths (Q3) Report</li> <li>• Research &amp; Development Strategy Quarterly Update</li> <li>• Board Assurance Framework Monthly Report (Q4)</li> <li>• Patient Safety &amp; Quality Group Monthly Report</li> <li>• Committee Annual Effectiveness Review</li> </ul>

The report covers the material matters that the Committee would like to bring to the attention of the Board. Overall the Committee was largely *reasonably assured* that the systems of internal controls are generally adequate and operating effectively in relation to the matters discussed at the meeting. However, some improvements were required to ensure that quality and safety risks are managed well enough to deliver high quality services and care to patients. There were no areas where the Trust had no, or limited assurance.

### 1. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality and safety performance in months 10 and 11 (2020/21). The Committee is aware that the Board would also consider the month 11 report later under agenda item 2.2 and would like to highlight the following:

- In the period, the Trust had seen positive movements in the following areas:
  - *Duty of candour* (96% at month 09) with focus being on achieving 100%;
  - Number of *caesarean sections* (C-sections) (28.5% in month 10) from a high of 30% in month 07;
  - The *Carmen birthing suite* was opened 90% of the time in month 11;
  - *Pressure ulcers* with a category rating of 2 or above had reduced;
  - Contributing factors to the number of *falls* related to patients laying in one position for extended times in the intensive care unit (ICU), especially patients with Covid-19. The Trust had ordered additional '*pressure release mattresses*' to mitigate this risk in the future;
  - Only one moderate fall recorded in month 11 compared to four in month 10. All falls were subject to thorough 'falls risk assessments' and appropriate actions were taken to address any issues and prevent further occurrences;
  - The number of cases with *norovirus* remains low; and
  - With 38 cases of *clostridium difficile* (C. difficile) the Trust remains below the annual threshold of cases (48).
- The following areas remain cause for concern:



- The complications of managing patients with Covid had led to an increase in the number of *intravenous (IV) line infections*. These patients were bed-bound which presented complications with change IV lines.
- Whilst the number of C-sections had reduced there were some challenges in maternity services including the number of *stillbirths (two in month 11)* and whilst there were no direct lapses in care the Trust would conduct full investigations into these cases. The Committee was due to receive a *deep dive report on maternity services* at its March 2021 meeting but it was agreed that this would be deferred until April 2021 to give teams sufficient time to address the key areas of concern and set out the benchmark against similar peer organisations. This report would also be presented to the Trust Board in May 2021.
- As previously reported to the Board, the Trust had not been able to deliver its full suite of *mandatory and statutory (MAST) training* as a result of staff being busy on the frontline or the inability of the Trust to deliver face-to-face training as a result of social distancing measures. The Trust had put in place additional steps such as more resources to deliver training and moving, where possible, to online training. These measures however had not improved the life support training performance. Whilst the Trust had a number of staff trained to provide and can respond effectively to cardiac arrest, more work was required to improve the number of staff completing *basic, intermediate and advanced life support training*. The Patient Safety and Quality Group would consider the measures to improve MAST training especially resuscitation training and the Committee would monitor progress through the reports from the Group each month.

Overall the Committee recognised the challenges facing the organisation and noted it was reasonably assured that the systems of internal controls were generally adequate and operating effectively but recognised that some improvements were required to ensure that quality and safety risks were managed effectively to deliver high quality services and safely care for patients. The Committee was also reassured to learn that the Trust would conduct a learning exercise to explore and codify the learning from managing Covid-19.

## 2. Learning from Deaths Quarterly Report

The Committee also received the quarter three learning from deaths report presented below under agenda item 2.1.1 for the Board's consideration. The Committee also noted that Dr Pui-Ling Li had been appointed as the Non-Executive Director responsible for learning from deaths.

## 3. Update on Care Quality Commission Action Plan

The Committee was reasonably assured by the progress update made on implementing the Care Quality Commissions Action Plan. The Trust had completed 11 actions with robust evidence, 26 have been completed and awaiting endorsement of evidence, one action was on track and 8 have been delayed as result of Covid-19 priorities. The Trust was on track with implementing the actions identified by the CQC in relation to outpatients.

## 4. Quality Priorities: 2020-21 Review and 2021/22 Proposal

The Committee endorsed the decision to roll forward the 2020/21 quality priorities as a result of the significant impact the first and second waves of the Covid-19 pandemic had on progress on completing the actions against each priority. Good progress had been made against the learning from deaths priority, and learning from complaints to improve patient experience other actions. The Committee also requested that the Trust consider, given the significant impact of Covid-19, a 2021/22 priority to reflect some of the challenges faced by the Trust, for example, nosocomial infection and the quality developments.





## 5. Serious Incident Reporting

In February 2021 the Committee considered the serious incident reports from December 2020 and January 2021 and in March 2021 it considered the report from February 2021. During these periods:

- A total of five serious incidents were declared (2 in December 2020, 3 in January 2021 and none in February 2021); and
- Nine serious investigations had been concluded (4 in November 2020, 3 in December 2020 and two in January 2021).
- There were two never events reported, one related to a retained foreign object and the other a wrong site surgery. The Board received full briefings on these incidents in January 2021.

Whilst the Committee welcomed the news that there were no incidents declared in February 2021, but noted that there were a number of incidents which are currently subject to assessment which may be declared as serious incidents.

## 6. Infection Prevention and Control Update

The Committee considered a comprehensive update on infection prevention and control. This included updates on the number of patients with Covid-19 at the point of admission including hospital onset healthcare associated (HOHA) Covid-19 between July 2020-February 2021.

- 180 HOHA and 196 hospital onset probably associated (HOPA) cases were reported, equating to 9.9% of all cases positive in HOHA and 10.8% for HOPA.
- There were 163 hospital of indeterminate association (HOIA) and 1281 community associated (COCA) cases, equating to 8.9% of all cases positive in the HOIA, and 70.4% being definitely COCA, with an overall position of 79.3% indeterminate or confirmed community acquired.

The Trust also had a total of 62 outbreak cases reported between August 2020 and 16 March 2021. Only three outbreak cases involving both staff and patients remained open (until 28 days after the last positive case).

The Trust was conducting a Covid-19 learning initiative with focus on personal protective equipment (PPE) and fit testing, diagnostics, estates provision, outbreak and incident management, data collation and corporate and board assurance processes.

The Committee were also provided with more information on MRSA, MSSA and *C. difficile* infections and these are reported under section one above.

The Trust also had a recent outbreak (three patients) of *Klebsiella carbapenemase*. The Trust had never had an issue with this type of infection and had identified the source patient who had transferred from another hospital trust. The Trust had taken steps to isolate the patients and close the particular ward to prevent future incidents.

Finally the Committee heard about the robust steps taken to protect patients from potential infection from the demolition of the old properties. Measures include weekly testing for biological spores (*aspergillus*).





## 7. Quality Improvement and Transformation Programme

The Committee considered the update on quality improvement and transformation programmes. Much of the quality improvement work had paused as most of the team were supporting the operational focus on managing the waves of Covid-19.

In quarter four, the organisation had begun to refocus on how to use the learning from Covid-19 operation changes to drive quality improvement and transform services. This would inform on how to respond more effectively to future waves of Covid, and improve the effectiveness of the hospitals operations. In February 2021 the Committee requested an update on the Outpatient Transformation work.

## 8. Nurse Staffing Report (Planned vs. Actual)

The Committee considered the nurse safe staffing report for January and February 2021. The overall fill rate was 80.2% and 84% respectively. Due to the COVID-19 surge, registered nurses were deployed from the wards and departments to support the increased critical care beds. Supernumerary staff, such as practice educators, matrons, and clinical nurse specialists, had been working clinically to support the wards during the second wave. There were 64 red flags raised in January 2021 which was a reduction from the 83 reported in December 2020. However in both these months they were all managed effectively and mitigated with no harm to patients. The Committee was substantially assured by the contents of the report.

## 9. Seven Day Services – Compliance Update

The Committee considered the progress the Trust had made in meeting the ten compliance standards to deliver effective seven day services. The Trust had identified short, medium and long-term actions to have effective services and systems in place. These plans included agreeing, in the short-term, a process for managing weekend and out-of-hour urgent MRI requests to optimise the use of MRI capacity. In the medium-term, changing the skill-mix and increasing staffing levels in MRI to increase capacity. Lastly, in the longer term increasing the number of MRI scanners which would be subject to a business case and requests for external funding.

## 10. Trust-wide Policies: Patient Care and Research

The Committee received a report on the trust-wide patient care and research policies. There are currently 141 Trust-wide patient safety policies that fall under the remit of the Committee.

## 11. Quality and Safety and Research & Development Strategies Implementation Plans

The Committee commended the good progress made on implanting the actions from the Quality & Safety and the Research & Development strategies implementation plans. The Committee noted that progress had been impacted by the focus on Covid-19 but work continued with 23 of the 38 actions in the Quality & Safety strategy completed, and the research teams progressing the application to establish a Clinical Research Facility.

## 12. Board Assurance Framework & Corporate Risk Registers

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

- **SR1:** Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality and learning across the organisation.



- **SR2:** We are unable to provide outstanding care as a result of weaknesses in our clinical governance.
- **SR10:** Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.

The Committee endorsed the current risk position for the above strategic risks at quarter four. The Committee noted the challenge of achieving the target risks, given the focus on managing Covid-19 wave two and other operational pressures. The Committee also noted the revised timeframes to close the gaps in assurance.

### **13. Patient Safety & Quality Group (PSQG) Reports**

The Committee received and noted the reports from the January and February 2021 meetings of the Patient Safety and Quality Group. The Committee commended the report which provided insights and assurance in several areas.

### **14. Annual Committee Effectiveness Review**

The Committee also considered the results of its annual review noting that whilst there were areas for improvement, most respondents felt that the Committee was effective. Committee members reflected that social distancing measures in place since March 2020 had impacted on the effectiveness of the Committee. The three non-executive directors who joined the Committee in January 2020 had lacked the opportunity to triangulate discussions at the meetings with intelligence gained from visits to wards, corporate and other clinical areas.

### **Recommendation**

**The Board is asked to:**

- **Note the updates from the February and March 2021 meetings; and**
- **Receive and note the Quarter 3 learning from deaths report (2.1.1).**

**Dame Parveen Kumar  
Committee Chair  
March 2021**



Meeting Title:	Trust Board		
Date:	25 March 2021	Agenda No	2.1.1
Report Title:	Learning from Deaths and Mortality Monitoring Committee (MMC) Report		
Lead Director:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Mr Ashar Wadoodi, Lead for Learning from Deaths Kate Hutt, Head of Mortality Services		
Presented for:	Discussion      Update		
Executive Summary:	<p>The paper provides an overview of the work of the MMC and Learning from Deaths in Q3 2020/21. A brief outline of work in progress to strengthen governance processes is outlined. This includes the completion of the new learning from deaths policy, the recruitment of a band 6 Mortality &amp; Morbidity Team Leader, as well as the planned recruitment of five band 5 Mortality &amp; Morbidity coordinators.</p> <p>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.</p> <p>In order to demonstrate processes in relation to monitoring and investigating mortality outlier alerts, current work related to major trauma, cardiology and neurosurgery are presented.</p> <p>National mortality measures are also reported. Our SHMI and HSMR are lower than expected. The investigations underway to examine mortality at a more granular level are detailed.</p>		
Recommendation:	The Committee is asked to note the report.		
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:	N/A	Date	N/A
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		



## **Learning from Deaths and Mortality Monitoring Committee (MMC) Report**

### **1.0 PURPOSE**

- 1.1 The purpose of this paper is to provide the Quality and Safety Committee 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.

The MMC is currently overseeing investigations involving cardiology, neurosurgery and major trauma. The cardiology work was initiated by the committee in order to better understand outcomes data available to us locally through the Dr Foster Intelligence platform. Neurosurgery has been involved in the investigation of the intracranial injury diagnosis group following notification by the Dr Foster Unit at Imperial College in February 2020 that our mortality was higher than expected. Major trauma is being investigated in response to a mortality outlier alert received from the Trauma Audit & Research Network (TARN) in June 2020.

### **2.0 LEARNING FROM DEATHS**

This quarter the Learning from Deaths policy was revised and in January 2021 was ratified by the Patient Safety and Quality Group. The policy sets out our processes for complying with the National Learning from Deaths Framework (March 2017) and outlines how the Trust responds to and learns from deaths of patients who die under our care. It defines the categories of deaths in scope for case record review, the role of the Mortality Monitoring Committee in conducting and instructing case record review and in identifying and disseminating learning.

The April 2019 Governance review suggested that we make some improvements to the mortality governance structure of the Trust. To support clinical teams the Trust has invested in administrative support for these processes and has agreed to appoint a team of six Mortality & Morbidity (M&M) coordinators. We have recruited the Team Leader who will start in post on 29<sup>th</sup> March 2021. Interviews for the five coordinators will be completed by 6<sup>th</sup> April 2021.

To strengthen governance surrounding morbidity and mortality, we have recruited three surgical groups, vascular surgery, general surgery and orthopaedics. This small group will trial a unified implementation of the surgical colleges recommended M&M format. The goal of this new system will be to make M&M reviews simpler to record into a database. This will allow complication data from across the trust to be accessible centrally and learning to be shared more easily. This process will likely take some time to roll out across the different care groups within the trust but will be aided by the coordinators when they are in post.



## 2.1 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. 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 produces 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 to provide assurance to Patient Safety and Quality Group, Trust Management Group, Quality and Safety Committee and ultimately the Trust Board in March 2021. 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 21/03/2020-20/06/2020 and the actions and learning arising from them. In this quarter there were 20 perinatal deaths. 16 of the babies were born and died at St Georges, four cases were of babies who were born elsewhere and died at St George's.

All St George's cases were graded as having either no issues or issues which would have made no difference to outcome. There was one neonatal case which related to the care given at another maternity unit and feedback has been provided accordingly.

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 <b>compliant</b> with this standard. 100% of reviews for babies who 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	We are <b>compliant</b> with this standard. 100% of babies suitable for a review using the PMRT who were born and died at St George's trust had at least a



CNST Safety Action One: 4 Standards	Compliance
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	draft report within four months of the death of the baby
<b>3.</b> 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 <b>compliant</b> with this standard. 100% of parents of babies suitable for a review using the PMRT who were born and died at St George's trust were contacted informing them of the review taking place

Although no deaths were graded as having issues that would have made a difference to outcome, a number of areas for improvement were identified. The neonatal thermal management pathway has been revised in order to support improved practice and documentation. Additionally, a new placental histology form has been created to enable clinicians to complete the documentation in a more timely manner. This has been shared and is being implemented at several other London Trusts. A full time equivalent Bereavement Midwife has been recruited to support the bereavement pathway and they will be involved in a review of our current processes to ensure compliance with national best practice.

### 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 deaths of patients with confirmed learning disabilities (n=7), severe mental health diagnosis (n=7) and those in which the ME has detected a potential issue with care (n=4).

All deaths that have followed elective admission have been reviewed (9 cases this quarter). In line with the recently revised Learning from Deaths Policy 1 case in a specialty that is subject to enhanced oversight, 1 death as a result of a family concern and 1 death as a result of a query raised by a specialist team were reviewed. The findings from these structured judgement reviews are shown below.

### 3.2 Overview of October to December 2020

Between October and December 2020 there were 418 deaths. Members of the Mortality Review Team (MRT) reviewed 30 deaths, representing 7.2% 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 30 deaths reviewed this quarter problems were identified in relation to 9 (30 %) patients. In total





10 problems were identified, as one patient experienced 2 problems. In one instance it was thought that a problem related to infection control led to harm.

Problem in healthcare	No harm	Possible harm	Harm	TOTAL
Assessment	0	0	0	0
Medication	0	0	0	0
Treatment	1	1	0	2
Infection control	1	1	1	3
Procedure	0	1	0	1
Monitoring	0	1	0	1
Resuscitation	1	0	0	1
Communication	1	0	0	1
Other	0	1	0	1
<b>TOTAL</b>	<b>4</b>	<b>5</b>	<b>1</b>	<b>10</b>

A judgement regarding avoidability of death is made for all reviews. 23 of 30 (76.7%) deaths reviewed were assessed as definitely not avoidable and 1 death (3.3%) was judged to be probably avoidable. No deaths were judged to be definitely avoidable.

The death that was felt to be probably avoidable was also the case in which a problem in healthcare was thought to have caused harm. This was a case of hospital acquired Covid-19 infection at Queen Mary's hospital. The patient had a four-week stay at Queen Mary's in November and was exposed to Covid-19 just prior to discharge following contact with a patient transferred from St George's.

Following the death an outbreak meeting was held with the Infection Prevention and Control Team and new processes introduced whereby Covid-19 testing is carried out on admission, day 1, day 3 and day 7 after arrival. Patients who are to be admitted from another hospital are also required to have a negative test report 48 hours before being transferred.

Avoidability of death judgement	Number	Percentage
Definitely not avoidable	23	76.7
Slight evidence of avoidability	5	16.7
Possibly avoidable but not very likely (less than 50:50)	1	3.3
Probably avoidable (more than 50:50)	1	3.3
Strong evidence of avoidability	0	0
Definitely avoidable	0	0
<b>Total</b>	<b>30</b>	

An assessment of overall care is also provided for each death reviewed. For 24 patients (80%) care was felt to have been good; for the remaining 6 patients (20%) it was felt to be adequate. Poor care was not observed in any of the deaths.



Overall care judgement	Number	Percentage
Excellent care	0	0
Good care	24	80
Adequate care	6	20
Poor care	0	0
Very poor care	0	0
Total	30	

### 3.3 Learning disabilities

All deaths that occur in patients with learning disabilities are 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.

The mortality review team 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 Q3 2020/21. In total there have been 40 deaths, with reviews completed for each.

This quarter there have been 7 LD deaths. In the review of one patient a potential problem in healthcare was identified and consequently it was judged to be slight evidence of avoidability. The Learning from Deaths Lead sought clarification from the clinical team at the time of the review and following discussion at the specialty Mortality & Morbidity meeting it was clarified that the possible aspiration that had been documented during proning was not a definitive diagnosis. Consequently, no potential learning was identified. 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	Q3 20/21
TOTAL DEATHS	1	3	3	2	3	7	4	2	4	4	7
LOCAL REVIEWS COMPLETED	1	3	3	2	3	7	4	2	4	4	7
Definitely not avoidable	1	3	3	2	3	7	4	2	4	4	6
Slight evidence of avoidability	0	0	0	0	0	0	0	0	0	0	1
Poss avoidable, not very likely (< 50:50)	0	0	0	0	0	0	0	0	0	0	0
Probably avoidable (> 50:50)	0	0	0	0	0	0	0	0	0	0	0
Strong evidence of avoidability	0	0	0	0	0	0	0	0	0	0	0
Definitely avoidable	0	0	0	0	0	0	0	0	0	0	0

In November the Clinical Nurse Specialist for Learning Disabilities presented the annual report to the Mortality Monitoring Committee. This report considers the national picture for patients with a learning disability who have died, alongside local performance. The report highlights that St George's has a well-resourced team whose role is to ensure adults with a learning disability have access to supplementary support, if required.





The Learning Disability Nursing Liaison Team (LDNLT) reports all deaths of adult patients with learning disability to the Learning Disability Mortality Review Programme (LeDeR). Feedback from these external reviews has been very positive. Locally, each death is also subject to a structured judgement review and no avoidability has been observed.

The LeDeR annual report was detailed. A difference was observed between the national and local rate of Coroner's referrals, at 32% and 18% respectively. The LDNLT has not identified any patients who should have been referred to the Coroner but were not. All the referrals made were felt to be appropriate. Feedback from LeDeR reviews supports this finding.

## 4.0 LEARNING FROM MORTALITY

The following summaries give an overview of mortality investigations that are currently underway, demonstrating the processes of monitoring, identification and examination. The investigations are ongoing and details are provided below regarding anticipated completion dates.

### 4.1 Trauma Audit & Research Network (TARN)

In June 2020 the Trust was informed by the Trauma Audit & Research Network (TARN) that it appeared to be an outlier for case-mix adjusted mortality outcomes for the period July 2017 to June 2019. A previous alert was received in November 2019, relating to the period July 2016 to June 2018.

The previous Learning from Deaths report explained in detail the nature of the alert, work already undertaken and a plan for comprehensive investigation. An interim update on progress is detailed below. It is anticipated that the investigation will be completed in Q4 and the outcome will be presented to MMC and subsequently reported to Patient Safety and Quality Group and Quality and Safety Committee.

#### 4.1.1 Investigation to date

In line with TARN's outlier policy, TARN requested engagement from the Trust in investigating the alert. The Trust convened a working group to take responsibility for the investigation. This is chaired by the Chief Medical Officer and is formed of senior consultants from all specialties involved in the major trauma pathway, supported by the Learning from Deaths Lead.

The Trust has utilised the expertise and guidance of TARN to inform our methodology. Following recommendation from TARN it was decided that we would first explore data quality issues. It was agreed that the initial focus of the investigation should be the reporting of the CT scan following major trauma. TARN suggested that documenting greater detail in the scan report could 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. The CT scan reports of 200 patients were reviewed by the Radiology team and the data were resubmitted to TARN to allow for



recalculation of our case mix adjusted outcomes. This did not impact on our case-mix adjusted outcomes.

TARN identified several missing fields in our case submissions and suggested that improving the completeness of our data may impact on our reported outcomes. Significant time was invested by the Clinical Lead for Major Trauma to obtain clinical data such as Glasgow Coma Score (GCS) on arrival and comorbidities. These data were resubmitted to TARN and our outcomes reanalysed.

On 14<sup>th</sup> January 2021 TARN informed us that due to the improvements in our data quality we are no longer considered an outlying hospital and that our outcomes are within the normal range. TARN consider the Data Quality review complete. The outcome of the review was reported to MMC in January and whilst this positive position was acknowledged, both the MMC and the working group agreed that the planned investigation should continue. This work began as an investigation into why the service had appeared to be in alert. The emphasis of the investigation has now shifted, by agreement, into an exploration of further quality improvement opportunities.

A key element of this investigation is the clinical review of all mortality in the review period where the injury severity score predicted an 80% chance of survival. Five clinicians with an interest in trauma from general surgery, orthopaedics, neurosurgery and emergency medicine are currently reviewing approximately 100 patients. The Lead for Learning from Deaths will act as a secondary reviewer for any cases where there is significant cause for concern about patient management. A proforma has been developed which focuses on both clinical care and logistics of patient management. It is anticipated that the clinical review will be completed by April and data analysed by May.

TARN has continued to support our investigation by providing additional analysis and this identified a significant number of major trauma patients who did not arrive in the hospital as trauma calls. These cases are being reviewed with a focus on whether this may have caused delays or omissions in elements of their care. To date it appears that a large proportion of the cases were transfers from other hospitals within the network. At the last working group meeting it was agreed that as per Major Trauma Centre protocols all transfers should come via the emergency department to ensure that no injuries are missed and that the patient is treated on the correct pathway. Members of the working group, particularly those from ED, Neurosurgery and Orthopaedics are now working on a pathway to transfer appropriate patients via the emergency department for a primary and secondary survey prior to transfer to the specialty team.

#### 4.1.2 Actions currently underway

In addition to the clinical review of cases and pathway development, work is underway to improve the quality of our data. The Clinical Lead for Major Trauma has engaged the Chief Clinical Information Officer to improve iClip templates for major trauma patients to support complete and accurate data collection. It is essential that we



improve our data prospectively in order that our TARN data accurately reflects our outcomes and can be used as a source of assurance regarding quality of care.

The working group will meet in April to consider the findings of the clinical review and to agree an action plan. The MMC will continue to oversee this investigation and will report progress to this committee in the Q4 Learning from Deaths report.

#### 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 provided assurance that in most cases reviewed there was no avoidability. This review process led to several 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.

At present 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.

##### 4.2.1 Investigation to date

Dr Simon Wilson, Consultant Cardiologist, is leading the investigation and presented an outline of the current status to MMC in January 2021. The investigation has focused on the period January to June 2020, including deaths in the groups AMI, PTCA and contrast radiology. There were a total of 36 deaths: 26 in AMI, 22 in PTCA and 1 in contrast radiology; 13 deaths were common to the PTCA and AMI groupings.

To date the investigation has identified 3 patients who could possibly have been managed differently. Each presented with STEMI and cardiogenic shock. One patient had a severe left main lesion that was not treated at the index procedure with no other apparent culprit. The other two patients both had persisting deep cardiogenic shock post PPCI (primary percutaneous coronary intervention) and may have benefited from early mechanical support.

##### 4.2.2 Actions currently being considered

The investigation to date has revealed several issues that need to be explored further. It appears that we take longer to accept transfer patients than others and it is



important to understand if we have a different process to other centres. It is felt that oversight of the inter-hospital transfer list could be improved, and a Band 8 nurse has recently been recruited specifically to help with this by supporting real-time liaison with other centres and our labs. The reduction in the bed base was noted and it was reported that other interventional units have dedicated beds. The service proposes that having dedicated beds to support a 'treat and discharge' or 'treat and transfer' approach would support efficiency.

Review of the cardiogenic shock pathway is also required, particularly in relation to young patients and consideration for the use of mechanical support. It is suggested that a protocol-defined approach to managing these patients is required and this work will be taken forward as a priority. The investigation process has shown that the cath-lab reporting system does not support the measurement and monitoring of the pathway and associated outcomes. The cardiologists believe that a review of the current software would be beneficial.

It is anticipated that the final investigation report will be completed in April 2021 and will be presented to MMC in quarter 4. This will subsequently be reported to Patient Safety and Quality Group, and Quality and Safety Committee.

#### 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.

##### 4.3.1 Investigation to date

As a result of ongoing monthly alerts related to intracranial injury MMC requested further input from neurosurgery. Ms Sam Hettige, Governance lead for Neurosurgery recruited two further neurosurgical consultants to review the images and referrals for the 79 cases reviewed by the Learning from Deaths Lead in the first alert. This was in an effort to examine concordance in clinical decision making amongst neurosurgeons. They found that in 76% of cases, decisions were unanimous amongst three surgeons. Although it was accepted that there was an inherent bias in the review, as the surgeons were all aware of the outcomes of these patients, this was reassuring. Further discussion was had with the coding department as it was felt that some of these deaths should not have been coded as an intracranial injury.

##### 4.3.2 Actions

Clinical coding will now be reviewed with specialist clinical input to confirm the validity of coding process. The outcome of this stage of the investigation will be presented at



the MMC in April. Depending on the outcome the committee will consider what the next phase of the investigation should be and whether an external review of practice would be helpful.

## 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 October 2019 to September 2020, was published on 11<sup>th</sup> February 2021. The Trust's overall mortality is categorised as 'lower than expected' at 0.86.

During the 12-month period there were 72,230 inpatient spells at the Trust, with 1,675 deaths observed, compared to 1,950 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 was 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	0.83	As expected
Acute myocardial infarction	1.25	As expected
Cancer of bronchus; lung	0.33	Lower than expected
Fluid and electrolyte disorders	0.54	Lower than expected
Fracture of neck of femur (hip)	1.17	As expected
Gastrointestinal haemorrhage	1.07	As expected
Pneumonia (excluding TB/STD)	0.80	Lower than expected
Secondary malignancies	0.77	As expected
Septicaemia (except in labour), shock	1.08	As expected
Urinary tract infections	0.95	As expected

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



<b>HSMR analysis: November 2019 – October 2020</b>	<b>Value</b>	<b>Banding</b>
HSMR (all admission methods)	92.1	Lower than expected
HSMR: Weekday emergency admissions	88.3	Lower than expected
HSMR: Weekend emergency admissions	105.5	As expected

In addition to considering the high-level data above, which is 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. As detailed in section 4, cardiology signals are currently being investigated. A response to a new signal reflecting three deaths in the 'Transplantation of kidney' is currently being prepared.

<b>Diagnosis/Procedure Group</b>	<b>Current status of investigation</b>
Burns	This signal was first observed in November 2020 and relates to 2 cases from November 2019.
Intracranial injury	Investigation underway as detailed in 4.3
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 each of these quarterly reports.
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. 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 fewer episodes and lower 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.
Short gestation, low birth weight, fetal growth retardation	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.

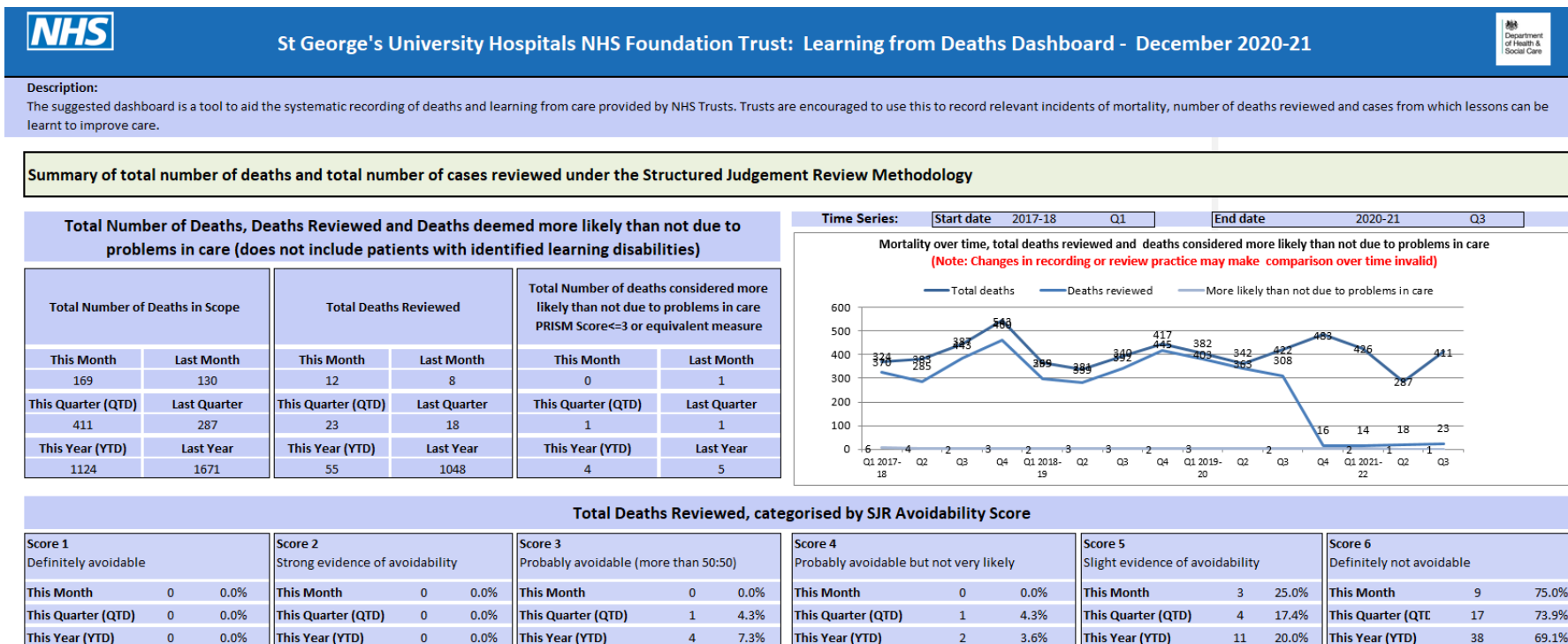




Diagnosis/Procedure Group	Current status of investigation
	Increased understanding of outcomes and assurance is provided by the quarterly PMRT report which is summarised in each of these reports.
Coronary angioplasty (PTCA)	This signal was investigated and reported to MMC in March 2020 and has been presented to PSQG and QSC in the 2019/20 Q4 reports. This grouping is included in the current Cardiology mortality review.
Craniotomy for tumours	This signal was first observed in December 2020 and relates to 5 deaths against 1.5 expected.
Rest of respiratory (diagnostic/minor)	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 continues to be monitored but is not felt to be a priority for more detailed investigation at this time.
Rest of upper GI	This signal was first observed in November 2020. The Clinical Coding team investigated and reported to MMC in December 2020. This reflects a change in coding practice nationally, which took effect from April 2020. Now coders are required to assign a code every time an NG tube is inserted. No further investigation was required.
Transplantation of kidney	This was a new signal observed in February 2021 and includes 3 deaths over the last 12 months. Each of these deaths has been subject to comprehensive scrutiny at the time of the event. The Clinical Lead for Transplantation is preparing a response to the signal which will be presented to MMC in March 2021.
Liveborn	This signal was first observed in December 2020 and relates to 1 death. This death is subject to usual governance processes through completion of Perinatal Mortality Review Tool (PMRT).
Viral infection	This signal was first identified in September 2020 and the data were immediately reviewed. This was 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. Deaths are observed once again in the most recent data and we expect to see an increase, reflecting the second Covid-19 surge.
Contrast radiology or catheterisation of heart	This procedure grouping is included in the current Cardiology mortality review.



## Appendix 1: National Quality Board Dashboard – data to 31<sup>st</sup> December 2020







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



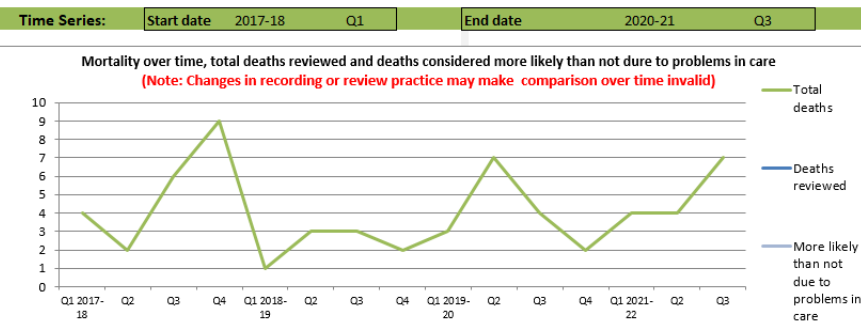
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping 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
6	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	4	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
15	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
6	0	6	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	4	7	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
15	16	15	16	0	0





<b>Meeting Title:</b>	<b>Trust Board</b>		
<b>Date:</b>	25 March 2021	<b>Agenda No</b>	2.2
<b>Report Title:</b>	Integrated Quality & Performance Report		
<b>Lead Director/ Manager:</b>	James Friend, Chief Transformation Officer		
<b>Report Author:</b>	Kaye Glover, Emma Hedges, Mable Wu		
<b>Presented for:</b>	Assurance		
<b>Executive Summary:</b>	<p>This report consolidates the latest management information and improvement actions across our productivity, quality, patient access and performance for the month of February 2021.</p> <p><b>Our Finance &amp; Productivity</b></p> <p>Outpatient activity including adjustment for catch-up is anticipated to be 10% above previous year's activity; excluding COVID-19 activity, the activity was 93% of the previous year. The outpatient DNA rate continues to show improvement with 6.3% of patients not attending their appointment which is significantly lower than any previous month.</p> <p>The Daycase and Elective activity was 53% of previous year's activity with the expectation that this will rise to 58% once coding is complete. A minimal theatre schedule continued throughout February. The highest priority patients (Priority 1 and 2 &amp; cancer work) continue to be reviewed weekly to determine demand allowing the Trust to continue to treat our most unwell patients.</p> <p>Length of Stay for non-elective admissions continues above the upper control limit due to the high proportion of COVID inpatients, however compared to January there has been an overall decrease of one day. The decrease in length of stay this month is also reflected in the reduction of patients we have in our wards with a length of stay greater than 7, 14 and 21 days.</p> <p><b>Our Patient Perspective</b></p> <p>The number of 2222 calls increased by 20% (10 patients) compared to January reflecting the acuity of patients, however the rate of cardiac arrests per 1,000 patients remains within the upper and lower control limits. The completion of Treatment Escalation Plans (TEP) has remained higher than the mean at 39.5%.</p> <p>In February there were no Never Events and no Serious Incidents reported.</p> <p>Both Category 2 and 3 pressure ulcers reduced in February with both showing common cause variation. In month, there were 24 Hospital Onset, Healthcare Acquired COVID-19 nosocomial infections and 35 Hospital Onset, Probable Healthcare Acquired infections, reducing significantly compared to January. Mask wearing has been introduced for inpatients and patient testing frequency has increased to mitigate cross infection risk and to promote earlier asymptomatic detection.</p> <p>All services achieved their targets of having "Good" or "Very Good" overall ratings as measured by the Friends and Family Test (FFT). ED's score has increased from 88.8% in January to 90.8% in February meeting the target of</p>		

90% for the first time since August 2020.

The total number of women giving birth remains below the mean and 12% lower than the same month last year. The caesarean section rate remained at 28%, with the emergency rate just over 13% which is within the normal range. There were two stillbirths in the month and one feticide for foetal abnormalities. There was one neonatal death in the month.

### **Our Process Perspective**

The Trust's Four Hour Operating Standard performance was 92.1% increasing from 81.7% reported in January. Performance continues to exceed the London average. Both the admitted and non-admitted pathway performance increased and are back within the upper and lower control limits. Improvement in the number of patient discharges per and a decrease in AMU midday occupancy has helped support patient flow throughout the hospital.

In January, the Trust was below target for six of the seven cancer standards.

14 day standard performance fell to 91%. It is expected that the Trust will return to compliance in Quarter 1.

31 day treatment standard performance was 88.7%. It is anticipated that the Trust will return to compliance in Quarter 2 once the priority 3 patients have been treated

62 Day Referral to Treatment Standard performance was 68.1%. The number of treatments increased compared to December. Patients continue to be prioritised as per NHSE guidance and currently all Cancer priority 2 patients have been treated within 28 days. Specialities have agreed a trajectory to have treated all the priority 3 patients in the backlog by the end of April and a return to 62 day compliance in Quarter 2

The six-week diagnostic standard was 14.8% in February compared 18.1% in January with a further decrease in the number of patients waiting for more than six weeks. The total waiting list size is now within the upper and lower control limits and compared to the same period last year is 21% lower.

January's 2020's RTT performance was 69.1% against a National target of 92% with 2,108 patients waiting longer than 52 weeks. Through the month of January the number of patients on the admitted patient tracking list has increased with 461 more patients waiting more than 18 weeks. Focus remains on ensuring that the quality of our data is accurate and that we understand the clinical priorities, seeing and treating the most urgent of our patients.

### **Our Workforce Perspective**

Trust level sickness absence rate decreased to 3.6% in February compared to 4.2% in the previous month and although above target has moved within expected range. The Trust vacancy rate has increased by 0.8% however remains below the target of 10% at 8.6%.

COVID-19 Risk Assessment form completion rate was 83.8%. Medical and Dental Staff having the lowest completion rate of 64%, this cohort of staff is the third highest proportion group of total staff.

The Trust's total pay for February was £51.27m. This is 2.39m adverse to a plan of £48.88m. Agency cost was £1.36m, which is a £0.11m adverse position



	to target. The biggest areas of overspend were Interims (£0.26m), Non Clinical Support (£0.08m). The largest area of underspend was Nursing (£0.22m)		
<b>Recommendation:</b>	The Board is asked to note the report.		
<b>Supports</b>			
<b>Trust Strategic Objective:</b>	Treat the Patient Treat the Person Right Care Right Place Right Time		
<b>CQC Theme:</b>	Safe, Caring, Responsive, Effective, Well Led		
<b>Single Oversight Framework Theme:</b>			
<b>Implications</b>			
<b>Risk:</b>	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
<b>Legal/Regulatory:</b>			
<b>Resources:</b>	Clinical and operational resources are actively prioritised to maximise quality and performance		
<b>Equality and Diversity:</b>			
<b>Previously Considered by:</b>	Trust Executive Committee Finance & Investment Committee Quality & Safety Committee	<b>Date</b>	15 Mar 21 18 Mar 21 18 Mar 21
<b>Appendices:</b>			



## Integrated Quality and Performance Report

For Trust Board  
Meeting Date – 25 March 2021



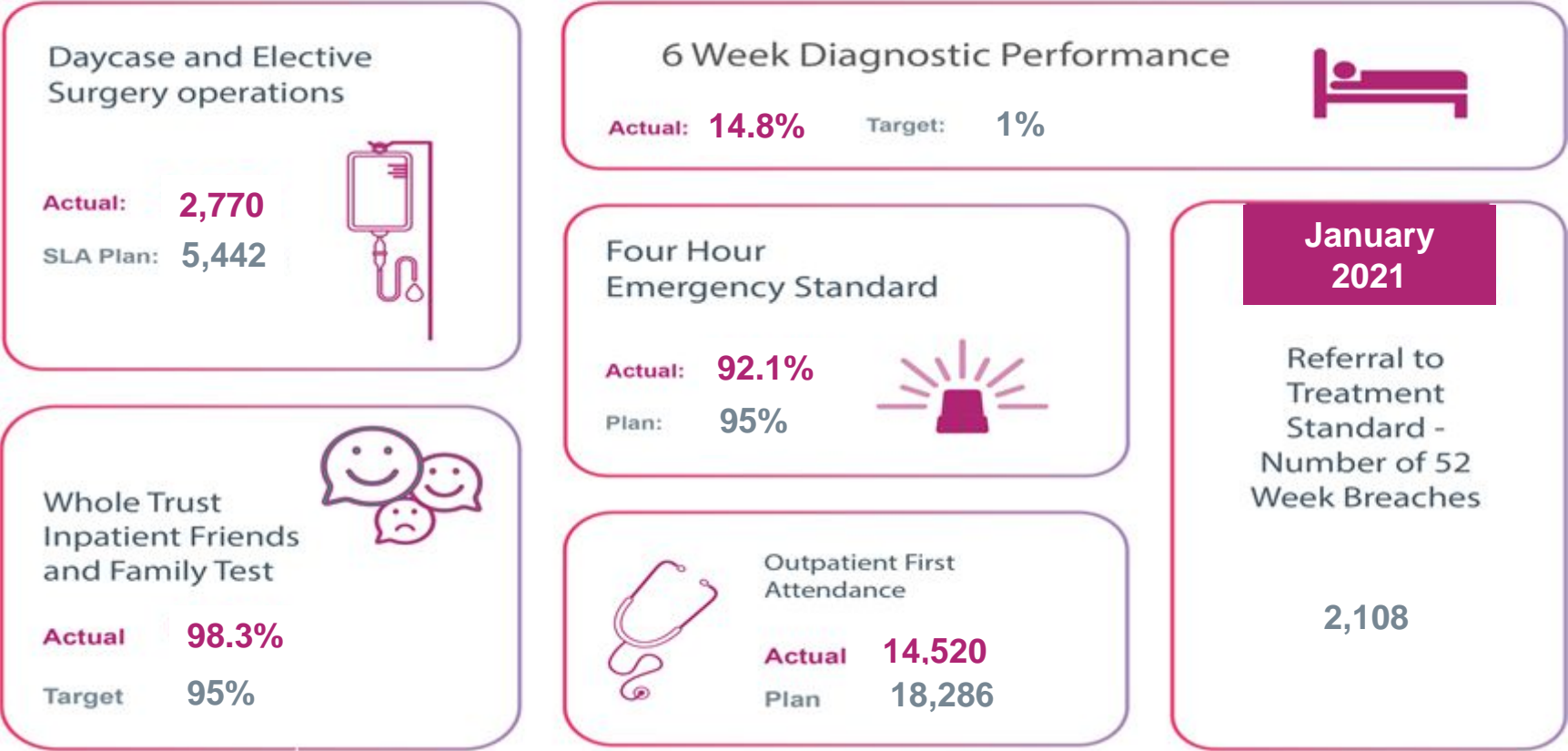
**James Friend**, Chief Transformation Officer

12 March 2021

Our Outcomes

How Are We Doing?

February 2021



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

# Balanced Scorecard Approach



Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan



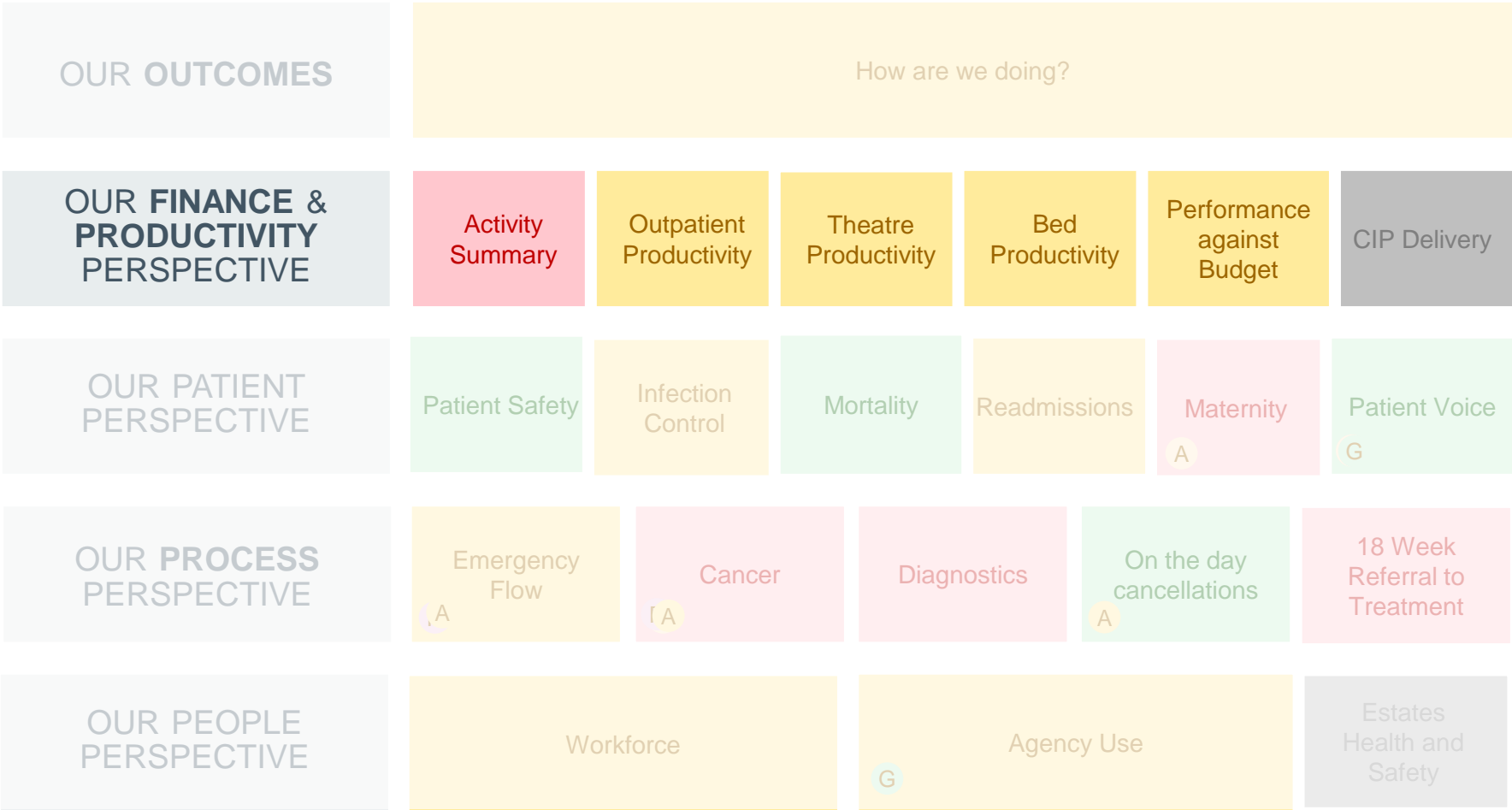
## Executive Summary – February 2021 (1 of 2)

	What the Information tells us	Actions and Quality Improvement Projects
Finance & Productivity Perspective	<ul style="list-style-type: none"> <li>Outpatient activity, excluding COVID-19 activity, was 92.7% of 19/20 activity; a significant rise from the previous month's 76%</li> <li>Outpatient DNA rates remain low with 6.3% of patients not attending their appointments</li> <li>Daycase &amp; Elective activity was 47% of 19/20 activity with 15 of 29 operating theatres open</li> <li>Non-Elective Length of Stay fell from 7.0 days to 5.9 days; Impacted by the higher proportion of daycases performed, Elective Length of Stay decreased to 1.9 days showing special cause variation</li> </ul>	<ul style="list-style-type: none"> <li>Space remains a challenge with Outpatient clinics however this is being mitigated with the arrival of additional technology to increase virtual activity and investigating using offsite community space</li> <li>Patients' letter and text communication processes are being reviewed and improved to ensure correct information is being sent</li> <li>Theatre capacity will be increasing in March with the return of staff from ITU work; a phased approach is being taken to ensure staff recover from Wave 2</li> <li>Strong system working continues to ensure timely discharge with               <ul style="list-style-type: none"> <li>Repatriation issues identified early and escalated via COOs to maintain surge capacity</li> <li>Full electronic integration of COVID-19 discharge process (Discharge to Assess) completed</li> <li>Continued 7 day discharge services working with partners</li> </ul> </li> </ul>
Patient Perspective	<ul style="list-style-type: none"> <li>Basic Life Support Training fell for the second consecutive month and is now at 71%</li> <li>Category 3 Pressure ulcers occurrences rates on inpatient wards have fallen back showing common cause variation</li> <li>There were 24 Hospital Onset, Healthcare Acquired (HOHA) COVID-19 infections and 35 Hospital Onset, Probable Healthcare Acquired (HOPA)</li> <li>Maternity – There were two stillbirths and one feticide for foetal abnormalities</li> <li>Patients continue to rate our services as "Good" or "Very Good" as per our Friends &amp; Family Test (FFT) performance with all services meeting their targets</li> </ul>	<ul style="list-style-type: none"> <li>Basic Life Support Training self assessment pod is under development</li> <li>Concurrent learning exercises are taking place across the Trust to collate and reflect on lessons learnt during COVID-19 second wave</li> <li>National COVID-19 HOHA and HOPA submissions are validated daily and signed off by the Director of Infection Prevention &amp; Control</li> <li>Maternity – Stillbirth reviews are being conducted and are being reviewed at the Serious Incident Declaration Meeting where appropriate</li> <li>Midwifery services are sending text message surveys to women from previous months to gain quantitative and qualitative feedback to support service improvement and FFT response rates.</li> </ul>

## Executive Summary – February 2021 (2 of 2)

	What the Information tells us	Actions and Quality Improvement Projects
Process Perspective	<ul style="list-style-type: none"> <li>The Four Hour Operating standard improved to 92.1% from 81.7% with only four days in February below the 95% target.</li> <li>For January, the Trust met the standard for Cancer 31 Day Second or subsequent Treatment (Drug) but was not able to achieve national targets for the other standards</li> <li>Six week diagnostic standard improved to 14.8% from 18.1% with the number of patients on the waiting list staying at pre-COVID levels</li> <li>Referral to Treatment for January:               <ul style="list-style-type: none"> <li>69.1% of patients were treated within 18 weeks of referral</li> <li>2,108 patients were waiting over 52 weeks</li> <li>44,291 patients on the waiting list which is a 4% reduction from December 2020</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Focus on ensuring flow across the Trust remains a priority with 7 day discharges and early identification of repatriation issues</li> <li>Cancer               <ul style="list-style-type: none"> <li>All services have reviewed capacity to expect to return to compliance for the 14 day standard</li> <li>Priority 1 and Priority 2 patients remain prioritised with agreement that all Priority 3 patient will be offered a date or treated by the end of April contingent upon sufficient theatre capacity</li> <li>Head &amp; Neck diagnostic pathway will be redesigned across the sector with summit to be held in March</li> </ul> </li> <li>Diagnostics               <ul style="list-style-type: none"> <li>Close collaboration between senior clinicians, management and the executive continues in order to mitigate the risk of long patient waits for diagnostics.</li> <li>The Cardiology diagnostic service will be working with NHS England and NHS Improvement on the Echo Recovery Project for South West London exploring the use of a demand and capacity tool.</li> </ul> </li> <li>Referral to Treatment actions are focussed on three key areas:               <ul style="list-style-type: none"> <li>Effectively managing the triage process</li> <li>Removing any historical data ensuring accuracy of the position</li> <li>Assigning COVID priority status to all patients</li> </ul> </li> </ul>
People Perspective	<ul style="list-style-type: none"> <li>Trust sickness absence rate was 3.6% compared to 4.2% from the previous month</li> <li>Appraisal rates for non-medical staff continues to decline for the sixth consecutive month and is now at 65.6%</li> <li>Appraisal rates for medical staff is not available as they have been paused</li> <li>Formal Employee Relation cases have fallen from 44 cases to 26 cases</li> <li>In month agency spend was £1.36m which is above the threshold of £1.25m with Nursing being the largest area of underspend (£0.22m) and Interims being the largest area of overspend (£0.26m)</li> </ul>	<ul style="list-style-type: none"> <li>The Employee Relations team is working closely with managers to ensure timely referral to Occupational Health and to commence sickness absence meetings.</li> <li>HR partners are meeting with managers to encourage completion of appraisals for non-medical staff</li> <li>The Deputy Chief Medical Officer is making arrangements to recommence appraisals for medical staff</li> <li>Employee Relations surgeries are being run on a monthly basis to train managers with the knowledge and skills on how to resolve cases informally</li> </ul>

# Balanced Scorecard Approach



Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

## Activity against our Plan

2.2

Our Finance &amp; Productivity Perspective

		Activity compared to previous year			Activity against SLA plan for month		Activity compared to previous year			Activity against plan YTD	
		Feb-20	Feb-21	Variance	SLA Plan Feb-21	Variance	YTD 19/20	YTD 20/21	Variance	Plan YTD	Variance
ED	ED Attendances	13,171	7,900	-40.02%	13,344	-40.80%	154,851	97,712	-36.90%	159,188	-38.62%
Inpatient	Non Elective	4,127	2,975	-27.91%	4,731	-37.12%	51,450	37,327	-27.45%	54,094	-31.00%
	Elective & Daycase	5,225	2,770	-46.99%	5,442	-49.10%	58,871	36,255	-38.42%	61,263	-40.82%
Outpatient	OP Attendances	45,596	42,243	-7.35%	50,207	-15.86%	546,421	444,760	-18.60%	561,672	-20.81%

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

Note: Figures quoted are as at 08/03/2021 and do not include an estimate for activity not yet recorded e.g. un-cashed clinics, To Come In's (TCI's). Plan for 2020/21 is based on pre COVID-19 SLA plan. Outpatient data above **excludes COVID-19 activity**. Activity data presented above is now based on POD1

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

## Phase 3 Implementation- Elective Incentive Scheme

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

- The letter 'Third Phase of NHS Response to COVID-19' dated 31 July 2020 from NHSE/I sets out expectations for activity performance for Trusts in the latter part of the financial year 2020/21. From September 2020 onwards, systems are expected to deliver at least 80% of last year's activity for both overnight electives and for day case procedures, rising to 90% from October through the balance of the year and 100% of last year's activity for outpatient attendances from September through the balance of the year.
- February's expected performance is adjusted for catch-up based on M6-10 catch up levels for each specialty. **58% for Elective and Daycase is under target by 32% and 110% for Outpatients is over target by 10%.** The Trust has been advised on a financial penalty for adverse performance in earlier months, which is being clarified centrally. For information, Non Elective performance is 69% compared to last year. Endoscopy performance in 20-21 is skewed by the suspension of Bowel Scope Screening, which was 379 in February 2020.
- The Trust is not expecting a financial penalty for EIS in M11 owing to the COVID surge.

DAYCASE & ELECTIVES					
Specialty	Last Year February	This Year February	% of Previous Year Activity	This Year February updated for catch-up based on Jan/Dec/Nov /Oct/Sept	% of Previous Year Activity Updated
Endoscopy	1,422	435	31%	484	34%
Neurology	734	548	75%	577	79%
Plastic Surgery	401	235	59%	272	68%
Cardiology	282	147	52%	150	53%
Urology	282	170	60%	189	67%
Paediatric Medicine	278	190	68%	201	72%
Gynaecology	246	88	36%	96	39%
Paediatric Surgery	190	139	73%	144	76%
ENT	169	65	38%	71	42%
Trauma & Orthopaedics	167	42	25%	46	28%
Other	1,393	842	60%	1,010	72%
<b>TOTAL</b>	<b>5,564</b>	<b>2,901</b>	<b>52%</b>	<b>3,240</b>	<b>58%</b>

<b>TARGET FEBRUARY</b>
<b>VARIANCE</b>

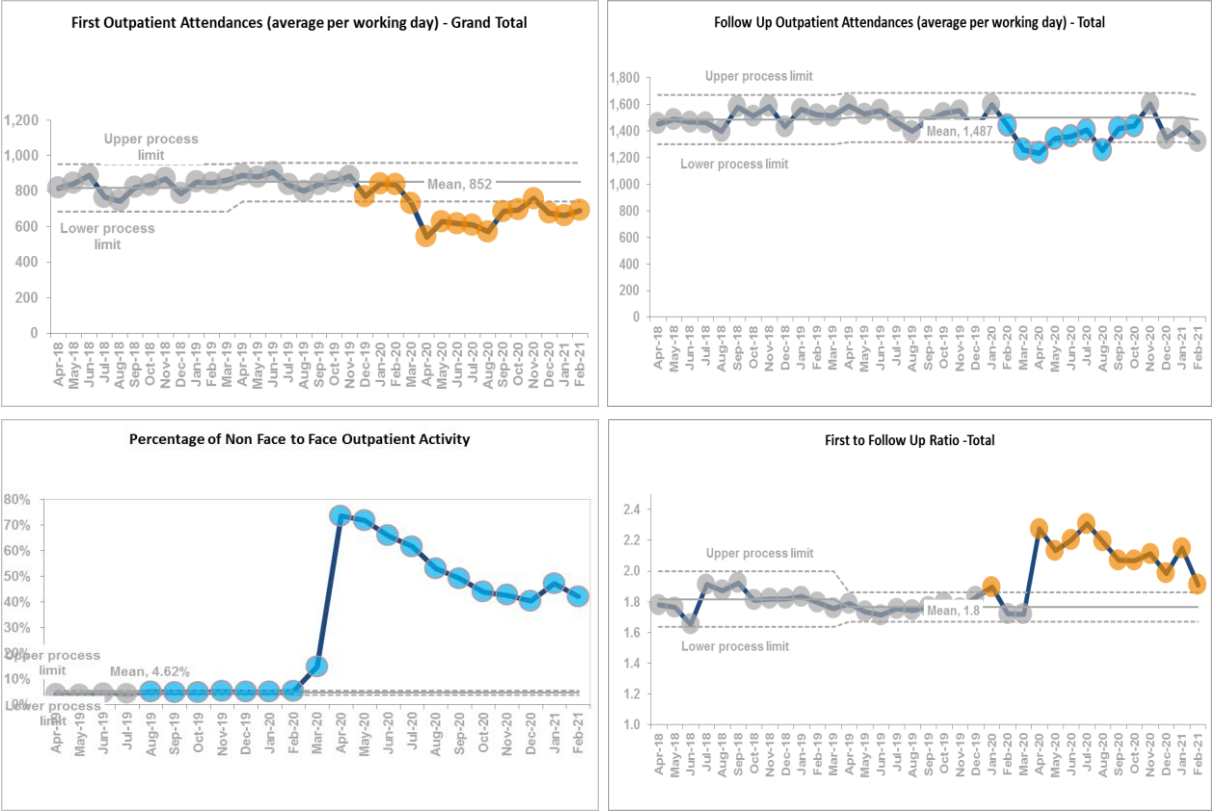
<b>90%</b>
<b>-32%</b>

OUTPATIENTS					
Specialty	Last Year February	This Year February	% of Previous Year Activity	This Year February updated for catch-up based on Jan/Dec/Nov /Oct/Sept	% of Previous Year Activity Updated
Dermatology	3,137	2,809	90%	2,842	91%
Gynaecology	3,069	1,890	62%	2,390	78%
Neurology	2,846	2,387	84%	2,565	90%
Chest Medicine	2,846	1,965	69%	2,161	76%
Diabetes/Endocrinology	2,791	2,086	75%	2,135	76%
Cardiology	2,736	2,284	83%	2,479	91%
Trauma & Orthopaedics	2,461	1,992	81%	2,203	90%
Gastroenterology	2,133	1,677	79%	2,024	95%
Rheumatology	2,112	1,795	85%	1,861	88%
Paediatric Medicine	2,085	1,825	88%	2,234	107%
Other	26,835	33,683	126%	35,379	132%
<b>TOTAL</b>	<b>53,051</b>	<b>54,393</b>	<b>103%</b>	<b>58,273</b>	<b>110%</b>

<b>TARGET FEBRUARY</b>
<b>VARIANCE</b>

<b>100%</b>
<b>10%</b>

# Outpatient Productivity



## Actions and Quality Improvement Projects

Going forward the Trust will look to align best practice reporting with South West London outpatient reporting.

Project under way working with the services to “restart” outpatient activity; the recent arrival of additional technology will support an increase in virtual activity as space remains a challenge. There is also an intention to look again at offsite community space to support restarts.

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

## What the information tells us

Outpatient (OP) first attendances per working day increased throughout February with 691 attendances compared to 664 in January. Activity remains below the lower control limit and was 13.4% lower than the same period last year.

The Women’s directorate had an increase of 11 patients per day with activity levels returning to within the upper and lower control limits within the month. Cardiology, Oncology and Surgery Directorates had activity levels below the lower control.

At Trust level, follow-up activity decreased with on average 1,320 attendances per day compared to 1,426 in January although this is expected to increase with data catch up.

Although most specialities continue to have activity levels below the lower control limits Specialty Medicine continues to have activity levels above the mean and, compared to the same period last year, 37 more follow-up attendances per day. Surgery and Women’s services’ activities remain show common cause variation.

In total, all outpatient activity in February was 93% of the activity reported in the same month last year.

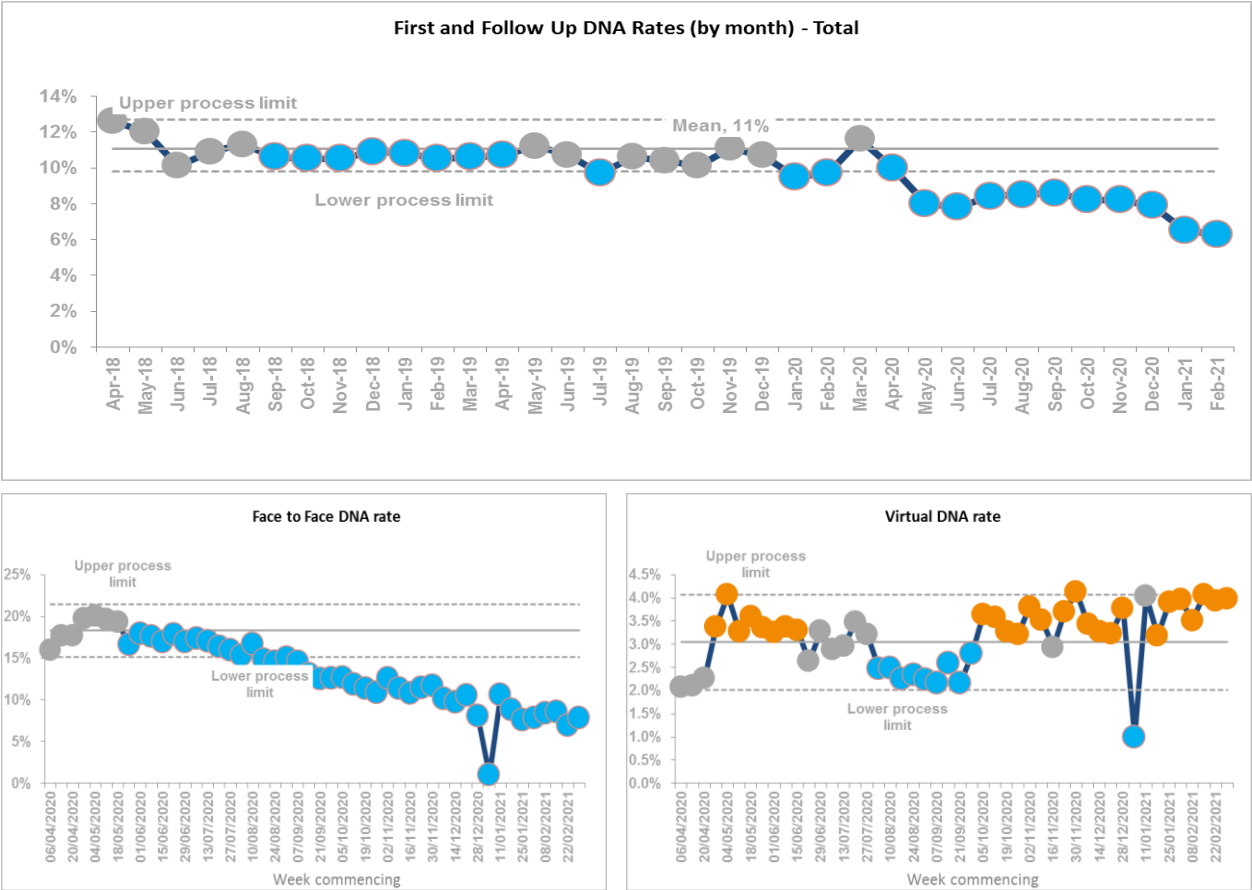
In February, 42% of our outpatient appointments were undertaken in a virtual setting, seeing a decrease of 5% compared to the previous month.

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





# 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 slightly lower than normal, the DNA rate in February remains below the lower control limit showing a further decrease with 6.3% of patients not attending their scheduled appointment. This is compared to 6.5% in January and 9.7% in February 2020.

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.

Our Finance & Productivity Perspective

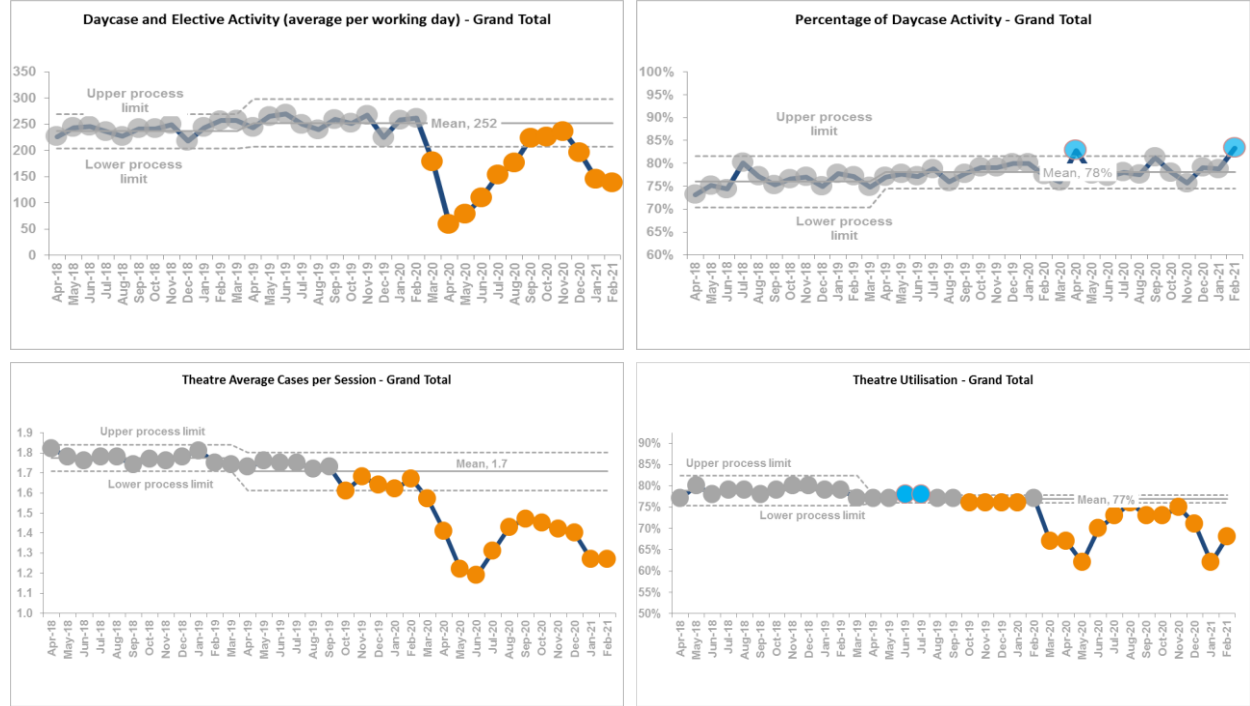
## Actions and Quality Improvement Projects

A disconnect between the information received by patients and the actual appointment type has not yet been resolved as the remaining template changes were put on hold due to the second surge; as part of the restart process, template changes will need to be reviewed again to take into account the increased space challenges, and will then submitted to our Information Technology department for build within iClip. Once this project is complete, patients will receive the correct information in letters and text messages that will then prevent confusion and reduce the number of F2F DNAs.





# Elective Activity & Theatre Productivity



## Actions and Quality Improvement Projects

A minimal theatre schedule continued throughout February, with no increase in capacity compared to January due to availability of staff (both nursing and anaesthetists) who have been redeployed to support the wards and ITU. The highest priority patients (Priority 1 and 2 & cancer work) are reviewed weekly to determine demand and the schedules are amended as the demands have changed. This has allowed us to continue to treat our most unwell patients, though having a significant reduction in activity.

During February, we had 15 of 29 operating theatres open, of which 7 were for elective surgery. From 8 March, nursing staff were released from ITU back to theatres and as a result, we have been able to increase the template to 20 operating theatres and should see an increase in activity in March.

The current capacity gap is also being supported through the use of the Independent Sector, though this is currently forecasted to end on 26 March.

Bowel Scope Screening endoscopy activity, which were on average 400 procedures per month, has been discontinued since March 2020, with official notice from NHS England received to decommission this service. In addition to this, the endoscopy service operated at 49% reduced capacity for the period 29 Dec 2020 to 26 Feb 2021 as a result of the ITU surge onto the Endoscopy Unit at SGH. Both events has therefore had an impact on the service's ability to meet similar activity levels reported last year up to March 2020. The recovery programme aims to open 10 rooms by the first week in April, however, this is contingent on ICU staffing returns and bank/ agency staffing configurations.

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

## What the information tells us

Elective activity in February fell further below the lower control limit with routine elective work paused throughout the month.

On average, 139 patients were treated per day compared to 145 in January and 261 per day in the same month last year (not all this activity is theatre based). Overall elective activity was 53% of February 2020's activity.

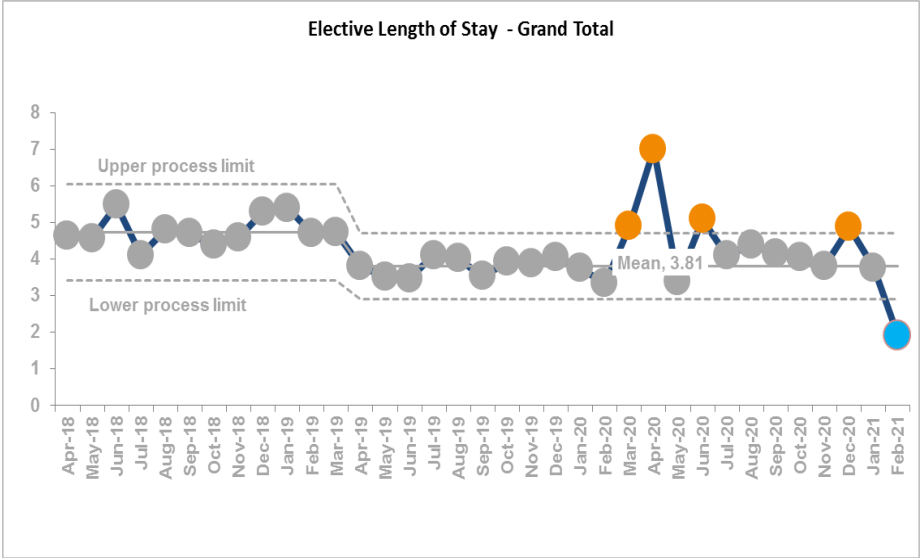
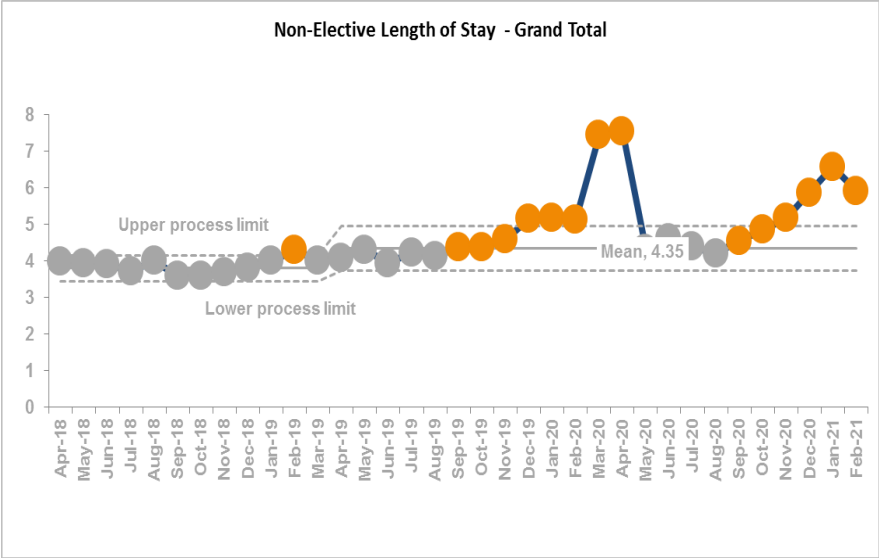
Although below the mean activity levels, within Cardiology, Cardiac Surgery, Max Fax, Neurosurgery and Trauma & Orthopaedics had an increase compared to the previous month. Endoscopy activity remains significantly below the mean with activity 61% lower than the same month last year.

In February, Theatres ran 489 theatre sessions, 51% of the number of sessions in the same month last year.

Trust level theatre cases per session remained in line with previous month however utilisation increased; both metrics remain below the lower control limits. Theatres continue to adhere to process changes implemented as a result of COVID-19.

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

Length of Stay



What the information tells us

Non-elective length of stay although remaining above the upper control limit has seen a reduction in February, this is also reflected in the number of patients with a length of stay in all 7-, 14- and 21-day cohorts. On average, patients admitted to a hospital bed stayed for 6 days compared to 7 days in January. The specialties where length of stay is higher within the month are Intensive Care and Clinical Infection Unit as expected with a high proportion of COVID inpatients. The number of non-elective admissions per day reduced slightly compared to January and is 28% lower compared to the same month last year.

Elective length of stay has seen a significant decrease in February in parallel with reduced activity.

Actions and Quality Improvement Projects

7 day discharge services maintained via the Discharge Hub with increased weekend discharge profile and planning within the Trust planning and with SWL Partners.

Discharge 2 Assess – D2A has now transitioned from paper referrals to electronic iClip referrals.

Repatriation: Pan London expectations from COVID-19 are to provide repatriation response times within 48 hours. Issues are highlighted early and escalation calls via COOs to maintain adequate surge/speciality capacity.

Long length of stay coding analysis - improved data collection and dissemination of internal/external actions for inpatients to maintain predicted Estimated discharge dates (EDDs), check and challenge on criteria to reside and reduce any delays in discharges.

# Balanced Scorecard Approach



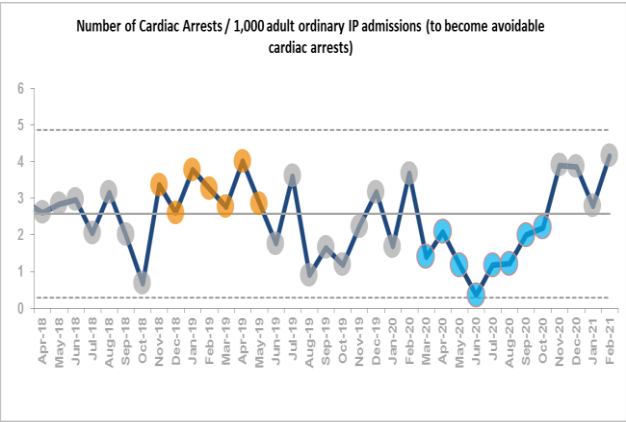
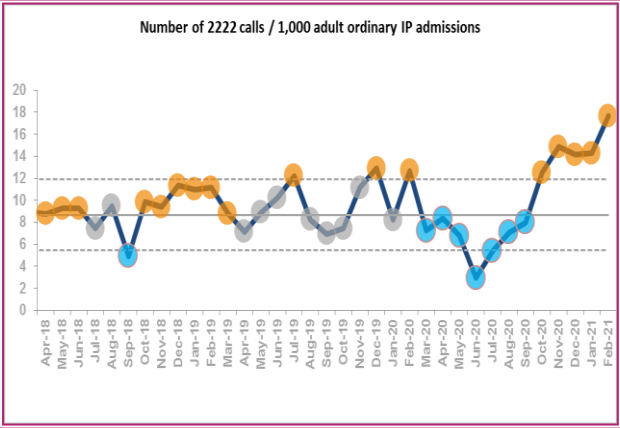
Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

# Quality Priorities – Treatment Escalation Plan

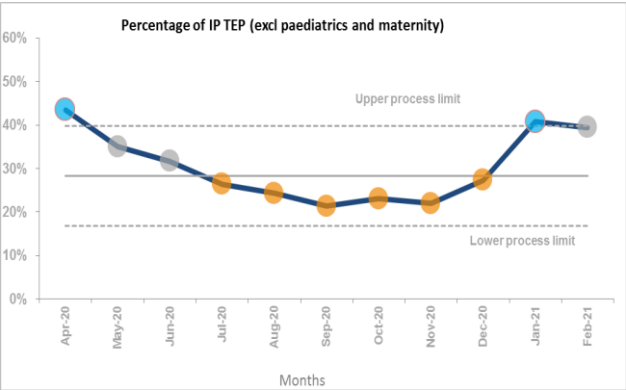
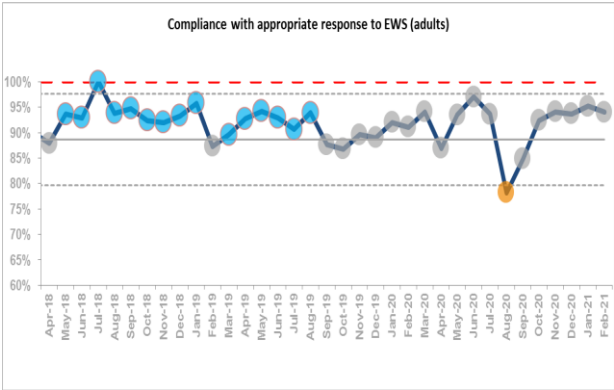


- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

## What the information tells us

- The rate of 2222 calls per 1,000 Inpatient (IP) admissions shows special cause variation however the rate of cardiac arrests per 1,000 inpatients shows common cause variation.
- Compliance with appropriate response to Early Warning Score (EWS) remained at 94% this month and continues to show common cause variation.
- TEP completion rates fell slightly with completion rates at 39.5% showing common cause variation.

Our Patient Perspective

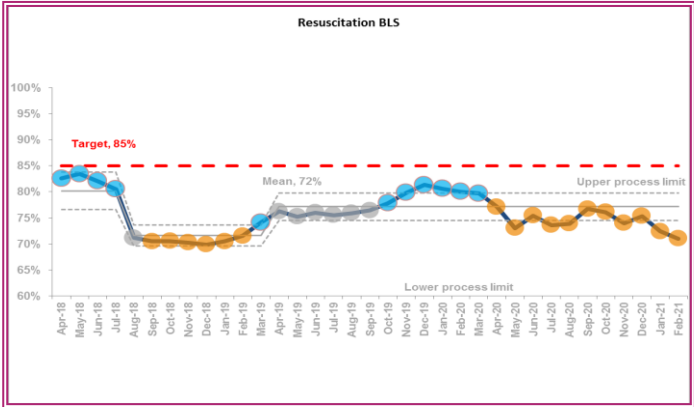


## Actions and Quality Improvement Projects

Verbal update to be given



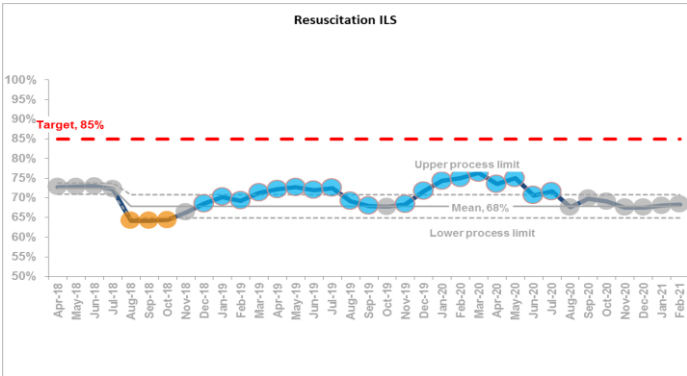
# Quality Priorities – Deteriorating Patients



## What the information tells us

- BLS (Basic Life Support) training performance shows special cause variation with performance falling to 71% compared to 72% last month,
- ILS (Intermediate Life Support) continues to show common cause variation.
- ALS (Advanced Life Support) training performance shows special cause variation with further decrease in performance.
- All training life support training modules have not reached their targets.

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

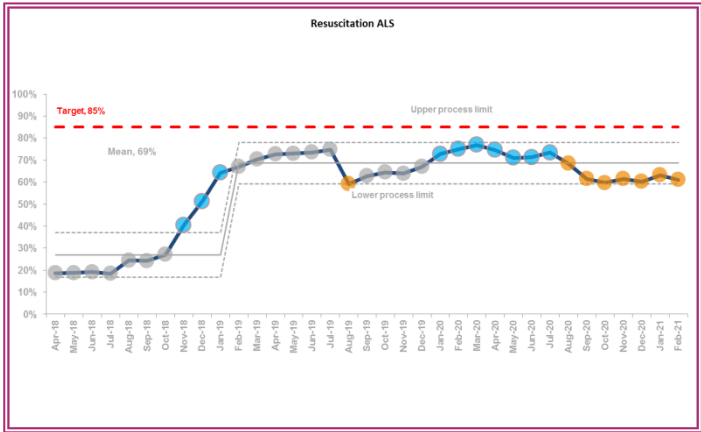


## Actions and Quality Improvement Projects

BLS - self-assessment pod in development

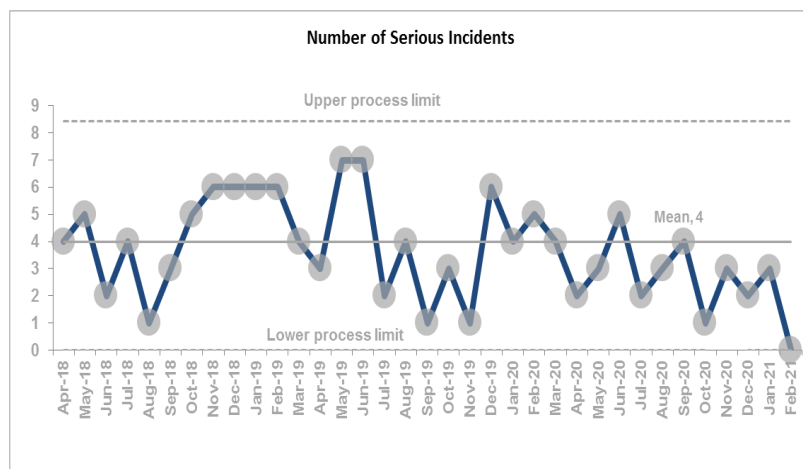
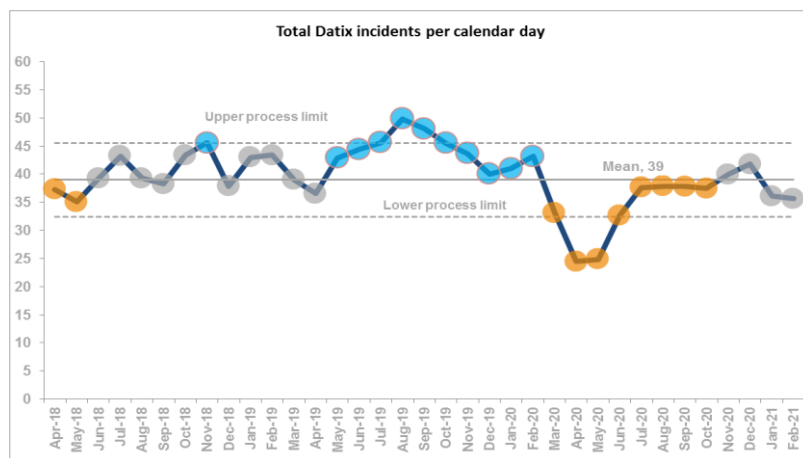
ILS – reduced candidate numbers due to social distancing and relocation of the service during building works. From August 2021, the plan for set days for provision of ILS training will be implemented to fill the capacity gap for 2021/22

ALS – reduced candidates as above. The number of ALS has been increased with 75% of available places allocated to St. George's staff



## Quality Priorities – Learning from Incidents

Indicator Description	Threshold / Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Monthly percentage of Incidents of Low and No Harm		96.0%	93.0%	93.0%	94.0%	95.0%	97.0%	97.0%	95.0%	97.0%	95.0%	96.0%	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%	82.0%	86.0%	84.0%	80.0%	89.0%	87.0%	93.0%	94.0%	89.0%	97.0%	96.0%	data two months in arrears	
Total Datix incidents per calendar day		43	33	24	25	33	38	38	38	37	40	42	36	36



### What the information tells us

- Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- There were no Never Events and no Serious Incidents reported.

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

### Actions and Quality Improvement Projects

There were 47 qualifying incidents for Duty of Candour (DoC) in December 2020 of which 45 had DoC completed within 20 working days.

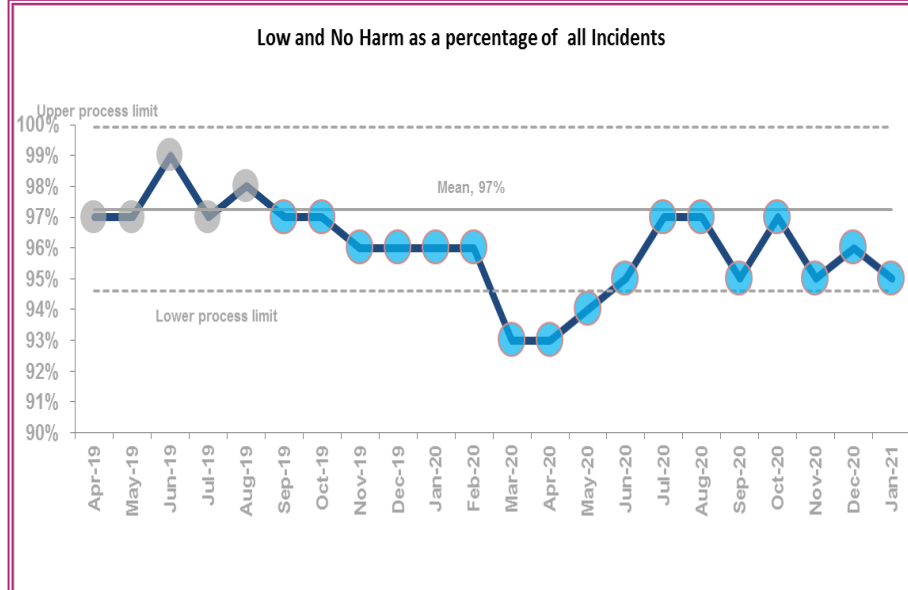
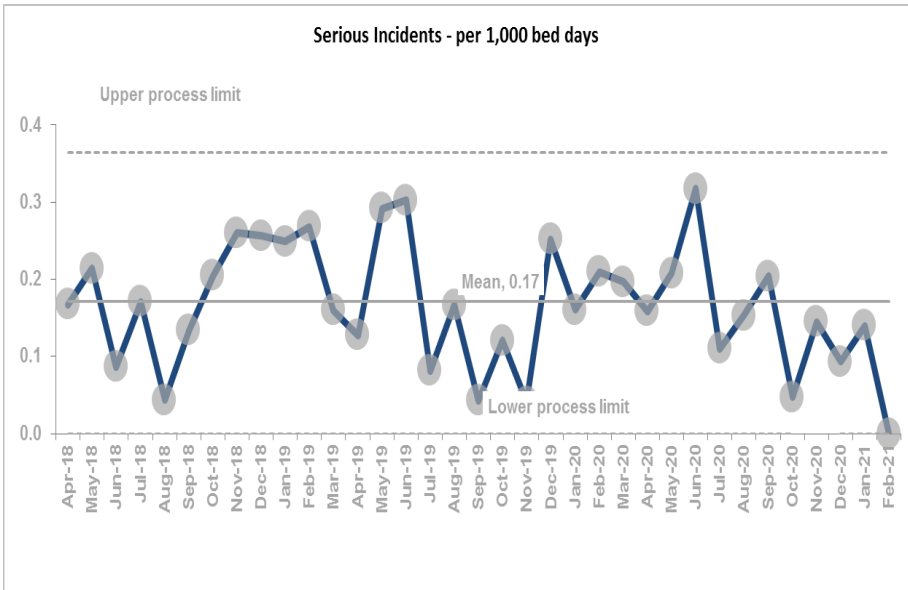
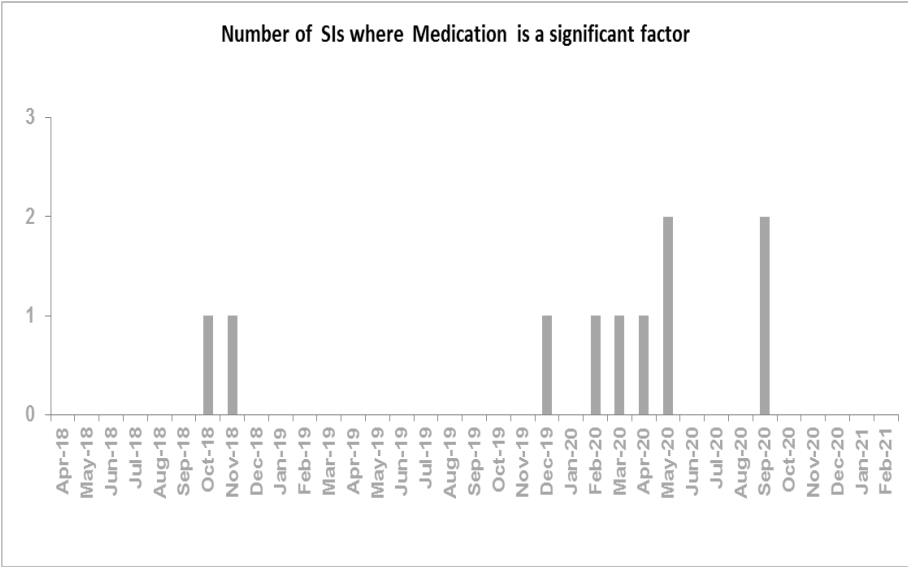
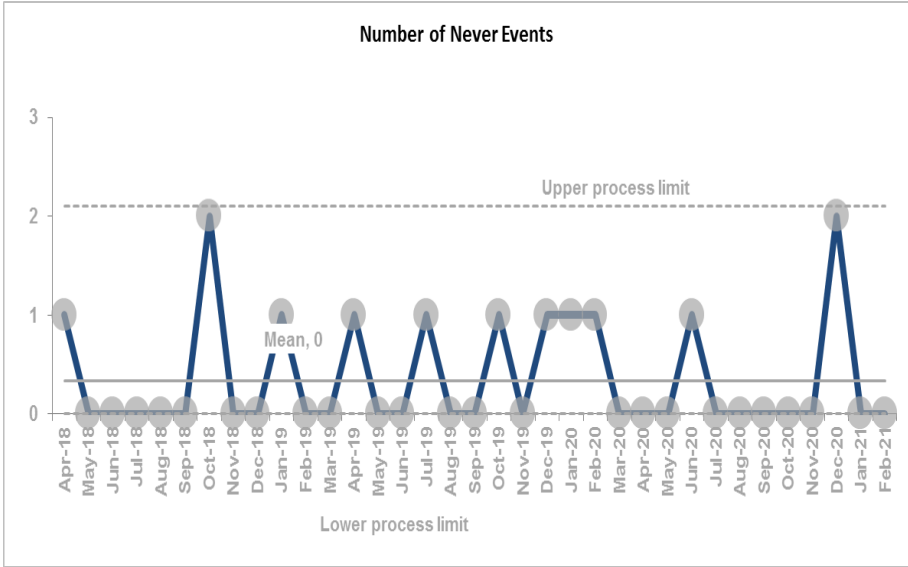
There were 2 qualifying incidents in the Children Women Diagnostics and Therapies Division (CWDT) where DoC was not completed.

A weekly monitoring meeting has been established between the CWDT governance manager and the patient safety manager to track progress and provide support where required.

# Quality Priorities – Learning from Incidents

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

2.2



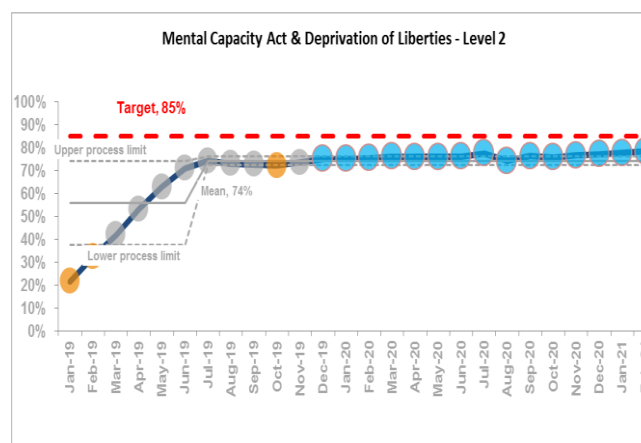
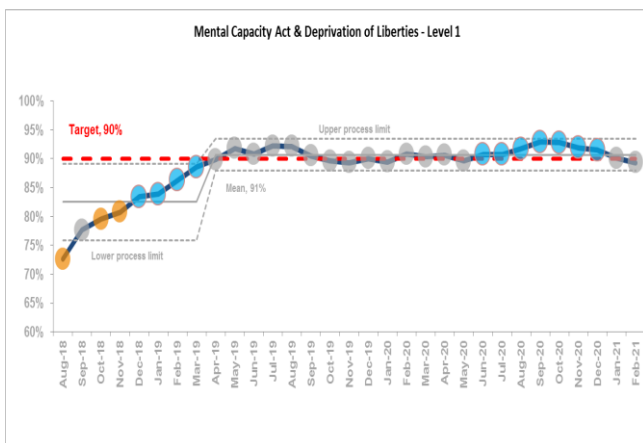
Data is 1 month in retrospect.

Our Patient Perspective





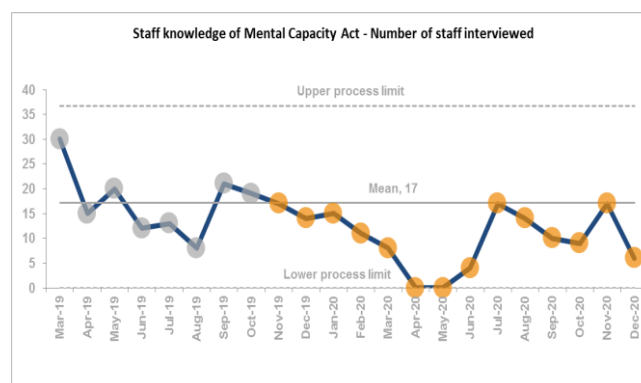
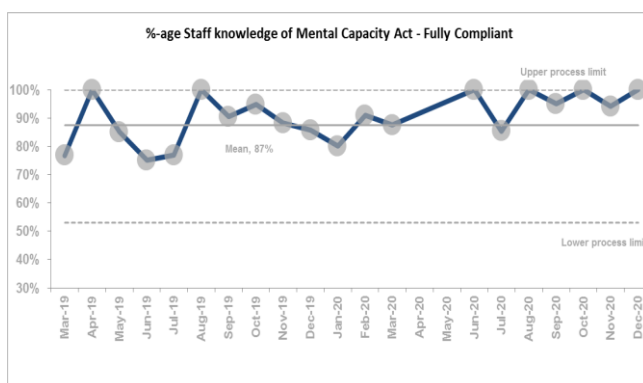
## Quality Priorities – Mental Capacity Act & Deprivation of Liberties



- 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 shows common cause variation.
- Level 2 training performance has plateaued. Overall Level 2 compliance was 78% this month.
- Metrics showing the number of staff interviewed and their level of knowledge has been suspended as part of the ward accreditation process due to COVID-19. Ward interviews was resumed at the beginning of March and will be reported on next month report.



### Actions and Quality Improvement Projects

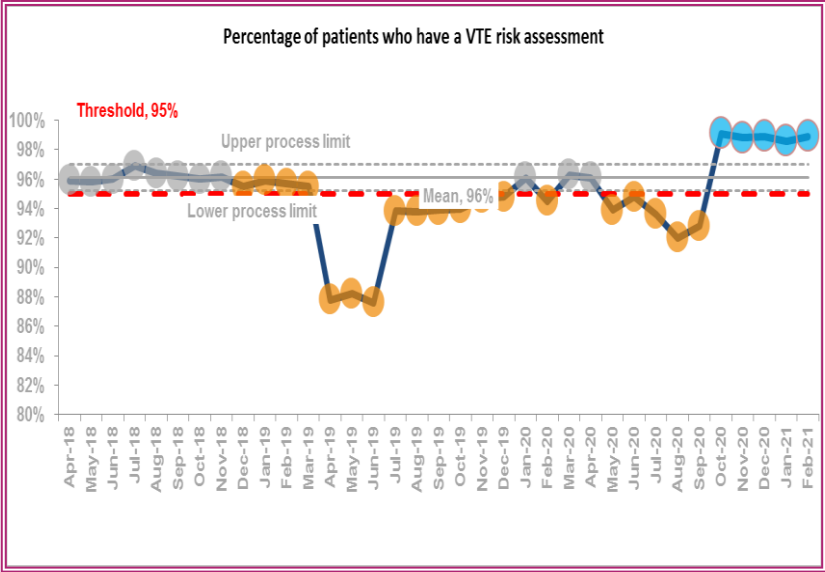
The first quarterly MCA Staff Knowledge Survey was launched in January 2021. Due to operational pressures the audit report is now planned for presentation to Patient Safety and Quality Group in April 2021

MCA lead and HON Mental Health worked with stakeholders Trust wide to review and update the Trust's Restrictions and Restraint policy which will be presented for ratification at the Patient Quality and Safety Group in March 2021.

In February 2021, MCA lead and Senior Health Consultant/ Trust Delirium Lead revised COVID-19 vaccine 'consent' paperwork to support inclusion of patients who may lack capacity to consent facilitating inclusion of some of our most vulnerable in-patients in the vaccination programme.

Work has commenced with the Patient Records Team and Trust Consent lead to design supplementary documentation for those patients who may lack the capacity to consent and signpost to the iClip Capacity and Best Interests proforma

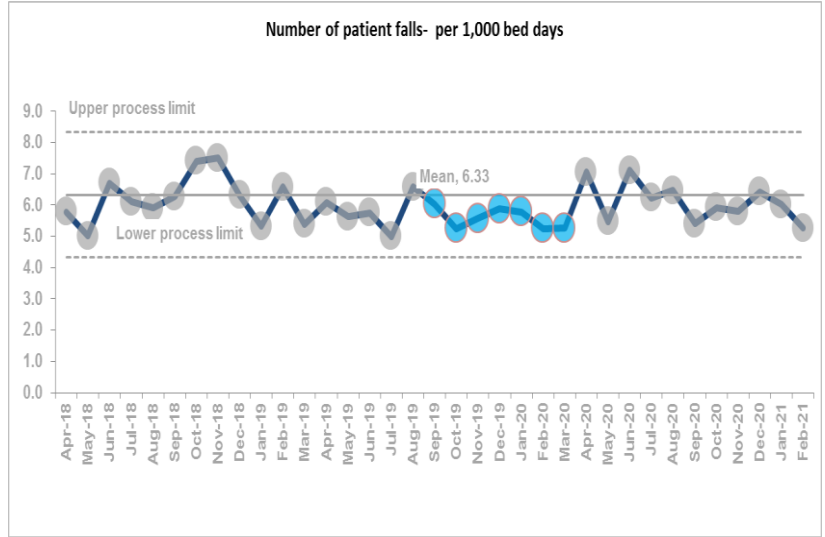
Patient Safety



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

What the information tells us

- The percentage of patients who have had a VTE risk assessment was 98.9% against a target of 95% continuing above the upper control limit.
- The Number of Patient Falls per 1,000 bed days show common case variation though the total number of falls has fallen as shown in the following slide.
- On the following slide, total number of Category 2 Pressures ulcers shows special cause improvements being consistently below the mean for the last eight months however Category 2 Pressure ulcers per 1,000 bed days shows commons cause variation.
- The number of Category 3 Pressure ulcers fell this month showing common cause variation and the number of Category 3 Pressure ulcers per 1,000 bed days shows common cause variation.

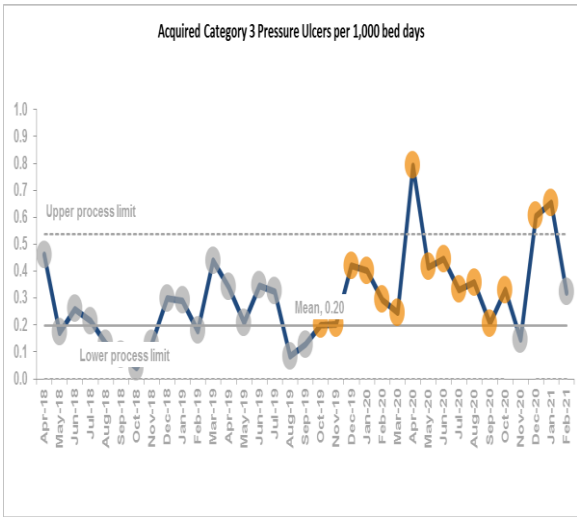
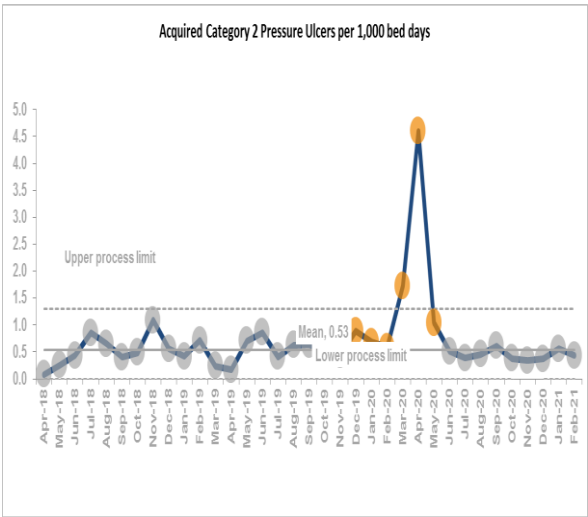
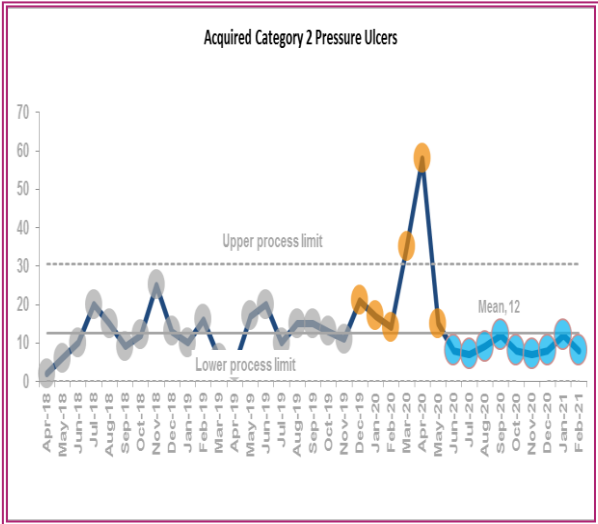
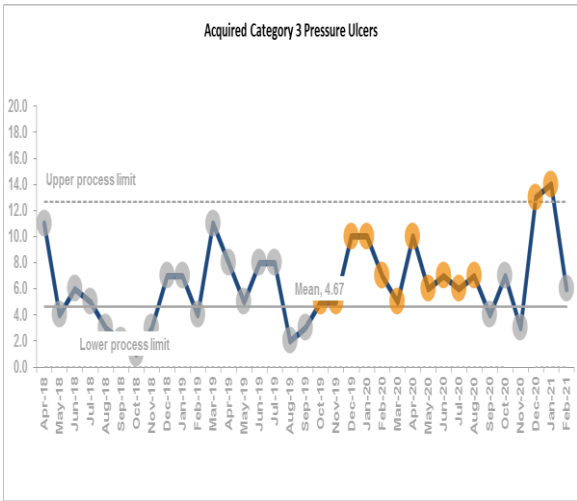
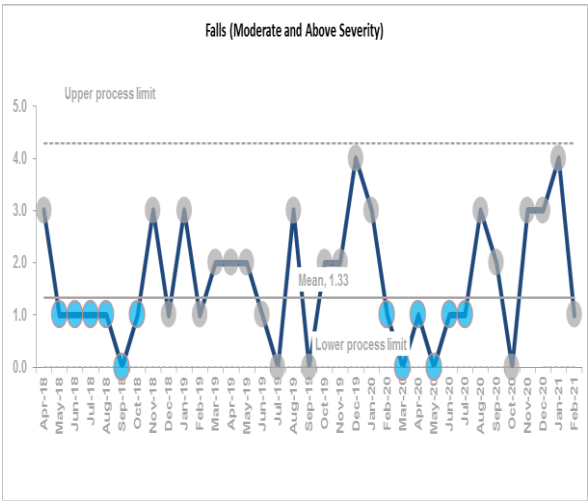
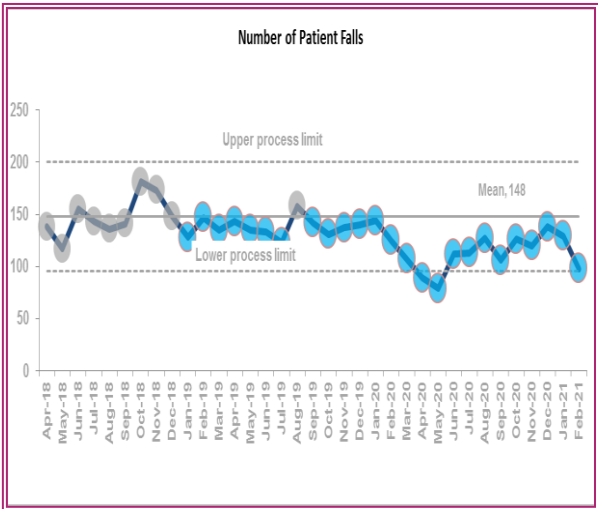


Actions and Quality Improvement Projects

Verbal update to be given.

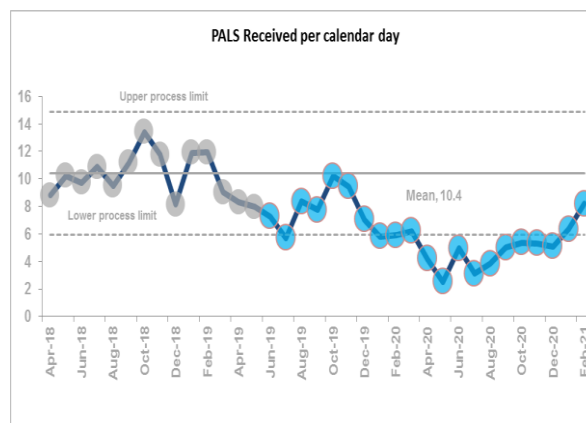
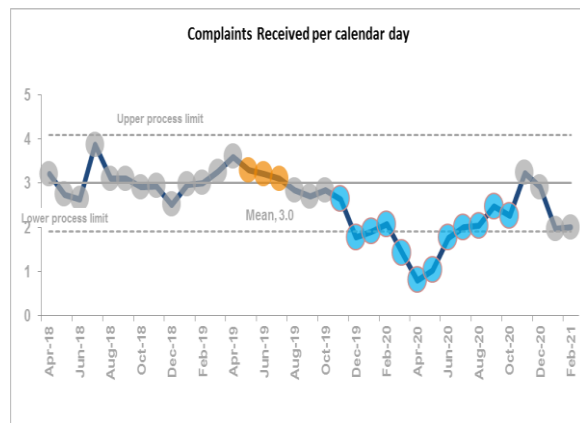
Patient Safety

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



# Complaints

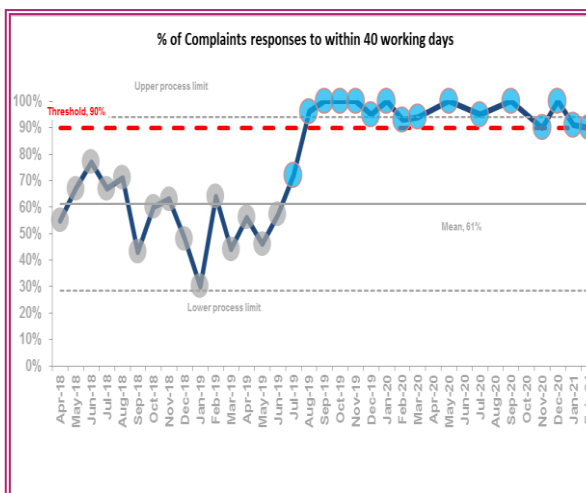
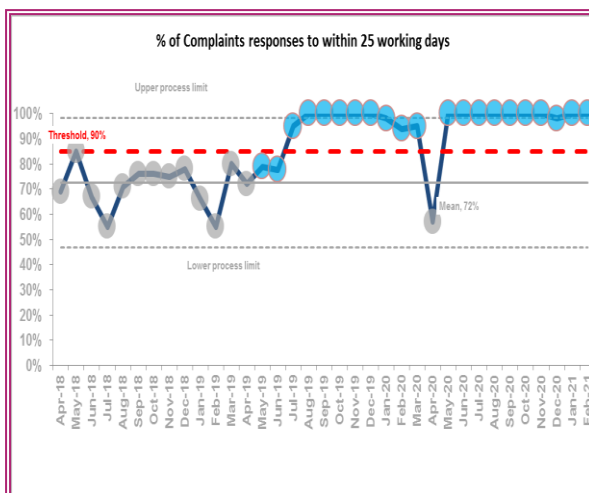
Indicator Description	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Complaints Received per calendar day		2.1	1.4	0.8	1.0	1.8	2.0	2.0	2.5	2.3	3.2	2.9	2.0	2.0
% of Complaints responses to within 25 working days	85%	94%	95%	57%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%
% of Complaints responses to within 40 working days	90%	93%	94%	75.0%	100%	100%	95%	100%	100%	94%	90%	100.0%	91%	90%
% of Complaints responses to within 60 working days	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0



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

## What the information tells us

- The number of complaints received shows common cause variation.
- All response categories show special cause variation.
- The percentage of complaints responded to within 40 days continues to show special cause variation.



## Actions and Quality Improvement Projects

Verbal update to be given

## Infection Control

2.2

Our Patient Perspective

Indicator Description	Threshold 2020-2021	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	0	0	1	1	0	0	0	1	0	3
Cdiff Hospital acquired infections	48	3	1	1	3	5	4	3	2	0	5	5	1	3	38
Cdiff Community Associated infections		0	2	0	0	1	0	0	1	0	0	3	1	0	
MSSA	25	3	2	3	0	2	5	4	2	3	5	4	8	5	41
E-Coli	60	7	4	4	8	3	3	0	6	5	3	9	6	6	53
Nosocomial Infections Hospital Onset healthcare associated (>14 days) HOHA	N/A						0	0	0	7	28	62	59	24	180
Nosocomial Infections Hospital Onset Probable associated (8-14 days) HOPA	N/A						0	1	0	0	28	76	56	35	196

### What the information tells us

There were no MRSA bacteraemia reported in February. Following investigation and review an MRSA incident which occurred in January has been allocated to the Trust. The Trust now reports a total of 3 MRSA incidents year to date.

There were 3 cases of hospital acquired *C.difficile* infection bringing the total of *C.difficile* infections reported between April 2020 – February 2021 to 38. These consist of 30 hospital acquired cases where the specimen has been taken more than two days after admission to the Trust; and 8 Community cases where the specimen was taken on admission or the next day, but where the patient had also been admitted to the Trust during the previous four weeks.

Targets for *C.difficile* infection for 2020-21 have not been set on a national basis but are instead measured against the trajectory for 2019-20 which was no more than 48 cases. The total of 38 cases between April 2020 to February 2021 indicates a within-trajectory position.

There were 5 MSSA cases showing special cause deterioration, and E-Coli continues to show common cause variation.

During February there were 24 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19, where the sample was taken > 14 days after admission and 35 Hospital Onset Probable Associated (8-14 days) HOPA cases.

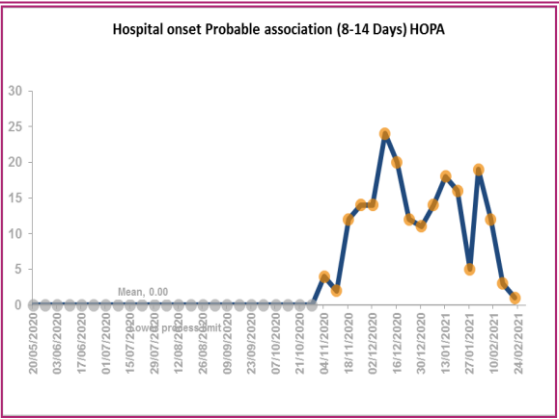
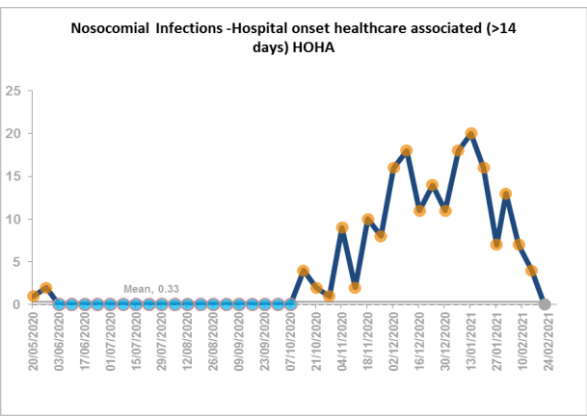
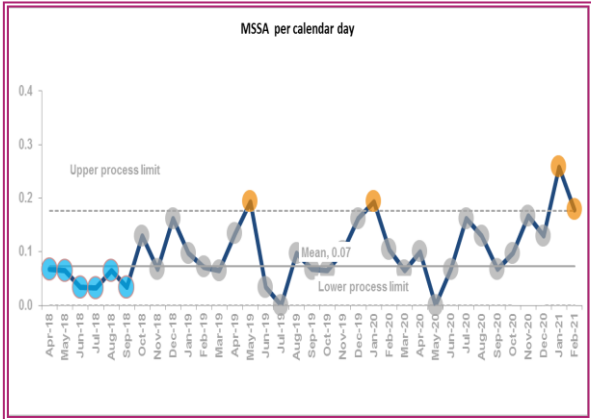
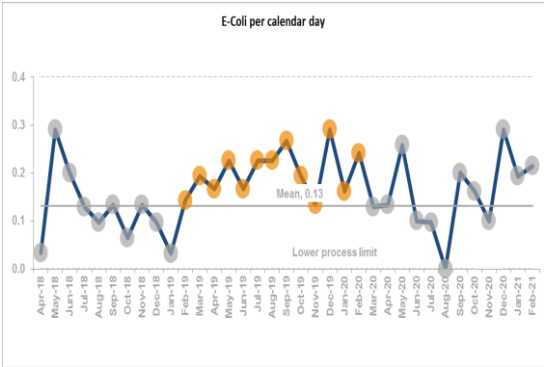
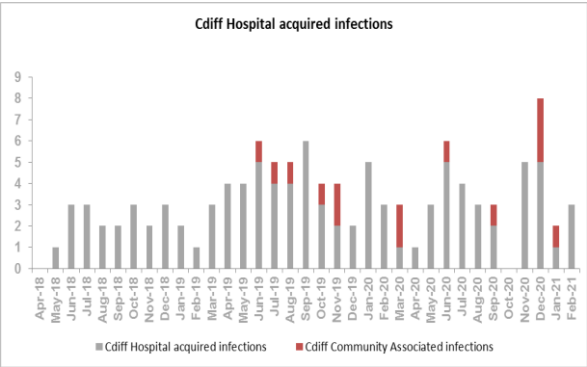
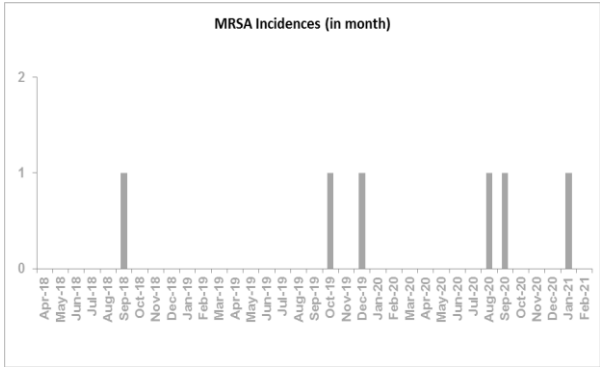
### Actions and Quality Improvement Projects

- National COVID-19 data submissions continue to be validated daily and signed off by the Director Infection Prevention and Control
- Concurrent exercises are taking place at the Trust and across the sector to review and collate lessons learned from COVID-19 second wave

Infection Control

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

2.2



Our Patient Perspective





## Mortality and Readmissions

2.2

Indicator Description	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec 2019 to Nov 2020
Hospital Standardised Mortality Ratio (HSMR)	105.5	87.9	92.1	88.5	95	101.6	91.4	90.2	64.1	105.8	81.8	59.3	82.7	81.9	75.0	75.7	95.4	92.2
Hospital Standardised Mortality Ratio Weekend Emergency	113	77.2	93.8	107.3	80.6	100.1	87.6	112.3	68.4	102.7	62.7	66.8	91.1	96.3	150.6	127.9	111.8	109.2
Hospital Standardised Mortality Ratio Weekday Emergency	100.4	90.8	96.2	80.4	102.9	102.9	90.8	90.1	57.4	96.7	87.5	54.7	74.3	77.8	69.2	63.1	86.1	87.1

Indicator Description	Jul18-Jun19	Aug18-Jul19	Sep18-Aug19	Oct18-Sep19	Nov18-Oct19	Dec18-Nov19	Jan-19-Dec19	Feb-19-Jan20	Mar-19-Feb20	Apr-19-Mar20	May-19-Apr20	June-19-May20	July-19-June20	Aug-19-Jul20	Sep-19-Aug20	Oct-19-Sep20
Summary Hospital Mortality Indicator (SHMI)	0.83	0.83	0.83	0.85	0.85	0.85	0.86	0.88	0.89	0.89	0.88	0.88	0.87	0.87	0.85	0.86

Indicator Description	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	9.9%	7.9%	10.7%	10.1%	10.4%	11.3%	11.1%	9.7%	9.5%	9.4%	8.8%	10.1%

Note: HSMR data reflective of period December 2019 – November 2020 based on a monthly published position. This month we see discharges to November 2020. SHMI data is based on a rolling 12 month period and reflective of period October 2019 to September 2020 published (Feb 2021). 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 October 2019 – September 2020. We are one of 15 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 December 2019 to November 2020 also shows our mortality to be lower than expected.

Looking specifically at emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend. SHMI and HSMR have taken differing approaches to managing the impact of Covid-19, which is now included in the periods reported. Dr Foster, who produce the HSMR, include Covid-19 activity; whereas NHS Digital who are responsible for SHMI have excluded all Covid-19 activity.

### Actions and Quality Improvement Projects

We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Committee (MMC). Investigations which are currently underway related to cardiology, intracranial injury and major trauma are being monitored by the committee and are progressing well.

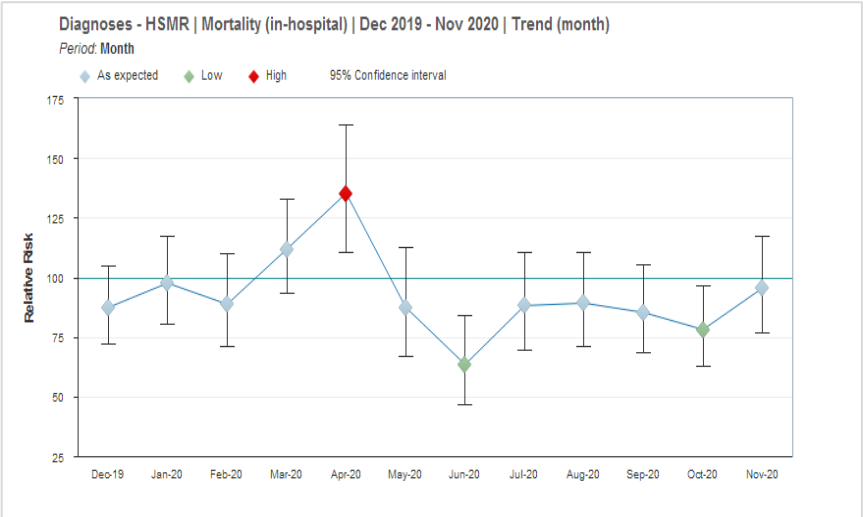
Our Patient Perspective



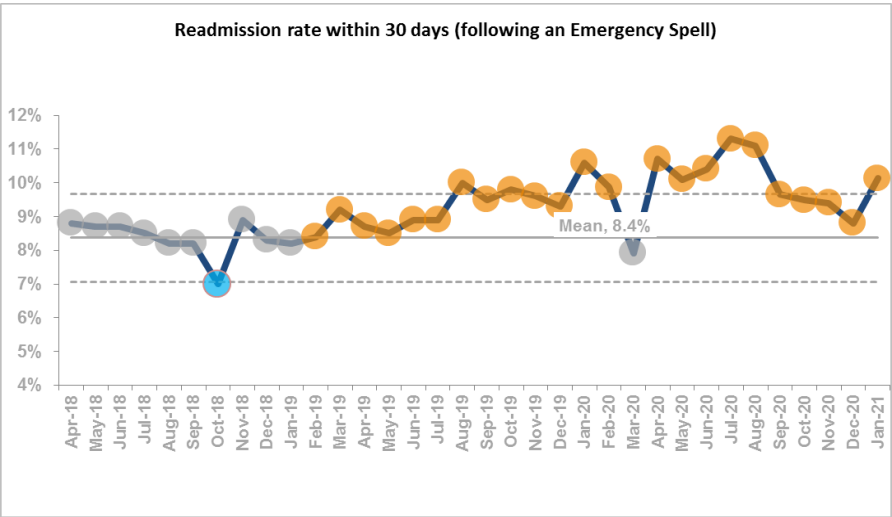
# Mortality and Readmissions (Hospital Standardized Mortality Rate)

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

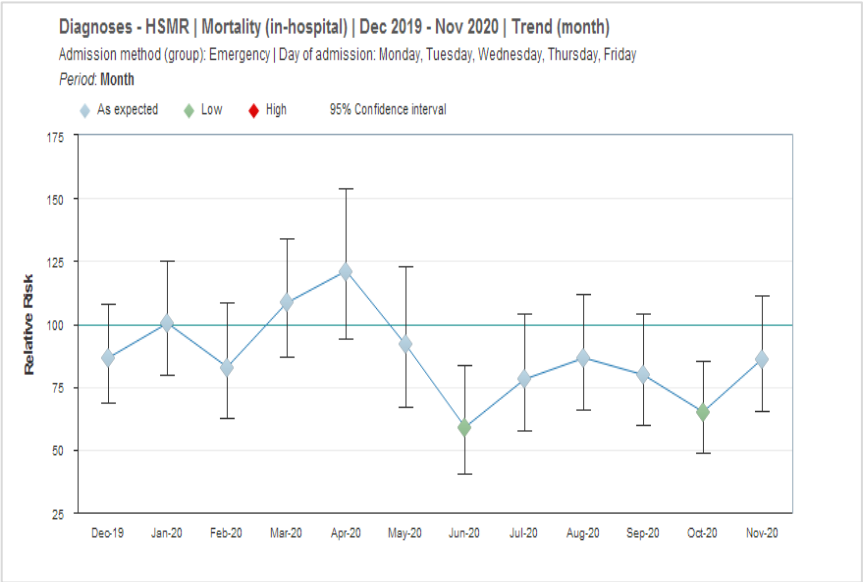
HSMR



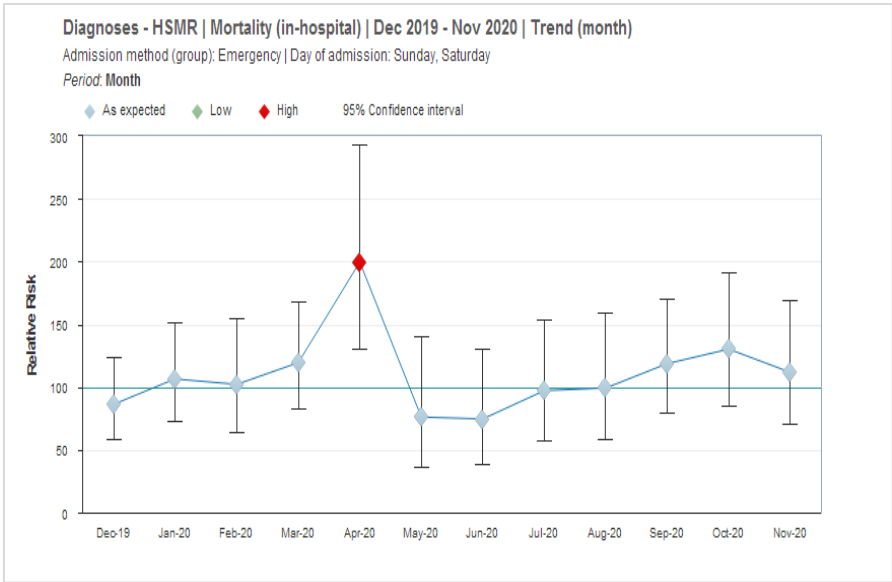
Readmission rate within 30 days (following an Emergency Spell)



HSMR Weekday

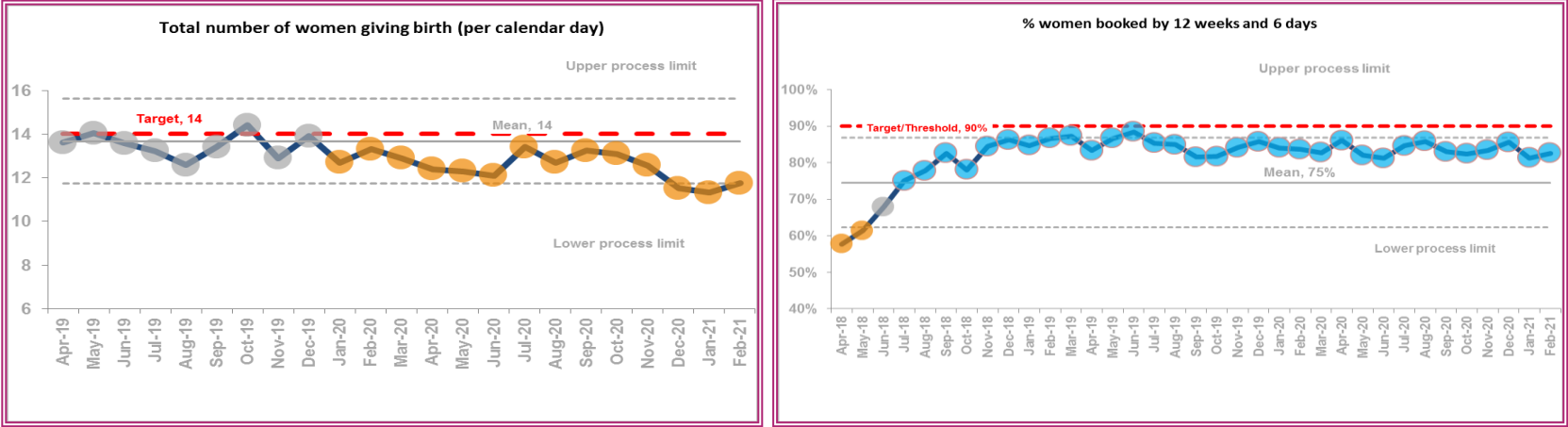


HSMR Weekend



Maternity

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



What the information tells us

The number of stillbirths per 1,000 births increased in February.

35% of women booking for care in the month were assigned to Continuity of Carer teams, with more transferred during pregnancy. Carmen Suite remained open for over 90% of shifts in the month because of an improvement in staffing numbers across the unit; this led to 36 babies being born there. Additionally, 10 babies were born at home, giving the highest home birth rate (3%) in over a year.

The caesarean section rate remained at 28%, with the emergency rate just over 13% which is within the normal range.

Actions and Quality Improvement Projects

The review of stillbirths are being conducted and, where appropriate cases will be reviewed at Serious Incident Declaration Meeting (SIDM).

The increase in demand for planned caesarean sections due to concerns over Induction of labour has led to work being done to improve information and understanding about this process.

Birthrate Plus review is due to conclude shortly.

Peer review of initial Ockenden Response due in mid-March.

# Maternity

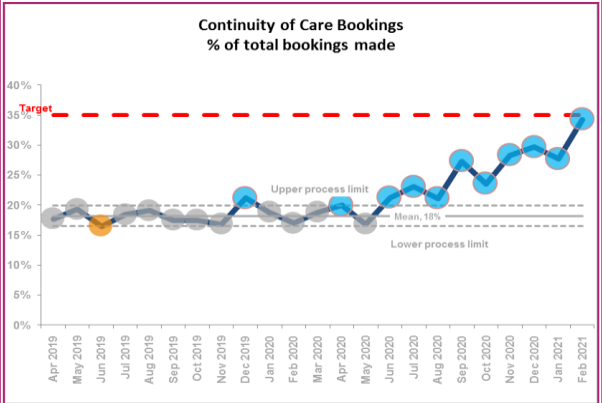
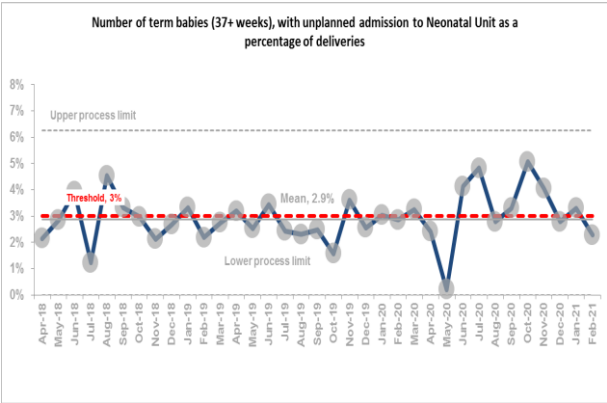
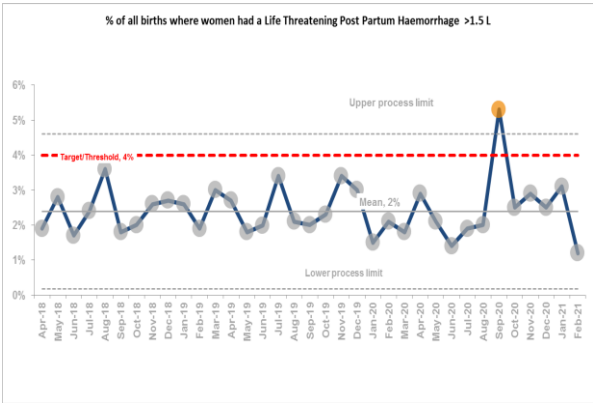
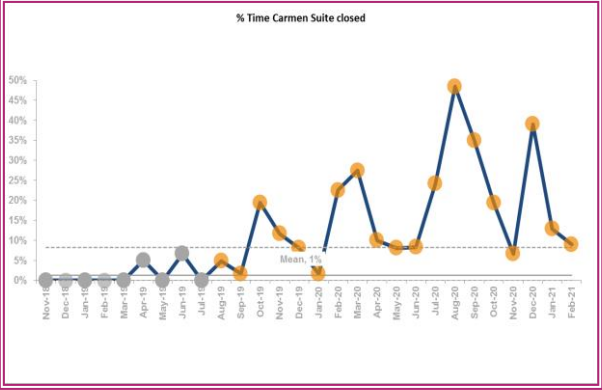
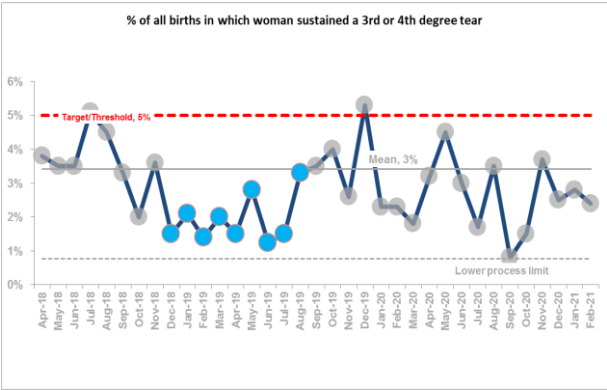
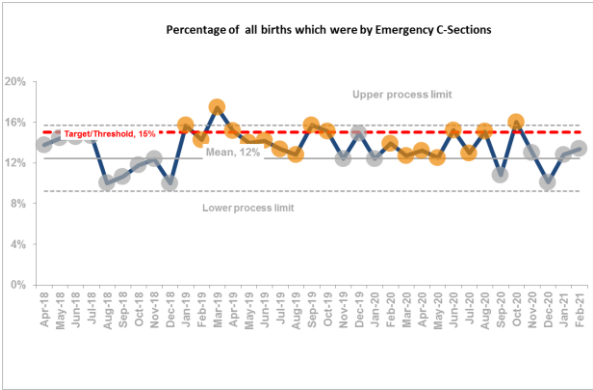
## Maternity Dashboard

Definitions	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Total number of women giving birth (per calendar day)	14 per day	13.3	12.9	12.4	12.3	12.1	13.4	12.7	13.2	13.1	12.6	11.5	11.3	11.8
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	26.0%	23.3%	24.9%	22.3%	29.4%	24.1%	27.1%	23.4%	30.9%	27.3%	23.8%	28.5%	28.0%
% deliveries with Emergency C Section (including no Labour)	<8%	3.6%	3.3%	1.9%	2.6%	2.7%	3.1%	4.6%	3.0%	3.7%	2.9%	3.4%	2.3%	3.3%
% Time Carmen Suite closed	0%	22.5%	27.4%	10.0%	8.1%	8.3%	24.2%	48.4%	35.0%	19.4%	6.7%	39.0%	12.9%	9.0%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	2.3%	1.8%	3.2%	4.5%	3.0%	1.7%	3.5%	0.8%	1.5%	3.7%	2.5%	2.8%	2.4%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.1%	1.8%	2.9%	2.1%	1.4%	1.9%	2.0%	5.3%	2.5%	2.9%	2.5%	3.1%	1.2%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		11	13	9	9	15	20	11	13	20	16	11	13	9
Supernumerary Midwife in Labour Ward	>95%	94.8%	93.5%	100.0%	96.8%	96.7%	96.8%	93.5%	90.0%	100.0%	98.3%	91.9%	100.0%	94.6%
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	<2	0	0	0	0	4	0	0	1	0	0	3	0	0
Still Births per 1000 Births	<3	2.6	10.0	8.0	7.9	8.2	16.9	12.6	2.5	7.4	8.0	5.6	2.8	9.1
Continuity of Care Bookings- % of total bookings made	35%	17.0%	18.8%	20.0%	16.8%	21.3%	23.0%	21.4%	27.3%	23.6%	28.3%	29.7%	27.7%	34.3%
Percentage of all births which were by Emergency C-Sections	15%	13.9%	12.7%	13.2%	12.5%	15.2%	12.9%	15.1%	10.8%	16.0%	13.0%	10.1%	12.80%	13.4%
% women booked by 12 weeks and 6 days	90%	83.6%	82.7%	86.1%	82.0%	81.2%	84.6%	85.8%	83.0%	82.4%	83.4%	85.6%	81.3%	82.6%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	2.9%	3.3%	2.4%	0.2%	4.1%	4.8%	2.8%	3.3%	5.1%	4.1%	2.8%	3.3%	2.3%

Maternity

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

2.2



## Friends & Family Survey

2.2

Our Patient Perspective

Indicator Description	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Emergency Department FFT - % positive responses	90%	86.2%	87.8%	93.9%	93.6%	90.0%	89.7%	90.1%	89.5%	89.7%	89.2%	80.6%	88.8%	90.8%
Inpatient FFT - % positive responses	95%	96.6%	97.2%	100.0%	97.2%	93.6%	97.7%	97.2%	96.3%	97.1%	98.6%	97.9%	99.0%	98.3%
Maternity FFT - Antenatal - % positive responses	90%	N/A	100.0%	100.0%	100.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	N/A	100.0%	N/A	100.0%	N/A	66.7%	N/A	89.2%	100.0%	90.4%	93.0%
Maternity FFT - Postnatal Ward - % positive responses	90%	96.9%	100.0%	N/A	0.0%	0.0%	89.9%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	90.0%	100.0%	N/A	100.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community FFT - % positive responses	90%	98.6%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Outpatient FFT - % positive responses	90%	89.9%	91.7%	98.2%	89.9%	88.8%	90.3%	89.1%	89.0%	89.1%	89.5%	90.4%	96.9%	90.4%

### What the information tells us

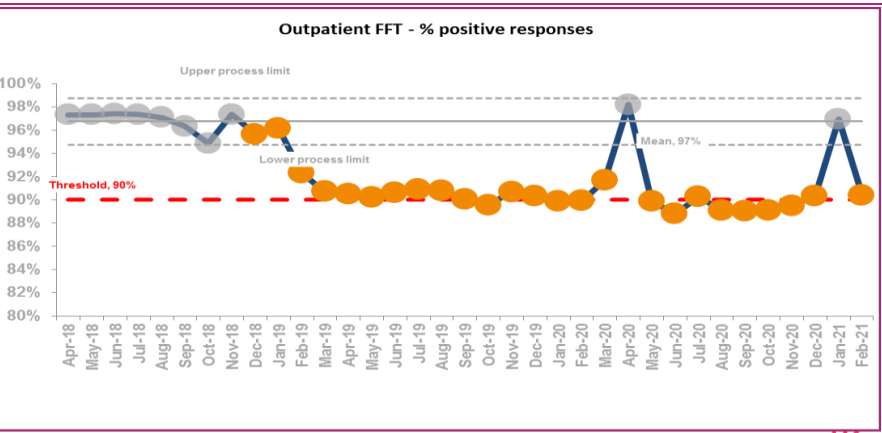
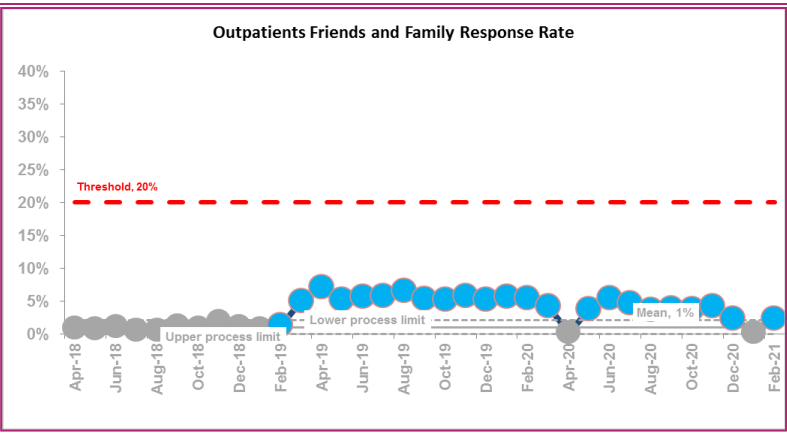
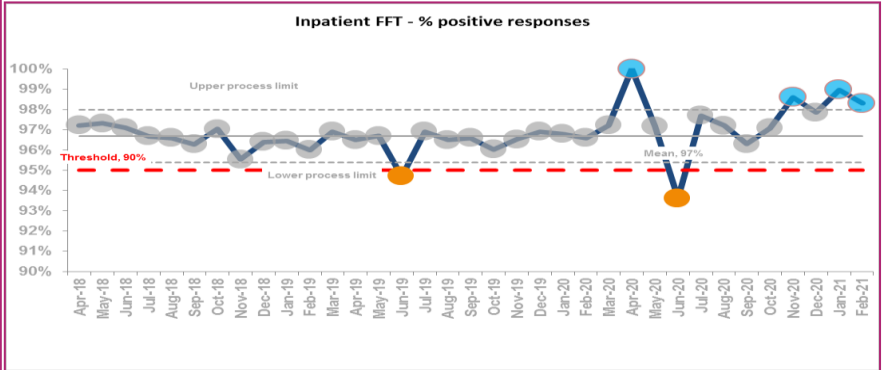
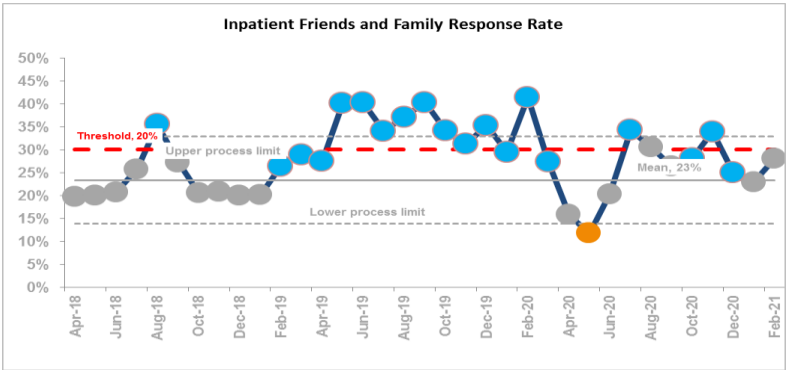
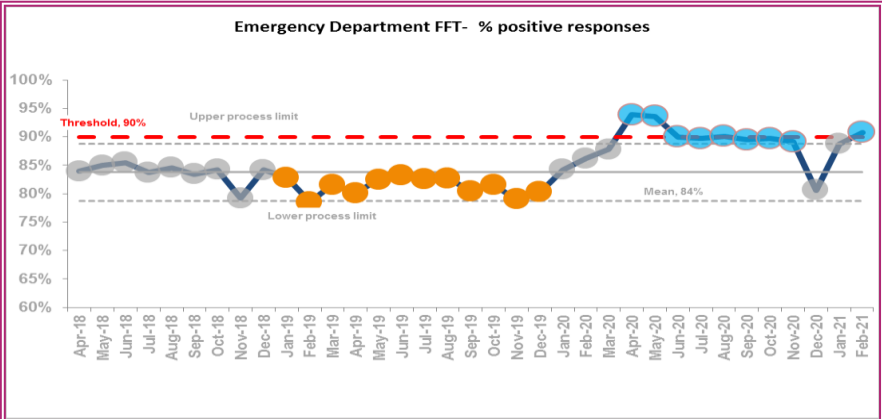
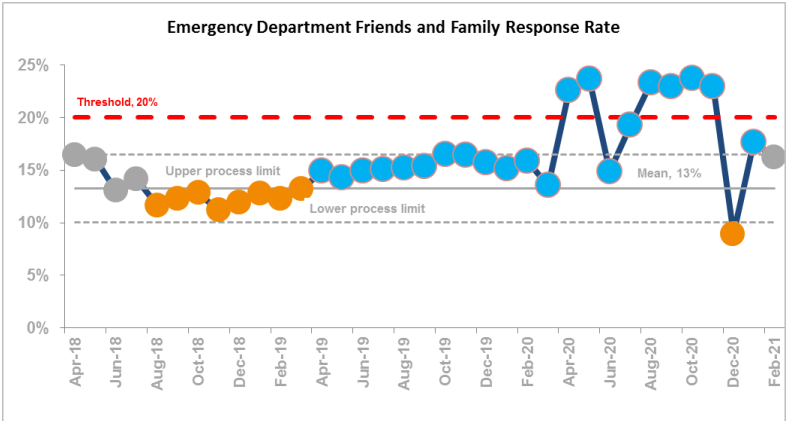
- All our services have exceeded their target for positive FFT responses.

### Actions and Quality Improvement Projects

For Midwifery Services, text message surveys are now being sent to women who have given birth in the previous month, which has helped to increase the number of responses. Women are also providing very useful narrative comments alongside their quantitative feedback which is shared with the senior team.

# Friends and Family Test

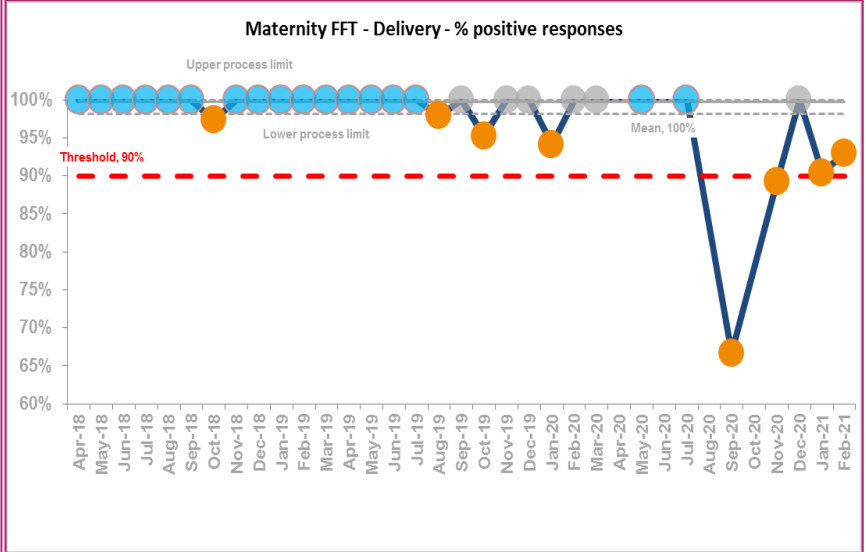
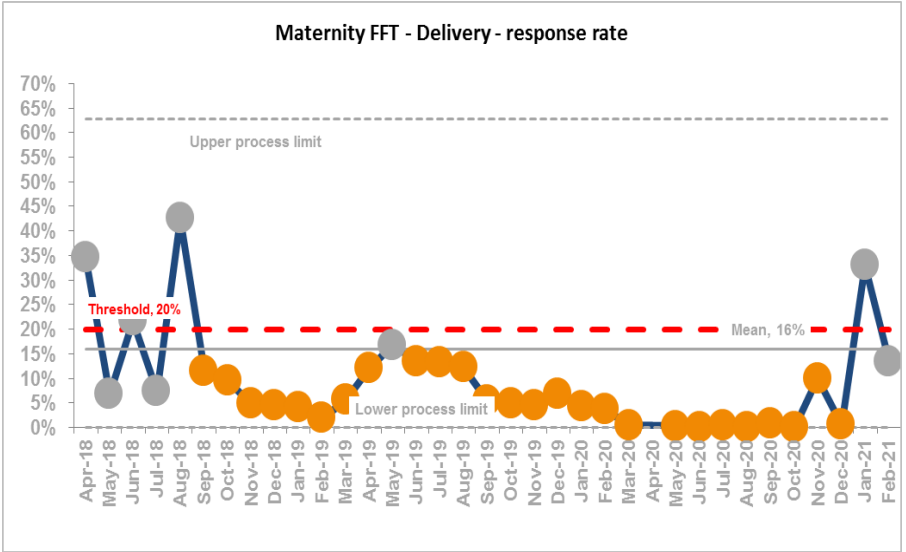
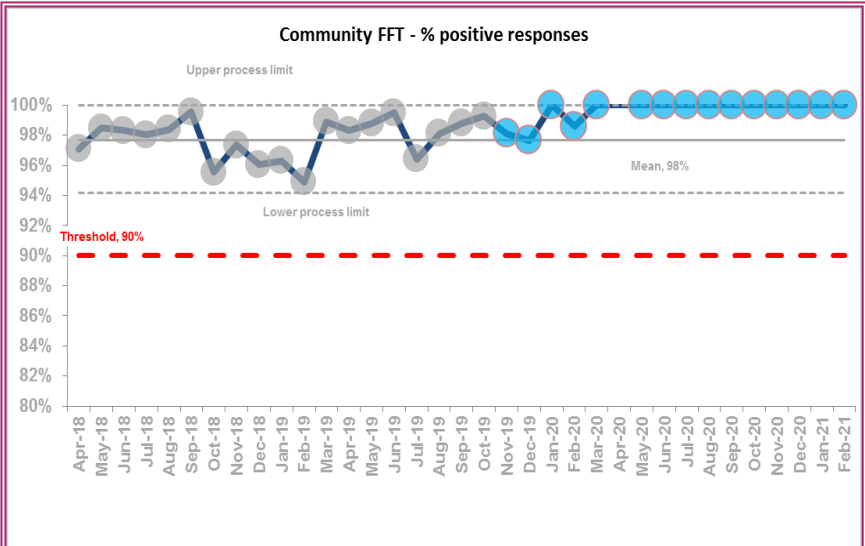
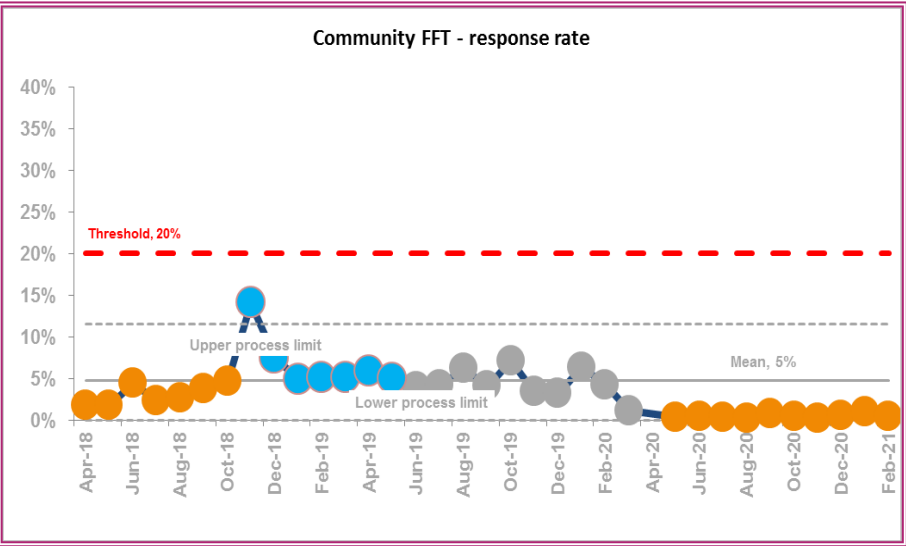
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



# Friends and Family Test

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

2.2



Our Patient Perspective





# Balanced Scorecard Approach



Key

Current Month

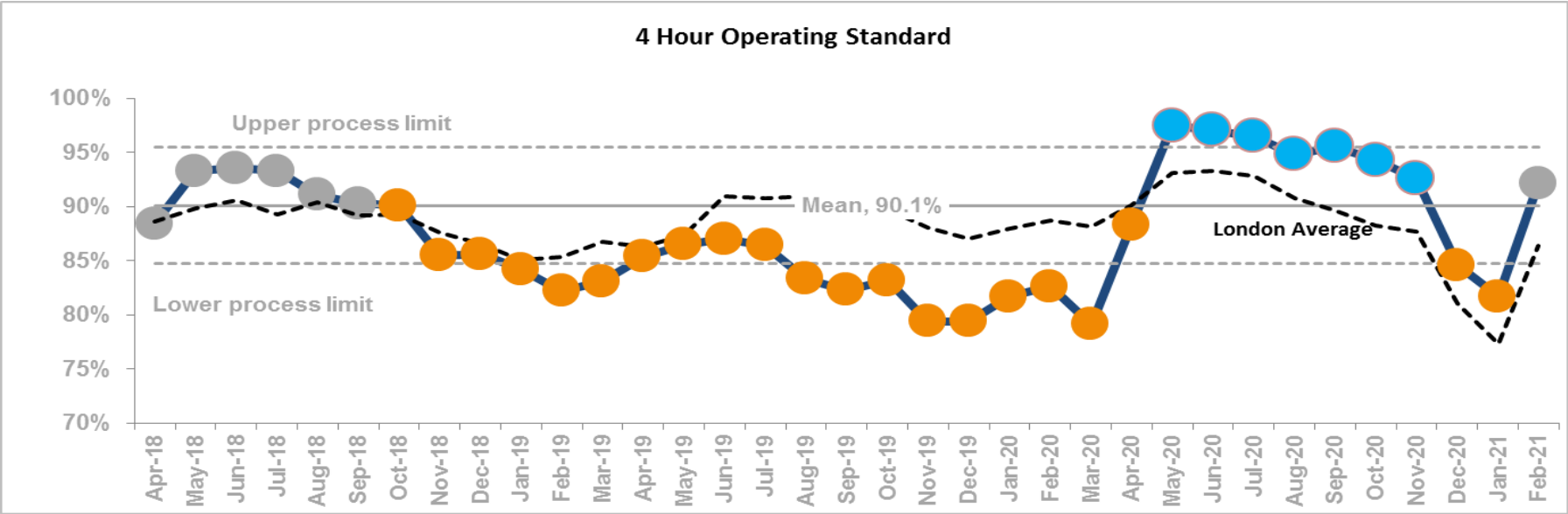
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Previous Month

Scorecard RAG rating based on PreCOVID-19 plan



Emergency Flow



What the information tells us

The Trust delivered an improved performance against the Four Hour Operating Standard in February with 92.1% of patients attending the emergency department being able to either go home, be admitted or transferred within four hours of their arrival. In the last week of February performance exceeded the national target of 95% being one of the top performing Trusts in London.

The number of patients attending ED increased by nearly seven patients per day with the proportion of high acuity patients changing, with on average, 53% of patients scoring between 1-3 against the Manchester Triage Score System compared to 57% in January. The number of walk-in patients attending the department in February was 12.7% higher compared to the previous month with ambulance conveyances reducing, on average, by 6 patients per day.

Both the admitted and non-admitted pathway performance increased and are back within the upper and lower control limits. Although performance remains challenged with varied daily performance, improvement in the number of patient discharges per day in the month of February allowed for an improvement in patient flow throughout the hospital. The occupancy rate on our AMU ward at midday was below our aim of 80% for most days. There were also decreases in the average number of patients who have been in a hospital bed longer than 7,14 and 21 days. The average number of patients through February with a length of stay of more than 7 days reduced by 17%, 14 days seeing a 14% reduction and 21 days a 10% reduction.

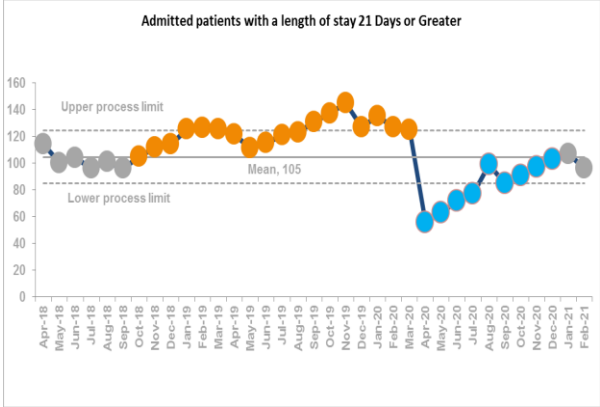
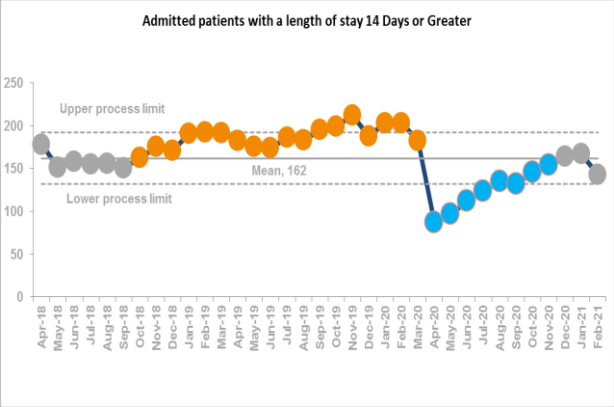
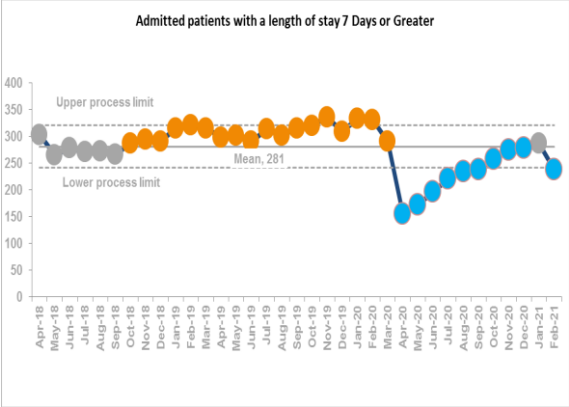
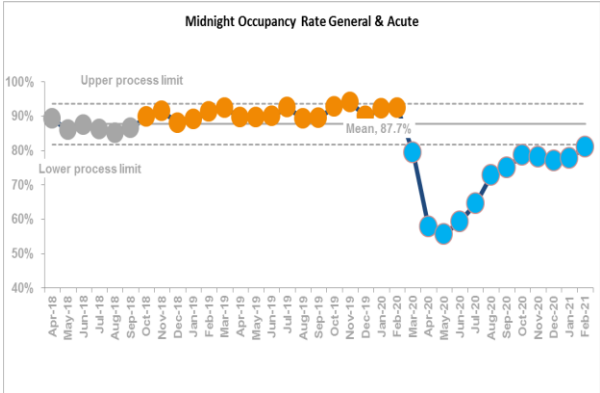
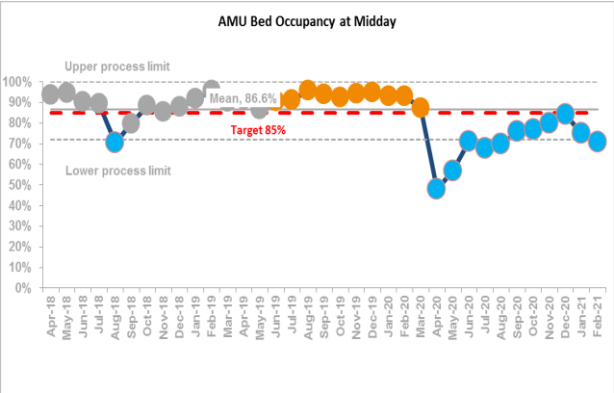
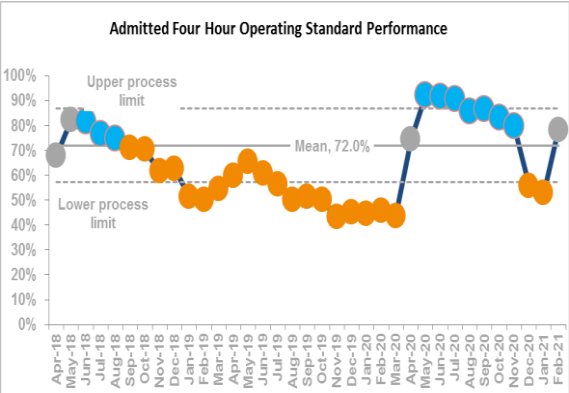
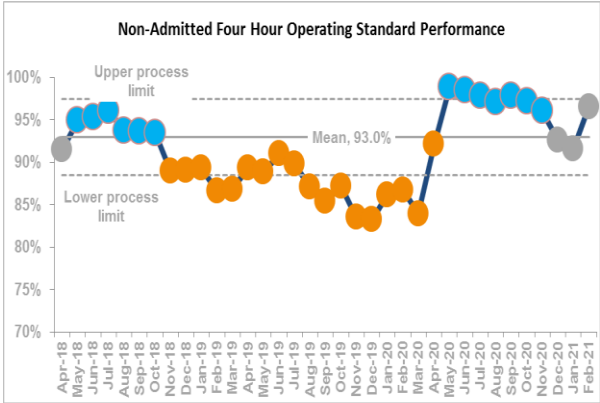
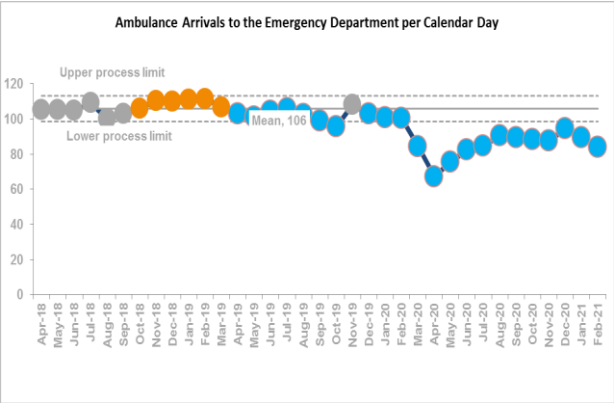
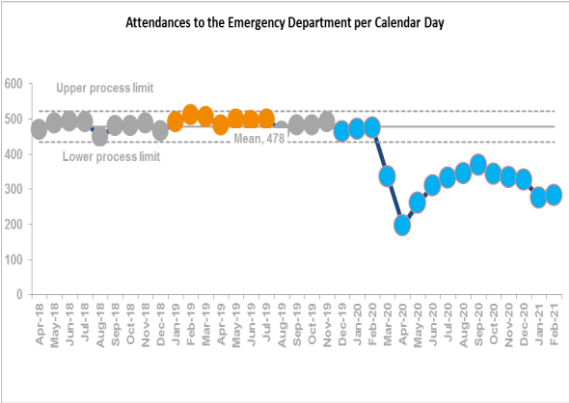
**Actions and Quality Improvement Projects**

Verbal update



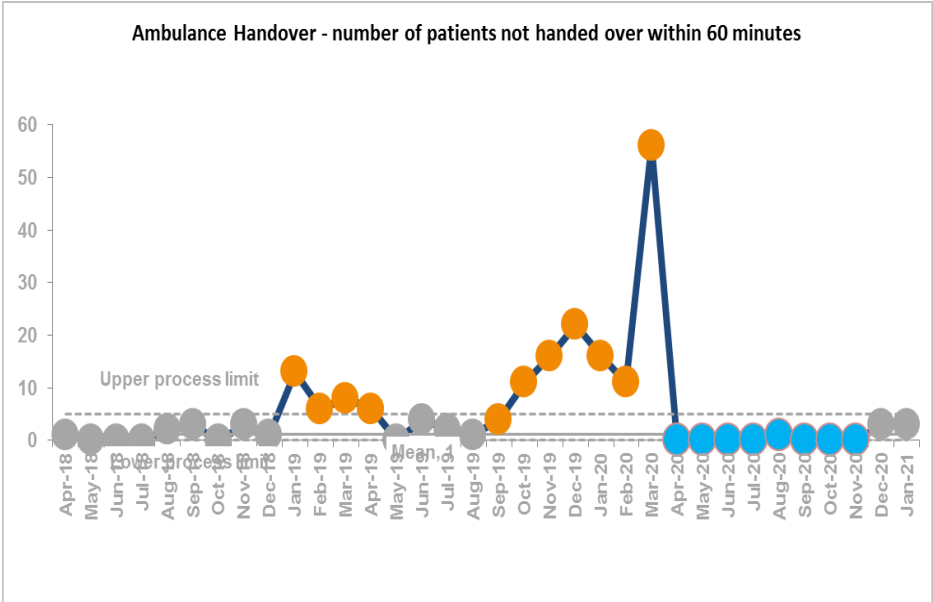
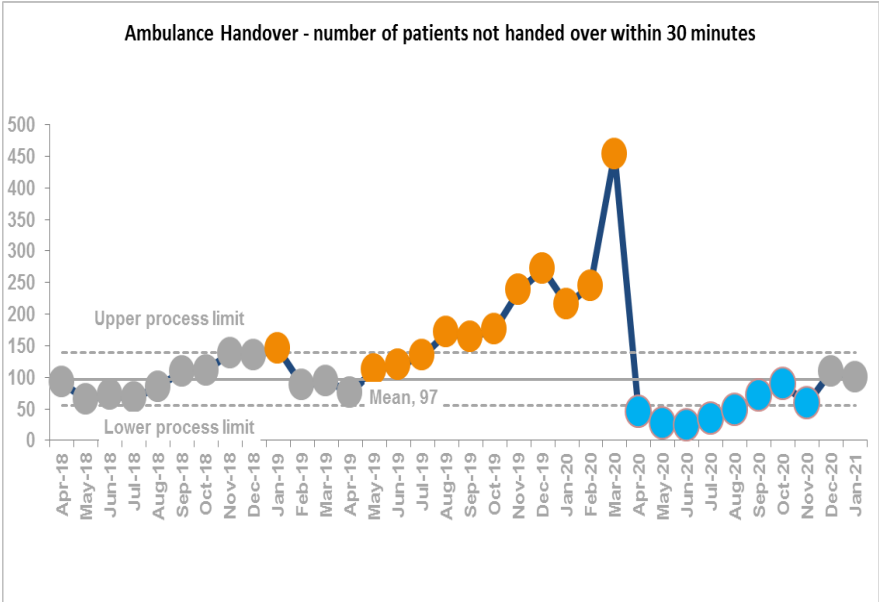
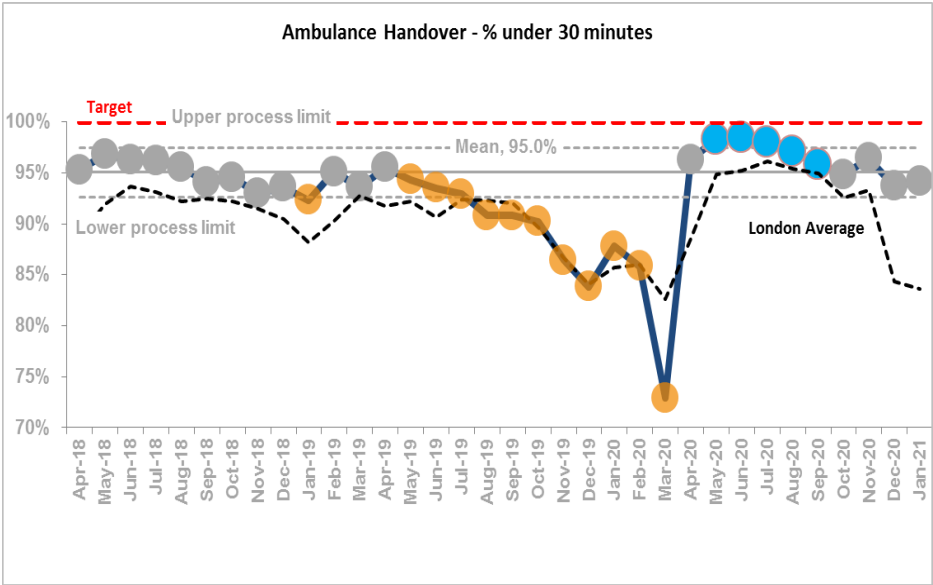
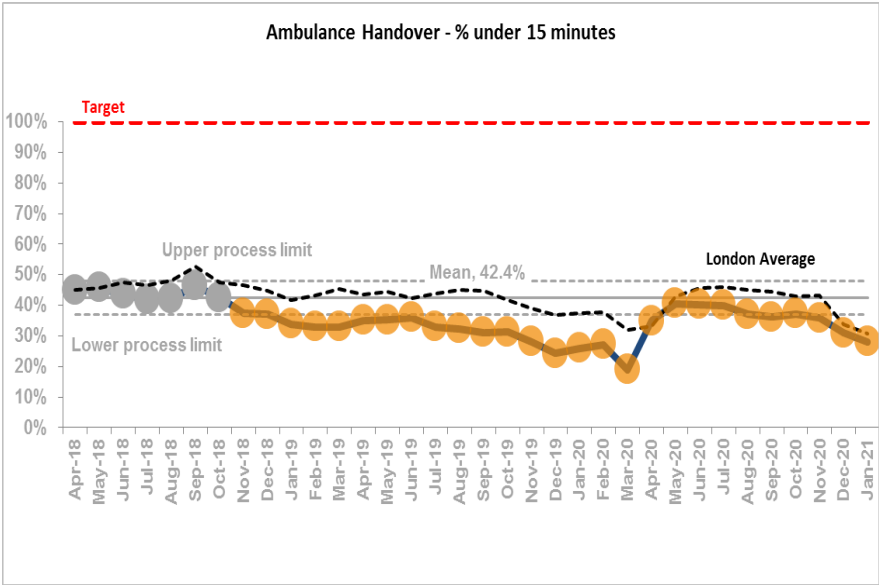
# Emergency Flow

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

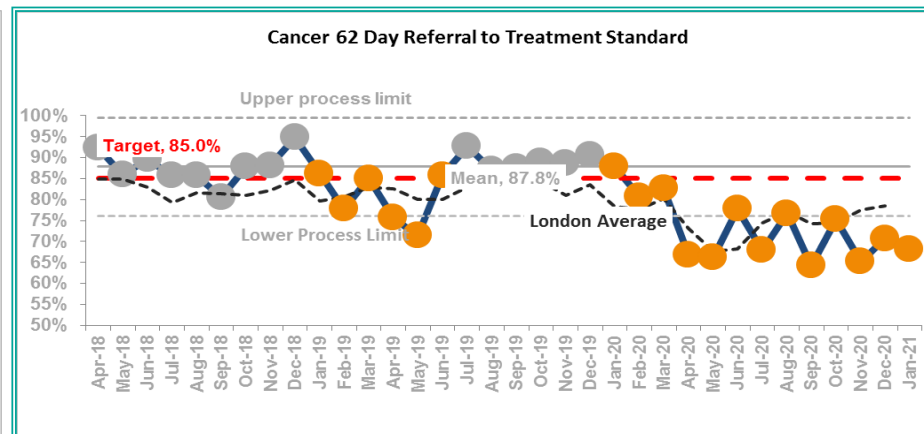
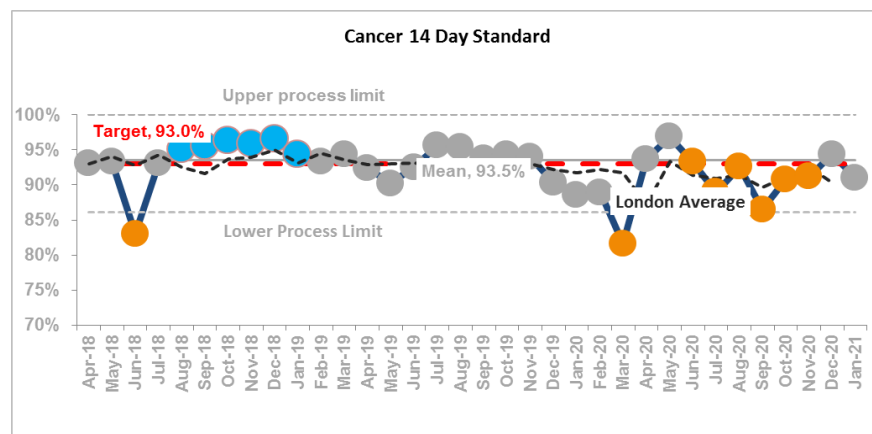


# Emergency Flow

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



## Cancer



### What the information tells us

In January, the Trust was below target for six of the seven cancer standards. Performance against the 14 day standard was 91% compared to 94.4% reported in December. Performance fell below the mean however shows common cause variation. The number of patients seen within 14 days decreased by 31% compared to December (15.5% lower than the same month last year).

Five tumour groups were below the 93% target with Breast, Head & Neck, and Skin falling below target after exceeding target in December. Performance against the 14 Day Breast Symptomatic was 89.6% compared to 94.8% in December with 39% drop in the number of patients seen. All tumour groups, with the exception of Breast, have agreed to return to compliance in March, and Breast in April. It is expected that the Trust will return to compliance in Quarter 1.

Performance against the 31-day treatment standard fell below the lower control limit reporting 88.7%, the number of patient treatments were in line with the baseline pre-COVID with activity levels being maintained. Five tumour groups were below the standard of 96%. It is anticipated that the Trust will return to compliance in Quarter 2 once the P3 patients have been treated.

There were 70.5 (0.5 being a shared treatment) total treatments on the 62-day GP pathway, an increase of 20 patients compared to December. Patients continue to be prioritised as per NHSE guidance and currently all Cancer P2 patients have been treated within 28 days. Monthly performance continues below the lower control limits, with a performance of 68.1% in month. There were 22.5 breaches of the 62 Day standard, attributed to IPC guidance, other COVID delays, clinical complexity and patient choice. Specialities have agreed a trajectory to have treated all the P3 patients in the backlog by the end of April and a return to 62 day compliance in Quarter 2.

### Actions and Quality Improvement Projects

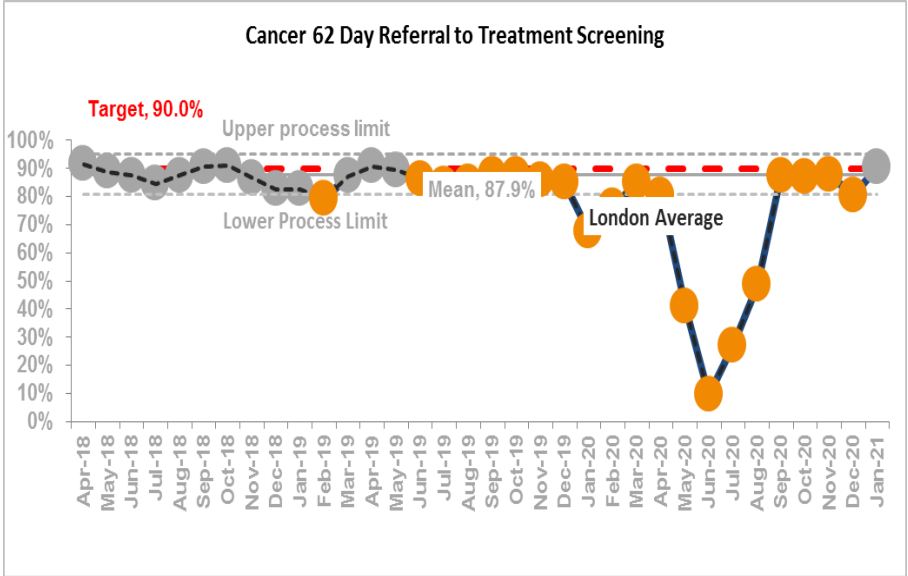
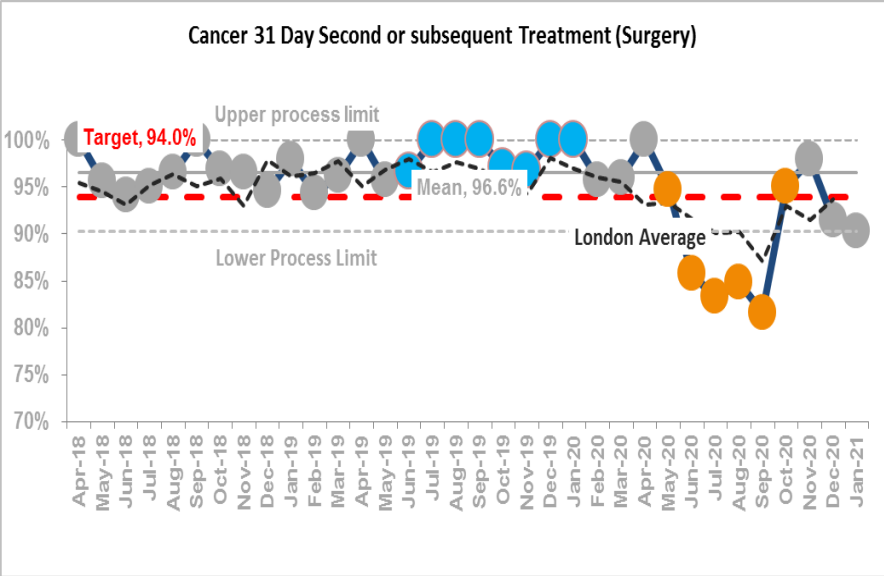
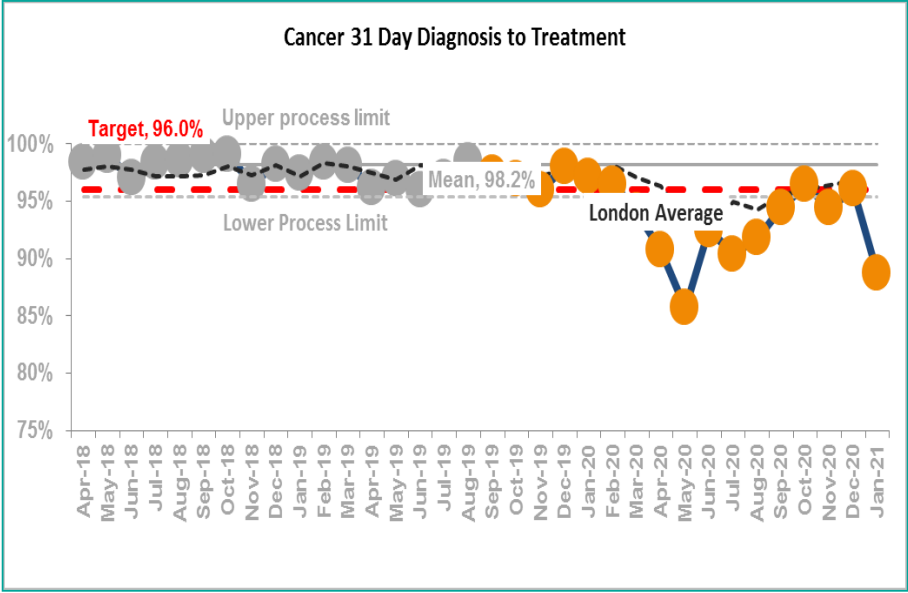
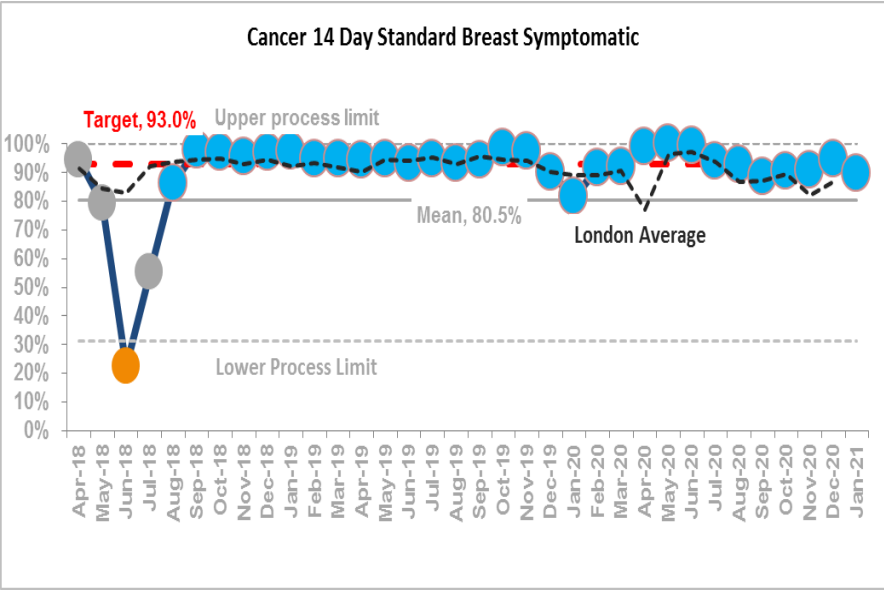
**TWR** – All services have agreed to return to compliance from April - The Rapid Diagnostic Clinic is supporting the earlier diagnosis of cancer in patients who have a range of vague symptoms

**63+ days** – There is agreement that all P3 patients will be offered a date or treated by the end of April and that there is sufficient theatre capacity. It is expected that the numbers of patients over 63 days will return to the BAU baseline in June.

**Head & Neck** – Sector wide summit in March to redesign the H&N diagnostic pathway

Cancer

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



# Cancer

## 14 Day Standard Performance by Tumour Site - Target 93%

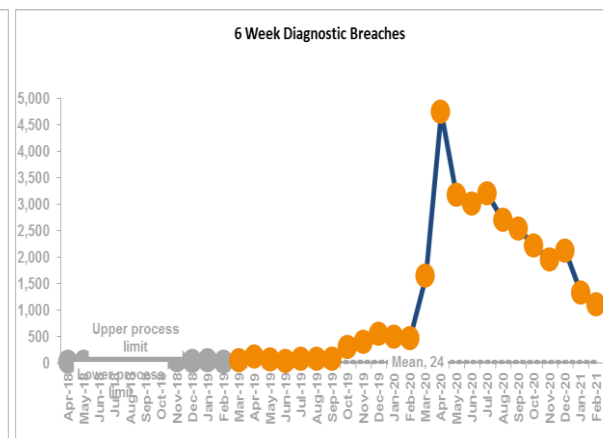
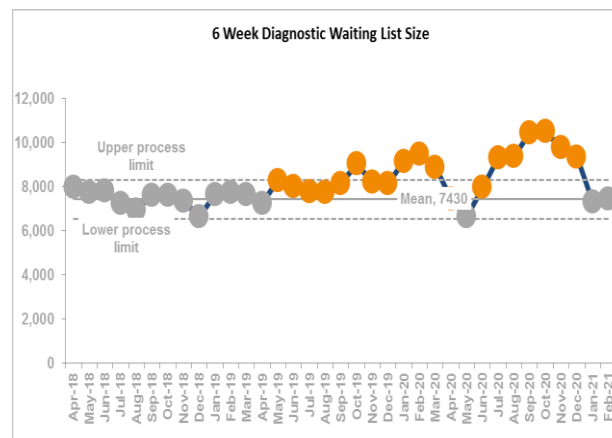
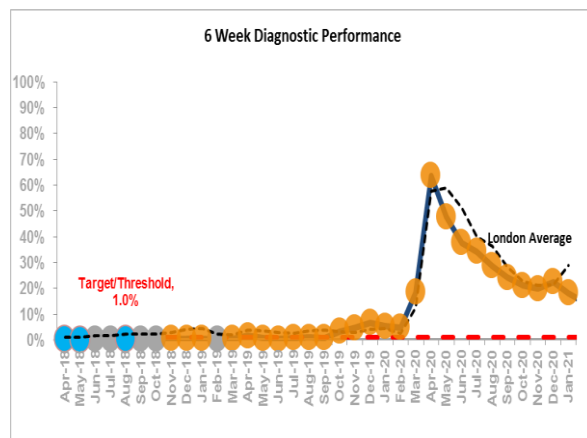
Tumour Site	Target	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	No of Patients
Brain	93%	100.0%	-	-	-	-	-	-	-	-	-	-	-	-	0
Breast	93%	84.7%	95.6%	93.3%	97.5%	100.0%	98.6%	95.5%	94.3%	88.6%	92.0%	91.6%	95.0%	86.6%	224
Children's	93%	85.7%	100.0%	100.0%	-	83.3%	100.0%	75.0%	75.0%	100.0%	75.0%	100.0%	100.0%	100.0%	2
Gynaecology	93%	94.4%	95.9%	86.9%	93.0%	96.3%	93.8%	92.5%	97.2%	91.6%	91.9%	94.3%	91.6%	79.3%	87
Haematology	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	91.3%	96.0%	96.2%	96.2%	96.2%	95.5%	22
Head & Neck	93%	95.2%	95.5%	90.8%	97.1%	100.0%	97.7%	96.1%	96.2%	84.1%	93.7%	96.0%	98.8%	91.6%	107
Lower Gastrointestinal	93%	81.8%	69.9%	63.8%	86.8%	95.6%	93.6%	86.9%	78.7%	61.8%	83.1%	76.4%	92.2%	99.3%	152
Lung	93%	80.6%	90.9%	85.7%	83.3%	90.9%	72.7%	62.5%	80.0%	90.5%	100.0%	94.4%	76.5%	90.0%	20
Skin	93%	94.7%	93.3%	84.1%	93.2%	96.7%	91.4%	87.4%	97.0%	95.4%	93.7%	95.1%	93.0%	90.7%	236
Upper Gastrointestinal	93%	75.3%	84.4%	75.5%	93.5%	98.4%	93.1%	84.4%	95.8%	93.0%	94.8%	90.6%	98.0%	95.3%	86
Urology (Suspected testicular cancer)	93%	93.6%	93.6%	93.9%	94.0%	85.5%	82.4%	80.4%	78.3%	85.6%	83.3%	93.3%	98.2%	95.3%	64

## 62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	No of Treatments
Brain	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Breast	85%	100.0%	66.7%	58.8%	100.0%	100.0%	100.0%	100.0%	50.0%	92.3%	83.3%	84.6%	84.6%	75.0%	16
Children's	85%	100.0%	100.0%	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	66.7%	100.0%	100.0%	0.0%	50.0%	50.0%	100.0%	100.0%	71.4%	33.3%	100.0%	0.0%	50.0%	2
Haematology	85%	85.7%	66.7%	33.3%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%	87.5%	100.0%	2
Head & Neck	85%	89.5%	73.7%	81.0%	50.0%	66.7%	83.3%	52.4%	100.0%	25.0%	60.0%	61.5%	57.1%	52.9%	8.5
Lower Gastrointestinal	85%	60.0%	71.4%	75.0%	42.9%	50.0%	-	100.0%	60.0%	22.2%	25.0%	42.9%	38.5%	60.0%	5
Lung	85%	100.0%	100.0%	100.0%	62.5%	0.0%	85.2%	50.0%	60.0%	77.8%	55.6%	33.3%	100.0%	50.0%	3
Skin	85%	91.7%	100.0%	100.0%	52.9%	81.8%	85.2%	82.4%	100.0%	100.0%	100.0%	50.0%	81.5%	87.1%	15.5
Sarcoma	85%														
Upper Gastrointestinal	85%	0.0%	40.0%	-	0.0%	33.3%	71.4%	80.0%	100.0%	28.6%	100.0%	100.0%	53.8%	50.0%	2
Urology	85%	85.0%	84.0%	81.5%	100.0%	64.3%	25.0%	27.3%	78.8%	55.6%	71.4%	57.1%	78.4%	57.6%	16.5
Other	85%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	28.6%	-	0.0%	100.0%	100.0%	-		0



## Diagnostics



### What the information tells us

In February, the Trust reported a continued improvement in performance against the six-week diagnostic standard with a performance of 14.8% compared to 18.1% in January. The number of patients on the waiting list is within the upper and lower control limits for a consecutive month with a total of 7,436 patients, an increase of 1.6%. In total at the end of February there were 1,101 patients waiting beyond 6 weeks compared to 1,327 patients in the previous month - a decrease of 17%. And there was a total of 601 patients waiting for more than thirteen weeks, compared to 595 patients in the previous month. All areas with the exception of Urodynamics and Flexi Sigmoidoscopy have seen an improvement against the 1% target.

Non-obstetric ultrasound has returned to compliance where Gynaecology specifically has reduced the number of patients waiting and currently have zero patients waiting for more than six weeks.

For patients who have been waiting more than six weeks, they are waiting nearly 17 weeks, on average, for a diagnostic test; this has increased by five days compared to December. Endoscopy has seen an increase of 6% in the number of patients waiting for more than six weeks with the average wait time increasing by 1.5 weeks compared to December. Echocardiography are currently reporting 223 patients waiting for more than six weeks, which is 20% of all breaches. Waits within Echocardiography have continued to decrease with a 42% reduction in January.

### Actions and Quality Improvement Projects

**Audiology** – Capacity has increased compared to pre-COVID, with additional evening and weekend slots being available. The service continues to review the waiting list and optimise capacity.

**Endoscopy** - reduced endoscopy clinics from 21 December as the endoscopy unit at Tooting was being used as an ITU surge area. As ITU areas are de-escalated more Endoscopy activity will come back on line throughout March

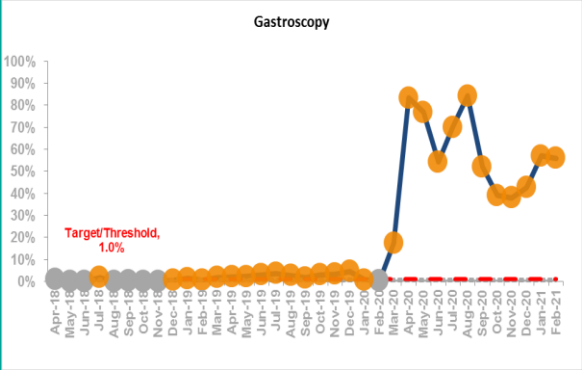
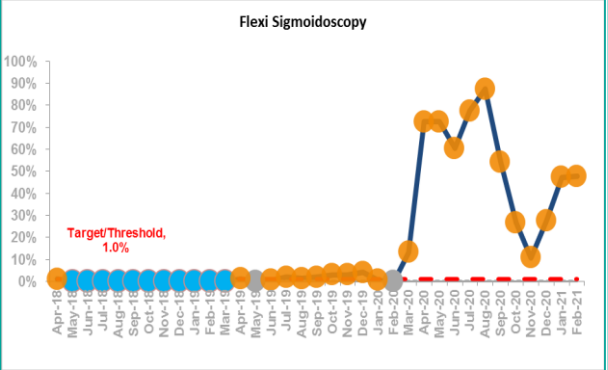
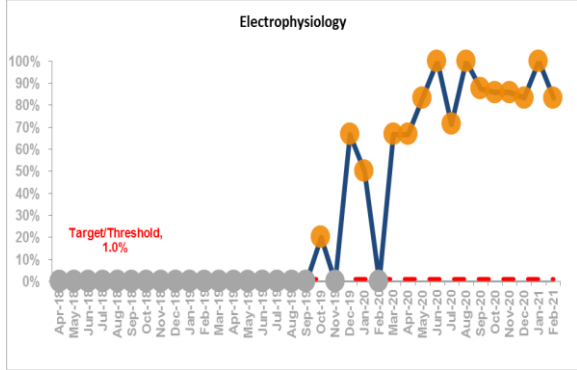
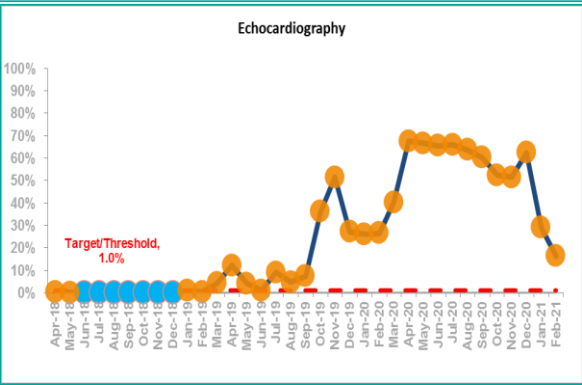
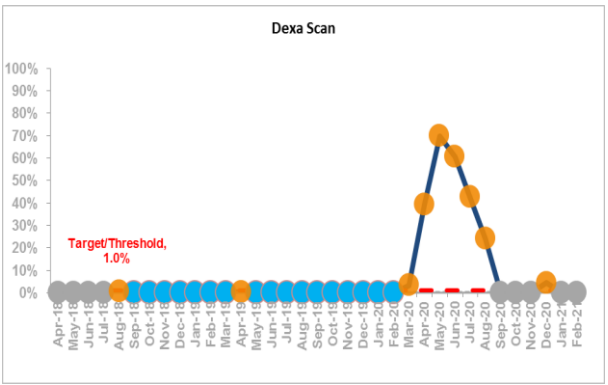
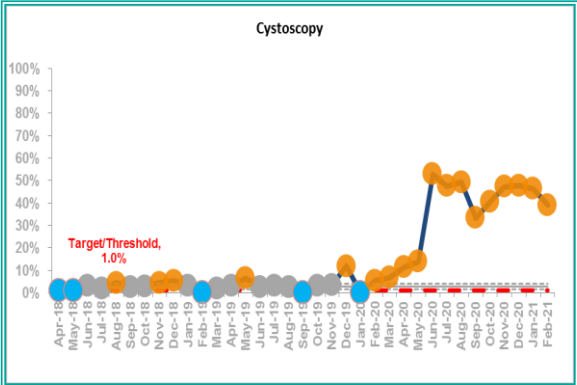
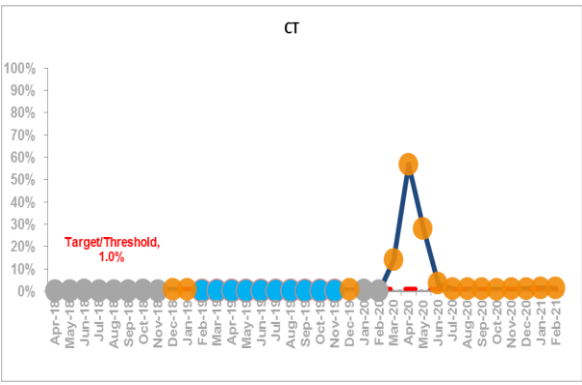
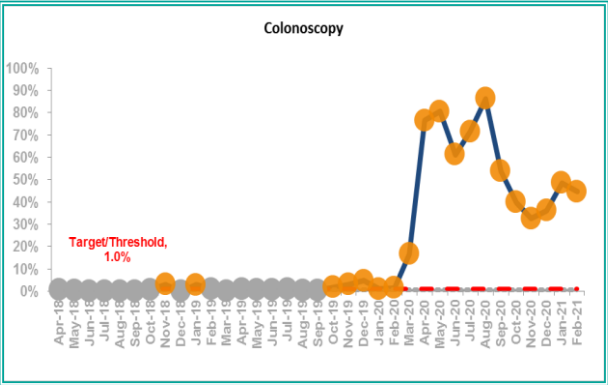
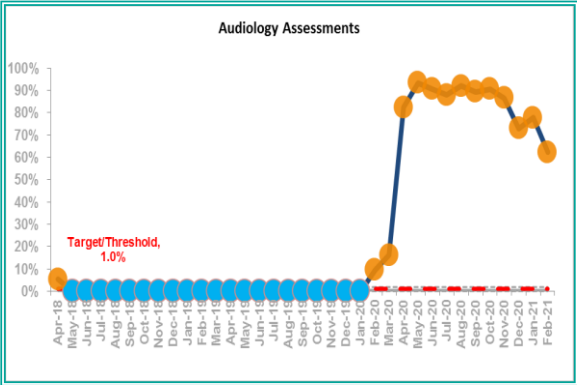
**Echocardiography** - Significant reduction in the waiting list due to

- 1) the use of weekend insourcing work by an external company. Echocardiography capacity was increased due to the use of this company on weekend and even during the week (6-7 lists every Saturday a Sunday since the 18 July 2020)
- 2) review of the Echo waiting list moving the incorrectly placed 'routine' requests to planned where patients are booked for a specific date or to be repeated at a specific frequency as per DM01 guidance

The Cardiology diagnostic service will be working with NHS England and NHS Improvement on the Echo Recovery Project for South West London exploring the use of a demand and capacity tool.

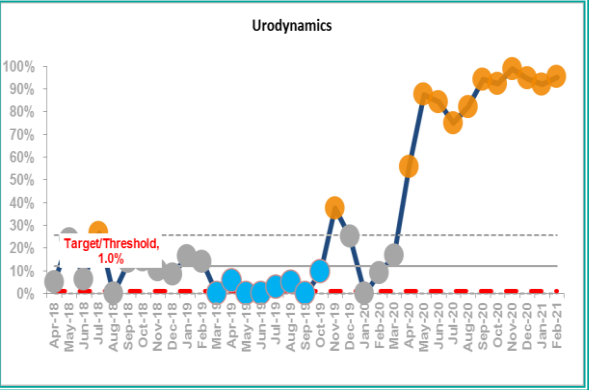
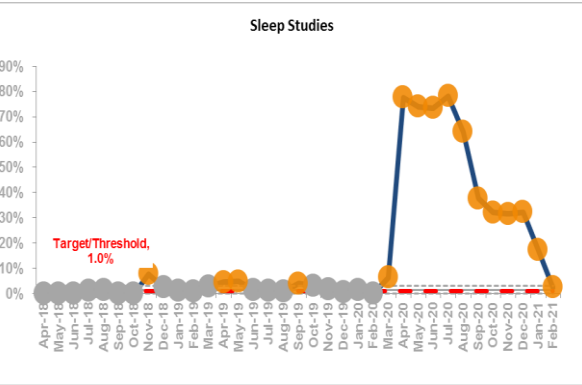
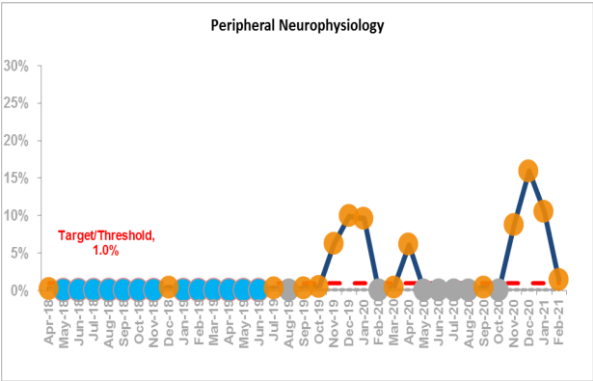
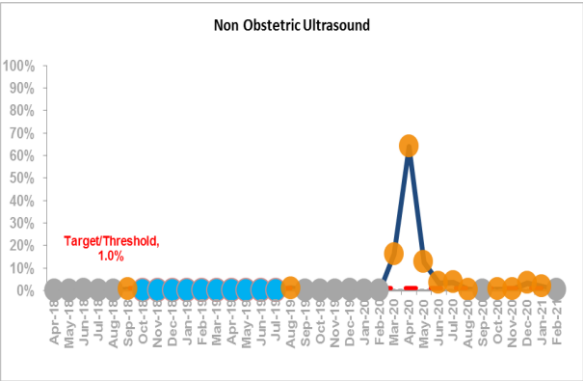
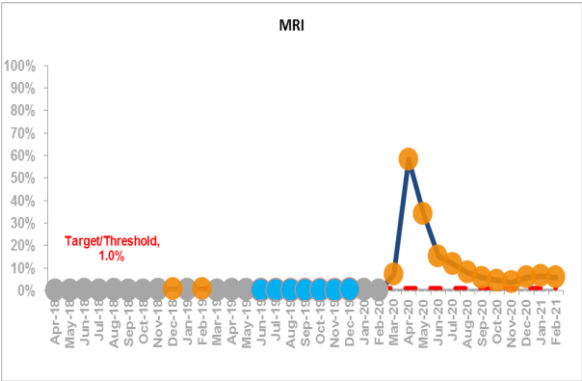
Diagnostics

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



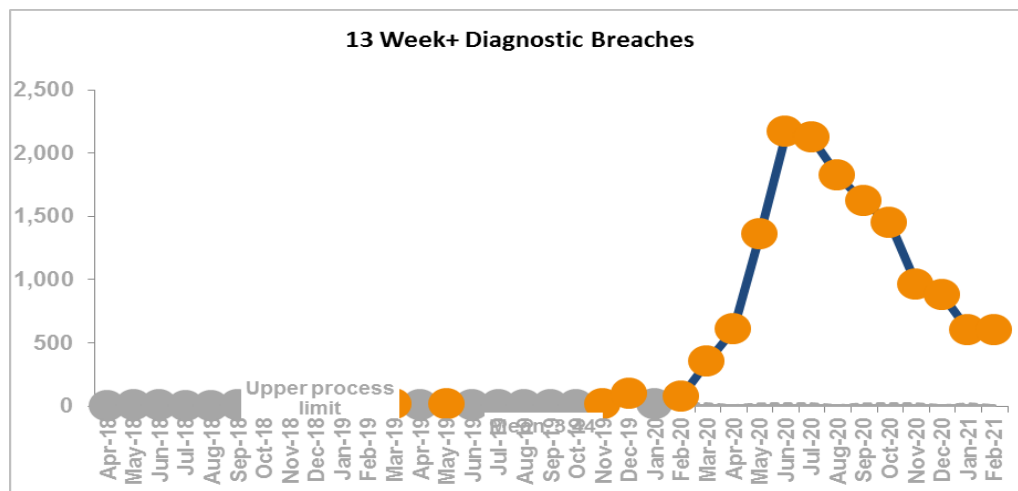
Diagnostics

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



Our Process Perspective

## Diagnostics – Patients waiting for more than 13 Weeks



Modality	Dec-20	Jan-21	Feb-21	Variance last month	% Variance last month
Audiology - Audiology Assessments	67	70	95	25	35.7%
Cardiology - echocardiography	526	216	154	-62	-28.7%
Cardiology - electrophysiology	4	3	4	1	33.3%
Colonoscopy	68	68	90	22	32.4%
Computed Tomography	4	4	4	0	0.0%
Cystoscopy	41	29	22	-7	-24.1%
Flexi sigmoidoscopy	5	20	36	16	80.0%
Gastroscopy	92	132	163	31	23.5%
Magnetic Resonance Imaging	19	18	19	1	5.6%
Non-obstetric ultrasound	2	0	0	0	0.0%
Respiratory physiology - sleep studies	23	10	2	-8	-80.0%
Urodynamics - pressures & flows	27	25	12	-13	-52.0%
<b>Grand Total</b>	<b>878</b>	<b>595</b>	<b>601</b>	<b>6</b>	<b>1.0%</b>

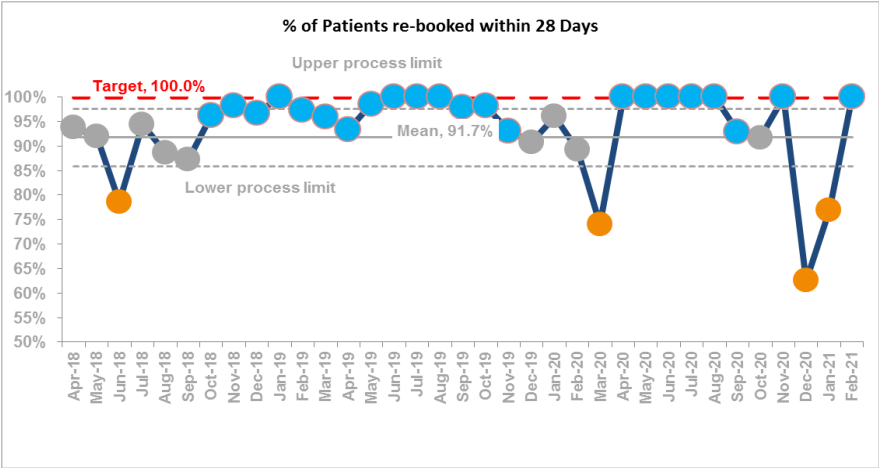
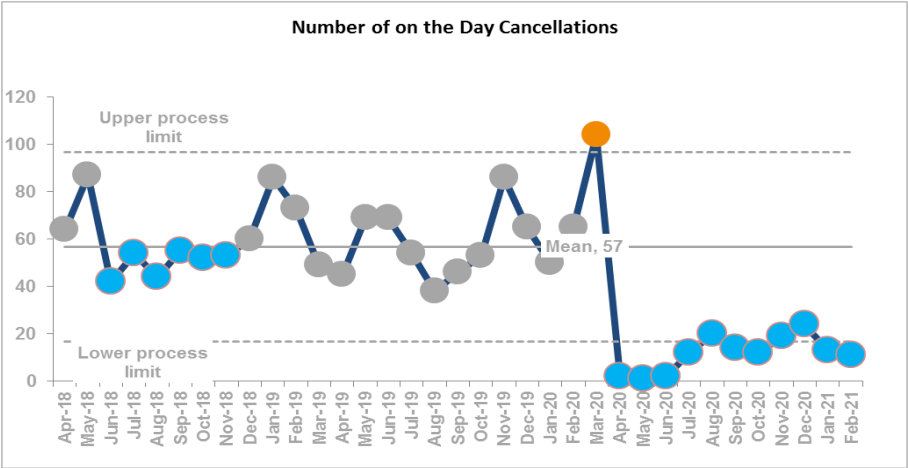
### What the information tells us

In February, there were a total of 601 patients waiting for more than thirteen weeks which is a slight increase of 1% (6 patients) compared to January.

**Echocardiography** has the largest decrease with 154 patients waiting over thirteen weeks compared to 216 patients in January. The reduction is driven by both increased activity and review of the waiting list. Within the service, all patients on the waiting list (whether within or over 6 weeks) have had senior clinical validation since April 2020 and have been triaged according to nationally agreed criteria.

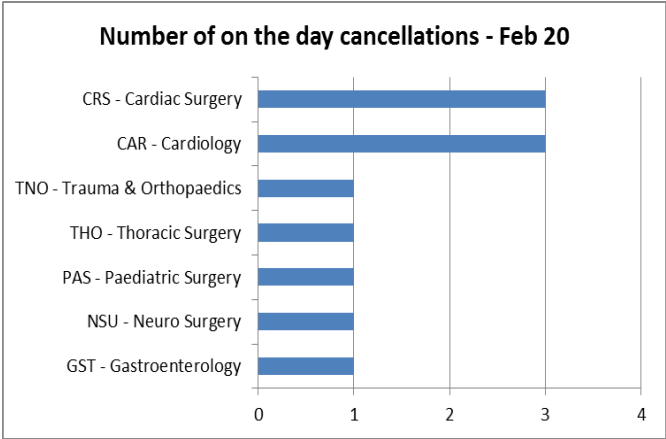
**Endoscopy** has seen an increase in patients waiting more than thirteen weeks with an average waiting time of 23 weeks for patients within this cohort although decreasing from 26 weeks in January. Within Endoscopy, Gastroscopy has the largest proportion of patients waiting for more than thirteen weeks, rising by 23% compared to January. The increase within Endoscopy is driven by the Endoscopy unit at Tooting site being converted to an ITU surge area. There is on-going close collaboration between senior clinicians, management and the executive to mitigate the risk this has presented, and to recover the position. The service have had senior clinician led validation of the endoscopy waiting lists throughout the pandemic.

# On the Day Cancellations for Non Clinical Reasons



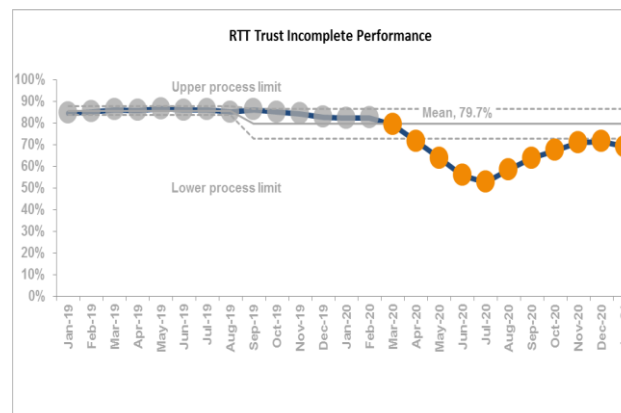
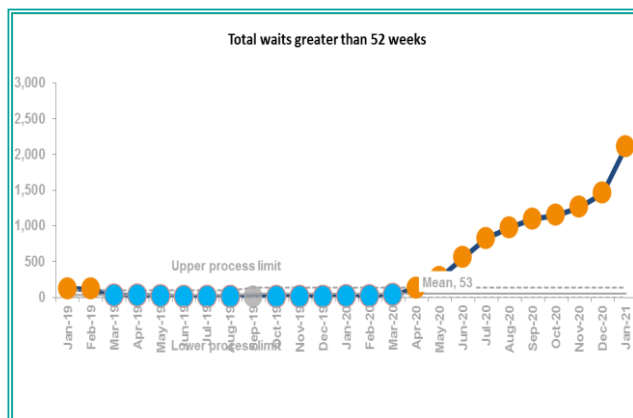
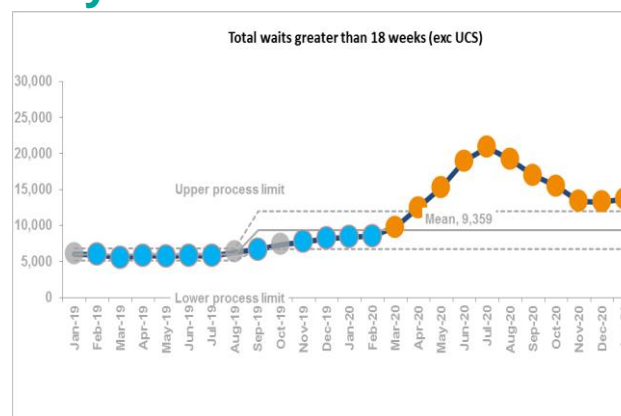
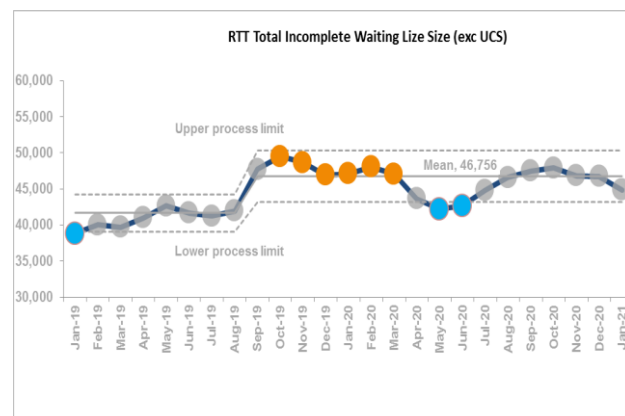
**What the information tells us**  
The number of on-the-day cancellations for non-medical reasons remain below the lower control limit. In February, a total of eleven patients were cancelled on the day of which all patients were offered a rebooking date within 28 days.

- Cancellation reasons are broken down as follows:
- Timing (Emergency case / List overrun) - 8
  - Booking Error - 1
  - No bed availability - 2



- Actions and Quality Improvement Projects**
- 8 of the 11 cancellations were as a result of timing issues (ran out of theatre time or cancelled to create capacity for emergency patients – however all patients were subsequently rebooked within 28 days. Clinical decision making on the day of the cancellation ensures there is no clinical harm as a result of the cancellation.
  - 2 patients were cancelled as a result of no ITU capacity, which is as a result of no appropriate ‘green’ ITU beds for cardiac. This is now resolved, and the patients have received treatment.

## Referral to Treatment — January 2021



Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in January was 568, this is an increase from 433 reported in January. Compared to the same month year this is a 59% improvement.

### What the information tells us

In the month of January, there were 44,859 patients waiting for treatment on the Patient Tracking List (PTL), this is a reduction of 4% compared to the previous month. Decreases were generally seen across all specialties with large decreases within Cardiology, Dermatology, Gynaecology, Plastics and Trauma & Orthopaedics.

In the non-admitted pathway, the total waiting list size reduced by 6% (2,614 patients), however an increase is reported within the admitted pathway of 6% (615 patients) mainly within General Surgery and Ear, Nose & Throat.

The incomplete waiting time standard was at 69.1% in month; a decrease in performance of 2.3%. We have seen an increase of 444 patients waiting for more than 18 weeks overall.

The Trust reported 2,108 patients waiting for more than 52 weeks to receive treatment which accounts for 4.8% of the total waiting list, with both admitted and non-admitted pathways seeing an increase of over 300 patients. Ear, Nose & Throat have seen the largest increase compared to the previous month with an additional 157 patients waiting beyond 52 weeks.

As a result of COVID-19 our focus has been seeing and treating the most urgent of our patients within a restricted amount of capacity in both outpatients and operating theatres. Capacity continued to be significantly restricted in January, with 14 of 29 operating theatres closed and outpatient capacity limited due to space and staffing issues. As a result, the number of patients waiting more than 52 weeks continues to increase, however we continue to provide capacity for our most urgent patients.

Our focus remains on ensuring that the quality of our data is accurate and that we understand the clinical priorities. Services are focused on three key areas:

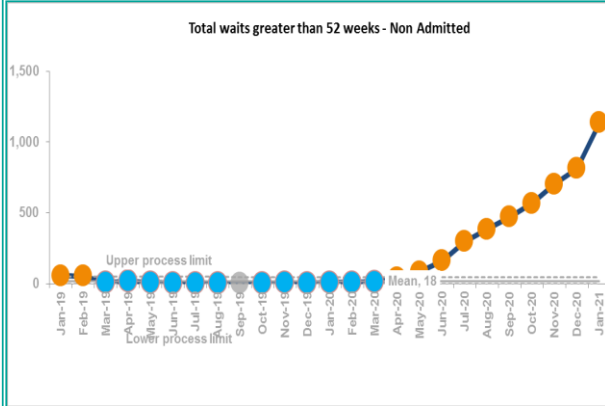
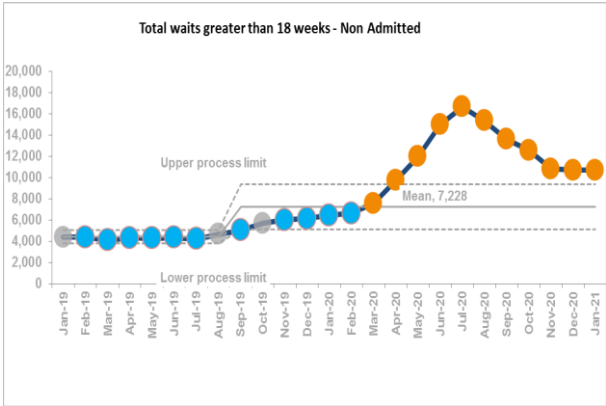
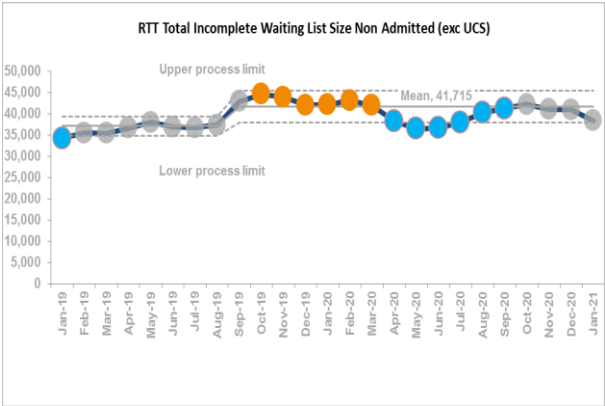
- 1) Managing the triage processes at the front end of the pathway (e.g. Appointment Slot Issues)
- 2) Removing any historical data (e.g. historic TCIs awaiting removal from the system and uncashed appointments)
- 3) Tracking patients COVID priority status ensuring all patients are assigned a category

Significant improvements have been made with action 1 and 3, however more focus on action 2 is required to improve historical data, particularly regarding uncashed appointments.

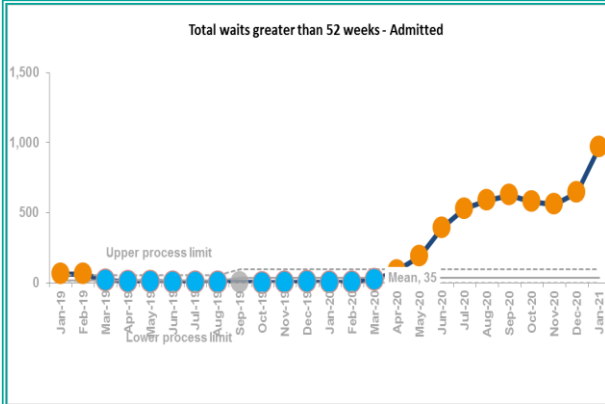
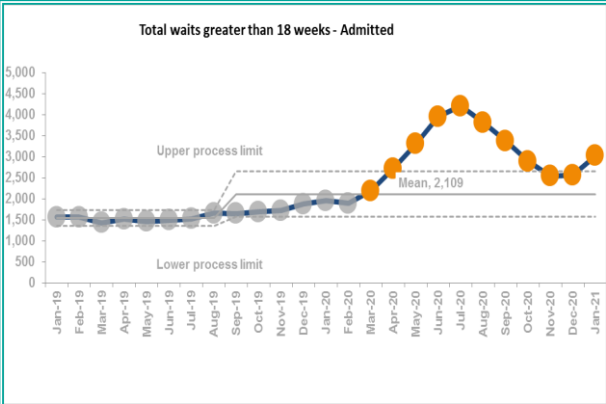
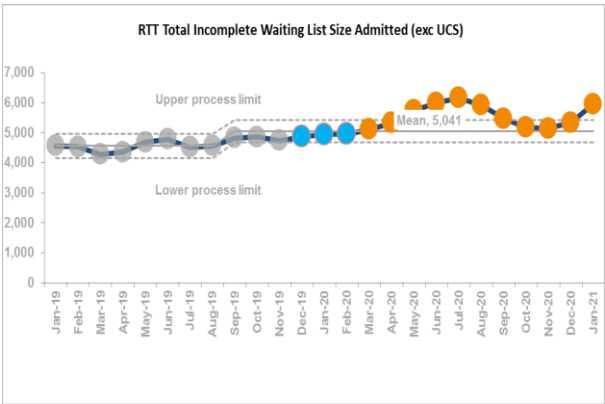


# Referral to Treatment — January 2021

## Non Admitted PTL



## Admitted PTL



Our Process Perspective



# Balanced Scorecard Approach



Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

## Workforce

2.2

Our People Perspective

Indicator Description	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Trust Level Sickness Rate	3.2%	4.0%	5.1%	5.6%	4.1%	3.5%	3.2%	3.4%	3.6%	3.3%	3.3%	3.9%	4.2%	3.6%
Trust Vacancy Rate	10%	10.7%	10.6%	10.5%	6.8%	8.3%	8.4%	8.2%	9.1%	9.4%	9.1%	8.5%	7.8%	8.6%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.3%	16.9%	16.7%	16.1%	15.3%	15.1%	15.2%	15.4%	15.3%	15.3%	15.0%	15.0%	14.7%
Total Funded Establishment		9,369	9,369	9,373	9,098	9,289	9,256	9,263	9,265	9,320	9,331	9,336	9,330	9,451
IPR Appraisal Rate - Medical Staff	90%	81.7%	80.0%											
IPR Appraisal Rate - Non Medical Staff	90%	72.4%	69.6%	67.9%	67.6%	69.9%	73.6%	74.6%	72.4%	71.7%	70.6%	69.6%	65.8%	65.6%
Overall MAST Compliance %	85%	90.6%	90.7%	90.2%	89.7%	89.9%	89.8%	89.9%	89.9%	90.5%	90.0%	89.4%	88.9%	88.2%
Ward Staffing Unfilled Duty Hours	10%	6.2%	15.2%	17.4%	3.0%	1.6%	2.8%	3.7%	5.4%	6.3%	10.4%	15.8%	19.9%	
Trust Stability Index	85%	83.0%	83.0%	83.7%	84.2%	84.9%	85.4%	86.3%	86.1%	85.8%	87.0%	88.5%	87.7%	88.0%

### What the information tells us

- The Trust's sickness absence rate is above the set target of 3.2%.
- Vacancy Rate at 8.6 % is below the set target of 10%,.
- The Trust turnover rate remains above set target
- Appraisal rates for Non Medical staff declined again this month to 65.6% against a target of 90%
- Stability Index at 88.2% is above target, and is used to inform retention strategies.

### Actions and Quality Improvement Project

Over the last 2 months, the Employee Relations team has made contact with relevant line managers to commence sickness absence meetings and support in making referrals to Occupational Health.

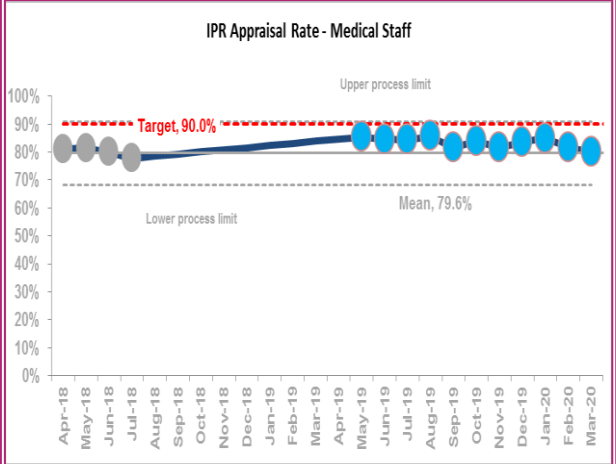
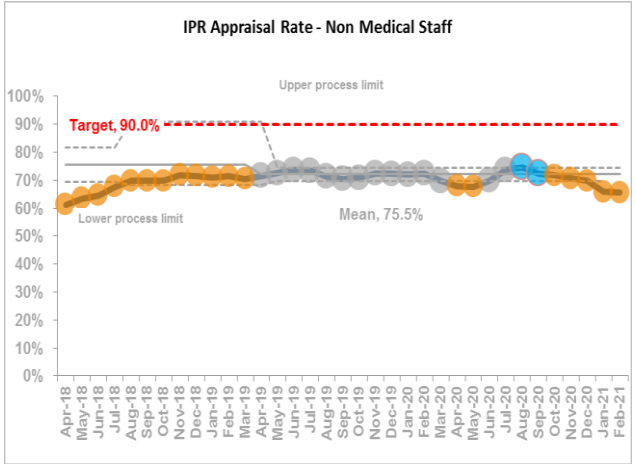
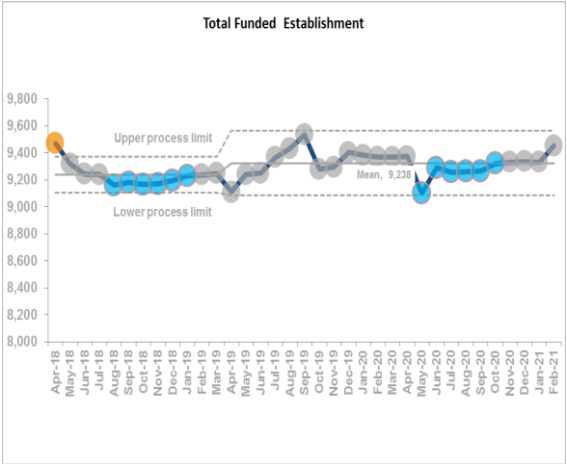
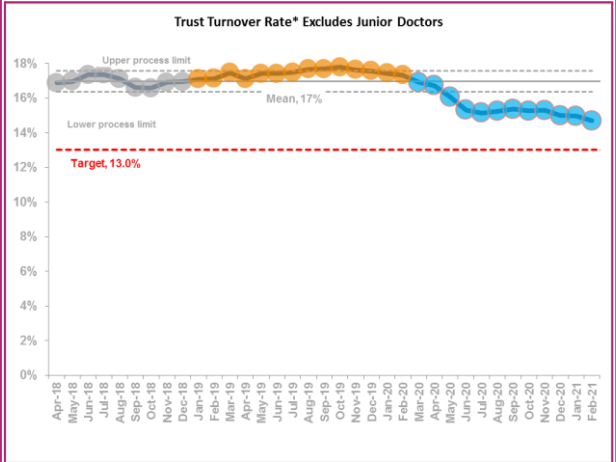
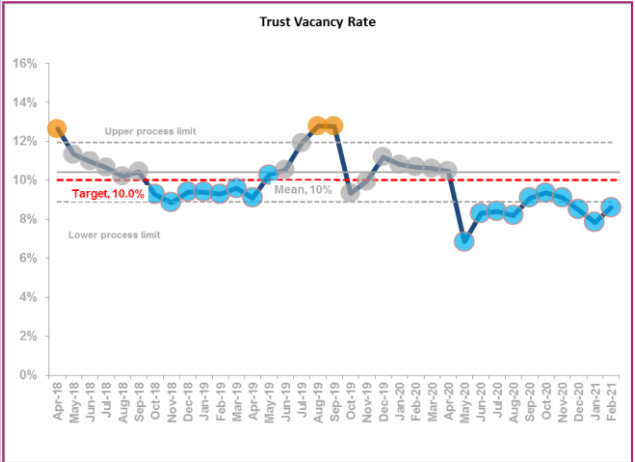
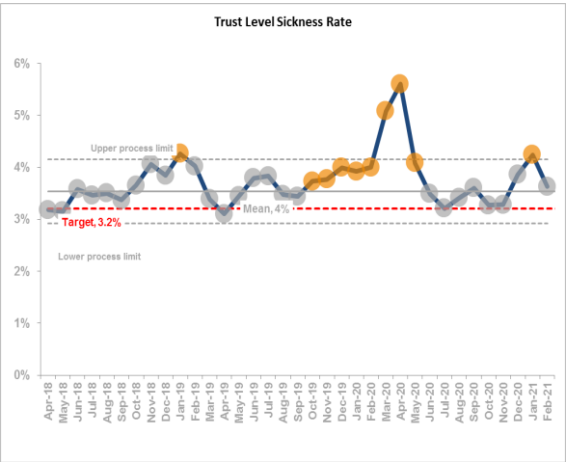
Trust turnover– a new approach to completing exit questionnaires was implemented on 2 November 2020 and will provide useful and timely information to help with putting in place required strategies.

Completion of appraisals for non-medical staff continues to be encouraged with HR Business Partners developing projected trajectories for completion.

Medical Appraisals – Deputy Chief Medical Officer is making arrangements for commencement following a pause by GMC during COVID-19 pandemic.

Workforce

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

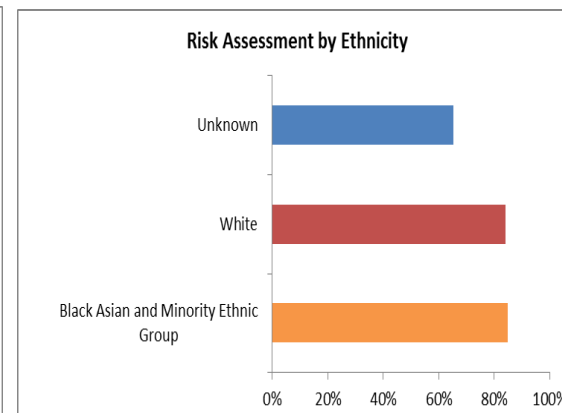
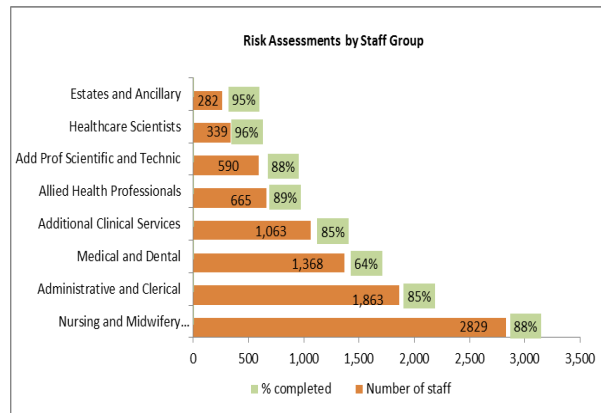
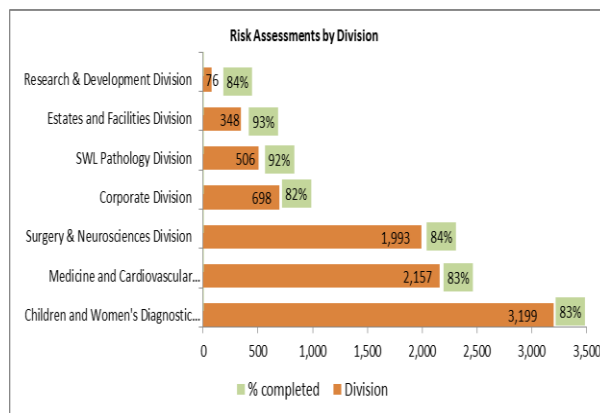


## Workforce – January COVID-19 Risk Assessment

Division	Number of forms completed	Number of staff	% completed
Children and Women's Diagnostic and Therapy Services Division	2,643	3,199	83%
Medicine and Cardiovascular Division	1,787	2,157	83%
Surgery & Neurosciences Division	1,678	1,993	84%
Corporate Division	569	698	82%
SWL Pathology Division	463	506	92%
Estates and Facilities Division	323	348	93%
Research & Development Division	64	76	84%
<b>Trust Total</b>	<b>7,527</b>	<b>8,977</b>	<b>83.8%</b>

Staff Group	Number of forms completed	Number of staff	% completed
Nursing and Midwifery Registered	2499	2829	88%
Administrative and Clerical	1,579	1,863	85%
Medical and Dental	868	1,368	64%
Additional Clinical Services	899	1,063	85%
Allied Health Professionals	592	665	89%
Add Prof Scientific and Technic	518	590	88%
Healthcare Scientists	326	339	96%
Estates and Ancillary	246	260	95%
<b>Grand Total</b>	<b>7,527</b>	<b>8,977</b>	<b>83.8%</b>

Ethnicity	No of forms completed	Total number of staff	% completed
Black Asian and Minority Ethnic Group	3,600	4,239	85%
White	3,704	4,396	84%
Unknown	223	342	65%
<b>Trust Total</b>	<b>7,527</b>	<b>8,977</b>	<b>84%</b>



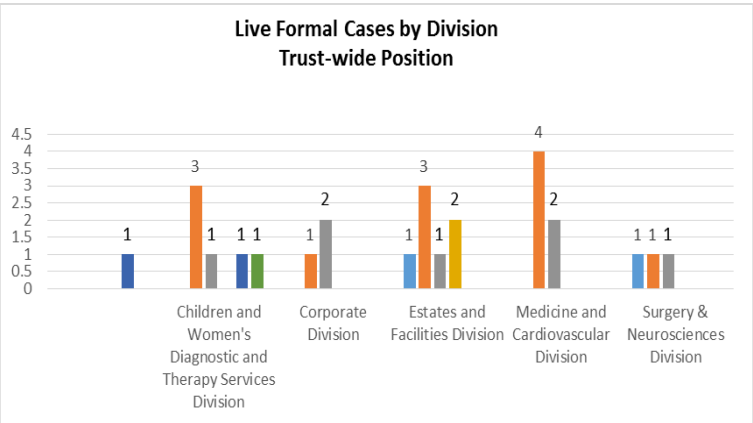
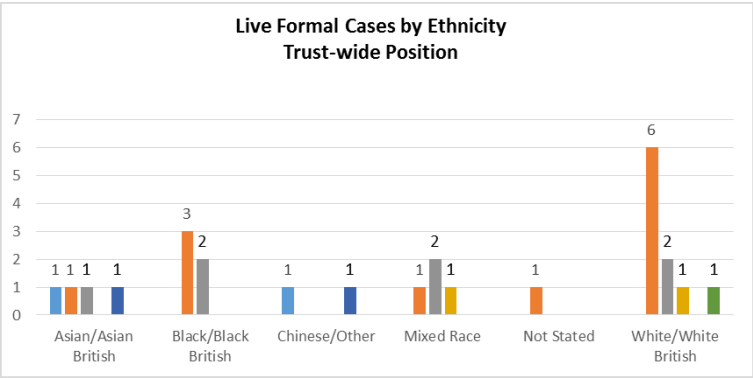
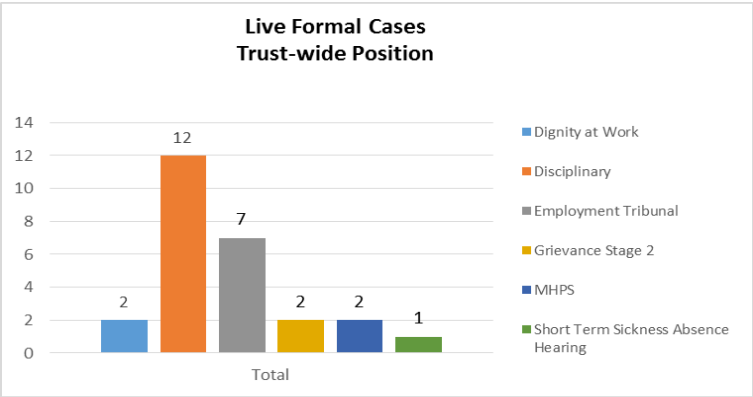
### What the information tells us

- The table shows completion of COVID Risk Assessment as at 8 March 2021.
- The Trust completion rate is at 83.8%. Completion rate for BAME staff stands at 84.9% and White staff 84.3%.

### Actions and Quality Improvement Project

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

# Workforce - Employee Relations Cases as at 28<sup>th</sup> February 2021



## What the information tells us

As at 28 February 2021, the Trust had 26 live Employee Relation (ER) formal cases. It is worth noting a downward trend in the number of formal cases Trust-wide falling from a total of 44 live ER cases in October 2020 to the current 26. Disciplinary cases remain the highest at 12 followed by Employment Tribunal cases at 7.

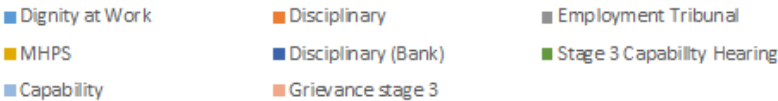
CWDT and Estates & Facilities Divisions have the highest cases at 7 each followed by MedCard with 6 cases.

Disciplinary cases by ethnicity - White/White British ethnic group has the highest number of disciplinary cases at 6, followed by Black/Black British ethnic group at 3.

## Actions and Quality Improvement Project

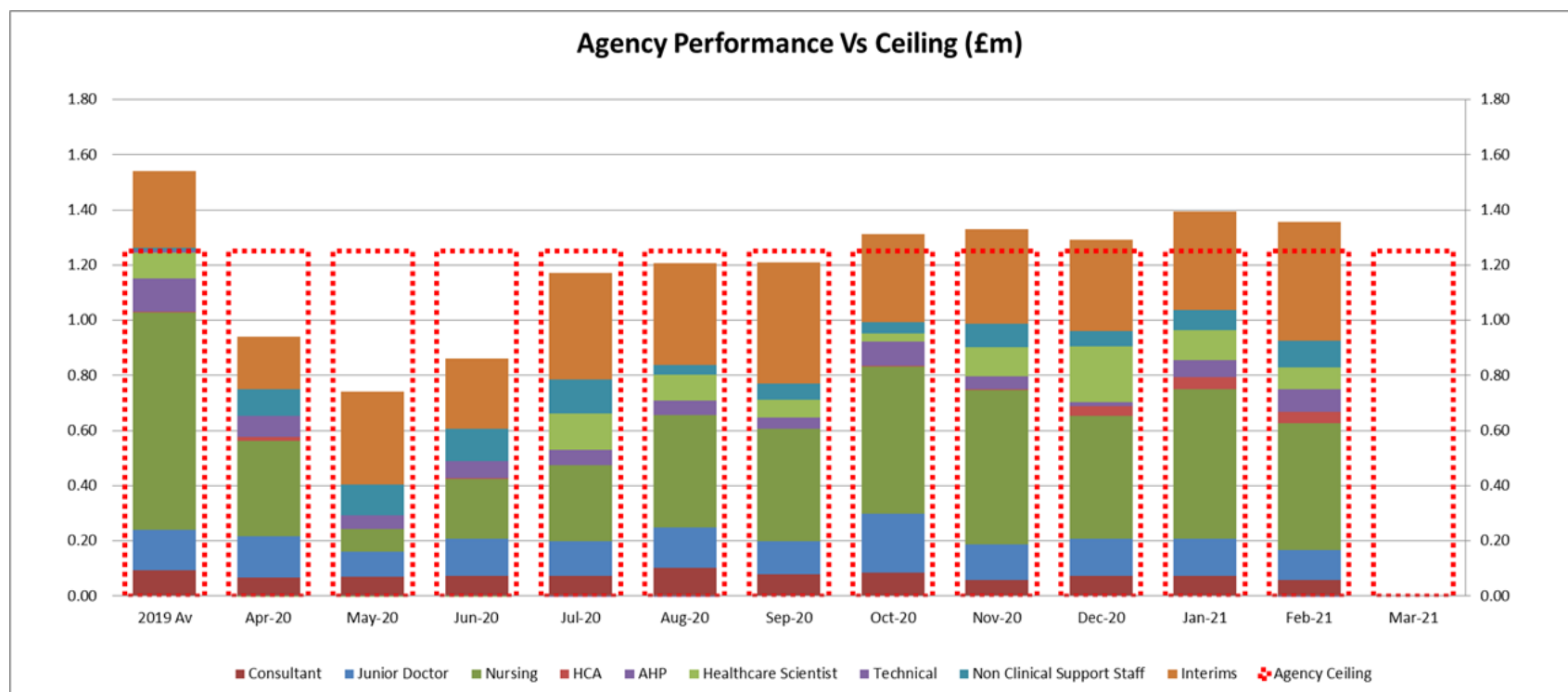
The newly introduced disciplinary pre-investigation providing coaching from HR, has enabled managers to engage with staff locally and address less serious people issues resulting in 6 cases being resolved informally instead of the formal route.

Employee Relations surgeries run on a monthly basis to equip line managers with knowledge and skills on how to resolve cases informally has seen a number of historical cases going back several years closed.



## Agency use

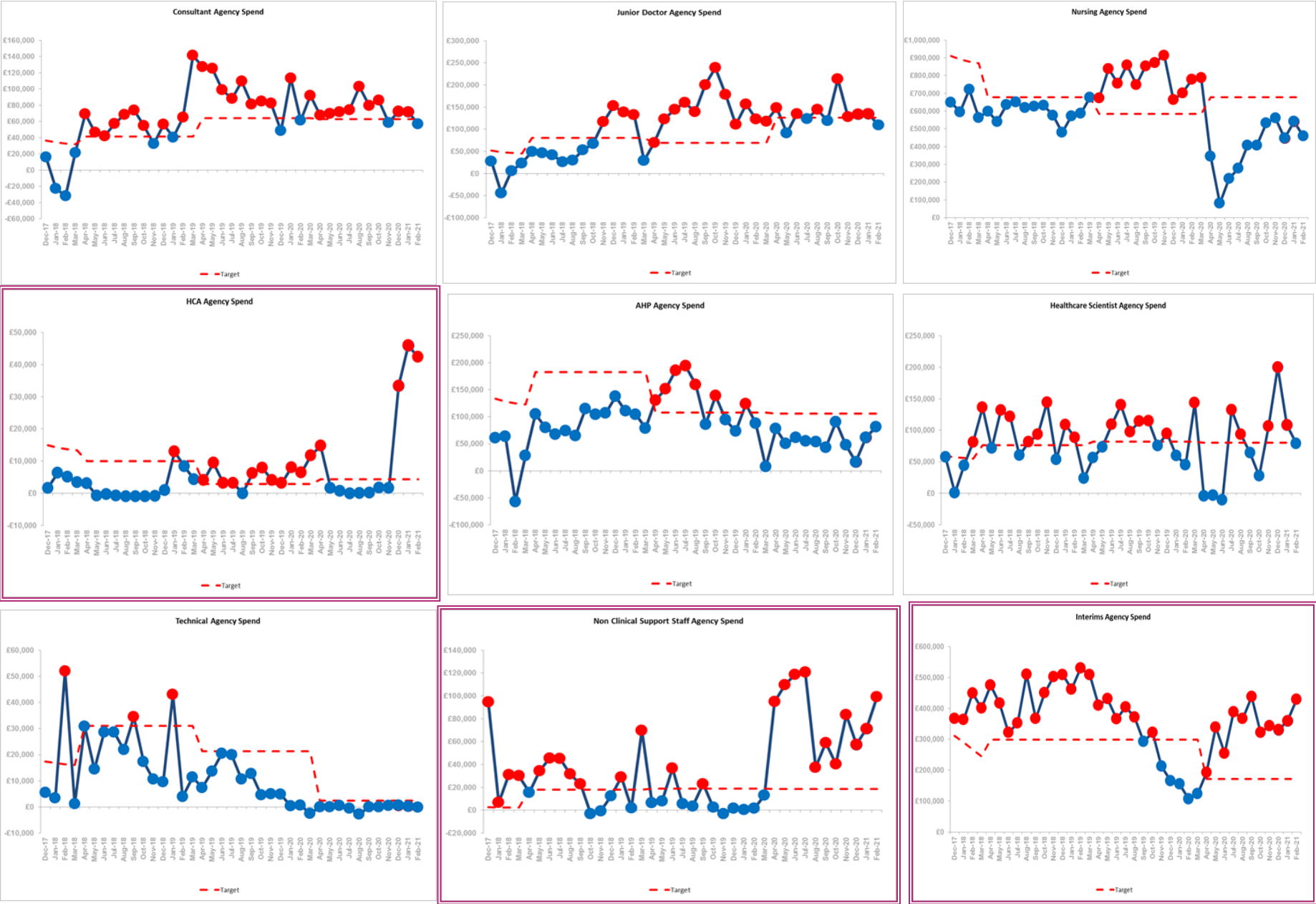
2.2



- The Trust's total pay for February was £51.27m. This is 2.39m adverse to a plan of £48.88m
- 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 £1.36m or 2.6% of the total pay costs. For 2019/20, the average agency cost was 3.3% of total pay costs
- For February, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.11m
- The biggest areas of overspend were Interims (£0.26m) and Non Clinical Support (£0.08m). The biggest areas of underspend were Nursing (£0.22m)

Our People Perspective

Agency use





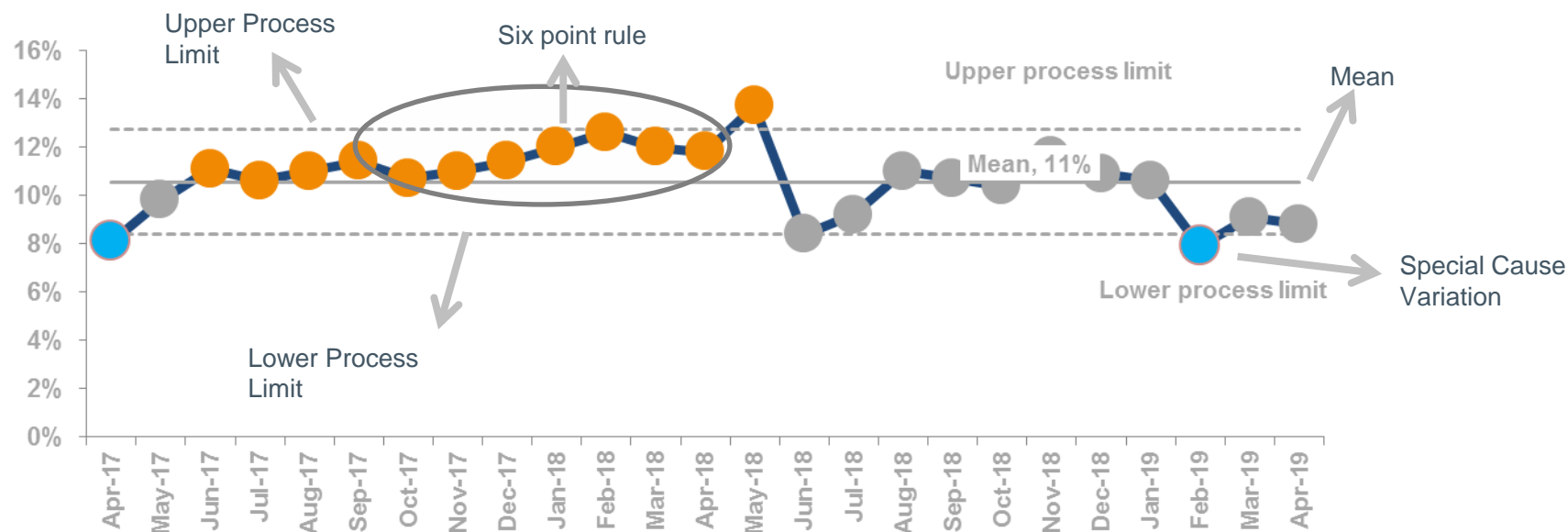
# Appendix

## Additional Information



## Interpreting SPC (Statistical Process Control) Charts

First and Follow Up DNA Rates (by month) - T&O



**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	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Compliance with appropriate response to EWS (Adults)	100%	91.1%	94.1%	86.9%	93.5%	97.0%	93.6%	78.2%	84.8%	92.4%	94.1%	93.7%	95.2%	94.0%
Number of EWS Patients (Adults)		460	289	290	403	474	512	634	465	474	426	478	230	348



## RTT Performance - January 2021

Indicator Description	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
RTT Trust Incomplete Performance	82.3%	79.3%	71.5%	63.8%	55.7%	52.7%	58.4%	63.7%	67.4%	71.0%	71.4%	69.1%
RTT Total Incomplete Waiting Lize Size (inc UCS)	48,061	47,048	43,643	42,196	42,672	44,117	46,139	46,755	47,399	46,142	46,290	44,291
Total waits greater than 18 weeks (exc UCS)	8,498	9,755	12,440	15,268	18,924	20,863	19,177	16,974	15,443	13,365	13,251	13,695
Total waits greater than 52 weeks	11	32	129	274	554	825	972	1,097	1,146	1,261	1,456	2,108
RTT Incomplete Performance - Admitted	61.9%	57.2%	49.0%	42.4%	34.1%	31.8%	35.6%	38.3%	44.2%	50.6%	51.9%	49.2%
Total waits - Admitted	4,958	5,112	5,330	5,746	5,997	6,165	5,923	5,470	5,178	5,141	5,335	5,950
Total waits greater than 18 weeks - Admitted	1,891	2,186	2,720	3,308	3,955	4,207	3,816	3,373	2,891	2,541	2,564	3,025
Total waits greater than 52 weeks - Admitted	3	20	88	190	393	529	588	626	579	559	643	971
RTT Incomplete Performance -Non Admitted	84.7%	82.0%	74.6%	67.2%	59.2%	56.1%	61.8%	67.1%	70.3%	73.6%	73.9%	72.2%
Total waits - Non Admitted	43,103	41,936	38,313	36,450	36,675	37,952	40,216	41,285	42,221	41,001	40,955	38,341
Total waits greater than 18 weeks - Non Admitted	6,607	7,569	9,720	11,960	14,969	16,656	15,361	13,601	12,552	10,824	10,687	10,670
Total waits greater than 52 weeks - Non Admitted	8	12	41	84	161	296	384	471	567	702	813	1,137

Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in January was 568, this is an increase from 433 reported in January. Compared to the same month year this is a 59% improvement.

## RTT Performance – January 2021

Specialty	Admitted		Non Admitted	
	Total	% within 18 weeks	Total	% within 18 weeks
GENERAL SURGERY	466	31.8%	1,122	63.6%
UROLOGY	360	61.9%	1,770	85.7%
TRAUMA & ORTHOPAEDICS	193	57.0%	2,075	83.3%
ENT	413	33.9%	3,440	67.4%
OPHTHALMOLOGY			946	39.2%
ORAL SURGERY			227	66.1%
NEUROSURGERY	223	58.7%	2,166	72.1%
PLASTIC SURGERY	545	57.6%	657	73.7%
CARDIOTHORACIC SURGERY			5	1
GENERAL MEDICINE			30	60.0%
GASTROENTEROLOGY	769	82.8%	2,386	73.9%
CARDIOLOGY	965	29.6%	2,500	73.8%
DERMATOLOGY	4	100.0%	2,685	69.9%
RESPIRATORY MEDICINE	1	100.0%	1,080	93.7%
NEUROLOGY	11	72.7%	1,742	86.6%
RHEUMATOLOGY	4	1	1,104	69.3%
GERIATRIC MEDICINE			63	90.5%
GYNAECOLOGY	157	45.2%	2,427	78.8%
Other	1,224	56.8%	14,530	73.4%
Grand Total	5,335	51.9%	40,955	73.9%

Incomplete Pathway					
Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
862	726	1,588	54.3%	198	141
1,740	390	2,130	81.7%	74	32
1,839	429	2,268	81.1%	47	23
2,460	1,393	3,853	63.8%	338	167
371	575	946	39.2%	217	36
150	77	227	66.1%	17	22
1,693	696	2,389	70.9%	180	62
798	404	1,202	66.4%	83	96
5	0	5	100.0%	0	0
18	12	30	60.0%	3	0
2,400	755	3,155	76.1%	77	25
2,131	1,334	3,465	61.5%	321	175
1,881	808	2,689	70.0%	215	31
1,013	68	1,081	93.7%	8	0
1,516	237	1,753	86.5%	61	0
768	340	1,108	69.3%	36	16
57	6	63	90.5%	0	0
1,983	601	2,584	76.7%	163	45
11,354	4,400	15,754	72.1%	1,064	585
33,039	13,251	46,290	71.4%	3,102	1,456

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



Meeting Title:	Trust Board Meeting		
Date:	25 March 2021	Agenda No.	3.1
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Stephen Collier, Chair of Workforce and Education Committee		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	<p>This paper sets out the key risks and issues reviewed by the Committee at its meeting on 11 February and 15 March including commenting on assurance to the Board on <b>key risks</b> allocated to the Committee and assurance received.</p> <p>After detailed consideration at the February meeting, the Committee recommends a change to the level of the assurance rating for SR8 from ‘limited assurance’ to ‘partial assurance’. In addition, the Committee recommends that the risk score for SR8 would be moved from 20 to 16. Further detail is set out below.</p>		
Recommendation:	The Board is asked to note this report.		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		



## 1. Committee Chair's Overview

At its meetings on 11 February and 15 March the Committee received updates on a number of programmes and initiatives which are currently under way. Progress is being made across all fronts, and the sense is that we are beginning to move past the immediate impact of the pandemic although its impact will be with us for some time to come. The Culture Change programme remains the critical priority, and it would be helpful for the Trust's Chief People Officer to update the Board on next steps on implementation given that the planning workshop was held after the Committee's meeting.

The focus at the 11 February meeting was reviewing and receiving assurance on the Trust's response to the second wave of the Covid pandemic. At the March meeting we also reviewed the results of the Staff Survey undertaken at the end of 2021, and heard from the Chief Executive on her priority areas for action.

The Committee also reviewed the results of its Effectiveness Review, undertaken during February, and noted progress since the previous Review. Areas which require to be further addressed are: Committee engagement with its Terms of Reference; training for new members; verification of evidence of implementation, to gain confirmatory assurance; and attendance by divisional directors of operations. These will be included within the Committee's 21-22 planning.

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

## 2. Key points:-

### **Board Assurance**

The Committee has two Trust-level risks<sup>1</sup> allocated to it as part of the Board Assurance Framework. After detailed consideration at the February meeting, no changes are proposed to the current risk score for Trust Risk SR9.

However, the Committee noted encouraging progress in a number of areas and agreed to recommend a change to the level of the assurance rating for SR8 from 'limited assurance' to 'partial assurance'. In addition, the Committee recommends that the risk score for SR8 would be moved from 20 to 16. Our recommendation is that the Board accept these changes. Full details of the discussion are available in the Committee minutes for February, and this will be reflected in the Q4 2020/21 BAF report to the Board at its next meeting.

It is sensible to comment here on the issue identified in the Committee's Effectiveness Review about the need for the Committee "*to gain confirmatory assurance*". This is a result of a discussion the Committee had at its February meeting. It transpired there that the assurance the Committee had received some time ago about the Trust linking its pay progression to completion of staff appraisals had not, in fact, been implemented. Whilst management has been clear that the intention is still to implement this, the Committee felt that it had (unintentionally) been misinformed. For this reason, the Committee will for 21-22 develop more of a verification focus.

### **Theme 1 - Engagement**

**NHS Staff Survey – Review of SGH results.** The Trust continues to make progress in improving staff sentiment and their experience of working at the Trust. There is still some way to go, but a real opportunity now in sight to move staff experience well above the average for the NHS. In a long and open discussion with the Chief Executive and the Chief People Officer it was clear that, whilst cautiously optimistic about the further progress that can be made, there was a realism about the challenge in addressing some of the more intractable areas. These remain bullying and harassment, and diversity and inclusion.

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





The Trust's overall assessment of the survey results is that they represent a further step forward which also highlight specific areas for attention. Key focus areas for the future will include: staff engagement; clearer and more focussed communication; sharper management induction and training; as well as maintaining the pressure for change through the Trust's Diversity and Inclusion programme.

All that said, the Trust's performance against the three bellweather indicators (Trust focus on patients; Trust as place to work; and Trust as place to be treated) have all shown positive movement and are either at or close to the NHS average (see Appendix A to this Report). For those who have followed the Trust's progress over the last four years, this is really encouraging progress although there is further to go. The Trust intends to benchmark its results against other London Trusts (as opposed to the NHS as a whole), given the specific challenges of the London healthcare environment and the results of this will be reviewed at a subsequent meeting of the Committee.

**Culture Programme Update – From 'Discover' to 'Design'.** We received an update from Paul daGama, Chief People Officer, on the way in which the Trust was developing its culture-change delivery plan, and linking this to the post-Covid decompression and re-set of the Trust's operational activities. The workshop to agree an implementation plan was scheduled to take place the day after the Committee's meeting, and so it would be helpful if Paul would update the Board on decisions made and any timescales or targets set. The key point that was made to the Committee – which we accepted – was the need for the team to design and implement a change process that is owned by 9,000 members of staff, not just by an implementation group.

**Freedom to Speak Up Guardian's Q3 Report** – Karyn Richards-Wright joined the March meeting to update on current cases and trends, as well as the progress on implementation of the Trust's FTSU Strategy. The number of concerns being raised continues to grow, which Karyn regarded as a positive sign of growing staff confidence in the process. Karyn's assessment was that some staff still had concerns about using the Freedom to Speak Up process, and she and the Trust would continue to address this. The number of concerns and themes that had been raised within the FTSU process were reviewed by the Committee by staff group and by functional area, and certain trends noted. Covid, bullying and harassment, and leadership were the three thematic areas with high levels of concerns raised. The Committee noted how the Trust was aiming to address these. The use of the process by groups of staff was noted, and seen as an important and positive development.

The Chief Executive regarded the system as helpful in identifying areas for intervention and or management development. A number of findings in the Staff Survey triangulated with the experience of the Guardian, notably improvements noted in the Staff Survey about raising concerns (see Appendix B to this Report). There was good joint working between the Guardian of Safe Working and the Freedom to Speak Up Guardian, and any issues initially raised in the wrong domain were being quickly redirected. This had highlighted the need for continued education of staff as to the types of concern appropriate to each system. Timeliness of the completion of investigations remained a challenge and the Trust will look to improve on this. The new IT platform had encountered some difficulties due to problems with the Trust's servers, but the Trust was now addressing this.

**Health and Wellbeing Report** – the Committee received reports on this area at both its February and March meetings. It is clear that significant effort is being put into this area by the Trust, and the scale of support being delivered was noted. Based on data showing uptake since the end of December, there had been a marked increase in the numbers of staff accessing support. The Committee reviewed the guidance to managers on Wellness Action Plans for members of staff. The Committee noted the importance of this activity and its positive impact, and hoped that it would continue long after the pandemic.

**Diversity and Inclusion Action Plan – Progress Update.** The Committee received and noted the content of an update at each meeting, showing continuing delivery of planned activities.



Although the Trust is not yet where it intends to be, progress is being made. The Committee noted the less positive experience of working at the Trust reported by black staff, notably in AfC bands 2-5 and noted the Trust's commitment to actively address this. The use of a Recruitment Inclusion Specialist had been mandated for all appointments at Band 7 and above, and the intention was to further extend this initiative to Band 6 appointments in the near future. Initial feedback from individuals involved has highlighted some areas for improvement, and we were assured that this feedback was being acted on.

We received an update on the various staff networks and how they were progressing. People's available time to lead these was becoming an issue, and the Trust was considering how to address this.

## **Theme 2 – Leadership and Progression**

**Workforce Update** – at its February meeting the Committee reviewed a detailed operational update for Q3, noting effective planning for and management of the Covid situation. Vaccine hesitancy was discussed in detail and we were given strong assurance that, with time and persuasion, high levels of vaccine uptake could be achieved. We will return to this at our April meeting. The involvement of over 60 British Army staff at the Trust during wave 2 had been extremely well received, and the psychological as well as the resourcing benefit of this was noted. Their involvement had been much appreciated by all staff, and the plan was for them to remain on site as a resource through to the end of March.

## **Theme 3 - Workforce Planning and Strategy**

***Maintaining High Professional Standards*** – the update to the policy was being discussed between the Trust and the BMA's local medical committee, and an update will be brought to the next meeting given the time that has elapsed since this process began.

***Renormalising and home working*** – outside of the Committee's meetings, I have agreed with the Chief People Officer that this item will be deferred to June 2021 to enable the Trust to undertake and complete a wider piece of work on re-setting Trust operational activity, of which this is one component.

## **Theme 4 – Compliance.**

***Bank Staff Holiday Pay*** – The Committee in private session received a further briefing from Paul da Gama on the impact of the Working Time Regulations and endorsed the approach being adopted by the executive team to resolving this.

***Other*** – we sought and received assurance from Paul that so far as he was aware there were no areas where there had been or was any non-compliance by the Trust.

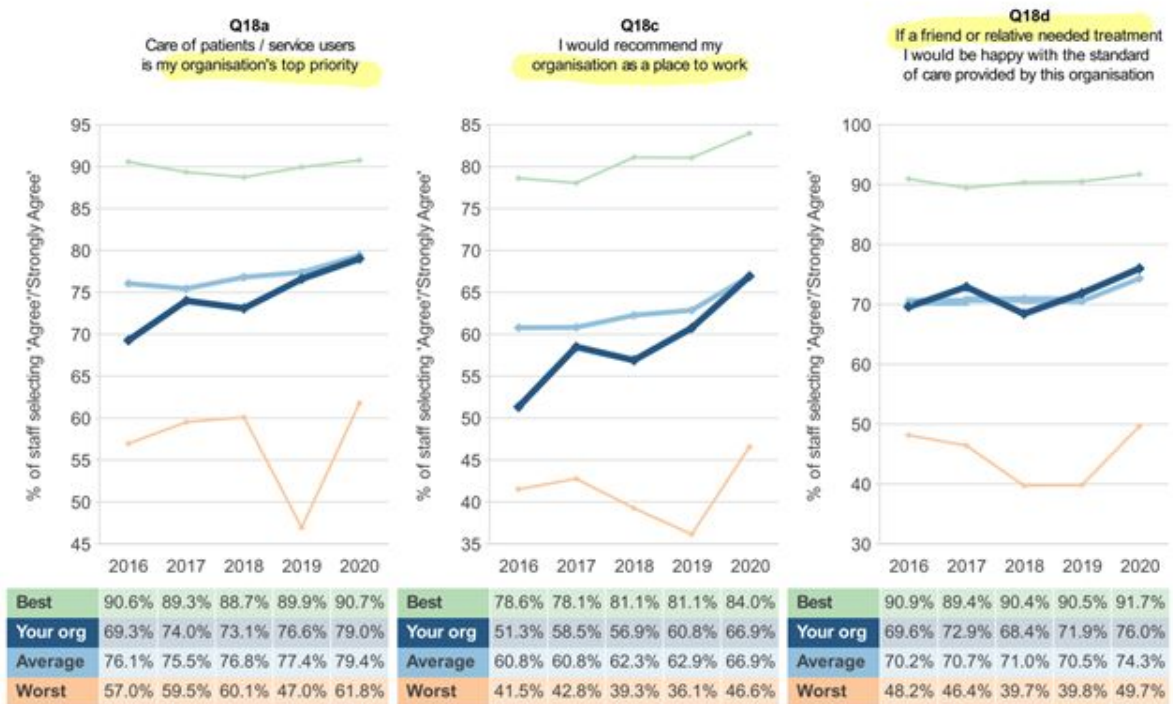
**Stephen J Collier**

**Committee Chair,**

19 March 2021

## Appendix A

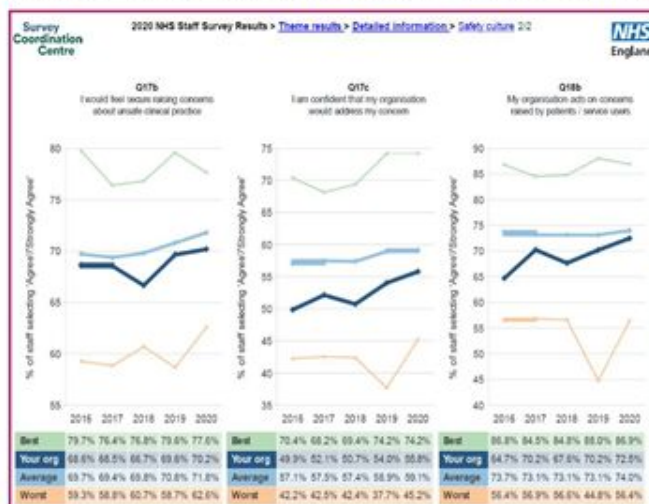
2020 NHS Staff Survey Results > [Theme results](#) > [Detailed information](#) > [Staff engagement](#) – Recommendation of the organisation as a place to work/receive treatment



## Appendix B

### 2. Current activity and themes

#### Triangulating increases in 2020/21 FTSU cases with 2020 NHS Staff Survey responses



- The increases in the number of staff raising concerns with the FTSU Guardian in 2020/21 has taken place in the context of improvements in the feedback from staff about raising concerns in the 2020 NHS Staff Survey.
- In the 2020 NHS Staff Survey, there were small increases in:
  - the number of staff reporting that they would feel secure in raising concerns about unsafe clinical practice (69.6% in 2019 to 70.2% in 2020);
  - the number of staff saying they were confident the Trust would address their concerns (54.0% in 2019 to 55.8% in 2020); and
  - the number of staff reporting that the Trust acts on concerns raised by patients and survey users (70.2% in 2019 to 72.5% in 2020).
- It is not possible to draw or evidence any direct correlation between the improvements in the survey results and the increase in the number of concerns raised with the FTSU Guardian. However, small increases in the confidence of staff in raising concerns and in how the organisation deals with concerns will likely foster greater willingness of staff to approach the Guardian.



Meeting Title:	Trust Board Meeting		
Date:	25 March 2021	Agenda No	3.2
Report Title:	Annual National NHS Staff Survey 2020 – results, analysis and action planning		
Lead Director/ Manager:	Paul da Gama, Chief People Officer		
Report Author:	Humaira Ashraf, Deputy Chief People Officer Liz Woods, Staff Engagement Lead		
Presented for:	Assurance		
Executive Summary:	<p>This report provides a summary analysis of the 2020 Staff Survey results and plans for next steps.</p> <p>In general terms, the Trust has performed well in comparison to our historical results. We have seen an improvement in results with seven out of the ten of the ‘themes’ experiencing a year on year level of improvement. In two areas the perception of trust staff has worsened and in one area the results have remained as in 2019.</p> <p>It is pleasing to note that we have improved in all three indicators related to its Friends and Family test questions and is significantly above average for these pivotal questions.</p> <p>The Trust’s results remain below the average for NHS trust’s, although on closer analysis we can note that our current scores are very close to the average for the majority of survey themes.</p> <p>One area of particular concern is around diversity and equality where the Trust’s scores have worsened, although this is common to most organisations in the sector.</p> <p>The Trust is intending to run a much more proactive approach to how it communicates and manages its response to what our staff are telling us, with a new engagement programme called ‘The Big 5’ being instigated.</p>		
Recommendation:	The Board is asked to note the summary analysis of the 2020 Staff Survey results and the proposed action planning.		
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		
Implications			
Risk:	Failure to act on the results of the 2020 Staff Survey risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.		



<b>Legal/Regulatory:</b>	National Annual NHS Staff Survey		
<b>Resources:</b>			
<b>Equality and Diversity:</b>	The staff survey results provide an indicator on how well we are doing as a Trust in terms of creating a culture that is inclusive and where diversity thrives.		
<b>Previously Considered by:</b>	Workforce Education Committee Meeting	<b>Date</b>	15 <sup>th</sup> March 2021
<b>Appendices:</b>	Appendix (A) – power point slide deck providing overview of 2020 staff survey results		



## Annual National NHS Staff Survey 2020 – results, analysis and action planning

3.2

### 1.0 PURPOSE

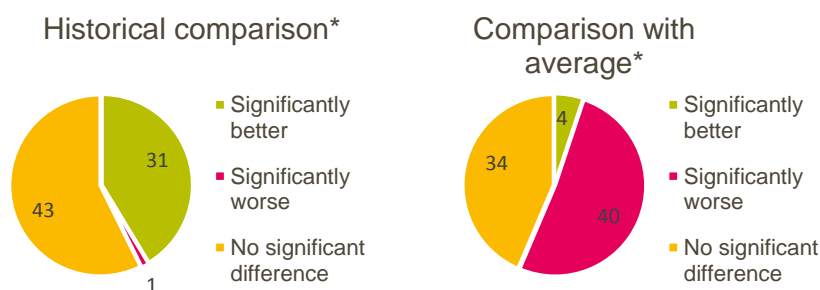
- 1.1 This report seeks to update the Trust Board on the results of the annual national NHS Staff Survey 2020.
- 1.2 It also seeks to provide assurance that the proposed action planning will contribute to improvements across the Trust and to an increased response rate to the 2021 Staff Survey later this year.

### 2.0 BACKGROUND

- 2.1 Picker on behalf of 59 Acute and Acute & Community Trusts organisation were commissioned to run the NHS Staff Survey 2020. This report presents the Trust's results in comparison to these organisations.
- 2.2 The 2020 NHS Staff Survey ran from 5<sup>th</sup> October to 27<sup>th</sup> November 2020.
- 2.3 The response rate in 2020 was 59.4%; this represents 5107 out of 8602 eligible staff completing the survey.
- 2.4 The results were under embargo until 9.30am on 11<sup>th</sup> March 2021 and were not be shared outside the organisation before then.
- 2.5 The results of the staff survey and associated analysis are in the process of being shared within the organisation so that detailed action planning can be undertaken and staff are informed of the results.

### 3.0 2020 NHS Staff Survey Results - Overview of the Findings

- 3.1 A total of 78 questions from the survey can be positively scored. 75 of these can be compared historically between 2019 to 2020.



- 3.1 In general terms, we have performed well in comparison to our historical results. Our staff engagement score is 7.0, up from 6.9 last year. Specifically we have improved in all three indicators related to the trust's Friends and Family test scores.





Key Staff Engagement Indicators		
	2019	2020
Would recommend organisation as a place to work	60.8%	67.9%
If friend/relative needed treatment would be happy with standard of care provided by organisation	71.9%	76.0%
Care of patients/service users is organisation's top priority.	76.6%	79.0%

3.2

3.2 When benchmarked against other similar Trusts and we are neither the best nor the worst performing Trust in any of the survey themes.

3.3 The top 5 scores and most improved scores from the last survey compared to the average are provided below:

Top 5 scores (compared to average)	
76%	Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation
11%	Q11g. Not put myself under pressure to come to work when not feeling well enough
55%	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties
91%	Q7b. Feel my role makes a difference to patients/service users
48%	Q13d. Last experience of harassment/bullying/abuse reported

Most improved from last survey	
55%	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties
67%	Q18c. Would recommend organisation as place to work
35%	Q4g. Enough staff at organisation to do my job properly
53%	Q5h. Satisfied with opportunities for flexible working patterns
49%	Q19b. I am unlikely to look for a job at a new organisation in the next 12 months



### 3.2 The bottom 5 scores and the least improved compared to the average are provided below:-

3.2

Bottom 5 scores (compared to average)	
74%	Q14. Organisation acts fairly: career progression
52%	Q4f. Have adequate materials, supplies and equipment to do my work
49%	Q19b. I am unlikely to look for a job at a new organisation in the next 12 months
40%	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours
27%	Q11a. Organisation definitely takes positive action on health and well-being

Least improved from last survey	
84%	Q12a. Not experienced physical violence from patients/service users, their relatives or other members of the public
75%	Q11f. Not felt pressure from colleagues to come to work when not feeling well enough
11%	Q11g. Not put myself under pressure to come to work when not feeling well enough
72%	Q11e. Not felt pressure from manager to come to work when not feeling well enough
64%	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours

### 3.3 Although our comparison with the average is not favourable, however, on closer analysis we can note that our current scores are very close to the average for the majority of survey themes, for example:-

- We score the same as the average for staff engagement;
- There is only one point difference between us the average benchmark group on our Quality of care score;
- There is only two point difference between us and the average benchmark group on following five themes:-
  - Health & well-being;
  - Immediate Manager;
  - Morale;
  - Safe Environment – Violence;



○ Safety Culture

- There is a three point difference between us and the average benchmark group on Safe Environment;
- The biggest difference between our scores and the average scores is in relation to Equalities and Diversity theme, where we are **seven points below the average**.

3.2

#### 4.0 Overview of the Findings of the Staff Survey Themes

- 4.1 Equality, Diversity and Inclusion – This indicator generally displays a downward trend for all Trusts in the benchmark. Of concern is the gap for career progression and experience of discrimination from where we are as a Trust and the average benchmark group. We have improved by 6% from last year on making reasonable adjustments for staff to do their work.
- 4.2 Health and Wellbeing – This shows an upward trend for all Trusts in the benchmark. With an improvement in scores of 0.4% the Trust has seen the steepest increase in improvement in this area compared to the benchmark.
- 4.3 Immediate Managers – The best and average benchmark groups are showing a decline in scores, however, as a Trust we have improved by 0.1% in 2020.
- 4.4 Morale – The general trend suggests an improvement in this area for us, the average and worst benchmark groups. Compared to other benchmark groups, we have improved the most by increasing scores by 0.3% in 2020.
- 4.5 Quality of Care – We are making steady progress on improving our quality of care and this year we have scored above the average by 0.1%.
- 4.6 Safe Environment: Bullying and Harassment – As a Trust we have stayed static at 7.6 for the past 4 years and have seen an improvement by 0.2% in 2020.
- 4.7 Safe Environment: Violence – We have dropped by 0.1% for the first time in 4 years and in doing so we are going against the trend.
- 4.8 Safety Culture – There is a general upward trend for the majority of the benchmark groups. We improved by 0.1% this year.
- 4.9 Staff Engagement – Having improved by 0.1% we are scoring the same as the average benchmarking group.
- 4.10 Team Working – There has been a general decline for the best and average benchmark groups, however, we have stayed the same.
- 4.11 Further analysis on each of the staff survey themes is provided as appendix (A).

#### 5.0 CONCLUSIONS

- 5.1 Given the pressures placed on our workforce during the covid pandemic, we should be cognisant and pleased by the general upward trend of improvement seen in the 2020 staff survey results.
- 5.2 We should not, however, be complacent as there is still a long way to go for us to be amongst the best performing Trusts in the benchmark.



- 5.3 The results for the Equality, Diversity and Inclusion theme could be explained by the heightened exposure of inequalities within the health care workforce system in the past year. Nevertheless as a Trust we show the biggest gap in E&D compared to the average, suggesting that there is considerable room for improvement in this area.

## 5.0 IMPLICATIONS

### Risks

- 5.1 Failure to act on the results of the 2020 Staff Survey risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.

### Resources

- 5.2 The contract with Picker runs from the 2019 survey to the 2021 survey at a cost of £2,700 + VAT per annum. There are additional costs for Picker to run the incentive scheme (£350 + VAT per survey) and to provide the thematic analysis of the free text comments (£750 + VAT per survey). There are also printing costs for promotional banners and posters.

## 6.0 NEXT STEPS

- 6.1 The embargo lifts on 11<sup>th</sup> March 2021.
- 6.2 During March 2021, the HR Business Partners will work with their Divisions and Directorates to develop detailed action plans.
- 6.3 An improvement action plan for the whole Trust will be developed during April 2021 and this will be based upon the 'Big 5' concept which will see 5 key areas of activity which the trust will prioritise on the basis of staff survey feedback. During April- August one topic will be chosen per month which will have organisational wide focus. This programme will be accompanied by high profile communication campaign culminating in September with a 'You said, we did' type month.
- 6.5 Concurrently, behind the scenes "housekeeping" will prepare the Trust for the 2021 Staff Survey, agreeing the incentive scheme and improving email address accuracy for example.

## 7.0 RECOMMENDATION

- 7.1 PMG is asked to note the 2020 Staff Survey results and approve the proposed next steps.

**Paul da Gama**  
**Chief People Officer**  
**March 2021**



2020 Staff Survey - Themed Analysis		
Theme	Overview	Analysis
<b>Equality, Diversity and Inclusion</b>	This indicator is generally showing a downward trend within the benchmark group. There has been an increase in reported cases of discrimination generally and a gap between Trust scores (13%) and the average (7.9%) for experience of discrimination from managers or colleagues	This could be explained by the heightened exposure of inequalities within the health care workforce system in the past year
<b>Health and Wellbeing</b>	The benchmark group and the Trust have seen a marked improvement in this area. We improved by 5% for flexible working opportunities. The trend for all benchmark groups is suggesting staff have felt unwell due to stress (4.1% increase for the average benchmark group, 0.3% for us)	Improvements explained by the health and wellbeing and staff support interventions made during pandemic
<b>Immediate Managers</b>	he Trust has improved overall by 0.1% whilst the best and the average performing Trusts have seen a decline. For support and feedback from managers, we have seen improvements of 2.4% and 1.7% respectively, whilst the best and average benchmark groups have seen declines	A considerable achievement in a covid year
<b>Morale</b>	The general trend is overall improvement. Being involved in change and on how to carry out roles have both improved (0.5% and 1.6% respectively), whereas the benchmark group has seen a downward trend	Improved team working and line management, plus the culture diagnostic work may explain the uplift
<b>Quality of Care</b>	There is a general upward trend of improvement for all benchmark groups, with the Trust above average by 0.1%. We are edging closer to the average for satisfaction with quality of care given...	... but we are still below our 2016 score, possibly explained by staff not feeling able to provide the level of care they'd like, because of the pandemic
<b>Safe Environment – bullying and harassment</b>	For the past 4 years, we scored 7.6 for this indicator. In 2020 we scored 7.8. The general trend demonstrates improvements for most benchmark groups and a 3.5% improvement on personal experience at the Trust of harassment, bullying or abuse at work from managers	To improve during a covid year is quite an achievement and possibly linked to the improvements that we are seeing in health and wellbeing and general engagement scores



<b>Safe Environment - violence</b>	The 0.1% decline here puts us behind the benchmark trend. Whilst we've seen a marked improvement of 0.5% for experience of physical violence from managers, we've seen a negative decline of 2.5% of experience of physical violence from patients and members of the public	Staff may have experienced increased verbal and physical abuse whilst trying to enforce social distancing and mask wearing measures
<b>Safety Culture</b>	There is an overall trend of improvement in this indicator. We have seen an uplift of 0.6% for feeling safe to raise concerns about unsafe clinical practice and an increase of 1.8% in confidence that the organisation will act on those concerns	The concerted efforts to embed a raising concerns and Freedom to Speak Up culture can be attributed to this improvement
<b>Staff Engagement</b>	We are going against the trend by showing an improvement in this indicator. 3.2% more staff compared with last year say they look forward to coming to work and 1.2% more are enthusiastic about their work	A significant achievement during a covid year
<b>Team Working</b>	The best and average Trusts have seen a decline, whilst overall we have stayed the same. For the teams with shared objectives indicator the Trust has demonstrated an improvement of 2.1 %. This improvement means that we are edging closer to the average	There has been much evidence of team and collaborative working during the pandemic



## Appendix (A)

# Staff Survey 2020 – Key Headlines, Communication & Action Planning

Trust Board Meeting  
25<sup>th</sup> March 2021

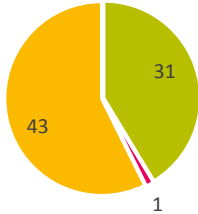
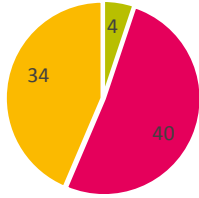
Paul da Gama  
Chief People Officer



# NHS Staff Survey 2020 – Executive Summary

Picker was commissioned by [59 Acute and Acute & Community Trusts](#) organisations to run their survey – this report presents our results in comparison to those organisations. A total of [78](#) questions from the survey can be positively scored. [75](#) of these can be compared historically between 2019 and 2020. Our results include every question where our organisation had the minimum required 11 respondents.

<b>8876</b> Invited to complete the survey	<b>8602</b> Eligible at the end of survey	<b>59.4%</b> Completed the survey (5107)	<b>49%</b> Average response rate for similar organisations
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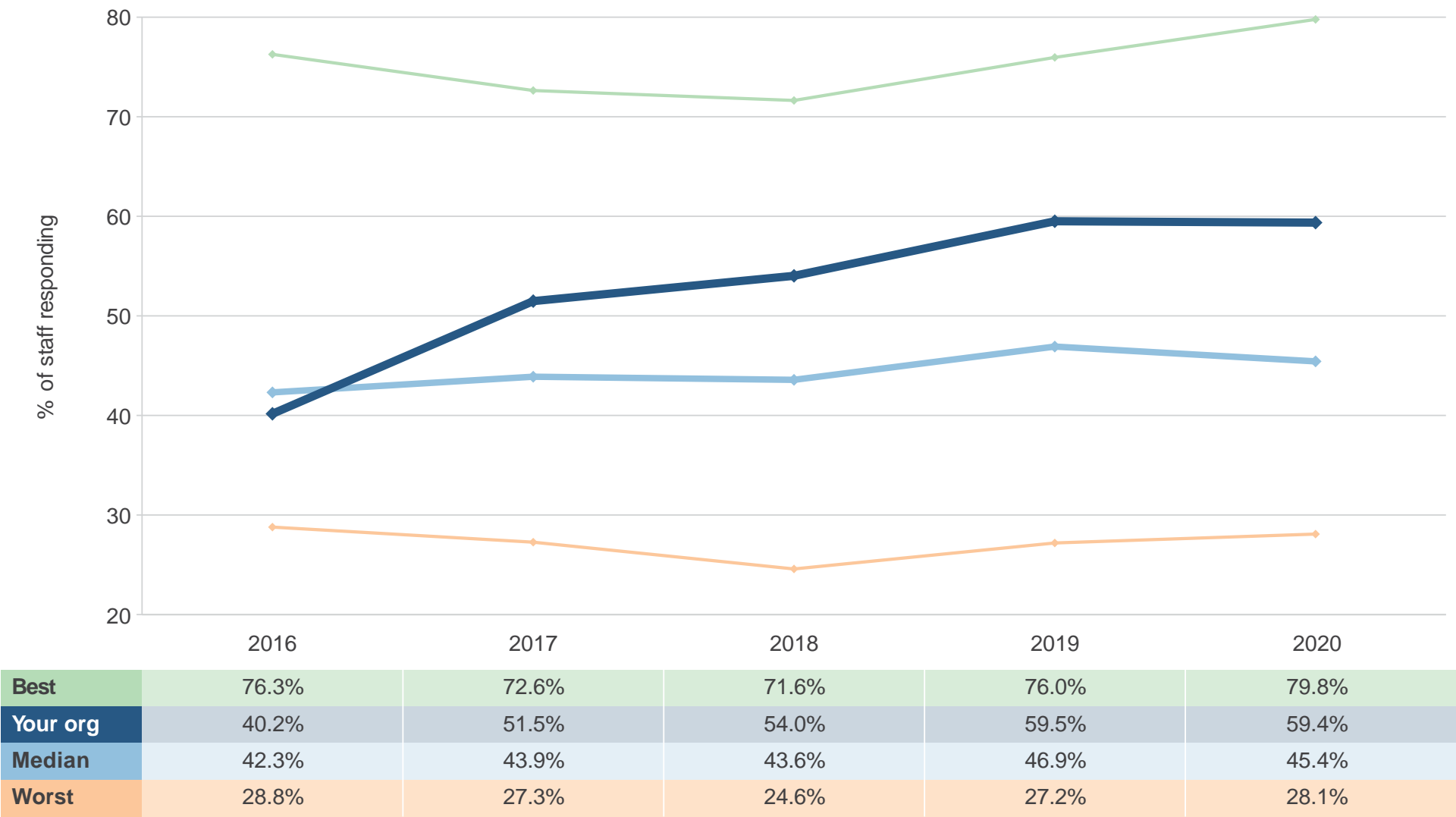
<b>67%</b> Q18c. Would recommend organisation as place to work  <b>76%</b> Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation  <b>79%</b> Q18a. Care of patients/service users is organisation's top priority	Historical comparison*   <ul style="list-style-type: none"> <li>Significantly better</li> <li>Significantly worse</li> <li>No significant difference</li> </ul>	Comparison with average*   <ul style="list-style-type: none"> <li>Significantly better</li> <li>Significantly worse</li> <li>No significant difference</li> </ul>
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	No difference	1 point difference	2 Point Difference	3 Point Difference	7 Point Difference
<b>Difference between Trust scores &amp; average scores</b>	Staff Engagement	Quality of Care	Health & Wellbeing Immediate manager Morale Safe Env – Violence Safety Culture	Safe Env - Bullying & Harassment	Equalities and Diversity

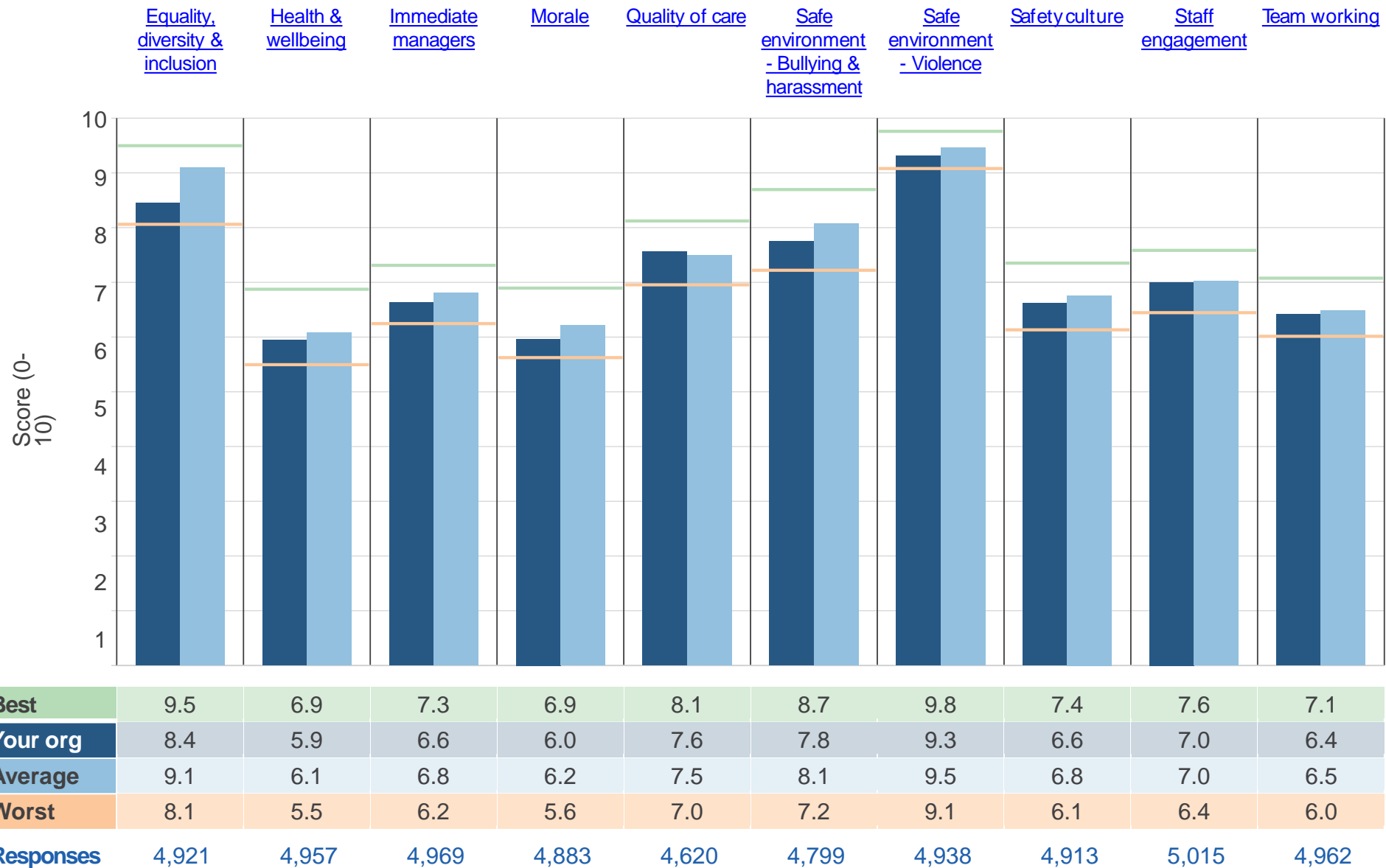


2020 NHS Staff Survey Results > Response rate

3.2



## 2020 NHS Staff Survey Results &gt; Theme results &gt; Overview



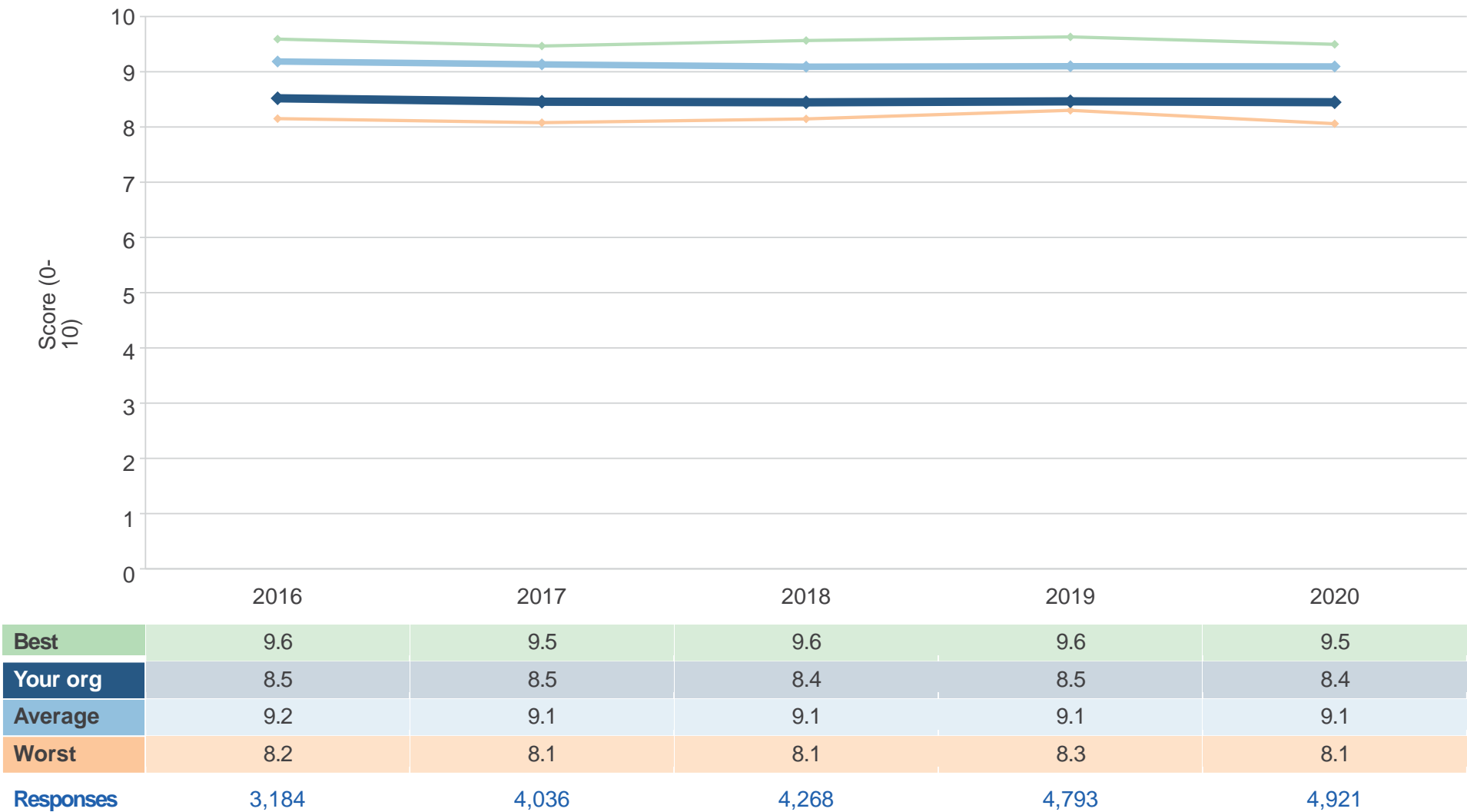
3.2

## Theme results performance

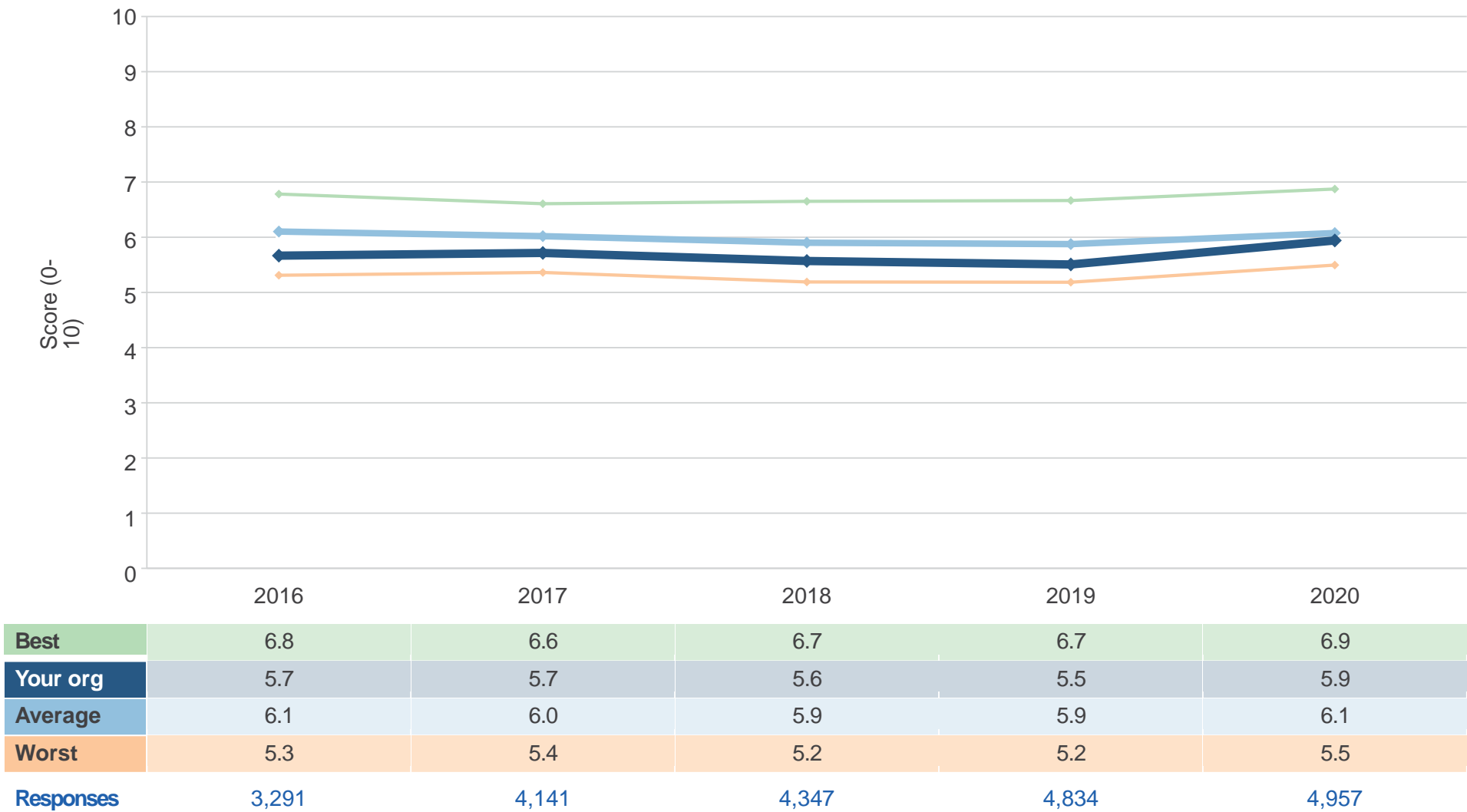
Theme	Compared to last year			Compared to sector average		
	2019	2020	Performance	Sector average	St George's	Performance
Equality, Diversity and Inclusion	8.5	8.4		9.1	8.4	
Health and Wellbeing	5.5	5.9		6.1	5.9	
Immediate Manager	6.5	6.6		6.8	6.6	
Morale	5.7	6.0		6.2	6.0	
Quality of Care	7.5	7.6		7.5	7.6	
Safe Environment – Bullying and Harassment	7.6	7.8		8.1	7.8	
Safe Environment – Violence	9.4	9.3		9.5	9.3	
Safety Culture	6.5	6.6		6.8	6.6	
Staff Engagement	6.9	7.0		7.0	7.0	
Team Working	6.4	6.4		6.5	6.4	

# Theme results

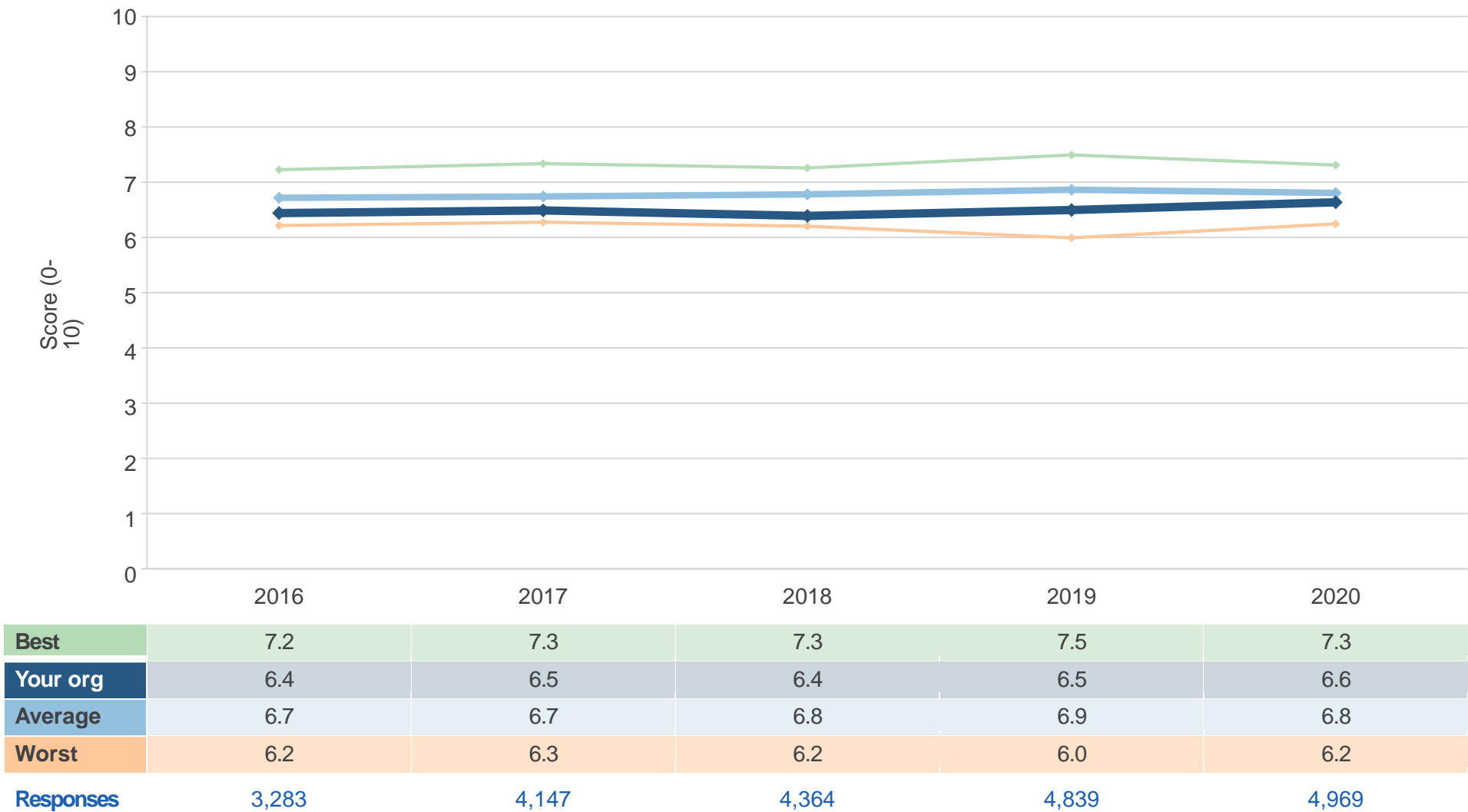
2020 NHS Staff Survey Results > Theme results > Trends > Equality, diversity & inclusion



2020 NHS Staff Survey Results > [Theme results](#) > [Trends](#) > Health & wellbeing

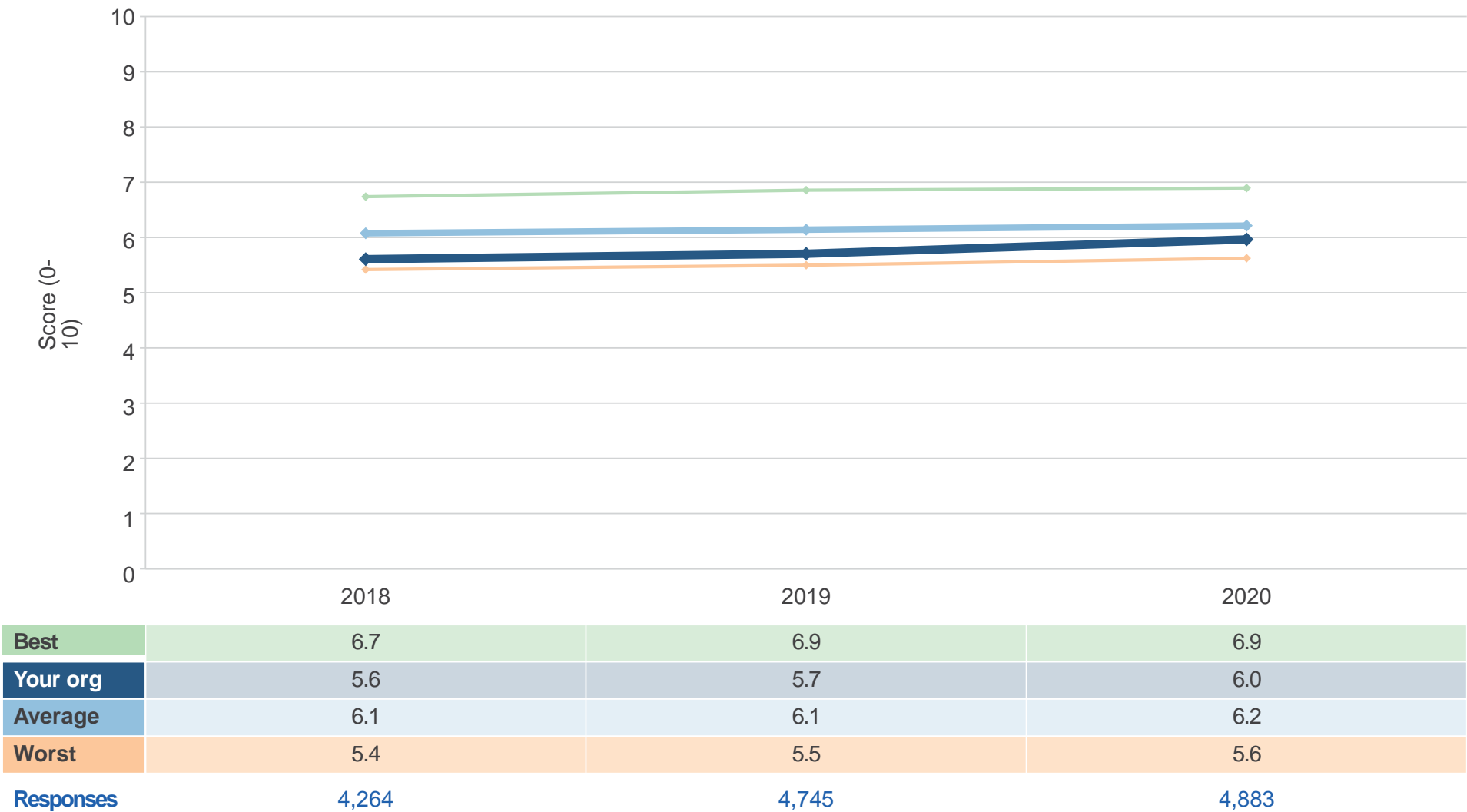


2020 NHS Staff Survey Results > [Theme results](#) > [Trends](#) > Immediate managers



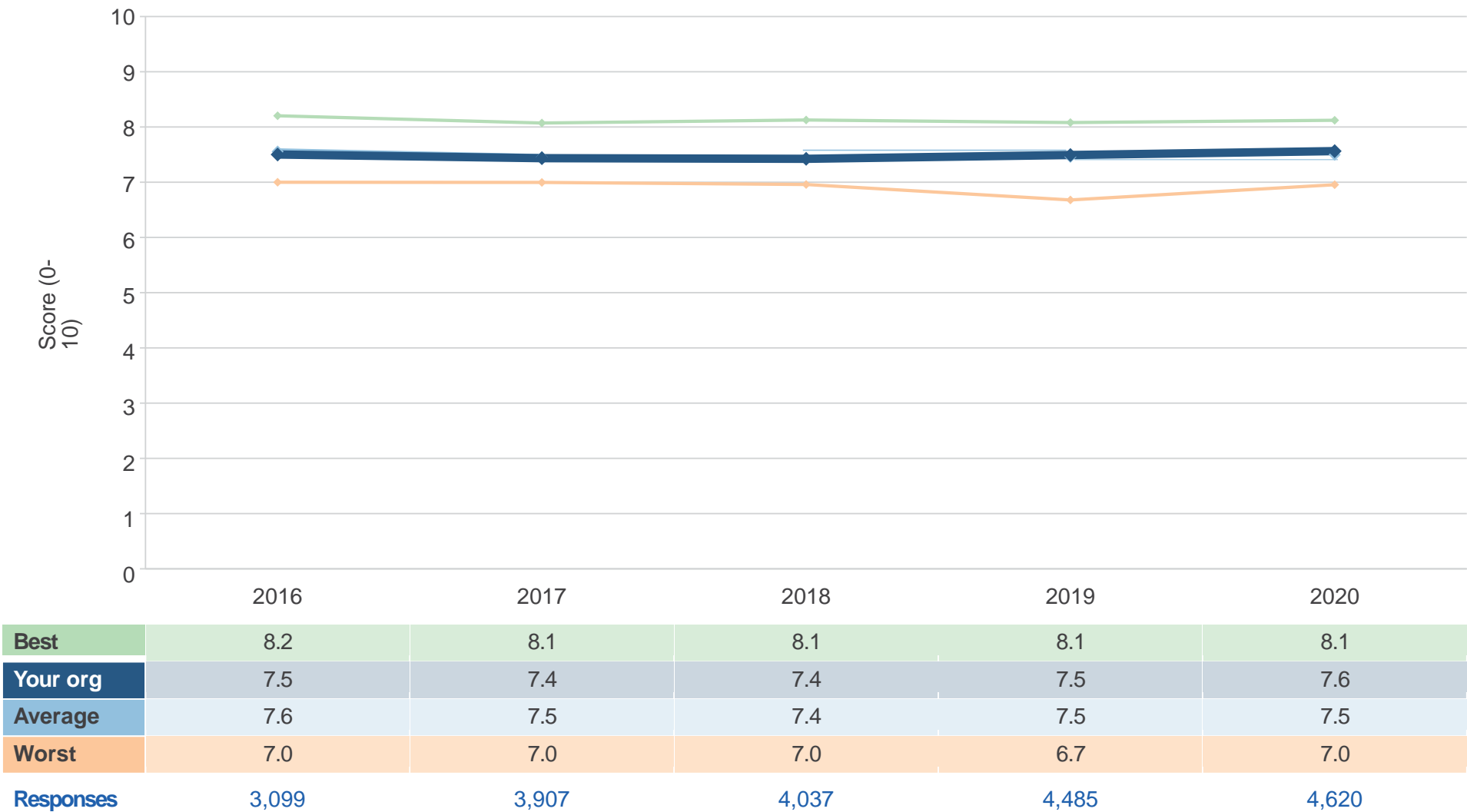


2020 NHS Staff Survey Results > [Theme results](#) > [Trends](#) > [Morale](#)

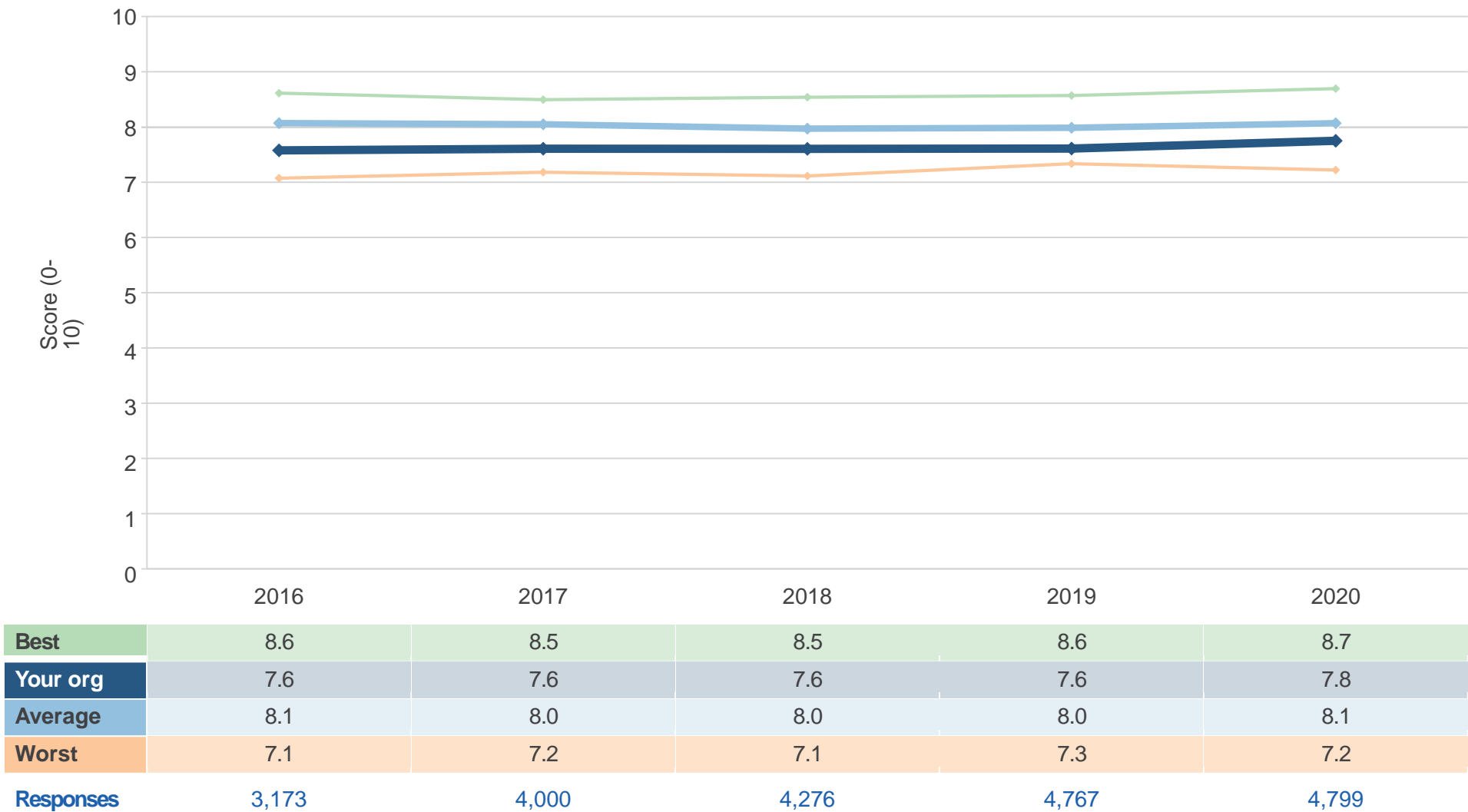


3.2

2020 NHS Staff Survey Results > [Theme results](#) > [Trends](#) > Quality of care

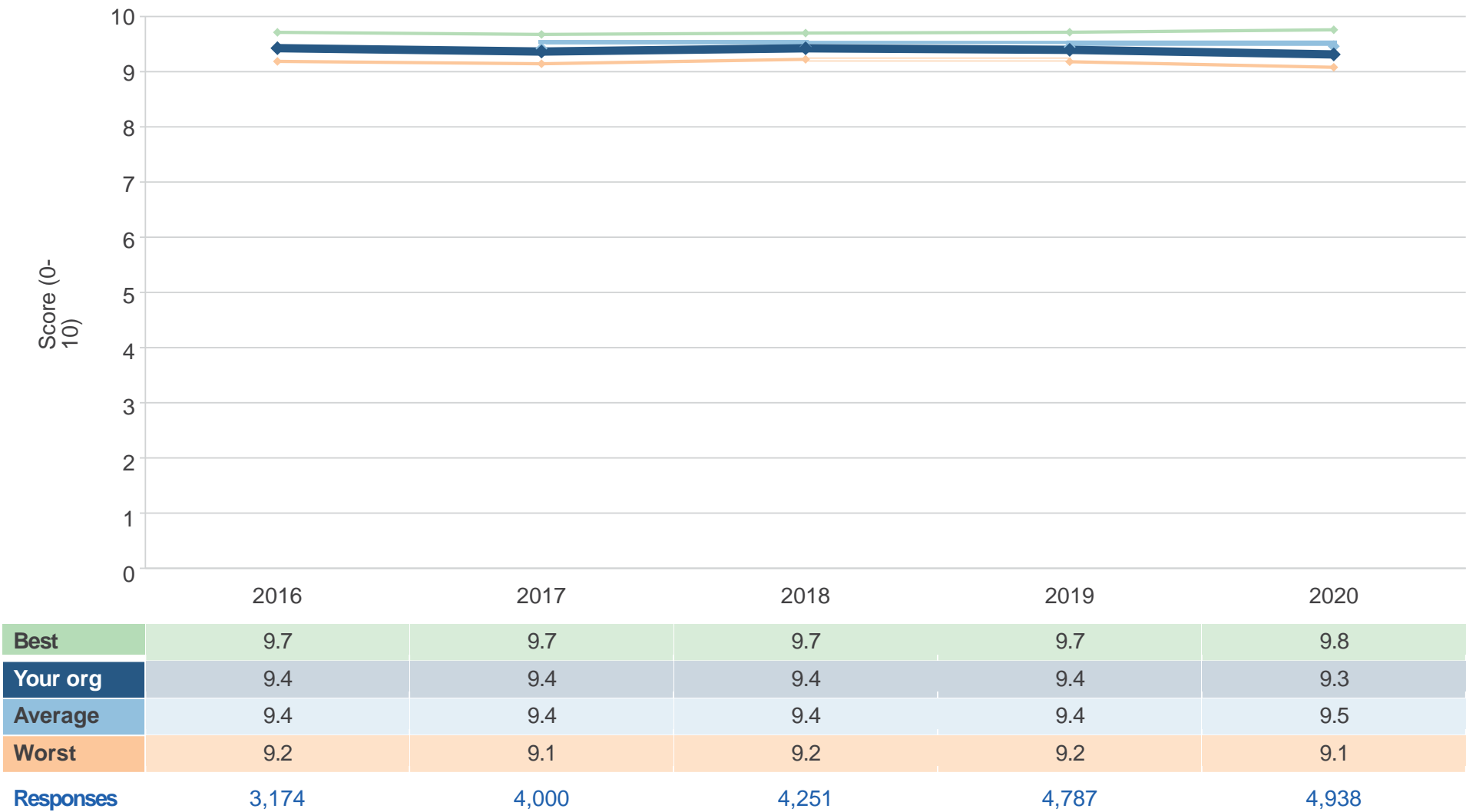


2020 NHS Staff Survey Results > [Theme results](#) > [Trends](#) > Safe environment - Bullying & harassment

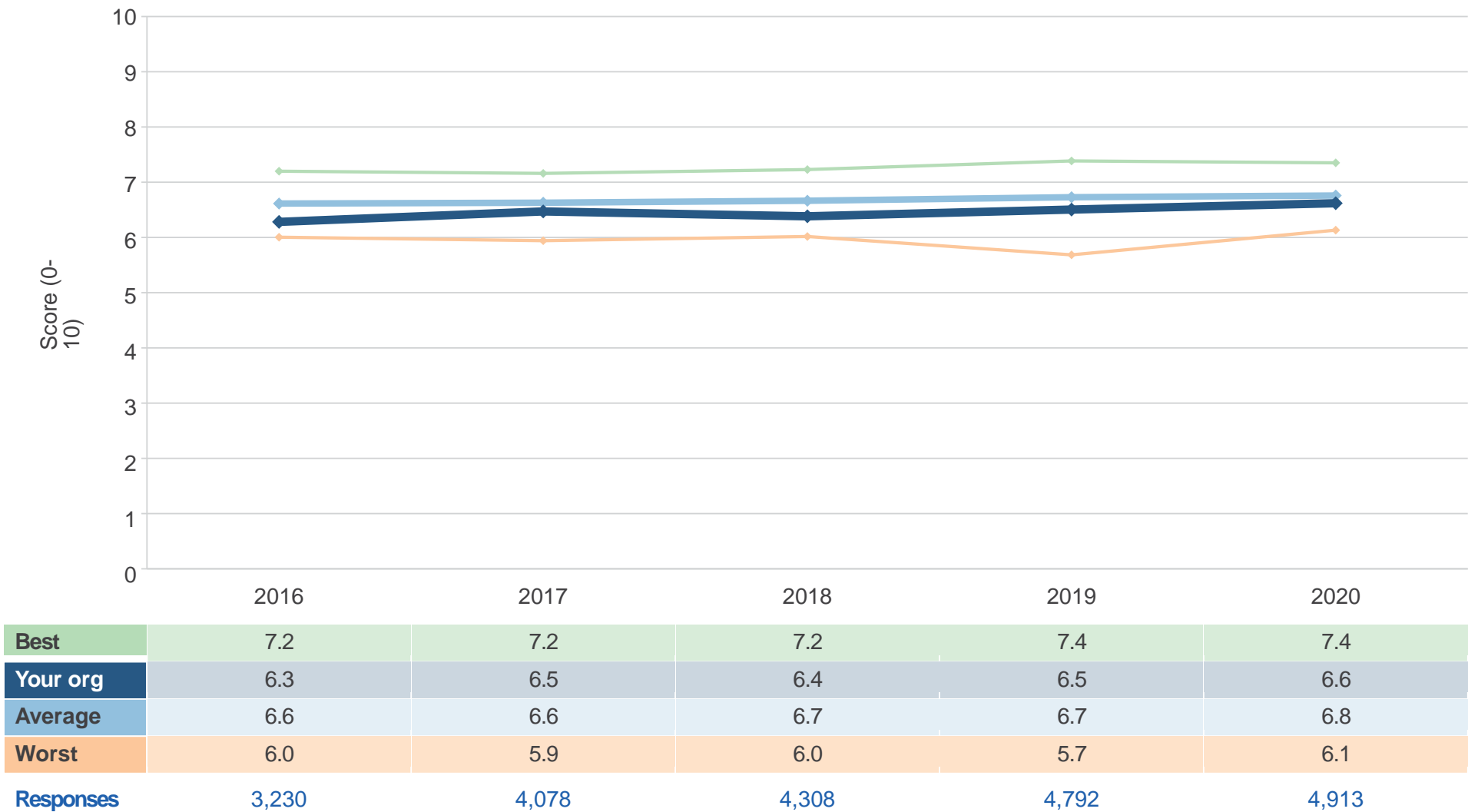


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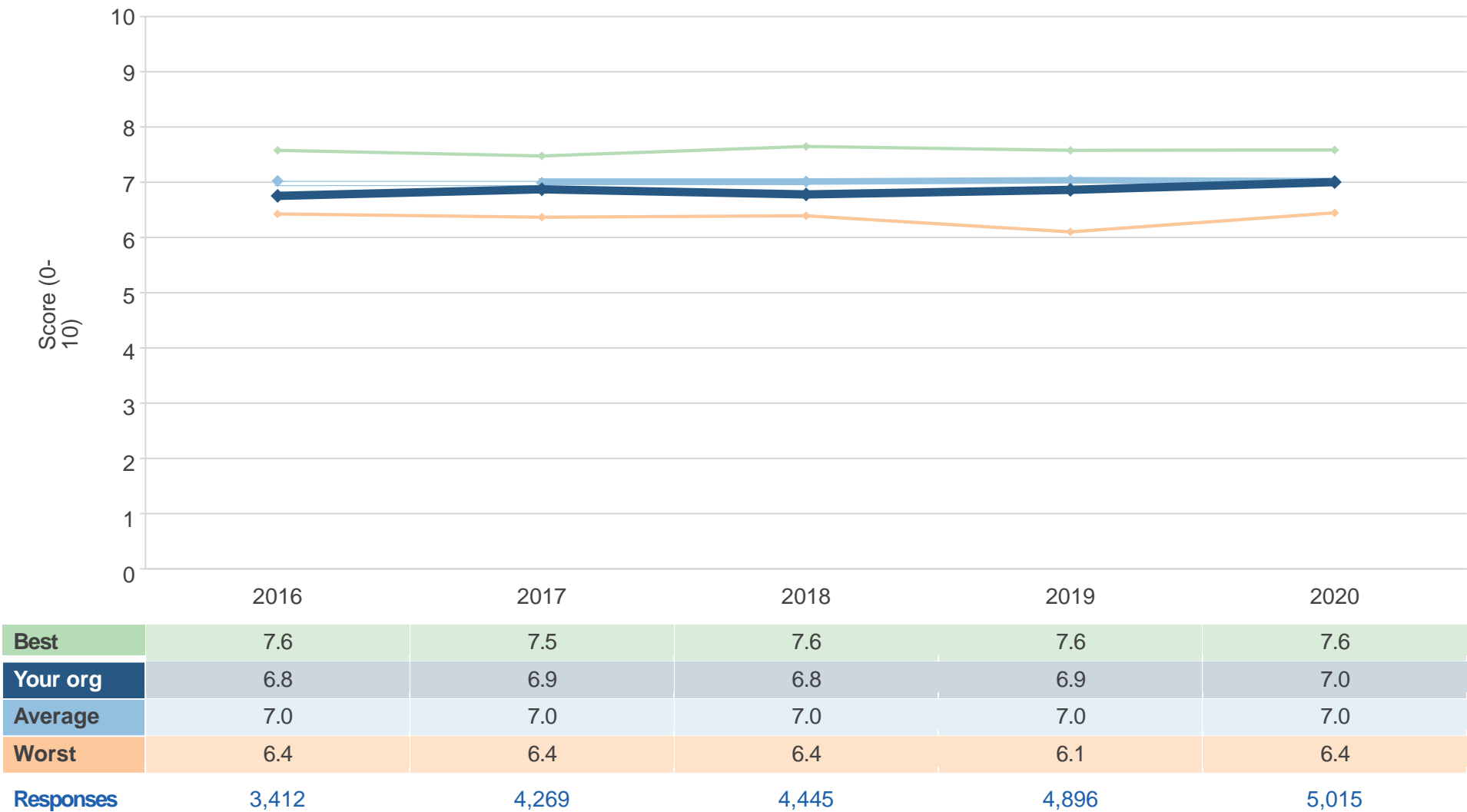
2020 NHS Staff Survey Results > Theme results > Trends > Safe environment - Violence



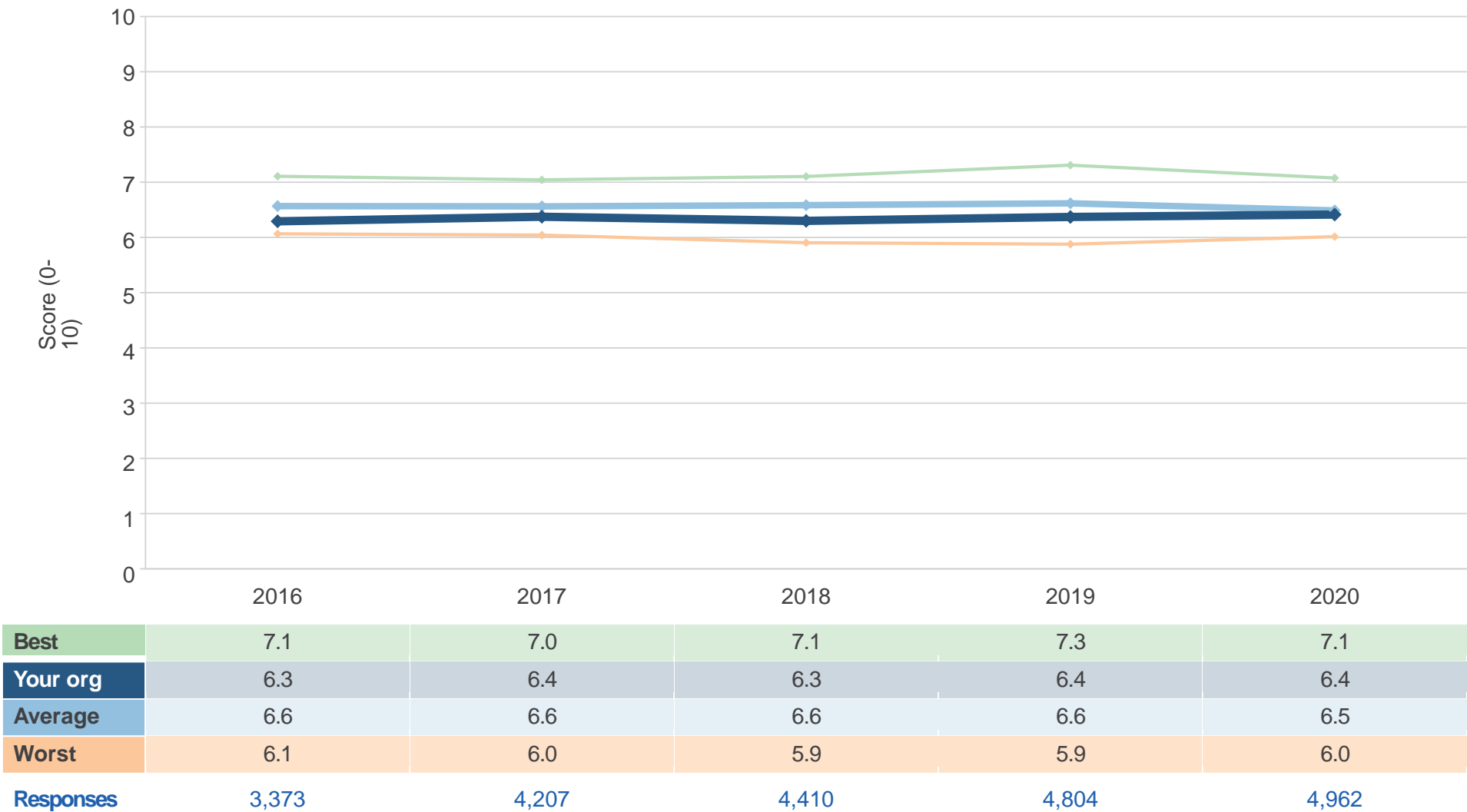
2020 NHS Staff Survey Results > [Theme results](#) > [Trends](#) > Safety culture



2020 NHS Staff Survey Results > Theme results > Trends > Staff engagement



2020 NHS Staff Survey Results > [Theme results](#) > [Trends](#) > Team working





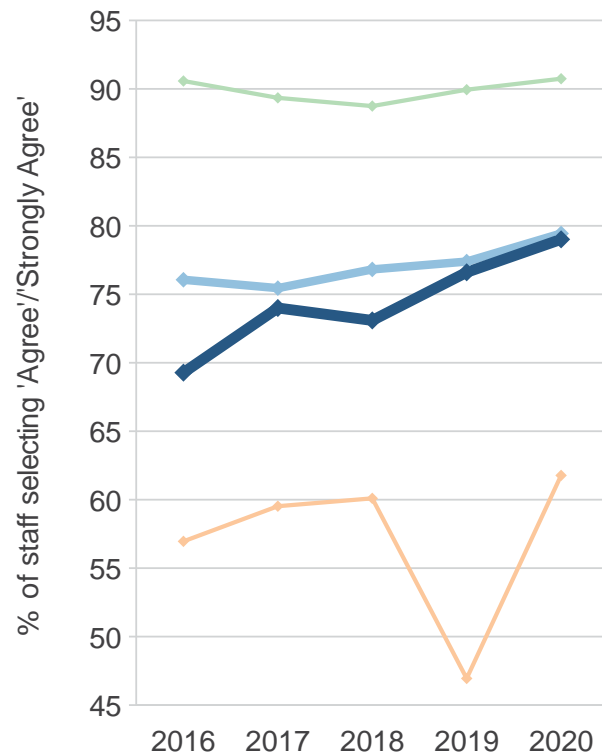
## Theme results – Detailed information - Key Indicators with a Positive Upward Trend

2020 NHS Staff Survey Results > [Theme results](#) > [Detailed information](#) > [Staff engagement](#) – Recommendation of the organisation as a place to work/receive treatment

3.2

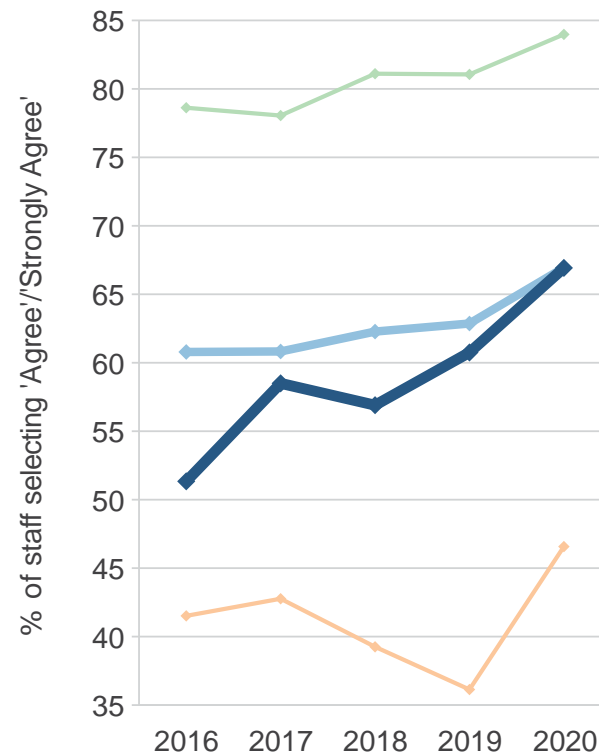
Q18a

Care of patients / service users  
is my organisation's top priority



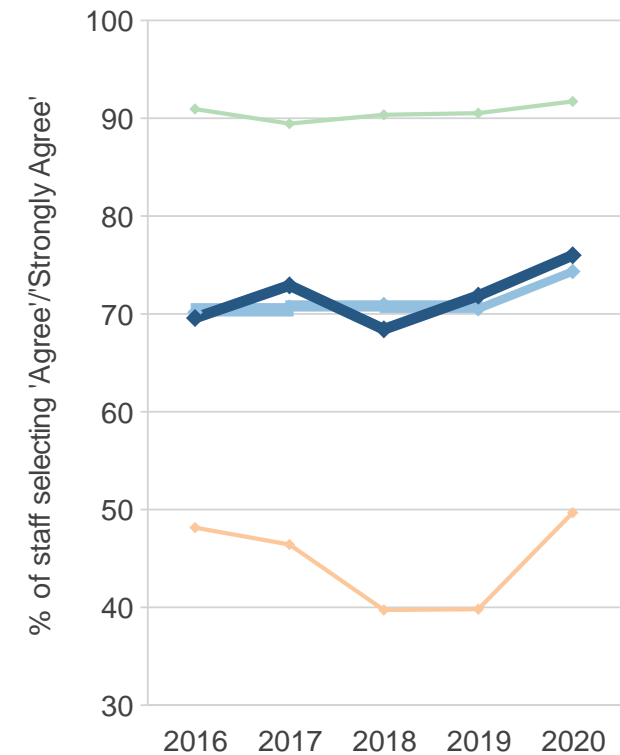
Q18c

I would recommend my  
organisation as a place to work

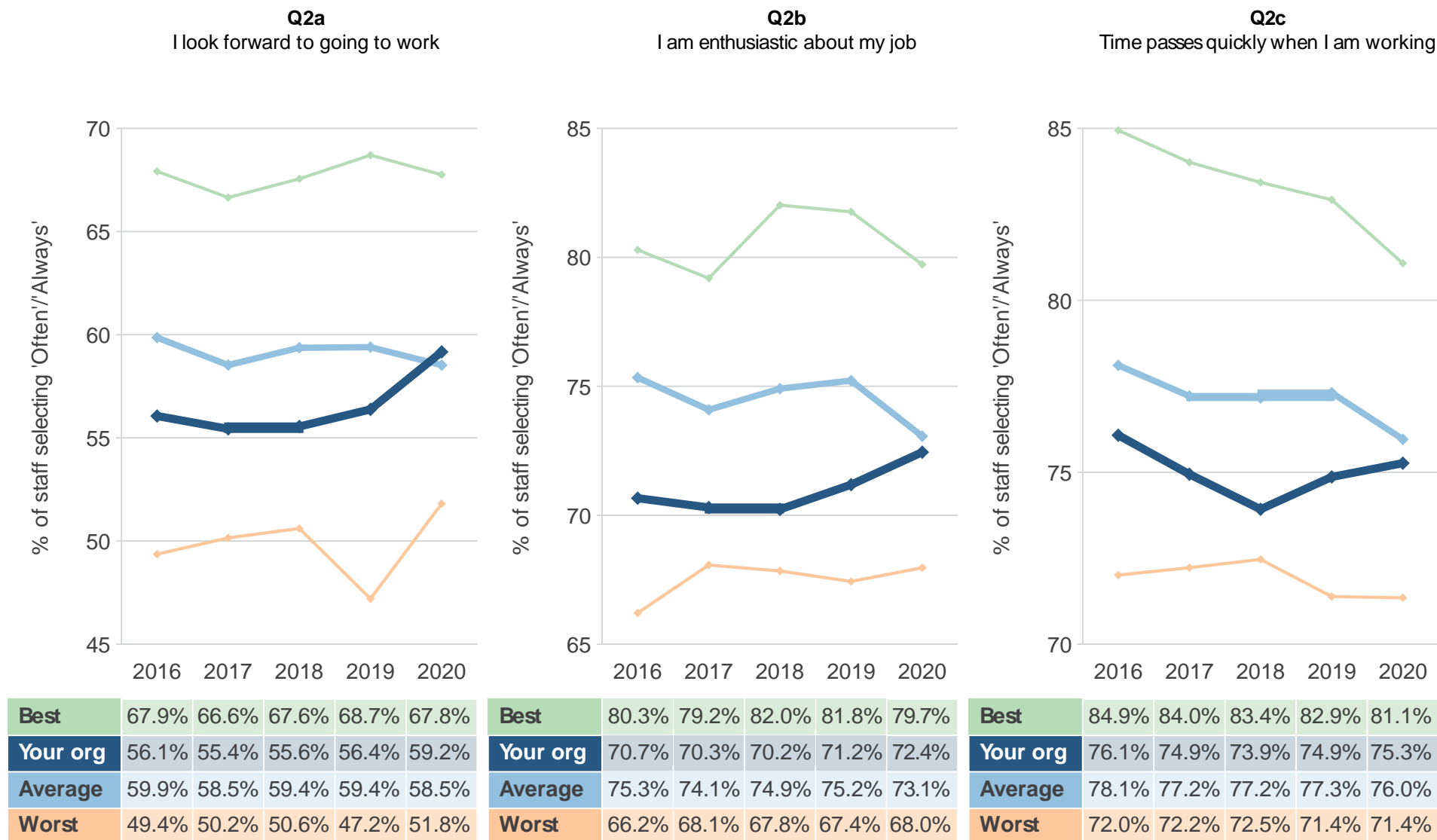


Q18d

If a friend or relative needed treatment  
I would be happy with the standard  
of care provided by this organisation

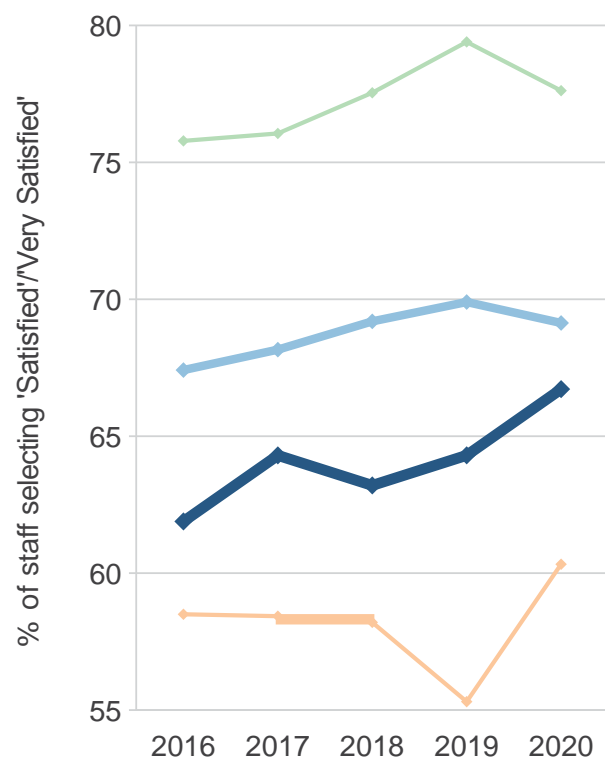


<b>Best</b>	90.6%	89.3%	88.7%	89.9%	90.7%	<b>Best</b>	78.6%	78.1%	81.1%	81.1%	84.0%	<b>Best</b>	90.9%	89.4%	90.4%	90.5%	91.7%
<b>Your org</b>	69.3%	74.0%	73.1%	76.6%	79.0%	<b>Your org</b>	51.3%	58.5%	56.9%	60.8%	66.9%	<b>Your org</b>	69.6%	72.9%	68.4%	71.9%	76.0%
<b>Average</b>	76.1%	75.5%	76.8%	77.4%	79.4%	<b>Average</b>	60.8%	60.8%	62.3%	62.9%	66.9%	<b>Average</b>	70.2%	70.7%	71.0%	70.5%	74.3%
<b>Worst</b>	57.0%	59.5%	60.1%	47.0%	61.8%	<b>Worst</b>	41.5%	42.8%	39.3%	36.1%	46.6%	<b>Worst</b>	48.2%	46.4%	39.7%	39.8%	49.7%

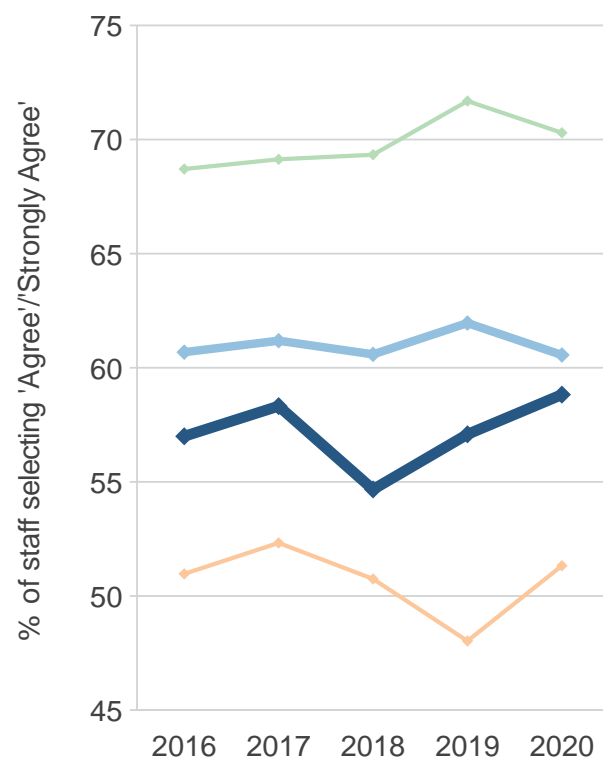


**Q5b**

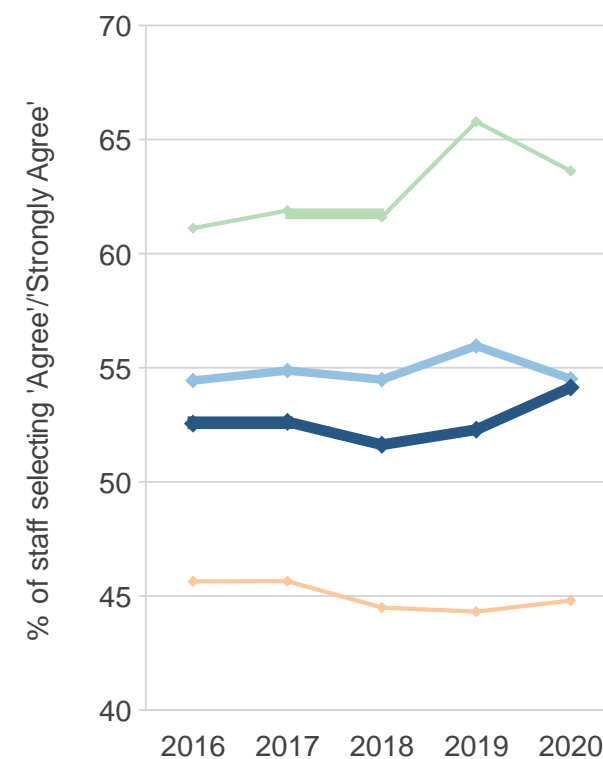
The support I get from my immediate manager

**Q8c**

My immediate manager gives me clear feedback on my work

**Q8d**

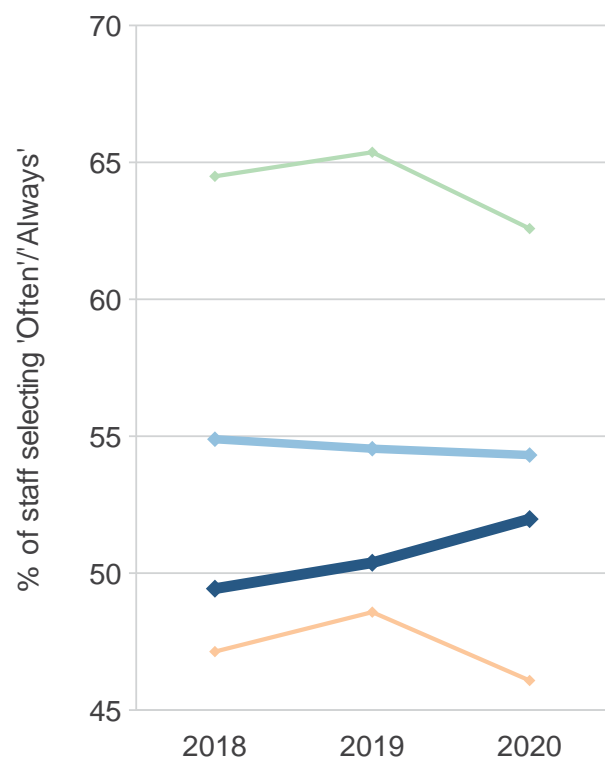
My immediate manager asks for my opinion before making decisions that affect my work



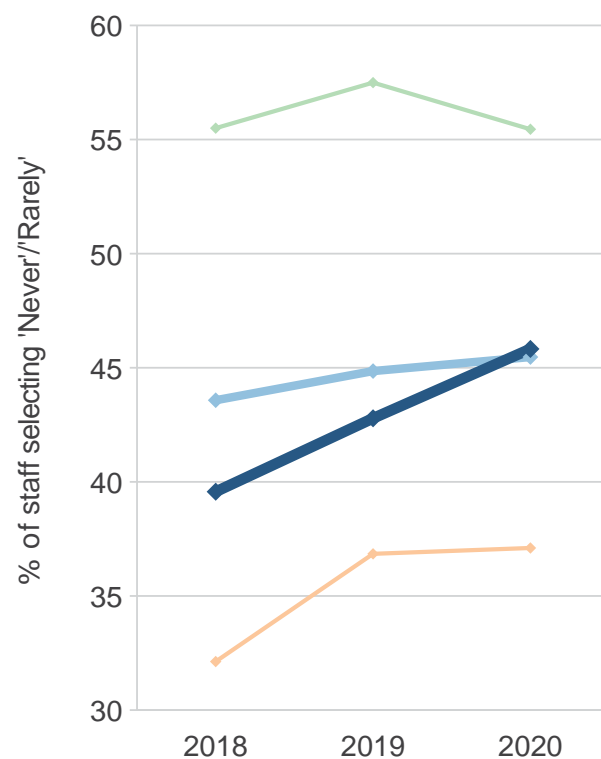
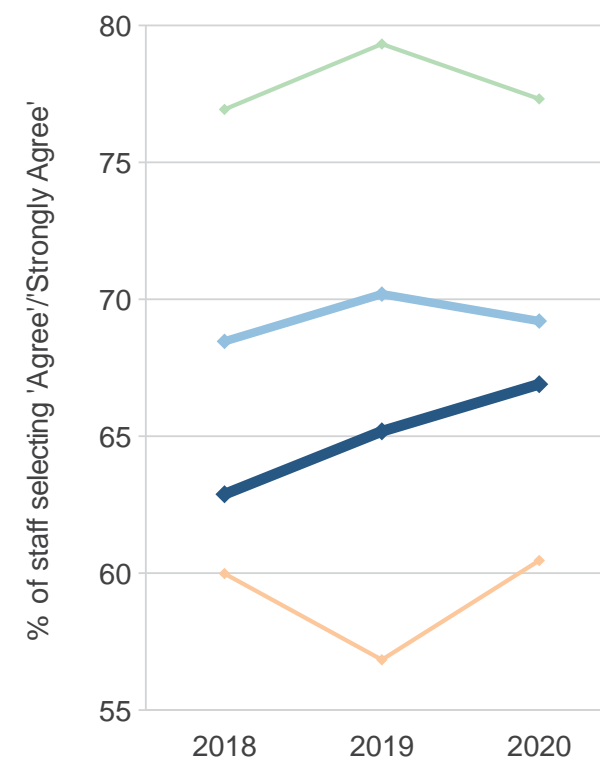
<b>Best</b>	75.8%	76.1%	77.5%	79.4%	77.6%
<b>Your org</b>	61.9%	64.3%	63.2%	64.3%	66.7%
<b>Average</b>	67.4%	68.2%	69.2%	69.9%	69.1%
<b>Worst</b>	58.5%	58.4%	58.2%	55.3%	60.3%

<b>Best</b>	68.7%	69.1%	69.3%	71.7%	70.3%
<b>Your org</b>	57.0%	58.3%	54.7%	57.1%	58.8%
<b>Average</b>	60.7%	61.2%	60.6%	62.0%	60.6%
<b>Worst</b>	51.0%	52.3%	50.8%	48.0%	51.3%

<b>Best</b>	61.1%	61.9%	61.6%	65.8%	63.6%
<b>Your org</b>	52.6%	52.6%	51.6%	52.3%	54.1%
<b>Average</b>	54.4%	54.9%	54.5%	56.0%	54.5%
<b>Worst</b>	45.6%	45.7%	44.5%	44.3%	44.8%

**Q6b**I have a choice in deciding  
how to do my work**Q6c**

Relationships at work are strained

**Q8a**My immediate manager  
encourages me at work

Best	64.5%	65.4%	62.6%
Your org	49.4%	50.4%	52.0%
Average	54.9%	54.5%	54.3%
Worst	47.1%	48.6%	46.1%

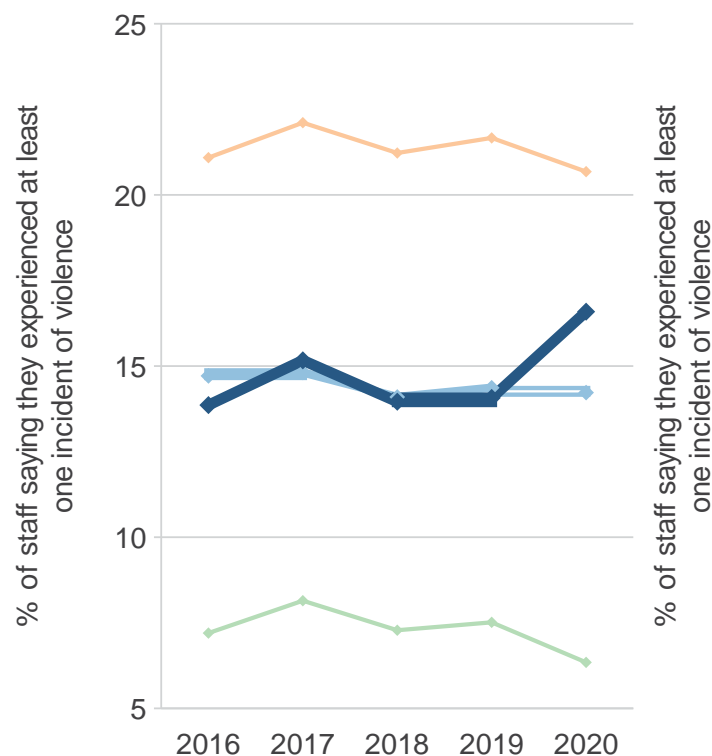
Best	55.5%	57.5%	55.5%
Your org	39.6%	42.8%	45.8%
Average	43.6%	44.9%	45.5%
Worst	32.1%	36.9%	37.1%

Best	76.9%	79.3%	77.3%
Your org	62.9%	65.2%	66.9%
Average	68.5%	70.2%	69.2%
Worst	60.0%	56.8%	60.5%

## Theme results – Detailed information - Key Indicators where significant improvement is required

**Q12a**

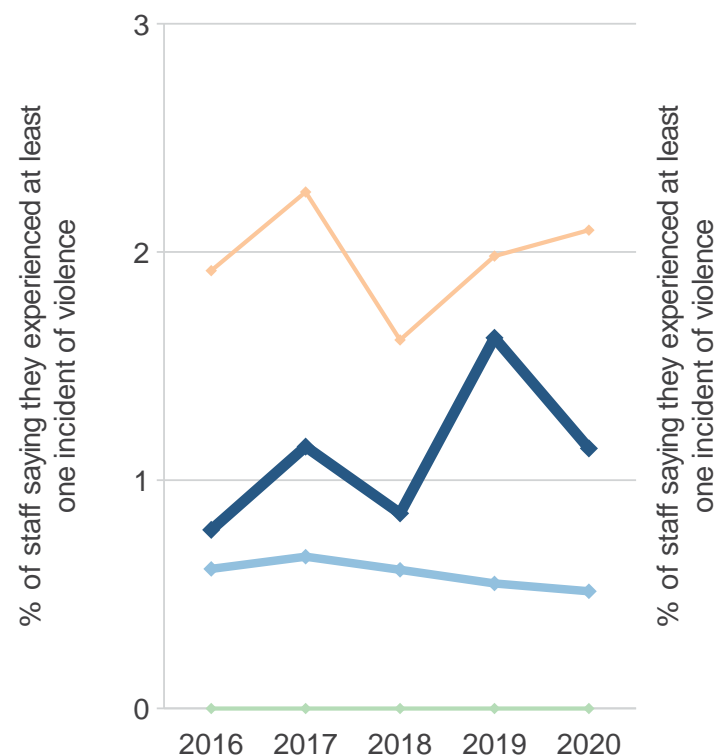
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



<b>Worst</b>	21.1%	22.1%	21.2%	21.7%	20.7%
<b>Your org</b>	13.9%	15.2%	14.0%	14.1%	16.6%
<b>Average</b>	14.7%	14.8%	14.1%	14.4%	14.2%
<b>Best</b>	7.2%	8.1%	7.3%	7.5%	6.3%

**Q12b**

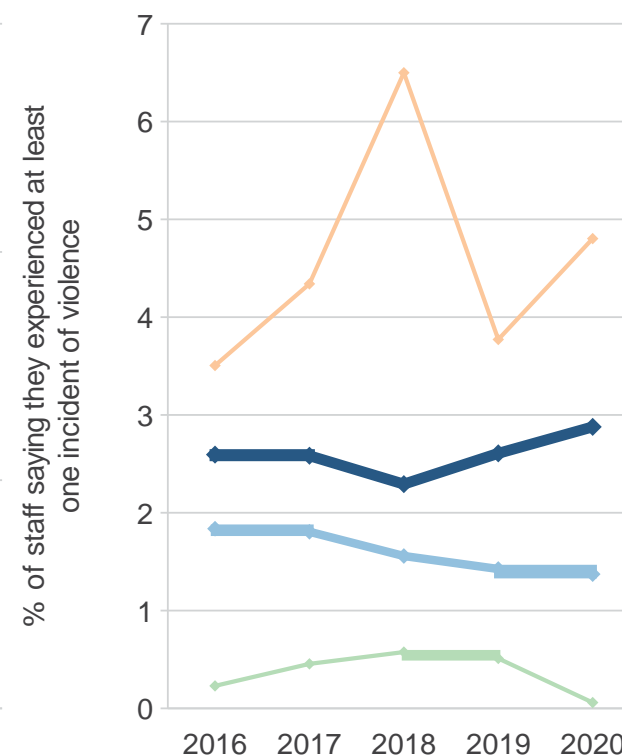
In the last 12 months how many times have you personally experienced physical violence at work from managers?



<b>Worst</b>	1.9%	2.3%	1.6%	2.0%	2.1%
<b>Your org</b>	0.8%	1.1%	0.9%	1.6%	1.1%
<b>Average</b>	0.6%	0.7%	0.6%	0.5%	0.5%
<b>Best</b>	0.0%	0.0%	0.0%	0.0%	0.0%

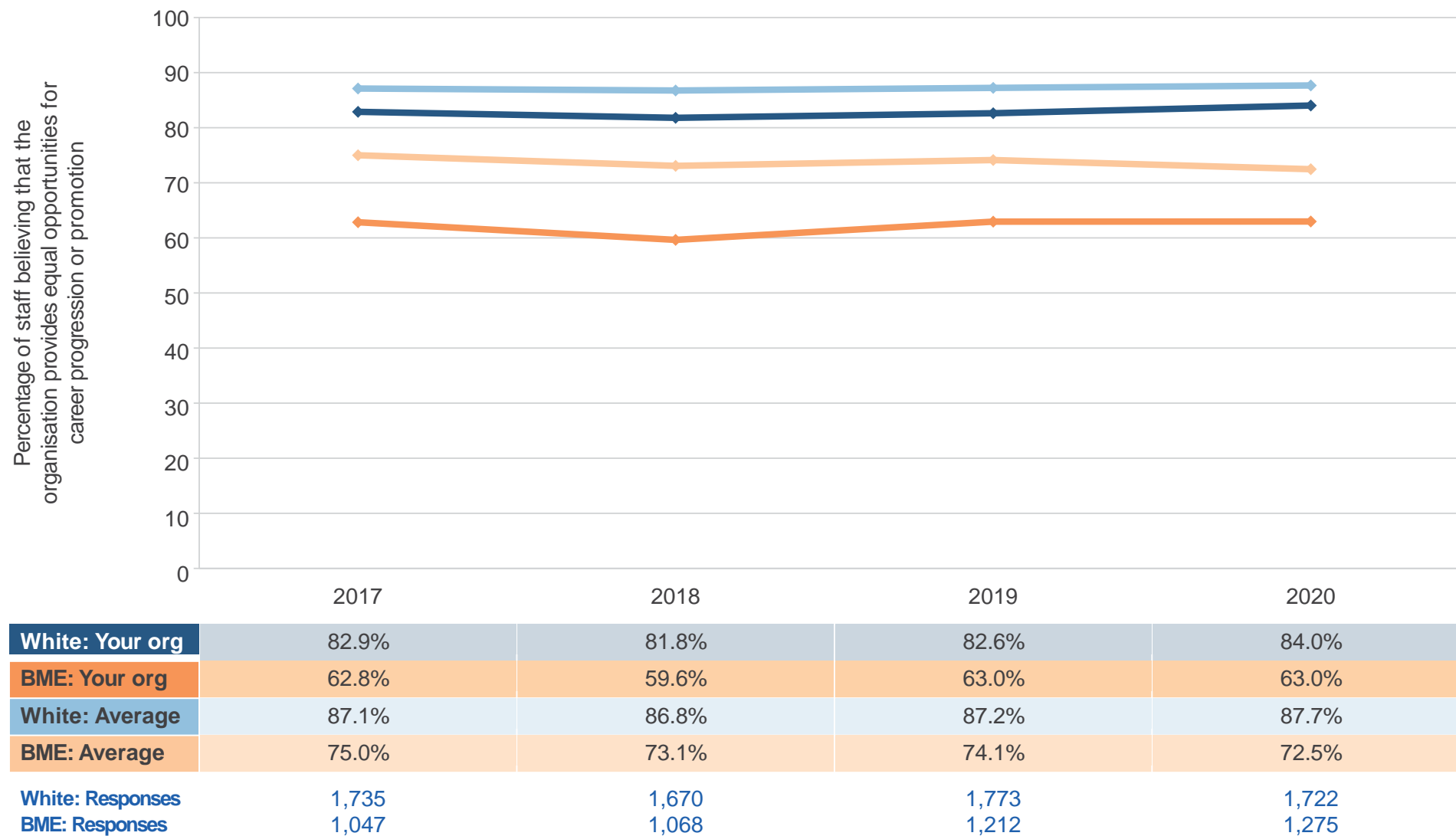
**Q12c**

In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



<b>Worst</b>	3.5%	4.3%	6.5%	3.8%	4.8%
<b>Your org</b>	2.6%	2.6%	2.3%	2.6%	2.9%
<b>Average</b>	1.8%	1.8%	1.6%	1.4%	1.4%
<b>Best</b>	0.2%	0.5%	0.6%	0.5%	0.1%

**2020 NHS Staff Survey Results > [WRES](#) > Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion**

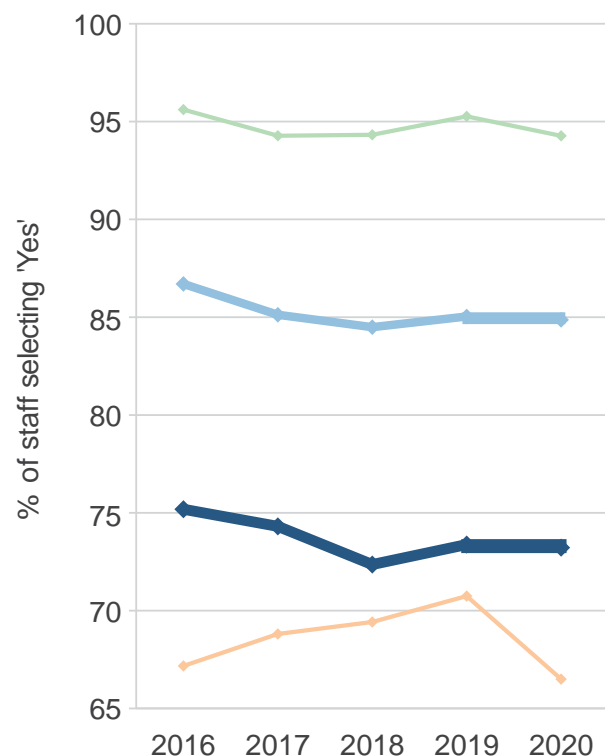


Average calculated as the median for the benchmark group



**Q14**

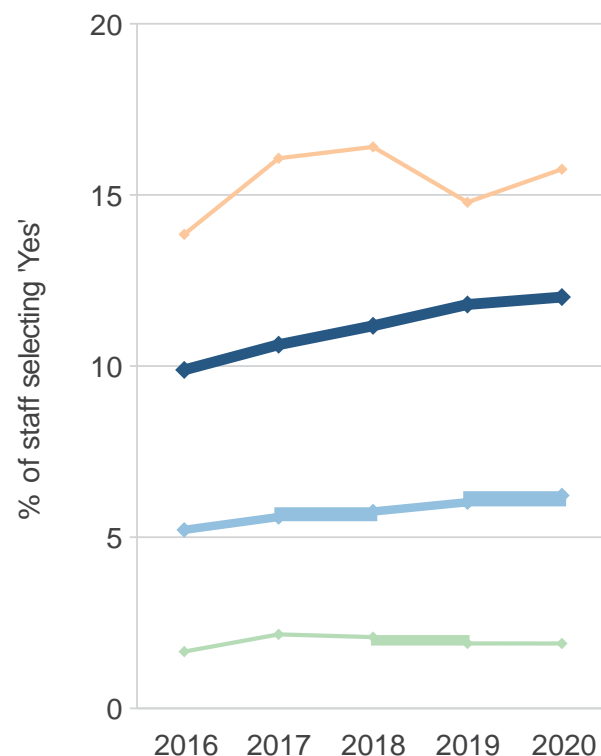
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



<b>Best</b>	95.6%	94.3%	94.3%	95.3%	94.3%
<b>Your org</b>	75.2%	74.3%	72.4%	73.4%	73.2%
<b>Average</b>	86.7%	85.1%	84.5%	85.0%	84.9%
<b>Worst</b>	67.2%	68.8%	69.4%	70.7%	66.5%

**Q15a**

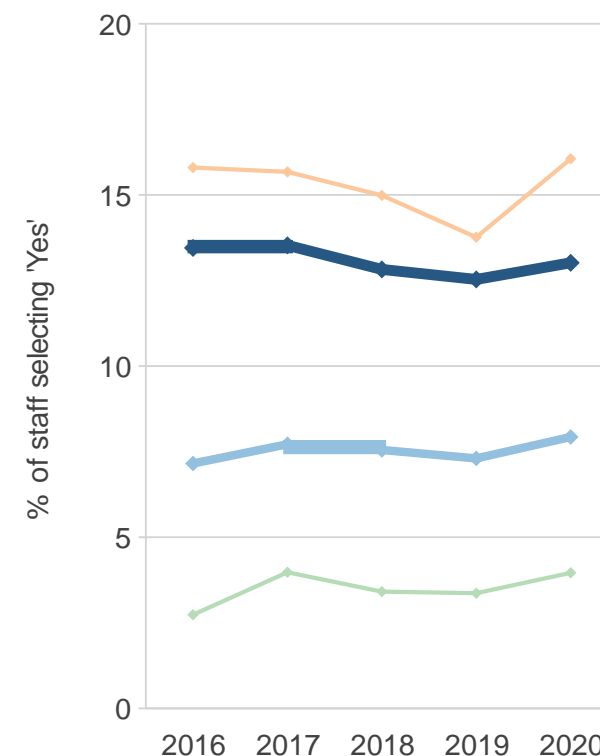
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



<b>Worst</b>	13.8%	16.1%	16.4%	14.8%	15.7%
<b>Your org</b>	9.9%	10.6%	11.2%	11.8%	12.0%
<b>Average</b>	5.2%	5.6%	5.8%	6.0%	6.2%
<b>Best</b>	1.7%	2.2%	2.1%	1.9%	1.9%

**Q15b**

In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



<b>Worst</b>	15.8%	15.7%	15.0%	13.8%	16.1%
<b>Your org</b>	13.5%	13.5%	12.8%	12.5%	13.0%
<b>Average</b>	7.2%	7.7%	7.6%	7.3%	7.9%
<b>Best</b>	2.7%	4.0%	3.4%	3.4%	4.0%

## Communication Plan

A branded communication campaign with 5 Trustwide impactful actions, with Executive sponsorship, to respond to the staff survey feedback and supported by Divisional action plans.

We will identify the 5 actions by mid March and will roll these out from April, promoting one theme each month from April to August.

March (Embargo lifts 11 <sup>th</sup> )	April - August	September	October
Communicate staff survey results Agree 5 actions and branding Identify sponsors	Run campaign	Review campaign progress	Launch 2021 staff survey



Meeting Title:	Trust Board		
Date:	25 March 2021	Agenda No	4.2
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 18 <sup>th</sup> February 2021 and 18 <sup>th</sup> March 2021.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	Date:	N/A
Appendices:	N/A		



## Finance and Investment Committee – February 2021 & March 2021

The Committee met on 18 February and 18 March. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on Short and Long Term Estates planning, Annual Planning for 2021/22, Big Projects and Committee Effectiveness.

Committee members discussed the Board Assurance Framework (BAF) risks on Finance, Estates, and Operational Risk via their respective 'deep dives', as well as a report by exception in March on ICT following a request at the February Committee to review the profile of ICT extreme risks and consider progress towards mitigation. The Committee praised the day to day operation of the Trust and commitment of staff in view of unprecedented challenges posed by the virus on ITU and General & Acute beds, which has had a detrimental impact on Trust performance metrics; Emergency Flow 4 hour target, Diagnostics, Cancer and RTT. The Committee discussed current financial performance, cash management and capital expenditure. **The Committee wishes to bring the following items to the Board's attention:**

**1.1 Finance, ICT and Operational Risks** – the Deputy Chief Financial Officer (DCFO), the Chief Information Officer (CIO) and the Chief Operations Officer (COO) gave updates on their respective BAF risks. In March the committee discussed the merits of the Finance and Operational Risk scores remaining as '20', in view of the changes in operational and financial pressures from COVID-19. The committee also discussed progress on ICT extreme risks as outlined in the paper brought to committee in March.

**1.2 Estates Report** – in February the Director of Estates & Facilities (DE&F) introduced a number of papers. The quarterly BAF update led to discussion on fire risk and progress being made in Lanesborough Wing with compartmentation. The Long and Short Term planning papers focussed on progress with demolitions and how the site may develop in the coming years. The general monthly update addressed oxygen usage.

**1.3 Activity Performance** – the Chief Operations Officer (COO) noted the challenges of delivering daycase and elective targets during January and February due to COVID-19 pressures, as increasing numbers of COVID+ admissions in acute and ITU beds meant other services needed to redeploy staffing to support. The expected performance of 52% in January and 58% in February confirmed this challenge.

**1.4 Emergency Department (ED) Update** – the performance of the Emergency Care Operating Standard was recorded at 92.1% in February. The COO noted that ED performance slowly improved over the month as the impact of COVID-19 reduced across the hospital, including performance above 95% in the last week, which was the best performance in London trusts.

**1.5 Diagnostics Performance** – the COO noted that the six-week diagnostic standard performance was 14.8% in February compared to 18.1% in January. The COO also noted that the Trust had made significant efforts to sustain diagnostic activity during this current COVID surge, and that this was reflected in the reduced numbers on the waiting lists.

**1.6 Cancer Performance** – the COO noted challenges in Cancer performance in January where 1 of the 7 targets were met, owing primarily to capacity pressures from COVID-19. The IQPR noted the expectations of when each target would return to compliance.

**1.7 Referral to Treatment (RTT) Update** – the performance against the RTT target was discussed, where performance in January of 69.1% had deteriorated against the previous month's value of 71.4%, with the number of 52 week waits of 2,108 being more than the previous month's 1,456. The size of the waiting list (including QMH patients) was 44,859 patients.



**1.8 Financial Performance**– the DCFO noted performance in month 11 of an £8.9m surplus, which is £8.9m favourable to budget, including £4.9m of COVID costs. The YTD deficit is £2.0m which is £2.0m adverse to budget. The Trust is on forecast which is a £8.9m surplus in month. This aligns to the forecast submitted to NHSI/E in November.

He also noted that the trust cash balance is £116.7m. The Trust has spent £57.7m of capital at month 11, against a plan of £72.2m (values including COVID).

**1.9 Capital Update**– in March the DCFO introduced the Committee to the paper providing an update on capital which showed that since February's committee, the £2.4m agreed slippage in the schemes to enhance the critical care facilities on Ben Weir and McKissock Ward has been partially offset by £1.0m of additional COVID funding, to give a total capital plan of £90.0m.

**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 March. The paper noted the movements to this month's annual forecast of breakeven, owing to a block contract adjustment that has been approved through SWL between other Trusts in the sector, bringing all Trusts to breakeven.

**1.11 Planning 21-22** – the DCFO noted the progress being made on planning for 2021/22, including arrangements for an interim budget to be agreed for the first quarter and potentially first half of the new financial year.

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

**1.13 Committee Effectiveness** – the DCFO noted improvements in committee effectiveness results from last year, whilst outlining the actions to be made related to some of the key feedback areas.

## **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,**  
**March 2021**



Meeting Title:	TRUST BOARD		
Date:	25 March 2021	Agenda No	4.3
Report Title:	M11 Finance Report		
Lead Director/ Manager:	Tom Shearer		
Report Author:	Tom Shearer		
Presented for:	Update		
Executive Summary:	<p>The in-month reported position at M11 is a £8.9m surplus, which is £8.9m favourable to budget, made up of: £4.9m of COVID costs; £3.4m shortfall in block income, offset by; £0.7m lower Non NHS income due to significantly reduced BAU activity due to COVID; £1.1m reduced expenditure as a result of not undertaking BAU activity because of COVID; £6.1m of revised block income and additional funding (net of high cost drugs expenditure funded); and £10.8m of non-NHS income top-up. The YTD surplus is £2.0m which is £2.0m favourable to budget.</p> <p>The Trust is on forecast which is a £8.9m surplus in month. This aligns to the forecast submitted to NHSI/E in November, which is expected to show a £2.2m surplus at year end. This includes the £13.0m of Non-NHS income adjustment, £10.8m of which is reported in M11. Performance by division is shown in section 4.</p> <p>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.</p> <p>The Trust has spent £57.7m of capital at month 11, against a plan of £72.2m (values including COVID). The YTD COVID plan is £8.8m, with COVID cost £8.8m. There is also £15.0m of YTD SWL underspend that the Trust is hosting. The non-COVID/non-SWL underspend capital spend is therefore £0.5m adverse to plan, with £48.9m spend against the plan of £48.4m.</p> <p>The Trusts cash balance at M11 was £116.7m.</p>		
Recommendation:	The Trust Board is asked to note the update on the financial position at M11.		
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	18/3/21
Appendices:	N/A		



# Financial Report Month 11 (February 2021)

4.3



**Chief Finance Officer**

25<sup>th</sup> March 2021

# Executive Summary

## Month 11 Financial Position

- From M07 onwards, the Trust has received a revised level of block commissioning income. In addition, the Trust is funded on a cost and volume basis for NHSE 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 M11 is a **£8.9m surplus, which is £8.9m favourable to budget**, made up of: £4.9m 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, offset by; £0.7m lower Non NHS income due to significantly reduced BAU activity due to COVID; £1.1m reduced expenditure as a result of not undertaking BAU activity because of COVID; £6.1m of revised block income and additional funding (net of high cost drugs expenditure funded); and £10.8m of non-NHS income top-up. This is shown graphically in the slide in section 2. The **YTD surplus is £2.0m which is £2.0m favourable to budget**.
- The Trust is **on forecast** which is a £8.9m surplus in month. This aligns to the forecast submitted to NHSI/E in November, which is expected to show a £2.2m surplus at year end. This includes the £13.0m of Non-NHS income adjustment, £10.8m of which is reported in M11. Performance by division is shown in section 4.
- The Trust has received retrospective top up income covering the underlying deficit in full for M1-6, following payment being confirmed for the value of bad debt provision included YTD.
- The Trust has spent **£57.7m of capital at month 11, against a plan of £72.2m** (values including COVID). The YTD COVID plan is £8.8m, with COVID cost £8.8m. There is also £15.0m of YTD SWL underspend that the Trust is hosting. The non-COVID/non-SWL underspend capital spend is therefore £0.5m adverse to plan, with £48.9m spend against the plan of £48.4m.
- The Trusts cash balance at M11 was £116.7m. This is due to two months block payment being received in M1. The Trust is actively ensuring suppliers are paid in good time.

4.3



# 1. Month 11 Financial Performance

			Full Year Budget (£m)	M11 Budget (£m)	M11 Actual (£m)	M11 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding COVID and Income Top Up	Income	SLA Income	787.5	65.8	67.2	1.4	721.7	708.9	(12.8)
		Other Income	163.9	13.6	24.1	10.5	150.2	152.2	2.0
	Income Total		951.4	79.4	91.3	11.9	871.9	861.1	(10.8)
	Expenditure	Pay	(583.5)	(48.9)	(49.0)	(0.1)	(534.6)	(527.6)	7.0
		Non Pay	(328.8)	(27.3)	(25.3)	2.0	(301.5)	(287.6)	13.9
	Expenditure Total		(912.3)	(76.2)	(74.3)	1.9	(836.1)	(815.2)	20.9
	Post Ebitda		(39.1)	(3.3)	(3.2)	0.1	(35.9)	(36.5)	(0.6)
	Grand Total		(0.0)	(0.0)	13.8	13.8	0.0	9.4	9.4
COVID and Income Top Up	COVID	Pay	0.0	0.0	(2.2)	(2.2)	0.0	(19.5)	(19.5)
		Non Pay	0.0	0.0	(2.7)	(2.7)	0.0	(17.9)	(17.9)
	Total COVID		0.0	0.0	(4.9)	(4.9)	0.0	(37.3)	(37.3)
	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)	8.9	8.9	0.0	2.0	2.0

## Month 11 Financial Position

- The in month reported position at **M11 is a £8.9m surplus, which is £8.9m favourable to budget. The YTD position is a £2.0m surplus, which is £2.0m favourable to budget.** Between April and September, guidance from NHSE&I stated that the Trust should report a breakeven position, which was achieved by an income top up accrual to balance the position.
- For October to February, the Trust's revised forecast Block Commissioning income is £331.5m, 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 (£5.1m YTD); and COVID Testing Funding (£3.4m YTD).
- In February, the Trust has reported £10.8m of non-NHS income top-up. This is 5/6ths of the £13m the Trust has been paid for this financial year.
- The YTD financial impact of COVID on the Trust from additional expenditure is £37.3m and the YTD income top up value, received between April and September, is £29.9m (with no top-up between October and February).
- Excluding COVID costs, and excluding the income top-up accrual, the Trust's YTD position would be £1.4m adverse to plan. This is due to the shortfall in block income of £37.7m, £7.5m of lower non-NHS income as a result of not undertaking BAU activity because of COVID. This is offset by £17.5m of underspends as a result of not undertaking BAU activity because of COVID, £26.1m of Commissioning income from revised block and additional funding (net of drugs overspend), and £10.8m of non-NHS income top-up.

Financial Report Month 11 (February 2021)  
St George's University Hospitals NHS Foundation Trust



## 2. Balance Sheet as at February 2021

Statement of Financial Position	M11 February-21		
	FY 19-20 Audited Mar-20 (£m)	FY20-21 YTD Actual (£m)	Movement YTD
<b>Fixed assets</b>	<b>426.9</b>	<b>459.6</b>	<b>32.7</b>
<b>Current assets</b>			
Stock	11.9	12.4	0.5
Debtors	93.7	111.5	17.8
Cash	3.5	116.7	113.2
<b>Total Current Assets</b>	<b>109.1</b>	<b>240.6</b>	<b>131.5</b>
<b>Current liabilities</b>			
Creditors	(94.0)	(210.4)	(116.4)
Capital creditors	(22.5)	(26.2)	(3.7)
PDC div creditor	0.0	(4.7)	(4.7)
Provision<1 Year	(0.3)	(0.3)	0.0
Borrowings< 1 year	(322.5)	(5.4)	317.1
Int payable creditor	(0.1)	(0.1)	0.0
<b>Total current liabilities</b>	<b>(439.4)</b>	<b>(247.1)</b>	<b>192.3</b>
<b>Net current assets/-liabilities</b>	<b>(330.3)</b>	<b>(6.5)</b>	<b>323.8</b>
Provisions> 1 year	(2.5)	(2.9)	(0.4)
Borrowings> 1 year	(69.9)	(56.9)	13.0
<b>Total Long-term liabilities</b>	<b>(72.4)</b>	<b>(59.8)</b>	<b>12.6</b>
<b>Net assets</b>	<b>24.2</b>	<b>393.3</b>	<b>369.1</b>
<b>Taxpayer's equity</b>			
Public Dividend Capital	135.7	503.5	367.8
Retained Earnings	(226.5)	(225.2)	1.3
Revaluation Reserve	113.8	113.8	0.0
Other reserves	1.2	1.2	0.0
<b>Total taxpayer's equity</b>	<b>24.2</b>	<b>393.3</b>	<b>369.1</b>

### M11 FY20-21 YTD Statement of Financial Position

- Fixed assets increased by £32.7m since March-20. This includes the impact of depreciation and capital expenditure YTD.
- Stock level is £0.5m higher compared to Mar-20.
- Debtors has increased by £17.8m since March 2020.
- The cash position is £113.2m higher than reported at year-end in March-20. This is due to the block contract payment for March-21 received in advance in February-21.
- Cash resources are tightly managed monthly to meet the £3.0m minimum cash target at the end of the year.
- Creditors are £116.4m 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 March-21 fund received in advance.
- Capital creditors are £3.7m higher than March-20.
- Department of Health (DoH) has converted £325m of both capital and revenue loan to PDC on 1st September-20. So in M06 PDC increased to £462m. After conversion, the Trust was left with outstanding loans to DoH of £11.4m for capital as shown on slide 12g.
- Trust received a total capital PDC of £42.7m to Feb-21.

4.3

### 3. YTD Analysis of Cash Movement

Statement of Cash Flow	M11 YTD FY 20-21 Actual £m
<b>Opening Cash balance</b>	<b>3.4</b>
Income and expenditure deficit	1.3
Depreciation	25.2
Interest payable	3.2
PDC dividend	8.9
Other non-cash items	(0.2)
<b>Operating surplus/(deficit)</b>	<b>38.4</b>
Change in stock	(0.5)
Change in debtors	(17.8)
Change in creditors	116.4
Change in provisions	0.4
<b>Net change in working capital</b>	<b>98.5</b>
Capital spend	(57.7)
Capital Creditors	3.7
Capital additions Finance leases	2.5
Interest paid	(4.5)
PDC dividend charge paid	(4.0)
Interest Received	0.0
<b>Net change in investing activities</b>	<b>(60.0)</b>
PDC Capital Received	367.8
DH Loan converted to PDC	(325.0)
Accrued Interest YTD (DH & LEEF)	(0.1)
DH Capital £14.747m Loan repaid	(0.6)
LEEF Loan (Other Loan)	(1.5)
PFI	(1.1)
Finance lease payments	(3.0)
<b>Net change in financing activities</b>	<b>36.4</b>
<b>Cash balance as at 28.02.2021</b>	<b>116.7</b>

#### M11 FY20-21 YTD cash movement

- The cumulative M11 20-21 I&E surplus is £1.3m. (\*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E surplus of £1.3m, depreciation (£25.2m) does not impact cash. The charges for interest payable (£3.2m) and PDC dividend (£8.9m) 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 £38.4m.
- The net change in working capital has increased to £98.5m in February-21. This is due to major movement in creditors of £116.4m, which is due to the deferred income as a result of Covid-19. Stock level has increased by £0.5m in M11 as compared to March-20.
- DH capital loan repayment of £0.6m and LEEF loan payment of £1.4m have been repaid as at December-20.
- Total capital PDC of £42.7m has been received as at Feb-21.
- DH loan amount of £325m was converted to PDC on 01st September 2020.

#### February-21 cash position

- The Trust achieved a cash balance of £116.7m on 28th February-21, £113.7m higher than the £3m minimum cash balance required by NHSI. This is due to March-21 block contracts income received in advance in February-21 receipt of loss on non NHS income and receipt of capital PDC, The Trust expects to end the year with £35m cash balance due to Capital invoices paid in March clearing in April 21

## 4. M11 Capital

The Trust has spent £57.7m of capital at month 11, against a plan of £72.2m (values including COVID). The YTD COVID plan is £8.8m, with COVID cost £8.8m. The YTD variance includes the £15m YTD SWL underspend.

### TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	Budget £000	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M11 YTD budget £000	M11 YTD exp £000	M11 YTD var £000
Infrastructure renewal	24,245	680	706	1,204	449	464	617	378	1,253	351	2,909	1645	10,683	10,656	27
P22	10,000	47	72	560	793	1,322	1,629	165	1,686	974	428	14	9,319	7,690	1,629
Major projects	22,260	864	172	51	578	370	853	912	3,482	2,368	3,817	4633	16,520	18,100	-1,580
IT	7,670	1,736	1,335	(933)	753	425	729	300	810	257	1,804	88	6,730	7,304	-574
Medical equipment	2,218	215	223	(12)	82	58	22	(173)	576	(46)	79	141	1,265	1,165	100
Leases	5,000	913	(894)	477	241	157	1,173	229	68	744	26	510	3,500	3,644	-144
SWLP	835	-	108	(108)	-	-	-	79	218	(17)	14	90	335	384	-49
SWL PDC Underspend	15,000	-	-	-	-	-	-	-	-	-	-	-	15,000	0	15,000
<b>Total</b>	<b>87,228</b>	<b>4,455</b>	<b>1,722</b>	<b>1,239</b>	<b>2,896</b>	<b>2,796</b>	<b>5,023</b>	<b>1,890</b>	<b>8,093</b>	<b>4,631</b>	<b>9,077</b>	<b>7,121</b>	<b>63,352</b>	<b>48,943</b>	<b>14,409</b>
COVID	8,801	1,595	1,441	766	1,976	329	8	51	77	(276)	2,664	131	8,801	8,762	39
<b>Total inc COVID</b>	<b>96,029</b>	<b>6,050</b>	<b>3,163</b>	<b>2,005</b>	<b>4,872</b>	<b>3,125</b>	<b>5,031</b>	<b>1,941</b>	<b>8,170</b>	<b>4,355</b>	<b>11,741</b>	<b>7,252</b>	<b>72,153</b>	<b>57,705</b>	<b>14,448</b>

4.3



Meeting Title:	Trust Board		
Date:	25 March 2021	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:	<p>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 December 2020 and March 2021, highlighting particular developments relating to:</p> <ul style="list-style-type: none"><li>• The political and legislative environment;</li><li>• System and professional regulation</li><li>• Reports from key stakeholders</li></ul> <p>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.</p> <p>Previous reports on emerging political, legislative and regulatory issues were provided to the Board in July 2019, October 2019, February 2020, July 2020, and October 2020.</p>		
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:	N/A	Date	N/A
Appendices:	N/A		



## Horizon Scanning report

Emerging policy, political, legislative and regulatory issues, December 2020 – March 2021

**Stephen Jones**  
Chief Corporate Affairs Officer

25 March 2021



# 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 report is intended to help ensure the Board receives 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.



4.5



## 2. Political and legislative developments



### Integration and Innovation, Department of Health and Social Care White Paper (1 of 2)

- The Department of Health and Social Care published its White paper for NHS reform on 11 February 2021. This follows two separate sets of NHS England and NHS Improvement (NHSE&I) recommendations for legislative reform. The first was published in September 2019 and the second was published in February 2021 following consultation in the period November 2020 to January 2021. The Trust responded to the November 2020 consultation on the strengthening of Integrated Care Systems in January 2021. The Board has previously been briefed on the scope of the proposed reforms set out in the White Paper and the below therefore sets out the key aspects.
- **Statutory ICSs:** Plans to establish statutory Integrated Care Systems, comprised of an ICS NHS Body and a separate ICS Health and Care Partnership – intended to promote integration within the NHS and between NHS and other bodies.
- **Delegation of specialised commissioning:** Plans to give ICSs (through the ICS NHS Body) several of NHS England's current powers over specialised commissioning and primary care.
- **Finances at system level:** NHS England will have the power to set financial allocations and financial objectives at system level. ICSs will have a duty to meet these objectives and deliver financial balance.
- **Position of providers:**
  - NHS Trusts and NHS Foundation Trusts will remain "separate statutory bodies with their functions and duties broadly as they are in current legislation".
  - The ICS NHS Body will not have a power to direct providers, but providers will have a new duty on them to "have regard to" the system financial objectives.
  - Government to have reserve power to set a legally binding capital spending limit (CDEL) on individual named NHS FTs – but not a general power of direction over FTs' capital spending.
  - Providers' relationships with the CQC to be unchanged.
- **Duty to collaborate:** This will apply to all NHS organisations and local authorities.
- **National NHS leadership:** Formally fold what was Monitor and the Trust Development Authority (currently NHS Improvement) into NHS England.

4.5



## 2. Political and legislative developments

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### Integration and Innovation, Department of Health and Social Care White Paper (2 of 2)

- **Patient Choice and Competition:**
  - Proposes to scrap parts of the Health and Social Care Act 2012 and the 2013 Procurement, Patient Choice and Competition Regulations.
  - Replace this with a new "Provider Selection Regime".
  - ICSs, provider collaboratives and individual providers will be required to protect, promote and facilitate patient choice.
  - Proposes to remove the Competition Market Authority's function to review NHS mergers.
- **Healthcare Safety Investigations Branch (HSIB):** Plans for legislation to put the HSIB on a statutory footing so it can continue to reduce risk and improve safety. The Healthcare Safety Investigations Branch already investigates when things go wrong, so that mistakes can be learned from, and this strengthens its legal footing.
- **Education:** Proposes to scrap Local Education and Training Boards (LETBs) to give Health Education England more flexibility to adapt its regional model.
- **Role of Department of Health and Social Care:**
  - New powers to create new Trusts
  - Broadening the scope of potential Ministerial intervention in reconfigurations
  - Enhanced powers of direction over the merged NHS England
  - Powers to transfer functions between DHSC's arms length bodies
- **Social care:** A package of measures to deliver on specific needs in the social care sector. This will improve oversight and accountability in the delivery of services through new assurance and data sharing measures in social care, update the legal framework to enable person-centred models of hospital discharge, and increased powers for Health Secretary to directly make payments to social care providers.
- **Public health and inequalities:** Legislation to support the introduction of new requirements about calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed.

## 2. Political and legislative developments



### Budget 2021 – NHS Funding

- On 3 March 2021, the Chancellor presented the Budget to Parliament, which included the Government's plans for NHS funding over the coming year. The key points relevant to the health sector are set out below:
- The Department of Health and Social Care's (DHSC's) total revenue budget for 2020/21 will be £199.2bn. The rise in its budget compared to the SR forecast is almost entirely accounted for by the additional COVID-19 costs incurred by the NHS. DHSC's 2021/22 revenue budget will then fall by £30bn to £169.1bn. The NHS England revenue budget for 2020/21 (excluding COVID-19 costs) will be £129.7bn: this is £0.2bn lower than forecast. This will then rise to £136.1bn in 2021/22, consistent with the trajectory in the November 2020 SR, and the long-term funding settlement originally announced in 2018. The additional COVID-19 funding for the NHS in England in 2020/21 will be £18bn: this is £8.5bn higher than forecast in November. COVID-19 costs in 2021/22 remain the same as already outlined in the November SR, which announced a £3bn 'NHS recovery package'.
- While DHSC's core capital departmental expenditure limits (CDEL) will be £0.8bn lower than anticipated in the November SR (due to underspend on capital projects), additional COVID-19 capital funding means there has been a £1.8bn uplift to the Department's total capital budget. However, the Budget has not announced any additional headroom for additional COVID-19 capital spend for DHSC in 2021/22.
- In November 2020's spending round, the government announced an additional £3bn for 2021-22 to support the NHS recovery in England from the impacts of COVID-19. This included: around £1bn to begin tackling the elective backlog; and funding to help to address waiting times for mental health services, give more people the mental health support they need, invest in the NHS workforce.
- The chancellor announced a further £1.65bn to continue the rollout of coronavirus vaccines and improve future preparedness. This includes:
  - £733m for the UK Vaccines Taskforce in 2021-22 to purchase successful vaccines.
  - £128m for research and development (R&D) and vaccines manufacturing. Further funding will be allocated from the COVID-19 reserve as needed. The government also provided £3bn in 2020-21 for deployment costs in England.
  - £28m to increase the UK's capacity for vaccine testing and support for clinical trials. This increase the UK's testing capacity and improve the ability to rapidly acquire samples of new variants of COVID-19.
  - £5m upfront investment in clinical-scale mRNA21 vaccine manufacturing to the Centre for Process Innovation in Darlington, on top of £9m funding which has already been provided to develop their mRNA vaccine manufacturing capability and support mRNA process development. The funding will support the creation of a 'library' of mRNA vaccines for COVID-19 variants for possible rapid response deployment to allow the UK to get ahead of potential virus variants. This will enable development of a set of potential COVID-19 vaccine updates, similar to the way annual flu vaccine updates are developed.
  - £22m to fund the expansion of the world's first trial of combining different vaccines as part of a two dose regime.
- Links to Strategic Risk 5 (financial sustainability) and Strategic Risk (capital) on the Board Assurance Framework, both scored at 20.

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## 2. Political and legislative developments



### Digital technology in the NHS

- On 18 March 2021, the Secretary of State for Health and Social Care announced new investment for the NHS frontline to address historic IT problems and ensure the NHS was ready to benefit from digital transformation. He also set out the impact of technology on healthcare providers' ability to respond to Covid-19 and the role digital technology will play in the future, including the potential of technology to help reduce unnecessary hospital appointments and speeding up diagnosis and treatment.
- The Health and Social Care Secretary announced that a second wave of NHSX's Digital Aspirant programme will build on the current position to help digitise hospitals needing additional support. Seven trusts including East Sussex Healthcare NHS Trust, Liverpool Heart and Chest Hospital NHS Foundation Trust, University Hospitals Coventry and Warwickshire NHS Trust, Sussex Community NHS Foundation Trust, West Hertfordshire Hospitals NHS Trust, Gloucestershire Hospitals NHS Foundation Trust, and the Walton Centre NHS Foundation Trust will receive up to £6 million each over the next 3 years to help deliver their digital ambitions – while a further 25 trusts will receive seed funding of £250,000 to develop their digital strategy and business cases. Last year NHSX launched the Digital Aspirant programme, tasked with boosting the procurement, deployment and uptake of technologies. The first wave of the programme helped 27 trusts to boost their digital infrastructure.
- Links to Strategic Risk 3 (access to care) and Strategic Risk 6 (capital funding) on the Board Assurance Framework, both scored at 20.



Mental Health Act 1983

### Reform of the Mental Health Act

- On 13 January 2021, the Secretary of State for Health and Social Care made an Oral Statement to the House of Commons setting out the Government's plans for the reform of the Mental Health Act as set out in a new White Paper.
- The proposed reforms draw on an independent review of the Mental Health Act led by Professor Sir Simon Wessely and set out what needs to change in both law and practice to deliver a modern mental health service. The White Paper sets out four principles for reform:
  - Choice and autonomy: ensuring service users' views and choices are respected
  - Least restriction: ensuring the Act's powers are used in the least restrictive way
  - Therapeutic benefit: ensuring patients are supported to get better so they can be discharged from the Act
  - The person as an individual: ensuring that patients are viewed and treated as individuals.
- The Government will consult on the White Paper, to which it will respond later in 2021. It will then bring forward a new Mental Health Bill.

### 3. System and professional regulation

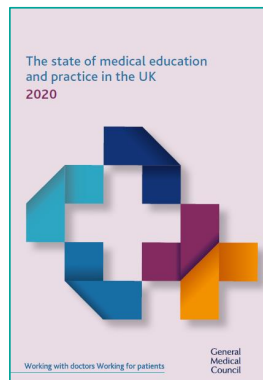


#### New CQC strategy

- The CQC launched a consultation on its new draft strategy on 7 January 2021. The CQC says that its new strategy was the product of more than 10,000 interactions with stakeholders and is intended to set “a bold ambition” for the CQC for the next five years. The CQC says that the Covid-19 pandemic has forced health and social care to think differently, and that it has as a result reconsidered its approach to regulation and accelerated the need for the CQC to change. Its draft strategy was developed to “enable more effective regulation for the future and support services to keep people safe”, and to help ensure that regulation assisted in finding solutions to problems and improve outcomes.
- The draft strategy is based on four themes :
  - 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 from 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 services.
  - 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.
- The consultation closed on 4 March 2021 and the CQC is currently examining responses to the consultation.
- Links to all Strategic Risks on the BAF.

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### 3. System and professional regulation



#### GMC: The State of Medical Education and Practice in the UK 2020

- On 27 November 2020, the General Medical Council (GMC) published its annual report on the State of Medical Education and Practice in the UK. Completed by a representative sample of over 3,600 doctors, the key findings include:
  - The Covid-19 pandemic had had a significant impact on doctors' lives, with 81% experiencing significant changes to their work and 42% being redeployed.
  - Compared with 2019, a greater proportion of doctors reported being able to cope with their workload, and fewer reported being at high risk of burnout, which was seen as being a consequence of the impact of the pandemic on elective work.
  - Most doctors say that despite the impact of the Covid-19 pandemic on healthcare, there have been positive impacts such as teamwork and knowledge and information sharing. Despite the pandemic, 89% of doctors reported that they had experienced at least one positive change during the pandemic.
  - Positive experience, however, were not shared equally by BAME doctors compared with white colleagues. Positive changes to teamworking were reported by 68% of white doctors, but this fell to 55% among BAME doctors. Positive change in the sharing of knowledge and experience across the medical profession was reported by 61% of white doctors compared with 46% of BAME doctors. Positive change in the speed at which workplace changes were made were reported by 57% of white doctors compared with 38% of BAME doctors.
- Links to Strategic Risk 9 on the Board Assurance Framework (workforce), currently scored at 16.



#### Good Practice in Prescribing and Managing Medicines and Devices

- On 18 February 2021, the GMC published new guidance on prescribing, to support doctors who are increasingly seeing patients via remote and virtual consultations. The new guidance sets out the GMC's standards for good practice when prescribing remotely and face-to-face, when prescribing unlicensed medicines, and for when patient care is shared with another doctor. The guidance makes clear that the same standards apply when prescribing remotely as they do when seeing a patient face-to-face. The new guidance also includes new advice to doctors not to prescribe controlled drugs unless they have access to patient records, except in emergencies; stronger advice in relation to information sharing, making it clear that if a patient refuses consent to share information with other relevant health professionals it may be unsafe to prescribe; and alignment with the GMC's guidance on decision-making and consent.
- Links to Strategic Risk 1 on the Board Assurance Framework (patient safety), currently scored at 16.

### 3. System and professional regulation

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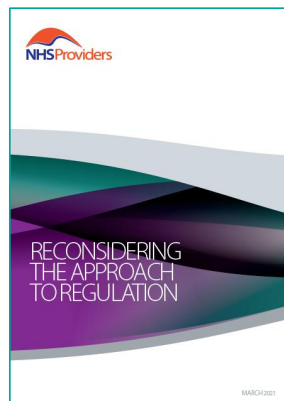


#### Nursing and Midwifery Council launches new fitness to practise resources for employers

- On 2 February 2021, the Nursing and Midwifery Council (NMC) launched a new resource for to support employers of nurses, midwives and nursing associates to take effective action where concerns are raised about someone's practise. The NMC states that its person-centred approach to fitness to practise focuses on promoting a just culture that is free from blame, and encourages health and social care professionals to be open and learn from mistakes. The NMC states that its approach is to encourage people to be honest when things go wrong, so that learning can make services better. In line with this approach, the new resource supports employers to avoid fear and blame when looking at concerns and to help everyone feel confident that they can speak up. It also sets out when it is not appropriate to make referrals to the NMC, and supports employers to act first, with fairness and kindness, so that regulatory involvement only occurs when necessary. The resource includes principles and questions for employers to consider when investigating and managing concerns about staff; practical case scenarios to illustrate when to make a referral; update online resources for completing referrals.
- Links to Strategic Risk 8 (culture) and 9 (workforce) on the Board Assurance Framework, both currently scored at 16.

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## 4. Reports and updates from key stakeholders

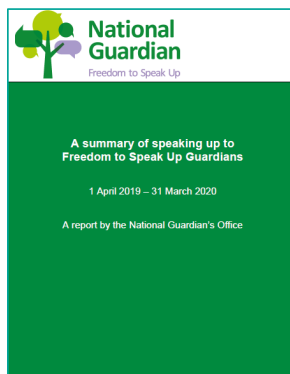


### NHS Providers Report: *Reconsidering the Approach to Regulation*

- On 17 March 2021, NHS Providers published a new report setting out the findings of their annual survey of trusts' views of regulation and the lessons that can be learned from changes in the approach to regulation adopted during the Covid-19 pandemic. The key highlights of the report are set out below:
  - The Covid-19 pandemic placed unprecedented pressures on trusts and their partners in local health and care systems. During the pandemic regulators scaled back their activity to allow frontline organisations to concentrate their full efforts on patient care. This leaner approach enabled health and care organisations to work together with the shared aim of tackling Covid-19. Trusts also told NHS Providers this period accelerated positive change, with an increase in collaborative working and added impetus to deliver care in new and innovative ways.
  - The emergence of new regulatory models from both CQC and NHS England and NHS Improvement provides an opportunity to re-evaluate how regulators interact with providers and ensure a regulatory model which is responsive and proportionate and delivers for patients.
  - Successive surveys of regulation by NHS Providers have highlighted the need for better alignment between national policy aimed to advance collaborative working in systems and regulatory requirements which are currently organisationally focused. Trusts are encouraged by the direction of travel towards more system-focused models of oversight, though some respondents flagged the need for any new role for Integrated Care Systems (ICSs) as a performance manager to be accompanied by a proportionate reduction in oversight from other parts of the system.
  - There is strong support among trusts for many of the core proposals in CQC's new strategy, but trusts were also clear that CQC will need to ensure it avoids duplication with other national bodies, does not overstep its core regulatory role, and continues to work with providers to understand the impact of new approaches.
  - There are clearly lessons for trusts and the regulators to learn from the Covid-19 period. The regulators both implemented welcome changes to their approach at the start of the pandemic, to reduce burden and help trusts to focus on the COVID-19 operational response. While trusts' experiences of regulation during the first wave were largely positive, this was not reflected uniformly across the sector particularly during the second wave, where many trusts felt reporting requirements and other regulatory activity increased disproportionately once again.
  - The importance of sustaining dialogue between providers and the two regulators moving forwards underlies all of this year's findings of the NHS Providers survey.
- Links to all risks on the BAF, and in particular to Strategic Risk 4 (system working), currently scored at 12.



## 4. Reports and updates from key stakeholders



### Freedom to Speak Up Guardian Survey 2020

- The 2020 Freedom to Speak Up Guardian Survey 2020 was published on 11 March 2020. The survey, which is conducted annually, seeks to gain insight into the implementation of the Freedom to Speak Up Guardian role and how this could be improved. The 2020 survey was the fourth such survey to be undertaken by the National Guardian's Office. The survey was conducted by Picker and all of the FTSU Guardians on the NGO's database (591) were asked to participate. The response rate was 48.7%, with 273 FTSU Guardians completing the survey. The key themes to emerge from the 2020 survey are:
  - There has been a significant rise in the number of concerns raised with FTSU Guardians
  - Guardians report that they feel that the FTSU Guardian role is having a positive impact
  - The majority of Guardians felt that their organisation had a positive speaking up culture – but there was a correlation between this and the CQC rating for the organisation, with “outstanding” rated organisations scoring more strongly than “good” or “requires improvement” organisations
  - The existence of barriers to speaking up also had a correlation to CQC rating, with higher rated organisations reported as having fewer barriers to staff raising concerns
  - There was an increase in the number of Guardians with ring-fenced time to focus on their roles as Guardian, but fewer than half of Guardians felt they had enough time to carry out their FTSU Guardian role
  - There remained a gap in how valued Guardians felt by senior managers as compared with middle managers
  - While the majority of Guardians fed back that speaking up training was available in their organisations, many said such training should be mandatory. Where training did exist but was not mandatory, uptake of speaking up training was significantly lower.
  - Detriment treatment for speaking up remained a concern, with fewer than half of Guardians reporting that staff did not suffer detriment for raising concerns.
- Links to Strategic Risk 8 (culture) on the BAF, currently scored at 16.

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# 5. Key appointments

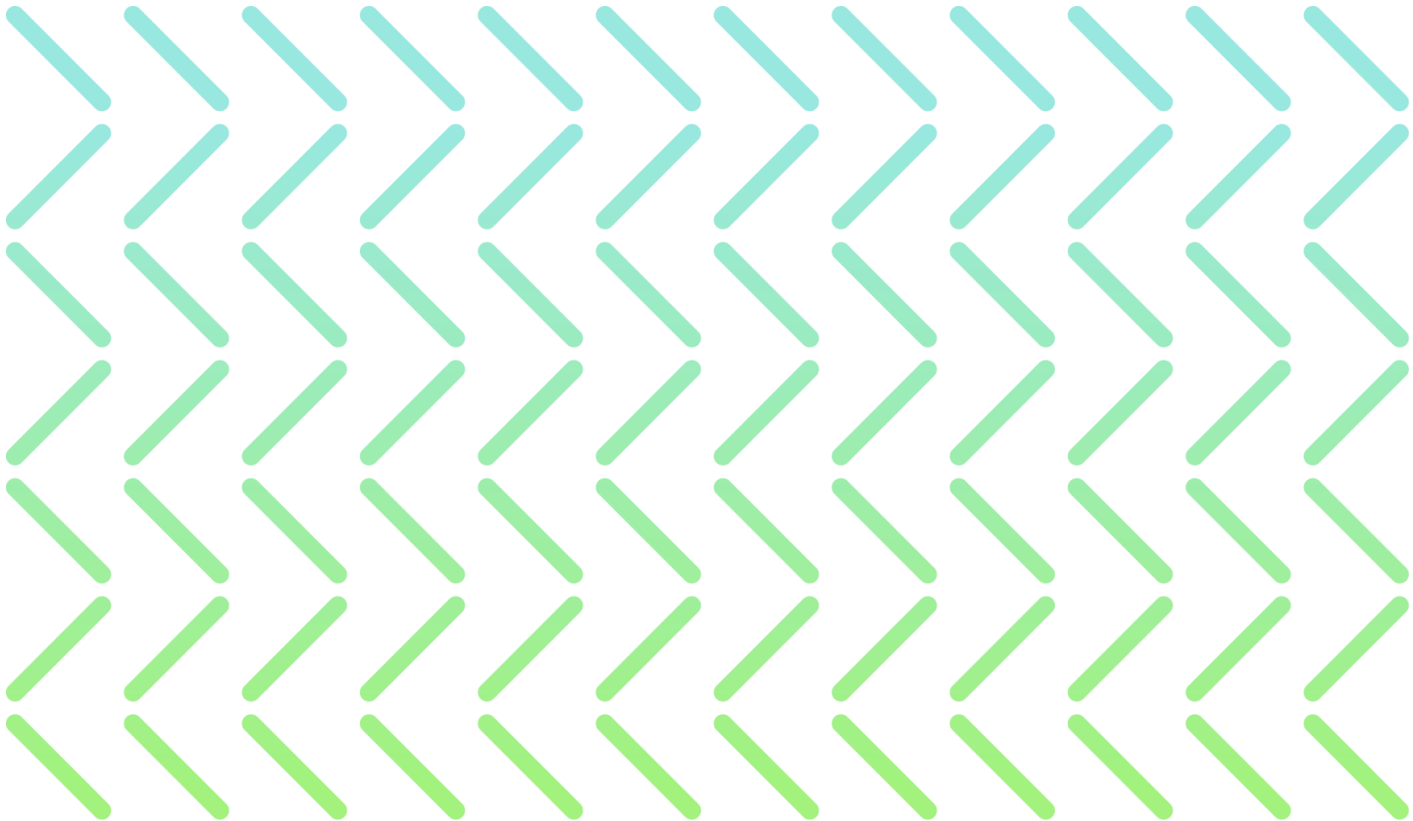


Medicines &  
Healthcare products  
Regulatory Agency

## Appointment of new Chief Executive of the Medicines and Healthcare products Regulatory Agency

- On 23 February 2021, the Department of Health and Social Care announced that Dr June Raine had been appointed as Chief Executive of the Medicines and Healthcare products Regulatory Agency (MHRA), having served in the role on an interim basis since 2019.
- Before becoming interim CEO, Dr Raine was Director of Vigilance and Risk Management of Medicines and has worked for MHRA and its predecessor organisations since 1985. Dr Raine qualified in medicine at the University of Oxford and undertook postgraduate research leading to an MSc in pharmacology. After several general medical posts, she joined the then Medicines Division of the Department of Health, and has worked in several licensing and patient safety areas including widening the Yellow Card Scheme for patients and the public.

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Meeting Title:	Trust Board		
Date:	25 March 2021	Agenda No	4.5.2
Report Title:	Horizon Scanning Q3 & Q4, 2020-21 Report		
Lead Director/ Manager:	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Laura Carberry, Strategy and Partnership Manager Phoebe Foster, Strategy Projects Manager		
Presented for:	Update		
Executive Summary:	<p>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.</p> <p>It should be considered alongside the Corporate Office's Horizon Scanning Q4, 2020-21 Report on National Policy.</p> <p>Areas of interest/ particular relevance to the Trust, include:</p> <ul style="list-style-type: none"><li>• Covid-19</li><li>• Child Death Overview Panel (CDOP) Annual Report;</li><li>• ICS White Paper; and,</li><li>• Clinical Tenders for the Abnormally Invasive Placentas (AIP) Service and the Non-Invasive Prenatal Testing (NIPT) Service from St George's have been successful.</li></ul>		
Recommendation:	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:	Safe; Effective; Responsive; Well Led		
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:	Trust Executive	Date	15 March 2021
Appendices:	N/A		



# Horizon Scanning Report Q3 and Q4, 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 Q4, 2020-21 Report on National Policy.

**Suzanne Marsello**, Chief Strategy Officer

**Laura Carberry**, Strategy and Partnership Manager

**Phoebe Foster**, Strategy Projects Manager

*March 2021*



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# 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	<ul style="list-style-type: none"> <li>Health and Wellbeing Boards in SWL continue to work on Health Inequalities in relation to Covid-19</li> <li>Health and Wellbeing Boards in SWL to work on improving vaccine uptake – community-based approach to tackle mistrust</li> <li>Croydon Hospital identified as the SWL lead provider for the vaccination programme</li> <li>NHS11 30-40 bookable appointments at St George's went live on 1<sup>st</sup> October 2020 to reduce A&amp;E walk-ins – slow uptake at present</li> <li>SWL-wide focus on backlog of diagnosis and elective care</li> </ul> <p><u>Covid-19 &amp; mental health:</u></p> <ul style="list-style-type: none"> <li>Health and Wellbeing Boards in SWL highlighted importance of continued mental health support in relation to Covid-19</li> <li>Investment at St George's to increase capacity for assessments for children who might have ASD (autistic spectrum disorder) across SWL</li> </ul>	<ul style="list-style-type: none"> <li>Executive Management Team</li> <li>Chief Operating Officer</li> <li>Chief Nurse</li> </ul>
Child Death Overview Panel (CDOP) Annual Report	<ul style="list-style-type: none"> <li>For this past year, the Panel had been overseen by the CCG and Local Authority following a change in legislation, and local child deaths fed into the South West London CDOP comprising six boroughs (Kingston, Richmond, Wandsworth, Merton, Sutton and Croydon)               <ul style="list-style-type: none"> <li>2017/18 – 21 deaths</li> <li>2018/19 – 25 deaths</li> <li>2019/20 – 13 deaths (3 in Kingston, 10 in Richmond; 3 unexpected)</li> </ul> </li> <li>The 3 unexpected child deaths were discussed at Joint Agency Response (JAR) meetings, FKA Rapid Response meetings</li> <li>Key themes: neonatal death, safer sleeping, communication, suicide and self-harm, asthma and allergies, and ethnicity</li> <li>Children with underlying health conditions were likely to have poorer outcomes as a result of Covid-19</li> <li>The Local Learning Review (LLR) subgroup and CCG are working with “feeder hospitals” to coordinate local child death processes, including St George's</li> </ul>	<ul style="list-style-type: none"> <li>Executive Management Team</li> <li>Chief Nurse</li> </ul>
Integrated Care System (ICS) White Paper	<ul style="list-style-type: none"> <li>The CCG Governing body noted the Government's white paper on integration, and that the paper supports the key principles established in the South West London Health and Care Partnership.</li> <li>Sutton health and wellbeing board supported the general policy direction; welcomed the high profile of collaboration; and stressed importance of 'place'; agreeing each system should have flexibility to develop arrangements that work best for each place</li> </ul>	<ul style="list-style-type: none"> <li>Executive Management Team</li> <li>Chief Finance Officer</li> </ul>
Clinical Tenders	<ul style="list-style-type: none"> <li>Clinical Tenders for the Abnormally Invasive Placentas (AIP) Service and the Non-Invasive Prenatal Testing (NIPT) Service from St George's have been successful.</li> </ul>	<ul style="list-style-type: none"> <li>Executive Management Team</li> <li>Chief Finance Officer</li> </ul>

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# SOUTH WEST LONDON CCG: Q4, 2020- 21

## GOVERNING BODY MEETING PAPERS SUMMARY

Bi-monthly Meetings

4.5

### CCG Governing Body Meeting: 3 March 2021

The CCG Governing Body has received the following reports.

#### Chair & Accountable Officer reports key points:

- ICS White Paper: government published white paper on 11<sup>th</sup> February 2021 outlining proposals to bring NHS and social care closer together. The paper supports the key principles established in the South West London Health and Care Partnership.
- System Pressures update: combination of winter pressures, and patients whose condition is now urgent as a result of delaying accessing care. SWL has managed to maintain urgent planned and cancer surgery as well as an impressive response in primary and community care. Plans are in place to support staff including input from local mental health providers.
- Covid update (vaccination): 1.7 million vaccines will need to be administered in SWL, Croydon Hospital identified as the SWL lead provider for the programme. Now modelling for phase 1b – that everyone in cohorts 5-9 are offered their first dose by end of April 2021, alongside administering second doses to those who received their first dose in December 2020. The biggest challenge will be ramping up Vaccination Centres and determining the best approach for Hospital Hub sites

#### Committee Updates and reports key points:

- [SWL CCG Audit Committee](#)
- [SWL CCG Finance Committee](#)
  - Exceptional expenditure requests for Covid-19 were ratified for extending primary care facilities in each borough
  - The contract with Totally PLC (Vocare and SELOC) for NHS111 and Out of Hours has been extended until September 2021

- [Month 10 Finance Report](#)
  - Have requested a further £10.4m of funding for the hospital discharge programme; CCG on plan to achieve its control deficit (£0.2m)
  - The £0.5m of top up funding from month 6 has now been confirmed
- [Primary Care Commissioning Committee](#)
  - GP access survey results - SWL CCG response rate 27% (national response rate: 31.7%). Overall, achieved well for all 8 questions in comparison to other London CCGs.
- [Quality and Performance Oversight Committee](#)
- [South West London Performance Highlight Report 20/21 Month 9 – December](#)
  - Headline messages - Urgent and Emergency Care; Planned Care; Diagnostics Update; Cancer Access; and Mental Health

### Richmond & Kingston Improving Access to Psychological Therapies (IAPT) contract proposals

- Following the notification from East London Foundation Trust (ELFT) stating they wish to cease providing services within Richmond under the existing arrangements from April 2021 the Governing Body were asked to:
  - Agree the commissioning approach of varying the South West London & St George's Mental Health NHS Trust (SWLSTG) main contract to include the Richmond IAPT and Primary Care Liaison (PCL), with the provision of ELFT being sub-contracted by SWLSTG for 2021/22 to allow for a year-long transition of service
  - Agree the Single Tender Waiver approach for a 1-year contract extension with Kingston iCope, primary care mental health and substance misuse services with Camden and Islington NHS FoundationTrust,

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Horizon Scanning Report Q4, 2020- 21  
St George's University Hospitals NHS Foundation Trust



# SOUTH WEST LONDON CCG: Q4, 2020- 21

## GOVERNING BODY MEETING PAPERS SUMMARY

Bi-monthly Meetings

4.5

### Update on Kingston & Richmond community provider collaboration

- In November 2020 SWL CCG Governing body supported the award of contract for a Lead Provider model for a single community service offer across Kingston & Richmond (K&R) supported by a single contract to be delivered from 1<sup>st</sup> April 2021.
- Key next steps (March 2021): Complete Service Specification alignment and standardisation; monitor action plan to address areas identified through due diligence; agree contract monitoring and management group for new contract; agreed contract for signing prior to 1<sup>st</sup> April 2021

### Information Governance (IG) annual report

- Key issues: note the changes to information sharing brought about by the Control of Patient Information notice issued on 17<sup>th</sup> March 2020; note the creation of the SWL Covid-19 IG Strategy Group; note the progress made against compliance with statutory and nationally mandated information governance standards
- Recommendation that the Governing Body notes the actions and progress made within the CCG and the wider SWL footprint over the past 12 months

Board Papers can be found at: <https://swlondonccg.nhs.uk/governing-body-meetings/march-2021-governing-body-meeting/>

**DONM: 5 May 2021**

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Horizon Scanning Report Q4, 2020- 21  
St George's University Hospitals NHS Foundation Trust





# HEALTH AND WELLBEING BOARDS: Q4, 2020- 21

## BOARD PAPERS SUMMARY

Quarterly Meetings

4.5

### Croydon HWB: 20 January 2021

Discussion focused on the [Healthwatch Annual Report 2019/20](#), primarily on plans for 2020/21:

- Supporting improvements at Croydon University hospital following CQC inspections
- Improve access to mental health services access
- Continuing conversation regarding One Croydon and Integrated Care Networks implementation
- Social care – enable resident insight to inform decision-making. The Board agreed Healthwatch would carry out a number of commitments including a second T-level student's project in the first quarter of 2020/21 following the success of the survey on young people's mental health needs devised by 6 T-level students from Croydon College in 2019/20
- Responding to Covid-19 – including working with Healthwatches and the NHS across SWL to ensure local views are considered regarding NHS recovery programme proposals, and keeping informed about the impact of Covid-19 on BAME and learning disability communities

Other key points discussed:

- BME mental health and well-being centre (Whitgift Centre) opened in February 2020
- One Croydon Alliance, Carers Information Centre, and Healthwatch Croydon plan to organise an event with carers to further discuss reaching isolated and vulnerable groups, support in schools, mental health hubs, and better support for disabled people
- Further work dedicated to support street homeless and encourage training to support into employment
- Focus on improving signage, patient letters, mobility access at Croydon University Hospital following patient views, as well as focus on improving GP capacity to reduce A&E attendance
- Looking to build strong relationships beyond health and social care services (e.g. schools) to support Long Term Plan and Integrated Care Networks model with a focus on community mapping and hard-to-reach groups.

Board Papers can be found at:

<https://democracy.croydon.gov.uk/ieListDocuments.aspx?CId=172&MId=2268&Ver=4>

**DONM: 31 March 2021**

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### Kingston HWB: 17 November 2020 and 25 February 2021 (cancelled)

Discussion focused on the [Health Partners Updates Report](#), primarily on Covid-19:

- Local test and trace commenced 5<sup>th</sup> November 2020
- Kingston Outpatients Department had continued to provide 98% of usual business
- Arrangements confirmed for hospital staff testing, sickness, and relocation of recovered patients
- Primary care performance at 110% compared to previous year – includes enhanced flu vaccination programme
- Policies regarding visiting elderly in care homes/hospitals is a work in progress
- Continued importance of mental health support, including young people's wellbeing (Healthwatch report)

There was discussion on [Child Death Overview Panel \(CDOP\) Annual Report](#):

- 2019/20 deaths: 13 (3 in Kingston, 10 in Richmond). 3 were unexpected child deaths and were discussed at Joint Agency Response (JAR) meetings, FKA Rapid Response meetings
- The Local Learning Review (LLR) subgroup and CCG are working with "feeder hospitals" to coordinate local child death processes, namely West Middlesex University Hospital and St George's
- Pan-London work to streamline coordination of child deaths is ongoing
- Children with underlying health conditions were likely to have poorer outcomes as a result of Covid-19
- Support for regular child safety campaigns and leafleting

Board Papers can be found at:

<https://moderngov.kingston.gov.uk/ieListDocuments.aspx?CId=488&MId=8966&Ver=4>

**DONM: 16 March 2021**

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# HEALTH AND WELLBEING BOARDS: Q4, 2020- 21

## BOARD PAPERS SUMMARY

Quarterly Meetings

4.5

### Merton HWB: 24 November 2020 and 26 January 2021

There was discussion on Covid-19:

- Additional staff being trained to administer vaccines, and ongoing effort to encourage flu vaccine uptake
- Continued rise in infections in schools – some schools may need to access support from LCRC (London Coronavirus Response Cell)
- Mental health referrals (primary and acute) were higher compared to last year

There was an update on Merton Carers' Strategy 2021-26:

- Carer Strategy Multi-Agency Implementation Board (carers to play an important role) to oversee the Carers' Strategy with required task groups
- Implementation Plan outlines 11 key priority outcomes, including promoting digital equality and friendly work environments
- Health and Wellbeing Board Members' invited to Carers' Strategy Multi-Agency Implementation Board
- Strategy captures diversity of carers' roles

There was an update on Merton CAMHS Strategy 2020-23:

- Discussion on iThrive concept – build on strength in communities, focusing on need rather than diagnosis
- The Board acknowledged challenges regrading access to service and emphasised importance of actively listening to children and young people in day-to-day provision
- Discussion on opportunities to extend current social prescribing activity to children and young people (innovative digital engagement)

Board Papers can be found at:

<https://moderngov.kingston.gov.uk/ieListDocuments.aspx?CId=488&MId=8966&Ver=4>

**DONM: 23 March 2021**

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# HEALTH AND WELLBEING BOARDS: Q4, 2020- 21

## BOARD PAPERS SUMMARY

Quarterly Meetings

4.5

### Richmond HWB: 26 November and 10 December 2020 and 8 February 2021

- Update on Adult health and social care (ASC) including discussion on published detailed winter plan, with ASC to lead review of hospital discharges
- Update on Public Health including discussion on local contact test and trace & lateral flow testing, and ongoing work to support schools and universities
- Update on Achieving for Children (AfC) including discussion on the increase in cases where social work intervention was necessary/ domestic violence/ family breakdown leading to increased pressure on social workers; increase in number of Covid-19 cases in schools; and winter grant fund & voluntary sector partners to support children on free school meals
- Update on Voluntary sector including discussion on particular pressure on unpaid carers for people with dementia; mental health and high levels of anxiety and depression and increased waiting lists for counselling services; and residents without digital technology suffered with reduction in face-to-face contact
- Update on Child Deaths Overview Panel Report 2019/20: 13 deaths, 10 in Richmond
- Update on Richmond Joint Strategic Needs Assessment (JSNA) including modifications to JSNA process due to Covid-19; JSNA strategic group moved delivery production forward by one quarter; most sections had working draft completed – HWB to produce final draft by latter part of 2021

There was discussion on CCG updates, key points:

- Campaign to encourage residents to utilise NHS 111 rather than attend A&E
- Focus on flu vaccinations, covid-19 vaccination and digital mental health services
- Confidence bid for transformative funding to support mental health was successful
- Patient demand in GP services 10% higher than previous year; all GPs managed to stay open
- Face-to-face GP consultation had continued but patient numbers had increased – to be reflected in feedback to Healthwatch of patient experience

There was discussion on Healthwatch updates, key points:

- Mid-year review to be published shortly, dentistry review published
- 30,000 people had accessed Healthwatch website for information
- Covid vaccine: software enabled interrogation on data on deprivation and ethnicity to identify highest priority patients for Covid-19 vaccine; history of anti-vaccination arising in Richmond following MMR vaccine a few years ago; Board reviewing sites for vaccination programme; priority for care home staff who moved between homes

There was discussion on SWL vision focus points:

- Start well: mental health in children; support for children with Special Educational Needs and Disabilities (SEND); reduce childhood obesity
- Live well: reducing health inequalities for those with learning difficulties, mental health conditions and long-term conditions including improvement on update of annual health checks; social prescribing – 15 link workers recruited and Richmond active fund grant launched
- Age well: ongoing work on hospital discharge with acute Trusts; care homes; support for unpaid carers – HWB to draft action plan on deliverables; 3 council day centres reopened in August; Front Door hub pilot launched in October; dementia – council champion identified; obesity; HWB supportive of systems approach re social prescribing

Board Papers can be found at:

<https://cabnet.richmond.gov.uk/ieListDocuments.aspx?CId=643&MId=4937&Ver=4>

**DONM: 18 March 2021**

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# HEALTH AND WELLBEING BOARDS: Q4, 2020- 21

## BOARD PAPERS SUMMARY

Quarterly Meetings

4.5

### Sutton HWB: 25 January 2021

- Update on Sutton Health and Care Plan with a focus on programmes during Covid-19 and the ongoing recovery phase; how partners have adapted; the development of new work streams; and the forward plan for the next 12 months.
- Update on the Children's Review including discussion on endorsement of the four pilot projects for 2021 (Being a parent, School readiness, Outreach & engagement, and Complex needs) Also resolved findings and recommendations from the Children's Commissioning Review.
- Update on Covid-19 including discussion on need for messaging around vaccine mistrust; ongoing development of additional vaccine centres in addition to St Helier Hospital and Nonsuch Manor; and social impact with a focus on health inequalities along with universal credit claims, mental health, and long Covid-19.
- Update on Better Care Fund including discussion on hospital discharge service (including the Discharge to Assess model) introduced in Sutton.
- Update on Infection Control Fund including discussion on allocation £2.3 million to be paid in two instalments with a focus on care homes and CQC-regulated community care providers to increase infection control measures and prevent non-elective admissions in Sutton.
- Update on Integrated Care Systems Consultation including discussion on Sutton's response and SWL's response to NHSE/I document which supports general policy direction; welcomes high profile of collaboration; and stresses importance of 'place'; agreeing each system should have flexibility to develop arrangements that work best for each place.
- Update on Hidden Disability Sunflower Scheme including agreement to promote scheme within other organisations represented on the Board.

Board Papers can be found at:

<https://moderngov.sutton.gov.uk/ieListDocuments.aspx?CId=471&MId=5435&Ver=4>

**DONM: 22 March 2021**

### Wandsworth HWB: 19 November 2020 and 11 February 2021

There was discussion on Partner updates relative to Covid-19:

- Focus on recovery and response of partners
- Vaccination programme
- Significant delays in CAMHS assessments, average wait increased to 52 weeks
- Investment at St George's to increase capacity for assessments for children who might have ASD (autistic spectrum disorder) across SWL
- Access to dental services, in particular for vulnerable children
- NHS11 30-40 bookable appointments at St George's went live on 1<sup>st</sup> October 2020 to reduce A&E walk-ins – slow uptake at present
- SWL-wide focus on backlog of diagnosis and elective care
- Health Inequalities e.g. Roehampton North West having 3x as many Covid-19 patients
- Links to resources on mental health and wellbeing partners to be distributed with Members of the Board, including translations of information

Other key points discussed:

- Wandsworth Learning Disability Strategy – NHSE target for annual health checks 75%, in September Wandsworth's performance was 58%. Vaccination roll-out had not explicitly included people with a learning disability – issue raised by multiple charities.
- Social Isolation Advisor – data suggested some groups are disproportionately at risk of loneliness, elderly people less lonely than the 45-60 age group, focus on this cohort. However, query raised on whether survey was fully representative of Wandsworth residents
- Better Care Fund (BCF) 2020-21 – Board decided Assistant Director of Health and Care Integration would arrange a briefing on the different budget areas of the BCF and to give a background on the programme to Members of the Board

Board Papers can be found at:

<https://democracy.wandsworth.gov.uk/ieListDocuments.aspx?CId=508&MId=6596&Ver=4>

**DONM: 24 June 2021**

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# CURRENT OPPORTUNITIES FOR ST GEORGE'S

## CLINICAL TENDERS

### CWDT Division

#### Abnormally Invasive Placenta (AIP) Services

Following attendance at an Evaluation Panel led by NHSE/I Specialised Commissioning in October 2020, it has been confirmed that the Comprehensive Proposal from St George's University Hospitals NHS Trust has been successful.

The Evaluation Panel agreed that St George's University Hospitals NHS Trust should continue to deliver its established AIP Service.

Next Steps include alignment with current and future flows/ footprints geographically within the Local Maternity Network/ System (LMS) and determining clear and cohesive Clinical Pathways and Communication Plans for Service Users/ Stakeholders– in collaboration with the South West London LMS.

The Clinical and Contracting Teams at St George's are due to discuss a formal Implementation Plan with NHSE/I Specialised Commissioning in March 2021 (Date, TBC).

#### Genomic Medicines Alliance Services (GMSA) - Joint Bid St George's and Guys and St Thomas' (GSTT)

NHSE have confirmed arrangements for the South East England GMSA, with SGUH and GSTT leading it in partnership.

#### Non-Invasive Prenatal Testing (NIPT) Services

Following attendance at an Evaluation Panel led by Public Health England (PHE) in December 2020, it has been confirmed that the Expression of Interest (EoI) from the Genomic Laboratory Hub (GLH) in partnership with the SAFE (St George's Antenatal Fetal Evaluation) Test Laboratory at St George's University Hospitals NHS Trust has

been successful.

The St George's Antenatal Fetal Evaluation (SAFE) Test services was developed in preparation to undertake nationally commissioned Non-Invasive Prenatal Testing (NIPT) activity.

We are 1 of 3 GLHs awarded the Contract in England for NIPT Services- Central and South GLH (led by Birmingham Women's and Children's NHS Foundation Trust), North Thames GLH (led by Great Ormond Street Hospital NHS Foundation Trust) and the South East GLH (led by Guy's and St Thomas' NHS Foundation Trust and including St George's); there are 7 GLHs nationally.

Alignment to the established Fetal Medicine and Neonatal Networks and Pathways and the allocation of areas is being discussed by the 3 GLH's. NHSE and PHE (TBC). The arrangements re the Contract and the details re the Service Specification are being discussed and finalised by the GLH, PHE and St George's.

### MEDCARD Division

#### Severe Intestinal Failure Services (SIF)- Integrated Centres

The joint bid for South East (East) (Kent, Surrey, Sussex) with St Mark's was not successful. Following a meeting on 25<sup>th</sup> February 2021, NHSE has proposed St George's to submit a development plan for consideration. The Trust will work with St Mark's to prepare the plan in the coming weeks, to be submitted by Q1 21/22.

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